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"Shut Up… and Push!" - Obstetrical Violence, Dignified Health Care and the Intersection with Human Rights

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Abstract

Violence against women is a globally pervasive issue that can take multiple forms affecting women regardless of age, class, race/ethnicity, or ability. Within a patriarchal paradigm the subjugation of women is consistent across cultures and is reflected in social structures including health care facilities and systems. Obstetrical violence is understood to be actions of abuse or disrespect experienced by women during the prenatal and postnatal periods and is especially prevalent during labour and delivery. During a time of intense vulnerability women can be subjected to verbal and physical abuse, lack of respect, acts of coercion, gross violations of privacy and the withholding of pain medication, often occurring at the hands of their care providers. These acts can be paralleled with similar experiences of women who have been abused by domestic partners and may inform a woman's decision making related to future access to health care services. Pregnancy and child birth continue to be one of the leading causes of death amongst women of childbearing age. In response, governments have worked to increase women's access to appropriate health care services, including emergency obstetrical care, which can be provided in a health care facility with skilled birth attendants in place. The application of a human rights framework to women's sexual and reproductive health shows promise as an effective tool to address the underlying structural inequalities that lead to acts of violence and pose a threat to women's health.

Keywords: women's health, violence against women, obstetrical violence, human rights

Violence against women can take shape in many forms, occurring across all societies and effecting women of any age, race, class or ability (Alhabib, Nur & Jones, 2010). Within patriarchal societies, the domination of men over women is a critical element to understanding social relations between genders as well as other forms of domination based on systems of power and control (Hunnicutt, 2009). Arguably, patriarchal societies rely on embedded social structures to mediate relationships and to determine the validity of an individual's right to participate in social, economic, political and cultural activities (Amirthanlingam, 2005). Situating violence against women within a patriarchal context provides an understanding of why these activities occur and offers a basis on which to develop comprehensive solutions to address these issues (Bunch, 1990; Hunnicutt, 2009). Women's rights advocates and international bodies, such as the United Nations and individual state actors, have begun to address the issue of violence against women through the application of a human rights framework arguing that women are individuals in their own right and are entitled to basic human rights. (Amirthanlingam, 2005).

Through the application of a human rights framework, it is possible to work towards gender equality and, as such, address violence against women as a public, socially based issue rather than a personal, domestic matter (Bunch, 1990). Within this context, the issue of 'obstetrical violence', also understood to be disrespect and abuse during facility-based childbirth committed by physicians, nurses, midwives,

doulas and other professionals involved in the delivery of a baby, has attracted international attention as a significant issue effecting maternal and child welfare (WHO, 2014). Through an exploration of the concept of obstetrical violence, patriarchal systems of power and control within health care facilities, prevalence rates, sociocultural implications and particular demographic factors that may increase a woman's vulnerability, it will be demonstrated that this form of gendered violence is globally pervasive and, in many ways akin to situations of domestic violence. Further, an application of a human rights framework to addressing the disrespect and violence a woman may experience while giving birth will present potential solutions to address the systemic gender inequality that creates conditions whereby women are forced to give birth in potentially traumatic or life threatening situations while having their basic human rights violated.

Defining the Issue - Obstetrical Violence and Power in Health Care

Pregnancy and childbirth are often considered to be highly momentous occasions in cultures around the world, often bearing significant personal and cultural meaning, and, as such, represent a time of marked vulnerability for women (Limbu, 2013; White Ribbon Alliance, 2011). Rarely is it acknowledged that trauma and violence can occur in situations of medically facilitated childbirth by individuals who are held to be trained and competent health care providers. In facility-based settings, such as hospitals and community clinics where some women give birth to their children, the incidence of disrespect, abuse and neglect during the delivery process has been called 'disturbing' by the World Health Organization and further identified as an important area of human rights research, advocacy and policy development (WHO, 2014). The World Health Organization (2014) indicates that abusive and disrespectful treatment during childbirth can include verbal and physical abuse, humiliation, coercive or unconsented medical procedures, lack of confidentiality and neglect before and after childbirth. This form of violence and degradation towards women is not limited to certain geographic locations or those of particular socioeconomic status, though women who are of lower status, adolescent or unmarried, from ethnic minorities and those living with HIV/AIDS are more likely to experience this form of abuse (WHO, 2014).

