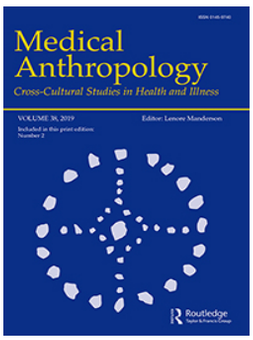

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Obstetric Violence as Reproductive Governance in the Dominican Republic

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ABSTRACT

A human rights violation, obstetric violence encompasses numerous forms of mistreatment against women giving birth in health care facilities. Based on this framework, we conducted open-ended exit interviews with 43 women who had given birth at either one of the two largest public maternity hospitals in the Dominican Republic. Women's narratives revealed a contrast between scholarly definitions of obstetric violence and their own perceptions of receiving abusive care. Analyzing obstetric violence as a form of reproductive governance and the adaptive preference that ensues helps explain why most women accepted with endurance the poor quality of care that they received.

SPANISH ABSTRACT

La violencia obstétrica es una forma de violación de los derechos humanos que abarca numerosas formas de maltrato contra las mujeres que dan a luz en establecimientos de salud. A partir de este marco conceptual, realizamos entrevistas abiertas a 43 mujeres que habían dado a luz en una de las dos mayores maternidades públicas de la República Dominicana. Las narrativas sobre sus experiencias de maltrato revelaron un contraste entre nuestra definición de violencia obstétrica y sus percepciones sobre la atención abusiva. Nuestro análisis sobre la violencia obstétrica como expresión de la gobernabilidad reproductiva y sobre la preferencia adaptativa que genera ayuda a explicar por qué la mayoría de las mujeres aceptaron con entereza la mala calidad de atención que recibieron.

KEYWORDS

Dominican Republic; adaptive preference; birth; discrimination; mistreatment; obstetric violence

PALABRAS CLAVE

República Dominicana; preferencia adaptativa; nacimiento; discriminación; maltrato; violencia obstétrica

"The underdog learns to bear the burden so well that he or she overlooks the burden itself" (Sen 1984).

Obstetric violence is an urgent issue that affects women giving birth in clinical settings throughout the world (Castro 1999; Castro, Savage, and Kaufman 2015; Castro and Erviti 2014; d'Oliveira, Diniz, and Schraiber 2002; Savage and Castro 2017; Zacher Dixon 2015), and needs to be understood and addressed as a key driver of inequitable maternal and child health outcomes. The term "obstetric violence"—also labeled dehumanized care, disrespect and abuse, or mistreatment during childbirth—was first legally defined in Venezuela in 2007 as "the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalization and pathologization of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life" (República Bolivariana de Venezuela 2007). Researchers and policymakers have since emphasized that obstetric violence stems from both the actions of medical personnel and structural issues within health care facilities and health systems, which fracture the provision of health care (Bohren et al. 2015; Bowser

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and Hill 2010; Castro, Savage, and Kaufman 2015; Freedman and Kruk 2014; Herrera Vacaflor 2016; Sadler et al. 2016; Smith-Oka 2013). In all of its forms, we maintain that obstetric violence violates the human rights of women "to the highest attainable standard of health, which includes the right to dignified, respectful health care" (WHO 2015) and it both reflects and perpetuates social and gender inequalities (Castro, Savage, and Kaufman 2015; Van Lerberghe et al. 2014).

In our study, we used obstetric violence as a conceptual framework to collect and analyze formative data concerning mistreatment during childbirth in the Dominican Republic (DR)—a setting with inequitable access to high-quality maternal health care. In this article, we explore if our conceptual framework is aligned with women's perception of mistreatment in the DR, and we discuss the implications of study findings for the future use of obstetric violence as a framework to analyze patterns of mistreatment in reproductive health care services. We also analyze obstetric violence as a form of reproductive governance, defined as: "the mechanisms through which different historical configurations of actors—such as state institutions, churches, donor agencies, and non-governmental organizations (NGOs)—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviors and practices" (Morgan and Roberts 2012).

As in other countries throughout Latin America and the Caribbean, people from low socioeconomic positions in the DR most frequently receive medical care from public facilities overseen by the Ministry of Public Health, whereas private sector and social security institutions provide services to those in high- and middle-income populations and those formally employed (La Forgia et al. 2004; Rathe 2010). We argue that obstetric violence is a tool of reproductive governance by health professionals that creates a fault line "along which moral regimes are produced" (Morgan and Roberts 2012). On the safer side of the fault are wealthy female "consumers," who can choose among private health facilities and who receive the best care available in the country, whereas on the other side of the crack, and in the crack itself, are poor female "charity beneficiaries" who have the single option of seeking health care in state-operated facilities, where health professionals and other staff may treat them as "favor beggars" devoid of any rights. These moral regimes set the stage for what has been termed "stratified reproduction" (Ginsburg and Rapp 1995); that is, the different worthiness that society assigns to women and their reproductive processes (Castro, Khawja, and González-Núñez 2007; Suh 2018).

