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FOR CONSTITUTIONAL LAW, GOVERNANCE AND HUMAN RIGHTS

Combating obstetric violence in Africa: Human rights, dignity and accountability in maternal health care

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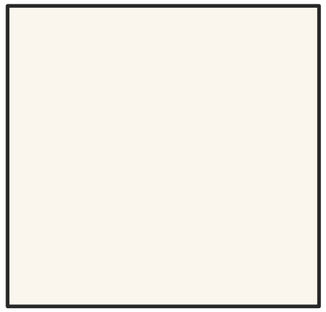
Background

- Sub-Saharan Africa, as of 2020, accounted for 70 per cent of maternal deaths in the world (WHO 2023)
- Most deaths are from avoidable causes – delays in accessing care, poor quality of care and limited capacity to manage obstetric emergencies.

- Strategies adopted by states

a. Ensure quality care.
b. More women give birth in health facilities
c. Family planning
d. Social determinants
e. Skilled care



Recognition of OV

- International Federation of Gynaecology and Obstetrics, the International Confederation of Midwives, the White Ribbon Alliance, the International Paediatrics Association, and the WHO in 2014 launched the Mother–Baby Friendly Birthing Facilities Initiative

- September 2014, the WHO issued a statement (endorsed by over 90 organisations) emphasising the right of women to respectful maternity care and the need for health stakeholders to prioritise actions to prevent and eliminate disrespect and abuse during facility-based childbirth.

- 2015, the UN and regional human rights experts and special mechanisms jointly released a statement condemning various acts of OV such as unconsented interventions, refusal of pain relief, physical and verbal abuse and physical restraint of incarcerated women while giving birth

- Latin America, the Network for the Humanisation of Labour and Birth (founded in 1993) and the Latin American and Caribbean Network for the Humanization of Childbirth (founded in 2000) and other similar social movements have led activism and discussions around OV in the region and championed calls for the respect of women's rights during childbirth.

Africa

- African Commission's Resolution 260 on involuntary sterilisation

- African Commission General Comment No. 2 (Article 14 Maputo Protocol), No. 4 (torture)

- *Community Law Centre and Others (on behalf of the Five Victims) v Federal Republic of Nigeria* (Communication 564 of 2015) [2024] ACHPR 1 (23 May 2024) - The crux of the complaint was the high maternal mortality rate due to preventable causes resulting from inadequate access to care and mistreatment of birthing women.

  County Government of Bungoma & 2 others v JOO & 2 others (Civil Appeal 61 of 2018) [2024] KECA 1377 (KLR) (23 February 2024) (Judgment) – Mistreatment during childbirth – human dignity- torture.

  Millicent Awuor (Mai-muna) and Margaret Anyoso Oliele V AG and others Constitutional Petition No. 562 of 2012, High Court of Kenya – Maternal detention – human dignity

- *LM and Others v Government of the Republic of Namibia* [2013] AHRLJ 10- Forced sterilisation of HIV positive women –informed consent

Defining Obstetric violence

Contested terminology

- mistreatment’,
- ‘maltreatment,’
- ‘disrespect’,
- ‘abuse’ of women ‘during childbirth’, ‘facility-based delivery’/ ‘maternity care’
- respectful maternity care’; ‘
- ‘dehumanised care,’
- ‘compassionate maternity care’
- ‘respectful and non-abusive care
- The WHO has, for instance, urged states to prevent and eliminate ‘disrespect and abuse’ during facility-based childbirth.
- Bohren et al. proposed ‘mistreatment of women’ as a more inclusive term that better describes the full range of women’s experiences. (Both interactional and structural (lack of privacy))
- **Challenges with streamlining the terminology**
  - Fear of labelling health workers as perpetrators of violence
  - linguistic and cultural differences
  - normative behaviour and
  - research methodologies used to capture women's experiences

Obstetric violence- when are women most vulnerable?

- Perera et al. define obstetric violence as ‘mistreatment’ that occurs in the care provided during pregnancy, childbirth and the immediate postpartum period (2018).

