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Original Research Article

Obstetric violence: a health system study

Raksha K. Shetty, Padmaja Y. Samant*, Priyanka U. Honavar

Department of Obstetrics and Gynecology, Seth GS Medical College and KEM Hospital, Mumbai, Maharashtra, India

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***Correspondence:**
Dr. Padmaja Y. Samant,
E-mail: mavanipadmaja9@gmail.com

ABSTRACT

Background: Disrespect and abuse during facility-based childbirth is a global problem with differing driving factors in different contexts. Obstetric Violence (OV) refers to professional deficiencies in maternity care. The objective of this study was to assess knowledge and attitudes towards OV in a cohort of members of the obstetric healthcare team at a tertiary care, teaching hospital in Western India (Mumbai).
Methods: A questionnaire-based study involving 80 participants comprising of trainee doctors and faculty, nursing students, staff and teachers from the department of Obstetrics and Gynaecology and hospital administration.
Results: 57.97% of participants had heard the term 'Obstetric violence' earlier. 75.36% reported verbal abuse as a form of OV, others being physical abuse, non-consented care, discriminatory care, abandonment/neglect or refusal of care and imposition of interventions without scientific basis. 53% and 89.8% of the participants did not consider routine episiotomies and artificial rupture of membrane respectively as forms of OV. 84.06% and 59.4% of participants considered instrumental delivery without consent and Caesarean section citing safety/convenience respectively as forms of OV. 82.6% participants endorsed the need of birth companion. Improving the number and training of healthcare providers and better institutional policies on respectful maternity care were suggested as solutions.
Conclusions: Majority of the participants had witnessed some form of OV. The need for practical training of healthcare personnel and better infrastructure in the healthcare system were emphasised, but there appeared to be a lack of consciousness of the paternalistic mindset and approach to women in labour. Soft skills training of healthcare providers with emphasis on key ethical principles like autonomy, respect and dignity is crucial to address the issue of OV.

Keywords: Non-consensual care. Obstetric violence, Professionalism, Respectful maternity care

INTRODUCTION

Disrespect and abuse of women seeking maternity care is becoming an urgent problem as per the growing body of research from maternity care systems in countries across economic strata creating a growing concern spanning the realms of healthcare research, quality and education, human rights and civil rights. Global efforts during the era of Millennium Development Goals largely focused on increasing coverage of antenatal care and facility-based childbirth as a key to reduce maternal mortality. There was lesser focus on quality of care, although individual studies suggested that poor quality of services led to limited health benefits.[1,2]

Improving quality of care and experience of care is an important strategy to further reduce preventable maternal mortality and morbidity and achieve the health-related

Sustainable Development Goals targets.[3] In 2016, World Health Organization (WHO) published new guidelines for respectful maternity care in healthcare facilities.[3]

The seven domains of disrespect and abuse defined in Bowser and Hill's landscape evidence review (2010), describing interpersonal aspects of care during labour and delivery are- physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in facilities.[4]

In 2007, Venezuela became the first country to legally define and outlaw 'obstetric violence', outlined in the country's Organic Law on the Rights of Women to a Life Free of Violence.[5] Limited data exists regarding healthcare providers' understanding of OV in Indian healthcare system. This study is aimed at assessing perceptions of healthcare team about OV in the regional context and its associated causes and implications.

Aims and objectives was to study understanding of the terminology, causes and impact of Obstetric Violence (OV) among all the cadres in medical staff and nursing staff, to understand aspects of the care and training deficiencies from the administrative and academic seniors, to study legal views and responses to OV, and to explore possible solutions to OV.

METHODS

Study type: Cross-sectional, questionnaire-based study

Study place: Seth GS Medical College and KEM Hospital, a tertiary care, teaching hospital in Mumbai, India.

Study period: 3 months, from August, 2020 to October, 2020.

Inclusion criteria

All postgraduate students and faculty members in the department of Obstetrics and Gynecology.

