

# Dignity in Childbirth

Category: New Voices

written by Debra Eluobaju | February 22, 2022



My interest in women's health began when, in high school, I became aware of the ongoing genocide in Darfur. Learning about that conflict's impact on women in terms of sexual trauma and maternal mortality opened my eyes to the depths of inequality that women face in the Global South. This, combined with the fact that I'm a first-generation Nigerian-American, led me to pursue a career in obstetrics and gynecology, with a global-health focus.

As a second-year medical student, I received a research fellowship to study Nigerian women's choices of childbirth settings and medical care. I traveled from Chicago to Benin City, the capital of Edo State, in southern Nigeria, and spent eight weeks volunteering in a local labor ward.

I had often wondered why any woman with access to modern healthcare facilities with skilled birth attendants (SBAs, in medicalese) would choose instead to deliver at home or under the care of traditional birth attendants (TBAs) lacking formal Western medical education. My experience on the labor wards dramatically changed my perspective on this.

I quickly discovered that in Nigeria, as in the US, women of lower socioeconomic status receive a significantly lower quality of obstetric care. This is reflected in everything from a lack of skilled birth attendants to abusive treatment by providers.

Like most urban regions, Benin City has a mixture of richer and poorer areas. People in the wealthier areas, near the University of Benin, had access to tertiary-care centers, whereas people in the poorer parts of the city had to

travel upwards of an hour to reach the nearest clinic.

The labor ward where I volunteered, in central Benin, was small and under-resourced, with frequent power outages. It had ten beds, five against each wall, with a bucket by each bed in which the laboring women could relieve themselves. There were no dividers to provide privacy, and the women were left to labor alone. Five nurse midwives were on the labor ward, but only one was handling deliveries at any time, while the other nurses chatted. Occasionally one of two physicians would stop by to see if any of the women needed to go to the operating room.

I was struck by the nurses' and midwives' interventionist approach with the laboring women—monitoring each patient's labor and speeding it along with repeated doses of pitocin—and how this was coupled with what seemed an almost complete emotional detachment.

If a woman cried out in pain, the nurses never responded—except, at times, with mockery. I never saw any of them attempt to gauge a patient's pain or try to make her more comfortable. The expectation, it seemed, was that a laboring woman should be able to “control” herself and “behave.” For instance, all of the women were required to lie on their backs throughout labor and delivery.

When one woman, Ede, was ready to push, I watched as she held her own ankles and did her best to push without any instruction.

“You said you want to push. Now push!” the nurse said, slapping Ede's legs open. “Don't waste my time!”

“Okay, I want to listen,” Ede answered, clearly scared and in pain. I stood frozen, as everyone around me continued working, completely unbothered. I felt helpless. As a visitor being welcomed into this space, I chose not to speak. Was this out of shock, fear of how I would be perceived, or cultural indoctrination regarding respect and power dynamics? I'm not sure.

I watched as another woman, Esosa, whose pain seemed to worsen with each contraction, shifted about in bed, trying to find relief.

“This is a labor ward,” the nurse said sternly. “If you want to behave this way, you can leave.”

“I'm sorry,” Esosa said, turning to lie on her back once more.

A while later, I held Esosa's hand as a nurse forcibly examined her cervix while she was in mid-contraction, ignoring her obvious pain.

When the nurse left, Esosa said, “Please find my husband and have him come to support me.”

Due to the lack of privacy, family members were required to wait in the hallways or outside the hospital. Failing to locate Esosa's husband in the hallways, I finally found her sister.

"Please go back and stay with her," she begged. "It's her first child, and she should not be left alone."

I stayed at Esosa's bedside for the next four hours, acting as her doula, rubbing her back and offering words of encouragement. The nurses' reactions came through clearly in their rolled eyes, giggles and whispers.

The hour grew late, and with a heavy heart I told Esosa, "I have to leave."

"If you leave, who is going to stay with me?" she asked, grabbing my shirt.

I could only promise to visit her and her newborn the next day.

A wave of helplessness and anger washed over me. *How can people treat laboring women with such contempt?*

As easy as I found it to mentally vilify the nurses and midwives, I also remembered conversations in which they'd revealed that they were understaffed, overworked and exhausted. During my time on the ward, I was impressed by their resilience and resourcefulness in handling power outages and other challenges. Although a lack of resources is no excuse for negligent or abusive patient care, seeing their difficult work environment provided me with some perspective.

In the end, the women in the labor ward had uncomplicated labors and delivered healthy babies. But I couldn't help wondering, *Is that all that should be expected?*

If what I witnessed is typical of delivery in healthcare clinics in Nigeria, then the question is not why some women still deliver with traditional birth attendants but rather why any woman would ever choose to deliver in a healthcare facility. Granted, the ward I observed does not reflect the entirety of Nigeria's maternal healthcare system; but the fact that only 43 percent of Nigerian women deliver in a healthcare setting points to a broader systemic problem.

Obstetric care should, at the very least, allow women to maintain their dignity throughout labor and delivery. Regardless of her educational, socioeconomic or marital status, a laboring woman should never have to beg to be attended to, or feel pressured to "behave." If a clinic setting is not emotionally and medically supportive, women may well conclude that they are better off delivering with a traditional birth attendant.

As I continue my medical education in the US, I'm becoming increasingly aware of instances of mistreatment of women, particularly minority women, in the US healthcare system. A well-known statistic is that Black women in the US die from maternal causes at two to three times the rate of white women. I can only wonder how often some form of mistreatment may lead to a woman's missing her prenatal visits. On the flip side, how much power might there be in making sure that every woman, regardless of who she is, has a high-quality, dignified labor and delivery?

Dignity during labor is a human right. A mother bringing a child into the

world should be celebrated, honored and supported in that process. This should hold just as true in the remotest villages of Africa as it does in the wealthiest hospitals of North America.