POLICY BRIEF

MARCH 2023

POLITICS 4 HER

OBSTETRIC VIOLENCE AGAINST INDIGENOUS WOMEN IN LATIN AMERICA

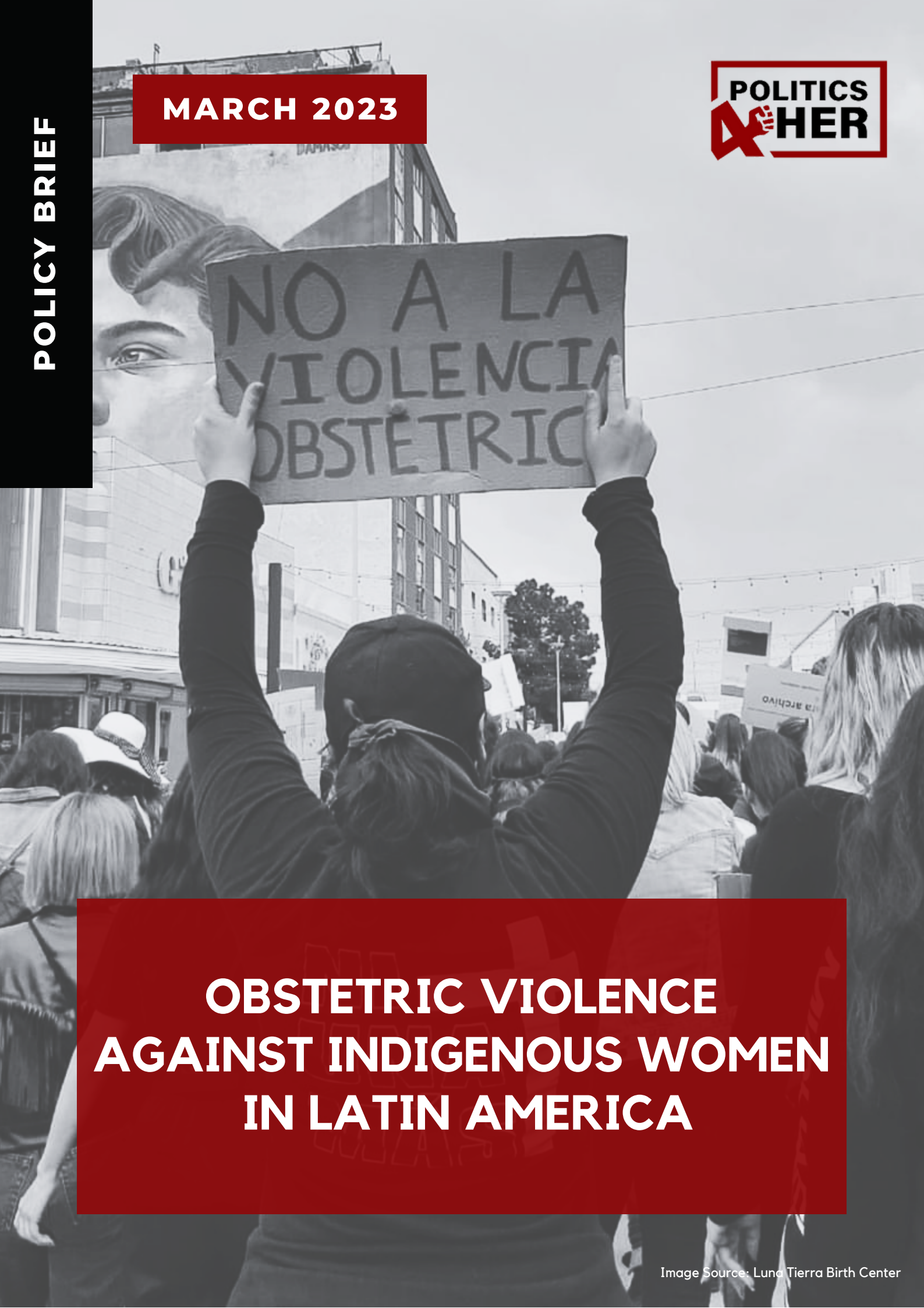

Image Source: Luna Tierra Birth Center

ABOUT THE AUTHOR

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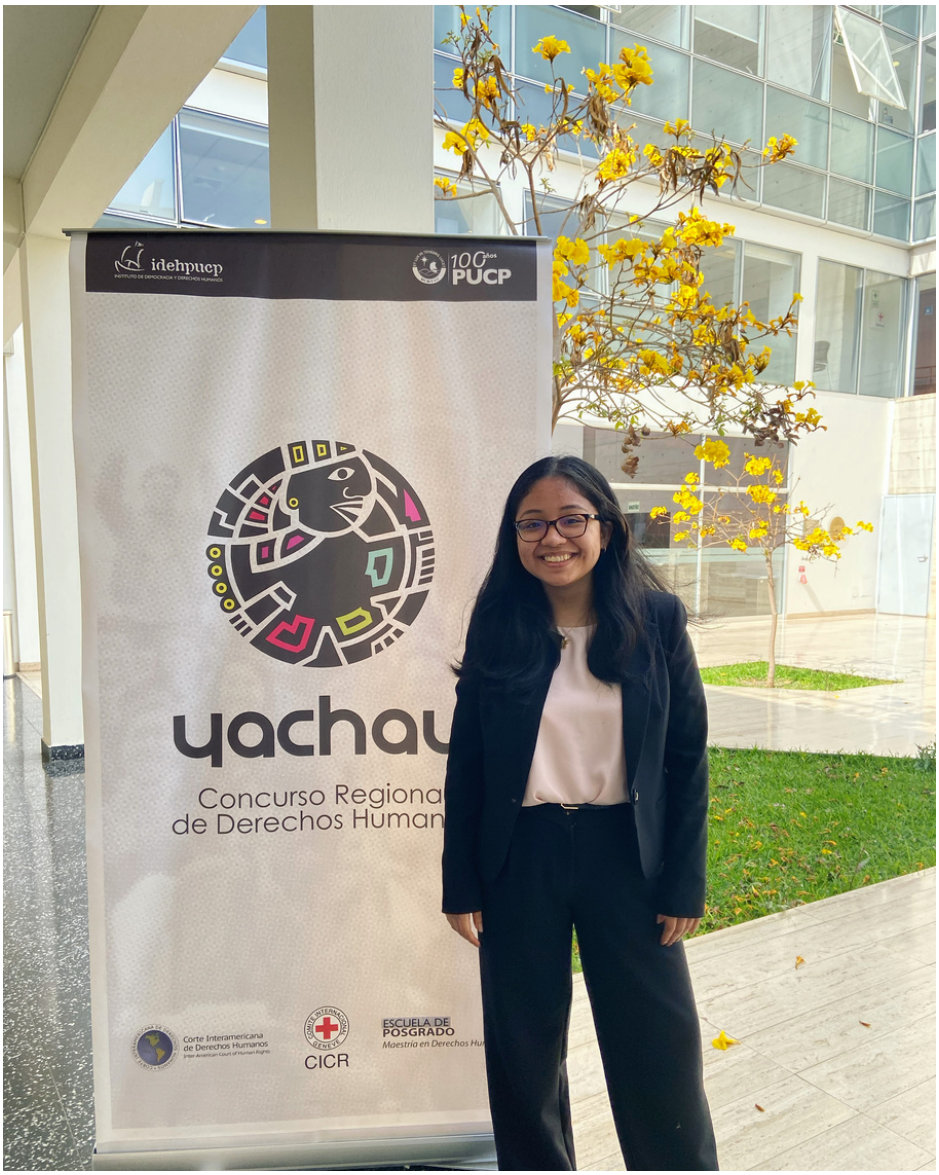

