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MASTER THESIS
on topic: «WOMEN'S EXPERIENCES OF MISTREATMENT DURING CHILDBIRTH IN UKRAINE»

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TABLE OF CONTENTS

INTRODUCTION

> They all say that no one has ever left them [while still] pregnant. That is, everyone gives birth. But you want it to be a pleasant and joyful experience as well.
>
> Respondent 14

The topic of mistreatment during childbirth is relatively new. It has started emerging at the turn of the 21st century (Jewkes, Abrahams & Mvo, 1998; Doliveira, 2002; Castro & Erviti, 2003; Goer, 2004) but has been gaining more and more attention and recognition around the world in recent years. In 2014, the WHO issued a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth, emphasizing the unacceptance of mistreatment during childbirth and the need for dignified maternity services (WHO, 2014), and its 2018 guidelines on intrapartum care include recommendations for respectful maternity care (WHO, 2018).

Considering relatively new concept and respective studies, it is rather predictable that the understanding of the definition of mistreatment of women during childbirth is lacking consensus. It is partly due to many terms that are used interchangeably to describe this phenomenon: obstetric violence (Perera et al., 2018; Borges, 2018), disrespect and abuse (Freedman & Kruk, 2014), disrespectful and abusive care (Gebremichael et al., 2018), disrespectful care (Morton et al,, 2018), institutional violence (Souza, Rattner & Gubert, 2017), and some others can be found. Most papers on the topic describe the phenomenon of disrespect and abuse of women in childbirth by providing examples and recounting cases (Freedman et al., 2014).

The following categories of conduct can be classified as mistreatment during childbirth: physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in

facilities (Bowser and Hill, 2010), as well as sexual and verbal abuse, stigma, unmet standards of care, poor rapport between women and providers, and healthcare system failures and limitations (Bohren et al., 2015). Freedman et al. (2014) provide three "building blocks" that compose disrespect and abuse, including: (a) behavior that is considered disrespectful and abuseful by local norms; (b) subjective experience of a woman; (c) intentionality (even in cases when a woman does not see such actions as abuse or disrespect).

Studies identify that mistreatment of women during childbirth has many undesirable outcomes, for women themselves and their communities as well. Mistreatment during childbirth can undermine women's trust in healthcare systems and decrease their willingness to seek medical care in the future. It can also lead to complications during delivery, impact women's health, their future pregnancies, and have many other negative consequences (Bohren et al., 2015; Vacaflor, 2015).

In 2018, Ukraine had 335 874 live births (SSSU, 2019); the majority of them took place in the healthcare facilities. However, there is evidence that the maternity care provided in Ukrainian hospitals is of substandard quality (Demianova-Ponomarenko et al., 2016). Ukrainian policy-makers identify the issue of childbirth services provision as a priority for 2020-2022, which is reflected in the Program of Medical Guarantees for 2020 (NHSU, n.d.). According to the objectives of the reforming, the provision of childbirth services in Ukraine is to become completely free of charge for the patients (Stepurko et al., 2013; MHU, 2018), however, the objectives do not reflect the issue of mistreatment during childbirth, perhaps due to lack of evidence. Apart from general attention to the childbirth and care issues (Stepurko et al., 2013; Borozdina, 2017; Temkina, 2019), the mistreatment of women during childbirth is lacking scientific attention in the post-Soviet countries and in Ukraine in particular. For instance, Ukrainian research on the topic almost entirely consists of NGO Natural Rights Ukraine activities and advocacy work.

Therefore, the aim of this study is to reveal and describe the practice of mistreatment during childbirth in Ukraine from the women's perspective.

The objectives of the research are as follows:

1) to reveal the most relevant to the study concepts, theories, approaches, and methods while conducting the study on the mistreatment of women during childbirth;

2) to classify types and patterns of mistreatment of women during childbirth in Ukraine;

3) to describe reasons of mistreatment of women during childbirth in Ukraine;

4) to describe the perceived outcomes and perceived effects of mistreatment during childbirth in Ukraine.

The object of the research is women who gave birth in Ukraine since January 1, 2015.

The subject of the research is the experiences of mistreatment of women during childbirth in Ukraine.

In order to study the topic, we apply qualitative approach to data collection and analysis. Our expected results are that in Ukraine, verbal abuse, non-consented clinical care, non-confidential care, non-dignified care, unmet standards of care, poor rapport between women and providers, and healthcare system failures and system limitations are experienced by women and on the contrary physical and sexual abuse, discrimination based on specific patient attributes, abandonment of care, and detention in facilities are not experienced. We assume that mistreatment does not occur or occurs to a much lesser extent in private facilities. We assume that the mistreatment does not occur in cases of presence of a partner or other close persons of a labouring woman.

CHAPTER 1. UNDERSTANDING MISTREATMENT DURING CHILDBIRTH

1.1. Conceptualization of Mistreatment During Childbirth and Its Classifications

The topic of mistreatment is relatively new globally and thus, there is the lack of consistency in thesaurus for mistreatment of women during childbirth (Bohren et al., 2015; Vogel et al., 2016; Savage & Castro, 2017). For example, such concepts as "obstetric violence" (Perera et al., 2018), "disrespect and abuse" (Freedman & Kruk, 2014; Sadler et al., 2016), "disrespectful and abusive care" (Gebremichael et al., 2018), "disrespectful care" (Morton et al, 2018), "institutional violence" (Castro & Erviti, 2003; de Souza, Rattner, & Gubert, 2017), "violation of reproductive rights" (Castro & Erviti, 2003), and others can be found (Bowser & Hill, 2010; Bohren et al., 2015; Savage & Castro, 2017). The terms and their implied meanings vary across articles and studies (Savage & Castro, 2017). Vogel et al. (2016) are convinced this is due to the methodological differences in studying the subject, cultural dissimilarities, and "normative behaviours".

At the same time, Freedman et al. (2014) underline the lack of definitions of the phenomenon in the literature. Perhaps the absence of a clear conceptualization is one of the reasons for existence of various terms that describe potentially the same phenomenon. This may hinder the comprehensive research on the topic and limit the comparability of available data, especially that over time and in the same settings, and particularly quantitative (Bowser & Hill, 2010; Sando et al., 2017; Savage & Castro, 2017; Raj et al., 2017; Asefa et al., 2018). For example, according to different studies, the prevalence of mistreatment during childbirth varies from 12 to 98 percent; in some of these studies, the prevalence of mistreatment might be underreported due to its normalization among both providers and patients (Raj et al., 2017).

Therefore, we can comprehensively grasp the essence of mistreatment during childbirth only if we bring together fragments of definitions provided by different research articles. For instance, Perera et al. (2018) state that mistreatment may occur "during pregnancy, childbirth

and the immediate postpartum period" and therefore "is violence that directly affects women". Vogel et al. (2016) underline the need to take into consideration such factors as intentionality, potential risks of harm, and the fact that this can happen on different levels of care provision. The obstetric violence is defined in the Venezuelan Organic Law on the Right of Women to a Life Free of Violence. It is stated there, as cited by Diaz-Tello (2016), that it is "...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" (Organic Law on the Rights of Women to a Life Free of Violence, 2007, cited by Diaz-Tello, 2016, p. 61). On the other hand, Freedman et al. (2014) note that most papers on the topic describe the phenomenon of disrespect and abuse of women in childbirth by providing examples and recounting cases.

Another way to understand the essence of mistreatment during childbirth would be to categorize it into related subclusters. This approach is often applied in the systematic reviews that outline it by describing its features or criteria. For example, the landscape analysis report on disrespect and abuse in facility-based childbirth by Bowser and Hill (2010) that is perceived as a conceptual cornerstone and framework upon which many other studies are built does not provide any specific definitions of the phenomenon but identifies such categories of mistreatment as physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. They emphasize the fact that usually, an event falls into not only one, but several categories, and the presence of one does not exclude others (Bowser & Hill, 2010).

Freedman et al. (2014) criticize Bowser and Hill (2010) for not taking into account the levels on which disrespect and abuse occur (Savage & Castro, 2017). In order to cover this conceptual gap, they provide the so-called three "building blocks" that compose disrespect and abuse, including: (a) behavior that is considered disrespectful and abuseful by local

norms; (b) subjective experience of a woman; (c) intentionality (even in cases when a woman does not see such actions as abuse or disrespect), and, as a context of these, the right of a woman to health, as in accessible, available, and acceptable healthcare of good quality. They have developed a tool to evaluate the abuse and disrespect that consists of a bullseye chart of three levels (individual, structural, and policy) with two facets in each. These facets are: (a) behavior everyone agrees is disrespectful and abuseful; (b) behavior that is seen as disrespectful and abuseful by either women but not providers or others but not women; (c) low level of services caused by system insufficiencies and considered as disrespectful and abuseful by providers and women or (d) low level of services caused by system insufficiencies but not considered as disrespectful or abuseful; (e) deviations from national quality care standards; and (f) deviations from human rights standards (Freedman et al., 2014; Freedman & Kruk, 2014).

Building on the before-mentioned systematic review by Bowser and Hill (2010), Bohren et al. (2015) outline seven domains of mistreatment of women during childbirth based on the sixty-five analyzed studies: (a) physical; (b) sexual; (c) verbal abuse; (d) stigma and discrimination; (e) unmet standards of care; (f) poor rapport between women and providers; (g) and healthcare system failures and limitations. Additionally, they point out that mistreatment can be active (intentionality) or passive (unintentionality) and can be related to the behavior of individuals or to the healthcare systems.

Savage and Castro (2017) in their review of the terminology claim the existence of certain debate around the interchangeability and nuances of language usually used to describe the phenomenon synonymously (Savage & Castro, 2017). They outline the ambiguity of the mistreatment during childbirth itself that leads to difficulties in its conceptualization. Mistreatment of women in childbirth, they claim, belongs to many areas at the same time: it is a form of gender-based and institutional violence; it illustrates intra-hospital as well as general societal gender power dynamics; and it is thus an interdisciplinary issue that has to be addressed from different perspectives (Freedman & Kruk, 2014; Diaz-Tello, 2016; Savage & Castro, 2017; Warren et al., 2017).

Vogel et al. (2016) and Bohren et al. (2015) argue that among the variety of existing terms, the mistreatment during childbirth is the broadest and most inclusive and must therefore be used instead of all other terms. Additionally, mistreatment during childbirth may be seen as a more provider-friendly term that does not emphasize their blame for causing abuse or other forms of unsatisfactory obstetric services (Savage & Castro, 2017). Vogel et al. (2016) provide three arguments in support of such choice: 1) this term puts into focus the experience of a woman; 2) it eradicates the allusion of intentionality that such terms as abuse or violence carry and covers the wide spectrum of mistreatment; 3) it reflects different levels and contexts of mistreatment that are being inflicted upon women.

Hence, considering these notions, we use the term "mistreatment during childbirth" throughout the paper, except for cases of providing information on previous research that have used other terms.

1.2. Reasons of Mistreatment During Childbirth

As it was mentioned above, the explanations for mistreatment during childbirth occurrence can be identified at all levels of healthcare services provision: system level, facility level, interpersonal and even personal levels (Warren et al., 2017).

Warren et al. (2017) and Perera et al. (2018) claim that mistreatment during childbirth is the result of a wider problem of discrimination of women that happens in many if not all social contexts and is simply being transferred to the terrain of healthcare. They internalize gender inequality and violence they face at home and in the society and stay silent and passive about the mistreatment, especially in the so-called traditional societies, because they see relationships between a healthcare provider and a patient as hierarchical and act in accordance with the norms of behaving in front of a person whose standing in the hierarchy is higher. In other words, women are silenced by their gender socialization that tells them "not to challenge authority" (Goer, 2010).

Castro & Erviti (2003) have analyzed in-depths interviews and direct observations in the birth and labor rooms in Mexico applying ground theory qualitatively to study violations of women's rights and have revealed three patterns of behavior during childbirth that lead to "violation of women's reproductive rights": 1) the usage of the "positions of power and control" by staff in order to intimidate female patients; 2) the replication of human rights violation situations due to women's lack of familiarity with defending their rights that leads to accepting the patients' roles imposed on them; 3) the structure of healthcare facilities that discourages women from filing complaints. They claim that abuse of women's reproductive rights during childbirth is related to the organization of gynecology and obstetrics services provision and lack of attention to gender issues on the state level, as well as to the medical educational system, mainly medical residency practices. The researches state that the mistreatment incidents cannot be seen as individual or separate but as a systematic tendencies reflecting institutional norms that enables and promotes institutional violence and objectifies women.

This is supported by Goer (2010) who states that abuse in childbirth happens because of the rigidity of hospital social system hierarchy; in other words, the hospitals and healthcare system themselves are authoritarian institutions where people have different proportions of power (Perera et al., 2018). Sometimes such hierarchies may be based on the age and years of work (Warren et al., 2017). Because of this, people in the system have no other options unless to adapt. Nurses whose standing is lower than medical doctors' but higher than female patients' may enforce, collude, conceal, or inflict abuse upon women, either willingly or not, because they are forced into this behavior by the hospital system that abuses them as well, usually by medical doctors. This is supported by findings of Asefa et al. (2018), more than half of providers of whose study (57,1%) reported being disrespected or abused themselves in their workplace by either clients or colleagues. Also Raj et al. (2017) report that nurses seek to apply their power over patients who are usually less educated and poorer than themselves. Possible explanation of this lays in the fact that most nurses are women who are raised to conform with authority, which brings us to the issue of broader

gender hierarchies and inequality. Participants in the study by Balde et al. (2017) even reported that they preferred to have a male provider attending to them as they believed a man would not treat them as badly women did.

Similar perspective on social hierarchy in hospitals is provided by Castro & Erviti (2003): they point out that physicians have a central role in the healthcare settings while a patient is left with a passive role; this implies the imbalance of power that may lead to mistreatment. They are convinced that the hierarchical relationship between healthcare providers and women is the foundation for violation of the rights of laboring women. Being taught in the authoritative environment, physicians internalize such line of behavior and are unlikely to change it when challenged by those who stand lower in the social hierarchy, for example, nurses or patients (Goer, 2010; Raj et al., 2017). This is perhaps only facilitated by the asymmetry of information that a provider possesses in comparison to a woman (Warren et al., 2017; Perera et al., 2018).

This asymmetry can in some cases be a justification for mistreating actions by healthcare workers, for instance, in situations when it is assumed that a provider knows better what is best for a patient and her unborn child (Warren et al., 2017; Perera et al., 2018). It can also be a reason why the courts often take the side of the hospital or a healthcare professional. The reason for this, Diaz-Tell (2016) claims, is that the jury sees the situation from the perspective of physicians who base their decision on the conviction of knowing better what is best for a patient and her unborn child. Diaz-Tell (2016) claims that this is the result of the tendency to assign a greater value to a woman's childbearing and childbirthing function than to her agency and her body's autonomy. This, as well as the perception of fetus being a "second patient" whose interest the health workers seek to defend, are the reasons why many women are forced into caesarian sections despite their disagreement.

Goer (2010) emphasizes that the childbearing settings promote unique forms of abuse, such as the rejection of the right to informed choice due to provision of no information, not enough information, or misinformation and rejection of the right to deny medical intervention, especially surgery. Finally, there is the abuse by the legal system that considers

fetuses' rights as superior to the rights of a woman. Goer (2010, p. 37) writes that "in this respect, women are worse off than they were with domestic violence before the women's rights movement". She provides examples of legal cases held against women who somehow resisted the instructions of medical staff that were in favor of the children's potential wellness but totally disregarded women's wellbeing.

Lack of complaint or feedback, as well as redress mechanisms on both system and facility level, has been reported to facilitate the mistreatment (Castro & Erviti, 2003; Warren et al., 2017; Bohren et al., 2017). This is true in regards of not only women, but healthcare staff as well. Those staff members who dare to speak up about abuse, face the threat of being intimidated, revenged, or even fired: "closed systems create a conspiracy of silence", which means that those who attempt to challenge the system may become ostracized; this imposes conformity (Goer, 2010).

In case of women and their reporting opportunities, an important detail lies in the fact that healthcare staff are often aware of the ineffectiveness of legal and regulation systems and are sure of their impunity due to the fact that medical board and other healthcare professionals tend to protect each other in situations that may arise (Warren et al., 2017). However, even if there are effective reporting mechanisms in place, women are often unwilling to use them due to fear of the effect the complaining may have on the quality of future healthcare services provided to them and their family, not being aware or them, simply not knowing the names of their physicians and other staff tending to them during childbirth, being generally afraid or ashamed, or seeing the procedure as too consuming in terms of time, money, and emotional and physical energy (Castro & Erviti, 2003; Warren et al., 2017; Goer, 2010; Perera et al., 2018). Some women noted that when they saw other women being mistreated, they remained silent because they felt incapable to help them (Balde et al., 2017). Moreover, women were reluctant to share their mistreatment experience even with their close ones. This is how the normalization of mistreatment during childbirth happens (Perera et al., 2018). Some of them see their childbirth experience as positive despite the

mistreatment as they perceive it as successful in cases when the child is born alive (Balde et al., 2017).

Another important notion concerns the quality of medical education that, among other disadvantages, does not provide students with information on human rights or ethics (Balde et al., 2017). This leads to healthcare professionals failing to behave in accordance with professional standards. Additionally, a number of studies demonstrate healthcare staff's inability to communicate with patients effectively (Thomson & Downe, 2008; Bohren et al., 2017; Balde et al., 2017; Perera et al., 2018); this indicates that curriculums of medical universities lack courses on patient-provider communication as well.

One more system level explanation for mistreatment during childbirth lies in the system constrains that crease "stressful working environment" as opposed to healthcare staff's intention to mistreat patients (Bohren et al., 2017; Perera et al., 2018). Perceived neglect can be explained in terms of staff shortages, especially that of support staff and skilled physicians at night, heavy workload, and overcrowding by patients (Bohren et al., 2017; Warren et al., 2017; Balde et al., 2017; Perera et al., 2018). Staff shortages may be especially dare in the rural and peri-urban areas, where this can lead to the situations where the majority of staff on duty are made up of trainees (Balde et al., 2017). The healthcare system may create the ground for mistreatment if it does not address these issues (Perera et al., 2018). However, it was noted that in some cases mistreatment occurs despite hospitals having enough staff to cope with the scope of work, so this argument cannot be always used as a justification for mistreatment during childbirth (Bohren et al., 2017).

Lack of teamwork and leadership, demotivation, lack of professional ethics, deviation from set procedures and protocols or poor implementation of policies, poor management and inadequate supervision, especially over trainees who may be more likely to inflict mistreatment onto women, and lack of accountability (for example, concerning cleaning) that may result from weak leadership and stewardship, as well as corruption on the system level, may also contribute to mistreatment (Warren et al., 2017; Balde et al., 2017).

The condition of a healthcare facility and its financial and resource constraints may play a role in mistreatment as well. Some hospitals do not have enough beds, so women have to give birth on the floor or share beds, separate wards, curtains, or doors to ensure privacy, or lack constant water supply, electricity, hygienic surroundings or other basic infrastructure. Some facilities have to request money to buy drugs or food. This is sometimes due to poor forecasting of needs, lack or misuse of funds. In turn, this lack of essential physical resources leads to increased stress in providers who project it onto women (Balde et al., 2017; Warren et al., 2017).

In some cases, the mistreatment (or rather actions seen as such) can be provoked by a woman's behavior. For instance, women may lash out on providers who in turn do not wish to provide good care (Castro & Erviti, 2003; Warren et al., 2017; Bohren et al., 2017; Balde et al., 2017). Healthcare providers sometimes justify their behavior by women's lack of cooperation and obedience explaining that they seek to help them by being strict (Bohren et al., 2017; Balde et al., 2017). For example, slapping is seen as justifiable if it is intended to make a woman cooperate or encourage her in order to ensure good health outcomes for baby; providers use such behavior because they are afraid of being blamed for bad pregnancy outcomes as they believe that they should appear tough in order to be listened to (Warren et al., 2017).

Finally, women might not know what to expect during childbirth and not know their rights which makes it easy to mistreat them (Warren et al, 2017). Castro & Erviti (2003) suggest that women are generally inexperienced in defending their rights and childbirth is just another aspect of a broader picture; moreover, it may contribute to the basis of women's rights violation in general. They argue that women may contribute to the mistreatment themselves by justifying the actions of staff. Authors note that in some cases women internalize the judgments of providers, clearly using healthcare staff's words and opinions when talking about their experiences of giving birth.

1.3. Displays of Mistreatment During Childbirth: Overview of the Previous Studies

Mistreatment during childbirth has been studied from a range of frameworks which indicates the variety of perspectives on this phenomenon. Some studies treat it as a human rights violation, still others apply feminist approach and view it as a type of gender-based violence (Castro & Erviti, 2003;Vogel et al., 2016; Oladapo, & Gulmezoglu, 2016; Raj et al., 2017). Castro & Erviti (2003) specify that mistreatment during childbirth is the violation of reproductive rights or naturalized form of rights violations, not merely an issue of quality of care, and should be therefore viewed as one of the manifestations of gender oppression, a concept that lies in the center of feminist theory.

Goer (2010) draws parallels between abuse in childbirth and domestic violence, explaining that the same motives, desire for power and control over "victim's inferior position", lay at the base of both. Healthcare providers attempt to strengthen this power and override the opposition in many ways: by eliminating the potential sources of resistance (for example, banning doulas from participating in the childbirth, either during the process or prior to it), by using coercion, verbal or physical abuse, threats of physical harm, and comments with sexual hints. Goer (2010) states that some abuse that happens during childbirth would often be seen as sexual assault should it happen in any other medical department, but is not considered as such in the childbirthing context due to the "intimacy and sexuality of childbirth".

Perera et al. (2018) have come to studying obstetric violence after researching Sri Lankan women who experienced domestic violence during pregnancy and learning that many of them face violence coming from healthcare providers, including that during childbirth, as well. They applied the intersectional theory that grounds on the concepts of power and oppression and how different hierarchies intertwine and guide social interactions between people. Simply put, according to the theory, how one is treated depends on the interlacing of their identities.

