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VIOLATION of the RIGHTS of the CHILD during pregnancy, birth and in the first days of life

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Introduction

Pregnancy and birth are the most natural things in the world. Soon eight billion people will have been born. However, notwithstanding this large number, expecting a child and giving birth remains a totally unique personal experience. They represent a fundamental transformation of a woman's life and also of the child. The life of a father will also change if he gets involved in what happens. The circumstances in any individual case can be quite unusual and complex. The physiology of pregnancy and birth is in itself a huge field of study. The interaction between the child and the maternal organism still requires more research.

Mental processes undoubtedly play an essential role in this interaction. Here also, the unique intimate connection between mother and child leads to shared mental experiences, which have received far too little attention so far. The well-being of the mother is an essential prerequisite for a fulfilled pregnancy and a good birth for both mother and child. On the other hand, if a woman is emotionally hurt, especially if she suffers a trauma during childbirth, this can have a lifelong negative impact upon the child. Ultimately, it should not be forgotten that for many people a birth can also include spiritual experiences, which should be respected.

All of this takes place within communities which forget the fact that the birth of a child should also be a joyful social event. However, ignorance, false expectations and a hightech healthcare system have made the conditions required for a good pregnancy and a natural birth highly problematic. The fundamental rights of women and children have been and are being called into question.

Because the following remarks deal primarily with the violations of these rights and because of the complexity of pregnancy and childbirth, it cannot be avoided that some aspects will be pushed into the background. However, as a closer look will show, the situation has become so dramatic that this risk has been deliberately taken.

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Foreword by the editors

The violation of rights around birthing demand more attention. Parents, midwives and birth physicians criticise what is happening around births in hospitals. These voices are becoming increasingly audible in recent years.

What is to be made of the fact that women experience their hospital births as bad and therefore forego having further children in order not to have to expose themselves again to a birhing situation? What does it tell us when women are looking for alternative places to give birth to their child which have an atmosphere that appears to be more appropriate for this unique moment in the life of the child, the mother and the father? What impact does it have on us as a society when a high proportion of women and men speak of experiencing violence in connection with birthing? How does such a beginning affect these children now and in their future life? Obstetric medicine is increasingly coming under criticism. The situation today is characterised by the closure of numerous maternity wards and progressive centralisation. Pregnant women have to travel long distances and may have to stay in boarding houses separated from their families – while waiting for the birth of their child. Parents are being rejected because of overcrowded delivery rooms. They have to reorganise during the birth and experience having to share a midwife with three or even more other women. The external circumstances of hospital births have worsened considerably. Similarly, the individual care of pregnant women has changed noticeably over the past decades: Women go to a doctor as soon as they are pregnant. This changes their view of pregnancy. With the maternity pass, a medical perspective comes to the fore. The women are shown, which risks and dangers are possible. 70-80 % are affected by being classified and treated as high-risk pregnant women.

Doctors are socially recognised experts. That is why most pregnant women in this new phase of life brust in the guidancethey are given. They want to do everything right and not miss out on anything that could benefit their child. Joyful anticipation, self-confidence and connection to their own child is replaced by prevention that seeks orientation through medical examinations and their results. A lack of inner security leads to a dependence on medical assessments. Concern and insecurity determine the pregnancy and lead to 98% of women seeking safety in clinics and trusting medicines and apparatuses that were originally developed for pathological birth processes. Very few women are aware that the conventional birth management in clinics follows health policy and economic premises. The individuality and uniqueness of each birth process is not taken into account, nor is the basic child-bearing capacity of most women. The "Programmed Birth" which was introduced 45 years ago due to overcrowded hospitals, provided for acceleration and standardisation of all the birthing procedures. This policy became routine and now is the standard for all obstetric medicine. In the following years there was a focus on possible pathological developments. What is reasonable in an emergency has become routine and disturbs or prevents the natural course of birth, especially when these interventions occur without medical indication. Thus, over time, the empirical knowledge about physiological birthing is being lost. Healthy mothers and their children are being injured, physically and mentally, by medical and technical interventions. From the very first moment of their existence, children manage their extraordinary path of development - physically, mentally and socially. They are recognised by the parents as their child as soon as they become pregnant. Long before they are born, they are conscious and communicative people, who perceive in the womb what is happening on the outside. Mother and child live in close physical and hormonal

communion during pregnancy. The birth takes place under mutual hormonal influence. This must be respected and observed as a prerequisite for physiological births. What the mother experiences, the child also feels. In the same way, what happens to the child affects the mother. To protect the child, one must protect the mother. With this work we want to address those responsible in the health care system, in politics, in the public and also future parents, in order to make them aware of grievances and undesirable developments.

A first positive development in German-speaking countries is the "S3 Guideline Vaginal Birth at Term"(2021). After decades, high-quality evidence-based recommendations have been developed, which will determine the training and further education of obstetric personnel in the future. How quickly the new guideline will be implemented remains to be seen given economic pressures and considerable shortages of midwives in hospitals.
The present work makes us aware of the urgency to recognise and question high-consequence and high-risk routine treatments at mother and child during birth.

The present study highlights a number of consequential and routine treatments in hospital births that carry risks.

In parts I and II of her present study Iris Eichholz uses her medical expertise and experience to describe primarily how routine interventions around birth affect children. She distinguishes between direct and indirect interventions and identifies risks, which are – partly deliberately – accepted. In part III she dedicates her work to health policy structures, which have a direct negative impact on the work of midwives - to the detriment of mother and child. The insight of recent decades that a child is a competent, active human being is recognised in the UN Convention on the Rights of the Child. However, this is still not reflected in the awareness of the public and of those responsible in the health sector. Therefore Dr. Reinald Eichholz establishes and deepens the human rights context of pregnancy and birth from page 39 onwards. Every reform is preceded by the recognition and acceptance of grievances. Therefore we hope that we can reach many people with this present work.

Irene Behrmann, Anna Groß-Alpers
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I. Violation of the rights of the child caused by procedures performed directly upon the child

1. At the beginning of pregnancy

1.1 Determining a Date of Delivery (EDD)
Calculation of the EDD is usually the first thing that happens when a pregnant woman enters professional care. Instead of a probable period of birth, the pregnant woman is given a specific date, which is calculated according to defined criteria. All further support is determined by this date.

Pregnancy and birth are natural processes of growth and development, which are subject to individual fluctuations. In fact, the maturation period of human children up until birth can vary by about 4 weeks (2).

This fact is ignored by the rigid method of calculation, which assume that pregancy and birth can be evaluated and managed like any process of manufacture.

Most of the interventions and manipulations, which are carried out during the last trimester of pregnancy, are based upon the calculated date (EDD), even though this date does not adequately correlate with the development of the child in the womb. Signals sent by the child determine the course of birth in a decisive manner. This applies not only to the onset of birth but also to all other stages of the birth process (see below).

The determination of the EDD right at the beginning of the pregnancy sets a course, which not only has a massive impact upon the whole of what follows but also influences the basic attitude of the woman towards the pregnancy and birth. She is pushed in one specific direction: as will be shown below, she will be expected to undergo the examinations, stipulated in the maternity pass. She will gradually be subjected to more and more external supervision.

Not only are specific medical procedures based upon this questionable date but the pregnant woman's freedom of choice concerning the place of birth can be drastically restricted.

If a birth outside the clinic is desired but the EDD is exceeded by 3 days, the pregnant woman is forced to visit a specialist for gynaecology and obstetrics. Under the pressure of their liability, the latter decides whether an extra-clinical birth can be approved or not.

If the woman decides against the doctor’s advice and gives birth outside the clinic, the midwife loses her insurance cover and the woman loses the right to reimbursement of costs by her health insurance.

This regulation is a serious move towards restricting women's freedom of choice and undermining midwives' professional competence. As a result, extra-clinical obstetrics is becoming increasingly uncommon.

The strict determination of an EDD violates the right of the woman to self-determination and disregards the legal status of the child, its individual developmental needs and the natural beginning of birth as an expression of the child’s unique personality.

2. Before the start of labour or during birth

2.1 Amniotomy
Amniotomy is the deliberate opening of the amniotic sac with the finger or a pointed hook by a doctor or midwife.

The two membranes that form the amniotic sac are made up exclusively of foetal tissue. They envelop the child during the entire pregnancy. The amniotic fluid it contains protects the child from mechanical impacts and allows the child to move. By swallowing amniotic fluid and by early breathing movements, the child‘s organs prepare to function.

An intact amnion protects the child from any germs within the vagina and thus from potential infection. The routine opening of this well-protected space leads to unnecessary risks for the child.

Possible reasons for opening the amniotic sac:

Before birth:

– The EDD has been reached or exceeded and it has been decided to induce the onset of contractions.

During birth:

– In the opinion of the nursing staff, the birth is "too slow" and should be accelerated. The amniotomy is presumed to strengthen the contractions and to increase the pressure of the baby's head within the mother's pelvis.

– A micro blood test (MBU) is required or a scalp electrode (FSE see below) has to be applied.

– Amniotomy can also simply be an unquestioned habit of an obstetrician without any medical indication.

Can a birth be "too slow"?

Occasionally the mother and/or child may have problems, which can delay the birth and lead to danger. A midwife, who continuously supervises the birth, should recognize this situation and the need for appropriate and well-timed action. Because this sort of supervision by a midwife is not generally practised in the day-to-day running of a clinic, it has been all but impossible – for decades now – to observe births in hospital, in which medical intervention does not take place.

Expectations of how long a particular phase of birth may last are determined by observation of births in which the process has already been influenced by, for example, amniotomy, the use of medication to control contractions and the use of force. As a result, an understanding of the physiology of a natural birth, its variability and complexity, is being increasingly lost.

The risks incurred by amniotomy:

– Due to the destruction of the natural barrier between the amniotic cavity and the outside world, the risk of infection of the child, caused by bacteria ascending into the womb, is increased. In the case of frequent, routine vaginal examinations, for which there is often no medical indication, bacteria are transported to the child on the glove.

This increases the risk of infection. This danger has then got to be counteracted by administering an antibiotic as prophylaxis to the mother. The consequences of this medication for the child's microbiome (3, 4) have not been sufficiently studied.

– Provocation of an abnormal birthing position: The sudden change in pressure, caused by amniotomy, can provoke a change in the position of the child's head, which can lead to a standstill in the process of birth.

– Provocation of a pathology in CTG: An increase in pressure on the child's head can

lead to a change in the child's heart rhythm, which may then lead to further intervention. (5)

– Prolapse of the umbilical cord: When the child's head is not yet firmly in the maternal pelvis at the time of the amniotomy, the umbilical cord can sometimes slip in front of the head as the amniotic fluid drains out. Then, the only way to save the child is an immediate emergency Caesarian section. (6)

– Insertio-velamentosa bleeding: In rare cases, vessels of the umbilical cord run across the amnion, instead of directly into the placenta. These can be damaged by an amniotomy and lead to a dangerous loss of blood in the child.

– Premature detachment of the placenta: The sudden and copious discharge of amniotic fluid (together with a reduction in intrauterine volume), caused by an amniotomy, can bring about shear forces, which then lead to a partial or complete detachment of the placenta. For the woman, there is a risk of massive loss of blood. The child may suffer a life-threatening interruption in its oxygen supply. The only possible therapy is immediate delivery, usually by emergency C-section.

The last three complications mentioned are rare. However, routine amniotomy without medical indication knowingly takes the risk. Routine amniotomy without medical indication represents an avoidable risk to the child's health.

2.2 Micro blood analysis (MBA)

A MBA is carried out when the staff are not sure about the CTG (cardiotocogram, "heart tone contraction recorder") (7) and when it is necessary to rule out a critical condition in the child (impending or existing oxygen deficiency). In order to do this, the amniotic sac must first be opened while the mother is supine. Then, an amnioscope is inserted into the vagina and the scalp of the child is scratched with a pointed lancette. (8) A sample of blood is taken and within a few minutes, the pH value is ascertained. Depending on the result, decisions are made about further procedures. (9) This intervention is justified by the argument that the aim is to avoid unnecessary Caesarean sections caused by misinterpretations of the CTG. (10)

The condition of the child after birth (the 'infant outcome') is not affected by whether a CTG is written or whether the heartbeat is simply auscultated intermittently (heartrate determined at certain set intervals). Regular and standardized auscultation is considered equally appropriate and recommended to ensure the safety of the child. One has to ask, however, how often an indication to the MBU is actually based on a pathology. A CTG makes deviations from what is considered normal heart rate patterns visible, which would not be noticed at all during auscultation. The CTG values lead to a significant increase in the rate of medical intervention with the corresponding risks. With CTG – as a routine treatment for healthy woman - a lot more can be seen and heard – but without proven benefits for the child.

