

ABUSE AND DISRESPECT IN CHILDBIRTH CARE AS A PUBLIC HEALTH ISSUE IN BRAZIL: ORIGINS, DEFINITIONS, IMPACTS ON MATERNAL HEALTH, AND PROPOSALS FOR ITS PREVENTION

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Abstract

Disrespect and abuse (in Brazil called obstetric violence), described by different terms, is increasingly used in social activism, in academic research and public policy formulation, and was recently recognized as a public health issue by the World Health Organization. As an innovative theme, it requires a mapping its origins, definitions, typology, impacts on maternal health and proposals for its preventing and remedy. We present a critical-narrative review about this issue, including academic literature, productions of social movements and institutional documents, in Brazil and internationally. After a short historical overview, we map the definitions and types of violence. The complex causation of these forms of violence is discussed, including the role of professional training, the organization of health services, and the implications for maternal morbidity and mortality. Finally we present interventions in public health that have been used or proposed to prevent and mitigate obstetric violence, and an agenda for innovation and research in this area.

Keywords: humanized birth, abuse and disrespect, violence against women, gender and health, human rights, patients rights, patient safety.

INTRODUCTION

In the second decade of this century, obstetric violence became visible, being subject of numerous studies, art shows,^{1,2} documentaries,³⁻⁵ actions in the judiciary,⁶ parliamentary investigation,⁷ several initiatives by the Public Prosecutor to defend women's rights⁸⁻¹² as well as a new set of public health interventions. Its relevance and legitimacy as a public health problem was corroborated by the recent statement from the World Health Organization (WHO) called "*The prevention and elimination of disrespect and abuse during facility-based childbirth*",¹³ and by the creation of the Mother and Baby-friendly Childbirth Facility Initiative.¹⁴ These innovative actions are geared to make visible, prevent and remedy this form of violence in health practices, in the public and private sectors, change the training of health providers, and to encourage governments and institutions for research and interventions.

As an innovative and recent topic, it is still surrounded by imprecisions. What is needed are

therefore provisional mappings of its origins, magnitude, definitions, typology, impacts on maternal health, and proposals to address it, in order to better make justice to its importance in terms of public health.

In this critical-narrative review, we included academic literature, productions of social movements, policy documents, legal documents, in Brazil and internationally, in order to highlight different dimensions of violence in facility-based childbirth, some of its antecedents, consequences and proposals to overcome it. The goal is to introduce the reader in the debate in order to assist in the search on specific aspects that can be addressed as research and intervention issues.

Abuse and disrespect (obstetric violence) around the world

Although considered a "recent" or a "new" research theme, reports of women subjected to abusive treatment during institutionalized childbirth appear in different historical moments, albeit under different names, finding responses in different

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contexts, and often having an important effect on the change of care practices in pregnancy and childbirth.

For example, by the end of the 1950s, violence in the birth narratives broke the barrier of silence in the US, when the Ladies Home Journal, a magazine for housewives, published the article "Cruelty in Maternity Wards". The text described as torture the treatment received by pregnant women, subjected to twilight sleep (a combination of morphine and scopolamine), which produced deep sedation, frequently accompanied by restlessness and possible hallucinations. Health providers used to put handcuffs and shackles on the feet and hands of patients so they do not fall from the bed, and often women postpartum had bruises on their bodies and injuries to wrists. The article also reports the injuries resulting from routine use of forceps deliveries in unconscious women. It caused a flood of letters to the magazine and other media, with similar testimonies, prompting major changes in care routines and the creation of the American Society of Psycho-prophylaxis in Obstetrics.¹⁵

In the UK in 1958, a Society for the Prevention of Cruelty to Pregnant Women was created.¹⁶ The letter that calls for its foundation, originally published in the Guardian, says:

[...] In hospitals, [...] mothers put up with loneliness, lack of sympathy, lack of privacy, lack of consideration, poor food, unlikely visiting hours, callousness, regimentation, lack of instruction, lack of rest, deprivation of the new baby, stupidly rigid routines, rudeness, a complete disregard of mental care or the personality of the mother. Our maternity hospitals are often unhappy places with memories of unhappy experiences. [...] (1960 apud Beech; Willington, (2007) p. 2)¹⁶

Feminist theorists like Adrienne Rich¹⁷ reported her grief with the experience lived by women of higher income and education in the 1950s: "We give birth in hospitals [...] carelessly drugged and tied against our will, [...] our children removed from us until other experts tell us when we can embrace our newborn" (p. 269). The classic *Our Bodies, Ourselves*,^{18,19} as well as other feminist books of the decades from 1960 to 1980, reinforced these criticisms with extensive narratives, helping to raise awareness and inspired generations of professionals and activists in the field, denouncing the irrationality of practices.

