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REPRODUCTIVE HEALTH matters

FEATURE

Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina

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Abstract: *Argentina has recognized women's right to not be subjected to obstetric violence, the violence exercised by health personnel on the body and reproductive processes of pregnant women, as expressed through dehumanizing treatment, medicalization abuse, and the conversion of natural processes of reproduction into pathological ones. Argentina's legislative decision to frame this abuse and mistreatment of women under the rubric of gender-based violence permits the identification of failures in both the healthcare system and women's participation in society. This article examines how applying the Violence Against Women framework to address issues of abuse and mistreatment of women during maternal health care provides a beneficial approach for analyzing such embedded structural problems from public health, human rights, and ethics perspectives. The framework of Violence Against Women seeks to transform existing harmful cultural practices, not only through the protection of women's reproductive autonomy, but also through the empowerment of women's participation in society.* © 2016 Reproductive Health Matters. Published by Elsevier BV. All rights reserved.

Keywords: maternal health, violence, women, gender, human rights

Introduction

A woman, experiencing her first pregnancy, undergoes an unconsented episiotomy during childbirth which, as a result of poor care, leads to loss of sphincter control.[1] A woman experiencing a healthy pregnancy is given oxytocin for easier labor management during six hours without monitoring, consequently the fetus is harmed.[2] A woman, pregnant as a result of rape, is denied access to an abortion by a physician who demands prior judicial authorization.[3] These are examples of women's experiences of maternal health services in Argentina. They also represent different dimensions of ongoing challenges to guaranteeing safe and high quality maternal healthcare.

These experiences have been conceptualized, although with variations, as the abuse and mistreatment of women during the provision of maternal healthcare. International health institutions, such as the World Health Organization (WHO) have described such phenomena as "disrespectful, abusive, and neglectful treatment", focusing on the provision of treatment during childbirth at healthcare facilities. The WHO, among others, considers that "disrespectful, abusive, and neglectful treatment" may involve physical abuse, humiliation or verbal abuse, coercive or unconsented practices on women, failure to maintain confidentiality or obtain informed consent, as well as refusal of pain medication or admission to a health facility, among others.[4]

In 2014, the International Federation of Gynecology and Obstetrics launched a "Mother-Baby Friendly Birthing Facilities Initiative." The Federation has been developing guidelines for identifying practices constituting "abusive, coercive, and neglectful treatment"; these include lack of privacy in labor/delivery; physical, verbal, emotional or financial abuse; and prohibiting preferred positions and/or the ingestion of food and beverages in labor.[5]

International organizations are producing systematic studies and benchmark documents on understanding and measuring the abuse and mistreatment of women in health facilities during childbirth.[6] A systematic review of studies in thirty-four countries identified that women suffer from physical abuse, sexual abuse, verbal abuse, stigma and discrimination, health system constraints and bad quality conditions, and failure to meet professional standards of care that impact on their health.[7] The review concluded that in conceptualizing and measuring the different sufferings experienced by women during childbirth at health facilities, "mistreatment of women" should be proposed as the terminology best capturing the range of experiences.

Alongside these international developments and advocacy for safety and quality of care for

women during different maternal health services, in 2009, Argentina enacted a statute on Violence Against Women. This Argentinean law establishes a woman's right to be free from obstetric violence, which the statute defines as,

"[v]iolence exercised by health personnel on the body and reproductive processes of pregnant women, expressed through dehumanizing treatment, medicalization abuse, and the conversion of natural processes of reproduction into pathological ones…" [8]

This statute considers the abuse and mistreatment experienced by women in different maternal health services (prenatal, labor, childbirth, postpartum, and abortion care) within a Violence Against Women (VAW) framework and aims to raise awareness about the abuse, mistreatment and disrespectful care that women experience within the health sector. Furthermore, the legal concept of obstetric violence seeks to shed light on the ongoing lack of state oversight of the provision of maternal health services in both the public and private health sectors. It is also noteworthy that the concept of obstetric violence established by Argentinean legislation represents a different terminology for conceptualizing the abuse, mistreatment, and disrespectful maternal care that women receive in health facilities than the "disrespectful, abusive, and neglectful treatment" chosen by the WHO and the "mistreatment of women" proposed by Bohren et al.[9]

This article critically explores the concept of obstetric violence as a legal framework for identifying healthcare practices that constitute abuse and mistreatment of women. It examines different legislations and health policies on maternal health and VAW as tools for complementing the scope and interpretation of obstetric violence. Furthermore, this article aims to demonstrate, from a public health, ethical, and human rights perspective, that the concept of obstetric violence serves to identify and address persisting systemic practices that harm women, put them at risk, or disempower their decision-making in the context of maternal healthcare.

