



UNDERSTANDING THE PHENOMENON OF LABOUR ROOM VIOLENCE AGAINST PREGNANT WOMEN: PERCEPTIONS AND PRACTICES OF HCP'S AND CHANGES AFTER RMC PRACTICES

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ABSTRACT

Objectives: To understand the phenomenon of labour room violence against women and HCP's perceptions of behaviours constituting mistreatment in labour room, to study the factors responsible for mistreatment in labour rooms and to study the changes after training of RMC practices. **Methods:** This study analyses mixed-methods data obtained through systematic clinical observations and open-ended comments recorded by the observers to describe care and in -depth interview to capture HCPs perception of labour room violence. **Findings:** There are 7 major categories of disrespect and abuse that women encountered during childbirth in health facilities which are verbal abuse, non-consented clinical care, non-confidential care (including denial of privacy), non-dignified care, discrimination based on specific patient attributes, abandonment or denial of care and detention in facilities.(1) According to the present study, these forms of mistreatment has been drastically reduced in our institute in addition to which good RMC practices are adopted, so that a woman can experience decent & ethical but an honourable start towards her motherhood. **Conclusions:** Training of HCPs to understand the concept of respectful maternity care, development of a handbook with standard operating protocols(14) for women in labour, introduction of different birthing positions as well as birth companions were described as key components to inculcating respectful maternity care. The programme was on going one, with respectful maternity care practices being passed on from older to newer staff through a system of continuous teaching and guidance on the job, hence institutionalising these new practices through constant engagement, supervision and incremental.

KEYWORDS

Maternal, Newborn, Quality, India, Mistreatment, Disrespect, Abuse, Labour, Childbirth, RMC.

INTRODUCTION:

Childbirth is the most profound initiation to spirituality a woman can have but at the same time the period of childbirth places women at a particular vulnerability⁽¹⁾. There is fledging evidence from across countries for the mistreatment of women at the time of childbirth^(2,3).

There is evidence to show that many women choose to not avail of health facility services for childbirth in spite of recognizing the health benefits of the same; these decisions often stem from past experiences of poor quality care, which include being hit, slapped, physically restrained, and abandoned^(4,5).

Defining mistreatment of women during childbirth:

The mistreatment of women during childbirth has been termed and defined variously such as: "mistreatment of women in childbirth at health facilities", "obstetric violence", "disrespect and abuse" and "dehumanized birth," among others, the typologies of "disrespect and abuse" and "mistreatment during facility based childbirth" being the most frequently employed in global studies⁽⁷⁾. However, all the terms share commonalities in underscoring the medicalization of the natural childbirth process, the mistreatment of women being rooted in gender inequities, drawing parallels with violence against women, the potential for harm, and the threat to women's rights⁽³⁾. In 2010, Bowser and Hill undertook a landscape analysis to encapsulate available knowledge and evidence on the phenomenon, this being the first major synthesis of evidence on the issue. Their report titled Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth, through in-depth searches of published and technical literature along with interviews and discussions with experts, described seven major categories of disrespect and abuse that women encountered during childbirth in health facilities⁽⁹⁾. **1) Physical abuse** comprises acts such as beating, pinching, slapping, tying up or physically restraining the woman in labour, pushing on the woman's abdomen, using excessive force to pull the baby out, and stitching post-partum sutures without the use of anaesthesia, sexual abuse of the woman through acts such as performing vaginal examinations using excessive force or pulling the woman's legs apart roughly. **2) Non-consented clinical care** refers to

carrying out birth-related procedures such as caesarean sections, episiotomies, hysterectomies, blood transfusions, and sterilization, without the consent of the woman. **3) Non-confidential care (including denial of privacy)** refers to denying the woman physical privacy wherein she is compelled to give birth in public view, as well as lack of confidentiality with regard to sensitive patient information such as HIV status, age, marital status, medical history, and so on. **4) Non-dignified care (including verbal abuse)** comprises acts such as blaming, scolding, insulting or threatening the woman. **5) Discrimination based on specific patient attributes** refers to providing the woman differential care, or poor treatment, on the basis of attributes such as race, ethnicity, educational level, socioeconomic status, and HIV status among others. **6) Abandonment or denial of care** refers to women being left alone during labour and birth, as well as failing to monitor the woman during the course of labour, and intervening in situations which may threaten her health. **7) Detention in facilities** refers to detaining women and/or their babies in health facilities owing to the women's inability to pay the hospital bills. Factors contributing to mistreatment of women during childbirth are women's lack of awareness about their rights at the time of childbirth, higher parity, had HIV positive status, lower socioeconomic status, or had complications during delivery, shortage of staff, lack of resources and poor supervision, lack of or inadequate emphasis on communication skills in medical training is a factor leading to poor attitudes of healthcare providers towards women availing of delivery services from health facilities⁽⁷⁾.