Limbu (2013) suggests that women's experiences with health care providers during the delivery process have the power to both empower and comfort women or to inflict lasting and permanent emotional trauma that can erode a woman's sense of self and her confidence related to childbearing and motherhood. For example, in the United States during the mid-twentieth century, descriptions of obstetrical violence included situations where women were strapped down for hours in the lithotomy position [laying on back with legs spread and tied to stirrups], women being hit and threatened with the potential to give birth to a dead or brain damaged baby for crying out in pain and a doctor cutting and suturing episiotomies without anesthetic while having a nurse stifle a woman's cries with a mask (Goer, 2010). While practices and standards within American maternity wards have changed, the actual number of occurrences of these types of abuses suffered by women are recorded globally, including in the United States, in the present day and only further reinforce the scale of the issue (Erdman, 2015). Further, examples of treatment received by women in the Dominican Republic include "being shouted at to push or yelled at to stop pushing… yelling, cries of pain, screams during the episiotomy (Bowser and Hill, 2010, pg. 11). In Ghana, one patient reported that nurses "put fear in me and threatened that they would take me to the theatre [for a caesarian section] if I dared push again" (Bowser and Hill, 2010, pg. 11), and in Kenya, women reported that they were told to "stop pretending you are in pain" and "do not cry as [I] am not the one that made you pregnant" (Bowser and Hill, 2010, pg. 11). These occurrences only serve as a very small sample of the disrespectful and abusive behaviour that women in labour may experience while giving birth in a health care facility; however, they are illustrative of the nature of obstetrical violence and the forms in which violence can occur.

Other situations women encounter in maternity wards are akin to outright verbal, physical and sexual assault that within any other context would likely be considered a criminal act (Goer, 2010). According to the World Health Organization (2014), the experience of women who are subjected to obstetrical violence during delivery violates the trust between women and their health care providers and can serve as a powerful disincentive for women to seek adequate maternal health care services in the future. Erdman (2015, pg. 47) suggests that in research on childbirth occurring in health care facilities many women describe "being at the mercy of providers, waiting without explanation and fearful of being abandoned within medicalized systems that they do not understand." For example, in Tanzania, women cite the most important facility characteristics as being access to pain medications and the *attitudes of*

providers; as such, it is estimated that, if these conditions were improved in health care facilities, this could lead to a significant increase in the number of women that choose to give birth in a facility setting, which is assumed to be the best location to give birth due to access to trained staff and emergency obstetrical care (Bowser & Hill, 2010). A further example from Ecuador suggests that 18% of Indian women prefer to deliver at home, citing *the poor interpersonal skills of the health care facility staff* as their primary deterrent (Bowser & Hill, 2010). Therefore, it can be suggested that a woman's right to life, health and bodily integrity (WHO, 2014) are compromised and her fundamental human rights are not only jeopardized, but routinely violated because of her ability to bear children in this often overlooked component of health care delivery.

Power within health care settings arguably rests in the hands of physicians and is maintained through a hierarchical structure that ensures each health professional knows their role and place within the structure (Ceci, 2004). It is suggested that within health facility settings "Providers regard themselves as entitled, even obligated to use harmful practices to ensure healthy deliveries" and that "Medical authority can thus foster a culture of impunity, where human rights violations do not only go unremedied, but unnoticed" (Erdman, 2015, pg. 48). Employing a post-structuralist paradigm to understanding the relationships between position and power, it can be suggested that physicians are afforded greater power in decision making and the care plan of each patient by the very nature of the knowledge they maintain (Ceci, 2004; Charles, 2011). The wants, needs and desires of patients may be given little consideration as decision making is made within a power vacuum, whereby a physician's orders are followed regardless of potentially negative consequences. Within this contextualized understanding of social structures within health care facilities, it can be argued that the normalization of violent, traumatizing and potentially deadly acts performed on or committed against pregnant women in labour is not entirely surprising. Situating health care facilities as social entities provides for a deeper analysis of the systemic influence of patriarchy and assists in developing a broad understanding of gender dynamics and the relationship between physicians and patients. Accordingly, it can be argued that in maternity care gender is the central organizing feature as women are the patients and as such are vulnerable to systems and arrangements that reinforce domination (Hunnicutt, 1999). Goer (2010) indicates that abuse toward patients that results from inherent systemic inequalities makes the implementation of reforms that much more difficult. These systemic factors include norms, hierarchies and conventions through which acts of disrespect and abuse are routinely rationalized and are also reflected in the treatment of health care providers and staff who are considered of lower status in the health facility hierarchy.

