Internship Training

at

International Institute of Health Management Research
New Delhi

# Mistreatment faced by mothers in Obstetric department of Public Health Facilities in Three States in India: A Qualitative Study

By

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PG/21/093

Under the guidance of

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PGDM (Hospital & Health Management)

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**International Institute of Health Management Research New Delhi**

# CERTIFICATE

Dr Shama Bhati, affiliated with IHMR, Delhi, conducted a research project titled "Mistreatment faced by mothers in Obstetric department of Public Health Facilities in Three States in India: A Qualitative Study"

A Primary Study conducted between 1ST March 2023 to 15th June 2023. The study involved the collection of primary data from the study participant and data analysis and report writing.

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The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavours.

Sidharth Sekhar Mishra

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The following dissertation titled **"MISTREATMENT FACED BY MOTHERS IN OBSTETRIC DEPARTMENT OF PUBLIC HEALTH FACILITIES IN THREE STATES IN INDIA: A QUALITATIVE STUDY"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **PGDM (Hospital & Health Management)** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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## Certificate from Dissertation Advisory Committee

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**Date:**

**Place:**

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| CHC | : Community Health Center |
| DH | : District Hospital |
| IEC | : Information Education and Communication |
| JSSK | : Janani Shishu Suraksha Karyakaram |
| JSY | : Janani Suraksha Yojana |
| LaQshya | : Labour room Quality improvement Initiative |
| MMR | : Maternal Mortality Rate |
| NVD | : Normal Vaginal Delivery |
| PHC | :Primary Health Center |
| PMSMA | : Pradhan Mantri Surakshit Matritva Abhiyan |
| PNC | : Post Natal Care |
| PPH | : Post Partum Haemorrhage |
| RMNCH+A | : Reproductive, Maternal, New-born, Child and Adolescent Health |
| SBA | : Skill Birth Attendant |
| SDGs | : Sustainable Development Goals |
| SDH | : Sub Divisional Hospital |
| SRB | : Student Review Board |
| WHO | : World Health Organization |

***Mistreatment faced by mothers in Obstetric department of Public Health Facilities in Three States in India: A Qualitative Study***

## ABSTRACT

Obstetric violence continues to persist within healthcare systems, posing a threat to the well-being of pregnant individuals and their infants.
This qualitative, phenomenological study was conducted from March 1st to June 15th, 2023, the study focused on three aspirational districts of three states in India: Fatehpur (Uttar Pradesh), Dahod (Gujarat), and Vizianagaram (Andhra Pradesh). The study population consisted of women who had delivered within the last two months and healthcare providers associated with Maternal and Child Health (MCH) services.
Data collection was conducted through community-based in-depth interviews Thematic analysis was employed. The '4A NOT' model (Not Acceptable, Not Available, Not Accessible, Not Affordable) was used to categorize forms of obstetric violence, and the 'Three Delays' of maternal mortality were used to categorize the consequences of obstetric violence. Causes of obstetric violence were further categorized into broader themes, including individual impact, social impact, and system constraints.
Instances of physical and verbal abuse, discrimination, failure to meet professional standards of care, and poor rapport between patients and providers are considered unacceptable forms of mistreatment. Structural deficiencies, such as the lack of resources and staff, as well as gaps in the process of care, contribute to non-availability. Non-accessibility barriers include poor road conditions, delays in ambulance services, ineffective referral systems, and misuse of government programs. Non-affordability arises due to limited resources, inadequate staffing, insufficient infrastructure, and abusive behavior, leading individuals to seek costly private healthcare options. The normalization of bribery and abusive behavior, hierarchical structures, inadequate administrative responses, and cultural beliefs contribute to obstetric violence. Fragmented and impersonal care, coupled with overburdened staff, further perpetuate mistreatment. Addressing these factors is crucial to ensure respectful and dignified care for pregnant individuals

## BACKGROUND

Every 24 hours, India welcomes the arrival of approximately 67,385 newborns, accounting for one-sixth of the global number of births. Disturbingly, almost half of all maternal deaths and 40% of neonatal deaths occur either during labor or within the initial 24 hours following delivery. For the past fifteen years, India has implemented measures to encourage institutional deliveries, recognizing their effectiveness in enhancing the health and overall welfare of mothers. This initiative has yielded significant improvements in the Maternal Mortality Rate (MMR). [1,2]

Between the years 2018 and 2020, the Maternal Mortality Rate (MMR) in India has shown improvement, declining from 103 deaths per lakh to 97 deaths per lakh. This positive trend puts India on track to achieve Sustainable Development Goal 3 (SDG 3), which aims to attain an MMR below 70 by 2030. However, despite this progress, there is still a considerable distance to cover. Merely reducing MMR is an insufficient objective unless there is a simultaneous enhancement in the childbirth experience for women. It is crucial to ensure that the priorities of healthcare providers do not overshadow the needs and empowerment of birthing women, preventing them from being reduced to passive participants. [3]

Currently, the focus should not solely be on increasing service utilization but rather on enhancing the quality of care provided. In recent years, there has been a notable increase in facility-based deliveries as women are encouraged to utilize healthcare facilities for childbirth. Various strategies such as demand generation, community mobilization, education, financial incentives, and policy measures have contributed to this positive trend. However, an alarming body of research has emerged, highlighting the distressing experiences women face during pregnancy and, more specifically, childbirth. Many women worldwide encounter disrespectful, abusive, or neglectful treatment during their time in healthcare facilities [14,15]. This not only breaches the trust between women and their healthcare providers but also acts as a significant deterrent for women seeking and utilizing maternal health services [16]. Although disrespect and abuse can occur throughout the entire pregnancy journey, women are particularly vulnerable during childbirth. These practices can have direct adverse consequences for both the mother and the newborn.

Instances of disrespectful and abusive treatment during childbirth within healthcare facilities have encompassed various forms of misconduct. These include explicit physical abuse, extreme humiliation and verbal mistreatment, imposition of coercive or non-consensual

medical procedures (such as sterilization), breaches of confidentiality, denial of pain medication, severe violations of privacy, rejection of admission to healthcare facilities, abandonment of women during childbirth resulting in preventable life-threatening complications, and the unjust detention of women and their newborns in facilities due to financial constraints [15].

In 2007, Venezuela achieved a significant milestone by becoming the first country to establish a legal definition and prohibition of "obstetric violence." This concept was clearly outlined in the country's Law on the Rights of Women to a Life Free of Violence. Obstetric violence is described as the act of health personnel appropriating women's bodies and reproductive processes, leading to dehumanizing treatment, excessive medicalization, and pathologization of natural processes. As a result, women experience a loss of autonomy and the ability to make free decisions regarding their bodies and sexuality, ultimately negatively impacting their overall quality of life [4].

