CLINICAL ARTICLE

Components of obstetric violence in health facilities in Quito, Ecuador: A descriptive study on information, accompaniment, and position during childbirth

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Keywords

Accompaniment; Childbirth experiences; Disrespect and abuse in childbirth; Information; Mistreatment; Obstetric violence; Position during childbirth

Synopsis

Obstetric violence is present in the selected public health facilities in Quito, Ecuador, for the tree components addressed: information; accompaniment; and position during childbirth.

ABSTRACT

Objective: To describe three factors of obstetric violence in health centers that attend births in Quito, Ecuador: information; accompaniment; and free position.

Method: A cross-sectional descriptive study of 388 women was conducted, focusing on the analysis of three factors of obstetric violence. This study forms part of a larger study that explores the experiences of women in childbirth in Quito between July 1, 2016 and July 1, 2017.

Results: Of all procedures, the performance of episiotomies and the application of fundal pressure during the second stage of labor (Kristeller) stand out, as more than 35% of the

women were not informed about them. In total, 121 (46.9%) women who gave birth vaginally were not given the opportunity to be accompanied by someone of their choice, neither in labor nor during delivery. While in the cases of cesarean deliveries, this increased to 116 (92.1%) women. A total of 119 (37.2%) women did not have the opportunity to choose their birthing position (or they did not know they could choose). During delivery, 138 (53.5%) women indicated the same.
Conclusion: Obstetric violence is seen in all three components: information; accompaniment; and free position.

1 INTRODUCTION

WHO [1] denounces that all over the world “many women suffer disrespectful and offensive treatment during childbirth in health centers, which not only violates women's rights to respectful care, but also threatens their rights to life, health, and physical integrity.”

Obstetric violence, a specific type of violation of women’s rights, includes the right to equality, freedom, information, integrity, health, and reproductive autonomy. In 2007, obstetric violence was defined in legislation for the first time in Latin America, in Venezuela [2]. Shortly before that, in 2006, a law addressing Accompaniment during Labor, Birth and Postpartum was published in Puerto Rico [3].
In Ecuador, the latest definition of obstetric violence has been extended to include the concept of “gynecological-obstetric violence” [4, 5]. It includes: abuse; imposing cultural practices and non-consented scientific procedures; violation of professional secrecy; improper medicalization; inconsideration for natural processes of pregnancy, childbirth, and postpartum; forced sterilization; loss of autonomy and women’s incapacity to freely decide over their body and their sexuality; all of which can have a negative impact on women’s quality of life, especially in regards to their sexual and reproductive health.
The guidelines intended to assure the quality of maternal and neonatal care are laid out by the Ministry of Public Health [6, 7]. Although they aim at ensuring high quality care that is respectful of women’s rights, this is not always the case.

In this context, the objective of this study is to describe the level of obstetric violence in public health facilities in Quito, for the following three components: (1) the information provided to the mother; (2) the accompaniment of the mother; and (3) the positions during childbirth.

In Ecuador, patients have the right to be informed about the care they receive, as well as the right to make decisions about the procedures they are about to undergo [8]. Maternal care is not an exception. For women to be able to make informed decisions, they must become the main focus of maternity care [9].

Indicators of the International Federation of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), the White Ribbon Alliance (WRA), the International Pediatrics Association (IPA), and WHO mention the use of informative material and community engagement to protect the right to be informed, as feasible interventions for low- and high-resource countries alike [10].

Access to information is an important issue for women. In a qualitative study [11], a large group of women were asked what they believed could have prevented or diminished their traumatic experiences during childbirth. Good communication with health personnel to make informed decisions and feel empowered is essential.

This article describes the information that women received during the application of one or more of the following seven medical procedures: Kristeller (fundal pressure in the second stage of labor); episiotomy; shaving (pubic hair); enema; amniotomy (artificial rupture of membranes); use of forceps; and tubal ligation. As specified by multiple clinical guidelines, as well as by both state institutions and global organizations, most of these procedures are not recommended medical practices [1, 2]. The application of forceps should only be practiced during certain situations following specific indications [4, 11]. In the case of ligature, the lack of information is a violation of women's sexual and reproductive rights [12].

The right to accompaniment and support during childbirth was also examined. As described in a systematic qualitative review [13], it is important for women to feel supported in a caring environment during childbirth. The present study shows that most women hope to have an experience of labor and delivery that allows them to be “in a psychologically safe

environment with continuity of practical support and the emotional support of a birth partner" [14]. They attribute the lack of practical and emotional support as one of the main causes of trauma during childbirth.

