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Faculty of Social Sciences

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'Women are supposed to endure that!' A critical feminist exploration of obstetric violence in women's and midwives' birth narratives in India

by

Kaveri Mayra

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Thesis for the degree of Doctor of Philosophy

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Abstract

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Birth and violence against women are sensitive areas of research surrounded by a thick cultural silence. Women around the world experience different forms of obstetric violence during childbirth in a variety of settings by providers and support workers within health care systems. While there is evidence of obstetric violence as a global issue, more systematic exploration is needed on its causes from the perspectives of women and their carers. Obstetric violence is closely linked with issues of women's positioning at the intersections of different forms of oppression and their experiences and perceptions of obstetric violence can be influenced by socio-cultural, demographic and economic characteristics, their immediate contexts, their reproductive histories and geographies. In this thesis, I apply a feminist perspective to explore the nature of obstetric violence and the factors that makes women vulnerable during childbirth, considering that women's and nurse-midwives' perspectives and experiences. I first conduct a quantitative examination of the determinants of obstetric violence in one of the economically deprived states of Bihar in India, and find women's experiences of obstetric violence are often plural and multi-layered. Age, parity and education are found statistically significant attributes that increase women's vulnerability to obstetric violence in Bihar. I follow this with a qualitative exploration through participatory arts-based methods to cut across the power-based and language-based barriers and learn from and present women's embodied experiences of childbirth and obstetric violence. I used feminist methods such as birth mapping, birthing story, poetic inquiry, feminist-relational discourse analysis and voice-centered relational analysis for data collection, analysis, interpretation and presentation, to bring forth women's and nurse-midwives' voices on this sensitive embodied issue. My research indicates that the determinants driving obstetric violence are related to women and their nurse-midwives, at the individual level, in their immediate birthing environment and in the larger social and policy level. Gender, power, culture and structure are the key themes holding the individual and the interactions of the determinants leading to obstetric violence. They need to be addressed at each of these levels through multi-sectoral approaches with women and their midwives as key stakeholders driving the change towards ensuring respectful maternity care.

Keywords: Obstetric violence, Feminist methods, Respectful maternity care, Body mapping, Birth, Nurse, Midwife, Health systems, Bihar, India

I dedicate my dissertation to women

Women in my life, my mother, my sister, my niece, my grandmother, my friends, my midwives, my nurses, my tribe. Women who have experienced respectful care and obstetric violence during childbirth.

Women who have kindly and bravely shared their stories of birth and violence.

Line art of a birth map by Aditi Parischa

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Preface

‘I’

I am a restless soul

I love dancing

I was two or three when I first performed on stage

I am loved for dancing

I am stigmatised for dancing

I had a nomadic upbringing

I moved to a new state in India every 3-4 years, my father is a retired airman

I get restless when I live in a state or country for more than 3 years

I feel roots growing from my whole body

I find a new destination, I move

I was educated by my mother, she was my most persistent teacher, very strict too

I am a doctoral researcher

I am a midwifery researcher

I have assisted childbirths, the most life changing experience

I am a nursing researcher

I have felt life leaving people’s body

I have washed that body for the family

I get attached

I advocate for gender-equality, for respectful care, for orgasm equality, for midwives' & nurse's role in health policy making and against all forms of gender-based violence

I am a feminist

I am a global health leader

I do a bit of salsa, swing, bachata, folk, classical and a whole lot of free style

I dance in the shower

I dance when I cook

I love travelling

I have led campaigns

I love cooking, I am not a foodie, I am a fussy eater, I love *posto* and *chingri*

I love therapy

I wanted to fly planes

I do not like maths

I love talking about intersectionality, positionality, inclusivity and diversity

I love people

I love people's stories of birth

I do birth mapping

I am passionate, I am kind, I am very weird

I have been sexually harassed, multiple times, at all ages

I think the stigma around female masturbation should end

I think women experiencing pleasure is sexy

I am a confident public speaker

I am a nervous wreck before I face an audience

I am impatient, I am incapable of meditating

I love research, I have always loved research

I am a woman of science

I have made awesome friends, 99% don't live around me

I have a sister, Keya, she is my life, we have our parent's names tattooed on our arms, her tattoo is nicer, it's colourful, she is my favourite company, she's an artist

I felt liberated after my divorce

I bonded the strongest with my parents after my divorce, I love them very much

I have two tattoos

I got my Kalpana Samar's tattooed on my arm in rebellion before my marriage

I always wanted to get married, since I was a child

I thought the key to freedom from oppression is in finding the most equal-minded husband

I love my eyes, everyone does, I wanted to donate them since I was a child

I have tokophobia

I love being in love

I propose when I fall in love, it's a pattern

I like sticky notes, big notes, white boards, postcards, letters, stationery

I am scared of pet dogs

I think music can heal everything

I write about Docsplanation

I think one day I will adopt a child, I always wanted to, since I was a child

I think feminist writing is amazing

I read every morning

I can't do without Chikki, Chikklett is my niece, she is Chikktastic and all things Chikk

I love my surname more than my first name, I wish it was my first name

I knit scarves when I go through anxiety and depression

Preface

I learnt knitting from my mom

I learnt embroidery from my dad, no-one embroiders better than him

I have travelled to over fourteen countries

I think people have no-idea how to behave around a divorced woman, they feel now that her life is ruined let the poor-thing do whatever makes her happy, it is fascinating

I am a Bengali, from India

I speak three languages well

I understand many more

I am a workaholic

I need to learn to drive

I love colours, I wear colours, I dress to resist

I am awesome in verbal communication

I write to resist

I feel that switching to a menstrual cup was the best decision

I think people who author good books are super-humans, so are vegans

I will write a book someday

I know some really amazing women

I picked up hula-hooping in the pandemic

I am boxing these days, I love punching

I carry several layers of guilt

I hope Keya, Chikki and I live together for 3 years in another country, just us

I will have a room with a cupboard somewhere in the world, to call my own

I can’t settle, I can never settle

I will find patience and calm

I love waterfalls, oceans & rivers

I am named after a river

Research Thesis: Declaration of Authorship

Print name: Kaveri Mayra

Title of thesis: 'Women are supposed to endure that!' A critical feminist exploration of obstetric violence in women's and midwives' birth narratives in India

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:
    - Mayra K., Matthews Z., Padmadas SS. 2021. Why so some health care providers disrespect and abuse women during childbirth. *Women and Birth.* In press. Doi. https://doi.org/10.1016/j.wombi.2021.02.003
    - Mayra K., Matthews Z., Sandall J. The case of 'surrogate decision-making' in India for women competent to consent and choose during childbirth. *Agenda.* Doi. https://doi.org/10.1080/10130950.2021.1958549
    - Mayra K., Sandall J., Matthews Z., Padmadas SS. 2021. Breaking the silence about obstetric violence: Body mapping women's narratives on respect, disrespect and abuse during childbirth in Bihar, India. *BMC Pregnancy and Childbirth.* Accepted.

Signature: ..... Date: 21/07/2021

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Deborah Gearing who gave me a home away from home and became my family away from family, and supported me through the toughest of times be it a pandemic, or numerous personal crisis. She has also entertained my several 'English' related questions, with immense knowledge, supported by many dictionaries and language style guides.

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Keya, Chikki, Baba (Samarendra Nath Mayra) and Ma (Kalpana Mayra), I can finally book tickets to see my family back in India. I am looking forward to the biggest reunion ever! It has been almost two years I have not seen them and I feel the pandemic has brought us closer. This PhD would not be written without their support and sacrifice and the genes I recently found out about that turns all the women in our family into bookworms. I am told my grandmother, married of before she hit puberty learnt to read from her children's school books and then no one could separate her books, newspapers, advertisements, everything, with a tiny lamp she would hide from everyone. If there were words anywhere, she would read them. Her two library cards were her greatest possession and could not satisfy her hunger to read. This passion for education was shared by my mother who passed it on to me and my sister and I see it in my niece who is never without a book. We are all voracious readers.

PS: Now that you have seen your names in the acknowledgement, do read the thesis. ☺

Definitions and Abbreviations

ANC..... Antenatal Care

ANM ..... Auxiliary Nurse Midwives

AMANAT..... Apaatkalin Matritva evam Navjaat Tatparta

ASHA..... Accredited Social Health Activist

BPHC..... Block Primary Health Centre

BEmONC..... Basic Emergency Obstetric and Neonatal Care

CHC..... Community Health Centre

CEMONC..... Comprehensive Emergency Obstetric and Neonatal Care

CEDAW ..... Convention on the Elimination of Discrimination Against Women

CS..... Cesarean Section

CME ..... Continued Medical Education

CMS ..... Centre for Media Studies

CAMT..... Centre for Advanced Medical Training

CORE..... Continuum of Respectful Experiences

EAG..... Empowered Action Group

ERCC ..... Essential Respectful Care Course

FRDA..... Feminist Relational Discourse Analysis

GE ..... General Examination

GOI ..... Government of India

GNM ..... General Nurse and Midwife

HH..... Household

IDI ..... In-depth Interview

IUCD ..... Intrapartum Uterine Contraceptive Device

IMR..... Infant Mortality Rate

INC..... Indian Nursing Council

ICM ..... International Confederation of Midwives

Definitions and Abbreviations

ICN ..... International Council of Nurses

IPV ..... Intimate Partner Violence

IV ..... Intra Venous

JSY ..... Janani Suraksha Yojana

NFHS ..... National Family Health Survey

NHM ..... National Health Mission

NPM ..... Nurse Practitioner in Midwifery

NRHM ..... National Rural Health Mission

MDG ..... Millennium Development Goals

MMR ..... Maternal Mortality Ratio

MNMT ..... Mobile Nurse Mentoring Training

LMIC ..... Lower Middle Income Countries

OT ..... Operation Theatre

PSE ..... Pre-Service Education

PTSD ..... Post Traumatic Stress Disorder

PMNCH ..... <Kaveri Mayra to fill>

QoC ..... Quality of Care

SDG ..... Sustainable Development Goals

SES ..... Socio-Economic Status

SOMI ..... Society of Midwives India

SIDA ..... Swedish International Development Agency

SNC ..... State Nursing Council

SPSS ..... Statistical Package for Social Sciences

SRS ..... Sample Registration System

SBA ..... Skilled Birth Attendants

UNFPA ..... United Nations Funds for Population Activities

UNHCR ..... United Nations High Commission for Refugees

UN ..... United National

VE ..... Vaginal Examinations

WHO..... World Health Organisation

WRA..... White Ribbon Alliance

Chapter 1 Why study obstetric violence?

1.1 Introduction

"Do No Harm" is the key ethical principle for health care providers, yet evidence is mounting showing women's experiences of obstetric violence during childbirth – arguably the most vulnerable phase of their life (Vogel et al., 2015; Khosla et al., 2016; Patel et al., 2015). Childbirth is a natural process and though the event is marked by rite de passage and celebrations (Nayak & Nath, 2018), evidence from over half of the world's nations indicate that obstetric violence is a global issue. This thesis makes an original contribution to understanding the extent of obstetric violence in resource constrained settings in India with a focus on experiences and perceptions of both women and nurse-midwives, as their primary care providers.

I refer to the problem as 'obstetric violence' throughout this thesis with reasons explained through my positionality in the next chapter, although there are several terminologies used by researchers that I refer to when I quote studies. Mistreatment of women in labour is recognised as a deterrent to facility-based birth which also threatens progress towards reductions in maternal mortality (Bohren te al., 2015). It is a violation of women's right to the highest attainable standards of health (WHO, 2015) that includes respectful and dignified care during childbirth. It is important to understand what it means to receive quality of care and how respectful care is situated in its realm while being mindful that every woman's experience, needs and expectations of respectful care can be unique and needs to be understood to provide person-centered care (Downe, 2019).

The World Health Organization (WHO) defines quality of care as '*the extent to which health care services provided to individuals and patient populations improve desired health outcomes*' and further says, '*to achieve this, health care needs to be safe, effective, timely, efficient, equitable and people centred*' (WHO, 2016, p. 14). In recognition of this, WHO has included experience of care as a main aspect in the process, which is further divided into: 1) effective communication; 2) respect and preservation of dignity and 3) emotional support as the three components in the WHO framework for Quality of Care (Figure 1.1) (Hulton, Matthews & Stones, 2000). The framework is in line with Donabedian's Model of Quality of Care (Donabedian, 1988), but the sub-components on respect and dignity for women seeking care makes it more responsive to women centred care and outcomes.

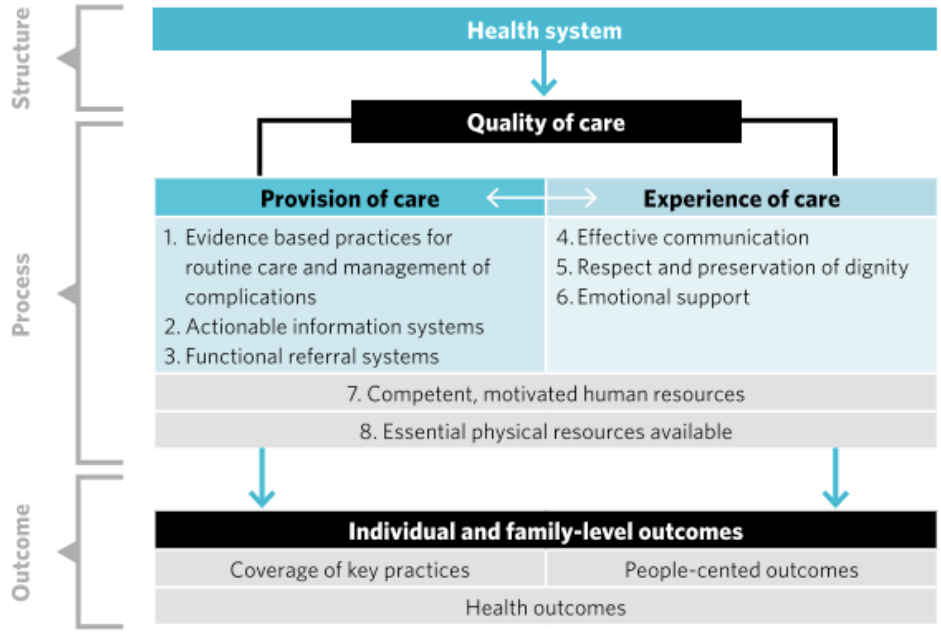

Figure 1.1 The WHO quality of care framework (Source: WHO, 2018, p. 12)

Respectfulness has been identified as an essential action point when it comes to person-centred care provision (WHO, 2015). WHO's guidelines for intrapartum care consists of four new recommendations specifically on: 1) respectful maternity care; 2) effective communication; 3) companionship during labour and childbirth and 4) continuity of care. Other recommendations also aim to ensure respectfulness and dignity of women during childbirth by ensuring her choice of position and adequate mobility, by avoiding unnecessary interventions, and ensuring adequate pain relief. These recommendations intend to make childbirth a positive experience and care to be women centred (WHO, 2018).

There is a growing evidence related to obstetric violence from around the world but there have been limited efforts to understand what drives this issue and the determinants of obstetric violence during childbirth (Bhattacharya et al., 2013; Murray, 2008; Jeffery et al., 2010; Hunter, 2009). It is also important to note that often what drives the problem is not learnt from those who experience it and those at the frontline of care provision, such as the nurse-midwives. There is a lack of studies exploring women's understanding of the issue of obstetric violence where the issue exists, given the culture and context driven subjective nature of perceptions of respect, dignity, disrespect, abuse and violence. This gap needs to be addressed to call for an end to obstetric violence by learning the ways to address this issue from women and care providers (such as nurse-midwives in India), as the key stakeholders involved in this process of experiencing care and providing care. The determinants of obstetric violence lie at different levels such as the individual, structural and policy levels (Freedman et al., 2014). They therefore need to be explored at these three levels to be addressed in these respective levels. While women can share their

experience from the care seekers end at these three levels, nurse and midwifery leaders can share the side of the care providers, having provided care at frontlines of primary care provision, following by reaching the highest level of policy making. Therefore, the inclusion of nursing and midwifery leaders is essential to this thesis to understand the entire gamut of determinants of obstetric violence.

India is home to over 1.3 billion people (Census, 2011) with the second highest number of births in the world. Indian women present a diverse profile in different states based on attributes such as education, occupation, religion, health status and especially when compared with men. For instance, the current literacy rate for women in India is 68% when compared to men (86%), which further varies for women by rural (62%) and urban (81%), as reported by the National Family Health Survey (NFHS-4). It also found that 27% women aged between 20-24 years were married before turning 18 years, which is the legal age of marriage for women in India and have 2.2 children per woman. The report furthers suggests that 8% women aged between 15-19 were already mothers or pregnant at the time of survey. There are disparities in family planning too, where more women undergo sterilisation (36%) than men (0.3%) (NHFS-4).

India faces unique challenges in maternal health care provision, which are more pronounced in particular Indian states, such as Bihar. India also has one of the most institutionalised systems for childbirth in the world, both in terms of speed and scale, with over 79% women giving birth at health care institutions, which is credited to have brought India's share of the global burden of maternal deaths from 19% (WHO, 2015) to 12% (WHO, 2019). Although, its impact on the quality of care has often been questioned in its move towards medicalisation that further makes it an interesting setting to understand obstetric violence during childbirth, considering over-medicalisation as one of its enablers in this context. The high caesarean section rates (17%) indicates this, which shows further disparities between private (41%) and public sectors (12%) (NFHS-4). Violence is generally high in women's lives with 31% married women reportedly experiencing spousal violence and 4% while being pregnant (NFHS-4). There are no systematic efforts to collect evidence on obstetric violence and research on this sensitive subject is the need of the hour.

Aim: My thesis investigates obstetric violence and respectfulness in care provision during childbirth and how it can be improved through midwifery leadership, learning from the perspectives and experiences of women as primary care-receivers and nurse-midwife leaders from their experience as primary care-providers in India.

1.2 Research objectives

This thesis is presented in a three paper format, with an exception of an additional paper, addressing the following interrelated objectives:

- **Paper 1** uses quantitative secondary data to examine the social determinants of obstetric violence during childbirth in Bihar, India.
- **Paper 2 and 3** use body mapping aided in-depth interviews to understand women's perception and how they attach meaning to respect, disrespect and abuse from their experience of giving birth and their understanding of what drives respectful, disrespectful and abusive care during childbirth in Bihar, India.
- **Paper 4** qualitatively documents and analyse the experiences of midwifery leaders on respect, disrespect and abuse and recommend new evidence-based policies to strengthen respectful care for women during childbirth in India.

1.3 Research questions

- What are women's experience of obstetric violence in Bihar? (Paper 1 and 2)
- What makes a woman vulnerable to experience respect, disrespect and abuse during childbirth in public health institutions in Bihar? (Paper 2)
- How do women attach meaning to their experiences of respect, disrespect and abuse during childbirth in Bihar? (Paper 2)
- What are women's understanding of the underlying factors driving respect, disrespect and abuse during childbirth in Bihar? (Overarching question- Paper 3)
- Why do some care providers disrespect and abuse women during childbirth in India? (Paper 4)
- What are midwives' experiences of respect, disrespect and abuse during childbirth in India? (Overarching question- Paper 4)

1.4 Thesis organisation

My thesis is organised into 10 chapters. Chapter 1 lays out the rationale and need for the PhD and helps to understand the research objectives and questions. Chapter 2 presents a review of literature to understand the typology and the factors influencing respect, disrespect and abuse during childbirth globally. It also narrates the challenges in respectful maternity care provision along with the global evidence of obstetric violence during childbirth. It includes my positionality for doing this research which is blended throughout my thesis. Chapter 3 sets the context of maternal health care provision during childbirth and the status of women in Bihar and India to

understand the issue in the geopolitical location of my research. Chapter 4 presents the methodology and different methods used to explore the research objectives with a conceptual framework that connects the four papers.

My PhD is structured in the three paper format, which is presented in the next four chapters, which essentially are one paper each. Chapter 5 investigates the social determinants of obstetric violence quantitatively through the secondary data from a large scale household survey done in Bihar that includes self-report of the women within a month of their institutional birth. Chapter 6 presents how women experience and perceive respect, disrespect and abuse during childbirth. This is conducted qualitatively through a visual-arts based participatory research in Bihar, India. Chapter 7 discusses the impact of gender, power, culture and structure on women's birthing experiences which is an extension of findings from Chapter 6 but presented separately to acknowledge the thematic change in content. With the first three findings chapter exploring the experience and perceptions of what consists of obstetric violence and what drives in, I then present the care provider's experience and perspective of the same, from who are nursing and midwifery leaders in the context of India. Chapter 8 examines why some care providers abuse women during childbirth qualitatively from midwifery and nursing leaders experience and perceptions in India. In Chapter 9 binds the findings together from an intersectional lens and concludes the thesis. In chapter 10 summarises the thesis, presents recommendations for policies, future research and limitations. The study tools, a published manuscript and details on knowledge translation are appended.

Chapter 2 Obstetric Violence: A literature review & positionality

Obstetric violence during childbirth is an important and sensitive issue for various reasons. Firstly, it is a violation of women's fundamental human rights. Secondly, care providers and health systems policymakers have acknowledged it as an indicator of a lack of quality care which can lead to poor maternal and neonatal health outcomes. As evidence on obstetric violence during childbirth evolves, it becomes increasingly difficult to ignore the widespread nature of this issue and the efforts required to address this challenge.

In this chapter, I present how obstetric violence is perceived in different countries with global evidence, typologies and choice of terminologies. The subsequent section on the impact of obstetric violence highlights the importance of respectful maternity care for a positive birthing experience. While there is a dearth of literature discussing the factors linked with obstetric violence during childbirth, there are some studies connecting women's background characteristics and care provider attributes that may influence maternity care provision.

Obstetric violence during childbirth can be understood from two key perspectives guided by the literature: 1) feminism, following the principles of equality, equity, diversity, inclusivity and human rights and 2) health systems, guided by the principles of ethics and quality of care provision. The stakeholders working in this area are divided into user groups and advocates of women's rights demanding for their right to a dignified birthing experience. The care providers and policy makers on the other hand, are trying to ensure respectful and dignified care while addressing the existing health systems constraints. The existing literature on the definitions, terminologies, typologies, impact, drivers and ways to address obstetric violence during childbirth fall under these two domains, feminism and health systems.

The feminist rights activist Adichie (2014), warns her readers about the dangers of listening to a single story without understanding the context. The issue of obstetric violence is no exception, and should be understood from the feminist perspective and health systems perspective; from the care-seeker and care-provider, both predominantly women, sharing their sides of the story from their standpoint based on their lived experiences. This review emphasises and presents both perspectives from feminist ideology and under the quality of care framework, both of which eventually lead to the commonly desired outcome of women-centred care and a birthing experience that is respectful and dignified.

Gender is a key background factor that infuses the entire narrative and is embedded in all the chapters of this thesis starting with this literature review. Even though it is reflected in the narratives around feminist perspective more predominantly, the health systems perspective is also presented. In the following sections, I present these two perspectives including definitions, determinants, impact and the way forward.

2.1 Obstetric violence from a rights perspective

Obstetric violence of women during childbirth is a violation of human rights (Miller & Lalonde, 2015; Allotey-Reidpath et al., 2018; Miltenburg et al., 2018). Human rights acknowledges that *"…each individual is entitled to enjoy his or her rights without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."* (United Nations, 1948). There are 32 articles in the Universal Declaration of Human Rights which have been ratified by 192 countries, including India. Any country that is signatory to the Universal Declaration of Human Rights is legally mandated to ensure these rights to its citizens (United Nations, 1948; Khosla et al, 2016). As per my understanding, obstetric violence during childbirth is a violation of human rights under these six articles, shown in table 2.1.

Table 2.1 Violation women's right during childbirth

Article no.	**Universal Declaration of Human Rights**	**What it means for childbirth**
1	All human beings are born free and equal in dignity and rights	All women and birthing people are born free and equal in dignity and rights in life, including during childbirth.
2	Everyone is entitled to all the rights and freedoms set forth in this declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status	Every woman and birthing person is entitled to all the rights and freedoms including her right to satisfactory birthing experience free from unnecessary interventions, disrespect, abuse and with best possible care during childbirth.
3	No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment	No woman or birthing person should be subjected to any form of disrespect, abuse and violence when seeking maternal and reproductive health care.
7	All are entitled to equal protection against any discrimination in violation of this declaration and against any incitement to such discrimination	No woman or birthing person should be discriminated on the basis of colour, caste, religion, background, gender, sexuality, physical and socio-economic characteristics while seeking maternal and reproductive health care, which would be a violation of this declaration.
21	Everyone has the right to equal access to public service in his country	Every woman and birthing person has the right to be treated equally and fairly in terms of resource allocation and maternal and reproductive health care they receive, including during childbirth.
25	1) Everyone has the right to a standard of living adequate for the health and well being of himself and his family. 2) Motherhood and	1) Every woman and birthing person has a right to quality and respectful maternal health care during childbirth for the health and wellbeing of herself, her new-born and her family. 2) Every woman and birthing person is entitled to special care during

Article no.	Universal Declaration of Human Rights	What it means for childbirth
	childhood are entitled to special care and assistance	pregnancy, childbirth and postnatal period when seeking maternal and reproductive health care.

The declaration of human rights is not gender neutral or inclusive in language. A major drawback of the declaration is that it fails to recognise women and refers to only men. It refers to people as 'he', 'his', 'him' and 'himself' around 22 times in the document, ignoring the global push for gender neutral and gender fluid language.

The Universal Declaration of Human Rights also does not refer to women's rights during childbirth directly, but this gap was filled by the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). It is one of the eight major human rights treaties, the only one that directly refers to respectful health care for women under the provision of Article 11(1)(f), 12, 14 (2)(b) and general recommendation 24 on women and health for non-discrimination in the field of healthcare. It specifically states, "…*the duty of the states parties to ensure, on a basis of equality between men and women, access to health care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care."* (WHO, 2007, p. 3). There are 180 signatories to CEDAW that are liable to ratify this in their country, including India (CEDAW, 1980).

The third key document in this regard is the charter on respectful maternity care which takes it further by presenting the seven Universal Rights of Childbearing Women (WRA, 2015) which is updated in 2019 to include the rights of the newborn (WRA, 2019). This charter embeds the rights of childbearing women within the context of human rights, though it is not legally binding as the CEDAW and Universal Declaration of Human Rights are.

2.2 'Obstetric violence': Terminologies, definitions, resistance, movements and the history

Naming violence in public discourse is essential to ending violence against women. Although there is a disbelief, a reluctance to accept and name violence against women, which is not new. I wanted to find out when it was that the first woman suffered domestic violence and/or intimate partner violence. Then I wanted to trace how long it took from when these abuses were named, to when progress was made in considering it to be a key form of violence against women,

embedded in gender-based violence. It probably took centuries! Similarly, it would be difficult to tell when the first woman experienced obstetric violence.

The history of the Sim's speculum and the notorious experiments by Dr. J Marion Sims, the father of Gynaecology (Davis, 2019), on black enslaved women's bodies is a gory detail in history (Davis, 2019). It probably is as far back as recorded history goes regarding obstetric violence embedded in and indicating obstetric racism (Davis, 2019; Cleghorn, 2021; Hamad, 2021). Almost two centuries later, I see and read similar anecdotes of women being traumatised through un-anesthetised episiotomy repairs. The expectations for some women to bear more pain based on their race or class and other social constructs, also called 'Obstetric Hardiness', persists two centuries later (Davis, 2019). I have a personal connection to this concept. My mother told me that she was on her 'best-behaviour' and not making a sound, and clenching her teeth through the painful contractions, as it saved her from facing any humiliation. She reports satisfaction from her birthing experience as she had managed to avoid 'misbehaviour' (*baje baibohar* in Bengali). I think my mother performed obstetric hardiness to avoid obstetric violence when I was being born in the mid-eighties at a government military hospital in India (elaborated in Chapter 6).

While the problem remained unnamed in the mid-eighties, a connection can be drawn from the anecdotes of women's rights activists such as bell hooks, Ann Oakley and Sheila Kitzinger to the beginning of recorded over-medicalisation of birth in the eighties. A manifestation of this could be seen in the exodus of women from home to hospital births and the rising cesarean section rates around the world. While these feminist authors did not use specific terminologies, the characteristics of dehumanised birthing experiences were evident in the content and book titles such as 'Captured womb' and 'Confined women'. Espinoza-Reyes (2020) and Solis position this 'colonisation of the womb' as obstetric violence and a human rights violation in the Mexican context.

'Obstetric', a term treated as holy, sacrosanct, and implying connection to obstetricians, makes it a battleground when 'violence' is attached to it. The term is considered feminist, activist, journalistic, non-academic, alarming and dangerous. Academics find it difficult to publish and make presentations with obstetric violence in the title (Levesque & Parayre, 2021). For example, in India, two of my own papers were removed from the final stages of review because the issue is deemed controversial and could cause a political turmoil when reports of obstetric violence are published. Governments, globally, do not appreciate being told that women are experiencing obstetric violence, it's too strong, harsh and real, they can't bear it. They prefer being gently made aware that women are experiencing 'a lack of respect' when they give birth. Brazil's Ministry of

Health's decision to drop the terminology from official documents is an example of a pattern seen in many countries that are still in denial (Ignacio, 2019).

The competing terminologies include 'disrespect and abuse' that have been defined by Freedman (2014) categorising into individual, structural and policy factors that drive the practice (Figure 2.1); while Sen, Reddy and Iyer (2018) focused on the context of India and explained disrespect as the less and abuse more extreme instances while referring to many underlying factors from an intersectional perspective. Both the definitions mainly referred to the process and drivers of the issue. Other noteworthy terms include structural violence (Miltenburg, 2018), normalised violence (Chadwick, 2017) and symbolic violence (Morgan, Thapar-Björkert 2006) that can be used to explain aspects of obstetric violence bringing in the hierarchy, power, status and control related arguments which are also covered in some way in the previously mentioned definitions.

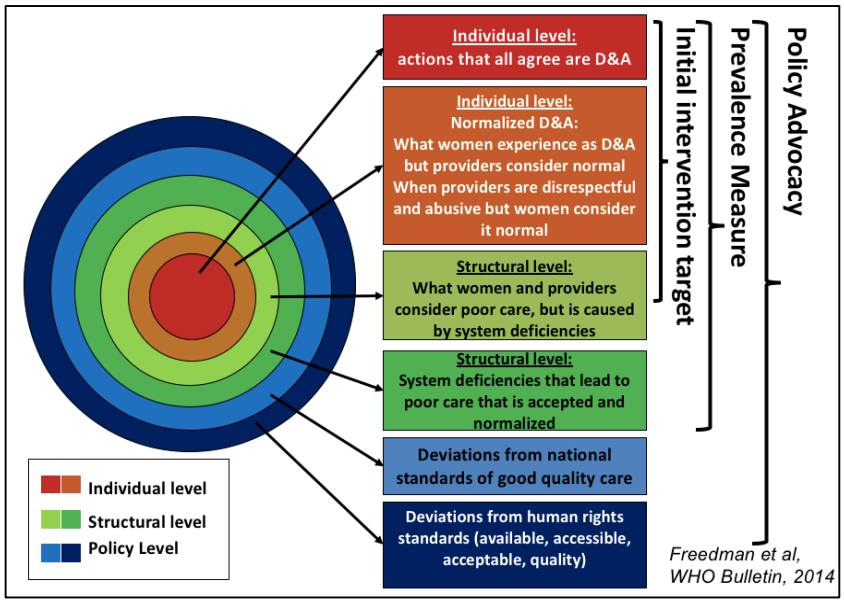

Figure 2.1 Definition of disrespect of abuse during childbirth

(Source: Freedman et al., 2014, p. 916)

Obstetric violence can be considered to fall under the larger domain of reproductive violence that goes beyond the 'obstetric' realm. Mistreatment is the third most common of the terminologies, although it has not been defined properly but has been used to present typologies by Bowser and Hill (2010) and Bohren et al. (2015). Obstetric violence is also the most contested terminology (Rost, Arnold & Clerq 2018; Sadler, 2016). The following table brings together the definitions of all the terminologies discussed in this section.

Table 2.2 Definitions of disrespect and abuse; and obstetric violence during childbirth

Terminology	**Definitions**
Obstetric Violence	*"the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanised treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women."* (Perez D' Georgio, 2010, p. 201)
	"*an assemblage of disciplinary, bodily and material relations that are shaped by racialised, medicalised and classes norms about good patients, good women and good birthing bodies*." (Chadwick, 2017, p. 504)
Disrespect and abuse during childbirth	*"the individual disrespect and abuse (i.e. specific provider behaviour experienced or intended as disrespectful or humiliating such as slapping or scolding women) and the structural disrespect and abuse (i.e. systemic deficiencies that create a disrespectful and abusive environment, such as overcrowded and understaffed maternity ward where women deliver on the floor, alone, in unhygienic conditions)."* (Freedman & Kruk, 2014, p. 915)
	"In the context of obstetric care, we define disrespect as the violation of a woman's dignity as a person and as a human being on the basis of her economic status, gender, caste, race, ethnicity, marital status, disability, sexual orientation, or gender identity. Disrespect is often revealed in the biased normative judgments that health workers make about women and the resulting acts of omission or commission. Abuse refers to actions that increase the risk of harm to the woman and are not in the best interests of her health or well-being. Such actions maybe learned and reproduced through the practices of institutional medicine. They may or may not be intended to cause harm and are often justified by resource constraints that can become a cover for prioritising the convenience of health providers over the well-being of the woman." (Sen, Reddy & Iyer 2018, p. 8)
Structural violence	"*social forces that create and maintain inequalities within and between social groups, which make way for conditions where interpersonal maltreatment and violence may be enacted… the essence of structural violence lies in the indirect, systematic and often invisible infliction of harm on individuals by social forces that disable individual from having their basic needs met*." (Miltenburg et al., 2018, p.2)

Obstetric violence is a commonly used terminology in the Latin America and the Caribbean (Savage & Castro, 2017). The definitions of obstetric violence focus mainly on women as the object of victimisation and its impact on herself and her body. It also draws from the gender perspective as an underlying factor in the definitions that authors have presented over the years influenced by feminist literature on women's rights and women's bodies as mentioned in Perez D' Giorgio's definition.

Chadwick's definition sheds light on how society expects women to be, which influences how they are expected to behave during labour and birth. Women are expected to appear and behave in a dignified way (Kitzinger, 1992) in general. Actions of screaming, not being able to bear pain and being in control of the actions of the physical pain during labour, are considered undignified and

hence need to be disciplined. Studies suggest that any work attempting to understand disrespect and abuse in care during childbirth needs to recognise many relevant theories and principles. At the core of this issue lies the human rights violation at the women's most vulnerable phase of life which is influenced by the cultural context on how women are regarded in a community which is best explained in feminist literature on women's rights, choices and bodies (Friedan, 1963; Oakley, 1986; Kitzinger, 1992; Stones, 2004; Menon, 2012; Nayak & Nath, 2018; Davis, 2019; Criado-Perez, 2019; Cleghorn, 2021).

The definition of structural violence by Miltenburg et al. (2018) takes the meaning of structure a level higher from the birthing environment and health system structure to the larger social construct of the society. The most recent definition of disrespect and abuse during childbirth is a blend of the feminist perspective, the health systems constraints and the deep-rooted cultural constructs of the society (Sen, Reddy & Iyer, 2018). The terminologies, related to obstetric violence (not all discussed here) seem to have different territories, which can appear different to the reader, based on their subjectivity. I created a mind-map based on my readings, to better understand these terminological territories shown in Figure 2.2.

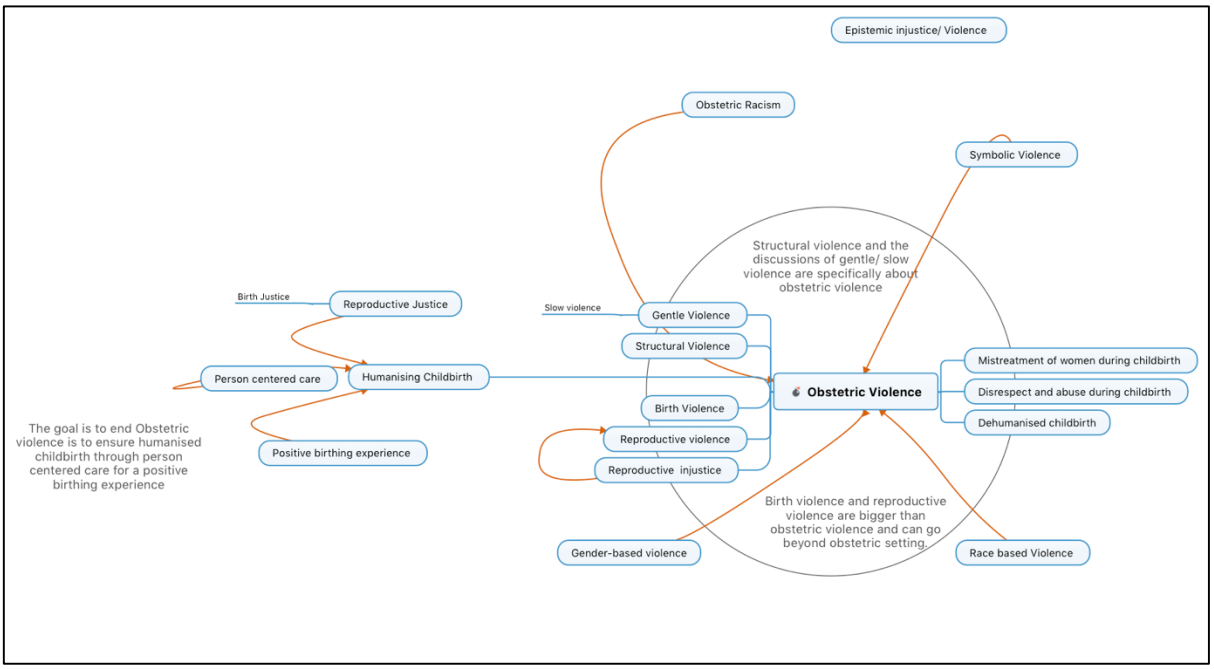

Figure 2.2 Terminological territories around 'obstetric violence' (*Author's own*)

It is noteworthy that a recent correspondence in The Lancet identified this lack of consensus in naming the problem (Amorim, Bastes & Elcatz, 2020). The authors of the letter advocate for the term obstetric violence in the correspondence. The authors respond to a study reporting that over one-third of the sample of women experienced physical abuse, verbal abuse, stigma and discrimination during childbirth in Nigeria, Ghana, Guinea and Myanmar (Bohren et al., 2019),

while not naming the issue on the title. Amorim, Bastes and Elcatz (2020) argue that obstetric violence transcends structural and logistical issues by indicating the violation of women's human rights, equality, health and reproductive economy. Bohren et al.(2020) responded to it referring to the issue of intentionality that the term 'obstetric violence' poses, making it difficult to engage with health care workers and policy makers, hence they were keen to continue engaging with the issue by referring to the issue as 'mistreatment during childbirth'. I acknowledge and understand why researchers often have to pick and navigate between terminologies for reasons of reach and preference, to influence policies and policy makers, to publish and secure funding, as each terminology has a certain boundary. I have done that too, and I am trying to change that by placing 'obstetric violence' at the centre in my work. The reasons behind the need for navigation between terminologies, the arguments around 'obstetric violence' and its misinterpretations, can be best explained by two recent examples, one each from the global north and the global south.

In Italy, Rivaldi et al. (2018) reported evidence of obstetric violence from an online community survey. The Presidents of three obstetrician associations and one midwives' association wrote a strong correspondence objecting to the evidence produced, calling it 'presumed deplorable behaviour'; 'damaging' and 'alarming' to put 'violence' next to 'obstetric'. They state that the findings '*do not take into account the power-duty of the professionals to co-decide, guide women's choices, act urgently, even without consent, to avoid serious danger to the person's life or integrity*.' (Scambia et al., 2018). Similar language has been used in a German article where the author referred to 'obstetric violence' as an attempt of '*boiling up the problem of violence*' (Deutsches Äezteblatt, 2019).

Rost, Arnold & Clerq (2020) responded to the discourse in Italy and Germany from an ethics perspective, condoning the harsh language used in these response articles which are devoid of empathy, and superciliously denying the issue rather than listening to women's experiences. They also raised the pertinent question indicating the language of furious rejection of the terminology, and the assumption that an issue of this nature can be 'boiled up'. This raises the question of whether health care providers are actually unaware of this problem, in any name, while serving in the same system, now that there is ample evidence about obstetric violence globally. Is obstetric violence then a well-preserved problem to which there is a serious resistance to acknowledge? Is it a wanted phenomenon to discipline women's bodies, to ensure continued oppression of women through various forms of violence, including in the obstetric setting and to keep control of womb and birth? This has been noted and explained in feminist writings as a classic feature of patriarchal post-colonial structure that benefits from obstetric violence by continuing the culture of dehumanisation of women in various settings (Chattopadhyay, 2018), also a manifestation of patriarchal violence (hooks, 2000).

Intentionality is at the centre of the discourse of naming and addressing obstetric violence, frequently referred to the WHO's definition of 'violence' that lays emphasis on the intent of causing harm. While there is sufficient literature on drivers of obstetric violence that acknowledge care provider's challenges and support the lack of intent (Barbosa, Jardim & Modena, 2018), that is not an argument to deny obstetric violence and the fact that health care providers inflict violence in birth settings whether intentionally or unintentionally. A recent case study from South Africa explains this discourse best. This started with Chadwick's (2017) book on obstetric violence in South Africa, specifically referring to 'gentle violence' which hides in plain sight and is embedded in the culture and is normalised but regardless, is indeed obstetric violence. A study by Lappeman and Schwartz made an argument about the lack of intent on the health care providers part while presenting findings from a study conducted in two public hospitals in South Africa, while strongly criticising Chadwick's use of the term 'obstetric violence' in her research with a diverse group of women's experience of birth. Lappeman and Schwartz express concerns that naming the 'silent ward milieu' as 'gentle violence', while drawing the term's similarities with slow violence (Nixon, 2011), is demoralising for health care providers who provide good quality care against all (systemic) odds. They further add whether the term disempowers inadvertently the women it aims to empower. Their central argument lies in the question- *'How gentle must violence be in order for it to not be violent?'*.

Three commentaries, strongly rejecting this central argument, are published in response in the same issue of journal 'Violence Against Women', all of who made arguments in support of using the term obstetric violence. Levesque and Parayre (2021), while highlighting WHO's definition of intent in violence as outdated, raise an important point of whether an act is violent only when perceived as such, indicating its roots in sexism, which is an indicator of a patriarchal and sexist system. Burnett (2021), criticised the notion of making the issue about time (slow vs fast) and intensity (gentle vs harsh) while also drawing attention to the context of women that guides their perception of violence. In my experience, this argument also holds for the Indian context. The authors rest their case emphasising on the importance of language which has the ability to drive change or leave an issue unaddressed when not named fairly. In the same vein, Salter (2021) argues that the act of calling violence out does not outweigh the challenges the health care providers face due to the systemic issues, which is inherently discriminatory, disempowering, harmful and oppressive towards women whom it promises to do no harm. They centre the terminology into the reproductive justice framework while reflecting on the intersectionality that could influence women's vulnerability to obstetric violence; finally rejecting the focus on the argument fixated on intentionality for acts of physical abuse, belittling, sexually abusing and humiliating women which are evidently intentional (Salter, 2021).

Lappeman and Schwartz (2021) acknowledge all the three commentaries agreeing to several points raised by the authors but re-state their opinion that the term is provoking and undermines the good practices by health care providers who are themselves victims of system's internalised oppression. Shaming them by making them take blame and accepting 'jarring terminologies', in their opinion, is counterproductive to ensuring respectful care, in line with behavior change literature. I don't think that researchers who report on obstetric violence, including myself, attempt to generalise that all care workers are abusers, nor do they undermine the efforts of all those health-care providers who are providing respectful and dignified care to women and taking a stand against all odds. Referring to marital rape and intimate partner violence as marital dispute; or rape and sexual abuse as 'offence' is just as harmful as is referring to 'obstetric violence' as 'mistreatment', 'misbehavior' or 'a lack of respectful care', makes us all accomplices in letting a serious issue go unaddressed while well recognising its consequences and impact on women and their families. A simple response to Lappeman and Schwartz's question (how gentle should obstetric violence be for it to not be violence?), would be that there should be no violence against women in order for it to not be violent.

2.3 Types of obstetric violence during childbirth

The first typology of disrespect and abuse during childbirth was presented by Bowser and Hill (2010) from their landscape analysis based on a comprehensive review of evidence from their work in Tanzania. They categorised disrespect and abuse during childbirth into: 1) physical abuse, 2) non consented care, 3) non confidential care, 4) non dignified care, 5) discrimination based on specific patient attributes, 6) abandonment of care and 7) detention in facilities.

The second typology of mistreatment of women during childbirth was presented through three levels of domains, sub domains and specific indicators. The domains include; 1) physical abuse, 2) sexual abuse; 3) verbal abuse; 4) stigma and discrimination; 5) failure to meet professional standards; 6) poor support between women and providers; 7) health system conditions and constraints (Bohren et al., 2015). This typology breaks the actions of abuse down to the specifics and hence is easy to identify in health care facilities (Table 2.3).

Table 2.3 Typology of mistreatment of women during childbirth

Domains	**Sub-domains**	**Indicators**
Physical abuse	Use of force	Women beaten, slapped, kicked or pinched during childbirth
	Physical restraint	Women physically restrained to the bed or gagged during childbirth
Sexual abuse	Sexual abuse	Sexual abuse and rape
Verbal abuse	Harsh language	Harsh or rude language
		Judgemental or accusatory comments
	Threats and blaming	Threats of withholding treatment or threats that poor outcomes will ensue
		Blaming women for poor outcomes
Stigma and discrimination	Discrimination based on socio demographic characteristics	Discrimination based on ethnicity / race / religion
		Discrimination based on age
		Discrimination based on socio-economic status
	Discrimination based on medical conditions	Discrimination based on HIV status
Failure to meet professional standards of care	Lack of informed consent	Lack of informed consent process
		Breaches of confidentiality
	Physical examinations and procedures	Unnecessarily painful vaginal examinations
		Refusal to provide pain relief
		Performance of unconsented surgical operations
	Neglect and abandonment	Neglect abandonments or long delays
		Skilled attendant absent at time of delivery
Poor support between women and providers	Ineffective communication	Poor communication
		Dismissal of women's concerns
		Language & interpretation issues
		Poor staff attitudes
	Lack of supportive care	Lack of supportive care from health workers
		Denial or lack of health companions
	Loss of autonomy	Women treated as passive participants during childbirth
		Denial of food, fluids or mobility
		Lack of respect of women's preferred birth positions
		Denial of safe traditional practices
		Objectification of women
		Detainment in facilities
	Lack of resources	Physical condition of facilities

Domains	Sub-domains	Indicators
Health system conditions & constraints		Staffing constraints
		Staffing shortages
		Supply constraints
		Lack of privacy
	Lack of policies	Lack of redress
	Facility culture	Unclear fee structure
		Unreasonable requests of women by health workers
		Bribery and extortion

Source: Bohren et al. 2015

A third typology of mistreatment during childbirth is an adaptation of the Bohren et al. typology for mistreatment of newborns (Sacks, 2018). This is the first typology focusing on respectful newborn care. Though it includes some examples which indicate disrespect and abuse of women too, for instance "*women blamed for poor neonatal outcomes, small infant and female newborn".* (Sacks, 2018). None of these typologies incorporate obstetric violence of women during childbirth by family members at home or hospital settings. These typologies have been used to generate evidence in many countries, as described in the next section.

2.4 Global evidence of obstetric violence during childbirth

Evidence of obstetric violence has been reported from around the world regardless of the income and level of development of the country. While undertaking the literature review, I found evidence of obstetric violence in over 75 countries globally, indicated in red in Figure 2.3.

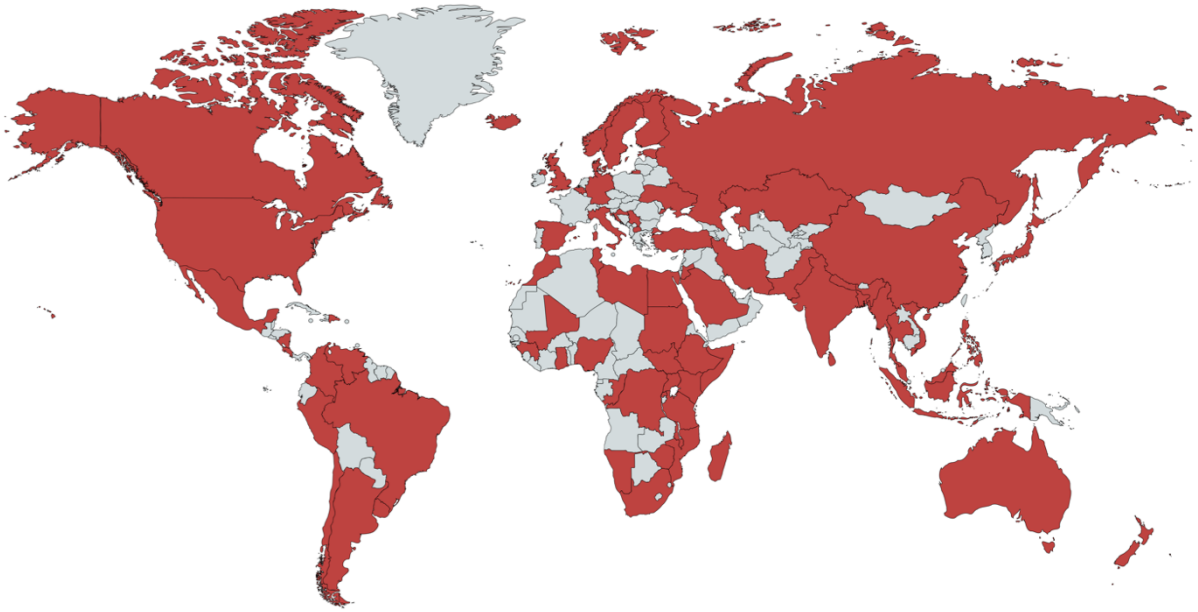

Figure 2.3 Evidence of mistreatment of women in countries around the world *(Author's own)*

The literature is divided in reporting on obstetric violence during childbirth. There are some studies that use the Bowser and Hill and otherwise Bohren et. al's typology to classify the types of mistreatment at birth systematically (Abuya et al., 2015; Srivastava & Sivakami, 2020). There is some overlap when it comes to reporting, if the type of obstetric violence is unclear. Some studies report on non-dignified care, verbal and physical abuse separately, others may look at physical and verbal abuse as types of non-dignified care. This lack of consensus is quite evident in the literature, failing to recognise that the perception of respect is subjective and depends on the conditioning into what is acceptable and what is not. Therefore, studies employ different approaches that include asking women about their perceptions and experiences after birth, or sometimes reporting direct observations of the childbirth process (Dey, 2018; Mayra & Kumar, 2017; Jha et al., 2017).

Kitzinger, (1992) refers to the absence of greeting and welcoming women into the birthing space or environment as a kind of disrespect that every woman experiences when she visits a service provider for childbirth, often alongside other extreme forms of obstetric violence (Miltenburg et al., 2018). This was reported in a study done in Tanzania, with authors indicating that all women experienced disrespect and abuse during childbirth. Women have shared reports of obstetric violence starting from a lack of communication, to unconsented care and sexual abuse (Reed et al., 2017). In a study conducted in Jordan, women (average age of 28 years) reported neglect (32.2%) and verbal abuse (37.7%) during their last childbirth (Alzyoud et al., 2018). A cross sectional study carried out among 173 women through an exit interview in Ethiopia found 39.3% women reporting of being left unattended during labour (Asefa & Bekele, 2015). Researchers

categorised disrespect and abuse as per the Bowser and Hill typology in a survey with 641 women in 13 Kenyan facilities and reported on non-confidential care (8.5%), non dignified care (18%), neglect and abandonment (14.3%), non-consensual care (4.3%), physical abuse (4.2%) and detainment for non-payment of fees (8.1%) (Abuya et al., 2015).