There is a need for much better staffing of the delivery rooms because auscultation, which is less invasive, requires more intensive care than is required by the technical control provided by continuous CTG. The trend towards continuous monitoring is also due to the tremendous forensic pressure, which rests upon obstetric departments. This leads to the desire for security through flawless records, suitable to be used as evidence in the rare case of damage to the child. In so doing, it is completely overlooked that obtaining records by permanent CTG is in itself a factor that could endanger the child.

This example shows how staff shortages result in an increased risk of injury to the child. As a result, not only the structural problems posed by clinical institutions (see below) but also the forensic requirements for documentation need to be scrutinized in the light of the rights of the child. A complete record in order to safeguard the staff is not reasonable. However, every woman giving birth should be comprehensively supported by a midwife. In each individual case, she can assess the possible risks for the child and decide upon the most appropriate form of monitoring.

2.3 Foetal scalp electrode (FSE)

If the child's heart sounds are difficult to detect by CTG through the mother's abdominal wall, a FSE is often inserted. In the process, two sharp, bent wires are screwed into the scalp of the child. This requires experience on the part of the obstetrician or midwife so that the FSE is placed in the correct position on the head (11). Together with the CTG, this electrode then keeps a check on the child's heartbeat.

If delivery rooms were better staffed and if a carer was assigned to every woman, a midwife could assist with both overweight women in childbirth and, in the vast majority of cases, independent of birth position, also monitor the child's heartbeat through the mother's abdominal wall without invasive measures.

This procedure also clearly shows the link between staff shortages and physical injury to children.

Without a clear medical indication and a corresponding declaration of consent by the mother/ parents in the name of the child – if an intervention is carried out after the onset of the opening contractions – physical injury of the child is punishable under § 223 StGB.

2.4 Forceps and suction extraction

The birth is well advanced and the child's head has passed through the narrowest part of the maternal pelvis. Pulling on the head is intended to accelerate the final phase of the birth.

The reasons for a so-called "vaginal operative delivery" are manifold and are often connected. Especially in the case of first-time mothers, rigid time schedules and understaffing in the clinic are often the cause of problems.

In most clinics, a first-time mother is entitled to receive a PDA 2 hours or a maximum of 3 hours before the "expulsion period". However, as a result of the epidural, women are often so immobile that an upright birth positions, which makes for a rapid birth is more difficult. In addition to this is the fact that birthing women with fully opened cervix are often brought into the supine position and are instructed to do forced pressing (Valsalva manoeuvre). The supine position with the mo- ther's knees being simultaneously pushed wide apart results in the sacrum becoming rigid and the ischial tuberosities being pushed together. The child then has about 30% less space available in the pelvic outlet. The birth is thereby severely hindered. Forced pushing also increases the risk of the child being under- supplied with oxygen. Frequently in this phase, because of "poor heart rate" and/or "standstill" in the "expulsion period", there is resort to forceps or suction.

Many of these surgical deliveries could be avoided if women needed an epidural less often by receiving one-to-one support; if the upright birthing position or, at least, the lateral position were encouraged; if women were allowed to deliver without deadlines and without being forced to press; if women were allowed to follow their own feelings and to deliver in their own good time.

For the child, forceps and suction extraction

bring dangers as a result of a variety of risks and complications. Forceps can cause both external injuries to the head, the face and the ears as well as damage to the facial nerves with subsequent paralysis. Suction can sometimes lead to quite pronounced haematoma on the head, the consequence of which may be more severe neonatal jaundice, requiring treatment. This in turn may involve separation of the mother and child. The risk of cerebral haemorrhage is increased. Sometimes the suction cup disengages and causes serious wounds on the child's scalp. Problems caused by blockages in the cervical spine are commonly caused by both procedures. The incidence of shoulder dystocia (the child's shoulder getting stuck in the maternal pelvis with high risk of oxygen deficiency) is increased. (12)

In the case of an vaginal-operative termination, indications are often not sufficiently considered; a vaginal birth may actually be the safest and gentlest way to deliver the child, which is already facing considerable difficulties. As a result, interventions are carried out, which often subject the child to further physical stress and strain (tensile energy). In such cases, it is quite possible that a Caesarean section might be the gentler and more appropriate way to deliver. In many places, the choice of the method (forceps or suction cup) is not based on a consideration of the tolerable burden on the child but determined by the insufficient skills of the obstetricians involved. Nowadays, hardly anyone knows how to deliver by forceps.

Without appropriately informing the mother/parents and gaining their consent on behalf of the child at the beginning of birth, i.e. at the onset of the opening contractions, any damage to the child represents unlawful bodily harm.

2.5 Primary Caesarean section (planned and before the onset of labour or rupture of the bladder) and secondary Caesarean section (mostly unplanned and after the onset of labour or rupture of the bladder)

The World Health Organization (WHO) assumes that for Western industrial nations, a Caesarean section rate of approx. 15% is medically indicated. For anything, which goes beyond that, it cannot be assumed that a Caesarean section is of benefit to the health of the mother and/or child. (13)

Caesarean section is not a uniform obstetrical procedure. There is a distinction between:

– "Rescue C-section": the mother and/or child are in an adverse obstetrical situation that acutely endangers their health. The Caesarean section resolves this crisis, fraught as it is with danger. The necessity of these interventions is undisputed. However, only about half of all Caesarean sections come under this category.

– "Indicative C-section": in this case, neither the mother nor the child are in a critical state. However, in the opinion of the obstetricians, the Caesarean section is the safer way to deliver, for example, as in the case of a breech presentation. This fraction of the Caesarean section rate (just under 50%) is currently under criticism because a large number of the indications (breech position, a "big child") are not justified by the current state of scientific knowledge and a Caesarean section could often be avoided.

– "Anxiety C-section": This category, which represents a quite small proportion of the total number of Caesareans, could also be avoided in many cases: the women, who for various reasons cannot imagine giving birth vaginally, could be identified early and be duly provided with competent support.

The average Caesarean section rate in Ger many is currently 32%.

Of the many reasons, only a few can be mentioned here:
– First of all, the determination of the EDD. This increasingly leads to births being initiated with synthetic substances (e.g. oxytocin), the use of which is associated with an increase in the rate of Caesarean sections. In many clinics, a primary C-section will be performed at the latest after EDD + 14 has been reached.

It has now been established that the routine use of CTG on arrival in the delivery room in itself increases the probability of a Caesarean section (14) – regardless of the circumstances in which it is used. This is then often followed by continuous CTG during the birth, which further increa-ses the rate. This results from frequent misinterpretations as well as from the required immobilization of the women. Lack of movement very often leads to delay and standstill because the child is in an awkward position in the maternal pelvis and "gets stuck".

The CTG should make the birth safer for the child. It was extensively introduced in the 1980s in the hope of decreasing both the rate of stillborn children and of severe brain damage caused by oxygen deficiency. 35 years later the rate of damaged children is almost unchanged. However, the rate of Caesarean section has risen from 10% to the current 32%.

Caesarean section has both short- and long-term consequences for the life and the health of the child:

– In the short term, there is more frequent transfer to the neonatal intensive care unit due to respiratory disorders, hypoglycemia or hypothermia.

– In addition, the immediate cutting of the umbilical cord in the operating theatre leads more often to anaemia.

– In the medium and long term, breastfeeding disorders are more common; the children must be given substitutes for mother's milk soon after birth. The lifelong consequences on metabolism, digestion and the immune system have still not been comprehensively researched.

– The long-term consequences, which have been proven beyond doubt, are an increased risk of asthma and an increased likelihood for the development of diabetes Type I.

– In all phases of life, a variety of attachment disorders can be seen as resulting from the abrupt and early separation of mother and child (15, 16, 17, 18).

Research into the effects of Caesarean section, particularly on attachment and physiological health, is still in its infancy. However, it is already to be expected that we are dealing with a variety of negative effects upon the development of the child.

Following the principle of caution, our practice needs to be controlled in order to prevent damage to the child and disadvantages for the mother. A planned, not medically indicated Caesarean jeopardizes the right of the unborn child to physical well-being. It remains to be ascertained whether there is a loophole in the criminal law between the scope of § 218, including the 12th week of pregnancy, and the law, which commences with the onset of birth. If there is, the legislator is obliged to close this regulatory gap by harnessing all apppropriate measures to guarantee the rights of the child (Art. 4 CRC).

3. After birth

3.1 Early cutting of the umbilical cord

The immediate cutting of the umbilical cord after birth is one of the most common routine interventions in the delivery room. On closer examination, it is evident that there is no meaningful indication for this. However, this practice brings with it a multitude of easily avoidable disadvantages for the child.

– If the child's umbilical cord is cut immediately after birth, the child is deprived of at least one third (19) of its total blood volume. This results in the loss of, among other things, valuable stem cells.

– Prematurely cutting the cord denies the child an important source of oxygen, which should be available during the transition to self-regulated respiration.

– Premature cutting before the cessation of pulsation or before the placenta is born encourages a more abrupt separation of mother and child. This inhibits the release in both mother and child of oxytocin, the hormone most involved in bonding.

– As a result of a reduction in fluid volume, premature cutting increases the probability that artificial baby food must be fed within the first 3 days of life. This has negative consequences for the health of the child and on breast-feeding. This is because any replacement of breast milk without a strict medical indication violates the right of the child to receive the highest level of health support (Art. 24 CRC).

In everyday life in the clinic, it is apparent that especially the children, who are dependent upon an increased oxygen supply and would particularly benefit from proximity to the mother (premature babies, children with low APGAR values), instead of being supported longer via the umbilical cord, are immediately cut from it in order to receive paediatric care. After that, they then often need oxygen as a primary intervention.

Several studies have shown that even 6 months after birth, children, who were severed from their cords immediately, are more likely to have severe iron deficiency than children whose umbilical cords were cut several minutes after birth (20, 21). Negative effects of immediate cord clamping on the brain and motor development were also demonstrated (20, 21, 22).

The current practice of immediate or early cutting of the cord entails risks for the child, which are completely avoidable. Therefore, there is no justification for the common practice of cutting the cord quickly. Since this concerns an intervention after the beginning of birth, it remains to be checked whether early cutting - without explicit consent on behalf of the child and with or without the extraction of blood – for example for storage in a stem cell bank – has legal implications.

3.2 Routine oral administration of glucose solution for painful interventions, e.g. blood sampling

It has been proven that early painful events have a deep and long-term impact upon the experience of the child.

In the clinic, in order to counteract the impact of pain, children are routinely administered glucose before blood sampling (metabolic screening, blood sugar checks).

This procedure certainly has the desired effect. However, little attention is paid to the long-term effects and the parents are usually not infor-

med. Even small amounts of glucose disturb the balance of the intestinal flora, thereby encouraging colonization by pathogenic bacteria. In this early phase, the intestine as a "centre of health" is extremely prone to disturbance. An imbalance of the intestinal flora can lead to various diseases. (24)

In addition, the administration of glucose has a negative influence upon the development of a functioning breastfeeding relationship. Even the smallest amounts of glucose are sufficient to delay the child's next natural bout of hunger for hours. As a result, the baby receives less colostrum (first milk), the mother's milk production is not stimulated sufficiently and the flow of milk is delayed. Artificial baby food is then often given.

It has been proven that colostrum has the same analgesic effect as glucose. (25)

It is just a little more time consuming to take a blood sample while the child is on the mother's breast; or to get the mother to collect the colostrum beforehand in order to be able to administer it by syringe while taking a blood sample. However, simply placing the child in direct skin contact with the mother's breast reduces the perception of pain. (26)

In the clinic, there is not the time or the staff to implement these simple methods, which are free of negative side-effects but which support bonding - at the expense of the best interests of the child.

Regarding the fact that the child has a right to the highest possible level of health, the current practice cannot be approved. Routine intervention and the failure to explain the options open to parents deprives them of the possibility of making an informed decision and thus of exercising their parental rights.

II. Indirect violation of the rights of the child through interventions upon the mother

1. During pregnancy

1.1 Setting a date of delivery (EDD)

As already described at the beginning, this universal procedure is not good for the child or the mother. A complex natural process cannot be assessed or controlled merely by technical means.

Nor does the information offered in this context meet with what is required to comply with and respect women's rights.

