EVIDENCE OF OBSTETRIC VIOLENCE AMONGST THE INDIAN MIDDLE-CLASS WOMEN

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Abstract

Increasing the number of institutional deliveries is a major goal of any government. However, at times, this focus leads to unwanted consequences such as neglect of women during childbirth due to inadequate infrastructure and acts of abuse during childbirth. The main victims of such apathetic development are women belonging to the disadvantaged sections. However, this paper, using information collected from surveys, argues that obstetric violence is not just a developmental issue that arises due to the lack of public facilities. Rather, it is a reflection of patriarchal norms and violence against women in general as women from even economically advantaged sections and those who have access to proper private facilities have to face significant amount of obstetric violence too, as evidenced in this paper.

Introduction

A major focus of the government towards the cause of development has been to invest in policies and programmes to increase the number of institutional deliveries. However, this focus has been extremely myopic, with the aim being a higher number of deliveries rather than the quality of care provided to women. This is what is witnessed during institutional births, when substandard, sometimes almost inhumane, care is delivered by healthcare professionals. Women face verbal abuse and discrimination; made to deliver on the floor due to lack of beds; not provided pain relief to avoid prolonged births and invasive procedures are performed on them without their knowledge or consent. These acts of violence taken together are termed obstetric violence.

Obstetric violence is categorized into various categories such as physical, verbal and sexual abuse, neglect and abandonment of care, any form of discrimination, and lastly, unnecessary surgeries and iatrogenic procedures such as caesarean sections. The last category, that of over-treatment has been witnessed on a large scale in developed countries, especially, USA. The other forms of violence have been attributed to developing and underdeveloped countries, but mainly in the context of economically and socially disadvantaged women, who mainly rely on the public system for health needs. This paper presents a study of women belonging to the middle-income category and their experiences during childbirth.

Literature Review

- ***Concept and Terminology***

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Obstetric violence is a relatively new term, which first gained recognition amongst the legal circles in Venezuela around 2007. However, discussion around dehumanized birth procedures emerged in Brazil during the early 1990s. 'Obstetric violence' is defined as having occurred when routine medical or pharmacological procedures associated with labor are conducted without allowing the woman to take decisions regarding her own body (D'Gregorio, 2010)[1]. Such treatment is antithetical to the Universal Rights of Childbearing Women charter according to which every woman has the right to dignified, respectful sexual and reproductive health care, including during childbirth (White Ribbon Alliance, 2011)[2]. Global public recognition of the issue came only during the mid-2000s. It is only during the last decade that the term has come to be recognized as both a legal, as well as a social category. A rights-based approach to addressing the issue such as the WHO's stance that 'abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights' (Vacaflor 2016)[3], has been helpful in bringing public attention to this issue. However, a lack of global standard measures of abuse means that reported prevalences of mistreatment varies across different populations and national contexts, from 20% in Kenya (Abuya et al., 2015)[4] to 43% in Ethiopia (Wassihun & Zeleke, 2018)[5] to 98% in Nigeria (Okafor et al., 2015)[6].

- ***Evidence from other countries***

While the term "obstetric violence" is not commonly used in studies in the USA, the abuse of women undergoing pregnancy and gestation is now gaining increased attention in recent years. Often referred to as "dehumanized care" or "medicalization of birth," reports of women feeling objectified, disrespected, or otherwise violated during pregnancy and childbirth have surfaced repeatedly. Pathologization and medicalization have been attributed as the main causes behind the continuance of obstetric violence (McGarry et al. 2017)[7].