In 1998, the Latin American Center for the Rights of Women²⁰ published the report *Silencio y Complicidad: Violencia contra la Mujer en los Salud de Servicios Públicos in Peru* with extensive documentation of abuses of human rights of women during insitutionalized childbirth, which applies to across the continent.

Obstetric violence in Brazil

In Brazil, the issue was already being addressed in feminists in academic institutions and social movements. The pioneer research Espelho de Vênus (Venus' Mirror), by the Ceres Group

(1981),²¹ in the 1980s, was an ethnography of the female experience, explicitly describing the institutionalized birth as a violent experience. This group of activists researchers published narratives demonstrating that:

It is not just in sexuality that violence appears marking the existential trajectory of women. Also in the doctor-patient relationship, once again the ignorance of their physiology is key to explain the feelings of helplessness and hopelessness when a woman watches her body being manipulated when resorting to medicine in the most significant of his life moments: contraception, birth and abortion.(p. 349)²¹

In the early 90s, the action-research coordinated by the City of São Paulo, called "Violence - A Glimpse of the City"²² clearly states, with many narratives, that childbirth in institutions was described an experience of violence, and often providers had aggressive and intimidating postures, humiliated patients and did not respect their pain.

Obstetric violence was also been the subject of health policy at the end of the 1980s: the Comprehensive Care Program for Women's Health (PAISM), for example, recognized the impersonal treatment and often aggressive attention to women's health. But while the subject was on the feminist agenda and even in public policy, it has been relatively neglected in the face of resistance from professionals and other pressing issues on the agenda of movements, and the problem of lack of access of poor women to essential services. Still, obstetric violence was present in initiatives such as training for the care of women victims of violence, as in the courses promoted since 1993 by the Feminist Collective Sexuality and Health and the Department of Preventive Medicine, USP. From this project, a booklet was published on this theme.²³

From the turn of this century, many studies in Brazil documented how frequent are discriminatory and inhuman attitudes in childbirth care both in the public and the private sectors.²⁴⁻²⁹ The academic interest has expanded, and studies in recent years includes the training of providers, and more recently, population-based data, such as research by Venturi and colleagues.²⁴ This last study, the second round of the national survey "Brazilian women and gender in public and private spaces," raised a surprising interest by the mainstream media and contributed in an unprecedented manner to the visibility of obstetric violence. According to the survey, a quarter of women who had passed through childbirth reported some form of violence in care, which was also reported by more than half of those who have undergone an abortion.

These evidences are more than eloquent about the magnitude and importance of the issue for maternal health and public health in Brazil.

Definitions and terms about obstetric violence

In Brazil, as in other Latin American countries, the term "obstetric violence" is used to describe the various forms of violence during institutional

care to women during pregnancy, childbirth, postpartum and abortion. Other descriptors are also used for the same phenomenon, such as gender-based violence in childbirth and abortion,³⁰ violence in childbirth,^{21,27} disrespect and abuse,³¹ cruelty in childbirth,¹⁵ inhumane/dehumanized assistance, human rights violations of women in childbirth,^{20,32,33} abuse, disrespect and maltreatment during childbirth,¹³ among other terms.

In 1993, the ground-breaking and influential Network for the Humanization of Labor and Birth (Rehuna) in its founding charter, starts from the recognition of "the circumstances of violence and harassment in which care happens".³² However, the organization deliberately decided not to talk openly about violence, favoring terms like "humanizing childbirth", "promoting the human rights of women", fearing a hostile reaction from professionals on the charge of violence.³²

A set of legal definitions of obstetric violence have been proposed, and legislation in Venezuela was the pioneer in typifying this form of violence³⁴:

Obstetric Violence is the appropriation of the body and reproductive processes of women

by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.³⁵ (p. 30).

In recent years, several authors have proposed typifications and ratings on obstetric violence, including more recently the World Health Organization (WHO).¹³ Among several typifications of obstetric violence, we believe that the synthesis made by Bowser and Hill³¹ in their review about the forms of abuse and disrespect has been quite explanatory, listing the main verifiable categories in the health institutions.

Based on Browser and Hill, Tesser et al.,³⁶ in 2015, summarized the categories of disrespect linking them to the corresponding rights on the basis of a legal and social point of view, and with concrete examples of the Brazilian reality, as Table 1.

