

## Mistreatment of Women in the Labour Rooms of India: A Call to Action

-Durga A. Vernekar & Sangeeta Rege

Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

*“The discourse on motherhood has many hidden places that have been very little studied, analyzed or criticized. These issues are, nonetheless, very influential with respect to our values, our worldviews, and our forms of life. The importance of such a topic as the dehumanization of birth for the research on values is certainly worth considering.”* (Villarrea Requejo & Fernández Guillén, 2011)

There is mounting evidence, globally and in India, of mistreatment of women at the time of childbirth in health facilities. Women in labour are beaten, slapped, physically restrained, verbally abused and humiliated by healthcare providers (Bhattacharya & Ravindran, 2018; Patel, Makadia & Kedia, 2015; Khanday & Tanwar, 2013). Indian policies and schemes to address maternal health have historically been directed towards arresting the maternal mortality rate and enhancing birth outcomes; the quality of healthcare provided has often been overlooked. For example, the Janani Suraksha Yojana under the National Rural Health Mission (NRHM) aims to increase the rates of institutional deliveries in order to prevent maternal deaths (Ministry of Health and Family Welfare, 2016). However, an evaluation of this scheme shows that whereas there was an increase in the rate of facility-based childbirths following the scheme, women were also subjected to abusive practises such as denial of privacy, verbal abuse, administration of fundal pressure, and being made to lie on floors immediately after delivery (Khan, Hazra & Bhatnagar, 2010). Whereas maternal health policies have thus far remained silent on the conduct of healthcare providers in labour rooms, the LaQshya (Labour Room Quality Improvement Initiative) guidelines released by the government in 2017 attempts to address it (Ministry of Health and Family Welfare, 2018).

Most research studies on the issue of disrespect an abuse of women in childbirth have been conducted with women, and have aimed to assess the prevalence

rates of abusive behaviour. CEHAT (Centre for Enquiry into Health and Allied Themes) conducted a study to understand healthcare providers' perspectives on mistreatment of women in labour rooms, and the causes they attributed it to. The study was carried out in one tertiary care hospital, and one secondary care hospital in India. The three cadres of healthcare providers namely doctors, nurses and class four staff members (i.e. hospital orderlies) were interviewed, as they invariably came into contact with women in labour. Following are findings of the study.

**Physical and verbal abuse to obtain women's compliance:** Shouting at the woman or threatening her with discontinuance of care if she did not comply with instructions was a common practice in the hospitals. Furthermore, women were frequently physically restrained to make them take the delivery position desired by healthcare providers; class four workers were usually called upon to perform this task. The practice of 'nil-by-mouth' was practised indiscriminately for all patients without any prior risk-screening process. Whereas the deleterious effects of fundal pressure on the woman and the foetus are well-documented and the practice forbidden (WHO, 2018), the study found that this practice had not been completely eradicated from health facilities, and fundal pressure was administered to hasten delivery. Episiotomies were virtually a standard practice for all primiparous women, without any assessment of whether it was required; many a time, episiotomies were administered without the use of local anaesthesia.

*It is an on the spot decision. ...In the midst of the (labour) pains even if you give a cut, she does not understand. Some women don't get to know even if there is no anaesthesia. For some patients, even if you do not give anaesthesia, you have to give an epi (episiotomy), because the baby's head is big, and there is very little space.*

(Staff nurse)

<sup>1</sup>Email: [durga@cehat.org](mailto:durga@cehat.org), [sangeetavrege@gmail.com](mailto:sangeetavrege@gmail.com)

Respondents denied the occurrence of any form of sexual abuse of the woman during childbirth, although some respondents recounted isolated complaints of sexual abuse against doctors at the time of conducting vaginal examinations. They however stated that it was the women who had misunderstood the situation, and that there was nothing of sexual in nature involved in the doctor's actions.

**Denial of 'violence' in labour rooms:** Whereas healthcare providers openly acknowledged the aforesaid practices, they did not perceive these practices as violence or abuse, but as a necessity for better birth outcomes.