There is indeed evidence that mistreatment during childbirth is of intersectional nature, meaning that it does not exist in the "situational vacuum" but can rather be induced by some factors. Particularly, studies have shown that certain women are more likely to experience mistreatment during childbirth than others.

One of such factors is age. Young women, especially adolescents, those giving birth for the first time, and unmarried ones are reported to be more vulnerable to mistreatment during childbirth (Soet, Brack, & Dilorio, 2003; Vogel et al., 2016; Bohren et al., 2017; Warren et al., 2017; Perera et al., 2018). It is suggested that adolescent girls may be more susceptible to mistreatment due to being judged for becoming pregnant too early (Bohren et al., 2017; Perera et al., 2018) or because of lack of experience and knowledge regarding what to expect from the healthcare system (Bohren et al., 2017). On the other hand, this lack of experience with healthcare system and knowledge on the childbirth process can lead to situations when certain professional conduct of healthcare workers, especially that delivered in a strict fashion, may be seen as violence or mistreatment (Perera et al., 2018). The opposite, that is, knowing too well what to expect and seeing every overstep as a mistreatment, is true for more experienced (multiparous) and, respectively, older women who are more likely to experience mistreatment as well (Warren et al., 2017; Perera et al., 2018). Studies show that experienced and older women can be left to give birth alone seeing as they "already know what to do" (Warren et al., 2017; Raj et al., 2017).

Another category that may be at higher risk of being mistreated during childbirth is poorer women, women belonging to lower castes, and less educated women; this might be related to their economical inability to pay for the private services of higher quality (Vogel et al., 2016; Bohren et al., 2017; Warren et al., 2017; Raj et al., 2017; Perera et al., 2018). In some cases, providers are less willing to provide poorer women with any information because they see them as stupid or being not able to understand anything anyway while the medical workers do not have enough time to explain (Warren et al., 2017). As justified by a participant of the study by Bohren et al. (2017), educated women face less abuse because

staff does not feel the need to “clash” with them seeing as they are educated enough to understand them.

Women practicing certain, usually minority religion or religion that differs from the provider’s or speaking a minority language are reported to be more likely to be subjected to mistreatment during childbirth as well (Bohren et al., 2017; Perera et al., 2018). Having certain ethnic or tribal background or being a migrant has been noted to also be a risk (Soet, Brack, & Dilorio, 2003; Vogel et al., 2016; Bohren et al., 2017; Warren et al., 2017; Perera et al., 2018). Research on mistreatment during childbirth in Kenya shows that belonging to the same ethnic group (tribe) as a healthcare provider can mean better treatment, less chances of abandoned in childbirth and decreased necessity to give bribes; on the other hand, if a woman knows that a majority of providers of a certain facility belong to a different ethnic group, she may not go to this facility in favor of the one where people from her tribe work, or give birth at home (Warren et al., 2017). This shows that prejudice against certain groups of people can extent to the services provided by healthcare personnel (Perera et al., 2018).

Some health statuses may increase the risk of mistreatment and birth-related trauma, for instance, having a preexisting mental illness, high level or anxiety, history of sexual trauma (Soet, Brack, & Dilorio, 2003), or being HIV-positive (Vogel et al., 2016). Women living with HIV sometimes attempt to hide this from medical workers in order to avoid being discriminated, endangering providers and their newborns (Bohren et al., 2017). On the other hand, if they do not do this, they risk being avoided or abandoned due to fear and lack of knowledge. Some women even refuse to go to the facility because of fear of being tested and their test result being disclosed to the community (Warren et al., 2017).

Not arranging for childbirth in a certain hospital in advance (as in not having a record in a hospital) may lead to mistreatment as well seeing as healthcare providers may see this as being not prepared for delivery (Bohren et al., 2017).

Studies conducted among providers demonstrate that healthcare personnel is mostly aware of mistreatment during childbirth occurring in the hospitals; furthermore, some providers view it as common and even to some extent trivial practices (Perera et al., 2018).

However, providers often deny the fact of mistreatment happening in their healthcare facilities and claim that it is the outcome of women's imagination; they support their opinion by stating that women sometimes cannot articulate in what way exactly they were mistreated. However, women themselves claim that mistreatment, especially in a form of verbal abuse, happens all the time, and this is supported by other healthcare providers. At the same time, providers that participated in the Nigerian study on mistreatment state that they do not have an intention to harm women by using abusive language and that they feel bad and apologize to them afterwards (Bohren et al., 2017). According to some studies, abuse of women during childbirth is not always seen as mistreatment (by both providers and even sometimes by women themselves) because of the good intention behind it, and mistreatment being a tool for gaining obedience and cooperation (Bohren et al., 2017; Balde et al., 2017; Warren et al., 2017). In some cases, women participating in the study blamed other women for lack of cooperation instead of blaming staff for mistreatment (Bohren et al., 2017). In other words, providers and patients view abuse as an acceptable approach of clinical practice. This leads to the normalization of mistreatment during childbirth (Raj et al., 2017; Perera et al., 2018; Asefa et al., 2018) which is, concurrently, one of the biggest risk factors for its occurrence (Bowser & Hill, 2010; Asefa et al., 2018). An important notion is however that women see their childbirth experience as mistreating mostly because of how they were treated, not because of the external conditions (Reed, Sharman, & Inglis, 2017).

There is mixed data concerning whether certain medical staff mistreats women more than other medical staff. Certain publications support this suggestion: in Sri Lankan study, it was noted that the mistreatment is mainly coming from nurses and midwives and that they tend to behave much more civilly with the presence of physicians. However, this contradicts the words of other study participants who experienced violence coming from medical doctors as well (Perera et al., 2018). The results of Indian study also show that women are more likely to report mistreatment if they are tended to by a nurse or an "unskilled birth attendant" instead of a medical doctor or a midwife (Raj et al., 2017).

There is evidence that the presence of trainees may increase the chances of mistreatment in childbirth. The providers in the Guinean study believe mistreatment happens because of the lack of experience and expertise and underqualification of providers, which is especially true of trainees. Women in the study report that they like trainees less of all and feel nervous around them because they never provide any explanation after the exams, are more short-tempered than other staff and tend to send women for cesarean section if they do not deliver fast enough, conduct painful and unnecessarily frequent vaginal examinations and low quality episiotomies because of their lack of experience and skill (Balde et al., 2017; Warren et al., 2017).

Region-, country-, and healthcare system-specific manifestations of mistreatment during childbirth can be found. For instance, in the United States of America, perhaps the most commonly reported kind of mistreatment is coercion into the caesarian section. Women are often forced into having cesarean section despite the lack of objective necessity for this and without regard for their willingness to undergo the procedure. In these cases, the coercion is not physical but rather psychological and emotional as the tools applied include intimidations and threats, for example, the threat to contact child protection services, sue for the deprivation of parental rights, arrest a patient, or get a court order to conduct surgery against a patient's will. In some cases, these threads are brought into action (Goer, 2010; Diaz-Tello, 2016).

On the other hand, the types of mistreatment that are typical mostly for so-called developing countries are restraining a woman by tying her to the bed, making her clean after herself after giving birth, and forced detainment in the hospital (Bohren et al., 2017; Balde et al., 2017; Warren et al., 2017; Asefa et al., 2018). Women are often asked to pay informally for materials or to give bribes despite maternity healthcare in the countries being free. They can be held in the healthcare facilities until they pay the bills, fees, or provide bribes despite it being illegal (Balde et al., 2017; Warren et al., 2017). In some cases, women are forced to work in the facility. Often, mothers are not provided with a bed or nutrition, and only an infant is given accommodation. Mothers can be separated from babies and be

allowed to breastfeed only at fixed times. An alternative form of detainment is keeping the woman's ID card at the hospital so that she is unable to receive any other social services or medical care. However, there is also an alternative view on detainment in hospitals: as some providers in the study by Warren et al. (2017) explain, women are sometimes abandoned at the hospitals by their relatives because they do not own enough money to pay the fees.

Perhaps the most often reported manifestation of mistreatment is verbal abuse (Goer, 2010; Bohren et al., 2017; Perera et al., 2018). One of the examples is threats or coercion in a form of a threat for acquisition of a woman's consent to a certain medical procedure (Castro & Erviti, 2003; Balde et al., 2017; Perera et al., 2018). There are different examples of threats: to conduct cesarean section without a woman's consent under general anesthesia if she does not agree to the surgery before the labor, to take away her baby or to contact child protection services if she does not consent to a proposed intervention, to use contraceptive devices, to make her leave health facility or to not provide care to her, threats of physical harm or violence (Castro & Erviti, 2003; Goer, 2010; Diaz-Tello, 2016; Reed, Sharman, & Inglis, 2017; Balde et al., 2017; Bohren et al., 2017). Reed, Sharman, & Inglis (2017) even distinguish such phenomenon as a "dead baby threat", a threat used by healthcare providers to coerce women into interventions they initially do not consent to or to make them cooperate by telling them that their babies would otherwise die or asking them if they wanted their babies dead (Bohren et al., 2017; Reed, Sharman, & Inglis, 2017). Some women in their study report that the danger to the life of their babies has been unfounded. Reed et al. (2017) note that threats are mainly justified by the wellbeing of a child, but when the wellbeing of a mother is taken into consideration, the providers do not consider psychosocial risks and focus solely on the physical ones.

Among other forms of verbal abuse are insults, scolding, humiliation (including humiliation for occurrences that are out of women's control, such as "when amniotic fluid or blood splashed on the provider"), yelling, lying (for the sake of coercion into procedures and interventions), rudeness, silencing, discussions about a woman's intimate life, mockery, criticism, judgment, blaming, for example, for bad pregnancy outcomes like the death of a

child (Balde et al., 2017; Warren et al., 2017; Bohren et al., 2017; Reed, Sharman, & Inglis, 2017; Perera et al., 2018).

Physical abuse is often accompanied with verbal abuse (Balde et al., 2017). Among manifestations of physical abuse are slapping, hitting, pinching, pushing, physical punishment, tossing around, application of pressure or sitting on women's abdomens during childbirth. Healthcare providers are reported to use physical force to make women comply with the procedures, remain in a certain position (on their back) during labor, be still while they conduct a procedure (Bohren et al., 2015; Balde et al., 2017; Warren et al., 2017; Reed, Sharman, & Inglis, 2017; Perera et al., 2018; Asefa et al., 2018).

Sexual abuse, despite it being isolated in the classification by Bohren et al. (2015), is not reported very often. Among the cases provided in the literature are being touched on the breast by a male worker while lying after a cesarean section and inappropriate sexual comments (Castro & Erviti, 2003; Goer, 2010; Perera et al., 2018). When talking about mistreatment during childbirth, researchers usually mention sexual abuse only superficially (Goer, 2010; Bohren et al., 2015). However, some researchers compare mistreatment during childbirth with sexual abuse or sexual crimes seeing as women may perceive it in the context of their sexuality (Thomson & Downe, 2008; Reed, Sharman, & Inglis, 2017).

Reed et al. (2017) studied birth-related trauma and found that many women perceive their experience through the lens of sexual trauma. When talking about their childbirth, many compare it with being raped or sexually assaulted and use rape-associated language. They share that they feel humiliated, violated, damaged, disgusting and treated as "a piece of meat" or like animals. Those who have previously experienced rape or sexual assault report they feel triggered, and one woman even states that giving birth felt worse than being sexually abused. And indeed, Soet et al. (2003) suggest that women with previous experience of sexual trauma are twelve times more likely to perceive childbirth as traumatic.

Castro & Erviti (2003) have discovered that the childbirth process may be seen as sexualized by healthcare providers as well. They may voice inappropriate sexual allusions, as in seeing the childbirth pain and suffering as a punishment for having sex and enjoying it

(Bohren et al., 2017). In some extreme cases, healthcare providers may voice assumptions of women enjoying the process of vaginal examination or diving birth, taking their groans of pain for groans of pleasure.

Thomson & Downe (2008) study childbirth in the context of a wider trauma. They compare the trauma gained during childbirth with trauma as the result of crime violence and abuse, noting that there is a lot in common. The three notions they distinguish (being disconnected, helpless, and isolated) have a strong similarity with what criminal victims claim to feel as the result of an assault. The women participating in the study use quite strong adjectives to describe their experiences, comparing them with "violence, torture, and abuse". This is supported by the study by Goer (2010) who states that some women describe their childbirth as an assault or torture.

Women explain that they have no opportunity to bond with staff due to their coldness and formal attitude towards patients (being disconnected). This is only enhanced by the fact that throughout childbirth, women are usually treated by numerous people and have no opportunity to create a strong bond with any of them. Healthcare staff often dismiss women's experiences. Researchers see the alienation women feel during childbirth as the "effort to create a connection with the perceived perpetrator of abuse to control an otherwise uncontrollable conflict". Women say they feel as if they were observing what happened from the outside, which indicates the highest degree of alienation and is an example of a coping mechanism which is often described in the contexts of "torture, sexual abuse and domestic violence" (Thomson & Downe, 2008).

Thomson & Downe (2008) note the imbalance of power between providers and women and that this is the factor that usually leads to violence. The alienation leads to helplessness due to the lack of agency related to the lack of personal attention of the providers. They claim they do not feel as if they participate in their own labor because they do not have a say in it. The researchers explain that a patient's agency is limited in three dimensions: physical, cognitive, and psychological. This, again, reminds of an actual torture and how it feels. Women explain that they have to agree to certain procedures they would otherwise not

consent to in order to avoid further distress. During childbirth, women feel pain, fear, and lack of understanding that is the result of the alienation. Women report feeling isolated, as in childbirth being a dehumanized process that objectifies them and strippes off their agency. Women describe actual fear of death due to the lack of communication and understanding of what is happening that yet again resonates with the wider understanding of trauma. Women do not feel as if they have given birth. The expectations about childbirth and the reality differ grandly. They describe childbirth as a situation "in which no-one can help them".

Some kinds of abuse are often overseen by women because they happen behind their backs, without their consent or knowing of a procedure taking place (Goer, 2010). Lack of consent is an important notion in the context of mistreatment during childbirth seeing as providers often do not acquire it before a procedure or do not provide women with sufficient information to make an informed decision (Soet, Brack, & Dilorio, 2003; Goer, 2010; Warren et al., 2017; Asefa et al., 2018). Sometimes providers lie in order to calm women and conduct the procedure anyway, and sometimes they can do it despite their explicit objections (Reed, Sharman, & Inglis, 2017). This can be seen as a facet of miscommunication or lack of communication between healthcare providers and patients that may lead to or create the perception of violence (Perera et al., 2018). Among medical procedures that happen despite the lack of consent or after a woman is forced to provide her consent are cesarean sections, inductions of labour, and vaginal examinations (Diaz-Tello, 2016; Reed, Sharman, & Inglis, 2017; Reed, Sharman, & Inglis, 2017).

Another indicator of mistreatment during childbirth is diminishment of a woman's knowledge, feelings, or experiences "in favour of their care provider's assessment of events" (Reed, Sharman, & Inglis, 2017). Goer (2010) provides examples of medical staff devaluing women's judgment by not believing them when they state that the anesthetic does not work and continuing the surgery. Reed et al. (2017) provide an example of providers not paying attention to women who felt that there was something wrong with their children. Castro & Erviti (2003) explain that during childbirth, women are being directly or indirectly instructed

to obey the medical staff in order to avoid any health consequences without questioning their authority. Women's experiences, knowledge, and opinions are being dismissed, providers may withhold information, invalidate women's discomfort and pain, and minimize their role in the childbirth to a "helper". This can also be expressed in a form of small autonomy, as in not being involved in the decision making, and is only intensified by usage of language the women do not understand. This lack of control over what is going on makes women feel violated (Warren et al., 2017; Reed, Sharman, & Inglis, 2017). As a result, they feel that what happens during childbirth is not in their best interests, but providers', as they tend to prioritize their own agenda over women's needs (Reed, Sharman, & Inglis, 2017). Diminishing is closely related to objectification. Women can be used as "learning resources", especially if their cases are somehow unusual (for example, giving birth to twins or breech birth), or be learned upon by trainees without their consent (Reed, Sharman, & Inglis, 2017).

Another form of mistreatment during childbirth is neglect and abandonment (Warren et al., 2017). It can appear in a form of punishment for not complying with the instructions, for example, to stop crying or shouting in pain, or in the form of ignoring; sometimes providers do not pay women any attention till the moment of delivery because they have not yet delivered and therefore do not need any help, in other cases neglect and abandonment during all stages of hospital stay is reported (Castro & Erviti, 2003; Warren et al., 2017; Balde et al., 2017). The participants of a Guinean study complain that they always deliver alone because providers have other things to do or take time to rest. Women note that providers do not even look at them when delivering their babies (Balde et al., 2017). Patients may also feel neglected if their privacy is violated (Bohren et al., 2015). Providers in the study by Balde et al. (2017) do not agree that women are abandoned and show understanding of the outcomes an unobserved childbirth can have. They explain that some women do not need assistance during childbirth and believe that women should be prepared for childbirth upon coming to the health facility. They note that those who give birth for the first time usually need more attention.

Disclosure of personal information is an important sign of mistreatment during childbirth. Healthcare workers may discuss patients and their medical information with other personnel thus breaking their confidentiality or disclose information about their HIV-status. Confidentiality can be broken because of lack of resources and privacy, leading to situations when women have to undergo examinations or provide personal information where other people can see or hear them (Balde et al., 2017; Warren et al., 2017).

Perera et al. (2018) have discovered that mistreatment during childbirth gets publicity quite rarely and only in the extreme cases. More “routine” and moderate cases that have no visible health damage are often not seen as crimes and are difficult to address.

There is a distinct lack of studies on mistreatment of women during childbirth that apply quantitative methodology. After exploring the existing quantitative research on the trauma related to childbearing and childbirth, Soet et al. (2003) estimated its prevalence at 20 to 30 percent and the prevalence of posttraumatic stress disorder (PTSD) as 2 to 6 percent. This is supported by their findings: 34% of prospectively interviewed USA women have experienced obstetric care as traumatic and almost 2% have developed PTSD. They discovered that available literature lists such environmental factors that may contribute to the development of postpartum stress disorder as staff hostility, the perceived lack of power, insufficient provision of information, and interventions provided without prior consent. On the other hand, the presence of a female support or a partner decreases this risk, and vice versa. This relates to their own findings of factors that increase the risk of childbirth being perceived as traumatic: cesarean section, “more medical intervention, more pain in the first stage, longer labor, more negative expectation differences, more feelings of powerlessness, and receiving inadequate information”. Soet et al. (2003) note that 19 participants had symptoms of PTSD but did not recognize their experience as traumatic. They suggest that possible explanations for this may be unwillingness to acknowledge negative childbirth experience and pressure on women to feel happy about giving birth to a child and prioritize it over themselves.

Raj et al. (2017) discovered that 20,9% of participants of their study experienced mistreatment by a healthcare provider during birth, however, the real number might be even higher as the researchers did non include the system manifestations of mistreatment as outlined by Bohren et al. (2015). Most often mentioned manifestations of mistreatment in their study are “discriminatory behavior” (9,7%) and forceful pressure on the abdomen during delivery (8%). They have also discovered that those women who reported pregnancy complications were statistically more likely to experience mistreatment during childbirth. Similarly, those who have experienced mistreatment were more likely to report postpartum complications. However, the researchers emphasize the inability to establish the causality of these events.

Asefa et al. (2018) provide evaluation of mistreatment from the viewpoint of healthcare providers. 25,9% of them stated that they witnessed the staff of their facility use physical force or abrasive behavior towards women. 14,5% reported that they have ever personally inflicted disrespectful and abusive behavior onto women. Furthermore, 40,4% have never introduced themselves to women, 20,4% have never let women choose the position during birth, 19,6% have never provided proper pain relief, and 14% have never received consent prior to a procedure. 7,4% have seen that children were separated from mothers after the labor unreasonably, 13,2% have observed mothers being unattended during childbirth. A third part of providers stated that a women’s privacy during labor and delivery was not ensured.

Recent observational study of mistreatment during childbirth in four countries (Ghana, Nigeria, Guinea, and Myanmar) by Bohren et al. (2019) showed the following results: 14% of respondents have been physically abused during their labour, 37,8% abused verbally, 0,6% have faced stigma or discrimination. The rate of unconsented cesarean sections amounted to 13,4%, and 75,1% have been subjected to unconsented episiotomies. More than half (59,4%) were examined vaginally without prior consent or informing, 33,8% did not receive pain relief they asked for. 94,4% patients have not been asked about their preferred birthing position.

1.4. Effects of Mistreatment During Childbirth

Mistreatment during childbirth can have consequences for women personally and for the society in general and scale from minor to major, but most of them are long-lasting (Goer, 2010). Balde et al. (2017) have divided women's responses to mistreatment into three categories: (a) "acceptance and forgiveness"; (b) revenge; and (c) changes in the patterns of applying for healthcare services. In the first case, women forgive the providers because everything ended well, that is, they delivered a healthy baby, or because they do not see any other options. This is supported by Goer (2010), who explains that some women prefer to forget and leave what happened behind. Another reason why this happens is because women do not see mistreatment as something serious (Balde et al., 2017).

Some women stated that they would not return to the same hospital for future childbirth or would give birth at home (Bohren et al., 2017; Balde et al., 2017; Warren et al., 2017; Asefa et al., 2018; Balde et al., 2017; Reed, Sharman, & Inglis, 2017; Perera et al., 2018). This is perhaps the most often cited outcome of mistreatment during childbirth. Vogel et al. (2016) explains that, despite facility birth being more safe in terms of maternal and perinatal morbidity rates, as well as having other health benefits, some women avoid giving birth in healthcare facilities in favor for more dangerous home births mostly due to previous experience of receiving health services in a facility. Warren et al. (2017) have discovered that in Kenya, poor women decide to give birth at home or with a traditional birth attendant mostly due to fear of being detained in the facility. This is due to the fact, as Perera et al. (2018) conclude, that obstetric care facilities are sometimes the places where pregnant or delivering women face violence, undignified care, and suffering. Women report decrease in the trust towards medical workers (Perera et al., 2018); some decide to not attend healthcare facilities at all (Bohren et al., 2017).