There are 12 universal rights of childbearing women and newborns:-

1. Everyone has the Right to freedom from harm & ill treatment.
2. Everyone has the Right in information and informed consent.
3. Everyone has the Right to a companion of their choice and preference during maternity care.
4. Everyone has the Right to privacy and confidentiality.
5. Everyone has the Right to be treated with dignity and respect.
6. Everyone has the Right to equality, freedom from discrimination and equitable care.
7. Everyone has the Right to healthcare & to highest attainable level

- of health.
- 8. Everyone has the Right to liberty and autonomy.
- 9. Every child has the right to be with their parents or guardians.
- 10. Every child has the right to an identity & nationality from birth.
- 11. Right to adequate nutrition and clean water.
- 12. Every woman and newborn has the right to timely and effective grievance and redressal.

In India, policies and schemes to address maternal health have been chiefly directed towards curbing the maternal mortality rate and enhancing birth outcomes by encouraging facility deliveries⁽⁸⁾. The Janani Suraksha Yojana under the National Rural Health Mission (NRHM) is a flagship programme to increase the rate of institutional deliveries⁽⁹⁾. An evaluation of the program found that while there was an increase in the numbers of facility based childbirths following the scheme, women narrated being subjected to mistreatment and abusive practices. In India, the Ministry of Health and Family Welfare launched the LaQshya (Labour Room Quality Improvement Initiative⁽¹¹⁾) guidelines in 2018, of which respectful treatment of women during childbirth forms an integral part⁽¹⁰⁾. The guidelines include provisions for privacy to pregnant women during childbirth, presence of a birth companion, providing women the freedom to choose the position they want give birth in, using labour beds instead of tables, early skin-to-skin contact between the mother and baby, and initiating breastfeeding within one hour of birth, and adherence to all clinical protocols for management of labour. The guidelines also prohibit acts such as inducing or augmenting labour without sound clinical indications, verbally or physically abusing the woman in labour, insisting on a particular position for delivery, and making the woman or her caregivers incur out-of-pocket expenditures. The need to understand provider perspectives of labour room violence also arose from CEHAT's close engagement with the public health system. On numerous occasions, women availing of the services of Dilaasa1, a hospital-based crisisintervention centre, have spoken to counsellors about the mistreatment they were meted out at the time of childbirth; such mistreatment has ranged from rude behaviour and negative remarks to physical and verbal abuse. CEHAT's program on integrating gender perspectives in medical education also threw light on specific practices in labour rooms⁽¹²⁾.

The present study conceptualises that in order to bring about a positive change in maternity care practices, it is important to understand HCP's behaviours constituting disrespect and abuse of women at the time of childbirth. The results of the study would hence help to address the issue by inculcating positive attitudes and practices among healthcare providers working in the labour room.

OBJECTIVES:

1. To understand the phenomenon of labour room violence against women and HCP's perceptions of behaviours constituting disrespect & abuse in labour room.
2. To document their recommendations to prevent & stop disrespect and abuse in labour rooms.
3. To study the changes after training of RMC practices.

METHODOLOGY:

The present study was carried out Government Medical College, Aurangabad from April 2022 to October 2022. All the required information gained from RMC book⁽¹⁵⁾ and a semi-structured interview guide was developed based on the study objectives. The tool covered the following domains of enquiry:

1. Work profile and training
2. Perceptions and practices of privacy, confidentiality and consent-taking (including consent for contraceptive counselling)
3. Perceptions of violence in labour rooms
4. Perceptions and practices of the birth companion policy and offering different birth positions
5. Recommendations to prevent violence in labour rooms
6. Case example - Implementation of respectful maternity care (RMC) practices.

