



Report on the Mistreatment and violence against women during reproductive health care and childbirth in Finland

A response to the call for submissions by the OHCHR-UN

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This report was compiled by the Minä Myös Synnyttäjänä campaign in collaboration with the NGO Aktiivinen Synnytys Ry.

The campaign's aim is to strengthen women's right to self-determination in the reproductive health care system, make obstetric violence visible and demand decision makers and hospitals to react to the problem. The campaign was initiated by a network of people interested in reproductive health and women's rights: we are midwives, doulas and women who have given birth. The NGOs Aktiivinen Synnytys ry (Active Birth) and Suomen Doulat ry (The Finnish Doula Association) support the campaign.

The Active Birth association is the only existing Finnish organisation that works towards safeguard the rights of women in maternity care. The organisation was established in 1986 and has since been working towards a more women centered maternity care in Finland. The organisation consists of a network of local level groups that offer information in regard to childbirth and maternity options. The foundational ethos of the organisation states that women should be given the choice to decide where, how and with whom they give birth. On a societal level the organisation seeks to ensure that individual rights and choices are respected in maternal health care. The organisation is fully volunteer based. We must regretfully acknowledge that there is no official watchdog organisation in Finland, with employed staff members that would oversee the state of maternal healthcare in Finland, or be able to provide legal advice to women in pregnancy and birth related issues.

Report on the Mistreatment and violence against women during reproductive health care and childbirth in Finland

We are grateful for the opportunity to make a submission regarding the mistreatment and violence against women during reproductive health care and facility-based childbirth in Finland. The following report is based on personal narratives shared by Finnish women in May 2019 during the campaign *Minä Myös Synnyttäjänä - Me Too during Childbirth*. The report focuses on pregnancy and birth related care. There is no official data collected on violence or mistreatment of women during pregnancy and childbirth in Finland, and the subject is for the most part completely ignored in official statements.

1. Cases of mistreatment and violence against women during pregnancy and childbirth in Finland and the responses to it

Obstetric violence has not been formally studied in Finland, and no statistics are kept about it. The psychological wellbeing of women after giving birth is not evaluated outside of, at best, the very short term. Births in Finland take place almost exclusively within the public healthcare system and the public birthing hospitals, while pregnancy and postpartum care are conducted in public maternal and child healthcare centres. There are no private birthing facilities, and only a very small handful of women choose to hire private midwives for home births, which are not recommended nor supported by the official healthcare system. Thus, this report focuses solely on maternal healthcare and births that take place within birthing hospitals and in maternal and child healthcare centres in the Finnish public health care system.

In birthing hospitals the measure of customer satisfaction is based on a numerical “grade” given verbally a few days after the birth (usually on the scale of 1-10). The mother is not usually informed of the fact that she is being asked for a formal evaluation of the hospital’s performance. The numerical grade given to the birth is not supposed to reflect the experience of relief after a baby has been born. A recurrent theme in the accounts shared by women is that they gave their birth a high number, a 9 or a 10 on the day after the birth, but had they been asked for an evaluation of the birth after some months, it would have been a 2 or a 3. Some have expressed that they felt like their own performance during the birth was being evaluated, as no information was given to them about what the grade measured.

The qualitative data gathered by the Minä Myös Synnyttäjänä ('Me Too during Childbirth) social media campaign reveals violations and violence at various levels. The campaign started on the 2 of May, 2019. In just two weeks, we have received over 150 accounts of violence, rights violations, and inappropriate conduct in maternity care, during prenatal care and birth as well as during postpartum care. We have thus far analysed 60 personal narratives that occurred between 2005 and 2019. Nearly half the stories shared report of events that took place between the years 2013 and 2019. The year was not mentioned in 13 of the stories and the 11 of the stories did not mention the location in which the events took place. See Appendix 1 for a discussion of how data has been analysed.