Sometimes women decide to "change the course of their reproductive lives" (Diaz-Tello, 2016) by deciding to not have any more children, avoiding having more children, or undergoing sterilization just to avoid being mistreated in the future (Soet, Brack, & Dilorio,

2003; Warren et al., 2017; Perera et al., 2018). An important issue concerning prospective influence of mistreatment is that it can influence a woman's decisions about childbirth even if it happened with other people; in other words, the mistreatment should not happen to a particular person in order to influence her (Balde et al., 2017).

Women who have experienced mistreatment during childbirth may have psychological and emotional traumas related to triggering events and therefore need therapy (Goer, 2010; Diaz-Tello, 2016; Bohren et al., 2017). Some develop depression and posttraumatic stress disorder (Soet, Brack, & Dilorio, 2003; Reed, Sharman, & Inglis, 2017) and such posttraumatic stress reactions as nightmares, disturbing memories, and anxiety; still others may fear sexual intimacy. Among possible outcomes are difficulties with post-delivery acclimatization and psychological functioning (Soet, Brack, & Dilorio, 2003). Also, women may struggle with bonding with a baby and "long-term attachment problems" (Soet, Brack, & Dilorio, 2003). In turn, this can negatively influence the future development of a child (Reed, Sharman, & Inglis, 2017).

Mistreatment during childbirth may have professional consequences for women as well. Goer (2010) provides an example of a physician unable to return to medical practice after suffering abuse during childbirth due to acquired PTSD and healthcare environment becoming a trigger for her. In some extreme cases mistreatment during childbirth can result in the death of a baby (Castro & Erviti, 2003; Balde et al., 2017). Women who have experienced mistreatment may sue or at least attempt to sue practitioners or institutions, but this rarely ends in their favor (Diaz-Tello, 2016).

1.5. Solutions for Overcoming Mistreatment During Childbirth

Mistreatment during childbirth is not a new or emerging problem, but it is not yet widely recognized and just begins being acknowledged. Most countries do not regulate or punish mistreatment during childbirth seeing as only few have it mentioned in their law (Diaz-Tello, 2016), and there is little evidence as for how to eliminate or decrease its

prevalence (Vogel et al., 2016). This is why we can list recommendations on the ways to eradicate this problem, but not best practices and strategies that have proven effectiveness.

Many researchers underline the need for addressing the issue at several levels: at the level of a healthcare system, at the level of facilities, and at the personal level (Bohren et al., 2015). It is also impossible to prevent mistreatment during childbirth without addressing the context in which it occurs, as the environment of service provision often creates the basis for it (Castro & Erviti, 2003; Vogel et al., 2016).

Perhaps the first recommendation would be to introduce policies banning mistreatment during childbirth, as well regular supervision, monitoring, and evaluation enforced by an accountability and effective punishment system. The literature suggests that women should be provided with legal support (for example, advocates) in cases they were mistreated (Bohren et al., 2017; Raj et al., 2017; Perera et al., 2018). An alternative way would be to reorient the system to endorse those who provide women-friendly services (Goer, 2010).

Vogel et al. (2016) suggest introducing audits and feedback for maternity care as these interventions have demonstrated effectiveness in improving the provision of general healthcare services. They propose to use interventions that have proved to be successful in similar areas, such as stigma and discrimination reduction or addressing gender-based violence. The issue, however, should be addressed collectively with many parties and stakeholders, including women themselves. More close supervision of staff and feedback mechanisms are generally supported by several other researchers (Castro & Erviti, 2003; Raj et al., 2017; Perera et al., 2018). As an option, a hospital-level mechanism for complaining and meetings for provider-patient communication should be established (Bohren et al., 2017).

The changes should be introduced at the point in time before healthcare providers enter the professional field (Raj et al., 2017; Perera et al., 2018): namely, when they get their education. Topics on reproductive and sexual rights, professional ethics, and empathy should be introduced in the curriculum of medical students (Castro & Erviti, 2003; Perera et al., 2018) and repeated in the form of professional training for those who have already graduated

(Perera et al., 2018). The trainings should also be related to the issues of stress management (Bohren et al., 2015; Warren et al., 2017), burn-out, motivation, and patience techniques (Bohren et al., 2017), values, attitudes and beliefs (Warren et al., 2017).

However, it is also important to address the system limitations, as in providing staff with higher salaries and increasing the number of staff in the hospitals. The hospitals should be planned in such a way to ensure they have enough private space for all patients and their companions and have proper restrooms (Bohren et al., 2017).

Participants of the study in Guinea (both women and providers) have provided the suggestions for preventing mistreatment during childbirth that can be divided into three groups. First, the solutions related to women: to better prepare them to what they should expect during childbirth in order to increase their knowledge on the topic and to enable the exchange of ideas between them, their families, and providers to solve the issue of mistreatment. Second, solutions related to service providers: to make services equitable for all women regardless of their income level, conduct trainings for providers on the "interpersonal skills, coping with stress and effective communication" and increase their motivation to provide services by increasing their salaries and introducing pay-for-performance. This last recommendation is supported by Bohren et al. (2017), who think that introducing the system "pay for performance" may have a positive effect in terms of decreasing mistreatment. Thirdly, solutions related to facility and healthcare system level: to increase the number of qualified healthcare providers to decrease the workload of medical workers accordingly, improve supply chains for reliable supply, to "improve physical resources", including increasing the number of beds, and increase the quality of basic infrastructure (Balde et al., 2017).

It is important to raise awareness around mistreatment during childbirth (Warren et al., 2017). One of the ways to ensure the problem is visible is encouraging women to be vocal about their experiences during childbirth by providing them with tools to do this (Castro & Erviti, 2003).

Finally, studies show that the presence of a labor companion (husbands, partners, relatives, close ones, doulas, or other persons) may decrease the chances of mistreatment during childbirth due to advocacy partners provide for women (Soet, Brack, & Dilorio, 2003; Bohren et al., 2017).

1.6. National Context of Mistreatment During Childbirth

Ukraine is a country that has been reforming its healthcare system since 2016, for the first time since its independence in 1991. As of May 2020, it has successfully conducted the first stage of health financing reforming of the primary healthcare and has launched the second stage of reforming of the secondary healthcare level that includes maternity and childbirth services. One of the main focuses of the reform is to shift the principle of healthcare funding from the centralized Semashko-based model of facility funding to the patient-based funding of separate cases (MHU, n.d; MHU, 2018). According to the objectives of the reforming, the provision of childbirth services in Ukraine is to become completely free of charge for the patients, seeing as up until now, they were supposed to provide informal payments (Stepurko et al., 2013; Miteniece et al., forthcoming).

According to the national statistics, in 2017, there were 75 state maternity hospitals, 17 006 hospital cots for pregnant and postpartum women (17 per 10 thousand women aged 15-49), 11 549 obstetricians (2,7 per 10 thousand population: 5,1 per 10 thousand women of all ages and 11,6 per women aged 15-49), 18 199 midwives (4,3 per per 10 thousand population: 8 per 10 thousand women of all ages and 18,2 per women aged 15-49). The incidence of pregnancy, childbirth, and postpartum care was reported to be 381 816 in 2017 (SSSU, 2018).

The literature body on the mistreatment during childbirth in Ukraine almost entirely consists of or is related to the research and advocacy work done by the Natural Rights Ukraine NGO and goes back only to 2016. For instance, their first report “Human Rights in Childbirth” (Demianova-Ponomarenko et al., 2016) prepared in cooperation with several

other organisations and institutions has been the first publication to complexly explore the issue of violation of human rights in the context of childbirth. The report provides the following examples of such violations: resistance to partnered birth, lack of information, including that of the side effects of certain medical manipulations, psychological pressure, including pressure into labor induction or stimulation, limitation of freedom of movement or free choice of birth position, lying (breaking promises given at the prenatal stage), punishment by abandonment for arguing or not confirming with the staff, "dead baby threats" as articulated by Reed et al. (2017). The report mainly focuses on the non-consensual care and its numerous variations, for example, conduct of manipulations without information and consents, such as episiotomy or amniotomy, lack of information concerning the manipulations patients are supposed to provide consent to, formality of consent forms, for example, its provision at the moment when a woman is not able to read and understand it due to being in labor, asking consent for interventions without an option to deny them, inability to refuse certain manipulations. Demianova-Ponomarenko et al. (2016) conclude that there are no real accountability mechanisms. Even though there are "ways" to complain, for example, by appealing to a head physician (which often proves to be ineffective due to high "intra-doctoral and intra-hospital loyalty"), there are no legal mechanisms or precedents of accountability for mistreatment during childbirth in Ukraine. Moreover, the authors add that they are not aware of any cases of physicians being punished for it as well. Because of this, women do not even try to complain.

In 2016, the Natural Rights Ukraine launched an internet-based flashmob #BreakTheSilence! (Ukr. #ГодіМовчати!) that led to the first media mentions of obstetric violence in Ukraine and generated public interest in the topic. The flashmob encouraged women to speak up about abuse they experienced during their childbirth. It was followed by several media articles on the topic by the organizers of the flashmob (Salnykova, 2016; Gorbenko, 2016). In 2018, the Natural Rights Ukraine published a pamphlet on the rights of women during childbirth, examples of mistreatment they can encounter in the maternity

hospitals, and ways to avoid it (Salnykova et al., 2018). The information presented in all these publications corresponds to the described above.

As a result of advocacy work done by the Natural Rights Ukraine, the topic of mistreatment during childbirth started attracting public attention, as evident from several publications in the media (Goncharuk, 2018; Panasyuk, 2018) and acknowledgment by former Ukrainian Minister of Healthcare Ulana Suprun (Suprun, 2020). Hence, a public discussion of mistreatment during childbirth in Ukraine has been initiated, however, the topic still lacks reliable and representative quantitative data on the prevalence of this phenomenon, as well as publications based on the academic approaches.

To summarize the literature review, the mistreatment during childbirth is an emerging topic that has accumulated enough evidence to indicate its international prevalence. It manifests through a variety of displays, including physical, sexual, and verbal violence, abandonment in care, neglect, discrimination, coertion, and others. Reasons for mistreatment during childbirth are identified on the personal, institutional, and system levels and include lack of redress mechanisms, system constraints, unpreparedness of patients, and many others. It can lead to changes in the reproductive plans of patients, decreased trust in medical workers, traumas. Among the solutions for overcoming mistreatment during childbirth are legal interventions, supervision and feedback mechanisms, and education of women. There is limited evidence concerning mistreatment during childbirth in Ukraine, however, the available data indicates its existence.

CHAPTER 2. METHODOLOGY

2.1. Research Design

The empirical part of this thesis employed the qualitative approach to data collection and analysis in the form of grounded theory. The main reason for choosing this approach was associated with the little scientific evidence of mistreatment during childbirth in Ukraine and therefore lack of relevant categorizations and frames applicable to the national context. Because of this, it seemed that an exploratory qualitative study would be more preferable in terms of the preliminary framing of the phenomenon. The results of the current study could support future quantitative research on the topic and reinforce the validity and reliability of quantitative tools necessary to conduct them.

Preparation of data collection tools took place in October-November 2019. The expert interviews were collected in November; this was followed up by several short consultations with the experts throughout the process of thesis writing. The interviews with women who experienced mistreatment during childbirth took place in November-December 2019. The transcription of interviews was conducted in January-March 2020; the analysis took place in April 2020.

2.2. Respondents and Their Selection

To recruit the expert-respondents, the snowball method was used. An expert who was among the first people to articulate the problem of mistreatment during childbirth in Ukraine in the public discourse was chosen as the seed agent. The rest of the expert-respondents were chosen on the basis of their professional involvement with the topic of mistreatment during childbirth. We did not consider medical workers involved in childbirth as a sample unit in our study because, due to the sensitivity of the topic, we do not expect them to be honest but rather expect a high degree of socially desirable bias as they could show their incompetence.

All interviews were conducted during November 2019; several experts were contacted additionally at the later stages of the study for clarification of data received from women. The list of interviewed experts is provided in the Appendix A.

After interviewing the experts, women-who-had-childbirth-respondents recruiting was launched. It was done through the post on the personal Facebook page of the researcher (see Appendix B) that was then shared by Natural Rights Ukraine (the NGO whose main focus is the advocacy in the field of pregnancy, childbirth, and motherhood, several representatives of which participated in the research as experts) and other people (78 shares in total).

The Facebook post provided information about the study and encouraged the participation of women who gave birth in Ukraine since January 1, 2015 (during five years preceding the study) and whose childbirth experience left them with a certain "aftertaste" (Ukr. "осад"). It was decided to set a time limit for the childbirth experience seeing as it was repeatedly stated by the experts and by the respondents themselves later on that the situation with childbirth in Ukraine has markedly improved in recent years. For this reason, it was determined to study the latest experiences in order to correct for time bias.

2.3. Research Tools

In the first stage of the empirical study, two semi-structured guides were developed: one for the experts in the topic and one for the women who had childbirth.

The guide for interviewing the expert-respondents contained questions on the expert's history within the topic, typical dysplays of mistreatment observed in Ukraine, reasons for them and effects they might have on the women and society in general, and ways to solve the problem of mistreatment (see Appendix C for the guide for the experts).

The guide for interviewing the women-who-had-childbirth-respondents consisted of several blocks: introduction (see subchapter 2.5. Ethical Considerations for information that was provided at the beginning of every interview), icebreaker, preparation to childbirth, beginning of the labor, childbirth (with an additional block for those who delivered through

cesarean section), checklist, stay in the hospital after the childbirth, effects, reasons, ending (see Appendix D for the guide for the women who had childbirth). The block with the checklist included a list of situations that may be regarded as mistreatment during childbirth. The list was derived from the literature review presented in the previous part of this thesis and was then shown to several experts and corrected according to their comments and recommendations. The final version included thirty items but was extended to thirty-five ones as the interviewing process progressed due to adding five additional items that were consistently mentioned by the respondents but were not initially included in the list (these five items are “Manipulations, ultimatums”, “Dissection of the perineum”, “Lies”, “Use of a second-person informal singular pronoun”, and “Presence of strangers”). The respondents were read the situations aloud and were asked to answer whether each of the situations happened to them or someone they knew. If the situation was applicable to their experience, they were asked to estimate how traumatic it was personally for them.

2.4. Data Collection and Analysis

In total, seven interviews with experts and thirty-five in-depth interviews with women who had childbirth were collected during November-December 2019 as it was mentioned above. The interviews were conducted in either Ukrainian or Russian language as the respondent preferred. Upon collection, all interviews were transcribed in the language they were conducted and anonymized by the researcher. After this, the first round of reading was done and the initial code mapping was conducted with the use of Google Sheets and application of grounded theory. The second cycle of coding consisted of reading through the first coding draft and focused coding and resulted in a consistent categorization. Next, the coding matrix was shared with several colleagues experienced in data analysis for consultation. Upon receiving their comments, the last reading of codes was done, at which point the model was finalized.

2.5. Ethical Considerations

The Facebook post purposefully avoided such collocations as “mistreatment during childbirth”, “obstetric violence”, or any other that would indicate the “negative” focus of the study, but each participant was explicitly explained the research purpose at the beginning of the interview. All respondents consented to the recording of the interview, were informed of their right to terminate it at any moment, and were assured that in such a case, no information already obtained from them would be used in the study. They were also told about their right to not answer any given question and to pose questions of their own at any point in the interview. The respondents were guaranteed the confidentiality of the information and explained the algorithm of recording management, in particular, that only the researcher would have access to and conduct the transcription of the interview recordings, that the recordings would be destroyed upon the finalization of the transcription process, that the full transcripts would not contain any personal information and would be available only to the researcher, and that the citations provided in the thesis would be anonymized and encoded to protect the respondents’ confidentiality. Ultimately, the respondents were explained that there were no right answers to the questions being asked and that they would not be judged for anything they said.

2.6. Limitations of the Study

The empirical part of this thesis contains several limitations. First of all, the fact that the recruiting was conducted mainly through the Internet-based community of followers of “Natural Right Ukraine” presents us with several potential sampling biases. To start with, because of their involvement with the NGO, the respondents might be more aware of the protocols and requirements to medical staff’s code-of-conduct and might be able to identify mistreatment more easily or define it more widely than an average Ukrainian woman. They might also tend to evaluate their childbirth experience more critically and define as

mistreatment those situations that average Ukrainian women tend to not see as problematic. Additionally, there is the risk that the reason why the respondents were following the Natural Rights Ukraine in the first place and were willing to participate in the study is because they have faced extreme cases of mistreatment during childbirth.

Secondly, the sample of this study is relatively homogeneous in terms of sociodemographic characteristics. As far as the researcher is aware, most women who participated in the study with several exceptions were ethnic Ukrainians or passed as such, were married to a man at the time of childbirth, were of age (the youngest respondent was twenty-one at the time of her childbirth), and generally did not belong to any groups that could be discriminated against in the context of Ukraine. Because of this, the patterns that were discovered do not take into consideration the intersectional aspect of mistreatment in Ukraine that can be experienced by people who are perceived as less "normative".

Thirdly, because of the sensitivity of the topic, there is the risk that respondents might have left some aspects of their experience out. This is especially valid seeing as some respondents were interviewed in public where they could be overheard or recognized by other people, two women had to talk in the presence of their husbands, and a number or respondents who participated through the Internet had to be interviewed in the presence of or while attending to their children.

Fourthly, because of the qualitative methodological frame, we are not able to talk about the prevalence or extent of the mistreatment during childbirth in Ukraine even if experts and respondents provide their opinion on this.

Fifthly, there is an ethical consideration to take into account about the morality of making women talk about the experiences that were traumatic for many of them. On the other hand, the participation in the study was voluntary and could be terminated at any point during the interview.

Finally, the study in general and data analysis and conclusions drawn from it in particular might be altered by the researcher's personal childfree position that could have influenced the perception of obtained data and its interpretation.

CHAPTER 3. WOMEN'S EXPERIENCE OF BEING MISTREATED DURING CHILDBIRTH IN UKRAINE

3.1. Sociodemographic Characteristics of the Sample

In total, thirty-five women were interviewed during November-December 2019. Out of these, sixteen interviews were conducted face-to-face in the offline mode and nineteen either through Skype, Viber, or Facebook (as it is presented in the Table 1). Most of the Internet-based interviews were conducted without a visual connection. Twenty-three respondents lived and gave birth in Kyiv; out of the rest, seven Ukrainian oblasts were represented. The mode age of respondents at the time of the last childbirth amounted to thirty. Thirty women have chosen the maternity hospital they gave birth in beforehand, out of them, three have chosen private hospitals. Thirty-three respondents gave birth in the state hospitals. Twelve respondents have had contractual childbirth services, twenty-eight women had partnered childbirth, three out of them had a doula present. Two respondents were not allowed to have a partner present during their childbirth. Seven out of thirty-five deliveries were conducted by cesarean section, four more respondents have an experience of home birth.

Table 1. Characteristics of the Sample

Mode of interview	
Face-to-face	16
Skype	14
Viber/Facebook Call	5
Place of residence/birth	
Kyiv oblast	23
Lviv oblast	3

Uzhhorod oblast	3
Dnipropetrovsk oblast	1
Poltava oblast	1
Zhytomyr oblast	1
Kharkiv oblast	1
Khmelnytskyi oblast	1
Age at the time of last childbirth	
Average	30,7
Mode	30
Type of delivery	
Vaginal	28
Cesarean section	7
Home birth[1]	4
Have chosen the maternity hospital in advance	30
Contractual childbirth	12
Type of maternity hospital	
State	33
Private[2]	3
Partnered childbirth	28
Presence of doula[3]	3

[1] One respondent was going to have home birth but had to refer to a hospital where she eventually delivered; another respondent gave birth at home but had to refer to a hospital right after the delivery.
[2] One respondent has given birth in both state and private hospitals.
[3] In all three cases, doulas were present alongside women's husbands.

3.2. Reasons of Mistreatment During Childbirth

Six categories of reasons for mistreatment during childbirth were identified within our research; each is going to be reviewed below (the corresponding diagram is available in the Appendix E).

In Ukraine, soviet heritage is the go-to reason for almost every problem; many respondents claimed the mistreatment during childbirth is at least partially rooted in the Soviet past of the country. Most of their arguments can be linked to the Semashko healthcare system Ukraine has inherited upon its independence. The general ineffectiveness of Semashko system and lack of competition between HCF (healthcare facilities) it entails, inadequate funding principle and the devastation associated with it, low wages and hospital overload due to lack of staff and alternative childbirth arrangements creates a toxic context in which medical workers are not motivated enough to provide services of not even high but at least adequate quality (Romaniuk & Semigina, 2018; Stepurko et al., 2018). The mistreatment becomes even more apparent when corruption enters the equation, dividing patients into those who give informal payment and receive slightly better services and those who are punished for not paying for seemingly free care. However, it was argued by several respondents that, considering the amount of the official salaries medical staff receives, they have no other choice than to take bribes because otherwise, they would have to literally survive.

Education was identified to be another factor facilitating the mistreatment. It is very closely related to the soviet heritage seeing as the majority of medical staff either started their career in the time of Soviet Union or have been socialized within its professional culture. These are also the same people who teach future medical workers in the educational facilities and in the workplaces, which promotes the internalization of current professional culture, values, and attitudes. This is backed up by the low quality of general medical education in Ukraine, outdatedness of medical workers' knowledge and skills, and their

unwillingness to learn during their life. For example, here is how one of the experts commented on physicians' struggle with modern tools that help women in contractions:

> The doctors did not know what to do with all that at all. [...] One doctor confessed that—she said, "When I show a woman the delivery room, I tell her, "Here is a ball, here is a swedish wall, here is a carpet." After I have told this to her, I try to leave right away, because I don't know what to do with all that." She said, "I leave her to it, let her sort it herself."

The general lack of education is supported by bureaucratization of the childbirth process. Medical staff mechanically executes the protocols or algorithms applied in certain facilities and has difficulties adapting their actions to the situation. This is only facilitated by the routinization of the process and general trend towards medicalization of childbirth and perceiving it as a clinical situation that requires interventions. This is best illustrated by a situation described by one of the respondents:

> During our third childbirth, we came to the hospital when I was already in labor. The labor started outside, so I delivered in the corridor, we just didn't make it. I didn't know it would be so rapid. And they started screaming at me, "What are you doing? We don't have time to give you a drip!" A drip. With oxytocin. To accelerate the labor. When the woman is already delivering the baby, here is the head! They just do it to everyone and it's difficult to switch and do something else.
>
> Respondent 12

Many respondents and experts accused medical staff of caring only about statistics which consists primarily of maternal and infant mortality rate, with no regard to other outcomes their actions may have on women, including their mental health. This means that

the personnel is focused on the quantitative indicators and does not pay enough attention to the qualitative side of the services they provide.