Two researchers were present at the time of each interview. While one researcher conducted the interview, the other researcher documented the same by hand; the presence of the other researcher was also to ensure that they could fill any gaps in information which were missed by the interviewing researcher. Additionally, field notes in the form of observations about the environment, the note-taker's impressions during the interview, and non-verbal communication were maintained

in the course of data collection, which provided critical contexts to place the data in, and helped supplement the data derived from the interview

OBSERVATION:

Table 1: Themes and their observation during study- clinical observations of labour and childbirth during study:

Categories	Themes	Observation during
1. Over-treatment	a) Routine episiotomy	Occurs infrequently but whenever conducted, local anaesthesia given.
	b) Extreme fundal pressure	It is 100% abolished.
2. Under-treatment	c) Deficiencies in Infection prevention by individual health workers	Due to increased number of admissions in emergency and shortage of supplies, sometime vaginal douching before cesarean section is not possible.
	d) Birth attendants	As it is tertiary care centre, deliveries are conducted by skilled birth attendants.
	e) Health facility environmental hygiene	Proper hand washing before conducting deliveries by birth attendants is 100% followed.
3. Disrespect and abuse	f) Physical violence and verbal abuse	Due to proper training of staff and resident doctors and implementation of standard operative procedure(14) towards Respectful Maternity Care, any form of abusive behaviour by birth attendants not seen.
	g) Informal payments	Infrequent

Table 2: Socio-demographic characteristics of the sample by two overall levels of mistreatment

	Total n=50	Percentage (%)
1. Women's age		
a. < 20 years	12	24%
b. 20–35 years	23	46%
c. 35 years or more	15	30%
2. Parity		
a. Primipara	14	28%
b. Multipara	26	52%
c. Grandmultipara	10	20%
3. Referral status		
a. Patient comes directly to this facility	37	74%
b. Patient referred from another facility	13	26%
5. Socio-economic status		
a. lower	12	24%
b. upper lower	23	46%
c. lower middle	14	28%
d. upper middle	1	02%
e. upper	-	-
6. Delivery by qualified attendants		
a. Qualified attendants	50	100%
b. Unqualified attendants	-	-
7. Timing of admission		
a. Within work hours	33	66%
b. Out of hours	17	34%

8. Admission day		
a. Admission during weekdays	38	76%
b. Admission during weekends	12	24%

DISCUSSION:

Present study summarises qualitative information obtained from observers' open-ended comments on mistreatment. It provides information on categories and themes of mistreatment and observation regarding same during study. Mistreatment such as deficiencies in infection prevention, lack of analgesia for episiotomy, informal payments and poor health environment hygiene which were not captured by the quantitative checklist were studied (Table 1). It was found that only two factors were responsible for mistreatment and those were increased workload and lack of resources. RMC practices was being strictly followed for every woman. Every pregnant woman made aware about her 12 RMC rights.

Amongst our sample, the majority of participants were between 20 and 35 years of age (46%), multiparous (52%), came directly to the facility (77%) and were from the upper lower(46%). Most deliveries were performed during regular workhours(66%) on weekdays (76%). The only variable significantly different was timing of admission and greater proportion of mistreatment was observed in cases admitted after work hours compared to regular working hours.

Of the 50 respondents who were interviewed, only 11 (22%) reported having experienced some form of mistreatment during childbirth and those were either due to lack of resources or increased workload, while 39 (78%) received Respectful Maternity Care.

Of the types of mistreatments that were studied, zero cases of non-consented care, verbal or physical abuse were found, and non-confidential care seen in 3 cases (6%). In past days, the commonly reported criterion in the domain of non-consented care was 'provider did not allow me to assume my position of choice during birth' followed by 'provider did not allow my companion to stay with me during labour'. These particular things used to happen as patients coming to emergency in active labour or head on perineum with untrained companion making it difficult to offer a doula. Hence women used to deliver in conventional dorsal position without any companion. The continuous support during labour might have improved outcomes for women and infants, including increased spontaneous vaginal birth, shorter duration of labour, and decreased caesarean birth, instrumental vaginal birth, low five-minute Apgar score and negative feelings about childbirth experiences⁽¹³⁾. In our institute, being an acolyte of Respectful Maternity Care special emphasis given on birth companion and different birth positions a woman can adopt during labour making their journey towards motherhood smoother & more memorable.

Respectful Maternity Care entailed practices free of physical and verbal abuse of women, and which were judicious in their use of medical interventions (e.g., not administering episiotomies indiscriminately to every woman but only to those for whom it was indicated). Nurses and class-four workers referred to the initiative by individual practices which were carried out under it (e.g. allowing of birth companions, allowing different birth positions, etc.). All cadres of providers shared that these new practices had been introduced in a step-by-step manner, and after orienting all the cadres of healthcare providers through an initial training workshop. This is an ongoing program, and changes are underway as mentioned by respondents. The process of respectful maternity care practice is ongoing process of continuous learning and teaching on the job from older to newer staff members. Most providers reported that patients' satisfaction and positive birth outcomes motivated them the most to keep up their efforts.

