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Making dignified care the norm

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When Joan (a pseudonym), a mother of three children, experienced labor with her firstborn, she went to one of the main maternity hospitals in Nairobi, Kenya, but the healthcare workers “refused to attend to me, since there was a doctors’ and nurses’ strike.” She was transferred to another hospital “where they also refused.” At someone’s recommendation, she went to another large hospital, and by the time she arrived she was “in consistent labor pains; they admitted me and I was rushed to the labor ward.” Because it was her first child, she did not know what to do; when she asked the attending doctor questions, she was scolded and told that he had no time to answer her. She waited for two hours in pain before anyone truly attended her. When the doctor finally saw her, he asked her to lie down on the bed and realized that the baby’s heartbeat was slow. She described, “I started having difficulties in breathing; my baby was swollen at one side of his body. […] That’s when [the doctors] started speeding up; they brought [an] oxygen tube and after a while they took me to [the surgical] theatre.” She received a cesarean that helped deliver her baby boy. She concluded her story by elaborating on how the staff infantilized her:

Imagine! Those [hospital] doctors are very rude; […] the nurses will insult you and humiliate you and make you feel like a child; they will wake you up earlier in the morning to bathe with cold water, and the toilet was too dirty [and] there was no place to step on. I was still weak, weak from the operation [and] they won’t attend to you. Wherever I asked them what medicine they were giving me, they wouldn’t give [me] a response on how it was helping [my] body.

Anthropologists of reproduction have long examined the contestations present within the medicalization of childbirth (Davis-Floyd 2003), particularly frictions around the production of authoritative knowledge (Jordan 1997), hierarchical interactions between practitioners and patients (Sargent and Bascope 1996), and the complexities underlying women’s choices (Lazarus 1994; Van Hollen 1998). These studies provide the substrate for recent examinations focused on abuse and mistreatment within childbirth worldwide (Savage and Castro 2017; Zacher Dixon 2014).
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Two frameworks are important to understand maternal mistreatment. The first is reproductive justice, which shifts attention from reproductive choice—which has primarily privileged the lives of white middle-class women in industrialized nations—to a more encompassing social justice approach that positions reproduction within the intersections of class, race, and gender. This approach centers unequal power relations produced within the state or other institutions (Luna and Luker 2013). It includes women’s rights to choose whether to have children, “to raise them with dignity in safe, healthy, and supportive environments” (Roberts 2015: 79), and to not be subject to coercive obstetric practices (Luna and Luker 2013). The second framework places a postcolonial gaze upon institutions and regimes of knowledge and power (Good 2012) to examine how the echoes of colonialism haunt contemporary spheres of interaction (Towghi 2018; Varley and Varma 2018) and leave “spectral geographies” (Coddington 2011: 744) that extend the remnants and contradictions of the colonial system into the present-day. An anthropological lens that analyzes these colonial debris focuses on “the secret, the hidden, the unspoken, and the unspeakable” as well as irrational and incomprehensible forms of violence and aggression (Good 2012: 519). This perspective allows us to address violence against women, particularly its effect on the most vulnerable. Obstetric violence is central to the anthropology of reproduction because it addresses the nexus between social and biological reproduction, framed within questions of power, politics, and struggles for control.

As a term, obstetric violence was first leveraged in a legal-institutional fashion to facilitate change in Latin America in response to intense scrutiny from women’s groups, feminists, professional organizations, and national and international entities about the quality of prenatal, perinatal, and postnatal medical care (Belizán et al. 2005). In 2007, Venezuela became the first nation to create a law protecting the right of women to live a life free from violence. Part of the law defines as violence 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. (Pérez 2010: 201)

This law was the first example of legal-institutional recognition that bodily coercion, disrespect, and other abuses during childbirth, pregnancy, and postpartum constitute a form of violence (Pérez 2010). It was a groundbreaking attempt to curtail, among other things, occurrences of mistreatment and abuse during childbirth by establishing legal guidelines. Venezuela’s legal resolution paved the way for other nations and groups in Latin America to do likewise, and recent years have seen abuse during childbirth become a focus of region-wide interest and concern (Williams et al. 2018). These frameworks have been greatly influential in modeling discourse around obstetric violence in other regions of the world (Quattrocchi 2019). The World Health Organization (2014) calls obstetric violence an important public health and human rights issue and states that “such treatment 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.” Likewise, various discussions and calls to address the issue of obstetric violence have taken place globally in recent years (Jewkes and Penn-Kekana 2015; Koblinsky et al. 2016).

