

# SYMPOSIUM INSTITUTIONAL VIOLENCE AGAINST WOMEN DURING OBSTETRIC CARE

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## How we understand obstetric violence Cómo entendemos la violencia obstétrica

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### ABSTRACT

What is called obstetric violence we prefer to call institutional violence against women during obstetric care, mainly to avoid stigmatization of professionals. Research has been carried out worldwide on its occurrence, although in Latin America there is limited information from fieldwork. There is still no agreed definition at the level of health or medical organizations, and different names have been adopted to define it. Its etiology is multifactorial, and its consequences are physical, mental and sexual, and in extreme cases it can lead to maternal and/or perinatal death. This section reviews the different components of this type of violence and the measures adopted to control its occurrence.

**Key words:** Gender-based violence, Violence against women, Obstetric violence

### RESUMEN

Lo que es denominada violencia obstétrica preferimos llamarla violencia institucional contra la mujer durante la atención obstétrica, fundamentalmente para evitar los estigmas contra los profesionales. Se han desarrollado investigaciones a nivel mundial sobre su ocurrencia, aunque en Latinoamérica existe limitada información procedente de trabajos de campo. No existe aún una definición consensuada a nivel de organizaciones de salud ni de organizaciones médicas, adoptándose diferentes denominaciones para definirla. Su etiología es multifactorial y sus consecuencias se hallan a nivel físico, mental y sexual, pudiendo ocurrir en casos extremos la muerte materna y/o perinatal. En esta sección se revisa los diferentes componentes de este tipo de violencia y las medidas adoptadas para controlar su ocurrencia.

**Palabras clave.** Violencia de género, Violencia contra la mujer, Violencia obstétrica

### INTRODUCTION

Obstetrics and gynecology is a discipline of the medical sciences that encompasses the study and care of women's health and disorders of the genital tract, as well as the care and monitoring of pregnancy, childbirth and the postpartum period<sup>(1)</sup>. The late Professor Mamhoud Fathalla proposed in 1997 to call it women's health as a broader term<sup>(2)</sup>.

After the International Conference on Population and Development held in Cairo in 1994<sup>(3)</sup> and the IV International Conference on Women, held in Beijing in 1995<sup>(4)</sup>, the concepts of sexual and reproductive health and sexual and reproductive rights, one of which is non-violence against women, were consolidated. Historically, violence against women (gender-based violence) has been part of human behavior throughout time in all social groups and is a consequence of the lack of balance of power that occurs between men and women to the detriment of the latter.

According to the Belem do Para Convention, violence against women should be understood as 'any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere'<sup>(5)</sup>. According to this definition, violence can be physical, psychological, sexual and economic. In recent years, particularly from civil society, attempts are being made to incorporate the term 'obstetric violence', which we prefer to call according to the title of this symposium. We would like to add that maternal death is the type of extreme violence that occurs against women<sup>(6)</sup>.

In Latin America there are few figures on the frequency of what has been called 'obstetric violence'. We have noted that in Mexico, a 2016 national survey found that among 8.7 million women who gave birth



between 2011 and 2016, 33.4% of them reported having suffered mistreatment by caregivers<sup>(6)</sup>. Similar experience has been reported in Peru.

The World Health Organization (WHO) reports that many women suffer or have suffered violence in health facilities during childbirth and therefore states that all women have the right to receive health care, which must be respectful of dignified and affectionate attention during pregnancy, childbirth and the postpartum period and, therefore, the right to be free from violence and discrimination<sup>(7)</sup>.

In this review we will develop the definition of so-called obstetric violence, its causes, manifestations and an overview of what progress we have made in the country towards its prevention, since physicians have a duty to apply our knowledge and best judgement in the care of women's health, to promote the best interests and optimal care of pregnant women and to foster the trust of the people we serve in our profession. We recognize that there is often an inherent power imbalance within the patient-physician relationship. Therefore, conflicts between patients and physicians must be managed with empathy and professionalism at all times during sexual and reproductive health care, and primarily during pregnancy, childbirth and the postpartum period<sup>(8)</sup>.

## DEFINITION

If we review the literature on the subject, we will see that, at the international level, within the universal and inter-American system for the protection and defense of human rights, we do not find a standardized way of defining obstetric violence. However, within this same system, the right to a life free of violence and the right of women to use the most appropriate health services for the care of their pregnancy, childbirth and puerperium and, in general, for their sexual and reproductive health are recognized. In Latin America, Argentina, Ecuador, Costa Rica, Suriname, Brazil and Venezuela are known to legally define obstetric violence, as well as in some states in Mexico<sup>(6,9)</sup>.