From March to July 2015, we conducted semi-structured, open-ended interviews with 43 adult and adolescent women who had recently given birth at either one of the two largest public maternity hospitals in the country, both located in the capital city of Santo Domingo. In 2014, one of the hospitals, situated in the northern edge of an upper-middle income section of the city, where most inhabitants seek care in private settings, had 16,196 live births; the other, which is in the center of a low-income neighborhood, had 11,769; that is, an average of 46 and 33 live births per day, respectively (Ministry of Public Health of the Dominican Republic 2015). Our study focused on women's experiences and perceptions and served as the basis to develop a more extensive, ongoing study—Mistreatment of Women in Labor in Three Latin American Countries (M3C)—whose primary aim is to determine whether mistreatment during institutional childbirth is associated with adverse infant and maternal outcomes; the larger study includes direct observations and interviews with women and health professionals. We selected the hospitals for being public, the large number of births they attend, their designation as teaching hospitals, and prior ethnographic and epidemiological research conducted by the first author in these hospitals—covering day and night shifts all 7 days a week and during extended periods of time (Connolly, Bautista, and Castro 2009; Pérez-Then, Miric, and Castro 2011; Tunçalp et al. 2013).

Like most of the Dominican population, women who deliver in public hospitals are overwhelmingly Afrodescendant, and so are most health professionals and other hospital staff. However, Dominican ethnic identity and skin color identity are constructed on an imaginary colonial past that emphasizes the "white" Spanish origin of the population and the denial of their "black" African heritage in a complex attempt to differentiate themselves from the Haitian population with whom they share the binational island of Hispaniola and centuries of history (Mella 2016). Although in our

study we did not specifically explore ethnic and skin color identities, based on our prior research in this setting and supported by our review of multiple related studies (Castro, Savage, and Kaufman 2015; Savage and Castro 2017), we argue that mistreatment is based not only on the large socioeconomic, educational, and gender distances that exist between health care providers and female patients who live with many socioeconomic deprivations, but on a racist, prejudicial treatment according to which those of higher socioeconomic position identify with the "white" colonialist identity in opposition to, and above, the "blackness" of the population whose rights continue to be infringed.

Our study revealed discrepancies between our definitions of obstetric violence and women's perceptions of experiencing mistreatment. While many women acknowledged experiences of mistreatment during their hospital stay, few couched these issues negatively. On the contrary, women frequently presented minimal expectations for what they considered as good attention and described experiences of mistreatment as uneventful or inevitable, rarely detracting from positive perceptions of care. Participants also conceptualized *buena atención* (good attention) through a medicalized perspective, in which standards for quality care depended on perceptions of timeliness and effectiveness of service delivery, rather than on factors such as privacy or the demeanor of medical personnel. These findings are shared with various research studies throughout the world that have documented cases in which different forms of mistreatment become normalized to the extent that women or health providers do not view these as abusive (Castro and Erviti 2003; Grigoryan et al. 2015; McMahon et al. 2014). To our knowledge, Freedman and colleagues have proposed the only framework that accounts for deviations between researchers' definitions of mistreatment and women and medical personnel's perspectives of those issues (Freedman et al. 2014; Freedman and Kruk 2014). However, none of those studies have explained why women accept mistreatment: one of our primary objectives was to understand this phenomenon.

Investigating obstetric violence as a conceptual framework

Most definitions of obstetric violence in Latin America and the Caribbean have emphasized the medicalization of the natural processes of childbirth and unbalanced power dynamics between health personnel and women in labor that result from a combination of institutional and structural violence. At least since the 1990s, regional research started to focus on mistreatment as a form of violence or abuse that resembled other forms of violence against women, with some forms specific to clinical maternity settings, such as unnecessary cesareans or episiotomies and unconsented intrapartum sterilizations (Castro 1999, 2004; Castro and Erviti 2003; d'Oliveira, Diniz, and Schraiber 2002; Freyermuth 1998; Goer 2010). Some studies also discussed the institutional and structural violence that reflect gender inequalities and power hierarchies within health facilities (Castro and Erviti 2003; Goer 2010).