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ABOUT POLITICS4HER

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Politics4Her is an intersectional feminist platform & youth-led movement advocating for the inclusive participation of young women and girls in politics. Politics4Her works to broaden dialogue and to bring international human rights into practice through advising policymakers and states by bringing international best ideas. Politics4Her strives to contribute to a more equitably governed world by democratizing national laws and legislations.

ABOUT THE PROGRAMME

The Young Feminist Scholars Programme is meant for any student who is extremely passionate about feminism and gender issues. The goal will be for each scholar to deliver a report specializing on a region in the world covering issues related to gender-based violence and/or women's political participation.

Our two criteria for our scholars are to identify as international feminists (regardless of their gender) and most importantly to be able to showcase leadership. Scholars get to work in research, writing, policy as well as communications advocacy. Our main goal is for them to explore these different fields and see what they are most interested in while offering them guidance and mentorship so that it potentially helps them launch their early career.

TRIGGER WARNING

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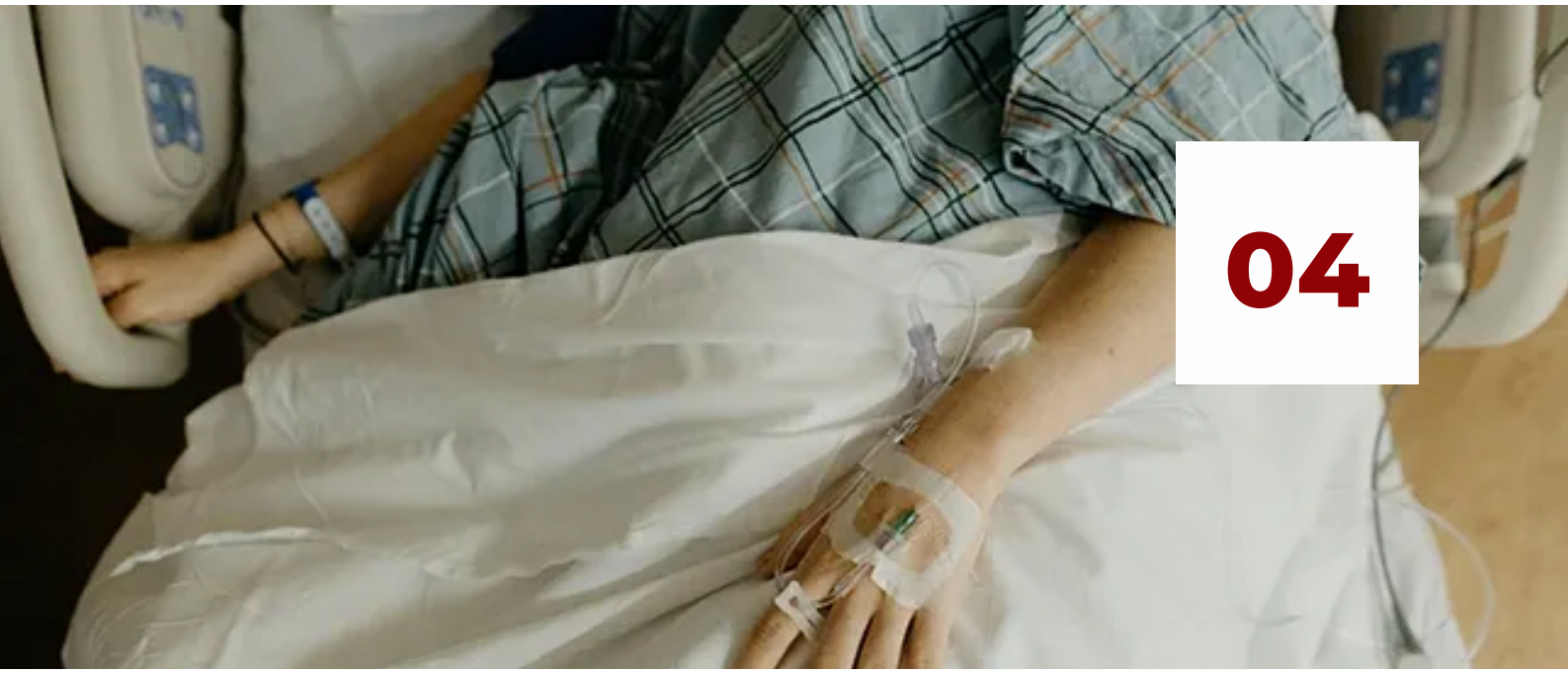
Source: United Nations Development, 2019.

Please keep in mind that this document explores aspects of obstetric violence and contains depictions of verbal violence, physical violence, sexual violence, psychological violence, social discrimination, neglect of care, and inappropriate use of procedures and technologies in a medical context. While it is important to shed light on obstetric violence, we recognize that these may cause distress to the reader, particularly those who have experienced and/or witnessed this problem firsthand. Please take care in the reading of the policy brief and prioritize your well-being.



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Source: Sidney Morgan, 2022.

EXECUTIVE SUMMARY

This policy brief explains the general aspects of obstetric violence, which is defined as any action or omission by healthcare personnel in public or private medical institutions during the processes of pregnancy, childbirth, and the puerperium against birthing people. It can be manifested in eight ways: lack of cultural sensitivity, verbal violence, physical violence, psychological violence, sexual violence, social discrimination, neglect of care, and inappropriate use of procedures and technologies. It also examines one of its causes: the paternalistic model of health care which assigns the doctor the role of a wise and caring father; whereas, it assigns the patient the role of a helpless and ignorant child. This is why medical paternalism situates the clinician in charge of the decision-making process, giving them power over the patient. In order to highlight the devastating scale of obstetric violence in Latin America, this policy brief reports the experiences of indigenous women affected by obstetric violence in the region, focusing on Peru, Mexico, and Colombia. Aiming to contribute to the fight to end obstetric violence, this document shares the solutions proposed by healthcare professionals who provide maternal care in Peru.