There are also personal and professional factors that influence how medical workers treat women, for example, professional deformation and burning out. As a result of these, the process of childbirth becomes something routine and medical workers forget that «[childbirth] is not a conveyor, but a miracle», as one of the respondents put it. Several respondents suggested that the staff's attitude and behaviour is merely a mechanism of self-preservation and a way to separate themselves from being too emotionally invested in every woman they treat and every baby they deliver. Low emotional intelligence, another factor suggested by the respondents, is perhaps also associated with this attempt to preserve oneself. At last, several respondents suggested that everything depends on an individual and that only personal reasons and attitudes guide medical workers in how they treat patients.

The respondents claimed that how a patient is treated may also depend on herself. For instance, some believed women come in the maternity hospitals unprepared, not knowing anything about the process of childbirth and what might happen to them there. Indeed, several respondents indicated that they were not aware of the fact that certain manipulations should not have been applied at the moment of their delivery. On the other hand, the gathered data shows that being prepared does not secure one from being mistreated as well. Another factor that facilitates mistreatment is low patient expectations: for instance, we have noticed several respondents repeating a phrase that sounds approximately like this: «the most important thing is that everyone is alive». Coupled with the support of their own objectification in the form of expectations for medical workers to treat them as if they were objects, not subjects, this facilitates medical staff acting in a way that is associated with mistreatment. Finally, the mistreatment is enabled by the helplessness of women in childbirth and their inability to defend themselves. This to some extent recreates a situation similar to the Stanford prison experiment where the powerless patients are being abused by medical workers who have the power over them.

This leads us to the factor of power imbalance created by information asymmetry and impunity of medical workers. Many respondents empathized the difference in knowledge and expertise between themselves and medical personnel; because of this, they can not always be absolutely sure the decisions the physicians make are indeed as well-grounded and good as they are made to believe. In other words, the patients have no way to know for sure they are not manipulated into anything. Concerning impunity, there is evidence that no real ways to punish mistreating behaviour or bring those guilty to justice exist. It is facilitated by the lack of information on how to file an official complaint and ambiguity of the complaint mechanism itself, professional solidarity of medical workers («circular guarantee»), and unwillingness and inability to manage the complaint process by women seeing as they have a newborn to take care of.

To sum up, mistreatment during childbirth was seen as a result of soviet heritage, education, bureaucratization, personal and professional factors, patient factors, and power imbalance.

3.3. Displays of Mistreatment During Childbirth According to the Pre-Prepared List

As a part of the interview, the respondents were presented with a list of mistreatment examples and asked to answer if they have experienced each of them. Table 2 contains a summary of obtained answers in the descending order.

As can be seen from the table, almost all women reported having painful, unpleasant vaginal or other examinations. It was noted by some respondents that it is quite expected considering the circumstances, however, several emphasised that these examinations could have been not as painful or unpleasant as they were or that they were purposefully or carelessly rough.

Majority of respondents reported encountering inappropriate or obscene comments, devaluation of their thoughts or sensations, lack of explanations and support from medical

staff. When asked if the staff addressed them by their names or introduced themselves upon the first meeting, many answered negatively and sounded surprised by realizing it.

The larger part of women reported they were injected with oxytocin, however, the item did not include specifications as for the stage of labour during which it was done. After being asked whether they were informed about the injection and provided consent to it, many respondents replied negatively, same as in the cases of amniotomy and episiotomy. Considering the number of respondents who reported having amniotomy and episiotomy (25 out of 33 and 22 out of 31 respectively), there is a suspicion these manipulations are done routinely, which contradicts the recommendations provided by the medical protocol on management of normal childbirth (MHU Decree #624, 2008).

More than two thirds of respondents admitted they were shouted at, judged, blamed, neglected, and subjected to manipulations without consent or warning (marginally less reported they were outright forced into manipulations). An equally prevalent part was not allowed to give birth in a comfortable position (slightly less were not allowed to conduct practices that help manage the pain, for example, walk). Only one in three respondents did not report physical violence in her childbirth. Those who did referred to painful examinations, manipulations without their consent, and violation of protocol, for example, application of Kristeller maneuver that is forbidden by the protocol (MHU Decree #205, 2014).

Slightly less respondents confirmed they were objectificated, threatened or manipulated by the staff or had their confidentiality or privacy violated. An issue of informal addressing was introduced in the latter stages of the interviewing process, however, the obtained results show consistency in medical staff using second-person informal singular pronoun towards patients.

One in three respondents reported the lack of informed consent and rough language or profanities, however, these two items showed low validity and reliability seeing as respondents tended to interpret the first item differently and focused on the profanities in the

latter item. The same can be said about the issue of being lied to as respondents tended to answer that they could not possibly know this.

As was mentioned before, the sample of this study mainly consisted of women who represented the majority of Ukrainian society, however, seven noted they were discriminated against, mainly on the grounds of refusal to give informal payments.

Several women stated they were denied pain relief or, on the contrary, injected with anesthesia without prior consent, refused or tried to refuse the right of partnered childbirth, or kept away from their babies. Three respondents reported language barrier, but only one of them referred to Ukrainian experience. Two respondents gave positive answer to the issue of sexual abuse.

Table 2. Quantitative Slice on the Reported Mistreatment According to the Questionnaire Provided to Respondents

Mistreatment Display	**Number of Positive Answers/ Number of Respondents Asked**
Painful, unpleasant vaginal or other examinations	30/35
Inappropriate, obscene comments	29/35
Devaluation of thoughts or sensations	27/35
Oxytocin stimulation	27/34
Lack of explanations	26/35
Use of inappropriate words when addressing, non-use of the name	26/35
Lack of support from medical staff	25/35
Medical staff did not introduce themselves prior to medical manipulations or upon entering the ward	25/35
Piercing of the amniotic sac	25/33
Shouting, raised voice	25/35

Mistreatment Display	**Number of Positive Answers/ Number of Respondents Asked**
Judgement	24/35
Manipulations without consent or warning	24/35
Blaming	23/35
Neglect, lack of attention from medical staff, ignoring	23/35
Dissection of the perineum	22/31
Prohibition to give birth in a comfortable position	22/28
Physical Violence	21/35
Manual squeezing of the baby out, pressure on the abdomen	20/32
Treating as an object, not a person	19/35
Threats	17/35
Use of a second-person informal singular pronoun	16/21
Manipulations, ultimatums	15/34
Execution of the procedure despite being told not to, coercion to the procedure	14/35
Violation of confidentiality or privacy	14/34
Lack of informed consent (consent was not requested, the information provided was insufficient to make an informed decision, not enough time given to read the consent form, the consent form was signed retrospectively)	13/35
Lies	11/33
Use of rough language or profanities	11/35
Presence of strangers	9/22
Prohibition of safe practices	9/31

Mistreatment Display	**Number of Positive Answers/ Number of Respondents Asked**
Discrimination (worse treatment due to certain characteristics or belonging to a certain group)	7/35
Refusal or compulsory administration of analgesics	7/35
Prohibition of partnered childbirth	6/33
After birth, the child was kept separate for no objective reason	4/34
Language barrier	3/35
Sexual violence	2/35

3.4. Displays of Mistreatment During Childbirth

According to the model developed on the basis of the gathered data, fifteen categories of mistreatment displays were identified, each of which is going to be reviewed below (the diagram is available as Appendix F). The order of review does not indicate the extent of importance or reference frequency but rather serves the ease and adequate logic of data presentation.

As the respondents repeatedly reported, the mistreatment during childbirth often starts and is enhanced by the general context of the service provision. Many state healthcare facilities in Ukraine are critically underfunded or show the dire lack of resources. This leads to the general impression of devastation that is expressed through the lack of repair work and outdatedness of the facility itself and its equipment. Respondents explained that in some cases, the maternity hospitals where they gave birth seemingly were not repaired or modernized since the Soviet times or since the time they themselves were born.

> I don’t know if you have ever been to [name of a city], if you’ve seen our maternity hospital. It’s a nightmare. It is indeed a nightmare. These iron cribs for

> babies... When my mom saw [them], she said, “Oh, you lay in the same one!” I said, “Very well”. Twenty-three years have passed.
>
> Respondent 3

The respondents described situations when the general plan of the facility forced them into situations of physical discomfort, for example, having to wait in the cold basement or go across the building or to another building altogether for the postpartum ultrasound examination. Many respondents complained about the remote location of the toilets and showers and being too cold in wintertime or too hot in the summertime. The equipment used during childbirth, for example, chairs or beds, was reported to be so old and worn out the respondents were disgusted of using it. Women reported that many maternity hospitals across Ukraine did not have hot water even in the wintertime or that hot water was only available during certain hours; sometimes, the “hot” water was barely warm. Respondents recalled they had no other way than to take cold showers, in some cases up to several times per day, and bath their children in cold water.

This is not the only way through which the lack of resources in the HCF is evident. For instance, we have learned about a common understanding that one has to come to a maternity hospital with a so-called «childbirth package» that includes not only medications but also the most basic materials such as gloves and syringes in it. In some cases, women reported they had to bring soap, beading, suture material, and even stationery. If one comes without this package, they are expected to replace the materials used afterwards. Often, women who come empty-handed are forced to buy the items from the «childbirth package» in the hospital-based pharmacies that reportedly set higher than the average market prices. The respondents assume that this is the way for the hospitals to attract additional funding. However, this might also be an example of a corruption scheme. For example, one respondent described her experience of looking up what resources a hospital had on the anti-corruption «Є ліки» (Eng. «The Drugs are Available») project website and being confronted by the staff when she presented with only those drugs that were not available in the hospital

according to the website. Thus, this is also a potential point of mistreatment seeing as women who come without the package of outright refuse to provide it may face judgement or be treated roughly.

Many respondents reported their privacy and confidentiality being violated. The main factor that facilitates this in Ukraine is the prevalence of multi-bed prenatal and postpartum wards in the hospitals. Because of this, the examinations and consultations are often conducted in the presence of the rest of the patients. A striking example of this is the story described by one of the woman about a physician making sure one of the patients understood her HIV-positive result in the presence of the said respondent. The multi-bed wards also mean that women are rarely left alone seeing as there are always someone's visitors present.

> There were six or even seven of us. There were too many of us. Everyone came in. Like relatives. They ate stuffed cabbage, they drank, [...] they shouted. Well, some went outside to smoke and came back with this fumes. They even managed to toast with wine for the healthy baby. Whether I want to sleep or I don't want to sleep. I was bleeding, I told a nurse that it was impossible to even rest, right? Because I want to shower and rinse myself, [she told me], "Well, then go! What is the matter? There are all women here, go!" To tell you the truth, it was very uncomfortable. To raise my leg, to shower, right, to at least get out of the bed. There even was [a situation] when I was too ashamed to get out of the bed. There were people, the relatives of one of the women came, so I soaked through. I leaked through and was too ashamed to get up. I lay like this for almost an hour.
>
> Respondent 3

The respondents complained that the doors to delivery rooms were often open and they could be seen by staff, other patients, or visitors. Several women explained that the examination or delivery rooms were passage rooms, meaning that other patients and staff

had to cross them in order to get to another room or to the toilet. Moreover, the delivery rooms were sometimes planned in a way that made it possible for patients to see each others.

> Imagine two wards connected by a door, right? So the doctor ran from one ward to another, from me to another woman whom I was able to see from the breasts down, her lower body, right? I think she was able to see me like this as well. Well… The thing is, it all ended with me not hearing the cry of her baby and not hearing her cry. Then her husband came and the doctor was explaining that they did everything they could. I don't know whether she died or the baby died, well, I know that something bad happened. [...] This too does not facilitate the psychological state of the person who gives birth.
>
> Respondent 13

In addition to this, the staff often neglected that small amount of privacy the patients were left by barging in the wards, toilets, and showers without permission or warning. Many respondents noted that there were too many staff members during their delivery in the ward. Often, they did not directly participate in the process and went about their own business which made women uncomfortable. The women were usually not asked if they minded their presence. In a similar way, women were rarely asked their consent about the presence of interns and students. In several instances, the interns conducted training examinations and even were involved in the suturing, all without respondent's consent.

The most voluminous category within the model is associated with the lack of communication culture seeing as almost all women reported mistreatment that was classified into this theme. The respondents described various situations of staff being rude, passive aggressive, cold, sarcastic, hostile, unfriendly and treating them in a rough fashion that made them feel unwelcome and generally upset. This attitude would begin in the reception area and continue throughout their stay. The respondents complained that the staff would often shout at them or talk in a raised voice, sometimes accompanied with insults, with some

women noting that all their communication consisted of shouting. The personnel screamed when women did not follow their instructions or when they voiced their disagreement or discomfort, which only added to confusion and the general sense of dread many women described experiencing. However, several respondents added that during the labor, the shouting was welcome as it made them concentrate on their task.

The subcategory of inappropriate comments has the largest amount of codes among all themes in the model. Such comments vary in form, content, context, and severity, however, their presence indicates the lack of boundaries often witnessed in the maternity hospitals in Ukraine. The women would often remark that they were shocked upon hearing these kinds of comments, often not only tactless, but even cruel and degrading, as they did not imagine it possible to encounter something like that in a maternity hospital. To name just a few: several women were told not to scream because they did not scream while they had sex, some more were accused of not shaving before the childbirth or involuntary defecating during the labor; a few reported careless comments about the health of their baby that made them nervous and stressed for weeks or being accused of being too happy and joyful upon arriving to a hospital, and many others.

> We were told that people like us should be hung, "I would have strangled you, you and your little one." [...] "You have hacked the system, you think you are the slyest ones? How dared you give birth at home? After that, I'm disgusted to even touch you!" And so on and so forth.
>
> Respondent 12

> The episode when a doctor came to examine me, he was on the shift, and asked me in this quite mundane tone, "So, do we have an abortion here? Take off your clothes for the examination." Well, I was there on preservation, and a person just comes in, a man, and [asks] in this absolutely mundane—well, the job, an abortion. [...] I was alone in the ward then, he must have confused me with someone else, or, or

> all [of his patients] that day were having an abortion, I don't know. Just not familiarizing himself with my history at all… And considering my ambiguous state, whether I would have a miscarriage or not, [I was on the] preservation. This statement was quite… inappropriate to say the least, cruel.
>
> Respondent 30

Along with voicing inappropriate comments, the staff often used second-person informal singular pronoun while addressing the women, which is considered quite rude in Ukraine as one only uses it while addressing peers, younger people, or people who they are close with. The respondents noted that the staff is usually being formal at the prenatal stage but starts using informal pronoun while in the delivery room. Considering that women keep using the formal pronoun throughout the childbirth process, it creates a power dynamic that diminishes patients' status.

Furthermore, the staff rarely addressed women by their names and often used words such as "mommy", "woman", "girl" to refer to them. Some respondents noted they were not addressed during their childbirth at all; while answering this question, many women sounded surprised upon realising this. In a similar fashion, the staff seldom named themselves and their positions, meaning the women usually did not know who were attending to them or only knew the names of the physicians and only because they had met before. As one respondent deftly noted, «Nameless. Everyone is nameless». Several respondents explained that they had to look the pictures of the staff that attended to them up on the hospital website to learn their names and positions. This only facilitated the confusion women felt during childbirth. Below is an example of situation one respondent found herself in because the staff did not introduce themselves:

> The anesthesiologist was nice, she tells me something, "And what name are you going to give [the baby]?" I remember this moment, how I learned that I wasn't under general anesthesia. [She] says, "You are going to feel cold now, there will be a tube,

> the anesthesia. Who are you having? A boy? A girl?" — "A boy." — "And what is his name?" But I listen to this and I think to myself, "Why the hell is she bothering me with these questions? Come on, do you really care what my child is going to be named? Why do you ask?" — "[Name of the respondent], don't be silent, I need to know that you are adequate," she says. "Ah, so you are the anesthesiologist!" — "Yes, what, I didn't introduce myself? Sorry."
>
> Respondent 31

Just as they do not offer their names and positions, the staff rarely provides women with any information about literally anything. The examples provided by respondents included staff conducting manipulations without any comments, warnings, or explanations, not providing any details considering the results of the examinations, not giving any needed instructions, and not communicating with women in general. Respondents reported feeling lost, scared, desperate and disoriented as of what was going on. Moreover, there is a subcategory of accounts of women using such wordings as «I still don't know», «I think it was», «I am almost certain», «I suspect» about certain aspects of their childbirth. This is how one of the respondents depicts her experience of having an abortion due to medical reasons:

> I just followed them, I wanted to hear at least something. There was my ward doctor, he would come, ask about my body temperature, and tell me, "The head of the department will come and you will talk to her." This is what he said all the time. I knew nothing about my state, and the head of the department, the only thing she told me was like, "Yes, that's a difficult situation you are having, I won't promise you anything. Like, you have a difficult situation." I just—well, that was it, I just waited for someone to come and tell me something. And they would come and tell me nothing. And in the end, I just cried. They would tell me, "We are going to decide on this issue, like, the head of the department will come soon and will decide on this

> issue," it was after the abortion. And I cried. The doctor said, "Why are you crying? We are going to decide whether we should let you go home!" But I didn't know what they were going to decide upon! [...] It was unclear to me, what they were going to decide about. I just, for real, followed them. There was another moment, I looked what I had been scheduled for that day in the nurse's book because the doctor didn't tell me.
>
> Respondent 10

In addition to not providing any information, the staff was reported to ignore the direct questions or redirect the questions to other staff who usually did not provide any answers as well.

> The behaviour of this head of the reanimation was like—I ask him [something], I say, "And what is this for?" He says, "Hm, really, what is this for?" and leaves. You know, it's not like he is really being rude, but, you know, he has this manner, perhaps for avoiding answering the questions that irritate him.
>
> Respondent 1

According to Ukrainian law, a woman should provide informed consent to most manipulations during childbirth (MHU Decree #624, 2008), however, the gathered data indicates that this requirement is usually satisfied only formally. We were told that the staff can forgo the informed consent at all or act against explicit objection to a certain manipulation. The women were rarely explained what exactly they were consenting to; in some cases, the respondents were pressed into signing the form or almost tricked into it, for example, when the staff asked them to do it during a contraction, or had to sign the consent post-factum, after the manipulation was already conducted. Some complained that the form presented to them presumed blanket consent for any action the staff might want to take and discredited the concept of informed consent itself. All in all, the respondents believed that

the form they signed was a formality that would not protect them from manipulations they refused and would not be enough evidence to protect or support them if they decided to somehow report the mistreatment.

> And I was given [a paper] in which it was stated that in a case of a, like, life-threatening emergency, doctors have the right to act accordingly to the protocol, like, [take] some appropriate actions, like to inject some appropriate drugs and the like. And I asked, "In what cases?" Does it mean that I agree to anything they can do in advance? And then what is the point in the fact that I ask them to not inject me with any hormones or painkillers, that is, without my consent? Does it mean that it is not necessary for them to coordinate all their actions with me? And I asked, "In which case? Is it when I faint that the doctors have the right to apply that protocol? Or during the childbirth in general?" To which I was told, like, "Why are you being smart here [...]? Sign it and go give birth with the help of god." That is, I understood that I give them my consent in advance and that it is not necessary to coordinate all their actions, all their actions during the childbirth with me.
>
> Respondent 20

This is sometimes followed by staff directly lying to women. Perhaps the most common example of this is a lie associated with the injection of oxytocin: both respondents and experts told us about the widespread practice to call this hormone «a vitamin» or «a saline» and inject it not only without woman's consent and knowing, but also with her believing she is injected with something entirely different. Several respondents also indicated their physicians lied to them about agreeing to let them have physiological birth (that is without any unnecessary intervention) while they were not going to follow up on this promise. One respondent reported that she was told that she teared up while in reality, an episiotomy was conducted, which she learned only during her second childbirth.

Another variation of lie relates to entering false data into medical documentation or concealing manipulations. Several respondents reported they did not find information about questionable manipulations conducted during their childbirth in the medical abstracts they received upon being discharged from the hospital. However, here we should indicate that it is not entirely clear whether such information should indeed be included in the abstract and this is truly concealing or the abstract just should not contain information in such detail. Nonetheless, there are at least two testimonies that indicate that the staff does forge data entered into medical documentation: one respondent told us she overheard her physician instructing the nurse to not indicate that her childbirth was overdue in the medical abstract and another respondent who gave birth at home had had her medical record altered as if she had given birth in a maternity hospital:

> They wrote in my documents retrospectively that all vaccinations were done—I didn't provide consent to any vaccinations and my children were not vaccinated in the maternity hospital. They wrote retrospectively that they injected me with a hemostatic drug, but again, neither me not my child were injected with anything. There was no need for this. [...] They had to do this according to the protocol—but they didn't. [...] It turned out that my fourth childbirth was institutional, there was the labour history. [Laughs.] It turned out I gave birth not at home but in there. [...] They rewrote everything retrospectively.
>
> Respondent 12

This leads us to the next category, pressure, seeing as the staff not only does not provide any information, but is also reported to pressure the patients into certain manipulations and behaviours.

> I was driven into a corner and I couldn't say no. Well, even if I wanted to, that is, I had my doubts, but I realized that I could not say no. [...] So I said yes, but I said it with tears in my eyes and only because they were standing there and shouting at me.
>
> Respondent 10

In order to reach its goals, the staff often used threats and ultimatums. For example, the respondents told us they were threatened with cesarean section, being thrown out of the hospital or not admitted into it, or having their childbirth not overseen by a physician. Another similar tool applied was intimidation: in some instances, the respondents believed the arguments used to frighten them were ill-founded or outright false. We have also encountered a variety of what Reed et al. (2017) call «dead baby threat». The respondents explained that this was a particularly effective tool seeing as they tended to agree to anything they were pressured into because, even if they were sure of the correctness of their own judgement, they did not risk opposing the staff if there was even a slight chance the lives of their babies were indeed at stake.