- Most studies around the world on OV focus primarily on women’s experiences during childbirth

- The WHO has noted that although disrespectful and abusive treatment can occur during pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth.

- In an investigation of whether women would use health facilities for future pregnancies, women noted that they would use the same facilities for antenatal care, but would use facilities they perceived were better because they felt more vulnerable at the time of childbirth. Orpin, J., et al (2018)

- Forced sterilisation often occurs at the time of childbirth, highlighting women’s vulnerability around that time.

- Abuse of women during antenatal care and postpartum detention equally essential and respectful maternity care should be seen to include these.

Legal definitions

Venezuela - Law Number 38,668, Articles 15.11 and 51

- The ‘appropriation of women’s bodies and reproductive processes by health professionals, expressed as dehumanising treatment and/or abusive medicalisation and pathologisation of natural processes, resulting in loss of autonomy and the capacity to decide freely about their own bodies and sexuality, negatively impacting women’s quality of life.’

Argentina - Law Number 26,485 (2009), Article 6

- OV is ‘exercised by health personnel over a woman’s body and reproductive processes, expressed as dehumanising treatment, and/or abusive over-medicalisation and medicalisation of the natural processes

Bolivia - Law Number 348 (2013), Articles 7 and 8

‘violence against reproductive rights’ and ‘violence in health services,’ defined as ‘actions or omissions that impede, limit or otherwise violate women’s right to information, orientation, comprehensive care and treatment during pregnancy or miscarriage, labour, birth, postpartum period, and breastfeeding’ and ‘any discriminatory, humiliating, or dehumanising action, and anything which omits, negates or restricts access to immediate, effective care and timely information, committed by health personnel, that puts the life and health of women at risk,

Legal definitions

Panama - Law Number 82 (2013), Article 4

- OV is ‘exercised by health personnel over women’s bodies and reproductive processes, expressed as abusive, dehumanising, humiliating or vulgar treatment.’

Mexico City, Law Number 180: (2014), Article 6–7

- ‘all actions or omissions by medical and health professionals that damages, harms, denigrates or causes the death of the woman during pregnancy, birth and the postpartum period’

- **Common themes –**
  - *Control of women’s bodies and reproductive processes – denial/disregard for agency or autonomy*
  - *Over-medicalisation of birth*
  - *Human dignity*
  - *Health implications*

Scholarly definitions

- **What should a definition cover?**
- Vogel et al (2015)- health, human rights, legal and socio-cultural dimensions of the issue, its interactional and structural dimensions, vulnerabilities and harm.

- Freedman et al (2014) - a definition should capture health system deficiencies that are experienced as mistreatment, as well as women's, providers', and other stakeholders' perspectives on what constitutes mistreatment in various cultures.

- Freedman et al – define disrespect and abuse in childbirth as the “interactions or facility conditions that local consensus deems to be humiliating, or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified.”

- Vogel et al - women's experience of maternity care should be central to describing the problem – that is, women should be the main determinants of what constitutes violence in obstetric care.

- Lévesque, S. and Ferron-Parayre - the use of the term should be done carefully to avoid blaming health workers.

Interactional and structural dimensions of OV

- **Interactional (interpersonal)**
  - verbal abuse,
  - physical mistreatment, or
  - neglect by healthcare providers

- **Structural**
  - institutional policies, cultural norms, socioeconomic inequalities, and systemic power dynamics
  - inadequate funding for maternal health care,
  - lack of recognition, understanding of or respect for the rights of women (by policymakers, health workers and communities),
  - power imbalances (gender, medical paternalism),
  - limited opportunities for seeking redress,
  - inadequate infrastructure in health facilities, shortage of health care staff, poor supervision in health facilities, lack of professional support, weak implementation of standards and quality of care guidelines.
  - Health provider training

- Freedman et al suggest that more focus be given to the structural components, as the interactional violence could create unproductive hostility towards health workers.

Manifestations of OV?