Nurses, nursing tutors and nursing students in their second and third year of curriculum,posted in the department of Obstetrics and Gynaecology.

Administrative officers (Key informants) responsible for provision and maintenance, who:

Should have qualification of MD/MS in any speciality. Administrative experience of atleast 1 year.

Exclusion criteria

Those who refuse to consent.

Nursing students in their first year of curriculum.

Purposive sampling was done and 80 members of the healthcare team were enrolled in the study. After valid, informed, written consent, a structured pre-validated questionnaire was administered to participants. Interviews of key informants were conducted by the research team.

The study was approved by the Ethics Committee of the institution.

Data collection and statistical analysis

The questionnaire was not taken from any existing literature. It was generated as per the local needs and training. Questionnaires for both- healthcare provider participants and key informants, were validated by subject experts including gender and ethics experts.

Initial questions assessed participants' demographics, prior training and familiarity with and understanding of the term 'Obstetric Violence'.

Differences in demographic data between the two groups i.e. doctors and nurses were analysed using the student's t-test (for means) and Fisher exact test.

Prior understanding of OV, perceptions about ethics of various routine obstetric procedures and experiences pertaining to OV in clinical practice of both groups were analysed using Chi-square test. p-value < 0.05 was considered statistically significant for all measures.

We sought participants' suggestions about solutions to the problem of OV and possible implementation methods. While analysing opinions and feelings, commonly used terms and phrases were picked up and their frequency noted. Responses to questions in the questionnaire for key informants were analysed in a similar manner.

RESULTS

Key informants

Eleven key informants were interviewed including 6 faculty members of the department of Obstetrics and Gynaecology (ObGyn), 4 nursing teachers and an administrative senior clinician.

There was no significant difference in the mean age, duration of clinical experience and gender between the two groups of key informants (doctors and nursing faculty). Average age for both groups was 48 years, and average number of years in practice was 20 years.

There was a significant difference in terms of training in professional conduct (communication skills, ethics and good clinical practice) and human rights. All the nursing faculty had undergone training in professionalism and

human rights as students. All the key informant doctors reported that they did not receive training in professional conduct & human rights as students; but did so during their in service training.

Formal administrative training was received by 5 key informants (all 4 nursing teachers and 1 doctor). 3 nursing teachers underwent mandatory training, one did so voluntarily.

Out of 6 Ob Gyn faculty members, 5 felt that training in administration is desirable and 1 felt that it should be mandatory.

All nursing teachers and 4 faculty members had heard/read about the term 'Obstetric Violence' in academic texts. All key informants considered it to be a reality in Indian healthcare setting and not just a western concept. 2 faculty members added that there is more awareness in the west about the concept of OV as they have a strong system of clinical governance in place, conduct of audits, Patient Advice and Liaison Services (PALS) etc.

Causes of obstetric violence as per the key informants

Personal factors

Lack of fulfilment of expectations, reaction to behaviour of patients & relatives, patriarchy, disrespect and greed (reason for very high Casarean section rates) were discussed as personal factors causing rights violation and violence.

Institutional factors

Understaffing, absence of clear delegation of responsibility and lack of responsibility beyond medical duties was reported as a cause for apathy and impatience.

Training issues

Lack of role models, deficient training in ethics and professionalism came up repeatedly in interviews with key informants. Other issues cited were, poor technical knowledge/experience amongst junior doctors leading to anxiety about outcome of delivery and fear of litigation for mishap which could lead to impatient, disrespectful behaviour and aggression.

Curricular reforms suggestions to address instances of OV

Mandatory training in professional conduct and human rights at undergraduate and postgraduate levels with credits system to encourage active participation.

Teaching of bioethical principles of justice, human rights, dignified patient care, truth telling at entry to medical school (introduced this year by the National Medical Council of the Government of India).

Introduction of psychology, sociology, bioethics and topics on gender discrimination and gender based violence in medical curriculum.

Additional supervision in academics, clinical work with remedial training and emphasis on documentation.

