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Obstetrical Violence: Women's Experience at the Maman Elisabeth Domitien University Hospital Centre

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Abstract

Introduction: Access to the best quality of obstetrical care sometimes conceals acts and behaviors that fail to respect women's physical, mental and social integrity. These negative experiences are referred to as obstetrical violence. The aim of this study is to contribute to improving the quality of maternal health care. **Patient and Method:** This was a cross-sectional study with a quantitative component carried out in the obstetrics and gynecology department of the Maman Elisabeth Domitien University Hospital from November 1 to 30, 2024. All women in childbed seen for postnatal consultations within 42 days of delivery were included. **Results:** We included 109 women. Age ranged from 16 to 44 years with a mean of 26.9 (±6.02). The majority of women were living in common-law unions with 79.8% and 57.8% of mothers having a secondary education level. More than half of the participants (52.9%) said that they had not been prepared for childbirth during prenatal follow-up and 44.0% had not freely chosen their path of delivery. The vaginal route was the most observed route of delivery (97.3%). Of all vaginal deliveries, episiotomy was performed in 21.7% and uterine revision in 66.0%. For episiotomies, 26.1% of women in childbed were informed about its performance and 87.0% had had a bad experience with this event. For women who had undergone a uterine revision, 52.9% had been informed of its performance and 77.1% had a bad experience with the event. Women in childbed had been victims of inappropriate acts and verbal aggression in 18.4% and 14.7% respectively. Of all the participants, 45.0% said they had experienced the birth episode badly. **Conclusion:** This

study has given us an idea of the subject. However, a large-scale study will enable us to understand the different facets of this subject.

Keywords

Obstetrical Violence, Women in Childbed, Bimbo

1. Introduction

Since the 2000s, the intensification of the medicalization of childbirth has been a major step forward for the health of women and children. This medicalization of pregnancy and childbirth has undeniably contributed to the significant decline in maternal and neonatal mortality rates worldwide. However, the improvement in these indicators, due in particular to better access to care and a better quality of care, hides acts and behaviours that do not respect women's physical, mental and social integrity, or even practices that are not justified from a medical point of view [1] [2]. There are many names attributed to these negative experiences [3]-[5]. Several researchers agree on the use of the concept of "obstetric violence" in order to make the structural dimension of this violence visible [6]. Although some researchers have contributed to clarifying the term "obstetric violence", this concept is less present in the scientific literature and its use is relatively uncommon in practice settings [3]. However, these experiences have negative consequences, whether on women or on newborn children, and constitute a violation of their fundamental rights [5]. Today, the World Health Organization (WHO) warns against violence against women during childbirth in health care facilities and denounces disrespectful and abusive treatment, *i.e.*, treatment that is not medically justified [4]-[6]. In the Central African Republic, no study on obstetrical violence has been conducted to date. The aim of our study was to contribute to the improvement of maternal health care in the CHUMED.

2. Methodology

This was a cross-sectional study with a qualitative component carried out at the Centre Hospitalier Universitaire Maman Elisabeth Domitien (CHUMED) in Bimbo between 1 and 30 November 2024. The CHUMED is located at the southern exit of the city of Bangui. He receives most of the patients from the commune of Bimbo, which is a semi-urban area. The population is very heterogeneous in terms of ethnicity, religion, and socio-economic level. All women who had given birth at the CHUMED maternity ward and who had come for postpartum follow-up or growth monitoring for the newborn within 42 days of delivery were included. The survey was comprehensive, with all women who met the selection criteria and were accepted included. Data were collected through a survey sheet that was designed, structured, and pre-tested for clarity, length, and apparent validity from a small group of ten women not included in

the study.

Data entry and analysis were carried out using Microsoft Excel (version 2016) and Epi-Info version 7.

Ethical consideration: We obtained the informed and signed consent of the participants before any interviews and the data was treated in strict compliance with confidentiality.

3. Results

A total of 109 postpartum girls were included in the study. Age ranged from 16 to 44 with a mean of 26.96 (±6.02). The majority of women were living under common law (79.8%), and many had reached the secondary level (57.8%), followed by the upper level at 29.4%.

1) Prenatal consultation: Several participants felt that the follow-up of ANCs was confidential (100%) and respectful (97.3%). Inappropriate payments were reported in 8.3%. 47.1% of them were prepared for childbirth and 56.0% freely chose their route of delivery.

2) Delivery: The vaginal route was the most observed route of delivery (97.3%). All caesarean sections were performed as an emergency. Episiotomy was performed in 21.7% and uterine revision in 66.0%. Most of them were uninformed about the performance of these acts. Their consents were not taken in 73.9% for episiotomy and 55.7% for uterine revision. In nearly 87.0%, the participants had a bad experience performing these medical procedures. For women who had undergone a uterine revision, 52.9% had been informed of its performance and 77.1% had had a bad experience of the event.

3) Inappropriate acts and words: Of parturients experienced inappropriate acts and negative words in 18.4 and 14.7% respectively. While 16.1% of parturients were forbidden to drink or eat during labour. Overall, 45.0% of these women had a bad experience of the birth episode.