The experiences reported by the women took place all over Finland and in hospitals of varying size. The hospitals in which one or more case were reported are: Kuopio University Hospital, Päijät-Häme Central Hospital, Seinäjoki Central Hospital, Tampere University Hospital, Joensuu Central Hospital, Espoo Hospital, Lapland's Central Hospital, Satakunta Central Hospital, North-Karelia Central Hospital, Turku University Hospital, Central-Finland Central Hospital, Jorvi Hospital (Espoo), the Women's Hospital (Helsinki), Mikkeli Central Hospital, Oulu University Hospital, Oulaskangas Hospital (which no longer has a maternity or birthing unit), Länsi-Pohja Central Hospital (Kemi) and the now closed Kätilöopisto Maternity Hospital (Helsinki).

"I only heard after the baby was born that they had done an episiotomy."

The women's accounts collected by the campaign in the first two weeks since its launch, tell of various degrees of physical violence and emotional abuse that took place in public hospitals during pregnancy and birth. The response has been nearly overwhelming as in addition to the hundreds of stories collected, there has been a widespread response from women sharing about how they are hearing the term obstetric violence for the first time and how it is helping them come to terms with events that have left them emotionally scarred for years. In addition to the reports of actual abuse, violence and neglect during birth in Finnish hospitals, there are several accounts of how the events left women severely traumatised and suffering from post traumatic stress symptoms in the months and years following the birth. Several also shared that the treatment received during birth was so terrifying and left them so traumatised that they chose to not have more children.

“The midwife repeated over and over ‘Just enjoy the baby now,’ while I was crying and yelling and trying to kick the doctor away from in between my legs where they were stitching me up.”

The most common physical violations were medical interventions and procedures that were carried out violently or painfully, or procedures that were performed secretly or without consent. Typical examples included episiotomies done without informing the client, as well as violently performed vaginal examinations. Some stories reported the use of physical force such as pushing the woman to the birthing room bed, or holding her down while examinations were done against her consent or without informing her about what was happening. There were several cases of interventions and procedures carried out against the client’s will or continued despite her requests to stop.

“I remember lying on the floor, crying hysterically from fear and pain.”

The women’s stories include recurrent cases of emotional and verbal abuse. Examples of emotional abuse and neglect of the birthing woman were common. Women were often left alone during birth without support, information was commonly concealed or withheld, and several reports also accounted healthcare professionals lying to the client in matters regarding her care or the necessity of different interventions. There were cases of leaving unbearable pain untreated, obstructing movement during birth without medical reasons, as well as dictating the birthing position in the second stage of labour.

The start of the campaign was followed by wide media coverage. In media articles, many hospital representatives downplayed the women’s accounts of obstetric violence shared through the campaign and refused to call them violence. Instead, hospital representatives and the chairperson of the Finnish Midwifery Union, Marjo Lyyra expressed worry over unnecessarily increasing people’s fears of birth, and referred to rare emergency situations to justify violations of birthing people’s basic human rights. The article in the Helsingin Sanomat (08 May, 2019) reported that Lyyra thinks that the things mentioned in the campaign are important to discuss as maltreatment during birth happens. Lyyra, however, finds the use of the word violence to be cruel towards the health care staff. It would appear that in Finnish maternity care the right to self-determination and bodily integrity it is not fully understood. Healthcare officials have expressed in several occasions in the last weeks’ reports, that it is often necessary and acceptable for doctors to cross the birthing person’s right to self-determination, despite the fact that the Finnish law defines it as absolutely unconditional right. To our knowledge, political authorities have not commented on the issue.

The mother has, after all, come to the hospital, in which case the responsibility is not hers. It is our responsibility to make decisions and possibly also to override the mother's will. Do we commit violence and mistreatment if we go against the mother's will?

Marjo Lyyra, President of the Midwives' Union, as reported in Helsingin Sanomat, Nyt-liite, 8 May 2019 [authors' translation from Finnish]

Doctors are being compared there quite carelessly to even perpetrators of sexual violence. It was very sad to read,' says Mäntymaa. [...] 'The risks associated with birth have also grown with the rise in the median age of mothers.. [...] Decisions sometimes have to be made very quickly. In the case of an emergency c-section, the baby must be born within ten minutes of making the decision to perform surgery. In that case there is not always time to listen to or discuss with the patient, because all energy must be focused on action.