Obstetric violence in the Argentinean legal order

The definition of obstetric violence in the Violence Against Women statute identifies three main ways in which this kind of violence may be perpetrated on women: dehumanizing care, over-medicalization, and the conversion of biological processes into pathological ones. A definition of how these three practices impact on women is absent in the general VAW statute. However, a previous Statute on Humanized Labor, an executive decree regulating the VAW statute, and Ministry of Health public policies, can complement the scope or definition of obstetric violence.

Dehumanized care has been defined by the executive decree regulating the general VAW statute as "cruel, dishonourable, dismissive, humiliating or threatening treatment provided by health personnel",[10] causing physical or psychological harm. However, the executive decree does not specify particular practices. The general Statute on Violence against Women defines physical violence as cruel or threatening when a woman experiences pain, harm or battery. It also recognizes psychological effects resulting from "restrictions, dishonesty or actions that produce emotional suffering or loss of self-confidence; or prevent personal development; or seek to degrade; or control a woman's actions, behaviours, beliefs or decisions."[11] Here, the definitions of physical and psychological violence contribute to a better understanding of how some obstetric practices constitute dehumanizing care of women.

The 2004 Statute on Humanized Labor, which recognizes the rights of women in health facilities during the provision of various maternal health services, characterizes over-medicalization as procedures that do not translate into better maternal health, or fail to prevent maternal mortality and morbidity.[12] Examples include: routine episiotomies, routine practice of enemas, or unconsented or unjustified cesarean section. There is clear evidence that episiotomy is an unnecessary routine procedure and can be harmful.[13] Similarly, enemas, which are still routinely practiced, cause extreme discomfort and there is no evidence that they improve sanitary conditions or reduce infections.[14] In response to such over-medicalization, the Humanized Labor statute establishes health personnel's obligation not to prescribe medication and to avoid invasive practices unless such treatment is necessary for protection of the health of the mother or fetus.

Finally, practices considered to pathologise the natural processes of reproduction can be determined by examining the 2004 medical practice guidelines issued by Argentina's Ministry of Health, which recommends safe and respectful maternal healthcare practices during labor and childbirth. Under the guidelines, orders or decisions by healthcare personnel to restrict women's intake of food or

beverages during childbirth can be construed as converting natural processes of reproduction into pathological ones, as these actions do not complicate care provision, but rather increase comfort, and function as non-medical means for pain relief.[15] Such guidelines can contribute to an improved understanding of good practices and a reduction of medicalization.

Notwithstanding this, women can be subject to obstetric violence during different stages of maternal healthcare provision other than childbirth. While the WHO's statement on the prevention of women receiving "disrespectful, abusive, and neglectful treatment" primarily focuses on care provided to women during childbirth, Argentina's statute recognizes that obstetric violence may also occur in prenatal, labor, post-partum, and abortion healthcare.[16] Thus, women's right to be free from violence when receiving maternal health services is broadly protected. In this sense, the executive decree regulating the VAW statute considers that obstetric violence against women can also be perpetrated in the context of abortion or post-abortion care, independently of the legality of the abortion. Past studies have documented dehumanizing care of women who had sought abortion or post-abortion care,[17] for example, through the practice of curettage without pharmacological pain relief, or verbal insults, judgmental, or derogatory remarks by emergency room staff.[18]

Moreover, as regards to the perpetrators of obstetric violence, the definition in the VAW statute explicitly mentions 'health personnel'. However, the executive decree specifies that 'healthcare personnel' also includes administrative personnel or other personnel associated with the health facility as well as physicians, nurses, social workers, psychologists or obstetricians.