Based on these definitions and on reviews of English, Spanish, and Portuguese-language publications that gathered various dimensions of mistreatment during childbirth (Bohren et al. 2015; Castro, Savage, and Kaufman 2015; Savage and Castro 2017), we have created six typologies of obstetric violence. These are: *verbal abuse*, such as harsh and disrespectful language, patient blaming, public humiliation, scolding, and name-calling; *poor rapport with women*, such as miscommunication of procedures and processes, and language and communication barriers; *sociocultural discrimination* based on socioeconomic position, cultural insensitivity, and lack of intercultural care; *physical abuse*, such as performance of unconsented or unnecessary examinations and procedures, hitting, slapping, or touching women in painful or uncomfortable ways, refusal to administer pain medication, and sexual abuse; *failure to meet professional standards of care*, such as delays and purposeful neglect, denial of medical attention for both minor and life-threatening health concerns, lack of accountability to patients, lack of supportive care, and breaches of confidentiality; and *health system conditions*, such as failure to ensure privacy, assigning multiple patients to a single hospital bed, lack of resources to provide more comfort to women, and refusal to allow visitors or family members

present. All these constitute forms of reproductive governance that lead women to lose control of their own reproductive processes.

Considering previous research in Dominican maternity hospitals conducted by the first author, we used these categories of obstetric violence to create a rights-based, conceptual framework that informed the development of an original interview guide with questions about women's experiences of different forms of obstetric violence, demographic information, obstetric history, expectations for care, overall perceptions of their hospital stay, and satisfaction with care. We recruited participants via convenience sampling in the patient discharge areas in the two public maternity hospitals. We interviewed 43 women—17 in one hospital and 26 in the other—who had recently given birth and were awaiting discharge at either hospital.

Whereas our first interview questions were designed to allow women to express their experiences, perceptions, and satisfaction without being prompted about any particular issues, as we proceeded we asked specific questions that addressed the different dimensions of obstetric violence we sought to investigate. Based on prior experience during exit interviews, we expected most answers to be positive, which is why our following questions addressed specific circumstances associated with mistreatment that we had observed during other studies and that women rarely mentioned unless prompted. We audio-recorded the interviews, transcribed them in Spanish, and analyzed them using qualitative coding software. We grouped responses into three key themes—health system conditions, verbal abuse and poor rapport with women, and failure to meet professional standards of care—, created subcategories on divergent perspectives of those dimensions, and ran queries on commonly used concepts. We found no evidence of physical abuse—a finding consistent with the previous research conducted by the first author in these hospitals.

Maternity care in the Dominican Republic

As we expected to find, all 43 participants originated from disadvantaged socioeconomic positions. The majority of them—35 women (83%)—were involved in a consensual union, a socially accepted though not legally binding form of union through which partners cohabit and raise children. Evidence suggests that women with low socioeconomic positions and adolescents are more likely to enter into consensual unions, relationships that may be less stable than formal marriages (UNICEF and Tulane University 2016). Participants were aged 17 to 44, 18 participants were 22 years of age or younger, and two women were above the age of 40 years. Seven women spoke Haitian Creole as their first language and nine had achieved some level of university education. Similar to the national cesarean delivery rate of 56.4% (CESDEM 2014), 24 women (56%) had a cesarean delivery. Hypertensive disorders, such as preeclampsia and eclampsia, were the most commonly experienced medical complications, and 11 women—nearly 25% of participants—had been diagnosed with those conditions. At the time of the interviews, two had newborns interned in the pediatric area of the hospital.

These participant characteristics highlight the social stratification of health services in the DR, a country that, from a public health perspective, has achieved great success in promoting hospital births, with 98.5% of institutional deliveries in 2013 (CESDEM 2014). Yet, the country's maternal mortality ratio is the tenth worst in the region and the neonatal mortality rate is the third worst, only after Haiti and Guyana (UNICEF and Tulane University 2016). These contrasting statistics raise pressing questions about the quality of care provided at maternal health care facilities, which previous research has indicated may be lower than in private facilities and characterized by low-quality clinical care, lack of supplies and human resources, lack of accountability mechanisms for hospital personnel, inefficient governance (Foster et al. 2010; La Forgia et al. 2004; Miller et al. 2003; Rathe 2010; Ruminjo et al. 2003), and what Miller and colleagues have termed as "too little, too late (TLTL)," which is when health facilities have limited resources and provide care that is insufficiently evidence-based, and "too much, too soon (TMTS)," that is, the delivery of interventions that can be lifesaving when indicated but harmful when not (Miller et al. 2016). This reality contrasts with the fact that, at the First Latin American and Caribbean Regional Conference on Population and Development