1.2 CTG in pregnancy

In most gynaecologist's practices and nowadays also among many midwives, a CTG is routinely taken from the 26th – 28th week of pregnancy onwards – in addition to those taken during standard medical checkups. This procedure is not supported by the currently valid guidelines concerning pregnancy. These stipulate that the initial taking of a CTG in this phase of pregnancy should only occur if there is a clear indication (imminent premature birth, suspicion of premature labor, abnormalities in the auscultation of the foetal heart). The repetition of the CTG is only required when there is a deviation from the norm (abnormalities in heart tone, multiple preg-nancies, bleeding, suspected overdue pregnancy, placental insufficiency, intrauterine child death in a previous pregnancy). (27)

Routine CTG during pregnancy has been demonstrated not to be very meaningful when it comes to assessing the actual condition of the child or the risk of a premature birth. For example, sporadic drops in heart tone and a limited variability in the early weeks of pregnancy are merely signs of foetal immaturity and not a sign of pathology. Nevertheless, pregnant women in such cases are often quickly sent to the hospital; this is always accompanied by uncertainty and fear.

Due to routine CTG, "premature labour" and "imminent premature birth" is often diagnosed. Instead of asking the pregnant women about their well-being, what they feel is going on and the behaviour of their child, a print out from a machine becomes the sole centre of attention. This inevitably causes pregnant women to become uncertain, sometimes even leads to unnecessary hospitalization and the unnecessary administration of tocolytic medication and cortisone. (28, 29) The cause of the increased uterine activity is often cystitis, constipation or professional/private stress. However, in medical antenatal care and in the clinic, there is often a lack of both time and personnel to allow for a detailed examination of the pregnant woman.

The CTG uses pulsed-wave Doppler, which is more energetic than normal ultrasound and is therefore more likely to disturb the child. Damage is possible especially when there is a rise in temperature of the brain. However, studies in children have not yet been carried out. (30)

1.3 Prenatal diagnostics (PND): Invasive and non-invasive diagnostics such as amniocentesis or chorionic villus sampling and ultrasound examinations during pregnancy without medical indication

Parents have the understandable and justified desire to receive a healthy child. What is rarely discussed in this context is the question: "What does 'healthy' actually mean?" Which criteria are used to judge this? Who sets the standards? How should health be "ensured"? As a rule, health is usually reduced to the anatomi-

cally correct positioning of the limbs and organs and the existence of a normal set of chromosomes.

The growing healthcare market around pregnancy and birth offers expectant parents diverse possibilities of prenatal diagnostics. So much is on offer: everything from basic ultrasound to the detailed diagnostics of organ screening and even baby TV via 3D- and 4D-ultrasound. Furthermore, there is the possibility of risk assessment, for example, through first-trimester screening for trisomy 21, (31) as well as through blood tests for genetic diagnostics. But even more invasive methods are also recommended. In amniocentesis, a needle is inserted through the abdominal wall of the mother and through the uterus and is pushed through the membranes into the womb in order to collect amniotic fluid. The cells, which this contains, are then used for genetic diagnosis. In chorionic villus sampling, cells are removed from the developing placental tissue by means of a needle pushed through the mother's abdominal wall or through the cervix.

There is technical-medical information, which should be available, especially when an extra-clinical birth is desired. This is necessary to exclude the possibility that acute danger for mother and/or child might occur during or after the birth. Included in this assessment are childhood malformations such as spina bifida ("open back"), omphalocele (umbilical/abdominal hernia), malformations of the heart or lungs or a malpositioning of the placenta. However, all of this information can be obtained in a single ultrasound examination.

What is often lacking in the methods on offer is a thorough instruction of the parents concerning the possible risks, consequences and complications for the mother and the child.

The parents are generally informed in advance of invasive examinations that *they* might lose their child, but not that the child might lose *his* or *her* life.

As a result of the more invasive methods, an increased risk of miscarriage of approx. 1% has been verified. Very rarely, the child may also be injured, amniotic fluid can be lost or become infected.

Concerning ultrasound, there is as yet no scientific proof that the non-ionising radiation involved does not harm the unborn child. On the contrary, there is evidence that there are thermal and mechanical effects in infantile tissue, on brain and nerve cells and in the amniotic fluid. Both the German Society for Ultrasound in Medicine (DEGUM) and the US Food and Drug Administration (FDA) also recommend not to perform ultrasound examinations during pregnancy without clear medical indication. (32, 33, 34, 35, 36, 37, 38, 39, 40)

On the basis of the "Law on the protection against harmful effects of non-ionising radiation during application on people", which applies in Germany, and using the framework of the "Regulation on further modernisation of the Radiation Protection Act" of 29. 11. 2018 (BGBl 2187-2196, 2018, Part 1 No. 41.), the Federal Government has ruled that ultrasound, which is not medically indicated ("Baby-TV", "Baby-Watching" or similar) is prohibited as of 31. 12. 2020 and a violation is punishable as a misdemeanour.

Even if all tests are carried out and all the results are within the normal range, this does not provide certainty that the child will be healthy.

Current maternity guidelines do not allow for the additional foetometry (determination of a child's estimated weight by measuring the thighbones,

head and abdominal circumference), which many gynaecologists in private practice carry out during every check-up. It has been proven that these measurements are subject to a high rate of error and do not provide a reliable prediction of the presumed course of birth. However, they do hold an enormous potential to worry the parents-to-be. In extreme cases, this may even lead to the desire for a primary Caesarean section, even though in the end a child of completely normal weight is born.

It is highly questionable under which pseudo-scientific pretexts it has become customary to gain repeated access through the use of various methods to the protected space within the mother's body without these investigations having any proven health benefits for the child.

Furthermore, the excessive increase in prenatal diagnostics often does not lead to peace of mind and better bonding of the expectant mother to her child but to more worry. The pregnancy changes from being a period of "good hope and joyful expectation" to a time of uncertainty, endless tests, the assessment of risks and the constant questioning of fundamental female capability. The need to develop a healthy awareness of her own body and of the new life growing within it is suppressed by the feeling of being dependent upon external approval, based on technology and the assessment of so-called experts.

The autonomy of the woman is a legally relevant issue when she demands to be seen as competent in regard to her being pregnant; instead of leading her into ever more far-reaching dependency by conjuring up false security, she should be given advice, accompanied and supported to develop her own competence.

According to the UN Convention on the Rights of the Child, the support required by the mother is also explicitly understood to be the right of the child (Art. 24 KRK).

1.4 Causing psychological stress for women through threatening information, paternalism, scaremongering and unnecessary examinations

It has been proven that increased levels of stress hormones in the mother's blood have a negative effect on the development of the unborn child and can even influence subsequent generations by way of epigenetics. Prenatal care in Germany generally gives parents the impression that it is primarily about identifying and naming risks, instead of acknowledging, promoting and developing resources and the existing potential of the expectant mother.

The expectant mother gets lost in a flood of information and offers, which promise her maximum safety and health but for the most part only reduce her confidence in her own body, in the vital strength of her child and in her healthy ability to give birth. Instead of being confidently expectant, pregnancy is turned into a state of tense anticipation of the worst. This is not only subjectively perceived in this way by women but is actually associated with elevated concentrations of stress hormones in their blood.

It is still far from being sufficiently understood that not only technical or drug-based interventions are potent but also that which is written and said. Anxiety, once it has been aroused in pregnancy, is very hard to eliminate – especially not´with the means of prenatal diagnostic, which may be offered in addition to prenatal care. (41, 42, 43, 44)

According to Art. 24 UNCRC, this practice is not compatible with the right of the child to attain the highest level of health.

2. During the birth

2.1 Induction and all interventions, which are exclusively oriented to the EDD

The current guidelines for induction of birth wrongly assume that every child matures according to a standard timeplan and as a result is in danger from a certain point of time in the pregnancy. In the process, the individually specific nature of childhood development is ignored.

There are children, who are already mature before the mean duration of pregnancy of 38 weeks after fertilization. They have reached the limit of their placental reserves and therefore want to be born early. On the other hand, there are other children, who reach this maturity much later, without thereby being in any danger. For these children, when there is no compelling medical necessity, a shortening of their time in the womb represents an increase in risk and a violation of the fundamental right to an individually specific period of maturation within the womb.

In this context, another factor has a direct effect upon the child: the massive psychological pressure that the mother is under as soon as she reaches EDD. With every day that passes without contractions, the checks become more frequent, facial expressions more worried and the fears greater. It is implied to the pregnant woman that her womb is no longer a safe place for her child. She perceives herself and the functions of her body as "defective".

If one considers the physiology of birth and above all here the beginning of birth, the following is evident:

– According to current knowledge, on a hormonal level the child initiates the beginning of birth – it signals to the mother "I am ready. In the near future, my placenta will no longer be adequate for my needs. We can start now!"

– The maternal birth hormones require certain basic conditions in order to be produced in sufficient quantity and to be able to take effect. First and foremost, this process needs the absence of stress. The mother needs a safe, secure place which she can depend on and in which she can relax. If tests are carried out, then these should cause as little stress, anxiety and irritation as possible.

It would appear that the current reality of antenatal care from EDD onwards has achieved the exact opposite of what would be required: because it is expected that the woman should start birth as soon as possible, she is put under such pressure, that the onset of labour is disturbed due to the stress and the hormonal processes required for birth become seriously impeded. Thus, on a physiological level, it becomes impossible for the mother to respond adequately to the hormonal signals coming from her child.

The unique, finely tuned interaction of the vital processes of mother and child requires that both are respected as individuals. Respect for life demands that every unwarranted intervention be withheld. Sticking instead to rigid and simplistic timeplans violates the legal status of the child as a subject and also subtly undermines the dignity and autonomy of women. This causes doctors, midwives and maternity nurses to develop an understanding of their profession, determined more by information generated automatically by machines than by their individual experience and competence.

2.2 Acceleration of birth by using oxytocin and amniotomy

The processes in the body of the child and its mother that control the birth process are ancient

and highly complex. The idea established today that human beings are modern, civilized beings, who can control nature, invites us to repress and neglect the fact that pregnancy and birth are natural phenomena. As can be observed during all phases of pregnancy and birth, they are all inseparably connected to the individual emotional experience of mother and child. It is, therefore, vitally necessary to pay attention to this dialogue between human being and nature and to refrain from unnecessary intervention. This requires a conscious effort because nowadays there is an increasing conflict between what is practiced as being suitable, modern and safe birth management and what a birth, understood as a unique natural event, actually calls for.

Instead of understanding birth as a natural process, it is "treated" as an illness and is then taken over by the medical system.

The following facts must be emphasized:

– Oxytocin is the most important hormone during birth. It is produced in the hypothalamus and is released intermittently through the posterior lobe of the pituitary gland. During pregnancy, more receptors for oxytocin are formed in the uterus, so that it is ready for the release of oxytocin when the child is ready for birth and can then react with rhythmic contractions. Apart from this "mechanical" effect, oxytocin is above all else the most important "love and bonding hormone". It is released more abundantly in situations which are characterised by closeness, trust, security, skin contact, intimacy, peace and relaxation.

– Oxytocin is one of the most volatile hormones and it is quite prone not to function. Unfamiliar smells, sounds, strange people, unexpected touch, bright light, fear and stress disturb and reduce the release of oxytocin and thereby weaken the strength of the contractions.

– Looking from this point of view at the way in which modern delivery rooms are equipped and the type of care provided during birth, it is not surprising how frequently "weak contractions" are diagnosed.

– It must also be considered which parts of the maternal brain are active and what function they have. From the point of view of evolution, there are brain areas of different developmental ages. The oldest part, the brain stem, is responsible for our involuntary survival functions: such as breathing, circulation, other vital reflexes.

– The limbic system with the amygdala is located in a younger part of the brain. This is where emotions are processed. This system can make specific connections to events, which may have occurred long ago. Here is where it is decided whether an experience is to be classified as harmless. Or whether, in extreme cases, it reactivates a previous trauma. Here is the centre for instinct and drive – and thus also for important aspects of birth. Sounds, smells and pictures are unconsciously compared with past experience and evaluated. During birth, this area of the brain is very active and can take over control – as long as it is not disturbed.

– The youngest part of the brain is the cerebral cortex. That's where conscious information processing, our "everyday thinking", takes place. During birth, the cerebral cortex and the limbic system are precisely coordinated with each other: the more active the limbic system is, the more the cerebral cortex takes a back seat. The woman in labour "switches off" and enters a kind of trance, which she instinctively allows to take over and thus reduce her sensation of pain throughout the birthing process. However, exactly to the extent to which the cerebral cortex is

forced into action, so is the function of the limbic system inhibited and the birth process is persistently disturbed.