> Here always comes something like, “Your baby is going to die if we don’t do this!” Well, what decision are you going to make? [...] You will agree to anything whether it’s true or not.
>
> Respondent 29

The respondents reported medical staff judging them for refusing certain manipulations or for actions that were not favoured by them. The judging was also used to pressure women into conforming with the instructions or to show them the staff did not approve of something, for example, home birth. It should be added that medical workers generally strongly oppose the idea of home birth and persecute those women who are known to attempt or succeed in giving birth at home.

At the same time, the staff seems to transfer responsibility to the women. For instance, the respondents described situations when the staff asked them to sign the documents saying they were not going to have any claims for the childbirth outcomes or denied them admittance because of their health conditions that might have complicated the childbirth. They were blamed for negative outcomes of the childbirth, including those cases when respondents believed the fault was entirely on the staff. A seemingly typical situation can be described in the following way: the staff pressures a woman into something she does not want to be done, a complication associated with the conducted manipulation arises, the staff blames this complication on a woman's reluctance to provide consent. A number of women also reported they were punished for their actions by rough treatment, ignoring, or separation with the baby. This is how one of the respondents described being punished for coming to the hospital after a home birth:

> There was a nurse call button on the wall but the bed was pushed away from that wall to the opposite one despite the fact that they knew I couldn't get up, that I came to the maternity hospital for the reason that I couldn't stand upright and was fainting, but they put me near the opposite wall so that I wouldn't be able to press it.
>
> Respondent 12

The respondents reported the staff devalued them in a number of ways, starting with them discarding their personal opinions, knowledge, and requests. They denied women's right to refuse or question certain manipulations, disparaged their suggestions on alternative ways of childbirth management, even if they were evidence-based, ignored their desire to be informed, and dismissed their previous childbirth experience.

> Squeezing of the umbilical cord: we asked [them] to wait but were told that we behave like fools, that everything is fine, it has already stopped pulsating.
>
> Respondent 15

The staff reportedly belittled women's feelings of sadness, fear, shame, and dismissed their sensations, especially that of discomfort and pain. The respondents told us how physicians, midwives, and nurses did not believe them when they told them about the beginning of labor or feeling too weak to stand up, did not let them remain in a comfortable position during contractions and forced them to lie or sit down. Many said the staff disregarded them being in pain, silenced them or told them to «be patient» (Ukr. "терпіти") when they cried out or complained, or did not believe they were in that much of a pain or in pain at all.

> When the baby was going down, well, had left the cervix and went down the birth canal, I remember that I told the doula twice that, "[Name of the doula], I'm dying!" And that—I don't know whether it was a nursemaid or a midwife or a nurse, I don't remember who it was, [...] and she said, "Oh, she is dying, listen to that!"
>
> Respondent 8

Medical staff often does not see women as independent individuals and treats them as objects. The respondents used different words and collocations to describe how the medical workers treated them or how they felt during childbirth, for example: «medical simulator», «test object», «biomaterial», «a piece of meat», «a piece of shit», «a device for birthing children that must function right», «machine», «brainless unintelligent creature», «cow», «pig», «sow», «cattle». This being said, several respondents recalled situations when the staff was talking about them in the third person in their presence.

> And this doctor, why I did not choose her, [she is] quite harsh, [with] a quite obscene attitude. I gave her [my] documents, she looked at me, "Well, yes, more than 4 kg, of course, problematic childbirth. [...] Well, your age…" [...] I sit and look at her, and she [tells] my husband, "I see that the mommy doesn't like what I say." As if

> I did not exist, as if I was a third person. I say, "[name of the husband], there is no one to talk to, let's go."
>
> Respondent 7

The quote provided above is simultaneously an example of another issue we have identified, the centrality of a man. While the women are seen as objects, their male partners retain their subjectivity throughout the childbirth process. The respondents recalled situations when the staff ignored them in favor of providing all information to and asking consent from their husbands. Several told us that the staff had forced their husbands to be present during the labor despite women explicitly telling them they wanted to give birth alone, and two respondents shared stories of how the physicians might suggest to sew a woman up "to her husband's liking".

There is another effect of women's objectification we have noted: the staff tends to disapprove of their competency and desire to be active participants of the process. The respondents described the sharply negative reaction they received from the staff after they showed signs of knowing the protocols or good practice standards and asked them to proceed in accordance to them or to let them give birth in a certain way. As one respondent has aptly noted, the physicians seem to be afraid of women «encroaching on their authority».

The respondents reported that medical workers frequently manage childbirth according to their own convenience, bypassing their comfort and even to some extent their and their babies' well-being. This attitude is perhaps best shown in the words of a physician as it was reported by one of the respondents:

> "This is my childbirth and I am going to act as I know to during it, and if you want to command during my childbirth," — this was the key, that it was his childbirth, not mine, "I will simply hand you over to the team on the shift. I will not oversee you, I will not give birth with you."
>
> Respondent 8

An example of this is a seemingly widespread practice to schedule childbirth, often without a woman's consent and even knowing. The respondents reported physicians conducting amniotomy, episiotomy, or manual cervix widening and initiating or stimulating labor by oxytocin IV or inserting a tablet into their vagina either without letting them know what they were going to do or after pressing women into consenting to the manipulation in order to accelerate the childbirth. This is reportedly done in order for the childbirth to end during a certain physician's shift.

> The doctor didn't care to wait, so he decided to conduct an episiotomy to speed all this process up.
>
> Respondent 8

> The doctor came. [He] turned me on my side and started pressing on my abdomen under my breasts. [He] started telling me something along the lines of how his shift was ending at six a.m., that I should, well, I should have already delivered.
>
> Respondent 3

> Why did I deliver on that day? Because my doctor had been on shift for twenty-four hours already and after that, she should have had a day for sleeping-in, and she didn't want to come to collect her money the next day, because this is what would have probably happened.
>
> Respondent 16

The respondents complained that the stimulated contractions were much more painful than the natural ones and that by scheduling their childbirth to physicians' convenience, staff made it unbearable for them. Those respondents who had both stimulated and non-stimulated labor experiences reported the difference was striking.

> And then started—well, it was either an hour or a half hour of this hell. Because no natural labour can compare to this oxytocin, when you are unable to more, when—well, your eyes almost pop out because of the pain.
>
> Respondent 14

Similarly, the horizontal birth position the respondents were usually forced into and the chairs themselves are comfortable for the staff in the first place. Participants described that they had difficulties trying to climb the high chairs while having contractions and were afraid of falling down. The common notion throughout the experiences we have gathered was that the staff did not outright force women into horizontal position but did not offer them any alternatives as to other birthing positions and insisted on the gynecology chair. Many respondents reported that lying down decreased their labor activity and that they felt uncomfortable and wanted to sit up or even stand up but were not allowed to do so.

> Even the chairs all stand on a raised platform so that it is convenient for the doctors to look. But when you climb this chair with the belly, with contractions, [they] tell you, "Hurry up, I don't have time," and you cannot even move, you say, "Wait, let it pass, let me take a breath," they drag you [on it].
>
> Respondent 5

Many respondents described staff being indifferent to them, not caring about them, not examining them or conducting the examination or suggesting treatment negligently and only after being specifically asked to. Another commonly described situation is respondents staying alone in their wards at the prenatal stage with no staff nearby and not knowing how or where to find them. (This indifference, however, is replaced with urgent attempts to accelerate the process if it is suitable for the staff as was shown above.)

> But there is no one! [...] That is, morning, silence in the corridor, there is no one, no nurse. Someone is moaning in the next ward, someone is moaning in the ward next to it. Someone is delivering somewhere. Where to run? Whom to call? She [a friend] went, found [someone] and asked for an anesthesiologist. “He is busy right now on the surgery.” By around eleven o'clock the anesthesiologist finally became available, by that time I was saying, “Call for an ambulance, let’s go to another [hospital], maybe they have an epidural anesthesia, I don’t care anymore, I just can’t anymore.” [...] We have been looking for him for two hours, he appeared, injected me, promised I would fall asleep, and in ten minutes, I delivered.
>
> Respondent 4

This is accompanied by the general indifference to a woman's comfort, examples of which include switching the light on or barging in the ward in the middle of the night while the respondents were trying to sleep, examining women during contractions, insisting on examining their babies while they slept. Additionally, many respondents complained about long bureaucratic admission process of staff asking them for information that was all available in the provided documentation which they had to endure while in contractions.

Another commonly mentioned subtheme is the loss of interest in women after childbirth. Several respondents described their despair upon being left alone with a baby right after the childbirth with no explanations about how to take care of it and what to do next.

> No one told me how to tend to a baby. How to hold it. I looked at my daughter and—what should I do with her? What if she starts crying? [...] I look at my baby and I don’t know what to do. How to hold her head? How to put her [to my breast]? What if she starts crying? What if she pees or poops—just how?! So I spent a full hour just sitting there looking, well, lying and looking at her. Later on, I asked the girls in the ward how to hold the baby. They gave it to me, well, a girl gave me my own daughter.

Respondent 3

All throughout their stay, the respondents felt the lack of support from medical staff, with some noting that they did not really expect being supported: after being asked if she was supported by the medical workers during her stay, one woman sarcastically asked: «They were supposed to support me?» The respondents described how they wanted to be caressed and calmed down and quite symbolically asked the personnel to hold their hands but never received any encouragement or help. In those cases when women described receiving support from the staff, the effect of its lack on them became contrastly clear. Respondents compared their different childbirth experiences and found those that were accompanied by lack of support much more traumatic. Several women told us how they were supported by only one staff member and how strikingly different and important their care seemed to them. While talking about these people, the respondents used such workings as «she was like a good angel sent to me», «like a ray of sunshine in the dark realm», «this was my only support, I will probably remember it for my whole life», «the only soul», «the contrast».

From what we have gathered, the staff often acts almost mechanically according to the protocol and recommendations with no regard for woman's wishes or sensations, for example, forces her into walking or using fitball or swedish wall when she feels like lying down. If one were to take into consideration the already explained process of adjusting childbirth to staff's convenience, they would notice an almost comical extreme of staff's style of childbirth management: they either pay women too little attention almost to the point of neglect or stimulate the labor to accelerate its progress. The only notion that unites these two courses of conduct is the inattention to patient's needs and wishes.

Finally, we have noticed that there is sometimes a lack of cooperation between physicians of different profiles, namely between obstetricians and neonatologists, in a sense that obstetricians tend to prescribe treatment without taking into consideration the well-being of a baby. For example, one respondent recounted how she was prescribed a strong

painkiller: right before her discharge from the hospital, she asked the physician for the name of the drug but was denied this information; she did learn it from the nurses afterwards; however, when she passed the information about the drug to her pediatrician, it turned out that she was not supposed to take it seeing as it could provoke a heart attack in her baby.

The respondents shared that the medical workers often initiated manipulations without informing them of this and receiving their consent, thus violating their personal autonomy. Among such manipulations were injections, insertion of suppositories and tablets, manual cervix widening, examinations, including that of breasts. Concerning the latter, one respondent commented that she felt «as if even her breasts belonged to the hospital's property». The three most commonly reported manipulations done without prior consent were episiotomy or suturing, oxytocin, and amniotomy. According to the testimonies we have gathered, the staff rarely warned women about them. In many cases, they were conducted despite women explicitly stating they did not want them or even signing the refusal forms. For example, for the most part, the respondents realized they were being incised the moment the episiotomy had been conducted or when the staff started suturing them. In a similar fashion, the respondents reported that the physicians would sometimes conduct amniotomy during the initial or follow-up examinations and put in an IV with oxytocin without providing any explanations as to what they were injecting.

> They tell me, "We are going to inject you with oxytocin for the third stage of labour." I say, "I refuse, I don't want to, I wrote that I refuse, I want a natural process, I want it to come out on its own." She is like, "No," and — bam! I have a shot in my ass! That's it. I was injected, they injected me.
>
> Respondent 33

The check-list of mistreating situations we provided to every respondent included an item labeled «coercion to manipulation». Quite a few respondents answered that they did not experience coercion seeing as they were not asked to consent to the manipulations or because

they did not have any options. This is another example of how the staff violates the autonomy of the patients.

At last, the staff did not only violate the autonomy of the respondents but also of their children. Several women described situations when their babies were taken away from them, held without their consent, or treated quite roughly.

Physical violence is perhaps the most worrisome category among those that were outlined, not only in itself but also considering the seeming commonness of several of its subcategories. For instance, many respondents described having had painful vaginal examinations, with several noting that some physicians were unnecessary rough compared to other physicians or their previous vaginal examination experiences. Several women reported physicians conducting manual cervix widening or cervix massage, often without warning them or receiving their consent.

An alarming practice of suturing episiotomy cuts or tearings without or with inadequate amount of anesthesia was discovered. Women commented that they screamed, cried out, and twitched during the manipulation; one respondent reported that she was held down by the staff. When women asked for anesthesia, a typical answer was: «Be patient, there are only several stitches». One respondent explained that this was done after each of her two childbirth which indicates the commonness of this practice. Often women were not warned about the procedure before its initiation.

> The suturing can be sorted into this one [category], when they seemingly injected novocain, well, they did inject it, but it did not work, and they were suturing [while I felt everything]. I was lying with a baby in my arms, and they sutured me. [...] I was screaming. I was shrieking. “Here, there are only four stitches. Why are you screaming?” Only four stitches in the place with more nerve endings that in the brain!
>
> Respondent 26

> When I delivered, [they] started suturing, put the baby on me and started suturing immediately after. Well, [without anesthesia], this as I see it might be a kind of a psychological move, that you have a baby lying on you and you will not scream in order not to scare it. [...] No one even suggested giving me any anesthesia. [...] I wasn't even warned they were going to suture me. [...] This was very unexpected. [...] I realized that I cannot not scream, it is painful, but I cannot scream as well because the baby is lying on me. If the mom will start screaming, it will feel it. [...] Its state depends on your state, so I started singing, although I cannot sing, I don't have a voice and I am tone deaf, but I sang "Black Crow" loudly for the whole maternity hospital to hear because I was in pain.
>
> Respondent 6

Several women reported being restrained at various point of childbirth and having their mobility restricted.

> They got in the way very much during the childbirth. They were holding my arms, they were holding my legs, they screamed at me—well, this doesn't help one deliver. [...] I was held. They didn't let me—they held me by my arms, by my legs, they didn't let me change [the position]. [...] During the labour, the doctor told my husband to hold me down by my shoulders and to not let me do it [get up], and the doctor and a midwife were holding my—holding my legs, that is, my legs were pressing into their chests, they were holding me like this. I wanted to raise, lower, well, bend my knees a bit—they were holding me like this, in this position.
>
> Respondent 28

However, a situation that dominates throughout this theme is of different origin. The typical story that was observed in the respondent's stories is the restriction of mobility on the stage of contractions. Women depicted situations when they were prohibited to stand up,

move, and even go to the bathroom or outright forced to lay down because of the monitors on their abdomens and IVs. They described being uncomfortable, in pain, and resenting the situation. Many felt that moving would relieve them of pain and discomfort and that the situation was convenient for the medical staff but not for them.

> It happens when they give you a drip, you can't exactly more [with it]. [...] As far as I know, they encourage the vertical position, moving, but only if a woman is not tied to some device.
>
> Respondent 12

Several respondents described being pushed or slapped or knew women who experienced such treatment. Seeing as these actions are difficult to perceive as anything other than acts of physical violence, the respondents who reported them did this with notable distress. This is how these situations were described by two women:

> Oh god. My doctor came and started examining me again. Accordingly, it was very painful again, and my hand involuntarily reached down, to the place where it hurt, and the doctor hit me. The doctor hit me and got scared of her own action and started telling me that she was responsible for me, something along the lines of having sterile gloves and me not having sterile gloves, I did not have them at all. That is, she started telling me I was harming myself. I said that I hurt, so it was my natural reaction to avoid this. Then I realized it was going in a wrong direction. I just started crying, I started crying for my husband. They got a bit scared of—I said that I want to give birth in an absolutely different atmosphere.
>
> Respondent 20

> And another moment that has scared me very much, but I still can't understand if it was right or not. When I was pushing very hard, I was told that, "You will harm

> your baby," and they slapped my leg with a hand, like, "Calm down, what are you doing, like, you don't even realize what you are doing, come to your senses at last!" And so that fact that she slapped my leg when I was [laying] with my legs open, well, this was very unpleasant.
>
> Respondent 2

According to Ukrainian law, the Kristeller maneuver, that is the fundal pressure in second stage of labor, is forbidden (MHU Decree #205, 2014), however, there is evidence that it is still extensively used. Moreover, seeing as it was mentioned by almost every expert and many respondents, even those who reportedly had not had it applied to them, we conclude that its usage is widely known. Many respondents recounted that medical staff has or has tried to apply pressure to their abdomen, but it is difficult to tell if it was indeed Kristeller maneuver. Nevertheless, it is clear that the staff does apply pressure to accelerate or facilitate the childbirth, often without informing women of their intentions. They do it by using their forearms, towels, by laying on a woman, or pushing on her stomach with her own legs.

> So then she jumped on me and started pushing the baby out with her elbows. I had hematomas all over my stomach afterwards, these bloody bruises.
>
> Respondent 34

> And it was precisely at that moment when the child was supposed to be born—she was chubby and short, well, this midwife—she began to press on my stomach with her hands. I tried very hard to push, but this was clearly not enough, so she began to press on my stomach with her hands. Then, on the next contraction, she just lay on me. You see, she just lay on my stomach with her body and started to push the baby. As far as I understand, this was that forbidden method, I found this all out after the

> childbirth. [...] She laid on me with all her body and started to press on the other side of the stomach with her elbow.
>
> Respondent 2

> They started jumping on the stomach. They just climbed the cot, one woman, and started pressing like this. [...] Some man came, and he kind of twisted the sheet and started pressing on the stomach. [...] I remember that my nightshirt tore at the seams, I remember this crunch of the seams. It astonished me so much at that moment!
>
> Respondent 10

We have included sexual violence as a subcategory of the physical violence because of its scarcity, but it should not be seen as any less valid because of this. Only one respondent reported being sexually harassed during her childbirth, however, it does not attest that such cases do not happen in general population. Below is the situation how the respondent recalls it:

> And in particular, this intern. At a time when I was exhausted and was just lying down and couldn’t push, [he] stimulated my clitoris in order to enhance the labour. Well, I realized it later. [...] I saw him stimulating my clitoris, I did not understand what was happening at all, only a few days later I realized what that was. [...] Yes, the doctor who supervised the birth saw it. [...] I was very confused. Captured by surprise. I didn't even expect something like that.
>
> Respondent 11

However, seeing as childbirth is an extremely intimate process, the abuse associated with it was described as sexual violence on several occasions.

> I have an impression after the childbirth with him as if I was raped, [...] this can probably be compared to a rape, when you do not want to do something and they do it to you.
>
> Respondent 35

Even while it was emphasized in the methodological part of this thesis that the majority of our respondents belonged to a privileged majority, we were able to distinguish many cases of discrimination. For example, three respondents described instances of medical staff commenting on the issue of them either being single or being assumed single. However, none elaborated on the issue or even recalled it without the prompt, from which we conclude it was not seen as very traumatic.

> Well, for example, in the first childbirth, everyone asked me where my husband was. At that time, I did not have a husband, that is, I was giving birth to the child alone. He left me three months into pregnancy, so that you understand. And accordingly, there was an attitude like, "She gives birth without a husband, so, well..."
>
> Respondent 13

There were also several cases of religious and ethnic discrimination. The specific detail about these subcategories however lies in the fact that no respondents have directly experienced them but rather witnessed or knew about discrimination on the grounds of these two attributes. For instance, one respondent recalled a muslim woman being humiliated for refusing certain medical manipulations due to her religion; another respondent told us she was asked if she was baptist after she did not provide consent to the insertion of some kind of tablet in her vagina, assumingly to stimulate the labor. In the same fashion, all five respondents who reported cases of ethnic discrimination did not experience it themselves. All these cases concerned Roma people who, according to the respondents, are made to give birth and stay in separate postpartum wards than non-Roma women, are being discharged

right after the childbirth instead of on the third day, and generally encounter abuse and neglect on the ground of their ethnicity. Below are two testimonies by women who have witnessed such discrimination.

> A Roma woman was put just on a mattress in the ward, despite the fact that there were free beds in other wards. She was put next to two other women. They were on the beds, she was given just this mat on the floor, that's all, and she was there with her child. Because she was a gypsy. Well, and because she was like dirty.
>
> Respondent 12

> Oh, those poor Roma women! [...] There was a poor young girl, seventeen or eighteen years old. And she had contractions. My god, how she screamed! She wasn't even brought to the delivery room. She screamed! She begged! God! It was so traumatic, for us all, because we heard it. She—"Please, please, help me! It hurts!" She was screaming! She was screaming, right? They said, "Eh! Gypsy! Let her scream." So what if she is a gypsy? Isn't she human? Maybe she is dirty, maybe—so what?! But she is a human being, she is a girl! So—it's her first childbirth, and she is in pain, and no one comes to her! No one does anything! I don't know what happened to her, but she had been just crying, she had been screaming from morning till evening, she was even praying, screaming. The staff did not care. The nurses just screamed at her, "Why the hell are you screaming? Shut your mouth!"
>
> Respondent 3

Several respondents told us they were discriminated against on the grounds of their age. One woman recalled staff commenting about her being too young during her first childbirth (happened outside of our timeframe criteria), several more mentioned staff calling them «elderly primigravida» (Rus. «старородящая»), a term widely applied in the post-soviet countries. The respondents also reported that the staff differentiated those women who paid

for childbirth from those who refused or was not able to provide payment and that the latter received worse level of services that the former and were shamed for not paying. At last, we were told about cases of discrimination on the basis of rural origin, foreign citizenship, appearance (having tattoos), and social background. One woman who gave birth in the infectious maternity hospital recalled a comment by medical staff about her being positively different from their usual patients.

