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Disrespectful Maternity Care: Labour Room Violence in Government Health Facilities

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The government aims to enhance the quality of healthcare services for pregnant women ensuring "respectful maternity care" at public health facilities. However, observations in public hospitals reveal that many women are subjected to verbal and physical violence.

Lovey Pant, Kanika Sharma, Nazar Khalid and Nikhil Srivastav write:

On a winter afternoon, Reena, who was nine months pregnant, began having strong labour pains. This was in rural Uttar Pradesh and an ambulance took her to a nearby community health centre (CHC), but by then she had started to bleed. The CHC did not have blood transfusion facilities that Reena may have required for a complicated birth. So, she was referred to the government district hospital. Reena remembers, "On the way to the district hospital, I was constantly worried for my child. The question of whether my child would survive never left my mind."

It took Reena and her family about two hours to reach the district hospital. By then, she was bleeding profusely. While she was still in the hallway, her blood dripped and stained the floor. Reena, scared and distressed, was expecting some empathy from the staff. Instead, she was yelled at for dirtying the floor by her blood. She was in severe pain and began to cry, for which the attending doctor scolded her. When she could not control her cries, a nurse slapped her. Despite her pleas, all her companions were sent out of the antenatal care room she was in. Reena eventually had a stillbirth, and perhaps, her treatment at the hospital exacerbated her trauma.

Like Reena, we observed numerous women facing disrespect and violence during childbirth at public health facilities in two other large states—Madhya Pradesh and Chhattisgarh. As student researchers interested in new-born care and contraceptive equity, we visited two medical colleges, two district hospitals, and two CHCs in 2018, and observed 31 vaginal deliveries. We witnessed widespread mistreatment of pregnant women and extensive labour room violence. We also observed that compared to primary health centres (PHCs) and CHCs, mistreatment was more common in district hospitals and medical colleges. Physical violence and verbal abuse were not the only hardships that pregnant women had to go through. Women were also often humiliated for their fertility choices and had intrauterine devices (IUDs) inserted into them without their full knowledge or consent.

These forms of labour room violence threaten women's safety, dignity, and human rights (Vernekar 2019). They also have serious consequences for maternal and child health. While research is still under way, a preliminary analysis shows that such disrespect persuades pregnant women to choose to deliver outside public hospitals—sometimes at home, and sometimes at relatively less equipped and more risky unregistered private facilities. Choosing not to deliver at public hospitals can result in not so good child health outcomes. In several north Indian states, neonatal mortality is the highest among babies born in private facilities, intermediate for those born at home, and lowest for births in public facilities (Coffey et al. 2020). Therefore, improving women's experience in government health facilities is an important part of the larger health, reproductive, human rights, and human development agenda (Vernekar and Rege 2020).

Physical violence and verbal abuse

We found delivery rooms in public hospitals to be sites of extreme stress for both the staff there and pregnant women. In several cases, this stress manifested itself as physical and verbal abuse directed at the patient. Of the 31 deliveries we observed, 10 pregnant women were subjected to physical violence (slapped or hit), and 17 of them were insulted, threatened, or shouted at. To give an example, during Neerja's delivery at a medical college, she was threatened multiple times to stop screaming. Referring to a staff member who was not on the shift, a nurse said, "If she was here, she would have inserted her hand in your vagina, made her glove dirty, and then used it to slap you in the face. That's how she treats patients who scream a lot."

Physical violence inside delivery rooms can be initiated by any staff member, including attending doctors. In several instances, we saw that doctors were the primary perpetrators. A case in point was Karishma's delivery in a tertiary care hospital. She was crying out in pain, and this irritated the resident doctor. She hit her hard on the leg and yelled, "*Aise kyun kar rahi hai aurat, pagal ho gayi hai*

kya? (Woman, why are you doing this, have you gone mad?).” Later, when the baby’s head had just crowned in Karishma’s birth canal, pain made her slide back on the delivery table. It was disrupting a procedure and the infuriated doctor again hit Karishma on her leg.

