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ANALYSIS AND RECOMMENDATIONS FOR THE PREVENTION OF OBSTETRIC AGGRESSION

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Abstract: *The term obstetric aggression was proposed by renowned obstetrician-gynecologist, doctor of medical sciences and corresponding member of the Russian Academy of Sciences Viktor Radzinsky, who views obstetric aggression as iatrogenic, unreasonable actions aimed at supposed benefit but leading only to harm, including complications of pregnancy and childbirth, as well as increased perinatal, infant, maternal morbidity and mortality.*

Obstetric violence goes unrecognized and unreported, in part due to a lack of effective reporting procedures. Moreover, like other types of violence, it is an extremely sensitive subject that often evokes disturbing memories for those who have experienced or witnessed it. For this reason, many people are unwilling or unable to talk about their experiences.

To prevent harm to women and newborns resulting from excessive obstetric aggression, in 2018 the World Health Organization (WHO) published new recommendations for non-clinical interventions to reduce unnecessary caesarean sections.

Keywords: *midwife, prevention, aggression, birth, medical standard, best practices*

INTRODUCTION

Every woman has the right to the highest attainable standard of health, which includes the right to decent and respectable health care (WHO, 2016).

Many women around the world face disrespectful and negligent treatment during childbirth in medical facilities (Bohren, M., J. Vogel, E. Hunter, et al. 2015). This violates trust between mothers and health professionals, which is a deterrent for patients to seek and use maternal health services (Sripad, P., M. Merritt, D. Kerrigan, et al. 2022). Disrespectful treatment of women can be observed throughout pregnancy, childbirth and the postpartum period. Women are particularly vulnerable during childbirth. These practices can have direct adverse consequences for both the mother, the baby and the entire family.

Data on disrespectful treatment during childbirth in health facilities are:

- open physical violence;
- humiliation and verbal abuse;
- forced or uncoordinated medical procedures;
- lack of confidentiality;
- absence of informed consent;
- refusal to give analgesics;
- gross violation of privacy;
- denial of admission to health facilities;
- neglecting women during childbirth.

In addition to the data listed, adolescents, women of low socio-economic status, women from ethnic minorities, migrant women and those with HIV face disrespectful and abusive treatment (WHO, 2016).

EXPOSITION

The term obstetric aggression was proposed by the renowned obstetrician-gynecologist, doctor of medical sciences and corresponding member of the Russian Academy of Sciences Viktor Radzinskii, who viewed obstetric aggression as iatrogenic, unreasonable actions aimed at a perceived benefit but leading only to harm, including increased complications of pregnancy and childbirth, as well as increased perinatal, infant, maternal morbidity and mortality. It refers practices such as unwise emergency caesarean section, unwise initiation of labour, induction of labour and others to aggressive obstetrics. Thus, Radzinskii views obstetric aggression precisely as the medicalization of childbirth, i.e., excessive and unreasonable medical intervention in the physiological process (Radzinskii, V., 2011).

The UN Special Rapporteur has also written a report on obstetric violence. He summarizes a range of abuses, including the overuse of episiotomies and caesarean sections, the use of procedures without evidence, such as Kristeller (pressing the abdomen during labour), symphysiotomies (surgical pelvic dilation during labour), the unnecessary use of Oxytocin, and the conducting of second period labour (Wojcieszek, A., M. Bonet, A. Portela, et. al. 2023).

Veronika Nazarova, doctor and publisher of the famous French obstetrician-gynecologist Michel Audin explains that obstetric aggression is an intervention unjustified by the situation and medical needs, which leads to subsequent health complications. Women may consider disregarding their opinion as violence. It is quite common for a birth to have been successful but for the woman to remember it as something terrible - the injuries she received were not physical but emotional. The consequences can include depression, heart disease, family breakdown. Discussing obstetric violence can be challenging for maternity staff who may not admit that established practices that are embedded in the culture of maternity care can cause harm. Challenging these cultural norms can be difficult for the individual doctor or midwife. The staff in the delivery room need to be made aware of this issue, take responsibility for their own practice and be supported in this regard. Ignorance or lack of bad intentions can never be an excuse.

A French non-governmental organisation says: "In our view, the main problem underlying obstetric violence is the systematic deprivation of women's right to autonomy once they have come into contact with a health facility."