In 2015, the World Health Organization (WHO) issued a statement emphasizing the fundamental right of every woman to receive the highest attainable standard of health, which encompasses the right to dignified and respectful healthcare. The WHO identified five key areas that require collaborative efforts from researchers, policymakers, and healthcare professionals to address mistreatment: (1) enhancing support for research and intervention, (2) establishing programs aimed at promoting respectful and high-quality maternal healthcare, (3) developing frameworks based on rights for effective action, (4) generating data on the prevalence of disrespect and abuse, as well as interventions to mitigate these issues, and (5) driving intersectional initiatives that actively engage women in the decision-making process. To instill confidence in women regarding healthcare centers, it is crucial to ensure they receive respectful and dignified treatment. In line with this goal, the government of India has launched the national LaQshya program, which provides a set of guidelines and protocols for healthcare providers. These guidelines promote the principles of no verbal or physical abuse, avoiding leaving women unattended, respecting privacy, and obtaining consent before conducting examinations and procedures. [4,5]

SDG Target 3.8 emphasizes the achievement of Universal Health Coverage (UHC) and the delivery of high-quality healthcare. Within the context of quality healthcare, the utmost

importance lies in providing respect and dignity to individuals. Respectful care encompasses honoring women's autonomy, preserving their dignity, acknowledging their emotions, safeguarding their privacy, respecting their choices, ensuring freedom from mistreatment and coercion, and considering their personal preferences, including the option of having a companion during maternity care. Regrettably, recent research has revealed that women often encounter neglectful, abusive, and disrespectful treatment during childbirth in healthcare facilities. This mistreatment, deemed humiliating or undignified within local consensus, tarnishes the experiences of women during childbirth worldwide. Every woman receiving healthcare services related to childbirth, regardless of the setting, deserves to be treated with respect by maternity care providers. The absence of respect and the occurrence of abuse during labor and delivery dissuade many women from seeking professional maternity care, potentially leading to increased instances of birth injuries and even maternal and newborn deaths. Despite the severe consequences, such disrespect and abuse during childbirth persist undisclosed, particularly in developing countries. [6,7]

The mistreatment of women during childbirth within healthcare facilities is not solely attributable to the interaction between women and healthcare providers. Systemic failures at the levels of the health facility and the overall health system also contribute to its occurrence. Putting an end to disrespect and abuse during childbirth requires a comprehensive approach that involves the active participation of various stakeholders. This includes women, communities, healthcare providers, managers, training and certification bodies, professional associations, governments, health system stakeholders, researchers, civil society groups, and international organizations. It is essential to engage these entities and collaborate in order to ensure that instances of disrespect and abuse are consistently identified and reported. Moreover, it is crucial to implement locally appropriate preventive and therapeutic measures to address this issue effectively. [8]

**Rationale of the study**

The rationale behind this study stems from the lack of research in India that specifically examines the experiences of mothers in government facilities located in aspirational districts. It has become apparent that there is a need to shift the focus from merely increasing service utilization to enhancing the quality of care provided. If the issue of disrespect and abuse is not addressed, it is plausible that such detrimental practices may drive women towards opting for

home deliveries. Although home deliveries are generally riskier, they offer a more empathetic environment compared to facility-based birthing options. Therefore, the objective of this study is to gather evidence regarding the prevalence of mistreatment of women in public health facilities and identify contributing factors. This evidence will support decision-making based on empirical data for further enhancements in the quality of care.

***Objectives:***

***General objectives***:

To investigate the form of mistreatment in public facilities and identify associated factors

***Specific objectives***:

- To assess the prevalence and types of obstetric violence experienced by women in public healthcare facilities.
- To identify the factors contributing to obstetric violence
- To explore the impact of obstetric violence on the maternal health.

## REVIEW OF LITERATURE

- A qualitative study conducted by Lovey Pant et al. in public hospital of MP and Chhattisgarh of found that women were subjected to different extensive verbal and physical violence. They were also humiliated for their fertility choices and had intrauterine devices (IUDs) inserted without their full knowledge and consent.[9]
- Singh S et al. used a mixed-methods strategy to perform a cross-sectional study in 18 tertiary healthcare facilities in India. The quantitative information was gathered to describe the number of laboring women, their birth partners, and the medical staff present, as well as the types of disrespect and abuse (D&A) these women experienced. Their research shows that birth companionship is still a rather uncommon practice in public hospitals in India. Less than half of the observational time saw birth partners present, and fewer than half of the laboring women had a birth companion with them. Birth companions are not permitted in labor rooms due to lack of hospital policy, space restrictions, patient overcrowding, and privacy issues for other patients. Despite their supportive responsibilities, otherwise generally acknowledged within the qualitative interviews, both for women and providers. Additionally, it was discovered that the likelihood of D&A in laboring women was significantly adversely correlated with the presence of birth companions. [10]
- Smith N conducted a cross-sectional study of women age 16–30 who had delivered infants in health facility in the previous five years and were living in slums of Lucknow India. Data were collected on their experiences of mistreatment, the types of support they received, and who provided that support and found that women who reported lack of support were more likely to report mistreatment. Lack of support in regard to discussions with providers and provider information were most strongly associated with a higher mistreatment score. Women who received any type of support from their husband or a health worker were significantly more likely to report lower mistreatment scores. Receiving informational support from a mother/mother-in-law or emotional support from a health worker was also associated with lower mistreatment scores. However, receiving emotional support from a friend/neighbor/other family member was associated with a higher mistreatment score.[11]
- Saxena M et al. published an article on 27 september,2018 about women's experiences of childbirth in Nine public health facilities of two rural districts of Uttar Pradesh (UP), India, and found that inadequate clinical care like lack of routine monitoring of labor

progression, inadequate postpartum care; partially compromised privacy in the labor room and postnatal ward; and few incidents of abuse and demand for informal payments.[12]

- Sharma SK et al. conducted a descriptive study in tertiary care center in central India and found that all women experienced at least one form disrespect in labor room. [13]

## METHODOLOGY

***1.Study design***- qualitative, phenomenological

***2.Study period-*** the study was conducted from 1st march to 15th June 2023

***3.Study duration***-the entire study is for a period of 3 and half month and data collection will span for a period of 2 and half months.

***4.Study area***- the study was conducted in 3 different states that are, UP, Gujarat and Andhra Pradesh. Only three states were selected because of limited time. States were selected on the basis OOPE and percentage of private institute to total institutional deliveries. One state from each zone was selected.

***5.Study population***- women delivered in in last two month and health care providers associated with MCH

***6.Selection criteria***-

- *Inclusion criteria*-
    - Women delivered in last two month.
    - Women of 15-49 years old.
    - Health care providers associated with MCH.
- *Exclusion criteria*-
    - never had institutional delivery.
    - clinically unstable.
    - any person who does not provide consent to be part of the study.

***7.Sampling technique***-

Multistage sampling technique will be used for this study.

***Step 1: Selection of States***

Percentage of Deliveries Conducted at Private Institutions to Institutional deliveries (Public Institute+Private institute) was undertaken as a significant indicator for the selection

of other states. As per the HMIS: (2019- 20) there were three states which were selected these three states have higher Percentage of Deliveries Conducted at Private Institutions to Institutional deliveries (Public Institute + Private institute). Three states with higher percentage were Kerala, AP, Guajrat were selected . Other three states were selected on the basis of Out of Pocket Expenditure. As per the National Health Accounts: (2017- 18) released in November 2021, three states were selected with OOPE above national average, so Uttar Pradesh, WB and Punjab were selected.

| India and States | OOPE % of THE (NHA 2017-18) |
|---|---|
| Uttar Pradesh | 72.6 |
| West Bengal | 69.8 |
| Punjab | 69.4 |
| Kerala | 68.7 |
| Jharkhand | 68 |
| Andhra Pradesh | 67 |

*(Source: https://nhsrcindia.org/sites/default/files/2021-11/National%20Health%20Accounts-%202017-18.pdf)*

But, as in the stage 2 we have utilised the Aspirational districts which were not available in West Bengal and Kerala so they were exluded, and Punjab was excluded as Gujarat was already selected from West zone. Therefore in end we selected three states, Andhra Pradesh (from South Zone) and UP (from north  zone) and Gujarat (from west zone).

| S.NO | STATES | Deliveries Conducted at Private Institutions | Institutional deliveries (Public Insts.+Pvt. Insts.) | % of Deliveries Conducted at Private Institutions to Institutional deliveries (Public Insts.+Pvt. Insts.) |
|---|---|---|---|---|
| | | 2019-20 | 2019-20 | 2019-20 |
| 1 | Kerala | 2,44,014 | 3,57,826 | 68.19 |
| 2 | Gujarat | 5,48,854 | 8,90,638 | 61.62 |
| 3 | Andhra Pradesh | 3,30,077 | 5,71,651 | 57.74 |
| 4 | Telangana | 2,53,837 | 4,86,177 | 52.21 |
| 5 | Maharashtra | 6,95,915 | 13,74,975 | 50.61 |
| 6 | Punjab | 1,40,810 | 2,84,331 | 49.52 |
| 7 | Tamil Nadu | 3,32,824 | 7,40,609 | 44.94 |

*(Source https://hmis.mohfw.gov.in/#!/standardReports)*

***Step 2: Selection of Districts***

The district were selected based on Aspirational district index published by NITI Aayog from the selected states. These are the districts coming on high index on Niti Aayog aspirational district program.