Scholars and activists suggest that obstetric violence needs to be actively linked to examinations of gender inequality and structural violence (Sadler et al. 2016; Savage and Castro 2017). Researchers in African countries have primarily used the terms mistreatment, disrespect, and
abuse (Pickles 2015; Bradley et al. 2016), while those working in Latin America have mostly used the term obstetric violence (Zacher Dixon 2014; Sadler et al. 2016). Obstetric violence is a politically charged term that explicitly defines problematic childbirth care as a form of violence (Chadwick 2016). Our approach contrasts obstetric violence with dignified maternity care: Seeing a patient as a whole person and as worthy of care. Dignity also means fostering autonomy, inclusivity, identity, and individuality; supporting physical, emotional, and spiritual comfort (Royal College of Nurses 2008, cited in Morad and Parry-Smith 2013); and creating relational trust between providers and patients (Morad and Parry-Smith 2013). This relational aspect is echoed by Sadruddin (2019), who shows that a lack of dignity is bodily felt; and that both individual and collective dignity can be cultivated, even in small ways, by mutual care.

Some authors have created typologies to understand the characteristics of maternal abuse during childbirth. These typologies include behaviors such as physical, verbal, or psychological violence towards mothers, sexual abuse, the overt manifestation of stigmatization and social discrimination within caregiving, and the overuse of medical technologies and interventions (Diniz and Chacham 2004; Bohren et al. 2015; Savage and Castro 2017; Jardim and Modena 2018). Certain scholars argue that maternal mistreatment additionally consists of a lack of consented, confidential, and dignified care, abandonment or refusal of care when patients are perceived as “difficult,” and detention in facilities for reasons such as non-payment of medical fees (Bowser and Hill 2010). Castro and Savage (2019) bring an anthropological lens to these typologies and argue that within these types of abuses are also present issues of medical miscommunication, language barriers, and cultural insensitivity. Additional problematic practices include non-evidence-based interventions, which Sadler and colleagues (2016) argue are distinct from the more overt forms of verbal, emotional, and physical abuse. Bradley and colleagues (2016) suggest a tiered approach to understanding obstetric violence: Macro-level causes such as structural inequality, colonial legacies, and health policies shape meso-level influences (such as gender, poverty, inequality, medicalization, hierarchy, etc.), which in turn shape micro-scale interactions during clinical encounters.

Researchers have made important connections between instances of abuse during childbirth, and the broader societal factors which underpin them. Afulani and Moyer (2019) argue that although institutions, facilities, and individual healthcare practitioners are beginning to become aware of the pervasiveness of mistreatment of women during childbirth, and sometimes even have taken steps to reduce the occurrence of abuse, from no quarter has there been any substantive movement toward holding accountable those who commit these abuses in the first place. Freedman and Kruk (2014) and Sadler et al. (2016) argue that the prevalence of disrespect and abuse during childbirth are symptomatic of health institutions that devalue women and indicative of a crisis in institutional accountability. However, interventions geared towards allaying the occurrence of obstetric violence often do not address these power imbalances as a root cause of the issue, which is why a reproductive justice framework is so vital. Sadler and colleagues (2016) argue that various forms of maltreatment during birth must be understood as a consequence of structural violence against women—and that the term obstetric violence itself, as it is being deployed in legal measures and activism efforts in Latin America, provides a helpful tool in combating some of the structural inequities that contribute to the incidence of abuse during birth.

**Kenya and obstetric violence**

To contextualize the lived experience of obstetric violence, we draw from a case study in Nairobi, Kenya, that illustrates the multiple voices embedded in maternal care, and especially how vulnerable women experience problematic care. We use a feminist approach that draws
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from both anthropology and global health to analyze the ways that impoverished women are often victims of obstetric violence. This analysis focuses on experiences of abandonment of care, and the consequences to women and their babies. We address the structural underpinnings and the colonial debris that shape this violence (Stoler 2013), and how these speak to questions of reproductive justice. Like the hospitals in Kashmir examined by Varley and Varma (2018), the hospitals in our study were also scarred by the past in ways that linked to various contemporary forms of violence—structural, symbolic, obstetric—affecting the lives of the women who sought care there.