Studies suggest potential under-reporting of obstetric violence during childbirth (Kitzinger, 1992). This can be a result of women's low expectations or not knowing what to expect during childbirth; experiencing disrespect and abuse but considering it a part of care provision; being aware of the experience of disrespect and abuse during childbirth but considering it women's fault due to the fear of consequences such as not to speak against the only care provider in the area or fear of not being heard and taken seriously (Kitzinger, 1992). In Ethiopia, 78.6% women in a study had reportedly experienced obstetric violence during childbirth, but only 16.2% reported about it (Asefa & Bekele, 2015). This changed when the 'What Women Want' campaign reached out to 1.2 million women in 114 countries asking their one demand for quality reproductive and maternal health care. Women broke their silence in solidarity stating their top ranking 'want' from 1,03,584 women (10%) as respectful maternity care (WRA, 2019).

Recognition of obstetric violence is not limited to the individual but depends on the larger systems of communities and countries, as previously discussed. Over-medicalisation, for example, has gradually been recognised as a key form of obstetric violence in many countries, due to the underlying structural inequality, that leads to obstetric violence when not prescribed for the right diagnosis (Sadler et al., 2016). WHO recommends a normal rate of caesarean section (CS) at 10-15%, which has been increasing exponentially in many countries. The rate of CS increased from 11% to 21% in Japan (Behrouzi, 2010). Around 98% women give birth in health facilities in Brazil, where the rate of CS was as high as 53.5% in 2013. It is particularly challenging in the Brazilian private sector where the rate of CS was 80% in 2007 (Diniz et al., 2018). The CS rates in Chile are 39% in public hospital and 72% in private hospitals (Sadler et al., 2016). High rates of CS are reported from the USA and Canada as well, where obstetricians reportedly prefer CS to avoid lawsuits resulting from an adverse birth outcome, so they convince women for an elective CS (Hausman, 2005; Nayak & Nath, 2018). There has been an increase in tokophobia and caesarean section on maternal request. Studies tracking episiotomy rates from different countries range from 21% to 91%. Even though it is difficult to determine an acceptable rate, WHO does not recommend routine or liberal use of episiotomy for spontaneous vaginal birth (WHO, 2018).

Studies report the presence of different forms of obstetric violence embedded in the medical education, which is becoming a part of care providers learned behaviour (Sen, Reddy & Iyer, 2018; Nayak & Nath, 2018; Diniz et al., 2018; Mayra 2020b; Srivastava & Sivakami, 2020). This leads to

particularly extreme cases of disrespect and abuse in the tertiary level teaching hospitals, where much attention is given to medical student's practice, which surpasses the importance that should be given to women. This could be a reason why women may be more vulnerable to obstetric violence when experiencing and being cared for complications (Srivastava & Sivakami, 2020). In Brazil, a study reported a case in 2014, where a black undergraduate student was reportedly given two episiotomy cuts, on the right and left, so that two medical students could practice episiotomy and suturing on the same woman (Diniz et al., 2018). Obstetric violence during childbirth can lead to some severe consequences, as are discussed in the next section.

2.5 Impact of obstetric violence during childbirth on health and wellbeing

Discouraging and addressing obstetric violence during childbirth is not just about surviving childbirth, but acknowledging that women deserve much more than that. Studies in India have found that obstetric violence during childbirth leads to fear of birth, that can discourage women from care seeking (Mayra & Kumar, 2017; Jha et al., 2017), even when complications arise (Bhattacharya et al., 2013). It discourages women from facility-based birth during complications which threatens progress toward reductions in maternal mortality (Bohren, 2015; Bohren et al., 2014). Neglect and abandonment in a care facility has negative outcomes for the mother and newborn, as reported in the Dominican Republic, where missing heartbeats of infant and ruptured uterus for the woman went unnoticed (Miller, 2015). Lack of privacy is a commonly reported factor making women decide against institutional birth (Afsana & Rashid 2001; Oxnevad, 2011; Doctor et al., 2012; Otis et al., 2008; Sorensen et al., 2011; Mrisho et al., 2007; Hadwinger & Hadwinger, 2012; Bhattacharya, Srivastava & Avan, 2013).

Obstetric violence can have a lasting negative impact on women that may lead to postnatal depression, due to feeling out of control and traumatised during childbirth (Kitzinger, 1992; Larson et al., 1988; Green et al., 1988; Scotland, 2020). Women suffering from post traumatic stress disorder (PTSD), having experienced a traumatic childbirth may often relive the trauma every year on their child's birthday. They may suffer from guilt of not enjoying their child's birthday and having to put up an act to look happy on the outside, while recounting the trauma by the minute. Women have reportedly changed the narrative of their child's birth so they can reduce its impact on them. Women have also changed their child's birthday to deal with the trauma better (Beck, Driscoll & Watson, 2013).

A study by Kitzinger (1992) reports that victims of rape and violence during childbirth have similarities in how they hold back from sharing about it, in their feeling of depersonalisation

leading to fear, pain and distress; denial and feeling of isolation, feeling helpless thinking no one would understand, self-disgust and self-blame (Kitzinger, 1992). Women find it difficult to describe their experience and often use the language of their oppressor. In this case, it is the medical terminologies that the care providers tell them were necessary for the survival of the baby and woman. When they do find the words to share their experience they draw parallels with feeling raped and the language includes being 'stripped off', 'tethered', 'forcibly exposed', 'sexual organs put on display', 'disempowered', 'shocked', 'numb', and 'feeling like being a slab of meat being butchered'. Victims of both experiences remember details of the trauma for decades (Kitzinger, 1992). I have experienced and observed this communication gap between the information seeker (such as researcher) and information holder (women with birthing experience) for over a decade in my research experiences of trying to understand women's birth narratives in different parts of the world particularly influenced by patriarchy, gender and issues that are sensitive in nature.

Unnecessary interventions during childbirth is also a form of obstetric violence that has been reported extensively around the world. This over-medicalisation gradually takes the power and control of women's body away from them and over to the health care providers, mainly doctors and obstetricians, who are at the top of the medical and social hierarchy in most communities, countries and cultures (Oakley, 1986; Kitzinger, 1992; Bohren et al, 2015; Sadler et al, 2016; Nayak & Nath, 2018). There is evidence from many countries including Tanzania (Magoma et al., 2010), Nigeria (Shifraw et al., 2013; Parkhurst et al., 2007), Ethiopia (Seljeskog et al., 2006), Iran (Ghazi et al., 2012), Kenya (Mwangome et al., 2012), Bangladesh (Afsana & Rashid, 2001) and Malawi, (Seljeskog et al., 2006) where over-medicalisation has lead to the fear of cutting (episiotomy), that discourages women from seeking care (Bohren et al., 2014). Women may even choose an elective caesarean section, just to avoid the humiliation around over-medicalised and a violent institutional vaginal birth, as seen in Brazil (Diniz et al., 2018).

2.6 Determinants of obstetric violence during childbirth

It is essential to understand the determinants of obstetric violence to find sustainable solutions. There are some studies that have found determinants that are either related to the background characteristics of women such as level of education and socio-economic status or other systemic factors related to care-providers. There is some mention of the structural and systemic drivers of obstetric violence. While there is a dearth of studies that specifically try to understand the reasons behind obstetric violence during childbirth (Sen, Reddy & Iyer, 2018) but one can see patterns in drivers from the existing literature. These drivers can be categorised into: 1) individual,

2) structural, and 3) social and systemic level as shown in Figure 2.4. The individual and structural factors have been discussed in the next sub-section.

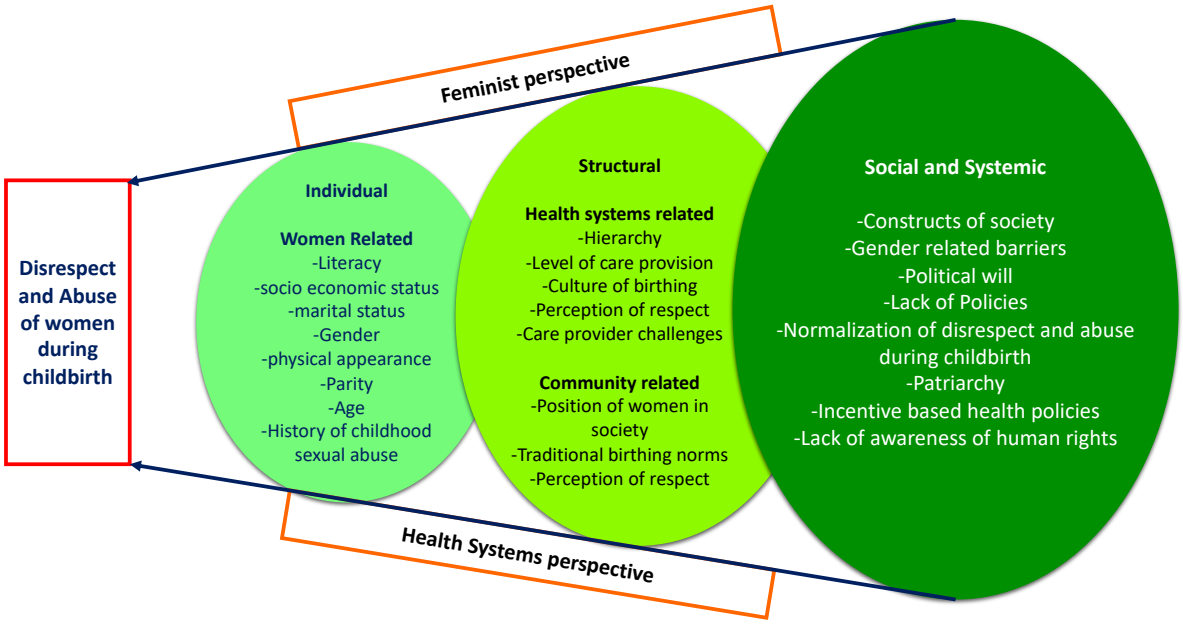

Figure 2.4 Determinants of disrespect and abuse during childbirth

(Author's own based on literature review)

2.6.1 Individual and household drivers of obstetric violence

Personal, demographic and socio-economic characteristics may increase women's vulnerability to obstetric violence during childbirth. Studies report that socio demographic characteristics can make women prone to poor quality of care, on the basis of societal inequalities (Gilmore, 2017). This may include education level, location, marital status, age, gender, socio-economic status, parity and physical appearance (Murray, 2008). Studies in India have reported poor quality of care provision to women who are illiterate or less educated, belonging to low income groups, with two to four children (Bhattacharya et al., 2013; Jeffery et al., 2010; Sen, Reddy & Iyer, 2018), are poor and living in rural areas (Chattopadhyay et al., 2017). Discriminations have been reported on the basis of the newborn's sex (Chawla, 2019). These reasons have been reported in terms of intimate partner violence (IPV) against women who are poor and uneducated (Dhar et al., 2018) in Bihar. The association of obstetric violence with women's background characteristics was noted in the northeast parts of India too (Chattopadhyay, 2018).

A study carried out in the United Kingdom found that childhood experience of sexual abuse can make women relive those experiences during childbirth (Montgomery, 2015). Reports state that one in every five women have been sexually abused as a child, which suggests that care providers

need to be sensitive and educated about trauma informed care, even when women may not share such experiences (Montgomery 2013; Montgomery, 2015; WRA, 2019).

2.6.2 Systemic drivers of obstetric violence

System relates to the institutional environment, including the care providers and the policies. Care providers-related drivers follow a spectrum, which changes from their pre-service education to service provision, particularly midwives and nurses. Studies raise two key challenges that are cadre relevant to understand in this context and include: 1) a lack of respect for midwives and nurses; and 2) medical hierarchy, that includes tertiary level care provision in teaching hospital and the resulting power dynamics. Midwives' and nurse's challenges are important to consider as they are primary stakeholders in care provision during childbirth and their problems are stemming from these two facts.

A lack of supportive attendance during childbirth can be considered a sign of disrespectful birthing environment that discourages care seeking (Bohren et al., 2014; Bohren et al., 2015). Retaining trained nurses and midwives has been an omnipresent health systems challenge. The world currently lacks more than 900,000 midwives particularly in the low and middle income settings (SOWMY, 2021). In the last few years, marked increase have been noticed in the establishment of training and education institutes to produce skilled nurse-midwives' for the international market (Kodath, 2013). This has not necessarily led to an improvement in care provision by targetting workload.

Midwives have historically been compared with 'witches' (Ehrenreich & English, 1970) and have been labelled 'half-taught', 'totally ignorant' (Oakley, 1993) and even blamed for negative birth outcomes. Midwifery is considered an extension of a women's role of caring at home. This mind-set is slowly changing with more reports of midwifery-led care being quoted as a way to most satisfying birthing experiences in many countries (Oakley, 1993) and with more research reporting the impact of midwives. A recent study in The Lancet reported that when enabled to perform at their full capacity, midwives can reduce maternal deaths, neonatal deaths and still births substantially, while also saving 4.3 million lives annually by 2035 (Nove et al., 2021). Yet, most countries do not have an independent midwifery profession and the investment in midwifery remains non-prioritised.

The cadre of nurse-midwives' face unique professional, economic, social and gender-based challenges that leads to burnout and stress (Sadler et al., 2016; Sheikh et al., 2012). Studies suggest that burnout and stress combined with poor treatment of nurse midwives as care providers, reduces compassion in care provision (Hall, 2013; Deery, 2009). The 'Midwives' Voices,

Midwives' Realities' report highlights these issues raised by 2470 midwives from 93 countries (Figure 2.5). Midwives report being disrespected at work (36%) by senior medical staff and felt not being listened to (32%). Workplace harassment such as verbal abuse, bullying, physical and sexual abuse are also reported by 37% midwives. One fifth of the participants depend on a secondary source of income for survival (Filby et al., 2016).

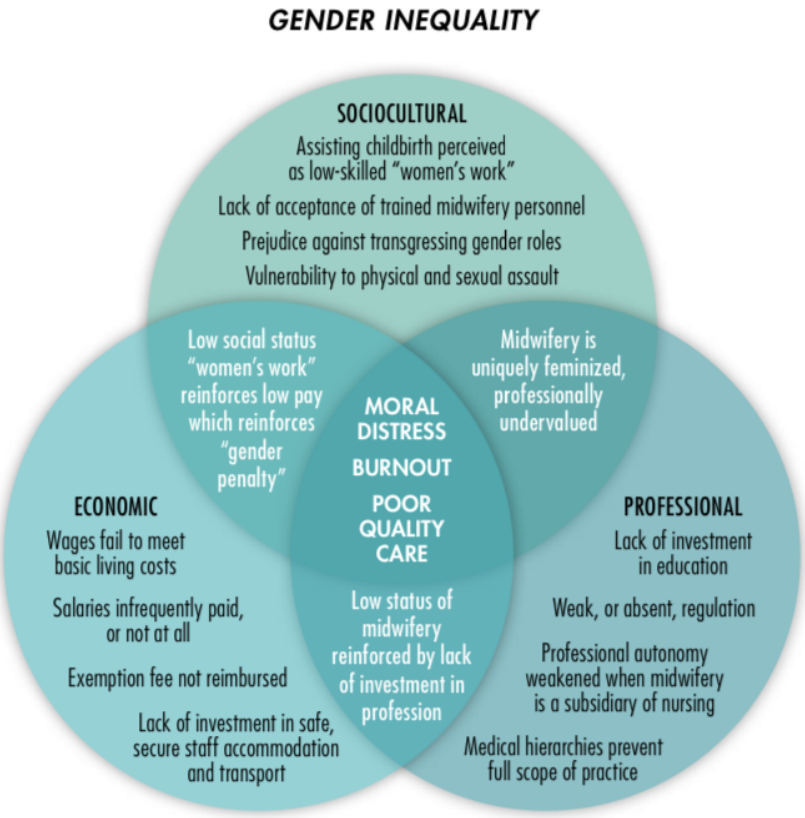

Figure 2.5 Personal challenges in midwifery (Source: Filby et al., 2016, p. 15)

The hierarchical nature of the team providing care also determines the experience of a woman around childbirth (Deery, 2009). Midwives often share that their role in care provision is unrecognised and is suppressed by the medical profession (Philby et al., 2016; Mayra, 2019; Mayra 2020a). Figure 2.6 presents challenges and barriers that midwives face in care provision, as a result of the larger community and system they are a part of. These are categorised into macro, meso and micro challenges that eventually lead to obstetric violence.

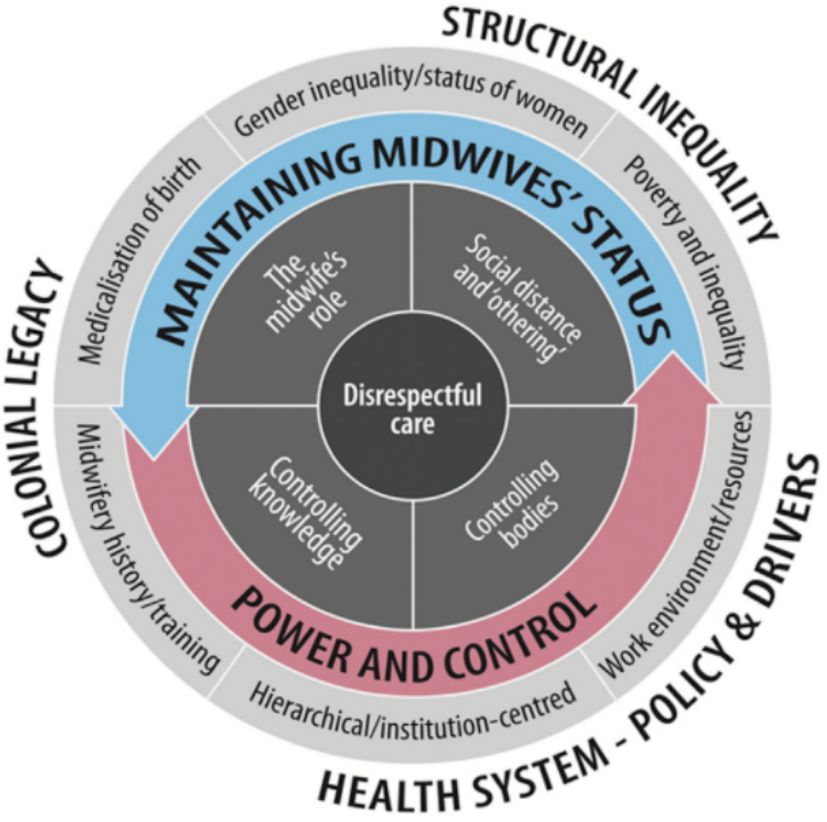

Figure 2.6 Structural and policy challenges in midwifery care (Source: Bradley et al., 2019. p. 4)

Bradley et al. (2019) further report that midwives are often trapped and left to struggle between the 'social model of care' and the 'medical model of care'. This requires them to switch between the organisational system of care and values, and the way midwives would want to provide care (Deery, 2009). Caring for women during childbirth is emotional work (not be confused with emotional labour), which requires coping mechanisms to provide care. In other words, not having a healthy state of mind for care provision may have negative effect on the care-seeker. Coping with one's personal struggles and the stress the work brings with it, is done in many ways. Some midwives just 'switch off' and put on their 'masks' or 'smiles' or 'happy faces' to appear dignified which leads to emotional withdrawing and physical distancing (Hunter, 2009). They feel the need to 'donne their emotional armour', which some refer to as 'surface action' or 'impression management', to be able to perform what the job requires (Deery, 2009; Hunter, 2009) while inside they might be feeling like a 'food mixer' (Edwards, 2009). This helps with care provision but it can cost the midwives, who may get overwhelmed and burnout in the long run. Midwives are expected to be advocates for women and their human rights defenders (Gilmore, 2017) but the challenges surrounding their work needs to be addressed for them to do their job well. Midwives' human rights need to be protected alongside women's rights. It can not be side-lined, as they are victims of the same systemic issues.

2.7 Situating 'obstetric violence' within gender-based violence

Obstetric violence is a feminist issue, embedded in the inherent gender-based inequality that applies to the women as care-receiver and midwives (and nurses) as care providers, who are predominantly women (9 out of 10 globally). All the sections described in this chapter have presented an interplay with gender, be it the terminology, definitions, typologies, evidence, impact and determinants. It is important to understand and investigate obstetric violence during childbirth from the gender lens, to address the inequalities it poses (Betron, 2018) and the fact that it is a result of generations of historic suppression of women.

Being a woman, makes one vulnerable to any kind of violence and victimisation (Jeejebhoy, 2018). Women are considered the 'second sex' (Beauvoir, 1949) and their priorities are also considered secondary (Betron, 2018). As a woman, one is supposed to behave in a fashion guided by the rules, stigma and norms of the society. This has been noticed in women's narratives of power and control around childbirth, which resembles how they interact with the patriarchal structures and how society controls them (Bradley et al., 2016). There are rules and regulations to determine what women should do with their bodies and this control usually takes the power over their own bodies, away from them. Any resistance from women is considered 'misbehaviour' and meted with 'punishment'. Women are expected to quietly endure the labour pains because screaming or crying violates the social norms and calls for punishment through scolding and many other forms of mistreatment during childbirth to discipline her body (Bradley et al., 2016; Sen et al., 2018). This punishment for women is based on the context of the community, country and culture depending on prevailing norms of violence against women. The diversity in the violence against women in a context, makes obstetric violence diverse as well.

Women's bodies and bodily 'purity' is attached to the honour of men, who own her body and the body's 'purity'. One way to ensure this 'purity' in the hospital environment can be seen when the family ensures a particular gender for the treating doctor (Jeejebhoy, 2018; Silan et al., 2012). The control of the female body during childbirth in a hospital setting is a reflection of how society is conditioned to treat women at home, in the community and in general (Sen et al., 2018). Birth, being a natural process, has traditionally been an affair of women, to be dealt with at home, though guided by patriarchal norms of the society (Kitzinger, 2012). There have been rituals around birth and pregnancy that have brought women of community together that has helped them in bonding (Chawla, 2019). The gradual shift from this social model of maternity care to the medical model, has led to medicalisation of the birthing process. The objectification of women's bodies during childbirth is stemming from the asymmetric gender-based power imbalance between the women and the medical profession managing childbirth that is usually masculine

(Sadler, 2016). This gender inequality is systemic and normalises violence during childbirth to an extent, where the women being victimised, starts to accept it, considers it a part of the birthing process and manages her own behaviour around it with an expectation of being abused (Sadler, 2016; Miltenburg, 2018). This is what Davis (2019) referred to as obstetric hardiness (section 2.2).

On the other hand, subjecting midwifery to humiliation and professional shaming is deeply-rooted in gender too. This hinders the growth of midwifery, gradually taking midwives out of the picture, and goes against the social model of birthing, by making birthing a risky business that needs to be handled by doctors guided by numerous medical interventions (Oakley, 1984; Davis, 2019; Cleghorn, 2021). The female-dominated midwifery profession is subjected to many stereotypes and has often been subjected to a lower status in the health system. Within the health care team environment, midwives have been bullied and made to feel undervalued. The undue work pressure along with the lack of recognition has led to burnout and a lack of compassion (WHO, 2019; Deery, 2009; Hunter, 2009; Sadler et al., 2016). This has been evident in the lack of midwives' involvement in policy making, lower salaries, less security and low market value because it is seen as a 'women's work' (WHO, 2019). This has been highlighted in WHO's 'Delivered by Women, Led by Men' report (2019).

Gender acts a double edged sword in the context of obstetric violence during childbirth, that negatively influences the care seeker and the care-provider. I explain this further in the Indian context and in the context of Bihar, a state in India, in Chapter 3.

Finally, I present my positionality, as an Asian feminist researcher conducting research on Asian women in India, to know certain positions I have taken and how it has guided the research-related decisions I made in my research and how my background, experiences and context makes me understand and approach the context in which I conduct my research. I am sharing my association with obstetric violence and what inspired, encouraged or pushed me to plan to do this research for over ten years of my life and then making it possible for the last four years. Researcher positionality and reflexivity are important aspects of my study, especially because shifting power dynamic needs were negotiated in the process of conducting research and is presenting the findings. This is essential because obstetric violence is deeply entrenched in and influenced by the constructs of power which are not fixed but fluid and is shifting based on the interactions and intersections around the individuals, their contexts, and backgrounds (Hamilton, 2020).

2.8 Positionality: My association with 'obstetric violence'

I am a Bengali Asian woman in my mid-thirties, born and raised in lower-middle income settings in different states in India, courtesy of my father's frequently transferable military deployment, with

him as a sole earner in the family. While it uprooted us every few years, it also opened me up to a diverse upbringing and culture where homogeneity in culture and context was never the norm and this diversity is my normality. I received an undergraduate degree in nursing with midwifery embedded in it, in a government college, affiliated to the largest tertiary level hospital in West Bengal, in eastern India (my parent's home state), that predominantly served people from poor income backgrounds. While I call India home, I struggle to place myself in a particular geography, so I will not do that.

I got selected in one of the only 15 seats available to millions of girls from eight states in the eastern part of the country and my fee was around 250 rupees per year (approx. 2.5 pounds), which was affordable for my family and it guaranteed a government job thereafter. In the four years of 'training', my midwifery education began in the 3rd year when I was 19 and had started assisting births in a very high caseload facility 'labour room'. My friend (student nurse-midwife) and I assisted 'deliveries' side by side without rest, although night shifts were busier and they were less violent to women. Exchanging smiles was the only encouragement for us in a busy maternity unit. There was never a dearth of 'cases' to conduct with four or five 'labour tables' placed next to each other and one heavy metal rickety screen, that screamed for attention when dragged, and was rarely used. We observed some form of 'mistreatment' and 'abuse' of women every day, numerous times.

It was common to see doctors, junior and senior, shout at women. Slapping or pinching on the outer thigh with artery forceps was common when assisting births. Slapping on the inner thigh or hitting on the vulva with an instrument was common during episiotomy repair, when this was done without anesthesia or when not enough time was given between anesthesia and repair. Senior staff nurses would shout and make derogatory humiliating remarks '*why did you not think before spreading your legs'*; '*remember the pain next time'*; '*your age isn't receding is it, yet you show up every year'*; '*this is common in their religion'*; '*you must get operated (tubectomy) or a copper-T inserted*[1]'. I registered them in my mind as unnecessary abusive behavior, that the women did not deserve. In my context, these practices were normalised 'misbehavior' of care providers. I stood at the centre of the scene with obstetric violence unfolding around me, conditioning me and my friends into it.

It would be fair to state that these violent practices are part of a medical, midwifery and nursing student's education (Madhiwala et al., 2018; Mayra, 2020b). The context of inequity teaches one to take advantage of the power-based inequality in a vicious cycle, subconsciously. A lack of privacy and confidentiality, verbal abuse, repeated vaginal examinations were usual and blended in our

[1] Also known as Intra Uterine Contraceptive Device (IUCD)

practice, that went unregistered in our minds. Observing the experience women were subjected to everyday, while changing out of uniform (a bright fluorescent yellow saree as shown in Figure 2.7) after shift, some friends would say *'I am definitely getting an elective cesarean, there is no point of this embarrassment for a healthcare professional!'* Some saved for years for an elective cesarean in a private hospital. After experiencing sexual abuse and violence myself, during a vaginal examination, in the hospital I practiced in, while in uniform, I was positive that my position had no positive influence on how I will be treated in the place where I provided care. I decided to never give birth. My decision, as a virgin, involved refraining from sexual intercourse. I could not take a chance of contraceptive failure or an abortion, exposing myself once more to similar humiliation and abuse. It made me go on 'birth strike' (Brown, 2018). Having experienced sexual violence numerous times (Mayra 2020a; Mayra 2020b), I wanted to steer clear of a circumstance I could not protect myself from.

Figure 2.7 Me and my classmates in our uniform

(Illustration by: Soumi Karmakar especially for this research, included with permission)

During my undergraduate course I tried to file a complaint against a doctor who abused the woman I was caring for saying '*how does your husband want to do anything with the jungle you have grown there'*, before performing an unconsented vaginal examination. Being at the bottom of the hierarchy, my voice did not reach far. Frustrated and determined, I decided to do a PhD on

this, so my voice is not ignored, and I am able to influence policies that change care that violates women. As planned, I have not given birth, I have never conceived, and I do not intend to do so either. Obstetric violence during childbirth remains my biggest nightmare and the greatest mystery and I am finally doing a PhD about it.

2.9 Summary

There is a growing body of evidence of different kinds of obstetric violence of women during childbirth, which needs to be addressed at the individual, structural and policy level, as the drivers and impacts are interconnected through all these levels. There is some research that helps to understand the determinants of obstetric violence during childbirth, but more efforts are needed to understand what makes women more vulnerable in relation to social determinants and what can be done to address it.

Global campaigns such as 'What Women Want', 'Me Too' and 'Time's Up' have opened up the platform for women to share their experiences against abuse and ask for respectful maternity care. It is therefore timely to address the issue of obstetric violence against women in the labour rooms too, aiming for quicker actions and sustainable changes. Obstetric violence of women during childbirth has been called 'Me Too in the Labour Room' in popular culture with a resulting outpouring of experiences of women from more educated sections of society with specific campaigns dedicated to obstetric violence related experiences in Latin America, Canada and Europe. Stories of women from rural areas and urban slums of poor socioeconomic status and lower education remain unheard. Understanding respect, disrespect and abuse around childbirth from women's perspectives in a holistic way is another gap in the literature.

Experience of care provision and of receiving maternal health care are the two key aspects when understanding quality of health care that I will study under the larger framework of quality of maternal health care provision. It is important to explore what respect means from the perspective and experience of women and care providers to understand the problem and sustainable solutions locally. My three paper thesis fills this research gap by starting with the exploration of disrespect and abuse from the perspectives of women and of care providers.

Chapter 3 Birthing in Bihar: setting the context

India presents a diverse context, influenced by different states. In this chapter, I provide information from literature to understand this context about India, as a country and Bihar as the state where most of my research is geographically located. I present information about maternal health, childbirth, women's status, empowerment and violence, to better understand the study context.

3.1 Quality of maternal care in India

India made considerable progress in the reduction of maternal mortality between 1990 to 2015, but could not meet the Millennium Development Goal (MDG) 5 targets, aimed at improving the maternal health care provision (Shah, 2016). India represents 12% of the global burden of maternal mortality. WHO estimates its current Maternal Mortality Ratio (MMR) at 145 (WHO, 2017; Shah, 2016). The wide range in health service indicators is evident in the difference between the states in other maternal health indicators. The north-eastern state of Assam, for instance, has the highest MMR of 237 (SRS, 2018) and the southern state of Kerala has the lowest MMR of 46 (SRS, 2018). Uptake of maternity care elements such as antenatal care and institutional birth, remains low, in comparison to other Low and Middle-Income Countries (LMICs). Even within country, given the diversity and size of population, the status of maternal health care provision varies between states. The institutional births in Kerala, for example, is 99.8% whereas in Nagaland it is 45.7% (NFHS 4). State wise percentages of institutional births in India from NFHS 4 are shown in Figure 3.1.

Health being a state subject, individual states have their own policies to manage health care and tackle state based challenges, and hence the rate of progress varies by state. It is, therefore important to understand the health status and service delivery for every state in its context. The upcoming sections describe the context of maternal health care during childbirth in India and specifically in Bihar, where much of this study is located.

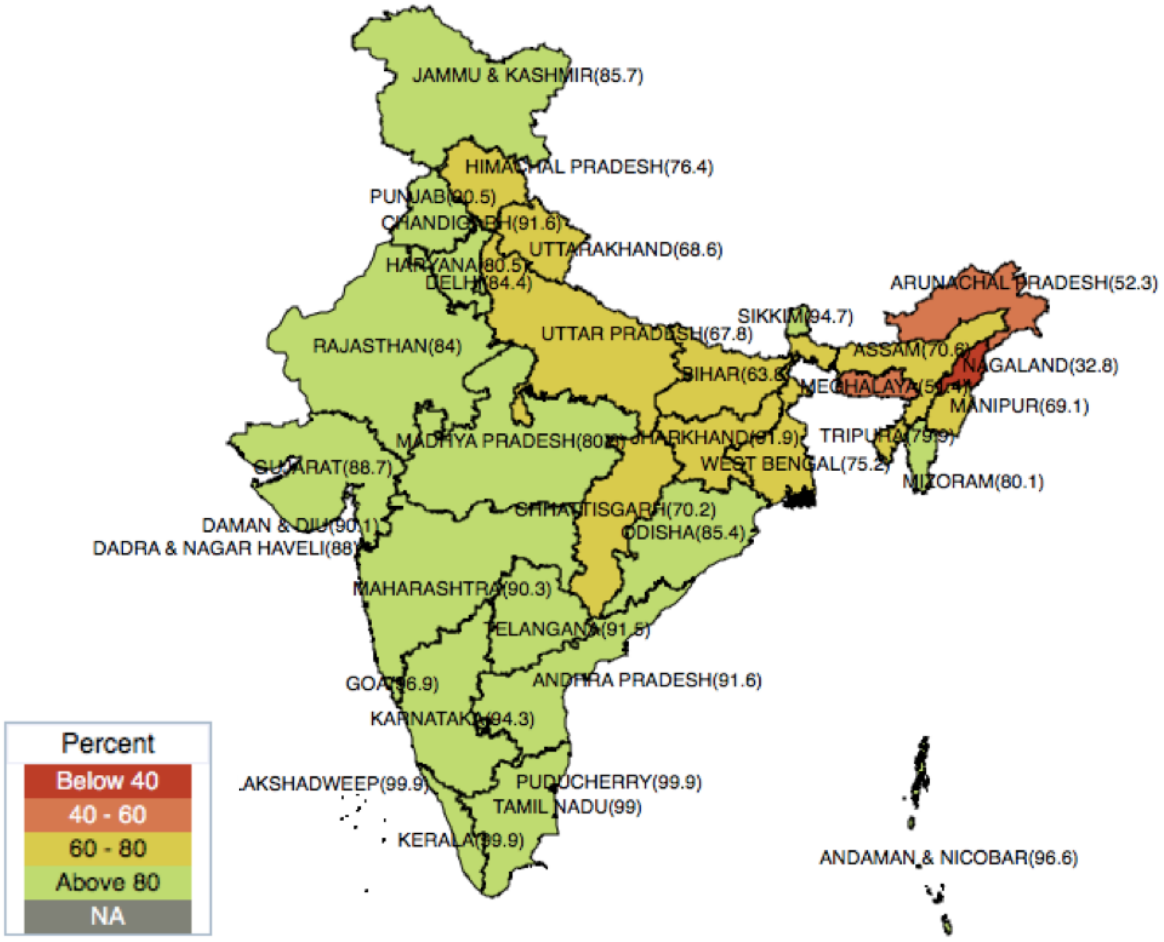

Figure 3.1 Map showing percentages of institutional births in India by state (*Source: IIPS, 2015*)

3.2 Evidence of obstetric violence during childbirth in India

There is a growing body of evidence on obstetric violence during childbirth coming from different states in India (Nayak & Nath, 2018). A systematic review reported evidence of obstetric violence in India against the Bohren et al. (2015) typology under all the six key domains except sexual abuse which is often left out of the research due to the sensitivity of asking questions of this nature to women (Srivastava & Sivakami, 2020; Bhattacharya & Ravindran, 2018). In my previous qualitative study, conducted in the eastern state of West Bengal, participants (pregnant women) reported verbal, physical, sexual abuse and unethical care provision (Mayra & Kumar, 2017). Verbal abuse is a common form of obstetric violence seen in India. Women often report that their care providers make derogatory and judgemental comments particularly when they are in pain. The time of birth has been used as a site for humiliating women with different versions of insults, in many countries including India (Sen et al., 2018). In my previous research, I have found that care providers who claim that obstetric violence (not mentioned with that terminology but translated in local languages) is a myth that can be broken by having a husband as your birth

companion during childbirth. A husband's presence is considered more as a witness, than a support in labour and birth.

A study carried out in Assam, India reported extreme forms of obstetric violence that include routine episiotomy without anaesthesia, hitting with a stick for soiling the bed, verbal abuse and neglect (Chattopadhyay, 2017). Studies from Uttar Pradesh state that 90% women report illegal payments, 28% verbal and physical abuse (Bhattacharya, 2015; Raj et al., 2017), 80% women reported routine manual exploration of uterus and 92% were not allowed a birthing position of choice (Sharma et al., 2019). Not informing women before vaginal examination and physical violence, are commonly seen in public hospitals, whereas routine perineal shaving is common in the private hospitals in Uttar Pradesh (Sharma et al., 2019). Women from the western state of Gujarat report unconsented care (57%), verbal abuse (55%) and physical abuse (40%) (Patel et al., 2015). A recent study conducted in India's national capital, New Delhi, brings forth several reports of unconsented post-partum intra-uterine device (PPIUCD) insertions, from the narratives of eleven muslim women who are all homemakers from low-income backgrounds (Nazdeek, 2020).

The increasing trend of unnecessary interventions during birth, especially the rate of episiotomy and caesarean sections (CS), is noticed in India. Currently, the average rate of CS is 17% (nearly 9% in 2005-06) ranging between 6% in Nagaland to 58% in Telangana (Radhakrishnan et al., 2017). There are variations within states in the public and private sectors. For instance, the lowest CS rate in the public sector is nearly 3% in Bihar and the highest is in Telengana (40%). The lowest CS rate in the private sector is in Rajasthan (23%) and the highest is in Jammu & Kashmir (75.5%) (NFHS 4, 2015-16). The lowest difference between the public and private sector's CS rate is 7% in Kerala and highest difference is 52% in West Bengal (NFHS 4, 2015-16). A study conducted at two tertiary hospitals in Maharashtra investigated structural violence through interviews with care providers and found normalisation of obstetric violence during childbirth. They also found medical students engaging in care that is disrespectful and abusive to women, similar to what was mentioned in the previous section in Brazil (Madhiwala et al., 2018). There are no studies specifically exploring the determinants of obstetric violence during childbirth in India. This is a crucial gap in the literature that is addressed in this PhD.

A frequently stated reason for poor quality of maternal health care is the lack of nurse-midwives as primary maternal health care providers (Sheikh, Raman & Mayra, 2012), a trend observed globally (presented in Chapter 2). India is yet to establish an independent cadre of professional midwives; this has been of benefit to many other countries including Australia, UK and New Zealand, that have been at the forefront of best care provision during childbirth. The GOI is now making organised efforts to implement midwifery in India. The operational guidelines have been

launched in December 2018 during the Partnership of Maternal, Neonatal and Child Health's (PMNCH) Partner's Forum, hosted by Government of India. I played a key role in drafting the operational guidelines as a consultant with WHO India.

Nursing and midwifery is taught as a combined degree with two separate registrations. This cadre forms the largest proportion of the health workforce and performs majority of care related services. India ranks second in terms of nursing and midwifery workforce migration, though within country the population is supported by only 24 care providers per 10,000 populations, 17 out of these are nurse-midwives (WHO, 2015). The lack of skilled nurse midwives is a serious issue in India. This was confirmed in WHO's 2010 projection that India needs 2.4 million additional nurse-midwives' to ensure good quality universal care to its citizens (WHO, 2010). The issues faced in preparing a nursing and midwifery workforce that could provide quality and respectful care, is further discussed in the next section.

3.3 The state of midwifery education in India

There are many initiatives involved in capacity building of nurses- midwives in pre-service and in-service education aiming to improve care at the frontline (Fisher et al., 2015; Das et al., 2016), but there is little evidence on their utility beyond immediate success. I discuss this within the domains of pre-service and in-service education of midwives in India.

3.3.1 Pre-service education

Nurse-midwives in India join the health care workforce after completing 2-4 years of mandatory pre-service education. Although the course curriculum is centrally designed and approved by the Indian Nursing Council (INC), yet the quality of education varies across states and institutions. Midwifery education is imparted as part of the three year diploma course called General Nursing and Midwifery (GNM) and the four-year degree course called BSc Nursing, with an additional six months' internship. There are elements of midwifery skills in the Auxiliary Nursing and Midwifery (ANM) education, which is a certificate course. The curriculum of these three levels of midwifery education are not comparable with the International Confederation of Midwives (ICM) recommended skill-set required to ensure knowledge and skills on seven competencies of midwifery (ICM, 2013). In India, plans for direct entry midwifery education have been in the pipeline for years.

3.3.2 In-service education

With the fast-evolving nature of health care, it is essential that care providers get updated frequently while in-service, through Continued Midwifery Education (CME). Over the last two decades, many initiatives have been implemented in India, with an aim to improve nursing and midwifery education, mainly through in-service education (Figure 3.2). Some are implemented in partnership with Government of India and others with various state governments in collaboration with national and international development organisations.

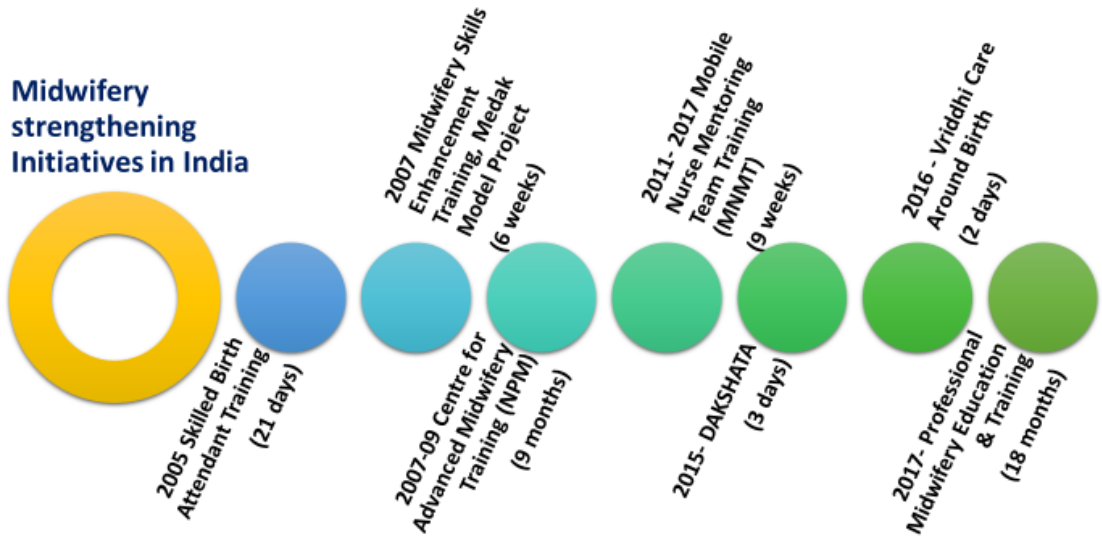

Figure 3.2 Timeline of midwifery strengthening initiatives in Indian states (*Author's own*)

The Skilled Birth Attendant's (SBA) training is the most common among these, that is delivered to ANMs, staff nurses and doctors, through offsite training, provided by a team of doctors and nurses over a period of 21 days (GOI, 2010).

Other training models include the United Stated Aid for International Development (USAID) funded two days training called 'Care Around Birth' under a larger intervention called Vriddhi in 2016 (IPE Global, 2016). The three days training called DAKSHATA has four 'pause points' based on WHO's safe childbirth checklist (GOI, 2015). The Bill and Melinda Gates Foundation (BMGF) funded a nine months in-service education called the Mobile Nurse Mentoring Team (MNMT) training under the larger interventions of ANANYA and AMANAT[2] in 2014 in Bihar. Few other states have implemented the education format (Das, 2017). The Medak model project provided Midwifery Skills Enhancement Trainings in Medak district, Andhra Pradesh in 2007. All these trainings targeted ANMs and staff nurses for improvement in maternal health care provision

[2] Apatkalin Matritva Avam NAvjat Tatparta (AMANAT) that loosely translates into Basic Emergency Obstetric and Neonatal Care (BEmONC)

including care during childbirth. The Swedish Initiative for Development Assistance (SIDA) supported (IIPH-G 2010) the Centre for Advanced Midwifery Training (CAMT) that started skill building of midwifery tutors from schools and colleges of nursing, who went on to build the capacity of care providers. The CAMTs were also used for providing the nine months Nurse Practitioner's in Midwifery (NPM) course in two Indian states with the Society of Midwives India (SOMI) as a key partner (Prakasamma, 2010). Fernandez hospital in Hyderabad is implementing the Professional Midwifery Education and Training (PMET) which is based on United Kingdom's model of midwifery education, founded on ICM's seven competency skills. This is an 18 months' course, adapted to educate 30 nurses from Karimnagar district, with support from Telengana Government that was piloted in 2017.

Most of these initiatives are led by obstetricians, with minimum to no involvement of nurses and midwifery leadership in the conceptualisation and designing phases, except for the Medak Model Project and CAMT. Most of these education models had overseas midwives visiting India to implement them, which makes cultural sensitivity of these initiatives questionable. It is also unclear if these training models were designed with support from the INC or the various State Nursing Councils (SNC). In 2012, the GOI brought out guidelines for strengthening the PSE nursing and midwifery in collaboration with INC. The difference in care provider education and training may lead to differences in quality of care provision, that is particularly poor in a few states. The common factor is the absence of any content on respectful maternity care in all these training initiatives.

In terms of recent progress, the GOI is implementing an 18 months NPM course. The timeline (Figure 3.2) does not include this 18 month adapted NPM course that is piloted in three states in India but it's progress has been stalled due to the pandemic. This course's curriculum has been co-designed by Indian Nursing Council (INC) and ICM. I worked with ICM as a consultant to co-develop the curriculum and also worked with the WHO to draft the GOI's operational guidelines for midwifery implementation in India (GOI, 2018). The draft Nursing and Midwifery Bill, 2020 is currently in the parliament. When passed, it will replace the 75-year-old INC Act of 1946. Although, there are several challenges with the implementation of this bill. It would be a regressive step that would not support midwifery implementation in India as the bill does not define the designation or the scope of practice and continues to undermine the profession by attaching it to nursing as can also be seen in the title of NPM which may suggest that midwifery wil continue to be dependent on nursing (Mayra, Padmadas & Matthews, 2021).

3.4 Bihar

Bihar has been an area of interest for international donors and development sectors alike for over a decade, given its continued poor performance of maternal health care indicators. Obstetric violence during childbirth remains understudied in Bihar too, which could be due to a lack of political will, the sensitive nature of this issue and the fact that violence against women takes time to receive attention. The next sections are dedicated to discuss the reasons that makes Bihar an interesting case study to explore obstetric violence.

Geography and demography

Bihar is in the east of India that shares boundaries with three Indian states of West Bengal, Jharkhand, Uttar Pradesh and an international boundary with Nepal. The state covers an area of 94,163 square kilometres which is further divided into 9 regions, 38 districts, 101 sub divisions, 534 blocks and 44,874 revenue villages. Bihar has the highest birth rate (26) in the country against the national average of 20 (SRS, 2020), which makes it all the more important to get birthing right in Bihar. The population of Bihar is 107 million, 88 % population resides in rural areas and 48% comprises of women. Bihar consists of the second highest rural population in the country (GOI, 2011). The sex ratio is 916 females per 1000 males and the female literacy rate is 53% against the state total of 64% and the Infant Mortality Rate (IMR) is 29, against the national average of 32 (SRS, 2020). Bihar underperforms in most other population and health related indicators in comparison to the national average, as shown in Table 3.1.

Table 3.1 Population and health related indicators of Bihar

No.	Population and Health indicators	Bihar			India
		NFHS 3	NFHS 4	NFHS 5	NFHS 4
1	Sex Ratio of total population (per 1000 females)	1083	1062	1090	991
2	Sex Ratio of children born in last 5 years (per 1000 females)	893	934	908	919
3	Households with electricity (%)	27.7	58.6	96.3	88.2
4	Households with improved drinking water source (%)	96.1	98.2	99.2	89.9
5	Households with improved sanitation facility (%)	14.1	25.2	49.4	48.4
6	Total fertility rate (per woman)	4.0	3.4	3.0	2.2

3.5 Maternal health care in Bihar

Bihar's health indicators are among the poorest in the country, specially that of the maternal and neonatal health care (Dehury & Samal, 2016) and improvement has been slow paced (NIPI, 2014). The Government of India classified Bihar as one of the eight Empowered Action Group (EAG)[3] states that receive most donor and development organisations attention for improvement in health and wellbeing. Maternal health care provision has been subject of much research and intervention in Bihar. Though, the expedited progress in improving targets and indicators have not necessarily meant humanised care during birth. Respectful maternal care is a cross-cutting issue when it comes to health and wellness, but efforts for improvement are yet to happen. Given the disparities in the state, the urban vs rural and rich vs poor gaps in maternal health care provision are evident (Awasthi et al., 2016).

[3] Empowered Action Group was constituted by Government of India following 2001 census to stabilise population in 8 states that consisted of 45% of the countries population.

The current MMR in Bihar is 165 (SRS, 2018) and the Infant Mortality Rate (IMR) is 32 (SRS, 2020), both higher than the national average of 130 (SRS, 2018) and 33 (SRS, 2020) respectively. NFHS 5 carried out in Bihar in 2019-20, shows marked improvements in some maternal health indicators in comparison with NFHS 3 and 4 from 2005-06 and 2015-16, as shown in Table 3.2.

Table 3.2 Birth indicators in Bihar

No.	Birth related indicators	Bihar			India
		NFHS 3	NFHS 4	NFHS 5	NFHS 4
1	Women who have had four ANC visits (%)	11.2	14.4	25.2	51.2
2	Women who had institutional birth (%)	19.9	63.8	76.2	78.9
3	Women who were assisted by skilled care provider during childbirth (%)	29.3	70.0	79.0	81.4
4	Institutional birth in public facility (%)	3.5	47.6	56.9	52.1
5	Births by CS (%)	3.1	6.2	9.7	17.2
6	Births by CS in public hospital (%)	7.6	2.6	3.6	40.9
7	Births by CS in private hospital (%)	17.2	31.0	39.6	11.9
8	Women who were visited by a care provider within two days of birth (%)	NA	10.8	57.3	62.4
9	Children born at home who were taken to a health facility for a check up within 24 hours of birth (%)	NA	NA	59.3	NA

NA=Not available

Bihar lags behind the national average in many birth indicators, including institutional births (Figure 3.1), even after substantial increases in institutional births owing to the widely implemented incentivisation scheme, Janani Suraksha Yojana (JSY) (Karvande et al., 2016; Dehury & Samal, 2016). This has not led to comparable progress in terms of antenatal, postnatal care (Dhar et al., 2018) and neonatal care (Das et al., 2016), as has been the trend in India.

Even within the state, there are disparities in terms of institutional births at the district level, ranging from 37% to 87%, as shown in the Figure 3.3.

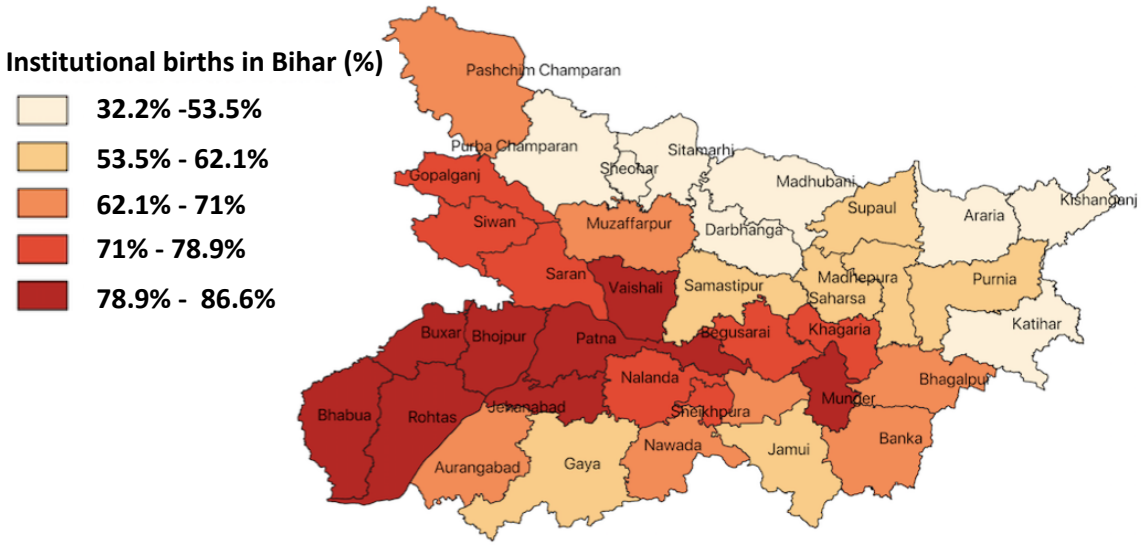

Figure 3.3 Proportion of institutional births in districts of Bihar (*Authors Own*)

(Source: NFHS 4)

3.6 Status of women in Bihar

Obstetric violence during childbirth can not be treated as an isolated issue without understanding the cultural context and the status of women in Bihar. NFHS reports on several gender-based indicators which are poorer for women when compared to men. Gender is a key underlying factor which shows in the fact that women's literacy is less than men by almost 23% or sterilisation rate being 35% in a state where 0.1% men got sterilised or that double the women are anaemic than men (NFHS 5) as shown in Table 3.3. Inequality in gender roles make women more vulnerable towards victimisation in a society that treats their women less than men (Jejeebhoy & Santhya, 2018). Women's high level of access to mobile phones and bank accounts is a false indicator of their level of autonomy. This could have increased to facilitate the JSY incentive that is directly transferred to the client's bank account, so it may not signify more than that.