In 2014, the WHO made it clear that there is no international consensus on how to define, let alone scientifically measure what we call mistreatment, or disrespect, or how to quantify

women's well-being and decisions during obstetric care, let alone its prevalence. In light of this reality, she proposed taking immediate action to prevent and eradicate abuse in health facilities that provide sexual and reproductive health, pregnancy and childbirth care<sup>(7)</sup>.

The Sustainable Development Goals (SDGs), in number 6 clearly state 'Promote just, peaceful and inclusive societies', and set two targets that relate to violence: 'Significantly reduce all forms of violence and related mortality rates globally and - End child abuse, exploitation, trafficking and all forms of violence and torture against children'<sup>(10)</sup>.

In 2019, the UN Rapporteur on obstetric violence defines it as violence suffered by women during childbirth in health facilities and acknowledges, as previously noted, that the term is not yet uniformly used by international human rights organizations<sup>(11)</sup>. On the other hand, in 2017 the Inter-American Court of Human Rights defined obstetric violence as comprising disrespect for women, abuse and negligence in the treatment of women during pregnancy, childbirth and postpartum, both in public and private services. No or inadequate information is provided or consent is sought for any intervention. They are treated with indifference or humiliated<sup>(12)</sup>.

In Peru, there is no definition of obstetric violence at the level of the Ministry of Health (MINSA), scientific societies or the Peruvian Medical Association, despite the fact that all these institutions have regulations and documents that show a clear commitment to sexual and reproductive health care and the fight against violence against women<sup>(13-16)</sup>.

However, in 2016, the Ministry of Women established that obstetric violence is one of the manifestations of violence against women, and defines it as follows: 'It comprises all acts of violence by health personnel in relation to reproductive processes and is expressed in dehumanizing treatment, abuse of medicalization and pathologization of natural processes, which negatively impacts on women's quality of life'<sup>(17)</sup>. We disagree that only health service personnel are involved in this type of violence; violence can also be perpetrated by other people close to or unknown to the pregnant women.



Likewise, during 2016, this same Ministry of Women approved the National Plan against gender violence 2016-2021, in which it defines obstetric violence in the same way as in the previous publication<sup>(18)</sup>.

As can be seen, in Peru neither medical institutions nor academic institutions have been part of these definitions, which are put forward by different institutions other than the health sector and further away from the discipline of obstetrics. Not only for this reason, but also because of the inconsistency of the different definitions proposed, we do not fully agree with them and we will argue this below.

### CAUSES OF THE SO-CALLED OBSTETRIC VIOLENCE

Ellsberg et al. used an ecological model to assign the causes of gender-based violence against women, in which they included various causes of this type of violence<sup>(19)</sup>. In the same way, we want to rescue this systematic approach in order to go beyond health workers as the perpetrators of 'obstetric violence' and to analyze the problem in a more holistic way. We believe that the state, the community, the family, the health workers and the woman herself are involved in the violence that can occur in a woman during pregnancy, childbirth and puerperium.

The involvement of the State has to do with the obvious structural problems, such as: lack of health sector leadership within the system, poor infrastructure and lack of equipment and medicines, serious problems with transport particularly with obstetric emergencies, poor working conditions for many health workers, insufficient budget to attend to women's sexual and reproductive health needs, insufficient training of health workers in ethics, patients' human rights, gender equity and interculturality, insufficient health personnel, large numbers of patients, salary problems, long working hours, and above all a lack of support and supervision of health professionals in the fulfillment of current regulations<sup>(11,20,21)</sup>.

The community's responsibility is based on deficient or non-existent comprehensive sexuality education from the years of basic education, the training and education of health professionals with a focus on rights, ethical and bioethical bases and with gender equity and interculturalism both at the undergraduate and postgradu-

ate levels and in continuing medical education. Prejudices based on religious, social and cultural convictions about sexuality, pregnancy and motherhood have not yet been overcome<sup>(11)</sup>. Universities should also promote research on sexual and reproductive health among their members, with special emphasis on the issue of gender-based violence and institutional violence during obstetric care.

The participation of the family should take place in the support that pregnant women require in order to help them make the best decisions, in accompanying them during pregnancy, childbirth and the postpartum period, ensuring that no aggression of any kind occurs.

Health workers should not engage in care without empathy, respectful of women's rights, gender equity and interculturality, with truthful information, compliance with ethical and professional standards. They have a duty to scrupulously respect the right to informed consent, which is nothing more than honoring their autonomy in the freedom to decide, and to produce research and publications on the subject of institutional violence. All this means woman-centered obstetric care, where the empowered pregnant woman is the real protagonist<sup>(1)</sup>.

