THE UNIVERSITY OF CHICAGO

Obstetric Violence: What Is It? An Overview Of Its Status, Challenges And Potential Solutions

By

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November, 2022

A paper submitted in partial fulfillment of the requirements for the Master of Arts degree in the Master of Arts Program in the Social Sciences

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1. Definitions

The term "obstetric violence" (OV) has become more visible in recent years, as hundreds and thousands of women around the world have begun to publicly expose their childbirth experiences. However, and as with many of these concepts, there is no single definition of what obstetric violence corresponds to. Jardim and Modena (2018) analyze the scientific production that has been developed on obstetric violence and identify its main characteristics. To do so, they review 24 publications indexed in different journals related to the subject. In conclusion, the authors point out that OV is a situation with multiple manifestations, among which negligent, reckless, omissive, discriminatory and disrespectful acts practiced by health professionals and legitimized by the asymmetry of power granted by technical and scientific knowledge stand out. For Shabot and Korem (2018), OV constitutes any type of physical and/or mental violence that is perpetrated during pregnancy and/or labor. To this, the World Health Organization (WHO) adds the postpartum as a period of extraordinary vulnerability that also makes highly likely for episodes of OV to occur.

Together with these definitions, there is a set of authors and organizations that, instead of describing what an act of OV constitutes, they have made an effort in describing what a dignified pregnancy, delivery and postpartum should look like. Perez (2021) defines health as a state of complete physical, mental, and social wellbeing and argues that the enjoyment of the highest attainable standard is one of the fundamental rights of any human being. Women, despite their pregnancy status, should be granted with the right to it.

2. History

The first country that officially recognized Obstetric Violence was Venezuela in 2007, as part of the Law on Women's Access to a Life Free of Violence. Nevertheless, the roots of the OV movement can be tracked to the feminist movement in the 60's and, with special emphasis, in Latin American feminist activists (Pérez, 2021).

One of the characteristics of the movement to end with obstetric violence that has remain constant through the years is its human rights approach. This means, for example, understanding OV as a violation of women's sexual and reproductive rights (Perrotte et al, 2020). In this line, in Venezuela, OV is defined as the appropriation of women's bodies and reproductive processes by the health personnel (Castro, 2019).

Together with the human rights approach, a strong critique made by OV activists relates to the biomedical model of care. Specifically, the critique is directed towards the pathologizing and medical regulation of women bodies (Pérez, 2021)[1].

[1] Broadly speaking, the biomedical model of care understands health as the absence of objective indicators of sickness, in opposition to the biopsychosocial model of health, which states that the absence of sickness is a necessary but not sufficient condition of health, since health involves an optimum level of psychological and social wellbeing also. Therefore, some of the main critiques that the biomedical model has received in the last year are the focus on duration of life rather on the

Nowadays, the attempts to make visible and end OV have consolidated as an important struggle of global feminist movements (Van der Waal et al., 2022). Nevertheless, this has happened with opposition of some relevant actors. In Spain, for example, health unions have raised their voices against the concept of OV since they consider it criminalizes professional practices that are performed under ethical standards, undermining with it the relationship of trust that should prevail between patient and health professionals (La Vanguardia, 2021).

3. Prevalence

Accessing reliable data on the prevalence of obstetric violence is a challenge considering that it is a phenomenon that has only relatively recently entered the public debate. Moreover, many women prefer not to report their experience both for personal reasons - it can be a re-traumatizing experience - and because of social norms -like the idea of women not complaining about their maternity. In addition, many women, especially those belonging to certain minorities who have historically been placed in a position of inferiority, resigned to suffer certain practices, do not recognizing that they have been victims of OV.

Despite the broad difficulties in collecting data, some countries have made progress in this area. In Mexico, the National Survey on the Dynamics of Household Relationships (ENDIREH) applies a nationally representative survey to female residents aged 15 and older. According to data from the 2016 survey, in the last 5 years, 33.4% of women aged 15 to 49 years who had a childbirth suffered some type of mistreatment by those who attended them In the United States, Vedam et al. (2019) applied a survey to 2,138 women and noted that 17.3% of women who were pregnant between the years 2010 and 2016 experienced some type of OV. Now, the numbers increase to 21.5% when considering patients of low socioeconomic status, to 32.8% for indigenous women and to 27.9% when considering women with at-risk pregnancies (Perrotte et al., 2020).