The results of prenatal follow-up and delivery are summarized in Table 1 and Table 2. The various inappropriate acts and words suffered by women are described in Table 3.

Table 1. Distribution of women according to the follow-up of the prenatal consultation.

ANC follow-up	Frequency (n = 109)	Percent
ANC adequacy		
Follow-up deemed adequate	97	89.0
Follow-up deemed inadequate	12	11.0
Confidentiality of ANCs		
Confidential prenatal care	109	100
Respect for pregnant women		
Respectful prenatal care	106	97.3

Continued

Non-respectful prenatal care	3	2.7
Attentive staff		
Caring prenatal care	106	97.3
Uncaring prenatal care	3	2.7
Inappropriate payment during ANCs		
Yes	9	8.3
No	100	91.7
Preparation for childbirth		
Yes	52	47.7
No	57	52.3

Table 2. Distribution of women according to childbirth practices.

Childbirth	Frequency	Percent
Mode of delivery	**(n = 109)**	
Caesarean section	3	2.7
Vaginal delivery	106	97.3
If vaginal delivery	**(n = 106)**	
Episiotomy	23	21.7
Uterine revision	70	66.0
No intervention	13	12.3
If episiotomy	**(n = 23)**	
Woman informed about its realization		
Yes	6	26.1
No	17	73.9
Consenting woman		
Agreement given	5	21.7
Agreement not given	18	78.3
Episiotomy experience		
Episiotomy well lived	3	13.0
Episiotomy badly experienced	20	87.0
If Uterine revision (n = 70)		
Woman informed about its realization		
Yes	37	52.9
No	33	47.1
Consenting woman		
Agreement given	31	44.3

Continued

Agreement not given	39	55.7
Experience of uterine revision		
Uterine revision well lived	16	22.9
Uterine revision badly experienced	54	77.1

Table 3. Distribution of women according to the acts and behaviours during childbirth

Item	Frequency (n = 109)	Percent
Woman who has given their consent to perform a vaginal examination		
Agreement given	54	49.5
Agreement not given	55	50.6
Women's experiences with vaginal examination		
Vaginal examination well experienced	85	78.0
Vaginal examination	24	22.0
Prohibition of drinking or eating during work		
Yes	18	16.5
No	91	83.5
Authorizing the use of a companion		
Yes	58	53.2
No	51	46.8
Inappropriate acts on parturients		
Yes	20	18.4
No	89	81.6
Negative speech/speech towards parturients		
Yes	16	14.7
No	93	85.3
Felt women for the whole process of childbirth		
Childbirth well lived	60	55.1
Childbirth badly experienced	49	44.9

4. Discussion

Childbirth is an important experience in a woman's life and this experience can have positive and/or negative impacts depending on how it is experienced. Despite the fact that mothers' experience during childbirth is a social issue, generally in Africa, women's experience is not considered "important" [7]. It is recognized that a negative childbirth experience can have a negative impact on women's physical and sexual health and self-esteem, but it can also have a detrimental effect on the attachment bond between mother and child, as demonstrated by Chabbert's

study [8]. In addition, it is now recognized that a woman's positive experience of childbirth is a measure of the quality of care she receives during labor [7] [8]. Respectful attitudes and behaviors on the part of health care providers create a sense of trust and safety in parturients, which can contribute to better health outcomes.

Our work focused on women's experiences during childbirth in the context of identifying obstetric violence most commonly encountered by them. We noted that 44.9% of the mothers surveyed said they had had a bad experience with childbirth. Although the negative experience of childbirth is subjective in nature, we believe that the reasons why they describe their experience as "negative" may be related to obstetric violence. Indeed, obstetric violence occurs differently depending on the local, national and regional context. Nevertheless, the different definitions reveal certain common elements of analysis: lack of respect for privacy and modesty, lack of information, lack of consent of women, abusive acts, words or practices on women during pregnancy or at the time of childbirth [9] [10]. This high proportion of women who reported a negative experience during childbirth calls into question the quality of care provided at the CHUMED maternity unit. Maternity care involves providing personalised care based on respect, empathy and emotional support throughout labour. Measures must be taken to ensure that each mother receives high quality care during childbirth at the CHUMED maternity unit, including consideration of her specific needs. The introduction of coaching or clinical mentoring for the various care providers could help to achieve these outcomes.

In our series, the majority of women surveyed were cohabiting (79.8%) and had a low level of education (only 29.4% had a higher level of education). This may reflect the fact that these women were predominantly from disadvantaged backgrounds. As a result, financial autonomy, which increases the use of health services, is limited in our study. This finding is in line with those of several authors who have demonstrated the influence of socio-economic status on the birth experience [9] [11]. It should be noted that obstetric violence is both systemic and interpersonal violence and is therefore influenced by social power relations (age, class, race, gender, sexual orientation, etc.). An in-depth study would give a clearer picture of the extent of the problem in our context.

The main obstetric violence observed was related to: the organization of care, the attitude of care providers and the failure to take into account the consent of patients for the various medical procedures.