Latin America has seen the emergence of the legal concept of obstetric violence that encompasses elements of quality of obstetric care and mistreatment of women during childbirth - both issues of global maternal health import. This new legal term emerged out of continuous efforts by women's organizations, feminists, international and regional institutions, and public health activists and researchers to improve the quality of care that women receive across the region. The result has been a number of legislations across countries of this region, with obstetric violence now being a recognized public health issue (Williams et al. 2018)[8]

- ***Studies in India***

Although research pertaining to obstetric violence has been geographically limited in India, high prevalence of different forms of 'obstetric violence' in both public and private medical facilities has been found, albeit with varying levels of intensity. It was found that institutional delivery was perceived as threatening and childbirth was considered to be a negative experience by a number of women (Barnes, 2007)[9]. Physical abuse was found to be the dominant form of violence, with women reporting

being slapped, pinched or beaten by health care providers while delivering, especially in public hospitals (Shrivastava and Sivakami, 2020)[10]. However, sexual abuse was found to be low, which could be attributed to perceived stigma and discrimination and accompanying discomfort while reporting the same (Bohren et al., 2015)[11].

Patel et al. (2015)[12] found that discrimination, especially caste-based discrimination, was a common phenomenon in obstetric settings. The findings corroborate with those of another study (Raj et al., 2017)[13], which reported that out of the women surveyed, 2.3% were treated differently because they belonged to a particular caste or community. For example, Goli et al. (2019)[14] found that obstetric violence was significantly higher among Muslim women when compared with Hindu women and among women of lower castes relative to women belonging to the general category. Apart from caste, class is also considered to be an important factor in determining the incidence of obstetric violence. Although Nawab et al. (2019)[15] found that women of lower social standing were subjected to greater levels of mistreatment, Diamond-Smith et al. (2017)[16] found that being in the higher wealth quintile (relative to the lower) was significantly associated with higher reporting of mistreatment during childbirth.

Dey et al. (2017)[17] reported that lack of informed consent was a major issue in public health facilities as 47.8% of women reported not being provided with adequate information on delivery procedures, and 27.0% reported that their consent was not taken before conducting delivery procedures. Moreover, medical negligence and carelessness were not uncommon (Chattopadhyay et al., 2018)[18]. Women faced difficulties due the unavailability of a professional and at times had to deliver alone (Sudhinaraset et al., 2016)[19]. Also, it was observed that only those women who were going to deliver were attended, otherwise they were left to suffer (Bhattacharya and Sundari Ravindran, 2018)[20]. A common practice that was reported by a number of studies was the lack of a birth companion as family members were generally not allowed in the room due to infrastructural constraints (Sudhinaraset, 2016)[19].

Nayak and Nath (2018)[21] highlight how as opposed to caesarian sections being the dominant form of operating procedure, India witnesses a high number of episiotomies, mainly amongst the patients of public hospitals. Though caesarean sections are very often seen as a means of making money quickly in the private sector and as a means of quicker labour in the public sector. But a more unknown, and widely performed invasive medical procedure is episiotomy, where an incision is made in the skin between the vaginal cavity and the anus to make the pathway for the baby bigger. Although this procedure is not supported scientifically, it is still carried out in large numbers. It is believed that hospitals that do not have enough resources find it is easier to surgically make a tear than to risk a tear later that will lead to complications that hospital staff and doctors are not prepared to handle. Sometimes, such operations are performed without anaesthetics, to either save time or costs, or due to the belief amongst health provider that since women are already in pain, no anaesthetic is required because they won't feel much' (Chattopadhyay et al., 2018)[18].

Bhattacharya and Sundari Ravindran (2018)[20] found that women reported being subjected to excessive force during examination or delivery.

Chaturvedi et al. (2015)[22] reported the lack of good-quality care in public settings, with inadequate staffing, infrastructure, equipment and cleanliness. According to Sharma et al. (2019)[23], reports of stray animals such as dogs and cows roaming throughout facility compounds and often taking shelter in wards and labour rooms were not uncommon. Such unhygienic conditions and a lack of basic amenities were considered to be forms of abuse by some women (Bhattacharya and Sundari Ravindran, 2018)[20]. Apart from this, Bhattacharya & Sundari Ravindran (2018)[20] highlighted how women experienced a loss of autonomy as they were made to undergo vaginal examinations or deliveries in the presence of strangers without any curtains or privacy.