In France, one in five births results in an episiotomy, with 50% of episiotomies being unconsented; in Italy, 21% of women experience physical or verbal abuse during their pregnancy; in Myanmar, 25.9% of women report vaginal examination without prior consent, and 66.4% for episiotomy cases, while in Iran 37% of women participating in a study defined their birth experience as traumatic. In Kenya, a study of 13 health centers reported an OV rate of 20%; while in Malawi 58.2% of women reported lack of privacy during their delivery (Perrotte et al., 2020).

These are just a few of the growing number of data available, but they serve to illustrate that, first, this is a phenomenon that transcends continents and, second, that the magnitude of the problem is not commensurate with the little attention it has received historically.

4. Manifestations

quality of it, and the attention on sickness rather than on the person itself.

As mentioned before, OV is a global phenomenon in the sense that it happens all over the world. However, it has multiple manifestations that, in part, depend on the women that are victims of OV and on the places they inhabit. Having a broad definition of OV is helpful to consider all these manifestations, but, for clinical, research and educational purposes, it is useful to at least identify the most common ways in which OV is happening.

One common type of obstetric violence corresponds to **verbal violence**, which tends to manifest in being shouted or scolded, feeling ignored when raising doubts, humiliation in response to complaints, among others (Castro and Frías, 2020).

A second form of OV that research has shed light on corresponds to **physical violence,** mostly noticeable in the execution of medical procedures or in the use of devices without the prior consent of women. Common ways in which this is occurring today is through the excessive use of episiotomies and caesarean sections (without being medically necessary). In a study in France, it was observed that 1 in 5 deliveries result in an episiotomy, and that 50% of them happen **without consent** of (Haut Conseil à l'Egalité Entre les Femmes et les Hommes, 2018). In the same lines, Bohren et al. (2019) detected that 25.9% of pregnant women in Myanmar reported vaginal examination without prior consent (Perrotte et al., 2020).

In third place, literature has identified **lack of privacy and confidentiality** during pregnancy and labour as a form of obstetric violence, considering that both privacy and confidentiality are part of human rights and, specifically, to the right of access to health. This type of OV is commonly observed when there is no privacy when procedures are to be carried out (Gaitán-Duarte and Eslava-Schmalbach, 2017), and when health centre resources cause women to share intimate spaces with other pregnant women without taking measures to compensate for this lack of privacy (Tobasía-Hege et al., 2019).

Fourth, there has been lately raised that the **conditions of health facilities** can also be considered a type of OV. Things such as infrastructure, skills of professionals, lacks of protocols can also be a way in which women's sexual and reproductive rights are violated.

In the following table there is a summary of detailed types of OV according to experts on the subject and to the World Health Organization.

Classification Types of Obstetric Violence according to the Literature

Castro, A. and Savage, V. (2019)	1	Verbal Abuse
	2	Poor Apport with Women
	3	Socio-Cultural Discrimination
	4	Physical Abuse
	5	Failure to Meet Professional Standards of Care
	6	Health System Conditions
WHO (2014)	1	Physical Abuse
	2	Humiliation and Verbal Abuse
	3	Coercive/Unconsented Medical Procedures
	4	Lack of Confidentiality
	5	Failure to Get Fully Informed Consent
	6	Refusal of Pain Medication

	7	Violations of Privacy
	8	Refusal of Admissions to Health Facilities
	9	Detention of Women in Facilities After Childbirth Due to Inability to Pay

Source: Own elaboration

5. Causes

As every social phenomenon, obstetric violence has multiple causes that range from the individual to the systemic. However, there is consensus in the literature that some situations are particularly relevant to explain the occurrence of OV and, therefore, should be considered when planning solutions to address it.

A first cause of OV that has been raised is the **vulnerability of women during pregnancy, childbirth and postpartum**. Both physical and mental components, like being naked and in pain during labour, and the high expectations throughout pregnancy, create an environment of high vulnerability for women. This is complemented by the fact that, on the side of the health team, pregnancy and childbirth are routine medical procedures.

Secondly, Chandra et al. (2021) highlight the cultural **stereotypes surrounding women and motherhood** as a relevant cause to understand the occurrence of OV. One example of this, particularly relevant in the health care setting, is the idea that women exaggerate pain. Within the same lines, Perrotte et al. (2020) note that it is very common that female patients are infantilized by the health care professionals, undermining with it their autonomy and capacity for decision-making. For Shabot and Korem (2018), it is important to take into consideration the predominant stereotypes of good mothering, for example, the idea that a good mother is one who makes a total sacrifice for the needs of her children.

