

Review Article

Silent Scream Obstetric Violence

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Abstract

The aim of this review is to evaluate the main causes, prevalence and possible solutions of obstetric violence. The articles accessed by searching Pubmed, Scopus, Medline, Science Direct, Google Scholar databases with the keywords "obstetrics and violence" "obstetric violence" were evaluated. The scope of the study consisted of 13 studies published between 2012 and 2022. According to the study findings, the prevalence of obstetric violence was reported to vary between 25 and 79.7%. In another study, it was determined that 33.3% of women experienced obstetric violence in their last births and 17.1% were exposed to non-consensual care. In addition, the lack of information on the subject and the fear of talking about women who have experienced it make it difficult to prevent and eliminate this type of violence. Obstetric violence is divided into various categories such as physical, verbal and sexual abuse, neglect and abandonment of care, all forms of discrimination and finally iatrogenic procedures such as unnecessary surgeries and caesarean sections. The last category, over-treatment, has been widely recognised in developed countries, particularly in the USA. Other forms of violence have been attributed to developing and underdeveloped countries. Every woman needs and is entitled to access to skilled and quality health care during labour. Tackling obstetric violence is a critical step for maternal, foetal and newborn health, given that an adverse birth experience leads to maternal stress and slows the birth process, thereby increasing the likelihood of complications and postnatal depression. Validated and reliable tools to measure mistreatment of women during labour should be developed, as well as interventions to prevent mistreatment and promote respectful care.

Keywords: Labour, violence against women, human rights, obstetric violence, violence

Introduction

Obstetric violence includes inappropriate or non-consensual acts of violence or perceived violence through action or omission during pregnancy, labour and the postnatal period. This violence is divided into various categories such as physical, verbal and sexual abuse, neglect and abandonment of care, all forms of discrimination and finally unnecessary medical practices and iatrogenic procedures such as caesarean section. Silva et al. characterised obstetric violence as a type of gender-based violence classified in three different categories.

These three categories are violent and aggressive speech by doctors, nurses and other health personnel; unnecessary/negligent medical

procedures; and institutional inadequacies such as inadequate physical facilities, equipment, and environment (Silva et al, 2020).

The World Health Organisation [WHO] has emphasised the importance of prioritising, assessing and eliminating obstetric violence against women during childbirth (WHO, 2015).

In recent years, situations during labour that undermine women's dignity and autonomy have attracted worldwide attention. These are situations in which women are clearly exposed to physical violence in the form of violent examinations, episiotomy, coercion or lack of informed consent, or procedures in which women are forced to open their genital areas, which cause pain and are

performed for the benefit of health personnel in labour (Darilek, 2018;Kujawski et al., 2015).

Women admitted to hospital for labour are subjected to a standardised routine of care. In the context of this care, women often become secondary elements in the birth scenario, subject to a controlled environment, surrounded by institutional rules and protocols that separate them from their social and cultural contexts and at the same time isolate them.

As a result of these practices, women lose their autonomy and can only give birth in compliance with the instructions given. Therefore, addressing the issue of obstetric violence and demarcating its boundaries are important for quality care and safe maternal and infant health. The aim of this review is to evaluate the main causes of obstetric violence, its prevalence and coping strategies for disrespect and abuse in labour.

Obstetric Violence

WHO (2019), defines violence as

"the intentional use of threatened or actual physical force or power against oneself, another person, a group or a community, causing injury, death, psychological harm"

and divides violence into four typologies as physical, sexual, psychological assault and deprivation. Any phenomenon that involves threats, pressure and fear and causes physical, sexual, economic or psychological harm or causes suffering to individuals in the family is defined as violence (General Directorate on the Status of Women, 2016).

In the obstetric violence literature, it includes physical, emotional violence, unnecessary practices such as unnecessary caesarean section and episiotomy, and structural violence due to system deficiencies, especially during childbirth or while receiving obstetric care (Jardim & Modena, 2018).

Obstetric violence is a serious public health problem involving violation of human rights. Obstetric violence includes many elements such

as routine application of episiotomy, use of birth instrumentation without obtaining consent from the mother, fundal compression, D&C and R&C without anaesthesia and unnecessary medication without medical justification, and cesarean section, which is used to unnecessarily accelerate uncomplicated birth, is among the most criticised practices (Mir & Gandolfi, 2021).