Table 3.3 Women empowerment and gender-based indicators in Bihar

No.	Women empowerment and gender-related Indicators	Bihar			India
		NFHS 3	NFHS 4	NFHS 5	NFHS 4
1	Women who are literate (%)	37.0	49.6	57.8	68.4
2	Men who are literate (%)	70.4	77.8	78.5	85.7
3	Women with 10 or more years schooling (%)	13.2	22.8	28.8	35.7
4	Women age 20-24 years married before age 18 years (%)	69.0	42.5	40.8	26.8
5	Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	25.0	12.2	11.0	7.9
6	Female sterilisation (%)	23.8	20.7	34.8	36.0
7	Male sterilisation (%)	0.6	0.0	0.1	0.3
8	All women age 15-49 who are anemic (%)	67.4	60.3	63.5	53.1
9	Men age 15-49 who are anemic (%)	34.3	32.3	34.8	22.7
10	Women who worked in the last 12 months who were paid in cash (%)	17.2	12.5	12.6	24.6
11	Women having bank or savings account that they themselves use (%)	8.2	26.4	76.7	53.0
12	Women who have a mobile phone that they themselves use (%)	NA	40.9	51.4	45.9
13	Women age 15-24 years who use hygienic methods of protection during their menstrual period (%)	NA	31.0	56.0	57.6

NA=Not available

This gender-based inequality presents one narrative of oppression of women in Bihar and India. As discussed in the previous chapter, women's geographic location, their cultural context and history, for example being in a postcolonial patriarchal context and their positioning at particular intersections, may make them more vulnerable to any kind of violence. This is further discussed in the next section, though it is important to draw connections to their intersections in regards to

their level of education, financial independence and reproductive decision-making from this section and the previous table.

3.7 Pleasure, shame, endurance: conversations around birthing

Women's journey to the 'labour room', pre-dominantly, is a result of sexual intercourse. Indian women experience extreme pressure to achieve a pregnancy and give birth, preferably to a male child, as soon as they get married. Women need to prove their fertility and men their manhood through quick procreation, the sooner the better. But that does not mean that there is a lot of frankness in the conversations about sexuality and birth. Women's sexuality is a hushed topic and there is no conversation about women's pleasure. Sex is considered shameful because the 'act' has been performed to reach the labour room. Shaming women through judgemental comments about their sexuality is a common form of abuse seen during institutional births. It is therefore highly likely that a woman is violated during childbirth for being there after exercising her sexuality, which is often not out of choice. The following quote connects this shame, sexuality, silence and violence well (Bhasin & Menon, 1998, p. 58).

'neither absolute nor monolithic this consensus is, nevertheless, at once deep and wide ranging and encompasses most forms of violence… It has two critical and distinguishing features: it sanctions the violent "resolution" of the troublesome question of women's sexuality and sexual status- chaste, polluted, impure- and simultaneously insists on women's silence regarding it through the attachment of shame and stigma to this very profound violation of self. Thus, the woman raped, the woman who may be raped, the raped child, the young widow whose sexuality can no longer be channelised, the wife raped by kinsman or others, the women who must be killed so that their sexuality is not misappropriated, the wives, daughters and sisters who must be recovered so that sexual transgression is reversed- are all compelled into acquiescing.'

This continuum of violence and endurance in women's lives presented by Bhasin and Menon (1998) in the South Asian context, has previously been explained by Kelly (1988) in her work on sexual violence. The narrative of endurance often transcends from the bedroom to the birthing room, where experiences that should be pleasurable, end up becoming traumatising, and a source of shame for exercising female sexuality. In case of obstetric violence particularly, a private experience of birthing becomes public and the private experiences of exercising sexuality is dragged out in public discourse too, to use as a device for humiliation and oppression.

3.8 Violence against women in Bihar

Bihar is known for its historically violent political climate (Rodgers & Satija, 2012). Studies have reported the evidence of violence embedded in the caste and religion-based feudal system in Bihar (Satija, 2013; Stephenson, 2013). Bihar leads in terms of violence against women too. It ranks high in Intimate Partner Violence (IPV) during pregnancy against other states (NFHS-5) (Table 3.1).

Table 3.1 Indicators of violence against women in Bihar and India

No.	Indicators of violence against women	Bihar			India
		NFHS 3	NFHS 4	NFHS 5	NFHS 4
1	Ever married women who have ever experienced spousal violence (%)	59	43	40	31
2	Ever married women who have experienced violence during pregnancy (%)	NA	5	3	4
3	Young women age 18-29 years who experienced sexual violence by age 18 (%)	NA	NA	2	NA

NA=Not available

Evidence suggests that violence against women during pregnancy has many negative outcomes for the woman and her baby (Dhar et al., 2018). Dhar et al, report on gender being a key factor for violence against women at home, where 43% married women are still experiencing spousal violence and 5% while pregnant. Associations were found with caste and religion as well (Satija, 2013).

There is a critical third angle to the culture of violence against women that needs to be considered, which happens in their childhood. A study conducted in 2007 found 47% of female children report being sexually abused in India. This study was carried in 13 states including Bihar, where the reported figure was 30% (WCD, 2007). Childbirth is a unique experience and exposes one to new procedures that may result in women reliving experiences of abuse from childhood (Montgomery, 2013). Research suggests that compassionate care is needed in handling women with such experiences that should be performed with utmost sensitivity (Montgomery, 2013). This is yet another challenge that needs to be addressed in care during childbirth and maternal health care provision in general.

Bihar reports high rates of all forms of violence against women, although there are no studies aiming to investigating obstetric violence in the state. Other states with similar context of women's status and violence have reported high rates of different forms of obstetric violence, such as Uttar Pradesh, West Bengal, Assam and Gujarat, as presented in this chapter. All these aspects make Bihar a particularly interesting state to study regarding how women as care receivers and; midwives and nurses as care providers, perceive respect and disrespect during childbirth and why women are not receiving maternal care that is respectful and dignified in nature.

Chapter 4 She smiles when she talks about violence: Epistemological underpinnings and methodological approaches

In this chapter, I describe the epistemological underpinnings and the key methods adopted in this thesis. This research is embedded in critical feminist theory. Feminist approaches and methods of inquiry have guided all the aspects of my doctoral research, including the presentation of the thesis. In the four papers, I explore the experiences, expectations, determinants and recommendations to address obstetric violence during childbirth from the perspectives of women as care seekers and midwives' as care providers. In chapter 5, I present the experience of obstetric violence from a household quantitative survey (Paper 1) and explore the social determinants of obstetric violence that make women more vulnerable to a dehumanised birthing experience. I investigate the depth and the nature of women's experiences of respect, disrespect and abuse during childbirth in chapter 6 (Paper 2). Chapter 7 (Paper 3) presents women's perceptions of why they had experienced obstetric violence and/ or respectful maternity care which emerged from data. This is followed by chapter 8 (Paper 4) with nursing and midwifery leader's perception of the drivers of obstetric violence as a primary care provider, particularly in the context of India. I have described the methods for each of the four chapters in detail in the respective chapters 5, 6, 7 and 8.

4.1 Epistemological underpinnings

Violence against women in public and private spheres have been the subject of incredulity and a central focus of feminist movements that can be credited for progress in addressing violence against women (Federici, 2018). *'Feminism is a movement to end sexism, sexist exploitation and oppression'* (hooks, 2000, p. 8). Feminist research aims to uncover and bring forth narratives of silenced, and women resisting, as a result of centuries of oppression, owing to power-based imbalance that women experience, as a result of patriarchy and colonialism. Feminist scholars have championed research with the marginalised, oppressed and secluded, by breaking the 'norms' of academic scholarship. Feminist scholars such as McKenzie, Chadwick, Montgomery use innovative participatory feminist methods such as arts-based research to overcome the challenges of traditional science that is embedded in sexism, racism, casteism and systemic biases, and therefore tends to reproduce oppressive structures (Weisstein, 1993; Magnusson & Marecek, 2017; Criado-Perez, 2019; Ali, 2019).

Under epistemology, I understand the way in which I, as a scientist, produce knowledge. It concerns fundamental questions such as 'What is knowledge?', 'How is knowledge (re)produced?' and 'Who owns it?' (McEwan,2001). Feminist epistemology accounts for the fact that not everybody is equally considered to be a subject capable of reproducing knowledge and that the knowledge that is produced by the elite bastion of universities often excludes the knowledge and ways of knowing of the less privileged. This has been a point of departure for South Asian feminist theorists who explain and critise, from using the feminist post-colonial theory, the pattern of researchers and academics (western and white) consisting research in the 'third-world' countries presenting a homogenous narrative of oppressed third-world women with no recognition to their resistance and heterogeneity (Talpade Mohanty, 1988). This is an essential insight I have drawn from my experiences of researching in low income settings over the last decade with participants whose voices are seldom considered important while also being a researcher whose voice has been sidelined for being a woman and a nurse-midwife. I am attempting to change that through my doctoral research, because women and nurse-midwives (pre-dominantly women) belong to the group excluded from knowledge-production, resulting in the silencing of their/ our perspectives within the hegemonic science of obstetrics and health. I have aimed to resist this traditional power-imbalance between the researcher and the research subject by addressing the women and nurse-midwives who participate, as 'knowers'. I have done this to ensure that the women's narratives of their embodied experience of birth and the nurse-midwives' experience of providing care are at the centre of my research.

With this aim, the research methodologies I choose to use all come forth out of critical feminist theory. For my data collection, I have used participatory research and visual arts-based methods such as 'birth mapping', an adaptation of body mapping. For my data analysis, I have used feminist relational discourse analysis and voice-centered relational analysis. I have used I-poems, birthing stories and the birth maps, as research outputs. Hence, the theoretical underpinnings of my doctoral research are those of feminist theory because I have been mindful of the influence of gender and power on my data collection, analysis, and on the constructs and contexts that I explore. Below, I will specify the epistemological underpinnings of my research as a whole, along with how other specific theories have influenced different aspects of research and methodological decisions, that include intersectional theory and feminist standpoint theory. The three aspects of feminism to consider for my research are 1) feminism and its relation to gender and power-based oppression; 2) feminism for medical health care research and 3) feminism related to violence. This approach is best explained by this statement from Allen (2013, p. 268) *'from the direction of a feminist theory that strives to be genuinely inclusive of the perspectives and experiences of all*

women, (including nurses-midwives' in predominantly female-led professions) *including those in the Global South, by developing an intersectional analysis of the cross-cutting axes of racial, gender, and imperial* (medical and patriarchal) *domination; and from the direction of a critical theory that can only be truly critical if it can take on board a postcolonial perspective.'*

4.1.1 Feminist theory

Feminist theory primarily presents an explanation of sexist thinking and how it can be challenged and changed (hooks, 2000). It understands gender to be an ideological construct, which means that women are expected to display and perform a set role and follow the norms that are laid out for women in our particular context and cultures. This also explains women's role in women-dominated professions such as midwifery and nursing, that are often considered an extension of women's domestic role. This is embedded in gender-based inequality which can influence women's activities, experiences, choices and values every day in their routine lives (Butler, 1993). This eventually subordinates women, generation after generation, being considered as the inferior sex. Feminist theorists believe that sexism was not necessarily consciously structured to oppress women, but in the process it has certainly resulted into centralising power with men and establishing patriarchal concepts, masculine norms and male dominated constructs that benefit only men (Keeling, 2011) such as the male-led medical model.

Feminist research is a broad field. It consists of criticisms of androcentric research. Global health policy making, for instance, is predominantly white male doctor led. Dorothy Smith (1987) refers to this as the circles of men (usually white and in the global north) who conduct research relevant to men, written and read by men (McEwan, 2001). For midwifery and maternal health is supplemented by white women publishing research. This issue exists in maternal health care delivery research where nurses, midwives and women's perspectives and experiences are often measured or examined through incompetent methods. These were particularly concerning with sensitive areas of research such as violence against women and research on maternal and reproductive health, which led feminist scholars to think out of the box and do research differently (Wigginton & Lafrance, 2019).

4.1.2 Critical feminist theory

Critical feminist theory provides the essential theoretical framework to understand women's experience of childbirth and specifically their experience of obstetric violence given childbirth and obstetric violence is a pre-dominantly women's experience. It also locates obstetric violence as

gender-based violence, rooted in power-based imbalance as a result of women's social positioning.

Critical feminist theory is a combination of feminist theory and critical theories. It is important to understand this amalgamation that creates critical feminist theory, as not all feminist theories are critical and not all critical theories are feminist. Critical Feminist theory explains the resistance and deployment of power and aims to *'identify, question and seek to reform patriarchal ideologies that give rise to asymmetrical rights and opportunities, roles and material circumstances'* (Wood, 2015, p. 293). Gender and patriarchy are two key aspects of feminist theory in my PhD, that intersects with the structures of power and equity-based oppression. In terms of obstetric violence, it relates to the structures that uphold the obstetric system of maternal health care provision, that allows this form of violence to go on (McEwan, 2001; Ray, 2020). The imbalance could be in formal and informal power-based relationships or interactions (Wood, 2015). In the context of my doctoral research, the medical institutions have formal power over the nurse-midwives as a result of a hierarchical health care governance structure. The power of the medical professionals over women who are seeking care, with the doctor usually heading the structure, is informal power, because the women are not obliged to formally accept or obey their orders. Doctors, are in the most respected profession. They hold power in the society informally over the members of the community and the people they 'serve', that comes mainly from the knowledge they hold, the power of knowledge (McEwan, 2001). Women are conditioned to obey, be disciplined and allowed to every action they take during their own childbirth. In the same vein, doctors and other health care providers are also conditioned to abuse this power, while women are conditioned to endure it, who may often share their experiences of routine violence and obstetric violence with a smile and even a laughter to neutralise the seriousness of the issue, and to not draw attention to themselves.

Critical feminist theory is influenced by postcolonial scholarship, which makes it a good fit for my research in India, that has a history of colonisation, that adds another layer of oppression for the women. This is a key feature of the patriarchal structure where everyone is at a particular position based on their gender, sexuality and social role, that guides whose voices, perspectives and values matter, and will be listened to. This is a continued battle of the cultural legitimacy of voices, also referred to as the '*theatre of struggle*' by Stuart Hall (1989). This power-based imbalance between doctor-patient (women) and doctor-nurse-midwife, makes the research through feminist methodologies crucial, because the historic oppression makes it difficult to ascertain the knowledge through traditional, conventional and man-made methods for androcentric knowledge (Wigginton & Lafrance, 2019; Espinoza-Reyes & Solis, 2020).

Childbirth is experienced predominantly by women, primarily cared for by midwives, (could be referred to as nurse-midwives' in India) in a profession dominated by women. Both categories of women have a history of oppression. The power-based imbalance is a crucial aspect of researching with both these categories of participants, where women are at the bottom of the social hierarchy and nurse-midwives are at the bottom of the medical hierarchy. Both women and nurse-midwives' face the consequential powerlessness that requires for them to continually resist such structures of oppression, hence it is important to understand how women and nurse-midwives interact with these systemic oppressive structures from the unique perspectives of subordination, powerlessness and resistance (McAra-Couper, Jones & Smythe, 2011; Mayra 2020a).

4.1.3 Feminist standpoint theory

Standpoint feminism considers that women and men lead significantly different lives that are shaped differently by their social roles and experiences. Standpoint theory has been used in research about reproduction and related experiences such as pregnancy, menstruation and birth, because only women, predominantly, can have these embodied experiences (Woliver 2002, Parry, 2008). Standpoint theory also enables the women experiencing the oppressive power structures to confront the save '*oppressive power structures'* (Jaggar, 1997), it is the obstetric care system in this case. While feminist theorists have presented their approaches and extensions to feminist standpoint theory, the consensus remains that feminist standpoint theory gives women voice to present their narratives from their standpoint (Keeling, 2011). I have often wondered about the act of 'giving' voice and strongly believed it is not ours to give. Feminist researchers can find feminist ways of research to unearth narratives that were hidden due to the inability of our research methods to examine and our incompetence to listen and understand such sensitive phenomenon. In my case, it is childbirth and obstetric violence, which I decided to learn from the standpoint of women as care-seekers and the standpoint of nurse-midwives as primary care providers, in a context of continued oppression in a patriarchal postcolonial context.

Generating awareness of the oppressive structures and the impact it has, is a crucial step in my study, as will be presented in the findings. Challenging these systems will be the next step, which some women show in the Indian and Bihari context in their efforts to completely bypass such oppressive systems and take birthing in their own hands, by either switching birth places, changing care providers or completely rejecting the obstetric setting by giving birth at home without assistance of a care provider or with a traditional midwife.

The knower knows best of what is being explored, for being in a position of having the experience in a context that constructed their perspective, and hence shares the narrative from their unique standpoint (Sprague, 2016). According to Dorothy Smith (1991) these knowers are '*the actual subjects situated at particular sites'* that as researchers we are trying to study. In the context of my PhD, the knower are the women who have given birth in the patriarchal culture, in a postcolonial context of Bihar, India and are particularly from low-income settings. I explore what they can share as a virtue of their standpoint, that others cannot provide. Similarly, the nursing and midwifery leaders share their standpoint of providing care to women in the same context, as their primary care provider, in a health care system influenced by patriarchal culture with remnants of postcolonial context. This can be seen in the governance of the largest primary cadre of care providers of nurses-midwives in India, and the challenges and struggles they face in care provision and what they perceive is the result of their bodily existence that locates their consciousness (Smith, 1991). Smith also criticises how past attempts have usually considered experience only when 'spoken' by the participants while arguing that it is embedded in our feelings, daily practices, in local settings and I believe, it even lies in the mundane and in our silences.

Women have embodied the experience of giving birth and respectfulness and/ or obstetric violence while giving birth. Nurse-midwives have embodied giving birth, assisting births, experiencing challenges in ensuring quality care, participating in respectful care and/or obstetric violence, and observing respectful care and obstetric violence unfold around them. These lived experiences of women and nurses-midwives are at the center of my research (Keeling, 2011), who are sharing their truth, based on their experience, relation and interactions with power (Ramazanoglu & Holland, 2006). It is important to understand how their continued oppression and resistance shapes their experience and makes them add meaning to their experiences. This is the *'concrete experience'* which I enter into research to explore and bring out from the participant's narratives.

How my positionality, as a woman, from lower-middle income background, educated in nursing and midwifery in the world the research participants and I inhabit, shapes my standpoint and influences my research decisions and methodological choices, is discussed throughout the research presentation through my reflexivity. It is important to acknowledge that this research could have been done differently when done by a non-feminist and/ or male and/or non Asian and/or non-health care worker's standpoint, to consider that my positionality in the discourse adds value to this research (Parry, 2008). In simple words, it is important to take note of what is being researched, who is being researched and who is doing the research in what context.

4.1.4 Intersectionality

My PhD is geographically located in India with participants hailing from different states (in the study with nurse-midwives'), and particularly from Bihar (in the studies about women's experiences of childbirth). These two categories of participants present many traits that can be a breeding ground for oppression. Gender is the connecting factor in their backgrounds, exacerbated by their level of education, status of occupation, geographical location, age, caste, religion, socio-economic status, marital status and physical appearance, among many other such characteristics that make nurse-midwives and women vulnerable to being oppressed and experience obstetric violence during childbirth (Sen & Chattopadhyay, 2018; Menon, 2012).

Feminist American lawyer Kimberlé Crenshaw is credited for coining the word and introducing the world to the concept of Intersectionality, to understand black women's double dis-advantage at the intersection of gender and race (Crenshaw, 1986). While standpoint theory helps to understand the perspective from the participant's standpoint shaped by their unique positioning, intersectionality explains this unique position at the intersections of all the characteristics mentioned before and how that influences their experiences, perceptions and expectations. Intersectionality provides a lens to understand the sensitive issues ridden with stigma and stereotypes, such as birth, and more specifically, obstetric violence (Boydell et al., 2020; Hill Collins, 2019).

The intersectional framing helps to further understand women's experiences from their standpoint, and how and why they may experience what they experience, in terms of violence during childbirth as well based on their positioning at the intersections of sexuality, gender identity, racism, sexism and ableism (Boydell et al., 2020). Although there are criticisms that intersectionality does not focus on sexual identity and orientation, that led to the theory of sexual configurations, which helps to understand the fluid nature of sexual orientation and preferences that keeps the person's identity flexible and open to configurations, as theorised by Van Anders (2016) (Grzanka, 2016). I do strongly believe that intersectionality is about all the attributes that explains the inequalities and power, that are relevant to a particular context, and that sexuality is one of those determining factors as well. As described in the literature review (chapter 2) and in the context of Bihar and India, (Chapter 3), women and their nurse-midwives' positioning at particular intersections could play a role in how they are treated and how they resist. In the context of India, birthing and matters related to women's reproduction are considered polluted and unclean requiring segregation in many communities (Chawla, 2019; Menon, 2012). Profession is a key attribute to include for the nursing and midwifery which have historically oppressed professions in India (Ray, 2020; Mayra 2020b). Intersectionality is essential because it explains

who is 'respectable' in a social construct based on their social determinants (Christensen & Jensen, 2012).

Intersectionality is the key framework to understand my doctoral research, in terms of understanding the participants, their experiences, the drivers of the violence they bear and how they perceive it and also the impact it has on their routine reproductive and non-reproductive lives along with my methodological choices. It explains the stigma and discrimination attached to the pain and pleasure surrounding the reproductive aspects of life and choices which is described in detail in the forthcoming relevant chapters. Intersectionality explains the positioning of people from where they are presenting their standpoint.

It is important for my research to adopt multiple lenses to understand obstetric violence because the multiple forms of oppressions and their complex interrelationships that shape the experiences and perceptions of women and nurse-midwives (McEwan, 2001).

4.2 Conceptual framework

This conceptual framework connects all the four papers. Overall, I have investigated women's and midwives' experiences of respect, disrespect and abuse during childbirth. I have also explored their perception of why women experience obstetric violence and respectful maternity care during childbirth. The determinants are divided into three levels: individual, structural and policy levels, based on participant's responses, in line with the definition of disrespect and abuse during childbirth by Freedman et al. (2014) as presented in chapter 2. The conceptual framework shows the study components, experiences, determinants and perceptions and recommendations divided at three different levels: individual, structural and policy (Figure 4.1).

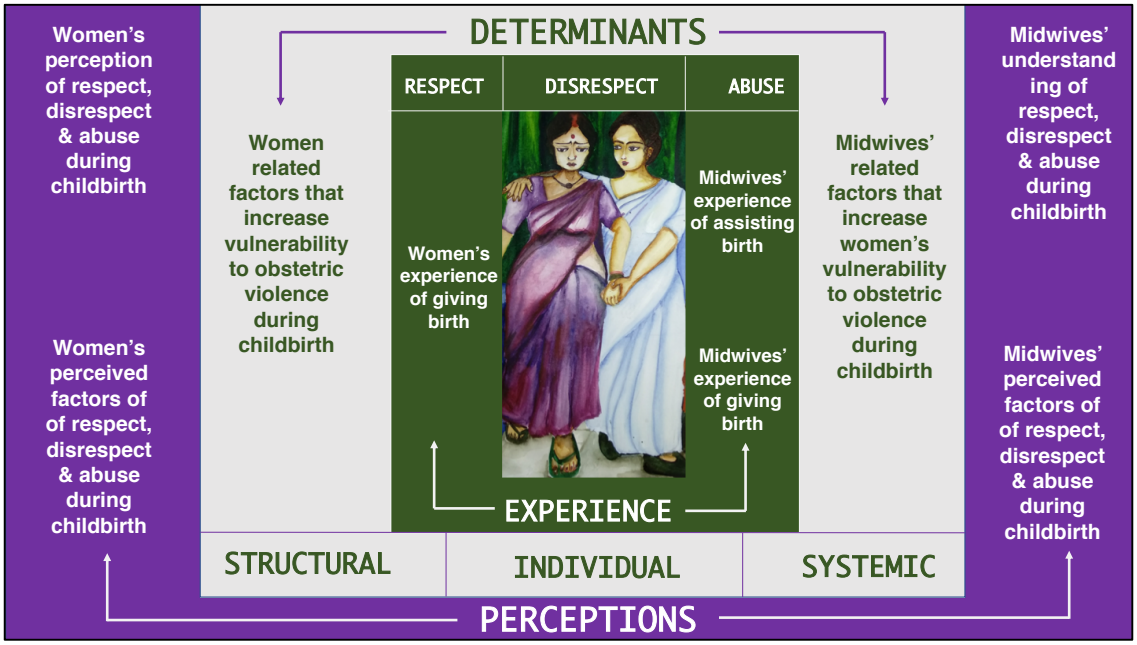

Figure 4.1 Conceptual framework

(*Author's own, with exclusive painting by S. Karmakar for this research, used with permission*)

Paper 1: Social determinants of obstetric violence- Women's experiences of obstetric violence are not a onetime occurrence, but often an embodied experience of multiple experiences that further explains the seriousness of this issue. This paper presents the diversity and plural nature of women's experience of obstetric violence along with an understanding of their socio-demographic background, that may increase their vulnerability to obstetric violence, and multiple experiences of violence during childbirth in an obstetric setting.

Paper 2 and 3: Women's experiences and perception of respect, disrespect and abuse- Paper 2 discusses women's embodied experience of respect, disrespect and abuse during childbirth to understand how they attach meaning to these, through participatory visual arts-based qualitative research. Paper 3 draws from the same data on exploring women's perception of why they experience respect, disrespect and abuse during childbirth and how birth can be made women-centered and satisfactory for each of the participant.

Paper 4: Nurses-Midwives' perceptions of obstetric violence- Midwifery and nursing leader's experience and perspectives of quality and respectful maternal health care is crucial for policies and practice because they are the primary care providers in India. Their perceptions and experience have been explored qualitatively to present the drivers of obstetric violence and also recommendations of what will make care respectful for women during childbirth.

4.3 Study design and analysis

This is a mixed-methods study that has qualitative and quantitative components. The key methods have been mentioned in Table 4.1 against each paper.

Table 4.1 Study design

No.	Objectives	Design	Type of data	Data collection	Respondents	Analysis
Paper 1	To examine the social determinants of obstetric violence during childbirth, in Bihar.	Quantitative	Secondary	Structured HH survey questionnaire	New mothers	Descriptive analysis Logistic regression Factor analysis Linear regression
Paper 2 & 3	To investigate the perceptions and experiences of respect, disrespect and abuse in care during childbirth and the factors driving it, in Bihar.	Qualitative	Primary	Body Mapping assisted IDI's	Women with birthing experience	Feminist Relational Discourse Analysis (FRDA) Voice Centered Relational Analysis
Paper 4	To document and analyse the experiences of nursing and midwifery leaders with respect, disrespect and abuse, and to recommend ways to strengthen respectful care for women during childbirth in India.	Qualitative	Primary	In depth interview (IDI)	Nursing & midwifery leaders	Thematic analysis

Paper 1: Social determinants of obstetric violence: This study uses secondary data. I had led an extensive data collection exercise in a course of 18 months (July 2016 to December 2017) before starting my PhD. This data collection was done to understand the quality and respectfulness in care during childbirth in all the 38 districts in Bihar. The survey covered all three levels of health care provision: primary, secondary and tertiary. The process involved visiting women at their households within a recall period of 30 days of birth to understand the quality and respectfulness of care during childbirth from their perspective with the help of a structured questionnaire. The household interviews were conducted by female enumerators experienced in conducting interviews in the local languages and dialects in Bihar. A total of 2194 interviews were conducted

with women who have given birth in an obstetric setting within one month preceding the interview.

My aim is to understand which background characteristics of women influence different forms of obstetric violence during childbirth. I conducted a descriptive analysis on the household interviews with women, followed by binary logistic regression analysis to understand the social determinants of obstetric violence. I conducted factor analysis to create new variables of obstetric violence that explain the most variance in the study findings on obstetric violence. I conducted a linear regression on the newly created variables to examine their correlation with women's background characteristics. Statistical Package for Social Sciences (SPSS) is used to analyse the data.

Papers 2 and 3: Women's experience and perception of respectful maternity care in Bihar: I interviewed women who have given birth in Bihar, in urban slums and rural villages, qualitatively using a visual-arts based participatory method, body mapping. Women from both these areas belong to the poorest of strata and seek maternal health care at different levels of care provision. Women from the rural areas mostly access care at primary and secondary levels of care provision that mainly include the Block Primary Health Centers (BPHCs), Community Health Centers (CHCs) and Sub District Hospitals (SDHs). Women in the urban slums have quicker access to the tertiary levels of care provision such as at government super-specialty hospitals and medical college hospitals.

I conducted a scoping visit in Bihar in January 2019, to identify the themes to explore, the methods to use and ethical measures to consider, to ensure the study is conducted with utmost sensitivity. The interviews were conducted in Hindi and other local dialects convenient to the participant. Having worked extensively in these districts and state, I am aware of the language barriers that may exist, as a result of many dialects spoken in Bihar including *Bhojpuri, Maithili* and *Magahi*. Audio recording was done and pictures were taken while maintaining anonymity of the participant with women's informed consent. Participants were requested to select a pseudonym to be used in the study that will make the results more realistic by adding cultural authenticity to it (Montgomery, 2015). I analysed the data using feminist relational discourse analysis (FRDA), with voice centered relational analysis embedded in it. I used NVivo 12 to aid the analysis.

Paper 4: Nurse-midwives' experiences and perspectives on respect, disrespect and abuse during childbirth in India: I conducted this component of the PhD qualitatively through in-depth interviews with senior midwifery and nursing leaders who represent the domains of education, regulation, unionisation or association, research, administration and health care provision. This

data were collected at state and national levels in India, with a global perspective shared by experts engaged in global midwifery and maternal health-related policy making. The state level data collection was carried out in Bihar, Rajasthan, Odisha and Madhya Pradesh that represent the underperforming states, in terms of maternal health care indicators and outcomes. Given the lack of leadership in midwifery and nursing in India, data collection in these four states helped to understand the background and context of challenges for a way forward. West Bengal was selected to represent a state with good governance structure in India in terms of nursing and midwifery leadership in policy making for health workforce and health service provision (Bagga et al., 2010; Sharma et al., 2010; Mayra, Padmadas & Matthews, 2021). Data is also collected at the national level in India.

Interviews are conducted with global experts for a reflection on how midwifery leadership can help improve respectfulness in care during childbirth and what drives obstetric violence during childbirth. I interviewed participants representing international organisations that influence policies in India and globally including WHO, United Nations, United Nationals Fund for Population Activities (UNFPA), ICM, ICN and the United Nations High Commission for Refugees (UNHCR). I also interviewed midwifery experts from United Kingdom who have successfully established a midwifery led model of maternal health care provision and closely collaborate with Indian counterparts to aid in midwifery implementation in India. These international experts are already playing a crucial role in implementing midwifery in India with the Government of India.

Interviews are audio recorded alongside thorough notes. Written consent is taken from the participants for audio recording, and for their participation in the research. The interviews are done in English, Hindi and Bengali, based on the convenience of participants. I am fluent in these languages which ensured that there was no language barrier. The recordings are translated and anonymised while completing the notes before starting data analysis.

I selected the participants through purposive sampling for the interviews. The participants hold key positions in the states, at the national level and in the development organisations at the global policy making level. The semi-structured in-depth interview (IDI) guide, for the nursing and midwifery leaders, is based on literature review of challenges that this cadres experience (Appendix 3) and my decade long experience of engaging in, influencing and researching nursing and midwifery governance and policy making in India (Mayra 2020a; Mayra, Padmadas & Matthews, 2021). The care-seeker's interviews analysis is guided by critical feminist theory. The care provider's interviews are analysed using thematic analysis. I used NVivo12 to aid the qualitative data analysis.

4.4 Research ethical approval

The ethical approval for the PhD was taken from the ethical review committee of University of Southampton. For paper 1, ethical approval was also taken from Center for Medical Studies (CMS) ethical review committee in India (Reference number IRB00006230), before conducting the data collection. The Government of Bihar had also approved data collection. The reference number of University of Southampton's ethics approval for the secondary data analysis of fully anonymised data is 31910. The ethical review committee at University of Southampton approved data collection for the study aiming to understand women's experience and perspectives of respect, disrespect and abuse during childbirth in Bihar (Reference number 49734). Due to the sensitive nature of data collection for paper 2 and 3, the study is assigned category A. For paper 4, to understand nursing and midwifery leader's experiences and perspectives of ensuring respectfulness in the care during childbirth, the reference number for ethics approval is 41164.

Chapter 5 Social determinants of obstetric violence in Bihar: evidence from a household survey

5.1 Introduction

Discriminatory health care provision on the basis of an individual's background characteristics, such as gender, race, socio-economic status, is a violation of human rights (Gilmore, 2017; Khosla et al., 2016). India is uniquely diverse in terms of class, caste, gender, socio-economic status, language, religion and geographic differences. The cultural context and factors underlying maternal health care provision can vary considerably in different Indian states. It is important that any kind of service provision be available to its people in an unbiased, non-discriminatory and equitable manner. Research evidence suggests that the quality of maternal health care received, varies by women's background characteristics, and in some contexts, influences adverse maternal health outcomes (Patel, Das & Das, 2018; Khosla et al., 2016).

A recent study from India highlighted that caste-based discrimination in reproductive health care and provision of incentives, such as the JSY scheme in India. A participant in a recent qualitative study reported caste-based discrimination and untouchability while describing care provider attitudes (Khanna & Sri, 2017). Inequality may result in a lack of access to information and decision-making power, which may lead to poorer health outcomes. In terms of women's access to and quality of reproductive and maternal health care, caste and social class can play a role in creating inequities in maternal and reproductive health care provision, along with other factors such as women's reproductive history, age, marital status and parity (Khanna & Sri, 2017). The aim of this chapter is to undertake a quantitative analysis of household survey data to investigate the social determinants of obstetric violence in the state of Bihar, India.

A study carried out in Uttar Pradesh reported that the highest mistreatment scores in health care facilities are for women older than 35 years (Sharma, 2019). Another study found that older women are more likely to report obstetric violence during childbirth, in addition to expectations for a bribe (Sudhiranaset et al., 2016). Studies conducted in Jordan (Fatima et al., 2018) and Ghana (Afulani et al., 2019) report that uneducated and unemployed women are more likely to be abused.

Disrespectful comments by care providers often target women's physical appearance, socio economic status, parity and age (Sharma, 2019). In the same vein, treatment of women may vary based on 'favouritism' that may result in inequitable use of limited resources and respectfulness in care provision when the labouring woman is known to the team, or comes from a wealthy and influential family (Freedman et al, 2018).

Freedman (2014) highlights that it is important to understand the different determinants of inequity in care provision, that varies by different cultures and countries. This is true for both developing and developed countries, as for instance can be learnt from the poor maternal health outcomes for women of colour in America (Shah, 2019). Evidence from Bihar, India shows discriminatory practices, whereby women from upper castes or social classes are given preferential care in health facilities while those in the lower caste group are either ignored or forced to wait (Patel, Das & Das, 2018). Another report suggests that there is no ASHA in a particular community because ASHA's are from upper caste families who often ignore women in the village from the lower castes. Women from poor socio economic backgrounds are more likely to receive disrespectful and abusive care. This may include ignoring their requests for attention or pain relief, being physically immobilised, undergoing multiple pelvic examinations, not being allowed a birth companion, giving birth lying down (supine position), receiving fundal pressure and having their cultural and spiritual rituals around birth ignored (such as placenta disposal). They are also more likely to be given episiotomies in comparison to women from affluent backgrounds (Sen, Reddy & Iyer, 2018). Gender is an underlying factor that increases women's vulnerability in general (Sen, Reddy & Iyer, 2018).

Discrimination can be seen in how medical, nursing and midwifery students are taught and the women they 'practice' on. There is limited research on hospital and student pairing for practice in their pre-service education (Madhiwala et al., 2018). The private and public hospital distinction is also important to note here. Midwifery, nursing and medical students in India practice in public hospitals or do not get enough practice if they are studying in private institutions affiliated to a private tertiary hospital (Mayra, 2020b; Mayra, Padmadas & Matthews, 2021). Most private hospitals have clients from affluent background who might not accept care from a student. Public hospitals predominantly receive clients from poor socio-economic backgrounds, indicating more power-based inequities between care seeker and care providers (Mayra, Padmadas & Matthews, 2021). Students and their training institutions find it easier to practice skills on women from poorer background seeking care in the public health facility. Figure 5.1 classifies these social determinants into: 1) individual attributes, 2) family and peer influences, 3) intermediary determinants of health and 4) structural determinants of health inequities.

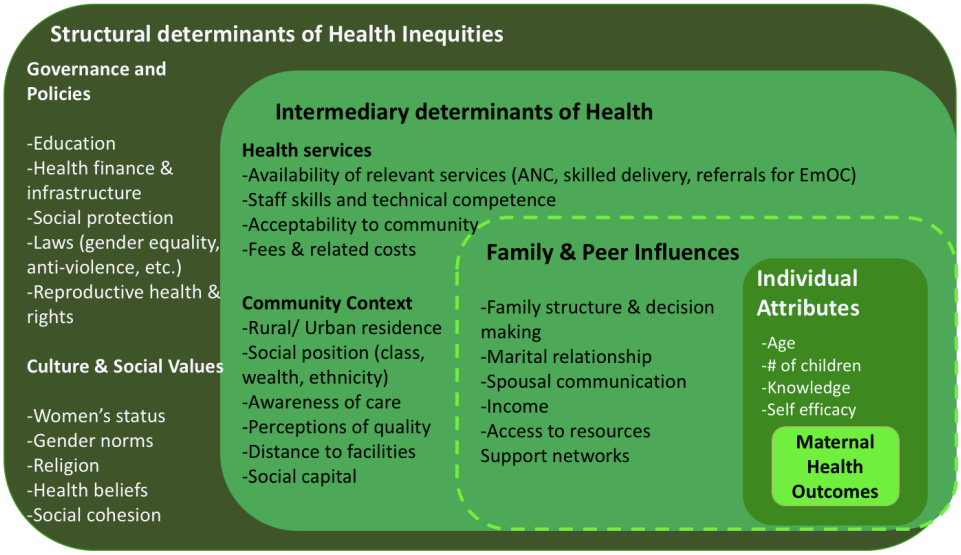

Figure 5.1 Social determinants of maternal health (*Source: Khanna & Sri, 2018. p. 194*)

Care providers understand that an educated woman is often aware of the care she would receive and has higher expectations (Downe, 2019). In line with this argument, a study found that literate women were more likely to have interventions explained to them (Sudhiranaset et al., 2016). On the other hand, it is difficult for women from marginalised background to report obstetric violence even after identifying it. Most studies on obstetric violence focus on different forms of violence, as can be seen through the various typologies, and not enough on the plurality of these different forms of obstetric violence in each woman's experience, which I address in this study along with examining the social determinants of obstetric violence against the specific indicators in the seven domains of mistreatment presented by Bohren et al (2015).

5.2 Objective

- To investigate the association between women's background characteristics such as age, caste, education, occupation, socio-economic status and parity and their likelihood of experiencing obstetric violence during childbirth in Bihar, India.
- To understand the plurality and complex multilayered nature of women's experience of obstetric violence in Bihar, India that may be better expressed quantitatively.

5.3 Methods

I analysed secondary data from a household survey conducted in Bihar, India.

5.3.1 Data collection

Data were collected by Oxford Policy Management Limited between July 2016 to December 2017 covering all of the 38 districts of Bihar, and the household survey was carried out as a part of the evaluation of quality of maternal health care provision in the state. The household survey included a separate section to capture respectful maternity care.

The household survey implemented a structured questionnaire, targeting a sample of 2194 women who had given birth within a month preceding the interview in health care facilities (obstetric settings) in Bihar. This data collection was related to another survey, which involved direct observation of childbirth in public hospitals in all the districts of Bihar, that aimed to explore the quality of care during childbirth through a quasi-experimental study. The findings of this study are published elsewhere (Ahmed et al., 2019). Consent was taken from women to observe their birth and to also visit them within 30 days of childbirth for an interview at their house. The enumerators visited the household of all the women who had given birth in the last 30 days when they visited the woman whose birth was observed in the health care facility along with contacting women whose birth were not observed but live in the same village and have given birth in the last 30 days.

The information about all the women who had given birth in the same village could be received from the ASHA, which was followed by interviewing the women after seeking consent. Women who gave birth at home were excluded from the sample, as I aimed to examine the social determinants of obstetric violence in obstetric settings only.

Of the 2194 interviews, 964 women's births were observed by nurse-midwife enumerators with consent. The interviews were carried out by female enumerators who were fluent in the local dialects such as *Maithli*, *Magahi* and *Bhojpuri*. Every interview was conducted by two female enumerators, using Computer Assisted Personal Interviews (CAPI) systems. A field supervisor was deployed with each team to monitor the survey and support the team.

A structured questionnaire in Hindi was used to document women's background characteristics, experience of care around childbirth, respect, disrespect and abuse, and satisfaction with the care received.

As the National Quality of Care Evaluation Manager at Oxford Policy Management, I was closely involved in the design and implementation of the household survey in Bihar including data collection and processing. I was also responsible for coordinating the fieldwork which included hiring and training the enumerators and supervisory team and performing the overall management of the data

collection, data management and quality control. I have also participated in report writing and dissemination of the study findings. My background in nursing and midwifery and in research on sexual, reproductive and maternal health care added value to the development and implementation of field work.

Ethical approval: The ethical clearance for data collection was taken from Centre for Media Studies institutional review committee in India before starting data collection (Reference number: IRB00006230). Informed consent was taken from all the participants for the interview at their household. In addition, I obtained ethical approval for secondary data analysis from the Faculty of Social Sciences Research Ethics and Governance Committee, at the University of Southampton (Reference number: 31910).

5.3.2 Data analysis

For the descriptive and multiple regression analyses, I used data from 2194 women who gave birth in obstetric settings. Based on the literature, I selected relevant background variables to understand the social characteristics associated with obstetric violence. These include: women's age, education, caste, occupation, socio-economic status, religion and parity. I have considered the household's socio economic status to be the participant's socio-economic status which was measured through questions on the household's land and car ownership as an indicator of wealth.

First, I created new variables that matched indicators under the Bohren et al. (2015) typology of mistreatment during childbirth, to understand the extent of women's experience of obstetric violence. These variables are classified under all the seven key domains of the typology: 1) physical abuse; 2) sexual abuse; 3) verbal abuse; 4) stigma and discrimination; 5) poor rapport between women and care providers; 6) failure to meet professional standards of care; and 7) health systems conditions and constraints. Second, I conducted binary logistic regression analysis to understand the statistical association between these specific forms of obstetric violence under Bohren.et al (2015) typology and women's demographic and social characteristics.

Finally, I conducted factor analysis to create scores to quantify obstetric violence, thereby reducing the different dimensions as identified under the seven domains of Bohren et al. (2015) typology. Based on the Scree plot, I extracted the first three components that represented more than 30% of the variance in my dataset. I conducted linear regression on the three newly created obstetric violence variables with the background characteristics to investigate their association with women's vulnerability to experience obstetric violence during childbirth.

5.4 Results

5.4.1 Participant profile

A total of 2194 women who participated in this study gave birth in a health care facility in Bihar. As shown in Table 5.1, the participant's age ranged between 18-25 years (72%), only 1.5% participants were aged above 36 years. Half of the women interviewed have not received any formal education and only 8% had received a higher or degree (5%) level education. The majority of participants belonged to Hindu religion (83%) and were married (99.9%). About 26% of survey participants belonged to schedule caste. Schedule tribe representation was insignificant (0.5%), while other backward castes represented 61% of all participants. Little more than 50% of women lived in households with better socio-economic conditions which meant their households owned either land or car, or both.

Table 5.1 Participant profile

Background characteristics	**Number of women (N=2194)**	**Percentage**
Age		
18-25	1587	72.3
26-35	574	26.2
36-45	31	1.4
46+	2	0.1
Education		
No education	1084	49.4
Primary education	226	10.3
Secondary education	594	27.1
Higher secondary education	179	8.2
Degree level	111	5.1
Occupation		
Homemaker	2179	99.3
Farmer	10	0.5
Employee	1	0.0
Own business/ self employed	2	0.1
Student	2	0.1
Religion		
Christian	3	0.1
Hindu	1816	82.8
Muslim	375	17.1
Marriage		
Married	2191	99.9

Background characteristics	Number of women (N=2194)	Percentage
Separated	3	0.1
Caste		
General	265	12.1
Schedule Caste	573	26.1
Schedule Tribe	12	0.5
Other backward castes	1342	61.2
Socio economic status		
Better SES	1182	53.9
Poor SES	1012	46.1

It is essential to examine the participant's birthing related profiles. Almost all women received some antenatal care (Table 5.2). About 4% women had a birth were referred from another facility. Most women were multiparous (70%), with a maximum nine births. Most of the women interviewed, reported satisfaction with their birthing experience at the health care facility (96%) and would prefer to seek care at the same health care facility if they gave birth again (92%).

Table 5.2 Participant's birth related variables

Birth related indicators	**Number of women (N=2194)**	**Percentage**
Received any antenatal care	2180	99.4
Referred from another facility	95	4.3
Received episiotomy	123	5.6
Given anesthesia before episiotomy	82 (N=123)	
Prefer to birth in the same facility again	2009	91.6
Women satisfied with their birth experience	2106	95.9
Parity		
1	652	30.0
2-3	1055	48.0
4+	487	22.2
Women rating respectfulness in care		
Excellent	138	6.3
Very good	1386	63.2
Good	488	22.2
Fair	130	5.9
Poor	52	2.4

5.4.2 Experience of obstetric violence

None of the women reported experiencing sexual abuse, being restrained and being discriminated based on caste. The graph below (Figure 5.2) shows the percentage of women who experienced obstetric violence, classified under Bohren et al. (2015) seven key domains.

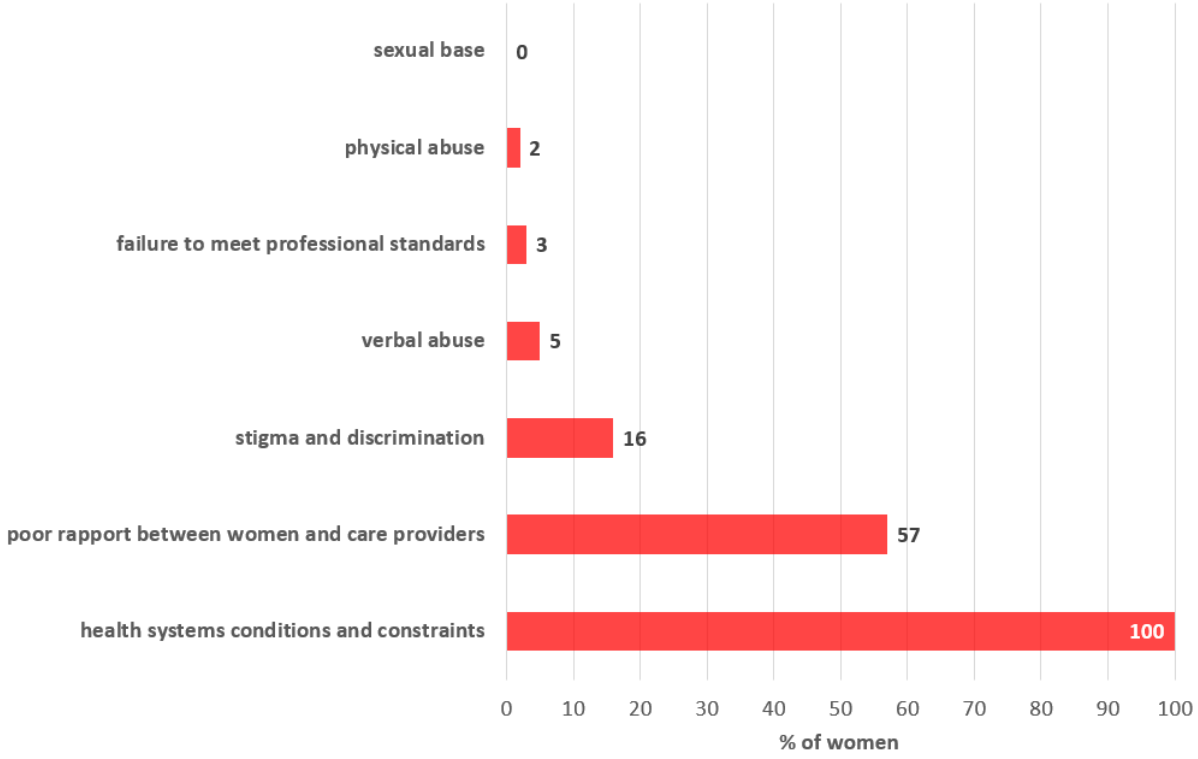

Figure 5.2 Women's experience of obstetric violence under Bohren et al. typology (2015)

The table below (5.3) shows women's experience of obstetric violence based on Bohren et al. (2015) typology on mistreatment of women during childbirth in an obstetric setting. The survey data show that, while JSY policy is the key driver for women to give birth in the health care institutions, 98% of women did not receive the money from government within 30 days of giving birth. Unclear fee structure is the commonest form of abuse followed by bribery and extortion (84%), which together suggests that all women had a challenging experience related to health system conditions and constraints, which is the 7th domain of the typology. This was followed by the 6th domain, 'Failure to meet professional standards of care', under which, women were denied food and fluid (27%), not allowed to walk around (22%) and not allowed their chosen position to give birth (12%). They were treated as a passive participant during their childbirth, and were not informed about the findings of their general examination (31%) and vaginal examination (7%), which indicates poor staff attitude. Women reported poor rapport with the care providers (Domain 5). They experienced a lack of clarity in communication in terms of not explaining the ward environment (13%), the progress (7%) and movement (21%) in labour. Some women (5%) felt neglected or abandoned when they needed a care provider. A few women reported being discriminated and stigmatized based on their age (0.2%), socio economic status (0.4%) and HIV status (16%). Although the number does not suggest that they were HIV positive, instead that they could have felt discriminated when they were asked about it. A few women reported breach of privacy (4%) and confidentiality (1%).

Women also reported that some of the most extreme forms of obstetric violence: verbal (5%) and physical abuse (2%). Women were hit, slapped and pinched (2%) and were subjected to judgemental and accusatory comments (5%), rude language (5%) and were threatened to withhold services (1%). Some women received an episiotomy cut without anesthesia (2%), that can be considered one of the harshest forms of obstetric violence.

Table 5.3 Types of mistreatment during childbirth experienced by women

Domain of obstetric violence	**Specific mistreatment category**	**Frequency % (N=2194)**
Physical abuse	Slapping, hitting, pinching	1.6 (35)
	Restraining	0.0 (0)
Sexual abuse	Rape	0.0 (0)
Verbal abuse	Judgemental and accusatory comments	5.0 (109)
	Rude language	5.0 (109)
	Threatened women to withhold services	0.6 (14)
Stigma and discrimination	Discrimination based on age	0.1 (2)
	Discrimination based on caste	0.0 (0)
	Discrimination based on SES	0.2 (4)
	Discrimination based on HIV status (asked about HIV status)	15.5 (341)
Poor rapport between women and providers	No pain relief (episiotomy without anesthesia)	1.9 (12)
	Neglect and abandonment	4.7 (103)
	Lack of confidentiality	1.2 (27)
	Poor communication- ward environment not explained	13.2 (289)
	Poor communication- progress in labour not explained	6.1 (134)
	Poor communication- movement for foetus in labour not explained	20.7 (454)
	Non consensual surgery (episiotomy)	0.5 (12)
	Non consensual care	3.7 (81)
	Not allowed to walk	21.9 (481)
	Woman or baby detained at the facility	2.4 (53)

Domain of obstetric violence	**Specific mistreatment category**	**Frequency % (N=2194)**
Failure to meet professional standards	Denial of food and fluid	27.3 (600)
	Birth companion not allowed	1.5 (34)
	Denied choice of birth position	12.1 (266)
	Treated as a passive participant (GE not explained)	30.8 (675)
	Poor staff attitude (VE findings not explained)	7.2 (157)
Health system condition and constraints	Lack of privacy during birth	3.9 (85)
	Bribe and extortion	84.2 (1848)
	Reported grievance	4.7 (104)
	Unclear fee (received any funds/ JSY money from the institutional birth)	98.0 (2150)

Table 5.4 shows the percentages of different forms of obstetric violence by women's background characteristics, based on Bohren et al. (2015) classification. More than 30% of the women aged between 36-45 years experienced stigma and discrimination, which is much higher than other age groups of participants. This is twice as high suggesting women may experience more abuse when giving birth at an older age than women aged between 18-25 and 26-35 years of age. Similarly, women who were highly educated, with degree level of education, did not report any experiences of physical abuse. However, highly educated women reported comparatively more stigma and discrimination than other women in this category.

