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Understanding Obstetric Violence as Violence against Mothers through the Lens of Matricentric Feminism

Obstetric violence—that is, the mistreatment or abuse of pregnant, birthing, or postpartum individuals by their maternity care providers, institutions, or systems—is a topic of growing concern around the globe among healthcare organizations, healthcare providers, birthing people, and advocates. As research and advocacy work has begun to denormalize and problematize obstetric violence, it has been framed as a distinct type of institutionalized gendered violence that violates the rights of women. This article approaches the topic of obstetric violence through the lens of matricentric feminism and theorizes how it constitutes not only violence against women (typically) but also violence against mothers. Using examples from my personal experience and recent project, I employ matricentric feminism to emphasize the unique discourses of good and bad motherhood that birthing people engage with and suggest that in the context of obstetric violence, motherhood can be weaponized to perpetuate the invisibility of and silence around this issue. I discuss the implications for an understanding of obstetric violence as violence against mothers, including how these implications may impact efforts to recognize and prevent obstetric violence.

Broadly speaking, obstetric violence refers to systemic violence that pregnant, birthing, and postpartum people may be subject to through interactions with their maternity health care providers, institutions, and systems. Obstetric violence has become a prominent concern for maternity health advocates, researchers, and birthing people only in recent years, but the field is rapidly growing to better understand and address it. In this article, through examples from my experience (italicized throughout the article) and recent projects, I explain how applying a frame of matricentric feminism problematizes efforts to address obstetric violence that derive from gendered violence and women's

rights paradigms. I discuss how through this frame, motherhood may be incidentally weaponized through discourses of good and bad motherhood to reinforce the barriers to recognizing and reporting obstetric violence.

I have birthed two children. During my first pregnancy, some of the first people to reference me by my newly acquired motherhood status were maternity care providers who I visited for prenatal care. These providers would make such comments as “how is mama doing today?” By virtue of the nearly microscopic fetus growing in my belly, I was no longer my named self; to my providers, I was “mama.” I was no longer recognized as my own individual person with her own rights and agency but as part of this dyad. It was no longer understood to be just me in my body.

I have since seen this sort of framing happen again and again to peers as well in subsequent research, advocacy, and committee work contexts: maternity care providers—including physicians, midwives, nurses, doulas, and lactation consultants—referring to a pregnant or postpartum person by their motherhood. This is not of course to say that all maternity care providers refer to their patients and clients this way, but in my experience, it is not uncommon. However, when motherhood is invoked in such a way, it engages certain cultural meanings of motherhood that create implications for those who are being labelled this way, particularly in the context of a complex phenomenon, such as obstetric violence.

Understanding and Theorizing Obstetric Violence

Over the course of my first birth, I experienced obstetric violence. The experience was surprising. Throughout my care experience, there were moments in which I was uncomfortable with some of the things that were happening, and increasingly throughout this process, I also felt as though the space for my agency was progressively shrinking. Once I was in labour and in the context of the hospital, the tone of the place and the interactions I had with staff—from the admitting clerk and porter who adamantly refused to allow me to walk to the labour and delivery unit and to the providers who attended me there—made me feel as though my agency was increasingly unwelcome, and my own willingness or ability to exercise it slowly wore down.

Obstetric violence is a topic of growing concern around the globe. Sometimes referred to as “mistreatment” or “disrespect and abuse” in childbirth (Diniz et al.), for the purpose of this article, I refer to these various terms under the umbrella term “obstetric violence.” In 2014, the World Health Organization (WHO) released a statement on preventing and eliminating the mistreatment of women in childbirth, finding that it “not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination” (WHO 1). The statement points

to a growing and disturbing body of research on a worldwide problem that lists a range of reported types of mistreatment: physical and verbal abuse, humiliation, coercive or unconsented medical procedures, lack of confidentiality, failure to get fully informed consent, refusal to provide pain medication, gross violations of privacy, refusal of admission to health facilities, neglect of women during birth, and detention of women and infants in facilities after birth. In 2015, Meghan Bohren and colleagues published a typology of obstetric violence based on a meta-analysis of sixty-five studies from around the world that highlights specific acts that can be understood of as obstetric violence, ranging from micro-level provider interactions to macro-level incidents, such as systemic failures of obstetric healthcare facilities and/or systems. According to this typology, obstetric violence includes several categories of abuse: discrimination, lack of supportive care, neglect, denial of autonomy (such as medical procedures done in the absence of informed consent), and health system conditions and constraints. Together, the WHO statement and the typology by Bohren and her colleagues provide a robust range of incidents that fall under the umbrella of obstetric violence.