– From this point of view, any activation of the cerebral cortex is to be seen as problematic. Yet this happens constantly during practically every hospital birth: by having to fill out long forms about medical history after arrival in the delivery room; by reading and signing treatment contracts, optional service agreements and data protection declarations; through frightening information about risks and complications during induction, epidural and Caesarean section; as a result of statements like "Oh, but that's a large head!" during routine ultrasound scan in the delivery room; by regular announcements about the opening of the cervix in centimetres per unit of time; by the loud noise of the CTG machine (45); by the lengthy introduction of a new colleague at shift changes; by … yes, even sometimes by asking the well-intentioned question, "Would you prefer fennel or chamomile tea?"

All these examples show that the birth process is often already subtly disturbed before anyone consciously considers making any direct intervention. Any activities that could affect either the hormone oxytocin or inhibit the function of the limbic system must be avoided as far as possible. Obstetric care must be planned according to these requirements in order thereby to allow for an undisturbed and safe birth.

Mother and child are, as described, in constant dialogue during birth; this takes place especially at a hormonal level. They shape the rhythm of birth together. For example, a child, who is heading towards a phase of exhaustion, caused by strong contractions and a rapid birth process, “requests” – by sending a hormonal message to the mother – longer pauses between contractions in order to recuperate. This often happens towards the end of the opening of the cervix – as if both are gathering strength for the final spurt. However, in everyday hospital practice, this necessary phase of recovery is often termed "secondary weak contractions” and is then overridden by an infusion of synthetic oxytocin.

The child, who actually needs a break, is thus forced by the pressure of massive and unphysiological contractions to continue the birth. Instead of looking for the true causes of the alleged weakness during labour (unsuitable environment, lack of knowledge of physiology and thus inadequate care), the dynamic process of birth is ultimately robbed of its naturalness. The mother is thereby deprived of the possibility to respond intuitively to the signals and needs of her child.

The use of synthetic oxytocin during birth does not match the natural processes – neither in the dosage nor in its effect – and leads to a converse regulation in the mother and child.

The use of oxytocin is blamed among other things for: foetal distress ("poor heart tone", oxygen deficiency), increase of the risk of a forceps delivery, vacuum extraction, Caesarean section, rupture of the uterus with danger to the life of mother and child, increased blood loss of the mother after birth due to weak uterine contraction and increased likelihood of postpartum depression. (46, 47)

In children, this disruption of the oxytocin system can adversely affect the psychosocial attachment system. In affected children, there is clear evidence of an increase in disorders such as ADHS. (48, 49, 50, 51) Both in terms of the rights of the child and women's rights, this practice requires a critical review.

2.3 Routine vaginal examination during birth

The vaginal examination of a woman giving birth is the most frequently performed examina-

tion, used to assess the progress of the birth. Both the width of the cervix as well as the relationship of the foetal head to the maternal pelvis is ascertained. In many delivery rooms, there are instructions, specific to each clinic, according to which, for example, every hour or every two hours, the collection of such data is demanded.

However, birth is a dynamic process, which progresses in phases and is sometimes faster, sometimes slower.

After the vaginal examination, the current width of the cervix is generally set in relationship to fixed units of time. Thus, also here, calculations (centimetres per unit time) are carried out, even though a rigid method of calculation is not suitable for the event of birth.

An additional problem is the massive infringement of female intimacy. Vaginal examinations are often performed routinely without seeking consent, without explanation and without medical indication. They are experienced by many women as very stressful and abusive.

The organization Terre des Femmes estimates that about 40% of all women in Germany have experienced abuse to varying degrees. Vaginal examinations, especially when they are performed by strangers and carried out without the necessary sensitivity, can lead to considerable stress and in extreme cases to retraumatisation.

The use of oxytocin, instructions for forced pressing, the use of suction and forceps, the decision to have a Caesarean section due to lack of progress in the birth, the psychological pressure which the mother experiences - "I can't do it, I'm too slow!" – all of these procedures during birth are based upon the result of a vaginal investigation. Understanding the circumstances, which a birthing mother needs in order to accept the process of birth, it becomes clear that the vaginal examination alone, due to its potential to engender stress, can be sufficient to bring the birth to a standstill. This means that the consequence of the investigation may be being caused by the investigation itself.

In the eyes of an experienced midwife, birthing women often show very typical patterns of behaviour. An understanding of these patterns allows conclusions to be drawn about the stage of birth and the speed of progress. Dedicated one-to-one support by a midwife would make it possible to observe the birth process continuously and thereby eliminate the need for innumerable vaginal examinations.

One factor, which directly affects the child and affects his health, is the increased risk of infection. The vagina is a self-cleaning organ that exhibits flow in a single direction: from the inside to the outside. The outer zone of the genital is physiologically conditioned to be strongly colonized by bacteria, especially because of its proximity to the anal region. Now these bacteria would need tremendous vitality to "swim against the tide", work their way up the vagina and infect the amniotic cavity, the uterine membranes and the child. However, by means of a vaginal examination, the bacteria hitch a 'cheap ride' right up to the head of the child. Especially after the rupture of the bladder, strict criteria are required for the implementation of this intervention with its many side-effects.

2.4 Subjugation of women in relation to the birthing position – restriction of freedom of movement

The humiliation of a woman giving birth begins as soon as she enters the delivery room. In most hospitals, delivery rooms are equipped in such a way that the only reasonable place for a bed is in the centre of the room. And that's what

the pregnant woman is told: "This is where you have to be!"

The CTG following admission, which has been shown to do more harm than good (52), is usually performed while lying down. This position is much easier and less time consuming for the personnel. In positions other than lying or in motion, the CTG buttons would slip off more often and would have to be readjusted.

During prenatal care, the woman has already "learned" that a CTG can only be properly written if they are motionless in a supine or lateral position or semi-seated. When asked, many women report that they have to deal with massive problems during the CTG (back pain, heartburn, severe restlessness of the child, etc.). However, they are not allowed to change position or to curtail the CTG. Only a few women have the courage to question these directives and to refuse to follow them.

If you ask the women which position they would prefer, most want to remain standing and to have a free choice concerning their posture. Especially when the birth is already underway, the contractions are often perceived to be much more painful while lying down than in any other position. Women, whose posture is imposed upon them, need epidural anaesthesia (PDA) during the birth more often and earlier. This often leads to further interventions such as the administration of oxytocin, Caesarean section or the use of of suction or forceps. The immobilization of the woman means that she can no longer respond intuitively to what she feels during the contractions and to the signals from her child. If, for example, the baby's head threatens to become wedged in the mother's pelvis in an unfavourable way, the pain of labour intensifies in particular parts of the pelvis. A mobile and unanaesthetized woman will then react and intuitively change her position and her movements in order to make more room for the baby's head. A woman, who is sedated and fastened in a bed, cannot do this.

The supine position of the birthing woman also has an influence upon the position of the child in the uterus. Because the pressure of the contractions when lying down cannot act in concert with gravity, that is, in the same direction, unfavourable presentation of the child is more likely to occur. This slows the process of birth and once again interventions, up to an including Caesarean section, are the result (e.g. because the child is "stuck" in the pelvis as a result of an unfavourable position of the head or the rotation of the infant's back).

The supine position (at approx. 86%, this is the most frequent birthing position in everyday hospital life!) is particularly unfavourable in the "expulsion phase". To understand this, one has to know that the maternal pelvis is not a rigid, bony structure but is to a certain extent flexible and can adapt to the spatial requirements of the child during birth. The part of the maternal pelvis, which offers the greatest potential for space, is the sacrum with the associated coccyx. Both can give way to the pressure of the head and move backwards and out of the way. However, this can only take place, if this area is not blocked by external pressure – as is the case with the supine position and also the sitting position.

In semi-erect lying position, a large part of the maternal weight pushes on the sacrum. As a result, the child loses about 30% of its possible free space! This means that even in this last phase delay in the process of birth, up to and including complete standstill, can be provoked. Then intervention with Kristeller's manipulation, forceps, suction or a Caesarean becomes necessary.

The supine position during birth also holds the greatest risk for the mother of serious perineal injuries. These can trouble and restrict a woman, who has given birth, for weeks and even years thereafter.

The psychological component is also immensely important. After the birth, many women report experiences and feelings of having been dominated, of being ordered around, humiliated and coerced; the feeling of being overwhelmed up to the feeling of having been raped and the fear of death.

An vulnerable woman with her legs spread wide apart, lying on her back, surrounded by strangers, has little chance of preserving her dignity.

With regard to the rights of women and of the child, it is high time to take a critical look at what is practised in the delivery room from the point of view of the exercise of power and to abolish passive childbirth – in favour of active and autonomous birth! Only in this way will we succeed in supporting psychologically stable and healthy mothers as self-sufficient individuals, who are able in the long run to maintain stable and healthy bonds with their children and are thus able to respond adequately to their child's specific needs.

2.5 Valsalva manoeuvre ("power pressing")

A phase of childbirth that is characterised by increasing impatience on the part of midwives and medical obstetricians is the so-called "expulsion period." This describes the period from the complete opening of the cervix until the birth of the child. Very often, the childbearer is specifically instructed to begin forced pressing with the aim of shortening this period.

At present, in most clinics, the mother and child are allowed a maximum of 2 hours to complete this phase. Depending on the clinic, the time of day and the doctor on duty, first-time mothers with PDA may be allowed up to 3 hours. This is often not inkeeping with the actual time requirement because many different factors have to be allowed to interact:

In order to adapt optimally to the shape, size and structure of the maternal pelvic, the unborn child has to perform difficult rotations around its own axis. First of all, it must push its chin to its breast but then later on its head must be extended once more. At the same time, contraction for contraction, it has to enter ever more deeply into the maternal pelvis. It supports this process by pushing against its mother's costal arch and the uterine dome with its feet.

However, the pelvis is not only a bony "birth canal". Apart from the uterus, it also contains the bladder and intestine as well as muscles, fat and connective tissue.

During this phase of birth, all of these so-called "soft tissues" must move out of the way to make room for the child. This process takes time. The pelvic floor also needs time to yield to the child pushing from above and to dilate until it can finally give way to the child.

In addition to these physical processes, on the psychological level, willingness on the part of the childbearing woman is required for her to take leave of being pregnant. The mother must let go of the child, which she has protected for so many months, in order now to share it with the world. At this stage of the birth, the magnitude of the event seems to influence a lot of women. At this time, the step from being a daughter to being a mother must be taken. This can be laden with conflict. Often at this stage, there can be once again apparent delays in the birth – as if the mother and child are together taking a breather in order to then face this great

transformative challenge: from being an unborn to becoming a newborn human being, from being a daughter to becoming a mother.

It should be quite apparent from these descriptions that this process needs sensitive and loving accompaniment and support. In reality, the following often is the case:

If the birthing woman has not been in bed, after the cervix has fully opened, she will be brought into the "Now it's serious!" position – the semi-seated supine position. If the mother and child are lucky, time will be allowed for the natural development of an urge to press. Very often, however, the woman in labour, even without any felt urge, will be instructed to press with every contraction. Because many women have an epidural, they frequently do not properly feel the pressure of the baby's head during the contractions. Sometimes they do not even realize that they are having a contraction.

This makes them completely dependent on the instructions of the obstetrician, who tells them when, how long and where to push.

Frequently, the midwife's finger remains uninterruptedly and without consent in the woman's vagina, trying to get her soft tissues and pelvic floor to dilate through artificially generated pressure. Usually the woman giving birth is asked at the beginning of each contraction to take a deep breath, then to hold the air without interruption over the entire duration of the contraction – that is, about 1 – 1,5 minutes – and to push with full force. The typical vocabulary used ("More, more, more! Keep going, keep going, keep going! Harder, harder!!!"), continually suggesting to the mother that her current efforts are not good enough.

Typical side effects in this phase are: the mother becoming completely exhausted, the exhaustion of the child, which results in changes in heart tone in the CTG, slow progress of the birth because of a blocked pelvis and because of the fact that the mother in this position has to push the child against gravity uphill.

The mother and child then have to be "helped" through this difficult phase of birth with the aid of forceps, suction, Kristeller's manipulation (described below), episiotomy or even a late Caesarean section: the mother has then been freed of her child.

How exactly does forced pressing affect the child?

During each contraction, the uterine muscles pull and push the baby downwards. Inside, the placenta lies on the uterine wall. It is through this organ that the exchange of gases between mother and child (oxygen, nitrogen and many other substances) takes place. From a physiological point of view, because of the pressure, not as much blood flows through the placenta during a contraction as does during a pause. So the child experiences a reduction of the oxygen supply. However, this is generally not at all problematic for the child. On the contrary: this slight physiological stress prepares it optimally for life outside the uterus by promoting the maturation of the lungs. This phenomenon is occasionally seen in the CTG as "early deceleration", (cardiac decelerations during the contraction).