Bowser and Hill (2010)

- Physical abuse,
- non-consented care,
- non-confidential care,
- non-dignified care,
- discrimination based on patient attributes,
- abandonment of care, and
- maternal detention

Bohren et al.

- physical abuse,
- sexual abuse,
- verbal abuse,
- stigma and discrimination,
- failure to meet professional standards of care,
- poor rapport between women and providers,
- health system conditions and constraints

WHO

- physical abuse,
- humiliation and verbal abuse,
- coercive or unconsented medical procedures
- lack of confidentiality,
- failure to get fully informed consent,
- refusal to give pain medication,
- gross violations of privacy,
- denial of admission to health facilities,
- Neglect
- Maternal detention

UN Special Rapporteur

- over medicalisation of birth,
- overuse of episiotomies and caesarean sections,
- application of non-evidence-based procedures like manual fundal pressure, symphysiotomy,
- overuse of synthetic oxytocin to induce contractions and labour,
- lack of respect for privacy and confidentiality,
- limited use of pain medication,
- husband stitch,
- extended delays in the provision of medical care,
- lack of autonomy in choosing birthing positions,
- practices of profound humiliation,
- verbal abuse and sexist remarks and threats during childbirth,
- physical restraint of incarcerated women during labour and birth,
- forced abortions, forced sterilisations,
- postpartum detention

Obstetric violence in Africa

What does the literature say?

- Interactional and structural
- Public and private healthcare facilities
- Mistreatment of women is widespread
- Ingrained in many health systems/facilities
- Affects women of all socio-economic levels, also some women are more vulnerable than others.

Manifestations of OV in Africa

- Non-confidential care- people in labour rooms without a woman's consent, lack of privacy in maternity wards, allowing health information to be heard by other patients. Lack of privacy can occur because of the design of maternity wards.

- Neglect/abandonment - occurs where there is a lack of support, ignoring requests for assistance before, during or after delivery. This has been cited by some studies to occur intentionally, negligently, or unintentionally

- Non-dignified care- include exposing women’s bodies against their wishes, offensive or humiliating words, threats of withholding treatment or undergoing a caesarean section or a poor outcome for the mother and baby

- Verbal abuse - overt aggression from health workers, including using harsh, disrespectful, or degrading words towards birthing women.

- Physical abuse - may include hitting women, forcing them into specific positions, performing episiotomy and/or stitching without anaesthesia

- Non-consented care - occurs when women are subjected to procedures such as vaginal examinations, caesarean sections, and episiotomies, sterilisation, without consent or prior explanation of the procedure.

- Denial of birth companions positive impact on women's birthing experiences and outcomes despite. This can happen because of hospital policy or the design of maternity wards.

- Denial of mobility in labour - women are sometimes confined to beds, and such restraint has been justified by health workers to protect the mother and baby

- Denial of choice of birthing position- This right has been denied to many women by health workers, who mostly like the supine position

- Denial of traditional practices- An example is women deciding to take the placenta home after birth in line with their customary or traditional practices, which nurses sometimes disagreed with. Women can as a result choose Traditional Birth Attendants

- Maternal detention - occurs when a woman and her baby are detained at the health facility due to an inability to pay bills

Structural dimension of OV in Africa

Discrimination

- Marriage, ethnicity, age, social status, rural-urban residence, education, and employment, and health status are factors that shape women's OV experience.

- Being an adolescents, having a poor background, and being HIV-positive increased women's chances of disrespect and abuse.

- Unmarried women are more likely to experience verbal and physical abuse compared married women.

- Women from low-income backgrounds are disproportionately affected by obstetric violence due to their limited ability to access high-quality care.

- Higher parity

- A lack of education and awareness about rights during childbirth exacerbates vulnerability, as such women are less likely to advocate for themselves or report mistreatment, perpetuating the cycle of structural violence

- **Socio-cultural issues and gendered expectations in maternal healthcare**

  - ***Cultural norms/expectations*** - Cultural norms around gender, reproduction, and childbirth frequently reinforce mistreatment of women.
  - Objectification of women (preferences disregarded)
  - Violence is a tool of dominance and control.
  - Expression of pain in labour is seen as a sign of weakness in some communities.

