Shifting Maternity Care in Canada:
A Feminist Post-Structural Study of Experiences of Disrespect and Abuse in Facility-Based Childbirth

By

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DEDICATION

This thesis is dedicated to those who have experienced disrespect and abuse during childbirth, for all that you have endured.

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ABSTRACT

From a feminist post-structural lens, this research explores the dominating discourses and power dynamics that shape experiences of disrespect and abuse during childbirth in Canadian facilities. First-person written accounts, in the form of anonymous submissions to an online blog, are analyzed using discourse analysis. Three prominent themes are provided: (1) feelings and emotions of disrespect and abuse; (2) provoking the birthing body; and (3) tensions in maternity care spaces. From these themes, several dominating discourses are identified, including medical discourse; legal discourses of punishment, criminal identity, sexual assault, and informed consent; and patriarchal and gendered discourses of objectification, infantilization, and sacrificial motherhood. The study further finds that interpersonal, institutional, and structural power dynamics, which shape and are shaped by dominating discourses, operate within maternity spaces in interrelated ways. Recommendations for health administrators to identify and facilitate the mitigation of disrespect and abuse during childbirth are offered.

LIST OF ABBREVIATIONS USED

FPS	Feminist post-structuralism
LMIC	Low and middle-income countries
OR	Operating room
RMC	Respectful Maternity Care
SRHR	Sexual and reproductive health and rights
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

Disrespect and abuse during childbirth is an issue that has received increasing attention from the global reproductive justice community in recent years. A 2015 report from the World Health Organization, titled "The Prevention and Elimination of Disrespect and Abuse during Childbirth," influenced the burst of interest this area has received by acknowledging and drawing attention to experiences of disrespect and abuse as they occur in facilities worldwide (World Health Organization, 2015). Subsequent empirical research focusing on disrespect and abuse during childbirth across low and middle-income countries (LMICs) led to the eventual creation of an advocacy agenda and an increase in interventions (Sen, Reddy, & Iyer, 2018).

Given the increasing attention that the issue of disrespect and abuse during childbirth has received, it is a rapidly evolving area of inquiry. A promising trajectory of research seeks to go beyond instances of disrespect and abuse during childbirth at the individual level of patient-provider interaction and instead account for the systemic dimensions that create the conditions in which disrespect and abuse during childbirth is enabled and tolerated (see e.g. Bohren et al., 2015). Despite this influx and trajectory of inquiry, there is a gap in the research seeking to explore the phenomenon of disrespect and abuse during childbirth in the Canadian context. This lack of research entails an absence of understanding of disrespect and abuse in Canada, including how various factors and aspects within Canadian health care systems and beyond shape and enable such experiences. Beyond this, other research also leaves gaps in our understanding of the phenomenon in that it has been underexplored from certain methodological standpoints, affecting the development of knowledge and further inquiry.

The present study, in focusing on facility-based childbirth in Canada, represents a necessary step towards addressing these research gaps. It is the ultimate aim of the research to provide unique insights into power dynamics that construct experience of disrespect and abuse in Canadian maternity care spaces and the discourses that shape them, and further, to do so through the unique application of a post-structural lens to the study of the phenomenon. The goal of the study is not to reveal any "truths" about disrespect and abuse, but rather, to generate understandings of disrespect and abuse during childbirth that are historically, socially, and culturally specific (Gavey, 1989). Through a post-structural approach, the research seeks to explore and challenge familiar assumptions and values in discourses through which power relations are exercised in maternity care spaces. Birthing individuals' subjective experiences of disrespect and abuse during childbirth can be mitigated or prevented through the disruption and negotiation of power relations that function within oppressive meanings and knowledge; as such, this research seeks to draw attention to such relations of power.

A note about inclusive language is warranted. The literature about disrespect and abuse during childbirth, and childbirth more generally, typically characterizes birthing individuals as women. Because of this, birthing individuals that do not identify as women are excluded, and their experiences are rendered invisible in discussions about childbirth. Thus, this research uses the language of "birthing individuals" at all times, except where using gendered terminology (such as "women" or "mother") is required to stay true to the source that is cited or the dominating discourse that is at play. Using gender-neutral language is imperative to ensure that the experiences of all individuals who give birth are

recognized, and further, is an important step toward rejecting the marginalization of experiences other than cisgender women in research.

1.1 Research Questions

The present research aims to contribute to the body of knowledge regarding disrespect and abuse in facility-based childbirth by focusing on the Canadian context and exploring the phenomenon from a feminist post-structural lens. Through a discourse analysis of first-person accounts of disrespect and abuse during childbirth, the research seeks to explore, from a feminist post-structural standpoint, the power relations that construct experiences of disrespect and abuse during childbirth. The research questions were designed to facilitate a deeper and nuanced understanding of the relations of power that operate in maternity care spaces, and further, to draw attention how birthing individuals' experiences of disrespect and abuse during childbirth can be mitigated or prevented.

To this end, the research study asks: *How are experiences of disrespect and abuse during facility-based childbirth constructed through relations of power, and what discourses are used to shape these relations? What do these experiences reveal about the interpersonal, institutional, and structural power dynamics operating within maternity care spaces in Canada?*

1.2 Contributions of this Thesis

Through a feminist post-structural lens, the study seeks to understand the discourses that shape the relations of power that construct experiences of disrespect and abuse in Canadian maternity care spaces. The study further seeks to explore what these experiences reveal about the interpersonal, institutional, and structural power dynamics

that operate in such spaces. The study fills research gaps in two ways. First, the study addresses gaps in the research by exploring the phenomenon of disrespect and abuse during childbirth in the Canadian context, a phenomenon and region that have received little attention in the literature. Second, the study addresses gaps in our understanding of the phenomenon by furthering our knowledge and affecting the development of inquiry, specifically through the application of a post-structural lens, which is an increasingly popular methodological approach that has not yet been applied to this area of inquiry.

By applying a discourse analysis, informed by feminist post-structuralism, to first-person written accounts of experiences of disrespect and abuse during childbirth in Canadian facilities, three themes emerged that provide unique insights into the power dynamics that operate within maternity care spaces. The themes that were identified include (1) feelings and emotions of disrespect and abuse; (2) provoking the birthing body; and (3) tensions in maternity care spaces. The dominating discourses that were found to construct experiences of disrespect and abuse include medical discourse; legal discourses of punishment, criminal identity, sexual assault, and informed consent; and patriarchal and gendered discourses of objectification, infantilization, and sacrificial motherhood. Further, the study found that interpersonal, institutional, and structural levels of power dynamics, which continually shape and are shaped by dominating discourses, operate within maternity spaces in interrelated ways.

These findings are significant for the field of health administration insofar as health administrators work in interprofessional teams in all corners of healthcare and health systems. In this respect, health administrators are in a specially unique position to affect how power dynamics operate in Canadian maternity care spaces and to mitigate

and prevent experiences of disrespect and abuse during facility-based childbirth. By understanding how experiences of disrespect and abuse during childbirth are connected to and shaped by relations of power and dominating discourses in maternity care settings, health administrators can combat disrespect and abuse on proactive and reactive levels.

1.3 Organization of the Research

The research consists of six chapters. Chapter one, this chapter, provided a brief introduction to the study, summarized the contributions of the research to the field of health administration and to qualitative health research more broadly, and outlined the organization of the study. Chapter two contains a comprehensive background and literature review, including reviews of post-structural health research as a relevant field of study; research pertaining to the frequency and magnitude of disrespect and abuse during childbirth in the Canadian context; and the various terminologies and definitions that have been employed to describe the phenomenon, with attention to the interpersonal, institutional, and structural power dynamics that have thus far been explored. Chapter three outlines the methodology and research design that were employed. Chapter four describes the findings of the study, and is divided into the identified themes that emerged from a discourse analysis of the data. Chapter five discusses these findings by exploring the dominating discourses that emerged from the analysis and discussing what experiences of abuse and disrespect during childbirth reveal about interpersonal, institutional, and structural power dynamics operating in Canadian maternity care spaces. Chapter five also provides recommendations for health administrators and outlines the strengths and limitations of the study. Finally, chapter six provides a conclusion of the research.

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

The purpose of this chapter is to provide background information about disrespect and abuse during childbirth in Canada and to convey what knowledge and ideas have been established in the literature on the topic. The literature review is guided by the research objective, which is to explore how experiences of disrespect and abuse are constructed through relations of power, the discourses that shape these relations, and what the experiences reveal about interpersonal, institutional, and structural power dynamics operating in maternity care spaces in Canada. The literature review provides a comprehensive overview of disrespect and abuse during childbirth by synthesizing existing literature into subsections.

The first subsection reviews feminist post-structural health research as a relevant field of study. The second subsection reviews literature and findings that relate to measuring the frequency and magnitude of disrespect and abuse during childbirth in Canada. This subsection provides important contextual background information with respect to what is known about the scope of the issue. The third and final subsection reviews the varying definitions and terminologies that existing literature from different disciplines and epistemologies has utilized to study the phenomenon, the discourse or discourses that each terminology is rooted in, and the power dynamic each terminology engages in, be it interpersonal, institutional, or structural.

2.1 Post-Structural Health Research

This subsection reviews feminist post-structural health research as a relevant field of study. Post-structuralism as a research methodology is rooted in post-structural linguistic philosophy, which posits that reality is accessed through language (feminist

post-structuralism as a research methodology is explained in depth in section 3.1, below). Post-structural feminism highlights subjugated knowledges and subject positions, and in this way, is used to draw attention to "unheard voices or experiences as a way to explore past, present and future meaning(s) as they relate to power" (R. Ollivier et al., 2019). Feminist post-structuralism, as such, can be used in various academic disciplines to research health and health-related topics so as to gain a deeper understanding of inequalities of power as well as health and health-related discourses.

Within the last decade, post-structuralism has been used by qualitative researchers across various health-related disciplines to inform their research. To name a few examples, within nursing research, Ollivier et al. have used feminist post-structuralism to understand and critique sexual health care and policy as well as postpartum sexual health (R. A. Ollivier et al., 2019, 2019), and Aston et al. (2020) used feminist post-structuralism as a lens to analyze an online discussion board with first-time mothers in Nova Scotia . Gingras (2009), a health sociologist, used feminist post-structuralism to understand the generation of dietic knowledge and the various institutional structures that reinforce this knowledge. Within the political science discipline, Smith (2015) argued that post-structuralist theories of power can be useful for understanding responses to the political context of health inequalities in research and policy. Post-structuralism, then, is a useful and increasingly popular lens for qualitative researchers in various disciplines to study an array of health-related topics.

Some researchers have employed a post-structural methodology to study issues in motherhood and childbirth (see, for instance, Mbekenga et al. (2018), a study guided by post-structural feminism involving relationships between Tanzanian nurse-midwives,

obstetricians, and women). Despite this, a review of the literature reveals that post-structuralism as a methodological lens has been applied to the area of abuse and disrespect in childbirth very seldomly, if at all. This is likely due to the fact that both abuse and disrespect in childbirth as an area of inquiry, and post-structuralism as a qualitative methodological approach to health research, have only begun to receive scholarly attention in recent years. Therefore, while the present study addresses a gap in the research insofar as disrespect and abuse during childbirth is an under-studied phenomenon in the Canadian context, it also addresses gaps in our understanding of the phenomenon by way of developing knowledge and further inquiry, specifically through the application of a post-structural lens to the study of the phenomenon.

2.2 Measuring the Frequency and Magnitude of Disrespect and Abuse During Childbirth in Canada

This subsection reviews the literature that seeks to measure the frequency and magnitude of disrespect and abuse in childbirth, the challenges that this endeavor faces, and what is currently known about the prevalence of disrespect and abuse during childbirth in Canada. It is important to note that it is not the purpose of the present project to focus on questions of measuring the frequency or magnitude of disrespect and abuse during childbirth; this is because post-structuralism is about phenomena as constituted through experience and discourse, rather than measuring an objective thing. Nonetheless, this subsection provides information about what is known about the scope of disrespect and abuse during childbirth in Canada, demonstrating that it is a real and pressing problem, while drawing attention to the gaps, risks, and challenges in monitoring its occurrences.

Disrespect and abuse during childbirth has proven challenging to measure empirically (Sen, Reddy, & Iyer, 2018). In addition to the conceptual challenges presented by varying definitions and typologies of the phenomenon (see section 2.2, below), the results of studies that attempt to explore the frequency of disrespect and abuse in childbirth are difficult to aggregate and compare. There are, for example, challenges related to comparing self-reported disrespect and abuse in childbirth with observational reports by researchers (Sen, Reddy, & Iyer, 2018). Moreover, both self-reported and observational data have limitations. Self-reported data, for instance, can be difficult to aggregate since what is thought of as disrespectful or abusive may shift according to personal, social, and cultural circumstance (Sen, Reddy, & Iyer, 2018). Conversely, while observational studies yield higher reports of disrespect and abuse in childbirth compared to self-reports (Freedman et al., 2018), there is the chance that observation modifies provider behaviors, and there are also ethical issues related to bystander intervention (Sen, Reddy, & Iyer, 2018).

Despite these empirical challenges, there has been considerable research since 2014 that seeks to measure the frequency and magnitude of disrespect and abuse in childbirth, particularly in low- and middle-income countries (LMICs) (see for example Abuya et al., 2015; Montesinos-Segura et al., 2018; Okafor et al., 2015; and Miller & Lalonde, 2015, among many others). While there is limited research that seeks to explore the frequency of disrespect and abuse in childbirth in high-income settings, existing studies on the topic demonstrate that it is a real and pressing concern. A recent 2019 study focusing on the American context, for example, determined that one in six women who have been pregnant in the United States have experienced one or more type of

mistreatment during pregnancy and childbirth (Vedam, Stoll, Taiwo, et al., 2019). Likewise, a 2018 study found that one-fifth of doulas and nurses in Canada and the United States have reported witnessing providers engaging in procedures explicitly against the patient's wishes during childbirth (Morton et al., 2018).

Research that seeks to measure the frequency and magnitude of disrespect and abuse in childbirth in childbirth in Canada is virtually non-existent. Rather, what research there is that pertains to disrespect and abuse in childbirth in Canada focuses on the impacts of disrespect and abuse in childbirth on individuals. For example, Stoll et al. (2020) found that negative interactions for people who decline care during pregnancy and birth resulted in feelings of invisibility, disempowerment, and trauma. Vedam, Stoll, McRae, et al. (2019) found that Canadian women's autonomy was altered depending on the model of maternity care and the nature of interactions with care providers, such that autonomy scores were lower when women's opinions differed with that of their provider. While not seeking to measure the frequency of disrespect and abuse in childbirth *per se*, these studies nonetheless demonstrate that instances of disrespect and abuse in childbirth occur.

The above research demonstrates that the precise scope of disrespect and abuse during childbirth has not been definitively quantified in Canada, which may be due in part to the ongoing and evolving challenge of empirically measuring disrespect and abuse and the absence of agreed upon tools and measures. While it is beyond the scope and inconsistent with the theoretical orientation of this study to embark on the task of quantifying experience of the phenomenon, existing research suggests that disrespect and abuse in childbirth does occur in Canada, even if its precise frequency and magnitude

have not been measured empirically (Stoll et al., 2020; Vedam, Stoll, McRae, et al., 2019). Additionally, there is currently a project underway at the University of British Columbia, called the RESPCCT study (Research Examining the Stories of Pregnancy and Childbearing in Canada Today), which seeks to explore how people experience care during pregnancy and childbirth in Canada ("RESPCCT," 2020). This promising research will serve to help fill the research gap on disrespect and abuse during childbirth in the Canadian context.

2.3 Varying Terminologies and Definitions

This subsection reviews the literature that relates to the most common terminologies and definitions that have been used to describe disrespect and abuse in childbirth, and consistent with post-structuralism as the theoretical orientation of the project, reads these terminologies and definitions as discourse while seeking to understand the power relations engaged by each. Indeed, the phenomenon of disrespect and abuse in childbirth can be understood by way of various terminologies and definitions that sit within differing epistemologies. The subsection also seeks to understand the interpersonal, institutional, and structural power relations engaged by each of the terminologies employed by researchers who study this topic. Finally, the subsection explains why, among the varying terminologies and definitions, language of disrespect and abuse in childbirth is the most appropriate for the purposes of this research.

Over the last two decades, the phenomenon of disrespect and abuse during childbirth has been labeled in a variety of ways, including "mistreatment of women in childbirth at health facilities," "obstetric violence," "disrespect and abuse," "institutional

violence," and "dehumanized birth," among other terms (Savage & Castro, 2017). Across these terms, there is a lack of an agreed-upon conceptual definition, which Sen et al. (2018) attribute to two main reasons. First, diverse stakeholders ranging from feminist activists to clinicians to health administrators have different perceptions on what is most important and what the focus should be on, i.e. women's bodily integrity; pregnancy outcomes; or meeting benchmarks, respectively. Second, due to this diversity, the field consists of a mixture of subjective accounts of disrespect and abuse in childbirth, medical practices, and normative standards (Sen, Reddy, & Iyer, 2018). The complexity of the field, in this way, reflects the varying epistemologies within which terminologies and definitions sit.

Reviewing the terminologies and definitions that have been employed by researchers to date reveals the epistemological contexts from which the terms have evolved, which in turn reveals what is included, downgraded, or ignored in the process of using that term (Sen, Reddy, & Iyer, 2018). Through this review, which is informed by a post-structural approach, the discourse within which the terms are rooted can be identified and studied. In some instances, the various labels are used interchangeably, despite many authors arguing that each term caries distinct nuances. This has led to debate about whether a single comprehensive and operationalizable definition is possible or even desirable (Savage & Castro, 2017; Sen, Reddy, & Iyer, 2018). For the purpose of this project, it is sufficient to point out that the complexity of the field, with its varying and evolving terminologies and definitions, reflects a post-structural insight.

Insofar as this study also seeks to explore what experiences of disrespect and abuse during childbirth reveal about the interpersonal, institutional, and structural power

dynamics operating in maternity care spaces, this subsection also identifies what has been said about these dynamics within established terminologies and epistemologies so that the present research can build on these findings. Interpersonal dynamics constitute the communication and interaction that occur between individuals, for example, between patient and provider (Govender & Penn-Kekana, 2008); institutional dynamics refer to institutional culture as well as the norms and conventions that are normalized within particular institutions (Behruzi et al., 2013; Erdman, 2015); and structural dynamics refer to invisible manifestations of power that are built into the fabric of society, creating and maintaining inequalities through complex political, social, historic, and economic processes (Montesanti & Thurston, 2015; Sadler et al., 2016). Interpersonal, institutional, and structural dynamics are different but interrelated levels of power dynamics through which experiences of abuse during facility-based childbirth are constructed. These three levels – interpersonal, institutional, and structural – have been used as a framework in other research that seeks to explore inequality and unequal power relations (see for example Nazroo et al., 2020 on racism and Osler, 2006 on violence in schooling). Similar features have also been emphasized in research that specifically studies childbirth. For example, Erdman (2015) used comparable features – namely, attention to lived experience, institutional culture, and structural injustice – in an application of the sociological critique of principle-based bioethics analysis to facility-based childbirth, and MacDougall (2020) looked at intrapersonal, interpersonal, and structural/institutional domains in her narrative analysis of childbirth distress. Notably, the dividing line between the levels can be unclear (MacDougall (2020) for instance conflates structural and institutional domains) and experiences can be, and often are, shaped by all three

levels. For example, an interpersonal interaction that takes place between provider and patient may reflect an institutional norm that rationalizes the interaction, which in turn, is shaped by the compounding effects of structural factors that relate to political, social, historic, and economic processes.

2.3.1 Obstetric Violence

In Latin America and the Caribbean, legal and research discussions since the late 1980s and 1990s have focused on mistreatment as a form of violence or abuse that resembles other forms of violence against women (Savage & Castro, 2017). It was during this time that concerns related to the over medicalization of maternal care began to emerge in Latin American countries (Diniz et al., 2015). Consistent with language of birth justice, obstetric violence emerged as a legal concept that expressly recognized how individual instances of obstetric mistreatment are part of the broader problem of gender-based violence, and as such, employing the language of obstetric violence highlights mistreatment as a type of structural violence that needs to be addressed systematically (Borges, 2017; Kukura, 2017). The discourse of obstetric violence, then, focuses on the violation of human rights, institutional practices, power inequality, and inequities present in marginalized versus privileged groups (Sen, Reddy, & Iyer, 2018). In doing so, obstetric violence is defined as

> "… the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women" (D'Gregorio, 2010).

The language of obstetric violence is rooted in social and political forces that structure such experiences within a certain historical, social, and culturally specific understanding.

In this way, obstetric violence is rooted in discourses of human rights, power inequalities, and violence against women. These discourses offer a way to understand and speak about the phenomenon. More recently, scholars from disciplines other than law have also employed language of obstetric violence; for example, scholars of history (see Wood 2018), women and gender studies (see Cohen Shabot, 2016), and social sciences more generally (see Sadler et al., 2016).

Obstetric violence literature engages in structural power relations; that is, the cumulative and invisible effects of an assortment of societal factors that relate to the political, social, historic, and economic processes, which systematically influence experiences of disrespect and abuse during childbirth (Montesanti & Thurston, 2015; Sadler et al., 2016). To consider the structural dimensions of disrespect and abuse during childbirth is to think about the broader dynamics that sustain it. For example, Kukura (2017), a legal scholar who employs the language of obstetric violence, characterizes the medicalization of childbirth as a structural factor that contributes to experiences of obstetric violence. Medicalization describes the process whereby conditions previously described in non-medical terms are defined as medical problems that need to be diagnosed, prevented, or treated (Cahill, 2001). The medicalization of childbirth refers to birth being described as pathologized, or put another way, treated as a medical irregularity or a clinical problem rather than as a natural process (Kukura, 2017). Kukura (2017) further points out that within the medicalization of childbirth, the maternity care culture in which new health care providers are trained impacts their expectations of the profession, with most of medical care being based on custom rather than on scientific evidence. Obstetric residents are trained to prioritize intervention as a way to manage

labour and decrease risk, and as such, have very limited exposure to births that are unmediated by intervention (Kukura, 2017). Wood (2018), a historian who also employs language of obstetric violence, has also drawn attention to the historical gendered power imbalances that have existed between physicians, nurses, and expectant patients, an additional feature of the medicalization of childbirth.