The child reacts with perfect physiological adaptation: during the phase of reduced oxygen supply, it puts a brake on its biggest consumer – its heart – just a little, until, when the contraction has subsided, the supply is again optimal and the heart rate rises once more. In the clinic, the response to a decrease in heart rate is often met with the administration of tocolytic medication. A side-effect of this is a sudden and sharp rise in the heart rate of both mother and child.

At a situation, in which the child's resources are in any case not optimal, the oxygen demand increases enormously because of the extra exertion of the heart and the distress of the child is intensified instead of being diminished. However, the early administration of medication is positively assessed by experts in court and approved much more than waiting and watching.

With forced pressing, because of the instruction to purposely tighten the abdominal muscles, there is in addition to the pressure of the contractions, the pressure on the uterus, the placenta and the baby, which is unnaturally increased. At the same time, due to the extended retention of breath, the oxygen supply deteriorates even further. As a result, the child very quickly moves beyond the limit of his ability to cope.

So does "power pressing" lead to a better, faster and easier birth?

The consequences of "power pressing" are exhausted and incapacitated mothers, whose risk of more serious birth injuries increases dramatically.

For the child, it means that they are not allowed to take this important step into life at their own pace but are forced into the world. Often, in addition to the consequences of the interventions they have endured, they also have to cope with early separation from their mother. The artificially induced stress more often leads to lower APGAR and umbilical cord pH values as well as hypoglycaemia, which then in turn requires paediatric monitoring and intervention. (53, 54)

These various interventions in the natural course of birth reduce the self-esteem and independence of the woman as well as the autonomy of the child.

2.6 Kristeller's Manipulation

This manipulation is used when the birth is imminent: the cervix is fully opened and the child's head has overcome the narrowest part of the maternal pelvis. Now an acceleration of the birth is desired, for which there can be many reasons: a mother exhausted because of prolonged pressing in the supine position, no or not enough progress in childbirth, weak contractions, exceeding the limits of the time permitted for the "expulsion phase", pelvic floor of the mother in spasm, "bad heart sounds" of the child.

However, the hospital system or staff issues are also possible factors: imminent shift change, impatience of the obstetricians, understaffing while several births are taking place in parallel, etc.

There is a "correct" way to carry out Kristeller's manipulation, whereby even this claim is very contentious: a doctor or midwife kneels at the head of the bed behind the mother, bends over her, knows the exact position of the child in the uterus and also knows that the placenta is not located on the front wall of the uterus. The child's posterior is grasped with both hands and then, in coordination with each contraction and in consultation with the mother, the child is pushed down the midline towards the exit of the pelvis. As soon as a contraction eases, the force from outside is also released.

However, the truth of the situation in the delivery room often turns out to be as follows: a doctor or midwife stands at the side of the bed, pushes a long sheet under the birthing mother, which is used as a brace to make the application of maximum force possible. Then, using the forearm or in the worst case even the elbow, i.e. without being able to pay the least attention to the position of the child, the woman's upper abdomen is pressed with full force in order to push the child deeper into the pelvis. This often takes place

quite independently of the contractions and also without any regard for the localization of the placenta. It even happens occasionally that a larger and heavier midwife or doctor is called to the delivery room specifically to apply Kristeller's manipulation.

Possible consequences for the child can be dramatic:

– in case of direct compression of the placenta, injury to the placenta and/or reduction of the oxygen supply,

– twisting and compression of the spine, caused by the randomly applied pressure; a variety of complaints after birth can be observed - often stemming from damage to the cervical spine,

– massive stress because the child is being squeezed through a pelvic floor, which is often not yet optimally dilated,

– increased risk of shoulder dystocia (the child's shoulder gets stuck in the pelvis),

– disturbance to the mother-child interaction because the mother panics with all the related hormonal consequences (adrenalin overwhelms oxytocin),

– difficulty in establishing contact after birth, because the mother needs time until the release of oxytocin resumes.

Possible consequences for the mother are: fractures of the ribs, breathing difficulties, fracture of the tip of the sternum, injury to the liver and other soft tissues, extensive bruising, increased rate of severe perineal injuries, severe trauma.

Typical accounts of having experienced Kristeller's manipulation are: "Suddenly someone threw themselves on top of me!", "I could no longer breathe and I thought I was going to die!", "I didn't even realize that they had put the child on my stomach and I couldn't feel happy!", "Weeks later, I still had pain in the area where they pressed into me."

This manipulation also has a huge potential to traumatise the father, if present, because he is not in a position to protect his partner and is powerless as he witnesses the events. "The doctor knelt with all his weight on my wife!" – "Suddenly, someone just threw themselves on my wife!"

The performance of the Kristeller's manipulation is frequently not documented. There are even clinics where the technique is used regularly but a record of its use is prohibited by the management.

This practice represents a serious contravention of the law, not only in terms of its results but the whole of the process is fraught with grave deficiencies. On the one hand, it is highly questionable whether the consent obtained from the woman on admission to the clinic covers this procedure because the drama of the procedure can hardly be made apparent while informing about risks. On the other hand, an evaluation of other possible courses of action, which the rights of the child require, does not take place.

It's obvious that Kristeller's manipulation could often be avoided by competent mentoring before the birth. Therefore, sound justification is required if the manipulation is to be used. Since the assessment involved must be legally robust, records are essential. Simply because the events are often difficult to judge in hindsight, any prior instruction to refrain from keeping records is unlawful.

2.7 Administration of medication/PDA

When asked, most pregnant women want "a natural birth, if possible". However, it appears that there are unclear ideas about the definition of a "natural birth". Both among women and often also among specialist staff in charge, this phrase is for the most part reduced to the idea that the child is born vaginally. But what actually happens during a vaginal birth is not taken sufficiently into consideration.

If "natural birth" is understood to mean birth free of any intervention, then only about 7% of mothers and babies experience this in Germany. For all other births, there are various sequences of intervention, which in many cases begin with the desire for pain relief, if oxytocin has not already been administered.

The "suffering of pain during birth" is portrayed as being no longer state-of-the-art and for that reason very few pregnant women are taught during antenatal care how to deal constructively with the intense experience of childbirth.

Often equally lacking are the ability and the will of obstetrical staff to tolerate a childbearing woman, who in certain circumstances can be instinct-driven and vociferous. In many cases, women are urged to have an epidural because obstetricians cannot and will not tolerate the noise of a woman in action.

Neither during pregnancy nor the birth are parents adequately informed about the consequences of medicalization for the unborn child. It has been proven that any medication given to the mother also reaches the child. Because of the immaturity of the child's metabolism, this can lead to substantially higher concentrations of substances in the body of the child than in the body of the mother. For this reason, many medicines have a higher half-life in the child. The high concentrations of the substances administered during birth can cause problems for the child for hours after the delivery. For example, respiratory difficulties can follow the administration of certain painkillers; drowsiness can have a negative impact on the child's search-and-suck behaviour.

In addition to a lack of information, there is also deliberate misinformation, probably resulting from the desire not to burden the expectant mother in the exceptional situation of birth with information about medication, which may cause her to worry. Many women, for example, are told that the epidural cannot in any way harm the child, since the substance does not get into the mother's bloodstream.

Here is a selection of the undesirable effects of the PDA, which have been proven to have a direct effect upon the child:

– disorders in the release of the birth hormone oxytocin with possible delay in the course of birth and the creation of difficulties for mother and child in establishing contact after birth,

– disruption of the release of catecholamines, hormones that give the mother the strength she needs at the end of the birth to push the child out – the ejection reflex - and which also influence bonding,

– disturbances in the release of endorphins (endogenous painkillers in mother and child), i.e. the mother receives pain relief via the PDA, which does not help the child in any way to cope with his own birth pains. The analgesic effect for the mother is induced locally near the spinal nerves. However, the child only endures the adverse effects of the reduction of oxytocin and endorphins.

– increased risk of the use of forceps or vacuum extraction and of Caesarean section,

– oxygen deficiency and drop in heart tone due to the fall in the mother's blood pressure,

– childbearers with PDA more often develop increased temperature during the birth. This is often misinterpreted by the obstetricians as fever caused by infection with the result that medications such as antibiotics or antipyretics are administered. After birth, this can lead to unnecessary admission of the child to the neonatal intensive care unit. An infection is assumed and is treated prophylactically,

– neurological effects, such as impaired self-regulation, disturbed search-and-sucking reflexes, resulting in a difficult start to breastfeeding. (55, 56)

In animal experiments, it was found that ewes, which had given birth to their first lamb with an epidural, did not bond after birth. It is therefore to be feared that the use of PDA can also have an impact upon "instinctive mothering behaviour", even when human beings try to resolve any feelings of estrangement mentally.

It is beyond the scope of this work to go into the specific effects of the various medications frequently used in obstetrical medicine. However, when all is said and done, the following must be firmly stated: under certain circumstances, the routine use of medication during pregnancy and birth constitutes serious violations of children's rights.

More staff in obstetric units would lead to better care for childbearers and this in turn would significantly reduce the need to use painkillers and thus ensure respect for the rights of the child and the woman.

III. Violations against the rights of the child caused by the development of inadequate systems

1. Reliance on rigid strategies and guidelines without regard to individual requirements

As in any other medical specialisation, there are also a variety of instruments in gynaecology and obstetrics in the form of recommendations for action: guidelines, internal standards and the results of evidence-based medicine (EBM). These are intended to help standardize and – based on scientifically proven findings – to provide the best and most effective methods of treatment.

These instruments simplify daily routines as it is always possible for the users to safeguard their own actions and personal decisions by "following the guidelines".

For the recipients – in this case, the mother and child – this method of working leads to stereotyped approaches in which individual factors and needs play a subordinate role.

In obstetrics, individuality and unpredictability have to be taken into account much more seriously than in, for example, surgery of the knee. In every other area of medicine, the physical state of affairs plays the most important role. In childbirth, the psychosocial situation of the woman concerned is of utmost importance. And this cannot be schematically described and standardized.

It is an unfortunate fact that obstetrics is the field in which the vast majority of and the most expensive compensation litigation is conducted. Of course, there can be no doubt that an injured child or an injured mother presents profoundly gruelling challenges for all involved and that they demand all possible support.

In the event of a judicial inquiry, an expert will judge the indicted doctors and/or midwives primarily according to whether their actions conformed to the guidelines, even when these guidelines are sometimes of only very low scientific standard, provided S3 guidelines are not involved. Whether the application of standard procedure to any particular case respected the rights of women and children is of secondary significance. Individually specific factors transcend theoretical thought and cannot be adequately reflected in general guidelines. This leads to the fact that clinic staff in the delivery room tend to make decisions which safeguard themselves, even when an alternative approach would have been more appropriate for both mother and child.

Looking at the existing guidelines and recommendations, it is noticeable that there are great differences in the implementation of the individual parameters.

When the widespread introduction of an intervention is demanded, as is currently the case, for example, with the administration of synthetic oxytocin for a faster expulsion of the placenta, then it is immediately implemented. The practice is approved because it results in a lower loss of maternal blood. However, for the child, this means that the umbilical cord has to be cut before pulsation has ceased. Any administration of synthetic oxytocin reduces the body's own release of this natural love and bonding hormone.

It is considered to be of secondary importance that as a result the mother has an increased risk of postpartum depression and that the sensitive phase of bonding – “getting to know each other” – immediately after birth is disturbed. Instruction about the various side-effects caused by the administration of this medication does not usually take place. However, an increase in continuous one-to-one support by a midwife for

every birthing woman – at the latest from the active "expulsion period" onwards – cannot be implemented in clinics on the grounds of cost. At the same time, the negative consequences of a poor care situation are sufficiently well known. (57, 58)

The logic behind guidelines is beyond question, as long as they conform to high scientific standards (S3). But even then, it must remain possible for qualified staff, who understand the current state of science, to deliberately overlook the guidelines and make specific decisions, which are more appropriate for a particular mother and child. Otherwise, actions based upon the guidelines actually only do justice to the guidelines.

According to the Convention on the Rights of the Child, when the special rights of the child are considered, the tendency of the courts to presume that procedures, which are informed by the guidelines also set the standard, has to be critically question. According to Art. 3 UN-CRC, the best interests of the child should not be based upon abstract obligations but upon the developmental needs of the child as an individual. What is correct in principle is not automatically correct in each individual case. It needs to be affirmed within the guidelines themselves that the freedom to decide for a specific form of treatment required by an individual case must always be preserved. If the courts fall short of this, they fail in their task of seeing that justice is done for the child.

2. Health hazards for mother and child as a result of privatisation and profit oriented practice

Increasing financial pressure, which has occurred in the healthcare sector, for example as a result of privatisation, is now abundantly clear in the day-to-day running of hospitals – with fatal consequences for all those affected.