INTRODUCTION 05

During the last few decades, the culture of silence around gender-based violence against women has been disrupted in Latin America. This is reflected in the process of criminalization of femicide in the region. It is important to remember that the concept of femicide "was created in the feminist theoretical field of studies, then migrated to the political feminist activism, influencing Law reform in Latin America since the decade of 1990" (Corn, 2014, as cited in Pasinato & De Ávila, 2022). As a result of this process, until 2022, 18 States in the region typified the gendered killing of women as a crime, including Costa Rica, Guatemala, Chile, El Salvador, Peru, Argentina, Nicaragua, Honduras, Panama, and Bolivia, along with other countries (Pasinato & De Ávila, 2022).

Source: Eduardo Luzzatti, 2022.

Despite the fact that passing laws is not the only way of combating the alarming rates of femicide, it must be seen as an important first step to hold the perpetrator of the femicide accountable for their actions. The criminalization of femicide in Latin America is an example of how numerous types of human rights violations against women that had been historically normalized are finally being named, recognized as such, and even punished by the criminal system.

INTRODUCTION 06

Obstetric violence can be also understood as any action or omission by healthcare personnel in public or private medical institutions during pregnancy, childbirth, and the puerperium against birthing people. It's a term that includes women and trans people and that can be expressed through a lack of cultural sensitivity, verbal violence, physical violence, psychological violence, sexual violence, social discrimination, neglect of care, and inappropriate use of procedures and technologies. Bearing this definition in mind, in 2015, a statement by the World Health Organization pointed out that many women worldwide experienced disrespectful and abusive treatments during childbirth, which constitutes a transgression of their right to the highest attainable standard of health. Four years later, a report by the Special Rapporteur on violence against women, its causes, and consequences of the United Nations, Dubravka Šimonović, shared the stories of survivors of obstetric violence worldwide. They claimed that they were verbally abused by healthcare workers during childbirth, who mentioned sexist and offensive phrases, such as: "You didn't cry when you did it, open your legs or your baby will die and it will be your fault" and "you didn't shout when the penis was inside you, why do you shout now?" (Šimonović, 2019). Then, on November 16, 2022, the Inter-American Court of Human Rights made history in the Brítez Arce et. al. v. Argentina case since it is the first case in which the above-mentioned regional tribunal applied the concept of obstetric violence and recognized it as a form of gender-based violence.

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Source: King's London College, 2023.

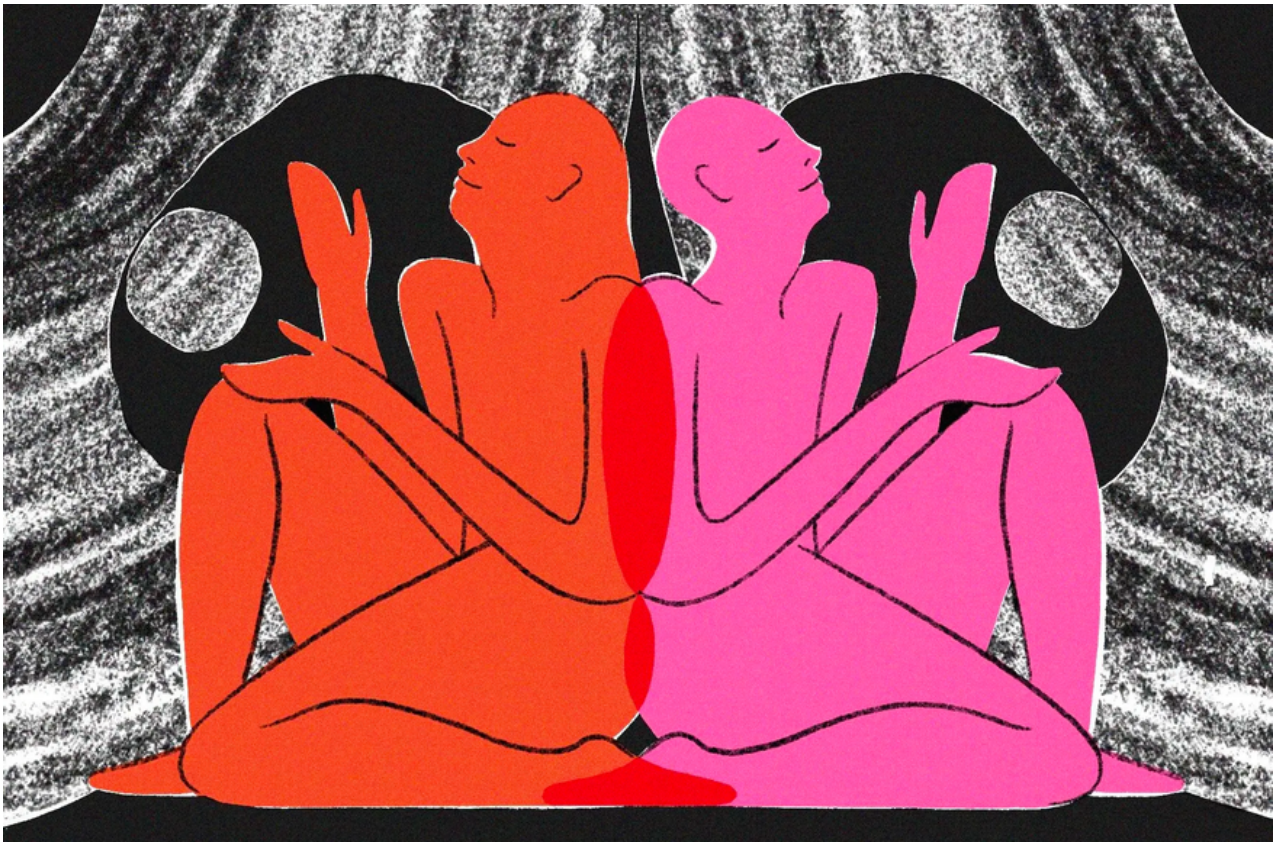
Despite the progress to name and condemn obstetric violence, little has been done to date at the policy level to tackle this gender issue in Latin America. For this reason,

THE PURPOSE OF THIS POLICY BRIEF IS

To provide general information about obstetric violence, while addressing one of its most overlooked causes: medical paternalism. In addition, this policy brief reports the experiences of indigenous women affected by obstetric violence in three Latin American countries owing to the need to amplify their voices since they are frequently not heard in the development of policies aimed at eliminating obstetric violence. Finally, in order to get to know the perspectives of those who witness how the medical healthcare system fails to account for the autonomy of patients and their culture, health professionals who provide maternal healthcare to Peruvian indigenous women in private or public centers in Peru were asked what the solutions to obstetric violence are and their answers are shared and formulated as policy recommendations.

METHODOLOGY 08

With the objective to offer a comprehensive and general approach to obstetric violence and medical paternalism, this study reviews academic and scientific publications related to these two medical concepts. In addition, this report presents data from studies that collected cases of obstetric violence against indigenous women in Peru, Mexico, and Colombia. The intention is to identify how obstetric violence is inflicted on indigenous women while providing their perceptions regarding this gender issue. Furthermore, five healthcare personnel who provide maternal care to indigenous women in public or private healthcare institutions in Peru were surveyed to share their opinions on the solutions to this problem.