Third, it is key to take into account the **power asymmetry** that exists between health professionals -specially doctors- and patients, granted both by technical skills and medical knowledge. This can impact the perpetration of OV since medical personnel encounter less resistance when performing any procedure or using certain devices (Shabot and Korem, 2018).

In fourth place, a reason for explaining the high incidence of obstetric violence relates to the **generalized gender-based violence and discrimination** that prevails in almost every society. For some, OV constitutes a form of gender violence by the only fact that is always directed towards women (Perrotte et al., 2020). For others, it has to do with the patriarchal system that we live in and that punishes bodies that are not feminine enough, such as a women's body while giving birth.

A fifth reason that has been pointed out by the literature is the almost total **absence of accountability mechanisms within the health system**, which tend to reinforce the already strong power that doctors have over patients (Perrotte et al., 2020). Castro and Savage (2019) state that the care of pregnant women is so diffused that it generates a breeding ground for OV to happen, considering that accountability tools main purpose is to function as an arbiter for the dynamics between partiers with different levels of power (George, 2003).

5. Consequences

The effects of obstetric violence can be analysed taking considering the actors affected (women, the new-born, and the health team), the timing of the effect (immediate, medium, or

long-term) and the dimension of health that is implied.

A first dimension of health that may be affected [redacted] **physical health**. Among the [redacted]ences of victims of OV, Taghizadeh et [redacted]2021) documented excessive bleeding, [redacted]aginal hematomas, more caesarean sections, and distress in the case of new-borns.

The second dimension of health affected by OV, and probably the one that has been better studied, is **mental health**. For women who have been victim of obstetric violence, it is common to suffer from stress, suicidal ideation, recurrent nightmares, panic attacks, feeling of loneliness, and fear of another pregnancy (Taghizadeh et al., 2021). In an interesting study that explored the effect of OV on women's mental health, Scanduna et al. (2021) concluded that abuse and violence had a greater impact on mental health compared to the performance of medical procedures without consent. Nevertheless, both types of OV were positively associated with psychological distress and post-traumatic stress disorder.

Third, Taghizadeh et al. (2021) identified **social bonds** as a feature that is strongly impacted by OV. In their study, the authors noted that women who suffer OV had more difficulties creating a bond with the new-born, more difficulties for breastfeeding, experienced emotional and sexual tension with their partners, and were less likely to made self-health-seeking behaviours in the future. The World Health Organizations relates this to the bond of trust between patient and doctor that OV tends to broke.

Finally, although incipient research has been done on the subject, there is evidence of OV having an impact on **health professionals**. In a study with health students, Mena-Tudela et al. (2020) conclude that obstetric violence tends to be normalized over time among health personnel. Nevertheless, an intervention in curriculum and training can create a change in the perception of OV.

6. Solutions

Developing a solution for such a complex problem like obstetric violence needs to consider multiple actors and interventions. A first step in doing so, before implementing any program or policy, is to select or create a **conceptual framework** to address the issue. The first framework proposed by different experts (Terrei, 2018; Chandra et al., 2011) to approach OV is a **Human Rights** perspective.

Adopting a human rights approach implies being conscious that women do not lose any of their fundamental rights because of their pregnancy status and, therefore, making efforts to warrantee its accomplishment. Among the human rights that must be granted to any individual within the health care system are the right to consent and refuse treatment, to receive equal treatment and to privacy and confidentiality (Terrei, 2018; Chanda et al., 2011). For Castro (2019), a human rights approach contributes to OV by making health personnel assume the responsibility for guaranteeing the right to health for every women in labor.

A second conceptual framework that could be useful to address the issue is adopting the lens of **intersectionality** so to identify the barriers that different groups of women in different contexts face towards having a dignified pregnancy and childbirth. Factors such as race, education, socioeconomic status, rurality, and ethnicity have an important impact in the prevalence and the manifestations OV takes.

Now, beyond the conceptual framework needed to design a pertinent solution, there are concrete practices that could be taken into consideration. For Castro (2019), a first step is to devote more resources and time to **research** on the subject. Although this would not, by itself, prevent OV, it makes the problem visible for relevant stakeholders.

Nevertheless, the most mentioned recommendation by the literature has to do with **promoting accountability systems within health care systems and professionals**. The following section explains the accountability proposal in more detail.