Little literature at this time tracks the prevalence of obstetric violence. In a very recent study on birthing people in the United States, Saraswathi Vedam and colleagues found that 17.3 percent of people surveyed reported experiencing one or more types of mistreatment. Based on the qualities of their sample, they suggest that an estimate of approximately 30 percent is likely more realistic for the general population (Vedam et al. 12). Another study focused on prevalence and based in Tanzania reveals that 15 percent of participants reported experiencing violence when they were asked three to six hours after birth while they were still in hospital; however, 70 percent of participants described violence when interviewed in their homes up to six weeks postpartum, and 84 percent of participants experienced at least some form of violence when the violence was measured only by the observations of a researcher present for the birth (that is, not basing the measurement on reports from the birthing person) (Sando et al.). This research points to the significance of both the timing of inquiries to birthing people about their experience (with perceptions of their experience as violent increasing over time), as well as to whether a subjective or objective characterization of violence is used as the measurement. No comparable prevalence data exist for Canada (where the author has given birth); however, recent media stories indicate experiences and awareness of the problem. The Canadian Broadcasting Corporation (CBC) has recently reported that hundreds of women contacted the network to share their stories of violence in maternity care (Burns-Pieper; CBC News). Known harms to birthing people stemming from obstetric violence include posttraumatic stress disorder, fear of childbirth, reluctance to seek healthcare, distrust between communities and health facilities, and, as a result, increased

maternal and perinatal mortality (Beck; Beck et al; Creedy et al.; Fawcus; Fernández; Forssén).

Lynn Freedman and Margaret Kruk argue that obstetric violence may be rendered invisible through its normalization by care providers and birthing people. Birth researcher Barbara Kitzinger has explained that birthing people who have had bad experiences in birth may be disinclined to report these events for a variety of reasons: in an effort to avoid thinking about them, if they suffer from feelings of guilt because they believe their reactions will not be validated or they feel they have no right to the emotions they have, or they think they must be “making a fuss about nothing ... silenced because their emotions are perceived as trivial” (Kitzinger 67). These works addressing the tendency of obstetric violence towards invisibility are especially important in light of the influence of discourses of good and bad motherhood discussed below.

Beyond the framework of obstetric violence as a violation of basic human rights, other scholars point to obstetric violence as “a systemic problem of institutionalized gender-based violence” (Diaz-Tello 56-57). Michelle Sadler and her colleagues argue that obstetric violence is not just violence against patients in healthcare contexts; rather, it is a type of gendered violence in which gender ideologies and the gendered nature of maternity care play a role. Through these respective frameworks of basic human rights and gendered violence, scholars demonstrate two (sometimes overlapping) approaches to problematizing obstetric violence.

Although obstetric violence continues to remain invisible in some contexts, certain states have deemed it such a significant issue as to create legislation in an effort to prevent it. Legislation passed by the government of Venezuela in 2007 regarding obstetric violence describes the phenomenon as

the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women. (qtd. in D’Gregorio 201)

Again, this law demonstrates the approach to obstetric violence as a violation of women’s rights and provides additional criteria that can be incorporated into a broad understanding of the phenomenon.

There is, of course, a long history of patriarchy’s impact on maternity care, including the medicalization of pregnancy and birth (Woliver; Zadorozny). In obstetric violence, birthing people (typically identified as women¹) are oppressed under the guise of patriarchy and structural gender inequality, which violates the rights of birthing people to autonomy and to respectful healthcare and so on. Here, however, the work falls short of recognizing the

role of motherhood as a construct and its role for understanding (and ultimately addressing) obstetric violence. By engaging the construct of motherhood as it directly speaks to the relationship between the birthing person and the infant, these incidents can be understood not just as acts of gender-based violence but as violence against mothers.

Obstetric Violence, Gender, and Motherhood

After the delivery, while I lay on an operating table in shock (not medical but psychological), my baby in the nursery being cared for by my partner, a physician repaired the birth injury I suffered during the delivery while a student she had called in to observe stared dutifully at my crotch. The physician explained to the student how to best sew “mom’s tissues” back together, and when they finished, they and the other healthcare professionals left, saying “Congratulations, mom.”

Both the WHO statement and Venezuela law cited above put forth a rights-based framework for interpreting obstetric violence, which emphasizes the breach of birthing people’s inherent rights to life, health, bodily integrity, and freedom from discrimination that occurs during obstetric violence. These texts (and the research and theorizing that have subsequently risen from them) drive forwards future research and advocacy work intended to address and prevent obstetric violence; however, this paradigm of obstetric violence as gendered violence neglects a significant theme that shapes discourse around birth: motherhood. This is the area where matricentric feminism reveals a significant gap present in much of the work on obstetric violence to date: how ideas and beliefs about motherhood affect our understandings of what obstetric violence is and who can (or should) complain about it. Andrea O’Reilly explains that matricentric feminism builds on a more general feminism but places its emphasis on the unique category of “mother”; it focuses on the unique issues that mothers face by virtue of their motherhood, which are distinct from the oppression and marginalization that all woman may experience. The concept of motherhood is complex with implications beyond pregnancy and birth, for the purpose of this paper the focus is largely on mother as a construct that understands birthing people in relation to the infant they have carried and given birth to.