Social norms have been identified as another structural power dynamic by researchers that employ language of obstetric violence (Borges, 2017; Kukura, 2017). These norms play a role in enabling and tolerating disrespect and abuse during childbirth, and are part of a value system that subjugates women and diminishes their status in society (Borges, 2017; Cohen Shabot, 2016). One norm that has been identified as enabling disrespect and abuse during childbirth is that of motherhood as sacrifice. Childbirth and motherhood were, for much of history, viewed as the primary duty of women and an essential aspect of womanhood (Sánchez, 2014). As Wood (2018) points out, the extent to which pregnant individuals in the mid-1900s presented themselves as "'good patients' and 'respectable' women" so as to avoid scorn from health care providers demonstrates just how strong notions of the "'good', 'subordinate', 'passive', and 'feminine' obstetric patient" were in the post-war period in Canada (p. 815). The myth of maternal self-sacrifice, which implies that "good mothers are those who subordinate their own needs (and bodies) in service of their children and families," continues to shape modern motherhood (Abrams, 2012, p. 776; Borges, 2017). For example, when social expectations of self-sacrifice are internalized, birthing individuals may downplay experiences of disrespect and abuse during childbirth and choose to

forego voicing concerns for fear of being construed as anything less than a "good," and therefore self-sacrificing, mother (Kukura, 2017; Wood, 2018).

Related to this is another social norm that forms a structural dynamic of obstetric violence: the stereotype of the birthing body as "anti-feminine." Cohen Shabot, a professor of gender studies who employs the language of obstetric violence, has argued that violence performed against a laboring body is also an action against a "subversive, rebelling femininity" (Cohen Shabot, 2016, p. 243). Laboring bodies threaten passive femininity because a "noisy, exuberant body" threatens the essence of the myth of femininity. The laboring body, in this way, needs to be "put in its place" by reminding it of its inherent passivity through violence so as to domesticate the body and make it "feminine" again (Cohen Shabot, 2016, p. 244). Cohen Shabot suggests that women may wish to avoid the violence used to domesticate laboring bodies by approaching childbirth through "an already hesitant, docile, silent body. Preemptively becoming feminine might save us from being put in our place by others" (Cohen Shabot, 2016, p. 245).

Another social norm that researchers who work within the area of obstetric violence have identified is the norm of female bodies as objects. The medicalization of childbirth, which entails the routinization of intervention through standard operating procedures, has been argued to structure birth as a technological process in which the "desired product is a healthy baby, and the woman as 'birthing machine' is only a secondary consideration" (Davis-Floyd, 2003; Lowe, 2016, p. 142). Obstetric violence during childbirth is enabled by social norms that understand "female bodies as objects to be acted upon" (Kukura, 2017, p. 776). The medicalized view that childbirth is a problem in need of a solution is akin to the objectification of the birthing body insofar as a

birthing individual's experiences are devalued and alienated when those experiences are controlled by a subject that does not share the birthing individual's goals and assumptions (Young, 2005). Treating a laboring body as an object, Cohen Shabot argues, is more comfortable for hospital staff because "Cartesian corpses" are "easier to handle than live bodies with desires and particularities" (Cohen Shabot, 2016, p. 244).

A final social norm that has been identified as a structural dynamic by scholars that employ the language of obstetric violence is that of women as dependent and inferior. These norms affect the level of control and knowledge that birthing individuals perceive they have with respect to their birthing experience. More specifically, as Sanchez (2014) points out, birthing individuals are treated as infants when they are viewed as lacking understanding with respect to what is happening to their bodies and when they fail to be recognized as capable of making decisions with respect to their health. This translates to a distrust on birthing individuals to exercise agency and control over their own bodies (Borges, 2017).

Legal institutions and economic pressures are other structural dynamics of disrespect and abuse during childbirth that have been identified. Kukura (2017) posits that fear of malpractice, for example, leads some health care providers to practice defensive medicine which can entail the use of unwanted, non-evidence-based, and unconsented interventions. Defensive medicine refers to the provision of medical services that is consistent with the desire to reduce legal liability by way of excessive testing, over-prescribing of medication, and recommending unnecessary procedures (Hermer & Brody, 2010). It has also been posited by legal scholars that models of legal malpractice "valorize medical judgments in response to uncertainty in childbirth and villainizes

maternal responses that do not conform to an essentialized, self-sacrificial, and historically myopic view of childbirth" (Abrams, 2012, p. 1955). Economic arrangements and pressures that govern and restrain labour and delivery services in hospitals have been identified as an additional structural factor insofar as economic pressures determine how birthing individuals access care and the conditions that shape childbirth experience (Kukura, 2017). In many jurisdictions, the cost of treatment has been found to influence clinical decision making in the context of maternity care. For example, in the United States, higher reimbursement rates for caesareans provides incentives to recommend this procedure, even when it was not medically necessary (Kukura, 2017).

A final structural dynamic identified by scholars working within the vocabulary of obstetric violence is that of gender-based violence. Borges (2017) argues that recognizing the gendered undertones of disrespect and abuse during childbirth is imperative to understanding its roots. In taking this approach, obstetric violence is situated within the broader field of structural gender inequalities by recognizing that women are the primary victims of disrespect and abuse during childbirth and pregnancy is, for the most part, a uniquely female experience (Borges, 2017). It has been argued, for example, that obstetric violence is the "last culturally acceptable form of violence against women" (Wood, 2018, p. 817).

The language of obstetric violence, rooted in discourses of human rights, power inequalities, and violence against women, holds certain rhetorical power by effectively conveying the seriousness of harms experienced by birthing individuals. On a post-structural understanding of discourse, the recognition of different meanings can disrupt knowledge. Some authors, sitting within epistemologies that understand the phenomenon

differently, have pointed out reasons to be cautious about applying this terminology. For example, Sen, Reddy, & Iyer (2018) have purported that the language of obstetric violence can have an antagonizing effect on clinical practitioners that must be engaged if change is to be achieved. Relatedly, there is a level of intentionality that is carried by the word "violence," which is not always the case: practitioners may not *intend* to cause harm, but still act in abusive ways (Sen, Reddy, & Iyer, 2018).

2.3.2 Disrespect and Abuse During Childbirth

Disrespect and abuse during childbirth is an alternative terminology that, unlike obstetric violence, seeks to speak to health system contexts more broadly (Sen, Reddy, & Iyer, 2018). It is a term used by public health scholars, among others (for example, human rights scholars: Erdman (2015)). One of the first comprehensive reviews on the topic of disrespect and abuse during childbirth occurred in Bowser and Hill's (from the disciplines of public health and medicine, respectively) 2010 landscape analysis which sought to synthesize existing research on disrespect and abuse in facility-based childbirth and problematize it as a barrier to institutional and skilled birth attendance (Bowser & Hill, 2010; Sen, Reddy, & Iyer, 2018). In this analysis, seven categories that grouped disrespect during childbirth were proposed, eventually becoming a conceptual basis for subsequent studies on the topic (Savage & Castro, 2017): (1) physical abuse, (2) non-consented care, (3) non-confidential care, (4) non-dignified care, (5) discrimination based on patient attributes, (6) abandonment of care, and (7) detention in facilities (Bowser & Hill, 2010). In this way, the typology of disrespect and abuse is rooted in health system discourse. A health system is defined by the WHO as "all organizations, people and

actions whose primary intent is to promote, restore, or maintain health" (World Health Organization, 2007).

Even though the use of Bowser and Hill's categories of disrespect and abuse became widespread, subsequent researchers pointed out the limitations of these definitions. In 2015, WHO researchers Bohren et al. (2015) pointed out that the seven categories lacked operational definitions that could be comparable between studies and investigations. Still working within a discourse of health systems, Freedman et al. (2014) argued that the categories could not differentiate between disrespect and abuse that stems from individual behaviours versus health systems deficiencies (Savage & Castro, 2017). As such, Freedman et al. (2014), coming from the discipline of public health, developed a new definition and framework that sought to connect individual, structural and policy level drivers of disrespect and abuse with broader perceptions and norms of health care providers (Savage & Castro, 2017). Freedman et al. (2014) defined disrespect and abuse as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified." Further, Freedman et al. created a diagram which is intended to be used as a tool for initiating discussion of disrespect and abuse at local, national, and international levels, and to assist researchers with making sense of findings so as to shape a principled and pragmatic responses (Figure 1).

Following this framework, a more recent definition of disrespect and abuse, which engages in health system discourse, developed by public health researchers Sen et al., (2018), has been developed as follows:

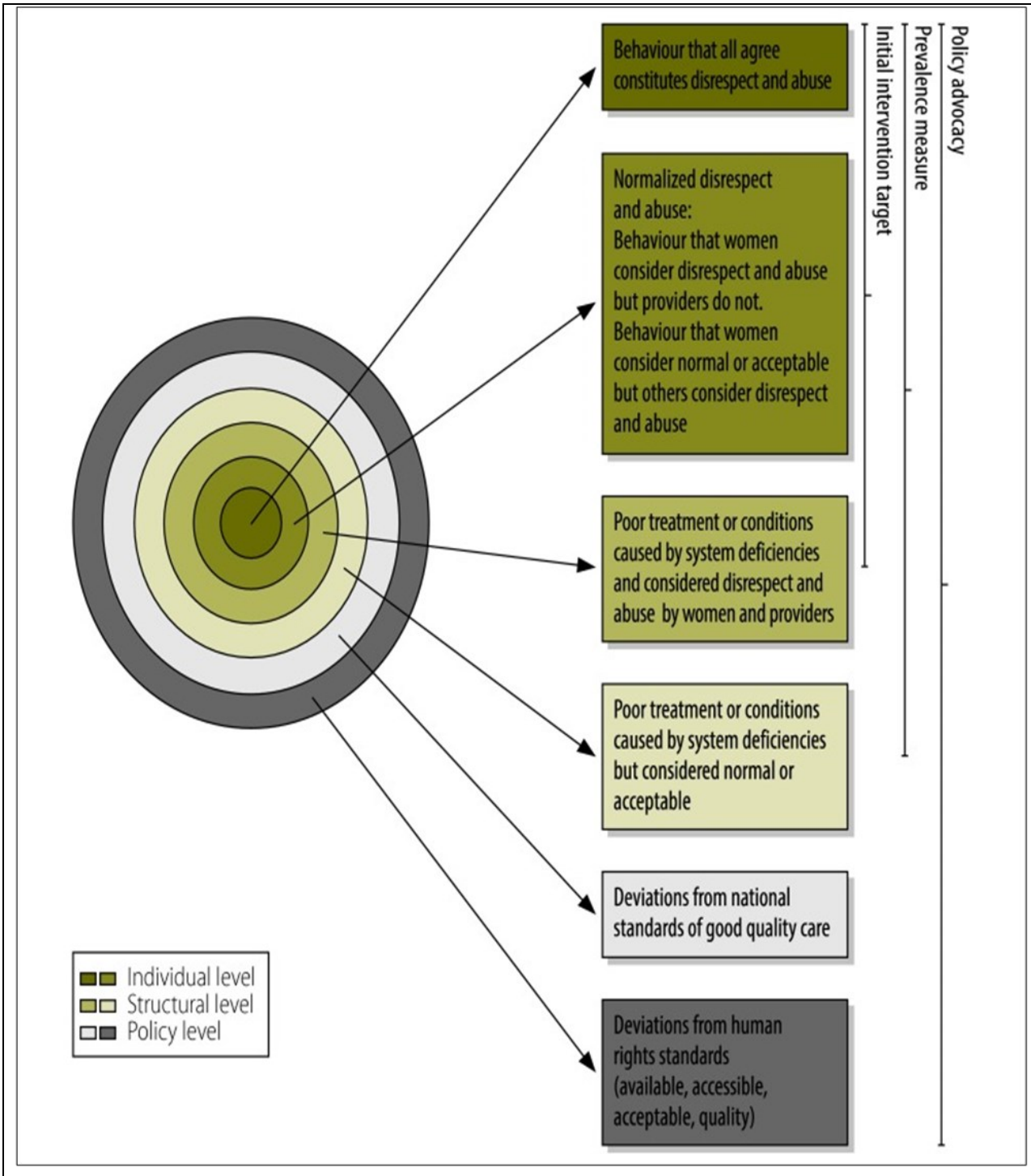

Figure 1: Freedman et al.'s "Defining disrespect and abuse of women in childbirth" (2014)

> "…we define disrespect as the violation of a woman's dignity as a person and as a human being on the basis of her economic status, gender, caste, race, ethnicity, marital status, disability, sexual orientation, or gender identity. Disrespect is often revealed in the biased normative judgements that health workers make about women and the resulting acts of omission or commission.
> …
> Abuse refers to actions that increase the risk of harm to the woman and are not in the best interests of her health or well-being. Such actions may be learned and reproduced through the practices of institutional medicine. They may or may not be intended to cause harm and are often justified by resource constraints that can become a cover for prioritising the convenience of health providers over the well-being of the woman" (Sen, Reddy, & Iyer, 2018).

Literature that employs language of disrespect and abuse tends to engage interpersonal and institutional power dynamics more so than structural dynamics. The interpersonal dimensions of disrespect and abuse during childbirth constitute the interactions that occur between individuals, for example, patient and provider (Govender & Penn-Kekana, 2008). One study that employs language of abuse and disrespect reported interpersonal interactions such as being overlooked, being informed of bad news without proper preparation, being examined without being informed, and being left unattended during labour (Gebremichael et al., 2018). Another study that employs language of disrespect and abuse reported birthing individuals not being welcomed or greeted at the hospital, not being provided with information, being ignored, not being taken seriously, and not being believed by health care staff (Solnes Miltenburg et al., 2018), which also constitute interpersonal interactions. Several other studies based in LMICs use first-person accounts to explore the interpersonal dimensions of disrespect and abuse during childbirth (for example, Abuya, Ndwiga, et al., 2015; Sando et al., 2016). As for the Canadian context, Morton et al. (2018), who used language of disrespect, found that two-thirds of doulas and nurses in Canada and the United States witnessed providers engaging in procedures without giving the birthing individual time or

options to consider them, and one-fifth reported witnessing providers engaging in procedures that were explicitly against the birthing individual's wishes.

Literature that employs language of disrespect and abuse also engages in institutional power dynamics. Institutional dimensions of disrespect and abuse during childbirth involve policies and practices that exist within particular institutions as well as the institutional cultures through which patients and health care providers interact and negotiate power (Behruzi et al., 2013; Erdman, 2015). Institutional dynamics of disrespect and abuse during childbirth do not merely refer to the location where such instances occur, but rather, to the "set of norms, hierarchies, and conventions through which acts of abuse and disrespect are rationalized, even normalized" (Erdman, 2015). Sen et al. (2018) have posited that disrespect and abuse during childbirth is reproduced through institutional factors within the health care system. They argue that gender power and control are integral to the institution of organized medicine, and the field of obstetrics in particular, insofar as the procedures and methods of obstetrics appear to serve the convenience of (often male) health care providers.

Sen et al. (2018) further argue that bias is built into the institution of medical education and training. More specifically, practical learning occurs through internships and residencies, and it is through the institution of medical education and training that attitudes are imbibed and where "new doctors start learning whether and how corners can be cut in terms of adherence to standards and protocols" (Sen, Reddy, & Iyer, 2018). Informal norms are passed to new providers, enabling disrespect and abuse during childbirth to continue. Indeed, when health care providers regard themselves as entitled to utilize convenient practices rooted in tradition rather than evidence, medical authority can

foster a "culture of impunity" where instances of disrespect and abuse during childbirth go unnoticed (Erdman, 2015). Moreover, policies that aim for efficiency may have the effect of pressuring health care providers to deliver services in cost-effective but questionable ways that "become routinized as informal norms" (Sen, Reddy, & Iyer, 2018), for example, unhygienic facilities and the unavailability of basic supplies (Gebremichael et al., 2018). Another aspect of the institutional dimensions of disrespect and abuse during childbirth within health care systems that Sen et al. (2018) point to is organizational dynamics. More specifically, nurses and midwives are perceived as inferior in the medical hierarchy and therefore lack power within organizational structures. Madhiwalla et al. (2018), who employ language of disrespect and abuse, have demonstrated, for example, that obstetric practices endorsed by senior staff are reproduced via providers' subservience to a medical hierarchy.

While scholars that employ the language of disrespect and abuse have most often focused on interpersonal and structural dynamics, they have also considered structural elements. For example, socioeconomic inequalities have been identified as a structural driver of disrespect and abuse during childbirth (Sen, Reddy, & Iyer, 2018). More specifically, gender inequities cut across other socio-economic inequalities that influence how medical staff interact with and perceive birthing individuals (Sen, Reddy, & Iyer, 2018). For instance, Diniz et al. (2015), who use language of disrespect and abuse in their study, have shown that disrespect is disproportionately felt by poorer, racial and ethnic minority women relative to their richer, Caucasian counterparts. Sen et al., (2018) have posited that histories of social relationships are linked to birthing individual's interactions with health care providers, and that socially and economically disadvantaged groups have

endured poorer access to maternal care. Erdman (2015) has argued that a focus on disrespect and abuse offers a means to connect with social movements that seek systemic-level reform, pointing to campaigns that situate experiences of abuse and disrespect during childbirth within patterns of violence and social inequalities based on gender, race, and class. Researchers have also discussed the ways in which birthing individuals perceive, internalize and justify their experiences of disrespect and abuse during childbirth with respect to entrenched norms and stereotypes surrounding gender and motherhood (Sen, Reddy, & Iyer, 2018).

Through a post-structural approach, knowledge can be disrupted by a plurality of meanings; indeed, other researchers have criticized the language of disrespect and abuse because framing the issue in such a way can be viewed as hostile toward providers, therefore rendering it challenging to work with providers when conducting research or investigating individual instances (Sen, Reddy, & Iyer, 2018). Moreover, in addition to being overly provocative, it has been implied that the terminology of disrespect and abuse does not go far enough differentiating between the intentionality of individual care providers and broader systems of healthcare quality (Bohren et al., 2015; Sen, Reddy, & Iyer, 2018). On this way, the language of disrespect and abuse has been challenged by researchers sitting within epistemologies that understand the phenomenon differently.

2.3.3 Mistreatment During Childbirth

In 2015, upon recognizing the limitations in Bowser and Hill's model of disrespect and abuse during childbirth, Bohren et al. (2015) created a typology that sought to capture how mistreatment occurs at the level of interaction between woman and provider as well as through systemic failures and the health facility and health system

levels (Sadler et al., 2016). A typology systematically classifies behaviours and objects that have certain characteristics in common (Bohren et al., 2015). The typology of mistreatment during childbirth focuses on seven themes: (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints (Bohren et al., 2015). While the typology does not provide an explicit definition of mistreatment during childbirth *per se*, it is intended by the authors to "inform efforts to develop global consensus on the definition of mistreatment of women during childbirth" (Bohren et al., 2015).

In this typology, the word "mistreatment" is preferred over "abuse" because, proponents argue, it is less provocative and goes further in separating individual intentionality from broader issues of healthcare quality (Sen, Reddy, & Iyer, 2018; Vogel et al., 2016). Indeed, "mistreatment of women during childbirth" is argued to be broader and more inclusive as it centers women's own experience; can account for intentional and unintentional actions of medical providers by emphasizing the different sources of mistreatment; and captures interactions with facility staff, the environment, and conditions of broader health systems (Savage & Castro, 2017; Vogel et al., 2016). In this way, the typology of mistreatment aligns with health systems discourse. The WHO used the mistreatment typology in the hope that it will enable the development of assessment tools that can standardize the measurement of mistreatment worldwide (Bohren et al., 2019; Savage & Castro, 2017).

Literature that employs language of mistreatment engages all of interpersonal, institutional, and structural dynamics. For example, Vedam, Stoll, Taiwo, et al. (2019),

midwifery researchers who employed language of mistreatment, used an online cross-sectional survey to capture lived experiences of maternity care among American women. The study showed that one in six birthing individuals reported experiencing mistreatment, much of which occurred at the interpersonal level of interaction, including: being shouted at, scolded, or threatened, and being ignored, refused, or receiving no response to requests for help. Notably, this study revealed that rates of mistreatment were higher for women of colour. Economic issues with hospital staffing, facility costs, and resource allocation have also been noted by nursing researchers who employ language of mistreatment to influence the childbirth experience, which constitutes an institutional dimension; for instance, facilities designed with a lack of privacy for patients can have the effect of minimizing the dignity of birthing individuals (Darilek, 2018). Public health researchers Jewkes & Penn-Kekana (2015) posited that a lack of research and investment in maternity services can be attributable to the fact that women's health issues are not perceived as a priority by policymakers, which can reflect both institutional and structural dynamics. Jewkes & Penn-Kekana (2015) also argue that disrespect and abuse during childbirth is a subset of violence against women, a structural dimension, further positing that power relations between health professionals and women in maternity care spaces are settings of hegemonic dominance that parallel the societal dominance of men over women. Negative behaviours, they argue, stem from social norms that develop within these settings, which influence practices and expectations of power (Jewkes & Penn-Kekana, 2015)

2.3.4 Respectful Maternity Care

The term "respectful maternity care" (RMC) has emerged into common usage most recently. It has been used by the WHO to frame the issue in a more positive light (Sen, Reddy, & Iyer, 2018; WHO Reproductive Health Library, 2018). More specifically, it depicts the mere absence of disrespect and abuse as being insufficient, instead focusing on what standards *ought* to be, thereby enabling women's entitlements to exceptional birth care using the tools and convenants of human rights (Sen, Reddy, & Iyer, 2018). In this way, RMC can be viewed as an effort to challenge and disrupt existing discourse by adopting and promoting a new one, or viewed another way, to disrupt and renegotiate power relations in maternity care settings. One definition of RMC, used recently by the WHO, is as follows:

> "…care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth…" (WHO Reproductive Health Library, 2018).