Since Jewkes et al.’s (1998) groundbreaking analysis of maternal mistreatment by nurses in South Africa more than two decades ago, the discourse around mistreatment, abuse, and obstetric violence has become more present in some of the nations of Africa and has been captured by research in countries such as South Africa, Kenya, and Nigeria that address the prevalence of gender-based mistreatment and abuse of birthing women (Kim and Motsei 2002; Chadwick 2016; Abuya et al. 2015; Okafor et al. 2015; Oluoch-Aridi 2018). Like in Venezuela, South Africa has seen the emergence of a criminal law aimed at reducing rates of obstetric violence (Pickles 2015).

The nations of Africa are obviously quite distinct from one another, but as was evident in the examples from Latin America, acceptance of the legitimacy of obstetric violence, particularly when delineated within a framing of gender-based violence and oppression, can occur at the scale of global regions. This discussion brings us to consider the issue of obstetric violence in Kenya, and how it has been addressed (or not) legally and in clinical practice. Literature around childbirth in Kenya reveals that there is specific local context of gender-based violence, and that women’s roles in the household and exposure to intimate partner abuse often play a key role in shaping women’s reproductive health, access to skilled care practitioners, expectations of treatment, and overall experiences during birth (Goo and Harlow 2012; Hatcher et al. 2013). Across Kenya, 45% of women and 44% of men aged 15–49 have experienced physical violence.
since they were 15, and nearly half of ever-partnered women of reproductive age report having experienced intimate partner violence at least once in their lifetime (Kenya National Bureau of Statistics 2015; UN Women 2014).

Kenya is a country in East Africa with a high level of inequality. Its health system offers a mix of public (47%), private (38%), and mission-based health facilities (15%) (Ministry of Health 2014). A survey commissioned by the World Bank and USAID describes poor quality services, in conjunction with limited infrastructure and lack of critical medical supplies, especially for maternal health (Martin and Pimhidzai 2013). Government health spending is only 6% of the total budget, falling short of the 15% suggested levels according to the Abuja Declaration (WHO 2011). The last decade has seen Kenya’s total health expenditure per capita rise from $20 in 2002 to $50 in 2012 (World Bank 2014). The health provider to patient density ranges from 0.09 to 1.48 doctors, nurses, and clinical officers working in the public sector for every 1,000 people, which is significantly lower than the WHO-recommended density ratio of 2.3 healthcare workers for every 1,000 people. Only a third of these healthcare workers are in the public health workforce (Taddese and Lehmann 2017). This acute shortage of healthcare workers, compounded by poor working conditions and low pay, creates sharp distinctions in healthcare coverage between wealthier and more impoverished areas.

Post-independence (1963), Kenya has seen the continued neglect of healthcare services—particularly government health facilities in low socioeconomic status areas. Medical facilities often had only limited access to essential finances and supplies, a colonial legacy of maintaining poor quality services for the local population. To address some of these inequalities, in 2010 Kenya ratified a new constitution, guaranteeing the “highest attainable standard of health” to everyone, including the right to reproductive healthcare. Subsequent health policies included reorganization of health funds, provision of free maternity services countrywide, abolishment of fees at primary health facilities, and subsidizing healthcare of vulnerable populations (The World Bank 2014). These changes led to a rapid increase in women’s demand for skilled birth attendance. However, as the access to maternity services increased, there were concomitant complaints of poor-quality care and overt mistreatment due to the higher patient volume. The issue at hand in this chapter is not women’s ability to access skilled birth attendance at health facilities, but rather the quality of services that are provided, especially at public health facilities.