Religion is also an important factor. Hindu women reported experiences (82%) of verbal abuse at a higher rate than Muslim women (5%). Scheduled tribe women reported experiencing physical (8%) and verbal abuse (8%) at a higher rate than the average (2% & 5%) and women's experience from other castes. Parity is an important factor, as primipara women have been more likely to experience physical abuse and poor rapport with the care provider.

Table 5.4 Percentage of women reporting obstetric violence by women's background

Variables	**Physical abuse**	**Verbal abuse**	**Stigma & discrimination**	**Poor rapport between woman & care provider**	**Failure to maintain professional standard of care**	**Health systems conditions and constraints**
TOTAL	**1.6**	**5.0**	**15.8**	**3.2**	**56.6**	**100.0**
Age						
18-25 years	1.7	5.4	**16.4****	**4.0****	55.3	99.9
26-35 years	1.4	3.8	**13.4****	**1.0****	60.6	100.0
36-45 years	0.0	3.2	**32.3****	**0.0****	48.4	100.0
46 years and above	0.0	0.0	**0.0****	**0.0****	50.0	100.0
Education						
No education	1.6	4.8	15.9	2.2	58.9	**100.0*****
1-5 years (Primary)	0.9	4.4	13.3	3.1	56.2	**100.0*****
6-10 years (Secondary)	2.4	5.9	15.0	3.5	55.4	**100.0*****
11-12 (Higher secondary)	1.1	4.5	17.9	5.0	51.4	**100.0*****
13+ (Degree)	0.0	3.6	21.6	8.1	50.5	**99.1*****
Religion						
Muslim	1.1	**4.5*****	15.5	3.7	59.7	100.0
Christian	0.0	**66.7*****	0.0	0.0	100.0	100.0
Hindu	1.7	**82.6*****	15.9	3.1	55.9	99.9
Caste						
General caste	1.5	4.5	19.9	4.5	58.3	100.0

Variables	**Physical abuse**	**Verbal abuse**	**Stigma & discrimination**	**Poor rapport between woman & care provider**	**Failure to maintain professional standard of care**	**Health systems conditions and constraints**
TOTAL	**1.6**	**5.0**	**15.8**	**3.2**	**56.6**	**100.0**
Other backward caste	1.7	5.1	15.6	3.4	57.2	100.0
Schedule caste	1.2	4.7	14.5	2.1	54.8	100.0
Schedule tribe	8.3	8.3	8.3	0.0	41.7	100.0
Occupation						
Homemaker	1.6	5.0	15.8	3.2	56.5	100.0
Farmer	0.0	10.0	30.0	0.0	70.0	100.0
Employee	0.0	0.0	0.0	0.0	100.0	100.0
Own business/ self-employed	0.0	0.0	0.0	0.0	100.0	100.0
Student	0.0	0.0	0.0	0.0	50.0	100.0
Marriage						
Married	1.6	5.0	15.8	3.2	56.6	100.0
Separated	0.0	0.0	0.0	0.0	66.7	100.0
Parity						
1	2.3	6.3	15.6	**8.9*** **	**49.4*** **	99.8
2-3	1.4	4.7	15.6	**0.9*** **	**58.1*** **	100.0
4+	1.0	3.7	16.4	**0.4*** **	**63.0*** **	100.0
Socio Economic Status						
Poor SES	1.6	4.9	**13.9** **	**2.2** **	**61.2*** **	100.0

Variables	Physical abuse	Verbal abuse	Stigma & discrimination	Poor rapport between woman & care provider	Failure to maintain professional standard of care	Health systems conditions and constraints
TOTAL	**1.6**	**5.0**	**15.8**	**3.2**	**56.6**	**100.0**
Good SES	1.6	5.0	**17.4****	**4.1****	**52.7*****	100.0

***significant at p <0.01; **significant at p <0.05 ; *significant at p <0.1

I developed a score for each of the 29 specific forms of abuse to understand whether each woman had experienced obstetric violence under each of the categories, by coding the responses as 0 for 'No, experience of obstetric violence' and 1 for 'Yes, experience of obstetric violence'. I wanted to understand the extent of each woman's multiple experiences of obstetric violence. Figure 5.3 shows the complex multi-layered nature of women's experience of obstetric violence. I found that every woman had experienced some form of obstetric violence. Very few women experienced one (6%) form of abuse during their stay in the health care facility. Most women experienced two (28%) to three (25%) forms of obstetric violence. Women who experienced four (13%), five (9%) or six (8%) forms of abuse was also high, as shown in Figure 5.3. It is important to note that 164 women reported experiencing seven to eight forms of abuse. Forty women reported experiencing nine and seventeen women reported experiencing 10 forms of abuse.

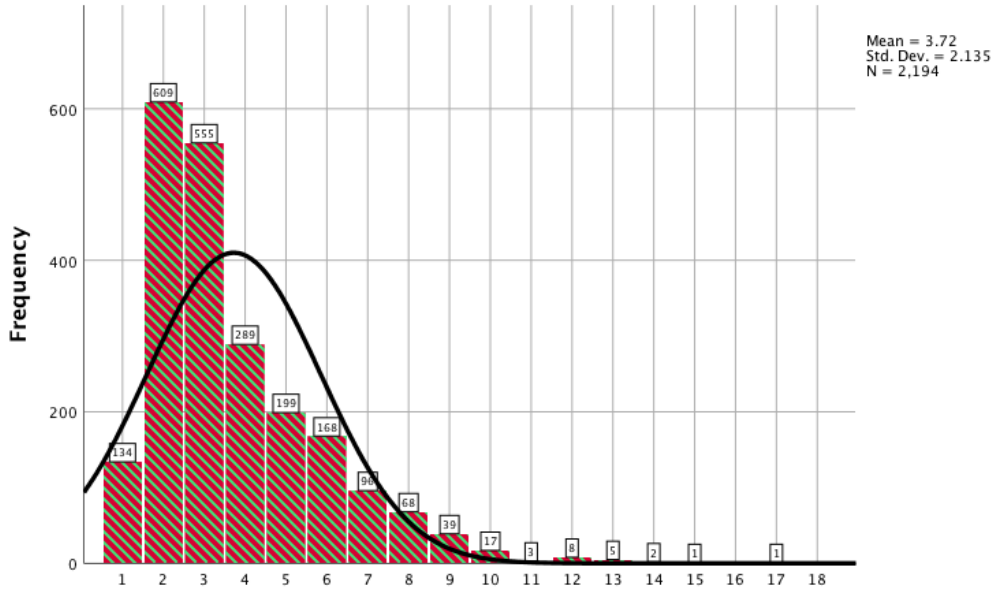

Figure 5.3 The number of types of obstetric violence suffered by women

To better understand the graph above in terms of the severity of women's experiences, I present a case study from my dataset. I present Trahi's (pseudonym) story, as the participant who experienced the maximum (17) forms of obstetric violence, which was the highest in my dataset in Appendix A. I constructed this story from her data, for a better understanding of women's experiences of obstetric violence with more context, and to highlight the value of every single woman's experience of obstetric violence, that I will explore in more detail in the next chapters.

5.4.3 Social determinants of obstetric violence

Binary logistic regression analysis

I conducted logistic regressions on five out of the seven key domains of obstetric violence (dependent variables) from Bohren et al. (2015) typology to examine their association with women's background characteristics (Table 5.5). I did not include sexual abuse because no one reported it while health systems conditions and constraints reporting was universal. The background characteristics describing women's religion, age, education, caste, parity and socio-economic status are the independent variables along with a variable on whether the participant's birth was observed in the survey by researchers in the health care facility. I did not use occupation data because 99.9% women are homemakers. I use the 1st category in each variable as the reference category.

The results show that women had higher odds of experiencing physical abuse, verbal abuse, and failure to meet professional standards by care providers, when their birth was not observed. Women were more likely to experience stigma and discrimination when their birth was observed. These results were highly significant. Increasing parity decreased the likelihood of women experiencing poor rapport with care provider but increased the likelihood of failure on the care provider's part to provide professional standard of care. Women with more children were more likely to experience failure to maintain professional standard of care. In addition, women aged between 25-36 years were less likely while women aged 36-45 years were more likely to experience stigma and discrimination compared to women giving birth at between 18-25 years of age. Poor rapport with care provider was more likely if the women are educated, with the most educated women experiencing the highest likelihood of poor rapport with care provider. Women were more likely to experience poor rapport with care provider and less likely to experience a failure to maintain professional standard of care if they belonged to a household with a good socio-economic status. Women from other backward castes and schedule tribe were significantly less likely to experience stigma and discrimination in comparison to women from general caste.

Table 5.5 Binary logistic regression (odds ratio) (95% CI)

Bohren et al. main domains of disrespect and abuse during childbirth	**Physical abuse**	**Verbal Abuse**	**Stigma & discrimination**	**Poor rapport between woman & care provider**	**Failure to maintain professional standard of care**
Religion					
Hindu	1.00	1.00	1.00	1.00	1.00
Muslims and Christians	0.56 (0.18, 1.79)	1.09 (0.62, 1.90)	0.87 (0.61, 1.22)	1.36 (0.69, 2.69)	1.02 (0.79, 1.32)
Age					
18-25 years	1.00	1.00	1.00	1.00	1.00
26-35 years	1.34 (0.49, 3.65)	0.86 (0.48, 1.56)	**0.68 (0.48, 0.95)****	1.20 (0.43, 3.36)	0.94 (0.71, 1.16)
36-45 years	0.00	0.77 (0.10, 6.13)	**2.03 (0.89, 4.62)***	0.00	**0.49 (0.23, 1.05)***
46 years +	_	_	_	_	0.34 (0.02, 5.58)
Education					
No education	1.00	1.00	1.00	1.00	1.00
Primary	0.52 (0.12, 2.28)	0.91 (0.45, 1.83)	0.77 (0.51, 1.18)	1.23 (0.51, 2.98)	0.93 (0.69, 1.25)
Secondary	1.22 (0.57, 2.62)	1.10 (0.69, 1.77)	0.87 (0.65,1.18)	0.87 (0.465, 1.65)	1.03 (0.81, 1.27)
Higher secondary	0.54 (0.12, 2.49)	0.74 (0.33, 1.67)	1.05 (0.68, 1.63)	**0.929 (0.40, 2.15)****	0.88 (0.62, 1.23)
Degree	_	0.65 (0.22, 1.88)	1.35 (0.81, 2.23)	**1.53 (0.64, 3.66)***	0.87 (0.58, 1.33)

Bohren et al. main domains of disrespect and abuse during childbirth	**Physical abuse**	**Verbal Abuse**	**Stigma & discrimination**	**Poor rapport between woman & care provider**	**Failure to maintain professional standard of care**
Caste					
General Caste	1.00	1.00	1.00	1.00	1.00
Other backward caste	0.87 (0.28, 2.71)	1.14 (0.58, 2.23)	**0.68 (0.47, 0.97)****	0.75 (0.37, 1.54)	0.92 (0.68, 1.23)
Schedule caste	0.56 (0.15, 2.15)	0.96 (0.44, 2.08)	**0.64 (0.42, 0.98)****	**0.49* (0.20, 1.23)**	**0.75 (0.54, 1.05)***
Schedule Tribe	3.85 (0.37, 40.68)	1.69 (0.19, 14.75)	0.32 (0.04, 2.60)	_	0.69 (0.21, 2.34)
Parity					
1	1.00	1.00	1.00	1.00	1.00
2-3	0.57 (0.27, 1.24)	0.73 (0.47, 1.14)	1.07 (0.81, 1.41)	**0.09 (0.05, 0.19)*****	**1.44 (1.17, 1.78)*****
4+	**0.57** (0.27, 1.24)*	0.60 (0.29, 1.23)	1.34 (0.89, 2.03)	**0.04 (0.008, 0.20)*****	**1.73 (1.36-2.54)*****
Socio-economic status					
Poor SES	1.00	1.00	1.00	1.00	1.00
Better SES	0.97 (0.48, 1.95)	1.00 (0.67, 1.51)	1.28 (0.99, 1.64)	**1.66 (0.95, 2.88)***	**0.71 (0.60, 0.84)*****
Birth observation					
Birth observed	1.00	1.00	1.00	1.00	1.00
Birth not observed	**1.98 (0.95, 4.14)***	**1.52 (1.01, 2.29)****	**0.61 (0.49, 0.77)*****	1.41 (0.85, 2.34)	**2.39 (2.00, 2.86)*****

Factor analysis

Analysing each separate Bohren et al., (2015) category was one way to reduce the dimensionality of the obstetric violence data. However, only five of the seven data groups could be used and the approach did not reduce the dimensionality enough. I, therefore, used factor analysis with principle component analysis as the method of extraction, to create scores that captured the variation more succinctly. I selected the first three components which explained the most variance in the data, as can be seen in the Scree Plot (Figure 5.4) which shows that the factors start tailing off after the 3rd component and the first three components explain 32% of the total variance.

To carry out the factor analysis, I selected 26 of the 29 types of obstetric violence based on the entire Bohren et al. (2015) classification because three forms of violence namely, sexual violence, restrained, and discrimination against caste, were not reported by participants. Table 5.6 presents the three components that represented the most variance in the 25 types of obstetric violence. I selected a cut off value for factor loadings at 0.3 (Tabachnich & Fidell, 2013) and highlighted the elements that loaded positively and strongly under the particular forms of violence.

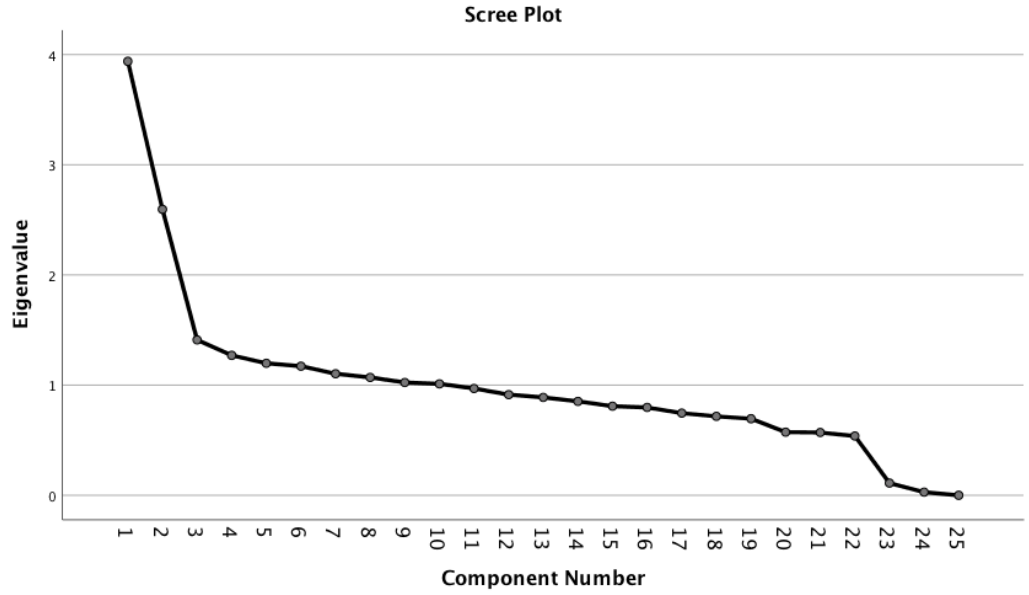

Figure 5.4 Scree Plot

Component 1 loaded positively for indicators concerning physical and verbal abuse. The three variables that loaded strongly under this component for verbal abuse are: 1) rude language; 2) judgemental and accusatory comments; and 3) threatened women to withhold services. Poor communication has strong positive factor loading for two main obstetric violence domains i.e. poor rapport between woman and care provider and a failure to provide professional care, for

component 2. There is a pattern in the high positive factor loading for the specific variables which were mostly related to poor communication and a lack of explanation, that include: 1) vaginal examination findings not explained; 2) ward environment not explained; 3) progress in labour not explained; 4) general examination findings not explained; and 5) movement in labour not explained. Factors loading were positive and strong for denial of food and fluids and not allowing women to walk when in labour. This shows a failure to provide compassionate care during childbirth, and can be considered related to poor communication when women are restricted from walking and eating. The third component, coercion, indicates a lack of consent, as the factor loading was positively correlated with 1) non-consensual care and 2) non-consensual surgery.

Table 5.6 Factor analysis

Individual disrespect and abuse indicators from Bohren et al's classification	**Components**		
	Physical & verbal abuse	**Poor communication**	**Coercion**
Woman or baby detained at facility	0.188	0.038	0.122
Asked about HIV status	-0.111	-0.197	-0.009
No birth companion	0.011	0.108	0.103
Denied choice of birth position	0.250	0.235	-0.032
Denial of food & fluid	0.188	**0.547**	-0.193
Physical abuse	**0.511**	-0.155	-0.057
Left unattended when needed	**0.437**	-0.017	0.202
GE examinations not explained	0.226	**0.370**	0.041
VE findings not communicated	0.222	**0.458**	0.322
Lack of privacy during birth	0.156	0.000	0.246
Confidentiality breach	0.215	-0.085	0.245
Ward environment not explained	0.247	**0.305**	0.052
Progress in labour unexplained	0.238	**0.371**	**0.476**
Non-consensual surgery	0.244	0.044	**0.556**
Non-consensual care	**0.372**	-0.028	**0.487**
Rude language	**0.906**	-0.271	-0.201
Received any funds from the institutional birth	-0.014	-0.038	-0.115
Judgemental and accusatory comments	**0.906**	-0.271	-0.201
Movement in labour unexplained	0.223	**0.816**	-0.256
Threatened women to withhold services	**0.483**	-0.140	0.068
Bribe and extortion	0.154	0.107	0.055
Reported grievance	**0.883**	-0.270	-0.204
Not allowed to walk	0.215	**0.809**	-0.270
Age based discrimination	0.185	-0.004	-0.059

Discrimination based on SES	0.213	-0.057	-0.125

Extraction method- Principle Component Analysis

Rotation method- Oblimin with Kaiser Normalisation

Exploring the obstetric violence factor scores by women's background characteristics

I created scores against three obstetric violence variables from the first three principle components for all the participants, to understand the pattern of obstetric violence by selected background characteristics, as shown through the following graphs. A higher score of each of the new domain, means more experience of obstetric violence. Poor communication scores increase with women's age, whereas coercion, physical and verbal abuse scores decreases with age (Figure 5.5).

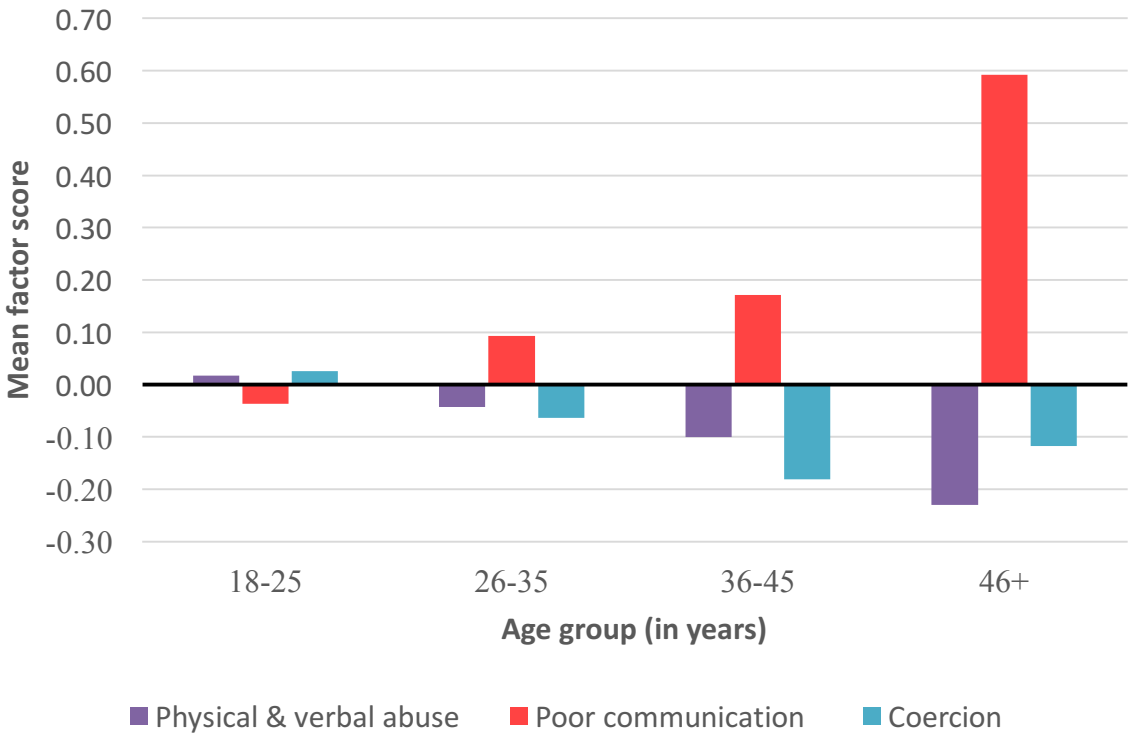

Figure 5.5 Mean scores of obstetric violence by age group

Communication improved and physical and verbal abuse decreased with increase in education, but coercion increased (Figure 5.6). The communication scores decreased for multigravida women, while primigravida women were more physically and verbally abused and coerced (Figure 5.9). The increase in positive factor scores show an increase in poor communication as the positive loadings indicate increase in obstetric violence and the negative loading indicate a decrease in the particular

form of obstetric violence. Women from general caste were well treated, while women from schedule tribe were physically and verbally abused. Coercion scores were high for women from other backward castes (Figure 5.8).

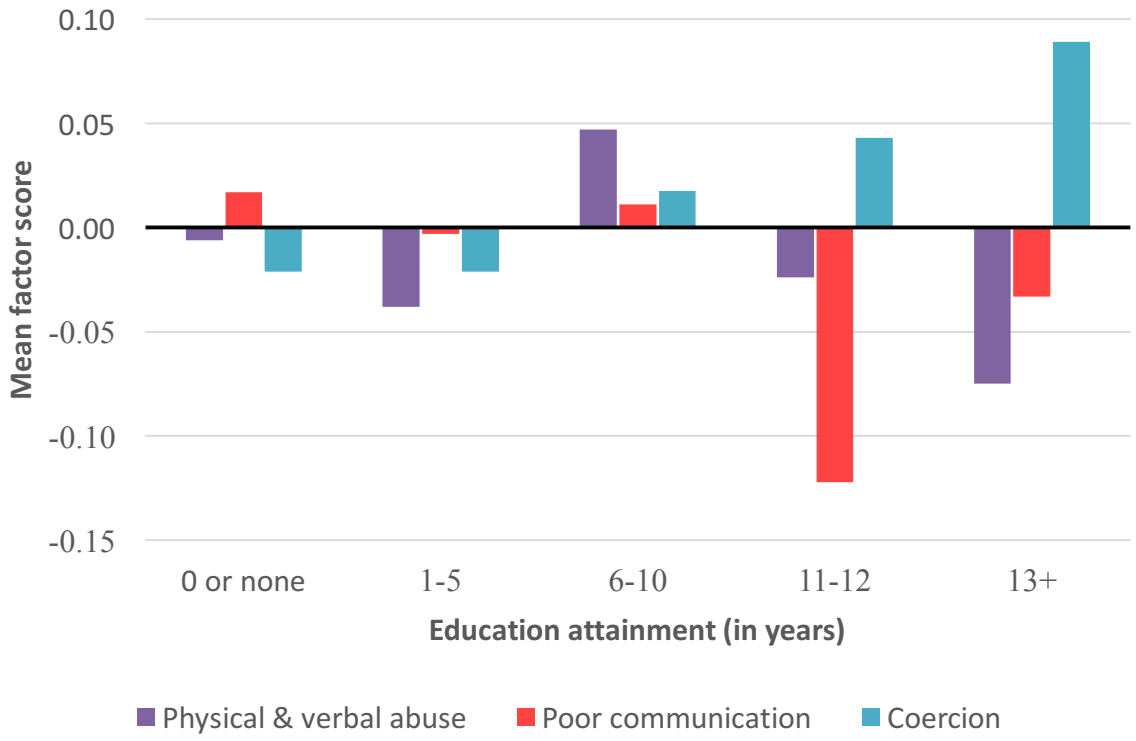

Figure 5.6 Mean scores of obstetric violence by education

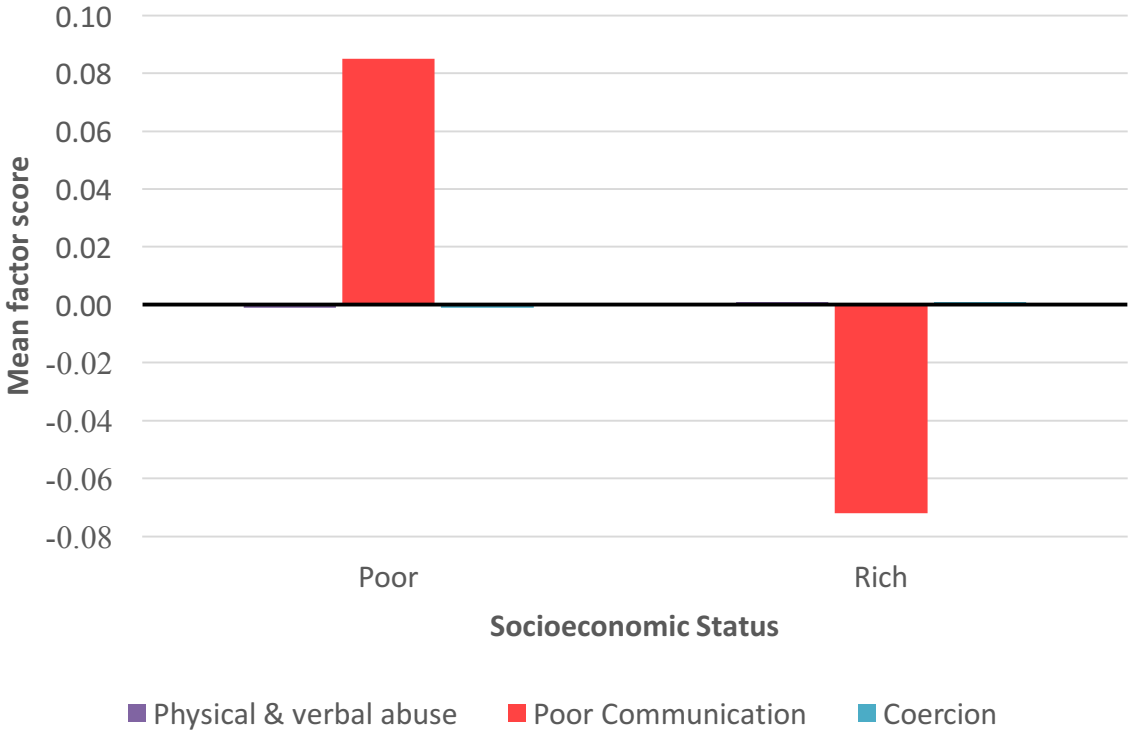

Figure 5.7 Mean of obstetric violence by socio-economic status

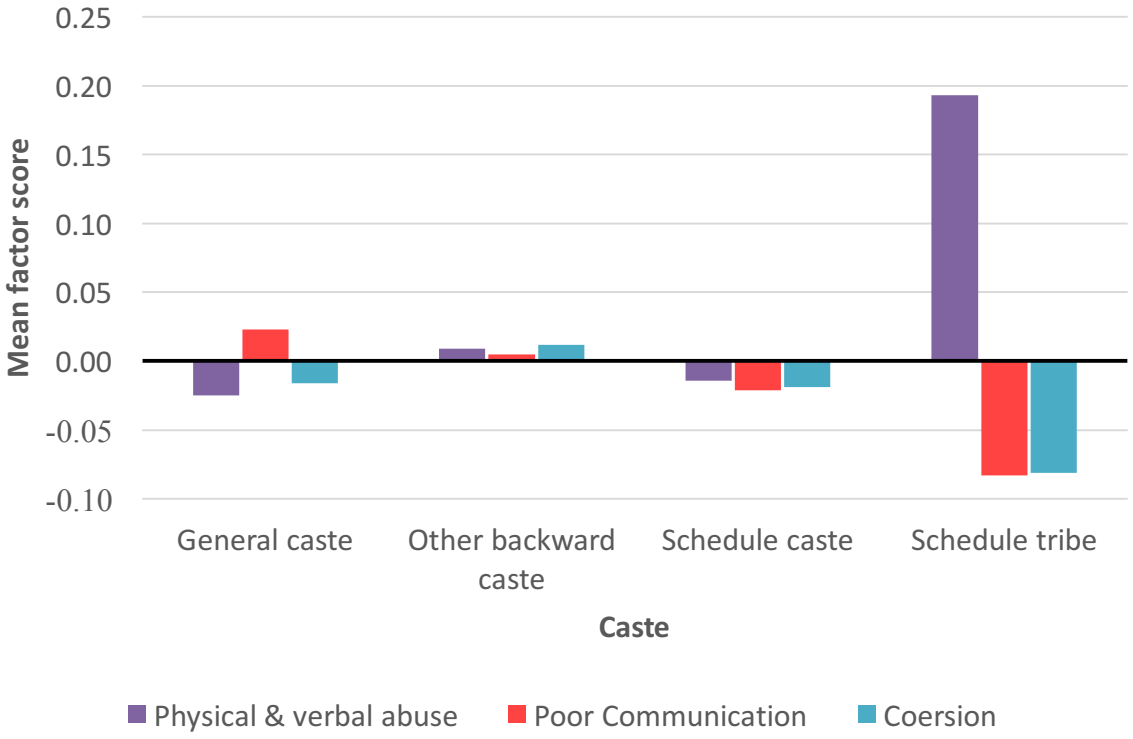

Figure 5.8 Mean scores of obstetric violence by caste

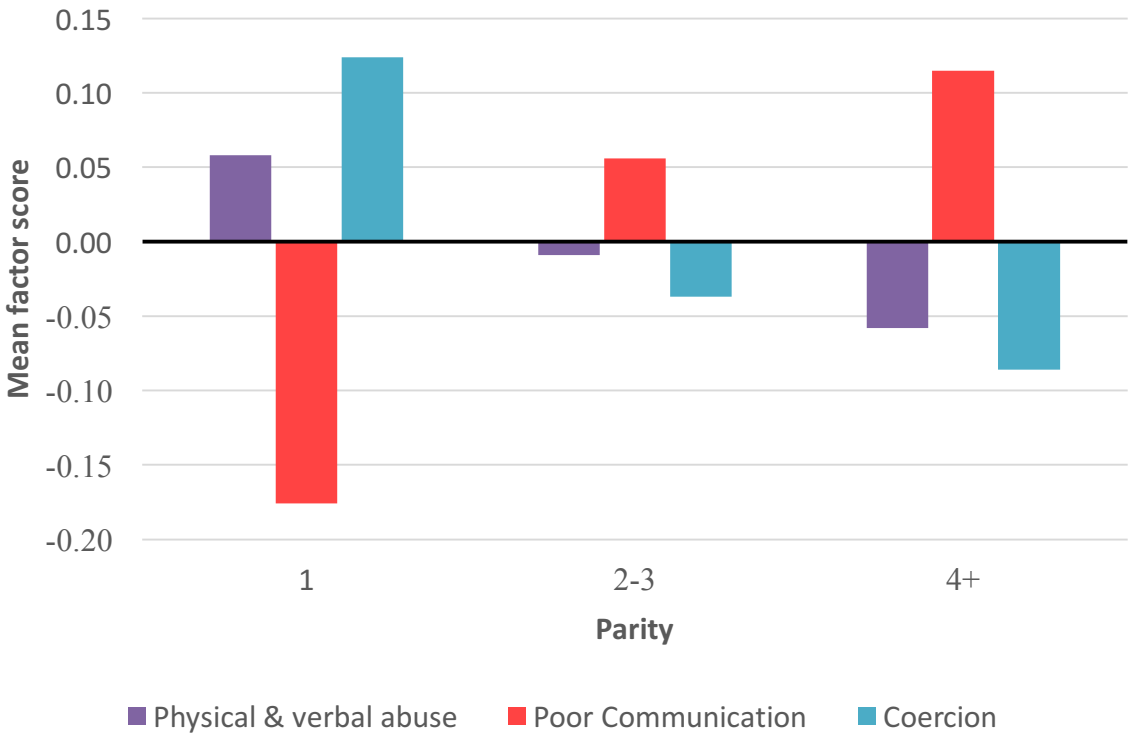

Figure 5.9 Mean scores of obstetric violence by parity

Linear regression with the new components

I conducted linear regression with the three new variables (physical and verbal abuse; poor communication and coercion) to understand their relationship with women's background characteristics. Background characteristics selected include age, religion, education, parity, socio-economic status and caste. The regression coefficient shows that parity had a significant negative effect on coercion scores, which implies that multiparous women are less likely to experience coercion. Similar significant and negative effect was noted for poor communication, suggesting that communication tends to improve with number of births. Women living in better living conditions were less likely to report poor communication, and the relationship was statistically significant. The relationship between obstetric violence scores and women whose birth was not observed was positive and significant. This suggests that women whose birth was not observed were more likely to report coercion, poor communication and physical and verbal abuse.

Table 5.7 Linear regression coefficients of background characteristics and the new obstetric violence scores

Background characteristics	**Coercion**	**Poor Communication**	**Physical & verbal abuse**
Age			
18-25 years	0.000	0.000	0.000
26 years and above	-0.007 (0.060)	0.008 (0.06)	-0.008 (0.06)
Education			
No education	0.000	0.000	0.000
Primary education	-0.002 (0.07)	0.002 (0.07)	-0.010 (0.07)
Secondary education	-0.002 (0.05)	0.038 (0.05)	0.012 (0.05)
H. secondary education	0.001 (0.08)	-0.009 (0.08)	-0.019 (0.09)
Degree education	0.011 (0.10)	0.015 (0.10)	-0.023 (0.10)
Religion			
Hindu	0.000	0.000	0.000
Muslim & Christian	-0.014 (0.06)	-0.010 (0.06)	-0.012 (0.63)
Caste			
SC ST	0.000	0.000	0.000
General caste	0.012 (0.08)	-0.033 (0.08)	0.012 (0.08)
Other backward caste	0.020 (0.05)	0.031 (0.05)	0.020 (0.05)
Parity			
1	0.000	0.000	0.000
2-3	**-0.079*** (0.05)**	**0.115***(0.05)**	-0.036 (0.05)
4+	**-0.081*** (0.08)**	**0.116***(0.07)**	-0.048 (0.08)
Socio economic status			
Good	0.000	0.000	0.000
Poor	-0.008 (0.045)	**-0.073*** (0.044)**	-0.003 (0.46)
Birth observation			
Birth observed	**0.000**	0.000	0.000
Birth not observed	**0.044** (0.04)**	**0.225*** (0.042)**	**0.038* (0.43)**
R square	**0.01**	**0.07**	**0.01**

Note: Standard Error in brackets.

5.5 Discussion and conclusion

The foregoing analyses shows that women's experience of obstetric violence is not a one-time occurrence during childbirth. These experiences are multilayered, non-linear and consists of different forms of violence. A crucial finding is that all participants have experienced at least one form of obstetric violence during childbirth. It is also noteworthy that none of the women experienced just one form of violence during childbirth based on the Bohren's classification. I found that while no woman reported experiencing sexual violence (2nd domain), every woman reported experiencing disrespect and abuse related to health systems conditions and constraints. The least abusive experience of women included, undergoing at least two forms of obstetric violence. On the other hand, one woman experienced 17 forms of disrespect and abuse as per Bohren et al. (2015) sub-classification. While it was possible to report different forms of abuse, the questionnaire did not allow to capture how many instances of abuse and disrespect occurred under each form. This is a limitation that should be explored in the future to obtain a complete picture of the nature and extent of women's experiences of obstetric violence.

I conducted logistic regressions with the main forms of obstetric violence and women's background characteristics such as age, education, caste, socio-economic status, parity and whether their childbirth was observed to understand the social determinants of obstetric violence. I found that women with more children were more vulnerable to experiencing unprofessional care. Women aged between 18-25 years were more likely to experience stigma and discrimination, when compared to women aged 26-35 years. This is in line with the assumption that women at the beginning and the end of their reproductive age may experience more obstetric violence in the form of stigma and discrimination for giving birth too early or too late. As education increased, women were more likely to experience poor rapport with care providers. This could be because educated women may ask more questions, know their rights and ask about procedures, which may lead to poor communication as the care providers may not entertain it. Religion had no significant influence on obstetric violence in these data. It is interesting to note that women from schedule caste and backward castes were more likely to experience stigma and discrimination and poor rapport when compared with women from general caste. This could be because over 88% of the participants were from low castes including schedule castes, schedule tribes and other backward castes. The opposite has been reported in previous studies in a different state in India (Khanna & Sri, 2017). In that study, women from poor socio-economic status were more likely to experience obstetric violence than women from affluent backgrounds, as is reported elsewhere too (Sharma, 2019). I could not examine the influence of occupation and marital status on obstetric violence as more than 99%

participants are married homemakers. Given that a substantial number of women were interviewed after observation of their childbirth experience, it is important to note that they experience more obstetric violence when their birth is not observed. This can be explained by the impact of hawthorne effect on care provider's behaviour as a result of being observed, as has been reported in our publication from the direct observation of birth data (Ahmed et al., 2019) and reported by other researchers too (Goodwin et al., 2018; Choi, Jung & Grantchrov, 2019).

I conducted factor analysis to examine the variation in the variables of obstetric violence through which I created three new obstetric violence scores which represent a large proportion of variance in (32%) the dataset. The patterns in the specific variables helped to name them: 1) coercion; 2) poor communication and 3) physical and verbal abuse. Parity is an important factor and significant for all the three variables. While primigravida women were more physically and verbally abused and coerced. With more number of births, multigravida women experienced poorer communication from the care providers. I also conducted linear regression analysis against selected variables from women's background characteristics as dependent variable. I found that women experienced poor communication with increase in parity. I also found that good socio-economic status resulted in better communication with women. Finally, more women whose births were not observed were coerced, physically, verbally abused and experienced poor communication. These results are in line with the results from logistic regression too.

Studies conducted globally have found that women from marginalised communities may be more vulnerable to experiencing obstetric violence due to their age, socio-economic status, race, gender expression, sexual orientation, health status and migration (Khosla et al., 2016; Chadwick, 2019). Obstetric violence, as I discussed in Chapter 2, makes way for negative health outcomes, for maternal, reproductive and sexual health. In the case of India, women's social and demographic characteristics such as education, parity, obstetric history, social position, culture, values and norms play a key role in determining their vulnerability to obstetric violence (Nambiar & Muralidharan, 2017). Some of these factors have been found to influence intimate partner violence as well, in the context of Bihar and other states in India (Dhar et al., 2018; Sharma et al., 2019; Dey et al., Sudhiranaset et al., 2016), as I discussed in Chapter 3. Future studies would benefit from exploring obstetric violence alongside all other forms of violence experienced by women as the prevalence of violence in women's lives, increases women's vulnerability for violence in other phases of their lives. The culture of violence is prevalent in Bihar (NFHS, 2020; Dhar et al., 2018). Women's positioning at the intersections of their background characteristics increases the inequalities, further increasing

their vulnerability to obstetric violence (Sen, Reddy & Iyer, 2018). Obstetric violence is a negative outcome of care provision in itself.

This study is the first of its kind based on a representative household survey in Bihar, which covers all the districts of the state and addresses the social factors underlying obstetric violence and respectful maternity care. Amongst the background characteristics, I found parity, age and education to be significant as social determinants of obstetric violence. I found that parity made women more vulnerable to being coerced with an increase in parity and experience poor communication, while women giving birth for the first time experienced more physical and verbal abuse.

There is an evidence of under-reporting of the extreme forms of obstetric violence such as physical, verbal and sexual abuse (Afulani et al., 2019). This could be because of women's lack of awareness about good quality and respectful care, their acceptance of violence and reluctance to share sensitive anecdotes of violence (Afulani et al., 2019). This suggests that newer methods are required to understand women's embodied experiences that cut across the stigma and shame of sharing birth and obstetric violence related stories. I explore this in the next two chapters. This is one of the first studies to present the multilayered and complex nature of women's experience of obstetric violence with a detailed understanding of their experiences, which I further presented through Trahi's story (Appendix A), the survey respondents who reported experiencing the most forms of obstetric violence. Developing Trahi's story is my attempt to help draw the reader's attention to women as people and understand their context and the context of obstetric violence (Jeffery & Jeffery, 2010). Women's stories of violence, birthing and obstetric violence are unique and important to be understood in the whole gamut of their sexual, reproductive and maternal lives, which I present in the upcoming chapters.

5.6 Limitations

The survey data does not capture everything about the nature of obstetric violence in Bihar, India. While it captures the different forms of obstetric violence, it does not report on how many accounts of violence women experience under each category. Surveys are subject to sampling errors which can not be underestimated. Underreporting could be a challenge in low resource settings such as Bihar, where women's expectations of care could be low, which may lead to acceptance of poor quality, disrespectful and abusive care. This could also be driven by women's lack of awareness of what quality and respectful care standards for the health care delivery systems are or could be from the awareness that they are not important enough in the social hierarchy to be treated respectfully.

This could limit the capacity of the health care providers and facilities to learn from women's experiences, to address them well and to provide women-centered care to the care seeker's satisfaction, particularly for women from poor and marginalized communities, given the diverse nature of populations in India.

Chapter 6 What does women's experience of respect, disrespect and abuse look like? Breaking the silence surrounding obstetric violence

6.1 Background

Respect originates from the latin word *respectere* which means to 'treat with deferential regard or esteem'. The 'What Women Want' campaign received 350,696 responses in India, where it is also called '*Hamara Swasthya Hamari Awaaz*[4]' (WRA, 2019). There is a growing body of literature, indicating that respectful maternity care is the need of the hour (Jeejebhoy & Santhya 2018; Mayra, 2017). Studies have brought out evidence of various forms of obstetric violence during childbirth across many Indian states. In some states, reports suggest that almost every woman experiences some kind of obstetric violence (Bhattacharya, 2015; Shreeporna, 2015), but these women may not report their experience. This is of particular concern in India, which accounts for 12% of the global burden of maternal deaths (WHO, 2019), and has a poorly resourced health system.

Respectful maternity care is a fairly new area of research for an ever existent issue. Context plays a key role in understanding obstetric violence during childbirth, because the meaning of respect, disrespect and abuse changes with people and across cultures and geographies. The Lancet series on maternal health brought out the challenges of women who received care that is either too much too soon or too little too late. This variation in the quality of care is dependent on culture and context. Researchers continue to explore the meaning of respectful maternity care and how to provide person-centered care (Downe, 2019; Afulani et al., 2019). The responsibility of women-centered care is on the team of care providers, to ensure that healthcare protects women's rights and dignity, and is satisfactory for them. Health care providers need to understand women's perception of respect, disrespect and abuse from their experience of childbirth, to be able to provide respectful maternity care (Bhattacharya, 2013). In the previous chapter, I presented how women's experiences consist of multiple types of obstetric violence which continues throughout their presence in the obstetric setting. Women-centered care requires a deeper understanding of what women want during childbirth. This may not be same as the care provider or the policy maker's perception of obstetric violence and respectful care, which I explore in Chapter 8.

[4] Translates to 'Our health, our voice'

Beck et al. (2013) aptly defines that it is not just beauty that lies in the eye of the beholder, it is also traumatic childbirth. Previous studies suggest a few reasons why respect, disrespect and abuse can be perceived differently by women and others, including care providers. Firstly, as Kitzinger (2005) shows in her work, women often lack the language to narrate their birth experience. Pain is often the common explanation of their experience of childbirth. Women may not be accustomed to medical language and terms. They may be silenced by the stigma and shame related to conversations that involve reference to body parts such as referring to one's genitals and the fact that birth is a result of intercourse (Chadwick, 2018; Beck et al., 2013; Kitzinger, 2005). 'The clinical language used by care providers could be difficult for women to understand and incorporate into their narrative. All these factors indicate the need for a method of exploring women's embodied experience of such sensitive areas of stigma and shame (Chadwick, 2017) particularly in a patriarchal postcolonial setting, such as India.

Studies have found that women's narratives of traumatic birth experience are often similar to narratives of rape victims (Beck, Driscoll & Watson 2013; Kitzinger, 2005). The same is true of non-verbal communication, such as touch. Touch can be comforting as well as discomforting. Given the experience of this pain usually ends with the birth of a child, there usually is a dilemma for women. Reporting a traumatic birthing experience becomes secondary when a woman is expected to be grateful for surviving childbirth and returning home with a live baby (Kitzinger, 2005). Some women, having experienced traumatic childbirth, may relive the birth trauma every year on their child's birthday as trauma anniversary. This dilemma leads them to feel disgusted and depressed every year on a day they are supposed to celebrate (Beck, Driscoll & Watson, 2013; Scotland 2020).

Secondly, women may not be aware that certain actions or behaviour are not part of care (Downe, 2019), even though they felt 'bad' when they experienced it, or they may expect to be mistreated (Lambert et al., 2018). They may not object to obstetric violence, thinking health care does not have to be a pleasant experience and sometimes needs to be endured. Their expectations are often so low that satisfaction is not a priority. A study in India reports that women considered the availability of health care providers and health supplies, such as medicines, as two key aspects of good quality care (Bhattacharya, 2013). They recommend that reducing waiting time, provision of seating arrangement and good laboratory services will increase women's satisfaction with the services (Das et al., 2010).

Women may refrain from reporting traumatic childbirth, as they may feel that is how health care is supposed to be (D'entremont, 2014) and even blame themselves for the violence they experience. Personal, social and cultural context plays an important role in shaping women's perceptions of

respect and disrespect; and influences their intent to report it (Sen, Reddy & Iyer, 2018). Findings from Chapter 5 show that while every woman reported experiencing some form of obstetric violence in the obstetric settings in Bihar, only 5% (2194) considered reporting their grievance formally. Not opening up to giving an account of obstetric violence during birth can be due to the stark inequalities in society leading to a power-based imbalance and the fear of consequences (Sen, Reddy & Iyer, 2018; Roberts, 1981).

Finally, women's autonomy and decision-making power could determine what a satisfactory experience of childbirth can be. In deeply patriarchal cultures, women have a limited decision making role, especially about their sexual, reproductive and maternal health and needs (Jeejebhoy & Santhya 2018; Koski, Stephenson & Koenig, 2011). There are several indicators that confirm a lack of women's agency in Bihar. The NFHS-5 reports that only 29% women had completed education upto 10 years and 41% (aged between 20-24 years at the time of the survey) were married before they turned 18. This highlights that child-marriage is a persistent issue in the state. The high rates of gender-based violence and crime against women shows further disempowerment and oppression of women (Dhar et al., 2018; Jejebhoy & Santhya, 2018). Intimate partner violence is another key issue in the state (Dhar et al., 2018), with 40% women having experienced spousal violence and 3% experienced it during pregnancy. Amongst the women surveyed between 18-29 years' age, 8% reported experiencing sexual violence before they turned 18. Gender-based discrimination is evident in other indicators as well. For instance, female sterilisation (35%) is much higher than male sterilisation (0%) (GOI, 2020).

A culture of violence and subjugation is part of a patriarchal structure, where women and girls have limited agency over their bodies and lives. This extends to obstetric settings too. Lack of consent and explanation of obstetric interventions are key indicators in this context, which is often very high (Bhattacharya, 2013; Patel, Das & Das, 2018) as seen for Bihar in Chapter 5, which confirms a lack of women's consent and choice in obstetric birth environments. This is a characteristic of the medical model of care, as a result of the gradual transition of home as the more common and accepted birth setting, to domination by the obstetric birth setting, over last many decades which continued the alienation of women's reproductive rights (Oakley, 1984; Menon, 2012; Hill, 2018; Cleghorn, 2021).

All these reasons normalise obstetric violence, as an extension of women being 'allowed' to do anything in their routine lives. It is a result of girl's and women's positioning at the intersections of several 'female' disadvantages, which increase women's vulnerability (Sen & Iyer, 2012: Chattopadhyay, 2018; Chadwick, 2018). It may further indicate that women find abusive care acceptable or feel that women deserve to be treated or disciplined during childbirth and act

accordingly (McAra-Cooper, 2011). Women may change their place of birth and not give birth in a health care facility based on their previous birth experience (Silan et al., 2018), rather than reporting their experiences. All these explanations point to the normalisation of obstetric violence during childbirth as the extreme forms of abuse (including physical abuse) become increasingly acceptable and part of care provision (Bradley, 2016; Freedman et al., 2018; Sen et al., 2018; Lambert, 2018).

This chapter, aims to explore how women attach meaning to respect, disrespect and abuse through their experiences of childbirth using unique participatory arts-based research methods that enable understanding of their embodied experiences.

6.2 Research questions

- How do women attach meaning to their experiences of respect, disrespect and abuse during childbirth in Bihar, India?
- How can women's embodied experience be explored through sensory interviewing?

6.3 Objectives

- To understand how women perceive and attach meaning to respect, disrespect and abuse during childbirth in Bihar.
- To undertake feminist participatory arts-based research in exploring sensitive embodied experiences of childbirth.
- To document women's expectations of respectful care necessary to ensure a positive birthing experience.

6.4 Methods

This is a qualitative study undertaken in Bihar, where I conducted in-depth interviews aided by a participatory visual arts-based research method called body mapping. Critical feminist theory informed all aspects of this study, which enabled an understanding of childbirth as a human experience, which is embodied, inter-subjective, contingent, and woven into personal and cultural webs of signification.

Women in India usually give birth in four types of settings: 1) public hospital; 2) private hospital; 3) home and 4) on the way to hospital (Figure 6.1). The figure shows the areas that were explored in data collection in each of these settings. Some of them have overlapping domains. The common

themes of respect, disrespect and abuse were explored in each of the setting with the help of some overarching questions on communication, touch, information, decision-making and consent during childbirth to understand the nature of this in each of these birth settings. All these key areas of exploration have specific probes as shown in the in-depth interview guide (Appendix B) and may indicate respect, disrespect and abuse during childbirth.

Both primigravida and multigravida women were selected for the interviews, under the criterion that study participants had given birth at least once in Bihar. I selected eight women purposively, to participate in a body mapping assisted in-depth interview.