The social position and prestige that is afforded to physicians because of the knowledge they possess creates an unequal power relationship that replicates patriarchal power relations, whereby one individual or group maintains power over another and necessitates the subordination of others. For example, the treatment and social positioning of nurses in many countries is relatively low and as a result these individuals are treated with little respect (Bowser & Hill, 2010). Evidence suggests that if the atmosphere of a health facility is one where disrespect and abuse are directed towards lower level care providers, such as nurses, it is more likely that these individuals will then abuse and disrespect their patients (Bowser & Hill, 2010). In the late 1980s, the Safe Motherhood Initiative brought to attention the large global inequity of maternal death rates and suggested that a majority of deaths could be prevented by ensuring women had access to skilled obstetrical health care professionals and emergency obstetrical care, both of which could be *provided in a health care facility* (Erdman, 2015). However, in more recent years research and advocacy related to maternal rights has shifted in focus from the provision of quality health facility based obstetrical care towards a change in the conception of 'health care' that goes beyond technical and clinical competency and includes treatment that is both humane and respectful of each woman (Erdman, 2015). This shift in thinking about the quality dimensions of health care from an empirically measured reproduction of clinical outcomes towards a patient experience perspective is both challenging and potentially unpopular. It can be argued that by employing a patient-focused framework that respects individual rights, established power hierarchies prevalent in health care facilities are directly challenged, raising awareness of macro-level paradigms that maintain the status quo.

Prevalence Rates and Sociocultural Implications

Obstetrical violence is a specific area of focus that has received limited attention from academics,

advocates and governments until only recently; therefore, the prevalence rates of this form of violence against women are only estimates and are limited in scope. Pregnancy and birthing continue to carry a high risk of death worldwide where the risk of death in developing nations can be as high as 1 in 39 women (Change, 2014). Cottingham et al. (2008) indicate that current estimates suggest that 536,000 women die annually around the world from pregnancy related causes. Even if women do have access to obstetrical care, the care received by women is neither rights-based nor of high quality in countries considered both developed and developing. For example, respondents to a 2012 survey of global maternal health stakeholders indicated that up to 56% of women identified a lack of privacy and informed consent, and verbal abuse was experienced during childbirth in their respective countries (Change, 2014). Arguably, these interpersonal aspects of care are vitally important determinants of women's future health seeking behaviours with a previous negative experience acting as deterrent to seeking health care services (Change, 2014), and as such may only further contribute to the risks associated with pregnancy.

Even with access to health services being identified as a key factor to improving maternal health outcomes, evidence suggests that rights-based care, or lack thereof, is a significant barrier to the provision of quality reproductive health services. The White Ribbon Alliance (2011) has identified seven categories of disrespect and abuse, which are physical abuse, non-consented care, non-dignified care, discrimination based on specific attributes, abandonment or denial of care, and detention in facilities, as areas of rights-based violations that are specific to maternity care and can be addressed through international law. It can be argued that the potential sociocultural implications of employing a rights-based understanding to incidents of obstetrical violence, abuse and disrespect are a challenge to normalized values and to the meaning attached to the childbirth experience and, therefore, require other systemic interventions to address structural inequalities that perpetuate the disrespectful treatment of pregnant women. This challenge is further emphasized by the fact that historically, intervention by public health officials related to the health of pregnant women was focused on improving the outcomes related to infant and child health (Cottingham et al., 2008), rather than addressing the systemic inequalities between men and women that lead to negative health outcomes for childbearing women.

Obstetrical Violence as Violence against Women: Coercion and Control

Situating obstetrical violence as an act of violence against women and taking into consideration its historical context together with its cultural implications provides the opportunity for deeper analysis of the power dynamics between patients and health care providers. For example, Erdman (2015) states:

> Consider vaginal examination in labor, which is used by providers to assess cervical dilatation and effacement, fetal head position, and membrane status, but which is also often practiced routinely without informed consent, and thereby analyzed as a violation of the human rights norm of bodily integrity… an ethnographic study on the transition to hospital birth among rural migrant women in Bolivia revealed that for many women the indignity of the vaginal examination was the public spectacle of it: dislike and fear of having to display one's genitals under a collective male gaze (p.46)

Consider further that the normalization of patient behaviour in health care facilities is that of obedience and submission to the interventions recommended by physicians and other health care providers with women expected to act in the best interests of their child (Erdman, 2015). Charles (2011) suggests that some of the practices routinely used by obstetricians and gynecologists share similarities with the rationalized gendered norms of abusive domestic partners, whereby men use manipulation, intimidation and violence to control women's behaviour and their bodies. Goer (2010) suggests further that the parallels between domestic violence and the abuse experienced in childbirth are similar and include name calling and put downs, restricting a woman's ability to contact her family and friends, and threats of or instances of actual physical harm and sexual assault. In cases of obstetrical violence perpetrators of these acts, whether they are obstetrical staff or other care providers, "feel entitled to exert this control on the grounds of the victim's inferior position" and may use coercive tactics to control a woman's decision making (Goer, 2010, pg. 34) in much the same way that perpetrators of domestic violence may justify their actions based on the normative status of women as being inferior (Sev'er, 2012).