FIGO and its global partners (IPA, ICM, WRA, WHO) consider accompaniment such an important issue that they started the Mother and Baby Friendly initiative Birth Facility (MBFBF) [15], an organization that provides mothers with information and options and that is dedicated to diminish disrespectful/abusive care during childbirth in facilities (DACF), and – more recently – the International Childbirth Initiative, a global initiative to provide guidance and support for safe and respectful maternity care [16]. One of the criteria used by FIGO to determine whether an establishment qualifies as friendly, is for a mother to be able to choose one or more companions during childbirth.

Hollander et al. [10] define the choice of the companion for childbirth as "allowing all women who give birth to have the comfort of at least one person of their choice (for example, father, partner, family member, friend and traditional midwife) to accompany them throughout the birth."

The third and last component is the choice of position during labor and delivery. The positions to choose from may include semi-sitting, left lateral decubitus, lithotomy, and supported on all fours. A systematic review [17] that includes 25 trials (5218 women) and that evaluates the effects of stimulating women in the second period of delivery to assume positions other than lithotomy, including walking, sitting, standing, and kneeling versus supine and semi-recumbent, shows that women in low-risk labor benefit from being informed of different positions during birth.

Evidence indicates that mobility, walking, and vertical positions in labor reduce its duration and lowers the risk of cesarean delivery and medicalization, such as epidural requirements for pain. The right to move freely can possibly decrease medical interventions, as it is not proven to increase them [18].

The vertical position in relation to the horizontal position during delivery decreases the expulsive period, with a considerably greater efficiency in the intensity and strength of the

uterine contraction, which are more effective in the vertical position, with a decrease in the perception of pain [19]. If a woman is forced to adopt a horizontal position, she is put at greater risk of an aorto-cava compression which worsens oxygenation during the expulsive phase. Such positions may also cause a decrease in the anterior and posterior pelvic diameters [18]. Free position is recommended both during labor and delivery, in pregnancies considered to be normal and free of complications.

The aim of the present study was to describe the level of obstetric violence concerning the three components: (1) the information provided to the mother; (2) the accompaniment of the mother; and (3) the positions during childbirth.

2 METHODS

The present study is part of a larger one, in which several criteria of obstetric violence were identified. The larger study investigates the postpartum experiences of women from units of the Ministry of Health of Ecuador, between the years 2016 and 2017, using a descriptive cross-sectional design with a quantitative and qualitative approach [20].

The study is based on a questionnaire that was designed and reviewed by national and international experts [21–23]. It consists of 32 questions, divided into six sections of obstetric violence, and one section on the knowledge and perception of it: (1) Non-consensual care; (2) Physical violence; (3) Information; (4) Psychological Violence; (5) Negligent Care; (6) Confidentiality and Discrimination; and (7) Perception of Obstetric Violence. This instrument was developed based on earlier research, initially inspired by the Bowser and Hill classification [24].

Out of 17 126 women who gave birth at institutions belonging to the public sector, a sample of 388 women was taken into consideration for the study. The sample was gathered taking into account an error of 0.05%, a confidence level of 95%, and expected prevalence of obstetric violence of 50%. All of the participants were interviewed in care centers provided by the Ministry of Health. The women were randomly selected using a stratified approach that is proportional to the number of deliveries in each of the institutions (health centers, maternity wards, and hospitals).

Woman were selected for the study only if they were in the postpartum period, 1 hour to 1 month after a low-risk delivery, and if their child's birth took place in one of the health units included in the study. Not included in the study were women in postpartum with signs of depression, mental disability, and/or cases of fetal death due to ethical issues. With the aim of describing obstetric violence in deliveries without complications, complicated ones were excluded from the study.

It cannot be ruled out that exclusion bias might play a role in this study. Women with negative experiences during childbirth might be less, or more, inclined to participate. Another possible source of bias relates to privacy. Though efforts were made to provide privacy to the women, the fact that the interviews were conducted in the same establishment where the participants gave birth might have influenced the freedom they felt to speak.

The study was conducted in 13 delivery units of the Ministry of Public Health (MSP) within the Metropolitan District of Quito-Ecuador, covering all the different levels of health care (health centers, hospitals, maternity hospitals).