**Aspirational districts as per NITI Aayog index**

| SL NO | STATE | DISTRICTS |
|---|---|---|
| 1 | Uttar Pradesh | Fatehpur |
| 2 | Gujarat | Dahod |
| 3 | Andhra Pradesh | Vizianagaram |

*(Source: https://www.niti.gov.in/aspirational-districts-programme)*

***Step 3: Selection of facilities in a districts***

Within each selected district, District hospital, PHCs were selected randomly with the help of district programme coordinator.

***Step 4:* Selection of Participants**

- Purposive sampling was done for selection of mothers.
- Health worker were selected on the basis of availability.

***8.Sample Size:***

| Respondent | Study population per state | Study population in all three states |
|---|---|---|
| **Women had at least one delivery at a health facility** | 5 | 15 |
| **Maternity care provider staff nurse /ASHA/doctor** | 2 doctors<br>2 nurse<br>2 ASHA | 18 |

***9.Data Collection: Tools and Technique***

community based using IDI tool and audio recorder was used for data collection and in some cases, notes were made as participant did not gave permission for recording.

***10.Data analysis***

- data was analyzed through Microsoft Excel and Microsoft Word.
- Interviews were transcribed in Microsoft Word.
- Thematic analysis was used to analyze data.
- Codes were made from transcribed data by keeping research question in mind.

- Similar codes were than categorized in sub themes and, then these subthemes were categorized in broader themes.
- We used '4A NOT' model (i.e., Not Acceptable, Not Available, Not Accessible, Not Affordable) to categories forms of obstetric violence. As given in Table 1
- 'Three delay' of maternal mortality was used to categories consequences of obstetric violence.
- Cause of obstetric violence were categorized in broader themes like, individual impact, social impact, system constraints as given in Table 2

| FORMS OF OBSTETRIC VIOLENCE | |
|---|---|
| 1.NOT ACCEPTABLE | |
| Physical abuse | women beaten |
| | Slapped |
| | Pinched |
| verbal abuse | harsh and rude language |
| | Shouting |
| | reprimanded and blamed |
| stigma and discrimination | Preference to known |
| | discrimination based on medical condition |
| failure to meet professional standards of care | refusal to provide pain relief |
| | Coercion |
| | potential negligence |
| | Abandonment |
| | Lapse in clinical judgement |
| | Detrimental post-natal care |
| poor rapport between women and providers | poor communication |
| | No compassion |
| | No professionalism |
| 2.NOT AVAILABILE | |
| lack of resources | lack of beds |
| | supply constraints |
| | staffing shortages |
| | Required facility not available |
| | skilled attendant absents at time of delivery |
| | lack of specialized facilities |

| | |
|---|---|
| physical condition of facility | unhygienic premises |
| | Space constraints |
| | lack of privacy |
| lack of policies | lack of redress |
| 3.NOT ACCESABLE | |
| geographical cause | interior location, poor roads |
| system constraints | failed referral process |
| | programme exploitation and misuse |
| 4.NOT AFFORDABLE | |
| high OOPE | Bribery |
| | Private preference |

Table 1

| FACTORS LEADING TO OBSTETRIC VIOLENCE | |
|---|---|
| social impact | normalisation of bribe |
| | normalization of abusive behaviours |
| | hierarchical dynamics |
| individual impact | patients lack patience |
| | no ANC check-ups |
| | Non-compliant patient |
| health system constraints | Fragmented and impersonal care |
| | Overburdened staff |

Table 2

***11.Ethical consideration*** the study was conducted after obtaining approval from student's Ethical Review Board. All data collected is kept confidential and was used only for the purpose of research. The participation of the respondents was on a voluntary basis. Written consent was obtained from each respondent who was willing to participate.

## RESULT

While some participants shared positive accounts of childbirth experiences in which women received attentive care from healthcare providers, both women and providers spontaneously mentioned instances of mistreatment, highlighting negative experiences they had personally encountered, witnessed, or heard about from others. Healthcare providers openly discussed situations where they observed their colleagues' mistreating women.

## FORMS OF OBSTETRIC VIOLENCE

1. NOT ACCEPTABLE

- Physical abuse

Many women share their experiences of physical abuse during the process of childbirth, these instances involve distressing acts including being subjected to beating, slaps or pinches.

A woman whose daughter gave birth in a specific healthcare facility has reported a incident involving physical abuse. She reveals that instead of addressing her daughter's pain during childbirth, the staff at the facility resorted to beatings. Considering that it was her daughters first child, it is expected that excruciating pain will be present, and her daughter repeatedly expressed her desire not to survive the ordeal:

*"Are chillane ki mat poocho… maar peet kerti hai, delivery valo ko aise karo vaise karo. Maam jab pehla baccha hai to kuch to dard hota hi hai, bacchi aise bolti thi ki maa mai nahi bachungi"*

Another women told that while experiencing intense pain during childbirth, she found herself instinctively closing and pressing her thighs together, at which point the individuals present there slapped her on her thighs as a response:

*"maarti hai… dard se hum jhang dawa rahe the to chaanta marte hai jhaang per"*

A women described her experience of physical abuse in the form of pinching, when she was exhausted from the exertion of pushing:

*"marte hai aur jor lagane se thak jao to choont dete hai"*

- Verbal abuse

  Numerous mothers reported verbal abuse, describing incidents characterized by the use of harsh and rude language, shouting, reprimanding, and unjust blaming.
  A woman in the MCH ward has reported instances where healthcare providers used inappropriate and rude language towards mothers.

*"kabhi kabhi bahot badtameezi se bolti hai"*

A mother in the Postnatal Care (PNC) ward has expressed her concern about a particular staff member who was on night duty, exhibits excessive and intimidating behavior by shouting frequently.

*"Vo chillati hai raat vali raat mai jiski duty thi jab chillay to daray hai"*

A mother shared her experience of being reprimanded and blamed by a staff member, at the hospital's MCH department. The mother had low hemoglobin levels, so she was referred to CHC from PHC. However, instead of providing support and understanding, the sister reproached her and held her responsible, suggesting that her negligence towards her health and dietary choices may have contributed to her condition.

*"Humara khoon kam tha isliye humko yaha bheja y daante hai ki tumko khaan paan ke apna dhyaan nahi tha yaha bhaag chali aayi ho."*

- Discrimination
    - Preference to known

      Patients in the maternity ward have expressed concerns about discrimination, specifically noting that the staff tends to show more preference towards certain patients, particularly those who are already known to them. This feedback indicates a potential issue of bias and unequal treatment within the healthcare setting.

