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Research Article

Obstetric Violence and Its Correlates: A Pilot Study in North Bengal Medical College, Darjeeling District, West Bengal, India

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Abstract

Background: Obstetric Violence is a topic of interest, concern and importance since ages. An issue which deals with the next progeny needs to be understood well to ensure well being of both physical and mental health of not only the newborn bit entire family. Post Pandemic this issue is of more priority. Dearth of literature exists.

Objective: An attempt to explore into it correlates with aim to formulate preventive measures has led to the study.

Methods: A cross sectional mixed method study in NBMCH after ethical permission was done.

Results: Obstetric Violence remains quite high and its statistically significant correlates have been identified.

Conclusion: Key Informant Interview revealed many other contributory factors which require exploratory analysis. A larger study is warranted.

Keywords: Obstetric Violence; Pilot Study; Darjeeling District

Introduction

Over recent decades, facility-based delivery rates have improved as women are increasingly incentivized to utilize facilities for childbirth, through demand generation, community mobilization, education, financial incentives or policy measures. However, a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture. Many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities [1-3]. This constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services. [4] While disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth. Such practices may have direct adverse consequences for both the mother and infant.

Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening avoidable complications and detention of women and their new-borns in facilities after childbirth due to an inability to pay [3].

In 2007, Venezuela became the first nation in the world to legally define and outlaw "obstetric violence", which was outlined in the

country's Law on the Rights of Women to a Life Free of Violence as: "the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalization and pathologizing of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life" [5].

In 2010, as part of the United States Agency for International Development (USAID)'s Translating Research into Action project, researchers Bowser and Hill published a landscape analysis existing research concerning "disrespect and abuse in facility-based childbirth". The report proposed seven categories to organize the various forms of disrespect and abuse documented by previous studies: (1) physical abuse, (2) non-consented care, (3) non-confidential care, (4) non-dignified care (including verbal abuse), (5) discrimination based on specific patient attributes, (6) abandonment of care, and (7) detention in facilities [2].

The World Health Organization (WHO) also released a statement in 2015 that emphasized that "every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care", and identified five areas of action in which researchers, policymakers, and health professionals should work to reduce mistreatment: (1) increasing support for research and action, (2) creating programs to promote respectful, high quality maternal health care, (3) developing rights-based frameworks for action, (4) generating data on the prevalence of disrespect and abuse and interventions to mitigate it, and (5) driving intersectional initiatives that encourage the participation of women [5].

The prevalence of obstetric violence in Indian hospitals has been widely reported. While in government hospitals inhuman practices such as negligence, physical abuse (such as slapping and episiotomies) and emotional/verbal abuse (such as scolding, shaming, yelling, not allowing husbands by the women's side) are common, in private hospitals, the incidence of (unnecessary) caesarean childbirths is very high (Chattopadhyay 2015; Rao 2015). Instead of the 10-15% ideal rate of C-section prescribed by the WHO, private hospitals in India have performed 40.9% C-sections according to latest National Family Health Survey 2015-16.

Respectful maternity care not only contributes in ensuring positive outcomes for the mothers and newborns, but also supports cognitive development of the babies later in the life. The National Quality Assurance Programme, Lakshya Guidelines are intended for achieving improvements in the intra-partum and immediate post-partum care, which are take place in the labour room and maternity operation theatre.

Although mistreatment of women during facility-based childbirth has received increasing recognition as a critical issue throughout the world, there remains a lack of consensus on operational definitions of Obstetric Violence and best practices to assess the issue. Moreover, only minimal research has focused on mistreatment in this part of India. The present study is planned to know the characteristics of Obstetric Violence to better understand the prevalence of the Obstetric Violence in the context of healthcare and which the possible repercussions are in current obstetric practice. The present study is designed to determine. Obstetric Violence and Its Correlatesin North Bengal Medical College, Darjeeling District, West Bengal, India.

Objective

Determining prevalence of Obstetric Violence (OV), to identify reasons of Obstetric Violence both from beneficiary and health care provider end and eliciting modifications from study subjects and dissemination of information.