Rampant physical violence in delivery rooms was often accompanied by verbal abuse of pregnant women and their humiliation. In many cases, we found that women were subjected to severe verbal abuse when they experienced pain. Not all women could control their cries and screams, and this resulted in a cycle of yelling, scolding, humiliating, and hitting throughout the delivery.

Women were also at the receiving end of verbal abuse when accidents or unintentional disruptions to the delivery process happened. As the bedsheet accidentally fell on the floor when Sarita changed her position, the *aaya* (midwife) slapped her, saying, “If this falls again, you will be the one picking it up.” These verbal abuses made pregnant women cautious, adding another worry other than the delivery. After the incident, Sarita tightly clutched the bedsheet the whole time. Despite being in pain, she had two tasks to do—the first was to push her baby out and the second was to make sure that the bedsheet did not fall.

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Similarly, another patient was subjected to insults about cleanliness when her excreta came out. To push the baby out, pregnant women must use the same muscles that we all use to push faeces out, and having faecal matter on the delivery table is not an uncommon sight. Yet, the foul smell disgusted the attending doctor who humiliated the patient by saying, “*Kitni budboo aa rahi hai. Pata nahi yeh log nahate bhi hai nya nahi*” (What a bad smell. Don’t know if these women ever take a bath). Another staff member asked the patient insultingly, “*Tum log nahate bhi ho ya nahi? Pichhle nau mahinon se nahaya bhi ya nahi?*” (Do you people ever take a bath? Have you had a bath in the last nine months?).

Inside the delivery rooms, such verbal abuse and humiliation often went hand in hand with threats of not completing the necessary procedures if the patients did not obey the staff. Some of the common threats we heard were the following: “We will leave you unstitched”; “We will leave you without getting the placenta out”; “You will kill your baby if you do not follow our instructions”; and “If something bad happens to your child, you will be responsible for it”. These frequent threats only added to the troubles of the already exhausted pregnant women.

Another form of verbal abuse common in delivery rooms was shaming the sexuality and fertility of women. One aaya said to a patient, “You guys have fun, and then cause trouble for us. You are screaming now, but when your husband asks you for sex, you will again run to him.” Humiliating women for their fertility was seen in all facilities. When Meena told the staff that she had a delivery about a year ago, everyone made fun of her for having another baby so soon.

While there are no circumstances under which it would be appropriate for a healthcare provider to shame a woman who comes seeking childbirth services, these comments may particularly sting for women who do not have enough autonomy to make decide when they can get pregnant. As a large body of literature shows, most reproductive decisions of women in India result from spousal, familial, systemic, and societal pressures.

Pressure for family planning and IUDs

Women in delivery rooms face extreme pressure to undergo family planning. It is well documented that staff at government health facilities in India continue to be given population control targets to fulfil (Sharma 2016). Delivery rooms and sterilisation camps are where these targets are achieved. Consequently, we found an aggressive push for family planning, particularly in the form of IUDs, in delivery rooms.

Family planning methods were pushed to the extent that ethical protocols related to providing contraception were ignored. In multiple cases, women were simply not told of the likely benefits and side effects of getting an IUD. In a district hospital, Rashmi had just delivered when an IUD was inserted into her. She had not been asked for her consent and was only told that a birth control procedure had already been done. In another incident, a nurse said to a patient after the procedure, “*Hum logon ne bacha na hone ke dawa dali hai. Sign kar do. Iske paise bhi mileinge*” (We have administered a medicine to stop future pregnancy. Sign this paper. You will also get money for this).

