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ORIGINAL ARTICLE

Women's Experience with Obstetric Violence during Hospital Birth

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ABSTRACT

Objective: The purpose of this study was to investigate obstetric violence in a Public Hospital.

Materials and Methods: This Cross-sectional study was performed at department of Obstetrics and Gynecology Government hospital in Karachi for one-year, from January 2020 to January 2021. Non-probability consecutive sampling technique was used for participants' selection and 200 patients were included. Data were collected on maternal and demographic characteristics, recent birth experiences and obstetric violence.

Results: The data of 200 participants were analyzed. The mean age (SD) of females in this analysis was 32.10 (7.20) years. About 75 percent of those surveyed said staff did not allow family members to attend the patient during birth. The most reported physical abuse was staff members who did vaginal examination painfully during delivery (40.5%), staff who pressed the abdomen during delivery (29.5%) and was not gentle, and staff who underwent episiotomy without anesthesia (25.5%). When asked about negligent care/ Abandonment, 108 (54%) reported experiencing screaming or blaming from the authorities during childbirth, while 97(48.5%) reported negative feedback or received threats from the authorities during childbirth. 97 people (48.5%) reported Non confidential care. In addition, about 71(35.5%) of women reported Non dignified care during childbirth, and 68 (34%) reported Non consented care. Physical abuse was reported in 36(18.0%) patients and bribe taken from 10 patients (5%).

Conclusion: Women during pregnancy were subjected to non-dignified care as an invasive method, drug use was not mandatory, their privacy was violated, they were largely exposed to physical violence and the needs of pregnant women were ignored.

Keywords: Violence, Obstetric, child birth.

INTRODUCTION

A key goal of government development was to invest in policies and programs aimed at increasing the birth rate of enterprises[1-2]. However, this is a very intensive approach that aims to increase the birth rate, not the quality of women's care. This is seen in organizational deliveries when health care professionals provide inadequate and sometimes almost inhumane care. Women are victims of verbal harassment and discrimination[3-4]. Delivery to the ground due to lack of beds; Pain relief is not provided to prevent prolonged labor, and invasive procedures are performed without their knowledge or consent[5]. Collectively, these acts of violence are called childbirth violence. Obstetric violence is divided into different categories, including physical, verbal and sexual abuse, carelessness and neglect of care, all kinds of discrimination, and finally unnecessary iatrogenic surgeries such as cesarean section[6-7]. The latter category, overdose, is widely observed in developed countries, especially in the United States[8]. Other forms of violence have been attributed to developing and underdeveloped countries, but mainly in the context of economically and socially disadvantaged women whose health needs depend largely on the public system[9]. This article examines middle-class women and their experiences during childbirth. Obstetric violence is a relatively new term and was first recognized in Venezuelan legal circles in 2007. However, there was a debate about inhumane methods of childbirth in Brazil in the early 1990s. This is defined as "childbirth violence". Or birth control medications are performed without the woman's permission to make decisions about her body (D'Gregorio, 2010)[10-11]. Such behaviour is in stark contrast to the Widespread Declaration of the Rights of the Child, which statuses that all females has the right for adequate and deferential care for her reproductive and sexual health, as well as during childbirth (White Ribbon Alliance, 2011)[12-13]. Global recognition of this problem did not appear until mid-2000. Only in the last decade has the term been recognized as a legal and social category. A rights-based approach to issues such as "Abuse, neglect or disrespect in childbirth may violate women's fundamental human rights" (Vacaflor 2016) has been helpful in drawing public attention to this issue[14]. There have been many reports of feelings of objectivity, disrespect, or insult to women during pregnancy and childbirth, often referred to as "inhuman care" or "medical delivery." Pathology and medicalization have been shown to be the main reasons for the continuation of labor violence (McGarry et al. 2017)[15]. Physical violence has been found to be the predominant form of violence, especially in public hospitals where health workers have been reported to have been flogged, pinned, or beaten during childbirth (Shrivastava and Sivakami, 2020). However, it has been found that sexual abuse is low, which can be attributed to perceived stigma and discrimination and the discomfort associated with reporting it (Bohren et al., 2015)[16]. Patel et al. (2015) found that discrimination, especially class discrimination, is widespread in childbirth centers. Goli et al. (2019) showed that childbirth violence is significantly higher among Muslim women compared to Hindu women as well as among lower class women compared to women in general. In addition to cassette, class is also considered an important factor in the occurrence of labor violence. Diamond Smith et al. (2019) found that women with lower social status were more likely to experience higher levels of abuse. (2017) found that being in the highest (relative to the lowest) wealth quintile was significantly associated with higher levels of abuse. The number of reports of childbirth abuse was found to be relevant. The aim of this study was to investigate obstetric violence in a tertiary care hospital.

MATERIALS AND METHODS

This Cross-sectional study was performed at the Obstetrics and Gynecology department of government hospital in Karachi for one-year duration from January 2020 to January 2021. Married women over 18 years of age with minimum one child was participated in this study using the non-probability consecutive sampling technique and 200 total patients were included. Individuals with mental illness, speech disorders, medical / surgical conditions, and those who did not wish to express informed written consent were omitted from the analysis.

