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**Obstetric Violence: What Is It? An Overview Of Its Status,
Challenges And Potential Solutions.**

Literature Review and Methodology Discussion

By

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Literature Review

I. What Does Obstetric Violence Means?

Several definitions exist around the term "Obstetric Violence" (OV), probably due to its recent history and the multiple manifestations that exist of it. In an effort to create a common understanding of the concept, Jardim and Modena (2018) analyze the scientific production that has been developed on obstetric violence and identify its main characteristics. To do so, they review 24 publications indexed in different journals related to the topic. As a conclusion, the authors point out that OV is a situation with multiple manifestations, among which negligent, imprudent, omissive, discriminatory and disrespectful acts practiced by health professionals and legitimized by the asymmetry of power granted by technical and scientific knowledge stand out.

Shabot and Korem (2018) present a more general definition of OV, understanding it as those acts of physical and/or mental violence that are perpetrated during pregnancy and/or labor. To this, the World Health Organization (WHO) adds the postpartum period as a stage of high vulnerability in which acts of this type can continue to be perpetrated (WHO, 2014).

Another set of definitions, beyond specifying those acts that constitute obstetric violence, detail the standard of health to which every pregnant woman should have access, and which is violated through acts of OV. For Pérez (2021), "Health is a state of complete physical, mental and social well-being" and "the enjoyment of the highest attainable

standard of health is one of the fundamental rights of every human being" (p 89). Similarly, WHO points out that during childbirth every pregnant woman should be guaranteed her right to receive information, receive care with dignity and free from discrimination, and enjoy the highest attainable standard of mental and physical health (WHO, 2014).

From the above, it can be concluded that obstetric violence is a type of violence with multiple manifestations, both physical, social and mental, directed against women during pregnancy, labor or postpartum, and which is exercised by health professionals.

II. Brief History of Obstetric Violence

The first country to officially recognize Obstetric Violence was Venezuela in 2007, as part of the Law on Women's Access to a Life Free of Violence (Pérez, 2021). However, the roots of the term come from feminist movements -mainly Latin American- since the 1960s (Pérez, 2021.; van der Waal et al., 2022).

From the beginning, the OV movement has taken a human rights approach, for example, by reformulating routine medical acts as violations of women's sexual and reproductive rights (Perrotte et al., 2020). Along these lines, in Venezuela, OV was defined as the "appropriation of women's bodies and reproductive processes by health personnel that is expressed through dehumanizing treatment, the abuse of medicalization, and the pathologizing of natural processes, resulting in a loss of women's autonomy and ability to

decide freely about their bodies and sexuality, negatively affecting their quality of life" (Castro, 2019, p. 109).

Along with the visibility of women's sexual and reproductive rights and how these have been historically and systematically violated in the context of pregnancy, childbirth and postpartum, the movement to end OV has made a constant critique of the biomedical model of care (Pérez, 2021). In other words, it questions the constant pathologizing and medical regulation of women's bodies and, in this particular case, of the process of pregnancy and childbirth.

Over time, the concept of obstetric violence has acquired a global dimension and has been consolidated as an important struggle of feminist movements (van der Waal et al., 2022), however, not without encountering important opposition. For example, in countries such as Spain, where an attempt has been made to legislate on OV, health professional unions have raised their voices because they consider that this term criminalizes professional practices that are performed under scientific and ethical standards, and that it generates an unnecessary concern between health professionals and patients, undermining the relationship of trust that should prevail (La Vanguardia, 2021).

III. Prevalence: What We Know

Linked to the lack of agreement on the definition of the term Obstetric Violence, the WHO (2004) has diagnosed as a problem the absence of consensus on its measurement. The

reasons for this are varied. The first of these is, of course, the difficulty involved in generating consensus on how to measure a concept if the definition is vague and diffuse. Secondly, as it is a relatively new concept in health and social science research, the reliability and validity of the multiple indicators that have been developed have not yet been tested. For this reason, the organization points out that both its prevalence and the magnitude of its impact are unknown (WHO, 2004), although they are probably higher than suspected. Third, as with most social phenomena, there are important variations at the cultural level. In this sense, although there is agreement that obstetric violence is a global phenomenon, its manifestations may differ significantly according to the region under study. Finally, perhaps the greatest challenge is to raise awareness of the issue and, through this, to enable more women to dare to report it.