A major benefit of the language of RMC, according to its proponents, is that it is less hostile to providers than other typologies, which could enable stronger buy-in from those that ultimately need to be part of the solution if change is to take effect (Sen, Reddy, & Iyer, 2018). A notable drawback about RMC, however, is that it cannot as effectively capture abuse when it is intentional or bordering on violence, and furthermore, it may not do enough to draw attention to underlying causes (Sen, Reddy, & Iyer, 2018). By focusing on what standards ought to be in an ideal world rather than on manifestations of disrespect and abuse as they occur in actuality, the RMC typology risks overlooking important details and specificities

that are central to identifying underlying causes and integral to developing effective solutions.

2.3.5 Birth Trauma

"Birth trauma" is an additional term that is popularly utilized in the literature. Birth trauma has been used predominantly in nursing research since the late 1990s and early 2000s. It is defined as an event that occurs during the labour and delivery process which involves "actual or threatened serious injury or death to the mother of her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror" (Beck, 2004, p. 28). Birth trauma can be closely connected to post traumatic stress disorder (see Beck, 2004).

Stemming from nursing research, the "birth trauma" typology in its early usage aligned with discourses of trauma, disorder, and mental health. Additionally, early literature tended to focus on its interpersonal dimensions; for example, Beck's (2004) discussion of birth trauma focuses in part on how communication between providers and patients relates to experiences of birth trauma, and what clinicians can do to prevent traumatic births. In more recent years, however, nursing scholars have sought to broaden understandings of trauma by examining structural dimensions of the phenomenon, for example, by exploring heteronormativity as structural marginalisation that occurs within perinatal care relationships (Searle et al., 2017) and structurally embedded heteronormative and homophobic healthcare practices and policies (Burrow et al., 2018). In this way, more modern conceptualizations of birth trauma align with discourses of harm reduction and trauma-informed care, while seeking to address the phenomenon's institutional and structural dynamics in addition to its interpersonal dimensions.

Interestingly, the typology of birth trauma began and remains within the disciplines of nursing and, to a lesser extent, midwifery (see for example Byrne et al., 2017; Reed et al., 2017). That is, unlike other typologies that are used by scholars from multiple disciplines (for example, "obstetric violence," as discussed above, is used by scholars of law as well as public health and gender studies), language of "birth trauma" is used predominately in nursing and midwifery research.

2.3.6 Why 'Disrespect and Abuse' is Most Suitable for this Research

Between the obstetric violence typology, the language of disrespect and abuse, the terminology of mistreatment, the optimistic framing of respectful maternity care, and language of birth trauma from nursing research, it is clear that there remains a lack of consensus in defining the issue in a universally acceptable way. There have been calls for interdisciplinary collaboration so that a truly comprehensive and universal definition can emerge (see for example Bohren et al., 2015; Savage & Castro, 2017). On the other hand, it has been argued that the phenomenon is so multifaceted that a universal, cross-disciplinary definition is not only impossible to develop, but could risk oversimplifying a complex issue that, by its nature, means something different to each discipline that studies it. It is beyond the scope of this research project to explore these questions or to attempt to develop such a universal definition, except to say that the complexity of the field reflects a post-structural insight insofar as each typology and definition draws from distinct epistemologies and competing discourses. Understanding that each term carries nuances that makes the terms distinct from other typologies and terminologies, and identifying the discourse from which each terms draws is an important endeavor for this research project insofar as it enables the phenomenon to be understood comprehensively.

Given this variety of terminologies, this research adopts the language of "disrespect and abuse during childbirth". "Obstetric violence" focuses on legal responses to the issue, particularly in the Latin American context, and limits much of its analysis to systemic dimensions of the phenomenon. "Mistreatment during childbirth" is typically used by the WHO and others when attempting to measure the frequency and magnitude of phenomenon (for example, Bohren et al., 2019). "Respectful maternity care" is focused on the ideal standards of care. The present research is instead concerned with the interpersonal, institutional, and structural power dynamics that operate within Canadian maternity care spaces. As Sen et al. (2018) point out, the language of disrespect and abuse captures intentional behaviours and unintended consequences; accounts for both socioeconomic inequalities and institutionalized medical practices; and enables the identification of underlying drivers of the issue, therefore reflecting all three levels of power dynamics.

The present research seeks to explore the discourses that operate in maternity care spaces and shape relations of power that construct birthing experiences, as well as to understand what these experiences reveal about interpersonal, institutional, and structural power dynamics. Therefore it is appropriate to adopt the same terminology—"disrespect and abuse during childbirth—employed by other studies that similarly focus on the complexity of the issue, including its interpersonal, institutional, and structural features (see for example Erdman, 2015; Madhiwalla, Ghoshal, Mavani, & Roy, 2018; and Solnes Miltenburg, van Pelt, Meguid, & Sundby, 2018).

CHAPTER 3: METHODOLOGY AND RESEARCH DESIGN

The purpose of this chapter is to describe the methodology and research design that were employed for this research. The first section describes the methodology of feminist post-structuralism and the important role of language, discourse, power, and knowledge within this methodology. The second section describes the research design, including the source of the data, the reflexivity of the researcher, the analysis of the data, the trustworthiness of the research, the ethical considerations of the research, and how the knowledge generated by the research can be translated.

3.1 Methodology

3.1.1 Feminist Post-Structuralism

A feminist approach to research centers on and problematizes women's diverse situations and the institutions that frame them. Because disrespect and abuse during childbirth is predominantly experienced by women (although it is acknowledged that not all individuals who give birth identify as women), it is appropriate to approach the present research topic from a feminist standpoint. Moreover, because feminist research aims to establish collaborative and nonexploitative relationships, it embraces many of the critiques of postmodernism and post-structuralism as a challenge to society's injustices (Creswell & Poth, 2018). For this reason, feminist post-structuralism (FPS) is an appropriate philosophical lens through which to understand disrespect and abuse during childbirth.

The post-structuralist philosophy of French philosopher Foucault was adopted by feminists in the late 20th century to analyze relationships of power and to challenge those relationships (Arslanian-Engoren, 2002). Chris Weedon, whose scholarly work has

largely influenced FPS (Wijlen & Aston, 2019), defines post-structuralism as “a mode of knowledge production which uses post-structuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change" (Weedon, 1997, p. 40). That is, post-structuralism seeks to deconstruct social and institutional discourses to expose and understand the meanings, assumptions and biases that underly relationships and experiences. Per psychology academic Nicola Gavey, whose work is often cited in studies that employ FPS and discourse analysis (see for example Jefferies et al., 2018), the goals of post-structuralism, rather than to “discover” reality or “reveal” the truth, are to generate understandings of the world that are historically, socially, and culturally specific, and further, to disrupt dominant knowledges through a plurality of meanings (Gavey, 1989). FPS, more specifically, seeks to analyze and challenge patriarchal discourse, social institutions, and relationships of power that oppress women (Arslanian-Engoren, 2002).

Insofar as FPS strives to expose and change structures of power within social and political institutions, it is a valuable lens through which to examine women’s healthcare since it can be used as a tool to illuminate and challenge the biases in health-care systems that prevent women from receiving comprehensive treatment and marginalize their healthcare needs (Arslanian-Engoren, 2002). Indeed, because the present research project endeavours to connect experiences of disrespect and abuse during childbirth with the relations of power and discourses that construct such experiences, it lends itself well to FPS as its philosophical underpinning.

A major disadvantage of FPS, and post-structuralist theory more generally, is that it is conceptually complicated and is typically discussed using difficult language (Gavey,

1989). This entails that FPS is inaccessible to people from certain disciplinary backgrounds. However, there is no simple solution to this issue, since as Belsey (1980) states, the complexity does not arise from "a perverse desire to be obscure" (p. 4). Instead, as Belsey argues, "to challenge familiar assumptions and familiar values in a discourse which, in order to be easily readable, is compelled to reproduce these assumptions and values, is an impossibility. New concepts, new theories, necessitate new, unfamiliar and therefore initially difficult discourses" (pp. 4-5) (Gavey, 1989). This is especially problematic to the task of sharing information in avenues outside of formal education in an effort to combatting elitism. Although this disadvantage is significant, it is outweighed by the theoretical basis that FPS offers (Gavey, 1989). Indeed, by allowing the analysis of women's subjectivities, FPS goes beyond theories that can only generate single-cause explanations, instead embracing complexity in the generation of "promising ways of theorizing about change" (Gavey, 1989, p. 472). FPS is more accessible today. Some may argue that qualitative research is inaccessible if one is not familiar with statistics, similar to qualitative researchers using FPS. In both, one needs to trust that researchers are competent.

3.1.2 Language and Discourse

According to post-structuralism, all knowledge and meaning is discursively constituted through language. Language, according to Weedon (1987), is an expression of an individual's understanding of the world. That is, an individual's understanding of a certain object or event is "made available through a particular discourse concerning or relating to that object or event" (Gavey, 1989, p. 463). This means that language does not merely reflect and describe human subjectivities and experiences; rather, language

constitutes subjectivity and experience (Gavey, 1989). For this reason, post-structuralism suggests that language does not have one static meaning, but rather, is understood differently based on an individual's social, historical, and institutional contexts.

Post-structural theory further posits that language is located in discourse. Discourse is conceptualized as an interrelated system of statements, cohered around common social meanings and values, that "systematically form the objects of which they speak" (Foucault, 1974, p. 49). Put another way, discourse refers to the way that meaning is formed within a particular group, culture, or historical period. By viewing language not as a stable representation of reality but as a social and political force that structures reality, discourses offer ways to understand and speak about the world (Grant & Giddings, 2002).

Certain discourses of meaning develop to become dominant over others through conscious or unconscious social and institutional hierarches (Weedon, 1987). The dominating discourse surrounding the "good mother", for example, involves things like "hospital visits, the routine check-ups, the normalizing techniques which define satisfactory maternal health or development, and so on" (Henriques et al., 1984, p. 219). This discourse is one of several that shape the birthing experience. For instance, when a woman's choice of birthplace and obstetric intervention differs from her health care provider's opinion, she does not fit into the dominating discourses of the "good mother," which may affect her sense of autonomy and respect. Because FPS purports that language and discourse are not fixed (Weedon, 1987), meanings can shift and women's subjective experiences of disrespect and abuse during childbirth can be mitigated or prevented.

3.1.3 Power and Knowledge

Power has a particular meaning within FPS. According to Foucault, power is exercised through people that are acting on the actions of others, such that everyone capable of action is part of a power relationship with others who are also capable of action (Foucault, 1986; Grant & Giddings, 2002). Further, Foucault's concepts of regimes of truth, subjugated knowledge, and power help explain the process through which people change their behaviours in response to relations of power, and further, how certain knowledges determine what is true and other forms of knowledge are discredited or marginalized (Foucault, 1977; MacDougall, 2020). It is through discourse that power relations are exercised. Because post-structuralism views knowledge as socially constructed and closely associated with power, individuals with power "control and regulate what constitutes the essence of the experience, the era, and our subsequent understanding of the event" (Arslanian-Engoren, 2002, p. 513). Rather than power simply being exerted against people, negotiations of power are experienced in a variety of ways (Cassidy et al., 2016).

A feminist post-structural examination of discourses surrounding childbirth reveals the strong influence that the concept of power has on birthing bodies. For instance, when particular ideas about motherhood and childbirth are reinforced through medical professionals and other sources, notions of an ideal childbirth become dominant and perpetuated. Beliefs and values are positioned with certain kinds of power, paving the way for socially constructed 'right' and 'wrong' ways to give birth. The recognition of different meanings through a feminist post-structural analysis disrupts oppressive meanings and knowledge (Gavey, 1989), enabling individuals to negotiate power.

3.2 Research Design

The overall goal of the present research project is to explore how experiences of disrespect and abuse during facility-based childbirth are constructed through relations of power which are shaped by discourse, and further, what these experiences reveal about interpersonal, institutional, and structural power dynamics in maternity care spaces. Because the project seeks to explore conditions that are relevant to the phenomenon of disrespect and abuse during childbirth, a case study approach is appropriate insofar as this approach enables the researcher to "explore individuals or organizations, simple through complex interventions, relationships, communities, or programs… and supports the deconstruction and the subsequent reconstruction of various phenomena" (Baxter & Jack, 2008, p. 544). Moreover, an intrinsic study (Stake, 1995) of multiple cases lends itself well to the project insofar as the intent of the research is to better understand cases of experiences of disrespect and abuse in childbirth (Baxter & Jack, 2008, p. 549).

To answer the research questions of how experiences of disrespect and abuse during facility-cased childbirth are constructed through relations of power; which discourses shape these relations; and what these experiences reveal about the interpersonal, institutional, and structural power dynamics operating within Canadian maternity care spaces, a research method of discourse analysis is employed. The data that will be analyzed are individual accounts of disrespect and abuse during childbirth as recounted through an anonymous blog.

3.2.1 Data Collection

The research project utilizes publicly accessible data that consists of accounts of lived experience of disrespect and abuse in childbirth. The Obstetric Justice Project is a

grassroots patient advocacy initiative that aims to expose disrespect and abuse in reproductive healthcare in Canada (*The Obstetric Justice Project*, n.d.). The goal of the initiative is to build "a public body of evidence" that reveals the effects that a lack of access to respectful, inclusive, patient-centered reproductive healthcare has on patients (*The Obstetric Justice Project*, n.d.). Ultimately, the initiative acts as a platform where patients and professionals can speak up about systemic issues in reproductive healthcare so as to "hold harmful systems accountable and influence change across the country" (*The Obstetric Justice Project*, n.d.).

The initiative revolves around a community story blog, a space where stories can be anonymously shared. Since January 2018, the blog has collected over 100 publicly accessible postings from individuals across Canada. To post a story, users are asked a series of questions about their experience. These questions are reproduced in Appendix A. Because the questions elicit personal experiences which are communicated through language, and because FPS is focused on language as an expression of an individual's understanding of the world, FPS and discourse analysis could be applied to submissions to the community story blog. These stories constituted the data that were used for the purposes of the present research project.

In total, 114 stories were posted to the community story blog between January 15, 2018 and October 24, 2020. Because the initiative collects stories involving reproductive health services generally, including abortions and sterilization procedures, only the submissions that recounted a first-person experience of disrespect and abuse during childbirth in Canada were retained for data analysis. As such, the following types of submissions were excluded from the dataset: those that recounted experiences during a

service, procedure, or process other than childbirth (e.x. abortion, miscarriage, acupuncture); those that recounted experiences that did not take place in Canada; those experiences that did not occur in a facility; those that were recounted from the perspective of someone other than the birthing individual (e.x. family members or health care providers); and those that did not include an instance of abuse or disrespect (i.e. a small number of submissions recounted a positive experience; these were excluded). After removing these types of stories, the dataset consisted of 82 submissions. Each submission varied in length from as little as 120 words to over 3000.

There are some notable limitations to the use of this data. First, while some may argue that the data are problematic because there is no way of verifying the truth of the stories that are posted, this is not a concern for the present research. The "truth" of the incident is not an issue since post-structuralism accepts multiple truths. Indeed, a feminist lens accepts all stories as "truthful" and to "check" another's story is disrespectful and oppressive. That is, it is contrary to feminist methodology to doubt what women have written: we must believe what women say is the truth, and cannot try to verify their stories as this would be oppressive and a patriarchal way of controlling women's stories. What is more, the initiative states on its "Policy and Guidelines" page that it is required for submissions to be true to the best of the user's memory. Including multiple truths in this way is a strength of the study.

Another potential limitation of the use of the data is that the initiative reserves the right not to publish submissions, which means that only the stories that were approved are available for viewing. This may cause concern about selection effect. Some of the reasons provided for not publishing submissions include being too vague for readers to

understand what happened; the incident not happening in Canada; and the submission containing hate speech, libel, or slanderous information that is untrue and intended to be harmful. This limitation is minor since submissions that meet the initiative's exclusion criteria were not likely to be appropriate for the purposes of the present research project anyway.

3.2.2 Reflexivity

Qualitative research is a reflection of the author's own interpretation based on factors such as culture, gender, class, social and personal politics (Creswell & Poth, 2018). In qualitative research, the act of positioning oneself in relation to their research is known as 'reflexivity', which Charmaz (2006) defines as the "researcher's scrutiny of his or her experience, decisions, and interpretations in ways that bring the research into the process and allow the reader to assess how and to what extent the researcher's interests, positions, and assumptions influenced inquiry" (pp. 188-189). When engaging with qualitative data in particular, past experiences and viewpoints, as well as biases and positions of privilege, influence the way in which one interprets language, symbols, and texts. This is why it is important for researchers to reflect on their own situations in relation to the data they are analyzing.

My personal experiences and privileges may have influenced this research. I am a student in my final year of a combined Juris Doctor/Master of Health Administration program at a University in Atlantic Canada. When working with the data, I considered my position as a Caucasian female as well as the knowledge and beliefs I accumulated while volunteering and working with organizations that focus on sexual and reproductive health and rights (SRHR). I was conscious of the role that these aspects of my identity

and background might play on my interpretation of the data. Additionally, I am aware that the intersecting facets of my identity entail that I am less likely to experience discrimination in healthcare settings and elsewhere. As well, I have never experienced motherhood or pregnancy. While this does not devalue my capabilities as a researcher or the knowledge I can contribute to this research topic or the SRHR field more generally, I am aware that the depth and scope of my analysis is limited by my life experiences and education. I made an effort throughout the research process to assess my role as researcher, and further, to make note of the personal biases I may hold with respect to the research subject.

3.2.3 Data Analysis

Data analysis is conducted through discourse analysis, a common analysis method for FPS that seeks to examine the ways in which understanding, relationships, and shared meanings are produced through language (Starks & Brown Trinidad, 2007). Simply put, discourse analysis is a tool for critical analysis (Gavey, 1989) and has been used to explore how relations of power result from the interplay of language, values, practices, and beliefs (Kirk et al., 2014). The focus of discourse analysis is on how "social relations, identities, knowledge and power are constructed in spoken and written texts," or put another way, how individuals' experiences are socially constructed through language (Crowe, 2005, p. 55). It is an appropriate method for the present research project because it illuminates experiences in a way that other research methods may not be able to, and further, allows opportunity for the identification of oppressive practices by focusing on the context in which treatment occurs (Crowe, 2005). Discourse analysis focuses on social and historical contexts and its relation to structures of power, with its aim being to

provide an analysis that will allow us to "explain the working of power on behalf of specific interests and to analyze the opportunities for resistance to it" (Weedon, 1997, p. 41). The focus of the data analysis in the present study, therefore, was on the language used by those who posted their stories on The Obstetric Justice Project's community blog, as well as their perception of their relations with those they interacted with during their childbirth experience.

Discourse analysis involves the reading of texts with the goal of "discerning discursive patterns of meaning, contradictions, and inconsistencies" (Gavey, 1989, p. 467) so as to illuminate how social norms, the construction of identities, and negotiations of political and social interaction are created and maintained (Starks & Brown Trinidad, 2007, p. 1374). However, there is no recipe for discourse analysis. Generally, discourse analysis involves the examination of text for linguistic strategies used to construct a particular way of thinking and acting (Crowe, 2005). In addition to patterns and regularities in language, discourse analysis is also concerned with the people who are using language, what they mean, the purpose for which they use language, and the context in which language is used (Bavelas et al., 2002). Discourse analysis looks at broader ideologies, philosophies, and messages beyond the words written or spoken (Bavelas et al., 2002)

The method of interpretation in discourse analysis involves interpretive analysis and the process of decontextualization and recontextualization (Starks & Brown Trinidad, 2007). In decontextualization, data are separated from its original context and codes are assigned to units of meaning in the texts. In the present project, then, stories were separated into individual sentences or statements. In the coding phase, sentences or

statements were highlighted a unique colour based on shorthand labels (or codes) to describe their content. For instance, the statement "*He ignored my concerns and questions, and brushed me after only seeing me for two minutes*" was assigned the code "feeling ignored/dismissed." Every sentence of every submission was read and flagged if it was relevant or interesting, and new codes were added as new ideas arose. After all codes were assigned, the data was collated into groups by code, allowing a condensed overview of common meanings and points that recurred in the data. In the recontextualization phase of discourse analysis, codes are examined for patterns and data are reintegrated around central themes and relationships that are drawn across all cases (Starks & Brown Trinidad, 2007). As such, in the present project, patterns were identified among codes, and themes were created which consisted of several codes. For instance, the "feeling ignored/dismissed" code, alongside many others, fell into the "feelings and emotions of disrespect and abuse" theme. Once all themes were created, a review of the themes ensured that they were useful and that they were an accurate reflection of the dataset. Following this, each theme was named and defined in a way that helped make sense of the data. Through discourse analysis, overarching and dominating discourses that played a role in shaping experiences of disrespect and abuse in childbirth were identified, in addition to relations of power.

A clear advantage of discourse analysis is that it can reveal hidden oppressive discourses that maintain positions of power in society. As well, discourse analysis can enable positive social change by critically challenging traditional theory, policy and practice and constructing new and alternative meanings that empower women and others who exist in marginalized positions (Mogashoa, 2014). However, there are also

disadvantages to using discourse analysis. It can be confusing for new researchers to sort through similarities and differences between concepts, and the lack of an explicit formula has been described as a hindrance (Mogashoa, 2014). As well, discourse analysis cannot provide absolute answers to specific problems. Nonetheless, the inherent complexity of discourse analysis and FPS more broadly should be embraced since, to cite Belsey (1980), "new concepts, new theories, necessitate new, unfamiliar and therefore initially difficult discourses" (pp. 4-5).

3.2.4 Trustworthiness

Trustworthiness describes the degree of confidence of a study's data, interpretation, and methods (Connelly, 2016). In discourse analysis, readers judge trustworthiness by evaluating how the researcher uses evidence to support the main points (Starks & Brown Trinidad, 2007). This involves consideration of the trustworthiness, credibility, dependability, confirmability, transferability, and authenticity of the research (Connelly, 2016).

Credibility refers to the level of confidence in the truth of the study (Connelly, 2016). In this research, credibility was established by engaging in reflexivity (see *3.2.2 Reflexivity*, above), working with committee members and professors who are knowledgeable about this research method and subject area, and consulting other academic works, including other student theses, that utilized a similar research approach. In discourse analysis, the researcher needs to be cognizant of her perspective and position in the analytic process. This entails being explicit about how the researcher's role within professional academic discourse shapes the thinking process (Starks & Brown Trinidad, 2007).