Systemic reforms suggested to address instances of OV

360-degree feedback and reporting of behaviour of healthcare staff.

There should be General Medical Council-like boards for disciplinary action against the erring healthcare staff.

Confidential reports of individual providers in the healthcare system to include adverse remarks, if any, in domain of professional attitude.

Incentivisation and public appreciation of good behaviour as well as disciplinary action like issuing memorandums to trainees in serious cases.

Better doctor: patient and nurse: patient ratios.

Periodic in-service education of doctors and nurses.

Creating awareness of gender-based violence, support and guidance to women who disclose OV.

Institutional policy formation to deal with OV.

Most key informants expressed that-

Inculcation of social responsibility, empathy and sensitivity by parents in their children is the basic step in attitude building.

Importance of change in cultural norms that condone discrimination against women/girls or any kind of violence against the vulnerable cannot be overemphasised.

Healthcare provider participants

Sixty nine frontline healthcare provider participants from Department of Ob Gyn were interviewed. These included 26 resident doctors (37.68%) and 18 consultants (26.09%), 20 nursing students (28.98%) and 5 nurses (7.25%).

Age- 88.4% participants belonged to the age group of 20-30 years.

Gender- 88.64% of the doctors and all the nursing participants were females.

Duration of clinical experience- 94.2% participants had clinical experience of 1-10 years.

The obstetricians' and nurses' groups demonstrated significant differences in terms of-

Training in professional conduct- 81.8% of obstetricians and all nurses had undergone such training as part of their clinical training.

Training in human rights-38.6% of obstetricians and 76% of nurses had undergone training as part of their clinical training.

61 participants had received training in professional conduct as part of clinical training in one or more of the following- communication skills, ethics, good clinical practice recommendations (GCPRs) as follows.

Table 1: Training in professional conduct.

Training	Obstetricians	Nurses	Total	p-value*
Received	36	25	61	0.0439
Not received	8	0	8	
Total	44	25	69	

*- Data were assessed using the Fisher Exact test

Table 2: Training in human rights.

	Obstetricians	Nurses	Total	p-value#
Received	17	19	36	0.0028
Not received	27	6	33	
Total	44	25	69	

#-Data were assessed using the Chi-square ($\chi 2$) test

Out of 69 participants, 40 (57.97%) had heard/read the term 'Obstetric violence' in training/ academic text/ non-academic readings and/ or other sources like conversation with peers and seniors.

All these 40 participants agreed that OV is a reality in Indian healthcare setting.

7 out of 40 were of the opinion that OV is a rare problem. 14 out of 40 participants considered that OV is perpetrated due to individual unethical nature. 32 participants considered OV is a public health problem. 17 participants (16 female, 1 male) opined that OV is perpetrated by female doctors more. 8 participants opined that OV is perpetrated by doctors only. 2 opined that that it is perpetrated by doctors more than nurses. 30 participants opined that it is perpetrated by doctors and nurses equally. There was no significant difference in understanding of the term between the two groups of respondents. 29 participants had not heard/read about OV.

Table 3: Participants who had not heard / read about OV.

Participants	Doctors	Nurses	Total	p-value#
Heard about OV	29 (65.9%)	11 (44%)	40	0.076
Not heard	15 (34.1%)	14 (56%)	29	
Total	44	25	69	

#-Data were analysed using Chi-square ($\chi 2$) test

The 29 participants who had not heard the term "Obstetric Violence" were then asked which of the following they would consider OV.

Intimate partner violence in pregnancy,

Stranger violence in pregnancy,

Domestic violence in pregnancy,

Violence against a pregnant woman in the health institute by healthcare providers.

Correct replies were given by 18 of 29. They were all explained about the same. All participants were asked to cite examples of OV they might have come across, to which 68 participants responded. The responses were grouped in the seven categories of OV identified by WHO as follows.

Table 4: Examples of OV cited by participants.