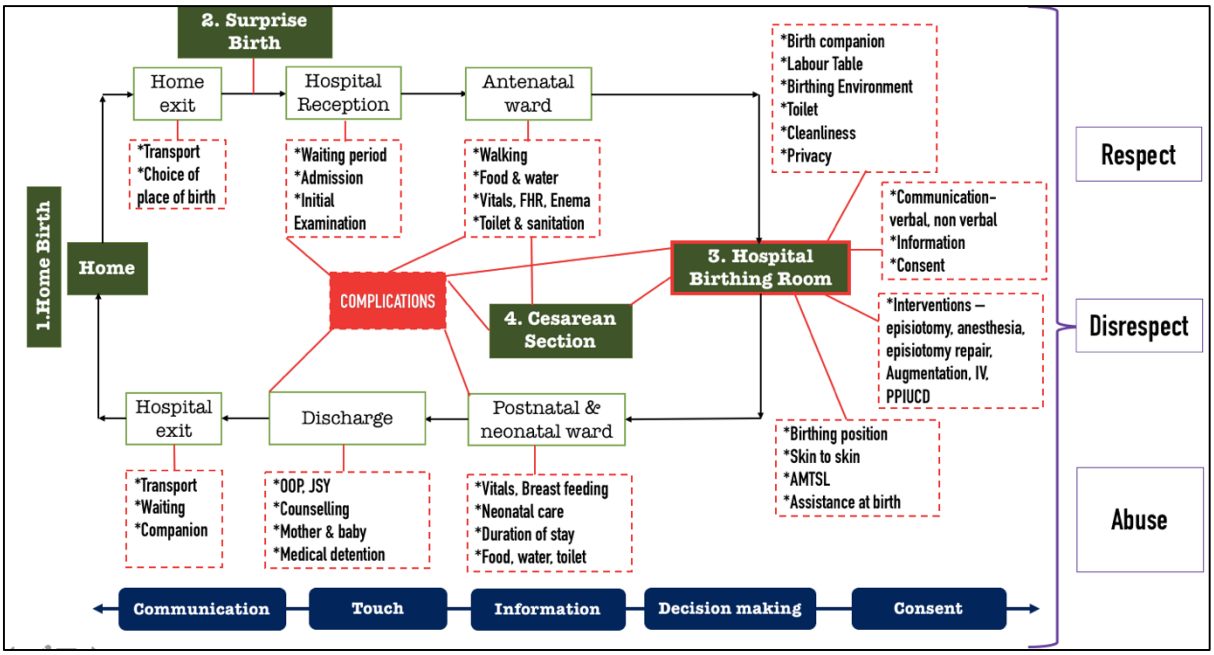

Figure 6.1 Themes of exploration for respect, disrespect and abuse during birth (*Author's own*)

The participants were selected from an urban slum from Patna and a rural village from Muzaffarpur, both in Bihar. Patna is the capital of the state and has access to specialised tertiary-level health care facilities, which is more accessible to women living in urban slums which are located in different parts of the city capital. The institutional delivery rate in Patna is among the highest in India, between 79-87%. Muzaffarpur, on the other hand, has an overall institutional delivery rate between 62-71%, which matches percentage of institutional births at the state level. It is also adjoined by neighbouring districts like Samastipur where institutional birth rate is between 53-62% and Darbhanga, Seohar, Sitamarhi, West Champaran; where it is the lowest, between 32-53% (NFHS 4).

6.4.1 Body mapping

Body mapping is a unique participatory approach that combines visual arts and therapeutic practice to guide participants in the artful communication about their embodied life experiences in ways that are safe and supportive (Orchard, 2017). Birthing maps is a term I coined to refer to my adaptation of the established body mapping method, whereby I use it to explore women's experiences of giving birth. This was an ideal method for data collection as it reduced literacy, stigma and power-related barriers to respondents' ability to communicate their experiences and the researcher's ability to listen and learn. Collecting narratives of birth involves talking about body parts that are shameful to talk about in the local context. Birth mapping is a culturally appropriate method because of its flexible nature, which gives room for adaption and enables women to bypass stigma and share rich accounts of their experiences. The exercise starts with the interviewer requesting the participant to lie down on the sheet in the position they gave birth in order to draw a live size outline around the person. I demonstrate this by lying down on the sheet, which I found helped to overcome any hesitation that women may have felt about lying down on the paper. Talking about birth is sensitive and body mapping helps women to open up over the course of a few interactions that allow development of trust between the interviewer and interviewee. Birth mapping have three components: 1) the birth map; 2) the birthing story, and 3) the body key.

Body mapping is a relatively new method of data collection in public health research. It was first developed by MacCormack and used in rural Jamaica for a study on women's understanding of their fertility (MacCormack, 1985). It was subsequently used in Zimbabwe to initiate conversations about sexuality, reproductive health and the anatomy of women (Cornwall, 1992) and in other parts of Africa in the context of HIV/AIDs (CATIE, 2006). This method has primarily been used in studies involving women's bodies where their understanding about their body, a particular function of it (reproduction) or impact of a condition (e.g. obesity, HIV/ AIDS) has been explored. Researchers have found it to be a good approach when trying to understand sensitive issues. They report that body mapping is an approach to bridge the gaps between embodied experiences and traditional research methods while also empowering the people who participate in the process (Cornwall, 1992). Body mapping helps to unearth difficult and *'meaningful, embodied experiences and life events',* which justifies using this approach to understand women's experience of childbirth (Orchard, 2017).

Though other studies have used body mapping to understand constructs of gender and body, there is little or no attention given to body mapping to understand birthing experience as a particular form of participatory visual arts-based research. Other forms of arts-based research, such as I-poems,

have been used in the analysis of birthing experiences before (Montgomery, 2014; Chadwick, 2018; McKenzie, 2021). Studies that have used body mapping have found high satisfaction from the participants about the approach to data collection. They also report that researchers going back to them and finishing the mapping exercise over a few days helps them to formulate their thoughts and experiences better, enabling a keener engagement in the process (Orchard, 2017).

While there are general guidelines to conduct the body mapping method, I adapted those guidelines for birth mapping in Bihar. It is essential to allow this flexibility to incorporate the context and setting-based changes.

Aspects for birth mapping

1. **People involved**- Apart from the participant, the process of birth mapping consists of two researchers: a facilitator and a note taker.
2. **Facilitator**- Guides the process of birth mapping, demonstrates on the sheet, draws the outline of participant with consent, answers any questions, asks the questions while facilitating the process of birth mapping.
3. **Note taker**- Takes thorough notes of the participant responses and prepares the body key, assists in the process with the arts-based supplies.
4. **Index birth**- The participant is requested to pick an index birth, which will be the birth the map will mainly focus on. But that will not restrict her from sharing about her other births. This may or may not be her most recent birth.
5. **Outline-** The exercise begins by tracing an outline of the participant's body on a large sheet of paper. The participant is requested to lie down on the paper in the position that she gave birth in. If she gave birth in a standing position, we will show it through vertical arrows. The facilitator lies down to demonstrate.
6. **Colours**- The participant is requested to choose any colour she wants to show the good and bad feelings, skin, clothes, environment and other aspects of the narrative while trying to maintain as close resemblance to the day of birth as possible.
7. **Symbols**- The participant chooses any symbols to signify the experiences (holding hands), people (birth companion; care providers) or emotions (pain; shame; fear; disgust; happiness). She may draw or write about her experiences on the map. She can also write quotes of people around her. The facilitator can participate in writing the quotes with the participant, based on participant's literacy level and request for help.
8. **Body key**- The note taker keeps a note of what the colours and symbols signify, which guides the birthing story to understand the birth map well.

9. **Birthing body**- The participant is requested to show her experience of giving birth by indicating the experience within the outline of the body that may include emotions and interventions.
10. **Birthing environment**- The participant is requested to show other aspects of the birthing environment outside the outline of the body. This may include the number of people around, who they were and their role. This can include important aspects of the narratives in the social environment, familial environment, community, along with the hospital environment.
11. **Birthing story**- It is a one-page summary of the conversations and interactions co-created with the participant and is approved by the participant on the last meeting. This is also an analytic outcome of the process which begins in the field with the participant.
12. **Final meeting**- The participant is requested to check the birth map before ending the last interaction to see if anything has been left out that they would like to add. She is asked about her satisfaction with the interview process. The co-created birthing story is read by or read out to the participant in their language to take their approval of the information sought.
13. **Picture of body map**- The participant is given an option to take pictures of the map and the birthing story.

6.4.2 Planning the data collection with body mapping

I conducted a scoping study in January 2019 in an urban slum and a rural village in Patna district of Bihar to understand the feasibility of birth mapping. The scoping study also helped to develop a semi-structured guide with the advice of women to aid the exercise. The structure and methods of conducting body mapping have evolved since. I started with a rough outline of a person on a notepad, followed it by a body outline only to show a few things with coloured pens (Figure 6.2). Finally, I conducted to body mapping during the data collection, where I used many other arts-based supplies. Expert consultations with qualitative researchers, midwives and people who have been involved in arts-based methods and storytelling, helped to shape the process. There are very few published studies on how to conduct body maps, which includes a couple of guidelines that have been used to prepare a detailed guide for this study (Gastaldo, 2012).

Figure 6.2 Birth mapping pilot

Research ethics approval- Ethical clearance for arts-based research methods is important and several ethical dimensions need to be thought through and planned for, which includes understanding the sensitivity of the method (Orchard, 2017). It requires many interactions and seeking time from participants. Given this is a participatory method, it needs participant's active involvement where they will be speaking, lying down on the paper for an outline and then participate in showing their birthing story on the map. My study involved recalling sensitive aspects of the birthing experience, so I had information of the nearest counsellor in a public hospital, in case

the participants felt and expressed the need to talk to a counselor or a health care provider about their experience. The ethical clearance was provided by the ethical review board of the University of Southampton (Reference number 49730). The ethical considerations of consent, confidentiality, anonymity have been addressed in the ethics application which is based on the integral principles of autonomy, beneficence and non-maleficence. Participants were requested for written or verbal consent in line with the university ethical clearance. Seven of the eight interviews were audio recorded with consent. I also requested participant's consent to take pictures while maintaining their anonymity. Every picture was shown to the participant before keeping them for the study and ones they did not approve of were deleted in front of the participant. Participants were requested to select a pseudo name which is used to address them in the study.

6.4.3 Birth mapping in Bihar

I conducted the data collection in urban slums and rural villages in Bihar to explore experiences of birthing in different birth settings at different levels of care for women who were socio-economically disadvantaged. The slums were selected in the state capital Patna, which has options for tertiary-level of care in both public and private hospitals. The rural villages are selected in Muzaffarpur district. I selected these districts based on the maternal mortality ratio, which is very high in Patna and moderately high in Muzaffarpur. I hired a female research assistant (note-taker) from Bihar to assist me with the data collection. The research assistant had previous experience of qualitative interviewing and is adept in many of the dialects in Bihar. She worked with me in Bihar on a different initiative for a couple of years.

Women who have given birth in the last 5 years in Bihar are included in the study. We visited urban slums in Patna and rural villages in Maraul block in Muzaffarpur district to recruit participants. We went from door to door to talk to women and seek consent. We planned to interview women regardless of where they have given birth. There were no exclusion criteria. Between two to five interactions were arranged with all the eight participants. All participants provided their consent and shared background information in the first interaction and we initiated the birth mapping exercise. In two cases, women gave us another appointment to begin working on the map with them. The last interaction involved clarifying any queries from the interview, taking women's approval of the completed birth map, making any final changes on the map, and reading and finalising the birthing story. The research team spent on average two to six hours with each participant.

We carried large sheets of thick white paper, 7 feet long and 3.5 feet wide. We carried coloured sketch pens, markers, crayons, and cut outs of facial expressions, small miniature cut outs of people, children, fetus and care providers, medical equipment, cut-outs of injections, intravenous fluids, weighing machine and blood transfusions. We carried the sheets in a large poster carrier tube (Figure 6.3).

Figure 6.3 Birthing mapping in action

(Included with ethical clearance and women's consent)

We maintained the privacy of the women at all times. We conducted the exercise in their bedroom on a wooden plank, on the floor of a storage area, on the roof top and in the backyard of a mud house. Women from the neighbourhood and female family members would often visit to see what we are doing. We explained our purpose and requested for privacy. We often engaged in discussions not relevant to the study, because the women wanted to talk. We told participants about our role, research and about our background with people. In two interviews, the mother-in-law had interrupted the interaction a few times, but we made sure to not work on the map or ask interview questions to the participant when we were interrupted. Every participant selected a pseudonym for herself to put on the birth map and to be addressed as in the study. None of the pictures taken showed the participant's faces and all were approved by them. Audio recordings were made in seven of the eight interviews with participant's consent. Detailed notes were taken in all the interviews.

6.4.4 Methodological challenges

We experienced many challenges over the course of data collection. We faced a high refusal rate to participate in the study because birth mapping is time consuming. Refusal to participate was higher in the rural areas. In one village every woman we approached refused to participate. This was a small village where we reached out to 12 households. Some of these women did not refuse initially, gave consent and asked us to come back another day. In our next visit we realised they did not want to participate but could not say no to us, expecting that we will not return. On our subsequent visit we would wait for them to talk to us for hours when they would do their household work after giving us an appointment. Women often did not say no to us but rather ignored us while we tried to talk to them. Often the elders of the family such as mother-in-law would tell us to go away. Often women who would want to talk to us but could not because their husband or elders in the family did not approve. This was a pattern which we understood after a series of experiences over a few days.

The cooperation of the family was important. Before interviewing one participant, we sat outside the house with the mother-in-law who invited us to tell her more about our work. Women we interviewed had one to four children and aged less than ten-year-old. In nuclear families, it was difficult for them to stay with us for long stretches of time and they would often tend to their children's needs mid-interview while we paused the recorder and waited. We helped to mind the children when possible. Children would often appear in the area of interview because we were working with colours and cut-outs, which made them curious. We gave away colours and paper to keep them busy. One little boy tried to tear away the map with a nail and tried to prick us with the nail too, he was taken away by an elder in the family.

Most households had pets and rodents. In Ria's household we had to enter the room crossing a very tiny room which was an urban cowshed, with two cows. In two houses, Urmila and Sita, there were rats that would come out of holes on the ground or the walls and twice I had to lie down on the sheet to demonstrate while the rat was very close. I am scared of rats. This data collection tested many of my fears but it helped to win the participant's trust. There were goats in Amrita's household, which were taken outside while we did the exercise in the goat-shed after cleaning the goat faeces. Pratima has two rabbits, who appear in her birth map as well. She took the rabbits to the roof when they started chewing the map. Husbands were in the house in a few cases, but they usually did not interrupt, except one who kept calling his wife and asking how long it will take us, while Amrita kept confirming that it's fine for us to talk to her. It was a rare experience for the participant to talk to someone and she wanted to talk to us as she said *'no one ever comes to meet me'*.

Finding space to spread the sheet and work around it was challenging. The participants were very helpful in making space. It was difficult to encourage them to participate as well because seven out of the eight participants were not used to holding a pen, and were concerned they would not be able to do a good job. They were not used to writing or drawing, but over the course of interactions they became comfortable and participated actively. They also opened up more in latter interactions as trust developed and they realised we ourselves did not have any artistic abilities, but found the process easier and more engaging as it unfolded.

Women found very little time for themselves away from their domestic chores and outside work, which stretched our working hours. We often conducted interviews in the evening and late night, or started before 6 am to get an hour with the participant before their day's work began. We made sure to make ourselves available at all hours whenever they gave us time. We had a day of thorough disinfection after we realised one of our participants, whom we came in close contact with while creating the birth map, complained of lice infestation. The research assistant's role in the exercise was challenging and unpredictable. She participated in taking reflexive notes and notes on interview environment, provided the resources to prepare the map and also helped in minding the children and at times engaged in conversations with the participant's family so that they would not interrupt the participant and 'allow her' to continue talking to us. This was often requested by the participant herself.

Work was done also when we were back in our hotel, which included getting more cut-outs that we would need in the ongoing exercise. We accomplished some of the colouring work for the last interaction and with permission from the participant when we filled in the skin colour, or other parts. The participants selected the colours that we started filling in her presence at her home. We also worked on the birthing story after listening and re-listening to the audio recordings of the interviews, many of which were indicated to be important aspects of the story by the participants.

The birth maps have many cut-outs pasted on them which were fixed with adhesive tape. This made the maps very heavy. The maps are scanned in live size and then printed on white cloth in their true size to make it easier to carry and display, because the paper-based maps are prone to wear and tear. These cloth maps are very good for dissemination.

6.4.5 Data analysis

Phenomenological constructs of different theorists were employed to understand and present how women attribute meaning to respect, disrespect and abuse from their experience of childbirth. Van Manen's work on existentialism that draws on lived time, lived body, lived space and lived

relationships helped to explore how women experience birthing. This has been used in the context of childbirth in previous studies (Thomson, 2011). I further explored the concepts of unpleasant sight, unpleasant sound, unpleasant feel, unpleasant touch and unpleasant taste which were also introduced by Van Manen. These concepts are important to explore, given the challenges discussed by other researchers with regard to language barriers when it comes to understanding childbirth through women's experience.

Critical feminist theory includes the constructs from critical theory and feminist theory (Keedle et al., 2009) as elaborated in Chapter 4. Feminist phenomenology can be defined as a critical phenomenology since it enables understanding of human experiences such as childbirth, which is embodied, inter-subjective, and contingent, and woven into personal and cultural webs of signification and are influenced by imbalances in power. Experiences of childbirth also vary based on culture and context. This method helps to interpret women's experiences from the perspective of imbalance of power and position in their community in a critical perspective (Simms & Stawarska, 2013). There are studies that report that the issue of disrespect and abuse during childbirth can be attributed to gender and gender-based subordination. This is seen in Bihar as well, as described in Chapter 3. Since childbirth is influenced by power imbalances in the society attributing to a person's gender, and the lived experience narrates about '*women's subordination in the society',* feminist theory provides a lens for analysis.

I analysed the data using embodied feminist methods (Chadwick, 2017). My data include audio recordings of the interviews, the transcripts with reflexive notes and the body maps along with their summaries. I used feminist relational discourse analysis to analyse the data, which is divided into two key domains of post-structuralist discourse analysis (steps 1-6) and emergent voices in relation to discourses (steps 7-10) (Thomson, Rickett & Day, 2018). FRDA guides analysis through a seven step process (Figure 6.4): 1) reading the transcripts and listening to the audio recordings; 2) 'chunking' the talk into sections; 3) labelling the chunks of talk with descriptive codes; 4) identifying recurrent codes or themes; 5) identifying discourses; 6) identifying discursive patterns; 5) filtering out the I-voice; 6) listening to the recording for reflexivity; 7) multiple listening; 8) generating the I-poems; 9) listening for contrapuntal voices; and 10) putting the personal in the political. I created memos and annotations throughout the analysis. This analysis method does not guide how to analyse the birth maps and birthing stories. I therefore adapted the method to add two more steps into the process: 11) applying the themes and codes to the births maps, 12) arranging the I-poems against the birth maps and birthing stories. This is a multilayered non-linear embodied analysis that ensures that the participant's voice takes dominance in the analysis, over the researcher's

interpretation (Frost, 2008; Chadwick, 2017). The detailed codes included in-vivo, process, emotion, values, attribute, provisional, causation, simultaneous and sub-coding.

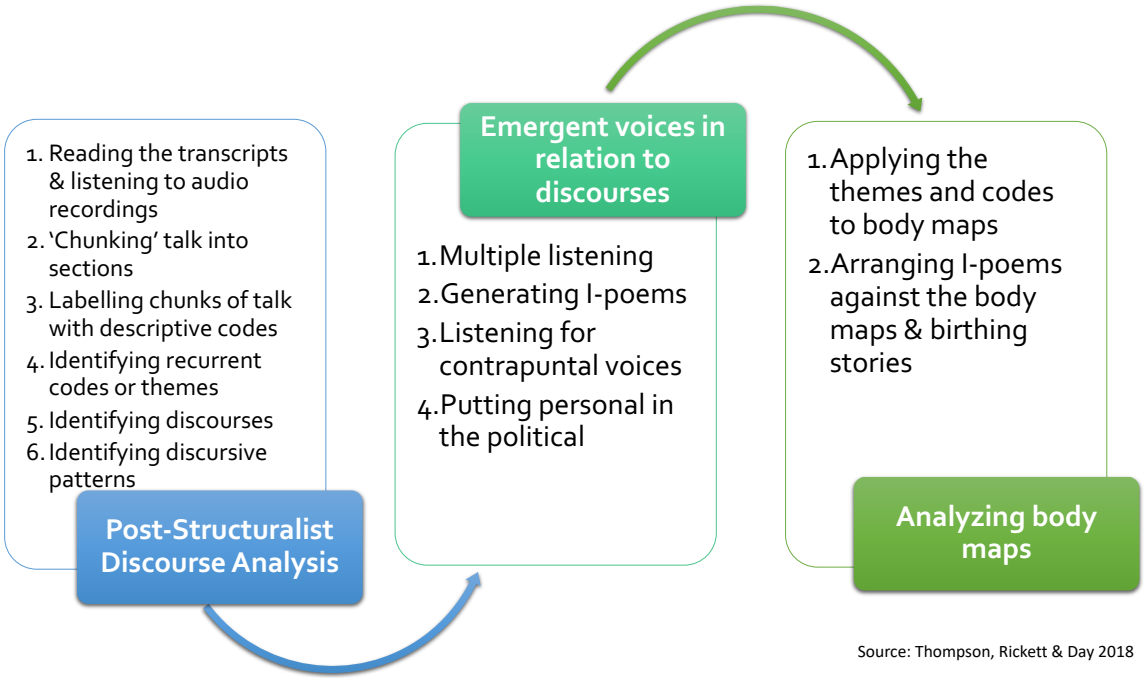

Figure 6.4 Feminist relational discourse analysis

(*Adapted from Thompson, Rickett & Day, 2018)*

Voice-centred relational analysis amplifies 'voices of the silenced by dominant cultural frameworks' especially in the context that involves experiencing stigma and shame (Sorsoli & Tolman 2008), including childbirth. Poetic enquiry allows the reader to deeply immerse in the participant's journey and experiences through the I-poems which are very emotive and telling (McKenzie, 2021). This could mean looking into their private and public experiences, where childbirth is a private experience made public. Previous studies have used it to understand women's experience with maternal health care, to explore maternal depression and women's decision to freebirth, which makes it an appropriate analytic choice for this study (Montgomery, 2012; Edwards & Wellers, 2012; Fontein-Kuipers, 2018; McKenzie, 2021). The listening guide is structured to enable: 1) listening for the plot; 2) listening for the voice of 'I' which involves tracing out and arranging participant's reference to self in first person starting with 'I', scattered throughout the transcript; 3) listening for contrapuntal voices and relationships which enables the researcher to understand the complex multiple, and often overlapping voices that exist within the same sentence or section of the narrative; and 4) listening for broader social, political and cultural structures that help to thaw out the larger discourses influencing the women's conceptions of their positionality, linking their narratives to socio cultural factors. The process includes the generation of 'I-poems' which captures

their actual voices. In our study the participant's references to 'I' were supplemented by references to 'my' and 'me' on a few occasions, to ensure more detail and depth in the narrative and for a richer understanding of the context. There are other pronoun poems that researchers have used to add to present a different perspective and another angle (Chadwick 2017). There are different ways of creating and constructing the I-poems, I focus on creating the 'full' poems to allow some context into the poems and add more depth to the narrative. Parts of the texts are bold, based on my subjectivity to emphasise certain aspects of the poem.

6.4.6 Positionality and reflexivity

It is essential for me as the researcher to be in a '*reflexive engagement'* with my own assumptions and knowledge. I sought help from Prof. Gill Thomson at University of Central Lancashire to conduct a pre-understanding interview with me before I started data collection. It helped me to understand and identify my 'fore having[5]', 'fore sight[6]' and 'fore conception[7]'.

"I don't think I went through an abusive birth. I knew about the doctor who was going to deliver you. I had heard that he doesn't like when women scream during childbirth. I was in my best behavior. With every pain that I clenched my teeth and didn't make a sound. So it all went very well. I did not get scolded at all because I did not give anyone a chance to scold me." – My mother

This is my mother's narration of my birth that I have included with her consent. I remember saying that she should have screamed if she wanted to scream. It was a respectful birth from my mother's perspective, because she was treated well. But it was not a positive birthing experience, in my view.

As a student nurse-midwife, I witnessed many examples of obstetric violence during childbirth, most of which was normalised to an extent that went unnoticed by the care providers and were not reported by the women who were abused. In my third year as a student midwife, I provided care for a woman who was supposed to undergo a vaginal examination. There was an area with curtains and a labour table. I accompanied her where the doctor would do the examination. There were three more people in attendance, including staff nurses and a peon who even after I mentioned there are too many people. The doctor wore a glove in one hand, lifted the woman's petticoat and saree without any explanation and said, "*how does your husband want to do anything with you, with the jungle you have grown there?"*. Everyone started laughing and I froze not knowing what to do. The

[5] Fore having- my familiarity and background to the study.
[6] Fore sight- my perspective which is influenced by my background.
[7] Fore conception- what I feel I am going to find.

woman did not say a word but just covered her face with the *pallu*[8] of her *saree.* It almost felt as if she expected to be abused. The staff nurse looked at me and said, "*the doctor is just joking!"*. The doctor was just joking. I reported the incident to the nurse-in-charge in the labour room and also to my supervisor. They could, at best, advise me to never practice what I witnessed.

Over the next couple of years I saw women being slapped on their face, on their thighs, pinched on their thighs with artery forceps, pulled down by her hair, left naked on the labour tables without curtains or clothes, given episiotomy without anesthesia, fundal pressure, subjected to multiple vaginal examinations (as a result of birthing in a teaching hospital), screamed at, commented on (based on their age or number of children or physical appearance or level of education) by care providers. "*What's the point of screaming now, didn't you think about this pain when you laid with your husband?",* was a common comment which I later heard being said to women in many other states. Privacy and confidentiality were not maintained. I identified many examples of women not being respected by hospital staff. For instance, not giving women all the information, calling women by their bed number or the colour of their *saree,* not introducing themselves to women and not encouraging women to ask questions or answer questions women have. Many of these examples of obstetric violence, I continue to realise as I read more literature on the subject.

6.5 Findings

The eight women who were interviewed, focused on any one birth experience of their choice, in detail, to present on their birth map. In total, they had 20 live births (10 each from urban and rural) and two stillbirths, at different levels of government hospital, at private hospitals and at home. Women shared their experience and perceptions of respect, disrespect and abuse during vaginal and cesarean birth. More information about the participants is provided in Table 6.1.

[8] Pallu is a part of saree that hangs from shoulder when worn.

Table 6.1 Participants Profile

Pseudonym	**Age (Years)**	**Education**	**Occupation**	**Age at childbirth(s) (in years)**	**Birth settings**
Urmila	25	6th standard	Home-maker	19, 21 & 23	Same private hospital for each birth
Ria	32	12th standard	Cleaner & milk seller	26	Birth in tertiary public hospital
Sujata	28	12th standard	Home-maker	23, 25, 27 & 28	One birth in a private hospital, the other three in different public hospitals
Pratima	19	5th standard	Home-maker	15 & 19	One birth in a private hospital and one home birth
Amrita	22	No formal education	Manages a grocery shop	18 & 20	Two births in different primary public hospitals
Sita	22	8th standard	Home-maker	19, 20, 22	Three births in different public hospitals at primary & secondary levels
Anju	25	No formal education	Farm labourer	20, 21, 22, 23 & 25	Births in government hospitals twice, home birth thrice
Pairo	29	MA, B.Ed, BA	Teacher	25 & 28	Births in different private hospitals

Participants did not use words such as *"samman"* or *"izzat"* that are literary terms used in reference to 'respect' and 'dignity' in *Hindi*. The vocabulary they used was colloquial. They conveyed their feelings through simpler words, such as *acchcha* (good) and *bura* (bad) which are more conversational. They communicated through facial expressions and by saying whether a particular experience made them feel angry, afraid, shy, ashamed, regretful, let down, happy or exhilarated. Women described experiences detailing the birth place, interventions, birthing environment, people

around birth, being touched during birth and communication and about their decision-making in all of these areas. They shared their experiences of giving birth, how their birthing experiences influenced their subsequent births, and the impact one birthing experience had on another in terms of perception and expectation of respect, disrespect and abuse. They explained what they meant by a 'good birth,' which also influenced decision-making during childbirth, their expectations of future births and the birthing experiences and expectations of women around them.

6.5.1 *'Good'* births, *'Bad'* births and expected births

Women were requested to choose one of their birthing experiences (in case of a multigravida) to show on the birthing body map. Ria was the only primi-gravida participant. Amrita, Pairo, Sujata and Urmila chose to narrate their most traumatic birthing story on the map. Pratima, Sita and Anju chose to narrate their good birthing experiences. Women were suggested to rank their birthing experiences to help them choose which birth to create on the map. This helped women to understand what according to them is a *'good birth'* or a *'bad birth'.* A good outcome in their perception was part of a good birthing experience. They reported the birth of a son as a good outcome. This is an indication of son preference, reflecting the patriarchal societal structure, as can be seen in Amrita's birthing body map (Figure 6.14).

"The boy! I felt better when I had the boy because I had good pain and took very less time. My girl's birth was very painful for me. I had so much problem. I would like to show the girl's birth on the map." (Amrita)

Women's understanding of an ideal birth was expressed in parts, throughout the multiple interactions, to the extent where births which were considered *'better'* became *'bad'.* As the trust developed over the interactions, they opened up more. The expected birth was asked in terms of respectfulness, apart from experienced birth, as compiled in Table 6.2.

Table 6.2 Women's understanding of good, bad and expected birth

Participant (live births)	Experienced birth		Expected birth
	Good birth	Bad birth	
Amrita (2)	-short duration of labour	-too painful -neglect and abandonment -verbal abuse discriminated against on the basis of sex of newborn	-no touching -proper communication -timely examination -no delay in care -polite care provider, serve with a smile -a bed -care provider should treat as family member -non discriminatory care regardless of newborns sex -availability of hospital supplies -no disrespect -no extortion -not more than two people around her during childbirth -incentive for institutional birth
Pairo (2)	-better prepared from experience -lower expectation than previous birth	-too many vaginal examinations by different care providers without maintaining privacy or seeking consent - extortion -blindfolded -inhumane treatment -many men around in the birthing room (OT)	-vaginal (normal) birth -comforting touch -no vaginal examinations -seek consent before touching -explanation and consent before interventions -birth companion in OT

Participant (live births)	Experienced birth		Expected birth
	Good birth	Bad birth	
Pratima (2)	-home birth -better neonatal outcome -respectful communication in hospital birth	-private hospital birth -unaffordable care -journey to hospital to give birth, travel along a bumpy road -unexplained, unconsented augmentation	-home birth -no vaginal examination
Sita (3)	-clean toilet -quick ambulance	-swelling of legs and arms -difficulty walking -unconsented and forced vaginal examination -restrained, physical abuse	-no touching -verbal abuse (hoped it won't happen) -no delay in care -no complications -respectful communication -birth companion of choice -food to be provided at hospital -clean bed, birthing room and bathroom -birth in the hospital - incentive for institutional birth
Ria (1)	-comforting touch from another birthing woman's companion -affordable care	-verbal abuse -shouted at -uterine prolapse repair without anesthesia -Baby declared dead by *dais* without newborn assessment	-no physical abuse -comforting touch -birth companion of choice -extortion, but hoped it won't happen -1:1 care -one bed, one room -curtains for privacy

Participant (live births)	Experienced birth		Expected birth
	Good birth	Bad birth	
			-respectful behaviour from care providers -care providers should introduce themselves -baby should be received with care and assessed properly after birth -proper light & ventilation
Sujata (4)	-presence of '*guardian'* though not of choice -care providers followed her beliefs (norms) after insisting -care providers did not do vaginal examination after refusal	-extreme pain -forgotten to remove gauge piece before episiotomy repair -extortion -unexplained and unconsented vaginal examination, episiotomy, episiotomy repair, uterine exploration and augmentation -no anesthesia before episiotomy repair	-husband's presence as a birth companion -no episiotomy -birthing woman's norms and beliefs to be followed
Urmila (3)	-no medicine -no vaginal examination -less pain -quick delivery -privacy protected	-shouted at, verbally abused -unconsented, unexplained vaginal examination, episiotomy, episiotomy repair, augmentation	-no cut -little pain -no stitching without anesthesia -no unnecessary touching -seek permission before touching and interventions

Participant (live births)	Experienced birth		Expected birth
	Good birth	Bad birth	
		-restrained, physically abused -detention of newborn -extortion	-respectful behaviour from care providers -come home alive after birth -no birth companion
Anju (3)	-home birth -three live births -same *dagarin*	-hospital -two stillbirths	-home births -continuity of care across all births

Disrespectful and abusive births

Women referred to various kinds of disrespectful and abusive encounters with the health and non-health care providers during their stay at the hospital. They reported hearing similar experiences from their friends, family members and women in the neighbourhood who often made similar choices of birth place. Stories of respect, disrespect and abuse were considered when giving birth again, and these stories symbolised desired behaviours, self-discipline and ways to avoid being violated, humiliated and have as close to a dignified birthing experience as possible. Women often said that they discussed obstetric violence in a hushed manner amongst peers when someone is due to give birth. These stories were not shared with authorities as a grievance, not even with senior members of the family including their husband, with whom the conversations about birth were rare. All the participants had experienced obstetric violence during childbirth.

Verbal abuse was the most common form of violence experienced. Some care provider's comments were so disgusting that women refused to repeat their words.

"Two sisters (nurses) *were very bad because they were abusing me and shouting at me like anything, I can't even tell you the things they said to me."* (Urmila)

"The doctor inserted her fingers inside me and I screamed very loudly. She said, 'Pairo has no pain threshold, she can never have a normal birth!'" (Pairo)

"She said, 'Shut up! Why are you screaming so much?'… 'behave! Look how you are screaming!'" (Ria)

Incidents of physical abuse were mentioned. Women did not perceive restraining as abuse. They reported that it is common and they considered it as a bad touch, but a part of quality care. Women disliked being held down, but were hesitant to say that because often their family members were the ones restraining them. Episiotomy repair without anaesthesia is a common kind of physical abuse that women (Ria, Urmila, Sujata) have experienced, but they considered that a part of care during childbirth as well. Every woman was touched without consent. They reported feeling *'uncomfortable'* and *'ashamed'* but could not say this to the people around them.

"They do hit women in that condition… A woman had come, she was screaming so much from the pain that she could not stay in her bed. The sister (nurse) *gave her two tight slaps across her face."* (Ria)

"People don't like being touched, but everyone has to go through it!" (Sita)

Women did not speak about experiencing sexual abuse, but the narration and non-verbal communications conveyed otherwise. One of the participants referred to comments with sexual connotation as '*colourful things'* while also sharing how uncomfortable it made her feel, but she believed that everyone had to endure.

"The doctor said 'you are not scared of other things, of doing it, but you are scared of injections!' Many people abuse like that. They said 'if you are so afraid then why did you conceive? When the baby had stayed, you should have taken the pill to get rid of it! What's the need of having children then?'" (Ria)

Extortion is the commonest form of abuse that was mentioned by every participant, except Anju. It has become a tradition for care providers to ask for *'khushi ke paise'* (happiness money), that also determines respectfulness and quality of care based on a care seeker's affordability to tip them. Money is sought as soon as the baby is born. The care providers do not miss an opportunity to demand money, as they do not know when the family might leave the hospital. Participants have reported that all types of health (doctors, nurses) and non-health care providers (ASHA, *Mamta*, cleaner, *dagarin/ dai*) ask for money although how the money is divided between the team could not be ascertained. They demand money, for everyone in the hospital, regardless of how many people were involved in care.

"Happiness money! She said 'your grand-daughter is like Goddess Lakshmi' then everyone asked for money. My husband gave 100-150 rupees to everyone. There were 11-12 people there… Happily!?

Some people give it happily but they have made a habit out of it. People who can't afford, they ask them too. That is greed!" (Pairo)

"My husband does garbage work (rag-picker)… *he lost his job and we have 300 rupees. Should we go to hospital or take care of the house! We had no money to go to hospital in the second birth… everyone had taken 100 rupees last time in the name of happiness, there were nine people."* (Pratima)

A participant mentioned that she had to bribe the New-born Intensive Care Unit (NICU) staff every time or they didn't let her visit her new-born daughter. This was traumatic for her. A similar experience was reported by Urmila, which led to her baby's detention in the private hospital until they paid extra, over the hospital fees. The baby was kept for hours until the care providers received the *'happiness money'*.

"There were two bad sisters (nurses)*. My father gave them 1000 rupees but they were not happy. They told us that other people give them gold earrings and necklace. My father was not giving them money so they kept the baby for two hours and when my father finally gave more money the sisters* (nurses) *handed over our baby to us."* (Urmila)

"Some guardians can not pay as much as the doctors ask for. The nurses detain the baby saying 'we want this much or we won't give the baby'. Many people don't have enough money to free the baby from them. Sometimes it turns into conflicts." (Sujata)

Unconsented procedures showed a failure to meet professional standards and there are many instances showing poor rapport between care providers and women, which includes a lack of explanation, detention and treating women as passive participants (as shown in Pairo's experience in Figure 6.11).

"The doctor said, I only went to bed at 1 am and you people started calling me. Stop this chaos! Go away! I will come in the morning" (Amrita)

The accounts of obstetric violence based on the findings reported by eight participants, are shown (Table 6.3) against an updated typology of mistreatment during childbirth by Bohren et al. (2015).

Table 6.3 Women's experience against Bohren et.al's adapted categories of mistreatment during childbirth

3rd Order Themes	2nd order themes	1st order themes	Women's experience
Physical abuse	Use of force	Women beaten, slapped, kicked or pinched during delivery	✓
	Physical restraint	Women physically restrained to the bed or gagged during delivery	✓
Sexual abuse	Sexual abuse	Sexual abuse	✓
		Rape	✓
Verbal abuse	Harsh language	Harsh or rude language	✓
		Judgemental or accusatory comments	✓
	Threats or blaming	Threats of withholding treatment or poor outcomes	✓
		Blaming for poor outcomes	✓
Stigma and discrimination	Discrimination based on socio-demographic characteristics	Discrimination based on ethnicity / race / religion	✓
		*Discrimination based on gender	✓
		Discrimination based on age	✓
		Discrimination based on socioeconomic status	✓
		Discrimination based on parity	✓
		Discrimination based on other obstetric factors (Example- previous neonatal death)	✓
	Discrimination based on medical conditions	Discrimination based on HIV status	✓
		Discrimination based on disability	✓
		Lack of informed consent process	✓

3rd Order Themes	**2nd order themes**	**1st order themes**	**Women's experience**
Failure to meet professional standards of care	Lack of informed consent & confidentiality	Breaches of confidentiality	✓
	Physical examinations & procedures	Painful (and *forced) vaginal examinations	✓
		Refusal to provide pain relief and *anaesthesia	✓
		Performance of unconsented surgical operations	✓
	Neglect & abandonment	Neglect, abandonments or long delays	✓
		Skilled attendant absent at time of delivery	✓
Poor rapport between women and providers	Ineffective communication	Poor communication	✓
		Dismissal of women's concerns	✓
		Language & interpretation issues	✓
		Poor staff attitudes	✓
	Lack of supportive care	Lack of supportive care from health workers	✓
		Denial or lack of health companions	✓
	Loss of autonomy	Women treated as passive participants during childbirth	✓
		Denial of food, fluids or mobility	✓
		Lack of respect for women's preferred birth positions	✓
		Denial of safe traditional practices	✓
		Objectification of women	✓
		Detainment in facilities	✓
	Lack of resources	Physical condition of facilities	✓

3rd Order Themes	2nd order themes	1st order themes	Women's experience
Health system conditions & constraints		Staffing constraints	✓
		Staffing shortages	✓
		Supply constraints	✓
		Lack of privacy	✓
	Lack of policies	Lack of redress	✓
	Facility culture	Unclear fee structure	✓
		Unreasonable requests of women by health workers	✓
		Bribery and extortion	✓

The hybrid birth map- The hybrid birth map conveys what could be the worst or best experience for a woman collectively, from the experiences of all the women interviewed from the researcher's perspective based on women's narratives. I placed the maps together and analysed women's experience on different parts of their body for the worst experience to emerge from the participant's collective experience, although this is a subjective process. All the worst experience on the body separately, such as on the hands, legs, head, chest, waist and genital area, are put together to create a hybrid birthing body portraying the collective worst experience that women can go through during childbirth in Bihar (Figure 6.5). The birthing environment is an essential part of women's birthing experience which was analysed to add to the environment of the hybrid map.

Figure 6.5 The hybrid map of the worst experience from the eight body maps

Respectful Birth

Women often just said they '*felt good*' about aspects of birth when they talked about respectful birth. But as stated before, better birth did not always mean a good and respectful birth. Women shared their expectations that could make their births respectful. Amrita had visited a tertiary level hospital in a different state for a few antenatal visits before moving back to Bihar to give birth. She talked about the cleanliness and good behavior of the hospital staff there, comparing with her birthing experiences. Getting a clean ambulance to go to the hospital on time was the only positive aspect from her experience. She expected cleanliness in the entire hospital. She has a very clear vision of what respectful care means to her.

"Care should be like, when I told them what problem I have, they should come and check me completely and tell me about my condition, that in how much time I will deliver. I will feel respectful when they will do my delivery on time without delay, when they will speak with me politely with a smile. When they will take care of me nicely. If they gave us a bed. Things should go well. They should treat us like family members. No matter whether I am birthing a boy or a girl, I should be treated well. If they talk to me nicely, then only I will come here… no matter whether it is the nurse, doctor or dai. They should give immunization, injection, medicines and other supplies from hospital if it is available. If it is not available, they should bring it from outside and give us. Then only we will share our good experience with other women in the neighbourhood that we are not disrespected there and people are not greedy. What's the point of going there otherwise!" (Amrita)

A touch that felt good was mentioned as a calming and rarely experienced aspect of birth. Pairo was relieved to have been given birth pain-free. After having a traumatic birth experience (Figure 6.11), it was difficult for her to go through another cesarean even though she had changed the hospital and the doctor. Memories of her first birth experience caused severe anxiety when she was lying on the operation table, blindfolded, and she got support from a stranger who held her hand and helped her calm down. Ria has a similar story of her vaginal birth in a public tertiary hospital when she was surrounded by five other women in labour, without any privacy (Figure 6.9). Both of them did not have the support from family when they were giving birth, but were supported by a stranger, which was the best aspect of their experience. For Pairo, it was the *'stem-cell-guy'* and for Ria it was the birth companion of another woman birthing next to her. Cord blood banking is available in most private hospitals in India, which explains the presence of this person in the OT whom Pairo referred to as the '*stem-cell-guy'*.

"There were many people in the OT and I had the stem cell guy in the OT with me. He held my hand. I knew I was going to be operated so I went completely numb in my heart. It was hurting like

an injection due to fear. I told him to press tightly on my heart, on my chest. He offered water but I refused to drink… 'just press tightly here' and he did so. (laughs) *No one will tell anyone like this but I was blindfolded and I didn't even know who he was. I didn't see his face. After sometime he asked 'are you okay?', I said 'yes'… I felt like he is my own, someone familiar."* (Pairo)

"I wanted only two people around me, a nurse and a doctor. The people who give medicine and injection should remain and the others should not be there." (Amrita)

The absence of bad behavior including what they consider bad touch, was also expected. Pairo recalled no vaginal examinations being a relief in her second birth. Good behavior could be seen in usual and unusual forms.

"She (doctor) was very nice because she also started praying with us (for the baby). *She was an innocent nice lady. She was so good. I felt good because those were good people, doing good things and taking care of me nicely. We were happy!"* (Pratima)

The place of birth matters as well. Pratima felt that she was most respected at home when compared to her previous birth in a private hospital. Ria perceived that women are abused in government hospital because they have not paid. In private hospital one pays for the services, so can expect to be treated with respect. This also was related to workload in the government hospital. Having family members may also ensure respectful care and if not, one at least felt supported with family's presence.

"In government, they do one work, then leave that and go to do another, then leave that too. They are constantly juggling between you and other patients. They only come when the baby is coming out. But in the private hospital they will stand next to you from the beginning until the end. The more money you give, the more convenience you get." (Ria)

Participants often changed birth places after a traumatic birthing experience. In many cases that was not an option. Anju gave birth at home three times after two still births at the hospital and she is convinced that home is where her babies survived, which would not have happened in a hospital. Sujata, Pairo and Sita changed hospitals as well. Pratima had a hospital birth which wasn't very bad in her opinion, but affordability was a challenge for her and home birth was light on the pocket.

"Obviously I will be most respectfully treated at home during birth! You get good care at home. If you give birth at home, then it is home only. There is no need to go anywhere else. Did not have to reserve a vehicle. There is no need to go running around, arranging things. Everything happens at

home. The roads have potholes, its bumpy, which is one of the reasons of discomfort while travelling to the hospital. That's why I got my birth done at home." (Pratima)

Receiving timely attention from the care providers was mentioned by Amrita and Sita. This was a cause of worry for most participants who gave birth in a hospital, and experienced neglect and abandonment. Apart from good behavior, there were many birthing environment-related aspects that Sita thought would be respectful to the birthing women.

"They should do delivery quickly without much delay, I mean on time. There should not be any problem or complication. They should talk nicely with everyone. Meals should be given in the hospital. Bathroom should be clean, room should be clean, bed should be clean. If you are alone, you will be scared. No body should touch. I do not want to be touched by anyone. There should be someone with you, it's important." (Sita)

Birth companions are considered important, although the husband is not considered a birth companion. Husbands are usually kept away, as it is deemed inappropriate culturally for men to be around birth. Birth companion or *'guardian'* could ensure they get respectful care because their presence will mean the care providers will get money after the birth, which will ensure they treat the women better. Women from the family accompany a birthing woman, though they are not allowed in the OT, as was seen for Pairo. The presence of husband is debatable and is mostly frowned upon. As mentioned by Pratima and Sita who felt there was no need for her husband to be there. Box 6.19 has Amrita's I-poem on her feelings about having her husband around while giving birth, and expressing that she feels she had to go through painful births because of him. Anju's husband played a key role in all her births as the only person around, other than the *dagarin.* He was also the one to catch the baby in her first home birth, though he waited outside in the two following births. Urmila's husband was in prison one time and not around her during rest of her births and Ria's husband abandoned her after she got pregnant. Sujata's husband had to wait outside the birthing room in all of her four births and that is one aspect of her birth she wanted to change.

"The benefit would be that when I was crying out of pain, I could have held my husband's hand. I could have shared my pain with him and that would be good for me (laughs)*. He may not have felt anything, but I would have felt everything. It was all about me, I was in pain so let's focus on how that would have helped me* (laughs) *I would have benefited from my husband's presence for sure. He was outside, waiting to hear about the baby. I wanted him in the room with me. If my husband would have been there, I would have asked him to come near me* (laughs)*… Just the feeling that someone from family is there. But having husband next to you is something different… holding his hand will be more than enough* (laughs) *In this condition husband is needed more. He can also hug*

me. I will be in pain but because of my husband's company, my pain will be less. I will feel relaxed. Being with him will make me happier." (Sujata)

Women want to avoid unnecessary interventions during childbirth and give birth naturally. Some of these interventions are perceived as bad touch to them and they want to give birth where there are *'no cuts, no checks'* because episiotomy, repair and vaginal examinations are some of the most disrespectful and abusive accounts narrated by participants including unnecessary exposure, that is shameful and traumatic for them. They want their privacy to be maintained at all times. It is important to ensure that their norms and beliefs are valued, as Sujata experienced when she felt the baby is not coming out because the fan needs to be turned off to increase her body heat. The nurse did that for her and Sujata reported that her baby came out quickly after that. When women have to undergo interventions, they want to be told about them and be given enough information to understand the purpose of it.

"They should have explained (about vaginal examination) *to me. Then I would have thought, okay they will do this to me and it is required. So I would have convinced myself to have courage. I would have prepared myself."* (Pairo)

Many of the respondents shared what their 'birthing experience of dreams' would be like, if they had all the resources imaginable, vested to make their birthing experience more respectful and satisfactory. The following quote shows Ria's hopes for her daughter's birth (Figure 6.9), because she does not plan to give birth again.

"There should be only one bed, surrounded by curtains on all sides… here everyone was screaming, here and there, everywhere. There should be a sister (nurse) *who will talk nicely and politely with love. They will guide us what to do saying 'dear this is this and it's a boy or a girl'… I will give birth lying down only, in a separate room. They should be encouraging. I want to be familiar with them* (doctor, nurse). *I would think that someone is there and I will feel less afraid and not panic. Encouraging environment! Everything should be done with love and care, then I will feel happy and satisfied… once the baby is received with care, check the general condition of the baby, assess the baby thoroughly, identify the presence of any problem… provide care. After cleaning the baby, it should be shown to me so I know whether I birthed a son or daughter. The room should be clean, no smells, the floor should be clean. The bed should be such that the head rises up. There should be proper light, ventilation, working air conditioner and running fan specially in hot weather. If television is there that would be better. There should be a bed for my family too in the same room. I should not have to spend so much money, but everything happens as per income. Can't spread*

the legs so much that it goes out of the quilt![9] The poor and needy should get all these facilities in the government hospital." (Ria)

Participants gave birth in a restrained supine position in the hospital and did not have an opinion on an ideal position to give birth in, though Anju gave birth squatting in three of her births at home as shown in her birth map (Figure 6.7). Having the same *dagarin*[10] for all her births was comforting, as she knew her carer and had developed a relationship of trust. Urmila was also cared by a team of health care providers known to her in all three of her births in a private hospital. The birth maps are also analysed in another way that increased understanding of the different ways women birth in Bihar, in one image. For this, I traced all the eight maps leaving out all the other aspects of the maps to focus only on the posture women take or are made to take when they are giving birth at hospital or home and in natural or cesarean birth. The range of birthing positions shows how diverse birthing can be (Figure 6.6).

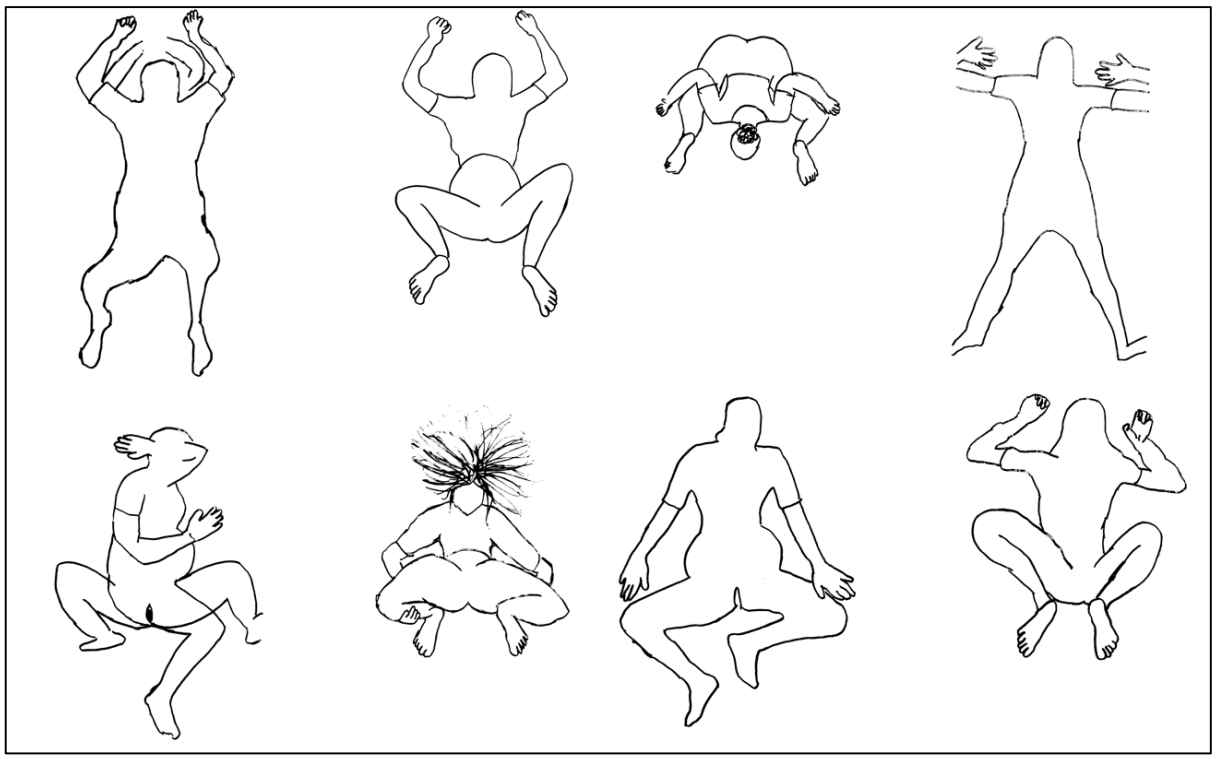

Figure 6.6 Birthing postures of women *(Author's own)*

The final aspect was about the choice of how to give birth, and all women wanted to give birth 'normally'. Pairo spent days crying when she could not give birth vaginally even the second time, because her first birth was cesarean. Even those who did have a vaginal birth reported having,

[9] This is a common Indian saying.
[10] Dagarin is dai or traditional birth attendant.

what they called, a 'mini-operation' (episiotomy) which was the most traumatic aspect of their birth, as Urmila and Ria narrated. Their happiest experiences were intervention free vaginal births, but they felt they did not have the right to make that choice over their own body.