Table: Categories of disrespect and abuse, corresponding rights and examples of situations of obstetric violence

Categories of disrespect and abuse	Corresponding rights	Examples of situations of obstetric violence
Physical abuse	Right to be free from harm and abuse	Interventions without clinical justification just for "teaching" purposes, such repetitive vaginal exams, unnecessary caesarean sections and episiotomies, physical restraint in painful positions, practice of painful interventions without proper anesthesia, under the belief that the patient "is feeling pain anyway"
Imposition of interventions without consent; interventions based on incomplete, distorted or false information	Right to information, to informed consent and refusal; right to have choices and preferences respected, including the choice of companionship during hospital stay	Performing episiotomy in women who verbally or in writing not authorized this intervention; disregard the birth plan without medical reasons; induction to cesarean section for misleading reasons, such as overestimation of the risks to the baby (nuchal cord, "post-term pregnancy" at the 39 th week, etc.) or to the mother (cesarean section to "prevent sexual harm," etc.); no information of potential long-term damage to those born by caesarean section (increase in chronic diseases, etc.)
Non-confidential care, denial of privacy	Right to confidentiality and privacy	Collective maternity labor wards, often without even a curtain separating the beds; claiming that lack of privacy is a justification to disrespect women's the right to the presence of a companion (after 10 years of a national law)
Undignified care, including verbal abuse	Right to dignity and respect	Disrespectful communication with women, underestimating and mocking her pain, demoralizing their calls for help; humiliation of sexual nature, such as "when you did you liked it, so do not cry now"
Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care	Differential treatment based on attributes considered positive (married, with planned pregnancy, adult, white, better educated, middle-class, healthy, etc.), belittling those with attributes considered negative (poor, not educated, younger, black), or women who question doctors orders
Abandonment, neglect or refusal to grant assistance	Right to health care in a timely manner and to the highest attainable standard of health	Abandonment, neglect or refusal to give assistance to women who are perceived as very complainants, "uncontrolled" or plaintiffs, and in cases of incomplete abortion, deliberate delays in care to these women, with significant risks to their physical safety
Detention in services	Right to liberty and autonomy	In Brazil and other countries, there are reports of police arrests of pregnant women if they refuse a cesarean indicated by the doctor

Source: Adapted from Tesser, et al³⁶ (2015), based on Bowser and Hill (2010)³¹

Causes of obstetric violence: the role of professional training professionals and of the organization of health services

The training of health professionals, especially doctors, has a key role in distortions of assistance and in the resistance to change. Hotimsky³⁷ states that while the best evidence is updated and disseminated quickly in electronic publications available via the Internet, many medical courses have their bibliography based on outdated books,³⁷ with little guidance to students on how to search, and appraise evidence. This means that students frequently have limited knowledge of evidence-based practice, and often deal with "best practices", "evidence-based issues" as "beliefs", "philosophy", and not as the gold standard of care. According to this author, medical practice is often apprehended in a way that is detached from its ethical dimensions, prioritizing skills at the expense of values, such as care. She describes situations in which women are objectified in favor of students' training, such as in negotiations between students and residents to perform an episiotomy for training purposes without the consent of the patient. Such understanding is frequently entrenched in the services; in other study,³² a professional interviewed, commenting on the practice of medical residents, explains: "They have to learn, and women are their teaching materials" (p.102).

According to these studies, women are selected for the "training procedures" such as episiotomies, forceps or even caesarean section, based on the patients' place in social hierarchy,^{32,36} exposing the existence of a sexual hierarchy, so that those women who are more vulnerable are subjected to a more rude and humiliating treatment.³⁸ Thus, poor women, black, teenagers, those without complete antenatal care, those without a companions, sex-workers, drug users, homeless women, are those more likely to experience negligence and denial of care. The trivialization of violence against consumers relates to gender stereotypes in the training of health professionals and the organization of services. Frequent violations of human and reproductive rights of women are thereby incorporated as part of routines and sometimes do not cause any strangement.³²

According to Rego et al., (2008) in medical school, patients tend to be dehumanized, deprived from their identity and transformed into a number in the hospital, a case to be studied, diagnosed and treated.³⁹ Studies about health providers' education show that this problem, however, is not limited to obstetrics, or even just to medicine, applying in different degrees to other health professions. The whole professional education has been criticized for its failure to provide students with basic humanistic education. Thus, the provider-patient relationship is no longer between human beings, and becomes a subject-object relationship, of the doctor with the disease.³⁹

