REPRODUCTIVE HEALTH matters

Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence

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Abstract: *During recent decades, a growing and preoccupying excess of medical interventions during childbirth, even in physiological and uncomplicated births, together with a concerning spread of abusive and disrespectful practices towards women during childbirth across the world, have been reported. Despite research and policy-making to address these problems, changing childbirth practices has proved to be difficult. We argue that the excessive rates of medical interventions and disrespect towards women during childbirth should be analysed as a consequence of structural violence, and that the concept of obstetric violence, as it is being used in Latin American childbirth activism and legal documents, might prove to be a useful tool for addressing structural violence in maternity care such as high intervention rates, non-consented care, disrespect and other abusive practices.*

Keywords: human rights in childbirth, non-evidence-based practice, medicalisation, violence against women, structural violence

Introduction

The World Health Organization (WHO) has shown concern about the excessive medicalisation of birth since 1985, when it recommended the appropriate use of technologies for birth, urging administrators and health personnel to review protocols and continuously investigate the relevance of certain practices, while promoting respect for women's autonomy and perspective when making judgements.[1] Yet, since then, the rates of non-medically justified obstetric interventions have increased in middle- and high-income countries without dramatic improvement in perinatal and maternal mortality and morbidity. Moreover, there is increasing concern about the iatrogenic effects of obstetric interventions in women who do not have a clinical need, thereby putting "normal" birth firmly on the agenda for the 21st century.[2]

It has been suggested that unnecessary interventions could be reduced through the clarification of and adherence to the basic legal principle of informed consent,[3] including the right to refuse medical interventions.[4] The principle of informed consent is not new, with United States court papers from the 19th century advocating for the right of each person, in particular women, to have their dignity respected and the unlawful touch of a stranger being deemed an assault or trespass.[5] More recently, the United Nations Educational, Scientific and Cultural Organisation (UNESCO), through its Universal

Declaration of Bioethics and Human Rights, recognised that "*health does not depend solely on scientific and technological research developments, but also on psychosocial and cultural factors*." Furthermore, it stressed that autonomy and the right to make decisions should be respected.[3]

However, it is necessary to acknowledge the flaws in the assumption that women fully understand their options and are always able to make free, adequate choices about the nature of medical care. This question was strongly raised in 1993, with the *Changing Childbirth* report, calling for women-centred care and stressing the importance of choice during childbirth.[6] Further reports have continued to highlight that women should be the focus of maternity care, being able to make decisions based on their needs, having fully discussed matters with the professionals involved.[2] But women worldwide continue to be excluded from participating in the design and evaluation of maternity care. Despite being invited to develop birth plans and exercise autonomy, the range of choices presented to women by the medical profession may be limited.[7,8] Furthermore, the available healthcare system might not provide appropriate, evidence-based care.

These limitations seem particularly evident in countries that have legislation making it illegal or close to impossible for healthcare providers to offer home birth services or midwifery-led birth centres. Even in settings where out-of-hospital births are not illegal, planning and experiencing one can be a challenging task for families and professionals. The existing evidence that many medical interventions are overused, while structural and social interventions are often underused, has had limited impact on practice.[9]

Non-evidence-based practices

It is a fact that in many countries, including high-income ones, the best available evidence is not always used to inform maternity care; rather practice is driven by local beliefs about childbirth, and professional or organisational cultures. This is particularly visible when taking into account the variations in intervention rates between and within countries, and even between institutions and health practitioners in the same country. As an example, we can look at the two most widespread interventions in childbirth, which are surgical in nature and are often used in healthy women with little or no justification: episiotomy and caesarean section.

Restricted use of episiotomy is associated with better outcomes when compared with routine use.[10] Yet, episiotomy rates vary immensely in European hospitals with rates as high as 70% in Cyprus, Poland and Portugal, 43-58% in Wallonia, Flanders, the Czech Republic, and Spain, and 16-36% in Wales, Scotland, Finland, Estonia, France, Switzerland, Germany, Malta, Slovenia, Luxembourg, Brussels, Latvia, and England.[11] In 2010, the lowest reported rates of episiotomy were in Denmark (4.9%), Sweden (6.6%), and Iceland (7.2%).[11] However, in some countries, first time mothers are routinely given episiotomies,[11] despite the lack of evidence to support this practice.[10] A hospital-based descriptive study which analysed data from 122 hospitals in 16 Latin American countries between 1995 and 1998 showed that 87% of the hospitals had episiotomy rates higher than 80% and 66% had rates higher than 90%,[12] and a study in Mexico carried out in 2005-2006 reported episiotomy rates of 84%.[13]

The use of unnecessary caesarean sections is also well documented. The World Health Organization (WHO) confirms that caesarean section rates higher than 10% are not associated with lower maternal and newborn mortality on a population level.[14] Nevertheless, according to the Organisation for Economic Co-operation and Development (OECD) the Nordic countries (Iceland, Finland, Sweden and Norway), Israel and the Netherlands had the lowest caesarean section rates in 2013, ranging from 15% to 16.5% of all live births; while Turkey, Mexico and Chile had the highest, with rates ranging from 45% to 50%.[15] Latin America is the region where the highest rates of caesarean sections in the world are concentrated, with several countries above 40%,[15] and Brazil leading the trend with 54%.[16]

If the huge variations in caesarean section between countries raise questions about the appropriateness of interventions that may not be medically required, the differential rates across regions and hospitals within the same country can be even more alarming.[15] In Canada, Finland, Germany and Switzerland, caesarean section rates vary by up to two times across regions, and by more than three times across Spain and six times in different regions of Italy.[17]