On this last point, Castro (2019) draws on philosopher Martha Nussbaum's concept of Adaptive Preferences to try to explain the reasons why many women who suffer OV do not report it. Through the concept of Adaptive Preference, Nussbaum refers to "the preference to put up with abuse" in response to restricted options among the structurally deprived, which creates "overtly subservient tendencies". In this specific case, it would be women who, faced with situations of obstetric violence, choose to cope with them instead of confronting them, considering that their position of deprivation limits their awareness on the subject and the possible courses of action.

Despite the difficulties just mentioned, there are increasing efforts to collect data on the prevalence of different forms of OV. On the American continent, studies on the subject

have been carried out in most countries. In Mexico, according to data from a 2016 survey, in the last 5 years, 33.4% of women aged 15 to 49 years who had a childbirth suffered some type of mistreatment by those who attended them in childbirth. In Ecuador, household survey data revealed that 18% of pregnant indigenous women preferred to give birth at home rather than in a hospital due to the behavior of health personnel (Bowser and Hill, 2010). In the United States, Vedam et al. (2019) applied a survey to 2,138 women and noted that 17.3% of women who were pregnant between the years 2010 and 2016 experienced some type of obstetric violence. Nevertheless, the numbers increase to 21.5% when considering patients of low socioeconomic status, to 32.8% for indigenous women and to 27.9% when considering women with at-risk pregnancies (Perrotte et al., 2020).

In the case of Africa, studies have documented the incidence of different types of OV in different countries. In Kenya, a study working with 13 health centers concluded that the rate of OV events reaches 20% (Perrotte et al., 2020). Also, according to the 2011 Ethiopian Sociodemographic and Health Survey, 29.5% of women who did not deliver in a health facility (90.1%) reported making this decision due to lack of personalized services. Lack of experience and knowledge of those attending a delivery is one of the major causes of maternal mortality in low- and middle-income countries (Asefa and Bekele, 2015). Galle et al. (2015) studied the experience of women giving birth in different locations in Maputo Province, Mozambique, through a cross-sectional descriptive survey. The authors conclude that the prevalence of acts of mistreatment and abuse during childbirth ranged from 24% to 80% depending on the type of institution.

In Spain, a study that applied an online questionnaire to almost 900 women who had given birth in the last 12 years concluded that two out of three of them perceived that they had been victims of obstetric violence during labor. Of these, 25.1% reported having been victims of verbal violence, 54.5% of physical violence, and 36.7% of psycho-affective violence¹. Likewise, by means of logistic regression, the authors observed that those women who required an emergency cesarean section, an episiotomy and those whose children required intensive care were at greater risk of being victims of OV. In contrast, having a birth plan and skin-to-skin contact were shown to be protective factors (Martínez-Galiano et al., 2021).

A similar study conducted in Poland -where more than 8,000 women who gave birth in 2018 in different health facilities in the country were surveyed- concluded that 81% of them experienced some type of violence or abuse by medical staff during their delivery. The most reported type of abuse was having received medical procedures without prior consent, followed by inappropriate comments (25%) and receiving inadequate treatment (20%). For the researchers, the lack of awareness of these abuses is largely due to ignorance of the laws that protect the human rights of pregnant women (Baranowska et al., 2019). In Switzerland, also thanks to an online questionnaire applied to women over 18 who gave birth during a 1 year period, it was known that 26.7% of them experienced some type of informal coercion during childbirth, a percentage that increased in the case

¹ E.g., prohibiting the presence of a companion, avoiding contact with the newborn, feelings of insecurity and guilt, among others

of having had a cesarean section or an instrumental vaginal delivery (Oelhafen et al., 2021).

Perera et al (2022) carried out a cross-sectional study of 1314 women in Sri Lanka -Asia- to measure the prevalence of obstetric violence in pregnant women. The authors conclude that OV is common in public health facilities, and that women of young age, low socioeconomic status, from minority ethnicities and women that live in rural areas are more likely to be victims of it. Interestingly, the authors found that women who were victims of OV were less likely to be asked by health personnel about domestic violence experiences. In India -one of the biggest and most populated countries in the world- multiple research on the topic has emerged during the last years. Goly et al. (2019) did a longitudinal study involving 504 pregnant women in Uttar Pradesh State (the largest state of India, considered a “microcosm” of the country). Among the results, they found that about 15.12% of women in Uttar Pradesh are facing Labor Room Violence, one of the forms of OV. Among the predictors of being victim of OV, they found being Muslim -in opposition to being Hindu-, being of a lower caste, and having no mass media exposure.