Coercion and control are suggested to be powerful tools that enable perpetrators of domestic violence to

inflict humiliation and degradation that violate a woman's personhood (Libal & Parekh, 2009). It is also suggested that the primary harm inflicted by coercive control tactics used by perpetrators is political in nature, rather than physical, as it is deliberate deprivation of the both rights and resources that are essential to a woman's personhood and citizenship (Libal & Parekh, 2009). Arguably, within a health care setting women in labour are debased and become 'just a patient' to care providers whose specific goal could be to complete their work and move onto the next patient. The individual context of each woman's pregnancy and birth experience may be ignored while the physicians and care staff may continue to exert their power and control. With these similarities between the abuse inflicted by domestic partners and the abuse and disrespect experienced by women in health facilities during childbirth, it can be argued that the replication of patriarchal systems of power and domination is both systemic and endemic, and it poses a significant challenge to women's basic human rights.

Additional parallels between the abuse experienced by labouring women and women being abused by domestic partners further facilitate the development of situating obstetrical violence as an act of violence against women. For example, Sev'er (2012) describes the experience of Nancy Sudbury:

> Roy [Nancy's partner] would go out and sometimes not come back for a few days. Nancy never knew where he went… When she complained, Roy would ignore her. If she continued to complain, Roy would get aggressive. A number of times she was slapped right on the mouth. "Close that trap, you bitch!" he would say. More than once, Nancy was choked and pinned to the door or the wall. One time, Roy pulled out a gun and stuck the barrel right between Nancy's eyes (p. 90-91).

The description of the abuse experienced by Nancy Sudbury at the hands of her partner paints a disturbing picture of an example of a woman's experience with domestic violence. This treatment is considered both socially and culturally reprehensible, and it could warrant criminal charges against the perpetrator. In a health care facility setting, it can be suggested that similar acts of violence and abuse are carried out against women, but they have become an accepted part of practice and are carried out by physicians who use their control over medical information and social authority to justify their behaviour (Charles, 2011). To illustrate, Goer (2010) describes the birth experience of a woman in Illinois in the United States whose physician refused to give her pain medication, and indicated that the woman deserved to feel pain because she had not called his office prior to her arrival. The labouring woman's experience is further described by Goer (2010):

> [The physician] repeatedly told her to "Shut up, close your mouth, and push..." and "there is only one voice in this room and it is mine"; performed a rough vaginal exam during a contraction, causing extreme pain, while she said, "No, stop!" ; repeatedly told the woman she was going to hemorrhage and that she and the baby might die, which was especially terrifying because she had experienced a prior stillbirth; told a nurse not to help her; sutured her without adequate anesthesia and had her husband hold her down when she squirmed in pain; and refused to let her or her husband hold the baby (p. 36).

The similarities between the experiences of both women could suggest that there is little difference in the treatment of a labouring woman in a health facility and a woman experiencing abuse at the hands of a domestic partner. Arguably, both situations are considered normative in their contextualized settings; however, the situation of domestic violence could result in a formal police investigation and the laying of criminal charges against the perpetrator, whereas the physician's behaviour is likely not to be questioned or considered improper as it occurred in a health facility. It could also be defended by claiming that the physician was acting in the best interests of the unborn fetus. The manner in which this particular physician acted towards the patient was both disrespectful and abusive and is suggestive of the power and control maintained by physicians within the hierarchy of a health care facility; it also serves as an effective illustration as to the position and status afforded to women when they are at their most vulnerable and are more likely to experience an incidence of abuse.

Potential Solutions: Employing a Human Rights Framework

The application of a human rights framework to maternal health is not without precedent and has become a tool employed by advocates, activists and the international community to campaign for access to safe health care services for women and their children during both pregnancy and the postpartum period. Various pieces of international law address the rights of women when seeking and receiving

maternity care and include the *Declaration of the Elimination of Violence Against Women,* the *International Covenant on Civil and Political Rights,* and the *Universal Declaration on Bioethics and Human Rights.* Early applications of human rights-based approaches to gendered issues were focused on two primary areas, one of which included the rights of women to have control over their own bodies (Cottingham et al., 2008). The application of a human rights framework to the elimination of acts of obstetrical violence towards women is a relatively recent occurrence that gained considerable international attention when the 2011 charter entitled *Respectful Maternity Care: The Universal Rights of Childbearing Women* ('Charter') was drafted by the White Ribbon Alliance, an international network of maternal health advocates (Erdman, 2015). Specifically citing the human right to health, the Charter emphasises the importance of dignity, respect, non-coercion and non-discrimination in the provision of health care services (Erdman, 2015).

