

Disrespect and abuse, mistreatment and obstetric violence: a challenge for epidemiology and public health in Brazil

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Abstract *Studies on disrespect and abuse/mistreatment/obstetric violence during pregnancy, childbirth and puerperium have increased in recent decades. However, researchers interested in the subject face many theoretical and methodological difficulties. In this sense, this study aims to discuss and reflect on how issues related to definition and terminology, measurement, and public policies in Brazil have hindered research on this topic and the mitigation of these acts. The first problem addressed was the lack of consensus regarding the terminology and definition of this construct. This situation causes a cascading effect, impacting the use of non-validated measurement instruments and, consequently, a lack of accuracy and comparability between studies. Another issue mentioned is the lack of studies exploring the consequences of these acts on women's and newborn's health, which is one of the main gaps on the subject today. The absence of causal studies affects health decision-making, impairing the elaboration of specific public policies.*

Key words *Violence, Violence against women, Pregnancy, Childbirth, Puerperium, Epidemiology*

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Introduction

The Sustainable Development Goals (SDGs) recognize that the gender inequality issue is of paramount importance in combating gender differences in terms of study opportunities, work, income, political participation and other areas¹. In this context, confronting all forms of violence against women is one of the themes to be addressed to achieve this equity¹.

Violence against women is classified into two distinct types of manifestations of violence: collective violence and interpersonal violence. The first contemplates acts perpetrated by the state or institutions, such as violence and sexual slavery during wars and conflicts, police violence, terrorism, and others. The second refers to violence perpetrated by individuals with or without a personal/intimate relationship with the victim. This can occur within the home or in the community and includes domestic violence (psychological, physical and sexual), reproductive coercion, sexual harassment, rape, genital mutilation, and other forms of abuse².

According to some researchers on the subject, societies whose cultures accept and tolerate violence against women are more likely to naturalize these acts, including those that occur within health services³. However, recent publications have shown that many women worldwide suffer maltreatment, disrespect, abuse, or even violence during pregnancy, childbirth and puerperium from health professionals⁴⁻⁶. The same is true for women undergoing abortion⁷. In Brazil, according to hospital studies carried out in 2011 and 2015, the prevalence was 44.3% and 18.3%, respectively^{6,8}. Due to its high prevalence, disrespect, abuse, maltreatment and violence during childbirth are considered a serious form of gender violence, compromising the fundamental human rights of women, in addition to being a global public health problem⁹.

In the last decade, interest in studying this form of violence against women during childbirth has grown, mainly due to the feminist movement and groups that seek to claim the individual rights of women, reinforcing their freedom and autonomy in this very special moment of life^{10,11}. The increase in women's education, entry into the labor market and the achievement of sexual and reproductive rights made the scenario quite favorable to broaden the discussion.

Despite the increase in scientific and civil society interest in the subject, many theoretical and methodological difficulties are imposed on re-

searchers who wish to explore this research topic. These include a lack of consensus between the terminologies and definitions used and consequently, the difficulty of measuring the problem, which hinder the identification and knowledge of the magnitude and conducting causal studies on the consequences of these acts on maternal and child health, the latter being scarce in the literature¹². Therefore, the objective of this study is to discuss the conceptual and methodological issues that hinder and restrict research on this topic based on the existing scientific literature.

Terminologies and definitions

There is no consensus in the literature on the terminology and definition that best express the acts of disrespect, abuse, ill-treatment and violence against women perpetrated by health professionals during the pregnancy and puerperal cycle. The most commonly used terms are "disrespect and abuse in facility-based childbirth"¹³, "mistreatment of women in childbirth at health facilities"¹⁴, and "obstetric violence"¹⁰. These terms are often used interchangeably. However, they have different definitions, criticisms and gaps¹².

The term "disrespect and abuse in facility-based childbirth" was the first to be used to endorse situations of disrespect, mistreatment and violence perpetrated by health teams during pregnancy and childbirth. The term was proposed by Bowser and Hill¹³ (2010) and includes seven dimensions in its definition: 1) Physical abuse, 2) Nonconsented care, 3) Nonconfidential care, 4) Nondignified care (including verbal abuse), 5) Discrimination based on specific patient attributes, 6) Abandonment of care, and 7) Detection in facilities. This term and its definition were the first to give visibility to the issue worldwide as it served as the basis for an important publication by the World Health Organization in 2015 entitled "The prevention and elimination of disrespect and abuse during facility-based childbirth"⁹. Furthermore, from the creation of this term and its definition, epidemiological studies in the area were conducted, and its development aimed to identify and better understand the then little studied subject^{4,15,16}. However, both the term and its definition have some limitations. The insufficiency of its categories to characterize all forms of existing disrespect and abuse and the lack of mention of the need for intentionality of the perpetrator are highlighted¹⁷. In addition, this definition emphasizes that acts