      *"Sampark valo ka jyada sunte hai"*

    - Discrimination based on medical condition

      A medical officer shared an incident involving the staff at a tertiary facility. According to her account, she referred a patient who tested positive for hepatitis B to the hospital late at night. However, upon arrival, the staff at the facility declined to provide treatment, citing the patient's condition as complicated and risky.

      "*HbsAg positive thi vo patient. To raat ko 12 baje usko pain hua to 108 ko call kerke vo dono husband wife vaha chale gaye, lekin vaha jaaker bolte hai ki yaha nahi hoga y complication hoga y risk nahi le sakte"*

- failure to meet professional standards of care
    - refusal to provide pain relief

      In the reported account by a patient attendant, it was alleged that anesthesia was not administered during the stitching process following an episiotomy. Consequently, the patient experienced intense pain, resulting in continuous shouting and crying. When the patient requested anesthesia, the attendant

claimed that the healthcare professional in charge requested it to be brought from an external source.

*"Jab taanka lagate hai us samay sun kerne ka injection hai vo dena chaiye, vo nahi de rahe hai….. patient barabar cheenkhta chillata rehta hai"*

*"Jab under ho rahi thi delivery to humse kaha injection bahar se mangva doge to laga denge cheela lagane se bahot dard ho raha tha"*

- Coercion

  a medical officer allegedly forced the patient and her husband to provide their thumbprints, and they were subsequently made to wait outside while the patient experienced pain. In conclusion, the reported incident involving the denial of treatment, coercion, and mistreatment of a hepatitis B positive patient highlights serious ethical and quality of care concerns

  *"Vaha staff n kaha angootha lagao, sign karo karke haath pakad ker angootha lagva liya. Phir lady ko pain hai usko bahar khada rakha, staff nurse koi baat nahi kerti, uske husband ko dhakka laga diya ki yaha nahi hoga delivery chale jao."*

- potential negligence

  In an unfortunate incident shared by a mother in the postnatal care (PNC) ward, she reported that her child was delivered in the bathroom, highlighting a situation where the staff's attention and level of care were lacking. Furthermore, the mother expressed that proper services were only provided if money was given. highlights potential corruption or unethical practices within the healthcare system.

  *"Baccha bathroom mai hi ho gaya tha phle aur abb bhi usi tarha kerte hai y, paisa dena padta hai jab acche se karti hai, paise dedo to suvidhay sahi mil jaati hai"*

- abondonment

  In a patient's account, it was conveyed that adequate care was not provided in the postnatal care (PNC) ward following delivery. The patient reported that no staff members came to check on them and that there was a lack of concern for their well-being.

  *"Madam dekh rekh nahi kerte matlab delivery hone k baad dobara yaha dekhne k liye nahi aaye hai, koi nahi aaya hai, theek ho ki nahi theek ho kuch nahi poocha hai"*

- Lapse in clinical judgement

In a concerning account shared by a nurse regarding the staff at a Community Health Center (CHC), it was reported that a patient did not receive an episiotomy, resulting in a tear of the labia minora. This led to excessive bleeding, and the patient was subsequently referred to another facility without receiving proper stitches. Instead, the patient was administered oxytocin and transported via ambulance.

*"maam uska delivery k time episotmy nahi lagaya tha aur uska labia minora tak tear ho gaya tha isliye bahot khoon baha aur usse bhej diya proper stitch bhi nahi kiya oxytocin deker ambulace mai bhej diya tha"*

- detrimental post-natal care

  an ASHA worker has raised a concern that when beneficiaries cannot find available space, they opt to leave the facility altogether. Additionally, due to the lack of space in the postnatal care (PNC) ward, patients are unable to stay for the required 48-hour duration as mandated for proper postnatal care. Instead, they are forced to leave the facility after only six hours, which is detrimental to their health. This situation arises primarily due to the constraints imposed by the limited space available.

  *"Delivery k liye ek do kamra aur honi chaiye abb jameen mai letaoge beecha ker to accha nahi lagta dekhne mai accha nahi lagta. labhaarti khud hi bheed dekhker chala jaata hai. Jagha na dekh ker chala jaata hai 48 ghanta nahi rukte hai ager theek hai to 6 ghante mai hi chale jaate hai delivery ke baad"*

- Poor rapport between women and provider
  - poor communication

    Patients in the postnatal care (PNC) ward have expressed dissatisfaction with the level of care and communication at the facility. One patient reported that their concerns and requests go unanswered, with a lack of attentive care from the staff. Additionally, they mentioned not knowing the identity of the attending doctor. Another patient mentioned that no doctor is available before 11 AM, leading them to seek care at a private hospital.

    *"sunai jyada nahi hoti, poochne per kuch bhi batate nahi hai, doctor ka to pata hi nahi hai kon hai."*

  - No compassion

    Furthermore, a MO of PHC talked about the gynecologist at tertiary care that she expressed frustration when presented with a case of placenta previa, stating that it had disrupted their personal plans.

    *"Vaha jo gynae thi to bolti hai ki placenta previa, mera Saturday kharab kerne k liye aap patient leker aa gaye."*

- No professionalism

  patient mentioned that no doctor is available before 11 AM, leading them to seek care at a private hospital.

  *"11 baje k phle to koi doctor aata hi nahi hai sarkaari mai…. nahi sunte hai to haarker private mai jaate hai"*

2. NOT AVAILABLE

- Lack of resources

  - Lack of bed

    The situation described involves a patient in the postnatal care (PNC) ward expressing concerns about the lack of beds and being instructed to share a bed with other women. Similarly, another patient in the maternal ward complained about the Community Health Center (CHC) having only two beds available, resulting in her roaming around. An Accredited Social Health Activist (ASHA) mentioned that there is only one delivery bed, which is inadequate given the sight of another patient lying on the floor and crying.

    *"Yaha letne k liye bed nahi mila hai ek mai double litane k liye bol rahe the y to jaruri hona chaiye ek mareez k liye."*

    *"do teen palang hai. Do chaar aa gaye to do chaar neeche parsh per hai, hum idher udher tahalte hi rahe."*

    *"vaha per itni bheed hoti hai ki kaho ki kuch bench hai jiski delivery ho rahi hai vo ho rahi hai koi pahunch gaya kaho usko bench hi nahi mile vo jameen mai pade hi chillate rahe ho."*

  - Supply constraints

    A patient within the maternity ward of a government facility has reported a lack of availability of certain medications, requiring them to acquire them externally. Similarly, a staff nurse from the labor ward at the Primary Health Center (PHC) has stated that there is a shortage of gloves, sanitary pads, and sterile gauze. The provision of only open gauze instead of sterile gauze may compromise infection prevention measures. Furthermore, an Accredited Social Health Activist (ASHA) has mentioned that medicines are not adequately supplied at the Community Health Center (CHC), necessitating the need to obtain them from external sources. The unavailability of gloves further exacerbates the situation.

    *"Dawa bahar se laye hai madam kuch mili thi kuch bahar se laani padi hai"*

*“supply mai hum logo k pass abhi dastan vagerha, sanitary pads, sterilize gauze nahi aa raha hai. Vo sterilize gauze se Clean kerne se patient ko infection nahi hota hai. abhi open vala hai usme supply ka issue bahot rehta hai”*

*“Dawa kha milti hai vaha bhi likh dete hai store se laana padta hai, vaha to daastane bhi lane padte hai”*

- Staffing shortages

  In a government facility, a doctor informed me that there are currently five vacancies for doctors. However, I will be the only doctor remaining as one doctor has been selected for post-graduation studies, and another doctor is leaving as their contract is nearing completion.