Several studies demonstrate that facility-based delivery did increase since the free maternity service implementation, especially in urban centers (Gitobu et al. 2018; Tama et al. 2018). However, the implementation was not without significant challenges, such as the poor reimbursement for the provision of delivery services, a lack of medical supplies for managing obstetric complications, and poor wages and a high workload for healthcare workers managing labor and delivery (Tama et al. 2018; Lang’at et al. 2019). These challenges led to a national medical worker strike in early 2017, which created difficulty for our research team in accessing healthcare workers at their workstations. The strike by the Kenya Medical Practitioners Dentist Union lasted 100 days and paralyzed services within the public health system. Consequences of this strike were an increase in the low quality of delivery services, which included maternal mistreatment and abandonment during labor and delivery. There was also an increase in mortality (Adam et al. 2018). Despite negotiations with the government that led to the restoration of services, the healthcare workers were held accountable for the ensuing mortality and morbidity that resulted from the strike.

**Setting and methods**

We carried out this research in a peri-urban settlement of Nairobi called Dandora, with a population of approximately 300,000 out of Nairobi’s total population of approximately
4.7 million people. In addition to high crime rates, Dandora lacks basic amenities, such as clean water, causing many health and development issues for its population. Ironically, given its location as the city’s garbage dump, it also lacks garbage disposal. Because of the marked inequality, criminal violence and gangs are ubiquitous. Dandora has a handful of health centers (two public secondary centers and four private centers). Our data in this chapter come primarily from the two major referral maternity hospitals that participants used outside of Dandora. Despite them being referral maternity units, some of the women in our study delivered there without being referred first.

The data were collected by Oluch-Aridi, who interviewed nurse-midwives, doctors, administrators, and patients for this study at two maternity hospitals outside of Dandora, which we pseudonymously call Hibiscus Hospital and Orchid Hospital. She carried out the data collection (using informed consent and ethical guidelines) in two phases; the first taking place between October and December 2016 with 46 in-depth semi-structured interviews and 15

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Figure 31.2 Woman (and baby) walking along one of the roads in Dandora. Source: Photo by Barbara Johnston/University of Notre Dame.
focus group discussions with women who had given birth during the previous five years. The second phase was conducted between January and March 2017, involving 20 in-depth interviews and observations of healthcare workers. The audio-recorded interviews lasted between 1 to 1.5 hours. Many women in our sample were housewives and depended on their spouses for their livelihoods; this power imbalance creates social norms that perpetuate the “female helplessness” that is reproduced by healthcare workers. Significantly, the majority of the women had only recently migrated into the city’s informal settlements seeking a better life; their status as relative newcomers and their relative lack of social support often made them more vulnerable. Using NVivo 11, we classified and organized the data according to emergent key themes and categories, and created a codebook using these inductively determined codes and an existing literature typology on the mistreatment of women.1

Beyond disrespect and abuse

In Kenya, obstetric violence seems to be prevalent in settings associated with low socioeconomic status. The most prevalent forms of mistreatment present in our study were physical and verbal abuse and issues arising from infrastructural constraints (i.e., bed sharing, lack of privacy, and non-dignified care). Like Castro and Savage (2019), our data also suggest that many of these forms of violence were culturally insensitive and threaded with poor communication. We identified problems such as failure to uphold professional standards, discrimination against the women based on age and/or socioeconomic status, and poor rapport between the women and the healthcare workers (see Bohren 2015). Many of these issues arose from imbalances in power and status. Both the women and healthcare workers stated that verbal and physical abuse were highly prevalent. Below we include some of the voices of the patients and healthcare providers and also address the structural and infrastructural issues that shape the care of female patients during labor and delivery. The women described verbal and physical abuse, discrimination, neglect and abandonment, and unprofessional treatment from the healthcare providers. Many
of them lost babies due to poor healthcare or decrepit infrastructure. The healthcare workers described a health system that was weak, fragmented, deeply underfunded, and with poor policy support—which in turn created a context where the mistreatment of women seemed to be inevitable. As we demonstrate below, this broader context can explain, though not justify, the mistreatment of women during labor and delivery.

Demoralized and confused: Women’s concerns

The women in our study didn’t understand why they were beaten or mistreated and said that they felt demoralized, shocked, and hurt by the treatment. They said they didn’t know what they were expected to do while in labor. Aurora, one of the women we interviewed in a focus group, expressed her concerns:

When you go to hospital to deliver and it’s your firstborn you have no idea what to do during labor; the doctors or nurses should handle any kind of situation at that time. A female nurse who was in the labor ward slapped me twice so that I could push out the baby.