Dependability refers to the data's stability over time and over the conditions of the study (Connelly, 2016). Dependability was established by keeping track of decisions about data analysis and interpretation. As this study did not involve interviews or observation, detailed process logs with respect to these aspects of qualitative research were not necessary.

Confirmability refers to the neutrality of the study, or the degree to which findings are consistent and repeatable (Connelly, 2016). Confirmability was established by sharing the data and data analysis process with the thesis supervisor.

Transferability refers to the extent to which findings are applicable to persons in other settings and situations (Connelly, 2016). Transferability was established by including verbatim quotes from submissions and by being transparent about how the data was analyzed.

Finally, authenticity refers to the extent to which the research shows a range of different realities and how realistically participants' lives are conveyed (Connelly, 2016). Participants were not selected for this research; rather, the dataset consisted of publicly accessible postings to an anonymous blog from individuals across Canada. To the extent that the community story blog is open to everyone, a range of realities and lived experiences are represented.

3.2.5 Ethics

The proposed research study on disrespect and abuse during childbirth in the Canadian context relied on publicly accessible data. As the Tri-Council states in article 2.2(b) of the policy statement on the ethical conduct for research involving humans,

research does not require research ethics board (REB) review when it relies exclusively on information that is "in the public domain and the individuals to whom the information refers have no reasonable expectation of privacy" (Canadian Institutes of Health Research et al., 2018, p. 15). REB review is not required for cyber-material to which the public is given uncontrolled access on the Internet and for which there is no expectation of privacy.

Because the present research project relies on data that is accessible to the public and does not invoke an expectation of privacy—namely, submissions on the Obstetric Justice Project website—REB approval was not required. This was confirmed with the Office of Research Services at Dalhousie University. Additionally, the findings of the research will be reported honestly, and all perspectives will be considered (Creswell, 2013). Finally, the researcher has no current conflicts of interest, and future funding agencies will not have invested interest in the study's results (Creswell, 2013).

3.2.6 Knowledge Translation

The product of discourse analysis can be used by clinicians, interventionists, and policy makers in several ways. First, discourse analysis can be used to understand how language achieves a desired outcome. Second, discourse analysis can be used to help understand why a particular practice is on a certain trajectory. Last, discourse analysis can be used to garner support for a proposed policy (Starks & Brown Trinidad, 2007).

The research provides invaluable information about the interpersonal, institutional, and structural dynamics operating within maternity care spaces in Canada that shape experiences of disrespect and abuse during childbirth. The findings could be used by health administrators in the development of more comprehensive models of

facility-based maternity care for birthing individuals, and by advocacy groups in pursuit of their objectives. As well, the findings may also be used by policy makers when generating policies that seek to prevent disrespect and abuse from occurring.

Ultimately, the research will add to a body of knowledge and fill current research gaps while encouraging health care providers and administrators to critically analyze present practices. It will also provide unique insights into the phenomenon that may serve as a starting point in the generation of recommendations for transforming institutional and systemic responses to the issue.

CHAPTER 4: FINDINGS

This chapter applies a discourse analysis to first-person written accounts of experiences of disrespect and abuse during childbirth in Canadian facilities. The chapter shares excerpts from some of the birthing individuals' stories which represent the analysis across the 82 submissions in the dataset. The specific excerpts were chosen as representative accounts for their ability to illustrate the overarching notions and ideas that were present within each subtheme.

In this research, the methodology of feminist post-structuralism was used to understand experiences of disrespect and abuse in facility-based childbirth in Canada and the interpersonal, institutional, and structural power dynamics that shape such experiences. As a phenomenon that has only relatively recently become a popular area of inquiry for researchers, the literature on the topic has identified and explored several drivers of disrespect and abuse, but has also expressed a pressing need for continued research. Building on and responding to these findings, this study seeks to explore disrespect and abuse during childbirth in the Canadian context.

To answer the research questions (1) How are experiences of disrespect and abuse during facility-based childbirth constructed through relations of power, and what discourses are used to shape these relations? and (2) What do these experiences reveal about the interpersonal, institutional, and structural power dynamics operating within maternity care spaces in Canada?, 82 first-person written accounts of experiences of facility-based disrespect and abuse during childbirth, in the form of anonymous submissions to an online blog, were analyzed using discourse analysis. Clauses were assigned into coding categories which were then examined for patterns and themes that

illustrated the discourses that shaped birthing experiences as well as the interpersonal, institutional, and structural power dynamics that operate in maternity care spaces.

The analysis provided three major themes pertaining to experiences of disrespect and abuse during childbirth, each with several subthemes. The first major theme was 'feelings and emotions of disrespect and abuse.' This theme involved feelings and emotions that birthing individuals experienced when facing disrespect and abuse in facility-based childbirth. The subthemes within this theme were feeling ignored or dismissed; feeling punished; feeling burdensome; feelings of shame and failure; feeling pressured; and feeling uninformed. The second major theme was 'provoking the birthing body.' This theme relates to the relationship between the birthing individual and their birthing body, and how this relationship is constructed by relations of power. This included the subthemes of the unconsenting body, the violated body, and the disconnected body. The third and final major theme was 'tensions in maternity care spaces.' This theme involves the surrounding circumstances through which power dynamics operate in organizations and institutions where instances of disrespect and abuse during childbirth take place. The subthemes were inadequate communication, lack of compassion, insufficient resources, incompetence, and discrimination and stigma.

These three themes were consistently identified across submissions. The themes and corresponding subthemes highlight how experiences of disrespect and abuse during childbirth are constructed through interpersonal, institutional, and structural relations of power as well as the discourses that shape these relations. Even though the submissions outlining experiences of disrespect and abuse came from birthing individuals across Canada, how they experienced disrespect and abuse during childbirth and the power

relations that shaped those experiences seemed to be consistent and highlighted in each story.

4.1 Theme One: Feelings and Emotions of Disrespect and Abuse

The first major theme was 'feelings and emotions of disrespect and abuse.' This theme included feelings and emotions that manifested in birthing individuals who experienced disrespect and abuse in facility-based childbirth. Such experiences were constructed through power dynamics that operate in maternity care spaces. Such feelings and emotions, which constitute the six subthemes that fall under the major theme of 'feelings and emotions of disrespect and abuse,' including feeling ignored or dismissed; feelings of punishment; feeling burdensome; feelings of shame and failure; feeling pressured; and feeling uninformed. The words and phrases that birthing individual used to describe their experiences of disrespect and abuse during childbirth and how they felt in those moments highlights the discourses that were in play and the power relations that constructed their experiences. The following subsections address each subtheme.

4.1.1 Feeling Ignored or Dismissed

The first sub-theme under the theme of 'experiencing and feelings and emotions of disrespect and abuse' was feeling ignored or dismissed. This sub-theme occurred where birthing individuals felt that their wishes were ignored or dismissed by health care providers:

> *"I was given oxytocin despite making it very clear in my birthing plan that I wanted a natural birth"* (C's story).
>
> *"I was very uncomfortable with the idea of being on an IV and my opinions did not matter"* (Mom now's story).

Wishes other than a drug-free birth – for example, wishes involving support persons and birthing positions – were also ignored:

> *"I didn't want my Mother OR step mother in the room during labor however it was decided for me by a nurse that they would both accompany me during pushing for "support""* (C's story)
>
> *"My request for intermittent monitoring was laughed at and denied"* (AM's story)
>
> *"I wanted to be on my side or squatting and was denied that"* (AM's story).
>
> *"My husband wants to get formula, because he doesn't think I should be breastfeeding in my state, we were told no, because it's the easy way out. Once again, our concerns were dismissed, I felt put down and ignored" (T's story)*

These retellings of being ignored or dismissed highlight how a medical discourse that emphasizes physicians and other health care providers as "experts" influences experiences of disrespect and abuse during childbirth. More specifically, medical discourse upholds the authority of medical professionals by positioning health care providers as authority figures and normalizing medicated births and interventions. These stories demonstrate how wishes that did not align with a medical model of childbirth – for example, where birthing individuals desired a birth without intervention – were ignored, influencing experiences of disrespect and abuse in the childbirth process.

Feeling ignored or dismissed was also present when birthing individuals were not believed by health care providers:

> *"They weren't taking me seriously. They told me there was no way I was feeling it, that it was all in my head"* (Pigion's story).

"While I was having an epidural I told the anesthesiologist that it was painful. I was told that I was experiencing pressure not pain. An insanely dismissive and inaccurate comment" (VB's story).

"I wanted to discuss the pains I was having as it was becoming unbearable. He immediately said, "There's no way you're in preterm labour." and walked out of the room. Not once did he examine me in any sort of way, or even let me explain the type of pains I was having" (Hilary's story).

Health care providers not believing birthing individuals is consistent with a dominating medical discourse insofar as it illustrates the pervasiveness of the view that health care providers are the ultimate source of knowledge on matters of labour and birth. Moreover, when birthing individuals are not believed, their agency in their own childbirth is diminished since health care providers, as "gatekeepers" to technology and knowledge, prevent them from accessing the knowledge they need to properly act out their agency. Birthing individuals not being believed by health care providers is consistent with other research in high-resource settings that has identified the disregard of embodied knowledge as a theme that influences women's experience of trauma during birth (Reed et al., 2017).

Similar to not being believed is birthing individuals feeling ignored or dismissed by way of being made to feel belittled, i.e. "stupid," "crazy," or "little." This was also a prevalent occurrence in the retelling of experiences of disrespect and abuse during childbirth:

"The doctor always made me feel stupid and was terribly condescending… Clearly my OB had his concerns but instead of talking to me and making me

understand her reasonings she made me feel like it was her way or no way and that I was stupid" (K's story)

"Yet my nurse brushed me off and made me feel like I was crazy… I'll never forget feeling so useless, stupid and unfit" (Morgan's story)

"At the hospital, I felt like I was made to feel little, like I couldn't possibly know what's right for me" (Nicole's story)

These retellings are also consistent with a dominating medical discourse in that they illustrate a power dynamic in which birthing individuals' knowledge of their own bodies is refused by health care providers. In this way, through a prevailing medical discourse, birthing individuals are denied agency over their own births.

The retellings also illustrate a discourse of women as dependent and inferior, specifically with respect to the knowledge they possess about their needs. Their perceived lack of understanding about what is happening to their bodies illustrates a discourse wherein birthing individuals are deemed incapable of making decisions (Sánchez, 2014) and cannot be trusted to exercise control or agency over their bodies (Borges, 2017).

In a similar vein, being treated "like a child" was an experience that was regularly iterated within stories that expressed feelings of being ignored or dismissed. Throughout the submissions, the treatment that individuals in birth received was often compared with being treated like a child or infant:

"…the doctors continuously rolled their eyes at each other as if my concerns weren't valid. Like I was just being a baby." (Twin mom's story)

"With no comrades, my protests seemed petty and argumentative. As if they were patting me on the head like a child." (LM's story)

"The anesthesiologist was very rude and spoke to me like he was disciplining a child instead of talking to a traumatized person in pain." (NH's story)

"The whole experience was unempowering and made me feel like a child rather than a woman doing an amazingly strong and powerful thing." (Jolinda's story)

"The nurse was very annoyed and impatient because it was excruciatingly painful and it took me forever to release my urine. I felt like a child." (AC's story)

A simile is a rhetorical figure that involves the comparison of one thing with another. Similes are rhetorical devices that conjure up relationships which serve to legitimize certain kinds of power dynamics by equating one thing with another; here, by equating a birthing woman with a child.

This simile – the birthing individual as 'like a child' – frames the meaning of the birthing individuals' statements by way of common social meanings and values within a particular culture and historical period. Infantilization refers to the treatment of someone who is not a child as though they are a child – for example, by treating them like they cannot made decisions on their own – a phenomenon that has been noted in the context of women, patients, and birthing individuals. The infantilization of women has been described as the "phenomenon by which our society systematically equates femininity with things like vulnerability, submission, uncertainty, and childhood" (Jhally, 2009). As well, the notion of female patients being infantilized by doctors has dominated discourse throughout history (Haynes, 2017). Pregnant women specifically are infantilized through the way that they are positioned in relation to health care providers (Rúdólfsdóttir, 2000). As Sánchez (2014) has stated, women are "treated as infants when they are not recognized as subjects capable of making decisions about their health nor understanding

what is happening in their bodies" (p. 60). The discourse of infantilization legitimizes a power dynamic whereby health care providers have power to control the essence of the birthing experience.

4.1.2 Feelings of Punishment

Another sub-theme under the theme of 'feelings and emotions of disrespect and abuse' was feelings of punishment. This sub-theme occurred where birthing individuals felt that they were being punished by medical staff. In describing their experiences, it was common for birthing individuals to borrow language from a discourse of criminal law, for example, by using words like "criminal," "trial," and "interrogate":

"I felt like I was being punished for choosing to birth without pain medication" (submitted anonymously)

"…it was incredibly disheartening to be treated like a criminal for giving birth" (Jen's story)

"I was monitored by nurses constantly, they would often walk away with my baby without explaining why. I was treated like a criminal!" (JJ's story)

"I was never allowed to be alone with my kids, CAS interviewed all my friends and family, it was like a trial" (JJ's story)

"She continued to ask me very personal, very prying questions and made me feel as though I was on trial; that there would be consequences if I didn't answer her questions or if I didn't answer in the "right" way. Her manner felt impeding, pressuring, and interrogative and made me feel very scared" (AB's story)

Rather than law in a strictly institutional sense, law can be understood as a structure that shapes experiences of disrespect and abuse during childbirth. That is,

vocabulary and concepts of criminal law appeared in the way birthing individuals wrote about and described their experiences. Their word choice framed the meaning of their statements *vis-à-vis* a common understanding of meanings and values surrounding criminalization within this particular cultural and historical period. That is, women who engage in criminalized activity are perceived and understood as deviant for both breaking the law and transgressing the invisible confines of femininity (Fiander, 2016). It was this common understanding of criminalization as deviance that birthing individuals alluded to when describing their experiences, underscoring a power dynamic that frames birthing individuals as powerless criminals, and medical staff as all-powerful police (see Peckover & Aston, 2018, for a feminist post-structural perspective on the surveillance of mothers).

4.1.3 Feeling Burdensome

The next sub-theme under the theme of 'feelings and emotions of disrespect and abuse' was feeling like a burden. It was common for birthing individuals to relay feelings of being a burden, an inconvenience, a hindrance, an annoyance, or a waste of time in their submissions:

> *"I asked to be checked and it was like I was a burden to the doctor"* (Pigion's story)
>
> *"I am saddened that I was made to feel like an inconvenience"* (A's story)
>
> *"I was made to feel like I was inconveniencing everyone there, and that my presence was a hindrance"* (Jacqueline's story)
>
> *"The one doctor I dealt with was very intimidating and made me feel like I was a waste of her time"* (K's story)

"Throughout the birth, I was made to feel like I was an annoyance to the doctor whenever I asked a question, and that wanting the right to question (even just to find out so I was prepared) what was being done to my own body was unreasonable and exasperating" (M's story)

"A shot of morphine was administered and I felt like I couldn't breathe. I was gasping for air. She looked annoyed, ignored my concerns and told me to suck on a candy" (KM's story)

"I didn't want to burden the nurse anymore after the ways she was making me feel. So I just went with it, I didn't feel in control of my labour at that point" (Sierra's story)

The medical model of childbirth prioritizes doctors' interest in efficiency, control, and convenience (Abrams, 2012; Wood, 2018). In this way, medical discourse plays a significant role in the way birthing individuals are treated and the power that is exerted over them, which can result in birthing individuals feeling like a burden to medical staff. As well, under-resourced health systems have been cited as a stressor that influences provider behaviours (Sen, Reddy, & Iyer, 2018). Under-resourced systems can therefore be understood as an institutional influencer of birthing individuals' experiences of disrespect and abuse during childbirth insofar as this influences the way providers treat and regard their patients, for instance, by treating them as a burden.

It was also prevalent for birthing individuals to feel burdensome with respect to the level of noise they were making throughout the childbirth process:

"…during pushing I was told repeatedly that I needed to "be quiet" or "keep it the hell down" as there were other mothers on the ward who were sleeping" (C's story)

"He looked at me and said "There's no need for you to make so much noise, you can just breathe through this"" (G's story)

"I was told not to moan or "yell". I wasn't even swearing, just a nice cow-like moan. The nurse told me I was scaring and stressing everyone out as if they were the ones in labour" (Y's story)

"I was still crying - he got verbally and visibly frustrated and told me to be quiet because he couldn't concentrate on what he was doing if I was making all that noise" (Terri's story)

"During this period of time the head nurse was screaming at me to stop yelling and crying (while I was delivering the baby). She was unbelievably rude and could be heard by family waiting in the vistors area" (Ana's story)

Prevailing norms about femininity influence medical staffs' perceptions of a female laboring body. As Cohen Shabot (2016) argues, a laboring body that is noisy and exuberant threatens the essence of femininity. In this way, dominating discourses about femininity place the birthing body as "anti-feminine." To approach childbirth through a stereotypically 'feminine' docile and silent body, Cohen Shabot argues, is to avoid the domestication of the body through violence. But where a birthing body does not fulfil this stereotype, it needs to be "put in its place" (p. 244) through violence from medical staff. In this way, dominating discourse about femininity shapes the birthing experience by influencing relations of power between the "anti-feminine" birthing individual and the

medical staff that use violence to remind the birthing body of its "inherent passivity" (Cohen Shabot, 2016, p. 244).

4.1.4 Feelings of Shame

Another sub-theme under the theme of 'feelings and emotions of disrespect and abuse' was feelings of shame and failure. Several stories recounted feelings of shame with respect to undergoing intervention when it was not part of the original birth plan:

> *"I hadn't felt prepared for a c-section, mentally or emotionally, and I felt ashamed that I had not actually "given birth" to my child"* (EP's story)
>
> *"I just felt like a complete failure, not only did I not dilate and have an emergency surgery…"* (LB's story)
>
> *"For several months afterward I felt I was less of a woman, I didn't give birth - my baby was taken out of me. I felt like I set myself up for failure writing that birth plan and allowing the first intervention"* (Holly's story)

These experiences reflect a prevailing social norm of motherhood as sacrifice. As Lowe (2016) points out, "natural" childbirth – which emphasizes the avoidance of intervention – understands pain as a kind of rite of passage which is necessary to prove oneself as a good and responsible mother. This discourse of good and responsible motherhood shapes birthing individuals' experiences of disrespect and abuse during childbirth by reinforcing the notion that "good" mothers subordinate their bodies and any desire for pain management or intervention to the needs of their children.

Interestingly, notions of sacrifice as integral to good and responsible motherhood also reinforces the opposite conclusion with respect to pain. That is, while "natural" childbirth (i.e. free from intervention) places birthing individuals as good mothers for

experiencing pain and therefore proving themselves as good mothers, medicalized childbirth (i.e. one with intervention and surveillance) places birthing individuals as good mothers for prioritizing the health of their fetus and sacrificing any desire for a particular birthing method (Lowe, 2016). This latter notion was reflected in submissions, with birthing individuals feeling shame for being in pain:

> *"The 5 hours was spent cramping with a nurse who belittled my medication-free choices and made me feel like I was weak for feeling pain at all"* (KM's story)
>
> *"She made me feel like I was the biggest wimp because I wanted not to be in pain anymore"* (Sammy's story)

These retellings reflect how a dominating discourse about motherhood, specifically one that is centered on notions of self-sacrifice, shapes the birthing experience by affecting how birthing individuals view themselves and their birthing process, and also by influencing medical staffs' perceptions of the laboring body.

Feelings of shame and failure were also present through experiences where birthing individuals were made to feel like they were unfit mothers or like they failed as mothers:

> *"I felt at the time if I didn't do what I was told that I would be deemed unfit as I was questioning the doctors"* (C's story)
>
> *"They made me feel like an idiot and like I wasn't fit to be a mother"* (Morgan's story)
>
> *"I felt like a failure as a new mom, that my daughter was crying and I didn't know how to soothe her"* (Kiwi's story)

These stories reflect relations of power between the birthing individual and the medical facility in which she gave birth. Such relations are shaped by medical discourse that prioritize the knowledge of physicians and health care providers over the knowledge of birthing individuals. Such relations are further shaped by discourse about gender motherhood, specifically the notion that women's primary duty is to be a mother and that this is an essential aspect of womanhood (Sánchez, 2014).

4.1.5 Feeling Pressured

Another sub-theme under the theme of 'feelings and emotions of disrespect and abuse' was feeling pressured. Experiences often included being pressured into an epidural, which is a way to deliver an anesthetic so as to reduce pain:

> *"My nurse on duty was pressuring me to have an epidural even though I did not want one"* (Mom now's story)
>
> *"As soon as I got there I was pushed into having an epidural. I felt like that was what everyone wanted so I did it"* (Pigion's story)
>
> *"The nurse kept trying to push the epidural on me which I had to refuse several times. I'm not sure whether it was because they believed that it would be the best way to deliver or they just wanted to keep me in the bed and control my labour"* (AC's story)
>
> *"4cm in they said it's really busy that night they suggest if I wanted the epidural to take it just in case if that was in the birthing plan"* (A's story)

These experiences reflect a dominating medical discourse, specifically in that they illustrate the primacy and routinization of interventionist measures and reliance of health care providers on these methods. The experiences iterate that through a medical

discourse, birthing women are understood as weak and requiring pain medication (Kukura, 2017).

The experiences also highlight a power dynamic between birthing individuals and health care providers, with providers possessing enough power in the relationship to be able to make birthing individuals feel pressured away from their initial birth plans and wishes. This power dynamic is especially apparent in retellings of experiences of disrespect and abuse during childbirth where the word "bully" was used:

> *"This beginning being constantly pressured to take pain medication, bullied into an epidural based on the fact that my OB prefers it for VBACs"* (AM's story)
>
> *"I gave in and took demerol because I felt bullied into taking it"* (Sally's story)
>
> *"I felt bullied into agreeing to try it against my better judgement"* (VB's story)

The conceptualization of health care providers as "bullies" underscores the relations of power that are present in maternity care spaces. In this way, medical discourse constructs relations of power that shape birthing experiences by shifting power away from the birthing individual and toward the medical staff, giving providers the power to control the experience through the exertion of pressure akin to bullying.