Implications of obstetric violence to maternal morbidity and mortality

Maternal mortality is an important social and public health problem and directly reflects the quality of care. According to WHO / UNICEF:⁴⁰

Maternal mortality is an indicator of women's status, access to health care and the adequacy of the healthcare system to respond to their needs. It is therefore necessary to have information on levels and trends of maternal mortality, not only for what it estimates about the risks of pregnancy and childbirth but also for what it mean for women health in general, and, by extension, their status social and economic status. (p. 481)

Obstetric violence has implications on maternal mortality in the following ways:

(1) In the additional risk associated with adverse events of aggressive management of vaginal delivery. There is potential harm associated with the use of inappropriate and excessive (also often not informed and not consented) invasive interventions in vaginal birth, such as the unregulated use of oxytocin to induce or augment labor, Kristeller maneuver, forceps, episiotomy, among others. These interventions have occurred well above of the justifiable clinical indications, as widely documented in national studies;^{41,42}

(2) Aggressive management of childbirth works as a constraint to cesarean section, increasing its occurrence and risks. Violence in vaginal delivery is a form of coercion to elective cesarean section,⁴³ when the options available to women boil down to this surgery, or an aggressively managed vaginal delivery,⁴⁴ not infrequently with the denial of any form of analgesia. As social movements say in Brazil, "no more violent delivery to sell cesarean"⁴⁵ According to Cesar Vitoria, 23% of maternal deaths in Brazil can be attributed only to the increase in cesarean rates occurred since 2000⁴⁶;

(3) Neglecting to assist women when they express their suffering (crying, screaming, moaning), or asking for help insistently. There is widespread culture in the services that women should behave properly, and when a woman cries or screams she should receive worse care, especially those considered "uncontrolled" or maladjusted, or those expressing any displeasure with the assistance, or insist on being assisted urgently. The delay in responding to these demands can be associated with increased risks of maternal morbidity and mortality.⁴⁷

(4) In the hostility toward women (and professionals) considered to be dissidents of the hegemonic model of assistance. In cases of transfer of a birth center or a home birth, verbal abuse and delays in care tend to be higher. These cases are an example of what has been called "professional hostility" in studies conducted in other countries,⁴⁸ and can be a major threat to the safety of patients;

(5) In the hostility, neglect and delay of care to women with incomplete abortions; when teams identify or assume that abortion was intentional, they often do not give it the urgent care it needs. The unavailability of services that perform abortions in situations where it is legal, also has major impact on maternal morbidity and mortality as it may lead many women to search for an unsafe abortion;²⁴

(6) In the prohibition of the presence of a companion: most maternal deaths occur during

delivery and postpartum (Kassebaum et al.⁴⁹ (2014) and, paradoxically, in Brazil the woman lies in a health institution almost all cases. Preventing the presence of companions is a threat to women's safety, because they could signal emphatically to professionals if the clinical condition of the patient deteriorated.⁴⁷ While it may be the difference between life and death and is ensured by law, this right is often not respected.

Concluding summary: how to identify, prevent and mitigate obstetric violence?

Based on the above, we present the following proposals to overcome this situation.

- Interventions in the training of health providers' during undergraduation, specialization and continuing education

1. Include women's rights, and sexual and reproductive rights in undergraduate courses (medicine, nursing, midwifery, psychology, etc.) not only those rights well established in the professional codes of ethics, such as autonomy and informed choice, but also to the recent rights guaranteed by Public Health System, such as the right to companionship during hospital stay. The rights of professionals and patients, their violations and how to prevent them should be included in the entrance exams for residency and postgraduate education and in all forms of specialization.⁵⁰

2. Invest in the training of midwives and obstetric nurses, the experts in physiological childbirth.⁵¹ It is unreasonable to expect that delivery care ceases to be eminently medical-surgical, if more than 90% of births in Brazil are assisted by a doctor with training in surgery. The medical providers should be valued for their ability to make diagnosis and medical or surgical prescriptions in the minority of cases that need them, so that the majority of cases could be assisted by professionals trained for protecting normalcy⁵². The experience of the direct-entry Midwifery program, in the School of Arts, Sciences and Humanities (EACH-USP) can be a great starting point for replication across the country⁵³.