held in Montevideo, Uruguay, in 2013, the DR became signatory of the Montevideo Consensus on Population and Development, which reaffirmed the Programme of Action of the International Conference on Population and Development (ICPD), adopted in Cairo in September 1994, and subsequent ICPD conferences (United Nations 2014). Among other articles, the signatories of the Montevideo Consensus agreed to "ensure that all women have effective access to comprehensive health care during the reproductive process and specifically to skilled, institutional, compassionate obstetric care and to the best possible maternal health services during pregnancy, childbirth and the puerperium" (United Nations 2014). However, the social stratification of health services that characterizes the DR creates inequitable access to quality maternal health care for women from low socioeconomic positions, perpetuates social and health-related inequalities by maintaining or increasing the width of the crack between the private and the public health spheres, and sets different moral regimes and ensuing expectations for each side. For the poor, it creates "self-controlled subjects" (Morgan and Roberts 2012) that readily accept the medicalization of their reproductive lives.

In our study sites, we observed many issues previously documented in Dominican public hospitals. In one hospital, postpartum and patient discharge areas contained between three and four beds per room in an open space and shared one bathroom with another room of patients. At the time of interviews, most women were sitting with their newborns and personal belongings on their beds, and few family members were present. Noise from construction reverberated through the hall, and hospital personnel entered and left the rooms frequently. In the other hospital, one postpartum room had 20 beds and one room for women recovering from surgery had nine. None of them had separations between the beds and sharing of beds between at least two women and their newborns was frequent. Despite substantial evidence of the benefits of birth companions (Hodnett et al. 2015), both hospitals forbid patients' families from entering except during a daily two-hour period. In the meantime, family members wait for hours outside the hospital, exposed to the Caribbean heat and heavy storms or the darkness of night. They wait with the anxiety and fear of not knowing the fate of their pregnant daughter, sister, or partner, while the *wachimán* (armed security guard) protects the hospital emergency entry, conducts—untrained—the patient triage, and, at times, acts as one of the few sources of communication between the street and the hospital wards and corridors—sometimes for bribes. Family members know they are on the wrong side of the fault line.

Health system conditions: Lack of privacy and sharing of beds in public maternity hospitals

In interviews, health system conditions emerged as a principal area in which study participants experienced mistreatment. However, although 28 women (65% of participants) reported experiences of sharing hospital beds, feeling physically exposed to patients and providers, or lacking clothes or covering, many did not complain about those issues and instead conveyed conceptualizations of mistreatment that diverged from our scholarly definitions.

A total of 17 participants described experiences of sharing a hospital bed with other women; that is, 12% in one hospital and 82% in the other, reflecting the difference in overcrowding between the two sites. A total of 13 had undergone cesarean deliveries and 10 stated that they shared a bed with up to four other patients and their newborns—which required them to either sit or having to take turns to lay down. Nevertheless, only 10 of the 17 participants described sharing beds in a negative way and only five expressed overall negative impressions of the care they received. Most participants justified sharing a bed as a result of the hospital caring for "too many patients" or other infrastructural issues, which they did not associate with poor quality care or mistreatment. For example, when asked if she would change any aspect of her care experience, a 44-year-old woman who had just given birth to her fourth child explained:

> The only tiny thing was just sharing the bed and, how do I say it, there are so many patients, and so I go through it in solidarity. There are so many patients they attend to in this hospital. One thing that must be done is deal with the government that they might donate more beds or put in bigger spaces. Because, look, last night I believe that more than 100 women came here to give birth. The rooms fill up.

Acting as though she did not want to complain, another 22-year-old mother of two children stopped mid-sentence to emphasize that she had received good attention, despite sharing her hospital bed with another patient. As she told us: "I … would bring more beds. I would bring more beds for the flow. Everything was very good. The doctors attend to people very well. But more beds, they should bring more beds." In addition to downplaying the discomforts of bed-sharing, some participants even mentioned its positive aspects, such as the potential for new friendships and solidarity with other women in labor. Sandra,[1] a 30-year-old mother of three who had suffered from preeclampsia, described to us:

> We were sitting three in the same bed, because we all three had preeclampsia … I know they preferred to put us together in the same bed and they sat us there and prepared us. About half an hour or 45 minutes. And they took each of us to the surgery room. But they weren't checking us or anything … It calmed me to have company, all of us with the same problem.