  *“Yaha to staff ka panch paanch doctor ki jagha hai, bharte nahi hai vo baat alag hai. Paanch doctor manjoor hai lekin mai abb akela hi padne vala hu. Ek PG mai jaane vala hai aur ek ka contract over hone vala hai. Mai abhi do din k baad akela hi hu.”*

- Required facility not available

  A patient's mother has shared her daughter's experience, stating that her daughter was experiencing bleeding before delivery. They initially went to a Community Health Center (CHC) for medical assistance, but were told to come back in the morning due to the unavailability of doctors. Since the patient required a cesarean section and had anemia with an abruption of the placenta, they decided to go to a District Hospital (DH). However, they were denied treatment there and referred to a facility that was far away. Unfortunately, the patient was not admitted to that facility.

  *“Blood jaa raha tha, hardo mai leker gaye the vaha kisi n dekha nahi, do din gaye hai lagataar, kaha koi chaara nahi hai operation kerna padega aur seedha gher bhej diya tha,kyuki raat mai doctor rehta nahi hai kahi bahar Kanpur ya Aligarh rehte hai. hum seedha sadar leker gaye the raat mai . Sadar mai unhone jabab de diya tha kaha kanhaari phat gaya hai. phir unhone ek injection lagaya tha blood rokne ka jab humne haat per jode hai verna haat hi nahi lagat rahi thi. Keh rahi thi Tum kaagaj nahi leker aayi ho to kaise kare abb Kanpur leker chali jao”*

- skilled birth attendant absents at time of delivery

  In the staff member's complaint regarding another facility, it was alleged that the staff refused to work there, leading to deliveries being conducted by sweepers or traditional birth attendants (TBAs). Similarly, another woman complained about a Primary Health Center (PHC) where deliveries were handled by staff nurses during the day but only TBAs were available at night. Additionally, a patient reported that nobody examined her, and only a TBA conducted tests.

*“Vaha per kuch staff hai jo kaam nahi kerna chahti unse, or jo vaha per aaya sweeper hai unse hi kaam kervati hai delivery jyadater vahi log kerva deti hai”*

*“dai delivery kerti hai, din mai to madam kerti hai per raat mai dai kerti hai delivery”*

*“vaha per humko koi dekha nahi, dai n dekha humko”*

- lack of specialized facilities

Many women highlighted deficiencies in the healthcare services provided at the government district hospital. The unavailability of ultrasound services on the same day of the antenatal checkups creates inconvenience and additional financial burden for patients so they have to seek private alternatives.

A woman in maternity ward of the district hospital, shared her experience regarding an ultrasound examination. She mentioned that she visited the hospital on February 7th for an ultrasound, but she was given a follow-up appointment for February 27th. It's worth noting that her expected due date (EDD) was February 22nd, indicating that the ultrasound was scheduled significantly later than expected. An ASHA informed about the unavailability of ultrasound services in primary health centers (PHC), community health centers (CHC), which compelled them to seek private facilities for ultrasound examinations.

*“Yaha ultrasound karvane k liye number lagana padta hai abb date bahot din baad ki milti hai abb majboori mai bahar kervana padta hai. 7 february ko aaye the 27 feb ki date diya tha aur jo inki date thi prasav vaali vo 22 feb ki thi”*

*“Yaha na PHC mai ultrasound hai na CHC mai hai jila mai hai bus vo bahot dur hai to private se hi kera lete hai”*

a woman admitted to the postnatal care (PNC) ward at the district hospital mentioned that her baby was transferred to a private facility's neonatal intensive care unit (NICU) because the district hospital did not have a NICU.

*“NICU nahi tha, baccha halka hai to private mai admit kiya hai.”*

- Physical condition of facility
  - Lack of hygiene

in the maternity ward of the healthcare facility, several patients have expressed concerns about the lack of cleanliness. One patient emphasized the poor condition of the ward, stating that nothing has been tidied up despite it being ten in the morning. Specifically, the patient mentioned the unclean washrooms, which were

in a state of disrepair. Another patient reported a high presence of mosquitoes and pointed out blood stains on the bedsheets.

“Abb saaf safayi ka hum kya batay y sab yahi pada hai abb dus baj raha hai abb hum kya kare, toilet gandi ha”

“Dekhlo yaha blood pada hai maam, is chadder ko bhi koi nahi badla hai, safayi nahi hai”

- Space constraints

  In the maternity ward of the Primary Health Center (PHC), a staff nurse has expressed concerns about the inadequate waiting area insufficient number of rooms and limited space in the labor ward and postnatal care (PNC) ward. Both patients and their attendants are facing numerous challenges as a result of these issues. Additionally, an ASHA worker has also complained about the lack of seating space. During the monsoon season, the situation worsens as everyone tends to gather in the maternity ward, leading to overcrowding. This overcrowding and the resulting noise levels make patients extremely uncomfortable.

  *“Sir waiting area ka bahot issue hai…. Delivery k liye ek do kamra aur honi chaiye… labour patient k saath jo attendant aate hai delivery k saath unko aur patient ko bahot dikkat hota hai. ASHAy bhi kehti hai ki didi baithne ka koi jagha nahi hai baarish ho raha hai Mausam kharab hai to vo log vahi labour room mai vahi baithte hai utne hi waiting area mai to shor sharaba y issue hai.”*

- lack of Privacy

  A woman has reported an uncomfortable experience during her delivery, stating that she was not adequately covered from the bottom during the process. Although curtains were available, they were not closed while she was delivering, which compromised her privacy and made her feel uneasy. Additionally, a staff nurse mentioned that in the postnatal care (PNC) ward, attendants of patients are present and sometimes share the same bed as their patient. This arrangement poses challenges in terms of maintaining privacy and ensuring a comfortable environment for other patients. However, it is difficult to ask these male attendants to leave as they are accompanying the patients they are attending to.

  *“nahi koi kapda nahi rakhte hai, parda bhi nahi lagate hai ajeeb lagta hai.”*

  *“hai jaise aapne bola ki privacy jaise male bhi uske palang per baitha hai aur unko baithe dena padta hai kyuki relative hai.”*

- Lack of policies

  Lack of redress

It is unfortunate to hear that a woman in the postnatal care (PNC) ward feels uncertain about where to voice her concerns and complaints. Additionally, she expresses fear that if she were to complain about the problems and negative experiences she has encountered, it may result in further issues or challenges for her. This situation can understandably create a sense of frustration and helplessness for patients who wish to address their concerns and seek resolution.

*"Bolate hai to aisa lagta hai ki vo log pange create karenge to vo accha nahi lagta vo saari cheeze acchi nahi lagti."*

3. NOT ACCESSABLE

- geographical cause

  interior location, poor roads

  One patient expressed a grievance that due to the remote location of her village; her baby was born prematurely before reaching the healthcare facility in the ambulance. This indicates a lack of accessibility and timely medical assistance in distant areas, which can lead to adverse outcomes for patients.

  *"bahot dur hai humara gav isliye baccha ambulance mai hi ho gaya tha, yaha pahunchne se pehle baccha ho gaya tha,humara gav k pass koi sarkaari aspatal nahi hai sab bahot dur hai"*

  "Phone kerte hai ager gaadi nahi aayi jaldi jaise humare yaha road nahi hai to Jyada se jyada delivery hui jaati hai gharan mai"

- system constraints

  - failed referral process

    Another patient reported an issue where the staff at the Community Health Center (CHC) declined to refer her to the District Hospital (DH) for further treatment, stating that they could only assist with one child and not both. Despite the apparent need for specialized care, the CHC staff did not facilitate the referral. It is worth noting that the outcome of both babies is unknown at this point.