Examples of Obstetric violence	Number of participants who cited
Physical abuse	29
Non-consensual care	6
Verbal abuse	52
Discrimination	1
Abandonment, neglect or refusal of assistance	12
Detention in services (denial of autonomy)	0
Non-consensual obstetric interventions without scientific basis	11

Unnecessary procedures/ Procedures without consent

Episiotomy

32 participants agreed that routine episiotomies could be considered an act of OV. They stated that - Routine episiotomies were no longer recommended. Each case should be individualised and episiotomy given only in

cases such as primigravida, big baby or instrumental delivery. This will also reduce blood loss. As per them, the practice of routine episiotomies was due to lack of awareness about restrictive episiotomy and it was practised in order to shorten the 2nd stage of labour.

37 participants did not consider routine episiotomies as a form of OV and thought that episiotomies prevented greater degrees of perineal tears, reduced morbidity and facilitated delivery.

Table 5: Responses to whether routine episiotomies constitute OV.

Episiotomy as OV	Doctors	Nurses	Total	p-value#
Yes	11	21	32	
No	33	4	37	<0.00001
Total	44	25	69	

#-Data were analysed using the $\chi 2$ test

Artificial rupture of membranes (ARM)

ARM without informing the patient did not constitute a form of OV according to 62 participants. They believed that it is a time-tested method of augmentation of labour with scientific basis, helps in early detection of meconium stained amniotic fluid or abruptio placentae and is associated with few complications if done in an aseptic and correct manner. 1 participant was not sure if ARM constituted a form of OV. 6 participants thought that ARM constitutes a form of OV as it could lead to complications such as cord prolapse, maternal/fetal infections. But they did not refer to violation of parturients' autonomy as a reason. The differences among the doctors' and nurses' groups were significant (p value-0.02).

Instrumental delivery

58 participants were of the opinion that instrumental delivery without consent constituted OV for following reasons-

It is associated with maternal and foetal complications and patient has every right to understand them and make an informed decision.

Any intervention even if well-indicated, if done without consent amounts to violation of patient's rights and autonomy. A written, informed consent is required to avoid medico-legal issues later. An instrumental delivery without consent was not a form of OV in opinion of 11 participants for reasons given below-

'Often it is done in unforeseen emergency situations like fetal distress, wherein only an expeditious instrumental delivery can save neonatal life.Precious time may be lost waiting for deliberation and consent by the patient, hence it may not be wrong to go ahead not waiting for consent.'

'Extreme pain makes it difficult for a patient in labour to make an informed decision.'

Cesarean delivery

When asked whether they considered "high rate of cesarean delivery citing safety or convenience for family", as a form of OV, 41 participants agreed stating that-

'Cesarean section (CS) is not without risk of complications and affects subsequent childbearing. It should be done for genuine indication only.'

'If patients and relatives are counselled properly about pros n cons of CS and vaginal delivery, they will be able to make a right choice.'

The remaining 28 participants stated - 'It is the patient's and relatives' choice, their request should be complied with if they wish to go for a CS.'

Witnessing OV

Participants were asked how often they have witnessed OV take place.

Table 6: Frequency of witnessing incidents of OV.

Respondents	Never	Rarely	Occasionally	Frequently	Total
Junior residents	0	3	13	10	26
Consultants	0	6	8	4	18
Student nurses	0	14	1	5	20
Staff nurses	0	4	1	0	5
Total	0	27 (39.13%)	23 (33.33%)	19 (27.54%)	69

Frequency of OV

Participants were asked to respond on Likert scale to the statement: "Obstetric violence is a common and grave problem in our healthcare institutions".

Private sector scenario

Out of 69, 13 (18.84%) participants had worked/ trained in private institutes.

They cited following differences in private and public sector practice-

Healthcare providers in private sector tend to be more soft-spoken,explaining everything in detail to patients as they are not overburdened like their counterparts in public sector due to lack of basic amenities and infrastructure for patient care, large influx of patients etc.