Additionally, 12 participants who were physically exposed or visible to other patients and hospital personnel expressed feelings of shame, discomfort, and losing sleep due to the lack of privacy. Unlike the stories of bed-sharing, women's descriptions of feeling exposed were universally negative in tone. Nevertheless, only three expressed overall negative perceptions, and every participant described her experience of being exposed only when directly asked about privacy in the hospitals. As with bed-sharing, most women attributed the lack of privacy to the high patient load. One 21-year-old woman, who had recently given birth to her first child, described with resignation: "*Ay no*, because in truth the doctors do see you, but what privacy are you going to have when you give birth?" Another 21-year-old woman related: "When I was in the postpartum area, there wasn't much privacy there. There are a lot of, you don't have privacy neither in the bathroom nor in the room, no place, not one. The hospital has too many women."

Finally, 15 participants described lacking clothing or sheets to cover themselves during their hospital stay. While six mentioned being naked or without clothes, other women described that hospital personnel would not replace or offer sheets for the bed. We do not know whether women were told to bring their own clothes and covering or if previous experiences at public hospitals had compelled them to bring their own supplies, as the interview guide did not explicitly include this question. Yet only one participant complained about the lack of clothing; the others described these experiences with a matter-of-fact tone. Ten participants, three of whom were among the 15 women who lacked clothing, implied or directly stated that it was the patients' responsibility to bring sheets and clothing. One woman sent her mother to find sheets when those on her hospital bed became dirty. Another 22-year-old woman of Haitian nationality with two children casually explained that "you go to the bathroom and change in the bathroom" as a way to ensure personal privacy. Other participants did not report if they had brought their own clothes or sheets.

Experiences of bed-sharing, feeling physically exposed, and lacking clothing demonstrate how obstetric violence acts as a form of reproductive governance in Dominican public maternity hospitals, as women are routinely subjected to uncomfortable birthing conditions. In addition to governing women's reproductive processes directly through biopower (Foucault 1976), public hospitals shape women's expectations for their birth experiences by normalizing poor health system conditions and constituting a moral regime for the poor. According to this, women come to perceive bed-sharing and lack of privacy as the result of "too many women" and take it upon themselves to adapt with practices such as bringing their own clothing and changing in the bathroom. Instead of blaming the hospital, women remained positive about their overall experiences and grateful for the medical attention they received, evidencing their self-control and resignation to experience childbirth according to the only moral regime designated for them.

Verbal abuse and poor rapport of hospital personnel with women

Twenty-two participants described negative interactions with hospital personnel, including instances of verbal abuse and lack of communication. We learned of these negative interactions from women

with different ages, number of children, and education levels—indicating that verbal abuse is widespread against women from different backgrounds. Fifteen described experiences in which hospital personnel used abusive, condescending, or cold language in speaking to them. Six of them used some variety of the phrase *me hablan mal* (they speak badly to me), and others described that hospital personnel acted in a superior manner to patients, became angry when asked questions, or generally used a harsh tone. Six women mentioned being scolded or belittled by nurses, and two specified negative interactions with cleaning personnel.

Nevertheless, many participants perceived verbal abuse as an accepted aspect of intra-hospital interactions. Eight women expressed overall positive perceptions despite acknowledging that they had been mistreated. Asked if they felt respected by hospital personnel, 11 women affirmed that they felt respected and one 41-year-old mother of four children even characterized the insults as humorous. She laughed as she explained: "There was a cleaning woman who said many ugly things, many bad words (laughs) … like disgusting, and that we were pigs who were throwing papers."

Other women justified mistreatment by noting that personnel ultimately provided the necessary care despite using harsh language—advancing a strictly biomedical definition of quality care. For example, a 26-year-old Haitian participant with two children told us: "Yes, there are people that have that manner, that talk harshly, that talk to you as if they don't care. But it is their form of speaking after all and they still take care of you." Similarly, a 23-year-old woman explained: "Well, they are people just like there are lots of people, you understand. After a while you ask them a question and they answer. You know, it is normal and all. They give you what is needed and leave you in peace." According to Paulina, a 23-year-old woman with two children:

> You know that there are some who are gentler with patients and understand patients more, and there are others who are dryer. Everything is fine, I can't complain. There are some who are very harsh, but some are like they don't have feelings. Some that don't have emotions, but in the end they treat you well. They give us medicine, but they talk to you very harshly. They almost never talk, you know. Sometimes they are going to ask us a question, whatever it might be, and they act as if they were mad. But it isn't everyone.