*You have to do it for the baby. And we have to hold their feet and force them (to push harder). It also becomes necessary to give pressure on the fundus – Then we have to tie up their legs. Such cases have happened... Such experiences are plenty in the labour ward, they are routine, actually.*

(Staff nurse)

Respondents largely opined that pain was an integral part of labour. Providers believed that though it became essential to use measures such as physical force during childbirth, women soon forgot these adverse interactions on the birth of the child. They derided and dismissed the usage of the term "violence" for such practices.

*See, the baby has to be delivered within that short period of time. ...At that moment, it (physical and verbal abuse) becomes necessary. But after the baby is delivered, they say sorry, and we say sorry. Once the baby is out, everyone is relaxed. Otherwise during delivery sometimes even four staff members are required to pin the woman down....*

(Resident doctor)

**Consent-taking as a mere formality:** Whereas informed consent-taking entails the client being an integral part of the decision-making process and understanding fully what he or she is assenting to, the study found that consent was equated to mere signatures or thumb-impressions on the consent form. Decisions regarding various childbirth

procedures were taken primarily by the healthcare providers on women's behalf as they believed they understood medical procedures best. These decisions were typically put forth to the relatives of the woman rather than the woman herself. Seldom was communicating the potential risks and complications of delivery practised in the antenatal period. Obtaining the signatures superseded the need to make patients and their relatives understand the implications of the procedure.

Consent was not taken before administering episiotomies, and they were considered "a part of the normal delivery process". As a staff nurse stated: No, not (consent is not taken) for episiotomies. Because that is a must. This procedure is a normal procedure and there is no need to take consent. *Ninety per cent of primis need episiotomies. They may be anaemic and therefore may need help through episiotomies.*

Consent for insertion of the intrauterine contraceptive device copper-T was taken when the woman was on the delivery table and had just delivered her baby; this was carried out intentionally as providers were aware that the woman was not in a mentally or physically conducive state to make informed decisions.

*Yes... it (copper-T insertion) is stressed on more during labour. Immediately post-delivery we do stress upon it. ...Because the patient is now tired after delivering. (She already has) two children. She is more receptive during labour.*

(Senior doctor)

**Financial abuse of women and their families:**

The practice of class four workers demanding money from women and their families for services rendered, or for passing on the 'happy news' of the child's birth was rampant.

*Yes maushis take money. This happens a lot. We have strictly told the maushis not to take. But the maushis take during shifting the patient. ...It is prohibited. But they don't take it in front of us. So we don't get to know.*

(Staff nurse)

**Neglect of quality in maternal healthcare provision:** Though the LaQshya guidelines by the Indian government broadly aim to improve the quality of care provided in labour rooms, their thrust area once again is reducing preventable maternal and new-born mortality and morbidity. The component of respectful maternity care is overshadowed by technical aspects of childbirth care such as facility-level infrastructure and equipment, human resource management, and clinical practices to prevent infection and morbidity. Hence the guidelines, for the most part, do not view childbirth care within the framework of reproductive rights, but as clinical case management. Nevertheless, whereas the LaQshya guidelines were released more than a year before this study, it is significant to note that neither were the healthcare providers interviewed aware about the guidelines, nor was any training conducted to acquaint them with the same. Whereas the guidelines speak about providing women a fulfilling childbirth experience, and put forth provisions such as birth companions, partitions for privacy, and confidentiality of client information, the study found that these aspects were conspicuous by their absence.

### Implications

The findings of the study underscore the institutionalization and routine practise of disrespect and abuse during childbirth in health facilities, and lack of recognition by healthcare providers thereof. There must be recognition of the fact that maternal and reproductive health policies cannot work in silos. There is an urgent need to adopt a human rights-based lens while charting policies and guidelines to address maternal health. This is a call to action for the Indian health system for providing healthcare during childbirth which is judicious, dignified, and rights-based.

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