Disregard for protocols and counselling was shown by doctors as well. Aarti had just delivered at a medical college when the attending doctor told her that she would be getting an IUD. Aarti refused. This annoyed the doctor who said, "I am not asking for your permission. I am telling you that you will be getting a copper T." She refused again, saying that she would get sterilised. The doctor agreed, with a condition, "If you want the operation, you will have to get it tomorrow." At a different medical college, a pregnant woman requested the doctor not to insert an IUD as she wanted to get a contraceptive injection. But the doctor paid no attention to her request and went ahead with the insertion.

In contrast to these women, a handful of pregnant women who had relatively more socio-economic advantages were not subjected to the same pressure for family planning. For example, a patient whose seemingly well-off family was taking selfies after the delivery was not asked about getting a copper T. Instead, the staff said among themselves, "This one is smart; she will herself use some contraceptive method." This differential treatment suggested that social inequality also played a role in the staff's insistence on contraception.

> The target-driven approach to IUDs and sterilisation and the push for population control in India have resulted in a sidelining of the necessary information, consent, and counselling.

In instances where patients or their family members resisted the staff's insistence on family planning, several tactics, including misinformation and threats, were employed. A doctor told reluctant relatives of a patient, "*Copper T toh lagwana hi padega, nahi toh humari job jaegi*" (You will have to get the copper T, otherwise we will lose our jobs). In a different incident, a nurse said, "*Yeh toh sarkari niyam hai, lagana padega. Is aspataal mein delivery kara rahe ho toh yahan ka niyam manna padega*" (This is a government rule, it will have to be put in. If you are delivering in this hospital, you have to follow the rules here). When a woman was not convinced, she was told that the hospital would not provide her childbirth services if she conceived again. None of this was true. There are no official rules that say that a woman must get an IUD if she goes to a government hospital, or that her future deliveries cannot take place at a government hospital if she does not get an IUD.

Inserting an IUD right after birth without proper consent and counselling can have far-reaching effects on a woman's well-being. If she does not understand or remember, she might be concerned about heavier periods after getting an IUD. She might also want to get pregnant again and mistakenly believe that she is unable to, which may lead to stigma and stress for her.

Extreme pressure for family planning and insertion of IUDs must be seen as another form of violence that women are subjected to in delivery rooms. But this form of violence is more systemic in nature. The target-driven approach to IUDs and sterilisation and the push for population control in India have resulted in sidelining the necessary information, consent, and counselling. They also undermine women's contraceptive choice and autonomy.

A case study in violence

Seeking assistance for childbirth, Deepa went to a district hospital in Madhya Pradesh. After her admission, the nurse did a pelvic exam to assess the progress of her labour, took her blood pressure, and used a Doppler to gauge foetal distress by hearing its heartbeat. The foetus was doing well, and Deepa was in the second stage of labour. This meant that it was time for Deepa to push the baby out. Her contractions were intense and because she had already been in labour for some time, she was tired.

The attending nurse instructed Deepa to lie down in the lithotomy position,[1] but she was having trouble in keeping her legs in the stirrups. With every contraction, she was feeling more exhausted. Seeing Deepa struggle, the attending nurse remarked, "*Aaj to sab mote-mote [mahilaaein] hi aa rahe hain*" (All the fat women are coming today). The ward aaya followed, "*Haan is se pehle jo aaaye thein, wo bhi mutallo hi thi*" (Yes, the one who came before her was also fat). While it is uncomfortable for any labouring woman to keep her legs up in stirrups, perhaps it is particularly difficult for women on the higher side of the body mass index (BMI) distribution. Ignoring this, the attending staff did not provide support or suggest a more comfortable position to Deepa. Instead, they ridiculed and shamed her for her weight.

When Deepa could not keep her legs in the stirrups, the staff told her to keep lying on the delivery table, hold her ankles instead, and then try pushing the baby out. But Deepa was still unable to follow the instructions. Anticipating that her delivery would still take some time, the staff nurse checked on the foetus's heartbeat and left Deepa to attend to another patient who had just arrived. All this while, when she felt contractions, Deepa continued to push.