IV. Obstetric Violence Manifestations

The most common definitions of OV, which include any act of physical or mental violence perpetrated during pregnancy, labor or the postpartum period, are useful in the sense that they allow the multiple manifestations of this phenomenon to be covered. However, for

research, educational and clinical purposes, it is important to identify at least the most common forms in which OV occurs.

In a study in Mexico, Castro and Frías observed that among the types of mistreatments most experienced by women were being shouted at or scolded; the delay in attention in response to alleged complaints and feeling ignored when they raised their doubts (2020). In these types of studies, verbal violence, humiliation, and manipulation to which women in labor are subjected are often emphasized.

Additionally, there are studies that emphasize the lack of consent in the use of certain devices or in the execution of medical procedures. For example, it has been pointed out that in France (Haut Conseil à l'Egalité Entre les Femmes et les Hommes, 2018) one in five deliveries results in an episiotomy, 50% of which were performed without the mother's consent; while in Myanmar (Bohren et al., 2019), 25.9% of women in a study reported a vaginal examination without prior consent (Perrotte et al., 2020).

Third, besides verbal and physical abuse, another common type of obstetric violence is related to lack of privacy and confidentiality. In a study conducted in Malawi (Sethi et al., 2017), 58.2% of women reported lack of privacy during their delivery (Perrotte et al., 2020). The lack of confidentiality and privacy can be observed in moments where pregnant women must make decisions, when medical procedures are to be carried out (Gaitán-Duarte and Eslava-Schmalbach, 2017), and in cases where the lack of resources

causes women to be hospitalized together with other puerperal women without measures that seek to compensate for this lack of privacy (Tobasía-Hege et al., 2019)

With the aim to systematize all the above, Castro and Savage (2019) created a six-category typology of obstetric violence. Similarly, the WHO (2014) designate list with 9 types of disrespectful and abusive treatment that qualify as obstetric violence. Both are presented in table below.

Classification Types of Obstetric Violence according to the Literature

| | | |
|---|---|---|
| Castro, A. and Savage, V. (2019) | 1 | Verbal Abuse |
| | 2 | Poor Apport with Women |
| | 3 | Socio-Cultural Discrimination |
| | 4 | Physical Abuse |
| | 5 | Failure to Meet Professional Standards of Care |
| | 6 | Health System Conditions |
| WHO (2014) | 1 | Physical Abuse |
| | 2 | Humiliation and Verbal Abuse |
| | 3 | Coercive/Unconsented Medical Procedures |
| | 4 | Lack of Confidentiality |
| | 5 | Failure to Get Fully Informed Consent |
| | 6 | Refusal of Pain Medication |
| | 7 | Violations of Privacy |
| | 8 | Refusal of Admissions to Health Facilities |
| | 9 | Detention of Women in Facilities After Childbirth Due to Inability to Pay |

Source: Own elaboration

From this classification, it is possible to identify a fourth mechanism in which obstetric violence is perpetrated, which has to do with health facilities. Whether the infrastructure

conditions of these facilities are not optimal for a respected childbirth, the professionals do not have the necessary skills, or the hospital protocols are not prepared for complex situations, all these cases - among others - make it likely that the sexual and reproductive rights of pregnant women and women in labor are violated.

V. The Multiple Roots of Obstetric Violence

As with any social phenomenon, the problem of OV has multiple causes, ranging from the individual to the systemic. The following is a brief description of the causes that have been explored in greater depth in the literature.

A first reason that specialists have given for understanding the occurrence of OV is related to the vulnerability of women during pregnancy, childbirth and postpartum. During each of these processes, physical and mental elements are combined so to create a context of high vulnerability for women. For example, during labor, physical components such as being naked and in pain are mixed with emotional factors such as anxiety and expectation, which creates an environment that is highly susceptible to the occurrence of OV. This is complemented by the fact that, on the side of health professionals, childbirth is a routine procedure, which makes it more likely that women's right to make autonomous decisions about their bodies is overlooked.

A second factor relevant to understanding OV is the cultural stereotypes surrounding women and motherhood. One of the prejudices surrounding women that has an important

effect on the perpetration of OV is the idea that women exaggerate pain (Chandra et al., 2021). Along the same lines, there is a tendency in the health care setting to infantilize female patients (Perrotte et al., 2020) and, thereby, undermine their capacity for agency. In terms of preconceived ideas of motherhood, it is assumed that a good mother is one who is willing to make a total sacrifice for the needs of her children (Shabot & Korem, 2018), ignoring her personal needs.