Many women from different parts of the world report practices of humiliation, verbal abuse and sexist remarks during childbirth that occur behind closed doors of health facilities. It is only recently that women have begun to speak out about being mocked, insulted and shouted at by health workers. In Honduras, women report comments such as "You didn't cry when you did it ..., Open your legs or your baby will die, and it will be your fault ...". Women of lower socioeconomic status described being humiliated by health workers because of their poverty, their inability to read and write, living in rural or poor areas, or women with neglected appearance (Kasaye, H., V. Scarf, A. Sheehy, et al. 2024).

In some Latin American countries, women's groups and non-professional organizations, international and regional bodies, as well as public health representatives and researchers are leading a movement to confront obstetric violence. The main objective is to improve the quality of care women receive during pregnancy, childbirth and the postpartum period. This new movement specifically situates "obstetric violence" at the crossroads of gender-based violence and clinical negligence and interweaves elements of respectful treatment and quality care (Leite, T., E. Marques, M. Mesenburg, 2023).

Argentina, Mexico, Panama, Suriname and Venezuela have passed laws criminalising obstetric violence (Williams, C. R., C. Jerez, K. Klein et al 2018).

In a small maternity hospital in Khakassia, a project is being implemented in the maternity hospital to make childbirth resemble home birth. The project is organised by a freelance

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employee at the maternity hospital who is a home midwife. The project, which is being implemented under the government's compulsory medical insurance programme, provides for individual monitoring during childbirth. Within the framework of this project, bathtubs have been installed in the hospital, and special psychophysical training courses for pregnant women have been launched. Doctors working on the project abolished the practice of obstetric interventions - manual manipulations performed during childbirth: control of the baby's head movement, head rotation, shoulder girdle release, etc.

The Ekaterinburg Perinatal Centre has developed its own clinical protocol that is evidence-based and follows WHO guidelines. Here, accompanied childbirth (presence of the child's father or another family member) and individual monitoring are offered for all patients under the state compulsory medical insurance program. The birth is carried out by a midwife, with one midwife working with a maximum of two women at a time (usually in maternity homes, the midwife works with all patients admitted and can attend 20 or more births in one 24-hour shift), and the doctor comes only when necessary. The introduction of checklists for medical manipulations led to a sharp reduction in the number of invasive procedures, routine amniotomy and episiotomy, and routine vaginal examinations were completely eliminated (FIGO, 2015).

States have an obligation to respect, protect and fulfil women's human rights, including the right to the highest attainable standard of physical and mental health during reproductive services and childbirth, free from abuse and violence, and to adopt appropriate laws and policies to combat and prevent such violence, prosecute perpetrators and provide redress and compensation.

Prevention of obstetric violence:

- ensuring women's right to a birth attendant of their choice in law and in practice;
- the possibility of allowing home birth and avoiding its criminalization;
- monitoring by health facilities and collecting and publishing data on rates of caesarean sections, vaginal deliveries and episiotomies, and other procedures related to childbirth, obstetric care and reproductive health services on an annual basis;
- active implementation of informed consent as a human rights instrument;
- lack of choice of position at birth and lack of respectful care must be changed;
- Establish human rights-based accountability mechanisms to provide redress to victims of abuse and violence, including financial compensation, acknowledgement of wrongdoing, a formal apology and guarantees of non-repetition;
- ensuring professional accountability and sanctions by professional associations in cases of mistreatment and access to justice in cases of human rights violations;
- Ensure that regulatory bodies, including national human rights institutions, ethics commissions and ombudsmen, as well as equality bodies, have the mandate and resources to oversee public and private maternity facilities to ensure respect for women's autonomy and privacy (Battisti, A., 2022).

Concerns about the dehumanisation of women's experiences during childbirth lead to calls for a return to a continuum of one-to-one support targeted at pregnant women giving birth, through the use of midwife-led interventions.

To address the rising rates globally and prevent harm to women and newborns as a result of excessive obstetric aggression, in 2018 the World Health Organization (WHO) published new recommendations for non-clinical interventions to reduce unnecessary caesarean sections. The document contains 56 recommendations. All 56 recommendations are based on substantial research and scientific evidence. They not only address the clinical requirements for safe childbirth, but also address the psychological and emotional needs of women. It seeks to ensure that women give birth in an environment that, in addition to being medically safe, allows them to have a sense of control through participation in the decision-making process. Underpinning all the recommendations are several elements:

- ✓ Caring with respect for the labouring woman.