Lindal Buchanan discusses the complex meanings that the idea of “mother” brings to any discourse as well as the complex conceptualization that understands “mother” and “woman” with distinct connotations. For example, she explains that in rhetoric, “woman” connotes self-centredness, immorality, hysteria, irrationality, extreme emotion, weakness, and self-indulgence, whereas “mother” connotes children, morality, and self-sacrifice. Individuals are placed on what Lindal calls the “woman/mother continuum,” which results

in different interpretations of them and their behaviour (7-9). Similarly, O'Reilly explains that her students generally describe mothers as “altruistic, patient, loving, selfless, devoted, nurturing, cheerful”; they “put needs of [their] children first” (12-13). Mothers do not have “a life before or outside of motherhood.” (13).

Other scholars reiterate that good mothers are selfless, place their children above themselves in all contexts, and also submit themselves to the instruction of experts relating to their motherhood. Susan Chase and Mary Rogers explain that a good mother “follows the advice of doctors and other experts” (30), whereas Jane Ussher specifies that “rigorous body management and adherence to medical discipline are the unquestioned tasks of the pregnant and birthing woman—failure to adhere to these practices positioned as negation of the needs of the unborn child, sign of a ‘bad mother’, [is] a position few women willingly adopt” (151). But if a good mother is selfless and obeys the advice of doctors, can a good mother have rights in obstetric care? If a woman exercises and fights for her rights to health and to her body, does that make her a lesser (or worse yet a ‘bad’) mother?

Approaching obstetric violence through matricentric feminism reveals that arguments problematizing obstetric violence which rely on the gendered violence/violation of birthing people’s rights frameworks may place victims of obstetric violence at odds with constructions of good (selfless) motherhood. Mothers may be framed as bad mothers if their complaints of obstetric violence frame them as insufficiently selfless or as putting their birth experience above the health of their baby. On top of that, if mothers are expected to follow experts’ instructions (in this case maternity care providers) in birth, their refusal to accept this treatment may similarly contradict this expectation of obedience.

The Woman-Mother Continuum in Obstetric Violence Media Coverage as Exemplifying Weaponized Motherhood

Even today what strikes me as one of the most interesting parts of my experience is how grateful I was to my providers immediately after the birth. I felt grateful towards the people who earlier in labour had seemed rushed and even sometimes annoyed at having to help me, despite my efforts to behave as a good patient would—to try and avoid taking too much of their time in light of their obviously heavy workload. I felt an overwhelming duty to thank them before they rushed off to other responsibilities. I wanted to thank the people who had grabbed me and shouted at me, and whose hands I had desperately attempted to push away.

In recent media coverage on obstetric violence, the tension between birthing people’s rights versus motherhood is on full display. In 2016, the CBC

produced a series of investigative news stories exploring women's complaints of obstetric violence (referred to as mistreatment in maternity care in the stories). Some of these stories were televised, and all of the coverage was made available online; viewers could post their comments to the stories posted on CBC's social media page (CBC News, "Untitled Facebook Post"). Whereas some of the posts empathized with the abusive experiences the interviewees were sharing, including many individuals who posted about their own violent and abusive maternity care experiences, other posts drew on the discourses of good and bad motherhood to criticize the interviewees who were telling their stories of mistreatment. One commenter described her own birth and the role of the maternity care provider's expertise to treat and reassure her, "and more importantly to deliver [her] baby safely" (CBC News, "Untitled Facebook Post")—a sentiment that subjugated her own experience and healthcare, and reinforced the selfless mother construct. Other comments placed the victims of obstetric violence in a different location on the women-mother continuum to negatively reflect on their complaints. One such comment began by stating "this article is about spoiled people for the most part" and drew on connotations of women as weak and self-indulgent in response to their complaints that they were mistreated by maternity care providers during childbirth (CBC News, "Untitled Facebook Post").

In another of the CBC reports, one interviewee discusses how her maternity care providers increasingly pressured her to consent to a procedure by telling her that she was harming her baby by refusing the procedure. In this example, the expectation that a mother be selfless is mobilized in order to pressure a patient into consenting to a procedure that they had initially refused (CBC News, "Diana Swain").