Regarding the organization of care, although almost all the participants had stated that the follow-up of ANCs was confidential and respectful, inappropriate actions and words were recorded. Thus, respectively 18.4 and 14.7% of the respondents felt that they had been subjected to inappropriate acts and negative words and 16.1% of them were forbidden to drink or eat during labour. Also, in 46.8% of cases, healthcare providers had not authorized the presence of a companion in the delivery room. These structural flaws do not allow for optimal health

care for women. At the CHUMED maternity unit, there is no delivery cubicle where an attendant can be present throughout labour. Even though national recommendations authorise the presence of an attendant in the delivery room, this organisational shortcoming is a flaw in its implementation. In this regard, Balde reveals that the multiple systemic flaws related to maltreatment at the time of childbirth, as well as the lack of equipment (separate rooms or curtains to allow for an area of intimacy), which occur repeatedly, tend to become invisible because they are thus normalized [12]. However, all of these weaknesses contribute to a significant shortfall in the provision of quality maternity care.

In childbirth, episiotomy and caesarean section are two examples of medical practices that are not always medically justified and/or performed with the free and informed consent of women. When justified, caesarean sections are effective in preventing maternal and neonatal morbidity and mortality. However, the practice is also associated with higher short- and long-term risks that may persist for several years after birth, affecting the health of the mother, child and subsequent pregnancies [13]-[16]. Episiotomy is one of the most commonly performed surgical procedures in the world, although no study has ever proven its effectiveness [15]. When performed systematically, some studies suggest that it leads to more perineal tears and complications [15]. Although the caesarean section rate in our series was relatively low at 2.7%, we found that episiotomy was performed in 21.7% of cases. This rate of episiotomy calls into question the practical threshold for this procedure recommended by the WHO, which is 10% [13]. Although there are different obstetric situations (occipito-sacral release, instrumental extraction, macrosomia, etc.) that vary the rate of episiotomy, it should be noted that there are inter-operator variations during delivery. All these differences could be attributed to the experience of the practitioners, as well as their adherence to clinical practice recommendations. One area for improvement could be personalised, anonymised feedback. In fact, the simple fact of giving each practitioner their episiotomy rate, which they could anonymously compare with that of their colleagues, would be enough to reduce the overall rate, as shown by a Danish study which found a 6.6% reduction in this rate among midwives after the introduction of this individual feedback [16].

One of the issues related to respect for women at the time of childbirth concerns obtaining free and informed consent. This means that: 1) the person must be informed; 2) they must be able to understand and receive information; and 3) it must express that it understands it [13]. Therefore, if consent is not respected, it is an infringement of the rights and integrity of the person [13] [14]. Consent is also specific and must be reiterated with each new treatment, routine or not. However, during this study, it appears that several medical procedures, such as vaginal examinations during childbirth, episiotomy or uterine revision were performed without obtaining the women's prior consent. This failure to take into account women's consent is often experienced as a loss of autonomy, control/power by women over the course of their childbirth. These results are consistent with the

study by Baker *et al.* [12] that show that women who have had no control or power over the situation are left with feelings of anger, disappointment, helplessness, distress and guilt, which is the case for the study participants. As a result, the "feeling of control felt by mothers during childbirth" can be considered an essential element of the positive childbirth experience, which is corroborated by various authors [15] [16].

In addition, the delivery room is an alienating environment for many women due to institutional routines such as systematic undressing on arrival, lack of privacy or stress about the outcome of labour. For these reasons, all parturients should benefit from ongoing emotional support throughout labour [17] [18]. Although we did not specifically explore this aspect in our work, we believe that the lack of this support may also be at the root of the high proportion of negative experiences found. The benefits of this emotional support during childbirth need no further demonstration. In particular, it reduces anxiety, increases self-esteem and reduces rates of postpartum traumatic stress [17] [18].

5. Conclusion

Although the study was short, it provided information on the extent of obstetric violence during childbirth in CHUMED. We found that a large proportion of participants had a poor experience of childbirth. This poor experience was associated with obstetric violence related to the organisation of care, the attitudes of care providers and, in some cases, the lack of informed consent. As the factors influencing the experience of childbirth are multifactorial, different strategies need to be developed to promote a positive experience of childbirth. These strategies should include not only better organisation of service provision, but also personalised monitoring of different providers in the maternity unit through feedback on performance indicators and clinical coaching or mentoring focused on good clinical practice during pregnancy and childbirth. In addition, a large-scale survey on perinatal care will provide a better understanding of the various facets of this issue.

Author Contributions

Songo-kette Gbekere Thibaut Clavaire and Doyama-woza Rodrigue Herman designed the study.

Doyama-woza Rodrigue Herman, Songo-kette Gbekere Thibaut Clavaire and Mbano-Dede Matike-Ayamboka Kely were involved in data collection and analysis.

All authors participated in proofreading the final version of the manuscript and contributed significantly to its content and to the management of the preparation of the manuscript. All authors read and approved the final version of the manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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