In third place, the asymmetry of power between health professionals -particularly doctors- and patients is something that should be considered as a cause of OV. This power asymmetry -given by the differences in the technical and medical knowledge that the doctor has over the patient (Jardim and Modena, 2018)- ensures that medical personnel encounter less resistance when performing any type of OV (Shabot and Korem, 2018).

A fourth reason that has been associated with the high prevalence of OV is generalized and institutionalized gender-based violence and discrimination (Taghizadeh et al., 2021). For Perrotte et al. (2020), the fact that OV is always directed toward women makes it a form of gender-based violence. Meanwhile, for Shabot and Korem (2018), OV constitutes a type of gender violence in the sense that it is based on a patriarchal system that seeks to punish those bodies and women who are not feminine enough. Inspired by the ideas of feminist philosopher Sandra Lee Bartky, Shabot and Korem investigates the role of shame in the perpetration of OV. Specifically, she argues that while shame is crucial for the moral and social development of every person, in patriarchal societies, shame is more prevalent and more severe in women than in men. The result is a strong female

disempowerment, which perpetuates events such as OV as women feel they must experience shame alone and passively.

Fifth, several researchers have raised the lack of accountability in health systems as one of the roots of the high prevalence of OV. Perrotte et al (2020) argue that the almost total absence of accountability mechanisms reinforces the power of doctors over patients, in a context of already strong power hierarchies (2020). In the same vein, Castro and Savage (2019) posit the fact that responsibility for the care of pregnant women is so diffused that it generates a breeding ground for acts of OV. The importance of having accountability tools lies in the fact that these function as an arbiter of the dynamics that occur between two or more parties with different levels of power, in order to balance the imbalances that may occur. In other words, it is a matter of controlling the arbitrary use of power (Geroge, 2003).

Sixth, it is important to mention the role of health facilities and the health system in the perpetration of OV. One of the criticisms that has been raised in recent times is the use of maternal and infant survival as an indicator of a successful pregnancy and delivery, to the detriment of other indicators that address the dignity of the process (Chattopadhyay et al., 2018). The roots of this would be in a focus on childbirth and motherhood to the detriment of a global vision of women's reproductive health. For Castro (2019), it is important to analyze the way in which hospitals are organized and function, because beyond clinical causes, women's complications in childbirth present certain patterns. In this sense, the author points out that the great cause of maternal death is the limited

capacity of the health system to provide patient-centered care, care that is holistic, longitudinal, proactive and in which the main responsible are the providers and health personnel.

VI. Consequences

Analyzing the effects of OV situations is a challenge as it involves a set of actors, different dimensions of health, and short-, medium- and long-term consequences. Regarding the actors involved, there is a consensus that those most affected by OV events are pregnant women. However, there are also records of negative effects on newborns and -incipiently- studies are being developed to analyze the consequences of OV on health professionals.

Another set of studies focuses on the different dimensions of health that are compromised by OV events. On the one hand, there is research that investigates the effects on the physical health of mothers and newborns. Among these effects, excessive bleeding during childbirth, vaginal hematomas, a significant increase in cesarean deliveries for mothers and fetal distress for newborns have been reported (Taghizadeh et al., 2021). On the other hand, there is vast literature available on the effects on the mental health of women who are victims of OV. Among women who have suffered various types of OV, severe levels of stress, suicidal ideation, recurrent nightmares, panic attacks, feelings of loneliness, and fear of a new pregnancy and/or childbirth have been identified (Taghizadeh, Ebadi and Jaafarpour, 2021). In a recent study, Scanduna et al. (2021) - through an online survey addressed to Italian women-inquired into sociodemographic

factors, types of obstetric violence, and its effects on mental health. From there they concluded that abuse and violence - materialized as coercion, physical and/or verbal abuse - have a greater impact on mental health compared to the performance of procedures without consent. Likewise, the authors concluded that being a victim of OV is positively associated with general psychological stress and with greater presence of post-traumatic stress.