Source: Adam Sternbergh, 2020.

UNDERSTANDING OBSTETRIC VIOLENCE

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WHAT IS IT?

Many academics and clinicians have proposed numerous definitions of obstetric violence, even though none of them have been universally accepted. However, for the purpose of this policy brief, obstetric violence refers to:

Any action or omission by healthcare personnel in public or private medical institutions during the processes of pregnancy, childbirth, and the puerperium against birthing people. It can be expressed through a lack of cultural sensitivity, verbal violence, physical violence, psychological violence, sexual violence, social discrimination, neglect of care, and inappropriate use of procedures and technologies.

UNDERSTANDING OBSTETRIC VIOLENCE

After determining what is obstetric violence, several questions may arise regarding the aforementioned concept.

Does the term “healthcare personnel” only include doctors?

No, it includes everyone who participates in the provision of healthcare before, during, and after childbirth: nurses, obstetricians, residents, midwives, neonatologists, and pediatricians, among others.

Why should we use the term “birthing people” instead of “women”?

Unlike the definitions given by the academia, this concept recognizes that obstetric violence is not a women’s sole issue because they are not the only one who can get pregnant. People under the trans umbrella (e.g. trans men, non-binary people, agender people, gender-fluid people, etc) can get pregnant too and, therefore, can experience obstetric violence just as women. Using trans-inclusive language when talking about obstetric violence does not mean erasing or dehumanizing women but recognizing that this problem not only affects them.

Can obstetric violence be expressed in one way?

No. Obstetric violence is a spectrum that includes numerous categories, which will be exemplified and examined through the three Latin American case studies.

UNDERSTANDING OBSTETRIC VIOLENCE

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HOW CAN IT MANIFESTATE?

A literature analysis of 24 publications on obstetric violence found that many categories of obstetric violence existed, demonstrating the diverse nature of this phenomenon (Modena & Barbosa, 2008) (Figure 1).

Figure 1: Classification and exemplification of obstetric violence based on the literature review.

Typology	Examples
Verbal violence	Rude, disrespectful, coercive, discriminatory, ironic, and negative comments that provoke humiliation, embarrassment, and inferiority. The presence of jargon, such as "Why are you crying" You did not cry when you were doing it", "Come on, it does not hurt that much, "Oh, don't cry, come on, next year you're here again", "If you do not force your baby will suffer", "Shut up and push the baby", "If you scream, I stop now what I'm doing. Blaming and discriminatory speeches to women in situations of abortion.
Sexual violence	Realization of digital vaginal examination without gloves, manipulation of genitals brutishly and disrespectfully, touching the body and performing a rectal examination on the woman without her consent.

Source: Barbosa, D. M., & Modena, C. M. (2018). Obstetric violence in the daily routine of care and its characteristics. Revista Latino-Americana De Enfermagem, 26(0). https://doi.org/10.1590/1518-8345.2450.3069

UNDERSTANDING OBSTETRIC VIOLENCE

Figure 1: Classification and exemplification of obstetric violence based on the literature review.

Typology	Examples
Physical violence	Repetitive and aggressive digital vaginal examination; routine use of episiotomy, unnecessary cesarean section; lack of adequate pain management (before, during, and after delivery); realization of procedures without adequate analgesia, use of directed pulls; slaps and pinches on the legs; physical restraint of legs and arms during normal or cesarean delivery; Kristeller's maneuver.
Social discrimination	Disrespect, stigma, prejudice, or differential treatment of women because of their color, race/ethnicity, or social, economic, marital, sexual choice, religion, and schooling. Financial abuse by professionals.
Neglect of care	Negligent care, abandonment, and refusal to promote care for women considered "complaining", "scandalous", "unbalanced", "non-cooperative", or "questioning". To procrastinate assistance to women in situations of abortion.
Inappro-priate use of procedures and technologies	Iatrogenic procedures; abusive use of oxytocin, immobilization in the bed during labor, delivery in the lithotomy position; routine amniotomy, continuous routine fetal monitoring, prolonged fasting without indication; inadequate management of pain without justification; no skin to skin contact and early clamping of the umbilical cord.

Source: Barbosa, D. M., & Modena, C. M. (2018). Obstetric violence in the daily routine of care and its characteristics. Revista Latino-Americana De Enfermagem, 26(0). https://doi.org/10.1590/1518-8345.2450.3069

UNDERSTANDING OBSTETRIC VIOLENCE

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WHAT IS ITS LEGAL FRAMEWORK?

The international obligations of the States emerge from the sources of international law. According to article 38.1 of the Statute of the International Court of Justice, the principal judicial organ of the United Nations, there are five sources:

Conventions	Judicial decisions	General principles of law
Teachings of the most highly qualified publicists		International custom

Since we are going to focus only on the first source, it's important to keep in mind what has been noted by Shaw (2008), who pointed out that conventions, treaties, pacts, charters, and declarations, among other terms, are the same; hence, they are all defined as:

> "The creation of written agreements whereby the States participating bind themselves legally to act in a particular way or to set up particular relations between themselves" (p. 93).

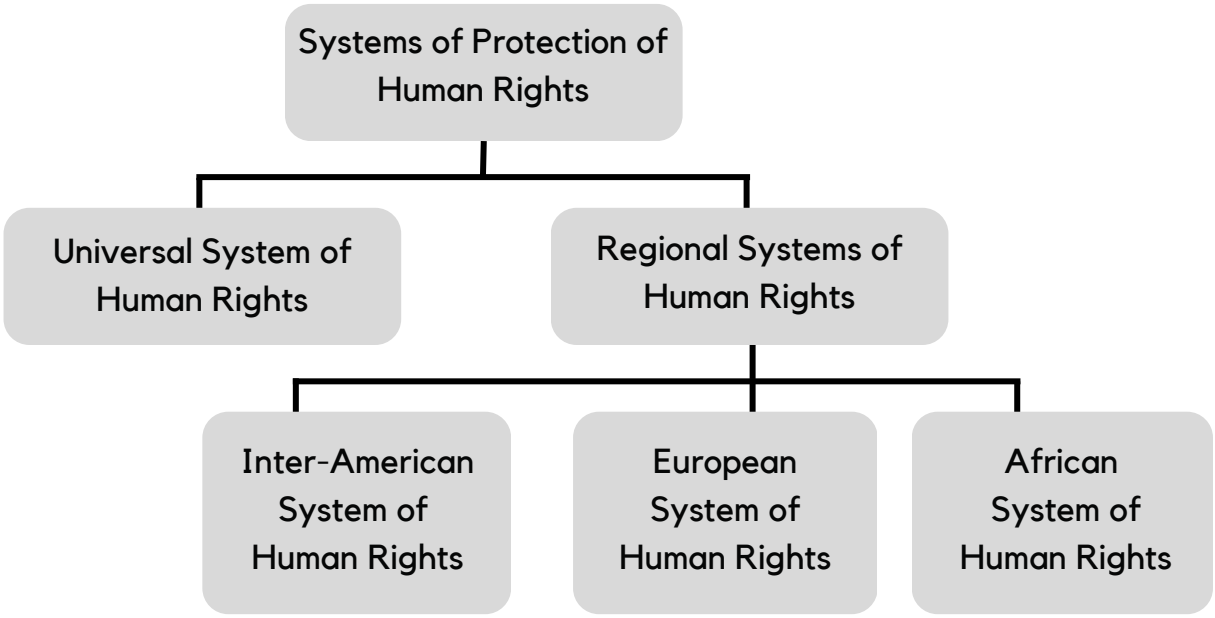
UNDERSTANDING OBSTETRIC VIOLENCE

WHAT IS ITS LEGAL FRAMEWORK?