The researchers were trained to conduct all the interviews themselves. The mothers decided to participate freely after an explanation of the study and signed an informed consent form. Data collection was done individually, with consideration for the privacy of the mothers. The study was approved by the Ethics Committee of Health Ministry from Quito, Ecuador.

SPSS version 24 was used for statistical analysis. The results were obtained using a descriptive approach and the frequency and percentage of women exposed to the established domains of violence were calculated and presented in charts. The present study does not intend to make any inference regarding the population under study.

3 RESULTS

The ages of the women who participated in the study were in the range of: 18–20 years (13.6%); 20–29 years (61.3%); and up to 30–39 years of age (24.9%). Regarding ethnicity, 331 (97.9%) define themselves as mestizo, 25 (6.4%) as indigenous, 8 (2.1%) as black, 8 (2.1%) as white, 8 (2.1%) as mulatto and 3 (0.8%) as montubia.

With respect to level of education, 239 (61.6%) of the women surveyed indicate completing middle school, 76 (19.6%) completed higher education, 70 (18%) elementary school, and 3 (0.8%) did not complete any studies.

1. Information for the mother

Table 1 presents the procedures that were performed, the information related to these procedures, and the information provided by the health personnel, according to the mother. The results show that for each one of the procedures carried out in different health units, the mothers were not provided with enough information.

Where episiotomy and Kristeller are concerned, more than one-third of the women indicated that information was not given to them before the procedure was performed. These data have already been explored in an earlier paper, when describing the omission of the right to information [20].

In regards to shaving of genitals and enema (both procedures not recommended by WHO) [25], users were denied information about the procedure performed in more than half of the cases. The situation is similar for premature rupture of membranes and use of forceps.

As for tubal ligation, an irreversible procedure of female sterilization, it was found that within the total valid data, 2 (5.3%) women of the 39 (49.4%) were not informed about the procedure beforehand.

2. Accompaniment for the mother

Table 2 presents the results of accompaniment in labor. Of the 360 women who responded, 254 (70.6%) women indicated that they had a vaginal delivery and 106 (29.4%) women indicated that they had a cesarean delivery.

In the case of vaginal delivery, 119 (46.9%) women indicated that the health personnel did not allow them to be accompanied. In the case of caesarean delivery, 90 (84.9%) women indicated that accompaniment was not allowed during labor before the surgical intervention.

Table 3 presents the results for allowing accompaniment during vaginal/cesarean delivery. In the case of vaginal delivery, 121 (46.9%) women indicated that the health personnel did not allow them to be accompanied. In the case of caesarean delivery, 116 (92.1%) women indicated that it was not allowed.

Table 4 presents the results for allowed accompaniment during the immediate postpartum period. In the case of vaginal delivery, 17 (6.6%) women indicated that the health personnel did not allow them to be accompanied during the immediate postpartum at any time. In the case of cesarean delivery, 11 (8.8%) women indicated that it was not allowed.

While the majority of women indicated that they were allowed to be accompanied in the immediate postpartum period, this was only permitted during the visiting hours.

3. Position during childbirth

Of the 388 women surveyed, 320 (82.5%) indicated they went through labor (Table 5). Of these women, 119 (37.2%) could not choose the position they wanted or did not know they could choose during labor.

When asking the same question about the childbirth phase, it was not possible for 138 (53.5%) women to choose the position they wanted or they did not know they could choose a position (Table 6).

4 DISCUSSION

1. Information for the mother

The Ministry of Public Health in Ecuador defines receiving information as a patient's right during the various stages of health care [8]. It is further specified that this right refers to “the information concerning the diagnosis of their health status, the prognosis, the treatment, the risks to which they are medically exposed, the probable length of incapacitation and the alternatives for care and existing treatments, in terms that the patient can reasonably

understand and be enabled to make a decision on the procedure to be followed." However, in practice, women do not always get the information they need to make an informed decision.

2. Accompaniment for the mother

When the focus is on women who give birth by cesarean delivery, it is seen that almost none were given the opportunity to be accompanied by someone of their choice.

In postpartum, the scenario changes, in the sense that almost all women (regardless of the type of delivery) were allowed to be accompanied, with the only restriction being that accompaniment is allowed only during visiting hours.

This result suggests that there is room for significant improvement.