During a research project I recently completed, one doula explained to me that when a healthcare provider uses what she calls "the dead baby card" (the threat that whatever the birthing person was refusing to do would kill their baby), they are no longer providing information about risks and benefits of a given procedure; instead, the health of the baby is being used to guilt or scare an individual into compliance. In the case of obstetric violence, then, motherhood can be weaponized to exercise control and gain compliance of birthing individuals. The use of the labels "mom" and "mama" to describe and engage with pregnant, birthing, or postpartum women is one example of how motherhood may be invoked to reinforce the expectation of that these individuals should conform to the normative understandings of good and compliant motherhood.

The examples discussed above demonstrate how motherhood can be leveraged against individuals who disagree with care providers and those who publically decry the obstetric violence they are subjected to. If other birthing people have internalized these discourses of good and bad motherhood, they

may contribute to obstetric violence's tendency towards invisibility, wherein individuals do not recognize their treatment as obstetric violence, nor do not feel that they can express concerns about the treatment they have experienced without potentially subjecting themselves to the label of bad mother.

If motherhood is weaponized to silence and control women regarding maternity care and obstetric violence, and if researchers problematize obstetric violence by adopting paradigms that do not account for the complexity of motherhood, its relation to obstetric violence, and the barriers it may create to recognize and speak out against obstetric violence, what hope is there towards ending the violence?

Concluding Thoughts

Immediately after my obstetric violence experience, I did not characterize it as violent. In the immediate hours and days afterwards, I knew I was uncomfortable with some of the things that had happened, but ultimately I felt grateful that my child and I survived the experience. Over time, I came to reflect on the experience more critically, and I allowed myself to consider that I had suffered violence. I recognized that I had been treated badly and that the sort of treatment I had been subjected to should not have happened. And such feelings did not make me a bad mother or less grateful that my child and I had survived.

Matricentric feminism provides an opportunity to begin breaking down barriers towards recognizing and addressing obstetric violence; it helps to recognize that mothers face unique challenges and forms of oppression that have significant implications related to obstetric violence. In recognizing this, we may be able to deweaponize advocacy strategies and ensure that normative discourses of motherhood are not potentially restricting birthing people from fighting for their rights to prevent obstetric violence.

It is also important to note that the WHO recognizes that teens, unmarried people, people of low socioeconomic status, people from ethnic minorities, migrant people, and people living with HIV are particularly likely to experience disrespectful and abusive treatment, which highlights the intersectional nature of the oppression that birthing individuals may experience. There are numerous sources that highlight the complex intersectional oppression birthing people from specific types of marginalized groups experience (Bridge; Chadwick; Chalmers and Omer-Hashi; Smith-Oka; Vedam et al). Though not the focus of this article, the complexities of these intersectional forms of oppression are also important in shaping advocacy work done to prevent obstetric violence. Another important consideration to discuss is the binary gender construction that serves as the basis for much of the work on women and birth and women and motherhood. Although birth

may be normatively conceived as a woman's task and those individuals who give birth may be understood to be mothers, the reality, of course, is that individuals who do not identify as women give birth and those individuals who give birth may not come to identify as mothers. Such is the complexity of navigating childbirth as a space that all at once may defy and still be shaped by binary gender norms.

This article also does not suggest that obstetric violence begins and ends with the bad behaviour of a few healthcare providers. Sadler and her colleagues argue that understanding obstetric violence is not as simple as a "limited focus on victims (women) and victimisers (health professionals)" (51). They explain that broader factors, including socialization that normalizes types of violence and power inequalities between groups, must be considered as well as healthcare professional curriculum, in which "the acceptance of norms, corporate discipline and punishment plays a central role" (51). Moreover, the poor working conditions that many healthcare workers have to contend with and which influence incidents of violence must be addressed (51). Furthermore, Cheryl Beck and Robert Gable have shown that exposure to obstetric violence not only harms the birthing people who experience it directly but may also traumatize healthcare providers who have secondary exposure to it.

By using a critical framework informed by matricentric feminism, which incorporates the significance of motherhood as a unique intersection of oppression as well as a gendered and constructed experience, advocates and researchers can deweaponize efforts to address obstetric violence. This approach would permit birthing people the space to speak out against bad birth experiences and obstetric violence while circumventing the illusion of the good and selfless mother and the concomitant label of 'bad mother' for those who assert their own interests and agency.

Endnote

1. Although birthing people are typically identified as women, there are individuals who give birth but do not identify as women, for example trans people who become pregnant and give birth as well as nonbinary individuals. This article uses the language "birthing people" to recognize these individuals as well, and it builds on the idea that pregnancy and birth themselves are often understood as womanly, which render birthing people vulnerable to gender-based violence. Furthermore, research demonstrates that various social categories and other factors beyond gender (including race, age, and socioeconomic status) also influence individual risk for obstetric violence (Vedam et al.). These factors present an important avenue to understand how intersectional forms of oppression relate to obstetric violence; however, that level of analysis is beyond the scope of this article.

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