Verbal abuse of patients is not seen in private set-ups where patients receive more dignified and personalised care.

Table 7: Likert scale responses to whether OV is a common and grave problem in our healthcare institutions.

Responses	Obstetricians	Nurses	Total	p-value[#]
Strongly agree	15	9	24 (34.78%)	
Agree	20	12	32 (46.38%)	
Neutral	5	4	9 (13.04%)	0.403
Disagree	1	0	1 (1.45%)	
Strongly disagree	3	0	3 (4.35%)	

#- Data were assessed using the Chi-square ($\chi 2$) test

Rate of unindicated CS is more in private set-ups.

Out of these 13 participants, 9 had seen some form of OV at these private institutes and cited following kind of violations that took place there:

CS, instrumental deliveries, pregnancy terminations done without a valid indication, only for convenience of doctors or patients/ relatives and sometimes due to anxiety of patients or relatives. Some thought that monetary gains might be one of the reasons.

Unnecessary antenatal visits, obstetric ultrasounds and investigations amounting to higher expenditure for the patients.

More guarded approach to vaginal delivery and higher rate/ tendency to perform CS.

Provision of birth companion

57 participants thought that a birth companion is essential to labouring women and 41 of them considered 'No birth companion' as a systemic inadequacy.

They considered that a birth companion could provide emotional support to labouring patient helping her to take decisions and safeguard the parturient from any form of violence from the healthcare providers. They also thought that patient's immediate needs at the time of labour are better taken care of by the companion. The participants knew that the incidence of CS rates is lower in deliveries where birth companion is available.

The 12 participants who were skeptical about merits of the facility of a birth companion thought that:

Maintaining aseptic conditions becomes difficult with an ignorant birth companion.

Anxiety, stress or inadequate understanding of birth companion and overcrowding may interfere with functioning of healthcare team and may even result in confrontation.

The participants had suggestions about policies, infrastructure and training to address the issue of OV:

Improving provider: patient ratio and up-gradation of infrastructure

Creation of policy of patient education regarding antenatal and intrapartum care, expected complications and medical procedures.

Zero tolerance for rude and hurtful behaviour.

Allowing birth companion of patient's choice.

Close supervision by seniors and creation of positive role models.

A system of 360 degree feedback for doctors and considering it for academic promotions.

Training of obstetric provider teams in communication skills, ethics and human rights and medicolegal implications of OV.

DISCUSSION

The reported incidence of OV is 15–97% worldwide with higher risk of OV to disempowered women with lower socioeconomic and educational strata even in developed countries.[6-10] OV as a public health problem and violation of women's human, sexual and reproductive rights was highlighted by the WHO stressing on 'Prevention and eradication of abuse, disrespect and ill-treatment during childbirth in health institutions'.[11] It also describes other

institutional violence (IV) categories including lack of quality and healthcare resources, as well as poor geographic, financial and cultural inaccessibility.

There was unanimity on OV as a reality in our society. 47.8% of them considered it to be common and 46.38% considered it as a public health issue.20.3% considered it to be a personal problem.

43.48% said that it is perpetrated by both doctors and nurses, 2.9% thought it was more by doctors than nurses and 11.6% thought it was perpetrated by doctors alone.

Ironically 24.63% of our respondents thought that it was perpetrated by female doctors more than males. Similar findings were reported in studies from Mozambique and Ethiopia.[12,13]

Verbal Abuse

75.36% of participants in our study reported having witnessed verbal abuse including shouting at a patient who failed to bear down or follow instructions, slanderous remarks (for poor follow-up, non-compliance with medicines, non-acceptance of family planning services), intimidation and intentional humiliation during labour. These are similar to verbal abuse reported in an Ethiopian study.[13]

Physical Abuse*:*

42% of our participants reported having seen physical abuse including beating, slapping or pinching of parturients (for being unco-operative or noisy) and suturing episiotomies without anesthesia. Other forms of physical abuse reported in literature include not allowing parturients their preferred birthing position, unwarranted per vaginal examinations, hitting with instruments, not allowing ambulation in labour.[13]