    *"Refer nahi kiya tha, kehti rahi yahi delivery karao ,keh diya tha ek baccha bachega aur dusra nahi bachega phir bhi refer nahi ker rahe the"*

  - Programme exploitation and misuse

    inaccessibility of services under the JSY and JSSK scheme was reported due to corruption. this type of corruption undermines the intended goal of the

schemes and restrict access to essential maternal health care services benefits of the MCH program must reach the intended beneficiaries without any exploitation.

Multiple mothers have expressed dissatisfaction with the fact that they did not receive money under the Janani Suraksha Yojana (JSY). They reported that individuals who assist them in filling out the forms for JSY take money for their services.

*"paisa nahi mila hai, form bherne vale bhi paisa maangte hai."*

In a government facility, it is generally beneficial for maternal health if the mother stays for 48 hours post-delivery. However, due to various reasons, some individuals may not be able to stay and prefer to leave the facility within 6 to 12 hours after delivery. Unfortunately, many patients reprted that some ambulance drivers see this as an opportunity and demand money if the mother chooses to leave before the recommended 48 hours. This abuse of the Janani Shishu Suraksha Karyakram (JSSK) program's free drop-back facility by ambulance drivers is concerning. Additionally, another patient mentioned experiencing misbehavior from the ambulance staff.

*"Ambulance le jayegi lekin paisa maangti hai .....aur muft mai 48 ghante rukne k baad lejaati hai, jaldi jaane k liye bolo to paisa maangte hai ".*

*"ambulace vaale badtameezi kerte hai."*

In another complaint, a patient expressed dissatisfaction with the provision of free blood under the JSSK scheme. They alleged that free blood is only provided if a family member donates blood in return. This implies that the availability of free blood is contingent upon the patient's family members being able to donate blood, which can pose difficulties and limitations in certain situations.

*"khoon dete hai, badle mai ghervalo ko khoon dena hota hai vaise kabhi nahi dete."*

4. NOT AFFORDABLE

- High OOPE
    - Bribery

A patient has expressed their dissatisfaction, claiming that bribery is necessary to get work done in every department of a government hospital. Additionally, an ASHA worker mentioned that at a Community Health Center (CHC) maternity ward, they only prioritize complicated cases if money is given, otherwise, patients are referred to the District Hospital (DH). Another ASHA

worker stated that when they bring a referred case from a Primary Health Center (PHC) to the CHC, the CHC staff demands charges, unless the patient seeks treatment elsewhere.

*"Har department mai yahi hai ghoosh do kaam ho jayega tumhaara."*

*"mai to maam paisa doge to kerva denge nahi to dikkat vala case hai to refr ker dete hai."*

*"Paisa leti hai maam, bolti hai ager vaha se refer layi ho to paisa lagega tabhi hum kervayenge verna apna le jao."*

- Private preference

  Some patients who have faced problems and mistreatment in government healthcare facilities may express a preference for delivering in private hospitals. They believe that private hospitals, even if they charge money, provide better treatment due to the expectation of better care in exchange for payment.

  "Haa isse accha bahar se kervalo vaha se ho jayega… Private mai to paise lete hai isliye vaha accha hi rehta hai"

**CONSEQUENCES OF OBSTETRIC VIOLENCE**

1.DELAY IN DECIDING TO SEEK CARE

a doctor at a Community Health Center (CHC) mentions that every patients prefer to come here for their deliveries. They find everything easier here and are hesitant to go to government tertiary care facilities even in case of complications due to the perceived complicated system and the rude behavior of staff.

*"koi patient ko sunta nahi hai.galat tarha se bolte hai… patient bhot conservative hai, gav se aate jaate hai to vo udher jaane mai derte hai. Aur vo bolenge ki tu udher jaaker case paper nikalva ker aa …Abb idher to yahi sister nikaalti hai case paper, Gujrati mai bolti hai. y well known centre k hisab se patient jyada idher khud se hi aa jaate hai aur complication mai bhi jaate nahi hai jabardasti k nahi vo bhejna hi padega ki bhai tughe jaana hi hoga aur vo jaate nahi hai."*

2. DELAY IN REACHING POINT OF CARE

An ASHA told that after calling sometimes ambulance is not able to reach on time so mostly delivery takes place at home.

*"Phone kerte hai ager gaadi nahi aayi jaldi jaise humare yaha road nahi hai to Jyada se jyada delivery hui jaati hai gharan mai"*

3. DELAY IN RECEIVING CARE

In a medical officer's account, it was revealed that a patient arrived at another hospital at 10 in the morning but was not taken to the operating table until 4 in the evening. The patient had a transverse lie, a potentially complicated position of the baby within the uterus. Unfortunately, due to the delay in providing appropriate medical intervention, the patient experienced placental abruption, a serious condition in which the placenta detaches from the uterine wall. Tragically, this delay in management resulted in maternal mortality.

*"vo subha 10 baje gaya th PHC se refer hoke gaye the  bleeding tha thoda sa to shaam ko 4 baje table per liya tha, transverse lie ka patient thi operation hona tha pata nahi kyu nahi kiya. to kuch collapse jaisa hua to maternal death ho gaya tha."*

## FACTORS LEADING TO OBSTETRIC VIOLENCE

1.SOCIAL IMPACT

- ◊ Normalization of bribe

  The statements shared by patients and healthcare providers in the maternity ward shed light on the normalization of obstetric violence

  One patient mentioned that they paid money because they were happy with the outcome of their delivery. This suggests that the payment might be viewed as an expression of gratitude, despite any potential mistreatment experienced during the process.

  *"Apni Khushi k liye de diye, nyochavar diya hai"*

- ◊ normalization of abusive behaviors

  Another patient recounted being shouted at by a sister (nurse) during delivery, but stated that they had no issues with it. They accepted that if they made mistakes or did not comply with the instructions given by the sister, they would be shouted at. This acceptance of mistreatment reflects the normalization of abusive behaviors within the healthcare system.

  *"Jab galti karenge to vo chillaenge hi. Delivery k samay vo jo kahenge von ahi karenge to vo chilaaenge hi na"*

- ◊ hierarchical dynamics

  Similarly, a patient acknowledged the hierarchical structure in the hospital and accepted that nurses have the tendency to shout. They believed that it is the nurses' job to shout, especially if patients bother them.

  *"abb gusse ka kya hai nurse hai to chillayengi hi nurse ka kaam hi y hai, pareshaan karenge to chillayeng"i*

2. INDIVIDUAL IMPACT

◊ patients lack patience

On the healthcare provider side, a doctor mentioned that patients lack patience and continually call the nurse for procedures such as PV (per vaginal). The doctor expressed concern about the nurses' ability to manage multiple patients and the repeated demands for immediate attention.

*"sir dekhiye hota ye hai ki ager ek hi sister hai, jaise patients ager aapke pass bees ho, at a time ager aapke pass bees ho ya pandrah bhi ho ager ek patient ko aapne already dekh liya hai uske aatendant baar baar chalas kare ki nahi abb to kyu nahi delivery hui hai to obviously vo chilaegi usme koi doubt nahi hai, ager dekhna hai to , to dono ka opinion alag hota hai patient ko lagta hai inhone mere saath misbehave kiya, lekin ager aap kahi sister ki taraf se dekho to vo bhi sahi hai abhi to dekha hai to turant tumhe dekhne ki kya jarurat hai, ek baar ager aapki PV ho chuki hai to their next PV should be after four hours, to aapko turant karane ki kya jarurat hai, to vo cheeze y log nahi samajhte hai. Awareness, patient k log kitne educated hai vo samajh sakte hai to samjhte hai otherwise vo aappe hi chadte hai ki nahi y log humse badtameezi ker rahe hai, hum nahi samajh paa rahe hai,yahi hai"*

◊ no ANC check-ups

a doctor expresses frustration with patients who come directly for delivery without having undergone proper ANC. This can lead to complications and difficulties in managing their care. It is important for patients to attend ANC visits regularly to monitor their health, identify potential risks or complications, and receive appropriate guidance and support throughout their pregnancy.