Many of the female patients said the lack of professional standards, combined with the significant health constraints, were major drivers of their feelings of violation. Some women described healthcare workers refusing to attend to them. As one woman said:

I called the doctor when I began feeling the baby coming down but the doctor refused to come and so I delivered on my own and that is when the doctor was called by the other people. When the doctor came, he cut the umbilical cord. [But] before [he] could attend to me there was another woman nearby also giving birth. The doctor left my child uncovered and unattended and went to the other woman. [He] came back after [that patient] had delivered and [he] took my child to the nursery.

Rose, another participant, said her attending doctor was drunk “and I didn’t like how he did the vaginal examination.” She said she
decided to rely on God as you cannot rely on the doctor only; I was placed on the bed and finally I gave birth. After I delivered, however, because he was alone and drunk, that doctor didn’t clean me or take good care of my child, I bled through the night but God saw me through and I came out of there safely.

This sense of abandonment and neglect was a recurring theme within our interviews, as recounted by Joan in the vignette at the start of this manuscript. This abandonment was compounded by the fact that they were sometimes attended by student trainees. The patients thought the inexperience of these student trainees placed them and their babies’ lives at risk. Almost every single woman we interviewed mentioned infant death—either their own or those of other women in the hospitals. Edith, who gave birth to twins, told us her devastating story of loss: “My babies were placed inside an incubator [where] there were four children.” She said one of the other babies had yellow fever and infected all of them. When she told the nurses, she was scolded: “I should not teach them their work.” She said all she could do was pray to God to intervene. She described:
At around 12:00 pm my first girl passed on. After one hour is when one of the nurses came to check on her and tried to put an oxygen tube on her but it was too late. […] Later I met with what I never expected: when I went to the nursery, three babies were dead in the incubator. When I tried to hold on to my second twin’s hand, she had already passed on. I was devastated.

Joan told us, “Whenever I visited [the] nursery to check on my baby you could see dead babies laid on one bed. Doctors and nurses were using abusive language if they saw you cry or sympathize with mothers who have lost their babies.”

At Hibiscus Hospital, women described trainees being left unsupervised for long hours where they had to treat patients with no ability to rest. One of the women in our study said that during her birth experience: “There were only two trainees in the ward; one doctor was drunk and was sleeping.” She added that the trainees seemed to take out their frustration on patients and “when the trainee gets stranded with anything, he comes and when you try to argue with him, he beats you up.” When she was about to begin pushing, the trainee was unable to help her, and when the doctor came he painfully pressed my stomach and I told him he was hurting me and he said that this was not his work […]. His work was to deliver the baby and he posed the question that I had called for help and that was why he was there.²

The woman added that despite all of these issues, she gave birth well. However, she said one of the issues at the hospital was that “when you give birth, they don’t stitch you up [for vaginal tears] immediately [and] you have to wait for another hour to get stitched; this occurred with my second child, they don’t even give you injections to make you numb.” Another woman described how when she gave birth to her firstborn at Hibiscus Hospital, she was entirely attended to by students and “the real doctors were nowhere to be found.” She said they performed an episiotomy and took a long time to suture her because the students were waiting for senior doctors to guide them in the procedure. “After waiting for a long time they decided to stitch [me]. Unfortunately, after 15 minutes, when the doctors came, it was redone. I felt a lot of pain.”

Other women emotionally expressed how their vulnerability during birth was used against them, such as one young woman who had delivered in a public hospital: “In the wards, [the] nurses and workers were shouting at [the] mothers; if they notice that you have soiled the bed sheets you are in trouble.” She said that she was told to “wake up quickly and bathe with cold water; and at that time, you are weak and can only move slowly.” Another woman added that she was in labor for three days because her cervix had not dilated. The nurses eventually artificially ruptured her membranes. “They looked at me with contempt and used abusive language when I was pushing the baby.” She received conflicting instructions about when to push and when not to, which “really confused me.” In her despair, she asked them to take me for an operation because I thought I could not manage [and] the head of the baby was already out. I was terrified to see the nurses hold my legs and force me to push the baby, because they had sensed danger.

Although her baby was ultimately safe, she concluded by saying: “I didn’t like how I was handled.”