Preliminary data were gathered using a structured questionnaire through face-to-face interviews with study participants. The closed structure questionnaire comprised of 3 parts. In the 1st part, the maternal and demographic features of the females were questioned, in the second part, the violence of childbirth and in the third part, the participants' last birth experience. This questionnaire was tested on 30 females and the

pilot study results were not used in the main study. Demographic data gathered is age, place of residence (urban or rural), education and household income over the years. In the second part of the survey, questions were asked about pattern of disrespect and abuse during childbirth. The questionnaire used by the three researchers was based on Pakistani and US guidelines on childbirth violence. The apparent accuracy of the questionnaire was chequered. The questionnaire was first interpreted into Urdu and then back into English. In this research, the Urdu version of the questionnaire has been used. The Obstetric Violence section included an information questionnaire in 9 areas related to dishonest care, unnecessary drug use, physical violence, disregard for patient privacy, disregard for women's needs, illegal care, and inappropriate requests for the payment. All questions had a binary yes or no answer option. Finally, the questionnaire last part included the participants reply on ignoring female's requirements and physical abuse by staff members was recorded with good, acceptable and bad answer options.

Data analysis was done using SPSS 22 (IBM). The information is entered into the software and re-checked to correct any incorrect input. Descriptive statistics were prepared. Quantitative data are presented as qualitative data as frequency / percentage and mean ± standard deviation.

RESULTS

The study included 200 participants. The demographic and maternal characteristics of the participants are presented in detail. The mean age (SD) of women in this study was 32.10 (7.20) years. Table-I

Table 1: Socio- demographic Characteristics of Respondents

Socio- demographic characteristics	Frequency (n)	Percentage
Age group (years) <20	16	8
20- 29	121	60.5
30- 39	45	22.5
40 and above	18	9
Religion Islam	185	92.5
Christianity	15	7.5
Educational Qualification None	60	30.0
Quranic	20	10
Primary	40	20
Secondary	66	33
Tertiary	14	7
Marital status Married	181	90.5
Divorced	11	5.5
Single	8	4
Occupation Housewife	102	51
Civil service	47	23.5
Students	34	17
Tailoring	17	8.5

Table 2 shows the study participants' response to inadequate care and unnecessary use of invasive methods and medications by staff. When asked about negligent care/ Abandonment, 108 (54%) reported experiencing screaming or blaming from the authorities during childbirth, while 97(48.5%) reported negative feedback or received threats from the authorities during childbirth. 97 people (48.5%) reported Non confidential care. In addition, about 71(35.5%) of women reported Non dignified care during childbirth, and 68 (34%) reported Non consented care. Physical abuse was reported in 36(18.0%) patients and bribe taken from 10 patients (5%).

Table 2: Pattern of disrespect and abuse during childbirth

Pattern of abuse	Frequency (n=200)	Percentage
*Abandonment/neglect of care	108	54
*Non confidential care	97	48.5
*Non dignified care	71	35.5
*Non consented care	68	34
Detention in health facility	11	5.5
Request for bribe	10	5

51 (25.5%) of the staff reported having had an episiotomy without medical need, while 21 (10.5%) reported that the staff had given birth without medical need by forceps / suction, while only Eight (4%) of them gave birth.

Table 3: Females Response on Ignoring Females Requirements and Physical Abuse by Staff Members

Ignorance for assistance requests from staff members	32(16%)
Ignored patient request for delivery position	24(12%)
Refused presence of attendant	150(75%)
Not allowed food or drinks	45(22.5%)
Treated patient as a passive participant	21(10.5%)
Physical abuse including slapping, pushing or pinching	16(8%)
Sexual abuse	1(0.5%)
Episiotomy without anesthesia	51(25.5%)
Not allowed to speak or bed restriction	42(21%)
Pressed abdomen forcefully	59(29.5%)
Painful vaginal examination	81(40.5%)

Table 3 lists participants' responses to female neglect and physical violence by staff. 150(75%) of the respondents in the survey believed that the authorities denied the presence of a family member during childbirth and then 32 (16%) of women ignored the request for help from the authorities. After delivery; Employees ignored the choice of delivery position (12%), employees were deprived of food and drink (22.5%), under the supervision of the worker during childbirth (10.9%) and passive treatment by the worker during childbirth during attendance (10.5%). 60% of the patients testified bad experience, 30% said satisfactory and good only in 10%.

DISCUSSION

The results presented above show that Obstetric violence is attributed only to poor public health infrastructure and that a large proportion of the poor depend on it and are the only victims of childbirth violence[13-16]. However, this study shows a group of middle-income women who rely heavily on the private sector to meet their health needs in the hope of better opportunities, but who are also vulnerable to abuse during childbirth[17-18]. Based on the survey results, some important observations need to be made. First, awareness of the concept of Obstetric violence is very low even among the richest women in the socio-economic sectors[19-20]. Second, the predominant form of violence is the increase in the use of non-confidential care in public hospitals and the physical abuse of surgery in developed countries. Third, discrimination is portrayed as an essential element of violence, and women experience it in any way[21-22]. This means that the question is related to class discrimination, skin colour discrimination, etc., and shows how it relates to other diseases in Indian society, for example, among the reasons attributed to this situation. It is the patriarchal nature of a society in which even physicians have negative gender stereotypes[23]. It should be understood that a woman has an absolute right to her body and should always have the right to be informed or to refrain from doing anything she does not want to do. In addition, the idea of a successful birth can not be simply defined as the survival of the fittest. It should also include safe and humane measures such as the presence of a supportive family member, a suitable place of birth, and respect and dignity at birth. In India and other parts of the southern hemisphere, structural violence distributes the risk of childbirth unequally, and poor women are disproportionately at risk. However, the lack of

infrastructure and space makes it impossible for women to be supported in hospitals due to overcrowding.

CONCLUSION

About 60 percent of respondents rated their delivery experiences as bad; thirty percent rated them as acceptable and approximately 10 percent as good. Obstetric violence and disrespect abuse during childbirth is very high and should be reduced therefore require special attention of the health department. Stricter rules against abuse must be enforced. There is a need of sending brochures to maternal health clinics and informing pregnant women about their rights to high quality care.

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