Taking into account all of the above, it is perhaps no wonder that many respondents perceived HCF as hostile institutions. This can be seen from the vocabulary women used, for example, to denote the maternity hospitals they gave birth in: «concentration camp for women», «maximum security prison», «war», «court», «den of sadists», «captivity», «hell», «factory», «to go upstate», «torture-chamber of the NKVD» (the Soviet People's Commissariat for Internal Affairs, a soviet state institution known for torturing and killing people); yet another respondent was referring to her wardmate as a «cellmate». Despite the researcher not using the word «conveyer» not even once, it was used by at least the third part of all respondents at some point during the interview. In a similar fashion, the respondents used the following words when talking about their childbirth: «horror», «hell», «torture», «to suffer», «the worst», «scary story», «crime against humanity», «brutal», «trauma», «survive», «nightmare». While talking about their experiences, women often used vocabulary that indicated the conflict, almost war between themselves and the staff, for example: «prevent», «interfere», «defend», «take him to their side», «fend off», «resistance», «fight», «fight off», «secure myself», «witness», «give up», «everyone stood up against me», «stand up for», «be on the alert», «capitulate».

Many respondents indicated that they needed to control the staff or have their partners do it because they were not to be trusted. On the other hand, the women themselves sometimes had to resort to deception: for example, several respondents explained that they had to «run away» from the hospital, lie to the staff, hide some information or be stealthy.

The respondents were convinced that more often than not, the staff interferes, but does not help. To begin with, they interfere in the process of childbirth: talk about non-relevant

things with each other or with women, create commotion, switch on the light, attempt to control women's movement, scare, insult, and generally distract them. This is how one respondent described this:

> I understand that I want to uprise or somehow change the position in order to ease the movement of the child through the birth canal. They don't let me do this. I want to get up, I'm being put [on the cot]. I'm trying to at least lift my legs up to help [myself], change the position of the pelvis a little bit, I'm being held by the legs. Well, it's hot, it's cold, they for some reason put boot covers on my legs, to keep me warm. I'm hot! Well, the absolute reluctance to look at the patient and make her comfortable in order to make their own work a little easier. Help make it comfortable, that's all that is required of you. No, they do as they usually do. [...] I understand now that these shoe covers, [...] it was the midwife's attempt to help me, to take care of make, make me more comfortable, but it's not—they did not take into account my wishes, they did as they thought [was best], and it was distracting.
>
> Respondent 28

Several respondents complained that the staff created barriers to them having partnered childbirth: they provided examples of staff not letting in the second partner despite it being allowed by the law, asking for informal payment to allow the presence of the partner, not allowing the presence of a partner because of the quarantine, or trying to send the partner away in order to pressure the patient into certain manipulations. Several respondents told us that the staff attempted to not let their doulas be present during the childbirth or sabotaged their presence in other ways.

Two respondents recalled very similar stories of their physicians being superstitions: they were asked to remove the rubber bands because there is a belief that if a woman wears rubber band during the childbirth, her baby will be born wrapped in the umbilical cord. Both women complained that this made them very uncomfortable because both had long hair.

There is a widely shared belief that physicians «help» or «save» women in childbirth, a fact that was strongly criticized by several respondents and also undermined by the facts presented above. Instead, the respondents argued, they create the dangerous situations that entail «saving» themselves, for example, by stimulating the labor, and then have to intervene in order to repair the damage done. Below is an ironic quotation of one of the respondents commenting on the situation:

> Like when you read the reviews on the sites of maternity hospitals, "Thanks to this doctor, I have two good healthy children!" But it's not thanks to the doctor, it's against his efforts that you have two good children!
>
> Respondent 19

Perhaps due to all of the above, the respondents tend to not believe that educational courses provided by the maternal hospitals are objective; instead, they «prepare you [to the idea that] this maternity hospital is going to be your maternity hospital» and to «what interventions they are allowed to conduct».

Despite the fact that the issue of corruption was not in the focus of our study and we did not ask the respondents anything directly related to this topic, almost everyone mentioned corruption at some point of the interview. According to the law of Ukraine, the provision of healthcare in the state healthcare facilities, including obstetric services, is free of charge (Verkhovna Rada of Ukraine, 1993), however, we have learned that basically every state maternity hospital charges for many of its services (such as examinations and certificates) and imposes a half-obligatory and quasi-official «charitable contribution» on their patients. Several stories provided by the respondents suggest it is indeed not legal seeing as the hospitals are not able to provide any documentation or receipts for those who do pay these contributions. However, those patients who refuse or are unable to pay the «charitable contribution» and other illegal fees usually face shaming and receive services of worse quality. Furthermore, in some cases, they can be even denied services, for example, being

admitted to the hospital or, contrarily, being officially discharged. Some respondents claimed they paid the fees just to be left in piece, for example, for a custom formality that dictates that on the day of discharge, the baby should be carried out by a nurse who should be paid a symbolic amount of money for this.

> We went and gave this doctor a financial reward, despite everything, we gave it to this doctor. Well, my motivation was such that I do not know what's wrong with me and I'm afraid [that] if we don't give her anything she'll just leave me. [...] I just know that for the first few months, you go to the doctor who supervised your childbirth.
>
> Respondent 34

Another common practice should be mentioned in this context, it being the system of contractual childbirth. More often than not, women arrange to give birth with a certain physician whom they pay. Seeing as this is not provided for in the law, these contracts are mostly unofficial (at least in cases of state hospitals). Ten out of thirty-five respondents have had contractual childbirth, however, some of those who did not felt strongly against this practice due to it being seen as corruption. We have learned that women can be provided worse services if they do not arrange for childbirth with a certain physician, however, there are drawbacks of contractual childbirth as well. For instance, a physician might not come due to being too tired after a shift or being away or come and stimulate the delivery to accelerate it, often without letting the patient know. Perhaps the best example of this situation is the following testimony of one the respondents:

> That doctor said—the green week was approaching, "If you will give birth during the green week, then do not call me, I will not be in the city, just come." And he says, "You want to give birth today, I'll give you a pill, you'll give birth today."
>
> Respondent 35

It was discovered that in many instances, the physicians do not understand or do not pay enough attention to such modern medical practices as skin-to-skin contact, exclusive breastfeeding, or delayed umbilical cord cutting. The respondents complained that their umbilical cords were cut before they stopped pulsating and that their babies were snatched away from them before the necessary two-hour contact was enabled or put on them fully clothed. Many were attempted to or pressed into feeding their babies with a mixture. At the same time, if women voised their objections or tried to maintain these practices, they were mocked or dismissed.

> Then we knew that we had to wait until the umbilical cord stops pulsating, it is better if the umbilical cord blood reaches the child. And then we understood that it was just cut off immediately. Everything has just finished, we exhaled, and it turns out it was not over, and we were not ready for this. And [name of the husband] only said, "But you have to… let the umbilical cord stop pulsating," but they have already cut it. We understood that it was not really that critical, and this perinatologist, she took the child and she began to snap [at us] at once, "I know better, you will be responsible."
>
> Respondent 17

Additionally to this, several respondents indicated the staff was reluctant to use new equipment, for example, air-conditioning or modern gynecological and birth chairs. This leads us to the conclusion that in some cases, the equipment available in the hospitals is in fact not fully used.

To conclude, the mistreatment during childbirth can manifest through lack of resources in the healthcare facility, lack of privacy, confidentiality, communication culture, and information, pressure, transfer of responsibility to women, devaluation, objectification, indifference, violation of personal autonomy, physical violence, discrimination, corruption, and lack of understanding of modern medical practices which leads to perception of health

care facility as hostile institutions. The situations we have presented do not occur outside of the context but rather overlap and create a unique picture of mistreatment that simultaneously follows the typical patterns of abuse observed in many personal stories.

3.5. Perceived Prevalence of Mistreatment During Childbirth

Although we cannot conclude on the prevalence of mistreatment during childbirth based on our qualitative data, we can assume it being quite prevalent based on several indirect indicators (the diagram is available in the Appendix G). According to both experts and respondents, mistreatment during childbirth is widespread in Ukraine. This is supported by the fact that almost every woman we have interviewed has provided not only her own story of mistreatment, but also that of her relatives, friends, or acquaintances, with several noting that it is a matter of pure luck whether one is mistreated or not during their childbirth. Respondents reported that many of those women they shared their stories with were not surprised not shocked by what they were told which yet again indicates that the cases we have gathered are not unique but rather quite typical. Moreover, it seems that the mistreatment is not limited to maternity hospital settings but rather mirrors the general situation observed in the Ukrainian healthcare sector. Several women shared their stories of mistreatment experienced outside of the childbirth context.

Perhaps partly because of this, we have noticed that the mistreatment is to some extent normalized by the society in general, medical community, and some of our respondents in particular. For example, several respondents revealed that other people did not understand why they were shocked by what happened to them because that was what «everyone goes through»; some stories we have gathered included remarks about medical staff not paying attention to mistreating actions of their colleagues or silently watching them abuse the patients; and some talked about their experience as if it was quite natural.

The respondents often compared their childbirth experiences with those that happened in different settings. For instance, several respondents had an experience of giving birth

abroad and unanimously stated that they were treated with much more dignity there than in Ukraine. In a similar fashion, there is a belief that the mistreatment is less spread in the private Ukrainian maternity hospitals compared to the state ones. However, it should be stated that several respondents believed that private hospitals can abandon women who have serious birth complications and refer them to state hospitals at the stage of labour because they do not always have necessary equipment or do not want to have bad statistics. Several respondents shared the opinion that mistreatment is noticeably less spread and less severe in the big cities (and especially in the capital, Kyiv) compared to small towns. Yet, considering the majority of our sample gave birth in Kyiv or other big oblast centers, this belief can probably be misplaced. The respondents indicated that the situation has markedly improved in comparison to the past. Those women who have had an experience of giving birth in the past, especially a decade or longer ago, stated that they have noticed a significant improvement in the quality of maternity services. This is supported by several extreme examples of mistreatment respondents' relatives or acquaintances experienced in the past that were shared with us.

Three respondents in the sample have had home births following their institutional births (another one woman planned to have a home birth as well but had to refer to a hospital and delivered there). All three described them as very positive and different from their institutional births, with one respondent describing her experience as «the unity with god».

3.6. Effects of Mistreatment During Childbirth

Three categories of effects of mistreatment during childbirth on women were identified (see the graph as the Appendix H). To begin with, several respondents have explained that their experience made them question their readiness to have children in the future. This is how one of the respondents reacted to being asked if she planned to have more children in the future:

> Oh no! No! A-a-a! No! [...] I can just go on like this the whole day: no, no, no! Now, that's stressful. This question was the most stressful of all.
>
> Respondent 30

Another respondent shared that a friend of hers decided to not give birth after being present during her childbirth. Other variations of refusal to give birth included decisions to not give birth in the same health care facility, in the state health care facilities in general, and in Ukraine. Several respondents were so traumatized by their experiences they decided to give birth at home and intended to act the same way if they became pregnant again, several more told us they consider this possibility.

Mistreatment during childbirth can cause health effects, not only for women themselves but for their babies and close ones as well. Several respondents told us they can subjectivelly assume traumatic childbirth has affected their children, physically and psychologically alike. Several more shared stories of their partners being traumatized by their experience of partnered births. Many more were psychologically traumatized themselves, explaining that it took them a long time to work through the trauma, while some reported that they were still struggling with it and overthinking what happened time after time. Respondents shared that they were still feeling afraid, humiliated, and horrified by their experiences and that it had been influencing their mental state long after the event itself. Several reported crying for days afterwards and being generally depressed, although it is unclear whether they were diagnosed with clinical depression. Several respondents told us they developed triggers. For example, a medical student reported she could not be present in the inpatient departments where her studies took place, and another respondent who works as a doula has to decline offers to accompany childbirth in the hospital where she was abused. Below is an example of yet another respondent being triggered by her experience:

> As a result of all this cataclysm, for two years, almost for two years, I had been immersed in post-traumatic syndrome, right? As the military people do. [...] Post-

> traumatic syndrome is in the first place a panic fear, a state. What to do? Where to run? Despite the fact the situation is seemingly not terrible. The trigger for this condition was a baby's cry. That is, when they were suturing, stitching me up, tearing me, they did it to me while I was alert [without anesthesia], I felt it, I heard the child crying in the background. [...] The small baby—it would barely croak—I mean, I watch someone's baby being rocked in the stroller, they rock it for two hours, it cries for two hours straight, no reaction. The mom doesn't care. I could not! I couldn't hear someone cry! I started twitching! Mine [baby] did not cry, I carried it in a sling, but if it barely squeaked, it would croak twice, and I'm already shocked into action! I'm already panicking. I want to immediately do something, rock it, shake it, do it more for it to calm down faster.
>
> Respondent 19

In order to overcome the trauma, the respondents had to apply for professional psychological help and use other therapeutic practices to «close» the trauma, for example, «swaddling». Several confessed the interview within this study was helpful and satisfied their need to talk their experience through.

Respondents also reported being stressed; several explained that they were stressed during their childbirth due to either being mistreated during the previous birth experience or on the stage of being observed while pregnant. It was also suggested that stress can affect lactation of some women. At last, mistreatment can influence women physically; for example, one respondent told us she had faced problems in her sexual life due to having an episiotomy she was not warned nor asked to consent to.

Mistreatment during childbirth can lead to a change of attitude towards medical workers and healthcare system at large. Respondents reported deterioration of attitude, decrease of trust, and becoming more wary of medical staff; several shared they delay applying for medical help. For instance, one woman explained she put at risk her health and the life of her yet unborn baby because she was too afraid of seeking medical help due to abuse she

suffered during her previous childbirth. However, several respondents commented that their opinion did not change for the reason of it being already very poor.

To conclude, mistreatment during childbirth can lead to refusal to have children in the future, in general and in certain settings alike, such as in the state hospitals or in the health institutions, health effects like psychological trauma or depression, physical health problems, and health conditions in children, and changes in the attitude towards medical workers and healthcare system in general.

3.7. Solutions to Mistreatment During Childbirth

Five categories of the solutions to mistreatment during childbirth were identified (available as an Appendix I). To begin with, quite a few respondents stated that the changes are already taking place but need some time to become apparent. The arguments that support this position include the initiation of healthcare reform in Ukraine, reforming of childbirth services that took place in Ukraine in the previous years (for example, introduction of partnered births), and comparison of current state of maternal services provision with that of past.

There are situational solutions to the mistreatment during childbirth: respondents suggested that arranging for childbirth with a certain physician might decrease the chances of women being mistreated (however, the data shows this is not always true and that the contractual childbirth can on the contrary be a contributing factor to certain mistreatment types). Many respondents believe that partnered births, including that with doulas, decrease the risk of mistreatment as well, with several assuming that they would be mistreated much more if not for the presence of their partners.

The respondents suggested that women should prepare to childbirth by self-educating themselves, reading materials on the process of childbirth and medical protocols, and talking to other women who have given birth. They recommended visiting the maternity hospital where they plan to give birth to acquaint themselves with it and its staff and pose questions

on the local practices if possible. Another proposition concerned attending preparatory courses. Here, the respondents repeatedly stressed that women should attend independent courses and not those provided by the state hospitals. Additionally, several respondents suggested developing informational materials on the childbirth and distributing them at hospitals.

It is also important to focus on the education of medical workers. Respondents suggested providing medical staff with special training on modern obstetric practices, sensitization, ethics, and empathy with continuous psychological support of staff at the workplace and enabling them to exchange experience with Ukrainian and foreign colleagues. However, seeing as the professional deformation of medical workers starts at the point of industry entry (due to being educated by representatives of current culture), it might be sensible to initiate a reform of medical education.

The mistreatment can be also reduced by means of control, that is if effective mechanisms of punishment and supervision were introduced. Publicity can also be used as a tool of control; for instance, many respondents emphasized that the reason why they decided to participate in the study is to make their stories known and help other women avoid mistreatment.

However, more radical solutions might be needed, such as a reform of maternity services. There are several aspects that should be taken into consideration according to the respondents: the increase of the salaries of medical workers, their psychological support, the change of the funding principle, and the revision of maternity services provision model with its reorientation towards alternative services, such as support of home births or “natural births under the protection of the maternity hospital” provided by one of Kyiv maternity hospitals (Tyshenko 2017).

To conclude, the suggested solutions for overcoming mistreatment include situational solutions, such as arranging for contractual or partnered childbirth, education of medical staff and women alike, control, and reforming of maternity care services.

CHAPTER 4. DISCUSSION

At the beginning of this thesis, we have stated that the aim of our study was to reveal and describe the practices of mistreatment during childbirth in Ukraine from the women's perspective. We assumed that in Ukraine, the mistreatment in childbirth is manifested with different forms of verbal abuse, failure to provide consensual and dignified care, and limitations due to lack of resources. We expected that such displays of mistreatment as physical and sexual abuse, detention in the facility, abandonment in care, and discrimination would not be often mentioned by the respondents. Beside this, we expected mistreatment to happen to a much lesser extent in the private hospitals compared to the state ones and to not happen in the presence of a partner according to the stories of the respondents.

Not all our assumptions were reflected in the data we have collected. While we indeed found evidence for the existence of verbal abuse, non-consensual and non-dignified care and barriers to provision of high quality care related to the lack of resources, we discovered the disturbing experience of women in physical abuse during childbirth, as well as systematic discrimination, denial of medical care, and detention in the facility along with other forms of mistreatment. The reason for this revelation lies in the fact that, seeing as the majority of literature body we have reviewed at the beginning of this thesis investigated African and Asian contexts, we did not account for the cultural and political specifics of mistreatment displays while we built our expectations of the results. For this reason, the severe forms of mistreatment presented in the literature (Bohren et al., 2015) were not anticipated to be found in Ukraine.

However, if we control for the national context and recognize that one mistreatment type may have displays of different severity, we receive results that are quite consistent with what we have discovered on the stage of literature review. For instance, even though we did not find evidence for literal physical detention in the facility as described by Bowser & Hill (2010), we observed analogous forms of detention realized through other means of control,

such as refusal to provide an official discharge certificate from the hospital necessary for arranging for maternity leave.

In a similar fashion, we did not expect to encounter physical violence to the extent it has manifested throughout the interviews for the simple reason of conceptualizing it as an extremely cruel beating and general physical abuse instead of as medical manipulations conducted without consent (as interpreted by many respondents) and episiotomies without anesthesia as was revealed by this study. This being said, we indeed found the categories of "slapping" and "pushing" to be more of an exception than a pattern, and in this regard, it met our expectations. However, the discovery of the practice of unanesthetized episiotomies was utterly unexpected for us for the reason that we did not encounter this form of mistreatment in the literature review. The motivation of healthcare workers who decide to not provide anesthesia when it is clearly needed and when there is no apparent shortage of in in the facility remains unclear to us. One could speculate that this is barely a tool, if only an extremely cruel one, for punishing those who do not conform with what is considered to be an approved behaviour in childbirth if it were not applied to women on a seemingly routine basis regardless of their behaviour.

Our sample contained a limited number of respondents who gave birth in private hospitals, perhaps partly due to the fact that there is a limited number of private maternity hospitals in Ukraine, but the data we have gathered does indicate that mistreatment is much less typical for this kind of facilities. This supports the argument put forward by the respondents about state hospitals not seeing their patients as clients and not being motivated enough to compete with each other for them. For instance, there are three private maternity hospitals in Kyiv as of 2020 competing for the same target audience; it means that the level of services they provide determines the number of their clients and the revenueaccordingly. This cannot be said about the state hospitals of which there are over ten in Kyiv seeing as up until now, their funding did not depend on the quality of services they provided nor the number of patients serviced. As far as we have gathered, right now state hospitals are mainly guided by the issue of "good statistics" which in turn focuses on the quantitative indicators

such as survival of the mother and the child and disregards qualitative outcomes of service provision, for example, patient satisfaction or necessity of further psychological support. Seeing as Ukraine is underway a second stage of medical reform that is going to change the model of funding of secondary level facilities, maternal hospitals included, towards "money follow the patient" principle (MHU, 2018), we expect the shift in the attitude of the staff and decrease in the reported mistreatment due to the introduction of competition between facilities and not funding the hospitals which do not meet the requirements for services in childbirth. However, we are concerned that the reform will only affect big cities where the competition between the facilities is technically possible. Several respondents from our sample reported they were not able to choose the hospital they were planning to give birth in due to there being only one facility in their place of residence.

The Ministry of Health implies that the reform will also address the issue of corruption in the maternity hospitals (Hromadske Cherkasy, 2017), a problem that seems to be of equal importance for our respondents seeing as almost everyone has mentioned it at some point during the interview despite the fact we did not ask them about it directly. Because the reform introduces a new financial mechanism and the autonomous facility management has the right to implement new policies of salaries of medical workers on the one hand, and one the other, the package "childbirth" is funded by the NHSU and the contract forbids to charge the patient additionally, it is expected that it will prevent doctors from asking for or hinting on informal payments for their services, seeing as at the moment, they have to do this in order to literally survive (Lutsenko, 2020). However, we doubt that the reform of healthcare facilities financing will indeed solve this problem because of the long history and existing culture of informal payments. In turn, this means that a part of patients will be still singled out and discriminated against on the basis of refusal to provide the payment.

It is equally important to address the issue of ethnic discrimination discovered within this study. Despite it not being the focus of our research and even though our sample to the extent of our knowledge did not include Roma women, it is apparent that this ethnic group faces significant barriers to receiving high-quality and dignified care. This reflects the

general negative attitude, various forms of discrimination, personal as well as institutionalized, physical assault, and stigmatization Roma people experience in Ukraine on a routine basis (Bocheva, 2019). The problem of Roma people discrimination clearly belongs to a wider context of the human rights violation and institutionalized discrimination, and the issue of childbirth should be included into this wider discurs and payed more close attention by researchers and human rights activists alike.

Our assumption of mistreatment not happening in the presence of birth partners did not prove to be accurate. While the respondents were indeed convinced that the presence of a trusted partner decreases the amount and severity of mistreatment, it does not prevent it as proved by the fact that the majority of our sample had partnered childbirth but experienced it nevertheless. We can assume that partnered childbirth can indeed prevent those forms of mistreatment that suggest actions, such as physical violence, but proves to be ineffective in preventing inaction, such as lack of information and support. On the contrary, sometimes partnered childbirth can be one of the reasons for mistreatment as proved by women who were judged for bringing doulas.