4.1.6 Feeling Uninformed

The final sub-theme under the theme of 'feelings and emotions of disrespect and abuse' was feeling uninformed. Birthing individuals often recounted feeling confused due to a lack of information, explanation, direction, or instruction with respect to their labor:

> *"I was confused by the misinformation and wondered what was actually true"* (Lauren's story)

"I was made to lay flat on my back pushed once with no direction or idea of what to do and a call was made that I was having a C-section" (AM's story)

"I completely broke down crying out of fear and was not given a second opinion or explanation as to why this was happening" (AM's story)

"No one explained anything. I got a new nurse at some point and she and my midwife argued through the rest of my labour. Never once telling me what was going on" (T's story)

"My first pregnancy/childbirth experience was so traumatic because I was not given enough information during childbirth" (Melissa's story)

"The induction wasn't explained very well and we were confused as to what was happening a lot" (T's story)

"I feel like because it was my first baby I was taken advantage of and not given the proper information" (C's story)

These retellings highlight a medical discourse where doctors are situated as the ultimate source of knowledge and authority with respect to childbirth. Wood (2018), in a review of personal narratives of Canadian mothers in the post-war era, posited that because of this power dynamic, doctors tended to restrict the information that was made available to patients. As demonstrated through these modern-day retellings of disrespect and abuse during childbirth in Canada, this practice of restricting information has lingered on. Not giving birthing individuals the appropriate information, explanation, direction, or instruction with respect to their labor is indicative of a power dynamic between providers and birthing individuals that fuels experiences of disrespect and abuse during childbirth.

Not having the appropriate information was not always construed as a negative thing, however. Several birthing women conveyed that despite being uninformed, they nonetheless trusted their health care providers:

> *"I just assumed that listening to what my OB said would be good enough"* (Twin mom's story)
>
> *"I thought it a little strange since I'd only been in labour about 7 hours but trusted that he had my best interests in mind"* (G's story)
>
> *"I trusted him when he told me I was fine"* (Hilary's story)
>
> *"I was young and scared, but I trusted that they knew what they were doing"* (Jesica's story)
>
> *"Understanding that I am not a doctor or a nurse, I can't control how "professionals" do their work, so we trust them"* (Ana's story)

This underlying notion of "trusting" one's health care provider in the absence of information highlights just how pervasive and all-encompassing medical discourse is in shaping experiences of disrespect and abuse during childbirth. More specifically, blind trust is demonstrative of a pervasive medical discourse in maternity care spaces.

4.2 Theme Two: Provoking the Birthing Body

The second major theme was 'provoking the birthing body.' This theme relates to how the relation between the birthing individual and their birthing body is formulated in submissions that recount experiences of disrespect and abuse during childbirth, as well as how such experiences were constructed through relations of power. Three subthemes that fall under the major theme of 'provoking the birthing body' are the unconsenting body, the violated body, and the disconnected body. The words and phrases that birthing

individuals used to describe their bodies in circumstances of disrespect and abuse during childbirth highlights the discourses that formulated their experiences as well as the power relations that were in play. These three subthemes are addressed in each of the following subsections.

4.2.1 The Unconsenting Body

The first sub-theme under the theme of 'provoking the birthing body" was the unconsenting body. A prevalent theme throughout submissions was a lack of consent. This included medical staff failing to obtain consent and patients not being informed before a procedure was performed on their body:

> *"I continue to wonder about the process whereby my birthing body allegedly relinquished its right to consent"* (Keavy's story)
>
> *"I went in for an induction at 42 weeks pregnant, and the obstetrician assigned to me (not my regular OB) was insensitive, brusque and did not obtain my consent to break my water"* (EP's story)
>
> *"Without warning, explanation or CONSENT he had BOTH hands in me "assisting" Twin B"* (Twin mom's story)
>
> *"She "checked me" and found that I was too dilated for either treatment we had discussed and without explanation of any risks or reasons, she announced that she was going to break my water and proceeded to aggressively enter my vagina with an amnio hook. This was not a treatment I had been previously informed about or had given consent to"* (Kerri's story)
>
> *""Help me here!" she yelled at a nurse, who then, without consent (or even informing me), shoved her entire hand into my undialated vagina"* (LM's story)

> *"…but I felt traumatized by having things done to my body without being informed or prepared, and without asking for any sort of consent"* (M's story)
>
> *"I gave no consent for any internals and just assumed that this was a requirement"* (J's story)

The notion of informed consent is assumed to reduce medicalization by assisting birthing individuals with making choices, which in turn, requires physicians and medical staff to relinquish their authority and the power they have over birthing individuals (Malacrida, 2015). However, as these examples demonstrate, informed consent was missing from many narratives, leading to experiences of disrespect and abuse during childbirth.

To challenge the power dynamics that exist in medical discourse with respect to unconsented procedures in facility-based maternity care, birthing individuals drew from concepts of legal rights and duties when retelling their experiences. More specifically, birthing individuals used legal vocabulary to negotiate relations of power. For example, birthing individuals spoke about relinquishing the right to consent and whether or not medical staff fulfilled their legal duties of informing patients and obtaining their consent. In this way, the legal doctrine of informed consent played an important role for experiences of disrespect and abuse during childbirth among birthing individuals. Rather than merely describing their experience, language of informed consent constituted the experience. In this respect, the law serves as a structure that shapes experiences of disrespect and abuse during childbirth. Legal discourse, in this way, acts as a countervailing force to medical discourse with regard to conceptualizations and experiences of consent (or a lack thereof).

4.2.2 The Violated Body

The second sub-theme under the theme of 'provoking the birthing body" was the violated body. Submissions from birthing individuals conveyed feelings of being violated by medical staff, and used language of sexual assault, abuse, and rape to convey their experiences:

> *"From this moment, nurses would regularly come into our room and grab my breasts without asking. I felt violated. This, along with the non-consensual vaginal exam, made me feel sexually assaulted, all by female doctors and nurses"* (Catherine's story)
>
> *"I have been the victim of sexual assault in the past, and even that did not compare to how* [doctor's name] *treated me or how it made me feel"* (SP's story)
>
> *"I felt violated and humiliated by a "health care practitioner" who was entrusted with caring for me during a very stressful time in my pregnancy, and not only was she unsympathetic, but she crossed the line of indecency, essentially raping me with the speculum"* (SP's story)
>
> *"…before I know it, I feel like I'm being raped by this resident as he keeps shoving his hand up my vagina trying to pull the placenta out"* (Nicole's story)
>
> *"I felt betrayed, embarrassed, assaulted, abused, mocked, belittled. I was failed by my medical team. I was robbed of my experience"* (KM's story)

These experiences highlight the discourse and social norms related to female bodies as objects, or put another way, a discourse that conceptualizes female bodies as objects to be interacted with and acted upon. As Cohen Shabot (2016) points out in an analysis of obstetric violence, rape is "the ultimate tool for putting women in their place. It reminds

women of their inherent condition in patriarchy, as objects to be owned instead of subjects to interact with" (p. 244). By equating their birthing experiences with rape, the birthing individuals used rhetoric that frames the meaning of their statements and legitimizes the power dynamic operating within maternity care spaces, namely, one where medical staff exert power and control over obstetric patients.

4.2.3 The Disconnected Body

The final sub-theme under the theme of 'provoking the birthing body' was the disconnected body. Submissions recounted of experiences of birthing individuals feeling disconnected from their bodies during childbirth, amounting to experiences of disrespect and abuse during childbirth:

> *"Yes, my baby was born and survived his birth injuries, but I felt like my body was not mine"* (Tarin's story)
>
> *"I left every appointment feeling like a vessel for my baby. I felt so disconnected from. I did not feel like a women in a changing body, growing a tiny human"* (Mom now's story)
>
> *"At one point I just physically broke. The doctor was literally yanking at what felt like my lifeless body on that table"* (Twin Mom's story)
>
> *"However, I was treated as if I wasn't even present in the room, just a body that needed to be dealt with"* (M's story)
>
> *"I had no inner joy, just empty feelings, like I was a just a vessel, that mom doesn't matter"* (T's story)

These submissions highlight social norms about female bodies as objects, a subset of the medical discourse of childbirth. Objectification refers to the treatment of a person as if

they are an object. This notion encompasses what birthing individuals were experiencing when they felt disconnected from their birthing bodies insofar as their bodies were viewed as a as "sacrificial lamb and a vessel" for the purposes of giving birth to a child (Borges, 2017, p. 839). The experiences highlight a relation of power wherein medical health providers exerted complete control over the bodies of birthing individuals, acting upon them as if they were not "live bodies with desires and particularities" (Cohen Shabot, 2016, p. 244).

To convey the feeling of being disconnected from their bodies, submissions also used the language of being "just a number" to health care providers:

> *"I was just another number billing OHIP"* (Twin Mom's story)
>
> *"My OB's barely knew my name. I felt like just a number and my baby too"* (Katie's story)
>
> *"We shouldn't feel unimportant or like a number/scheduled slot to the doctors delivering our babies"* (C's story)

Framing their experiences in this way speaks to the relations of power that exist between birthing individuals and medical staff, and also legitimizes an understanding of birth as a technological process and the birthing individual as a 'birthing machine,' consistent with both the objectification of the female body and a medical discourse of childbirth.

Similar to describing their experience of being treated as if they were 'just a number,' many submissions from birthing individuals used the simile of being treated like an animal:

> *"I felt I was treated like a number, or livestock or something"* (AD's story)

"I said no and they milked me like a cow and tried to get this little baby I had no attachment with to latch" (Sammy's story)

"I felt disempowered, like an animal that was at their mercy" (Ana's story)

"Obviously what the OB was yelling was more important because he patted my head like a good dog and completely ignored me" (LM's story)

"I downplay things just to get out. I'm terrified to question anything. I feel like a beaten dog" (T's story)

By equating a birthing individual with an animal, the submissions alluded to relationships that serve to legitimize the power dynamics that shaped experiences of disrespect and abuse during childbirth. Animals hold a common social meaning of being less than human, and in this way, the birthing individuals were expressing that they felt dehumanized by medical staff. Being dehumanized in this way is consistent with the objectification of birthing individuals to the extent that animals are also objectified in society. The comments about being treated like "livestock" and "milked like a cow" in particular highlight the birthing individual as being treated like a 'birthing machine,' where medical staff possess the power to control the essence of the birthing experience the same way a farmer might control the experience of farm animals he is breeding.

The theme of being disconnected from the birthing body was also present when birthing individuals were made to feel like their bodies and needs were not a priority to medical staff. More specifically, birthing individuals included in their stories that they felt like the health of their newborns took priority over their own, and that they, as mothers, did not matter:

"I was told, "We're not concerned that you have an infection – we're concerned about it being passed to your son."" (Catherine's story)

"I felt like once you give birth they don't give a crap about you" (T's story)

"That attitude, that I as a mother, don't matter is the prevalent theme I experienced" (T's story)

"They seemed more concerned about me breastfeeding than me being able to walk or go to the bathroom properly" (Tasha's story)

Abrams (2012) posits that the focus in maternity care was on maternal harms up until the 1980s because prior to the advent of fetal monitoring, the fetus was invisible and inaccessible. However, the focus shifted to fetal harms once fetal monitoring technology rose in prominence as it allowed physicians to access the fetal 'patient.' This created new tensions in maternity care. It has been suggested that a focus on fetal harms in modern childbirth still overshadows the birthing individual in maternity care spaces (Abrams, 2012).

This also ties into a broader medical discourse of the objectification of obstetric patients in maternity care. That birthing individuals are made to feel like they do not matter is consistent with the notion of birth as a technological process in which the "desired product is a healthy baby, and the woman as 'birthing machine' is only a secondary consideration" (Davis-Floyd, 2003; Lowe, 2016, p. 142). When the birthing individual's experiences are controlled by a subject that prioritizes the health and needs of a newborn over her own, her experiences are devalued and alienated.

4.3 Theme Three: Tensions in Maternity Care Spaces

The third and final major theme was 'tensions in maternity care spaces.' This theme does not refer to the feelings and emotions of birthing individuals or their relationship with their birthing bodies, as the first and second theme did, respectively. Rather, the third theme involves the surrounding circumstances through which power dynamics operate in organizations and institutions where instances of disrespect and abuse during childbirth take place. The five subthemes that fall under the major theme of 'tensions in maternity care spaces' are inadequate communication; lack of compassion; insufficient resources; incompetence; and discrimination and stigma. The language that birthing individual used to describe their experiences of disrespect and abuse during childbirth within institutions and organizations highlights the relations of power that constructed their experiences as well as the discourses that shaped these relations. The following subsections address each subtheme in turn.

4.3.1 Inadequate Communication

The first sub-theme under the major theme of 'tensions in maternity care spaces' was inadequate communication. This subtheme relates to the experiences of birthing individuals being shaped by the communication that took place with them and around them. For instance, several birthing individuals recounted experiences of medical staff talking around them:

> *"…there was side talk about forceps during labor, there were all sorts of side conversations, one with the nurse wanting the OB and the midwife saying no. Again no conversation with me"* (T's story)

"When I arrived at the hospital, the attending physician entered the room but never addressed me, speaking only to the other medical staff" (Keavy's story)

"They were talking all around me, but not to me and not explaining anything" (Terri's story)

"OB team comes in and talks about me not to me" (JM's story)

These experiences highlight a power dynamic in which the birthing individual is not viewed as an agent in her own care. By ignoring the birthing individual outright, she is removed from the decision-making process about her own body and her agency is diminished. This relation of power is shaped by medical discourse insofar as medical discourse facilitates a power dynamic between patient and physician that is characterized by a depersonalized approach to obstetrics. To the extent that the birthing individual was perceived as not being knowledgeable enough to participate in the conversation, the relation of power was also shaped by a discourse about women as dependent and inferior. The failure to recognize birthing individuals as capable of making decisions by failing to include them in conversations related to their health translates to a distrust on birthing individuals to exercise agency and control (Borges, 2017).

Another way in which experiences of disrespect and abuse during childbirth were constructed through inadequate communication is when communication was poor between medical staff among each other and toward patients and/or their support people:

"Anyways, that night my nurse never wrote anything down so the next nurse had no idea when I last had my needed medication or any of that stuff" (A's story)

"The nurse gave me an internal exam which confirmed the location of the baby. A doctor then gave me the same exam to reconfirm the location of the baby. Then, a

third doctor gave me the same exam yet again, this time without requesting my consent" (Catherin's story)

"My mom had originally been told to wait in the delivering room where we had spent the day, but when she went back, a nurse was packing our stuff. She took my mom to my new room and told her to wait there. They couldn't find her because there had been no communication of this" (KM's story)

These experiences demonstrate how disrespect and abuse during childbirth is reproduced through institutional factors within health systems, more specifically, organizational and institutional pressures. Such pressures can impact efficiency within health institutions, leading obstetric patients to be subject to unnecessary repeat procedures or to have a subpar experience due to administrative errors.

An additional way in which experiences of disrespect and abuse during childbirth were constructed through inadequate communication is when communication between different kinds of health care providers and about different models of birth affect the birthing individual's experience. Several birthing individuals spoke about the perceived hierarchy between doctors, nurses, and midwives or the perceived superiority of hospital rather than home-based births, and how this affected the treatment they received:

"There was a lack of communication between nurses and midwives" (T's story)

"At times, I do wonder whether the fact that I was transferred from a home birth had anything to do with the care that I received. When I woke up from sedation, one nurse told me that I would have to quit shaking or I would not be allowed to hold my baby. She then asked if I was going to come to the hospital the next time I gave birth. Was a bias against home birth a factor at the hospital? Did the doctor

believe me incapable of making good decisions--and therefore not worth consulting about my own body?" (Keavy's story)

"Sometimes, I also wonder why the numerous other medical professionals (nurse, midwife, obstetrics resident) who were in the room when this took place did not say anything. All of them were women, and all of them--except the midwife--were outranked by the attending physician" (Keavy's story)

"I do think that a part of my experience was a result of me being a midwife patient who was transferred to the doctor on call at the hospital when that became necessary. I think there is a dynamic that exists between doctors and midwives that patients can get caught up in, i.e. the doctor feeling a need to assert their authority" (M's story)

"I should also say they spoke in condescending tone to my midwife like this was her fault or she was less than them?" (JM's story)

These narratives speak to the organizational dynamics that operate within health care systems (Sen et al. 2018). That nurses and midwives are perceived as inferior to physicians in the medical hierarchy entails that they lack power within organizational structures. Even within perceived rankings of different kinds of professions, there are additional gendered power imbalances that further complicate power dynamics.

These power dynamics are shaped by medical discourse. Notably, childbirth was overseen by midwives for much of history. This was until medicine shifted from an occupation to a profession in the late 1800s and early 1900s and physicians took over the responsibility, leading to the decline of midwifery in Canada (Abrams, 2012; Wood, 2018). This decline has been attributed, among other factors, to a powerful and organized

medical profession, which used the legislature as a means to constrict midwifery to the point of near elimination (Biggs, 2004; L. Bourgeault, 2006; Mitchinson, 2010; Wood, 2018). This shift of power led to the erasure of women's support systems and the removal of their agency in their childbirth experiences (Abrams, 2012). With midwifery becoming more popular in recent decades (the number of midwives practicing in Canada has grown from 60 in 1994 to around 1700 in 2019 (Wilson, 2019)), power dynamics between doctors, nurses, and midwives continue to flux as medical discourse coexists with other discourses of childbirth. These discourses construct fraught relations of power that shape birthing experiences in Canada.

4.3.2 Lack of Compassion

The second sub-theme under the major theme of 'tensions in maternity care spaces' was lack of compassion. Birthing individuals wrote that a perceived lack of compassion from medical staff influenced their birthing experiences:

> *"They also completely failed to show compassion and understanding"* (VB's story)
>
> *"It is a teaching hospital but some compassion would be nice!"* (A's story)
>
> *"She had no compassion for what we were going through"* (Pigion's story)

The power dynamics that gave rise to a perceived lack of compassion toward birthing individuals from medical staff were constructed by medical discourse. A characteristic of a medicalized model of childbirth is that it facilitates the custom of a depersonalized approach to maternity care (Kukura, 2017), which entails an approach to care that is devoid of compassion. Biases built into medical education and training may also have contributed to a power dynamic which gave rise to a perceived lack of compassion. That

is, it is through internships and residencies were attitudes toward patients are developed and where new health care providers learn to regard patients and each other. Norms and behaviors that enable disrespect and abuse during childbirth are passed on to new providers through training and education, with scientific evidence playing a lesser role in maternity care culture than custom (Kukura, 2017).

4.3.3 Insufficient Resources

The third sub-theme under the major theme of 'tensions in maternity care spaces' was insufficient resources. This includes insufficient levels of staff, not having enough space within facilities, and not having the appropriate supplies to ensure optimal birthing experiences. Experiences of disrespect and abuse during childbirth that involve insufficient resources are shaped through relations of power, particularly institutional power dynamics. Institutional dimensions of disrespect and abuse during childbirth involve the institutional imperatives that are present in modern medical facilities; policies and practices that exist within particular institutions; and institutional cultures through which patients and health care providers interact amongst themselves and with each other. Institutional conditions, and the hierarchies and conventions within them, contribute to a culture that tolerates and enables disrespect and abuse during childbirth by rationalizing and normalizing such instances.

A prevalent subtheme across stories involved staff within institutions, particularly staff shortages within hospitals:

> *"They told me they were under staffed and to come back around 11am"* (LB's story)

"Without even giving my body a chance to try anything they hooked me up to pitocin to start induction. Again due to them being under staffed they wanted a faster delivery" (LB's story)

"That particular night they were pretty busy. I was told I should wait a couple days and come back" (A's story)

"Upon my husband's arrival, he cleaned up my spilled blood" (Lauren's story)

"The nursing staff started telling us they could not find anyone to break my water. The unit was very busy we were told and it was like a baby factory" (K's story)

"I had a male doctor. I am extremely uncomfortable with men assisting in medical procedures" (T's story)

"…the nurse who convinced me (at 9pm) that I NEEDED to get an epidural because the anesthesiologist was leaving shortly and he probably would not be coming back" (AD's story)

"Finally a student doctor came in to do my epidural, I wasn't comfortable with that idea but they insisted he do it because the real doctor was "busy with other patients"" (Sierra's story)

These stories reflect experiences within hospital facilities where a lack of staff contributed to experiences of disrespect and abuse during childbirth. Economic pressures that restrain maternity care services—for example, staff shortages—relate to the care that birthing individuals receive by governing the conditions in which birth occurs. In several instances, birthing individuals had to have their births and associated procedures hastened or delayed because of the unavailability of appropriate staff. There were also birthing individuals who did not feel comfortable having procedures conducted by students or

male physicians, however a shortage in appropriate staff meant that their preferences could not be accommodated. These experiences were constructed through institutional relations of power related to economic pressures insofar as hospital budgets place limits on how much staff a facility can sustain, however interpersonal power dynamics may also be at play insofar as under-resourced health systems have been cited as a stressor that influences provider behavior toward patients (Sen, Reddy, & Iyer, 2018). These relations are shaped by discourses about economic pressure within hospitals and across health systems more broadly.

Another theme across stories involved space within facilities. More specifically, several birthing individuals indicated that a lack of availability of operating rooms (ORs), maternity wards, and private rooms, as well as quiet physical spaces, contributed to their experiences of disrespect and abuse during childbirth:

> *"I was in the waiting room for over 7 hours before being admitted as they maternity ward was full"* (Twin Mom's story)
>
> *"I fought the urges to push for almost an hour before they rolled me into the OR"* (Twin Mom's story)
>
> *"I'm guessing they never had an OR available - they were really busy"* (Jennifer's story)
>
> *"I couldn't get a private room at the time and had them move three different people in and out of my two-bed room 'til I got my private room"* (Jennifer's story)

"…and I had to be in a shared room because the hospital was so busy - so I lost my bladder in front of another family who was staying in same space as us" (K's story)

"…every time she was asleep and we would try to sleep, someone was coming in the room to do some test, doors were slamming in the hall, people were talking in the hall, there was ALWAYS noise" (Kiwi's story)

These examples illustrate how institution-level pressures that restrain maternity care services can influence the care that birthing individuals receive, and in turn, impact their experience. More specifically, institutional pressures such as fiscal concerns or issues related to facility or land space govern the conditions in which birth occurs. These experiences of disrespect and abuse during childbirth were constructed through relations of power related to institutional factors, and those relations are shaped by discourses about institutional policies and practices.