In addition to the effects on the physical and mental health of the mother and newborn, OV has a significant impact in social and affective bonds. For example, suffering from OV during childbirth can cause difficulties in the bond that the mother establishes with the newborn. This, in turn, can present obstacles to successful breastfeeding. There is also a risk of emotional and sexual tensions between the woman and her partner (Taghizadeh, et al., 2021). Also, the WHO (2014) points out that OV breaks the bond of trust that should prevail between patient and doctor, affecting health seeking behaviors in the future, for both the women and the baby (Taghizadeh, Ebadi and Jaafarpour, 2021).

Finally, although not enough evidence has been accumulated yet, one of the few studies that has addressed the effect of OV in health professionals (Mena-Tudela et al., 2020) observed that OV tends to be normalized among health students as they advance in their studies and, even more so, if they have obstetric experiences. However, the study also concluded that an intervention in the training and education that students receive can significantly change their perception of these acts of violence.

VII. How We Address It: Potential Solutions

Considering that the problem of OV has only been recognized in recent years, it is logical that solutions are still incipient and that those that are available have not yet shown results in terms of their effectiveness. However, mainly thanks to the efforts of academics and activists dedicated to the subject, there are proposals on how to move towards a more humanized treatment of childbirth and pregnancy.

First of all, it is important to consider the framework within which any proposal for a solution to the OV challenge should be designed. In this regard, there are two relevant conceptual frameworks. The first is related to adopting a human rights perspective. This implies, in simple terms, understanding that women do not lose their fundamental rights when they become pregnant: "Every human being, regardless of their pregnancy status, has the following rights: consent; refuse treatment; health; equal treatment; privacy, and life" (Terrerri, 2018; Chandra, Sumant and Shiva, 2021). Now, faced with the question of how this translates into practice, Castro (2019) gives the following example: A human rights framework for addressing OV implies that health personnel assume responsibility for guaranteeing the right to health of every woman in labor.

Second, in addition to the human rights framework, experts suggest approaching the problem through the lens of intersectionality. This is based on the fact that, while much of the experiences related to OV are cross-cutting around the world, there are important variations according to certain characteristics of the women themselves and the places

they inhabit. For example, Fatima (2020) documented cases of indigenous women who were ridiculed for performing ancestral ceremonies at the time of childbirth. Similarly, different experiences of OV have been documented if factors such as race, educational level, socioeconomic level, rurality, ethnicity, are taken into account. Therefore, it is important to adopt the lenses of intersectionality in order to seek solutions that take into account the multiple identities and subjectivities of the universe of women and families. Only by knowing the barriers that different population groups face can one design a solution that goes in the direction of providing equal opportunities and dignity for all.

Now, once the human rights and intersectionality perspectives have been adopted, it is necessary to proceed with concrete programs, policies and practices to be implemented in the different spaces where OV originates and perpetuates. A first relevant line of action to attack OV is education, both of expectant mothers, their support systems, and of health professionals. Fatima (2020) suggests, for example, training caregivers to identify signs of flashback in women during childbirth, as well as making the use of caring and respectful language as important a requirement as hand washing. This and other tools should be considered in the educational curriculum of medical and health-related students. (Chattopadhyay et al., 2018) Along with this, it is important to provide information to women about what they can expect and demand in this instance (Chandra, Sumant and Shiva, 2021). This translates into disseminating information about OV through formal mechanisms, denouncing the bodies responsible for allowing it, and increasing cyber-activism.

Second, in addition to the importance of promoting education, there is a general consensus that more resources and time should be devoted to research on OV. Although denouncing and explaining the suffering experienced by thousands of women as a result of OV will not, by itself, prevent these violations from continuing to occur (Castro, 2019), making the issue visible is a significant step in the process of creating effective long-term solutions. One of the criticisms that have been raised against the research that has been carried out so far on the humanization of pregnancy and childbirth is that indicators such as maternal and fetal survival rate are considered as signs of successful childbirth, leaving the other complexities of the process hidden (Austveg, 2011). In any case, if we compare the current situation with that which existed in the academic field 10 to 20 years ago, there are significant advances. The World Health Organization (2014) attributes the improvement in delivery rates, in part, to greater support from government agencies and other institutions for research on the subject, as well as to the generation of more data on respectful and violent practices during pregnancy and childbirth.