Symptoms of Obstetric Violence

- Failure to manage obstetric emergencies (Postpartum haemorrhagia, Placental Abruption, Preeclampsia/Eclampsia etc.) in a timely and effective manner
- Forcing the woman to give birth in a position that is in the best interest of the health personnel (so that they can carry out their interventions comfortably).
- Preventing the early attachment of the newborn to its mother without justified reasons, denying the possibility of holding and breastfeeding.
- Changing the natural process of labour by accelerating it, without obtaining the woman's voluntary, explicit and informed consent.
- Treating women in a childish, paternalistic, authoritarian, condescending, humiliating manner with verbal insults, making depersonalised or humiliating statements (Perara et al, 2022).

Obstetric violence typologies

Obstetric violence takes many forms. Some of these are categorised as verbal, physical, psychological, sexual violence; social discrimination, neglect of care and inappropriate use of procedures and technologies.

The table below provides examples that fit the relevant typology and some of the human rights articles.

Table 1: Obstetric Violence Typologies

Typology	Examples
Verbal violence	Rude, disrespectful, annoying, annoying, coercive, discriminatory, moralising, critical, ironic and negative comments that expose women to shame, inferiority and humiliation, and blaming and discriminatory speech towards women in abortion situations. "Why are you crying, you didn't cry when you were doing this!"; "Come on, it doesn't hurt that much!"; "Oh, don't cry, come on, you'll be here again next year"; "If you don't push, the baby's heartbeat will drop"; "Shut up and push the baby"; "If you scream, I'll stop what I'm doing now" etc.
Physical violence	Repetitive and aggressive vaginal examination; routine use of episiotomy; unnecessary caesarean section; lack of adequate pain management (before, during and after labour); performing procedures without adequate analgesia (curettage, suturing, caesarean section); slapping and pinching of the female body; physical restraint of the legs and arms during normal or caesarean section.
Psychological Violence	Threats; shouting; authoritarian and hostile speech; intimidation before patient behaviour; blackmail and threats by staff; blaming women for complications that occur: controlling the woman when she wants to push
Sexual violence	Carrying out a vaginal examination without the use of lubricant; rude and disrespectful interference with the woman's genitals, touching the woman's body and performing a rectal examination without her consent
Social discrimination	Disrespect, stigmatisation, prejudice or different treatment of women because of their colour, race/ethnicity or social, economic, marital, sexual orientation, religion or school. Financial exploitation by professionals
Neglect of Care	Neglect of care; neglectful care, abandonment, refusal to promote care towards women who are considered "complaining", "scandalous", "unstable", "uncooperative/non-compliant", "questioning".
Inappropriate procedures and technologies utilisation	Iatrogenic procedures; oxytocin misuse; immobilisation of the woman in bed for interventions and interventions during labour; labour in the lithotomy position; routine amniotomy; continuous routine fetal monitoring; prolonged fasting during labour without indication; inadequate management of pain.

*Table created by the authors - (Office of the United Nations High Commissioner for Human Rights, 1948)

Obstetric violence is not recognised and has no place in the human rights articles accepted by the United Nations, and every woman has the right to receive quality care and services. Although the convention, which was submitted to the General Secretariat of the Council of Europe on 18 May 1954, entered into force on this date and includes articles on obstetric violence, there is still no legal regulation on this issue in Turkey (UN Treaty Body Database- Acceptance of the Interstate communication procedure for Turkey, 2021).