An additional theme that was present across stories with respect to insufficient resources involved insufficient or inadequate supplies:

"My waters kept breaking and I was given only one heavy flow maxi pad and one adult diaper (or mesh undies I can't remember which). I was leaking all over and felt like I had peed my pants. But I was told I would only be provided with one maxi pad" (Mom now's story)

"At one point I had bled through an entire pair of their maternity underwear - I'm talking no white left on them - and I sat in a puddle of my own blood. When I asked if I could have another pair to clean up, she told me I could go rinse mine in the sink and put them back on" (KT's story)

"…a broken bed, elevated to the max - despite requests for the bed to be swapped, no one cared to do it over three days" (T's story)

"I was given only one Jello a day. This was my 9 p.m. treat. That is all I ate all week long, one Jello a day, except for the attached IV" (Catherine's story)

These experiences illustrate instances in which a lack of appropriate materials and supplies contributed to experiences of disrespect and abuse during childbirth. Institution-level pressures – for example, economic pressures that impact the quantity of a particular type of supply a hospital can afford – can play a significant role in the conditions in which individuals experience the childbirth process. Experiences of disrespect and abuse during childbirth in this respect were constructed through institutional relations of power related to economic or other institutional-level pressures. These relations are shaped by discourses about economic pressure within hospitals and across health systems more broadly.

4.3.4 Incompetence

The fourth sub-theme under the major theme of 'tensions in maternity care spaces' was incompetence of medical staff. Several experiences of disrespect and abuse during childbirth involved birthing individuals perceiving medical staff as being incompetent. Such experiences included:

"She verbalized her hesitancy and difficultly with administering the needle" (Lauren's story)

"My catheter was left in for too long because they "forgot"" (AM's story)

"Every single nurse except for one, read my drug test WRONG" (Lysa's story)

> *"I asked the doctor who delivered my baby to get more information about what that doctor was talking about. When that doctor came back she told me that the other doctor had me mixed up with another patient. I can understand that we're all human and make mistakes but to give me attitude and make me full of anxiety over her mistake was uncalled for"* (K's story)
>
> *"Turns out when I was given the epidural, no one had put in a catheter, so that whole 10 hours my bladder was huge and that was the pain I'd been feeling!"* (Anna's story)

Perceived incompetence of medical staff has been identified in prior research as a facility related issue that influences experiences of disrespect and abuse during childbirth (Gebremichael et al., 2018). In these stories, birthing individuals contributed the incompetence of medical staff to their experiences of disrespect and abuse during childbirth. More specifically, administering medication incorrectly, reading tests wrong, and mixing up patients were each attributed to negative experiences.

Such experiences are constructed through institutional power relations, for example the institutional imperatives that are present in modern medical facilities and the policies and practices that exist within particular institutions. Sen et al. (2018), for instance, argue that the structures of medical education and training, as an institutional factor, enable new doctors to learn whether and how to "cut corners" with respect to adherence to protocols, standards, and guidelines. In this way, institutional conditions such as education and training contribute to a culture that tolerates and enables disrespect and abuse during childbirth by way of rationalizing and normalizing conduct of medical staff that is perceived as incompetent by birthing individuals and other patients.

4.3.5 Discrimination and Stigma

The fifth and final sub-theme under the major theme of 'tensions in maternity care spaces' was discrimination and stigma. Discrimination at the organizational or institutional level constitutes a surrounding circumstance, enabled by imbalanced power dynamics, that influences or shapes experiences of disrespect and abuse during childbirth. It has been noted that power dynamics in healthcare settings reflect entrenched biases based on characteristics such as gender, class, race, ethnicity, and other sources of marginalization that influence how birthing individuals are treated by providers, which results in differential care for certain groups (Sen, Reddy, Iyer, et al., 2018). Indeed, perceptions, expectations, and experiences of discrimination influence experiences of disrespect and abuse during childbirth.

Discrimination was a prevalent subtheme across stories. The most common characteristic that appeared in the retellings of birthing individuals experiencing discrimination was their age. More specifically, birthing individuals who were young often perceived experiences of discrimination based on their age:

> *"The staff at CK make new and young moms feel ostracized and they take authority in making decisions they have absolutely no right making"* (C's story)
>
> *"I cry every time I think about my experience and how I was treated less-than because I am a young mom."* (Y's story)
>
> *"Being a pregnant teen, I was completely stereotyped as someone who would continue to pump out babies because I didn't know any better (like I was some dumb young girl - I was an A student!), and disrespected by medical staff"* (Terri's story)

"So I believe the nurses felt I was too young and treated me horribly because of it" (Jas's story)

"I feel like I wasn't taken seriously because of my age, the fact that I'm a young single mom who was having her first baby, and that I was alone without a partner while I was in labour" (K's story)

"AFTER she was born the nurses continued to treat me like a teen mom..which in itself is horrifying because I would say that if a young mom was having a baby they should be treated with extra love and support not the opposite." (AD's story)

These stories illustrate that among several birthing individuals who experienced disrespect and abuse during childbirth, discrimination on the basis of age constituted a surrounding institutional or organizational circumstance that influenced or shaped the experience. Moreover, discrimination on the basis of age occurs through a relation of power that is shaped by an overarching discourse of infantilization: birthing individuals are infantilized in the way that they are positioned in relation to health care providers when they are not acknowledged as capable of decision-making (Rúdólfsdóttir, 2000; Sánchez, 2014). In this way, discrimination on the basis of age in the context of facility-based childbirth is enabled and normalized by relations of power and a discourse of infantilization.

Another characteristic by which birthing individuals perceived discrimination and stigma against them was weight. That is, several birthing individuals perceived discrimination against them on the basis of weight:

"The nurse was abrasive and seemed quite passive aggressive about my weight gain" (Mom Now's story)

"We were constantly dismissed as "just morning sickness" and on my medical records it was marked that I was obese and not active but no one ever weighed me or asked what my activity level was" (Jen's Story)

"They also made a lot of assumptions about me based on my weight" (Jen's story)

"I was scared into being induced because they said I was "overweight" and that my baby would be too big for me to birth naturally." (A's story)

This is consistent with prior research that has demonstrated that birthing individuals who are labelled as obese experience stigma in reproductive contexts in Canada (Bombak et al., 2016). Critical fat and obesity scholars have argued that obesity is in part a socially constructed category that is discursive, and therefore connected to relations of power and the reproduction of power through the stigmatization of larger people (Lupton, 2013; See also Sim, 2017). More specifically, a discourse of "risk" is deployed as a technology of surveillance to constrain birthing individuals' bodies, such that birthing individuals are made to feel that their weight puts their fetus of pregnancy at risk (Bombak et al., 2016). Risk discourse is closely connected to a dominating discourse about motherhood that is centered on notions of self-sacrifice, which shapes the birthing experience by affecting how birthing individuals view themselves and their birthing process, and also by influencing medical staffs' perceptions of the laboring body.

Race, sexual orientation, and gender identity were final characteristic by which birthing individuals perceived discrimination and stigma against them, although the language used by birthing individual to describe experiences of discrimination and stigma pointed to race, sexual orientation, and gender identity with less frequency than discrimination on the basis of age or weight:

"My name is AB and I identify as a queer woman of colour" (AB's story)

"I feel it may have had to do with my race, but I cannot really be sure." (HJL's story)

This is consistent with prior research that has demonstrated that women of colour experience disrespect and abuse during childbirth at higher rates. For example, in Vedam, Stoll, Taiwo, et al.'s (2019) online cross-sectional study of American women, rates of mistreatment were higher for women of colour.

CHAPTER 5: DISCUSSION

In this study, FPS and discourse analysis served as the lens through which the following research questions were explored: (1) How are experiences of disrespect and abuse during facility-based childbirth constructed through relations of power, and what discourses are used to shape these relations? and (2) What do these experiences reveal about the interpersonal, institutional, and structural power dynamics operating within maternity care spaces in Canada? Through FPS and discourse analysis, experiences of disrespect and abuse during childbirth—which were recounted through written submissions to an anonymous blog—were deconstructed and reconstructed so as to expose the meanings, assumptions, and biases that underlie the relations of power that constructed such experiences. In discourse analysis, texts are read as a means to discerning the "social relations, identities, knowledge and power" that the texts construct (Crowe, 2005, p. 55) as well as the social norms and identities that are created and maintained. To this end, submissions recounting experiences of disrespect and abuse during childbirth were broken down into clauses, which were separated from their original context and assigned codes. From there, codes were examined for patterns as the data was reintegrated around central themes. Three major themes emerged from the analysis: 'feelings and emotions of disrespect and abuse'; 'provoking the birthing body'; and 'tensions in maternity care spaces.'

The goal of the study was not to reveal any "truths" about disrespect and abuse during childbirth, but rather, to generate understandings of the phenomenon that are historically, socially, and culturally specific, and further, to challenge familiar assumptions and values in discourses through which power relations are exercised. As

FPS holds that discourse is not fixed (Weedon, 1987), birthing individuals' subjective experiences of disrespect and abuse during childbirth can be mitigated or prevented as power relations that operate within oppressive meanings and knowledge are disrupted and negotiated. That is, wherever dominant power is exercised and producing knowledge and discourse, resistance as a form of power can exist (Foucault, 1977; MacDougall, 2020). This section discusses the dominating discourses that shape power dynamics in maternity care settings which construct experiences of abuse and disrespect. The section then goes on to discuss what these experiences reveal about interpersonal, institutional, and structural power dynamics operating within maternity care spaces.

5.1 Dominating Discourses

Post-structural theory posits that language is located in discourse, which is defined as a structuring principle that both constitutes and is reproduced through interrelated systems of social meanings and values. Over time, certain discourses become dominant over others as meanings shift (Weedon, 1987). This subsection discusses the dominating discourses that, through a discourse analysis of the data, were revealed to shape experiences of abuse and disrespect during childbirth: medical discourse, which was deeply prevalent across all themes; legal discourses of punishment, criminal identity, sexual assault, and informed consent, which was unevenly represented across themes; and patriarchal and gendered discourses of objectification, infantilization, and sacrificial motherhood.

5.1.1 Medical Discourse

Medical discourse was a prominent across all themes much more deeply than the other identified dominating discourses. Medical discourse is characterized by an

emphasis on physicians and other health care providers as "experts" as well as doctors' interest in efficiency, routine, and convenience. In this way, medical discourse upholds the authority of medical professionals as the ultimate source of knowledge while normalizing intervention in medicated births.

The first theme, "feelings and emotions of disrespect and abuse", involved the feelings that birthing individuals experienced when facing disrespect and abuse during childbirth. An analysis of words and phrases that birthing individuals used to describe their experiences highlighted that medical discourse played a major role in shaping the power relations that constructed their experiences. More specifically, retellings were rooted within a dominating medical discourse insofar as they illustrated a power dynamic in which birthing individuals' knowledge of their own bodies was refused by health care provider; for example, "*They weren't taking me seriously. They told me there was no way I was feeling it, that it was all in my head*." In this way, through a prevailing medical discourse, birthing individuals were denied agency over their own births.

Within this first theme, medical discourse constructed experiences of feeling dismissed or ignored insofar as such experiences were shaped by a power dynamic wherein physicians and other health care providers positioned themselves as experts and authority figures relative to their obstetric patients. Medical discourse was also dominant where birthing individuals were not believed by medical staff, were made to feel like a burden or an inconvenience, or felt uninformed and confused. In these experiences, health care providers positioned themselves as the ultimate source of knowledge on matters of labour and birth, whereas birthing individuals were removed as agents in their own childbirth experience. The experiences also underscore a medical discourse where

doctors' interest in efficiency, control and convenience is prioritized, sometimes to the extreme of restricting the information that is provided to birthing individuals: "*I was made to lay flat on my back pushed once with no direction or idea of what to do and a call was made that I was having a C-section."* That many submissions indicated that birthing individuals exhibited blind trust toward their health care providers also demonstrates the pervasiveness of medical discourse in maternity care spaces. Feeling pressured was another recurring experience that was iterated in the submissions of birthing individuals that also reflects a dominating medical discourse since birthing individuals being pressured into accepting intervention illustrates the primacy and routinization of interventionist measures in health care. Birthing individuals also described being made to feel belittled, i.e. "stupid," "crazy," or "little." This also highlights a relation of power shaped by medical discourse such that birthing individuals' knowledge about their own bodies was refused by health care providers.

The second theme, "provoking the birthing body", similarly highlighted that medical discourse plays a major role in shaping the power relations that constructed the experiences of birthing individuals. A discourse of informed consent is assumed to be a countervailing force to medical discourse in that it requires health care providers to relinquish their authority and the power they have over birthing individuals. Despite this, consent was not present in many experiences. Additionally, birthing individuals also recurringly recounted experiences where they felt like their bodies were deprioritized relative to their newborns, and that they, as mothers, did not matter. This ties into a historical analysis of maternity care spaces wherein the focus is on fetal rather than maternal harms. Such accounts also highlight the dominance of medical discourse in

maternity care spaces because birth is constructed as a technological process in which the "desired product is a healthy baby, and the woman as 'birthing machine' is only a secondary consideration" (Davis-Floyd, 2003; Lowe, 2016, p. 142).

In the third and final theme, "tensions in maternity care spaces", medical discourses also played a major role in shaping the power relations that constructed the experiences of birthing individuals. This theme focused on the dynamics that operate within the institutions and organizations where disrespect and abuse during childbirth takes places. Birthing individuals recounted experiences of medical staff talking around them rather than to them about their medical care: "…*there were all sorts of side conversations, one with the nurse wanting the OB and the midwife saying no. Again no conversation with me."* Medical discourse is at play insofar as the birthing individual is removed from the decision-making process. Additionally, communication between medical staff from different roles and models affected birthing individuals' experiences, with the perceived inferiority of nurses and midwives to physicians and of midwifery to facility-based births influencing power dynamics within organizational structures. Medical discourse, which prioritizes medicalized births, was highlighted in such experiences. Many birthing individuals also spoke about the lack of compassion they experienced within facilities, which speaks to a dominant medical discourse insofar as a depersonalized approach to maternity care was facilitated.

5.1.2 Legal Discourses of Punishment, Criminal Identity, Sexual Assault, and Informed Consent

Legal discourses were also prominent, but only across two of the three themes. More specifically, legal discourses of punishment, criminal identity, sexual assault, and informed consent were present in the themes "feelings and emotions of disrespect and

abuse" and "provoking the birthing body". In the third theme, "tensions in maternity care spaces", legal discourses of punishment were not as readily present as in the first two themes. Although "discrimination," a subtheme within the third theme, can be viewed as a legal term, it did not present as a legal concept in the stories of birthing individuals in the way that the concepts of informed consent and sexual assault do.

Within the first theme, "feelings and emotions of disrespect and abuse," birthing individuals recurringly indicated feelings of punishment. That is, discourses of punishment and criminal identity constructed birthing individuals' experiences insofar as they used words like "criminal," "trial," and "interrogate"; for example, "*"I felt like I was being punished for choosing to birth without pain medication"* and *"…it was incredibly disheartening to be treated like a criminal for giving birth."* In this way, legal discourses can be understood to shape relations of power that construct experiences of disrespect and abuse during childbirth.

In the second theme, "provoking the birthing body", legal discourses were even more prevalent. Specifically, legal discourses of informed consent and sexual assault constructed relations of power that shaped experiences of disrespect and abuse during childbirth: "*This, along with the non-consensual vaginal exam, made me feel sexually assaulted…".* Further, a discourse of informed consent was present in instances of medical staff failing to obtain consent or inform patients before performing a procedure. Birthing individuals drew from concepts of legal rights and duties to negotiate relations of power within maternity care spaces, for instance by speaking about the right to consent and the legal duties of informing patients and obtaining consent: *"I continue to wonder about the process whereby my birthing body allegedly relinquished its right to consent."*

A legal discourse of sexual assault was also prevalent. More specifically, when writing about their experiences, birthing individuals used language of sexual assault, abuse, and rape to frame the meaning of their statements and legitimize the relations of power operating within maternity care spaces. Cohen Shabot (2016) has posited that disrespect and abuse during childbirth is best understood by appealing to an analysis of gendered violence rather than general accounts of medical violence precisely because the term *birth rape* has been used by some women to describe their experiences. Indeed, several studies demonstrate that birthing individuals use metaphors of rape to describe experiences of disrespect and abuse during childbirth (e.g. Elmir et al., 2010; Kitzinger, 2006). Notably, legal discourse in this theme functioned in a way that was empowering for birthing individuals insofar as it was taken up by birthing individuals to renegotiate power; that is, legal concepts of "informed consent" and "sexual assault" were used to recognize the problem, and their use are therefore an example of agency.

5.1.3 Patriarchal and Gendered Discourses of Objectification, Infantilization, and Sacrificial Motherhood

Patriarchal discourses were prominent across all themes. More specifically, discourses of objectification, infantilization, and dependence shaped relations of power that constructed experiences of disrespect and abuse during childbirth. In the first theme, "feelings and emotions of disrespect and abuse", the words and phrases used by birthing individuals to talk about their experiences of disrespect and abuse during childbirth and feeling belittled reflected a patriarchal discourse of women as dependent and inferior. More specifically, that birthing individuals were made to feel as if they had a lack of understanding about what is happening to their bodies during childbirth shapes relation of power such that birthing individuals are positioned as being incapable of making

decisions: *"At the hospital, I felt like I was made to feel little, like I couldn't possibly know what's right for me."* Moreover, birthing individuals also used recurring language of being treated "like a child." By using language that equates a birthing person with being a child or infant, a discourse of infantilization shaped relations of power. It has been noted by researchers that birthing individuals are treated like infants when they are not acknowledged as capable of decision-making or understanding with respect to their health and bodies (Sánchez, 2014), and that pregnant women are infantilized in the way that they are positioned in relation to health care providers (Rúdólfsdóttir, 2000). For example, one birthing individual stated *"The anesthesiologist was very rude and spoke to me like he was disciplining a child instead of talking to a traumatized person in pain."* Being made to feel "too loud" was an additional prevalent experience among birthing individuals. A loud and exuberant labouring body threatens the mythical essence of femininity as silent and docile: Cohen Shabot (2016) has posited that disrespect and abuse during childbirth occurs because a birthing body that does not fulfill stereotypes of femininity needs to be "put in its place" through violence (p. 244). A patriarchal discourse of good and responsible motherhood also shaped birthing experiences and corresponding power dynamics. Birthing individuals indicated feelings of shame both for undergoing interventions and for experience pain; these experiences were constructed by social norms relating to motherhood as sacrifice and motherhood as the primary duty of women.

Patriarchal and gendered discourses were also prevalent in the second theme, "provoking the birthing body." For instance, in conceptualizing disrespect and abuse during childbirth as sexual abuse, birthing individuals highlighted a discourse of female

bodies as objects to be interacted with and acted upon. Submissions also included experiences of birthing individuals feeling disconnected from their bodies during childbirth, experiences which similarly drew from a discourse of female bodies as objects. For example, birthing individuals stated "*I felt like my body was not mine*"; "*I was just a vessel*"; and "*what felt like my lifeless body on that table.*" A similar conclusion can be drawn from other instances of feeling disconnected. Several submissions, for example, spoke about experience in terms of being "just a number," a formulation which legitimizes a conceptualization of birth as a technological process and the birthing individual as a 'birthing machine.' Many submissions also likened their experiences to being treated like an animal: "*they milked me like a cow"; "I felt I was treated like… livestock"; "like an animal that was at their mercy."* Equating a birthing individual with an animal is to allude to the common social meaning of animals as being less than human. This is consistent with the objectification of the female body in that it highlights a relation of power wherein medical staff possess the power to control the essence of the birthing individual the same way that a farmer might control the experience of farm animals he is breeding.

Finally, patriarchal and gendered discourses were present in the third and final theme, "tensions in maternity care spaces." Many birthing individuals recounted experiences of medical staff talking around them rather than to them about their medical care: *"OB team comes in and talks about me not to me"* In such experiences, a discourse about women as dependent and inferior is present since the birthing individual was perceived as not being knowledgeable or relevant enough to participate in the conversation. Additionally, experiences involving discrimination on the basis of age

(specifically, being youthful) and weight (being too "heavy") were common, reflecting dominating discourses of infantilization and self-sacrificing motherhood: *"I cry every time I think about my experience and how I was treated less-than because I am a young mom"; "The nurse was abrasive and seemed quite passive aggressive about my weight gain."*

5.2 Power Dynamics

Interpersonal, institutional, and structural dimensions of power are different but interrelated levels of power dynamics through which experiences of abuse during facility-based childbirth are constructed. It is important to note that experiences of disrespect and abuse can be, and most often are, shaped by all three levels. That power operates at all levels is a notion consistent with Foucault's theory of power. The statement *"The anesthesiologist was very rude and spoke to me like he was disciplining a child instead of talking to a traumatized person in pain",* for instance, reflects interpersonal, institutional, and structural power dynamics. It reflects an interpersonal power dynamic insofar as the exchange constituted an interaction that took place between provider and patient. There is also an institutional power dynamic at play: the institutional culture in which the interaction took place was one where the act of disrespect reflects an institutional norm or convention within the facility that normalizes or rationalizes the act. Finally, structural power dynamics are additionally present insofar as such an institutional norm or convention is shaped by the compounding effects of societal factors that relate to the history, culture, and ideology of women as inferior and childlike among and across societies.

By looking carefully at how birthing individuals experience interactions of power–including reactions to social and institutional beliefs, values, and practices–meanings of the interactions as positioned within society and the health institution can be deconstructed. Connecting meaning and power, through reconstruction, speaks to how individuals address power through agency and subject positions. Indeed, the complexity of negotiating relations of power brings meaning and understanding to interactions.

This subsection focuses on what experiences of abuse and disrespect reveal about interpersonal, institutional, and structural power dynamics in maternity care settings. In short, experiences of abuse and disrespect reveal that all three levels of power dynamics–interpersonal, institutional, and structural–operate within maternity spaces in interrelated ways. Further, power dynamics are related to and continually shape, and are shaped by , the dominating discourses discussed above.