Marja-Liisa Mäntymaa, OB/GYN senior physician at the Kymenlaakso Central Hospital, as reported in Yle News, 8 May 2019 [authors' translation from Finnish]

It is worth pointing out that a significantly large portion of the shared experiences took place during induction of labour. In these experiences typical elements were the loss of self-determination, transfer of decision-making entirely to medical personnel, agonising and uncontrolled pain, instrumental delivery of the baby which was experienced as violent, and bad tearing, lack of support, and being left alone while experiencing unbearable pain. As several statistics already show (WHO, 2011), induced births, in the reported cases, also often led to cesarean sections.

In Finland, almost a third of all births are induced (28.9% in 2017). The amount of inductions has grown 55% in the last ten years, from 16.7% in 2006 to 25.8% in 2016¹. The percentage of inductions varies widely by hospital. Nine hospitals have induction rates of over 30%, and one hospital has an induction rate of over 45% (THL, 2018).

¹ The years of comparison used are 2006-2016 as the statistical criteria was changed in 2017 rendering the numbers after 2017 not comparable to the previous years (THL, 2018).

Several birthing hospitals in Finland have been closed down in the last eight years, in an effort to concentrate births into the larger urban based Central and University hospitals (THL, 2016). Long travel distances create the fear of birth taking place outside of hospital and to address this problem induction of birth has become common practice even when there is otherwise no medical reason for induction. It is notable, that the hospital with the highest induction rate of over 45% is that of Länsi-Pohja, situated in Kemi, Lapland, where one of the contributing factor to the inductions could be the greater distances between home and hospital.

From the point of view of the rights of birthing women, it is clear that determining the reasons behind the increase in induction rate is necessary. As induced births are disproportionately represented in the stories of mistreatment and violence, it is also necessary to closely monitor the fulfilment of the right to self-determination and bodily integrity to ensure a good birth experience in conjunction with induction of labour.

2. The administration of full and informed consent in reproductive health care and childbirth in Finland

The right to self-determination is apparent in the Constitution of Finland (731/1999), the second chapter of which lays out the basic rights possessed by everyone, such as the right to life and the right to personal liberty and integrity.

The right to self-determination has also been legislated in the Act on the Status and Rights of Patients (785/1992), more commonly known as the Patient Act, which is the leading principle of social and health care. The Act on the Status and Right of Patients states, in relation to the right to self-determination, that:

The patient has to be cared in mutual understanding with him/her. If the patient refuses a certain treatment or measure, he/she has to be cared, as far as possible, in other medically acceptable way in mutual understanding with him/her.” (Ministry of Social Affairs and Health, Finland, 1992, Section 6)

The law encompasses maternal and birth care, but the narratives from women throughout Finland express that informed consent is not practised in maternal healthcare or birth. For example, the stories gathered show that inductions are regularly

performed without informed consent, even without informing the birthing woman in advance that an induction will be performed, and it is common place for interventions to be performed without consent and certainly without informing the woman of any possible options. The responses from healthcare officials reported under Section 1 in this report also express that healthcare officials do not regard it as necessary or even possible to practice informed consent during childbirth.

There is no continuity of care during pregnancy and childbirth in Finland, as pregnancy related care takes place in maternal and child healthcare clinics, while births are concentrated into large regional hospitals. Birthing classes, in which women would be taught about the different risks and options relating to childbirth are not generally offered. The Finnish midwifery association has expressed that women coming to give birth in Finland are not educated about childbirth and thus their ability to make informed choices is severely restricted (Siivola, 2017; Poranen, 2017). The lack of knowledge on the part of the birthing women is, however, not a sufficient excuse for overriding her wishes and neglecting the law on the right to self-determination.