A hybrid body map of the best experiences could be created but that would equate to Anju's original birth map (Figure 6.7) that majorly depicted the birthing position and birthing environment of one participant, Anju, who chose to give birth at home thrice, with the same traditional birth attendant i.e. a *dai* after two still births at hospitals. Anju squatted to give birth every time, taking support from the two bamboo poles, in the presence of her *dai*. A couple of other participants, one of whom felt that quick access to a clean ambulance and the clean toilets in the hospitals, were key aspects of her good birthing experience. In contrast, Pratima, who also gave birth at home with a *dai*, felt the presence of her rabbits during her birth as something she would prefer if she gave birth again.

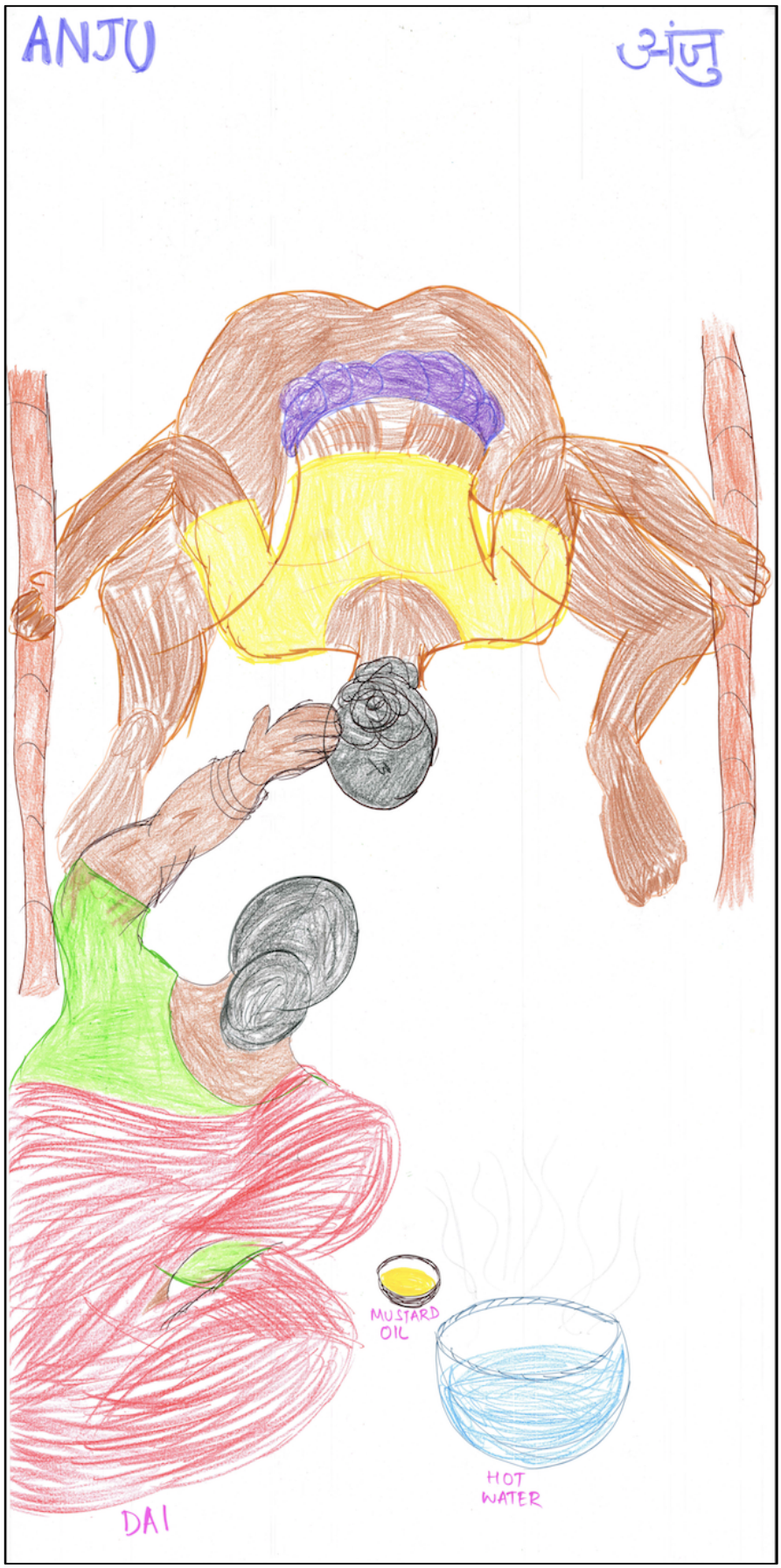

Figure 6.7 Anju's body map showing her home births

6.5.2 Respect, disrespect and abuse during medical interventions

Women experienced a range of medical interventions. All the eight participants gave birth in a hospital at some point. These interventions include getting intravenous fluids (IV), augmentation, episiotomy, episiotomy repair, perineal shaving and vaginal examination. The interventions also include blood transfusion, fetal monitoring and uterine exploration. Cesarean section has also been included as an intervention.

Augmentation and intravenous fluid transfusion- All women were augmented; except one woman who gave birth at home. Most of them were induced without consent and some were induced multiple times. Some of them understood only after realising that suddenly the intensity of their contractions had increased after an injection was added to the *'bottle',* without any communication. Sita wanted to be induced, to avoid vaginal examinations. Women generally reacted to augmentation with annoyance, though one of them felt it was an act of care. It is difficult to say how many of these women were induced on prescription, but it is certain that augmentation in labour is a routine procedure that women are well aware of.

"*My 'dard'* (pain) *increased a lot after the two injections. I did not not ask them to increase my pain"* (Urmila)

"They gave medicine to increase my pain. I did not ask, but she gave it so that the baby will be born quickly as she was watching me all night, I was restless due to pain. She was very nice!" (Pratima)

IV fluids were commonly given to women when they were admitted. Infusing oxytocin in the IV fluid is a common practice. Women understood this and often accepted IV infused oxytocin as part of the care during childbirth.

"*She said mouth* (cervix) *is not open enough and it is leaking water, so it needs to be infused. Otherwise the baby will dry up inside. They ran water day and night. 19 bottles in 3 days!"* (Pairo)

"She hung the bottle of water, added the injection in it and when it finished, the nurse asked me 'how's your pain?', gave me two injections and after that my condition was pathetic and I started crying and screaming loudly." (Sujata)

Episiotomy and repair- Women reported unpleasant and traumatising experiences of episiotomy and repair. None of the women were asked for their permission before the care provider subjected them to an episiotomy. Many were not informed about it before giving *'the cut'* or *'chota operation'* (mini-operation), as it is commonly referred to. Women often said they gave

birth through *'chota-operation'* and not normal / natural / vaginal birth. These experiences are etched in their memory with great detail, even though years have gone by since they gave birth.

"…8 stitches! I know from touching it. When she was stitching me, it was hurting a lot. Whenever the needle would pierce me from one end, I would count when it would turn around and come back again. I could feel all of it! I told them to give me an injection so I'll be unconscious. So many times I told them. But she did not give me the injection. I screamed a lot! She kept saying, 'it's done!'. It was very painful! It was very painful!" (Ria)

Ria gave birth in a tertiary level government hospital in the state capital. Urmila, 23 years old, mother of three, also had a very similar narrative of her episiotomy and repair. She gave birth in a private hospital. Sujata, experienced *'the cut'* in her two initial births in the government hospital. She was scared, anticipating she would be cut in her third childbirth, in a private hospital this time. She was preparing herself mentally, but was relieved when this did not happen.

"… that's why I called it a good birth!" (Sujata)

Pairo shared a story of her distant aunt who had gone through painful episiotomy and repair, which took very long to heal, leaving her in pain for months and unable to sit. She ultimately decided to never have children again.

Vaginal examination and uterine exploration- Women's accounts of vaginal examinations are harrowing and it is an experience every woman has endured multiple times. They called it *'bauaa wala check'.* Every vaginal examination is unpleasant and many are traumatic. A participant would usually know about vaginal examination when the care provider says '*lift your saree'* or would announce *'I am going to check'*. The I-poem in Box 6.1 is a narrative of Pairo's experiences of multiple vaginal examinations by different care providers. One of Sujata's I poems titled *'I am too important! I should not be checked from below'* is another account of an equally disturbing experience of vaginal examinations.

"She said lie down, hold your legs with both hands, I am checking you!... lift your clothes." (Pratima)

"People come in each shift and everyone checks. There was no doctor. Every hour she was checking and saying 'mouth is not open'. (expression of discomfort) *Don't you think it feels bad?... First my mother told me that let her check once. I told her 'no' I am already having a lot of problem with my baby, I don't want these things. But my mother insisted 'how will she know if she doesn't check.'* (Sita)

Women did not always know before experiencing vaginal examination, that it is a procedure. This is a lack of communication. They wondered why they were being treated like that. They were not told what was found in the examination and when there was an explanation it was vague, such as *'there's time!'* or *'it will take time'.*

"I would never have selected the one where they put their hand inside me (if I had a choice)*"* (Pratima)

Box 6.1 Pairo's I-poem- This is the fate of women and women must endure it!

"This is the fate of women and women must endure it!"

I felt very uncomfortable!
I was scared!
I kept shouting.
I complained to the doctor later, "Why is everyone checking me like this?".
I told the doctor why are your people checking me like this.
I complained to the doctor.
I found it out all in the end.
I was finding it very difficult to accept that they should do like that.
I felt very uncomfortable!
I have my own room, men are around, there is a crowd and there are other patients, then they should not check me in front of everyone.
I did not understand when the nurse did it for the first time.
I thought, what was she doing and in front of everyone?
I was wearing a nightie.
I thought what is she doing?
I told this to my mother again and again, after going home that whatever she has done in front of everyone, it was not right.
I used to say her they should not have done that.
I should have been told.
I used to feel very uncomfortable!
I would have thought that okay they will do this to me and it's required.
I would have convinced myself, to have courage.
I would have prepared myself.
I thought what are they doing with me?
I was feeling uncomfortable.
I was not at all supporting that they touch me like this.
I would have never selected the one when they put their hand inside me.

Uterine exploration was also reported being carried out to remove any *'kachra'* (dirt) from the uterus after childbirth or was done to take the foetus out. The difference between uterine exploration from vaginal examination was understood when they specifically mentioned that two fingers were inserted as someone also said *'two phinter'* but they mentioned that the *'whole hand'* was put inside in case of a uterine exploration. Two participants reported this experience and none were informed or consented before it was done by unqualified care providers.

"*She wore a glove and put her whole hand inside me. My pain increased a lot after this."* (Sujata)

6.5.2.1 Pain management

Pain is the common aspect that every participant knew and feared about childbirth. They talked of the extent of pain and how unbearable it was. They described that it was the kind of pain that could lead to death. Contractions were referred to as pain. Women did not tell the family members when they started getting pain, they waited until it got unbearable. They had ways to describe the degree and nature of pain. Sujata shared that the pain before one's water breaks as *'dry pain',* even after the pain is not intense and is infrequent, it is called *'sweet pain'.* To push, was also referred to as *'giving pain'*. They discussed the duration of pain in terms of days and sometimes just hours but the nature of birth was dependent on the kind of pain they had. A good birth may mean the shortest duration and lowest intensity of pain in a particular birth out of all the birthing experiences a woman may have had.

"When I am in pain obviously I will get very angry." (Amrita)

"I was laughing and going to the hospital because I had no pain… I was happy because at least I was birthing without pain (cesarean section)" (Pairo)

"I was in so much pain, I kept on turning all night." (Pratima)

Women's mobility was dependent on the pain. The posture they took during contractions and giving birth often depended on what position made it a little easier to bear the pain. Participants did not mention birthing in a position of choice and often birthed in a supine position in a hospital, as shown in most of the birth maps. They shared that it is supposed to be the best position to give birth because they have been told about that or that the baby may fall if birthed in a different position. This was often not encouraged by the care providers, who did not *'allow'* a position of choice and disciplined women when they reacted to pain by crying or screaming.

"I was in so much pain. I was sitting on the floor. I was lying down before but the pain was increasing so I got down and my mother-in-law was holding my hand and I was crying." (Amrita)

Pain was considered inevitable and women did not ask about pain relief. The language used to converse about pain in the hospital lacks clarity. Women would often ask for the injection for pain, or the care provider would say they have given medicine or injection for pain. This often meant augmentation and not pain relief. Women were often shocked when the care providers increased their pain, without information or consent. Pain was related to many other interventions that the women had not consented to. Giving an episiotomy cut without anesthesia was common with the notion that women would not feel it alongside the painful contractions. Women reported feeling everything, including when they were being sutured without anesthesia. The care providers continued suturing through the pain regardless of women's pleas to stop. Women complained of pain when forced vaginal examinations were conducted, fundal pressure was applied and uterine exploration was conducted. Pain was also often the only question care providers asked women and women asked care providers.

"My pain increased when she gave me the injection." (Sita)

"After the nurse gave me the second pain injection my condition was pathetic. I started crying and screaming loudly. I had too much pain." (Sujata)

"I told her don't put your hand inside because it's hurting but still they continued to do so and didn't listen to me." (Urmila)

Two participants shared they had to lie down to bear the pain and walk when it was less. One participant was keen to have her husband hold her hand, even though he would not understand her pain, but his presence would make it easier to bear the pain.

6.5.3 Birth setting/place related respect, disrespect and abuse

The participants have 22 birthing experiences which included government hospital (10), private hospital (8) and home births (4), including 20 live births and 2 stillbirths. The government hospital births include four at medical college hospitals in the state capital, which are at the tertiary level of care provision and the remaining four are at the primary health centres (PHCs), which are at the primary level of care provision. The women often chose between these three options of birth place in their subsequent births except Urmila, who birthed all her three children in the same private hospital close to her maternal house and Ria, who gave birth once. Women (Sujata, Pratima, Sita, Anju) have changed their birth settings in terms of sector as well. Pratima gave birth at a private hospital the first time and at home the second time. Some women (Pairo, Amrita, Sujata and Sita) changed the place of birth sometimes within the sector. Pairo gave birth twice in

two different private hospitals. Figure 6.8 shows more about birth setting changes where the order of arrows show the order of birth.

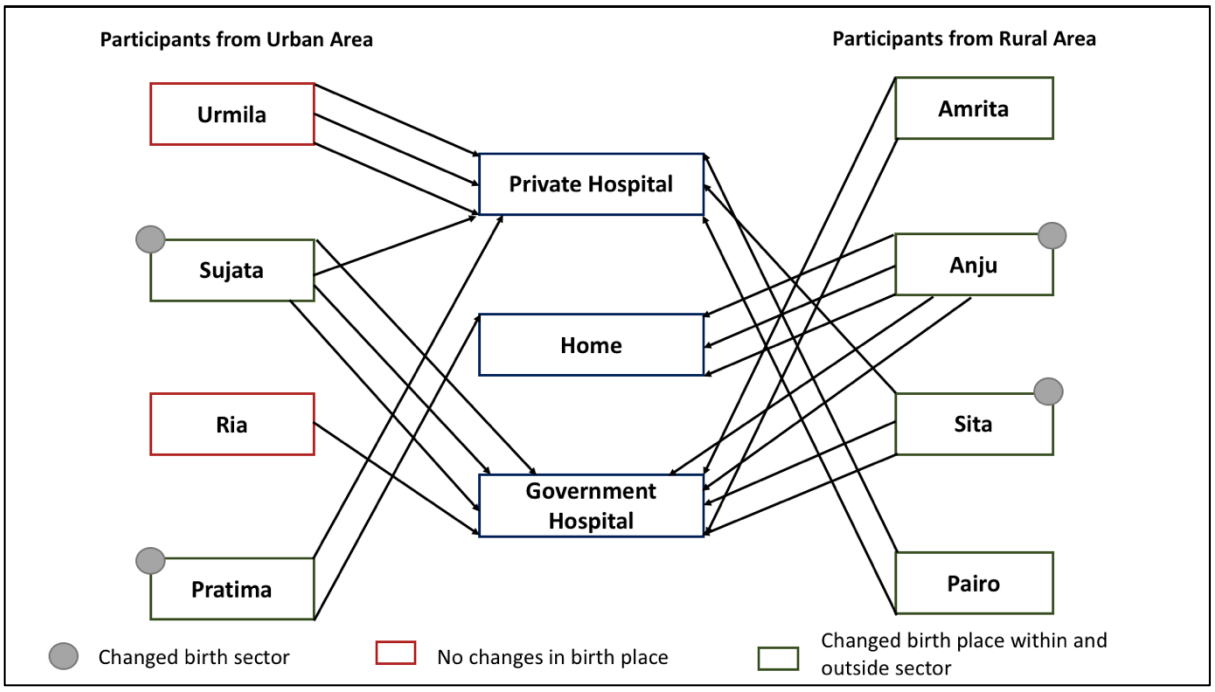

Figure 6.8 Birth place options and changes (*Author's own*)

The places women chose to give birth was not necessarily their nearest access to healthcare, as seen with Pairo, Sujata, Amrita and Sita. The women changed the setting: 1) to give birth closer to the maternal home, 2) avoid high fees at private hospitals, 3) avoid cesarean section, 4) provision of a higher facility for better services such as blood transfusion and 5) a last minute shift to hospital after *dai* could not manage the birth at home. The most unusual reason was because a mobile company went bankrupt and the participant could not contact her husband who would have taken her to the government hospital, which led to her giving birth at the nearest private hospital. This also suggests that the closest hospital to her was not public. Many women changed the venue of birth to avoid obstetric violence during childbirth. Their narratives show that they are looking for respectful care and continuity of care.

Women preferred to have the same birth place unless they expected better care or were looking for affordable care. Urmila birthed in the same hospital every time, at an added unaffordable cost, but her preference was supported by her maternal family. Ria had one baby in the tertiary government hospital and vows to never take her daughter there for her birth unless systems improve. Her mother gave birth to her in the same hospital. Sita chose to go to a particular PHC because it was close to her maternal house as did Amrita. Anju called the same *dagarin* to her home all three times, as did Pratima. However, Pratima had to be transferred to the nearby private hospital in the last minute.

"In government hospital one needs to call the doctor and nurse every time. They wait for your death. You have no right to say anything, you have not paid. In private hospital, I ask for my right since I have paid (money). *I have heard so many cases of exchanging babies in government hospitals. Those who want a male baby, get male baby… there is no guarantee you will leave the hospital with your own baby… in private, even though you pay 20,000 rupees at least you come home alive."* (Urmila)

"I saw the doctor checking all the women queueing up, down there (vaginal examination) *wearing a polythene glove. I was so scared to see it I ran from there!"* (Pairo)

"There is an advantage of government hospital that they will not operate on you immediately. They let normal birth take its course, as long as possible. Private hospitals look for every excuse to cut you open, all for money. Normal birth is not profitable to them. In government, I can give birth in the morning and leave in the evening. In private they keep you admitted for minimum 2-3 days." (Ria)

Sita's story is unique too and it shows some amount of decision making by her, in choosing the birth setting, which is rare. Her mother-in-law is a *dagarin* who assists all the neighbourhood births, but Sita refused to let her assist her birth and went to a hospital all three times.

"These days no one gives birth at home. I gave birth to all my three babies at hospital. Hospital is better for me." (Sita)

"They (hospital) *killed two of my babies so I did not go there the third time. Every time I had bleeding all through my pregnancies and every time I went to the hospital my babies died. Every time I gave birth at home, my babies survived!"* (Anju)

Home births were the primary choice for Pratima and Anju. Though Pratima could only have a home birth for her second childbirth, Anju had three home births assisted by the same *dagarin,* followed by two stillbirths at a government hospital. Pratima's home birthing experience has been narrated in her I-poem in Box 6.2.

Box 6.2 Pratima's I-poem- Born at home

Born at home

I liked the home birth!

I had my first child.

I have one more sister-in-law, she also has four members in her family.

I did not release water[11]*.*

I had completed all my work in the evening and my mother was in Puja rituals.

I was having pain since that the morning.

I had a meal, I kept eating and working.

I did all my work like cooking, cleaning up and down work from terrace.

I did everything.

I did all the work even in the evening.

I washed the clothes.

I mopped the corridor and terrace.

I prepared the dinner.

I had prepared the meal.

I served the dinner to everyone, then I went upstairs with a mobile.

I was watching a movie.

I was watching the Bhojpuri Movie.

I don't remember the name.

I don't know hero and heroine.

I used to hang up the phone and roam around.

I used to go up and down the stairs.

I got down from the terrace and I informed my mother-in-law that I am having pain.

I had the same type of pain.

I was lying on it.

I lay down this way.

I was holding them tightly.

I was holding my thigh too.

I wore a saree but they removed it, petticoat was there.

I was on a jute rag.

I am shameless!

I had pain for an hour.

I was alone in that room, then I called my sister-in-law to hold me at the time of birth.

I took a bath in the evening, so the hair remained open and so it remained open all night.

I feel two kids are enough.

I say, 'see, a son is born by god's grace!'

I got my birth done at home and I would not like to change anything.

[11] Amniotic fluid

None of the participants mentioned any aid they received or are supposed to receive from Janani Surakshna Yojana, or any other government incentive policies, as a reason for giving birth at the government hospital. It was often seen that women would get antenatal care from private or mission hospitals and would only go to the government hospital to give birth, as seen in Ria and Anju's story.

"I received (JSY money) *for my first birth but not for the second. ASHA blamed me saying 'how do I know? You probably received the money and did not tell me'. I have a right!... if government does not give anything to you how can you trust them? … I will not get it, so why think about it unnecessarily! Why get worried!"* (Amrita)

Sita's narrative is very similar to Amrita's in this regard, as shown in her I-poem in Box 6.3. There were other comparisons too which were made between government and private that included participant's lack of trust in terms of cleanliness.

Box 6.3 Sita's I poem on Janani Suraksha Yojana (JSY)

"Janani Suraksha Yojana money is for the mother and the baby, I heard"

I received [the money].
I had my third child also but did not receive [the money].
I updated the passbook but it was not showing in that.
I told ASHA to take my account details and check it if they don't trust me, but they did not do so.
I did not know, but when I went to my mother's house then my mother told me.
I didn't get it.
I have not checked.
I don't know whether I received it or not.
I don't remember exactly, but it was approximately Rs 3400/-.
I used to talk to my mother every day.
I did not check till date.
I heard that the money is given to utilise for the mother and the baby.

6.5.4 Respect, disrespect and abuse related to birthing environment

The birthing environment includes the infrastructure in that area, the people giving care and the toilet as well. Women not only described the birthing environment in their birth maps but also the ones that are not on it. The number of people around birth was related to whether they gave

birth in a government hospital, private hospital or home. Even when giving birth at a government hospital, birthing at a tertiary level of care meant birthing in a crowded hall with many other women, as can be seen in Ria's birth map (Figure 6.9).

"Birth was happening all around me! There were 6 beds. It was full! Everyone was screaming, which was making me more anxious and scared. Everyone's birth was happening! Someone was receiving water (IV). Doctor was scolding another for not pushing, 'Push! Push!'." (Ria)

The infrastructure of the birthing room often made it more chaotic where multiple '*labour tables'* were kept next to each other, as noticed in the stories of Ria and Sujata; both births took place at government tertiary hospitals. The private hospitals only had the participant (Urmila, Pratima) in the birthing room. The home births were also conducted privately, either just with the *dagarin* (Anju) or assisted by the women in the family (Pratima) along with the *dagarin.* A *'Labour table'* was common in government hospital birthing stories and in private hospital. There were women who also birthed on a wider bed. Women at home gave birth on the floor.

"Windows were covered with thick net and glasses. The labour room had air conditioner and fan but both were switched off. The labour table was quite high. There was a blue colour mattress on the bed and steps next to it. There was a thick rod at the head end to hold and bear down." (Urmila)

Figure 6.9 Ria's Body Map

Privacy is a key aspect of the birthing environment and is mentioned in all the women's narratives. Women want their privacy to be protected, they also demonstrated a forced acceptance of this lack of privacy. Their privacy needed to be protected at six levels as seen in the narratives, shown in Figure 6.10.

Level 1- is covering their body during interventions, not exposing it unnecessarily and exposing only as much as needed with consent;

Level 2- protecting privacy from the birth companion and the immediate health care providers who are assisting the birth;

Level 3- protecting privacy between other birthing women and their family members, if multiple women are birthing in the same room, by ensuring curtains/ screens between them;

Level 4- ensuring that outsiders are not able to peep in from any open windows by putting curtains in the windows or around the women;

Level 5- protecting privacy from all the other care and non health care providers such as cleaners, who may be in the birthing room, at the nurse's station or weighing station;

Level 6- from the family members, outsiders, others in the waiting area outside the door which usually opens to a hallway.

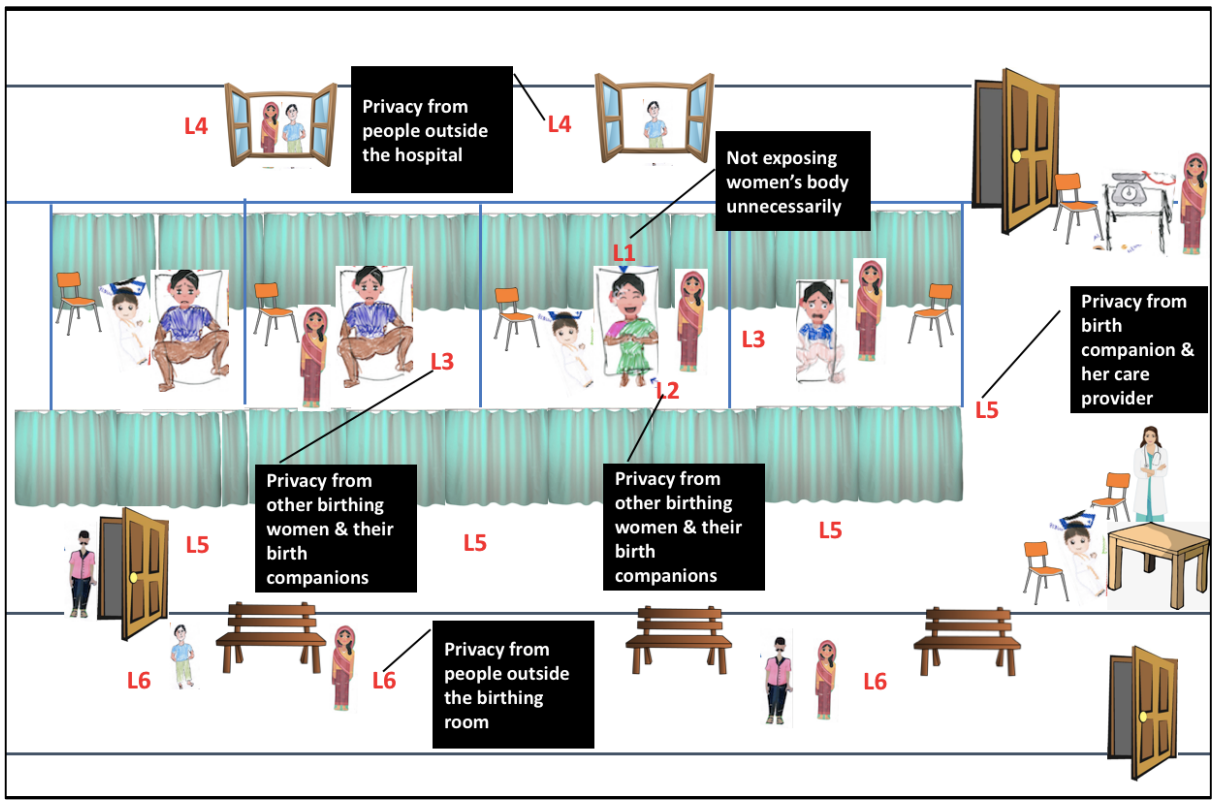

Figure 6.10 Levels of privacy to be protected for the women in birthing room (*Author's own*)

Curtains were mentioned where multiple women were birthing in the same room but they were to protect the privacy of all the four to six women birthing together from outsiders. There were no curtains between the labour tables to protect the privacy of birthing women from each other and their birth companions.

"I was able to see with my own eyes when the lady in the corner was giving birth. There were no curtains. There was only a hall. When you go inside you will find everyone naked there. Even if attendants would come then they will also see… Dhat! (Oh god!) *It's so embarrassing! I felt very bad! You don't want anyone to look at you in that state."* (Ria)

"My privacy was maintained … my body was not exposed much. Doctor only exposed my lower leg to knee. Rest of it was covered with the nightie. The lady doctor was good." (Urmila)

The issue of privacy worsened if men are allowed around birthing women. That is considered shameful, a huge invasion of privacy and some even consider this privacy to have been protected if no men were allowed in the labour room, regardless of how many women are in the vicinity. The birthing area for the cesarean section is very different from the labour room, as seen in Pairo's story. This also included a lot of men around birth in an operation theatre as shown in Pairo's body map in Figure 6.11.

"They were not taking my permission for anything… I felt someone removed my petticoat. I felt it." (Pairo)

"Not a single man was there. Men are not allowed. Ladies stay there with ladies! Men do not go there because women are naked… As soon as they see men, they start chasing them away. 'Go… Go… what are you doing here?' They do not let anyone in." (Sujata)

"They were all men. There were no women (in the OT). *Gents who do ultrasound were also there. There were around 8-9 men. The doctor was also male. I feel all those men should have worn uniform… They were there as if they are tourists."* (Pairo)

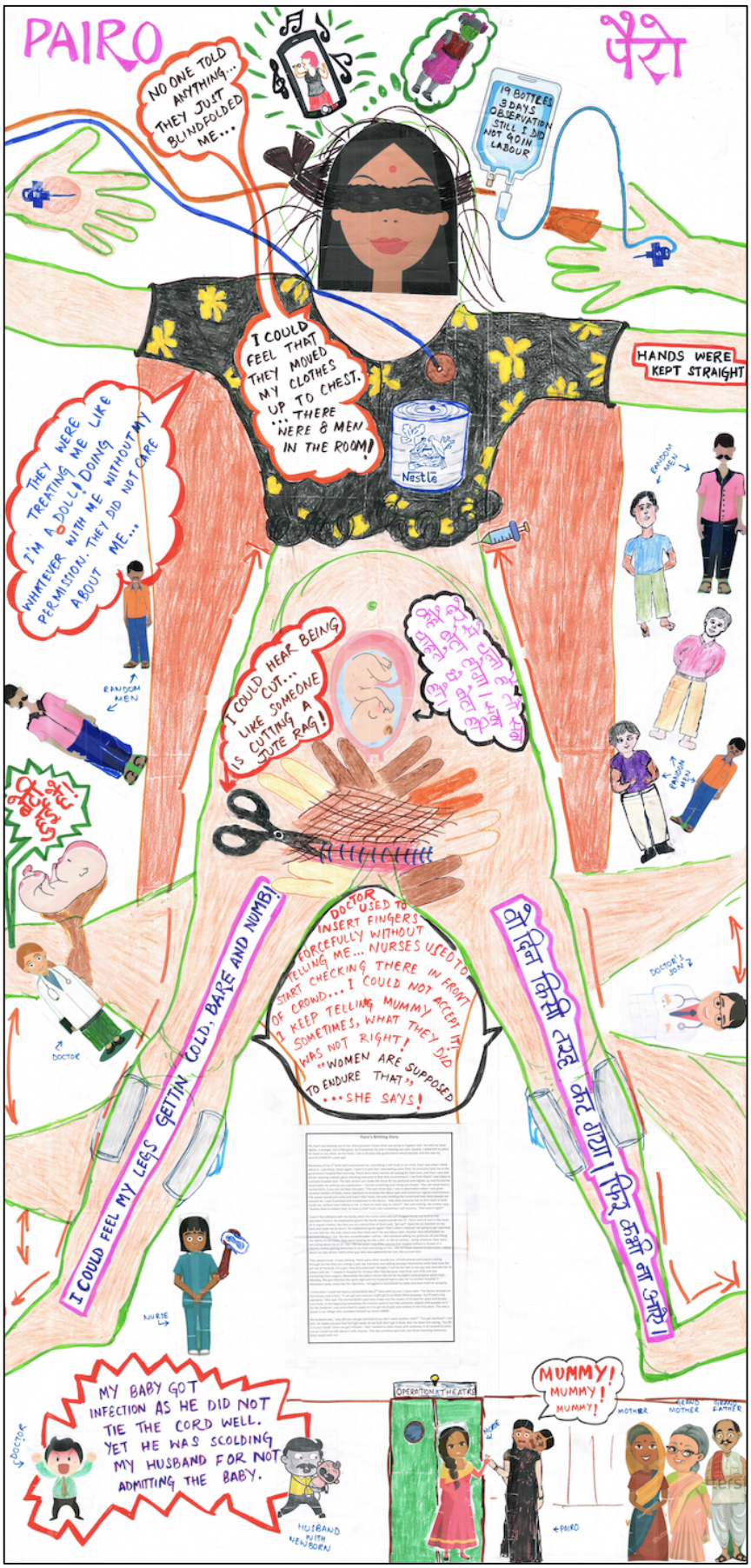

Figure 6.11 Pairo's Body Map

Cleanliness of the birthing environment, including the labour table, the toilets and the overall cleanliness of the hospital, is of utmost importance. The women who gave birth at home had no complains about cleanliness. Most of the issues were reported among those who had a birth in government hospitals, excluding one of Sita's birth at a PHC which she reported to be very clean. It is certain that this is a key aspect in terms of respectfulness for women.

"My goodness! The toilet was dirty. It was very much dirty! Too much dirty! Dirt was everywhere. There was even more dirt because of no water. The water was not drinkable and they were asking us to drink from the toilet tap. It had such a stench! Dirty pieces of cloth drenched in blood and fluids everywhere." (Sujata)

"The entire hospital… there was blood and dirty liquid everywhere. Suppose you have some illness and I used your dirty toilet, will I not catch it then? Bloody floors everywhere! I did not urinate there. That's why I didn't go there. I went to the jungle behind the bushes. There were some abandoned broken houses nearby and jungle, but it was cleaner than the hospital. I went there to urinate. I might be dark skinned, but I am very disgusted by dirtI" (Amrita)

6.5.5 Respectful, disrespectful and abusive communication around childbirth

Women barely spoke in the birthing room and it begins from the minute they stepped into the hospital compound. They usually come in contact with health care providers such as doctors, nurse-midwives' and non health care providers including the *Mamta*, cleaner, *dai* and ASHA. They rarely ask any questions or object to anything that is done to them during and around childbirth. A surrogate decision-maker from the woman's family, whom she may not have chosen at the first place, takes on the role of communicating on the woman's behalf who was often referred to by the women as *'guardian'.* All these women are above the age of 18 at the time of giving birth, except one.

"I have not asked anything to anyone. My mother-in-law asked everyone whatever I had to ask… I did not feel like talking to anyone." (Amrita)

"I was all alone there… I could not say anything. I was feeling bad but I could not say anything because we were in the hospital. Who am I supposed to tell?... if I say something to them they will say 'you are not the only one having a baby here. There are others too and they don't have any problem. You don't have something special down there." (Ria)

"Why would I ask them? What is the point of asking them things unnecessarily when the elders are there? They (parents) *need to know and decide things."* (Urmila)

The lack of communication from the care provider's side begins when the woman is admitted under their care. The lack of a welcome is the first instance of disrespect every woman experiences.

"Welcome?! (laughs)… *Who talks with you anyway!... loudly she said 'lie down', I too said, 'where to lie down?'. 'Find an empty bed and lie down' she said. I went and lay down"* (Ria)

There is no introduction or any effort to know each other's names because knowing names is not considered important where care provider's first words or instructions to the woman is to lie down and part her legs. That is, if she is spoken to directly by the care providers, the usual scenario would be a nurse, doctor, *dai* or *Mamta* parting the woman's legs forcefully without saying a word to her.

"They don't care about the name of patient. They were not calling by name. They were calling by what is happening, or to know how much pain one is in. There was no need to call as we were all just lying down. There was no hello or thank you!... what will I call? I shouted- 'listen', 'I am in pain', 'please someone come here'." (Sujata)

There was a lack of communication about examinations and interventions. Care providers did not tell the women about the care they were receiving. They would come and start intravenous fluids and give injections without telling them what it is for. It is not just about what is being communicated and how it is being communicated; but also who is communicating, as seen with Sita, which was something that should surely have been conveyed by a medical personnel and not a *Mamta*.

"They kept me in the hospital for three days and said 'we can save only one, either the mother or the baby' Mamta said." (Sita)

"They checked with that machine on my abdomen and said the baby will not survive!" (Anju)

The communication around vaginal examination is especially sensitive and it is an intervention which, as Sujata explains, *'the worst aspect of giving birth in a hospital!'*. Clearly, it requires an explanation and seeking consent before starting the vaginal examination. The doctors and nurses would at best say they are checking if the *'mouth'* is open or not. Participant's were horrified at the lack of sensitivity and communication around this intervention and were left feeling ashamed and humiliated. This lack of communication also subjected the women to a fear of not knowing what is next and left them expecting the worst.

"She started drawing the injection and setting up water… I was really scared to see this… she asked for my hand. I said 'what are you doing?'… how could I ask her what she was doing? We don't ask. We don't have the habit of asking… I got scared that probably I should not have asked anything, should not have interfered." (Sujata)

"She said 'lie down, I will see if the mouth is open'. She inserted her fingers. She did not say anything. I was scared and started screaming very loudly. The doctor said, 'she has no pain threshold, she can not have a normal birth.'" (Pairo)

"She inserted her fingers inside me without telling me. They didn't ask me or inform me." (Urmila)

The lack of communication wasn't just limited to examinations and interventions, that most women went through. The most harrowing account came from Pairo who was dragged to the operation theatre by a nurse and on the operating table she figured out she is going to be operated after she was given an injection which made her legs go numb while she was also blindfolded. Her narration has been captured in her I-poem titled *'Doll'* in Box 6.4.

Women felt like an object, a passive participant in the process and isolated even when they were surrounded by people who were there to take care of them. They often found that people were talking over them and not to them.

"I never had any conversation with the care providers. They were talking about me, around me, but not to me… After doing my check up, they were telling my parents, not me, and I was also not talking to them." (Urmila)

Some accepted this lack of communication and displayed an unquestioning behavior not because that is their nature, as seen in some of the earlier quotes. It was often led by the fear of inviting obstetric violence and the fear of consequences. They arrive at the health care facility having discounted on all their rights and given up on all their choices with an acceptance that there is nothing they can do or say, they are expected to follow instructions to leave the birthing room with the least harm done, even with some awareness of their rights in the birthing room.

"I feel angry but I am admitted under your care, so I will have to do what you say. If I do not do as per your order, then you will again do something to harm me. My mother was asking me not to talk back, or argue, because these people might do something ulta-pulta (inappropriate to harm you*)!"* (Ria)

Box 6.4 Pairo's I-poem- Doll

Doll

I had no guardians accompanying me.

I was screaming, Mummy! Mummy!

I was taken inside.

I felt like they gave me an injection.

I felt my legs were getting cold and numb.

I could not see who gave it to me.

I think a specialist had come for that.

I guess he was an anaesthesia doctor.

I guess he has only given me that injection.

I trust them at least that much, that any random person won't stick injections in me.

I was wearing the same nightie.

I had not changed, it was dirty.

I would have felt fresh if they had allowed me to take a bath.

They made me lie down on OT table.

I was sitting.

I was put to sleep.

I was blindfolded with cotton balls on my eye and then there was a cloth they tied on top of that.

So I wouldn't see anything.

I felt, there were so many men.

I would have felt uncomfortable because there were men.

I asked him 'where is madam (lady doctor)*?'*

I was blindfolded.

I heard a voice that madam had arrived.

I felt they removed my clothes, my legs had no sensation.

They did not consider me as a human.

They were treating me like a doll!

Doing whatever they want to do with me.

They were not asking for my permission.

I felt someone raised my nightie.

I felt this because of the loss of sensation below my waist.

I felt like this.

I was lying down.

I was lying on this adjustable thing, they could turn it around as they wanted, to their convenience.

They could just operate me like that.

I remember, clothes were removed.

I felt so!

I felt my legs getting cold so I thought my petticoat was removed by someone.

They did not have anything to do with me.

A lot of machines and wires were connected to me, one to my heart and one on my finger.

My eyes were kept shut.

I don't know.

I could not tell what was happening around me, or what was going to happen next.

I was conscious but nobody was talking to me.

I just lay there.

I was not sleeping.

I kept my eyes closed.

I was hearing everyone's voices.

I could feel that some one is cutting my belly.

I was hearing the sound of machines and instruments.

I did.

I heard my belly being cut.

I could hear somebody cutting me, like cutting a jute rag.

They cut me, took my daughter out, stitched me and sent me back to my room immediately.

I remember praying to God, so that everything goes well.

I don't know who stitched me or cut me.

I did not know anything, nor did I feel anything.

My eyes were closed.

I have a daughter.

I started imagining.

I will make two ponytails and take her to school with me.

I was happy.

I have a girl.

I was feeling like I am a doll.

I didn't know what will be done to me next.

My mother said, 'They were treating you like an animal'.

I do feel one thing, the bad experiences were with my body.

I love my daughter a lot more than my son.

Those things don't matter to me anymore.

What happened, happened to my body, my spirit is untouched.

My baby came into this world through that experience.

I am happy about that.

I feel that the bad experiences were with my body.

I feel they thought of me like I am a cow or a buffalo or a doll.

There were a couple of instances where the women said that the nurse or the doctor was talking to her nicely. This was often a rare person amongst all the people the participants would have come in contact with, which made them suspicious over the unusual nicety. A participant also shared how the care provider did not proceed with the vaginal examination after she requested her not to.

"The nurse was the first person I met that morning. She was calling me dear one, dear one! She was talking to me properly." (Sujata)

"My maternal uncle, an MBBS doctor, gave me a recommendation letter. She (the recommended doctor) *used to give me time and talk to me nicely. I used to wonder if she talks nicely only with me or with everyone."* (Pairo)

"The lady doctor and one sister were good who were caring for me. There were two sisters who were always frowning, shouting and screaming at me. She abused me so many times." (Urmila)

6.5.6 Respectful, disrespectful and abusive people around childbirth

Four types of people have played a role around childbirth in the hospitals and homes: 1) qualified health care providers in the hospital (nurse-midwife, doctor); 2) women's companions from family/ neighbourhood (husband, mother, mother-in-law and others); 3) unqualified care providers (cleaners, *Mamtas*, *dais*) and 4) mobilisers (ASHA).

The qualified health care providers included nurse-midwives (mostly referred to as nurse or sister by women) and doctors. All the women were examined and cared for by doctors and nurses at some point during their childbirth(s) except in homebirths. Their interactions with the doctors and nurses were respectful, disrespectful and abusive which also shaped their perceptions for their prospective childbirth and their expectation from care in general.

Doctor's role during childbirth

The doctor's role during childbirth is limited to vaginal examinations in government hospitals, after the initial examination. In the private hospital, they are also seen conducting cesarean section and also performing episiotomy repair. Participants had unique interactions with their doctors. Amrita came in contact with two doctors over the course of two childbirths. She experienced obstetric violence in the form of disrespectful communication from both of them. The first doctor in her first childbirth refused to assist her birth because she was anaemic and the doctor did not want to take a risk. The second doctor shouted at all her family members because she visited the health centre in labour very early in the morning and the doctor wanted to sleep in. After repeated requests the doctor arrived in the last minute to catch the baby. Pairo came in contact with five doctors including one paediatrician. The fifth doctor she met, who was the only doctor in her second cesarean section, was respectful to her. Three of the four doctors she came in contact with in her first childbirth were disrespectful and abusive. She wasn't sure if the third doctor (second doctor's son) was a doctor, her only contact with him was in the operation theatre, while being blindfolded. She assumed he was a doctor because he was there and he called Pairo's doctor, his mother. She did not have any interactions with the first doctor she saw in the government hospital. She saw him performing vaginal examination wearing the same *'polythene gloves',* for women who queued outside his clinic, so she left the place disgusted.

"They held me down because I was in pain… I lifted my waist and she (doctor) *pushed it down saying the baby will get injured. Then, I never lifted it up."* (Amrita)

"The former doctor's behavior was not good with me. I did not like her because she did not talk to me nicely. She used to think very highly of herself as if she is a genius and a know-it-all! She used to just prescribe without explaining what the medicines are for. She was over confident and I don't

know what she thought of herself? She thought very little of me or that I am worth nothing compared to her. Didn't even talk to me much. I used to think that its me who will have this baby, at least talk to me, say something!" (Pairo)

Both Pratima and Urmila came in contact with just one doctor while giving birth in a private hospital. Urmila found her doctor to be abusive. Pratima found her doctor to be respectful. Urmila was cared for by two doctors and she went to the same hospital for all her births. Urmila's experience with her doctor is shared through her I-poem 'The lady doctor was really nice', in Box 6.5. While the doctor was disrespectful and abusive, she took comfort in the fact that it was a female doctor.

"Then the poor lady (doctor) *searched for my vein and gave me an injection. She was innocent and nice lady. The way she took care of me, I felt like her own daughter. I felt good. I was feeling good because those people were good people. We were happy!"* (Pratima)

"Only female doctor checked me throughout my delivery… I was feeling so many things which I could not share with anyone else. I don't know why. I was so angry with the doctor because she called me so many times for vaginal check-ups… I did not like it. The doctor in the delivery room was good. She encouraged me with her words, 'Don't worry, everything will be alright!' she said." (Urmila)

Box 6.5 Urmila's I-poem- The lady doctor was really nice!

The lady doctor was really nice!

I told her not to do it, but she forced her hand inside me.

I told her don't put your hand in, it was hurting, but she continued to do so, didn't listen to me.

I was so angry with the doctor, she called me so many times for vaginal check-ups, every time she told me the passage did not open.

I didn't like it.

I was shouting and crying due to pain but still doctor kept on suturing.

I asked them for 'behoshi ki dawa' (anesthesia)*, but they were not listening to me and kept doing it.*

I thought my problems were over after giving birth, but the real challenge was post birth.

I was screaming, the doctor and sisters were holding me down from all sides and kept stitching me.

I felt all of it.

I kept screaming and asking for anesthesia.

I felt all of it!

I didn't have such pain in my first delivery while stitching.

I liked the behaviour of my doctor and one of the nurses.

I didn't like those two frowning sisters who shouted at me.

Ria and Sujata had almost no interaction with any doctor after admission, where they had only seen one doctor looking at laboring women from a distance. Both of them birthed in government tertiary level hospitals at the state capital, in a big room with four to five women birthing together. Doctors appeared in Sujata's story when she talked about bribes. The doctor was seen walking around in both cases, often just at the foot-end of the labour table while the women birthed and never communicating with the women in labour.

"There was a doctor. She gave advice to everyone and went away." (Ria)

"My husband gave rupees 1001 to the doctor and 500 to nurses." (Sujata)

"If she (doctor) *has to ask anything, then she can ask from there* (foot-end) *that 'are you having pain or not?' or 'what is the problem?'… they don't come close, they don't feel the need for that. There is only so much space between the labour tables so there is no need for that as well."* (Sujata)

The lack of communication was a common theme with all the participants. The doctors did not explain their actions or procedures and did not seek consent from the women for anything. When they did communicate, it was with the family members, often in the care seeking woman's absence or in the form of instructions to the nurse or aide for something the conscious participant is capable of doing. The same scenario played out in a completely different way in Pratima's case where she found the doctor was talking to her nicely. In Pairo's case, she was not told that she would undergo a cesarean section, her parents also did not inform her, she found out after spinal anesthesia was given in the operation theatre.

"She (doctor) *asked to the nurse to bend my leg."* (Pairo)

"She said 'lie down and hold your legs with both hands and I am checking you'. She asked me to lift up (my saree) *and I did the same. Then she checked me. No one was there. Just me and her* (doctor)*."* (Pratima)

"The doctor had already spoken with my mother about this (cesarean section). *They did not tell me anything. They just kept talking amongst themselves, no information had come to me."* (Pairo)

Two pediatricians were mentioned in Pairo and Sujata's narrative. In private hospitals they seemed to have more responsibilities, which included giving medicine and injections and starting the intravenous line, along with their initial role in sending the women for admission and signing for discharge.

Nurse's role during childbirth

Women could confidently identify the doctors, by title or by sensing the power dynamics. Any woman caring for them was considered a nurse and even though they confidently shared an interaction about the nurse they weren't sure. There was no introduction about each other's role between care provider and care seeker during their stay at the hospital.

"Yes they were nurses only. She was giving injection and helping in the birth." (Pratima)

"She gave her two tight slaps on her face. I guess she was a sister (nurse). *Yes, they were sisters only."* (Ria)

"Nurse means dai!" (Sujata)

"*I was in the waiting area when nurses approached me… the ladies who do all the cleaning work around birth… they took me inside the labour room."* (Urmila)

Nurses are usually referred to as 'sister'. Nurses at the tertiary government health facilities were seen giving injections, running IV fluids, augmenting and performing episiotomy repairs. At the secondary or primary level of care provision they were mentioned with similar roles but not for episiotomy repair.

"…nurses don't get involved in cleaning work usually." (Amrita)

In the private hospital it was not clear whether the people, participants were referring to as a nurse or sister, were actually licensed nurses. They were often only seen in the birthing area. In big private hospitals, they were seen doing multiple vaginal examinations. One nurse was mentioned as performing an abdominal palpation. But most were seen following doctor's instructions to part the participant's legs or to restrain her for vaginal examination or during episiotomy repair. It seems like being an aide in obstetric violence by physician's order.

"There was just one old nurse. She shifted me to that room for birth. She checked me from up on the abdomen, not below. Then took me inside the room and gave me an injection." (Sita)

Most participants came in contact with nurses and often more than one. They shared how nurses worked in shifts in tertiary hospitals, or about a nurse at a PHC whom they had known for years, who had passed away. This change in relationship or in knowing the care provider, was seen between urban and rural areas. It did not necessarily have any effect on the respectfulness of care these women received. There were contrasting opinions on whether the nurses were involved in extortion. Sujata felt they were, though others felt they were not. In private hospitals, they were seen asking for *happiness money.*

Communication with nurses was limited, although, one conversation with Pairo's mother stands out. The absence of any disrespectful language and actions often counted as being respectful and in some cases it involved specific actions that conveyed respect.

"A nurse… told my mother that the clothes of patient are removed at the time of operation in the OT. But she did not like that at all… there are ladies and gents everyone. She said she tries to keep the patients as covered as possible in that situation." (Pairo)

"Out of those three nurses one was very good because she used to hold my hand in between labour pains." (Urmila)

"She was talking nicely. She was saying not to panic and that everything will go well." (Sita)

Dai's role during childbirth

Dai was often confused with a nurse, *Mamta* and ASHA. *Dai* was mentioned by women who gave birth at all levels of government health care delivery system and at home. With the women interviewed in the rural area, Sita, Amrita and Anju mentioned the presence of a *dai* around their birth. In the urban area interview, Ria, Sujata and Pratima were aided by *dais* in their childbirth as well. Sita and Amrita's narrative sheds light on their role in the primary care hospital where they clean the birthing area, call the doctors when needed and restrain women when required. *Dai* often accompanied women from their homes to the hospital, if they are from the same neighbourhood or village.

Sujata and Ria had similar narratives of *dai's* presence in the labour room and their role during childbirth, even though they gave birth in different tertiary level hospitals in the state capital of Bihar. They came in contact with many *dais*. Two to three *dais* were seen assisting their births and that of the women birthing on the four to five labour tables next to them. *Dais* reportedly worked in different shifts and were at the forefront of asking for money at every level of public hospital. People paid a lot to *dais* at the tertiary level, especially because there were so many of them.

"The dai asked for 5000 rupees, 1000 rupees each… 'are you giving me alms? Am I a beggar? You keep it, you are treating me like a beggar…' There were three dais in one shift. They used to come for cleaning and mopping. The dais who sweep the floor are not the same dais." (Ria)

Sita's 50-year-old mother-in-law has been a *dagarin (dai)* for over 20 years, assisting births in her village and nearby villages, yet Sita insisted on giving birth at the hospital. Sita's mother-in-law goes to women's houses and puts her hand inside to know how much 'the mouth' is open *'one phinter, two phinter'*. She gives the injections so the foetus can come out quickly. She also stocks IV fluids at home. Her work is in less demand because the hospitals are functioning better. Sita shared that *dagarin / dais* from the village are elected to work in the hospital sometimes but her mother-in-law was not selected.