of disrespect and abuse are exclusive to childbirth situations and birth and does not consider that these events can also occur during pregnancy (prenatal care), postpartum and abortion situations. Finally, authors such as Savage and Castro¹² and Bohren *et al.*¹⁹ point out the difficulty of operationalizing the proposed dimensions^{12,18}, and, according to them, this was the reason why there was no proposed instrument for use in epidemiological studies.

In order to solve some of the limitations mentioned above, Bohren *et al.*¹⁴ (2015) proposed a new term, “mistreatment of women in childbirth at health facilities”. This term also has seven dimensions, called third-order terms: 1) Physical abuse, 2) Sexual abuse, 3) Verbal abuse, 4) Stigma and discrimination, 5) Failure to meet professional standards of care, 6) Poor rapport between women and providers, and 7) Health system condition and constraints. Each third-order term is divided into second- and first-order terms. Examples include physical abuse (third-order theme) - second-order themes of the (1) use of force and (2) physical restraint and - first-order themes of (1) women beaten, slapped, kicked, or pinched during delivery and (2) women physically restrained to the bed or gagged during delivery¹⁷.

The definition proposed by Bohren *et al.*¹⁴ (2015) advances by listing a greater number of acts that are considered mistreatment, making the concept more inclusive than the previous one. This definition allowed the expansion of some discussions involving the context of care during labor and birth and the intentionality of acts of abuse. Regarding the context, it is known that the working conditions of health professionals are related to the quality of care offered to women. Maternity wards that often operate beyond their capabilities can leave many women feeling neglected and having difficulty communicating with the health team. Thus, the condition of the health system is an important element that must be considered to explain possible motivations for mistreatment and negative experiences during childbirth¹⁷. Furthermore, the lack of structure available in the care of women is an important component since it does not depend on the health team and is considered institutional violence. Inadequate structure has the potential to harm women’s dignity and privacy, as well as reduce the hospital/maternity ward’s capacity to offer the best possible care, considering the scientific evidence¹⁷.

Another point mentioned by Bohren *et al.*¹⁴ concerns the intentionality of acts of mistreat-

ment. The authors recognize that these acts may be intentional or unintentional, but they do not deem it necessary to make this distinction, claiming that there is no difference in the assessment of the impact for the woman and the newborn. However, this position can be questioned since it does not agree with the definition of interpersonal violence proposed by the WHO². In this definition, violence is described as “acts of an intentional nature with the potential to cause harm”, which it associates the intentionality of the act of violence itself, regardless of the result it produces². It is important to point out that this definition of violence proposed by the WHO considers the possible negative effects of violence on the health and well-being of individuals. In the absence of a consensus on the terms and definitions in this area, it is necessary to critically analyze the positive and negative points of a definition that considers intentional and unintentional acts. As a positive point, the possibility of capturing subtle and subjective negative experiences stands out. The downside of incorporating this issue is the expansion of the scope of acts included in the definition, which can make operationalization through an instrument more difficult.

In addition to having enabled important discussions on the topic, such as those mentioned above, the main progress of the proposal by Bohren *et al.*¹⁴ (2015) was the creation of a questionnaire with the objective of measuring mistreatment in childbirth in a standardized way. The main objective is estimating the prevalence, allowing a greater comparison between studies and encouraging the development of causal studies²¹. Since the creation of this term and its definition, the WHO has adopted the term mistreatment in all its publications³.

Another very popular term, especially in Latin America, but not restricted to these countries, is the term “obstetric violence”. Venezuela pioneered the construction of the term and its definition in the form of legislation in 2007. The Venezuelan definition considers obstetric violence to be any direct or indirect conduct, action or omission of a health team in the public or private sphere characterized by the *appropriation of the woman’s body and reproductive processes by the health professional, which is expressed by a dehumanized care, abuse of medicalization and pathologization of natural processes, resulting in loss of autonomy and ability to freely decide about their body and their sexuality, negatively affecting their quality of life*²². In Argentina, in 2009, a law was passed that defines both obstetric violence and

violence against reproductive freedom. According to this law, obstetric violence is defined as *acts performed by health professionals on the body, also involving the reproductive processes of women, which can be expressed through dehumanized treatment, abuse of medicalization and pathologization of natural processes in childbirth, birth and puerperium of the woman and her baby*²².