A number of studies concluded that women tend to normalize acts of 'obstetric violence' that are evidently harmful, such as physical abuse and applying unnecessary force during delivery (Chattopadhyay et al., 2018, Nawab e al., 2019)[18][15]. Though women would report being subjected to physical coercion or shouting, they would not necessarily perceive these acts as abuse. Madhiwalla et al. (2018)[24] has elaborated on the practice of suppressing women's expression of pain while delivering a child. Some women are asked to keep quiet when they shouted out in pain, or are physically or verbally abused as it is considered important to 'discipline' labouring women. This is according to the expectations and norms set by providers around what is acceptable behaviour during delivery. This degree of normalization was also found to be associated with certain socio-demographic factors. When women who were poor or belonged to sections of lower social standing were subjected to 'obstetric violence', they were unable to identify and describe the low quality of care or discrimination (Diamond-Smith et al., 2017)[16]. The same study also found that dimensions of empowerment related to social norms about women's values and roles were associated with their experiences of mistreatment during childbirth. Similar studies from other countries have found that socio-demographic factors such as higher parity, lower socioeconomic status and HIV-positive status have been reported to predispose women to disrespect and abuse during childbirth in a facility (Bowser & Hill, 2010; Diniz et al., 2015)[24][25].

Methods

This paper makes use of the tool of online surveys to collect responses. The decision to conduct online surveys was taken after considering three factors in total. First of all, limitations imposed by the Covid-19 pandemic rendered data collection difficult and an unsafe procedure. Second, given that the survey involved answering questions that need one to recall possibly traumatic events and the fact that reproductive health is a highly stigmatized topic, in-person interviews could involve alteration of answers where the individual subject's perception of the interviewer's potential judgement of their responses might lead to altered responses as a type of Hawthorne effect. The element of confidentiality and anonymity increases the possibility of receiving true and more complete answers in case of issues that are considered taboo, such as sexual and

reproductive health. Lastly, given that the research was aimed at studying a population with a certain socioeconomic level and access to technology, the amount of bias in the data would be less than if one were to take a national representative sample due to the digital divide that exists in India.

A total of 112 responses were received and out of those, 91 were of women belonging to the middle-income category (defined as women belonging to households that have an annual income that ranges between Rs 2,00,000 and 12,00,000). A number of open-ended as well as multiple-choice questions were asked in the survey. The data was analyzed using the empirical-statistical method. The questions asked during the survey are mentioned below:

a) Have you ever heard the term "obstetric violence"?

b) Which of the following income brackets you belong to?

c) Obstetric violence is the neglect, any form abuse and lack of respect during childbirth. It can occur in any of the following ways. Please check any that you feel may apply to you and elaborate on your experience if you wish to.

- **i) Physical Abuse**
- **ii) Non-Consented Care**
- **iii) Non-Confidential Care**
- **iv) Non-Dignified Care**
- **v) Discrimination**
- **vi) Abandonment of Care**
- **vii) Detention in Facilities**
- **viii) Other**
- **ix) None of the Above**

d) Did you ever experience discrimination of any kind during pregnancy, labour or postnatal care? If so, please explain.

e) Were there any things that made you feel uncomfortable or that you wished had been done differently?

f) Choose the place(s) where your delivery/deliveries have taken place

- **i) Private Hospital**
- **ii) Public Hospital**
- **iii) Home**

g) On a scale of 1 to 5, answer to what extent did you feel emotionally and mentally supported during pregnancy and after giving birth? 1 signifies complete unsatisfaction and 5 signifies complete satisfaction.

Results

- ***Choose the place(s) where your delivery/deliveries have taken place.***

Out of the total respondents, 84.4% had given birth in a private hospital whereas the rest 15.6% had given birth in public hospitals.