At the hospital, the *dais* were seen doing everything from giving injections, vaginal examinations, episiotomy, assisting births, weighing babies, conducting uterine exploration and cleaning the labour table thereafter. The doctor or nurse's role in the labour room was the bare minimum. They were also mentioned in relation to much of the abuse.

"They were saying 'you are screaming unnecessarily while just producing one child. How much will you scream when you produce more! We have all birthed 15 children each and never behaved like you.' Dais were saying. One was standing near my feet. She was an old lady, kept saying rubbish and disgusting things." (Ria)

"My delivery was done by dais. Dai gave me an injection too… she wore a glove and checked me by putting her hand inside… three dais were there… saying 'push, push'… they were conducting the delivery… I was not able to figure out who was doing what. When the baby's head was out, all three were busy removing the baby… once the baby was out they cleaned everything. They tore a cloth and wiped the baby and cut the cord later. They removed the placenta by applying pressure on the abdomen. She took it out by putting her whole hand inside and checked so there is no dirt left inside the uterus… she held my hand and got my clothes changed. Asked about my pain and gave me medicine. They were not letting anyone (from family) *go inside at the time of birth because they were there."* (Sujata)

Dai assisted Anju's three home births. Pratima's second birth was assisted by a *dai,* as shown in her body map (Figure 6.17). She wanted her first birth at home as well, but the *dai* sent them to hospital after she thought the labour had lasted too long. This is similar to the pattern with births in public sector hospitals, be it tertiary level hospital or at home. Births assisted by *dais* are seen with Pratima (Figure 6.12) and Sujata (Figure 6.13).

"She did all the deliveries. Dagarin came at 12 at night. She was massaging my hands and legs. She cut the cord with blade. She massaged the baby with oil." (Anju)

"My father-in-law went and brought the dai home… whenever you go to call her, she comes. Poor thing! Even in the middle of the night. She is an old widow." (Pratima)

Figure 6.12 Pratima's body map

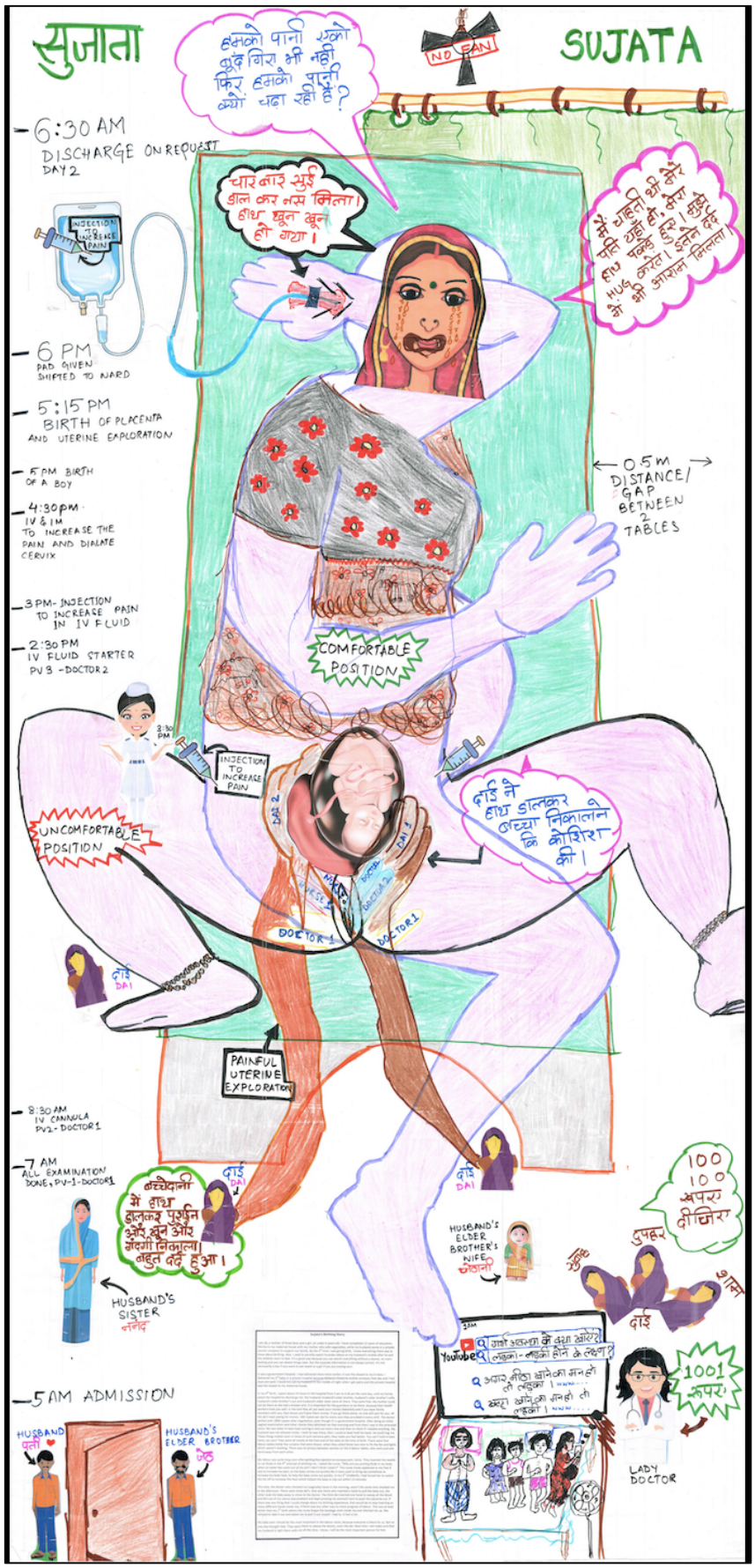

Figure 6.13 Sujata's body map

ASHA's role during childbirth

ASHAs were mentioned in Amrita and Sita's story. Her role is to call the ambulance and help the woman reach the nearby institution for birth. She also aids in getting the JSY incentive. But in both cases the women had not received their JSY incentives for their recent births. On complaining about this to the ASHAs, they blamed the complainants, saying that they probably received the money and spent it. ASHAs were also seen helping to get the birth certificate, but they charged a fees of 300 rupees. In the labour room, they were sometimes seen restraining women who are giving birth. One participant had an ASHA who was a family member. Participants often found it difficult to differentiate between women around birth and could not tell ASHA and *mamta* apart. ASHA's role was that of a mediator of services and a motivator for the women and family to seek health care services.

"She is in my maternal household. She is our family member, so she had done all the proceedings." (Sita)

"I gave her my passbook and told her if you don't believe me then why don't you check it. I told her 'you think I will grow richer by 1400 rupees?' Then she took and updated the passbook but she did not find out anything. She said now I will not get the money." (Amrita)

Mothers and mother-in-law's role during childbirth

Mother and mother-in-law were not mentioned to be together around birth. Amrita, Sita and Pratima had their mother-in-law's presence, while Pairo, Ria, Urmila and Amrita had their mother beside them. Sister-in-laws were present at Sujata and Pratima's births. Their role was that of a female from family who was around to call the care providers when they felt the need and facilitate communication from the family. Women were asking questions such as, how long will it take to give birth. They did not necessarily convey the information to the birthing women, as is seen with Pairo who wasn't informed by her mother that she was going to be operated the next day. They communicated the information to rest of the family members, including the husband / father of the child. They made some decisions around birth too. Mother, mother-in-law and sisters-in-laws were amongst the family members who restrained the birthing women. Sita's mother-in-law interrupted the interview a few times and also took over the conversation, until we could talk privately again.

"She (mother) *was holding my clothes and keeping my legs down."* (Amrita)

Women said they preferred their mother's company, except Urmila who felt very angry with her mother's presence. Ria feels her mother saved her baby's life, after she made a lot of noise because the *dais* announced a stillbirth and 'threw' the baby under the table. This is captured in her I poem (Box 6.6). Pairo has a similar story where her mother found the newborn's cord stump bleeding, hours after birth and reported to the doctors.

Box 6.6 Ria's I-poem- The dead baby

The dead baby

My baby was born with great difficulty.
My baby was moving in my womb, but after birth everyone said that the baby is dead and they threw my baby under the table.
My mother shouted at them, 'How can the baby be dead?'
My mother told me the baby is dead.
I was not aware of it while it was happening.
My mother went there and questioned everyone because the baby gets exchanged often.
I didn't know anything after that.
I was just lying down.
I was in a lot of pain.
I was drowsy.
I was restless too and my mother went to the baby.
I asked my mother, 'how is she?'
I repeatedly asked my mother how the baby was.
I would have become familiar with them.
I would think that 'Yes, I have someone here'.
I will feel less afraid and not panic.
My mother would have been there.
I had the baby, after half an hour they stitched me up and I was almost unconscious.
I was unconscious and they shifted me to another room.
I would have not known about the baby.
My mother saved my baby!
I was upstairs, my baby was in NICU.
I had to pay to see my baby, whom I gave birth!
I used to say that I am going to tell this to higher authority.
I was saying, 'let us see the baby once'.
I requested, 'show me from afar at least. How is my baby?'
My baby finally came in my lap after 8 days.
My baby was covered in her stool after 8 days.
I expressed milk in a glass and gave it to them.
I was not happy for twenty days at least.

I used to be very restless.
I started spending more time with my baby, I used to feel much better, satisfied.

Women did not choose their birth companion. Women often felt they had no choice in making that decision and found that having their mother or any women amongst relatives, was the most acceptable option. Sujata was the only participant who freely expressed her wish to have her husband by her side over anyone else, but she did not voice that choice due to societal barriers. She also had to follow traditional norms, such as wearing signs of marriage, because her in-laws were present during childbirth. They also had a role in convincing women to accept interventions that they did not agree with and felt they had no choice to deny.

"I was wearing bindi and vermillion, because my in-laws were there." (Sujata)

"My mother said to let her (nurse) check once." (Sita)

"I did not want anyone to touch me. Even when my mother came to hold me I felt like I will hit her… it was not comforting me… most of the time she was just sitting in the labour room. When I was walking she was trying to hold my hand, I did not like that. I wanted to do it on my own. What's the point of holding hand? It makes me look weak!" (Urmila)

6.5.7 Respect, disrespect and abuse in personal space and relationships: household and husband

There were no direct questions about women's household environment other than household income and source of income. Women shared about their relationship with their husband, while talking about the birth companion, their husband's occupation, the main source of household income and their husband's role during childbirth. Women often worked until they went into labour (please see Pratima's poem *'Born at home'* in Box 6.3 and Amrita's poem '*I*' in Box 7.2). This included their paid work and unpaid domestic work. This work was often described as a burden that was rarely shared. Of the eight women interviewed, four did not engage in paid work. Anju is a labourer on others farms; Ria works as a cleaner and reared cows to sell milk; Amrita ran a small grocery shop and Pairo is a government school teacher. Ria and Anju are the sole earners of the family. Amrita and Pairo's income was supplemented by their husband's, but they ran the household. Anju had the lowest household income (1000 rupees per month), for a five-member family and Pairo had the highest household income (65,000 rupees per month) for a four-member family. Women who engaged in paid work, managed all the domestic work as well. Women in joint families or domiciled at their mother's place, were able to rest for the first four to six weeks after giving birth, this was found to be a common norm. This was not possible in nuclear families.

"No one is there to look after my kids and family. I only go to the market to purchase grocery for the shop. I leave the children for a few hours at the anganwadi. I was 8 months pregnant and had to lift 25 kg jute sacks." (Amrita)

"After the first 3 months when my mother went home, I used to wash clothes and I used to sit and feel tired and think how will I go back to school, how will I take care of my baby and how will I do everything? Two months later I started taking bauua (daughter) *to school… it was quite troublesome but I managed."* (Pairo)

"At least in the first month and a half I did not have to do anything. Used to just roam around. Cooked food was brought to me… I was at my in-law's house." (Pratima)

Women felt shy talking about pregnancy and birth with their husband, and the narratives depict that this kind of conversation was not necessarily encouraged between them. Box 6.7 shows Ria's communication with her husband when she announced her pregnancy to him. Her narrative shows how her pregnancy led to her separation from him, which eventually led to a divorce. She recounted experiencing intimate-partner violence from her husband and of living in a violent domestic environment.

Box 6.7 Ria's I-poem- It has stayed

It has stayed!

I used to ask what the doctor said exactly.
My friend said, doctor used to say that, 'when you don't have the strength to give birth and bear the pain, then why did you keep the baby?'
My husband told me that he wants a son.
I told him, 'My periods have stopped, I guess I am pregnant.' He curled his lips in anger and said, 'I don't want a baby right now'.
I got pregnant.
I did not eat or drink much, I used to lift heavy weight and I used to carry two buckets of water, at a time.
I have been married for 6 years.
My husband does not stay with me.
I am divorced.
I was pregnant, he did not give me any money.
I also said, 'Don't give!'
I went for the delivery; he did not give money.
I went to hospital with my mother.
I called him from my mother's phone but he did not take my call.
I also left it like that.
I was scared.
I was not happy.
I told him, even if I am pregnant, I will not take a pill.
I will not take that pill.
I also told him, 'don't do, I will manage'.
I said to my mother to 'help me. I don't have anything today and I don't earn, I have no one to spread my hands in front of for money. You give me to eat'.
I also said then don't argue with me, who told you to argue with me… abuse me.

Urmila disclosed about her husband being an alcoholic and abusive, which led to her calling the police, followed by his imprisonment, as seen in her I-poem in Box 6.8. Not having a productive, respectful dialogue with husband was a common theme. This was seen with Sujata as well, who was otherwise quite frank with her husband about everything. Husbands often conveyed their opinion about the family size, and their word was usually the final decision.

"My guardian (husband) *did not let me… says our child* (son) *remains very sick. That's why I did not get it done. They* (in-laws) *said you have only two children. Operation* (tubectomy) *was my thought."* (Amrita)

"I could not ask him 'how will it come out'. But he wished I would deliver normally… he sometimes says 'do you want more children that you did not get family planning operation done?'. In the second time he said regardless of boy or girl, get the operation done… if the baby is healthy then only I will get it done. Neither I have done the operation nor he has. I tell him why don't you get it done. He says 'I will have to sit and work all day, I will get weak!'. So now whenever we get intimate, I tell him 'my life is in your hands!'. He gets scared! (laughs)*"* (Pairo)

"I feel two kids are enough but my husband keeps saying he wants one more. As in, a son! I say see, a son is born out of god's grace… how will one operate (Vasectomy) *on husband?!* (shocked) *No, no, no… a how can a man get operated!"* (Sita)

Box 6.8 Urmila's I-poem- I never made a decision about myself

I never made a decision for myself

I left my education when I was 13.
I got married very young.
I have no idea about money, my husband takes care of money.
I don't know what he earns.
What do I have to do asking about money anyway!

I put my husband in jail because of his addiction.
I should not have done that.
I don't know when my husband will be released.

I was better off alone.
I would have done something, earned some money.
I just don't like when he comes home drunk.
I feel like locking myself in another room.
I did not like the smell.
My husband had money to drink alcohol but no money for my children's education.

I feel, I should just take care of my children.
I will find the money to feed them, even if I divorced him.
He drinks and hits me.

I put him in jail.

None of the husbands were allowed into the birthing environment in the hospital settings. The husband's role was limited to calling for the *dai* or ambulance. In the hospital setting husbands paid the bills, paid the bribes to care workers, bought the supplies instructed from the hospital and waited outside the labour room or operation theatre, as seen in the case of Sujata and Pairo. Amrita, Sita and Pratima's husbands could not make it to the hospital. Amrita's husband was working in another state, as he is a migrant worker, and another time he did not want to go to the hospital because the baby was going to be brought home anyway. Pratima's husband is a rag picker and could not miss a day's work as he was earning a daily wage of 250 rupees that ensured food for 22 household members everyday. Pairo's husband works in a bank and was away during the time of her pregnancy but arrived right before childbirth from another city.

The husband's presence around childbirth wasn't always desired, as narrated in Amrita's I Poem in Box 6.9 and shown in her birth map in Figure 6.14. Sujata was the only participant who wanted her husband to be there during her births as mentioned in the previous section. Anju's husband played a key role in all her births, from calling the ambulance to accompany her for first two births which were stillbirths, followed by calling the *dai* for home birth in her next three births. He even assisted her first home birth as the *dai* arrived late and he waited outside the room for the rest of the two births.

"No no no… why will I call my husband to hold me! I was in so much pain! I did not think of husband and all." (Sita)

"To frankly tell you, it would have been most encouraging if my husband was there with me, but men can not be there. They are not allowed. So, if he isn't there, it doesn't matter who is! All others are same! Husband's presence is something entirely different. In this condition only husband is needed more." (Sujata)

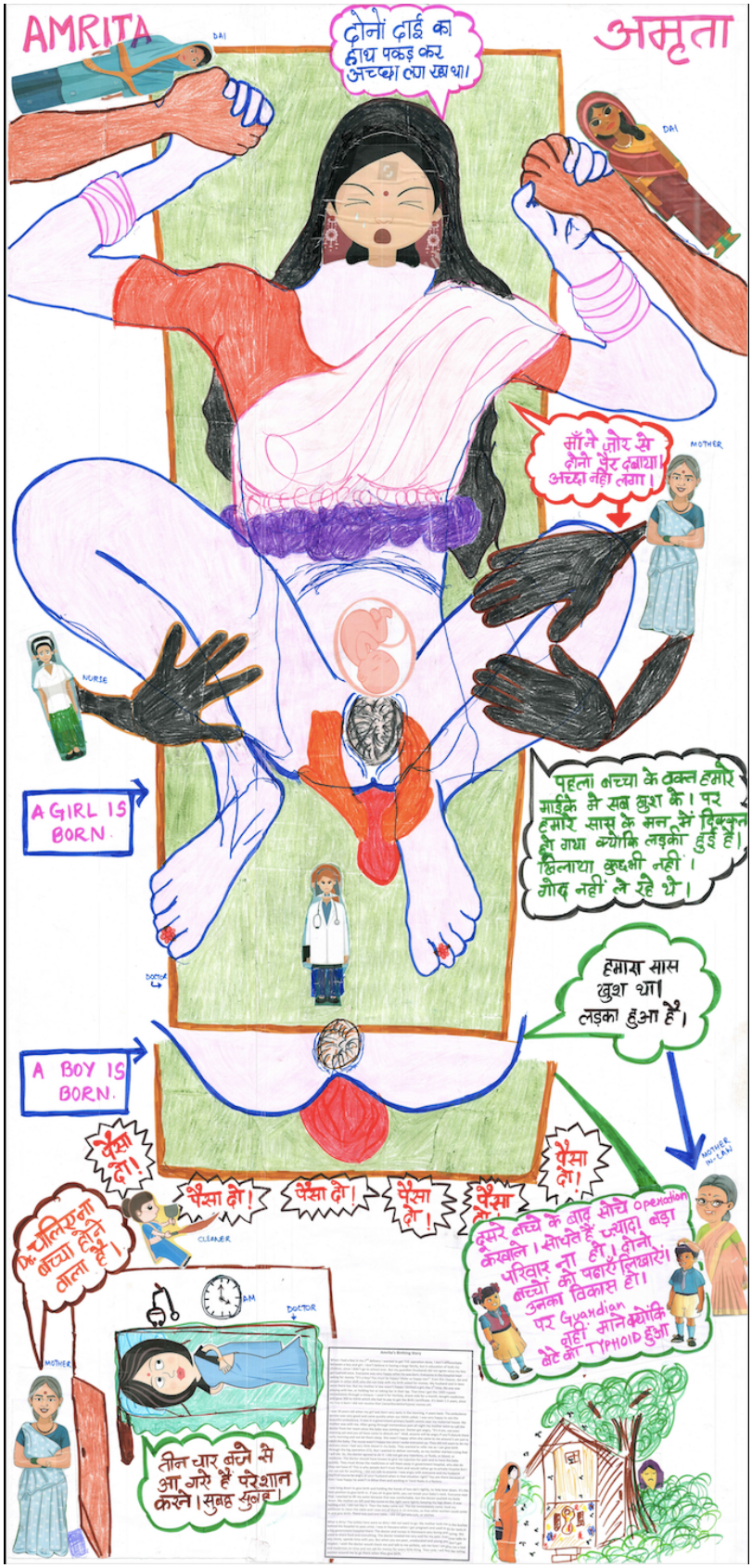

Figure 6.14 Amrita's birth map

Box 6.9 Amrita's I poem- Because of him, I am in this situation!

Because of him, I am in this situation!

I felt good!
I am in pain, obviously I get very angry when I will look at him.
I also get angry whenever I was in pain.
I am there, just because of him, I am here in this situation.
I feel he should be away.
I didn't want him to be there with me.
I don't know about it exactly, guardians paid that but the people who were cleaning there, they all have asked for money to eat sweets.
I don't know how much they paid.
I didn't ask anything to anyone.
I was just praying to God so I don't have any more babies.
I was crying.
I did not feel like talking to anyone.
I was thinking about the operation (tubectomy).
I think there is no point of having more than two children.
I wanted to give them a good life.
I wanted to send them to school for education, which I have not received.
I [could] go there for operation.
I did not get it done.
My guardian (husband) *did not let me.*

6.5.8 Birthing information, birth preparedness and myths around birth

Women did not talk to others about pregnancy and childbirth. They often had no information when giving birth for the first time. None of the women had any discussion about pregnancy or childbirth with their husbands. Any communication was limited to some conversations with other women in the neighbourhood, which was less often. One participant discussed it with her grand-mother too. The information shared amongst women were not always correct and full of myths. Women were asked to eat, drink and rest while they are pregnant and leave everything to God. Nobody talked about how the baby is born or other details of it for various reasons including shame, as Sujata shared.

"In winters they don't run water (IV fluids) *because it is so cold… my neighbourhood sister told me they ran water and the baby came out quickly after that."* (Amrita)

"It's a saying that if the environment is hotter, the baby will come out quicker. Like if someone does not want to have the baby when she is pregnant, everyone advises to eat and drink hot, like cardamom, which has heat. That heats up the body and the baby gets spoiled/ wasted. The same way when giving birth, heat will cause the baby to come out. Women whose expected date of delivery is up will have a safe delivery and those whose due date is far will get it aborted. Definitely it will get spoiled!" (Sujata)

*"Baby was poisoned inside the belly for 3 months and it stayed in the belly and mother also died because of that poison. (*A lady from the nearby village)" (Anju)

"My mother in law used to say if you want to eat sour then you will have daughter and if you want to eat sweet you will have a son. I told her I like both. She said then I will have a daughter." (Ria)

Women were shy to talk about birth with the women around them, with their husbands and with health care providers. The stigma to talk about birth can be seen in Pairo's I-poem titled 'It was my innocence!' in Box 6.10.

"I was very anxious during my first birth. I did not ask about it to anybody. I was feeling very ashamed and not understanding anything since I was very young. I was very ashamed. How will they do it, what to do, for all that I was nervous." (Sita)

"I did not know beforehand. I never went to hospital so how would I know? I don't talk to anyone. There was a fair woman in the next house... I used to discuss with her sometime. I don't go out of the house at all… what will happen will be God's will, when God will want it to happen. It's not in our hands." (Pratima)

"You know how women talk about these things… they used to share it happened like this and like that. One of my friends said that doctor said, 'when you you don't have the strength to bear the pain and give birth, then why did you keep the baby.' Everyone gets to hear this. This is very normal conversation around childbirth." (Ria)

Box 6.10 Pairo's I poem about conversation about birthing and preparedness

'It was my innocence!'

I was born in 1990.
I am a school teacher.
I am pursuing my MA degree.
I call my mother to take care of my kids and family.
I keep asking her to come here.
I am the eldest.
I must have been 10 years old.
I had to mind him.
I had to take him.
I used to beat him a lot.
I remember, when I was unable to take care of him as a child, so whenever he cried, I would beat him.
I did not know what to do with him.
I told this to him that I used to beat you a lot when you were small.
I told him that I used to do this with you.
I sometimes think that it's not possible for a mother to tackle too many children, so she puts that burden of responsibility on her eldest child.
I do that too.
I tell my daughter "you must take care of your brother".
I compare it with my childhood when my mother did the same.
I think this is a given thing to do.
I got my job here, so we stayed here.
I have also studied from my maternal grandmother's house, not even from my own maternal house.
I used to live there.
I did not understand so much about these things.
I have always just kept my focus on my education, then suddenly I got married and had children quite quickly after that.
I generally did not pay attention to these things.
I did not talk about this with anyone much, did not have much information about this.
I had never heard about it.
I used to think that the baby has gotten inside my womb one way, but how will it come out now (laughs).
*I too thought since it walked late (*in the womb) *then it would be a son.*
I was carefree about it.
I thought it's fine and I am pregnant.
I just have to keep eating and go to work.
I kept going till the last month.

I was waiting in my house that I will have pain any moment.
I was thinking, how will it come out?
I used to live alone when I had these thoughts.
I was not saying anything to anyone because I was thinking that these people would think about my wellbeing only.
I believe that these people should have told me this.
I was just a patient.
I never discussed about it with anyone.
I knew that I would have normal birth.
I was happy that my second birth will be normal.
I wanted to experience normal birth.
I will come to know how women give birth normally.
I never even watched a video on Youtube about how baby comes out of the mother's womb.
I never asked these things to my mother or aunt.
I never shared these things with my mother or aunt.
I thought it will happen somehow.
I was thinking how will it happen.
I used to meet my doctor for USG.
I used to ask her please tell me what is inside otherwise my husband will feel angry even though he won't tell me anything.
I assumed I have a daughter, it had to be a girl since she was not telling me.
I used to think that it would be a son.
I think because of my mindset when was she born, she was looking like a boy.
I thought second time I will have a girl but it was a boy.
I love her more.
I used to tell my brother and sister that I don't like him much.

With no one to talk to, Sujata looked into Youtube for information on birthing and care during pregnancy. Women carried many things with them when they went to the institution to give birth. Wearing a nightie was a common instruction that either came from the care providers or as a suggestion from women in the neighbourhood. Women often did not wear any jewellry when they were going to give birth. They carried a separate set of clothes to change after and old cloths to be used during birth in the hospital to clean the baby, the woman and the labour table.

"We carried everything. Petticoat, nightie, bedsheet. Not pads, they gave us there. The clothes which one wears at the time of birth, they throw it because they become dirty giving birth. That's why we carry extra clothes. They removed all my clothes and asked me to wear a nightie." (Sita)

"It shows on Youtube right, what is good to eat and what not. I used to watch it. My husband has a mobile phone, I used to search in that… I would engage in these mischiefs after my husband would sleep off. I used to look for all these secretly." (Sujata)

Women found it difficult to determine who is giving the right information and often they will only get that clarity after giving birth for the first time. Women did not feel the need to talk to anyone about it, as Urmila shared.

"I have never talked about my births with anyone. I did not feel the need to talk about this with anybody. We do not have the culture of talking about birth, before or after. I was not able to talk about this to my mother, husband anybody. I did not know I needed it, after talking to you I realised, I liked talking about my birth." (Urmila)

6.6 Discussion

Breaking the silence through birth mapping

Women were surprised to find someone knock at their door with the proposition of hearing their birthing stories. Birth is a tabooed topic of conversation among women because it is commonly ascribed to an outcome of sexual intercourse (Chawla, 2006; Chawla, 2019). Women are often verbally abused with judgmental comments using this fact, as is seen in Ria's narrative. This is not just about narratives of traumatic birth, the literature suggests that women sharing good birthing experiences are shamed for 'showing off' (Hill, 2019). Given the utility of body maps in understanding women's experience of crucial life events such as childbirth, my adaptation can be named 'birth maps' and the process 'birth mapping'. Birth mapping helped to break women's silence about their birthing experiences, where theirs is the crucial voice driving the improvements in sexual, reproductive and maternal health care (Oakley, 1984; hooks, 1989; Kitzinger 2005; Chawla, 2006). Birth mapping has proven to be an excellent choice for a method of data collection to understand women's experiences which are sensitive in nature, such as childbirth, and requires more time and willingness from participants to share in a trusting environment. It is an economic and flexible method (Devine, 2008) which requires relatively low cost supplies for the artwork (Gubrium et al., 2016).

The unique application of birth maps helped to address the language and power-based barriers and helped women to break their silence, especially about their experiences of obstetric violence, and share their birthing experience in detail with comfort. Birth mapping ensured that participants were attentive and focused throughout the exercise. Women had better recall, more than they expected themselves to remember. Some women were interviewed three to four times and all through the conversations they remained intrigued and were determined to find time out of their busy schedule and continue their participation. Participants were deeply engaged in the process. Their attentiveness reflects in the richness of the data collected through their narratives of birth (Lys et al., 2018). The birth maps enabled the conversation to move from one part of the

body to another, from the experiences that women felt on their body to their experiences of the birthing environment. It was easier for the participants to articulate their feelings through the map. Specific aspects such as the colours, cut-outs, facial expressions and people the women chose to put on the map, opened the way for relevant probes and gave options for women to choose from what to share of their story. This made it easy for the participants to reflect on certain probes and their perception from their experience. This was a key rationale for using this method to understand women's experiences of childbirth. Birth mapping made the data comprehensive and rich.

Listening to the contrapuntal voices

With the choice of feminist embodied methods, I have ensured that the women's voice is primary and the author's interpretation is secondary. This has been ensured during data collection, analysis and in the presentation of the findings through the birth maps, birthing stories and the generous inclusion of quotes. Feminist methods reduce the power-based imbalance between the researcher and participant. Feminist relational discourse analysis and voice-centered relational analysis are novel methods that ensure women's voices are prioritised and are at the centre. This multilayered analysis is a key strength of this study which guided my listening to the contrapuntal voices throughout the different forms of data. Figure 6.15 presents a range of contrapuntal voices heard in women's poems in this study through the language of music.

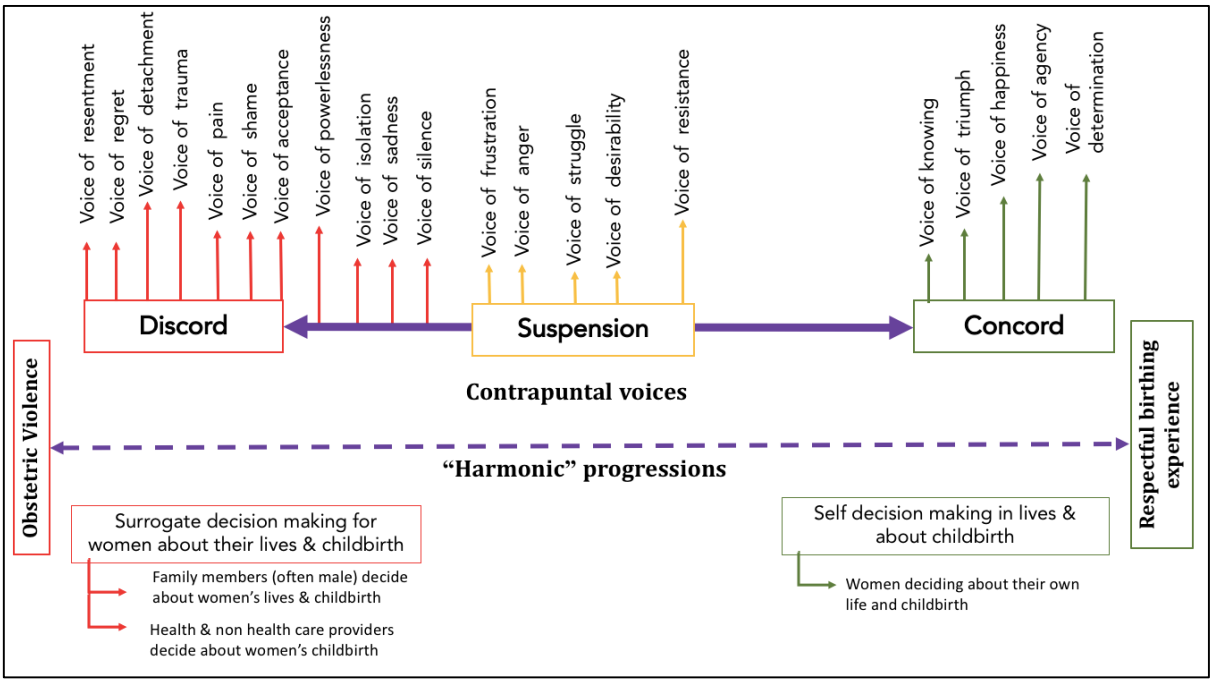

Figure 6.15 Range of women's contrapuntal voices about self decision-making and surrogate decision making during childbirth and in life *(Author's own)*

The range shows 'discord' of the negative end, where women experience extreme forms of obstetric violence and its consequences. It transitions through the 'harmonic progressions', which express women's struggle and resistance, extending to the extreme positive end of 'concord' for a satisfying and positive birthing experience. Women's experiences are not linear or one directional but rather complex and layered. The dominant discourse of the contrapuntal voices is of discord and suspension, rather than of concord. Some of the voices prevail more than others. One of these figures can be created for each participant, focusing on just her contrapuntal voices. Even within the poems, the maps and quotes (and the birthing stories presented in Chapter 7) show that the voices depicting concord were limited, whereas the length or duration of the voices of discord were longer for all four women's experiences. For instance, Pairo's poem 'Doll' had the voice of determination and happiness, once each, when she is happy that she has given birth to a girl and determined to take her to school with her. The other voices were those of shame, powerlessness, trauma, fear, silence, isolation, sadness, detachment and struggle. The two poems from Urmila's experience have an aligned narrative about decision-making in the birthing environment and about her life. These voices can be noticed not just in the birth-related poems but in their routine life-related poems as well, allowing the reader to see connections emerging between both aspects of lives, with birthing being an extension of how they experience life and the oppression that comes with it in routine lives. The voices of silence, powerlessness, isolation, pain, fear, anger, resistance and struggle can be noticed in both domains and similarly on the positive side, the less frequent voice of triumph can be heard when she describes sending her husband to jail.

Complex, rich and unique experiences of respectful births and obstetric violence

This study has opened up the rich, complex and multilayered birthing experiences that are not unidirectional and have aspects of both respectful care and obstetric violence, taking it a step further from the quantitative analysis of 2194 women's birthing experiences that I presented in the previous chapter. This chapter shines a light on each participant's embodied experience, enabling reflection by understanding them as a holistic being along with a deeper understanding of the health care infrastructure, birthing environment, policies, norms and much more from the women's perspective and experience. The hospital birth setting in a private hospital was not necessarily very different from the public settings at different levels. Women reported that the private hospitals discussed in this study were advantageous when compared with the public hospital in terms of getting a bed or a separate room, and to receive quicker attention from the care providers. Ria and Pairo have birthed in very crowded environments, but this is quite the opposite to the comforting experience of communal birthing, where everyone around the woman is there for her, supporting her and encouraging her (Chadwick, 2018; Shabot, 2020).

In hospital births, respectful care begins with the reception of women. An absence of basic human interaction is the most common form of disrespect that women experience (Vedam et al., 2019). There is scope for care providers and health systems to embed respectfulness at every point of interaction with women throughout their sexual, reproductive and maternal health needs. Respectful care could be ensured via better interpersonal communication, appropriate birthing environments, effective team communications, avoiding unnecessary interventions and conducting the essential intervention with consent and sensitivity, ensuring clean birthing spaces, access to clean water, hygiene and sanitation and birth companions of choice (United Nations, 1947; WHO, 2018).

Over-medicalisation makes the birth world impossible for women to understand and describe. Studies suggest that the culture of silence, leading to acclimatisation to tolerate violence in personal lives, often as a result of a patriarchal culture, may keep them from reporting their experience of disrespect and abuse in the birthing environment, as they may be conditioned to feel less valued (Chawla, 2006; Hill, 2019; Oakley, 1984; Mayra & Hazard, 2020; Jejeebhoy & Santhya, 2018). This is confirmed when medical interventions are prioritised over women's comfort, dignity and choice (Chawla, 2006; Madhiwala et al., 2018; Diniz et al., 2018; Kapoor, 2006). Women reported being the last priority in the birthing environment. This is a sad reality that is systemic and a part of the cultural conditioning of women that makes them accept unnecessary unwanted interventions, including cesarean sections (Diniz et al., 2018), and so that birthing becomes an experience that needs to be endured. Lambert et al. (2018) argues saying 'you barter your choice in return for skilled care'.

While other studies suggest that "being present with the woman" is crucial for a positive birthing experience (Kapoor, 2006), in women's opinion the care providers would rank the foetus / baby and their own convenience as top concerns in the order of preference for care. This is reflected in care providers coercing and compelling women and restricting women's choices about their body. It is imperative to understand the difference between having birth companions chosen by the family and health care providers, against having a supportive presence of someone chosen by the woman. A companion who is focused on the care seeker's needs and the birthing process (Chawla, 2019). The continuous presence of a health-care provider with every woman is not reported in these stories from Bihar, apart from a *dagarin* in one case, who was with the woman throughout her home births. Good touch, that is soothing, is highlighted as essential in the good birthing narratives (Chadwick, 2019) as could be seen in Sujata's expectations. This tactile comfort is usually sought in an atmosphere and relationship that women trust (Shabot, 2020; Scotland, 2020). My study predominantly reports bad touch, because most touch women reported during childbirth was uninvited, unconsented and traumatising. The current narratives of the birth world

are hostile and harrowing. They include women's exchanges about birth with their female family members or friends, which lead them to expect obstetric violence. That is unless they behave or abide by the care providers or let them do things and do not come in the way of care and act as a passive participant in a significant experience of their life.

From endurance to adaptation

Women in Bihar request '*dard ki dava'* (augmentation by un-prescribed uterotonics to hasten uterine contractions). They are often augmented before going to the hospital, to reduce the duration of their stay in the hospital. They do not consider it as abuse, as women in higher-income countries often do. The difference is in the perception of being abused and the extent of acceptability and reporting, which is different in high-income countries because of a better understanding by women of poor quality and disrespectful care. Women's choices are moulded by their previous birthing experience, and women often factor in memories of the respectfulness of their care, especially when they have previously experienced obstetric violence. Women often recover from their previous traumatic experience in their subsequent birth by trying to do everything possible to make it a positive experience, as a way to heal from their previous traumatic birth (Beck, Driscoll & Watson, 2013; Kapoor, 2006; Shakibazadeh et al., 2018; Keedle et al., 2019). This was true for women giving birth for the first time, based on what they had heard from women in their neighbourhood. Women in low and middle-income countries endure and often do not know that their experience can be better, they prepare themselves for an alarming experience. Sometimes the awareness of choice over what happens to their body and how they will be treated, comes as a revelation (McAra-Couper et al., 2011). This could be attributed to intersectionality of the women's background characteristics such as education, socio-economic status, gender, marital status, religion, age, gravida, caste, class etc. and the difference between her characteristics from that of her care provider and everyone who plays a role during childbirth (Sen, Reddy & Iyer, 2018; Chattopadhyay, 2018; Sen & Iyer, 2012). Intersectionality is better explained in terms of race and gender but could be used to understand what drives obstetric violence during childbirth (Chadwick, 2018). In countries such as India, care providers need to work harder to ensure respectful person-centered care, as they are up against women's low expectations from care (Roder-DeWan et al., 2019). Even though some instances of abuse are unintentional or a particular care provider's fault, but they need to be aware that abusive care during birth is the dominant discourse in the Indian birthing culture, and only they can change this narrative. Measures are required to also address the structural and policy related drivers that make the women vulnerable to obstetric violence but that will only be possible through the understanding of why women experience obstetric violence, and are not treated in a respectful and dignified manner during childbirth. I discuss this in the next chapter from the four important

constructs of gender, power, culture and structure that emerged from these eight interviews with women.

6.7 Strengths and limitations

This chapter presents women's experience of respect, disrespect and abuse during childbirth using the visual arts-based participatory method of body mapping. Adapting this method to birth narratives by producing novel birth maps is a key strength of the study. The resultant rich accounts of women's narratives help to enlighten to understand their contextual situations (through the maps and their birthing stories) help the reader to appreciate their perspectives. Women in my study experienced respect, disrespect and abuse in the home environment as well as in private and public facilities, though exploring these perspectives further was beyond the scope of this study. There were aspects of disrespectful or abusive behaviour linked to family members or at home that women narrated in regard to birthing experience that had an influence on, or added context to their perspectives. Childhood sexual abuse increases women's vulnerability to abuse during childbirth, but this could not be explored in this study due to added sensitivities to the already sensitive nature of the issue being explored. Women's experience of respect, disrespect and abuse changes with context and women's changing perspectives depending on their socio demographic background. It is essential to understand this through the intersectional lens to investigate the role of different cultures, religions and socio-economic backgrounds, to understand how it influences care during childbirth.

6.8 Conclusion

Women's missing voices in research about deeply feminine issues constitute a global phenomenon. Obstetric violence related research is dominated by surveys and perspectives of everyone but the women who give birth, especially in the diverse Indian context. Women remember the trauma of an abusive birth throughout their life, often without an opportunity to share it with anyone. This research makes an important novel contribution through the creation and use of the birthing maps as a participatory and culturally-appropriate visual arts-based method prove useful for accurately portraying women's respectful, disrespectful and abusive births in low resource settings. It helps women to break their silence about obstetric violence and express their experience of respectful maternity care. This is important to understand, as even in the eight case studies we observed diversity in women's expectations along with some similarities. This diversity can be well understood through birthing maps as care needs to adapt to

these changing circumstances, to ensure respectful person-centered care during pregnancy, labour and childbirth (Afulani et al., 2019).

The system of care during childbirth is very medicalised in Bihar, as seen in the narratives of women from this study and the rampant, often unethical use of interventions performed so that the care providers do not have to be at the mercy of the physiological birthing process. They create something that can fit their schedule and calendars. Pairo's story clearly shows how "Docsplanation" has taken over the birth world because the medical model has changed to suit the needs of obstetricians, especially male (Mayra, 2020a). Remnants of this can be seen in hospital birthing environments in India where women are restrained when giving birth. The presence of eight men in the operation theatre for Pairo, none of whom she had met before, is a severe violation of her privacy. Instead of keeping her comfort in mind, Pairo was non-consensually blindfolded, which perfectly signifies the oppression of women in the obstetric settings. All women have a universal right to respectful maternity care, regardless of the context and diverse backgrounds. This makes it important to systematically understand women's choices, experiences and expectations through innovative methods like birth mapping to inform changes in practices and policies around childbirth, which are diverse across cultures and contexts.

Chapter 7 *"I have to listen to them or they might harm me"*: Why do women endure obstetric violence?

The previous chapter presented the nature of respect, disrespect and abuse during childbirth from women's narratives. This could be considered their first step in breaking the silence about their experiences of obstetric violence during childbirth and state their expectations of respectful maternity care. Women's narratives are rich and they often mentioned their perspective of why they experience respect, disrespect and abuse entangled in their responses to the nature of their experience. I utilised the additional information women provided, by analysing it to understand the underlying reasons behind respect, disrespect and abuse during childbirth. This was thematically different from the planned objective of the previous chapter, so I am presenting it in this new chapter. Women went a step ahead from sharing what their experience and expectations are, by also stating why they expect to be treated with respect, disrespect and abuse and what drives it. This chapter is more than breaking the silence, it presents what caused the silence in the first place.

7.1 Background

Silence is a common theme when exploring women's sexual, reproductive and maternal health. Silence is noticed at home and in the hospital, which points at women's unquestioning attitude which starts at home and extends to the obstetric setting. Women hardly complain about pain, be it pain during intercourse or pain when giving birth (McAra-Couper, 2014).

In the previous chapter I presented evidence that women in Bihar raise concerns referring to aspects of the care that they considered respectful or disrespectful. The language women use when they referred to being *'allowed to'* or *'made to'* or *'forced to'* is a manifestation of the imbalance of power deep-rooted in gender-based discriminations and has become part of the structure and culture which ensures this conditioning is perpetuated. Women's narratives exemplify how power, gender, culture and structure influence the care they receive and how that is related to what shapes their perception of respect, disrespect and abuse during childbirth. These themes were not included in the previous chapter because they relate to the factors driving respect, disrespect and abuse that emerged from the data. But this is an important piece of the puzzle which provides the perspectives of the key stakeholder of childbirth, the women. Hence the impact of gender, power, culture and structure are presented separately in this chapter I

chose a different set of questions using the same data from the body mapping aided in-depth interviews and following the same methods of analysis as presented in the previous chapter.

This chapter and the next chapter explores why women experience obstetric violence. This has the potential for positive impact on providing respectful maternity care. The methods have been described in Chapter 6, but it is important to mention that I acknowledge the power-based inequality in the interview environment between me and the participant. I employed measures in terms of using the language of participants, dressing locally and being at the same level in terms of positioning oneself physically to try to reduce this inequality. These efforts may not go all the way in balancing the power dynamics, therefore the research team ensured that all communication and interaction with the participant and people in the communities are respectful, the interviews and the birth mapping exercise are conducted with utmost sensitivity and the participants are made aware that they can refuse to be a part of the exercise or answer any particular questions.

A research relationship often puts the researcher in a position of authority of power as creator of knowledge that they seek to create (Sprague, 2016). Studies have shown that arts-based research methods, such as body mapping, tend to minimize power-based imbalances between researcher and participant. Research methods shifts the power dynamics where the participant is the expert knowledge producer, and the researcher becomes a facilitator and co-creator of the outcome of the arts-based research (Klien and Milner, 2019; Lys 2018; Boydell 2018; Sweet & Escalante 2015; Boydell et al., 2020). I followed the course of discussion of the participant, probing only when required, and noticed many instances that could indicate a shift in power imbalance during the course of the interactions, such as participant's comfort about calling us at odd hours, halting the interview to attend to the household chores when required and with their frankness, humour, honesty and openness when sharing sensitive details of their experience of birthing and other aspects of their life. This trust was growing, it could be seen more strongly in subsequent interactions and in the nature of the content we discussed, that often went off track, but women shared what they found relevant to the context of my research. This chapter is a result of such off-track conversations that provided a rich understanding of the participant's unique perspectives of why women experience respect, disrespect and abuse during childbirth.

7.2 Research question

What are women's perceptions of the underlying factors driving respect, disrespect and abuse during childbirth in Bihar?

7.3 Objective

To understand the drivers of respect, disrespect and abuse during childbirth, from qualitative participatory arts-based data about women's experience of giving birth in Bihar, India.

7.4 Findings

7.4.1 Power influences care during childbirth

Power was evident in the way women interacted amongst themselves and with others in their home or their social environment and the obstetric environment. Two kinds of hierarchies could be noted from these interactions; 1) social hierarchy and 2) medical hierarchy (which is embedded within the social hierarchy). Power in relationships with people increases as one goes upwards and women are at the bottom of both the hierarchies, as shown in Figure 7.1. All kinds of people (especially as mentioned in section 6.5.6 about people in the birthing environment) and their relations to women mentioned by them in their interviews, are shown here. The hierarchy is created after analysis of women's narratives about these actors in the households, neighbourhoods, community and obstetric environments.

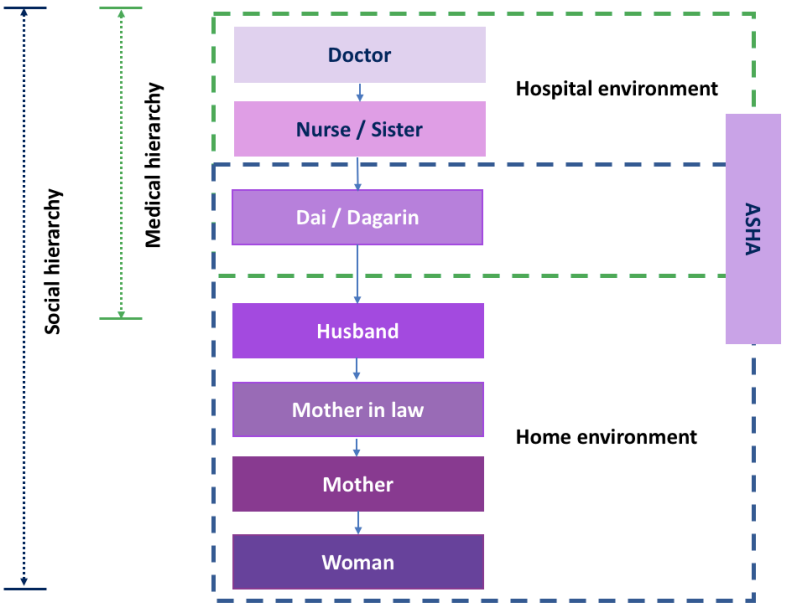

Figure 7.1 Hierarchy of power relations (*Author's own*)

In the hospital environment, the doctor could be seen at the top of the hierarchy, as observed from women's responses. When asked to rank all the people in the birthing room in the order of their importance, Sujata mentions that the doctor is the most important person in the birthing room, and even for the care providers around her like the nurse and *dai,* the doctor was priority.

Sujata forgets herself when ranking everyone in the order of importance and power; and when she is reminded of herself, she shares confidently, with a laugh, that while she should be the most important person in the birthing room alongside her baby, that is not the reality. The inferiority can be noticed in the language used by women in describing themselves as someone who will need to follow the care provider's orders and that they have no choice or right to consent in the situation. This was obvious in women's narratives of being treated like an object, a passive participant and often being at the receiving end of the care provider's anger.

" 'If you are so afraid why did you conceive? What is the need of having children?' They say such things, what can we say! I feel angry. But I am admitted under your care, so, I will have to do what you say. If I do not do as per your order, then you will again do something to harm me. So I have to listen to them…. Or they might harm me in some way." (Ria)

"They decided on their own… I was in the delivery room. We all want to have a normal birth but it depends on the doctor what they want to do. What is best!" (Sujata)

"The nurse was very sad because we were creating inconveniences for them early in the morning." (Amrita)

This was manifested in the way communication between these actors played out. Doctors and nurses did not directly communicate with the women, nor did they explain the procedures to them or seek consent. They treated women as a passive participant, as an object. The most extreme case was seen in Pairo's first cesarean birth which is also shown in her birthing story (Box 7.1)[12]. Pairo felt that the doctor was over-confident and did not care what her patients might be thinking of her, as she was prescribing medicines without describing what they are for and just expecting her prescription to be followed without any explanation. She also felt that the pediatrician, who scolded her husband after having been at fault himself, just made a mistake. She felt she had no right to feel angry or concerned about it because he was treating her baby, so was only exercising the power he had over her, and her family. A display of physical overpowering was also seen in terms of restraining women during various interventions where people around birth from home and hospital participated in restraining the birthing woman. Women did not like this, but considered it normal and hence did not report grievance. Power was displayed by completely ignoring the birthing woman's presence in the room, and not giving her any choice or voice by cutting all communications with her. The communication took place with what I call the 'surrogate decision makers' who converse on behalf of the birthing woman who is capable of making her own decisions.

[12] For better impact please look at Pairo's birth map in Figure 6.11 while reading her birthing story in Box 7.1.

"They were talking about me, around me, but not to me. They were only talking to my parents. They were informing them after checking me. I did not ask them anything. What is the point of me asking them things unnecessarily, the elders are there for that. They need to know and decide things." (Urmila)

"She did not need to ask my name. She was calling me you, you." (Sujata)

"I wanted to straighten my leg for a while but everyone was holding me down, my legs and hands from all four sides tightly. I could not bear that, the touch of anyone." (Urmila)

At home women follow the decisions of their *guardians* without questioning. Father at *mayka (*maternal home) and husband at *sasuraal* (in-laws place) are the people with the highest authority. In the birthing environment the father and husband have a limited role but the elderly women such as the mother-in-law and the mother often make the decisions about pregnancy and childbirth and also negotiated that women not fuss about the interventions with the classic *'women have to endure this experience'*. This is seen in some of the quotes in gender, culture and structure as well. *Dai* and ASHAs have a dual role to play as well, which is evident from ASHA's placement in bridging the gap between home and hospital. *Dai* is often seen providing care in both these environments.

"She (ASHA) told me 'you might have withdrawn the money from your account.' … I gave her my passbook and told her to check if she does not believe me" (Amrita)

Participants often did not question the authority of anyone and followed all the instructions without resistance. They would go back to the same care provider who have abused them, avoiding any confrontation. There are no consequences for health care providers for violence against women and the newborn in the obstetric environment.