Paulina was one of various participants who specified that only *some* providers used harsh language. A 22-year-old mother of two children originally from Haiti, who did not experience verbal abuse, noted that tone and respectfulness could vary between providers: "Yes, what happens here is that we have to respect the doctors and (lowers her voice) the doctors have to respect us as well," implying that providers' behavior may vary with different patients. Although she reported receiving respectful treatment, she added: "Yes, maybe with me they have an understanding, and with you it may be that they don't, you understand me?" Sandra, the 30-year-old mother of three, related an incident in which two nurses conveyed contrasting reactions to her expressions of pain, one of whom scolded her while neglecting to provide her with the care she needed:

> They tell me that I should try to sit to bathe myself. And, at 8 a.m. after leaving surgery, and when I am sitting, I feel that I am getting dizzy, but still they are continuing the insistence that I bathe myself. I try to stand up and I get dizzy and there is blood rushing out. And the nurse who was with me comes over and says: 'Rest there, lay down there, we will wait, right, until the dizziness is going away.' And the other nurse comes and says 'No, no, no. She is very silly, pick her up from there, get her up because this is just childishness.'

Finally, when asked if hospital personnel used kind language, a 27-year-old participant who had just given birth to her fourth child replied "some, some nurses no, but others yes. Some do not have much *educación* (politeness), but others do. They aren't all the same." To clarify what she meant with lack of *educación*, she later explained: "they don't have humanity." Overall, the idea that "some are good and some are bad" seemed to be a recurrent theme for many women who mentioned negative interactions with health providers.

Our findings suggest that patients in Dominican public maternity hospitals may accept verbal abuse and disrespectful care as standard aspects of the care experience—or may have normalized mistreatment as yet another manifestation of the persistent racism, sexism, and classism that they experience in everyday life. Consequently, these negative interactions serve as a form of reproductive

governance in that they promote an unequal power dynamic between women and their hospital personnel, and they compel women to accept a passive role in their birth experiences without the ability of gaining any control.

Failure to meet professional standards of care

Although 16 women (37%) described experiences of delays in receiving care, delays did not detract from women's overall satisfaction with care. Twelve described delays in being admitted to the labor and delivery wards of the hospital and noted lengthy, sometimes painful delays until they received attention. Two women attributed their delays to the high volume of patients requiring medical attention at the two hospitals, and six stated or implied that hospital personnel only admit patients at advanced stages of labor. Conversely, medical personnel told the other four women to wait until their water broke or they reached certain centimeters of dilation, indicating a very advanced stage of labor. The remaining participants who experienced delays said they occurred after admission to the hospital, either in being taken to the surgical room or in being transported from the delivery ward to the postpartum area. According to these participants, women waited "in line," sometimes for extended periods, until there was a vacant bed in the delivery area.

Yet again, only six women expressed negative perceptions of the overall quality of care that they received. Ten only mentioned their experiences with waiting when directly asked about delays. These factors suggest that women associate delays with flaws in hospital infrastructure and overcrowding—structural issues that are not perceived as obstetric violence or poor quality of care. As one 28-year-old mother of two described when discussing delays: "every patient has her own process." Consequently, in this context, delays were seen as the logical consequence of high patient load and became an accepted part of the "process."

Other experiences of failures to meet professional standards of care did make a negative impact on women's impressions of care. Eight women (19% of total) expressed overall negative perspectives of care and associated *mala atención* (bad attention) with either feeling that she or her newborn were being neglected despite being on the brink of death, feeling that she received unjustly poor treatment, or feeling neglected by hospital personnel through their failure to address her immediate need for assistance. Two participants expressed sadness, fear, and frustration about not knowing the health status of their newborns. At the time of their interviews, the newborns were interned in the pediatric intensive care ward of the hospitals and the participants had yet to receive any news of their condition. A 26-year-old mother of two originally from Haiti stated: "They have not told me anything this morning. This makes my head hurt." For Gladys, a 34-year-old woman who gave birth for the fourth time in the same hospital, bad attention was associated with a prolonged and nearly deadly delay that she experienced at the hospital. When she presented with preeclampsia, she was required to purchase a pint of blood at the Red Cross in case of an emergency transfusion, but, living in poverty, Gladys was unable to afford it and was denied admittance. For 3 days, she waited in the hospital lobby, in labor, struggling to find someone who might donate or buy her blood. She was finally admitted when her sister, who had lost a child during labor at the same hospital a few years earlier, brought the blood. In describing this, Gladys was distraught:

> I had 3 days with my pain and they would not admit me because of the blood. And, meanwhile, the *niña* (girl) had three turns and, if she turned again, I was going to die. I was going crazy and crying to get that blood. It's A+, an easy blood type. And no one, because I didn't have money to pay a donor, no one wanted to donate to me. They told me, if I didn't get the blood, they wouldn't allow me to go upstairs to get a cesarean. And I cried, I started to cry because I needed someone to help me. And nothing, they told me no …. You know, my friend, that there is no help, that the poor do not get help, but they need to have help …. And asking God, because the *niña* was doing another turn, that she was my only girl and that she wouldn't turn again. Because if she did, she would strangle herself and suffocate in my belly.