Then, based on the proposals of Venezuela and Argentina, several Latin American countries approved specific laws addressing the term obstetric violence. In 2013, this occurred in Panama and Bolivia²². Between 2007 and 2018, several Mexican states passed laws that defined and punished obstetric violence in the country. Finally, in 2017, Uruguay adhered to the use of this term²². In Brazil, there is no specific federal law that addresses the issue of obstetric violence. However, the Brazilian Federal Constitution subjectively contemplates protection against the occurrence of this type of violence as it makes it clear that the state must guarantee the right to health, physical and mental integrity and nondiscrimination. Another important milestone was the convention in Belém do Pará, where the rights of all women to live free from violence was recognized. Furthermore, to complement this, the medical code of ethics establishes patient secrecy and confidentiality in its fundamental principles²².

However, the term obstetric violence has been rejected among health professionals who work in childbirth care, especially in Brazil. The main reason for its low acceptance is mainly due to the incorporation of the pathologization and medicalization of labor and birth into the definition. Thus, although some acts can be more easily understood as violence, others, claimed by activists for the humanization of childbirth, are related to routine medical procedures. In this way, the denunciation of acts of obstetric violence, from the perspective of the social movement, is a way of questioning a certain worldview about what constitutes ideal childbirth care. In an attempt to alleviate this conflict, but without failing to reinforce the importance of a respectful birth/birth, the Network for the Humanization of Childbirth (Re-HuNa, acronym in Portuguese), for example, has chosen to establish a counterpoint using positive terms such as “humanization of childbirth” and “the promotion of women’s human rights” as opposed to the use of the term obstetric violence¹³.

Some empirical evidence found in Brazil reinforces the hypothesis that the unnecessary medicalization of childbirth may not be interpreted as a form of violence by the health team

and even for some women. For example, all indicators of quality of care in childbirth are evaluated worse by black women with low education²³. However, some interventions, such as episiotomy and elective cesarean sections, are more frequent in white women with high education²⁴, creating an apparent paradox. It is important to note that according to the WHO, excessive vaginal and multiple professional touches, routine episiotomy, the Kristeller maneuver, early amniotomy, routine use of oxytocin, cesarean sections without clinical indication and imposition of the delivery position are not recommended practices in childbirth care²⁵. However, many health professionals in Brazil do not view these practices as abusive but as acts inherent to childbirth care²⁴.

To break this paradigm, some researchers believe that it is necessary to change the way professionals who work during the pregnancy-puerperal cycle are taught and learn, emphasizing the approach based on scientific evidence and respect for the autonomy and dignity of women²⁶.

Measurement

The lack of consensus in the terminology and definitions used in acts of disrespect, abuse, maltreatment and obstetric violence and the absence of a validated instrument to measure this construct make epidemiological studies complex and difficult to compare.

The most popular instrument existing at the present time was proposed by Borhen *et al.*¹⁴ (2015). This instrument was created and used in some studies conducted in African countries²¹. Despite advances in the measurement process, this instrument has important limitations. The main dimension refers to the dimensions (or 3rd-order terms) contemplated, which clearly cover only three of the seven dimensions described (psychological/verbal violence, physical violence and stigma and discrimination). The instrument also presents questions about vaginal exams, nonpharmacological methods for pain relief, mobility, nutrition, and the presence of a companion during labor and delivery, but it does not describe in which dimension these questions are inserted. There is also a block of questions focusing on unreasonable demands, tariff structure and negligence, which mixes different situations that do not seem to be directly connected. Finally, sexual violence was completely excluded from this instrument.

Borhen *et al.*¹⁴ do not clarify whether they consider this set of proposed questions as a fac-

tual instrument or a questionnaire. The authors did not conduct any analysis of the psychometric properties of this instrument or a form of systematization of information and, consequently, the classification of women in relation to the violence experienced. In addition to the aforementioned limitations, the instrument is considered inadequate to assess possible situations of mistreatment against women during prenatal care and abortions.