Another important phenomenon we have noticed is the lack of holistic approach to patients and lack of coordination between different healthcare sectors associated with it. The majority of types of mistreatment in the model we have developed can be generally characterized by the staff's lack of larger perspective on the health and indifference towards those aspects of health that are not directly associated with their line of work. A good example of this is the prescription of drugs for mothers without consideration of breastfeeding possibility and general well-being of a child, but this issue goes much deeper than that. The medical workers do not consider what aftereffects their words, actions, decisions, and attitudes have on the future of a woman and her baby. This includes indifference to psychological harm caused by unnecessary roughness in communication, physical suffering and decrease in the quality of life associated with avoidable medical manipulations such as episiotomy, and potential harm done to a baby due to unwillingness to follow the WHO recommendations on exceptional breastfeeding, delayed umbilical cord

cutting, and skin-to-skin contact (WHO, 2011; WHO 2012; WHO, 2014). In other words, the staff is focused on achieving very straightforward and short-term pathology-oriented (Goncharuk, 2018) goals such as delivering the baby as fast as possible and with minimal fatalities while disregarding the long-term outcomes that will have to be managed by other specialists.

This is perhaps at least partly associated with objectification of patients we have noticed throughout the study. While the majority of mistreatment displays identified are somewhat related to each other, objectification and dehumanization associated with it is, in our opinion, is the cornerstone of our model, seeing as it is the foundation for most of the displays. For instance, the lack of information comes from the supposition that the women could not possibly understand or need it, the pressure and certain forms of physical violence are applied when the staff tries to persuade women to act or be manipulated the way it is best for them (their resistance in this case is seen as unreasonable, unfounded, and invalid stubbornness born of lack of expertise), the privacy and autonomy of women are systematically violated because patient bodies are viewed as objects stripped of any attributes of privacy or subjectivity, and all their opinions, feelings, or sensations are consistently devalued because an object cannot own any judgement capability. One can notice the centrality of information in most of these situations. Indeed, the justification for objectification seems to more often than not build upon the asymmetry of knowledge, a notion integral to the power dynamic of patient-provider relationship. However, in the case of current study, the natural doubt in the validity of a patient's ability to accurately assess the situation seems to be brought to absurdity.

Another fundamental matter of our model doubtlessly related to objectification is the medicalization of childbirth. Repeatedly stressed by the experts and supported by our empirical data, the process of childbirth in Ukraine tends to be perceived as a clinical situation that therefore requires intervention and cannot be simply overseen. This is supported by the existing literature on the topic: for example, according to Demianova-Ponomarenko et al. (2016), among surveyed women who gave birth in Ukraine between

2009 and 2015, only 31% did not have any interventions. This is surely not a feature unique to Ukraine or even childbirth area alone but rather an international trend that has been spreading to many other medical areas besides childbirth (Phelan & O'Connell, 2015). Nonetheless, this approach is institutionalised in Ukraine as well, for example, through education of obstetricians as specialists who are supposed to interfere with the process. For example, Demianova-Ponomarenko et al. (2016) note that physicians play a primary role in labor and basically lead childbirth while midwives are considered to be the help, which indicates the clinical focus in the childbirth. It is thus quite understandable that they attempt to intervene seeing as this corresponds to how and what they were taught. This argument can be also supported by the number of obstetricians involved in the current healthcare system: according to national statistics, there were 5,1 obstetricians per 10 thousand women of all ages and 11,6 obstetricians per women aged 15-49 in Ukraine in 2017; to compare, there were 8,3 general practitioners and 3,6 family doctors per 10 thousand population that year. Perhaps even more indicative, the report provides statistics on "pregnancy, childbirth, and the postpartum period" in the tables among different types of diseases labeled "Distribution of diseases by class", "The incidence rate of diseases by classes", and alike, a situation even more ironic considering the "incidence" word is derived from the word "to become ill" in Ukrainian (SSSU, 2018). This leads us to the understanding that if a childbirth is seen as a clinical situation, it justifies the transition of authority to make decisions to physicians who have the knowledge and skill necessary to manage it. In this regard, a woman is indeed an object that has to be managed or rather "treated" as if she were truly ill. However, this does not align with how women perceive the childbirth itself and themselves within it: as active participants with agency to make decisions concerning themselves. This gap is naturally the point of conflict and in many instances mistreatment. Accordingly, we need to take a step back and reconsider the way we approach the childbirth in order to manage the issue of mistreatment.

The general medicalization of childbirth in Ukraine however paradoxically coexists with an unwillingness to follow the new evidence-based protocols as obvious from the

interviews and literature (Demianova-Ponomarenko et al., 2016). This includes not only management of a newborn as mentioned above, but also such manipulations as amniotomy, episiotomy, and stimulation with oxytocin. The latest Ukrainian protocol on normal childbirth strictly regulates when and how these manipulations should be used (MHU Decree #624, 2008), but the physicians seem to apply them routinely and with no regard towards real necessity of the interventions, which naturally contradicts their claim of evidence-based approach that justifies taking the autonomy of choice away from a woman as the one who does not own medical credentials to make rational decisions.

Sometimes this leads to completely reversed and truly bizarre situations of women citing and referring to the protocols in an attempt to prevent unreasonable interventions only to be forced into them despite their objections. This can be an indicator of rigidity of medical staff, low level or their training, and their inability or unwillingness to update their knowledge or accomodate to the change.

The same can be said about the practice to schedule the childbirth according to the convenience of the staff which is seemingly so spread in Ukraine it was noticed in the statistics on distribution of childbirth by the day of the week (Tkachuk 2019). This, along with the inability to choose a birth position other than on their back, are the products of the exactly same three phenomena: the objectification, the lack of holistic view on patient, and the medicalization of childbirth. Both these practices seem to be widely spread, which speaks about their wide acceptance among the medical workers. For instance, according to Demianova-Ponomarenko et al. (2016), 49% of women in their 2015 survey reported giving birth on their back, however, they estimate this number to be even greater due to the specifics of question wording (the rest 51% respondents reported being comfortable in their position).

The latter brings us to the issue of consent that proved to be problematic due to its systematic violation by medical staff. The provision of non-consensual care is a typical display of mistreatment, worldwide and in Ukraine alike (Bowser and Hill, 2010; Demianova-Ponomarenko et al., 2016), however, it seems that in Ukraine, medical workers do not merely violate the consent but do not understand the concept of it itself. As one of the

experts noted, they do not always realise that the consent can be *not provided* and that it is an answer in itself. Instead, medical staff attempts to receive it at any cost, often by adopting such tools as pressure, threats, verbal violence, and many others presented in the previous part of this thesis. The formality of it is empathized by the fact women are made to sign the written consents for certain manipulations post-factum or at the time when they are physically unable to understand what they are given to sign (MHU Decree #624, 2008), or by the existence of local consent forms that grant medical staff blanket permission for any and all interventions that might be applied in childbirth. This impression is supported by Demianova-Ponomarenko et al. (2016) who note that these forms are seen as a bureaucratic formality by both women and medical workers: the former do not usually read or even have an ability to read them while in labor and the latter "care for the papers to be signed, not the women's needs to be met".

The literature argues that the normalization of mistreatment is one of the factors for its existence (Bowser & Hill, 2010; Raj et al., 2017; Perera et al., 2018; Asefa et al., 2018). Considering that our sample is screwed in a sense that our respondents are aware of being mistreated, we had an opportunity to contrast their experience with the reaction they received from their social environment. The evidence we have encountered does imply the normalization, perhaps closely associated with the prevalence (although subjectively perceived) of it. Almost every respondent was able to provide a story of a close one being mistreated in the childbirth, often not even one. There were respondents who kept providing examples of their friends, neighbours, colleagues, relatives experiencing the same they themselves have experienced or even worse. However, many marked that other women do not view what happened to them as mistreatment or see it as a common practice that "everyone has gone through". Moreover, while women might admit the "unpleasantness" of their childbirth experience, several respondents reported that their relatives and acquaintances among medical workers sometimes did not even realize the reason for their dissatisfaction. Considering the mistreatment, as it seems, has been institutionalized for at

least several generations, this perception, on the part of both women and medical workers, is to be expected.

It is perhaps not possible to avoid the subject of gender while talking about the mistreatment during childbirth seeing as it is an absolute example of gender-based violence (Goer, 2010; Freedman & Kruk, 2014; Diaz-Tello, 2016; Demianova-Ponomarenko et al., 2016; Savage & Castro, 2017; Warren et al., 2017). Women are systematically discriminated against in practically all societies and areas of life, but childbirth is a unique situation of absolute vulnerability where they are mistreated exactly for and because of their essentially expressed womanhood. Cahill (2001) argues that the childbirth situation in itself is designed not merely for the comfort of medical workers, but for and by male physicians. If we look at it from this perspective and apply the lens of this study, we can conclude that people in childbirth situations are objectified and subsequently mistreated not only as patients but as women as well. In other words, the power imbalance associated with the asymmetry of knowledge and subject-object dynamics is strengthened by the gender inequality and gender power dynamics.

Taking into account all discussed above, it is no wonder that many women see healthcare facilities as hostile institutions to the extent that ever more opt for home birth in order to simply avoid hospitalization (Demianova-Ponomarenko et al., 2016). This indicates the crisis of current maternity services model and the need for its reforming. The transformation of the health financing system that has been taking place in Ukraine since 2016 (CMU Decree #1013-p, 2016) might partly address some of the problems posed above: the principle of "money following the patient" that is being introduced at the secondary level of medical services provision as of 2020 introduces a mechanisms that is going to encourage hospitals and medical staff to provide dignified and high-quality health services or risk losing funding. However, it will not address the issue of the highly medicalized approach to childbirth that is observed in Ukraine and recognized as one of the contributors to the mistreatment. A solution presented by the experts suggests transition to a model of maternity services that is implemented, among some other countries, in the Netherlands and Great

Britain (Gorbenko 2016). The so-called three-level model of obstetric care heavily relies on midwives and general practitioners who manage uncomplicated low-risk pregnancies and deliveries that take place at home or in the birth centers, facilities associated with hospitals but providing services in a home-like climate. If complications arise, a woman can be rapidly transferred to the hospital or an obstetric ward within the birth centers. Accordingly, only difficult and problematic cases of pregnancy are being initially referred to maternity hospitals and are managed by obstetricians. This model is effective in a several ways: firstly, it enables low-intervention childbirth for those women who have uncomplicated pregnancies and are considered low-risk; secondly, it is economically efficient in a sense that it decreases the need for highly-trained obstetricians and highly-specialised hospitals and lessens the number of unnecessary interventions and costs associated with them; thirdly, it unloads the tertiary level of healthcare system (Demianova-Ponomarenko et al., 2016; Hermus et al., 2017; Boesveld et al., 2017).

CONCLUSIONS

In our thesis, we attempted to reveal and describe the practice of mistreatment during childbirth in Ukraine from the women's perspective. We were going to do this by addressing four objectives: by studying the existing research on the mistreatment of women during childbirth, classifying the types and patterns of mistreatment of women during childbirth in Ukraine, and describing its reasons and perceived effects.

First, we have learned that the issue of mistreatment had arisen not that long ago but has already accumulated a vast amount of evidence. This is not a national problem but rather a universal trend that has been recognized all around the world. Mistreatment during childbirth includes but is not limited to physical, sexual, and verbal abuse, neglect, abandonment of care, detention in the facility, non-consensual care, discrimination, and many other manifestations.

The displays of mistreatment during childbirth in Ukraine generally correspond to what was discovered in the literature review. There is a critical lack of resources in the healthcare facilities and high prevalence of corruption that facilitate the mistreatment which in turn manifests through violation of privacy and confidentiality, lack of communication and information, indifference, pressure, physical violence and violation of personal autonomy, transferring of responsibility to patients and reluctance to apply modern medical practices, devaluation, objectification, and discrimination. Because of this, many respondents perceive healthcare facilities as hostile institutions. There is evidence that indicates the high prevalence of mistreatment during childbirth in Ukraine, however, the methodology of current study does not allow us to support this argument.

The reasons for mistreatment during childbirth include soviet heritage, education, bureaucratization, personal and professional factors, patient factors, and power imbalance.

The perceived effects of mistreatment during childbirth include refusal to have children in the future, in general and in certain circumstances alike, health effects, including

psychological and physical, and change of attitude towards medical workers and the healthcare system at large.

Our results have supported the previous research on mistreatment during childbirth and have provided evidence for its relevance in the context of Ukraine. It is clear that this issue remains to be addressed, however, we believe that the current study can contribute to the body of evidence on the need to consider the changes to the model of maternal services provision in Ukraine seeing as the current reform of the financing principle of healthcare is unlikely to significantly change the situation. Our study can support the forthcoming research on the mistreatment during childbirth, including that using the quantitative approach.

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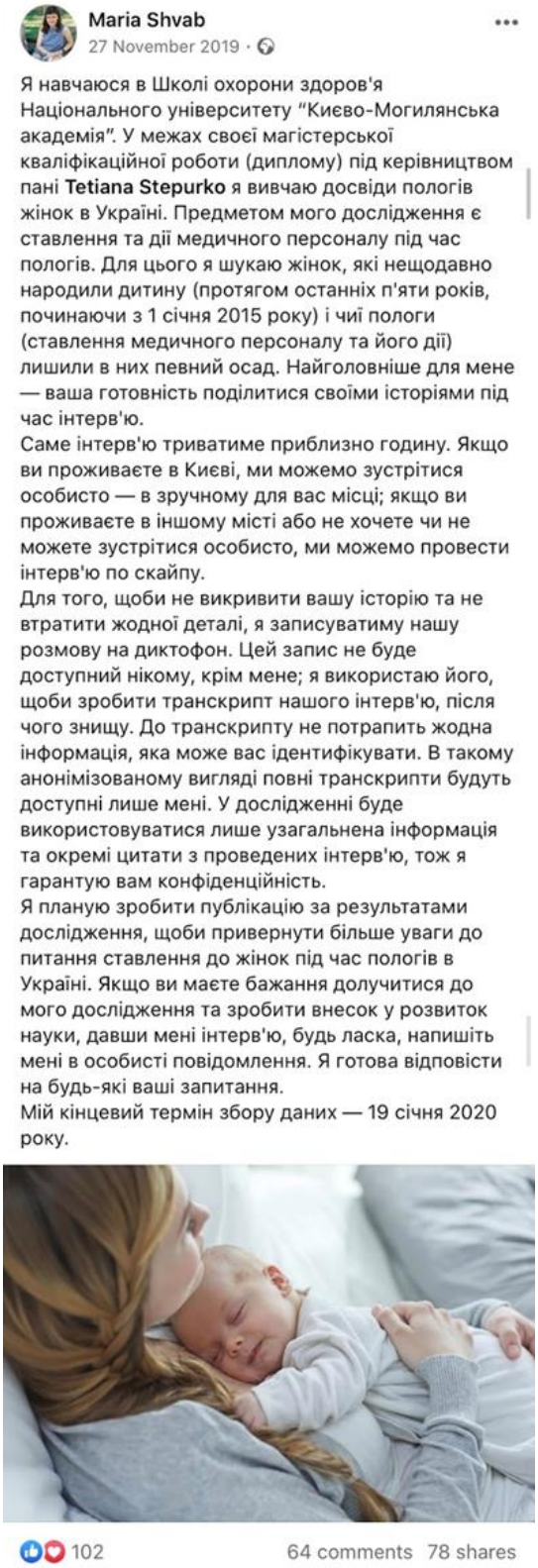
Appendix A. List of Interviewed Experts

Name of the Expert	Affiliation
Anastasiya Salnykova	NGO “Natural Rights Ukraine” (Ukr. “Природні Права Україна”), organization for human rights in the field of pregnancy, childbirth, and motherhood
Anna Petrovska	NGO “Natural Rights Ukraine” (Ukr. “Природні Права Україна”), organization for human rights in the field of pregnancy, childbirth, and motherhood
Euhenia Kubakh	NGO “Natural Rights Ukraine” (Ukr. “Природні Права Україна”), organization for human rights in the field of pregnancy, childbirth, and motherhood
Iryna Sozanska	Former member of NGO “Natural Rights Ukraine” (Ukr. “Природні Права Україна”), organization for human rights in the field of pregnancy, childbirth, and motherhood NGO “Care of an Angel” (Ukr. “Опіка Ангела”), organization that provides support for parents who have lost a pregnancy or whose newborn has died
Olga Gorbenko	NGO “Natural Rights Ukraine” (Ukr. “Природні Права Україна”), organization for human rights in the field of pregnancy, childbirth, and motherhood Psychologist, Doula
Olga Vereschak	NGO “Natural Rights Ukraine” (Ukr. “Природні Права Україна”), organization for human rights in the field of pregnancy, childbirth, and motherhood NGO Center of Family Development “Semytsvit” (Ukr. “Семицвіт”)
Yuliya Aleksandrova	NGO “Association of Parents of Premature Infants “Early Birds” (Ukr. “Ранні пташки”)

Appendix B. Post on the Personal Facebook Page on the Recruitment of Respondents



Maria Shvab
27 November 2019 ·

Я навчаюся в Школі охорони здоров'я Національного університету "Києво-Могилянська академія". У межах своєї магістерської кваліфікаційної роботи (диплому) під керівництвом пані **Tetiana Stepurko** я вивчаю досвіди пологів жінок в Україні. Предметом мого дослідження є ставлення та дії медичного персоналу під час пологів. Для цього я шукаю жінок, які нещодавно народили дитину (протягом останніх п'яти років, починаючи з 1 січня 2015 року) і чиї пологи (ставлення медичного персоналу та його дії) лишили в них певний осад. Найголовніше для мене — ваша готовність поділитися своїми історіями під час інтерв'ю.

Саме інтерв'ю триватиме приблизно годину. Якщо ви проживаєте в Києві, ми можемо зустрітися особисто — в зручному для вас місці; якщо ви проживаєте в іншому місті або не хочете чи не можете зустрітися особисто, ми можемо провести інтерв'ю по скайпу.

Для того, щоби не викривити вашу історію та не втратити жодної деталі, я записуватиму нашу розмову на диктофон. Цей запис не буде доступний нікому, крім мене; я використаю його, щоби зробити транскрипт нашого інтерв'ю, після чого знищу. До транскрипту не потрапить жодна інформація, яка може вас ідентифікувати. В такому анонімізованому вигляді повні транскрипти будуть доступні лише мені. У дослідженні буде використовуватися лише узагальнена інформація та окремі цитати з проведених інтерв'ю, тож я гарантую вам конфіденційність.

Я планую зробити публікацію за результатами дослідження, щоби привернути більше уваги до питання ставлення до жінок під час пологів в Україні. Якщо ви маєте бажання долучитися до мого дослідження та зробити внесок у розвиток науки, давши мені інтерв'ю, будь ласка, напишіть мені в особисті повідомлення. Я готова відповісти на будь-які ваші запитання.

Мій кінцевий термін збору даних — 19 січня 2020 року.

102 64 comments 78 shares

Appendix C. Guide for the Interview with the Expert-Respondents

Вітаю! Мене звати Марія Шваб, я студентка Школи охорони здоров'я Національного університету “Києво-Могилянська Академія”. У межах своєї дипломної магістерської роботи я вивчаю досвіди пологів в Україні з акцентом на проблеми, які можуть виникати при отриманні відповідних медичних послуг. Дякую, що погодилися виділити для мене час!

- Чи не проти ви, якщо я записуватиму нашу розмову?
- Короткий обрис дослідження.
- Чи маєте ви якісь коментарі чи запитання, перш ніж ми перейдемо до запитань?

1. Чи не могли би ви розповісти, як прийшли до вивчення/роботи з цією темою?

2. Чи не могли би ви розповісти про певні характерні практики неналежного ставлення в пологах, які є поширеними в Україні? Чи відомі вам конкретні випадки? Наскільки вони поширені?

3. Як ви вважаєте, чи є українська ситуація відмінною від ситуації інших країн? Чи існують певні культурні особливості? У чому вони полягають?

4. Як ви вважаєте, чи є неналежне ставлення більш характерним для певних професіних категорій (лікарів, медсестер, акушерок)?

5. Як ви вважаєте, чи існує різниця між приватними та державними пологовими будинками? Чи існує неналежне ставлення в приватних пологових будинках?

6. На ваш погляд, чи зменшує присутність партнерів у пологах ризик неналежного ставлення? Чи може це бути ефективною інтервенцією?

7. Як ви вважаєте, з чим пов'язано неналежне ставлення до жінок під час пологів? Якими є його причини?

8. До яких наслідків може призводити неналежне ставлення до жінок під час пологів? Чи можете ви навести конкретні приклади?

9. Яким чином можна попередити неналежне ставлення в пологах? Чи знаєте ви про певні інтервенції, що використовуються в інших країнах?

10. Можливо, є ще щось, що я не згадала, про що ви хотіли би мені розповісти?

11. Чи можете ви порадити, з ким ще я могу поговорити з приводу цієї теми?

- Подяка.

Appendix D. Guide for Women-Who-Had-Childbirth-Respondents

- Привітання.
- Загальна інформація про дослідження. Запитання?
- Немає правильних чи неправильних відповідей.
- Вільна участь, можливість зупинити інтерв'ю в будь-який час.
- Можливість не відповідати на запитання.
- Аудіозапис, конфіденційність.
- Запитання?

<u>Айсбрейкер</u>

1. Розкажіть, будь ласка, про себе: чим ви займаєтеся, скільки у вас дітей?

<u>Підготовка до пологів</u>

2. Будь ласка, розкажіть, як ви готувалися до пологів?
    a. Як ви обирали заклад, у якому народжувати?
    b. Чи домовлялися ви попередньо з лікарем?
3. Як ви планували народжувати: природньо чи шляхом кесаревого розтину?
    a. А як народили в результаті?

(Якщо заплановано і проведено кесарів розтин — перехід до наступного блоку; якщо планувалося та відбулося природним шляхом або планувалося природним, але закінчилося кесаревим — перехід до блоку "Початок пологів")

<u>Запланований кесарів (перед операцією)</u>

4. Якими були причини призначення кесаревого розтину?
5. Операція відбулася в той день, на який її призначили?
    a. Чому?