5.2.1 Interpersonal Power Dynamics

The interpersonal dimensions of disrespect and abuse during childbirth constitute the interactions or communications that occur between individuals, specifically, between patient and providers (Govender & Penn-Kekana, 2008). Discourse shapes interpersonal power relations. Specifically, medical discourse shapes interpersonal power dynamics which played a significant role in the way birthing individuals were treated by providers. That is, interaction and communication toward patients from providers often led to birthing individuals feeling ignored or dismissed; having feelings of punishment; feeling burdensome; having feelings of shame and failure; feeling pressured; and feeling uninformed because of what the provider said or how they said it; for example, *"I wanted to discuss the pains I was having as it was becoming unbearable. He immediately said,*

"There's no way you're in preterm labour." and walked out of the room." In this interaction, power can be understood by way of the birthing individual's agency and subject position, or where the birthing self is located in the interaction. The participant is challenging the interaction by demonstrating that she wanted to discuss her pains; the comment is a type of recognition of the problem, and therefore an example of agency. Further, power relations are challenged by virtue of the telling of the story on the community story blog.

Legal discourses also shaped interpersonal power dynamics that constructed experiences of disrespect and abuse during childbirth. Specifically, interactions that occurred between patient and providers made birthing individuals feel like they were being punished by providers, for example, "*She continued to ask me very personal, very prying questions and made me feel as though I was on trial."* This underscores an interpersonal power dynamic that frames birthing individuals as powerless criminals, and medical staff as all-powerful police. Another interpersonal power dynamic of disrespect and abuse during childbirth that is shaped by legal discourses is one of the birthing individual as sexual assault victim, and provider as perpetrator, insofar as birthing individuals used language of sexual assault, abuse, and rape to frame the meaning of their interactions with health care providers: "*This, along with the non-consensual vaginal exam, made me feel sexually assaulted".* The comment is again a type of recognition of the problem, which is therefore an example of agency.

Finally, patriarchal and gendered discourses shaped interpersonal power relations between patient and provider. For example, birthing individuals recounted, in their interactions with providers, being treated "like a child" or being told that they were "too

loud", which reflects a patriarchal discourse of infantilization. Interpersonal power dynamics shaped by a gendered and patriarchal discourse of objectification also constructed experiences of birthing individuals as being treated as "just a number" or "like an animal" in their interactions with providers. To frame their interactions this way is to exercise agency by acknowledging the problem.

Recognizing relations of power at the interpersonal level is the first part of identifying power struggles. That is, interpersonal interactions are where tensions and conflicts first manifest. Looking at how individuals experience the interactions of power through interpersonal interactions is part of meaning making between individuals. However, interpersonal power dynamics that shape and are shaped by discourse are not the only power relations that operate in maternity care spaces. Rather, such dynamics operate in interrelated ways with institutional and structural power dynamics as challenges and negotiations of power include reactions to institutional and structural beliefs, values and practices.

5.2.2 Institutional Power Dynamics

Institutional dimensions of disrespect and abuse during childbirth involve the policies and practices that exist within particular institutions. It also includes the institutional cultures through which patients and health care providers interact and negotiate power (Behruzi et al., 2013; Erdman, 2015). Institutional power relations contribute to a culture that tolerates and enables disrespect and abuse during childbirth (Kukura, 2017) via "norms, hierarchies, and conventions through which acts of abuse and disrespect are rationalized, even normalized" (Erdman, 2015).

Medical discourse shapes institutional relations of power that construct experiences of disrespect and abuse during childbirth because the procedures and methods of obstetrics serve the convenience of health care providers. That is, the stories of participants demonstrated how medical discourses were enacted through interactions with health care professionals who "practiced" the institutional beliefs and values that are perpetuated by a medical discourse. Feeling pressured, for example, was a recurring experience that was iterated in the submissions of birthing individuals that reflects a dominating medical discourse since birthing individuals being pressured into accepting intervention illustrates the primacy and routinization of interventionist measures in the institution of healthcare: *"My nurse on duty was pressuring me to have an epidural even though I did not want one."* Birthing individuals also often recounted experiences where they felt like their bodies were deprioritized respective to their newborns, which also reflects procedures and methods of obstetric care, an institutional dimension of disrespect and abuse during childbirth: *"I felt like once you give birth they don't give a crap about you."* Organizational dynamics are also an aspect of institutional relations of power: nurses and midwives being perceived as inferior in the medical hierarchy, and therefore lacking power within organizational structures, shaped birthing individuals' experiences because the communication between medical staff in different roles reflected the perceived inferiority of nurses and midwives to physicians: *"I do think that a part of my experience was a result of me being a midwife patient who was transferred to the doctor on call at the hospital when that became necessary. I think there is a dynamic that exists between doctors and midwives that patients can get caught up in, i.e. the doctor feeling a need to assert their authority"* Finally, economic arrangements and pressures that govern

and restrain labour and delivery services in hospitals constitute an institutional relation of power that shapes childbirth experiences insofar as policies that aim for efficiency have the effect of pressuring health care providers to deliver services in cost-effective but questionable ways or creating unfavourable environments for patients, for example, through insufficient supplies and resources: *"I'm guessing they never had an OR available - they were really busy"*; *"My waters kept breaking and I was given only one heavy flow maxi pad and one adult diaper (or mesh undies I can't remember which). I was leaking all over and felt like I had peed my pants. But I was told I would only be provided with one maxi pad."* Additionally, the experiences of birthing individuals underscored a medical discourse where doctors' interest in efficiency, control and convenience was prioritized, sometimes to the extreme of restricting the information that was provided to birthing individuals.

Legal discourses also shaped institutional relations of power that construct experiences of disrespect and abuse during childbirth insofar as it was common for birthing individuals to recount instances of medical staff failing to obtain consent or inform patients before performing a procedure. This can be construed as an institutional power dynamic insofar as it reflects a norm or convention within institutional culture, namely, providers forgoing the obtaining of consent. The institutional dimensions of disrespect and abuse during childbirth also include the institutional cultures through which power is negotiated between patients and health care providers, and to this end, birthing individuals drew from concepts of legal rights and duties, such as the right to consent and the duty of informing patients, to negotiate relations of power within

maternity care spaces: *"Without warning, explanation or CONSENT he had BOTH hands in me "assisting" Twin B."*

Finally, patriarchal, and gendered discourses also shaped institutional power dynamics that constructed experiences of disrespect and abuse in maternity care settings. Birthing individuals being made to feel as if they had a lack of understanding about what was happening to their bodies during childbirth, an experience shaped by a patriarchal discourse of infantilization, can be construed as being constructed by an institutional power dynamic insofar as it is an element of institutional culture to treat birth as a technological process in which the "desired product is a healthy baby" (Davis-Floyd, 2003; Lowe, 2016, p. 142). Such experiences can also be thought of as being constructed by legal institutions insofar as fear of malpractice may lead some health care providers to practice defensive medicine which can entail the use of unwanted, non-evidence-based, and unconsented interventions (Kukura, 2017).

5.2.3 Structural Power Dynamics

Structural dynamics refer to invisible manifestations of power that are built into the fabric of society, creating and maintaining inequalities through complex political, social, historic, and economic processes (Montesanti & Thurston, 2015; Sadler et al., 2016). Medical discourse shapes structural power dynamics, which in turn construct experiences of abuse and disrespect in maternity care settings. Specifically, the medicalization of childbirth can be construed as a structural dimension of disrespect (Kukura, 2017) and abuse that is shaped and perpetuated by medical discourse. Experiences of birthing individuals who felt uninformed, for instance (*"No one explained anything."*), were constructed by an overarching structural dynamic of the medicalization

of childbirth insofar as participants who struggled against disrespect and abuse recognized its impact, but were unable to voice concerns in the moment. In these moments, a dominating medical discourse was taken up by health care professionals, causing harm and oppression. There was also a common of experience of being disconnected from the birthing body ("*I was treated as if I wasn't even present in the room, just a body that needed to be dealt with")* and inadequate communication within maternity care spaces (*"When I arrived at the hospital, the attending physician entered the room but never addressed me, speaking only to the other medical staff").* That is, the medicalization of childbirth, a structural dynamic made up of the cumulative effects of political, social, historic, and economic processes, constructs such experiences. Beliefs and values are constructed through medical discourse, and medical discourse is perpetuated by people who practice those beliefs and values. Indeed, it is the experiences of people where medical discourse is made visible.

Patriarchal and gendered discourses similarly shape and perpetuate structural power dynamics that influence or impact experiences of disrespect and abuse. For instance, discrimination and stigma are experiences that are shaped by structural power dynamics, specifically, by structural racism, ageism, sexism, etc: *"Being a pregnant teen, I was completely stereotyped as someone who would continue to pump out babies because I didn't know any better (like I was some dumb young girl - I was an A student!), and disrespected by medical staff."* Additionally, certain norms and stereotypes surrounding gender and motherhood also constitute a structural power dynamic that influences experiences of abuse and disrespect; for instance, social norms of motherhood as sacrifice, (Borges, 2017; Sánchez, 2014; Wood, 2018); the birthing body as anti-

feminine (Cohen Shabot, 2016); female bodies as objects (Cohen Shabot, 2016; Kukura, 2017); and women as dependent and inferior (Borges, 2017; Sánchez, 2014) are social norms that have been identified as structural aspects of disrespect and abuse during childbirth that shape, and are shaped by, patriarchal and gendered discourse.

In summary, a discussion of what experiences of abuse and disrespect during childbirth reveal about power dynamics is that all three levels of power dynamics operate within maternity spaces in interrelated ways. Further, interpersonal, institutional, and structural power dynamics shape, and are shaped by, the dominating discourses discussed above.

5.3 Recommendations for Health Administrators

Health administrators seek to "improve health and wellbeing through effective administrative practices" (Dalhousie University School of Health Administration, n.d.). To this end, health administrators work in interprofessional teams within hospitals, universities, think tanks, community organizations, non-profits, governments, and in virtually every nook and cranny of healthcare and health systems. As such, health administrators are in a unique position to emphasize how interpersonal, institutional, and structural dynamics work to shape experiences of disrespect and abuse during facility-based childbirth. Moreover, discourse analysis can be used to understand how language relates to outcomes; to help understand why a particular practice is on a certain trajectory; and to garner support for a proposed policy (Starks & Brown Trinidad, 2007). Many of the implications MacDougall (2020) points out for social work with respect to traumatic birth experiences are also applicable to health administrators with regard to experiences of disrespect and abuse in facility-based childbirth. Guided by those recommendations,

and competencies required from health administrators and other health professionals, informed by the health administrators can combat disrespect and abuse during childbirth.

Health administrators can exemplify anti-oppressive understandings of disrespect and abuse during childbirth in their collaborative work with other professionals, consistent with interprofessional collaboration (Canadian Interprofessional Health Collaborative, 2010). This entails an approach to health care that seeks to disrupt dominant discourses that oppress and marginalize birthing individuals. For instance, health administrators who are knowledgeable about dominating medical discourses that infantilize and objectify birthing individuals can actively disrupt these discourses by discouraging or limiting the use of paternalistic language on informational materials. A major Toronto-based teaching hospital, for instance, has a webpage dedicated to information about labour and delivery that reflects and perpetuates dominating discourses and relations of power:

> "Remaining in control of yourself and your fear is the one major way for you to help your labour along. Let the doctors worry about any abnormalities and, if none have so far been discussed with you, rely on their care for you and your baby. You are there to breathe and cope and push the baby out when the time comes." (Department of Family and Community Medicine and St. Michael's Academic Family Health Team, n.d.)

This passage reflects several dominating discourses and relations of power: "Let the doctor worry about any abnormalities" and "rely on their care for you and your baby" infantilizes birthing individuals by framing them as incapable of decision-making, and "You are there to breathe and cope and push the baby out when the time comes" reflects a discourse of objectification insofar as it positions female bodies as 'birthing machines' with the desired 'product' of a healthy baby. The passage has the effect of devaluing and alienating the experience of the birthing individual insofar as it constructs the labouring

experience as controlled by the doctor. By being knowledgeable about dominant discourses and how they shape birthing experiences, health administrators can challenge the proliferation of prevailing discourses in informational resources, such as webpages.

As well, health administrators can create opportunities to speak with birthing individuals about their wishes and expectations with respect to their birth so that those expectations can be advocated for and considered valid (MacDougall, 2020). Health leaders may also be keen to create an organizational culture that fosters attitudes and norms that are more respectful toward the needs and desires of birthing individuals (Behruzi et al., 2013; Sen, Reddy, & Iyer, 2018). To do this, quotes from this study from those who shared their stories on the community story blog can be used by health administrators to demonstrate how everyday practices can be seen to be disrespectful and abusive. Health care providers must recognize the problem and the relations of power that are oppressive so as to know what *not* to do.

Where health administrators find themselves in more upstream roles in health care finance and policy, reversing the trend that women's health issues are not perceived as a priority by policymakers (Jewkes & Penn-Kekana, 2015) will have a widespread impact for research and investment in maternity services. Indeed, further research is required with respect to larger policies that can influence maternity care spaces and systematically counter disrespect and abuse during childbirth (Sen, Reddy, & Iyer, 2018). Adopting a more patient-centred approach across the board will enable health administrators to better support birthing individuals.

Health administrators who work directly with patients can speak with birthing individuals to ask about their experiences (MacDougall, 2020). Patients who have

experienced disrespect and abuse during childbirth can offer invaluable insights into how these experiences came into fruition, which may combat feelings of blame and shame that were found to be so prevalent in this research. Health administrators are also well positioned to advocate for better treatment of birthing individuals by supporting groups such as *The Obstetric Justice Project* that work to address disrespect and abuse during childbirth in Canada (*The Obstetric Justice Project*, n.d.).

Ultimately, health administrators and other health professionals can, where possible, respond to and criticize dominant discourses in healthcare settings that shape instances of disrespect and abuse during childbirth. The effect of revealing and combatting dominating discourses in the birthing experience is to facilitate the renegotiation of power dynamics within maternity care spaces. FPS purports that discourse is not fixed (Weedon, 1987), and insofar as meanings can shift, the subjective experiences of birthing individuals involving disrespect and abuse during childbirth can be mitigated or prevented.

Notably, this study focused on the dominating discourses that shape power relations which construct experiences of abuse and disrespect in childbirth, and how those discourses are negotiated by individuals during their experiences. Discourses are constructed through beliefs and values which are seen in the practices of individuals, such as health care providers, who take up discourses. That is, individuals take up or reject the social and institutional beliefs and values that are perpetuated through discourses. This opens up possibilities for individuals to use their agency and power. Importantly, positive birthing experiences were not part of the dataset and were not studied. As such, it is beyond the scope of this research to speak to the discourses and relations of power that

construct *positive* experiences. The study demonstrates that identifying and deconstructing certain discourses from childbirth experiences may facilitate the renegotiation of power relations within maternity care spaces, but it does not purport to make claims about which discourses can or ought to become dominant for experiences of disrespect and abuse to become nonexistent, or for all birthing experiences to be positive ones. Nonetheless, as discussed above, direct quotes from this study can be used by health administrators to demonstrate to health care providers how everyday practices can be seen to be disrespectful and abusive, enabling them to recognize the problem so that providers know what *not* to do. Direct quotes can be used to show health providers how they are being disrespectful and abusive, even when it is not intentional or when they are not aware of it, by virtue of their individual practices which are perpetuated by institutional practices and institutional structures (this is referred to by some as "unintentional harm"). Other research, moreover, can be drawn upon to inform such questions of what *to* do: Odero et al (2020), for example, have identified core values that influence the patient-healthcare professional power dynamic.

5.4 Strengths/Limitations of Study and Recommendations for Future Research

A major strength to the study is that it explores disrespect and abuse during childbirth in the Canadian context, an area in which the phenomenon has not yet been extensively researched. Using feminist post-structuralism to analyze the data adds to the richness of the study by describing how issues of power come into play in experiences of disrespect and abuse during childbirth in Canadian maternity care spaces.

There are several limitations of the study. First, a small limitation is that participants could not be interviewed. Despite this, the quotations offer depth,

description, and words that can be analyzed. Additionally, although *The Obstetric Justice Project* collects stories from participants across Canada, it is notable that most stories posted to the blog came from Ontario. This may be due to the fact that the initiative was created in Ontario and has not yet become well known in other jurisdictions, or because Ontario is a province with a very high population relative to other provinces. It is also notable that the dataset used in this research consisted of anonymous submissions made to the community story blog on *The Obstetric Justice Project* website. As such, only those who were aware of the recently created initiative and had access to a computer and the internet are able to submit stories. As well, while many submissions spoke to age as a facet of one's identity, only a few submissions touched on the impact that other planes of identity such as gender, race, and others may have had on experiences of disrespect and abuse during childbirth. This may have limited the diversity of the views obtained. For these reasons, the findings of the study are not necessarily transferable to all stakeholders that work or participate within maternity care spaces.

Further research could expand on these findings by exploring the relations of power that operate in maternity care spaces from the perspectives of health care providers or support people. As well, future research could look to explore experiences of disrespect and abuse during childbirth in settings other than hospitals, or disrespect and abuse during childbirth in other areas of sexual and reproductive healthcare, such as abortion, postpartum care, fertility care, surrogacy, breastfeeding and chestfeeding, accessing contraception, sterilization, gender-affirming reproductive care, pap smears, and others. Additionally, it would be interesting and insightful to see a deeper analysis

into how laws and policies related to reproductive health care directly and indirectly impact disrespect and abuse during childbirth in childbirth (MacDougall, 2020).

CHAPTER 6: CONCLUSION

Even though disrespect and abuse during childbirth is an issue that has received increasing attention from the global reproductive justice community in recent years, there is a gap in the research seeking to explore the phenomenon in the Canadian context. As well, disrespect and abuse has not been studied through a feminist post-structural discourse analysis approach. The present study aimed to address that gap by providing unique insights into the discourses that dominate maternity care spaces in Canada which construct experiences of disrespect and abuse in childbirth, and further, what these experiences reveal about interpersonal, institutional, and structural dimensions of the phenomenon. The research questions asked: (1) How are experiences of disrespect and abuse during facility-based childbirth constructed through relations of power, and what discourses are used to shape these relations? and (2) What do these experiences reveal about the interpersonal, institutional, and structural power dynamics operating within maternity care spaces in Canada?

The literature reveals that disrespect and abuse during childbirth is happening in Canada; however, its precise frequency and magnitude are not known. This is because disrespect and abuse during childbirth is challenging to measure empirically, and further, there are varying definitions and typologies that are utilized by researchers to describe the phenomenon. 'Obstetric violence', 'disrespect and abuse during childbirth', 'mistreatment during childbirth', and 'respectful maternity care' are the most prominent typologies used in the literature, each drawing from different epistemologies and discourses. Language of disrespect and abuse was deemed most appropriate for the

present research insofar as this typology lends itself well to explorations of discourse and power dynamics.

To answer the research questions, 82 first-person written accounts of experiences of facility-based disrespect and abuse during childbirth, in the form of anonymous submissions to an online blog, were analyzed using discourse analysis and feminist post-structuralism. Feminist post-structuralism centers on and problematizes women's diverse situations as well as the institutions that frame them, thus lending itself well to an inquiry of disrespect and abuse in childbirth. Through a discourse analysis of the data, three major themes emerged: 'feelings and emotions of disrespect and abuse', 'provoking the birthing body', and 'tensions in maternity care spaces.' Within these themes, several dominating discourses were at play, including medical discourse; a patriarchal discourse of women as weak, dependent, and inferior; discourses of good and responsible motherhood; discourses of criminal law; legal discourses of informed consent, obligations, and duties; discourses of sexual assault; and patriarchal discourses of objectification. Further, the study found that interpersonal, institutional, and structural levels of power dynamics, which shape and are shaped by dominating discourses, operate within maternity spaces in interrelated ways

These findings are useful for health administrators, who are well positioned to emphasize how interpersonal, institutional, and structural dynamics work to shape experiences of disrespect and abuse during facility-based childbirth. The research concludes with several proactive and reactive recommendations for health administrators, including the exemplification of anti-oppressive understandings of disrespect and abuse during childbirth in collaborative work with other professionals; the creation of

opportunities to speak with birthing individuals about their wishes and expectations; and to advocate for better treatment of birthing individuals. By disrupting and negotiating relations of power that operate within maternity care spaces in Canada, health administrators can facilitate the mitigation or prevention of birthing individuals' experiences of disrespect and abuse during childbirth.

REFERENCES

Abrams, J. R. (2012). Distorted and Diminished Tort Claims for Women. *Cardozo Law Review*, *34*(5), 1955–1998.

Abuya, T., Ndwiga, C., Ritter, J., Kanya, L., Bellows, B., Binkin, N., & Warren, C. E. (2015). The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. *BMC Pregnancy and Childbirth*, *15*(1), 224. https://doi.org/10.1186/s12884-015-0645-6

Abuya, T., Warren, C., Miller, N., Njuki, R., & Ndwiga, C. (2015). Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya—ProQuest. *PLoS ONE*, *10*(4). https://doi.org/10.1371/journal.pone.0123606

Arslanian-Engoren, C. (2002). Feminist poststructuralism: A methodological paradigm for examining clinical decision-making. *Journal of Advanced Nursing*, *37*(6), 512–517. https://doi.org/10.1046/j.1365-2648.2002.02134.x

Aston, M., Price, S., Hunter, A., Sim, M., Etowa, J., Monaghan, J., & Paynter, M. (2020). Second Opinions: Negotiating Agency in Online Mothering Forums. *Canadian Journal of Nursing Research*, 0844562120940554. https://doi.org/10.1177/0844562120940554

Bavelas, J. B., Kenwood, C., & Phillips, B. (2002). Discourse analysis. In M. Knapp & J. Daly (Eds.), *Handbook of Interpersonal Communication* (3rd ed., pp. 102–129). Sage.

Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report*, *13*(4), 544–559.

Beck, C. T. (2004). Birth Trauma: In the Eye of the Beholder. *Nursing Research*, *35*(1), 28–35.