The absence of valid and accurate instruments for measuring this problem leads to the impossibility of accurately estimating the prevalence of the event of interest, a lack of comparability between existing studies in different contexts and populations, difficulty in monitoring estimates over time, and an absence of studies focusing on the risk factors and consequences of these events on the health of women and newborns.

An example of the lack of precision in estimating prevalence and comparing data can be seen between the two hospital-based studies recently published in Brazil. Both studies used the term “disrespect and abuse in childbirth”. In the first study, a national survey on labor and birth conducted in 2011/2012, the prevalence of disrespect and abuse was approximately 44.3%. This study considered seven indicators that encompassed the occurrence of physical and psychological violence, disrespectful treatment, a lack of information, privacy and communication with the health team, the inability to ask questions and loss of autonomy¹¹. In the second survey, using data from the Pelotas cohort (2015), a prevalence of disrespect and abuse of 18.3% was estimated considering four questions about verbal violence, physical violence, interventions against the woman’s will and negligence. In this case, the difference in prevalence is mainly due to the different measurement methods⁶.

Lack of studies that evaluate the consequences of disrespect, abuse, maltreatment and obstetric violence

The literature on disrespect, abuse, maltreatment and obstetric violence includes a small number of studies focusing on the consequences of these acts on women’s health and, in some cases, on the newborn. The scarcity of this type of study is one of the main gaps on the subject today^{11,15}. This lack of causal studies involving this theme are, in fact, consequences of the lack of consensus regarding the terminology and

definition of this theoretical field and, mainly, the lack of a validated instrument to capture this construct more accurately.

Many causal hypotheses have been suggested by researchers in the field, but few have scientific support. Some research suggests that disrespect, abuse, maltreatment and obstetric violence may be associated with negative health outcomes for their victims, such as an increased probability of developing anxiety, posttraumatic stress disorder and postpartum depression^{11,27,28}, low use of health services by women and newborns in the postpartum period¹⁵ and greater difficulty breastfeeding¹⁵. Considering that one of the components of disrespect, abuse, maltreatment and obstetric violence is negligence, likely outcomes cited are the increase in the occurrence of maternal near misses and maternal and fetal mortality¹³. It is also possible that the experience of obstetric violence alters the decision regarding the delivery mode in subsequent pregnancies (e.g., women who suffered maltreatment during a vaginal delivery may opt for an elective cesarean section in future pregnancies). However, most of the outcomes mentioned are based on hypotheses with little or no empirical scientific evidence.

In addition, it is noteworthy that the occurrence of disrespect, maltreatment and obstetric violence during the pregnancy-puerperal cycle can also negatively impact more subjective issues, such as the perception of the quality of care received and satisfaction with childbirth, among others.

A new look at the terms, definitions, and forms of operationalization of obstetric violence

The elaboration of a term and, consequently, a definition that endorses most of the acts of disrespect, mistreatment and violence perpetrated by health professionals against women during the pregnancy and childbirth cycle and that is accepted by researchers and becomes a consensus in the area is still a major challenge. However, this question is of paramount importance to better understand the phenomena related to this problem. It is necessary to delimit these acts in a way that captures the negative and subjective experiences of the victim. Moreover, the definition cannot be so broad as to lose its meaning and marginalize any and all actions taken by the health team in the care of women. Furthermore, it is necessary to demarcate which acts are perpetrated by health professionals during the care of

women and which are due to the lack of investment in the structure, materials and equipment in the health sector². With this in mind, the use of the term obstetric violence to characterize the acts of psychological/verbal, physical, sexual violence, and intentional neglect by health teams in the prenatal care, childbirth, and abortion situations for women can be quite advantageous since it covers a delimited scope of manifestations, which are well defined in the literature².

In this sense, Bohren *et al.*¹⁴ (2015) has already taken the first steps in the development of an instrument. It is important to point out that the questionnaire proposed by these researchers encompasses three of these four dimensions already considered in the definition of obstetric violence. The development of an instrument could facilitate the execution of descriptive and causal studies in order to make it possible to understand the magnitude of the problem and to support the elaboration of public policies with the objective of mitigating and managing this problem with scientific evidence. Even so, the challenge would be the development of items for the dimension of sexual violence not included in the version proposed by Bohren *et al.*¹⁴ (2015) and conducting psychometric analyses to assess the instrument itself.

The use of the term obstetric violence restricted to these four dimensions would also be in accordance with the typology used by the WHO to define these same manifestations of violence in other subtypes of violence, such as interpersonal violence – which includes violence between intimate partners, violence against children and adolescents and violence against the elderly. Importantly, Bowser and Hill (2010) and Bohren *et al.*¹⁴ (2015) also identified these dimensions in their respective definitions of disrespect, abuse and mistreatment.