Experiencing no compassion from medical personnel and an extreme delay in receiving life-saving care, Gladys feared for her own life and that of her expected daughter. Moreover, as she implied with her laments, she felt that she received discriminatory attention due to her socioeconomic position:

"Because I'm poor, they don't listen to me, to what I say. But those who have, they are listened, they are cared for better. Do you understand me? It counts to have money here, but not having money doesn't." From Gladys's perspective, she received unjustly poor care and thus adamantly described her overall experience in terms of *mala atención*. Similarly, another participant who reported *mala atención* referred to sharing a bed with multiple patients as unjust. When asked if she would change any aspects of care, she replied "that they have at least one bed per woman, just because someone isn't paying for health insurance, they don't have to receive such bad attention. It isn't comfortable. I'm not comfortable." But unlike these participants, women with positive perceptions of care did not consider their experiences of mistreatment as unjust, but instead standard occurrences at public maternity facilities—another reflection of their self-control produced by the moral regime built for the poor.

Including Gladys, six of the eight women who expressed *mala atención* reported feeling neglected. In their narratives, neglect referred to instances in which personnel ignored or disregarded women's concerns or expressions of physical pain, nurses refused to assist with tasks such as walking or bathing, and personnel's infrequent visits compelled women to leave their hospital room in search of assistance. A 30-year-old woman, alone without her family members or partner, specifically mentioned neglect from nurses when she needed assistance: "The nurses want that you sit, that you stand alone, that you bathe yourself alone, that you do everything alone. One has no strength to do this because you just had an operation. You get dizzy and all. *No es fácil* (it isn't easy)." Unlike lack of personal privacy or harsh interactions, feeling neglected translated into women's overarching negative perspective of care.

Accepting obstetric violence as adaptive preference

Although we did not specifically ask participants to define mistreatment or high-quality care, our interviews offer insight into what women value and how they characterize quality on a spectrum ranging from *buena* to *mala atención*. Thirty-five women (81%) expressed positive overall perceptions of their experiences at the two public hospitals, even though 29 of those 35 also acknowledged experiencing some issue.

Twelve women said *me trataron bien* (they treated me well) or *me atendieron bien* (they attended to me well). They often associated good attention with the delivery of what they perceived as effective treatment and assurance of survival; seven women specifically associated good attention with frequent checkups from medical personnel during their stay and others with complications associated it with receiving the medicines and procedures that they needed. Having experienced a complication during labor, a 21-year-old described: "But the attention is good, because, you know, they noticed (the complication) immediately. Because sometimes they notice late and it's worse. They attended to me immediately. It is good, they are in your area, checking you." These participants often used statements about the frequency of visits from doctors either to explain general statements about their satisfaction with care or that they felt accompanied by medical personnel.

Additionally, in describing positive perceptions of care, seven women used the phrase *no me puedo quejar* (I can't complain), and others expressed a similar sentiment. While *no me puedo quejar* could be interpreted colloquially to indicate women's acceptance of care, the phrase also implies that women do not feel entitled to complain if hospital personnel fulfilled their roles of ensuring survival for herself and her newborn. When asked about her general perceptions of care, one 23-year-old woman noted that the treatment was: "Very good, I can't complain because when they realized that I had high blood pressure, they admitted me. They gave me medicines to lower it and they performed a cesarean." Another 23-year-old explained that health providers could not address every patient's needs, because it would obstruct them from fulfilling their job. When questioned further about the 'job' of providers, she explained: "Oh…to give medicines to everyone. Each time that she would come to give us medicine, a different one of us patients would complain. If she came to care for me and not everyone else, she would not do her job."

In addition to lack of privacy and negative interactions, other issues participants mentioned, such as restricted access of family members, lack of sanitation, and unappealing hospital food, did not affect women's satisfaction with care, which supports our argument that women have a medicalized perspective of quality care, in which *buena atención* depends on the delivery of medicines and physical checkups— strictly medical functions. It would then follow that women would only express *mala atención* when providers fail to meet those responsibilities.