The nurse came back to Deepa in a while. This time, she looked a little more composed and determined. She stepped on a stool that was next to the delivery table and began applying pressure on Deepa's abdomen. It went for several minutes until the aaya, who had performed a pelvic exam, announced, "*Delivery mein abhi thoda samay hai. Bachche dani ka rasta khula toh hai par woh abhi bhi thoda sakra hai*" (There is still some time for the delivery. The cervix has dilated; however, it is not wide enough for the baby to crown). The time for a change of shift was close, but Deepa was nowhere close to being done.

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The new nurse started her shift by checking the foetus's heartbeat and found it normal. Deepa was told to push but once again she failed to fulfil the nurse's expectations. Despite knowing how long Deepa had been on the delivery table, the nurse was irritated. She performed another pelvic exam and concluded, "*Bachcha bas aane he wala hai*" (The baby is just about to arrive). She reached out for a Doppler and once again checked the foetus's heartbeat. But this time a clear beat was not audible, a sign that the foetus might be in distress. Worry flashed across her face. She tried to change her position to listen to the heartbeat again, but Deepa's leg was in her way. This made the angry nurse hit Deepa's leg and push it aside.

It was not clear if the nurse was able to hear the foetus's heartbeat, but her actions showed that she had decided that it was time for the baby to be born. By now, the aaya was already standing on the stool and the cycle of pushing, putting pressure on the abdomen, and yelling began anew. But none of it was working. This made the aaya—who had dirty slippers on—leap on the delivery table. With her feet firmly planted at the edge of the delivery table, the aaya stood over Deepa. Once in balance, she started exerting even more pressure on Deepa's stomach. In exhaustion and rage, she even slapped Deepa several times. A female member of Deepa's family and her village's accredited social health activist (ASHA) saw this, but instead of intervening, they joined in, "*Haan, peeto!*" (Yes, yes, slap her!).

After much struggle, the baby crowned—its head began to show in Deepa's birth canal. Now with every push, it was sliding down. But suddenly the baby stopped making progress; it was stuck because its umbilical cord had looped around its neck. The attending nurse then grabbed a pair of scissors to cut the cord, pulled the baby out, cleaned it, and passed it to a staff member to rush to the Sick and Newborn Care Unit (SNCU).

Towards respectful maternity care

We highlight Deepa's case because it shows how complicated and tense labour rooms can become. The staff did try to help Deepa and her baby by taking the blood pressure at the time of her admission and checking on the foetus's heart rate several times during labour. Yet, they behaved in ways that made the experience disrespectful and abusive for Deepa.

While witnessing this, and while talking to the staff, a question that never left our minds was why these women were subjected to such behaviour. What triggered such behaviour by the staff? We concluded that answer to these questions has at least three parts—one, the staff's burn-out from too many patients and long shifts; two, the staff's inability to deal with legitimate stress of life and death situations; and three, a highly unequal society where it is socially acceptable to victimise low-ranking people.

In an informal discussion, a doctor shared with us that sometimes doctors and nurses worry for their patients and have trouble controlling their emotions and fears. So, they end up trying to nudge the patient with violence. "[During my residency years], I have been in that situation," an assistant professor at a Medical College, also a gynaecologist, told us with a smile. He added, "Students [in medical institutes] are overworked, and you can clearly see that frustration on their face. They have long shifts, often, as long as 16 hours in a row … There is so much that they are expected to do during a shift—see patients in OPDs (outpatient departments), attend deliveries, work in the emergency room, sit outside wards, and then on top of all this, fill out the paperwork for each of these. So, doctors prioritise. Amid all the chaos, there is just one thing they end up focusing on—is the patient alive."

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The professor was right in saying that resident doctors and staff nurses are overworked. In a 135-bed tertiary care facility, there were only about a dozen residents to look after all the patients. In several instances, we saw staff nurses multitasking while attending to

multiple women who were in their second stage of labour. But the burn-out theory, at best, can only partially explain the labour room violence that we witnessed.