Another point that deserves to be highlighted is the use of the term obstetric, as opposed to childbirth, which is more commonly used. This decision would show that this type of violence can occur in pregnancy, childbirth, puerperium and abortion, that is, in all events of the pregnancy-puerperal cycle. It is important to mention that the use of this term has also been suggested by other researchers from Latin America^{26,29} and has been used by researchers from other countries¹⁵.

It is noteworthy that the option to use the term obstetric violence to characterize acts of violence and negligence does not prevent the use of the term “mistreatment”. Both terms and their

respective definitions can and should coexist. For this, it is necessary to consider the fact that the term “mistreatment” refers to episodes of disrespect and violations of women’s rights and dignity and has a broader meaning. In this way, “mistreatment” contemplates both acts of violence per se and more subtle acts. Therefore, obstetric violence would be just one component of this larger construct called “mistreatment”.

However, we must mention that the redefinition of the term obstetric violence from the perspective of facilitating the measurement and adapting the WHO’s conceptual proposal may not be unanimous. It should be noted that the exclusion of the issue of medicalization and pathologization of the labor and birth process may not please everyone since the subject circulates in different discursive fields such as law, health and feminist movements³⁰. Although there is a dialog among the fields, each of these fields has different rationales and will produce its own meanings of obstetric violence with perspectives that do not always coincide. The breadth of perspectives can also be understood, in a sense, as part of a process of clashes and disputes³⁰. Opting for a narrow definition of violence and intentional neglect, we favor measurement, but we employ a term that is very dear to social movements that have a combative agenda against the excessive medicalization and pathologization of childbirth care in the Brazilian context.

Finally, it is important to mention that in Brazil, there are some public policies to improve the quality of care for women in prenatal care and childbirth with a potential impact on the reduction of obstetric violence, such as the National Program for the Humanization of Childbirth (2000), the Companion Law (2005), the Stork Network – Maternal-Infant Care Network (2011) and the National Guideline for Pregnant Women Care (2015/2016)³¹. In addition, the work of some social movements is also noteworthy, with emphasis on ReHuNa, which made the term “humanized childbirth” accessible to the general public and contributed to the dissemination of information through NGOs, social networks and films²⁶. However, these documents do not openly discuss obstetric violence or any of its “synonyms”.

In 2019, the Brazilian Ministry of Health published Official Letter No. 017/19 – JUR/SEC making the term obstetric violence inappropriate and banning its use in legal documents and public policies. After this controversial decision, based on the recommendation of the Federal

Public Ministry, the Ministry of Health published a note recognizing the legitimate right of women to use the term obstetric violence to portray the experiences of disrespect, abuse, mistreatment and violence experienced, as well as the use of practices not based on scientific evidence in health care situations³². However, official texts and Brazilian health policies still do not address the term. This omission by the state can be partially explained by the lack of reliable statistics on the prevalence of these acts in the Brazilian population and scientific evidence on the harmful consequences on the health of women and newborns who have experienced some of these acts. Finally, it is important to mention the resistance of health professionals to the use of the term obstetric violence.

Conclusion

There is much to be done in terms of scientific research involving the theme of disrespect, abuse, mistreatment and violence against women

perpetrated by health professionals in the pregnancy-puerperal cycle. The lack of a consensus regarding the terminology and definition of this construct causes a cascade effect causing a lack of precision in the estimation of the magnitudes of these acts, difficulty in comparing different studies and countries (different definitions and, consequently, different forms of measurement), and a scarcity of analytical studies focusing on possible negative outcomes of this problem for the health and well-being of women and newborns.

The absence of causal epidemiological studies involving the subject impacts health care decision-making since the knowledge generated by these studies influences the elaboration of specific public policies for the prevention of these acts by health managers. Given the issues mentioned, future studies focusing on the creation of a term and a consensual definition in the area and, consequently, on the development of an instrument with good psychometric properties to assess situations of disrespect, abuse, maltreatment and obstetric violence during pregnancy, childbirth, puerperium and abortion situations are necessary.

Collaborations

TH Leite and ES Marques: conception, planning, writing and approval of the final version. AP Esteves-Pereira, MF Nucci, Y Portella and MC Leal: critical review and approval of the final version.

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