Methodology

A mixed method cross sectional study with pragmatism in which quantitative method (one-to-one interview of the patients) followed by qualitative method (FGD of the healthcare providers) was carried out in Labor Rooms and PNC Ward, G&O department of North Bengal Medical College from July -September 2019. All pregnant women attending the labor room of the healthcare facility were included and Pregnant women attending only O.P.D of the facilities or unwilling were excluded. Complete enumeration was done for quantitative part and for qualitative part homogenous criterion sampling method was followed. One-to-one interview was conducted among 90 eligible beneficiaries who had their deliveries and abortions on the selected visit days in the study setting. Two FGD were conducted among doctors and nursing staffs who are working for more than 6months in the study setting and were

willing to participate. Well conversant participants were purposely chosen. (FGD1 = 6 Junior Doctors, FGD2 = 6 Nursing Staff). 1 Key Informant Interview was conducted involving 1 senior faculty of the study setting. Tools used were Questionnaire**,** FGD Guide. Ethical permission, informed voluntary consent was sought0. Record review was done to check any history of OV.

Qualitative

2FGD were conducted for exploring group experiences and free listing the factors responsible and measures to reduce OV. Anonymity and confidentiality of the participants was ensured. FGD was moderated by 2 trained female public health personals (PGT of Community Medicine and faculty of Community medicine) attached with the same medical college and both of the moderators were well versed in local language (Bengali) and English. Rapport building and briefing was done prior to study commencement. The FGD was conducted at the time and place convenient to the participants. Moderators used semi-structured guidelines which were based on Operation LAQSHYA document. Participants were asked for their perceptions, they were talking freely and spontaneously. No disturbance or deviation from topic and no dominance of any participant were ensured. FGD was audio-taped and transcribed as verbatim on the same day. Key Informant Interview was conducted among senior faculty of Obs. and Gynae. Informed consent was obtained from each participants on the day prior to the FGD session and before audio-taping the discussion. Refreshment was served to the participants after the session.

Data analysis

The transcripts were analyzed using Atlas-Ti version WIN 5.0. Structural coding and paraphrasing was applied to the responses specific to the research question and dendogram was made by faculty. Data was interpreted by inductive approach and content analysis. Reporting was done following - "Consolidated Criteria for Reporting Qualitative Research" (COREQ) guidelines.

Results

Quantitative analysis among beneficiaries - Prevalence of any one type of OV was 32.2%, none reported physical abuse. Among the participants 24.4% were teenage pregnancies.

Background characteristics

- Majority (62.2%) of study participants were in between 20-30 years, (65.6%) of Hindus, 46.7% were literates up to middle school and Multigravida. Majority (87.8%) of participants had no bad obstetric history
- Prevalence of Obstetric Violence: (Figure 1)

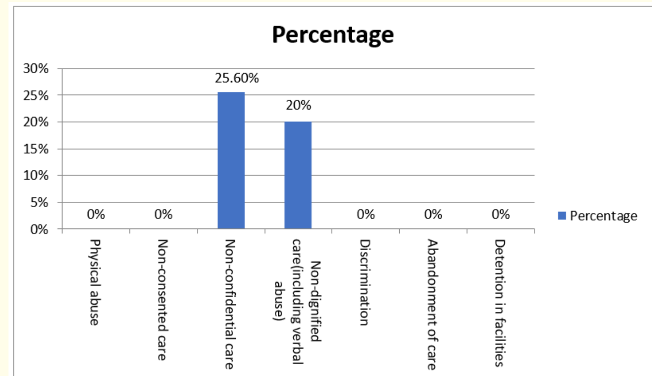

Figure 1: Obstetric Violence (OV) prevalence depicted pictorially (n = 90).

- At least one type of violence present in 32.2% and Total Obstetric violence is present in 38.9%.
- Chi square test revealed association with literacy status is statistically significant whereas with religion and age group and parity of presence of living children is not statistically significant (Table 1). Binary logistic regression analysis predicting Determinants of Obstetric Violence among the study participants also revealed similar result (Table 2)

Educational status	Obstetric Violence		Test of significance
	Present	Absent	
Primary and below	12 (85.7%)	2 (14.3%)	Chi-square = 16.793, df=2, p = 0.000(< 0.01)
Middle School	15 (36.6%)	26 (63.4%)	
High School	8 (22.9%)	27 (77.1%)	

Table 1: Distribution of study participants' experience of Obstetric violence according to their literacy status (n = 90). Association is statistically significant.