3. Introduce the teaching of the physiological care and modify routines and teaching ambiances, with an emphasis on Training Birth Centers. Review of the curriculum content of all health professions to the practical teaching, to overcome the present situation of exposing the students mostly to interventions not based on scientific evidence of their safety or effectiveness (for example, women with liberally accelerated with oxytocin deliveries, in lithotomy position with the unregulated use of episiotomy and forceps, very often without companions), and in the absence of critical reflection on interventions in the classroom. Promote the teaching of the neuroendocrinology of labor and delivery, its physiological progress and its facilitation, and the promotion of maternal comfort, which also requires a change of care ambience, combined with theoretical and practical training, as well as the teaching of evidence-based guidelines.⁵⁴

- Interventions aimed to inform and strengthen the autonomy of women and families

1. Provide information on childbirth care for women as part of the antenatal care routine, so that the contents can be explored calmly in the months when the pregnancy develops. Educational activities should be part of antenatal protocols and should not be treated as an afterthought, but essential for health promotion. The use of birth plans should be promoted as a health promotion educational resource, as proposed by Tesser et al.³⁶

2. Ensuring the right to companions: all women should be informed, in the prenatal course, about their right to companions during the hospitalization for childbirth, from admission to discharge, through labor, delivery and surgical recovery and / or anesthesia, as well as in cases of miscarriage and other complications such as ectopic pregnancy and molar pregnancy. This information must be provided in advance and with sufficient clarity so the woman and her family can make the necessary arrangements to ensure the selection and participation of companionship.

- Visibilization and accountability

1. To make the problem visible and stakeholders accountable: several institutions such as the Public Ministry, have taken responsibility to address the lack of culture of women's rights in health services, compiling complaints and calling for a dialogue on necessary changes those responsible for services and teaching institutions. Such initiatives, ignited by women's movements, were instrumental in promoting a climate of recognition of rights, hitherto unprecedented in Brazilian society, impacting public policy, such as the action against the National Health Agency (ANS) on regulation of rates cesarean from 2015.^{6,56}

2. To promote research and the development of indicators on obstetric violence (disrespect and abuse). In recent years, primary research and reviews of these studies have shown the importance, urgency and gaps in knowledge of this emerging theme. One of the current challenges is to develop indicators for the study of the occurrence of obstetric violence, as well as resources for measuring the effect of interventions for its prevention. These measures should include monitoring the change of the practices, routines and ambiances.¹⁴

3. To disseminate the Center for Assistance to Women - Dial 180, and train it to receive properly the complaints of obstetric violence: cases of violation of women's rights in assistance to prenatal care, childbirth, postpartum and abortion should also be forwarded to the ombudsman service and SUS, and to the Public Prosecutors.

4 - To include the assistance to miscarriage and access to safe abortion on the agenda of priorities: current focus on maternal and child policies only for women's health makes invisible the insecurity and violence in situations of miscarriage and also the difficulties of access to abortion, even in the few legal situations. The lack of services that work effectively and the use of aggressive

techniques such as curettage - it should be replaced by intrauterine manual vacuum aspiration (MVA) - are serious situations of obstetric violence, widely spread across the country, and in need of immediate intervention.⁵⁷

5. Implement the Perinatal Forum, for regulation and control by society of perinatal health services: this strategy has as one of its objectives to promote dialogue between stakeholders involved in perinatal care, including the managers of public and private sectors, professionals directly linked to the service, user and organized womens' groups, training institutions, researchers, Public Defenders and Prosecutors, professional boards, among others. The creation of Perinatal Forum is a victory in itself, given the strong resistance to dialogue and change, and its implementation and strengthening as an arena for debate and establishment of pacts, have been very powerful in producing change.⁵⁸

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Resumo

A violência obstétrica, descrita por diferentes termos, cada vez mais é utilizada no ativismo social, em pesquisas acadêmicas e na formulação de políticas públicas, sendo recentemente reconhecida como questão de saúde pública pela Organização Mundial da Saúde. Como tema inovador, requer um mapeamento de suas origens, definições, tipologia, impactos na saúde materna e propostas de prevenção e superação. Apresentamos esta revisão crítico-narrativa sobre o tema, abarcando literatura acadêmica, produções dos movimentos sociais e documentos institucionais, do Brasil e exterior. Após breve recuperação histórica do tema, mapeiam-se as definições e as tipologias de violência identificadas. Discute-se a complexa causalidade destas formas de violência, incluindo o papel da formação dos profissionais e da organização dos serviços de saúde e as implicações na morbimortalidade materna. Finaliza-se com intervenções em Saúde Pública que têm sido utilizadas ou propostas para prevenir e mitigar a violência obstétrica, e uma agenda de pesquisa de inovação nesta área.

Palavras-chave: humanização do nascimento, abuso e desrespeito, violência contra a mulher, gênero e saúde, direitos humanos, direitos dos pacientes, segurança do paciente.