In the International Human Rights Law sphere

Over the years, the States have adopted conventions that are related to obstetric violence, even though none of them have thoroughly developed this subject. It should be mentioned that these conventions are part of different systems of protection of human rights (Figure 2).

Figure 2: Visual map of the Systems of Protection of Human Rights.



Source: Prepared by the author.

UNDERSTANDING OBSTETRIC VIOLENCE

In the International Human Rights Law sphere

For a better identification of the conventions that are part of the international legal framework with regard to obstetric violence, a summarizing table was prepared with information on the title, the year of entry of force, and relevant points of the treaties (Figure 3).

According to Kaother (2022):

> **"The foundation of addressing obstetric violence in international human rights law is still very much underdeveloped compared to other human rights issues".**

This is reflected in Figure 3, which shows that all of the Systems of Protection of Human Rights, except the African System, have conventions that barely touch on obstetric violence.

Source: Flickr, n.d.

Figure 3: Conventions related to obstetric violence classified by their pertinence to a system of protection of human rights.

Name	Year	Relevant points
Universal Human Rights System		
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	1981	• First convention that vaguely touches on access to adequate maternity care as a human right. • Establishes the right to adequate health services for women, specifically around family planning, maternity, and postpartum services (article 12). It later repeats this provision but with a particular focus on rural women (article 14.b). • Does not expressly acknowledges obstetric violence.
Inter-American Human Rights System		
Belém do Pará Convention	1995	Recognizes that violence against women includes physical, sexual, and psychological violence experienced in health facilities (article 2.b).
European Human Rights System		
European Convention of Human Rights	1953	Notes that, because health is protected, there shall be no interference by a public authority with the exercise of the right to respect for private and family life.

Source: Table prepared by the author with the information retrieved from Kaother, D. (2022). Obstetric Violence in International Human Rights Law. https://www.humanrightspulse.com/mastercontentblog/obstetric-violence-in-international-human-rights-law?format=amp

UNDERSTANDING OBSTETRIC VIOLENCE

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WHAT IS ITS LEGAL FRAMEWORK?

In Latin America

In the 1990s, the movement against obstetric violence in Latin America originated from the "zero death objective", which was created in North America and Europe and whose purpose was to take action against the death rate at birth (Favre, 2020). In this context, Latin American activists, researchers, and health personnel founded the organization that would guide the discussion on women's right to respected childbirth in the region: RELACAHUPAN (Latin American and Caribbean Network for the Humanitarian of Childbirth), which was created in an event held in Brazil in 2000 called the First International Conference for the Humanization of Birth (Salder et. al, 2016).

Source: The Writer, 2022.

Bearing this context in mind, the term obstetric violence has been progressively added to the legal framework of Latin American countries. In fact, in 2007, the first country to pass laws around obstetric violence was Venezuela, leading Argentina, Bolivia, several states of Mexico, and Panama to do the same (Figure 4).

Figure 4: Latin American countries with the most important laws regarding obstetric violence.

Name	Year	Relevant points
Argentina		
Law Number 26,485	2009	Guarantees women the right to be treated as a healthy, informed, decision-making participant in her own labor, delivery, and postpartum period; to have a natural birth that respects her timing and natural processes; to be accompanied by a trusted birth companion of her choosing throughout the entirety of labor, delivery and the postpartum period; to room in with her newborn; and to receive counseling and support for breastfeeding (article 6).
Bolivia		
Law Number 348	2013	Assures women the right to a life free from violence, including "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, labor, birth, postpartum period, and breastfeeding" and "any discriminatory, humiliating, or dehumanizing 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", respectively (articles 7 and 8).
Mexico		
Law Number 180	2007 (modified in 2007)	Penalizes obstetric violence and also negligence, non-medically indicated cesarean section, sterilization and/or use of contraceptive methods without voluntary consent, and anything that interferes with the early bonding of the mother and infant (including breastfeeding) without medical cause (article 7).

Sources: Williams, C. R., Jerez, C., Klein, K. O., Correa, M., Belizán, J. M., & Cormick, G. (2018b). Obstetric violence: a Latin American legal response to mistreatment during childbirth. Bjog: An International Journal of Obstetrics and Gynaecology, 125(10), 1208–1211. https://doi.org/10.1111/1471-0528.15270 and Adjuntía para los Derechos de la Mujer. (2020). Violencia obstétrica en el Perú. Informe de Adjuntía N° 0232020-DP/ADM. https://www.defensoria.gob.pe/wp-content/uploads/2020/12/Violencia-obst%C3%A9trica.pdf

Figure 4: Latin American countries with the most important laws regarding obstetric violence.

Name	Year	Relevant points
Ecuador		
Law Number 175	2018	Conceptualizes obstetric violence as "any action or omission that limits the right of pregnant women or not, to receive gynecological-obstetric health services. It is expressed through mistreatment, imposition of cultural and scientific practices non-consensual or violation of professional secrecy, the abuse of medicalization, and those that are not established in protocols, guides, or laws; the actions that consider the processes natural pregnancy, childbirth, and postpartum such as pathologies, forced sterilization, loss of autonomy and ability to decide freely about their bodies and their sexuality, impacting negatively on the quality of life and sexual and reproductive health of women in all their diversity and throughout of his life, when it is done with practical invasive or physical or psychological abuse" (article 10.g).
Panama		
Law Number 82	2013	Guarantees women the right to a life free of violence, including obstetric violence, which is "exercised by health personnel over women's bodies and reproductive processes, expressed as an abusive, dehumanizing, humiliating or vulgar treatment" (article 4).
Venezuela		
Law Number 38,668	2007	Provides specific examples of actions that constitute obstetric violence, including failing to provide timely and effective care during obstetric emergencies, intervening to accelerate labor without the woman's express voluntary informed consent, and performing a non-medically indicated cesarean section without the woman's express voluntary informed consent (article 51).