Neglect

17.39% participants considered abandonment, neglect or refusal of assistance as a form of OV. This included inadequate communication with patient and relatives about- her condition, instructions at discharge, contraceptive counselling, postpartum neglect and abuse of patients during breastfeeding and mobilisation, neglect of parturients' needs of food and water, insensitivity to their psychological condition at the time of labour and delivery. Other forms of lack of care reported in literature included not attending the delivery, not listening/responding to patients' concerns and nonavailability of birth companion.[15]

Non-consensual care

8.69% of the participants reported having seen imposition of non-consensual obstetric interventions without a scientific basis including application of fundal pressure in labour, procedures such as induction of labour, termination of pregnancy, unindicated instrumental delivery/ cesarean section, for convenience of doctor, monetary benefits or to gain practical experience.

15.94% of the participants reported witnessing procedures like per-vaginal examination, amniotomy, episiotomy or instrumental delivery without explaining or obtaining consent from the patient.

A paternalistic undertone was evident from approach of the providers to propriety of procedures without consent. Nearly half defended routine episiotomies as facilitatory procedure that also prevented severe perineal trauma whereas evidence suggests that restrictive episiotomies are more beneficial.[14] 89.8% of participants did not consider that artificial rupture of membranes required consent and explanation as it was a routine procedure with benefits outweighing the risks.

Instrumental delivery without consent was considered an urgent action in emergency and one that should be left to obstetrician's discretion by 15.94% of participants.

59.46% of our respondents considered Caesarean section done for safety/convenience for family as forms of OV considering it as a medico-legal risk but didn't emphasise as an unethical act**.** Our participants who had worked in in private set ups, reported high rate of CS there, mostly due to guarded approach and sometimes without a valid indication. World-wide large disparity is observed in CS rates, highest rates being reported in Latin America and the Caribbean region followed by Northern America, Oceania, Europe, Asia and Africa.[15] In India as per latest District level household survey 4, in 2012-2013, CS rate was 37.9% in private sector and 13.7% in public sector. [16]

Discrimination

1.45% of our participants reported discriminatory and undignified treatment to HIV positive/HBsAg-positive patients.

The studies about problem of stigmatization and discrimination in low-income countries focussed on minority groups and HIV positive patients and recommended sensitisation and training of providers in ethical care.[17,18] Discrimination of obstetric patients on the basis of ethnicity/ religion/race, age, marital status, level of literacy, economic status and HIV status has also been reported.[13]

Detention

None of the participants in our study reported detention in services as a form of OV. It is the least reported category in low resource settings even in literature possibly because, maternity services are free of charge in most such settings; but some studies report detention of

women in the hospital due to inability to pay hospital bills.[19-21,13]

A category of OV- "harmful traditional practices and beliefs" emerged from Indian literature.[22]

Legal considerations

The "Organic Law on the Right of Women to a Life Free of Violence" was enforced by Venezuela in 2007.[5] Article 51 in the act enlists the actions that are considered OV which include intrapartum and antepartum neglect, non-consensual procedures among others. Argentina, Puerto Rico, Bolivia, Panama and Mexico have legal provisions against OV. Uruguay has a law assuring birth companion.

As per a WHO report, 'At population level, CS rates higher than 10% are not associated with reductions in maternal and new-born mortality rates'.[23] High CS rates in Latin America and the Caribbean region (40%) are a matter of great concern as also Indian private sector rates at 37.9%. The medical-surgical approach to childbirth portraying CS as a safer, painless, modern and ideal type of delivery, perpetuates the preference for it as a prophylactic measure that protects women from the intrinsic risks and the doctor from uncertain outcomes related to vaginal delivery.[24] The Indian judiciary is also taking note of these practices. In 2018, Delhi high court observed that unnecessary CS, in addition to being harmful, is violation of patients' health rights and held the government accountable to curb the same.[25]

A tendency for unnecessary and aggressive interventions by healthcare providers compounded by their paternalistic approach discouraging patients' participation in decision-making, heightens the actual risk of professional lawsuits. Lack of focus on soft skills during training is largely responsible for this and need for soft skills training stood out in our interviews.