*"Unpar mai thoda gussa ho gayi thi…y migrant population hai seedha delivery k samay aate hai yaha par na mamta card banta hai inka na koi test ho rakha hota hai aise mai takleef hoti hai humko. Na sickle cell pata hai na HbsAg aise mai kya ker sakte hai"*

◊ Non-compliant patient

The doctor highlighted that patients often exhibit non-compliance with the advice provided to them. Despite doctors working around the clock, a specific incident was mentioned where a patient was instructed to be admitted for a cesarean section. However, the patient spent the entire day roaming and eventually got admitted at 2 o'clock in the morning. This situation adds to the workload and fatigue of the doctors, who are then required to work during unconventional hours. Consequently, this leads to increased stress and frustration among healthcare professionals when dealing with such patients

*"Abb residency mai kya hota hai 24 hours resident ki duty hoti hai, chaubees gahnte delivery aur delivery. Patient samajhne vala hota nahi hai aur koi sunne vala nahi hota hai aur frustration kabhi kabhi nikal jaata hai aur patient aise kerta hai ki humne OPD mai patient ko bola ki aaj tughe aaj abhi admit hona hai tu aaj hoja to*

*tere liye accha hai cessar hoga to vo kya karega poore din kha-peeker sab ghoom ker raat ko 2 baje aaker admit hoga. Abb hum to poore thake hue hai, vo to 2 baje aaker admit hua hum to na to bolne vale nahi hai, emergency k hisab se lena hi hai hum ko to."*

3. HEALTH SYSTEM CONSTRAINTS

◊ Fragmented and impersonal care

Fragmented and impersonal care can contribute to the occurance of obstetric violence when women receive care from multiple healthcare providers who do not have a comprehensive understanding of their medical history and preferences, it can lead to miscommunication, and sense of being disempowered.

as conveyed by a doctor of DH, in the labor ward, Patients who have been consulting with her from the beginning have their comprehensive medical history available. However, patients referred from external sources, such as Community Health Centers (CHCs) or PHC, often lack completed medical tests. This situation poses a significant challenge as there is limited connectivity and familiarity with these patients, hindering comprehensive care.

*"jo patient humare pass labour room m aate h maximum patient jo aati h vo refer vali hi hoti h jo OPD vali humari patient hoti h vo to normal hoti h jo ki humare hi follow up m hoti h, hum jaante hai sub unke baare mai, jo patient bahar se refer hoke aate h unke pass janch k naam pr bus kuch kuch jaanche likh di jaati h otherwise saari jaanche nahi hoti to unka bhi koi status pata nahi hota h… jo phle se kara rahe hote hai humare pass unka record to rehta hai kum se kum."*

◊ Overburdened staff

a doctor shared that in a district hospital, a substantial number of deliveries, approximately 400-500, take place. However, the availability of fully trained staff is insufficient to handle this workload, leading to significant overburdening. As a result, the doctors and medical personnel experience frustration due to the overwhelming demands placed on them. This situation highlights the need for appropriate staffing levels and resources to ensure the well-being of both healthcare professionals and patients in the academic setting.

*"few patients have complained about misbehave as there 400-500 delivery take place and staff is less..so overburdened staff"*

# DISCUSSION

In our study, we have categorized obstetric violence into four broader themes for better understanding: not-acceptable, non-available, non-accessible, and non-affordable. while many previous research [17,18] has outlined mistreatment in seven categories as Illustrated by Bohren *et al*. (2015) [7] Like physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints.

1. Not-acceptable:
Consistent with previous studies [19,20] current research reveals instances of various forms of obstetric violence that are considered unacceptable, such as physical abuse (e.g., slapping, pinching), verbal abuse (e.g., shouting, reprimanding), discrimination based on disease or preference, and poor rapport between patients and providers. These behaviors, along with failure to meet professional standards of care, such as refusal to provide pain relief or potential negligence, can jeopardize the well-being of pregnant individuals and their infants. Despite the implementation of government programs, such as SUMAN and LAQSHYA, which aim to ensure respectful and dignified care, instances of unacceptable behavior persist within obstetric wards.

2. Not-available:
In an observational study by Saxena. *et al*.( 2018)[12], gaps were in process, not with structure. while in our study, structural deficiency as well as gaps in process of care was identified.
according to a study by Goncalves. *et al*.( 2011) [24] women who choose the Birthing Center to give birth seek humanized care and care that is centered on the needs of the parturient women. Inadequate availability of essential infrastructure, such as ultrasound machines (USG), neonatal intensive care units (NICU), beds, medicines, and consumables, can indeed contribute to instances of obstetric violence. While obstetric violence encompasses various forms of mistreatment, the lack of availability of necessary resources can be considered a form of obstetric violence. This viewpoint is supported by research and studies conducted in the field.(21)

For instance, a WHO report [22] has highlighted that the absence or limited availability of infrastructure, including USG machines, can lead to inadequate antenatal care and prevent the timely identification of potential complications or fetal abnormalities. This can result in suboptimal management or even a lack of appropriate interventions, negatively impacting the health and well-being of both the birthing individual and the fetus. Similarly, the scarcity of NICU beds can lead to delayed or compromised care for newborns requiring intensive medical attention. This can increase the risk of adverse outcomes for newborns and contribute to distress and trauma for parents. The unavailability of essential medicines and consumables can also lead to compromised care during childbirth. Lack of access to medications or the absence of sterile and functional equipment can result in unnecessary potential complications for birthing individuals. Insufficient staffing levels or absence of skill birth attendant at the time of delivery can further exacerbate the impact of non-availability. When there are not enough healthcare providers or skill birth attendant to attend to the needs of pregnant individuals, the quality and safety of care can be compromised. This can result in delayed response times, inadequate monitoring, and increased risks during labor and delivery.

Furthermore, the lack of effective redressal mechanisms and avenues for grievance resolution adds to the problem. If birthing individuals are unable to voice their concerns, seek accountability, or receive appropriate support for instances of mistreatment resulting from non-availability, the cycle of obstetric violence is perpetuated therefore in SUMAN a redressal mechanism is introduced [23]

3. Not-accessible:

In line with a study conducted by bhattacharya. S. *et al*. [21] our study have also found non-accessibility as a challenge in quality maternal care. It significantly impacts the provision of timely and appropriate care for pregnant individuals.
Non-accessibility refers to barriers that hinder individuals from reaching healthcare facilities and accessing the care they need. Poor road conditions, delays in ambulance services, ineffective referral systems, and misuse of government programs designed to support pregnant individuals, such as JSY and JSSK. This misuse creates additional barriers and obstacles for beneficiaries in accessing the benefits and services they are entitled to. The misappropriation of resources meant for pregnant individuals undermines the effectiveness of these programs and leads to further marginalization and mistreatment. A study by Tripathi. N (2020) has also found informal payment across all entitlements of JSSK as a significant issue.[25]
These challenges lead to delays in receiving essential obstetric care, including emergency services, and undermine timely and appropriate care for pregnant individuals.