**Needing to be firm: Healthcare providers’ concerns**

Recent research in Kenya has focused on the occurrence of abuse during childbirth at the hands of medical practitioners. For instance, in a survey of 641 women being discharged from postnatal
wards at 13 Kenyan healthcare facilities, Abuya and colleagues (2015a) found one in five women had births characterized by disrespect and abuse; experiencing such factors as non-consenting treatment, verbal and physical abuse, neglect or abandonment, and detainment for non-payment of fees.

In our study, the healthcare workers expressed the need to be firm with the women, stating that they sought women’s compliance and good health outcomes for both mother and baby and were not afraid to slap women to achieve these. The most common form of physical violence was slapping, which evidences the normalization of physical abuse. This was expressed by a midwife who worked at Hibiscus Hospital, who stated that mothers were sometimes “too dramatic.” She explained how the labor ward had some rails for the room’s curtains, and that one woman was “hanging on the rails” because of the pain. She added, “so you can imagine if the curtains can [unhinge], then she could fall down.” She said the woman was “not cooperating or anything” and once the baby’s head was out “she jumps [off the bed] and that’s putting the baby at risk.” She concluded by saying, “and you want a good outcome […] and it reaches a point [where] you have to be harsh; that good language you were using has to be put aside.”

Most of the nurses we interviewed said they were taught during their clinical training to gain compliance from laboring women by being tough. They used these teachings to justify physical abuse in order to make women comply and secure good health outcomes. The nurses framed their obstetrically violent practices as not only acceptable, but as an essential tool of compliance. One healthcare worker said they used force “to save the life of the mother and the baby.” She added, “afterwards you will tell her why you were doing that. We were taught this during our training.” Because doctors were more powerful within the healthcare system, they often placed the blame on the nurses, and nurses feared being held accountable for poor birth outcomes. The nurses used physical and verbal abuse as a way to achieve “good” health outcomes and avoid blame. However, as shown by Warren and colleagues (2017), the prevalence of disrespect and abuse from medical workers was a main deterrent to women seeking skilled practitioners or facility-based care during childbirth.

**(Infra)structural constraints**

Despite the trauma they experienced, some of the women justified their mistreatment as a result of a deficient health system. For example, one of the women who gave birth at Hibiscus Hospital said: “The women were seated on the bench outside. When one delivers that is when the other one gets a bed. The room was small.” She added philosophically, “What would you like the [healthcare workers] to do? They could add another room because I don’t know if people are still giving birth as much. The doctors there wanted to assist but the beds were occupied.” She said the healthcare workers would sometimes try to encourage women to go to other maternity clinics “even though the delivery process there was free.” Thus, she concluded, “women had to wait by the bench; when a woman would report that they were in pain; they would be told to go home and come back the following day; they were unable and others would sit on the bench for days.”

The healthcare workers also spoke about the constraints of the health system which led to perceptions of mistreatment. They said the demand for their time prevented good quality services. For example, health workers described situations at major maternity hospitals where there was a lack of beds and patients were sometimes forced to share. This situation sometimes led to women giving birth on the floor. One woman said that at one of the hospitals, “there was a woman who lost her twins because she gave birth on the floor. Unfortunately, the floor was too cold for them to survive.” The healthcare workers justified situations such as these as outcomes
of a severely constrained health system. One midwife at Orchid Hospital said that all five beds in the ward were shared, “which is very uncomfortable.” She said that one bed could simultaneously hold one woman screaming and another in early stages of labor who wanted to push. She added, “Now what do you do? So, at times when you hear a mother saying ‘I went to Orchid Hospital and I gave birth on the floor’ it is not a lie. The beds are full, so what can you do?”