CONCLUSION:

Moreover, despite the growing body of global evidence on respectful maternity care, the lack of integration of these new aspects in continuing medical education and nursing training prevents healthcare providers from practising human and empathetic ways to manage childbirth. This finding hence holds much significance for directions for medical and nursing education and training, which must include the aspects of social determinants of health and positive patient-provider communication within their ambit. Finally, this study draws the inference that providing RMC should be everyone's motto. Also, present study not only brings to fore the institutionalisation of mistreatment of women & put an example of efforts made to prevent such practice but also emphasise on respectful provider care for better

implementation of birth practices and sound environment for childbirth. The findings call for a holistic perspective towards quality of care during childbirth, taking into account patient-provider communication, and a childbirth experience free of discrimination, harm and ill-treatment. Nonetheless, a programme to inculcate respectful maternity care in Indian public health settings holds promise for efforts aiming to improve childbirth care.

REFERENCES:

1. World Health Organization. (2014). The prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva, Switzerland: World Health Organization.
2. Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., ... Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *Plos Medicine*, 12(6). <https://doi.org/10.1371/journal.pmed.1001847> Bohren et al., 2015.
3. Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility based childbirth. Boston: USAID-Traction Project, Harvard School of Public Health. Retrieved from https://www.ghdonline.org/uploads/Respectful_Care_at_Birth_9-20-101_Final1.pdf Bowser & Hill, 2010
4. Adinew, Y. M., & Assefa, N. A. (2017). Experience of facility based childbirth in rural Ethiopia: An exploratory study of women's perspective. *Journal of Pregnancy*, 1-6. <http://dx.doi.org/10.1155/2017/7938371> Adinew & Assefa, 2017;
5. Khan, M. E., Hazra, A., & Bhatnagar, I. (2010). Impact of Janani Suraksha Yojana on selected family health behaviours in rural Uttar Pradesh. *The Journal of Family Welfare*, 56, 9-22 Khan, Hazra & Bhatnagar, 2010
6. Savage, V., & Castro, A. (2017). Measuring mistreatment of women during childbirth: A review of terminology and methodological approaches. *Reproductive Health*, 14(1). <https://doi.org/10.1186/s12978-017-0403-5> Savage & Castro, 2017.
7. Kruk, M. E., Kujawski, S., Mbaruku, G., Ramsey, K., Moyo, W., & Freedman, L. P. (2014). Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy and Planning*, 33(1), e26-e33. <https://doi.org/10.1093/heapol/czu079>
8. Srivastava, A., Bhattacharyya, S., Clar, C. & Avan, B. I. (2014). Evolution of quality in maternal health in India: Lessons and priorities. *International Journal of Medicine and Public Health*, 4(1), 33-39. Retrieved from http://www.ijmedph.org/sites/default/files/IntJMedPublicHealth2014_4_1_33_127120.pdf
9. Ministry of Health and Family Welfare, Government of India. (2016). National Rural Health Mission: National Health Mission. Retrieved from <https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=969&lid=49>.
10. Ministry of Health and Family Welfare, Government of India. (2018). LaQshya: Labour Room Quality Improvement Initiative (pp. 37-40). New Delhi, India: Author.
11. Vincent, V., & Saha, M. K. (2019). A study on evaluation of LaQshya in Andaman. *Recent Advances in Pathology & Laboratory Medicine*, 5(3).
12. Centre for Enquiry into Health and Allied Themes, Seth G.S. Medical College and King Edward Memorial Hospital & Maharashtra Association of Resident Doctors (2018). Exploring the phenomenon of violence faced by resident doctors in public hospitals of Maharashtra by patient/s and/or relative/s and/ or escort/s: Factsheet. Retrieved from <http://www.cehat.org/uploads/files/VAD%20factsheet%2020%20Sept%202018.pdf>
13. Shrinivas N. Gadappa, Sonali S. Deshpande, (2021). A Quasi-Experimental Study to Compare the Effect of Respectful Maternity Care Using Intrapartum Birth Companion of Her Choice on Maternal and Newborn Outcome in Tertiary Care Centre © Federation of Obstetric & Gynecological Societies of India 2021.
14. Shrinivas N. Gadappa. Standard Operating Procedure. OBGY, GMCH, Aurangabad SOPs/SNG_2017
15. Shrinivas N. Gadappa. Respectful Maternity Care. OBGY, GMCH, Aurangabad.