4. Not-affordable:

Our research findings indicate that pregnant individuals face challenges in accessing affordable healthcare services in government facilities. Limited availability of resources, inadequate staffing, insufficient infrastructure and abusive behaviour of staff contribute to the suboptimal quality of care provided in these settings. As a result, individuals may seek alternative private healthcare options that are often more expensive, further exacerbating the financial burden on them which is In line with findings of previous research conducted by Goli. S. *et.al* (2016) [26].

Consistent with previous study in this field [21] bribery emerged as a significant factor contributing to non-affordability and obstetric violence. Our study found instances of bribery occurring within the healthcare system, where individuals seeking care were required to pay unofficial fees or bribes to healthcare providers in order to receive adequate treatment or access essential services. Such practices undermine the principles of equity and fairness in healthcare and perpetuate a cycle of mistreatment and financial burden on vulnerable individuals.

It is important to note that the guidelines outlined in the LaQshya program explicitly state that bribery, even if given in gratitude, is not acceptable. However, our study revealed that bribery remains prevalent despite these guidelines, resulting in further obstetric violence and non-affordability. [5]

FACTORS LEADING TO OBSTETRIC VIOLENCE

in line with previous studies [17,18] In our study also normalization of bribe and abusive behaviour, The prevailing hierarchical structures are found major causes of such unacceptable behaviour. Inadequate administrative responses and the absence of strict consequences for

healthcare workers who engage in obstetric violence can contribute to the normalization of such behavior. Societal attitudes and cultural beliefs around childbirth also play a role. Traditional views that prioritize the authority and expertise of healthcare professional over the preferences and experiences of the birthing person can contribute to normalization of mistreatment and unequal power dynamics in patient-provider relationship.

Moreover, the prevalence of fragmented and impersonal care, coupled with overburdened staff, contributes to obstetric violence. Healthcare systems that are overwhelmed by high patient loads and limited resources often struggle to provide comprehensive and compassionate care. This can result in rushed and insensitive interactions with patients, inadequate monitoring of pregnancies, and a failure to address the specific needs and concerns of pregnant women.

In our study, as reported by doctors factors leading to obstetric violence were, lack of patience exhibited by patients, the absence of antenatal care (ANC) checkups by patients, and non-compliance on the part of patients. findings similar to our study were also present In a research conducted by Ramanandi, Ananya *et al*. [27]

Firstly, the lack of patience exhibited by patients has been identified by doctors as a contributing factor to obstetric violence. This refers to instances where patients may be demanding or exhibit behaviors that healthcare providers perceive as impatience. Such interactions may lead to tension, frustration, or even mistreatment on the part of healthcare providers, compromising the quality of care provided to pregnant women.

Secondly, the absence of ANC checkups by patients has been reported by doctors as a factor contributing to obstetric violence. ANC checkups are essential for monitoring the progress of pregnancy, identifying any potential risks or complications, and ensuring the well-being of both the mother and the unborn child. When patients fail to attend these crucial checkups, it can result in inadequate monitoring, delayed interventions, and increased risks for both the patient and the baby, potentially leading to mistreatment.

Lastly, non-compliant behavior on the part of patients has also been identified by doctors as a cause of obstetric violence. Non-compliance refers to situations where patients do not adhere to recommended medical advice, treatment plans, or prenatal care instructions. This can lead to frustration on the part of healthcare providers, who may perceive non-compliant patients as challenging to manage or as potentially jeopardizing their own well-being or that of their unborn child.

CONSEQUENCES

In our study we have found “three delays” of maternal mortality as consequence of obstetric violence i.e. (1) delay in deciding to seek appropriate medical help for an obstetric emergency, (2) delay in reaching appropriate obstetric facility and (3) delay in receiving adequate care when a facility is reached.

STUDY LIMITATION

The study was limited to only three states.

Aims for only in-depth understandings rather than generalizability.

# CONCLUSION AND POLICY RECOMMENDATION

In conclusion, the study highlighted the presence of various forms of obstetric violence, their causes, and the resulting consequences. The government has implemented several programs, such as SUMAN, LaQshya, JSY, PMMVY, PMSMA, JSSK, AB-PMJAY, and HWC, with the aim of ensuring acceptability, availability, affordability, and accessibility of quality maternal and child healthcare services. Notably, SUMAN and LaQshya have established guidelines to prohibit mistreatment.

To address the systemic issues contributing to these problems, the proposed solutions encompass a wide range of strategies. These include expanding beneficiary and facility coverage under PMJAY, combating bribery by explicitly prohibiting informal payments and gifts, fostering cultural change initiatives, strengthening governance and monitoring mechanisms, promoting intersectoral convergence, digitizing the referral process, providing enhanced training for healthcare providers, and emphasizing transparency and accountability in MCH programs. Additionally, addressing administrative oversight, ensuring essential supplies and medications, enhancing staff motivation, conducting regular quality training, promoting evidence-based practices, and increasing incentives for LAQSHYA-accredited facilities are vital aspects of the proposed solutions.

By implementing these measures, the prevalence of obstetric violence can be reduced, and the overall quality of maternal and child healthcare services can be improved. However, it is crucial to continue monitoring and evaluating the effectiveness of these interventions to ensure sustained progress in addressing obstetric violence and promoting safe and respectful maternal and child healthcare.

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# ANNEXURE

## INTRODUCTION AND INFORMED CONSENT

Namaskar, my name is _____ and I am from International Institute of Health Management Research, New Delhi. I am carrying out a study for my dissertation on "mistreatment in labor room of public health facilities in India, and associated factors."
In this study, I will discuss with you points on mistreatment in labor room of public health facilities in India, and factors associated with it. This discussion points will help to gain a better understanding of the prevalence and reasons of mistreatment and ways to overcome them in the country. We will be collecting information from mothers and frontline health workers
This discussion may take about 45 minutes to complete. Whatever information you provide will be kept strictly confidential. Participation in this discussion is voluntary and you can choose not to answer any question or all the questions. However, we hope that you will participate in this discussion since your participation and input is important.
Currently, do you want to ask me anything about this study? [Answer any questions and address respondent's concerns.]
In case you need more information about this study, you may contact at IIHMR Delhi.
May I begin the discussion.
Respondent agrees to be participated……..1 [Start Discussion]
Respondent did not give consent……..2 [End the discussion]
Signature of all the participant _____

# IDI CHECKLIST OF MOTHERS

| Date of Discussion: | |
|---|---|
| State | |
| District | |
| Name of health facility | |
| Type of health facility | |
| Location of health facility | Rural / Urban |
| Name of Respondent | |
| Education | |
| Age in completed years | |

1. Tell me about what you experience?
2. How do you feel about experience?
3. How did that effect you?
4. What did you do about it?
5. If reported what was done about it?
6. If not reported, why did not report?
7. If you had money would you have come to get services here?
8. Did you get all benefits under JSY, JSSK
9. How you reached here?
10. Are you satisfied with the facilities here if not why?
11. What about availability of doctors and nurses at this facility?

# IDI CHECKLIST OF HEALTH WORKERS

| | |
|---|---|
| **Date of Discussion:** | |
| **State** | |
| **District** | |
| **Name of health facility** | |
| **Type of health facility** | |
| **Location of health facility** | Rural / Urban |
| **Name of Respondent** | |
| **Designation** | |
| **Education** | |
| **Age in completed years** | |
| **Year of experience in service** | |

- What is your view on the overall ambience of the health facility?
- What is your view on behaviour of health workers at facility?
- What are the reasons for such behaviour in your opinion?
- How much money facility charge for various services in this facility? (OPD, IPD, drugs, laboratory services, and transportation)
- What is your opinion about the availability of toilet facilities and water supply?
- What is your opinion about cleanliness of facility