- ***Have you ever heard the term "obstetric abuse" before?***

Out of 91 women, 19.8% reported having heard the term "obstetric violence", whereas, for the rest of 80.2% women, the answer was in the negative.

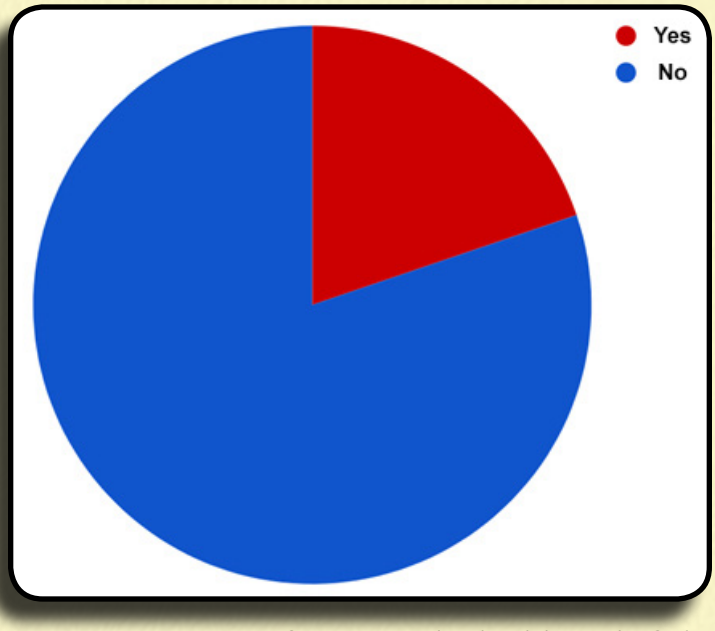

Fig.1: Percentage of women who had heard of the term "obstetric violence"

- ***Obstetric violence is the neglect, physical abuse and lack of respect during childbirth. It can occur in any of the following ways. Please check any that you feel may apply to you and elaborate on your experience if you wish to.***

54.4 % of women reported having faced at least one form of abuse, whereas the answer for the rest 43.2%, the answer was in the negative. Out of the women who had faced abuse, 9.25% reported having faced more than one kind of violence. The most prevalent form of abuse was reported to be physical abuse (24.2%), followed by discrimination (11.6%), non-confidential care (11.6%) and non-dignified care (6.3%). The prevalence of non-confidential care was shown to be high among public hospitals.

Amongst the private hospitals, the major category of abuse was found out to be that of physical abuse, followed by discrimination. Amongst the public hospitals, non-confidential care was the most widely chosen category followed by physical abuse and discrimination.

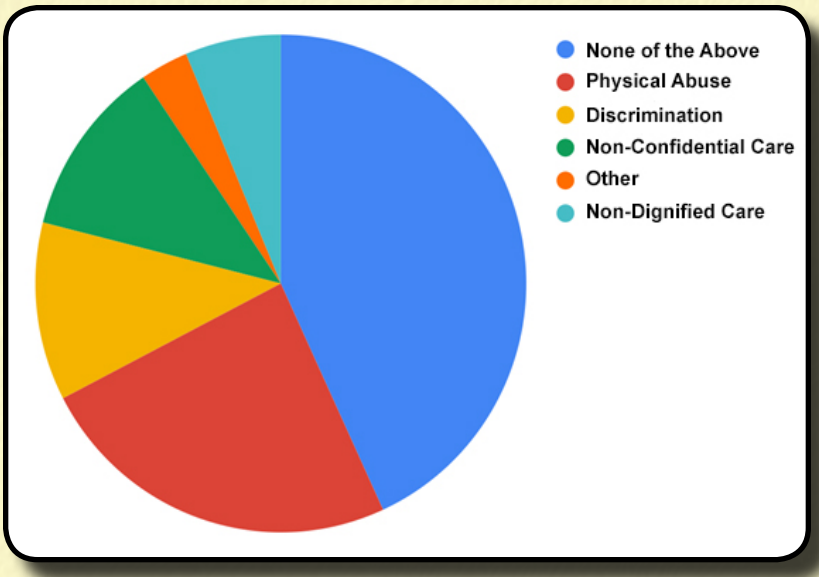

Fig. 2: Forms of obstetric violence experienced by women

- ***Did you ever experience discrimination of any kind during pregnancy, labour or postnatal care?***