Like in other countries, the Kenyan public hospital system is bereft of sufficient medical supplies. Anthropologists like Claire Wendland (2010) and Julie Livingston (2012) elaborate on this situation in Malawi and Botswana, respectively, where a lack of basic supplies, such as sutures or gloves, was common, and healthcare workers had to improvise in order to provide care to their patients. The doctors whom Wendland interviewed instead focused their attention on resourcefulness, teamwork, empathy, and activism. What was evident in our data in Kenya was ubiquitous anger at the system, which erupted in a 2017 medical worker strike. A medical doctor at Orchid Hospital described the government’s inefficiencies in providing new supplies as well as the lack of funds in hospitals and clinics for supplies and equipment. He said, “There are times we don’t have oxytocin.” Though he laughed, his frustration was evident when he said, “Are you serious? […] Sometimes you use ergometrine.” He continued,

We don’t have sterile gloves sometimes. Sometimes you want to remove a retained placenta; you don’t have the gynecology gloves and you have to improvise. You cut up the other gloves and patch it up. Sometimes in the [operating] theatre you don’t have stitches. Are you serious?

These under-resourced and severely strained health systems contribute to a culture of violence. Healthcare workers described chaotic situations where they had to triage and decide where to administer care based on who had the best chance of surviving. They mentioned the workload as a significant creator of stress, and not having essential drugs and supplies constantly frustrated their work and sometimes led to forms of mistreatment. Healthcare workers had to work long shifts, which became complicated when they had to attend to various laboring women simultaneously. One doctor said,

For example, in [the operating] theatre you can have six mothers that need to come [in]. […] We don’t have that capacity. Maybe it’s at night, and we have one anesthetist; this one anesthetist can only [work in] one theatre but we have six emergencies. […] We have two doctors but one is in the labor ward so obviously can’t leave and this always has some very serious repercussions to the mothers; sometimes it’s very hard for us to explain and it’s always us (as healthcare workers) who take the hit because [patients] don’t understand how the system works. So the fact that we have less personnel means that we have very bad outcomes. […] You have to make a decision who goes first and who comes later. It’s something that is quite sad and sometimes in the middle, things can be running smoothly then all of a sudden there is no stitch, there is no water, just like that.

The healthcare workers we interviewed expressed frustrations at the ineffectual regulatory agencies, which they claimed led to many unqualified people acting as healthcare workers and (mis)treating patients without consequence. They also described situations of women attended at unregistered facilities with unqualified healthcare workers. One doctor from Orchid Hospital emphasized the fear of assuming care (see Cheney et al. 2014) from accepting a hospital transfer: “They always refer [patients to our hospital] when it’s too late.” He added that sometimes “the
mother has been bleeding for quite a while; so when they realize that they are not going to help the mother they bring [her] to our facility.” One of the main reasons for the transfer was postpartum hemorrhage, and they frequently could not save the woman “despite making the necessary interventions on time.” Across the world, it is common practice for hospitals to out-refer to other centers if the situation exceeds the capacity to cope; however, like in the cases examined by Mirhosseini and Fattahi in Iran (2010), deception can also play a role in referrals. When women in these situations died, the blame would be placed on the hospital’s healthcare workers, creating a contested space embedded within “train wreck” hospital transfers (Cheney et al. 2014: 447).

**Conclusion: Reproductive justice**

The heartbreaking and troubling stories and narratives we have offered in this chapter exemplify not only obstetric violence, but also systems that consistently enact violence on and strip dignity from the most vulnerable. The Kenyan public medical system we have examined is bereft of funds, bursting at the seams, with healthcare workers struggling to provide care. The violence is not just present at the moment of birth, but is at all points in this system—from large maternity hospitals far away from impoverished areas like Dandora, to a system of referrals that push patients away to other hospitals where, if they are lucky like Joan, they might receive medical attention (if not necessarily care), to hospitals with a lack of beds, infected incubator systems, and a lack of basic supplies. Violence is enacted on women and their babies at each point, and only a lucky few emerge unscathed. Many women, as we have described here, contend with iatrogenic problems, with trauma, or with death. Given this situation, is it surprising that healthcare workers went on strike to protest their working conditions?

Though our case study is about Kenya, the issue of obstetric violence is found worldwide. We suggest that there is a normalization of violence within some medical spaces. Our participants accepted being stigmatized because of their origins and residence. They expected to be identified as being from Dandora and to be mistreated when seeking medical care. The women had internalized the social stigma and accepted being recipients of whatever type of treatment they received. Because of their circumstances, they could not avoid the potential risks to themselves or their babies. Though many women avoided primary care centers for fear of the risk of being treated by less-qualified healthcare workers, the tragedy was that when they went to the crowded tertiary hospitals the risk was higher. They experienced a dual burden of colonialism—both as former colonial subjects living within a decrepit postcolonial system and as marginalized populations within a deeply stratified country. We suggest that there is a great need for further investigation and overlap with the Kenyan justice system because there has been little legal recognition that obstetric violence is present in medical spaces.