Prior to the development of the Charter, momentum had been building on a global scale amongst various international women's organizations with respect to maternal health outcomes; specifically, these groups focused on two key objectives: access to safe, affordable contraceptives and to access safe child birth and antenatal services (Cottingham et al., 2008). The introduction of concepts related specifically to *treatment* received during child birth, rather than a strict measurement of objective health outcomes, arguably further situates obstetrical violence within a human rights framework and allows for the application of international law to address abuses by government actors. For example, the World Health Organization released a position statement related to the prevention and elimination of disrespect and abuse experienced by women during childbirth stating that "Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care (WHO, 2014, pg. 1).

The application of the human rights framework is not without limitations as measurements related to practices and outcomes is quantitatively collected and may be void of subjective experiential data that defines obstetrical violence as it occurs individually to each woman. Regardless, the current standard of measuring the level of abuse and disrespect experienced by women in individual nations is based on set criteria, and each birth experience is evaluated by objective means that have been developed as key indicators of performance. Abusive or disrespectful behaviour towards labouring women is then measured against deviation from normalized standards and expectations that health care services respect the human rights of each individual woman (Erdman, 2015). Though there are legal frameworks and charters to support the implementation of basic human rights for all women, enforcement is difficult as there are limited mechanisms that can be used by the international community and each country's response is dependent upon the adoption and execution of domestic legislation (Johnstone, 2006).

Further international attention to the issue of obstetrical violence occurred in 2013 when the United Nations Special Rapporteur on Torture issued a report on torture and abusive treatment in health care settings and specifically included the mistreatment of women seeking reproductive care (Erdman, 2015). Through the application of a human rights framework, new mechanisms of accountability can possibly be used to open up and challenge established hierarchical institutions like medicine (Erdman, 2015), turning issues related to obstetric violence into public health concerns that require comprehensive solutions to address the underlying structural inequalities that they represent. In recent years there has been success in employing a human rights framework to hold state actors accountable for failure to provide appropriate health care services to pregnant women. For example, the Committee on the Elimination of Discrimination against Women deemed the government of Brazil responsible for the 2002 death of Alyne da Silva Pimentel after she was misdiagnosed and denied emergency obstetrical care after seeking treatment at numerous state run or contracted health care facilities (Cook, 2013; Alyne, n.d.). The precedent this decision sets arguably makes a strong case for rights-based health care delivery and equal access to quality services for women globally.

Conclusion

Through an exploration of the concept of obstetrical violence and the patriarchal systems of power and control within health care facilities, it has been demonstrated that this form of gendered violence is globally pervasive and in many ways akin to situations of domestic violence. Globally, pregnancy and birth are considered to be significant life events often enshrined in social and cultural practices that further venerate the role of women as mothers (White Ribbon Alliance, 2011). Through systems of domination and control, systemic inequality situates women as subservient to men and, therefore, as

objects to be controlled; often this control is carried out through acts of abuse and violence including verbal threats, physical and sexual assault, harassment, psychological abuse and coercion (Bunch, 1990; Sev'er, 2002). Obstetrical violence can be understood as incidences of disrespect and abuse experienced by women while in health care facilities perpetrated by physicians and health care staff. These acts are often normalized routines in health care facilities as the social status and power afforded to physicians and other medical staff creates hierarchical power structures (Charles, 2011) where the patient may be considered to be an object to be dominated rather than as an individual with unique wants, needs and preferences.

Public health advocates and international bodies, including the World Health Organization, have recognized that the best and most effective way to reduce maternal morbidity and mortality is to increase access for all women to health care services including the provision of skilled birth attendants and emergency obstetrical care at health care facilities (WHO, 2014). Often overlooked is the interpersonal aspect of health care delivery that can serve to inform cultural attitudes and beliefs towards health care facilities, with negative experiences serving as a disincentive for women to seek medical care during pregnancy and childbirth (Limbu, 2013; White Ribbon Alliance, 2011). The connection between obstetrical violence and acts of violence against women can be demonstrated by comparing the methods of coercion and control employed by perpetrators of domestic violence with tactics used by physicians and health care providers when providing obstetrical services. The application of a human rights framework to the issue of obstetrical violence provides a mechanism in which international standards and norms can be used to hold individual governments accountable for their failure to provide appropriate, rights-based care to pregnant women (Alyne, n.d.). Though international law lacks formal enforcement mechanisms (Bunch, 1990; Johnstone, 2006), it can be used to maintain accountability amongst member states and provide a foundation to address the unique health care needs of women.

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