Variables	Obstetric Violence AOR (95% C.I)
Age Group <20 years	1
20-30 years	.245 (.022 - 2.708)
>30 years	1.146(.262 - 5.013)
Religion Hindu	1
Others*	.474(.155 - 1.451)
Literacy status Primary School	1
Middle School	.044 (.007 - .272)
High School and above	.486 (.167 - 1.416)
Number of living children < 2 (Primigravida)	1
>2 (Multigravida)	3.272 (.365 - 29.349)
Bad Obstretic history Abortion	1
Neonatal Death	.264 (.029 - 2.413)
None	6.451 (.223 - 186.537)

Table 2: Binary logistic regression analysis predicting

Determinants of Obstetric Violence among the study participants (n = 90).

*Others = Muslim, Christian, Buddhist.

Hosmer and Lemeshow Test, p value = 0.725, Nagelkerke R^2 = 0. 307.

- Content analysis of the Focused Group Discussion held revealed factors contributing and measures to reduce Obstetric Violence (Figure 2 a,b)

Factors responsible for OV

1. Workload
2. Wrong Counselling from some Quacks
3. Lots of patients without any antenatal
4. checkup, any usg, any serology reports

comes directly when they are in labour

4. No health education

5. Non co-operation from the patients and her relatives

6. Impatience of patient

7. For safe delivery and to save the child from birth asphyxia

Measures to reduce OV

1.Counselling for planned pregnancy and birth spacing, proper

ANC checkup, should be at ASHA Level

2.Birth attendant should be equally educated, regarding birthing process

3. Logistic support

4.Training and capacity building

5. Counselling centre/ room in the OPD

Figure 2: a, b: Content analysis of FGD regarding. Obstetric Violence among health care providers reveals.

- KII of attending faculty of gynecology regarding suggestions for customized modification revealed the following measures:
- Counselling of pregnant mothers regarding birth process before delivery
- Promotion of labour analgesia
- Birth companion to be allowed
- Work load of resident doctors to be reduced
- Strict law to be enforced
- Proper duty allocation

Discussion

In 2015 WHO pledged that "every woman has the right to the highest attainable standard of health which also includes the right to dignified, respectful healthcare". This paper empirically reports the occurrence of OV and its correlates in North Bengal Medical College, Darjeeling District, West Bengal, India. The findings are important in the Indian context where 100% facility-based delivery is yet to achieve. Despite significant under-reporting of, the estimate of OV in this study is high (Non-confidential care = 25.6%; Non-dignified care (Including verbal abuse) = 20%) and Inappropriate money demand = 100%. OV varies according to the literacy level of the female respondent. Thus, it particularly highlights the importance of awareness and knowledge about reproductive rights and entitlements of women in the health system.

Conclusion

The study concludes that OV is prevalent and significantly associated with few factors. Though in a same setting it is likely that all the mothers had gone through more or less same type of experiences, but the level of education implies a significant role with the occurrence of OV ($p < 0.01$). Majority of female encountered OV do not report or complain about it. Similarly during FGD, the healthcare providers told that majority of cases of OV was due to lack of health education, ignorance, non-cooperation from patient's side. Healthcare providers also opine that due to heavy patient load, prolong duty hours it becomes impossible for them to council each and every patients during labour and thus the need of Pre-conceptional counseling in ASHA, ANM level arises. Providers are not satisfied due to lack of infrastructure, insufficient staffs. They are also not receiving adequate guidance, support, training and capacity building facilitating the respectful and dignified maternal care. Overcoming identified issues like logistic constraints, workload and lack of training may prove beneficial. However a larger study is recommended.

Limitation

Being self-reported, this study might not have exhaustively captured all cases of abuse. This is particularly the case in settings disrespectful care appears to be normalized to some extent and may have resulted in underreporting. Since, different kinds of abuse can occur simultaneously, many categories of abuse were overlapping. Since this was a single setting based study may not generalized the result to the community.

Recommendation

Providers, beneficiaries and their family members must be made aware of women's right to respectful and dignified maternal care. Health education and counseling before conception.

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