The pregnant woman also has her own responsibility to maintain self-care and to make permanent use of her empowerment during obstetric care.

### EXPRESSIONS OF OBSTETRIC VIOLENCE

We must begin this section by stating that the information gathered from publications in Latin America shows that few are products of research or fieldwork, and that many refer to surveys or observations with a highly subjective content.

The Ombudsman's Office 2020 publication on obstetric violence in Peru<sup>(9)</sup> asks 11 'experts' questions about the manifestations of violence that can occur:

- Vaginal touching without consent.
- Vaginal touching without reasonable justification.
- Symphysiotomy.



- Excessive medicalization during childbirth.
- Omission or inadequate manner of obtaining informed consent.
- Excessive use of cesarean delivery.
- Unnecessary or non-consensual use of episiotomy.
- Overuse of synthetic oxytocin.
- Use of Kristeller's maneuver.
- Presence of third parties outside the birth without the mother's consent.
- Excessive suturing for reasons unrelated to the patient's health.
- Impossibility to choose the position of delivery.
- Reproduction of humiliating and sexist expressions during delivery.
- Performance of enemas to induce labour.
- Shaving pubic or perineal area before delivery.

On the other hand, the Ministry of Women's Affairs states that obstetric violence means that '1) there is an act of violence, 2) this act is produced by health personnel, 3) the act takes place in relation to reproductive processes, 4) the act has a negative impact on the quality of life of women'. It also affirms that obstetric violence is expressed in dehumanizing treatment, abuse of medicalization and pathologization of natural processes<sup>(18)</sup>.

In 2014, the WHO stated that many women suffer violence during childbirth in health facilities, which leads to a lack of trust from women and the community towards health personnel, and later they are inhibited from seeking care in obstetric services<sup>(7)</sup>.

The Inter-American Court of Human Rights (IACHR) states that obstetric violence can occur from the pre-pregnancy stage, during pregnancy, during childbirth and postpartum and that it results in physical, psychological and/or moral harm to the women who suffer it. According to

the IACHR, obstetric violence can be evidenced through<sup>(12)</sup>:

- Dehumanizing treatment: leaving women in labour waiting for long hours, immobilization of the body, deliveries without anesthesia.
- Abuse of medicalization and pathologization of physiological processes with invasive practices, unjustified medicalization.
- Psychological mistreatment: mockery, humiliation, omission of information, infantilization.
- Non-emergency procedures performed without women's consent: sterilization, the so-called 'husband's stitch', among others.

## COMMENTS

In the face of these expressions of 'obstetric violence' made manifest by different institutions, we, from the perspective of the Peruvian Society of Obstetrics and Gynecology, propose the following:

- It is not easy to qualify the humanization of childbirth, since there are subjective and emotional conceptions involved, although we could say in synthesis that it is a happy childbirth<sup>(1,22,23)</sup>.
- In the National Guidelines for Comprehensive Sexual and Reproductive Health Care of MINSA, which are obligatory for public and private health care services, we can see from the opening pages that the first priority for sexual and reproductive health care is respect for the human rights of all persons, respect for gender equity and respect for interculturality, which implies respect for language, ethnic considerations and the uses and customs of pregnant women. It also establishes very precise guidelines for prenatal, childbirth and postpartum care with profound respect for the dignity of women<sup>(23)</sup>.
- The information, education and psycho-prophylactic preparation of the pregnant woman, regulated in the Guidelines, helps to overcome the discomfort of uterine contractions and reduces the need for analgesia or anesthesia during labour, which is subject to the intensity of the pain expressed by the pregnant woman.