An example of the way in which women are regularly denied the right to refuse interventions within the maternal healthcare system in Finland, is the postpartum doctor visit. The visit is required after childbirth in order to receive maternity benefits by the state. Generally, it is accepted that these check ups involve the doctor performing an internal examination. The doctors performing the examination are not usually gynaecologists, nor obstetricians, but GPs who do not for example assess pelvic floor issues or vaginal prolapse. Women who do not consider it necessary to have a doctor perform an internal examination during this compulsory check up are often pressured and told that unless a vaginal examination is performed they are not eligible for maternity benefits. There is a lack of clarity on whether or not an internal examination is officially required. Women have reported different experiences when they have chosen to refuse the vaginal examination. While some doctors accept the woman's right to refuse the procedure, others refuse to write the certificate needed to receive the maternity benefits unless the examination takes place. In one instance a woman contacted the Finnish Social Insurance Institution KELA to ask whether it was necessary to submit to a vaginal examination against her will in order to acquire maternity benefits. KELA responded that that only a doctor's visit was required, no internal examination. However, in the same case, the Department of Health and Wellbeing was unable to confirm that internal examination is required. In another instance, the maternal and child healthcare department of the city of Lappeenranta challenged a woman's right to refuse the vaginal examination during the postpartum check up and her case went to the Ministry of Health, which responded by saying that

they could not confirm whether the vaginal examination was indeed a requirement for receiving maternal benefits. Similar cases were reported from the cities of Pori and Turku.

Though the are policies in relation to sexual and reproductive health they are unclear in relation to informed consent. The Ministry of Social Affairs and Health published an action plan on sexual and reproductive health in 2014 (Klemetti & Raussi-Lehto, 2014). The action plan is effective between 2014–2020. The action plan on sexual and reproductive health aims to improve the population's sexual and reproductive health care and includes recommendations for perinatal care and birth. The National Institute for Health and Welfare states on its webpage that previously there have been no national guidelines or recommendations on good care at birth. Informed consent is not explicitly mentioned in relation to reproductive health care, perinatal care or care at birth but it is stated that a pregnant person or a person giving birth should be allowed to be part of decision making concerning her care.

In light of the reports given by women (as no official data is collected), it is clear that despite the law on the patient's rights, informed consent, and the need for consent, are not seen as necessary, or are at best optional in maternal healthcare practice in Finland.

3. The accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition.

The National Supervisory Authority for Welfare and Health (Valvira) recommends that clients who wish to file a complaint to any healthcare facilities should first attempt to resolve the issue directly with the person in charge of the care or their supervisor. The next option they recommend is that of making a written reminder to the director in charge of health care at the unit where the patient received care. The director investigates the matter with the person(s) who provided the care and sends a response to the patient, usually within about a month (Valvira, 2008).

If the matter cannot be resolved otherwise, it is possible to file a complaint to the Regional State Administrative Agency or to The National Supervisory Authority for Welfare and Health (Valvira), depending on the subject of the complaint. The complaint may be free-form or it can be based on the provided complaint form. As a rule, the

complaint must be made within two years of the event that it concerns. According to their website, processing times for the complaints take about a year (Valvira, 2008).

It is possible to obtain help and advice for the reminder and complaint making process from the patient ombudsman of the health care unit responsible for the care. If a healthcare-related injury is suspected, an injury report can be filed for the Patient Insurance Centre. The injury report must be made within three years of receiving notification of the injury (Ministry of Health and Social Affairs, undated).

According to national news reporter Yle, the Patient Insurance Centre receives about one hundred injury reports regarding childbirth per year. Approximately one third of these reports result in compensation being paid to the claimant. Only major physical injuries or death resulting from malpractice are compensated (Siirilä & Krautsuk, 2019).

The narratives of the women who have shared their experiences in the 'Me Too during childbirth' campaign reveal that filing complaints or making official reminders does not result in their experiences of violence being validated, even in cases of serious breach of the law on the right to self-determination, or cases of serious violence where harm has been committed to the birthing woman. Of the women who shared their stories, 11 had filed a complaint with the hospital, and five had followed it up with a reminder to the Regional State Administrative Agencies. The majority of the women felt that the timeframe for making a complaint was too short, and the process too difficult to follow. Those that had made complaints agreed that the process was complicated. Complaints cannot be made by email or through the internet, but must be sent by mail. In Finland nearly every official and government related form can be compiled electronically so the 'old fashioned' system represented by the healthcare department was seen as unusual.