The following was observed in a second level perinatal centre with about 1400 births per year (tendency rising), with 2 midwives per shift, 4 birthing rooms and integrated delivery room managed by a midwife:

The hospital, which had been managed by the local authorities, was taken over by a private hospital group in the summer of 2016. One of the first obvious changes was to cut back on the cleaning staff in the delivery room. Since then, the cleaning staff are available during the week twice a day for 2 hours. During the night, no one is available and on weekends only once a day for 2 hours.

What does this mean in practice?

Over a period of weeks, the team of midwives documented the extra time and effort, which was demanded of them to tidy up and clean the rooms after the births. Up to 3 hours per shift were spent by state-certified, skilled and highly qualified midwives with cleaning and tidying up. Hours, in which women and children during and after birth were unattended; or during the sensitive phase of bonding immediately after birth, mother and child had to be pushed into the corridor because the midwives saw no other way to deal with the workload of cleaning.

In the increasingly common situations in which more women in childbirth are admitted than there are rooms available, it regularly happens that women have to give birth to their children in insufficiently cleaned rooms on contaminated beds and in poorly disinfected bathtubs. Faeces, urine, vomit, amniotic fluid and blood – childbirth is not a sterile business. Thorough cleaning by qualified staff is necessary. They have to follow the specific instructions for the

use of each of the disinfectant and cleaning agents in order to minimize the risk of infection for mother and child.

Only 2 years later (2018), a part of the once highly motivated team had either resigned or was permanently ill. New, motivated colleagues become frustrated and leave the clinic after a short time. Because of the tense staffing problem, increasingly more often, there is only one midwife on duty. Birth assisted by a midwife, the very reason why the women explicitly decided in favour of this clinic, must be refused at short notice, i.e. after the start of birth and the women must quickly come to terms with birth governed by doctors. Sometimes the delivery room has to be closed for several days due to the shortage of staff and women in labour have to be transferred to other clinics in the region.

Under these conditions, hardly any midwives are able or want to exercise their profession for very long.

This is where health policy comes in. Developments in recent years have led to financial pressure through the privatisation of clinics. This directly endangers the health of unborn and newborn children and their mothers. Politicians and parliamentarians should feel themselves called to stop these undesirable developments.

3. Adherence to the flat rate per case system: diagnosis related groups (DRG) in obstetrics

The flat rate per case system by which health care services are reimbursed is unsuitable for determining charges in obstetrics. With birth, we are dealing with a primarily healthy event, which is not sufficiently recognized by this system, since – grossly simplified – money is only available for diagnoses and technical procedures.

A maternity clinic, which attempts to practice natural and low-intervention obstetrics, can hardly function in a cost-effective way, since the flat rate for a natural birth in comparison to a birth involving many interventions is too small. As a result, completely false incentives for treatment are created, at the expense of the health of mother and child.

Neonatology also faces the problem posed by DRG. Especially in large perinatal centres, newborns are often transferred to the neonatal intensive care unit on the basis of questionable indications.

Two examples:

An obstetric hospital *without* a neonatal intensive care unit is allowed to manage births after 36th week of pregnancy, i.e. 36+0. After birth, the children remain with the mother under close supervision. Both are transferred together from the delivery room to the maternity ward.

However, in a perinatal centre with a neonatal intensive care unit, children born before the 37th week of pregnancy, i.e. between 36+0 and 37+0, are often routinely and without a specific diagnosis, apart from that of "preterm birth", separated immediately after birth from the mother and admitted for a full week into the ICU for monitoring. Here the corresponding flat rate per case is applied – with all the consequences of an early separation of mother and child – among other things, for the development of bonding, breastfeeding, the mental state of the woman with significantly increased risk of postpartum depression.

In addition, children, who are taken into intensive care, have a significantly increased risk of

infections with antibiotic-resistant hospital germs.

Similar things happen to children, who have a lower body temperature during the first hours and days after birth. They are taken into the intensive care unit and kept there for a full 48 hours, even if the problem is resolved within a few hours. This is because the flat rate per case can only be charged for a minimum stay of 48 hours. In many cases, constant physical closeness to the mother would prevent hypothermia from developing in the first place.

This disregard for the unity of mother-child occurs without any specific medical necessity and in both cases the problem is caused solely by the system.

In large centres, which have an extensive infrastructure, there is an incentive to use PICU much more often than is necessary in order to justify its existence and to operate in a financially profitable manner. The Statutory Health Insurance pilot project of 2011, applying the parameter "joint dismissal of mother and child" to 60,000 hospital births, established that in clinics *without* an associated paediatric intensive care unit, 95.4% of mothers were able to go home with their child. In clinics with PICU, it was just 90.6%. In this study, so-called "low-risk cases" - healthy women, who had experienced an easy pregnancy - were compared. (59)

4. Procrastination: refusal of political solutions as, for example, state-financed professional liability insurance for midwives and doctors

The problem of liability, especially in regard to the professional liability insurance of freelance midwives, has received increased media attention in recent years; however, since then, no satisfactory, forward-looking solutions have been forthcoming.

Liability premiums have increased dramatically since 2007. At least, the security surcharge enables midwives with few births per year to continue practising their profession. Nevertheless, the number of midwives working outside of clinics has been declining for years. What is rarely mentioned in the discussion is the fact that medical obstetricians are also affected by the problem. As a result, it is therefore, for example, almost impossible to find a gynaecologist, who is willing to be on call for a birth outside of a hospital.

The fundamental right of women to freely choose the place of birth, which is rooted in their right to self-determination, is thereby undermined. This is because it is in fact almost impossible to find a midwive or obstetrician, who is able to offer this support under the present circumstances.

The effect of the insurance problematic, particularly upon the health of mothers and children, is illustrated in the following example:

For professional liability insurers, the birth begins either with the onset of regular contractions or with the rupture of the bladder. Neither the time of the beginning of labour nor the time of the breaking of the waters allows any concrete prediction concerning the duration of the birth. Nevertheless, both midwives and medical obstetricians are not allowed to care for a pregnant woman in the initial phase at home or in the surgery, even in the case of a planned clinic birth, if they do not have the expensive liability insurance for obstetrics.

As a result, pregnant women are sent to the clinic after the very first signs of going into labour. Only in this way are midwives and obstetricians,

who work outside of hospitals, covered when it comes to liability.

This in turn leads to the fact that almost all pregnant women do not experience the start of birth as a long-awaited, joyful event but see it in the first place as potentially very dangerous. After all, the beginning of birth must be dangerous if it necessitates immediate admission to a clinic!

However, it has been proven that the rate of obstetric intervention in general as well as the rate of operative birth terminations increase, the earlier a woman giving birth is sent to a clinic during the "latency period", the first phase of the birth. Thus, in the current system, a pregnant woman has the choice: either to stay at home unattended or to expose themselves and their child to the significantly higher probability of intervention at the clinic.

Here the insurance industry is in charge, regardless of any scientific findings concerning the well-being of women and children.

What justifies the fact that a professional group, which is dedicated to the beginning of life, to the long-term protection of health through prevention and thus fulfils a task for society as a whole, has first to battle hard with the private insurance industry in order to be able to carry out this indispensable activity?

If political leaders do not recognize the urgent need for action as soon as possible and act accordingly, e.g. by setting up a state-financed liability fund for midwives, maternity nurses and obstetricians, an increasing number of midwives will be forced to give up their profession. This would have predictable and drastic consequences on the mortality and morbidity of mothers and children.

In the present situation, young women find it difficult to get enthusiastic about a profession that involves a constant struggle for financial survival while at the same time placing them under immense forensic pressure.

In view of the fact that there are few topics that are so obviously of such general social importance as the birth of the next generation, acceptance of joint responsibility for the beginning of the life and support for those working in obstetrics by civil society would indicate an increased appreciation and recognition of midwifery.

IV. Conclusion: Promoting education – improving structures – respecting fundamental rights – consistent implementation of the UN Convention on the Rights of the Child

I don't delude myself that my vision of pregnancy, birth and professional conduct will be met with understanding everywhere and without delay. Current practice is determined to such an extent by established routines, which can only be overcome by great dedication to mothers and children. The picture presented here, which is entirely based upon the observation of specific procedures, should definitely be a cause of serious discussion. In this sense, education is necessary: of parents and, with regard to their future, of students from the 9th grade onwards, of professional staff, of politicians and of the general public.

The correction of all the problems and violations must be understood as a list of tasks which, in view of the structural problems, must in the first place be dealt with at a political level. Fundamental changes are urgently needed. Associations and hospital management will be equally required to work together to change the financing of obstetrics. In particular, they will have to work towards abandoning the system of flat rate per case invoicing, based as it is on technology dependent medicine that promotes intervention.

Moreover, the effects of everyday routine in the delivery room are of immediate relevance for the human rights of women and children, independently of whether they take place before, during or after birth. The women are denied their fundamental rights, which are constitutionally guaranteed. The current practice is extremely degrading. It violates women’s dignity and their inalienable right to self-determination. Again and again, there is a lack of empathy for the unique situation, which demands competence so that assistants do not end up misusing their power because women rely upon being helped by them. People involved in pregnancy and childbirth should feel called upon to fundamentally rethink their professional conduct and their attitude towards the experience of birth, towards the women as well as towards the children.

The numerous violations of the rights of the child discussed here are unacceptable. It is necessary to counteract the misconception that the child is only a passive object during the process of birth. A thorough understanding of the processes confirms that the child hardly ever reveals itself so obviously to be 'a protagonist in its own development' as during birth. That is why it is vitally important before, during and after birth to implement the Convention on the Rights of the Child consistently.

Therefore, there should be a comprehensive provision of obstetrical services. Then, women would be given the true right to choose where to give birth and this would respect their right to self-determination. Furthermore, it has to be ensured that in every delivery environment, the woman can experience herself as being actively and competently in charge.

All those involved must be aware of the presence of the child and its rights, so that mothers *and* children come through birth healthy and strong.

List of references

1 O'Driscoll, K, Stronge, JM, Minogue, M: Active Managemente of Labour, British medical Journal 3: 135-137 (1973)

2 Duryea EL, McIntire DD, Leveno KJ. The rate of preterm birth in the United States is affected by the method of gestational age assignment. Am J Obstet Gynecol; 213:231.e1-5 (2015)

3 Seedar F, Stinton C, Patterson J, et al. Adverse events in women and children who have received intrapartum antibiotic prophylaxis treatment: a systematic review. BMC Pregnancy Childbirth 17:247 (2017)

4 Stockholm J et al. Maternal propensity for infections and risk of childhood asthma: a registry-based cohort study. Lancet Respir Med 2:631-637 (2014)

5 Barrett JF, Savage J, Phillips K, Lilford RJ: Randomized trial of amniotomy in labour versus the intention to leave membranes intact until the second 60 stage. Br J Obstet Gynaecol 99:5-9 (1992)

6 Cohain JS: The less studied effects of amniotomy. J Matern Foetal Neonat Med 26: 1687-1690 (2013)

7 Rhöse S, Heinis AM, Vandenbussche F, van Drongelen J, van Dillen J: Inter- and intra-observer agreement of non-reassuring cardiotocography analysis and subsequent clinical management. Acta Obstet Gynecol Scand 93:596-602 (2014)

8 Chandrahan E, Wiberg N: Foetal scalp blood sampling during labor: an appraisal of the physiological basis and scientific evidence. Acta Obstet Gynecol Scand 93:544-547 (2014)

9 Hilal Z, Mrkvicka J, Rezniczek GA, Dogan A, Tempfer CB: Accuracy of intrapartum foetal blood gas analysis by scalp sampling: A retrospective cohort study. Medicine 96:e8839 (2017)

10 Devane D, Lalor JG, Daly S, McGuire W, Cuthbert A, Smith V: Cardiotocography versus intermittent auscultation of foetal heart on admission to labour ward for assessment of foetal wellbeing. Cochrane Database Syst Rev 1:CD005122 (2017)

11 Kawakita T, Reddy UM, Landy HJ, Iqbal SN, Huang CC, Grantz KL: Neonatal complications associated with use of foetal scalp electrode: a retrospective study. Br J Obstet Gynaecol 123:1797- 1803 (2015)

12 Salman L, Aviram A, Krispin E, Wiznitzer A, Chen R, Gabbay-Benziv R: Adverse neonatal and maternal outcome following vacuum-assisted vaginal delivery: does indication matter? Arch Gynecol Obstet 295:1145-1150 (2017)

13 Molina G, Weiser TG, Lipsitz SR et al. Relationship between cesarean delivery rate and maternal and neonatal mortality. JAMA; 314: 2263- 2270 (2015)