Obstetric Violence in the World and Turkey

The mistreatment of women during childbirth has been documented globally, both in high-income countries and in middle- and low-income countries (Shetty et al, 2021; Chadwic et al, 2014). For example, in the Americas and Europe, caesarean section and episiotomy are very common (hypermedicalisation), while in low- and middle-income countries, unattended delivery in a health centre is more likely (undermedicalisation) (Perrotte et al, 2020). International human rights bodies have played a critical role in codifying, setting standards and monitoring human rights violations in the context of sexual and reproductive health and rights (Declaration of Commitment on HIV/AIDS, United Nation Human Rights Office Of The High Commissioner, 2001). In recent years, these institutions have developed and implemented human rights standards more specifically in the context of maternal mortality and morbidity, and have established legal bases in this context by stating that care during and after pregnancy is a critical human rights issue (Office Of The United Nations High Commissioner For Human Rights. *Information Series On Sexual And Reproductive Health And Rights: Maternal Mortality And Morbidity*. 2015). In 2014, the World Health Organization (WHO) addressed obstetric violence in a statement on ill-treatment during childbirth and related human rights violations, calling for more action, dialogue, research and advocacy on this global problem (WHO, 2014). This statement, endorsed by more than ninety international non-governmental and health professional organisations, recognised that "every woman has the right to the highest attainable standard of health, including the right to dignified, respectful health care throughout pregnancy and childbirth" (WHO, 2014).

In the context of the goal of safe motherhood and sustainable development, United Nations and

regional human rights experts, the Inter-American Commission on Human Rights and the African Commission on women's rights and human rights defenders issued a joint statement on reducing rates of obstetric violence (African Commission on Human and People's Rights. *Joint Statement, 2015*). This statement on obstetric violence is known to be the first step towards setting human rights norms and standards, addressing human rights violations during childbirth in hospitals, ensuring respectful and humane treatment, and developing a work programme to improve the overall quality of maternal care. One of the countries that has developed legislation on obstetric violence is Venezuela, where the practice of obstetric violence is criminalised. In addition, the definition of obstetric violence is also mentioned in Argentina, Mexico, Latin America Spain, Bolivia and Panama (Mir & Gandalfi, 2021; Argentina Ministerio de Justicia y Derechos Humanos 2022; Jardim & Modena, 2018).

Despite developments in the national and international literature, there is still no clear and comprehensive definition of institutional violence in childbirth, which is defined and accepted as ill-treatment and disrespect during childbirth, and defined and accepted as the use of procedures, behaviours and routines during childbirth that are harmful or lack scientific evidence. In Brazil, it is estimated that approximately 25% of women who give birth during maternity are exposed to some form of violence (Venturi et al, 2010; Leal et al, 2014). In a study conducted in Brazil, it was found that the health professional who applied the traditional care model in labour inflicted more obstetric violence than the one who applied the evidence-based care model (Silva et al, 2014).

The first target of evidence-based practices is effective communication. As a member of the healthcare team, midwives and nurses have to inform individuals about their diseases. Lack of accurate information prevents the individual from participating in care. In addition, sick individuals who experience lack of information are weakened and emotionally shaken while experiencing the disease. By determining the needs of the sick individual, planned trainings and effective communication can contribute to the well-being of the individual by eliminating the lack of information (Venturi et al, 2010). In a study examining the relationship between disrespect and abuse of women during childbirth and the

occurrence of postpartum depression (PD), the prevalence of at least moderate postpartum depression and marked/severe postpartum depression was found to be 9.4% and 5.7%, respectively. 18% of these women reported experiencing disrespect or abuse during labour (Silveira et al, 2019). In a meta-analysis study, it was observed that care at birth affected mothers' postpartum depression. It was found that mothers who had a negative birth experience had a higher risk of experiencing postpartum depression (Dadi et al, 2020; Waal and Nistelrooij, 2022).

The rate of disrespect and abuse of women during the trauma process in health institutions was 45%, of which 15.8% was physical abuse, 16.9% did not pay attention to privacy, and 16.9% abandoned the non-compliant patient while providing care (Shimoda et al, 2018).

High levels of burnout syndrome are observed in nurses and midwives working in obstetrics and gynaecology units. It was observed that caregivers with more working hours and more patients per nurse-midwife (more than 33%) were more likely to use verbal violence, one of the types of obstetric violence. Healthcare workers with burnout syndrome were found to have a high rate of obstetric violence (Solana et al, 2019).