The major obstacle in filing complaints was, however, the fact that women suffering from trauma related symptoms and caring for newborn babies did not feel able to undertake the task. The idea of having to face the person who had violated them was also seen as overwhelming. Some women reported that they could not even bear the idea of walking back into the hospital in which they had been abused during childbirth and experienced panic attack symptoms if they had to return to the facilities. Several women did not even know, that such complaints could be filed, or that hospitals had ombudsmen. Maternal and Childcare services do not educate women on the possibility of filing complaints and most women who had tried to express, to their maternal healthcare nurse, that their birthing experience had been traumatising had faced belittling. Not a single one of the women reported receiving any assistance or support in filing the complaints or reminders.

Of the ones that had filed complaints only one woman shared that she had received apologies from the hospital for the treatment and trauma caused to her after filing a complaint with the hospital. The other women expressed that after filing a complaint, it took up to six months for the hospital to respond. When women had been invited to speak with the people who had behaved inappropriately towards them during birth, they were generally told that the doctor or midwife had followed hospital procedure and no wrongdoing had taken place. Facing the people who had abused them was difficult as it re-triggered the feeling of not being heard and having no say in regard to their own care.

Generally the women shared that in their responses, either in person or via letter, the hospitals denied any wrongdoing, expressed regret for the fact that the woman had found her birth difficult, but no follow up measures were taken towards members of staff who had yelled at, rough-handled or otherwise behaved in inappropriate ways towards the women. One woman shared how in their response to her complaint, hospital staff excused their behaviour by expressing that “communication with the patient was difficult” while another, who had complained about inappropriate and rude behaviour by a doctor was told that his behaviour was caused by the patient “being so tearful and overweight.” In another instance a woman had complained to the hospital that prior to giving birth at her check up at the maternity ward she had been yelled at and threatened by a doctor. The doctor told her that she could be either induced or have a cesarean section, but would not give birth naturally. In this case, there was no imminent danger to the mother or child but, rather, the mother was simply asking to wait a few more days before conducting an induction. The mother was very aware of the risks involved with waiting and her options. The doctor had also called her private number and yelled at her on the phone, after she had requested to not have to talk to this doctor anymore. The complaint she made to the hospital did not satisfy her, and the doctor in question did not receive any reprimands. Some other mother’s shared that they were told that the hospital’s lack of staff and high amount of births had caused midwives to neglect or mistreat their clients.

Regarding the numerical grading of the birth experience mentioned under Section 1, which is done immediately after birth, women shared, that even if they had given a very low grade to the number because of experienced abuse, there was no follow up in which they would have been asked why they had rated their birth so lowly. Some women had also used hospital feedback forms to complain about the care they had received. One woman shared how she had used a feedback form to complain about a nurse whom she felt had been physically abusive towards her. Despite the fact that she

left contact details on the form she had filled out, she was never contacted by the hospital.

The most serious of the cases in which women filed complaints, involved malpractice that led to the death of the infant and the removal of the mother's womb. After the family filed an initial complaint and injury report they were told that no malpractice had taken place. Three years, and several complaints later, Valvira, the National Supervisory Authority for Welfare and Health Valvira, and the midwife, doctor and the hospital involved (the Women's Hospital in Helsinki) received a reminder. The family chose to hire a lawyer, and four years after the death of their baby, it was finally admitted that malpractice had in fact taken place. The family is still waiting for any compensations. Both the baby's death and the removal of the womb were results of malpractice in a long series of events during the birth. The mother herself had requested help several times during the birth, but her wishes had been ignored. She still suffers physically from the consequences, has severe PTSD, and has not been able to work after the events took place. She has been told that any possible compensations will be likely to only be awarded in regard to the death of their child, not in relation to the mother.