(Якщо ні, перехід до блоку "Початок пологів")

6. Розкажіть про цей день.
    a. Як ви потрапили до закладу?
    b. Як би ви оцінили ставлення до вас персоналу на цьому етапі?
    c. Як би ви оцінили свій емоційний та психологічний стан на цей момент?
7. Якби вам треба було описати цей період одним словом або реченням, яке слово чи речення ви би використали?
8. Який наркоз вам застосовували?

(Якщо повний, перехід до наступного блоку,
якщо місцевий, перехід до блоку "Початок пологів")

<u>Запланований кесарів із повним наркозом (операція та невдовзі після операції)</u>

9. Що би ви могли розповісти про той час, коли ви лише прокинулися?
10. Якими були ваші почуття?
11. Чи були з вами в цей момент близькі?
12. Скільки тривав кесарів розтин?
13. Яким було ставлення до вас персоналу після вашого пробудження? Чи підтримував він вас? Допомагав?

14. Якби вам треба було описати цей період одним словом або реченням, яке слово чи речення ви би використали?
15. Як би ви оцінили свій емоційний та психологічний стан на цей момент?

<u>Початок пологів (незапланований кесарів/природній шлях)</u>

16. Розкажіть про початок ваших пологів. Як усе розпочалося?
17. Як ви потрапили до самого закладу?
    a. Розкажіть, як вас прийняли.
    b. Яким було ставлення персоналу в приймальному відділенні?
18. Чи були з вами в цей час ваші близькі?
19. Якби вам треба було описати цей період одним словом або реченням, яке слово чи речення ви би використали?
20. Як би ви оцінили свій емоційний та психологічний стан на цей момент?

(Якщо закінчилося кесаревим розтином із повним наркозом, повернутися до попереднього блоку).

<u>Від початку до самих пологів</u>

21. Як довго тривали перейми? Розкажіть про цей період часу.
22. Яким було ставлення до вас персоналу в цей час? Чи підтримував він вас?
23. Якби вам треба було описати цей період одним словом або реченням, яке слово чи речення ви би використали?

<u>Пологи/кесарів</u>

А тепер давайте поговоримо саме про пологи.

24. Розкажіть у своїх словах, як усе відбувалося.

25. Якими були ваші попередні уявлення про пологи? Що ви від них очікували? Яким чином ваш досвід відрізнявся від ваших очікувань?

26. Скільки тривали ваші пологи?

27. Чи були під час пологів поруч ваші близькі люди?

28. Яким було ставлення до вас персоналу в цей час? Чи підтримував він вас?

29. Яким був ваш емоційний та психологічний стан під час пологів?

30. Якби вас попросили описати ваші пологи одним словом або реченням, яким би було це слово або речення?

31. Чи здійснював медичний персонал якісь дії, які вам не сподобалися чи які змусили вас відчути дискомфорт (психологічний, фізичний, емоційний)?

32. Чи здійснював медичний персонал будь-які медичні дії без вашої на те згоди?

Після пологів (всі)

33. Розкажіть, будь ласка, про те, що було одразу після пологів.

34. Яким було ваше перебування в пологовому будинку? Як довго ви пролежали в ньому?

   a. Чи влаштовували вас умови?
   b. Яким було ставлення персоналу? Чи підтримував він вас? Турбувався?

35. Як би ви описали свій емоційний та психологічний стан в період після пологів?

36. Якби вам треба було описати цей період одним словом або реченням, яке слово чи речення ви би використали?

Наслідки (всі)

37. Як ви вважаєте, як часто трапляються ситуації, які відбулися з вами?

38. Чи знаєте ви про інші випадки, схожі на ваш? Розкажіть детальніше.

39. Як ви вважаєте, чи вплинув на вас ваш досвід пологів? Як?

40. Чи змінилося ваше ставлення до медичних працівників, закладу, в якому ви народжували, після пологів? Яким чином?

41. Чи плануєте ви ще одну вагітність? Чи пов'язано це з вашими останніми пологами?

42. Чи обговорювали ви з кимось свої пологи та те, що під час них трапилося? Як реагували люди, з якими ви це обговорювали?

<u>Причини (всі)</u>

43. Як думаєте, яким чином можна було би уникнути того, що трапилося з вами, в майбутньому?

44. Як ви думаєте, чому так відбулося?

<u>Закінчення (всі)</u>

45. Що би ви порекомендували іншим вагітним жінкам, які мають скоро народжувати?

46. Що би ви порекомендували медичним працівникам, залученим до пологів?

<u>Анкета</u>

У мене на аркуші наведено список негативних ситуацій, які можуть траплятися з жінками незадовго до пологів, під час пологів та невдовзі після них. (Ви вже згадали деякі з них.) Я пропоную пройтися по кожному з пунктів, щоби пересвідчитися, що ми нічого не пропустили. Я називатиму ситуацію й проситиму вас відповісти, чи стикалися ви з нею на власному досвіді. Можливо, ви не стикалися з такою ситуацією

особисто, проте знаєте про такі випадки з досвіду своїх знайомих чи подруг, а може, чуєте про таке вперше.

Якщо названа ситуація траплялася з вами, я попрошу вас оцінити її травматичність особисто для вас на шкалі від 1 до 10, де 1 — зовсім не травматично, а 10 — дуже травматично.

Якщо ви захочете приділити якомусь із пунктів більше уваги або прокоментувати його — зупиніть мене, і ми обговоримо його детальніше.

(Заповнюється після анкети нижче!)

Соціально-демографічна інформація

Впевнитися, що я все записала правильно.

1. Місто.
2. Державний/приватний/вдома (якщо вдома — куди потрапили далі?).
3. Кількість дітей/пологів.
4. Вагінальні/кесарів.
5. Вік.

Номер інтерв'ю ___

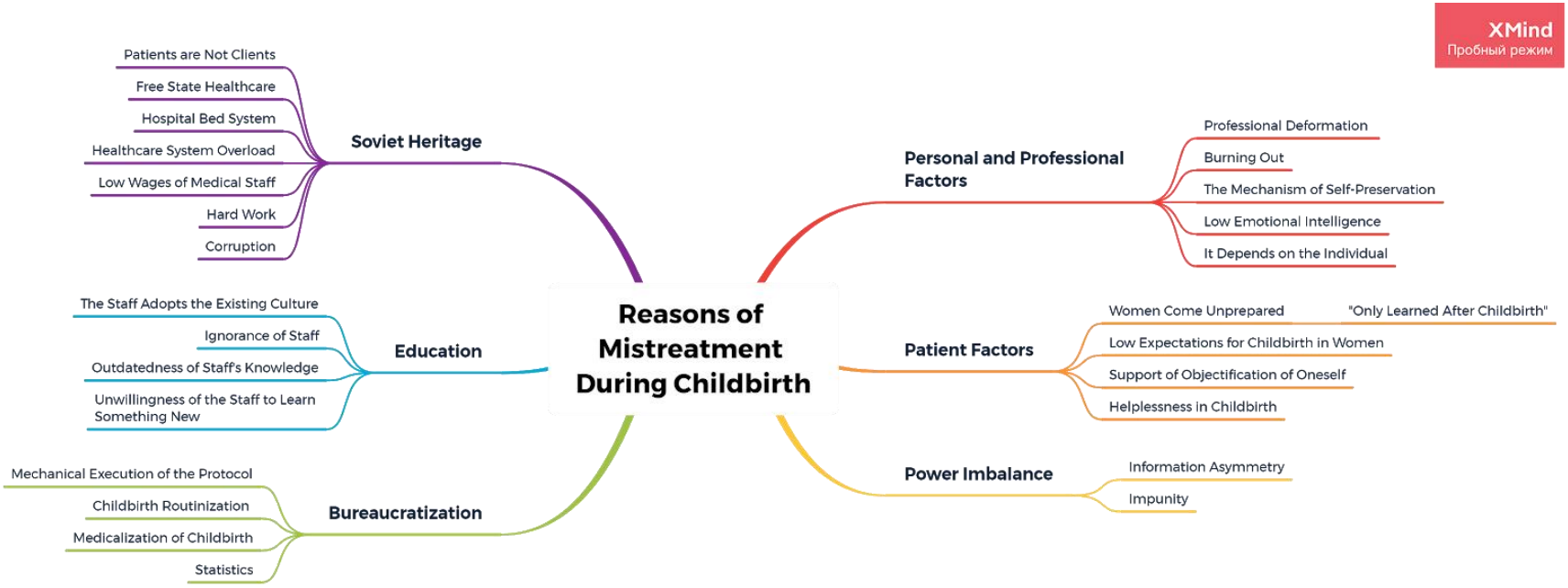
	2: пережила особисто; **1**: чула від знайомих; **0**: не переживала сама та не чула від знайомих	Травматичність **(у разі, якщо пережила особисто)** *1 — зовсім не травматично* *10 — дуже травматично*
Використання грубої, ненормативної лексики		1 2 3 4 5 6 7 8 9 10
Крик, підвищення тону		1 2 3 4 5 6 7 8 9 10

	2: пережила особисто; **1**: чула від знайомих; **0**: не переживала сама та не чула від знайомих	Травматичність **(у разі, якщо пережила особисто)** *1 — зовсім не травматично* *10 — дуже травматично*
Недоречні, непристойні коментарі		1 2 3 4 5 6 7 8 9 10
Використання неналежних слів при звертанні, невикористання імені		1 2 3 4 5 6 7 8 9 10
Засудження		1 2 3 4 5 6 7 8 9 10
Погрози		1 2 3 4 5 6 7 8 9 10
Звинувачення		1 2 3 4 5 6 7 8 9 10
Фізичне насилля		1 2 3 4 5 6 7 8 9 10
Дискримінація (гірше поводження у зв'язку з певною ознакою чи належністю до певної групи)		1 2 3 4 5 6 7 8 9 10
Видавлювання дитини, тиск на живіт		1 2 3 4 5 6 7 8 9 10
Болісні, неприємні вагінальні або інші обстеження		1 2 3 4 5 6 7 8 9 10
Здійснення процедури без отримання згоди на неї або без попередження		1 2 3 4 5 6 7 8 9 10
Здійснення процедури, незважаючи на висловлену незгоду, примус до процедури		1 2 3 4 5 6 7 8 9 10
Відмова в наданні або примусове введення		1 2 3 4 5 6 7 8 9 10

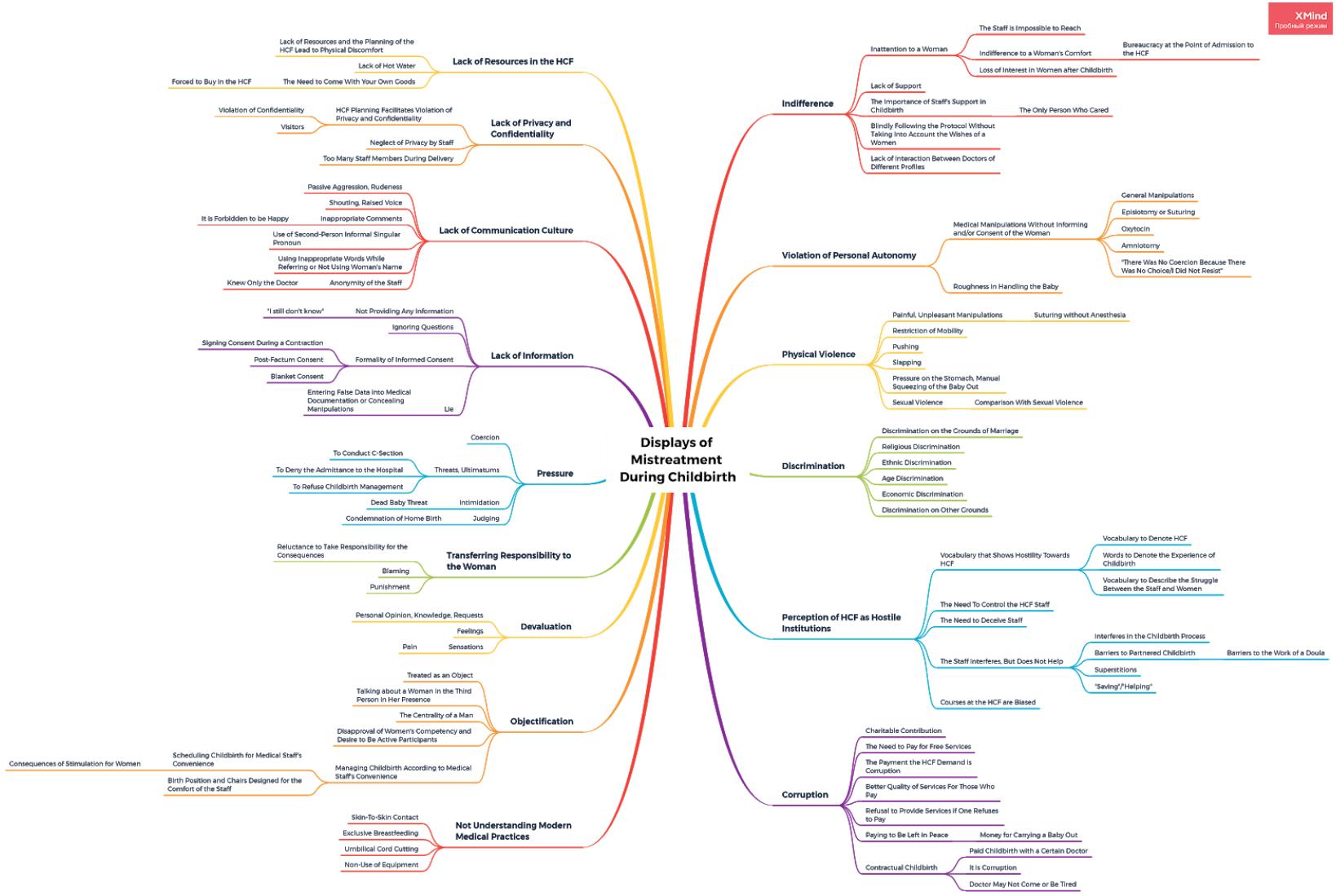
	2: пережила особисто; **1**: чула від знайомих; **0**: не переживала сама та не чула від знайомих	Травматичність **(у разі, якщо пережила особисто)** *1 — зовсім не травматично* *10 — дуже травматично*
знеболювальних препаратів		
Відсутність інформованої згоди (згода не запитувалася, наданої інформації було недостатньо для ухвалення поінформованого рішення або на це не давалося достатньо часу, згода підписувалася заднім числом)		1 2 3 4 5 6 7 8 9 10
Порушення конфіденційності або приватності		1 2 3 4 5 6 7 8 9 10
Нехтування, брак уваги з боку медичного персоналу, ігнорування		1 2 3 4 5 6 7 8 9 10
Знецінення думок, відчуттів		1 2 3 4 5 6 7 8 9 10
Поводження як із предметом, а не людиною		1 2 3 4 5 6 7 8 9 10
Відсутність пояснень		1 2 3 4 5 6 7 8 9 10
Мовний бар'єр		1 2 3 4 5 6 7 8 9 10
Відсутність підтримки з боку медичного персоналу		1 2 3 4 5 6 7 8 9 10
Медичний персонал не називав своє ім'я, перш ніж почати медичні		1 2 3 4 5 6 7 8 9 10

	2: пережила особисто; **1**: чула від знайомих; **0**: не переживала сама та не чула від знайомих	Травматичність **(у разі, якщо пережила особисто)** *1 — зовсім не травматично* *10 — дуже травматично*
маніпуляції, або входячи до приміщення		
Заборона присутності близької людини під час пологів		1 2 3 4 5 6 7 8 9 10
Заборона народжувати в зручній позі		1 2 3 4 5 6 7 8 9 10
Заборона застосовувати безпечні практики (наприклад, ходити)		1 2 3 4 5 6 7 8 9 10
Проколювання навколоплідного міхура		1 2 3 4 5 6 7 8 9 10
Стимуляція окситоцином		1 2 3 4 5 6 7 8 9 10
Після пологів дитину тримали окремо без об'єктивних на те причин		1 2 3 4 5 6 7 8 9 10
Сексуальне насилля з боку медичного персоналу		1 2 3 4 5 6 7 8 9 10
Маніпуляції, ультиматуми		1 2 3 4 5 6 7 8 9 10
Розтин промежини		1 2 3 4 5 6 7 8 9 10
Брехня		1 2 3 4 5 6 7 8 9 10
Звертання на “ти”		1 2 3 4 5 6 7 8 9 10
Присутність сторонніх осіб		1 2 3 4 5 6 7 8 9 10

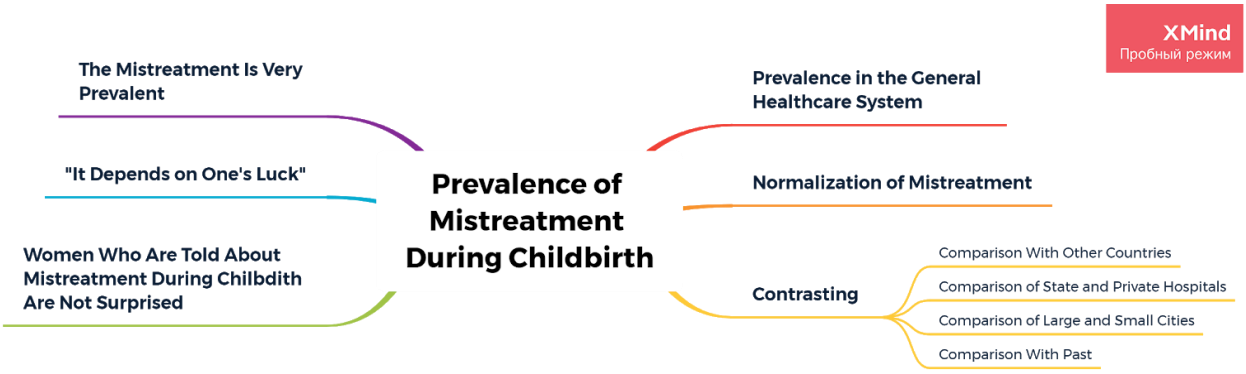
Appendix E. Reasons of Mistreatment During Childbirth



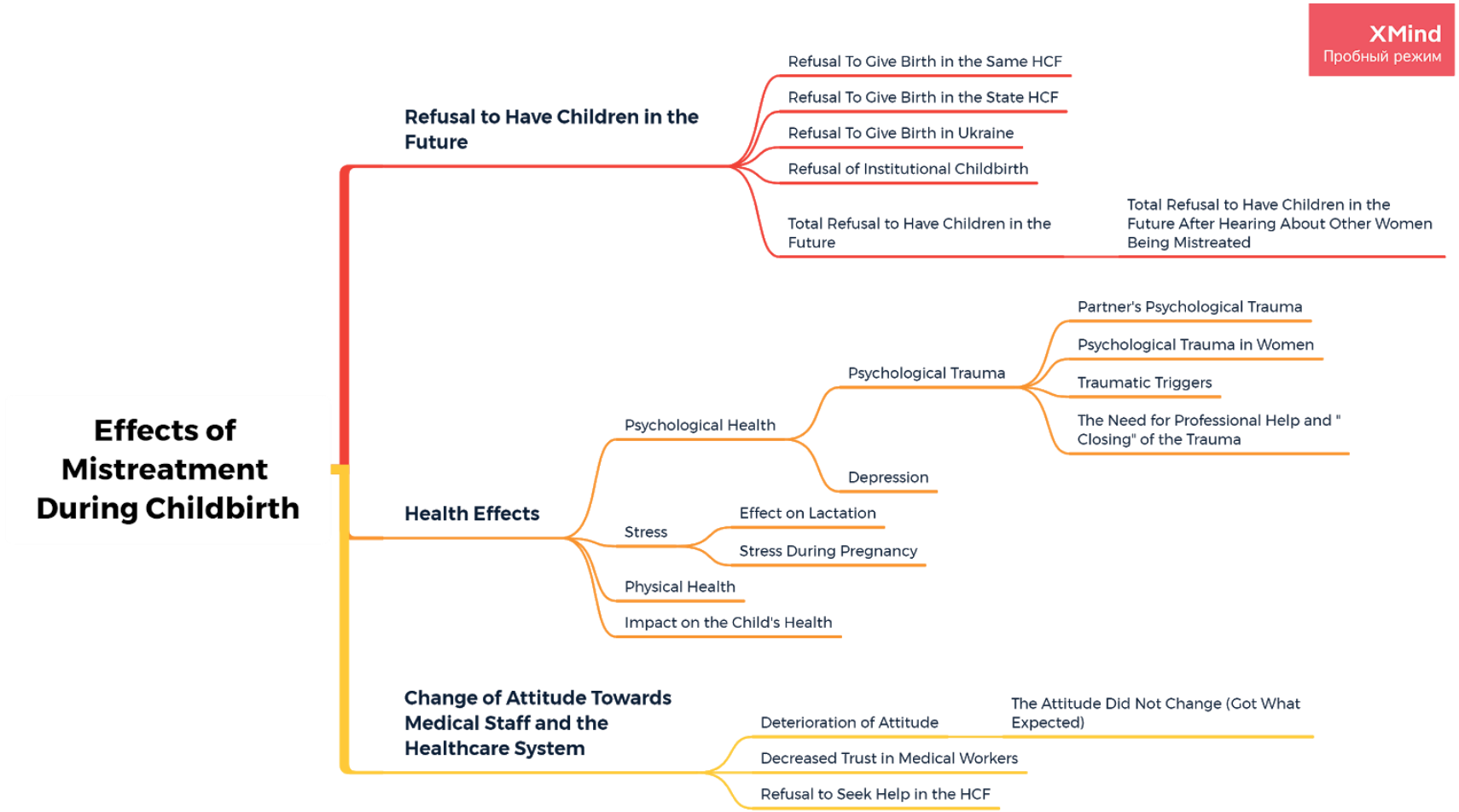
Appendix F. Displays of Mistreatment During Childbirth



Appendix G. Prevalence of Mistreatment During Childbirth



Appendix H. Effects of Mistreatment During Childbirth



Appendix I. Solutions to Mistreatment During Childbirth