In any case, it seems that the proposal that has been put forward most powerfully is that of improving accountability systems within health facilities. In this area, it is important to bear in mind that there are various accountability mechanisms that can be implemented within any institution. A first important distinction -especially in the world of healthcare- is between personal and institutional accountability (Wachter, 2013). Broadly speaking, and thinking in extremes, the former would imply making doctors and health professionals fully responsible for any act of obstetric violence, while institutional accountability implies that the responsibility falls exclusively on the hospital or health center. James Reason -

a leader in the study of human error - criticizes the use of the "no blame culture" in healthcare. Instead, he suggests adopting a "culture of just." To understand this, the classification David Marx makes - an expert in human risk management - between "human error", "at risk behavior" and "reckless behavior" is useful (Wachter, 2013). For Marx, only in the last category -which implies acting with the awareness that there is a significant and unjustified risk- can fault liability be attributed.

Methodology Discussion

I. How was this policy brief conducted

The development of this policy brief was carried out through an extensive and thorough literature review. The sources considered were mainly academic literature, both in the health and social sciences, and documents issued by national and international NGOs. As for the academic literature, articles using quantitative and qualitative methodologies were considered. Both types of research were necessary to generate a holistic view of the topic, addressing issues from the prevalence, causes and consequences of obstetric violence. Likewise, articles that address the topic from a theoretical perspective were also taken into account, exploring the different definitions or the history of the movement against obstetric violence at both regional and international levels. The reports and documents produced by non-governmental institutions such as the WHO were a substantial contribution in that they generally present a transnational view of the issue. In addition to this, they are extremely useful documents for envisioning possible solutions to problems such as these.

The following sections present brief reflections on the current situation and challenges of research -especially from the social sciences- on obstetric violence. Along with this, recommendations for a future research agenda on OV are added.

II. Current Status of OV Research

On the issue of obstetric violence, academia has been in the lead in terms of research, compared to non-governmental organizations and public institutions. Although it is an issue that has existed for decades, only since the 21st century - and especially in the last 10 years - has obstetric violence become a recurrent topic of research in the fields of social sciences and public health. For this reason, the testing phase of programs and policies that seek to put an end to OV is still incipient, and studies that attempt to diagnose and analyze the roots of the problem predominate.

Along these lines, Castro (2019) is emphatic in pointing out that although research on obstetric violence is the first step toward ending it, it is by no means a guarantee of it. The positive thing, in the author's words, is that research on OV helps to dispel the myth that obstetric violence is something uneventful. A good example of the contribution that research can make in this type of challenge is the case of the struggle to end maternal and newborn mortality. Although years ago, when this problem was addressed, the focus was mainly on the medical and hygienic causes of the problem, it is now recognized that the improvement in the rate of successful deliveries is positively associated with an increase in research on the subject (WHO, 2014).

Finally, in addition to highlighting the increase in research on OUV in recent years and the role it can play in promoting advances in the field, it is interesting to note the increasing

proliferation of transdisciplinary studies between the social sciences and the health sciences. For Rosenfield (1992), it is important to develop a conceptual framework that analyzes the social, economic, political, environmental and institutional context of health and well-being problems.

III. Quantitative Methods

Situation

Quantitative research in the social sciences plays a crucial role in diagnosing social problems, through the collection of numerical data and their subsequent analysis using various statistical techniques. Given this, it is the most indicative method to identify trends, magnitudes, work with large populations, study associations between factors, among others. However, since it works on a large scale, it is also a challenge to carry out quantitative research, especially on problems that are just becoming popular and therefore do not yet have an established research agenda or funds to collect the required information.

Given the above, it is not surprising that quantitative research on obstetric violence is still quite deficient. To date, what predominates are survey-based studies, especially those implemented for academic purposes. Likewise, the focus is still mainly on studying the prevalence of obstetric violence and the most common forms in which it manifests itself,

although little by little studies have emerged that - thanks to better data and more sophisticated tools - delve into the causes and consequences of OV.

Challenges

In line with the above, one of the main challenges facing quantitative research on obstetric violence is to promote the generation of representative data at the country level. A positive case that can be used as an example is Mexico's National Survey on the Dynamics of Household Relationships (ENDIREH). This survey, implemented by the National Institute of Statistics and Geography, in collaboration with other public government institutions, includes 10 items related to obstetric violence. Most of these indicators focus on collecting data on the prevalence and most common types of OV. The survey has a probabilistic design and is nationally representative, as it makes a selection of households in the country based on the latest available valid Census (INEGI, 2016).