Sources: Williams, C. R., Jerez, C., Klein, K. O., Correa, M., Belizán, J. M., & Cormick, G. (2018b). Obstetric violence: a Latin American legal response to mistreatment during childbirth. Bjog: An International Journal of Obstetrics and Gynaecology, 125(10), 1208–1211. https://doi.org/10.1111/1471-0528.15270 and Adjuntía para los Derechos de la Mujer. (2020). Violencia obstétrica en el Perú. Informe de Adjuntía N° 0232020-DP/ADM. https://www.defensoria.gob.pe/wp-content/uploads/2020/12/Violencia-obst%C3%A9trica.pdf

ANALYZING MEDICAL PATERNALISM

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WHAT IS IT?

Imagine you have a disease. You go to the doctor and they tell you that you can follow treatment "A" or treatment "B". The doctor states that following treatment "A" is the best option for you. However, you express that you think that the best option for you is treatment "B". The doctor reiterates that they are the expert and only they know what's best for you, reminding you that's why you must follow their recommendations.

This situation is an example of medical paternalism, which mandates that

> The physician assumes the role of a father and the patient the role of a child. The physician, as a father, has to decide unilaterally what is the best way to protect the patient and restore them to health, since they have the knowledge and training to do so; whereas, the patient, as a child, has to obediently follow the physician's order (Chin, 2002).

Whether the patient is competent or has the capacity to comprehend their own best interest, determines the type of medical paternalism:

If the patient is competent	→	Hard paternalism
If the patient is not competent	→	Soft paternalism

ANALYZING MEDICAL PATERNALISM

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IMPORTANT!

In practice, however, hard medical paternalism situations such as the one presented in the example are no longer common since they are considered outdated in health care (Lynøe et. al, 2018, as cited in Lynøe et. al, 2021). This is due to the evolution of the concept of medical paternalism. As Ogando and García (2006) contended:

> The physician-patient relationship has changed in the last few years more than in the last 25 centuries.

In fact, during the 20th and 21st centuries, the appearance of an element shifted tremendously the relationship between the doctor and the patient:

Informed consent	Also defined as "the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention" (Shah et. al, 2022).

ANALYZING MEDICAL PATERNALISM

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IMPORTANT!

The change in the healthcare model is explained by Ciota (2020), who posits that:

> "We currently experience a shift from medical paternalism to patient-centered care. With ancient doctrines becoming less and less acceptable for patients and also for many physicians we see a positive trend when it comes to putting patients and their needs first. (...) Physicians have come a long way from keeping patients in the dark and insisting on the medical supremacy. Today they are not only involving the patient but also the whole family and educating him about his health status and the respective procedures that will be undertaken to heal him."

NONETHELESS,

Because we are still going through a transformation, medical paternalism still exists, denying the patient of a health care service centered on them and this is reflected in obstetric violence against indigenous women, which will be analyzed in detail below.

Source: Getty Images, n.d.

ANALYZING MEDICAL PATERNALISM

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THE DOCTOR-FEMALE-PATIENT RELATIONSHIP

Gender plays an important role in every relationship and the doctor-female-patient interaction is not an exception. Leanne & Jackson (2022) describe the power dynamics between the doctor and the female patient and its relation with medical paternalism:

> Within healthcare systems, patriarchy, and male dominance find expression in medical paternalism. The traditional dominance of medicine, which once excluded women entirely, remains present to some extent within modern health care. Medical staff afforded the highest degree of autonomy within healthcare systems, and continue to lead in research, policy development, and service design and delivery the majority of the time. As such, doctors, nurses, and patients exist within an operational hierarchy with medicine dominating from above. This dynamic is inherently gendered, with medical staff acting in the masculine role as dominant protectors and patients as passive, feminine, and dependent recipients (p. 2).

Source: TI Consulting, n.d..

Simply put, medical paternalism takes a particular form when the patient is female. This is due to the historical control that medicine had and has over women's bodies which is expressed through the dominant and superior attitude of healthcare personnel who, in comparison to female patients, have the most power in the relationship.

THE THREE CASE STUDIES IN LATIN AMERICA

There is an absence of extensive and reliable data about obstetric violence against indigenous women in Latin American countries, which could cause in many cases not being accounted for. Even though the **statistical silence** constitutes an obstacle to understanding the real scale of this issue in the three case studies, the limited data that exists can provide insight into the magnitude of the problem in the region.

Information presented in surveys and reports regarding obstetric violence against indigenous women in Peru, Mexico, and Colombia was analyzed. The experiences and testimonies retrieved are organized into the seven categories of obstetric violence shown in Figure 3 (Figure 5). However, because obstetric violence has a particular impact on indigenous women, a ninth category was added: lack of cultural sensitivity, which refers to "rejection or ignorance of the traditional knowledge, practices, and wisdom experienced by indigenous women in relation to pregnancy and childbirth" (Gaffney et. al, 2021). In addition, in order to illustrate the experiences of the participants, some quotes have been added.

Figure 5: Manifestations of obstetric violence against indigenous women recognized in the data analyzed.

Author (Year)	Location	Partici-pants	Classificaction of experiences
Peru			
CHIRA-PAQ (2019)	Cusco, Balsapuerto (Alto Amazonas, Loreto), Vilcahuamán (Ayacucho)	Not specified	• **Verbal violence, social discrimination, and psychological violence.** Sexist and racist insults, and poor treatment at the moment of the attention of childbirth. • **Social discrimination and lack of cultural sensitivity.** Impediment to being accompanied in the delivery room, by relatives, or by a traditional midwife. It was also reported that there was an impediment to choosing the way they want to give birth and to what plants and various utensils can be used in the birthing process characteristic of their culture.

Source: Table prepared by the author.

THE THREE CASE STUDIES IN LATIN AMERICA

Figure 5: Manifestations of obstetric violence against indigenous women recognized in the data analyzed.

Author (Year)	Location	Partici-pants	Classificaction of experiences
Mexico			
Rangel et. al (2018)	Central part of the Huasteca region of San Luis Potosí	57 indige-nous women	• **Social discrimination and lack of cultural sensitivity.** Indigenous women could not exercise their essential cultural practices due to the resistance of health workers. For instance, they were not allowed to choose positions other than lithotomy, in which the individual lies on the back with the hips and knees flexed and the legs spread and raised above the hips often with the use of stirrups. In addition, it was reported that all of the participants were denied to right to have a companion during the delivery period (Quote 1). • **Physical violence.** The only act that was categorized as violent was the vaginal touch since it was a painful and uncomfortable procedure performed by many actors, who did not communicate because after someone finished, another person entered the room for another assessment. • **Verbal violence.** Women reported that health personnel verbalized phrases to invalidate their pain, while also receiving orders to shut up and stop complaining due to the pain (Quote 2). • **Neglect of care.** Having been separated from their children after delivery without even being able to see them, which was done without any explanation from the staff.

I would have liked my husband to be there, as they say, for moral support, which I guess is what makes us feel good.

Quote 1.

I complained and cried in pain, it was the first time I felt that way! Then they said: "Do not complain! Do not cry! They said I did not scream when I had sex with my husband!

Quote 2.

THE THREE CASE STUDIES IN LATIN AMERICA

Figure 5: Manifestations of obstetric violence against indigenous women recognized in the data analyzed.