The second reason for labour room violence seems to be related to systemic issues such as the inflexible way in which maternal and infant care is set up and the lack of training among staff. The Labour Room Quality Improvement Initiative (LaQshya) guidelines,[2] issued by the Government of India, suggests staff "not insist [that a woman in labour lie] in the conventional lithotomy position" (Ministry of Health and Family Welfare 2017: 2). However, in Deepa's delivery, the staff had her lie on her back the whole time. It is possible that if she had been allowed to push in the way that felt more comfortable to her, and in which gravity helped her baby descend, she may not have become so tired, and the baby's heartbeat might not have dropped.

But labour rooms in India are not set up to allow women to push in other positions, and the staff is not trained to conduct deliveries in different ways. As a result, they quickly resort to aggressive methods such as applying fundal pressure on a woman's uterus. And when this does not work, they anticipate foetal distress, and their first reaction is frustration and aggression.

In Deepa's case, the attending staff was not well trained in dealing with the legitimate stress of a life-or-death situation. At the same time, there also seems to be an overarching culture of abuse in healthcare settings wherein abusing pregnant women crying out in pain is considered a norm. As documented in an undercover report from a maternity hospital, doctors seem to informally learn this culture of abuse while in training (Chattopadhyay 2015). Many medical students believe that slapping a patient is a "rite of passage" and thus something to celebrate. Given that doctors hold significant power in India's hierarchical healthcare setting, it is likely that their approval and exercise of violence gives sanction for it to other staff members, thus initiating a culture of abuse in delivery rooms.

Another driver for violence in labour rooms is the prejudices that the staff hold against their patients. Most doctors and nurses in India come from a socio-economically advantaged background, whereas most of the maternity patients in public hospitals are from poor and socially disadvantaged backgrounds. This inequality between service providers and patients, in conjunction with a highly unequal setting, results in normalised violence and abuse.

Policy changes desirable

Given this reality, urgent steps must be taken to ensure truly respectful maternity care in government health facilities (Vernekar and Rege 2019). While we work towards addressing the structural issue of social inequality, medical education and healthcare staff training institutions should include curricula on ethical patient-practitioner relationships and justice-oriented healthcare provisions. The staff should be oriented in patient-centred care that can not only improve health outcomes but also have positive effects on their morale and productivity. Training birth attendants on how to manage stress and different positions for pushing during the labour process should be a priority. The target-driven approach to family planning in India must end and attempts to diversify contraceptive choices, improve obtaining consent, and provide counselling should be ensured. Finally, to prepare pregnant woman mentally, healthcare providers should talk to them and their family members beforehand on what the delivery may involve and make them aware of the issues that may come up.

Bureaucrats and policymakers, just like other service providers, should devise ways to measure the quality of services that citizens receive. One can learn the most by talking to the patients, who, in this case, are incorrectly called "beneficiaries". Governments should set up systems to get feedback from patients on the quality of care they received. Doing all this is likely to be a steppingstone to broadly improving the culture of care in health institutions. Given that we know public hospital deliveries have significant child health benefits over private facilities and home births, it will also help attract thousands of pregnant women to public hospitals. Improving the experience of patients in government hospitals and making maternity care in them respectful is a direct path to enhancing health and human development in India.

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Footnotes:

1 The lithotomy position is one in which a woman in labour lies on her back with her legs up, supported by straps or stirrups. Although nurses and doctors often find the lithotomy or supine (on one's back) positions convenient when attending births, research suggests that pushing in the upright position is more effective, especially for first-time mothers (Kilpatrick and Garrison 2012).

2 In 2017, the Ministry of Health and Family Welfare, India, launched the Labour Room Quality Improvement Initiative (LaQshya). One of the main stated aims of the LaQshya guideline is to enhance the satisfaction of beneficiaries by ensuring "Respectful Maternity Care" (RMC) at public health facilities.

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