7. Human Rights & Accountability in the Health System

Although since its beginnings the movement against obstetric violence has used human rights as a conceptual framework to understand the problem -mainly by defining OV as the violation of women's sexual and reproductive rights- this vision present in activism and in the diagnosis of the problem has not been used with equal force in the design of solutions.

Human rights are usually understood as a **system of laws based on international conventions** signed by multiple countries **(**Gruskin et al., 2008)[2]. However, authors such as Freedman (2001) distinguish between human rights as legal standards, and human rights as a **philosophy that consists of a series of principles that guide the development and implementation of policies**, the conducting principle being that of human dignity.

Now, when faced with the issue of what human rights are they, the answers are multiple and range from the right to life, equality between women and men, the right to health, the right to integrity, among many others. Therefore, it is important for this case to focus on those most directly related to access to health. **"FREDA" is an acronym created to designate a human-rights based approach to healthcare**[3] (Curtice and Exworty, 2010). The acronym comes from five human rights that are fundamental to incorporate in the world of healthcare, namely: **Fairness; Respect; Equality; Dignity, and Autonomy.**

The next question is why use a Human Rights Approach to address OV. At the end of the 20th century, maternal mortality and morbidity began to be seen as a **public health problem**, that is, as a health problem that does not affect specific groups but large populations. Likewise, viewing a problem through the prism of public health implies placing special emphasis on prevention and the provision of medical services. For Gruskin et al. (2008), this problem constitutes a human rights issue in that it is caused by discrimination against women and negligence in their health care, both of which are equivalent to a **violation of human rights.**

Having defined which human rights are important to incorporate into the health area and understanding why the problem of obstetric violence can be effectively addressed through this perspective, the need arises to operationalize these principles into concrete actions. One response to this case of OV is to **strengthen accountability systems**. As mentioned in the "Causes" section, the lack of accountability mechanisms in prenatal, postnatal, and delivery care is one of the reasons that has been pushed hardest to explain the high rates of OV globally.

For the UN, **the promotion and guarantee of human rights is directly related to the strengthening of accountability systems through three axes** (UN Human Rights Commissioner, 2015). Firstly, through **Responsibility**, since it encourages the authorities to be accountable, for which they must be clear about their duties, what standards are enforceable and what is the expected level of performance, so that they

[2] Some relevant treaties for the case of OV are the UN International Conference on Population and Development of 1994 at Cairo, the 4th World Conference on Women on 1995 at Beijing, among others.

[3] **Fairness:** giving due consideration to the person's opinion. **Respect:** objective, unbiased treatment. Considering rights, beliefs, values and property of other people. **Equality**: equity of access and of treatment. Different clinical needs must be determined through procedures that remove any arbitrariness. In other words, decisions must be justified. **Dignity**: arises from the dynamics between a person's own sense of worth and the manner in which others treat them, as a human being. **Autonomy:** it is one of the fundamental ethical principles of health. It refers to the right to self-determination, freedom to decide and to act based on clear, sufficient and relevant information.

can then be evaluated transparently and objectively.
Secondly, accountability systems guarantee **Asnwerability:** victims and those affected by human rights violations must receive justified responses for the acts suffered, and mechanisms and institutions must exist to deal with this type of cases. Third -through **Enforceability**- accountability generates mechanisms to monitor the work of organizations where this type of events can potentially occur, in addition to the existence of sanctions and corrective measures. Finally, accountability is also fundamental in that it can play a **preventive role** in promoting human rights in advance, by identifying which aspects of policies and programs are working and which are not, and potential systemic failures that put certain population groups at constant risk.

In this context, it is important to consider that there are multiple accountability mechanisms that can be implemented within an institution. For the medical case, a highly relevant distinction is between organizational accountability -which makes institutions responsible for their mistakes- and personal accountability -which associates responsibility to health professionals (Watcher, 2013). Experts on the subject, such as J. Reason and D. Marx, suggest not to install a culture of "no-fault" where responsibility for patient care is extremely diffuse, but a **culture of justice**. In this sense, it is essential to distinguish between human errors and reckless behaviors, since the latter - which involve acting in the knowledge that the risks are high and unjustified - deserve to be sanctioned.

A human rights-based accountability system has innumerable benefits for the problem of OV. It contributes to bringing the attention of public policy makers and implementers not only to outcomes but also to processes; it encourages attention to patients' rights to be considered before services are delivered, ensuring that human rights violations do not occur beforehand (Gruskin, 2019);

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