What can be seen in the data we have presented are Coddington’s spectral geographies (2011: 744) that have ultimately manifested in deep inequities and violence of care. As Towghi (2018: 685) shows in her troubling analysis of birth care in Pakistan, the systems set up to attend to laboring women “authorize medical practitioners to enact various unwanted medical interventions, often incorrect and unnecessary, in the guise of care.” The women in our study knew it was futile to demand other (better) forms of care in these spaces—their gender, their class, and their social background structured their choices and experiences, making them unable to contest this violence. However, many of them emphasized how, if they had a choice, they would give birth anywhere else. The healthcare providers did contest these inequities—even though they did not necessarily contest their own forms of violence—and did so by striking against the government and demanding an improvement in work conditions.
Our analysis contributes to research on the anthropology of reproduction, particularly by emphasizing reproductive justice. We believe the potential exists for an intersectional form of wellbeing, which, as Zavella (2016: 37) shows in her research among Latina immigrants in the US, “will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about [their] bodies, sexuality and reproduction.” Several public health projects have focused on interventions aimed at curtailing abuse and promoting respectful, woman-centered maternity care. Our previous research (Oluoch-Aridi et al. 2018) concluded that improvements to maternity healthcare might be made with increased governmental resource investments in health systems, improved health education outreach, and strengthened institutional means to recognize and enforce quality of care. Ndwiga and colleagues (2017) demonstrated that behavioral interventions and stress reduction among healthcare practitioners can decrease the incidence of abusive behaviors, but that they require sustained and long-term supportive environments within the health system. Morad and Parry-Smith (2013) show how in the UK greater dignity was fostered through structural factors, such as changes to the physical environment and interpersonal relationships within the medical team. Warren and colleagues (2017) recommended the development of multi-component interventions to decrease the occurrence of obstetric violence, including raising community awareness around human rights, behavioral interventions for healthcare providers to recognize and modify their own values, beliefs, and attitudes, and widening avenues for accountability and legal redress when abuse does take place. In a related article, Abuya and colleagues (2015b) describe the three-tiered nature of this same intervention, promoting the implementation of more respectful maternity care at policy, facility, and community levels; they reported that most subcategories of reported maternal disrespect and abuse declined by 40–50%.

What is needed across the world is a linkage between legal, activist, scholarly, and caregiving groups to address this issue and call for change. Scholars and activists involved in addressing reproductive justice call for a connection to broader political change through intersectional praxis (Ross 2017). Reproductive justice brings in the voices of those who have been marginalized or alienated by mainstream reproductive policies (Roberts 2015: 81), and can concretize the needs and concerns of these communities into broader change “for systemic change in law enforcement, health care, and education.” Governments need to provide resources for the provision of high-quality maternal health; this also includes supporting healthcare workers with dignified working conditions so they do not take out their frustrations on patients. Policymakers and professional medical associations need to work with communities to develop legal and regulatory frameworks protecting the rights of women seeking reproductive healthcare services, address mistreatment, and ensure woman-centered services. Thus, we argue, it is important to redress the structural and postcolonial disparities that structure risk and violate women’s autonomy. We call for the establishment of maternity care systems that foster patient autonomy and dignified care.

Notes

1 In this chapter we use pseudonyms for our interlocutors to protect their privacy and confidentiality.
2 This was likely a Kristeller maneuver, where manual pressure is applied to the fundus (the top of the pregnant belly) to, supposedly, facilitate childbirth during the second stage of labor. The WHO does not recommend this procedure, considering it abusive. It can cause damage to both the mother (uterine rupture, anal sphincter injuries) and fetus (brain damage) (Malvasi et al. 2019).
3 Oxytocin (also known as Pitocin) is a hormone that induces contractions and is used across the world to induce labor or to augment contractions; ergometrine is usually used to cause uterine contractions in order to prevent postpartum hemorrhage and is not usually recommended for labor.
Making dignified care the norm

References