  - ***Normalisation of violence***
  - Justifications – Disobedience or lack of cooperation of women and the need to ensure good outcomes.

  - Some studies show that some women are not even critical of the care received because they are not well informed about their rights or the expected standard of care, and are likely to see mistreatment as normal behaviour of health care workers.

  - Due to fear of denial of care or neglect, women choose to acquiesce and not challenge mistreatment.

  - Women's silence or acceptance of mistreatment also represents an imbalance in power dynamics between patients and medical staff, who are able to control women as they please without repercussions.

  - Normalisation leads to underreporting.

- **Health system failures**
  - Facility conditions/stressors influencing provider behaviour (overcrowded, underfunded and understaffed)
  - Workforce
  - Institutional practice
  - Policy failures
  - Health worker training
  - Redress mechanisms

Country perspectives

Prevalence

Manifestations

Associated factors

Structural drivers

Implications for women's health and reproductive justice

Nigeria

Maternal healthcare challenges

- Nigeria has one of the highest maternal mortality rates globally (Maternal Mortality Ratio stood at 1047 maternal deaths per 100,000 live births as of 2020, while the Global average was 223)
- Many maternal deaths are from preventable causes like haemorrhage, sepsis, obstructed labour, unsafe abortion, etc.

Why?

- Inadequate access to quality obstetric care
- Limited capacity to respond to obstetric emergencies in many areas (rural and urban)
- Rural-urban divide in access to care
- Poorly equipped facilities (rural and urban)
- Travel time constraints to seeking care
- Prohibitive cost of healthcare (high out-of-pocket expenses)

Uptake of care

- The uptake of skilled birth attendance, especially in rural areas, remains low.
- Reasons
  - Lack of transport,
  - tradition,
  - onset of labour at night,
  - preferred birthing position,
  - fear of surgery and
  - poor attitude of health workers

Manifestations of OV

’’When I came for my delivery of this child five months ago the doctors were sleeping some of them were hearing me shouting but they neglected me, the head of the baby was out but no one to help and I was not strong enough to push the baby out it was only the grace of God that helped me the baby come out, it was after the delivery my sister that come with me ran to them and call them, that negligence is a very bad attitude I was not happy at all’ (Agbor, 2019)

They make you feel like you don't matter when they talk to women in a rude way, and sometimes that can make a woman feel like she doesn't mean anything to them” (FGD3, P6).(Orpin et al, 2018)

Women’s experiences

- abandonment or neglect
- undignified care
- Non-confidential care
- physical - slaps, scolding, and performing episiotomies without anaesthesia
- and verbal abuse
- non-consented care in the form of episiotomies and stomach palpitations without consent
- Maternal detention

- No significant difference between public and private facilities

Associated factors

- Ethnicity
- Education (educated women reported more cases of abusive care)
- HIV positive status
- occupation,
- social class
- being a hospital staff or related to a hospital staff
- the mode of delivery
- duration of hospital admission before delivery
- Age

- **Normalisation**
- By women – considers physical abuse as well-intentioned
- By health providers – Physical abuse was considered important to ensure good outcomes for mother and child

Kenya

- **Maternal Health Care Challenges**
- As of 2020 Kenya's Maternal Mortality Ratio stood at 530 maternal deaths per 100,000 live births, well above the global average (223)
- 2013 Free Maternal Health Policy

- **Care gaps in maternal health**
  - health worker shortages,
  - a shortage of drugs,
  - overburdened health facilities,
  - limited capacity to manage obstetric emergencies and
  - uptake of skilled antenatal and delivery services by women
- The health system has been described as incapable of supporting the free maternity services program due to its weak and fragmented policies and poor policy support (Oluoch-Aridi et al 2018)