Based on the responses, 13.2% of women answered in the affirmative, whereas the others answered in the negative. Out of all the women who reported having faced discrimination, each response cited

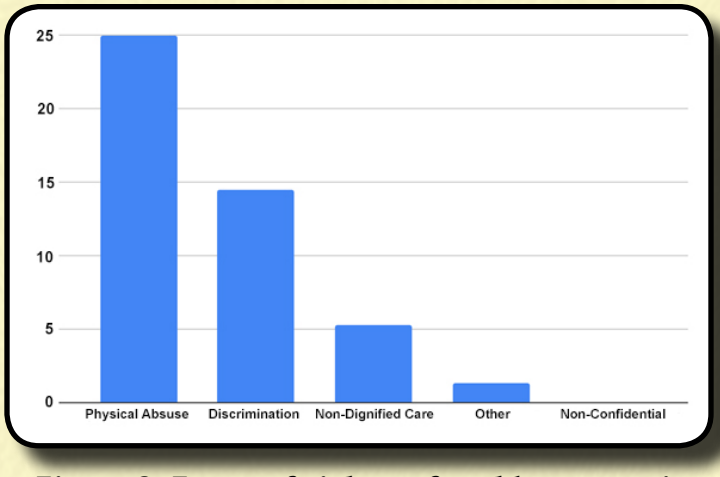

Figure 3: Forms of violence faced by women in private hospitals

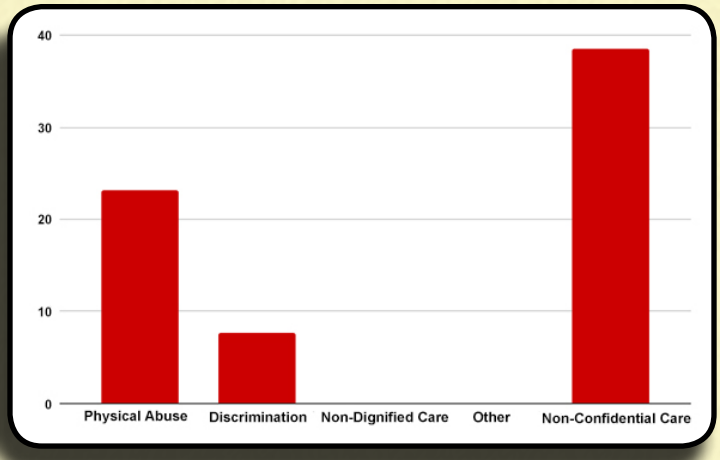

Figure 4: Forms of violence faced by women in public hospitals

caste-based discrimination as the reason, except one where the respondent complained of culture-based discrimination. All the cases of discrimination were reported for private hospitals and none for public hospitals.

- ***Satisfaction Rate***

The average satisfaction rate on a scale of 1 to 5, was found to be 3.93. When asked whether they wished there were things that could have been done differently, 52.7% responded in the affirmative.