Second, an important challenge for quantitative studies on OV is to generate greater consensus on definitions and indicators. Although obstetric violence, like almost every social phenomenon, presents significant variations depending on the context, one of the contributions of quantitative research in social sciences is to develop measures that can be used to compare phenomena globally and over time. The indicators tested and used to date to address the issue-such as the maternal and fetal survival rate-leave out complexities of the pregnancy and childbirth process (Austveg, 2011; Chattopadhyay et al., 2018).

IV. Qualitative Methods

Situation

Unlike quantitative research that focuses on collecting and analyzing numerical data, qualitative methodologies have as their main objective to understand the meaning behind social actions and relationships. Therefore, they focus on the cultural context in which people and societies live and develop.

In contrast to quantitative research, most academic studies on OUV have been developed using qualitative methods, with anthropology being the discipline that has probably been most dedicated to the subject. This is possibly due to the important role that anthropology has played in the field of medicine, and medical anthropology has been consolidated as one of the areas most studied by anthropologists for quite some time.

Now, as for the most used qualitative research methods, they are mainly interviews with victims of obstetric violence and non-participant observation during medical visits to the hospital during pregnancy, post-partum or even during labor itself.

Challenges

Just as it is a challenge to have the monetary resources to conduct large surveys to collect quantitative data with national representation, some qualitative methods require a large

investment of resources, especially time. This is the case of ethnography, since it requires that the ethnographer immerses himself/herself in the culture and the day-to-day life of the group being studied. In this context, it is not surprising that there are still few ethnographic studies on obstetric violence. Notwithstanding this, for Castro and Savage (2019) it is essential to begin to include ethnographic studies in studies of obstetric violence, especially ethnographic observations of hospital conditions and of the relationship and interactions between patients and health professionals. Along the same lines, for Arthur Kleinman - a psychiatric anthropologist - it is relevant to study the relationships between actors because, in his words, the ethnography of the misfortunes that afflict human groups tends to reveal that the source of suffering is interpersonal (Kleinman, 2012).

Secondly, in addition to the recommendation to include ethnographic studies, Perrotte et al. (2020) criticize the fact that most qualitative studies on obstetric violence focus exclusively on the patient's perspective, leaving aside the point of view of health professionals. Although the same literature has made it clear that women are the ones most affected by OV, in order to seek an in-depth understanding of the problem and thus propose effective solutions, it is necessary to take into account all the actors who contribute to its occurrence and perpetuation.

A third challenge regarding qualitative research on OV raised by Castro (2019) is to decipher the role of the researcher during fieldwork. For the author, it is important that each social scientist, when doing fieldwork, questions himself/herself about the

appropriate role he/she should have both at a professional and human level. The solution she arrives at is that, at least, he/she should have a role of participant observer and not a mere spectator. She also highlights the role of language, pointing out that, at the very least, she should choose the right words to describe what she is observing (such as the word "violence" in the term "obstetric violence").

V. From Academia to Public Policy

Based on the studies reviewed for the preparation of this policy brief, as well as the methodological suggestions made by the academics themselves, the following are three recommendations for the future research agenda on obstetric violence.

First, and inspired by a Kleinman approach that (i) researchers should engage in developing solutions and interventions to address the problems they are investigating. While the psychiatrist and anthropologist acknowledge that it is a risk to step out of the classroom to engage in concrete proposals for how to address the problems under study, it is something worth doing (2012). Especially after Covid-19, the gaps in access and quality of health care became even more evident and, even after this, these inequities have become even more pronounced. As a result of this, and of the need to join forces to seek effective and rapid solutions, initiatives have arisen that seek to bring academics closer to governmental and civil society organizations in order to contribute to concrete solutions to the needs of various communities.

A good example that can serve as an inspiration is the "Scholars in Service" program at Stanford University. Professors in this program spend a year working full-time with policymakers, advocates and community leaders to find and promote practical, evidence-based solutions to the problems facing each group. Stanford School of Medicine professor of pediatrics and obstetrics Suzan Garmichael worked with the Louisiana Perinatal Quality Collaborative program of the city's public health program and civil society groups to reduce maternal mortality in the area, especially among black women. Her duties included studying the factors and social conditions that contribute to maternal deaths of black women in Louisiana, identifying preventive strategies, and guiding professionals in interpreting and communicating research findings. After her participation, the professional stated that thanks to the program she was able to leave academia to build relationships that allow her to conduct research with greater impact and relevance (Stanford University, 2021).

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