Manifestations

"I was young when I went to deliver my first baby. Instead of being assisted, the nurses kept insulting me (you enjoyed doing it, why are you screaming now), don't try and scream here. I can never go back to facility XX. The nurses are just there not helping; you wonder if it's a hospital you were brought to?" (FGD, Women). (Warren et al, 2017)

"They have a habit of asking if it's first or second born. If you say third born, they say that you are used to giving birth, they leave you alone, you push the baby alone only for them to come to cut the cord after birth and weigh the baby" (FGD, Women). (Warren et al 2017)

Women’s experiences

- non-confidential care,
- non-consented care,
- non-dignified care,
- discrimination, and
- maternal detention
- disrespectful, abusive, uncompassionate, humiliating care, neglect, lack of privacy, harsh or rude language, threats of withholding treatment, being blamed for a bad outcome, lack of informed consent, failure to inform women about progress of labour, poor rapport between women and health personnel, denial of birth companions, vaginal examinations or episiotomies without consent.

Case law

County Government of Bungoma & 2 Ors v. JOO & 2 Ors,

She was admitted to a government health facility, was made to purchase her own supply despite the free maternity services, and shared a bed due to overcrowding. The respondent was left to give birth on the floor in the corridor in full view of others, having been left without assistance. She was physically and verbally abused and forced to carry her unexpelled placenta to the delivery room by herself, and left unattended still, without pain medication.

Millicent Awuor (Mai-muna) and Margaret Anyoso Oliele V AG and others

While detained, their movements were restricted, made to sleep on the floor, verbally abused and deliberately denied postpartum medical attention, often being the last to receive food which was sometimes insufficient or no food at all. All these were in addition to being poorly treated even while in detention.

Associated Factors

- age
- ethnicity
- health status and
- socio-economic status
- educational background
- multiparous women were sometimes neglected to deliver on their own because having delivered before, they ‘knew what to do.

Malawi

- **Maternal healthcare challenges**
- Maternal Mortality Ratio in 2020 stood at 381 maternal deaths per 100,000 live births, above the global average (223).
- The leading causes of maternal deaths are haemorrhage, infections, and eclampsia.
- These are avoidable as care is ordinarily delivered within a strained and under-resourced health system lacking
  - adequate financing,
  - human and material resources,
  - poor referrals,
  - poor leadership, governance, monitoring and evaluation.
  - improper health assessment/ observation of women,
  - prolonged inaction of health workers,
  - delays in diagnosis and treatment
  - inadequate monitoring and clinical management of infections
  - inability to manage obstetric emergencies,
  - Poor handover between healthcare staff
  - inadequate skills and mistreatment by health providers

Manifestations

"I was given medicine. ... I do not know whether it was bactrim or panadol....They just asked who delivered today and gave us the medicine. I do not know what it was for. I just received news that I am in the hospital". Participant # 4 (Kumbani et al 2012)

Women's experiences

- undignified care (women not being greeted respectfully, verbal abuse, threats during labour or after), non-consented care (unindicated manual exploration of the uterus after delivery), non-confidential care
- Poor communication
- No informed consent for caesarean delivery
- denial of birth companions

Some studies have shown that some women were not critical of the care they received because they were unaware of the standard of care or what to expect from the health workers, and in some cases, had low expectations

Associated Factors

- Delivering in a public facility
- Denial of birth companions as parity increased
- Younger women had higher chances of not having their own bed compared to older women
- HIV related stigma
- Being an adolescent or unmarried
- Pregnant women are being made to wait long hours, as nurses prefer to attend to women on family planning first.