Our study reveals that—unless women feared for their lives or their offspring's lives, or realized they were being neglected—they were resigned to accept an absence of privacy, harsh treatment by medical personnel, and delays in care as expected components of public health care, and to endure those issues alone, in the self-control mode they have been subjected to by the moral regime for the poor. These forms of endurance have been described as adaptive preference, that is, "the preference to put up with abuse" in response to restricted options among the structurally deprived (Nussbaum 2001) or a "special kind of failure to fully exercise the capacity for critical reflection that most of us have to a greater or lesser degree: they involve circumstances that either limit our awareness of the options that we have in some particular case, or make us recognize that the options that we would prefer are inaccessible, and so incentivize us not to waste time aiming for (or perhaps even seriously considering) them" (Terlazzo 2016). Emphasized here are the *circumstances* that coerce women into thinking that obstetric violence—the appropriation of women's bodies by health personnel—is acceptable: mostly, that the overcrowding of hospitals and other infrastructural issues are the source of the lack of privacy, the source of the harsh, condescending language, and the source of delays that do not become life-threatening. These discomforts are not perceived as the fault of the hospital personnel, particularly if they can still medicalize their bodies by delivering medicines and performing procedures *despite* the overcrowding—a factor that is perceived as external to their own subjected condition and to the will of the hospital personnel.

This "overtly subservient tendency" (Terlazzo 2016) inherent to adaptive preferences explains why most women in our study lost their autonomy and accepted obstetric violence as the expected form of care. Therefore, obstetric violence is a coercive form of reproductive governance that prevents women from making autonomous preferences about how they would like to experience the process of giving birth and from recognizing that alternative options could be available to them despite the overcrowding. However, women who fear for their lives or that of their newborns, or who realize they are being neglected, may develop a greater capacity to critically reflect the coercive circumstances that could eventually cause them to die, to understand that their survival depends on hospital personnel, and to develop an autonomous rejection of obstetric violence. In this way, women's perspectives of *buena* and *mala atención* highlight the extent to which obstetric violence acts as a coercive form of reproductive governance in Dominican public maternity hospitals that is sustained by adaptive preference. Not only does the normalization of mistreatment play a role in limiting women's expectations for their care and their disposition to express complaints, but it also contributes to controlling the functions assumed by patients and providers in public maternity care. Consequently, practices of obstetric violence contribute to the medicalization of childbirth in Dominican public maternity hospitals and constrict the roles of women in directing their own childbirth processes and their interactions with health care providers.

Strengths and limitations of using obstetric violence as a rights-based framework

Study findings highlight both the utility and limitations of using obstetric violence as a conceptual framework for analyzing mistreatment in reproductive health care. A primary strength of the concept is that it expands on traditional measures of quality of care, which until recently (Tunçalp et al. 2015; WHO 2016) had not sufficiently emphasized the rights of women to respectful care and often failed to capture the structural inequalities of the context in which provider-patient relationships take place and how mistreatment of women during labor becomes embedded in medical systems (Castro 2014; Castro, Savage, and Kaufman 2015; Castro and Erviti 2003). By using obstetric violence as a framework, we uncovered instances of mistreatment that many participants did not initially include when describing their overall satisfaction with care because, in their view, good attention became contingent solely on the

provision of medical treatment and ensuring maternal and child survival. Given that women only expressed criticisms when personnel did not fulfill their prescribed roles to medicalize their bodies and accepted with resignation the lack of privacy, negative interactions, and other dimensions of mistreatment as standard aspects of the childbirth experience in public hospitals, women might not mention those practices as unacceptable during interviews, even if directly prompted. Supporting this possibility, we observed deficiencies in privacy, sanitation, and other issues that were not always reflected in participants' interviews. To account for this gap, it is essential to include ethnographic observations of hospital conditions and patient–provider interactions as part of study design.

Analyzing obstetric violence as one form of reproductive governance that produces a moral regime built for people who live in poverty and women's perception as a form of adaptive preference helps to explain why most women in this context resiliently expect and accept the poor quality of care that they receive. Additional analyses of adaptive preferences could offer valuable insight into the extent to which reproductive governance operates in a society. As seen in our study, women's acceptance of mistreatment is particularly alarming in settings such as the DR, where segmented health systems create inequitable access to high-quality maternal health care. With various forms of mistreatment endemic in public maternity hospitals, eliminating obstetric violence requires structural transformations that both afford women more agency in their reproductive lives, and assigns state institutions and organizations a primary role in assuring that public health facilities respect their patients' human rights. No legal frameworks or initiatives have yet been developed in the DR to eliminate obstetric violence. Future research, interventions, and policies to eliminate obstetric violence in the DR should, first, closely work with women as active agents in determining their reproductive rights. Second, they should address issues that may not affect women's perceived satisfaction with care, but that perpetuate a power structure that allows health personnel to unabatedly, and unacceptably, misappropriate women's bodies and subject them to structurally governed reproductive lives.

Notes

1. All the names used are fictional.

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