- ✓ Effective communication.
- ✓ Attendant during childbirth.

An obstetric model of care in which a familiar midwife supports the woman during pregnancy, birth and the period afterwards (Chen, I., N. Opiyo, E. Tavender, et al. 2018).

The ongoing model of obstetric care is recognized by WHO as precisely the best practice that can be offered to women with low-risk pregnancies and uncomplicated deliveries. In the midwifery model of care, a woman's pregnancy, delivery and rearing of the newborn are processes of a physiological nature. This means that the best quality obstetric care for the pregnant and birthing woman is guided by monitoring the processes in their physiological course, with minimal interference and maximum flexibility for mother and baby.

Table 1. Analysis of obstetric model of care and standard maternity care in Bulgaria

	Obstetric model of care	Hospital standard care
Decision-making process	Informed and collaborative	Hospitalization and routine informed consents
Prospects for childbirth	Natural physiological birth	Conducted childbirth and caesarean section
Care	Birth is an intimate, family-centered moment, applying a continuum of care	Childbirth is a medical procedure involving the medical teams on duty
First period of childbirth	Free movement, non-pharmacological pain relief, empathy, closeness, optimal care for comfort and safety	Supine position, medication induction, continuous monitoring, protocol-based care
Second period	Assuming a desired position, expectant behaviour without pelvic fundus interventions, first contact with the newborn and breastfeeding	The parturient is on the birthing bed in gynecological position, controlled pushes, routine episiotomy
Third period	Intermittent, without medication interventions	Medicamentous conduction of placental delivery
Overall experience	High satisfaction	High technology but minimal satisfaction

There is no established medical standard for obstetric care in Bulgaria, which is the basis for quality care and overcoming obstetric aggression.

The medical standard is a precondition for preliminary assessment and subsequent control of medical activities, as well as for evaluation of the extent to which the due behaviour of medical specialists involved in the diagnostic and treatment process has been carried out. The positive impact of the existence of the standard is related to the use of standards as a tool to ensure and improve the quality of care provided and the measurement of the results of changes directly related to patients. There are also benefits for health professionals due to reducing frustration, reducing organisational and medical errors, improving communication between professionals and ensuring effective medical protection through risk avoidance.

The practice in European countries for setting parameters for quality of medical care is different. In Sweden, for example, there are quality standards for medical care. Some basic quality indicators are included in the Health and Medical Services Act. These state that all health and medical care must meet the following criteria: good quality and a high standard of hygiene,

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meeting patients' needs for safety, comfort and duration. All health and medical care must be based on integrity and respect for patients' autonomy. They should promote good contacts between the patient and the medical staff and ensure the accessibility of medical services.

The medical standard "Obstetrics and Gynecology" aims to facilitate access to population to medical activity, which occupies a special place in the fight against the demographic crisis in the Republic of Bulgaria, providing conditions for curbing the negative population growth by increasing the number of healthy children born, preserving the health of mothers and providing conditions for effective prevention, diagnosis and treatment.

CONCLUSIONS

Action is needed to support changes in health care professionals' behaviour, clinical settings and health systems to ensure that all women have access to competent maternal health services. This may include social support through partner choice, mobility, respect for patient wishes, confidentiality, privacy, informed choice, providing women with awareness of their rights, and redress mechanisms following a violation. Professional standards for clinical midwifery need to be developed. Medical institutions must ensure, develop and implement policies with clear rights and ethical standards. Practices and approaches need to be introduced to ensure that childbirth is by the so-called 'natural birthing route', i.e. vaginal birth; minimisation of medical interventions; prioritisation of maternity preferences over the requirements of medical standards; a high degree of responsibility to the woman for the outcome of the birth; active participation in the birth by the partner or other family members.

Obstetric violence goes unrecognized and unreported, in part due to a lack of effective reporting procedures. Moreover, like other types of violence, it is an extremely sensitive subject that often evokes disturbing memories for those who have experienced or witnessed it. For this reason, many people are unwilling or unable to talk about their experiences.

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