EDITORIAL

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Violence against women in the obstetric care setting

Violencia contra la mujer en el entorno de la atención obstétrica

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Violence against women has historically occurred at all times and in all societies and has been the result of the existing imbalance of power between men and women to the detriment of the latter.

According to the Convention of Belem do Para, violence against women should be understood as any action or conduct, based on gender, that causes death or physical, sexual, or psychological harm or suffering to women, whether in the public or private sphere[(1)]. According to this definition, violence can be physical, psychological, sexual, and economic; although in recent years there has been talk of 'obstetric violence', which we prefer to call in accordance with the title of this Editorial.

The medical profession has not been indifferent to this social problem affecting Peruvian women. Thus, in 1999, the Peruvian Medical Association (CMP, by its Spanish acronym) created the High-Level Commission on Reproductive Health, one of the main lines of work of which is the protection of women from gender violence. In 2002, the Peruvian Society of Obstetrics and Gynecology (SPOG, by its Spanish acronym) signed the "Declaration of Santa Cruz", one of whose points is to defend the right of women to exercise their sexuality without violence; and in the same year, SPOG created the Committee on Sexual and Reproductive Rights. In 2003, SPOG together with Latin American Federation of Obstetrics and Gynecology societies (FLASOG, by its Spanish acronym) held a National Workshop on Gender Violence, attended by professionals from other Latin American countries[(2)]. Since then, SPOG and the CMP have developed events among physicians and other professionals to disseminate women's right to sexual and reproductive health and to protect them from gender violence.

The different nomenclature that we allow ourselves to propose has been motivated by the reading of the document on 'Obstetric Violence in Peru' published by the Ombudsman's Office (DdelP, by its Spanish acronym) in 2020[(3)] and the recent Congressional Bill 3564/2022-CR which aims to incorporate section 121-C in the Penal Code, punishing the crime of obstetric violence.

In Peru, the Ministry of Women and Vulnerable Populations (MIMP, by its Spanish acronym) has defined 'obstetric violence' as a manifestation of violence against women, and that "It includes all acts of violence by health personnel in relation to reproductive processes and is expressed in a dehumanizing treatment, abuse of medicalization and pathologization of natural processes, which negatively impacts the quality of life of women"[(4)].

The WHO has declared that all women have the right to receive the highest standard of health care, which includes the right to dignified and respect-

ful care during pregnancy and childbirth, and the right to be free from violence and discrimination. It also recognizes that many women suffer or have suffered violence in health facilities during childbirth, which is expressed, among others, through the following manifestations: disrespectful, offensive or humiliating treatment, physical or verbal abuse, medical procedures without informed consent, incomplete or coercively obtained consent, sterilization without their consent, refusal to administer analgesics, flagrant violations of privacy, refusal of admission to health facilities, neglect of women during childbirth, retention of women and newborns in health facilities due to their inability to pay[5].

However, the same DdelP publication[3] referred to above tells us that the international instruments of the universal and inter-American system for the protection of human rights have not explicitly recognized obstetric violence. Only Argentina, Suriname, and Venezuela, as well as some Mexican states, have reported that they typify obstetric violence. Similarly, the Peruvian Ministry of Health (MINSA, by its Spanish acronym) does not identify obstetric violence[4]. Nor is there any information on the frequency of obstetric violence. Only in a survey published by the Grupo de Información en Reproducción Elegida (GIRE) in Mexico, 33.4 % of 8.7 million women surveyed who had a delivery between 2011 and 2016 reported expressions or manifestations of mistreatment by those who attended them at their delivery[6].

The DdelP document[3] advises that 11 key informants were consulted about the following expressions of obstetric violence: vaginal touch without consent, vaginal touch without reasonable justification, symphysiotomy, excessive medicalization during delivery, inadequate obtaining of informed consent, excessive use of cesarean delivery, unnecessary or non-consensual use of episiotomy by the woman, excessive use of synthetic oxytocin, use of the Kristeller maneuver, presence of third parties outside the delivery without the mother's consent, excessive suturing for reasons unrelated to the patient's health, impossibility of choosing the delivery position, reproduction of humiliating and sexist expressions during delivery, use of enemas to induce labor, pubic or perineal shaving before delivery.

Likewise, the WHO[5] has established that the following actions are necessary for adequate delivery care in health facilities:

- Conduct research and action on abuse and disrespect.
- Design and strengthen programs to improve the quality of maternal health care, focusing on respectful care as an essential component of quality care.
- Emphasize to health personnel the need to respect women's right to receive dignified and respectful health care during pregnancy and childbirth.
- Generate data related to respectful and disrespectful care practices, accountability systems, and valuable professional support.
- Engage women and other key stakeholders in efforts to improve quality of care and eliminate offensive and disrespectful practices.