Author (Year)	Location	Partici-pants	Classificaction of experiences
Mexico			
Rangel and Martínez (2017)	Six districts of the Huasteca region of San Luis de Potosí	57 indige-nous women	• **Verbal violence.** Women described as violent the conduct of health personnel who ordered them to silence their emotions that arose during labor, convincing them that their baby is at risk because of them. • **Physical violence.** Many women pointed out that an episiotomy was performed on them often without their consent and they became aware of this when they got home. The participants did not perceive Kristeller's maneuver as a violent act; on the contrary, they thanked health personnel for their help to make their babies born faster. • **Inappropriate use of procedures and technology.** The women narrate that they continue to be prematurely separated from their babies. It was also reported that technology was used to violate the participant's privacy and dignity in a healthcare context (Quote 3).

Since I had a C-section and I don't know if it's it is valid that they are recording with their cell phones, I don't know if that is valid... They were upstairs in the operating room, I didn't say anything, what could say? I didn't even know what they were recording for.

Quote 3.

THE THREE CASE STUDIES IN LATIN AMERICA

Figure 5: Manifestations of obstetric violence against indigenous women recognized in the data analyzed.

Author (Year)	Location	Partici-pants	Classificaction of experiences
Colombia			
Gaffney et. al (2021)	Medellín	9 indigenous women	• **Physical abuse.** Many of the participants pointed out that they experienced Kristeller's maneuver and called it humiliating and uncomfortable. • **Sexual violence.** One of the participants stated that the vaginal examination was performed on her without her informed consent. • **Social discrimination and lack of cultural sensitivity.** Some women said that health personnel often did not ask them —or could not ask if the women did not speak Spanish—about their cultural preferences regarding childbirth. This resulted in the refusal of health professionals to permit women to perform significant rituals, such as access to their own placenta, the presence of midwives, cutting their own child's nails for the first time, and drinking traditional hot teas during labor. • **Neglect of care.** Eight of the nine women interviewed described feeling ignored in the face of their doubts and demands for care that the rhythm of labor forced them to carry out. Some women also reported being denied the possibility of entering the hospital because they were not affiliated with a Health Promotion Agency (EPS) or not having medical gurneys. This led to women giving birth at the entrance to an operating room or at the door of the hospital (Quote 4).

> "I called a nurse and told him "(...) I'm in a lot of pain, I have many contractions... the nurse told me "and how do you know they are contractions?", I told him "I'm the one who is pregnant and I know I have contractions... you are putting my life and my son's life at risk, call the surgeon, call the doctor, the obstetrician-gynecologist who attended me." He never did. I told my sister "I don't feel well, I feel like I'm going into labor, find my doctor and call her", she ran, searched for her, and found her, I don't know how she did it, but she did."

Quote 4.

DISCUSSION

INDIGENOUS WOMEN AND OBSTETRIC VIOLENCE

Source: Kyenam, n.d.

After presenting the diverse experiences of Latin American indigenous women who have gone through obstetric violence, it's imperative to analyze the reasons behind them. Gleason et. al (2021) explain that colonialism and Western medical training are obstacles for healthcare workers to find significance and importance in the cultural practices and knowledge of indigenous women because they are viewed as not modernized or Occidentalized; therefore, they are silenced and stigmatized. Subsequently, due to their ethnicity, indigenous women experience forms of obstetric violence that Occidentalized women don't. Their ethnic heritage is not only dismissed but despised in the maternal healthcare system (Gleason et. al, 2021). This is evidenced in Figure 5, where indigenous women reported that there were denied to perform cultural practices before, during, and after giving birth, and, in some cases, medical staff didn't even ask about their cultural preferences.

CONCLUSION

This policy brief proposes a new definition of obstetric violence that recognizes that:

It is not a sole women's issue because it can be experienced by trans people.

There is not one way to experience it since it has eight manifestations.

Furthermore, this document supports the idea that medical paternalism takes place in a doctor-female-patient relationship, reinforcing gender roles and perpetuating an unbalanced dynamic of power between the two. This review also documents the prevalence of obstetric violence against indigenous women in Latin America, particularly in Peru, Mexico, and Colombia. Thanks to the knowledge acquired from the analysis of several reports, different manifestations of obstetric violence against indigenous women were identified in the three case studies, such as lack of cultural sensitivity, verbal violence, physical violence, social discrimination, and negligent care, among other categories. Later, it was discussed that indigenous women live a particular facet of obstetric violence, one that does not let them include their cultural knowledge, practices, and wisdom in the childbirth process. This is due not only because of the colonialist and Western medical healthcare system, which excludes the culture of indigenous women in maternal healthcare; but also because of the doctor-female-patient relationship, which is gendered and paternalistic and can result in obstetric violence.

Source: Khomanta, n.d.

POLICY RECOMMENDATIONS

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It all starts with a shift of mentality.

We've seen that obstetric violence against indigenous women is rooted in the colonial mindset and Western medical training. If we want to eradicate the problem, we have to change the mentality of healthcare workers. An excellent way to do so is by providing training to healthcare personnel who provide maternal service in the regions where the population is prominently indigenous. This training will be funded by the Ministry of Health of the States and will be conducted by Indigenous Human Rights Organizations.

The training will cover a wide range of topics, including (i) medical paternalism, (ii) obstetric violence, (iii) indigenous communities, and (iv) the childbirth model with an intercultural approach. The sessions of the training will be imparted during working hours. Each session will last 1 hour and all of them must be completed in six months.

Let indigenous communities be heard.

The movement against obstetric violence started because activists, health professionals, and governmental authorities held events to shed light on this concerning problem. However, it is important to include indigenous people's voices in the discussion. It is not possible to solve a problem that concerns them without hearing them. For this reason, the Ministry of Health of the State can organize an annual event in partnership with Indigenous Human Rights organizations, where indigenous people can express their demands, satisfactions, and complaints regarding the policies with respect to obstetric violence. The objective is to create a platform for dialogue between the State and indigenous communities.

This event will be held in every region of the country in order to avoid centralization and will require the presence of medical personnel that provides maternal health care. After the event, a report containing the most relevant points of the events will be written and published on the Ministry of Health website and will be available in native languages. This report will serve as a guide for the State to implement adequate policies.