As long as it is up to women to file complaints after a difficult or abusive birth experience, without any information or support provided to them, the system that is in place in Finland appears insufficient. The difficulty of the process, disregard and belittling by healthcare professionals, and shared stories about how making a complaint 'amounts to nothing', all discourage women from even attempting to file complaints. For those that do, results are rarely satisfactory, the process is difficult and hospitals rarely admit to any wrongdoing. Women's rights to self-determination and bodily autonomy are not regarded in high value in Finnish maternal health care and this is reflected also in the process of reporting and addressing violations.

4. Finnish health care policies guiding health responses to VAW and their alignment with WHO guidelines and standards

At the 2012 High Level Meeting of the General Assembly on the Rule of Law, Finland made a national pledge to ratify the Council of Europe Convention on preventing and combating violence against women and domestic violence (The Istanbul Convention). The ratification was concluded and the Convention entered into force in Finland in August 2015.

The Finnish Government's five-year multi-sectoral Action Plan to prevent violence against women reached the end of its mandate period in 2015. According to an NGO Parallel Report (Laaksonen, Matikka, & Åberg, 2018) the final report published in June 2016 shows deficiency in the prevention of violence, in legislation and legal praxis, in services for both victims and perpetrators, and in the coordination for combating violence. The final reports of both the programme for reducing violence and the Government Action Plan for Gender Equality 2012–2015 note that the poorly resourced measures for combating violence against women have led to defective implementation, leading to their goals have been entirely unachieved or achieved only partly. According to the report, the state must evaluate both the fulfilment and the effects of the measures and actively monitor the implementation process. So far, the evaluation and monitoring has been lacking (Laaksonen, Matikka, & Åberg, 2018).

At the end of 2016, the Finnish Government established a coordinating body, the Committee for Combating Violence Against Women and Domestic Violence. According to NGO parallel report, it lacks independent resources and an independent mandate to act. The power that the coordinating body has depends entirely on the powers of the governmental bodies represented within it. Amnesty International (2018) has also indicated that the body has not been properly resourced since the work of the Administrative Committee is conducted within the budgetary constraints of the existing budgets of various ministries and relies on the human resources of existing bodies. In an international comparison of 15 Council of Europe member states of the resources allocated to measures for combating violence against women, Finland ranked second to last. On average, Finland spent only €0.01 per capita on measures for combating violence against women, while neighbouring Sweden spent €32.26 per capita (Amnesty International, 2018).

The Ministry of Social Affairs and Health published the Action Plan for the Istanbul Convention for 2018–2021 in December 2017. According to the NGO Parallel Report, it represents one of the most central problems in the implementation so far: the four year plan focuses on the development of state authorities and their work but fails to notice the significant role that NGOs play in combating violence against women in Finland. In the introduction of the Action Plan, it is stated that “Finland has a strong tradition of cooperation between public authorities and NGOs, and the latter are also involved in the implementation of several Articles” (Laaksonen, Matikka, & Åberg, 2018). Despite this acknowledgement, NGOs remain absent later when actual measures for accomplishing the Action Plan are listed.

According to Amnesty International (2018), the Finnish government is still lacking a systematic approach to assess the human rights impacts of its actions and has been urged to review how bills, policies and budget proposals may impact human rights, prior to their adoption. To date, such assessments have been limited, or completely lacking, including in respect of bills related to violence against women and domestic violence (Amnesty International 2018).²

WHO guidelines (2017) include recommendations as listed as: to inform women about their rights as clients and to hold staff accountable for violations of client's rights (WHO, 2017:9); to provide information and services that enable women to have options and make choices about their treatment, care and support; to educate health care staff to understand how unequal power and social norms perpetuate violence against women (WHO, 2017:10); to encourage health care providers to respect women's choices and autonomy in making decisions related to their care (WHO, 2017:10); to create awareness of what behaviour is inappropriate in the health care system; to develop and make known a clear policy forbidding violence of any kind in the workplace, including sexual violence and sexual harassment or to include mechanisms of redress for those subjected to violence and clear disciplinary procedures for those found to be perpetrating it (WHO, 2017:73). No such guidelines were stated in the plan to reduce violence against women organised between 2010 and 2015. The policies concentrate on how to educate health and social workers to identify victims of violence, not to encourage health care providers themselves to respect women's rights or view themselves as potential violators.