14 Devane D, Lalor JG, Daly S, McGuire W, Cuthbert A, Smith V. Cardiotocography versus intermittent auscultation of fetal heart on admission to labour ward for assessment of fetal wellbeing. Cochrane Database of Systematic Reviews 1. Art. No.: CD005122. DOI: 10.1002/14651858.CD005122.pub5 (2017)

15 Linderkamp O, Linder R: Anstieg von Kaiserschnittgeburten auf 32% in Deutschland: Erwartet uns eine Epidemie von traumatisierten Müttern und Kindern? In Hildebrandt S, Alberti H: Verborgene Wahrheiten. Der verantwortungsvolle Umgang mit Erinnerungen aus unserer frühesten Lebenszeit. Heidelberg: Mattes, S. 129-145 (2013)

16 Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e. V. (AKF): Gegen den Trend – Wie es gelingen kann die Kaiserschnittrate zu senken – 5 Interviews. (2018)

17 ACOG/American College of Obstetricians and Gynecologists: Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery (letzter Zugriff: 31.7.2014) Obstet. Gynecol. 123: 693-711 (2014)

18 Rutayisire E, Huang K, Liu Y, Tao F: The mode of delivery affects the diversity and colonization pattern of the gut microbiota during the first year of infants' life: a systematic review. BMC Gastroenterol 16:86 (2016)

19 Linderkamp O: Placental transfusion: determinants and effects. Clin Perinatol 9:559-592 (1982)

20 Andersson O, Lindquist B, Lindgren M: Effect of delayed cord clamping on neurodevelopment at 4 years of age. A randomized clinical trial. JAMA Pediatrics 169:631-638 (2015)

21 Mercer JS, Erickson-Owens DA, Deoni SCL, Dean Iii DC, Tucker R, Parker AB, Joelson S, Mercer EN, Collins J, Padbury JF. The effects of delayed cord clamping on 12-month brain myelin content and neurodevelopment: A randomized controlled trial. Am J Perinatol. doi: 10.1055/s-0040-1714258 (2020)

22 Linderkamp O: Polycythemia and hyperviscosity. In: Buonocore G, Bracci R, Weindling M (eds): Neonatology, p. 593-598 Heidelberg: Springer (2018)

23 Carvalho OMC, Augusto MCC, Medeiros MQ, Lima HMP, Viana AB, Araujo E, Carvalho FHC: Late umbilical cord clamping does not increase rates of jaundice and the need for phototherapy in pregnancies at normal risk. J Matern Foetal Neonatal Med (2018)

24 Stinson LF, Payne MS, Keelan JA: A critical review of the bacterial baptism hypothesis and the impact of Cesarean delivery on the infant microbiome. Front Med 5:135 (2018)

25 Rutayisire E, Huang K, Liu Y, Tao F: The mode of delivery affects the diversity and colonization pattern of the gut microbiota during the first year of infants' life: a systematic review. BMC Gastroenterol 16:86 (2016)

26 Johnston C, Campbell-Yeo M, Disher T, Benoit B, Fernandes A, Streiner D, Inglis D, Zee R: Skin-to-skin care for procedural pain in neonates. Cochrane Database Syst Rev 2:CD008435 (2017)

27 https://www.g-ba.de/informationen/richtlinien/19/

28 Painter RC, Roseboom TJ, de Rooij SR: Long-term effects of prenatal stress and glucocorticoid exposure. Birth Defects Res C Embryo Today 96:315-324 (2012)

29 Witter FR, Zimmerman AW, Reichman JP, Connors SL: In utero beta 2 adrenergic agonist expo sure and adverse neurophysiologic and behavioral outcomes. Am J Obstet Gynecol 201:553-559 (2009)

30 Charach R, Abramowicz J, Shoham-Vardi I, Sheiner E (2011): "Is it safe for my baby?" acoustic exposure of diagnostic ultrasound. [Article in Hebrew] Harefuah. 150:588-592 617, 616. (2011)

31 Alldred SK, Takwoingi Y, Guo B, Pennant M, Deeks JJ, Neilson JP, Alfirevic Z: First trimester ultrasound tests alone or in combination with first trimester serum tests for Down's syndrome screening. Cochrane Database Syst Rev 3:CD012600 (2017)

32 Ang ESB et al. Prenatal exposure to ultrasound waves impacts neuronal migration in mice. PNAS 103:12903-12910 (2006)

33 Bellieni CV et al. Is an excessive number of prenatal echographies a risk for foetal growth? Early Hum Dev 81:689-693 (2005)

34 Blettner M. et al. Machbarkeit von Studien zur schädigenden Wirkung von diagnostischem Ultraschall in der Schwangerschaft auf die Gesundheit der Nachkommen. Bundesministerium für Umwelt, Naturschutz und Reaktorsicherheit: Schriftenreihe Reaktorsicherheit und Strahlenschutz (2003)

35 Linderkamp O: Pränatale Ultraschall-Untersuchungen: Gesundheitsrisiko für die Kinder? http://www.greenbirth.de/geburts-abc/u/378-ultraschall-grundinformation-2.html (2017)

36 McClintic AM et al. Mice exposed to ultrasound in utero are less social and more active in social situations relative to controls. Autism Res 7:295-304 (2014)

37 Newnham P Effects of repeated prenatal ultrasound examinations on childhood outcome up to 8 years of age: follow-up of a randomised controlled trial. Lancet 364:2038-2044 (2004)

38 Rosman NP, Vassar R, Doros G, DeRosa J, Froman A, DiMauro A, Santiago S, Abbott J: Association of Prenatal Ultrasonography and Autism Spectrum Disorder. JAMA Pediatr 172:336- 344 (2018)

39 Suresh R et al.: Effect of diagnostic ultrasound during the foetal period on learning and memory in mice. Ann Anatomy 190:37-45 (2008)

40 Webb SJ et al.: Severity of ASD symptoms and their correlation with the presence of copy number variations and exposure to first trimester ultrasound. Autism Res 10:472-484 (2017)

41 Källén B, Finnström O, Nygren KG, Olausson PO: Maternal and foetal factors which affect fetometry: use of in vitro fertilization and birth register data. Eur J Obstet Gynecol Reprod Biol 170:372-376 (2013)

42 Su Q, Zhang H, Zhang Y, Zhang H, Ding G, Zeng J, Zhu Z, Li H: Maternal Stress in Gestation: Birth Outcomes and Stress-Related Hormone Response of the Neonates. Pediatr Neonatol 56:376-381 (2015)

43 Zijlmans MA, Korpela K, Riksen-Walraven JM, de Vos WM, de Weerth C: Maternal prenatal stress is associated with the infant intestinal microbiota. Psychoneuroendocrinology. 53:233-45 (2015)

44 Baibazarova E1, van de Beek C, Cohen-Kettenis PT, Buitelaar J, Shelton KH, van Goozen SH. Influence of prenatal maternal stress, maternal plasma cortisol and cortisol in the amniotic fluid on birth outcomes and child temperament at 3 months. Psychoneurosendocrinology 38:907-915 (2013)

45 Martins R, Emilia O, Nurdiati DS, Brown J: Intermittent auscultation (IA) of foetal heart rate in labour for foetal well-being. Cochrane Database Syst Rev 2:CD008680 (2017)

46 Gaudernack LC, Froslie KF, Michelsen TM, Voldner N, Lukasse M: De-medicalization of birth by reducing the use of oxytocin for augmentation among first-time mothers – a prospective intervention study. BMC Pregnancy

Childbirth 18:76 (2018)

47 Brymdyr K, Cadwell K, Widström AM, Svensson K, Neumann M, Hart EA, Harrington S, Phillips R: The association between common labor drugs and suckling when skin-to-skin during the first hour after birth. Birth 42:319-328 (2015)

48 Devane D, Lalor JG, Daly S, McGuire W, Cuthbert A, Smith V: Vergleich vonelektronischer Überwachung des kindlichen Herzschlags bei der Aufnahme einer Schwangeren mit Wehen durch Kardiotokographie (CTG) versus Abhören in bestimmten Abständen. Deutsche Übersetzung: https//www.cochrane.org/de/CD005122/kardiotokographie-im-vergleich-mit-intermittierender-auskultation-der-foetalen-herztone-bei-aufnahme. Cochrane Database of Systematic Reviews 1:CD005122 (2017)

49 Lemos A, Amorim MM, Dornelas de Andrade A, de Souza AI, Cabral Filho JE, Correia JB: Pushing/bearing down methods for the second stage of labour. Cochrane Database Syst Rev 3:CD009124 (2017)

50 50 Kurth L, Haussmann R. Perinatal Pitocin as an early ADHD biomarker: neurodevelopmental risk? J Atten Disord 15:423-31 (2011)

51 Wahl RU. Could oxytocin administration during labor contribute to autism and related behavioral disorders?--A look at the literature. Med Hypotheses 63:456-60 (2004)

52 Oxytocin Increases Retention of Social Cognition inAutism Biological Psychiatry, Volume 61, Issue 4, Pages 498-503 Hollander Eric, Bartz Jennifer, Chaplin William, Phillips Ann, Sumner Jennifer, Soorya Latha, Anagnostou Evdokia, Wasserman Stacey Mount Sinai School of Medicine, New York; St. John' (2007)

53 Autism, ADHD, and Medicated BirthsMedscape Obstetrics/Gynaecology May 28, (2009)

54 Prins.M, Boxem J, Lucas C, Hutton E: Effect of spontaneous pushing versus Valsalva pushing in the second stage of labour on mother and fetus: a systematic review of randomised trials. BJOG 118:662-670 (2011)

55 Brymdyr K, Cadwell K, Widström AM, Svensson K, Neumann M, Hart EA, Harrington S, Phillips R: The association between common labor drugs and suckling when skin-to-skin during the first hour after birth. Birth 42:319-328 (2015)

56 Sepkoski CM, Lester BM, Ostheimer GW, Brazel - ton TB: The effects of maternal epidural anesthesia on neonatal behavior during the first month. Dev Med Child Neurol 34:1072-80 (1992)

57 Sandall J, Soltani H, Gates S, Shennan A, Deva - ne D: Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev 4:CD004667 (2016)

58 Declercq E: Midwife attended births in the United States, 1990–2012: Results from revised birth certificate data. J Midwifery Women's Health 60:10-15 (2015)

59 GKV-Pilotprojekt: Vergleich Geburten gesunder Frauen mit reifem Einzelkind aus Schädellage. Ca. 30 000 Geburtshausgeburten mit ca. 60 000 Geburten in Kliniken, S. 27 https://www.gkv-spitzenverband.de/media/dokumente/presse/pressemitteilungen/2011/Nov-2011_Pilotprojekt_Vergleich_klin-ausserklin_Geburten_GKV-SV_18221.pdf (2011)

Afterword by the author

I've been very lucky. I was allowed to experience the birth of my child without any medical intervention – in a birth house, continuously accompanied by my midwife. A birth that has strengthened me permanently – physically, mentally and emotionally; a birth that gave me a precious deep experience for my journey of motherhood and from which I still draw years later: "I did it!"

This experience was made possible in the first place because I wanted it but also because I had people around me, who did not want to give birth to me; people, who put up with letting me give birth.

After that I became a midwife.

Even during my first year of training – and because of my experience in the delivery room, one of my essays was titled "Macht und Machtmissbrauch in Obstetrics" (Power and the Abuse of Power in Obstetrics).

I learned that it's considered normal when women emerge from childbirth, hurt in body and soul.

I learned that violations of constitutionally guaranteed fundamental rights during birth are accepted without criticism and are justified by flimsy arguments – in so far as anybody notices them at all.

I learned that birth, which is one of the most human of all processes, does not generally take place in a safe and fitting place. This is because our societies have been tailored for efficiency and economic growth and thus become evermore inhuman.

I learned to take a close look and to ask critical questions.

And I began to wonder why so many women simply accept all of this and assume that modern obstetrics, based on technology, will give them the safety they need and that birth just has to be the way it is.

Human dignity.
Autonomous personal development.
Physical integrity.
Equal rights for men and women.
Protection and care of the community.

Our constitution offers a wealth of wonderful rights for members of our human community; however, for pregnant women behind the closed doors of delivery rooms, these rights do not seem to be fully applicable, not for the woman and even less for the unborn child.

My great wish is that mother and child are perceived as an inseparable unit, respected and strengthened from a salutogenetic point of view. The document presented here relates primarily to the rights of the child but includes disregard for the mother-child unit.

My work on the UN Convention on the Rights of the Child caused my diffuse "moral malaise" to become the realization: the current practice of antenatal care and obstetrics clearly violates current laws.