Ghana

Maternal health care challenges

- Maternal mortality ratio of 263 deaths per 100,000 deliveries as of 2020.
- out of about 95% of women who attend antenatal care, only about 65% deliver in health facilities, with others using TBA or delivering at home.
- Overall, only 21% of women fully utilise the WHO-recommended components of maternal health care -antenatal, childbirth and postpartum care

Manifestations

When I got there, I went there with a sister and I was asked what I am coming to do and I told them I am in labour. I was actually in pains so I couldn't even talk hard and they were shouting at me that I should talk for them to hear. Why? Am I a baby? How they received me I even felt sorry for myself for going there. It made me feel so bad. (IDI, Married woman, 32 years, Nsawam) (Maya et al, 2018)

When I was due for labour and was asked to push, I couldn't push and the nurse beat me very well. She used a cane to whip me so I could push, but I told her I was tired but she insisted I should push. So she really whipped me with the cane and later used her hand to hit my thigh. There I became conscious and was able to push. (FGD, Married woman, 35 years, Koforidua (Maya et al 2018)

Women’s experiences

- physical and verbal abuse,
- discrimination,
- abandonment,
- non-confidential care,
- unconsented vaginal examinations,
- poor communication,
- inadequate pain relief
- stitching without anaesthesia
- Denial of traditional practices
- maternal detention

Associated factors

- Being HIV positive
- Being attended by a midwife rather than an obstetrician or gynaecologist
- Being attended by a midwife or doctor compared to a nurse or community health nurse
- Being poor
- Being uneducated
- Teenage mothers
- Being unmarried

Structural Factors

- lack of basic resources and supplies such as water, beds, fuelled vehicles or ambulances to transport patients referred to larger facilities
- staff shortage
- delays in getting attended to
- poor physical conditions of facilities
- failure to uphold professional standards
- poor managerial oversight
- weak or non-existent redress mechanisms in health facilities
- a lack of electricity, water, and unsafe facilities

Perspectives of healthcare providers

'Severally, sometimes here we even beat the client when they are in labor, during labor, it is normal to do that because the baby's head has come, and instead of the client pushing, she will be relaxing, and the baby too will be asphyxiated. So, unless you beat the client's thighs, the baby might die. Some become relaxed, they think you the midwife should pull it for them. So, during labor, we do that. (Midwife, Agona Nkwanta Health Centre, Rural Ghana)'

- *'t is normal. There are some women, they like to make noise and shout, those people, we are hard on them not because of anything but because of their well-being. So, for the shouting at clients, it can't stop*.' (Midwife, Tafo Government Hospital, Urban)

'We ignore clients based on their reactions. Maybe when we review clients and it's just 1 cm dilatation, but the client is insisting the baby is coming. And you do the vaginal examination again and it's still 1 cm and she would be shouting and crying and making a whole lot of fuss. Most often we ignore such people.' (Midwife, Maternal and Child Hospital, Urban

- Midwives/ nurses are often spotted as the main perpetrators of OV

What some healthcare providers think of abuse

- Some health workers recognise the mistreatment of women as inappropriate.
- They identify such abuse as neither intentional nor deliberate.
- Disrespect and abuse are rationalised as appropriate to protect the life of the mother and child.
- There is a culture of blaming women and working conditions.
- Mistreatment is presented as the only option without alternatives, and it is often considered an essential means to ensure a positive birth outcome.

Impact of OV on women and maternal healthcare

- Physical impact
- Psychological - feelings of fear, shame, post-traumatic stress disorder, postpartum depression
- Poorer maternal health outcomes, including higher rates of maternal morbidity and mortality
- Undermines the quality of patient-provider relationships and patient trust in the health system
- Low use of antenatal services and skilled birth attendance.
- Avoidance of specific facilities with a reputation for abusive care
- Feeling of helplessness in deciding to give birth at health facilities

Recommendations

- Make OV visible
- Community engagement
- The role of birth companions
- Research – on interventions and their suitability to varied context, impact and sustainability of interventions
- Respectful maternity care interventions-
  - health worker training (on values, attitudes and communication)
  - improvement of working conditions
  - improving privacy in wards
  - creation of quality improvement teams
  - disrespect and abuse monitoring
  - provision of complaints mechanisms
  - mediation/alternative dispute resolution,
  - maternity open days,
  - counselling women who have experienced OV
  - educating women on their rights.

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Thank You!

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