Beck, C. T. (2004). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, *53*(4), 216–224. https://doi.org/10.1097/00006199-200407000-00004

Behruzi, R., Hatem, M., Goulet, L., Fraser, W., & Misago, C. (2013). Understanding childbirth practices as an organizational cultural phenomenon: A conceptual framework. *BMC Pregnancy and Childbirth*, *13*(1), 205. https://doi.org/10.1186/1471-2393-13-205

Belsey, C. (1980). *Critical practice*. Methuen.

Biggs, L. (2004). 'Rethinking the History of Midwifery in Canada. In I. Bourgeault & R. Davis-Floyd (Eds.), *Reconceiving Midwifery* (pp. 17–45). McGill-Queen's University Press.

Bohren, M. A., Mehrtash, H., Fawole, B., Maung, T. M., Balde, M. D., Maya, E., Thwin, S. S., Aderoba, A. K., Vogel, J. P., Irinyenikan, T. A., Adeyanju, A. O., Mon, N. O., Adu-Bonsaffoh, K., Landoulsi, S., Guure, C., Adanu, R., Diallo, B. A., Gülmezoglu, A. M., Soumah, A.-M., … Tunçalp, Ö. (2019). How women are treated during facility-based childbirth in four countries: A cross-sectional study with labour observations and community-based surveys. *The Lancet*, *394*(10210), 1750–1763. https://doi.org/10.1016/S0140-6736(19)31992-0

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F. S., Diniz, A. L. A., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine*, *12*(6), e1001847. https://doi.org/10.1371/journal.pmed.1001847

Bombak, A. E., McPhail, D., & Ward, P. (2016). Reproducing stigma: Interpreting "overweight" and "obese" women's experiences of weight-based discrimination in reproductive healthcare. *Social Science & Medicine*, *166*, 94–101. https://doi.org/10.1016/j.socscimed.2016.08.015

Borges, M. T. R. (2017). A Violent Birth: Reframing Coerced Procedures during Childbirth as Obstetric Violence Notes. *Duke Law Journal*, *4*, 827–862.

Bourgeault, L. (2006). *Push! The Struggle for Midwifery in Ontario*. McGill-Queen's University Press.

Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth. *USAID-TRAction Project, Harvard School of Public Health, University Research Co., LLC. 57.*

Burrow, S., Goldberg, L., Searle, J., & Aston, M. (2018). Vulnerability, Harm, and Compromised Ethics Revealed by the Experiences of Queer Birthing Women in Rural Healthcare. *Journal of Bioethical Inquiry*, *15*(4), 511–524. https://doi.org/10.1007/s11673-018-9882-5

Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery*, *51*, 1–11. https://doi.org/10.1016/j.midw.2017.04.017

Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: An historical analysis. *Journal of Advanced Nursing*, *33*(3), 334–342. https://doi.org/10.1046/j.1365-2648.2001.01669.x

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council,. (2018). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. http://www.pre.ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf

Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework*. The Collaborative.

Cassidy, C., Goldberg, L., & Aston, M. (2016). The application of a feminist poststructural framework in nursing practice for addressing young women's sexual health. *Journal of Clinical Nursing*, *25*(15–16), 2378–2386. https://doi.org/10.1111/jocn.13354

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage Publications.

Cohen Shabot, S. (2016). Making Loud Bodies “Feminine”: A Feminist-Phenomenological Analysis of Obstetric Violence. *Human Studies*, *39*(2), 231–247. https://doi.org/10.1007/s10746-015-9369-x

Connelly, L. M. (2016). Trustworthiness in Qualitative Research. *Medsurg Nursing : Official Journal of the Academy of Medical-Surgical Nurses*, *25*(6), 435–436.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (4th ed.). Sage.

Crowe, M. (2005). Discourse analysis: Towards an understanding of its place in nursing. *Journal of Advanced Nursing*, *51*(1), 55–63. https://doi.org/10.1111/j.1365-2648.2005.03461.x

Dalhousie University School of Health Administration. (n.d.). *Mission and Values*. Dalhousie University School of Health Administration. Retrieved December 6, 2019, from https://www.dal.ca/faculty/health/health-administration/about/mission.html

Darilek, U. (2018). A Woman’s Right to Dignified, Respectful Healthcare During Childbirth: A Review of the Literature on Obstetric Mistreatment. *Issues in Mental Health Nursing*, *39*(6), 538–541. https://doi.org/10.1080/01612840.2017.1368752

Davis-Floyd, R. E. (2003). *Birth as an American Rite of Passage: Second Edition, With a New Preface* (2nd ed.). University of California Press. https://www.jstor.org/stable/10.1525/j.ctt1pndwn

Department of Family and Community Medicine and St. Michael’s Academic Family Health Team. (n.d.). *Labour and Delivery*. St. Michael’s. Retrieved December 30, 2020, from https://www.stmichaelshospital.com/programs/familypractice/pre-natal-care-labour.php

D’Gregorio, R. P. (2010). Obstetric violence: A new legal term introduced in Venezuela. *International Journal of Gynecology & Obstetrics*, *111*(3), 201–202. https://doi.org/10.1016/j.ijgo.2010.09.002

Diniz, S. G., Salgado, H. de O., Andrezzo, H. F. de A., Carvalho, P. G. C. de, Carvalho, P. C. A., Aguiar, C. A., & Niy, D. Y. (2015). Abuse and disrespect in childbirth care as a public health issue in Brazil: Origins, definitions, impacts on maternal health, and proposals for its preention. *Journal of Human Growth and Development*, *25*(3), 377–382. https://doi.org/10.7322/jhgd.106080

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing*, *66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Erdman, J. N. (2015). Bioethics, Human Rights, and Childbirth. *Health and Human Rights*, *17*(1), 43–51. JSTOR. https://doi.org/10.2307/healhumarigh.17.1.43

Fiander, S. (2016). *Pregnancy, birth, and mothering behind bars: A case study of one woman's journey through the Ontario criminal justice and jail systems* [Wilfrid Laurier University]. https://scholars.wlu.ca/cgi/viewcontent.cgi?article=2980&context=etd

Foucault, M. (1974). *The archaeology of knowledge*. Tavistock.

Foucault, M. (1977). Truth and power. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings* (pp. 109–133). Vintage Books, Random House.

Foucault, M. (1986). The subject and power. In B. Wallis (Ed.), *Art after modernism: Rethinking representation*. New Museum of Contemporary Art.

Freedman, L. P., Kujawski, S. A., Mbuyita, S., Kuwawenaruwa, A., Kruk, M. E., Ramsey, K., & Mbaruku, G. (2018). Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth. *Reproductive Health Matters*, *26*(53), 107–122. https://doi.org/10.1080/09688080.2018.1502024

Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., Kujawski, S., Moyo, W., Kruk, M. E., & Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: A research, policy and rights agenda. *World Health Organization. Bulletin of the World Health Organization; Geneva*, *92*(12), 915–917. http://dx.doi.org.ezproxy.library.dal.ca/10.2471/BLT.14.137869

Gavey, N. (1989). Feminist Poststructuralism and Discourse Analysis: Contributions to Feminist Psychology. *Psychology of Women Quarterly*, *13*(4), 459–475. https://doi.org/10.1111/j.1471-6402.1989.tb01014.x

Gebremichael, M. W., Worku, A., Medhanyie, A. A., Edin, K., & Berhane, Y. (2018). Women suffer more from disrespectful and abusive care than from the labour pain itself: A qualitative study from Women's perspective. *BMC Pregnancy and Childbirth*, *18*(1), 392. https://doi.org/10.1186/s12884-018-2026-4

Gingras, J. (2009). The educational (im)possibility for dietetics: A poststructural discourse analysis. *Learning Inquiry*, *3*(3), 177. https://doi.org/10.1007/s11519-009-0044-x

Govender, V., & Penn-Kekana, L. (2008). Gender biases and discrimination: A review of health care interpersonal interactions. *Global Public Health*, *3*(sup1), 90–103. https://doi.org/10.1080/17441690801892208

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse*, *13*(1), 10–28.

Haynes, S. (2017). Infantilization: Historical Attitudes of Doctors Toward Female Patients. *Stellar Undergraduate Research Journal*, *11*.

Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). *Changing the subject: Psychology, social regulation, and subjectivity*. Methuen.

Hermer, L. D., & Brody, H. (2010). Defensive medicine, cost containment, and reform. *Journal of General Internal Medicine*, *25*(5), 470–473. https://doi.org/10.1007/s11606-010-1259-3

Jefferies, K., Goldberg, L., Aston, M., & Murphy, G. T. (2018). Understanding the invisibility of black nurse leaders using a black feminist poststructuralist framework. *Journal of Clinical Nursing*, *27*(15–16), 3225–3234. https://doi.org/10.1111/jocn.14505

Jewkes, R., & Penn-Kekana, L. (2015). Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women. *PLOS Medicine*, *12*(6), e1001849. https://doi.org/10.1371/journal.pmed.1001849

Jhally, S. (2009). *The codes of gender identity + performance in pop culture*. Media Education Foundation.

Kirk, S. F. L., Price, S. L., Penney, T. L., Rehman, L., Lyons, R. F., Piccinini-Vallis, H., Vallis, T. M., Curran, J., & Aston, M. (2014). Blame, Shame, and Lack of Support: A Multilevel Study on Obesity Management. *Qualitative Health Research*, *24*(6), 790–800. https://doi.org/10.1177/1049732314529667

Kitzinger, S. (2006). Birth as rape: There must be an end to `just in case' obstetrics. *British Journal of Midwifery*, *14*(9), 544–545. https://doi.org/10.12968/bjom.2006.14.9.21799

Kukura, E. (2017). Obstetric Violence. *Georgetown Law Journal*, *3*, 721–802.

Lowe, P. (2016). *Reproductive Health and Maternal Sacrifice: Women, Choice and Responsibility*. Palgrave Macmillan UK. http://ebookcentral.proquest.com/lib/dal/detail.action?docID=4720159

Lupton, D. (2013). *Fat Politics: Collected Writings* (SSRN Scholarly Paper ID 2273419). Social Science Research Network. https://doi.org/10.2139/ssrn.2273419

MacDougall, C. (2020). Childbirth Distress: A Call for Professional Engagement. *Affilia*, *35*(3), 376–396. https://doi.org/10.1177/0886109919873909

Madhiwalla, N., Ghoshal, R., Mavani, P., & Roy, N. (2018). Identifying disrespect and abuse in organisational culture: A study of two hospitals in Mumbai, India. *Reproductive Health Matters*, *26*(53), 36–47. https://doi.org/10.1080/09688080.2018.1502021

Malacrida, C. (2015). Always, already-medicalized: Women's prenatal knowledge and choice in two Canadian contexts. *Current Sociology*, *63*(5), 636–651. https://doi.org/10.1177/0011392115590075

Mbekenga, C., Aston, M., Macdonald, D., Jefferies, K., Price, S., Mselle, L. T., Murphy, G. T., Kohi, T. W., O'Hearn, S., & White, M. (2018). How Tanzanian Nurse-Midwives and Obstetricians Develop Postpartum Relationships With Women. *International Journal of Childbirth*, *8*(1), 41–53. https://doi.org/10.1891/2156-5287.8.1.41

Miller, S., & Lalonde, A. (2015). The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother−baby friendly birthing facilities initiative. *International Journal of Gynecology & Obstetrics*, *131*(S1), S49–S52. https://doi.org/10.1016/j.ijgo.2015.02.005

Mitchinson, W. (2010). *Giving Birth in Canada, 1900– 1950*. University of Toronto Press.

Mogashoa, T. (2014). Understanding Critical Discourse Analysis in Qualitative Research. *International Journal of Humanities Social Sciences and Education*, *1*(7), 10.

Montesanti, S. R., & Thurston, W. E. (2015). Mapping the role of structural and interpersonal violence in the lives of women: Implications for public health interventions and policy. *BMC Women's Health*, *15*. http://search.proquest.com/docview/1779685795/abstract/49DA3B44F7714308PQ/1

Montesinos-Segura, R., Urrunaga-Pastor, D., Mendoza-Chuctaya, G., Taype-Rondan, A., Helguero-Santin, L. M., Martinez-Ninanqui, F. W., Centeno, D. L., Jiménez-Meza, Y., Taminche-Canayo, R. C., Paucar-Tito, L., & Villamonte-Calanche, W. (2018). Disrespect and abuse during childbirth in fourteen hospitals in nine cities of Peru. *International Journal of Gynecology & Obstetrics*, *140*(2), 184–190. https://doi.org/10.1002/ijgo.12353

Morton, C. H., Henley, M. M., Seacrist, M., & Roth, L. M. (2018). Bearing witness: United States and Canadian maternity support workers' observations of disrespectful care in childbirth. *Birth*, *45*(3), 263–274. https://doi.org/10.1111/birt.12373

Nazroo, J. Y., Bhui, K. S., & Rhodes, J. (2020). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociology of Health & Illness*, *42*(2), 262–276. https://doi.org/10.1111/1467-9566.13001

Odero, A., Pongy, M., Chauvel, L., Voz, B., Spitz, E., Pétré, B., & Baumann, M. (2020). Core Values that Influence the Patient—Healthcare Professional Power Dynamic: Steering Interaction towards Partnership. *International Journal of Environmental Research and Public Health*, *17*(22), 8458. https://doi.org/10.3390/ijerph17228458

Okafor, I. I., Ugwu, E. O., & Obi, S. N. (2015). Disrespect and abuse during facility-based childbirth in a low-income country. *International Journal of Gynecology & Obstetrics*, *128*(2), 110–113. https://doi.org/10.1016/j.ijgo.2014.08.015

Ollivier, R. A., Aston, M. L., & Price, S. L. (2019). Exploring postpartum sexual health: A feminist poststructural analysis. *Health Care for Women International*. http://www.tandfonline.com/doi/abs/10.1080/07399332.2019.1638923

Ollivier, R., Aston, M., & Price, S. (2019). Let's talk about sex: A feminist poststructural approach to addressing sexual health in the healthcare setting. *Journal of Clinical Nursing*, *28*(3–4), 695–702. https://doi.org/10.1111/jocn.14685

Osler, A. (2006). Excluded girls: Interpersonal, institutional and structural violence in schooling. *Gender and Education*, *18*(6), 571–589. https://doi.org/10.1080/09540250600980089

Peckover, S., & Aston, M. (2018). Examining the social construction of surveillance: A critical issue for health visitors and public health nurses working with mothers and children. *Journal of Clinical Nursing*, *27*(1–2), e379–e389. https://doi.org/10.1111/jocn.14014

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth*, *17*(1), 21. https://doi.org/10.1186/s12884-016-1197-0

RESPCCT. (2020, January 30). *Birth Place Lab*. https://www.birthplacelab.org/respcct/

Rúdólfsdóttir, A. G. (2000). 'I Am Not a Patient, and I Am Not a Child': The Institutionalization and Experience of Pregnancy. *Feminism & Psychology*, *10*(3), 337–350. https://doi.org/10.1177/0959353500010003004

Sadler, M., Santos, M. J., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., & Clausen, J. A. (2016). Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence. *Reproductive Health Matters*, *24*(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002

Sánchez, S. B. (2014). *Obstetric Violence: Medicalization, authority abuse and sexism within Spanish obstetric assistance. A new name for old issues?* [Thesis, Utrecht University]. http://dspace.library.uu.nl/handle/1874/298064

Sando, D., Ratcliffe, H., McDonald, K., Spiegelman, D., Lyatuu, G., Mwanyika-Sando, M., Emil, F., Wegner, M. N., Chalamilla, G., & Langer, A. (2016). The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. *BMC Pregnancy and Childbirth*, *16*(1), 236. https://doi.org/10.1186/s12884-016-1019-4

Savage, V., & Castro, A. (2017). Measuring mistreatment of women during childbirth: A review of terminology and methodological approaches. *Reproductive Health*, *14*(1), 138. https://doi.org/10.1186/s12978-017-0403-5

Searle, J., Goldberg, L., Aston, M., & Burrow, S. (2017). Accessing new understandings of trauma-informed care with queer birthing women in a rural context. *Journal of Clinical Nursing*, *26*(21–22), 3576–3587. https://doi.org/10.1111/jocn.13727

Sen, G., Reddy, B., & Iyer, A. (2018). Beyond measurement: The drivers of disrespect and abuse in obstetric care. *Reproductive Health Matters*, *26*(53), 6–18. https://doi.org/10.1080/09688080.2018.1508173

Sen, G., Reddy, B., Iyer, A., & Heidari, S. (2018). Addressing disrespect and abuse during childbirth in facilities. *Reproductive Health Matters; Amsterdam*, *26*(53). http://dx.doi.org.ezproxy.library.dal.ca/10.1080/09688080.2018.1509970

Sim, S. M. (2017). *Choice or Circumstance? An exploration of breastfeeding practice among Nova Scotian mothers classified as overweight or obese and income-related food insecure* [Dalhousie University]. https://DalSpace.library.dal.ca//handle/10222/72729

Smith, K. E. (2015). Understanding responses to the political context of health inequalities in research and policy: Can post-structural theories of power help? *Social Theory & Health*, *13*(3), 355–376. https://doi.org/10.1057/sth.2015.24

Solnes Miltenburg, A., van Pelt, S., Meguid, T., & Sundby, J. (2018). Disrespect and abuse in maternity care: Individual consequences of structural violence. *Reproductive Health Matters*, *26*(53), 88–106. https://doi.org/10.1080/09688080.2018.1502023

Stake, R. E. (1995). *The art of case study research*. Sage.

Starks, H., & Brown Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, *17*(10), 1372–1380. https://doi.org/10.1177/1049732307307031

Stoll, K., Wang, J. J., Niles, P., Wells, L., & Vedam, S. (2020). *I felt so much conflict instead of joy: An analysis of narratives from pregnant people in British Columbia who declined care recommendations* [Preprint]. In Review. https://doi.org/10.21203/rs.3.rs-35291/v1

The Obstetric Justice Project. (n.d.). The Obstetric Justice Project. Retrieved October 18, 2019, from https://obstetricjustice.org

Vedam, S., Stoll, K., McRae, D. N., Korchinski, M., Velasquez, R., Wang, J., Partridge, S., McRae, L., Martin, R. E., & Jolicoeur, G. (2019). Patient-led decision making: Measuring autonomy and respect in Canadian maternity care. *Patient Education and Counseling*, *102*(3), 586–594. https://doi.org/10.1016/j.pec.2018.10.023

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L., Declercq, E., & the GVtM-US Steering Council. (2019). The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health*, *16*(1), 77. https://doi.org/10.1186/s12978-019-0729-2

Vogel, J. P., Bohren, M. A., Tunçalp, Ö., Oladapo, O. T., & Gülmezoglu, A. M. (2016). Promoting respect and preventing mistreatment during childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology*, *123*(5), 671–674. https://doi.org/10.1111/1471-0528.13750

Weedon, C. (1987). *Feminist Practice and Poststructuralist Theory*. Blackwell.

Weedon, C. (1997). *Feminist practice and poststructuralist theory* (2nd ed.). Blackwell.

WHO Reproductive Health Library. (2018). *WHO recommendation on respectful maternity care during labour and childbirth*. World Health Organization.

Wijlen, J. E. van, & Aston, M. (2019). Applying Feminist Poststructuralism as a Framework for Exploring Infant Feeding Interactions in the Neonatal Intensive Care Unit. *Witness: The Canadian Journal of Critical Nursing Discourse*, *1*(1), 59–72. https://doi.org/10.25071/2291-5796.12

Wilson, K. (2019, August 7). *25 years on: What midwifery in Canada has achieved and what it still needs*. The Conversation. http://theconversation.com/25-years-on-what-midwifery-in-canada-has-achieved-and-what-it-still-needs-120210

Wood, W. (2018). 'Put Right Under': Obstetric Violence in Post-war Canada. *Social History of Medicine*, *31*(4), 796–817. https://doi.org/10.1093/shm/hky057

World Health Organization. (2007). *Everybody's business: Strengthening health systems to improve health outcomes : WHO's frmaework for action.* World Health Organization.

World Health Organization. (2015). *The prevention and elimination of disrespect and abuse during childbirth*. https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf;jsessionid=E31376E1E26A0A6D9A98BFE082D2A1DC?sequence=1

Young, I. M. (2005). Pregnant Embodiment: Subjectivity and Alienation. In *On Female Body Experience: "Throwing Like a Girl" and Other Essays* (pp. 46–61). Oxford University Press.

Appendix A

Submission Form Questions for the Obstetric Justice Project

1. Name as you'd like it to appear publicly in your blog post (please provide a name/nickname, alias, or initial you'd like to go by)
2. Contact email address
3. Where did your experience occur? (Name of hospital/facility/clinic/practice or service organization (optional) + town or city + province or territory in Canada)
4. When? (Be as specific as you'd like (ie: "January 12, 2018", "Autumn 2015", "2011", etc)
5. What happened? (Share your story)
6. What has been the impact? (How did your experience affect you in the moment and long-term? What thoughts or feelings come up now when you look back on your experience?)
7. Other factors - (optional) (Was your experience positively or negatively impacted by: your age, (dis)ability, race or ethnicity, appearance, body size, marital status, family structure, religion, cultural group, sexuality, gender expression or presentation, education level, occupation or income source, geographical location, language, chronic health condition, HIV+ status, history of incarceration, mental health or trauma history, substance use, or other factors Is there anything else you'd like to share that contributed to your experience, the care you had access to, and/or the way you were treated by your care providers? Were your care providers able to meet your unique needs? Were you the target of bias, discrimination, bullying, or judgement? Were certain services or choices unavailable to you due to your location, income, or other factors?)
8. Did you provide feedback about your experience? (It's very common for people who have negative experiences to feel unsafe and unsupported to speak up. Most never file complaints or provide feedback. What were some of the things that prevented or allowed you to speak up about what happened? (ie: did you feel comfortable speaking with your care providers, writing a letter, filing a formal complaint with a regulating body, contacting patient relations, etc.?) Do you have advice for others who are thinking about providing feedback, filing a formal complaint, or sharing their story?)
9. Additional comments - (optional) (Is there anything else you'd like to include in your blog entry? A message to fellow patients? A message to the people or systems that harmed/helped you? Suggestions for care professionals who may read your story? Changes you'd like to see in your community? What "obstetric justice" means to you? Anything else you feel is important?)
10. Consent (By submitting, you give consent for your submission to be published. You have read and agree to the privacy policy, terms and conditions.)