Lastly, denying women access, through action or omission, to maternal health services may be considered another manifestation of obstetric violence under Argentinean law.[19] This issue has been specifically addressed in other Latin-American jurisdictions; article 51 of the Venezuelan 2007 Statute on Violence against Women establishes that failure to provide healthcare for obstetric emergencies in a timely and effective way constitutes obstetric violence.[20] Such negligence may be a result of institutional discrimination or general failure of the health system, such as a lack of beds or overtaxed health professionals.[21] The Supreme Court of Argentina has ruled that denial of access to abortion services to women pregnant as a consequence of rape may constitute institutional violence, clarifying that the routine of requesting judicial authorization is unconstitutional, since no law requires such authorization. Finally, the court proclaimed that the continuation of this practice would render the state responsible for institutional violence against women.[22] As this example reveals, although obstetric violence is itself a narrow concept, the broader framework of Violence against Women encompasses institutional violence, ensuring the protection of women's reproductive rights. By describing institutional violence as a manifestation of obstetric violence, the state includes situations where state officials, personnel, or agents of public entities or institutions impede, obstruct, or delay women's access to public services or the enjoyment of their rights.[23]

This analysis suggests that the right to be free from obstetric violence aims to ensure women's security, comfort, dignity, and autonomy during their use of different maternal health services. Furthermore, it highlights how other state health policies and laws, by identifying different relationships and maternal health situations where abuse occurs, contribute to complementing the definition of obstetric violence.

Obstetric violence as a public health issue

Health systems in middle- and low-income countries actively promote provision of maternal healthcare in health facilities to reduce maternal mortality and morbidity.[24] However, the abuse and mistreatment of women at health facilities and failure to guarantee care (e.g. due to overcrowding and understaffing) have been identified as factors that dissuade women from facility-based maternal healthcare and reflect the lack of progress in reducing maternal mortality and morbidity.[25]

In response, regional health institutions such as the Pan-American Health Organization (PAHO) have been highlighting the importance of evidence-based maternal healthcare. This approach postulates that women's medical care should be based on the best available scientific evidence subjected to systematic review, and the result of patient's preferences, respectful of their rights and principles instead of solely focusing on the disease or request for medical assistance.[26] This approach supports safe, effective, and individualized care, while eliminating inappropriate or unnecessarily risky interventions that fail to increase beneficial health outcomes.

As of 2001, 98-99% of deliveries in Argentina occur in health facilities.[27] Furthermore, 78-90% of pregnant women in Argentina have received at least one prenatal check-up at a health facility.[28] Nevertheless, Argentina's health system has struggled with adopting evidence-based, safe clinical practices.[29] Entrenched behaviours, such as the routine use of episiotomies or high rates of unjustified cesarean sections, which unnecessarily put women's bodies at risk, contribute to this failure. Argentina's legal response to these public health challenges involves imposing obligations on physicians to refrain from over-medicalized practices and requesting the Ministry of Health to issue health policies and practice protocols that identify and eliminate entrenched practices known to be harmful or unnecessary.

To address the knowledge gaps that have translated into unnecessary or harmful practices affecting women, the Ministry of Health enacted clinical practice guidelines for evidenced-based safe practices in maternal health as early as 2004. These clinical guidelines advise health professionals not to place undue restrictions on women at the moment of childbirth (e.g. by allowing psychosocial support by a person chosen by the woman). They also discourage the routine practice of episiotomies or enemas.[15] As stated in the previous section, in 2004 such recommendations were translated into obligations on physicians to avoid invasive practices that fail to improve maternal health outcomes and not to impede the pregnant woman from being accompanied by a person of her choice.[30]

However, these guidelines fail to translate in clinical practice.[31] For example, a study on public hospitals between 2004 and 2006 found that episiotomy is avoided only in 41.2% of primiparous pregnancies and that continuous support of women during childbirth occurs only in 17.9% of cases.[32]