Within this system in which not only pregnant women and children suffer unnecessarily, I have regularly met midwives and doctors, who go way beyond their breaking point, to provide good prenatal care and obstetrics. I wish to encourage them never to lose enthusiasm and dedication to the miracle of birth. I want to thank them for doing everything in their power to achieve more humanity under such difficult conditions. I also wish them the strength to participate in a change of direction so that they can practise their wonderful profession for a long

time to come, with joy and in good health. May this work contribute to this.

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Legal follow-up remarks on the rights of the child and his mother before, during and after postpartum

The problems presented in this paper not only touch on fundamental questions of the health system, but also concern first and foremost (the life and health of) the parents and their child. This has a widely neglected human rights background with regard to the rights of the mother as well as the rights of the child. Both legal spheres are closely linked, so the realisation of their rights are inter-dependant, as do infringements during pregnancy and birth also affect both. Beyond the protection of constitutional rights, both the mother's rights – protected from discrimination through the conventions on women's rights – as well as the rights of women in general need to be considered as should the rights of the child in accordance with the UN Convention on the Rights of the Child. The realisation of the rights of the child is not conceivable, without at the same time enabling the elementary right of the woman to a self-determined birth.

Although in the practical clinic operation the focus is on a healthy birth of the child in the interest of mother and child, before, during and after birth it is the adult professionals who evidently determine the process of the event instead of the directly affected woman, whose right to self-determination gets disregarded.

More importantly the role of the child, whose need for assistance is obvious, is barely considered in these processes even with all the attention and the care he receives.

Especially from a human rights perspective, this is too short-sighted. The reference of the editors to the findings of the last decades, that the child is an active and competent human being – even before birth – must lead to a change in thinking. For a quarter of a century this has been increasingly respected, due to the UN Convention on the Rights of the Child:

The United Nations adopted the 'Convention on the Rights of the Child' on 20 November 1989. For over 25 years it has been applicable law in Germany (Lorz, Ralph Alexander, Der Vorrang des Kindeswohls nach Art.3 of the UN Convention on the Rights of the Child in the German legal system. Ein Rechtsgutachten, Vol. 7 of the series "Die UN-Konvention umsetzen …", published by the National Coalition for the Implementation of the UN Convention on the Rights of the Child in Germany, Berlin 2003).

Although important steps to implement the Convention are still overdue, in particular the explicit emphasis on the rights of the child in the Constitutional Law (Grundgesetz der Bundesrepublik Deutschland), some progress has been made. Particularly the prohibition of violence against children according to § 1631d of the German Civil Code (BGB), has had a positive effect which has significantly increased public awareness of the vulnerability of children and has resulted in a number of other child protect ion initiatives (Law to strengthen the active protection of children and young people (Federal Child Protection Act - KiSchG) Of 22 December 2011, https://www.mkffi.nrw/sites/default/files/asset/document/bkischg.pdf).

On the other hand, important key points of the Convention have not been sufficiently observed to date. This includes above all the fact that the convention has asserted the subject position of the child as an independent personality through a variety of provisions. In 1968, the Federal Constitutional Court pointed the way forward by stating that "the child is a being with its own human dignity and its own right to develop its personality within the meaning of Article 1 para. 1 in conjunction with Article 2.2 of the Basic Law" (BVerfGE 24, 144). In terms of international law,

the child has been identified as a subject of international law.

This situation under international and constitutional law has a fundamental consequence: the child as an independent legal entity is not subject to any person's power of disposal. As an expression of its unmistakable individuality, which according to Art. 1 of the Basic Law must be respected and protected, the child has the right to self-determination, which every person is entitled to as an expression of their human dignity.

Even parents whose right to education is constitutionally guaranteed (Article 6.2 GG), have no 'right to the child'. They are, by virtue of their parental responsibility, duty-bound to the rights of the child and obliged "to provide appropriate direction and guidance in a manner consistent with the evolving capacities of the child, " (Art. 5 CRC).

In other words, they are trustees of the rights of the child, whose interests they represent, as long as the child is not yet able to give consent. For instance, when consenting to a medical intervention the parents must do so in the best interest of the child to the best of their knowledge and belief.

This legal status is not just applicable to a born child. Even the unborn child is entitled to protection under the Convention on the Rights of the Child and the Constitution. Even though the convention in Art. 1 does not expressly state the time of application, there was agreement that the Convention on the Rights of the Child does not fall short of the status of the Declaration of the Rights of the Child from 1959.

The declaration states, as it was then also stated in the preamble to the Convention on the Rights of the Child, that children need „(special safeguards and care, including) appropriate legal protection, before as well as after birth".

This is underlined by the fact that health care during pregnancy in particular is considered a right of the child, thus presupposing the prenatal validity of the Convention.

To fully realise this right, appropriate pre-natal and post-natal health care for mothers is stipulated as a right of the child.

Consequently, already before birth, the Convention rights are applicable to the child – as stated on the Day of General Discussion of the UN Committee on the Rights of the Child in 2004 (THE CRC RIGHTS OF BABIES AND YOUNG CHILDREN: THREE KEY ISSUES by Bruce Abramson, Committee on the Rights of the Child Day of General Discussion "Implementing Child Rights in Early Development" 17 September 2004, Palais Wilson, Geneva (rev.1)).

Even the unborn child therefore has the right to the "highest attainable standard of health care" (Art. 24 CRC). In this sense the Federal Constitutional Court clarifies on the right to life and physical integrity: "Article 2.2 sentence 1 GG also protects the life developing in the womb as an independent legal interest." (BVerfGE 39, 1 ff. Judgment of 25.02.1975). And already in Germany the Preußische Allgemeine Landrecht (General Prussian Common Law) expressed this by stating:

"The universal rights of mankind are granted even to the unborn children, already from the time of their conception" (Prussian General Common Law 1794, § 10 I. 1).

These rights, which are expressly granted to the child, are the core of the legal status of every human being since the Universal Declaration of Human Rights of 10.12.1948 and subsequent

Human Rights treaties. In the context of pregnancy and birth this applies to the rights of women as mothers, whose dignity and self-determination in the special situation before, during and after birth must be fully respected and protected.

The most compelling expression of this is based on the principle of human dignity, that no man may be degraded to a mere object. Respect for individuality forbids to deny the human being the right to self-determination.

Any routine, in which the woman is only an 'object' in the process of birth, violates her personal rights, even if the woman has formally consented in advance to the medical interventions during birth.

As an expression of his individuality this also applies to the child. Therefore, the right to participate plays a special role in the Convention on the Rights of the Child. Only through participation can be avoided, that the child becomes the mere object of others who act over its head. Because participation follows directly from the inviolable dignity of the human being, this covers all forms of expression of man, in which individuality is manifesting itself.

Especially non-linguistic expressions are to be considered (Daly, Aoife. Children, Autonomy and the Courts: Beyond the Right to be Heard. Leiden: Brill/Nijhoff, 2018) namely from the very beginning. So far, it is the so-called early childhood signals in which the child expresses itself. All parents know this, they listen to every stirring and thereby allow their actions to be influenced. Thus, even if they do not think about it, they are acting within the sphere of the rights of their child.

Accordingly, hunger, thirst and well-being are natural needs, which are at the same time of fundamental legal significance and their neglect is an encroachment of the rights of the child.

This concept needs further consideration, and in regard to the whole event - before, during and after birth. The natural processes of birth only appear to always be the same. In fact, they are individually 'child regulated' and interact with the mother's organism, therefore completely oriented to the concrete situation and as individual as the child being born itself. One is not only touched by the wisdom of these processes, but can recognise, that the individuality of the child is expressed here. The natural due date is an individual sign of maturity and therefore an expression of the child that must be respected in the same way as all other events before, during and after birth. Every intervention in the natural processes is in regard to the rights of the child relevant to its human rights and requires justification. Therefore, the present paper is subjecting the common routines from the micro blood test to the 'planned C-section' to a critical review, in that it is precisely the interventions, often thoughtless or due to structural circumstances, that are identified as child rights violations. As a consequence, violations of the child’s wellbeing must be prosecuted.

In order to achieve a thorough change in practice, it is also a question of attitude to consistently internalise the respect of human dignity. All professions participating in the birthing process must commit to this attitude.

Not lastly, this paper is therefore also intended as a review of the ethical principles of professional action in the context of birth.

The background to the criticism is, with regard to the child’s wellbeing, the principle of the UN Convention on the Rights of the Child that, in all areas of public services of general interest, whether provided by the state or by private pro-

viders, and thus also in the area of health care, "the best interests of the child shall be a primary consideration" (Article 3(1) CRC). In all cases, the existing needs of the child must be explored, named and weighed against other interests. Thereby political and entrepreneurial decisions in the health sector have come under criticism. In particular the financing procedures based on flat rates per case run the risk of leading to a systematic neglect of the interests of children. The closure of maternity wards, inadequate staffing as well as the insufficient remuneration for the services of midwives - quite apart from the disadvantages for those affected by it - ignore the needs of children mainly due to economic interests. Far-reaching planning decisions as well as the organisation of the daily operations, which lack this assessment, have procedural defects which question their legal validity.

The best interests of the child are paramount for all concerned in connection with pregnancy and the birth itself. Legally this is based on the fact that the child as a legal subject is the bearer of its own interests, that require a process of reflection in the field of tension between other concerns, whether the best interests of the child are given due consideration.

This is not only required under international law, given the subject position of the child but also professionally ethically binding for each and every associated person.

However, the child welfare argument often plays a problematic role when referencing that it was the best for the child, precisely when the necessary consideration is lacking and everyday routine takes place. The reference to the best interests of the child is then commonly the substitute for a serious debate, especially about the interests of women. Just before, during and after birth this offers a challenge that cannot be compared to any other life situation. The existential bond between mother and child causes a double concern, that of the child and of the woman. All the activities around the birth must be considered equally regarding the rights of the woman and child.

Non-required routine measures usually not only violate the rights of the child, but at the same time they intervene more or less obviously in the rights of the woman, with health consequences for both.

Existential needs, which are protected by the human rights of women to respect, self-determination, integrity, as well as life and survival and the natural needs of the child protected by its rights under the Convention on the Rights of the Child, are affected by a range of issues starting from the selection of the place of birth to all the individual actions required under birth.

While in the context of birth it is already difficult enough, as parental trustees to protect the rights of the child against a proficient medical operation, the respect for the rights of the woman is particularly endangered because the woman is incomparably impacted by the actions of the participating professions.

Because, as a general rule, women lack the necessary knowledge, they don’t easily disregard the recommendations of an experienced doctor, especially since everything that is seemingly necessary will, if in doubt, be justified with the welfare of the child.

But not least because a birth today is hardly a natural process, but is being treated as a 'disease' even down to the financing procedures, the challenges associated with childbirth increase for the woman because of emotions that are usually associated with diseases like fear and the desire to avoid such disease. The result

is an asymmetry of forces, to which the pregnant woman is usually helplessly exposed. Special attention should be paid to this as part of the necessary process of reflection.

Particularly challenging is the balancing of interests when the interests of mother and child differ from each other. This can already be seen when administering tranquillisers, but particularly painkillers, which might be desirable from a woman's perspective, can be highly problematic for the child, because they have an incomparably stronger effect on the child's organism than on that of the woman.

Nobody can take this decision away from the woman, but she must be aware of the consequence of the decision to her child. This presupposes that instead of routine recommendation of such drugs, advice should be provided, which in turn requires midwives and doctors to be aware of their special responsibility for the rights of the child.

This is also true in view of the problems of a caesarean section birth. As crucial as the procedure can be in order to save mother and child, so questionable is the current practice of planning and performing a caesarean section out of sheer convenience or for reasons of better financing. The fact that the operation as such is a routine medical intervention does not justify the habitual acceptance of the associated impacts to the child - and in the long run also to the mother.

The most difficult evaluation is the one between life and life, that of the mother and that of the child, when both are in question. In considering this, it is vital to remember that the right to life is not an absolute right, but that a balancing of interests is not only necessary but also possible while also respecting the highest responsibility and in reverence of both lives. The Federal Constitutional Court has set the standards for this within the adjudication around abortions (BVerfG 24, 119 [144], BVerfG 39, 1, BVerfG 88, 203).

Fortunately, in the day-to-day clinical practice, this problem is rarely encountered. This makes it all the more important to rule out infringements of the law that are caused by a lack of consideration during routine actions. To raise awareness of this it is necessary, as presented in this paper, to seriously examine of a wealth of details within the maternity practice - not least the fascinating insight into the wise processes of incarnation.

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