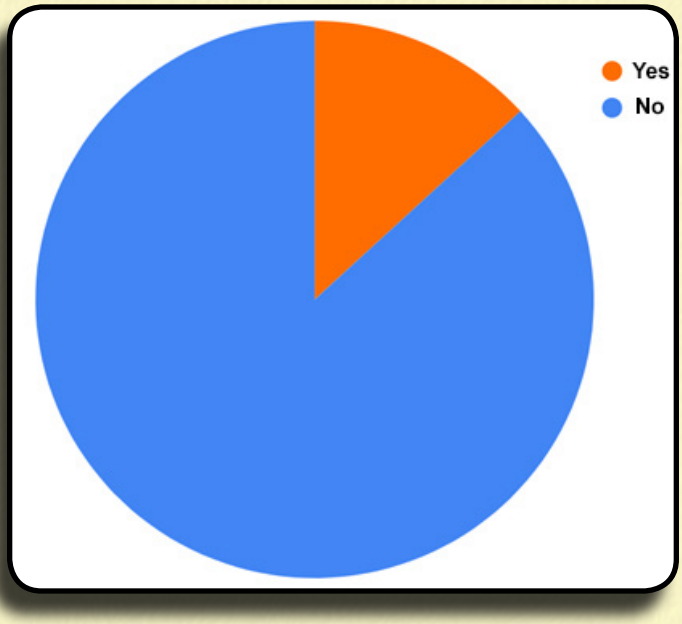

Figure 5: Percentage of women who faced discrimination of any sort

Discussion

The results presented above are revealing as obstetric violence is attributed only to poor public health infrastructure and since a major part of the poor relies on it, poor women are thought of as sole victims of obstetric violence. However, the survey brings to light a category of women who belong to the middle-income groups and rely mostly on the private sector for fulfilling their health needs in hope of better facilities, however, they too end up facing abuse during the process of childbirth. A few key observations are to be made from the results of the survey.

Firstly, the awareness about the concept of obstetric violence is abysmally low, even amongst women of socioeconomically better-off sections. Second, physical abuse is the dominant form of violence as opposed to non-confidential care, which is more prevalent in public hospitals, and surgical procedures which is more prevalent in the

developed countries. Thirdly, discrimination features as a key component of violence and has been experienced in one form or the another by women. This reveals how this issue interacts with other evils of Indian society such as caste-based discrimination, color-based discrimination, et cetera.

The reasons attributed to such a situation include the patriarchal nature of the society wherein, even doctors hold negative gender stereotypes. Also, the relationship between doctors and patients usually endows a doctor with more power, wherein a doctor's opinion commands greater attention, and this opens up space for misuse of power. It must be realized that a woman has an absolute right over her body and should always command the right to be informed about or refuse any procedure that she does not wish to materialize.

Also, the idea of successful childbirth cannot be defined just as the survival of the infant and the mother. It should also include practices that are safe and humane, such as the presence of supportive family members, proper place of birth and respect and dignity during labour. In India and other parts of the Global South, structural violence unequally distributes the risks associated with childbirth with poor women disproportionately bearing these risks. However, infrastructural and spatial deficiencies mean that such support is not available to women due to hospitals getting overcrowded.

Conclusion

Clear systemic issues such as an insensitive medical curriculum, lack of resources and time, a lack of accountability, patriarchal norms and a historic normalization of gender-based violence allow 'obstetric violence' to happen (Chattopadhyay et al., 2018)[18]. It is important that in the long-run, gender-transformative education and clinical practices are developed and taught to medical professionals. Such education and practice should be aimed at promoting gender equality and equity in health with the aim of addressing health inequalities that are a result of gender roles and unequal gender-relations in society (World Health Organization, 2007)[26]. With the serious mental health consequences that come up with such violence that prevails in the society, it is important that we start investigating into the issue of why despite proper infrastructure and better status of women does obstetric violence exist even in the private sector. Given that negative childbirth experience leads to maternal stress and slows down the labour process, thereby increasing the chances of complications and post-partum depression, there is need for a rights-based approach to tackling obstetric violence (Freedman et al., 2014; Gausia et al., 2012)[27][28]. There is also the need for a legal and justice system that recognizes this as an issue and locates obstetric violence as a peculiar form of violence that is gendered and intersects with multiple axes of structural inequalities such as caste, ethnic differences, class differences, region and

religion in India, producing a negative, violent and painful experience of pregnancy and childbirth.

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