An analysis of cesarean rates also points in the same direction. The WHO acknowledges that not only are cesarean section rates above 10-15% not associated with reduced mortality, but their unnecessary practice is associated with short and long term risks, affecting the current delivery, the woman's health, and future pregnancies.[33] Recently, PAHO issued a warning of an increase in unnecessary cesareans in Argentina, with a rate of 30% between 2012 and 2013. A study of 54,000 births, in private and public hospitals in 13 provinces, yielded a 75% cesarean rate.[34] The high rate of cesareans in Argentina does not translate into reduced maternal mortality, as the maternal mortality ratio has barely dropped between 2004 and 2013; from 39 to 32 per 100,000 births.[35]

The fact that Argentina has been able to guarantee that most maternal healthcare, in particular childbirth, occurs at a health facility has not necessarily translated into fewer risks for women's health. Despite efforts such as health policies and clinical guidelines by the Ministry of Health, women's bodies continue to be at the mercy of unnecessarily invasive and harmful medical practices. Hence, the physician's obligation within the obstetric violence concept to refrain from over-medicalization may provide an additional legal tool for effectively ensuring evidence-based, safe maternal care in public and private services.

Obstetric violence as a human rights violation

Argentina has ratified international human rights treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women, as well as the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women (Belem do Para Convention). Similarly, the Argentinean Constitution grants constitutional status to the International Covenant on Economic, Social, and Cultural Rights and the American Convention on Human Rights.

Equally important is the conceptualization of ill-treatment as a state failure to guarantee women's right to freedom from cruel, inhuman, and degrading treatment. The UN Special Rapporteur on Torture has reported that ill-treatment at reproductive healthcare facilities may amount to inhuman and degrading treatment.[36] Similarly, the CEDAW Committee, in General Recommendation No. 19, stated that gender-based violence "which impairs or nullifies the enjoyment by women of human rights" is considered discrimination and a violation of the right not to be subjected to cruel, inhuman, or degrading treatment.[37] In healthcare settings, the perpetration of obstetric violence through dehumanizing treatment of women could be considered an impairment or nullification of their human rights, and consequently amount to discrimination and a violation of the right to be free from cruel, inhuman, or degrading treatment.

Studies analyzing how women are treated at healthcare facilities, or how healthcare staff understand certain clinical practices vis-à-vis women's care needs, help shed light on current normative conventions and serve as evidence for

identifying human rights violations at health facilities.[38]

A qualitative study interviewing women who had received maternal healthcare reveals that the treatment received by women in vulnerable economic circumstances could be considered discriminatory, since their inability to afford private health care obliged them to deliver at public hospitals where they endured humiliation and mistreatment.[39] Such verbal and physical violence is considered a violation of women's right to personal as well as physical and psychological integrity.[40]

The abuse and disrespect suffered by women also constitutes a violation of the right to privacy and access to information. Individual testimonies reveal how disadvantaged women lack care adjusted to their particular needs and interests, or how service provision takes place for teaching purposes without the consent of the woman.[41] In one case, a woman reported that while receiving obstetric care, the physician invited students without her consent and testified that, "*around thirteen or so students were touching me. I felt shame, anger, and had to hide my face behind the bed sheet in order to avoid them seeing me.*"[42] The CEDAW Committee has highlighted the importance of informed consent as well as proper consideration of women's perspectives and needs in order for healthcare provision to be considered acceptable and respectful to women's right to privacy.[43]

Thus, the abuse and disrespect of women at public health facilities can be understood as a state failure to guarantee, on a basis of equality between men and women, appropriate services in connection with pregnancy, childbirth, and post-partum care.

The 2004 Statute on Humanized Labor recognized women's right to participate in the treatments they receive and not be considered a submissive object of care. The statute recognizes the right to be informed about different possible medical interventions, and the right to choose freely among possible alternatives. The statute also establishes the pregnant woman's right to respectful treatment, and to receiving individualized and personal medical assistance that guarantees her privacy and respects her cultural customs.