3. The position of childbirth

Even though it is recommended by the WHO to encourage the adoption of mobility during labor in women at low risk, the majority of women who give birth are not offered the opportunity to freely choose a position [25]. Providing freedom of position has a positive influence on neonatal and gynecological obstetric components [17, 18].

There are limitations to this study. First, the type of establishments included represent only the three levels of health care of the units in the Ministry of Health. Other establishments of the public health system will be included in a later investigation. A second limitation refers to the fact that obstetric violence is only analyzed in births that are deemed uncomplicated and low-risk.

In conclusion, obstetric violence is present in public healthcare facilities in Quito that provide pregnancy, delivery, and postpartum care, within the three components that were taken into account: information; accompaniment; and position during childbirth.

Author contributions

TB conducted the investigation and contributed to the conception and design of the study, data collection, and writing and revising the manuscript. MM and SC contributed to the conception design of the study, data collection, and writing and revising the manuscript. KF contributed to the conception and design of the study, data collection, and revising the manuscript. AG contributed to data analysis and writing the manuscript.

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Conflicts of interest

The authors have no conflicts of interest

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Table 1. Procedures performed and information given about them (n=358).[a]

	Procedure performed	Informed about the performed procedure		
		No	**Yes**	Total [b]
				Frequency
Episiotomy	94 (72.3)	32 (34.0)	61 (64.9)	93
Kristeller	46 (56.8)	20 (40.8)	29 (59.2)	49
Shaving	46 (55.4)	31 (67.4)	15 (32.6)	46
Enema	14 (24.1)	8 (57.1)	5 (35.7)	13
Premature rupture of membranes	117 (81.8)	46 (39.3)	70 (59.8)	116
Forceps	3 (6.7)	2 (66.7)	1 (33.3)	3
Tubal ligation	38 (49.4)	2 (5.3)	36 (94.7)	38

[a] Values are given as number (percentage).

[b] Valid totals: some mothers had a procedure but do not remember if they were informed or not; therefore, the information totals are not equal to the total of procedures performed.

Table 2. Permission for accompaniment during labor (n=360).[a]

		Did the health staff allow you to be accompanied by one or more people of your choice during labor?		
		No	Yes	Total
Your baby was born by:	Vaginal delivery	119 (46.9)	135 (53.1)	254
	Cesarean delivery	90 (84.9)	16 (15.1)	106
Total		209 (58.1)	151 (41.9)	360

[a] Values are given as number (percentage).

Table 3. Permission for accompaniment during vaginal/cesarean delivery (n=384).

		Did the health staff allow you to be accompanied by one or more people of your choice during delivery / cesarean section?		
		No	Yes	Total
Your baby was born by:	Vaginal delivery	121 (46.9)	137 (53.1)	258
	Cesarean delivery	116 (92.1)	10 (7.9)	126
Total		237 (61.7)	147 (38.3)	384

[a] Values are given as number (percentage).

Table 4. Permission for accompaniment during the immediate postpartum period (n=384).[a]

		Did the health staff allow you to be accompanied by one or more persons of your choice during immediate postpartum (24 h after delivery)?			Total
		No	Only during visiting hours	Yes	
Your baby was born by:	Vaginal delivery	17 (6.6)	204 (78.8)	38 (14.7)	259
	Cesarean delivery	11 (8.8)	100 (80.0)	14 (11.2)	125
Total		28 (7.3)	304 (79.2)	52 (13.5)	384

[a] Values are given as number (percentage).

Table 5. Free position, with and without labor (n=388).

		Did the health staff allow you to freely choose a position?			Total
		No	I did not know I could choose	Yes	
Were you in labor?	Yes, with labor	100 (25.8)	19 (4.9)	201 (51.8)	320 (82.5)
	No, without labor				68 (17.5)
	Total labor				388 (100.0)
Your baby was born by:	Vaginal delivery	102 (26.3)	36 (9.3)	258 (66.5)	258 (66.5)
	Cesarean delivery				130 (33.5)
	Total birth				388 (100.0)

[a] Values are given as number (percentage).

Table 6. Free position during childbirth (n=258).[a]

			Percentage valid
Valid	No	102 (26.3)	39.5
	I did not know I could choose	36 (9.3)	14.0
	Yes	120 (30.9)	46.5
	Total	258 (66.5)	100.0
Caesarean delivery		130 (3.5)	
Total		388 (100.0)	

[a] Values are given as number (percentage).