In a study examining the experiences of health personnel in patient follow-up, it was found that service providers (50.3%) often did not obtain women's consent before procedures, 25.9% witnessed physical abuse (physical force, slapping or hitting) in health facilities, observed privacy violations (34.5%), and women were admitted to hospital against their will (18%), while these participants (79.6%) believed that lack of respectful care deters pregnant women from coming to health facilities for childbirth (Asefa et al, 2018). In a study investigating the rate of 404 mothers receiving respectful care during labour, it was found that only 12.6% received respectful care during labour (Amsalu et al, 2022). Women state that health personnel are inadequate in number and have too much workload and therefore do not take care of them (Bohren et al, 2015; Amsalu et al, 2022).

In a study involving a total of 4275 women examining disrespect and abuse of women during the birth process; approximately 10% of women reported experiencing verbal abuse, 6% denial of care, 6% unwanted or inappropriate procedures, and 5% physical abuse. At least one type of

disrespect or abuse was reported by 18.3% of mothers (Mesenburg et al, 2018). Considering the multifactorial nature of institutional violence at birth at national and international level, it is seen that obstetric violence is experienced in many parts of the world. To address the problem of obstetric violence, different sectors of society (governments, civil society, health professionals, educational institutes, and researchers) should discuss establishing effective policies and guidelines. The most important way to prevent the institutional violent aspects of childbirth is to create structural arrangements that invite stronger action to expand access to quality maternity services with adequate infrastructure, sufficient human resources and supplies, and to create legal and social apparatuses that allow women to live with equality and dignity.

Obstetric Violence and Midwifery

According to the midwifery bachelor's degree, the main goal of this discipline is to obtain a suitable professional position according to the job descriptions approved for all midwifery graduates. The only way to achieve this goal is to successfully complete the educational processes (Bayar and Hazar, 2022). These training processes emphasise that women should be given the necessary care in line with ethical principles. Intensive and difficult working conditions often negatively affect the quality of care (Hunt & backman, 2008). Staff shortages, poor infrastructure, or stressful working environments that may pave the way for poor (or even abusive) behaviour of healthcare providers towards women (Bohren et al, 2015). Increasing the proportion of women giving birth with skilled health personnel is one of the most important efforts to improve the quality of care (Khosla et al, 2016).

Improvements in quality of care should not only ensure access to timely, safe and effective clinical care, but also protect and promote women's rights to dignified and respectful care (WHO, 2014). The WHO quality care framework for mothers and newborns makes clear the need for more evidence and action on good communication, respect, dignity and emotional support in efforts to improve the quality of care (Tunçalp et al, 2015). This approach can empower women, promote positive birth experiences and increase satisfaction, as well as increase demand for and utilisation of maternal health services. It is important to note that mistreatment or abusive

behaviour by health care providers is not necessarily intentional and can coexist with other compassionate and respectful care practices. Health system factors may provide contextual explanations for adverse experiences, but should not be seen as justification for the continued mistreatment of women.

One of the contemporary roles of midwives today is that of patient rights advocate. This role is based on human rights and patient rights. Midwives have professional roles such as protecting women from maltreatment and practices involving human rights violations such as obstetric violence, preventing violations, respecting the decision of individuals and acting as a spokesperson for women when necessary. Midwives should respect women's autonomy during the birth process and promote positive birth experiences by providing evidence-based clinical care as well as supportive care.

Conclusion and Recommendations: This article outlines the definition and typologies of obstetric violence by reviewing the existing literature on ill-treatment of women during labour in facility settings under national and international human rights law. The difficulty of approaching the topic is presented as an important limitation in this article due to its controversial nature resulting in few publications.

The first condition for the realisation of the steps of safe motherhood within the scope of human rights standards in international law is the exclusion of obstetric violence and its consequences. Considering all these, the following suggestions can be made regarding the prevention of obstetric violence:

- Regulation of intensive and difficult working conditions,
- Elimination of staff shortage,
- Increasing the number of midwives in line with WHO recommendations to improve quality care,
- A process for engaging women and health care providers to promote and protect women's participation in safe and positive birth experiences,
- A woman's autonomy and dignity during childbirth should be respected and health care providers should promote positive birth experiences through respectful,

dignified, supportive care as well as providing high-quality clinical care,

- Developing validated and reliable tools to measure mistreatment of women during labour, as well as interventions to prevent mistreatment and promote respectful care; and
- Future research and interventions addressing quality care during labour should emphasise that high quality care is respectful, humane care

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