The statute also encourages that women are empowered to advocate for their rights and bring their rights violations to the courts. Despite the fact that the statute has been operative since 2009, the number of complaints of obstetric violence at the National Ombudsman Office has been very low. In 2013, women had reported only 13 complaints.[44] In acknowledging this low reporting, Argentina additionally recognized women's right to timely and effective access to justice, which established the state's obligation to create legal defenders of victims of gender-based violence and guarantee free legal representation.[45] This adds another legal tool for women to access courts with fewer financial barriers for seeking legal redress.

The Statutes on VAW and Humanized Labor internalizes international human rights law and prescribes the state's obligation to guarantee appropriate maternal health services for women. They further aim to empower women through knowledge about their rights in health facilities, impose obligations on the health workforce, and provide women with legal resources for obtaining redress in courts or state agencies.

Obstetric violence as an unethical gender stereotyping

Sociological and medical studies reflect a culture among healthcare personnel of considering women as vessels for children, underpinning different expressions of obstetric violence. For instance, Checa's 1996 study of prenatal care at a public maternity hospital in the City of Buenos Aires shows how pregnant women are objectified and seen only on the basis of their reproductive capacity. Checa's findings revealed the gender stereotyping embedded in the provision of prenatal care, which thwarted women's capacity to act with agency over their pregnancies.[46]

Cook and Cusack explain that gender stereotyping occurs when applying stereotypes to someone or a group on the basis of "social and cultural construction of men and women, due to their different physical, biological, sexual, and social functions."[47] Gender stereotyping becomes problematic when it serves to disregard an individual's preferences or abilities, in ways that translate into a denial of human rights or the creation or entrenchment of gender hierarchies.[48] Checa's findings serve to illustrate how gender stereotyping disproportionately impacts women, since they lose decisional capacity at the hands of the physician's medical knowledge.

Furthermore, Cook and Cusack explain that gender stereotyping of pregnant women reinforces women's primary social roles as mothers, vulnerable individuals, or incompetent decision makers.[49] The

reinforcement of these social roles through gender stereotyping strips women of their decisional power to consider and express their views on childbirth and motherhood.

Eva Giberti has described the pervasive effect of gender stereotyping on how physicians respond to women's experiences in childbirth. She describes a predominantly masculine medical culture that, lacking understanding of women's subjective feelings and interests during maternity care, has construed women's reactions as illness, requiring medical diagnosis and intervention.[50] Under this conceptualization, women are permanently considered vulnerable individuals or incompetent agents with regard to decisions.

Furthermore, a study of public maternity hospitals in the Province of Buenos Aires found that only 42% of the healthcare staff always informed women about medical procedures. This study also revealed that 30% of healthcare staff considered that women should never be allowed to choose their position in childbirth, although they understood that such a choice would be possible and desirable.[51] A qualitative study of women's delivery preferences found that women in a public maternity facility were unaware that the mode of delivery was their choice; instead, they believed it to be a medical decision.[52]

These studies reflect the fact that many physicians consider it unnecessary to inform women about their choices or show regard for their needs and preferences. The gender stereotyping exercised by physicians generalizes and pathologizes women's feelings and experiences in a way that strips women of power, decision-making and control over their own bodies. Ignoring women's individuality by standardizing their needs and preferences, this healthcare culture consequently behaves unethically by eliminating women's understanding and decision making over the care they receive.[53]

In order to alter this paradigm, policies have recommended that healthcare facilities shift the culture of maternal care provision to a model providing individualized care, and concurrently addressing women's physiological, emotional, and cultural needs.[54]

Gender stereotyping by health personnel in the provision of maternal healthcare disproportionately impacts women by treating them as vulnerable individuals, incapable of controlling their own bodies or understanding their own experiences. Consequently, physicians believe that it is in a woman's best interest to remove her choice with regards to healthcare. The ethical objection lies in the clinician's failure to respect women as capable moral agents, treating them impersonally through infantilizing stereotypes.