18.84% of our participants had worked or trained in private institutes and 69% of them admitted to have witnessed OV there in the form of un-indicated obstetric interventions, unnecessary investigations and medications, probably for monetary gain and convenience of healthcare providers. Majority of them reported much less or even non-existent verbal and physical abuse in the private compared to public setups, probably due to lesser patient load and better facilities in the former. Also losing a patient due to such behaviour would mean monetary loss. Sharma et al also reported similar findings in an Indian study.[8]

Healthcare rights

Labour companionship

This is considered a key component of sensitive maternity care as per WHO standards for quality maternity care in health facilities.[26] Despite the benefits, implementation of recommendations for companion of choice throughout labour is not universal.[27] There is evidence that continuous support during labour aids the physiological process and improves outcomes- shorter labour with higher rates of spontaneous vaginal birth, decreased usage of intrapartum analgesia, less incidence of CS, increased patient-satisfaction and fewer babies with low five-minute Apgar scores.[28] 82.6% of our participants were of the opinion that a birth companion is essential to a labouring woman.

A birth companion can facilitate and ensure clear and respectful provider- patient communication in labour, especially in urgent situations and safeguard the patient against mistreatment and neglect by healthcare providers.[29] The companion can be any person chosen by the woman. Interestingly, a Cochrane systematic review concluded that the benefits of support are limited with facility's professional staff as companion.[28] Among barriers to provision of birth-companion besides absence of national or institutional policies on a birth-companion, studies reported infrastructural limitations (concerns over maintenance of asepsis with crowding) as well as negative attitudes and lack of awareness of healthcare providers (lack of training).[30] Our study participants too pointed out lack of infrastructure and hygiene as impediments.

Autonomy

Though all participants agreed that patient has the right to question, choose or give her opinion on the procedures and line of treatment suggested by the care team, it was clear from the answers of some participants that a patient has limited autonomy and when the healthcare provider anticipates risk to the patient's or unborn child's health , the patient must abide by the medical opinion.

The model of women's care is thought to be hierarchical and obedience is expected of the patient.[31] Non-obedience is perceived by professionals as disrespect, ignorance or aggression.[32] Women reported higher level of disrespect and intrapartum abuse in hospitals than in health centres.[13] Hospitals generally belong to the secondary and tertiary levels in most healthcare systems. They serve as referral sites and are expected to give better quality of care. Increased patient volume and insufficient staffing may impede the provision of respectful maternity care in hospitals.[33]

Also, working in under-equipped, overwrought and overburdened health systems affects provider enthusiasm and often contributes to disrespect and abuse in facilities.[34] Attending highly eventful and stressful process of labor for hours in poor working conditions may lead to providers' burnout and increase likelihood of inappropriate treatment of patients. Similar reasons were cited by our study respondents and solutions were suggested in the light of the same.

Limitations

Small sample size. Since we have included junior nursing students and trainee resident doctors as participants, we have not asked elaborate questions on ethics and professionalism in the questionnaire.

CONCLUSION

The results of this study demonstrated that majority of healthcare professionals in this cohort had witnessed many forms of obstetric violence, were able to identify negative behaviours, reflect on how this impacts the patient care and gave valuable suggestions. At the same time, prevalence of paternalistic understanding of care was also evident. Steps to address OV must focus on practical training to healthcare providers in interpersonal skills, women's rights and gender sensitivity. Institutional policies on respectful maternity care must also be developed and implemented. Also a long-term investment in healthcare systems is needed to ensure supportive and enabling work-environment. Further studies are needed to discern ways to prevent OV in low as well as high resource settings.

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