The WHO guidelines state that "it is essential that a health system collect and use data on violence against women at every level" (WHO, 2017:98). The campaign creating awareness about violence against women during pregnancy and birth is gathering important data via stories and narratives which according to the WHO guidelines can be viewed as qualitative data that can "raise awareness and sensitise people to the importance of a health system response to violence against women" (WHO, 2017:101). So far, this qualitative data has provoked reactions from the media that belittle women's experiences and give space to health care staff denying the phenomena, blaming the victims and asserting their right and even responsibility to violate women's rights during childbirth.

² Please see the NGO Parallel Report: <https://www.riku.fi/binary/file/-/id/79/fid/2029> as well as Amnesty International's report: <https://rm.coe.int/amnesty-international-submission-for-the-greivio-of-finland-final/16808b161d> for full assessment of the policies undertaken to address violence against women in Finland.

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APPENDIX 1

Analysis of the narratives

The qualitative data gathered by the *Minä Myös Synnyttäjänä* ('Me Too during childbirth') social media campaign reveals violations and violence at various levels. The campaign started on the 2nd of May, 2019. Since then, we have received over 150 accounts of violence, misdemeanour, and inappropriate conduct in maternity care, during both prenatal and birth care.

We have analysed 60 personally narratives that occurred between 2005 and 2019. Nearly half of the stories were from events that had taken place between the years 2013 and 2019. The year was not listed in 13 of the stories and the location was not mentioned in 11 of the stories.

Reports of minor and major violations of the right to self-determination were recorded throughout Finland and had taken place in hospitals of varying size. The hospitals covered in the reports were: Kuopio University Hospital, Päijät-Häme Central Hospital, Seinäjoki Central Hospital, Tampere University Hospital, Women's Hospital (Helsinki), Mikkeli Central Hospital, Kätilöopisto Maternity Hospital (Helsinki - this hospital was closed down in 2017), Joensuu Central Hospital, Espoo Hospital, Lapland's Central Hospital, Satakunta Central Hospital, North-Karelia Central Hospital, Turku University Hospital, Central-Finland Central hospital, Jorvi Hospital (Espoo), Oulu University Hospital, Oulaskangas Hospital (which at the time of writing no longer has a maternity unit) and Länsi-Pohja Central Hospital (Kemi).

The experiences were shared by women via email, through a feedback form on the campaign's website, private message to the campaign page on Facebook, and a closed Facebook group created for the campaign for people who have experienced obstetric violence. Short narratives shared through Facebook were excluded from the data used in this report. Experiences that had taken place over 15 years ago were also excluded from the report data.

We separately asked the women who had shared their experiences if they had filed complaints about the treatment they had received. Eleven women responded by saying that they had filed complaints through the hospital and five had followed it up with a reminder to the Regional State Administrative Agencies.

The acts of violence and violations were divided into the categories listed below. It is possible that one act falls under several categories. For example, suturing a tear without any - or without sufficient - use of local anaesthetics was categorised as both a violent procedure as well as a form of unrelieved overwhelming pain. Forms of psychological violence included causing fear or disturbing the birthing person with threats, coercion, and long lasting or repeated verbal abuse towards the client. The discrimination category includes two cases of discrimination on the grounds of weight and two based on language. One incident was also reported in which racism was directed at the client's spouse. It is worth noting that the campaign has not yet reached members of migrant populations, or women belonging to language minorities as all the materials used are in Finnish only.

CATEGORIES:

Interventions performed despite of refusal	9
Interventions performed without consent or in secretly	18
Violent or painful procedure	23
Withholding or hiding information or lying	12
Lack of support	22
Unrelieved overwhelming pain	14
Neglect	10
Emotional abuse	19
Discrimination	4
Physical coercion or rough-handed touch without consent	3
Restricting movement (without a medical reason)	4
Dictating the position for the second stage of labour	4
Disregarding the client's wishes	9