- The need for and frequency of vaginal examination in pregnant women is regulated in MINSA's National Guidelines for comprehensive sexual and reproductive health care. Similarly, the procedures for the prevention, diagnosis and management of violence against women are specified. These provisions are reinforced by other regulations and legal provisions<sup>(23-26)</sup>.
- The clinical monitoring of labour is perfectly regulated in the National Guidelines, which obliges the presence of the professional during labour and delivery. Palpation of the abdomen not only indicates the characteristics and frequency of uterine contractions, but also provides information on the descent of the fetal head by applying the technique of the fifths, which reduces the frequency of vaginal examinations<sup>(23)</sup>.
- It is not easy to define what we mean by over medicalization. Sometimes it is necessary to use some form of medication, such as painkillers or others, when there is a warning of a medical problem. The use of synthetic oxytocin is aimed at inducing or stimulating labour for medical reasons, or this same drug is routinely used for active labour to prevent postpartum hemorrhage, which has been the main direct cause of maternal death.
- The inappropriate medical or surgical procedures mentioned are not such, since, as an example, amniotomy can be diagnostic or therapeutic, or episiotomy an intervention that is decided precisely in the expulsion period of labour when it is necessary to avoid further damage to the genital apparatus or pelvic floor, as is regulated in the Guidelines<sup>(23)</sup>.
- Expressions of humiliation or disrespect should be replaced by expressions of empathy and support for the pregnant woman.
- The lack of privacy or the presence of third parties during delivery care is particularly related to the presence of students, which must be previously authorized by the parturient, in order to complete her professional training; otherwise, we would lack qualified personnel for the next generations.
- We can understand the excess of cesarean section, which we will obviously have to deal with, as it is our concern. However, we must also understand that the latest technology applied during labour reveals evidence that is not clinically detected and that forces an intervention. And, on the other hand, many pregnant women now, using their autonomy, freely request termination of pregnancy by cesarean section<sup>(27)</sup>.
- Excessive pathologization is also difficult to define because, although pregnancy and childbirth are generally normal biological processes, it is also true that in obstetric care what starts out as normal can suddenly turn into an emergency that needs to be resolved in a timely manner. Therefore, in order to reduce maternal deaths, pregnancies are no longer characterized as high-risk or low risk, but all pregnancies are at risk.
- Symphysiotomy is not used in Peru and the Kristeler maneuver is prohibited in our current regulations<sup>(23)</sup>.
- Informed consent is perfectly stipulated in the General Health Law, in the National Guidelines and in the Code of Ethics and Deontology of the Peruvian Medical Association<sup>(13,23,28)</sup>.
- Current regulations stipulate that the woman in labour must be accompanied by the person of her choice. However, in most facilities it is difficult to comply with these regulations due to inadequate infrastructure.
- Ambulation during labour and the position chosen by the woman for delivery are clearly established in MINSA regulations, as well as the administration of oral drinks, the non-use of routine venoclysis, evacuating enema and pubo-perineal shaving before delivery<sup>(1,23)</sup>. The so-called 'husband's stitch' is not known in our practice, unless it refers to the suture that the physician should perform at the time of a vaginal-perineal tear, so that the parturient does not continue to bleed at that level.
- The National Guidelines specify that, once delivery is completed, the parturient should be carefully monitored in the first two hours of the puerperium, to warn of and manage possible postpartum hemorrhage<sup>(23)</sup>. However, in our experience we must point out that, for greater safety, postpartum monitoring should



be done in the first 6 hours, the first 6 days and the first 6 weeks.

- Sterilization is necessarily performed after the woman makes a voluntary request and a reflection period is provided, as clearly defined<sup>(23,29)</sup>.

Finally, we consider that it is not correct for Peru to state that women refuse to return to the services they have used. On the contrary, Peru's experience shows that prenatal care and institutional delivery care has visibly increased in recent years, and now exceeds 90% of all pregnant women; and women surveyed after delivery have expressed their satisfaction with the care<sup>(22,30)</sup>. Moreover, maternal mortality began to fall significantly from 2000 onwards, almost reaching the millennium goal. However, as in other countries, it showed a worrying rise during the COVID-19 pandemic. Fortunately, with the interventions carried out by MINSA, after the pandemic, maternal mortality showed a downward trend again<sup>(22,31)</sup>.

For all these reasons, we reject the term 'obstetric violence', not only because it is stigmatizing for the professionals who provide obstetric care, but also because violence against pregnant women can also be carried out by other people outside the health personnel. Hence, the term 'institutional violence against women during obstetric care' is proposed within woman-centered obstetric care instead of obstetric violence.

We have no doubt that much remains to be done to reduce institutional violence during obstetric care and sexual and reproductive health care, which will be addressed in this issue.

## CONCLUSIONS

- There is a need to raise awareness that obstetric care is part of sexual and reproductive health care, which is based on respect for human rights and woman-centered pregnancy, delivery and postpartum care.
- The best obstetric care can be defined as achieving a happy birth.
- There is no national or international consensus on the definition of so-called obstetric violence.

- There are multiple causes of obstetric violence, ranging from state institutions to the woman herself.
- There are different forms of presentation of obstetric violence, including maternal and perinatal mortality.
- There are multiple scientific arguments that support some strategies, appropriate and complex technologies applicable to obstetric care.
- Despite the abundant regulations in force for obstetric care, it is necessary to support the monitoring and supervision of health professionals, from the central, regional and local levels, in the fulfilment of these regulations.
- It is proposed that this type of violence be referred to as 'institutional violence against women during obstetric care'.

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