The Inter-American Court of Human Rights[7] says that obstetric violence can occur in the pre-pregnancy stage, during pregnancy, during delivery and postpartum that causes women physical, psychological and/or moral harm; the manifestations of this harm are:

- Dehumanized treatment: leaving women in labor waiting for a long time, immobilization of the body, deliveries without anesthesia.
- Abuse of medication and pathologization of physiological processes, invasive practices.
- Psychological mistreatment: mockery, humiliation, omission of information, infantilization.
- Non-urgent procedures performed without women's consent: sterilizations, excessive sutures.

As we have been developing the definitions and expressions of so-called "obstetric violence", the origin of these is attributed to health workers; but, without ignoring that there is something of that, the problem deserves a holistic and systemic analysis, since the care of pregnancy, childbirth and puerperium is linked to the partic-

ipation of the state, the community, the family, health workers and the woman herself.

Structural problems can be observed in the participation of the State: deficient interaction of the health system, lack and deficient infrastructure and equipment, deficiencies in medicines, deficient transportation, poor working conditions of many health professionals, excess of men in gynecological and obstetric care, insufficient budget for sexual and reproductive health care, lack of training of health workers in medical ethics and patients' human rights, insufficient health personnel and the large number of patients, low salaries, long working hours, and lack of support and supervision of health professionals in complying with current regulations[8,9].

Community participation should be based on comprehensive sex education from the basic education years, the training of health professionals with a focus on rights, ethical and bioethical bases, and a gender and intercultural approach at both the undergraduate and postgraduate levels, overcoming stereotypes based on religious, social and cultural convictions about women's sexuality, pregnancy and motherhood (an example of this is the belief that childbirth is an event that requires women to suffer)[8]. Universities should also encourage research on sexual and reproductive health, with special emphasis on the issue of gender-based violence.

The family should participate in the support required by the pregnant woman, accompanying her during pregnancy, childbirth and postpartum.

Health care workers should participate in care that is respectful of women's rights, with a gender and intercultural approach, with truthful information, compliance with current regulations, scrupulous respect for the right to informed consent, which is nothing more than respect for the freedom to decide and produce research on the subject.

Regarding the expressions of 'obstetric violence' mentioned in the different publications, we would like to comment briefly on the following:

It is not easy to qualify the humanization of childbirth, since there are subjective conceptions involved. Likewise, it is not easy to define what we mean by overmedicalization, inadequate medical or surgical procedures. We can understand the excess of cesarean section, but we must also understand that the most recent technology reveals evidence that is not clinically detected and that forces an intervention, and on the other hand nowadays many pregnant women freely request to terminate the pregnancy via cesarean section. The excess of pathologization is also difficult to define because, although childbirth is generally a normal biological process, it is also true that in obstetric care what starts as normal can suddenly turn into an emergency that needs to be resolved.

The need for and frequency of vaginal examination in a pregnant woman is regulated at the national level in the National Guidelines for Comprehensive Sexual and Reproductive Health Care of the Ministry of Health (MINSA) which are mandatory for public and private health care services[10]. Symphysiotomy is not used in Peru. The Kristeler maneuver is prohibited in our regulations. Informed consent is perfectly established in the General Health Law, in the National Guidelines and in the Code of Ethics and Deontology of the Peruvian Medical Association[10-12]. The need for an episiotomy is determined at the time of delivery and, obviously, the laboring woman will be informed, because otherwise a perineal tear may occur; this intervention is well regulated in the National Guidelines. The regulations in force establish that the laboring woman must be accompanied by the person of her choice; however, in most facilities it is difficult to comply with them due to infrastructure reasons. The position chosen by the woman for delivery is clearly established in the MINSA regulations, as well as the non-use of the evacuating enema or puboperineal shaving before delivery.

With this last comment we want to say that obstetric care has been correctly regulated at the different levels of the State and that what is really required is permanent supervision and monitoring. Complaints of an alleged expression of violence against women can be channeled through the health facilities themselves, through INDECOPI, SUSALUD, the Medical Association and the Judiciary itself. And therefore, it will not be necessary to have specific criminal legislation, because there is a risk of punitivism, which refers to the state discourse that justifies the intervention of criminal law to solve any social

problem through the application of an irrational and disproportionate punishment. Punitive populism' does not help to reduce impunity; on the contrary, it can generate processes of re-victimization. For this reason, it is important to insist that the establishment of criminal sanctions or the stiffening of penalties be the last option to address structural social problems such as those at the root of situations of obstetric violence. Punitive populism is "a phenomenon of social hysteria, which can result in the expansion and exaggeration of penalties in order to appear as an effective reaction of the State against crime [6].

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