Conclusion

Argentina has been attentive to international developments and efforts to address the abuse and mistreatment of women in health facilities during childbirth or other maternal services. The Violence Against Women statute introduced the concept of obstetric violence in Argentinian law. However, the definition of this concept presents limitations, as it fails to determine which practices constitute dehumanizing treatment, over-medicalization, and the conversion of natural reproductive processes into pathological ones. In turn, this article has considered an executive decree regulating the VAW statute, the Humanized Labor statute, and medical practice guidelines as documents that can help complement the original statute and better determine the scope of obstetric violence practices. These instruments may also assist in identifying obstetric violence beyond the narrow definition in the VAW statute, since they recognize when it occurs in the context of abortion, as well as how health institutions may perpetrate violence on women by denying them access to maternal health services.

Judges, lawyers, and policy-makers must comprehensively consider all aspects of obstetric violence, including public health, human rights, and ethics. When a woman is caused irreparable physical and emotional damage as a result of obstetric care, this extends far beyond mere medical malpractice. Such mistreatment represents abuse and negligence at systemic levels, implying failure of proper implementation of maternal healthcare policies. Judges, lawyers, and policy-makers should be aware of and inquire into unnecessary and damaging institutional practices (such as episiotomies and non-essential cesareans) and the public health challenges that their routine practice, despite scientific evidence against them, creates. Besides violating rights, such cases also communicate failure at an ethical level, and reveal a gendered mindset whereby physicians routinely neglect women's interests, needs, and choices at the moment of healthcare provision. Thus, the legal concept of obstetric violence serves as a framework for making visible the underlying systemic challenges that women face in maternal healthcare. In order for the true depth and scope of the problem

to be addressed by public consciousness, a multifaceted approach that contemplates public health, human rights, and ethical perspectives must be undertaken to make women aware of their rights and agency while receiving obstetric care. One aspect of such an initiative must be fomenting studies that listen to women and incorporate their specific experiences, concerns, and priorities into enacting new solutions. Academic reflection should be undertaken alongside such data-collection and qualitative studies about how legislation and procedural guidelines are being implemented at all levels. A thorough dedication to all facets of this perverse phenomenon will ensure long-term improvements in guaranteeing safe and quality maternal healthcare to women, and giving them a central role in their own healthcare and well-being.

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Résumé

L’Argentine a reconnu le droit des femmes à ne pas être soumises à la violence obstétricale, la violence exercée par le personnel de santé sur le corps et les processus génésiques des femmes enceintes, telle qu’exprimée par des traitements déshumanisants, une médicalisation excessive et la transformation de phénomènes naturels de procréation en pathologies. La décision législative de l’Argentine d’encadrer ces abus et cette maltraitance des femmes sous le chapitre de la violence sexiste permet d’identifier les échecs dans le système des soins de santé et dans la participation des femmes à la société. Cet article examine comment l’application du cadre relatif à la violence faite aux femmes pour traiter les questions d’abus et de maltraitance des femmes pendant les soins de santé maternelle procure une approche bénéfique dans les perspectives de la santé publique, des droits de l’homme et de l’éthique pour analyser de tels problèmes structurels, profondément enracinés. Le cadre relatif à la violence faite aux femmes a pour but de transformer ces pratiques culturelles nuisibles, non seulement en protégeant l’autonomie génésique des femmes, mais aussi en renforçant la participation des femmes dans la société.

Resumen

Argentina ha reconocido el derecho de las mujeres a no ser sometidas a la violencia obstétrica, es decir, violencia ejercida por el personal de salud en el cuerpo y en los procesos reproductivos de las mujeres embarazadas, que se manifiesta por medio de un trato deshumanizante, abuso de medicalización y la patologización de los procesos reproductivos naturales. La decisión legislativa de Argentina de enmarcar este abuso y maltrato de las mujeres bajo la rúbrica de violencia de género permite la identificación de fallas tanto en el sistema de salud como en la participación de las mujeres en la sociedad. Este artículo examina cómo aplicar el marco de violencia contra las mujeres para abordar asuntos de abuso y maltrato de las mujeres durante la atención materna constituye una estrategia benéfica, desde los puntos de vista de salud pública, derechos humanos y ética, para analizar dichos problemas estructurales. El marco de violencia contra las mujeres busca transformar las prácticas culturales dañinas, no solo protegiendo la autonomía reproductiva de las mujeres sino también empoderándolas para que participen en la sociedad.