REFERENCES

Adjuntía para los Derechos de la Mujer. (2020). *Violencia obstétrica en el Perú. Informe de Adjuntía Nº 0232020-DP/ADM.* https://www.defensoria.gob.pe/wp-content/uploads/2020/12/Violencia-obst%C3%A9trica.pdf

Barbosa, D. M., & Modena, C. M. (2018). Obstetric violence in the daily routine of care and its characteristics. *Revista Latino-Americana De Enfermagem*, 26(0). https://doi.org/10.1590/1518-8345.2450.3069

Chin, J.J. (2002). Doctor-patient relationship: from medical paternalism to enhanced autonomy. *Singapore Med J.*, 43(3):152-5. https://pubmed.ncbi.nlm.nih.gov/12005343/

CHIRAPAQ. (2019). *Informe sobre maltrato y violencia contra las mujeres indígenas durante la atención de salud reproductiva, con enfoque a parto.* https://www.obstetricviolence-project.com/_files/ugd/f236ce_d878ecc195004b18b2456ef3ff5d5147.pdf

Ciotta, M. (2020). *Patient Education: From medical paternalism to patient-centred care*. Medium. https://medium.com/@mona.ciotta/patient-education-from-medical-paternalism-to-patient-centred-care-d51533bfcd29

Favre, L. (2022). South American legislation against obstetric violence: results from early mobilization. *Institut Du Genre En Géopolitique*. https://igg-geo.org/?p=1648&lang=en#f+1648+3+6

Gleason, E., Molina, B., López, J., & Mejía, C. (2021). "Parir no es un asunto de etnia, es un asunto de humanidad": experiencias frente a la violencia obstétrica durante la atención al parto en mujeres indígenas. *Salud Colectiva*, 17, e3727. https://doi.org/10.18294/sc.2021.3727

Kaother, D. (2022). *Obstetric Violence in International Human Rights Law.* https://www.humanrightspulse.com/mastercontentblog/obstetric-violence-in-international-human-rights-law?format=amp

Lynøe, N., Engström, I., & Juth, N. (2021). How to reveal disguised paternalism: version 2.0. *BMC Medical Ethics*, 22(1). https://doi.org/10.1186/s12910-021-00739-8

Ogando, B. & García, C. (2006). Veinticinco siglos de paternalismo, 25 años de autonomía: una aproximación histórica a los cambios en la relación clínica. *Revista De Calidad Asistencial,* 21(3), 164-169. https://www.elsevier.es/es-revista-revista-calidad-asistencial-256-articulo-veinticinco-siglos-paternalismo-25-anos-13089606

Pasinato, W., & De Ávila, T. T. (2022). Criminalization of femicide in Latin America: Challenges of legal conceptualization. Current Sociology, 71(1), 60–77. https://doi.org/10.1177/00113921221090252

Pasinato, W., & De Ávila, T. T. (2022). Criminalization of femicide in Latin America: Challenges of legal conceptualization. Current Sociology, 71(1), 60–77. https://doi.org/10.1177/00113921221090252

Patrick, L., & Jackson, L. E. (2021). The role of nurses in recognising and responding to violence against women. Journal of Clinical Nursing. https://doi.org/10.1111/jocn.16147

Rangel, Y. & Martínez, A. (2017). Ausencia de percepción de violencia obstétrica en mujeres indígenas del centro norte de México Revista CONAMED, 22(4), 166-169. https://www.medigraphic.com/pdfs/conamed/con-2017/con174c.pdf

Rangel, Y., Martínez, A., Hernández, L., & González, C. (2019). Construcción social de la violencia obstétrica en mujeres Tének y Náhuatl de México. Revista Da Escola De Enfermagem Da Usp, 53. https://doi.org/10.1590/s1980-220x2018028603464

Sadler, M., Santos, M., Ruiz-Berdún, D., Rojas, G. M., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reproductive Health Matters, 24(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

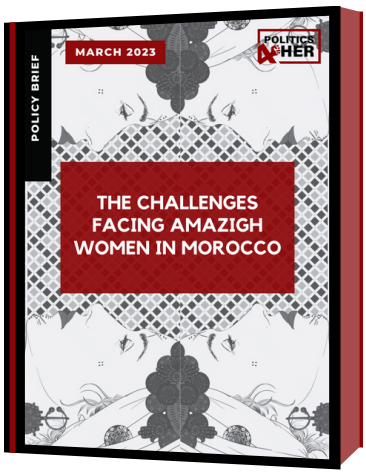
Shah, P., Thornton, I., Turrin, D. & Hipsking, J. E. (2022). Informed Consent. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK430827/

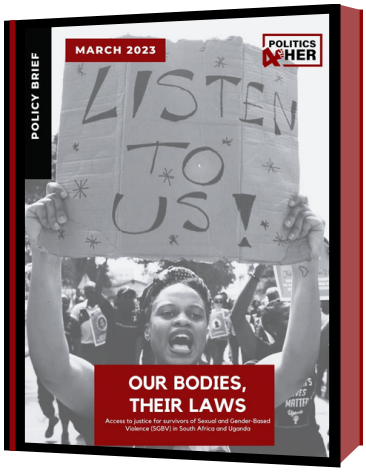
Shaw, M. N. (2008). International Law. (6th ed.). Cambridge University Press.

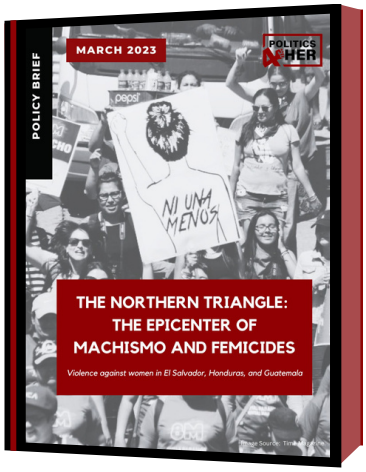
Šimonović, D. (2019). Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. United Nations. https://www.ohchr.org/en/calls-for-input/report-human-rights-based-approach-mistreatment-and-obstetric-violence-during

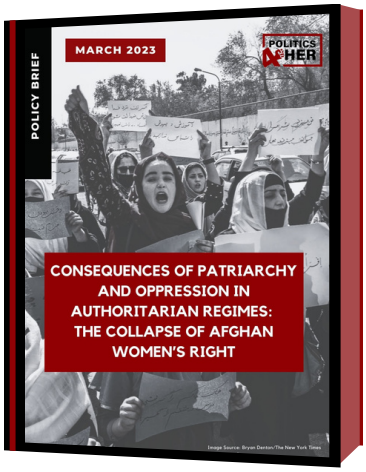
Williams, C. R., Jerez, C., Klein, K. O., Correa, M., Belizán, J. M., & Cormick, G. (2018b). Obstetric violence: a Latin American legal response to mistreatment during childbirth. Bjog: An International Journal of Obstetrics and Gynaecology, 125(10), 1208–1211. https://doi.org/10.1111/1471-0528.15270

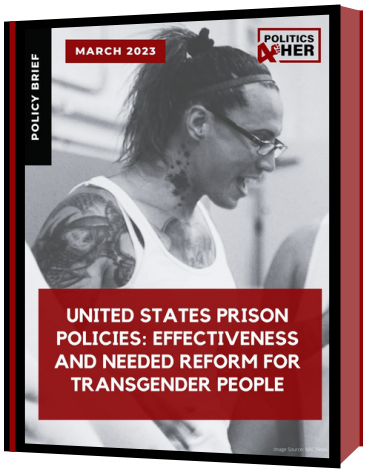
OUR OTHER POLICY BRIEFS











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