"He was a good doctor and we knew that he made a mistake… he scolded my husband… I just feel he probably did not do it intentionally. I trust him enough that I still go there for my child. But I never confront him (doctor)*. Did not want to hurt his feelings."* (Pairo)

"They are doing their work, they are not at fault. They were doing as they should do. According to my level of pain, I was also behaving a certain way. At the time of birth, they used to remove the clothes and lift it up, but that is necessary." (Sujata)

The fact that the 'surrogate decision makers' do not feel the need to convey the communication they had with the care providers about the course of treatment or decisions and choices made about the woman, is astounding.

"I was thinking these people would think about my wellbeing only. They'll have my best interest in heart, my mother and husband. I believe they should have told me about it but they did not. What should I say, I was just a patient. But these things should have been explained to me." (Pairo)

Box 7.1 Pairo's birthing story

Pairo's Birthing Story

My heart was beating out of my chest, because I knew what was going to happen next. He held my hand tightly, a stranger, but it felt good. As if someone my own is keeping me calm. Scared, I asked him to press his hand on my chest, on my heart. I am a 29 years old, government school teacher and this was my second childbirth a year ago.

Memories of my 1st birth had traumatized me. Everything is still fresh in my mind. Even now when I think about it, I just know, never again. I wasn't in pain but I was leaking some fluid. So everyone took me to the government hospital that morning. There were many women all waiting for their turn, and then I saw that doctor wearing a plastic glove checking everyone in that dirty environment. I ran from there! I was taken to a private hospital next. The lady doctor just made the nurse lift my petticoat and nightie up; and forced her hand inside me without any explanation. I started screaming and crying out of pain. "*You can never have a normal birth, if you can not bear this pain."* The next three days I was in observation when I was given nineteen bottles of fluids, many injections to increase the labour pain and numerous vaginal examinations. The nurses would just come and insert their hand, not even minding the crowd and how many people are around me. I was frustrated and complained to the doctor, "*why does everyone has to first insert a hand inside me, without even talking to me. Is there no other way to check?".* She said nothing. My mother says, *"women have to endure that, to have a child".* Even now sometimes I tell mummy, "*that wasn't right!"*

I was in the cafeteria with my family when the nurse came and just dragged me by my hand to the operation theatre. No explanation given! My family stayed outside the OT. There were 8 men in the room all in regular clothes, like they are on a picnic! One of them said, *"get up!".* Gave me an injection on my back and made me lie down. No explanation given again! That's when I realized I am going to get operated, no one told me. My only solace was that there won't be any labour pain. Another man blindfolded me because the less I see, the less uncomfortable I will be. I felt someone talking my petticoat off and lifting my nightie to my chest. They were treating me like a doll… or like an animal… doing whatever they want… not caring about me at all. Like I did not exist! I was filthy and my hair tangled without a shower in 4 days my clothes getting drenched in my fluid and drying on me. I did not know anyone in that room. I asked about my lady doctor to this other guy who was apparently her son. She arrived later.

They played music. It was calming. There were other sounds too, of instruments and scissors cutting through me like they are cutting a jute rag. Everyone was talking amongst themselves while they took the girl out of my body. It's a girl, they discussed and I thought, *"I will tie her hair in two pig-tails and take her to school with me."* I stayed in hospital for 10 days after that because I had fever and chills and was recovering from surgery. Meanwhile the baby's doctor did not tie my baby's cord properly which kept bleeding. She got infection the same night and my husband had to take her to another hospital, 3 kilometers away, every day for injections. I struggled to breastfeed my baby and even hold her properly.

I cried when I could not have a normal birth the 2nd time with my son, 2 years later. The doctor pressed on the incision and it hurt. *"it can get torn and you might get a cut down there anyways. You'll need a big operation."* She said. The normal birth's pain lasts 4 days but the misery of CS lasts for years and breaks your body. In the beginning sometimes the incision used to hurt like someone rubbed *chilli* powder on it for the medicine I was prescribed to apply on it to get rid of pain and redness in the first place. This was a quack in our village who considers himself our area's MBBS!

My husband asks, "*why did you not get sterilized if you don't want another child?". "You get sterilized",* I tell him. He makes excuses that he'll get weak. So we both don't get it done. But I do tease him saying, "*my life is in your hands"* when we get intimate. I feel I needed to share these with someone, it all needed to come out as I could not talk about it with anyone. That day somehow got over, but those haunting memories have stayed with me.

7.4.2 Gender influences care during childbirth

Gender manifested in many ways and is a key factor influencing the imbalance of power between different actors, as shown in Figure 7.1. Son preference is shown in different ways by people from home and hospital in the birthing environment. This seemed to be a part of the *Bihari* culture, that begins at birth and influences every part of the participant's life including their education, financial stability, occupation, marriage and every role they play. Care providers demand more money when a son is born and offer a discount on the birth of a girl, to make up for the sorrow that descended on the household. The families avail the discount.

"Nobody was playing with my girl. No one was taking her in their lap (when she was born). *Then slowly people started warming up to her… my mother-in-law was very happy when it was a boy."* (Amrita)

*"If it is a girl baby they ask for less money, it's more for a boy. If someone gives birth to 2-3 girls, then they don't ask for happiness money because it's a matter of great sorrow for the family. They (*care providers*) understand the situation, when to ask* (for money) *and when not to."* (Sujata)

Women often have no say in the major decisions of their life, regardless of education. This reflects in their decisions about pregnancy, birth and family size. Adopting family planning methods is treated as women's business and women accept it as they accept that domestic work is women's domain. This could be seen in the huge difference in the female and male sterilisation rate in Bihar and India, indicating that if one has to get sterilised between the couple, it will be the woman, and all the family members weigh in on that decision. Women did not know much about money-related matters, they had no say in expenses and often did not know how to manage a bank account, even though most women had a bank account which is mandatory to receive the JSY incentive.

"My work is to just cook and take care of the house. So I don't know much." (Sita)

Women are not accustomed to these gender roles for themselves and for others. For instance, they assume a woman in the birthing area is a nurse and a man is often a doctor. They also assume men in the OT to be nurses, to ensure oneself that their presence there was necessary.

"What will I call them, gents nurse? Are they nurse? I mean compounder may be?" (Pairo)

"The doctor played music on his mobile… I asked where is madam? He said 'mummy is coming!' The doctor whom I used to show was a lady but her son came in the operation room… he had a degree… I did not know, he is a doctor." (Pairo)

The person who Pairo referred to as doctor, may have mentioned that the doctor was his mother to indicate and exercise the same level of power over Pairo. Women cite many reasons for the obstetric violence. They feel that respect is for the rich and if one has the financial means to pay the 'happiness money', apart from bearing the cost of care, their 'patient' will be cared for well. A 'guardian' accompanying them indicate there are people who will pay. An experience of previous birth matters, because the women would have gone through the pain before and experienced obstetric violence, and would behave accordingly. Poverty and a lack of education invite abuse, according to participants.

"When poor come for care, they get scolded. We are poor, uneducated, weak and it is our need that we went, so we can not say anything and have to listen to everything they say. An educated person knows how to talk to them… an educated person will be able to reason well with them but we can't. We have to bear the brunt of their anger." (Amrita)

"The one who screams gets abused! They are not using their strength to push but to scream. They'll have to listen to abusive language. Those who have a habit of birthing, do not have to listen to such things. New mothers don't have a habit of birthing, so they don't know much, they have to listen to such things. So, they were abusing me." (Ria)

"I was blindfolded because I would have felt uncomfortable because there were men. There were no ladies. The doctor who was going to perform the operation was also a man." (Pairo)

Pairo assumes this to be the reason why she was blindfolded. There was no explanation. When women ask for an explanation or question about a procedure or medication or the duration of labour, it often falls on deaf ears and is not responded to by the care providers. Treating women as a passive participant in their birth is gender-based. Women understand this, and that as women they have little say. Women's pain is not addressed or even acknowledged in most scenarios as I discuss in the previous chapter.

"I kept asking for anesthesia but they were not even listening to me and kept doing it (episiotomy repair) … *I kept screaming and everyone was holding and stitching me. I didn't have as much pain during delivery as I did when they stitched me."* (Urmila)

"I do feel that the bad experiences were with my body. So, those things don't matter to me anymore. What happened, happened with my body but my spirit is untouched." (Pairo)

The manifestation of gender in different aspects of a woman's life can be seen in the poem from Amrita's narration titled *'I'.*

Box 7.2 Amrita's I-poem- '*I*'

I

I might have been 18 or 19 years old.

I have a husband.

I run my shop, take care of my children and my house.

I go to the nearby PHC.

I go there for medicines and all.

I go there.

I went there to get checked.

I had my boy there.

…I fall sick, my child falls sick.

I am fine now.

I have taken medicine at night.

I get headaches at night, I get fever.

I don't know whether it is due to tiredness or something else.

I was very healthy before.

I had no fever, nothing.

I take medicine and stay well for a week and then again I fall sick.

I am all alone.

…I fall ill, there is no one to look after me.

I only look after them.

I go to the market for purchasing the things for my grocery shop.

I sell it.

I leave my children at the nearby centre.

I leave my children with them.

I get help.

I leave the children with the women in my neighbourhood.

I was alone.

I used to do all the household work along with taking care of grocery shop.

I carried bags of rice, very heavy.

I used to lift 25kg jute rags.

I used to sit at the grocery shop.

I was almost 8 months pregnant.

I used to call my sister for household work… cooking and all.

I took rest then.

I had a two-year-old daughter.

I used to take care of her, like washing clothes, cleaning her, bathing her.

I used to keep her with me.

I used to get a lot of rest.

I just had to eat.

I took 3 days to give birth to my first child.

I was older (18 years) *when giving birth.*

I used to be very sick with the second child in my womb.

I did not like anyone talking to me.

I used to always feel tired.

I used to be lethargic.

I could not even eat much food or water.

I didn't like anything.

I relaxed.

I also had nausea and vomiting during my antenatal period.

I mean my lips and tongue became red and blistered and mouth was dry.

I wore a saree for both my births.

I had a baby boy, they all were so happy and they started talking with me politely.

I had the girl child, everyone was happy at my mothers' side.

I didn't have much trouble in my first baby.

I birthed a girl.

I used to do everything for her, put a kala-tika[13] *on her forehead and put her to sleep.*

[13] Black kohl dot on the forehead with with cultural significance of protection from evil eye.

I was also happy.

I was happy both times.

I used to feel a lot of pain while passing urine.

I might be dark skinned but I am very neat and clean.

I tell everyone how I gave birth.

I had normal birth.

I told them what problem I had.

I will feel respectful when they will do my delivery on time without much delay, when they will speak to me politely, with a smile.

I am birthing a boy or girl, I should be treated well.

I want sisters (nurses) *to check me nicely.*

7.4.3 Structure influences care around childbirth

Systems around birth follow structures that include certain norms and deep-rooted cultures, and are influenced by gender and power. Women, couples, families and communities are conditioned to carry on these structures which relate to their home, extending to the birthing environment and beyond. This is noticed in their narratives where they want to follow a ritual because it is normalized. The structure of birthing may include many good and bad aspects which may encourage women and people to make birthing choices. This structure encourages people to strengthen the 'doctor-knows-best' culture which makes them follow care providers unquestioningly. Questioning can also be considered offensive between people with such huge hierarchical differences.

"We all think we should have a normal birth. That's the best! But after going to the doctor, it depends on her what she will say." (Sujata)

"My mother-in-law said if she doesn't check you down there how will the baby come out?' We don't understand this but they do." (Sita)

Sujata feels what the doctor and other care providers do in a birthing environment is in the best interest of the birthing women. It might not be comfortable, but the women have to go through it anyway because they do not have a choice to deny care. Participants believe that the care providers know what is best for them and hoped that their respect, dignity and comfort would be considered when making choices for them, and that they should be given a choice. For instance,

Urmila shared that babies are exchanged at government hospitals based on sex. Ria feels her baby could have been exchanged when she was initially informed about a stillbirth. Women have assumptions about the quality of care they can expect at government and private sectors and also at different levels of care provision which helps them to decide and plan about childbirth, starting with wearing a petticoat to ensure a little privacy by keeping the lower half of the body covered, in an obstetric structure that provides bare minimum logistic support, to choosing where they want to give birth, based on how much agency they have in these matters.

"In government hospital they do not cut open the belly unnecessarily." (Amrita)

"People say about government hospital that you get the facility that you can afford to pay for. The money we give ascertains the convenience we get. If you go to a private hospital, they will rob you. You have to bring everything yourself in government but don't need to pay the doctor." (Ria)

"Those who are accompanied by their guardian are treated well… if they feel that they wont make money after birth from guardians, then they do not treat well... they do not give any attention." (Sujata)

Calling an ambulance and ASHA when in labour, is part of the structure, so is expecting the JSY incentive after birthing in a government hospital.

"We used it (JSY incentive) *up to buy knick knacks for home. For vegetables and other important things. If you have money in your hands, so many things come up. We used up the money for household related things."* (Sita)

Obstetric violence is structural and normalised. Women expect some extent of disrespect, abuse or the absence of respectful care. They accept it to a certain extent, and do not object to what they can endure, complaining and confronting is not desirable. They seek care, knowing many aspects of birthing practices that they do not necessarily like, but the consensus is that they have to endure it to give birth, every woman endures it. They share many arguments that support this belief which includes their lower status, low level of education in comparison to the care providers and the fact that they are care seekers, so the care provider has power over them as is the nature of the structure.

"He said, 'get up' and injected in my waist, taking my clothes off… they were treating me like a doll. They were not taking permission from me… No explanation!" (Pairo)

"I quickly drank it (soda) *as I had ordered it, but those people* (hospital staff) *wanted it too. It happens in the government hospital, people ask you to feed them."* (Sujata)

"I left my education when I was 13. But it's their (parents) *responsibility to send me for further studies which they did not do. They should have been stricter."* (Urmila)

The structure of society shapes people's attitudes and behaviour about how women should be treated in general. Their education, mobility, financial independence and decision making right and choices are all part of the societal structure. This has an influence on how women are treated in the hospital and all the actors are part of and acting according to the structure. Urmila's birthing story in Box 7.3 and her birth map in Figure 7.2, shows this about her life.

Figure 7.2 Urmila's birth map

Box 7.3 Urmila's birthing story

Urmila's Birthing Story

I am 25 years' old. I have three children, all under 5 years. I gave birth to all of them in a private hospital near my maternal house. I had heard from my sister in law about her horrible experience of giving birth in the most reputed government hospital in Bihar. She was always alone and had to shout for attention every time, as they were always busy chatting. Also, no matter which baby you gave birth to, a girl or boy, you can bring a baby of any sex, if you have the money. People in government hospital wait for your death. In private hospital we pay 20,000 rupees for birth, but at least we can ask for things as our right, since we paid for it. All my babies were born from down under through *tiny operation* (episiotomy), except the last one.

My grandmother had told me during my 1st childbirth, that you'll leak something from where you pass urine and the first three pains will be wrong. You must go to the hospital the 4th time you get the right pain. My second birthing experience was the worst among the three. The same people delivered my babies, the same doctor, one good nurse and two bad nurses. They kept shouting at me, where as the other nurse calmly instructed everything. They kept talking about my childbirth to my parents and others and amongst themselves, not to me. The doctor was nice too. She kept me covered and exposed only as much as needed. The doctor did everything from checking in my vagina if my baby is coming, to giving injections, fluids, and stitching me after birth. The nurses just cleaned everything around me. The nurses were there throughout though. The doctor had just instructed them to '*call me when it's time*'. I was given two injections, a tablet and there was an injection in the bottle which increased my labour pains. I kept screaming after that, as my pains increased so much. My father told my mother to be inside, because I might be scared. I did not want her to touch me since I was in so much pain. I wanted to hit everyone. Her too!

My third birth was the best! It was the shortest in duration with very less pain. I was waiting to be cut, but the doctor did not. I was so happy! In the previous birth they said it wont hurt while cutting and stitching me. They said it was just 2-3 stiches, but I know it was much more. I knew when she cut me *down there* and I felt every stitch. I felt everything. They held me down tightly! Two of them held my legs and one of them tightly held both my hands above my head as I screamed through the pain and the doctor ignored my pleas and kept stitching. They said don't you want to give us something out of happiness*?* They finally brought my baby to me hours later, after my father gave them 2000 rupees.

Have you done any research on alcoholism? Alcohol ruined my family you know! I am living for my children and I want to start earning to raise them to be away from my alcoholic husband. He drives a taxi, drinks and beats me, but I took him to court and he is now in jail. I probably shouldn't have done that. He has money for alcohol but not for children's education. I don't know anything to get a job, I stopped going to school when I was 13 and was married very young. I was very happy without a care in the world, but marriage ruined everything. My parent's should have forced me to stay in school, it was their job. I have an account in bank but no money. I don't know anything about money, I never did. I never ask for anything for me, but I can fight with anyone when it comes to my children's wellbeing.

I never shared these things with my mother or my husband. We don't talk about birth in family or with friends, you just don't do it. I did not know that I had the need to talk about my birth. You are closer to me than my family now.

7.4.4 Culture influences care around childbirth

Culture guides many actions during birthing that function at different levels. Families usually have some cultural norms, myths and traditions which could be limited to the family or shared by the community or even the state or country. This is based on the aspects that bind them together which could be family ties, gender, caste, religion etc. Who will be present around the woman giving birth is cultural and so is the presence of *dai, a*s noticed in all the home births in rural or urban interviews and even in the hospital births, although there is no formal role for a *dai* in the hospital birthing environment, and yet she seems to be one of the key care providers.

"Everyone wanted it to be normal because nobody had given birth by caesarean in my family before. Nobody wanted me to have a caesarean. That's why everyone was sad, my mother was sad and crying and saying 'what has happened to my darling girl!'." (Pairo)

Culture drives many small and big actions around childbirth. It's in women's culture to wear saree in general and when they give birth. Wearing a saree and/or petticoat under it, helps to avoid overexposure when giving birth, be it at home or hospital. Many care providers recommend women to wear a nightie when they go in labour, for the ease of wearing and removing. Not all the cultures are appropriate, some are quite damaging for the community and have a drastic impact. Son preference is one such dangerous and dominant culture in Bihar that turns the birth of a girl into an atmosphere of sorrow. Even though sex determination in pregnancy is illegal in India, people often try to determine the sex of the baby. On denial, they may feel that they are not being told because its not the 'preferred sex'.

"For 9 months I assumed I had a daughter because she (doctor) *won't reveal it to me. So I thought it's a girl because she wasn't telling me…The doctor said that this is a girl. People want their first child to be a boy. They also say if it starts walking late it will be a boy."* (Pairo)

"I thought I will have two boys and a girl and then I will get operated. But this is also a girl. I usually stay unwell so I don't want anymore children." (Sita)

It is essential to understand how the culture of abuse seaps into people's lives when they are growing up in their home and surroundings. This aids in normalising violence against women, where women adapt to it as part of their culture and do not resist violence during pregnancy or childbirth. Extortion is also obstetric violence during childbirth, which is called 'happiness money' especially offered generously following birth of a male baby. It is a cultural characteristic of Bihar.

Oppression of women, giving women a secondary status in society and women's overall lack of importance, is cultural. This is evident in women enduring pain. Women are supposed to endure pain and they do that as long as they can. Their silence about anything that happens in the birthing environment is part cultural. Women understand that they are not supposed to converse in the birthing environment, they are not supposed to question or do anything to draw attention.

"I was feeling bad but I could not say anything because we were in the hospital. If I say anything to them then they will say 'you are not the only one having a baby here. There are other people too who don't have any problem. You don't have something special down there'." (Ria)

"Everything was happening in front of me but I could not say anything. You are not supposed to talk about operation … you loose a lot of blood and the body becomes weak." (Pairo)

"I first tried to bear the pain but when it was unbearable for me, then I told my mother." (Sita)

Birthing is considered women's business, but ironically the woman giving birth has no say in it. The women around the birthing woman manage most things. Women often go to their mother's house to give birth, mainly expecting some rest during the late stage of pregnancy and immediately after birth.

"We don't do any heavy work just cook food after birth. No lifting heavy things." (Sita)

"I was at my mother's house… there was no one to take care of me here so I went home." (Sita)

Women do not talk about birth, regardless of their curiosity. They are surrounded by women who have given birth but do not share the gory details of the birthing process, and women accept it without questioning. They do not discuss it with their husbands as it is too shameful. The culture is to not talk about birthing and births in Bihar, it is stigmatised.

"At the time of birth everybody keeps searching for all this (information). *Everyone is curious to know all this."* (Sujata)

"How could I ask him (Husband) *'how will it come out?'"* (Pairo)

"What will happen is God's will. When God will want it to happen, it will happen." (Pratima)

The lack of importance accorded to women begins at birth and is cultivated through living a life that is not valued making women aware of that every day. Their date of birth is of less importance; it was not celebrated or remembered. Decisions are made for them and they are supposed to follow. Urmila and Ria's I poem (Box 7.5) present this aspect of their upbringing

which mentions how important it is to be a fair (light skinned) girl to be marriageable and to give birth to a son thereafter, as soon as possible.

"How old am I? I don't know." (Sita)

"I never took any decision for myself neither for my childbirth." (Urmila)

Box 7.4 Ria's I poem- *Had I been fairer and had birthed a boy*

Had I been fairer and had birthed a boy…

I would have been happier if I had a son.
I have no sons or brother at my home.
I had one sister, she passed away at an early age.
I have never seen my father.
I was 1 ½ years old, when my father passed away, he was murdered!

I was all alone at my home.
My mother took care of me as I grew up.
I thought if I had a son, then he would carry my family's name for another generation.
I was expecting a son, but I had a daughter.
I was sad.
I swear, I was sad!
I wonder why I did not have a son, why I have a daughter.

I live in this house and no one asks me where I work.
I go to work, but people say I am going to do wrong things.
I feel like crying.
I think, if I had a son, he could support me.
I should have had a son!

I was married with great difficulty.
I used to tell mother, 'I don't want to marry him.'

My family ruined my marriage.

My uncle said I work in a boutique, in a parlour.

I used to work very late, 11 am to 8 or 9 pm.

I don't work there anymore.

My husband started doubting me.

I said I will not stay with him.

If I had been fair[14], I would be beautiful, my mother would have married me off to someone nice.

I would have been educated, I would have been better off.

My luck was bad!

7.5 Discussion and conclusion

Gender, power, structure and culture influence the decisions made for women by women, by their family members and care providers about their lives, including pregnancy and childbirth. Figure 7.4 summarises various aspects of these four domains that are cross-cutting and overlap across domains. For instance, women's lack of choice is gender-based, culturally deep-rooted and women are conditioned into it, in a patriarchal societal structure. It maintains powerlessness by keeping women in a lower position in the society. Similarly, the other aspects have been put in one domain each, based on the researcher's understanding of which domain each of these aspects represent best. Their cross-cutting nature can be noticed in the findings as well. I decided to keep them in a particular domain based on what made most analytic sense to me, but this is subjective and the reader may feel that an aspect belongs to a different domain.

[14] Lighter skin colour

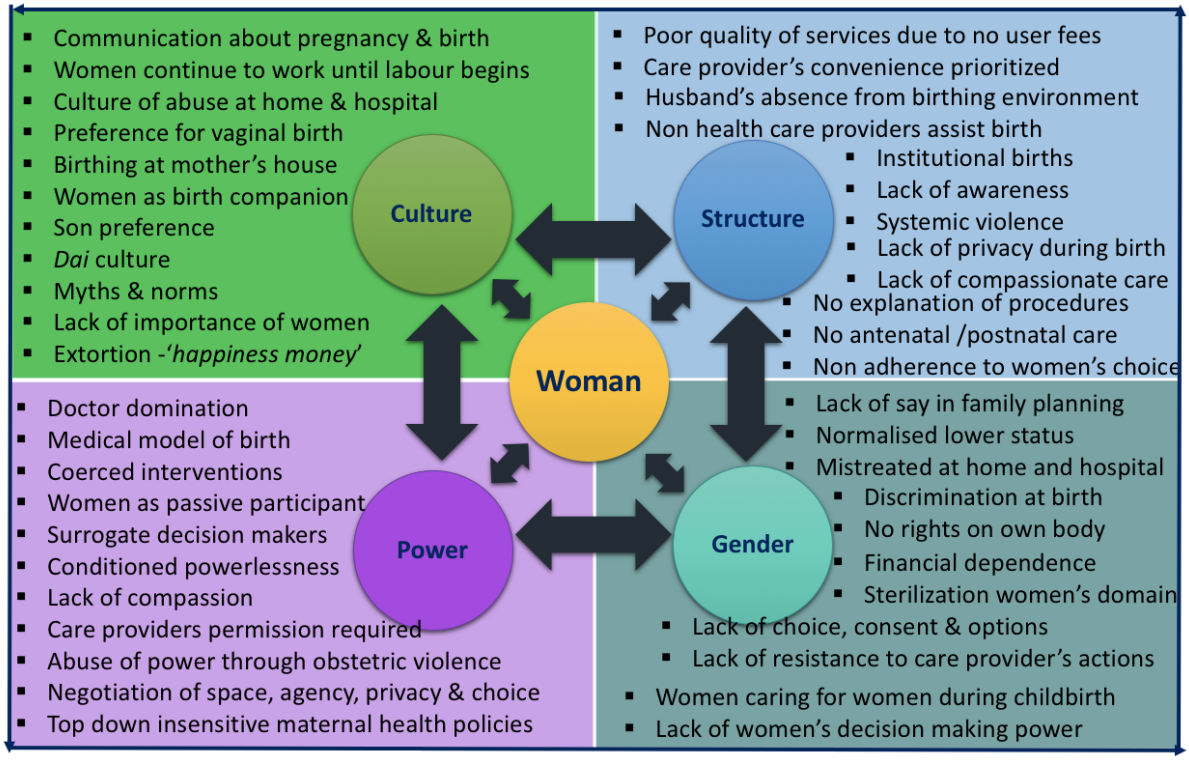

Figure 7.3 Impact of gender, power, culture & structure on women *(Author's own)*

Women report a lack of agency in making any decisions about themselves and their body including during pregnancy and childbirth (McAra Cooper, 2011). This begins with the uncertainty of whether women will be allowed to be born owing to the unwantedness of a female child (Hawkes et al., 2020). This is followed by a life course that includes not being allowed to make any decisions about their education; not having financial independence; having no say in conception and contraception; not being able to decide their family size; no say in age of marriage or partner of marriage; not allowed to decide where to give birth; whom to have as a birth companion; not being asked to consent for the medical interventions and being treated like an object; enduring obstetric violence without grievance which includes not being allowed to scream during labour pains and not getting a response to questions and being informed, even when being operated, and not given a say in the care of their newborn. This oppression of women around childbirth and a lack of agency in decision-making is in line with the literature from India and other countries (Menon, 2012; Chawla 2006; Chalwa 2019; Sen et al., 2018).

Villarmea (2020) explains that the reason behind a lack of women's agency, autonomy and the frequent disregard of their refusal to interventions is because of the 'uterine influence'. Women are considered incapable of making rational decisions due to pain, and women's choice and consent is often superseded because they are mere the 'container' for the 'foetus', who is considered the key stakeholder in childbirth. This is a characteristic of a patriarchal medical model of care (Oakley 1982; Hill 2019) evident also in the failure of the doctor to stop on Urmila's strong

resistance to unanesthetised episiotomy repair. Urmila's anxiety over her decision to put her husband in prison, is a sign of the patriarchy-driven mindset which comes from a deep-rooted conditioning into that culture. Her anxiety is about breaking the norms and the realisation of the repercussions of this act of resistance on her and her children from her husband's family, society and from her husband when he is released from prison. Women's narratives display a patriarchal culture where their voices and choices have limited scope. When patriarchy permeates the birthing environment, medical interventions are prioritised over women's comfort, dignity and choice (Villarmea 2020; Mayra, Matthews & Padmadas 2021). Urmila praised her doctor during her interview, regardless of the traumatic experience she narrated. This is indicative of a structural issue and a part of the cultural conditioning of women. We notice this in women's expectations, acceptance, endurance and their reaction to the violence and a lack of decision-making role during childbirth in an obstetric environment and in their routine life, in their social environment.

Women's resilience to endure violence in the hospital environment is in accordance to their intimate partner violence and domestic violence in their home environment in Bihar (Jeejebhoy, 2018; Koski et al., 2011). Just as women often do not expect repercussions for violence in terms of intimate partner violence and domestic violence in the home environment, they may not expect any repercussions for obstetric violence in the obstetric environment because violence against women is normalised. Repercussions are on self, not on the perpetrator. There are few examples in this study of women who broke this narrative and showed resistance, such as that of Urmila. Sita refusing to let her *dagarin* mother-in-law do a vaginal examination and deciding to give birth at the hospital, in an area where most of the births in the neighbourhood were traditionally assisted by her mother-in-law. In another scenario Urmila wanting to hit her mother when she was her birth companion, goes against the common culture and structure of birthing in Bihar. In the personal lives, both Ria and Urmila share about intimate partner violence and both have taken a stand against it, Urmila by sending her alcoholic husband to jail, and Ria by divorcing her husband without alimony, which is quite unheard of in India where the rate of divorce is 0.24% of the married population (Thadathil & Sriram, 2019). Receiving respectful care, along with the basic gesture of being spoken to respectfully, changes that power dynamics and indicates an equalisation of the power-based imbalance wherein women feel they are receiving way above their grade, which may lead to a relationship of trust between the care provider and care seeker. Women are constantly negotiating power at home and hospital and every other environment she engages with. She knows she is at the bottom of the hierarchy by structure, more so in an obstetric environment, so she discounts the good behaviour and does what is beneficial for her baby, follows orders, endures obstetric violence and she goes home with a live baby.

The power dynamic is more leveled in home births. Education or financial independence did not influence it much for Pairo, who wanted to be told about the interventions and deny vaginal examinations, and at least request for privacy, but she could not state any of these to her family members or the care providers. However, the impact of her education and financial independence could be seen in her decision to not give birth in a government hospital and go to a private hospital. The culture of silence is seen in most aspects of women's experiences which they accept and endure in their usual lives that reflects in the birthing environment as well (Shabot, 2020a). The norm around birthing is that women are supposed to endure it, as that is the usual course of institutional birth and does not fall in the category of violence or victimisation to be grieved (Shabot, 2020a).

Obstetric violence is gender-based violence. The intersectionality of a woman's other background characteristics such as education, socio-economic status, gender, marriage, religion, age, parity, caste, class, state and nation may determine her vulnerability to obstetric violence (Patel et al., 2018; Jeffery & Jeffery, 2010; Sen et al., 2018). This has also been reported elsewhere where scheduled caste women were seen to receive treatment after higher caste women are treated in Bihar (Patel et al., 2018). Literature also suggests that access to medical education has traditionally been limited to mostly men of higher caste and richer families, which increases the social distance between the woman and her doctor (Prakash et at., 1993). In my study we found women being abused due to some of these factors, which were also identified by the participants such as poverty, lack of education, being a woman and state of marriage.

Structural intersectionality explains why the women are at a disadvantage in a patriarchal culture, in a male-led medical model of care and through the various factors that maintain the dominant power over women. The current structure of birthing has changed to institutional births as a dominant culture, even in low-economic settings with the implementation of JSY as part of NRHM (now NHM). Anju challenged this status quo when she decided to freebirth in her three subsequent births followed by two stillbirths at a public hospital. Freebirthing or 'hands off births' have been on the rise and are being increasingly reported in countries such as Australia, Netherlands, UK and US for expressing women's desire to have an intervention free, vaginal and respectful birth (Freeze & Tanner, 2020; Jackson, 2020; Feely & Thomson, 2020; Hollander, 2020). There are many aspects in the structure of birthing that are violent to women, that violate women. Most women strongly expressed their disapproval towards vaginal examinations, when they were often given no privacy and were restrained by others. This can be considered a display of physical overpowering. Chawla considers routine episiotomy and female genital mutilation as violence against women as sexual beings targeted at their genitals, women's 'site of power' (Chawla, 2019). Regardless of the lack of agency and choice, the loss of power is part of the

culture. Respectful maternity care was seen where the family had some influence, such as for Pairo in her second cesarean section due to the influence of her doctor maternal uncle. The interplay of these four discourses, gender, power, culture and structure, are essential to understand to ensure respectful care to women (Figure 7.4) (Hutter, 1994).

Chapter 8 *"It's easy to abuse obese women!":* Why do some care providers engage in obstetric violence?

The previous findings chapters focussed on women's voice and embodied experiences of respectful maternity care and obstetric violence during childbirth as primary care-seeker. Nurse-midwives are the primary care providers to women, when they seek reproductive and maternal health care. Nurse-midwives' standpoint about obstetric violence is essential to ensure respectful maternity care and to understand the barriers they face in care provision, in low resource settings. As is discussed in the Freedman et al.'s definition, the determinants of obstetric violence need to be explored and addressed at all three levels, individual, structural and policy levels. Nursing and midwifery leaders have served at the frontline of care provision and experienced the challenges in their careers spanning decades. They are now at the highest decision and policy making positions in their domain. They are best placed to share the determinants of obstetric violence from the care providers side, at all these three levels. This chapter presents nurse-midwives' perspective from different policy-making positions, to understand how to make respectful maternity care a reality. Some nursing and midwifery leaders reflect on the issue and the solution from their own birthing experiences.

8.1 Background

Obstetric violence is a human rights violation and a recognised global phenomenon that may vary across different cultural and socio-economic settings. I have described the nature of obstetric violence from previous studies and from women's own experiences and perceptions in the previous chapters. This includes the commonly heard abusive and sexist comments that health workers direct at women during childbirth and I have presented how this is normalised, endured and tolerated resulting in lowering of women's expectations from care during childbirth. Studies often reflect on intentionality as a key construct in the context of health care workers engaging in obstetric violence. Intentional actions to harm women's health and wellbeing are disrespectful and abusive. Studies report evidence of several forms of disrespect and abuse globally, which begins with an absence of greeting on arrival, a common disrespect that many women experience, to extreme forms of abuse including physical violence, reported from developing and developed countries alike (Abuya et al., 2015; Miltenburg et al., 2018).

Despite growing evidence on the extent of disrespect and abuse during childbirth, the underlying reasons from a provider's perspective have not been systematically understood in the Indian context. These could be cultural, social or health system-related factors that may explain why women are disrespected and abused during childbirth by their care providers. Between 2005 and 2016, India has seen an unprecedented increase in institutional births from 39% to 79%, yet there has been little improvement in the provision of quality maternal care services (NFHS-3; NFHS-4). Positioning nurse-midwives[15] in an independent midwifery role has become more important in such circumstances, because they are the closest care provider that women come in contact with during pregnancy and childbirth. In India, every year, approximately 27 million births are reported, and of these, nurse-midwives attend one in four in rural areas and one in six in urban areas, as primary care givers (Radhakrishnan, Vasanthakumari & Babu, 2017).

Studies show that, globally, midwives face significant professional barriers because they are part of a profession dominated by women. Midwives have historically been compared with 'witches' (Ehrenreich & English, 1970) and labelled 'half taught', 'totally ignorant' (Oakley, 1997) and blamed for negative birth outcomes. From a feminist perspective, this represents a double context of powerlessness attributed to social hierarchies for both women in their socially prescribed roles and nurse-midwives at a low level in the medical hierarchy (Sheikh, Raman & Mayra, 2012; Filby, McConville & Portella, 2016; Mayra, 2020a). Furthermore, a lack of leadership opportunities among nurse-midwives in decision-making prevent them from advocating effectively for women in the provision of quality, respectful and dignified maternity care (Maslach & Leiter, 2016; Steege & Rainbow, 2016). Midwives argue that their role in care provision is unrecognised and they are often discriminated against and suppressed by physicians. Such challenges can lead to burnout, workplace harassment and bullying, causing care providers to show reduced empathy and compassion (Maslach & Leiter, 2016; Steege & Rainbow, 2016) thereby increasing the care seekers' vulnerability to disrespect and abuse.

The literature suggests that poor working conditions leading to burnout in care providers may lead to poor maternal health outcomes (Maslach & Leiter, 2016; Steege & Rainbow, 2016; Hunter, 2009). Midwives' work has been described as emotional work (Hunter, 2009). The resulting depersonalisation, cynicism and detachment are used as coping mechanisms to deal with workload and job stress (Maslach & Leiter, 2016; Steege & Rainbow, 2016). This is evident in

[15] India does not have an independent midwifery cadre as per the standards of International Confederation of Midwives. The Indian system of education enables practicing midwifery with nursing through a dual registration of registered midwives and registered nurses. Hence they are referred to as nurse-midwives in this study to acknowledge their dual role and absence of independent midwives in India.

many aspects of care during childbirth that includes addressing women by the colour of their attire or bed number; that displays a lack of empathy when intentionally mistreating women during childbirth. Midwives report 'switching off' and putting on their 'masks' or 'happy faces' to appear dignified, which leads to emotional withdrawal and physical distancing from women they are caring for (Hunter, 2009). They feel the need to 'don their emotional armour' which some refer to as 'surface action' or 'impression management', to be able to perform what the job requires (Hunter, 2009; Deery, 2009) while inside they might be feeling like a 'food mixer' (Edwards, 2009). Potential abuse of the midwife and a lack of opportunity for them to process the emotions in a job that involves dealing with vital events, such as births and deaths regularly, may add to women's vulnerability to mistreatment.

The 'What Women Want' campaign is very relevant, as it asked women and girls globally their one key demand for improvement in maternal and reproductive health services and the top ranking demand from 1.2 million participants in 114 countries was respectful maternity care (WRA, 2019). The need for respectful care can be better understood by unravelling the underlying causes of obstetric violence during childbirth, which remains a key gap in the obstetric violence literature. Clearly, midwifery, nursing and medical students should be provided with education free of hierarchy, gender and status based differences, and they should be sufficiently mentored to provide care without any form of bias or discrimination. The abuse of hierarchy in medical education is a significant barrier to respectful maternity care (Madhiwalla et al., 2018; Diniz et al., 2018). A recent study conducted in two tertiary level hospitals in Maharashtra, India looked specifically at structural violence through interviews with care providers and found normalisation of disrespect and abuse during childbirth and medical students engaging in such practices (Madhiwalla et al., 2018). Furthermore, respectful education, students observing respectful care and practicing it in their pre-service education is crucial, so that they are not conditioned to provide care that is disrespectful and abusive (Moridi et al., 2020; Dzomeku et al., 2020). Evidently, these underlying causes may be perceived differently by women (as care seekers) compared with the perceptions of midwives, nurses, doctors and other (as care providers) (Beck, Driscoll & Watson, 2013). I presented women's perception of the factors behind obstetric violence in the previous chapter. This chapter bridges the gap by exploring the nurse-midwives' perspective of the reasons behind obstetric violence of women during childbirth in the context of India.

8.2 Research question

Why do some health care providers disrespect and abuse women during childbirth in india?

8.3 Objectives

1. To investigate midwifery and nursing leader's perceptions and experiences of respect, disrespect and abuse during childbirth in India.
2. To understand the determinants of obstetric violence from midwifery and nursing leader's perspective in India.
3. To document midwifery and nursing leader's recommendations for respectful maternity care provision during childbirth in India.

8.4 Methods

The study participants are the midwifery and nursing leaders in India holding key, formal and informal leadership roles in the domains of education, regulation, administration, advocacy and service provision as presented in Table 8.1. Some of the participants represent more than one domain. It is crucial to explore the standpoint of primary health care providers and the study participants have decades of experience at the frontline, providing care to women before taking on various leadership positions to influence and make policies. The selected leaders have reached a level of prominence in terms of their official position. Most of them have reported limited decision and policy-making power even when they are at the highest attainable posts for nurse-midwives'. They understand the challenges inherent in care provision and how these challenges may be tackled. The perceptions and experiences of these leaders are useful in developing practical solutions to ensure respectful care during childbirth in India.

Table 8.1 Participant by domain of leadership

Domains	**State**	**National**	**Global**	**Total**
Administration	3	2	1	6
Advocacy	8	3	4	15
Education	9	4	2	15
Regulation	4	1	2	7
Service Provision	6	1	1	8

**some participants represent multiple domains*

I use qualitative methods to investigate the reasons underlying obstetric violence from the care providers' perceptions. I selected participants through purposive and snowball sampling in five states in India, namely Bihar (BH), Rajasthan (RJ), Odisha (OD), Madhya Pradesh (MP) and West Bengal (WB) and at the national level (NL). These states represent diverse contexts with unfavourable maternal health indicators including high maternal mortality. The leaders are selected in three categories comprising the state level and the national level in India and a third category from an international perspective with participants from advanced healthcare systems participating in global policy making.

In India, health is a state subject, therefore policy-making and governance is divided between the states and the centre. The states represent a wide range of health care contexts that are different in geography, culture and health outcomes, yet they share the similar health system infrastructure and face similar challenges. The selection of nurse-midwife leaders at a national level facilitates the understanding of the larger picture of health policy and governance structure in India. Additionally, I interviewed midwifery leaders in the United Kingdom because it represents a successful model of midwifery care that has made commendable progress in respectful care provision and has collaborations with partners implementing midwifery in India. I also interviewed eight midwifery leaders for a global perspective with professionals from WHO Headquarters, ICM, ICN and UNFPA, that play a key role in making and influencing policies at a global level that has an impact on countries such as India.

8.4.1 Study instrument

I prepared a semi-structured guide for in-depth interviews. The interview guide had three sections; 1) background information; 2) participant's role and responsibilities; and 3) perception of respect, disrespect and abuse in care during childbirth. Given the sensitivity in discussing disrespect and abuse of women during childbirth by care providers, I used an illustrated painting of a woman giving birth to initiate the conversation (Figure 8.1). The theme and contents of the painting reflected the lead researcher's experience and observations of childbirth in a public hospital setting in India.

Figure 8.1 Flash card showing a birthing environment in India

(Source courtesy: Exclusive image produced by S. Karmakar for this research)

I developed a questionnaire based on literature review of disrespect and abuse of women during childbirth in multiple settings (Annexure C). The open-ended questions are aimed to understand the participant's reflection and perspective on the painting. The interview guide helped to explore participant's perceptions on why women experience disrespect and abuse during childbirth, how that change in care provider behaviour happens and finally, the participant recommendations on how respectful and dignified care can be safeguarded during childbirth.

Research Ethics Approval: Respondents provided written consent to participate in the study. I took consent to audio record the interviews, gave them a participant information sheet and a copy of the signed consent form. Out of all the leaders approached, five did not give consent for the interview. Some participants are replaced by others matching the criteria, although it was not always possible given the leaders representing particular domains are few. Ethical clearance is provided by Institutional Review Board of University of Southampton (Reference number 41164). The study participants hold key positions which can be identifiable, therefore I have maintained anonymity throughout the process of data collection, analysis and presentation of the findings.

8.4.2 Data collection

I conducted the interviews between July 2018 and January 2019. I conducted three of the interviews over video calls and did the rest in person in different states in India, the United Kingdom and Switzerland. I interviewed leaders in Switzerland as most of the global health think

tanks that influence global policies are located there. Leaders from United Kingdom have established a midwifery led model and have collaborated with Indian counterparts to implement midwifery in India. I carried out the interviews in English, a few in Hindi and Bengali. I am fluent in these three languages and my native language is Bengali.

I contacted the participants by email initially, with a request to participate in the study. I conducted most of the interviews in the participant's office or residence. Most were free from any interruptions. I conducted the interviews with participants representing regulatory bodies in their offices, with quite a bit of interruption. Most interviews lasted between 30 minutes to 1.5 hours. I took reflexive notes with descriptions of the interview environment. I informed the participants about the study objectives prior to scheduling the interview. I introduced myself to the participants with information about my qualifications and professional background. Nine prospective participants either declined to participate or dropped out from the study due to a lack of time.

8.4.3 Data analysis

I analysed the data using thematic analysis (Green & Thorogood, 2014). The analysis approach is in line with reflexive thematic analysis which has themes drawn from the research questions and the semi-structured interview guide (Braun & Clarke, 2019). The themes are clusters of codes that have a shared meaning (Braun & Clarke, 2019). I supplemented it with emerging themes with deductive coding as analysis progressed. I decided the initial codes based on what made the most analytic sense and appeared frequently across data. Further codes were generated based on each code's property and refined with sub codes. Qualitative data analysis software NVivo 12 is used to aid in analysis. I coded the data, alongside data collection, to identify and explore the emerging themes and in the upcoming interviews.

8.4.4 Positionality and reflexivity

My background and involvement in researching and influencing midwifery and nursing policies in India and globally played a key role in participant's agreement to take part in the research. I have professional acquaintance with 11 out of the 34 participants. My subjectivity, shaped by my experiences, has been a potential resource throughout my doctoral research and as Braun and Clarke (2019) state '*it should not be treated as a threat to knowledge production'*. My experience of receiving education in nursing and midwifery in government hospitals in West Bengal, along with over a decade's experience of researching on the challenges in health care provision, helped to design the interview guide, conduct the interviews, analyse and interpret the data.

8.5 Findings

The findings are presented under three sections. First, I present the midwifery and nursing leader's reaction to the painting of a woman giving birth. Second, I examine their perceptions towards childbirth and the factors that make women vulnerable to experience obstetric violence during childbirth. Third, I present the recommendations of study participants on ensuring respectful care during childbirth.

Participant profile: Thirty-four participants are interviewed aged between 46 and 83 years with 24 to 60 years of general experience. All participants had previously received midwifery education except one who is a registered nurse, and 32 participants are registered as both a midwife and a nurse. Eleven participants have PhD level qualification. Four male participants are interviewed in Rajasthan, which is one of the few states in India that provides midwifery education to male candidates. The remaining thirty participants are women. More details about the participant's profile is presented in Table 8.2.

Table 8.2 Participant profile

Indicator	**No. of participants/ Range**	**Total responses (N)**
Age Range		
40-60 years	18	30
61-80 years	11	30
>80 years	1	30
Gender		
Female	30	34
Male	4	34
Qualification		
RN , RM	32	33
RM	1	33
MSc Nursing and MPH	22	33
PhD	11	33
Experience (years)		
Urban experience range	5-46	17
Rural experience range	0-25	17
Total experience range	17-60	29
Midwifery experience (years)		
< 15 years	19	25

Indicator	No. of participants/ Range	Total responses (N)
15-30 years	3	25
31-45 years	3	25
Midwifery experience range	0-41	25
Births assisted range (0-40,000)		
<25	4	26
25-100	6	26
101-500	6	26
501-1000	4	26
>1000	6	26

Participant's midwifery experience ranged from 0 to 41 years. They shared the total number of vaginal births assisted, including during their nursing-midwifery education. The responses range from 0 to approximately 40,000 births. Four of them assisted less than 25 vaginal births, even though it is an essential criteria of pre-service curriculum before registering as a midwife in India. Four respondents could not cite a number.

8.5.1 Reaction to the painting of a woman giving birth

The participants from India use the words 'terrible', 'bad', 'wrong', 'not right', 'familiar', 'uncomfortable', 'stressful', 'not conducive', 'horrible', 'extreme disrespect and abuse' and 'concerning' to describe the painting (Figure 8.1). One participant shared her perspective of the positive aspects in the painting.

"…the position she is in, the woman is not comfortable. People around her are stressful… look at the strained faces around her. The environment is not conducive for her. This looks like a rural facility. In a hospital labour room so many people will not be around. The assistant, doctor and maximum four people will be around. Students will be allowed. A screen is lacking, for privacy. This looks like a private facility as situations are deteriorating in the private sector." (O03)

"She (care provider) *is massaging the uterus for contraction and to reduce the chance of PPH. This looks like PPH. She* (labouring woman) *must be unconscious, that is why the staff is pinching the thigh with forceps."* (R01)

Most respondents acknowledge the issue and many confide they have not seen but have heard from others that disrespect and abuse during childbirth happens. A few participants assume that the painting is set in a private hospital, while others refer to a public tertiary hospital, but deny that nurses engage in such behaviour.

"Doctors engage in this kind of treatment" (CL01)

"Staff nurses' don't do that, only untrained dais (do)." (O02)

Participants at the global level reflect on how similar the situation seemed in many other parts of the world and say it is 'horrifying' and 'shocking'. A participant also found it hard to believe that the labouring woman consented to have so many people around her during childbirth.

"…the women are not looking at her but at the baby. This woman is struck with horror… blood pouring from her. She is lying on a flat bed with no sheet… the fundal pressure is very hard… I see a woman who is being tortured! She is in grave pain and is screaming… there is one woman with her arm around her and she has her hand on her heart. It indicates some kind of compassion for the woman. But because of the system of the care and place, she is flat on her back, in the worst position possible without any comfort at the time of her life… this is a picture of extreme dehumanisation!". (GL07)

8.5.2 Factors behind disrespect and abuse of women during childbirth

Factors affecting disrespect and abuse that are related to characteristics of women, are organised in a three level framework ranging from individual level to social level characteristics. Factors emerging from the research that relate to nurse-midwives' disrespectful and abusive treatment of women, as identified by the study participants, were categorised into individual, structural or policy levels, in line with Freedman et al. (2014) definition of mistreatment during childbirth.

8.5.2.1 Woman-related factors

Woman-related factors are organised into three levels too: (i) individual- which includes personal attributes of the woman that increases her vulnerability; (ii) community environment- the woman's immediate context including home, the place of birth, neighbourhood and community; and (iii) social environment- includes the state women come from in India and the country. The differentiation between the levels is not just geographic but also in terms of impact that may go across levels.

Individual attributes

Women's background and physical appearance could make them vulnerable to disrespect and abuse during childbirth. Age and parity are frequently stated reasons for predisposition to poor treatment as well. One respondent mentioned that women with four or more children are often verbally abused.

"*What do you plan, to score a century?" (CL03)*

A woman had come to give birth with her 16-year-old daughter, which may have provoked the conversation suggesting that the woman should have stopped childbearing after a certain age.

"*A multigravida should not come to a labour room so many times."* (WB03)

Parity is associated with religion too. One respondent mentioned that it is common to have many children in some religions and cultures.

"*Muslim women are multipara."* (RJ04)

Other respondents said that older women inevitably hear judgemental comments for having too many children or having them too late. Young girls had to hear them for getting pregnant too early.

Illiteracy increases women's vulnerability. According to respondents, judgemental comments on why uneducated women have more children are common. A woman's cooperation during labour often depends on how educated she is. This has a strong influence on her knowledge and expectations for care during childbirth. Interestingly, many respondents assume that the onus is on the woman to be able to communicate, and not the care provider on how to talk to women from different backgrounds. The difference in care provider and women's background can lead to obstetric violence, which includes their language, religion and cultures.

The way a woman dresses, smells, weighs, maintains her personal hygiene, including how her genitals are presented, may determine how she will be treated during childbirth. Obesity attracts judgemental comments. Physical appearance is the first thing that the care providers notice. Women who present with poor personal hygiene, in visibly dirty clothes and smelling bad, are considered unpleasant to care for.

"It is easy to abuse obese women. Personal hygiene is a factor too. They come with skin diseases at times. No one wants to touch them. They have to hear a lot of bad comments lying on the labour table… they do not bathe and we have to clean everything as the baby will be born through the unhygienic passage… wood sellers, coal sellers, Bihari women are very dirty. We do not care if one has shaved or not. Many mothers come after trimming. Looks like they have come straight from the parlour, freshly waxed. They get good care, we like touching them." (WB03)

Community attributes

Women's immediate environment includes her home, family and neighbourhood and the people she comes in contact with, who may share the same values and culture in the community.

Poverty increases women's vulnerability to obstetric violence. It is a cross-cutting factor, as it is associated with caste and economic status. Respondents opined that poor women have no option but to seek care in public hospitals. Many respondents commented that staff members have a tendency to ask for unofficial payments from the family after birth.

"She will have to listen to a lot of comments if she is poor. There is a lot of ignorance too. If someone is rich or from better income background, then every staff behaves very patiently and respectful maternity care pours out of them. They know how to do it, just depends on whether you are worthy of respect." (RJ04)

"This is the cultural construct of birthing in India which to me is where the issue is. When women accept that this is okay, that is what they will get. Women in India pass on this cultural construct as birth preparedness. When we think about abuse of women in health care, we need to be very clear that in societies where abuse is normal it's going to be very difficult to change that in a health environment. Do the people around her feel that it is not okay to pinch, hit women giving birth?" (GL02)

The stereotype of Muslim women having more children is also a norm about birthing and contraception in some cultures, from the care providers point of view. The stereotype about Bihari women is also prevalent and opens doors to discrimination against them in attracting obstetric violence.

Social environment

Being a woman increases vulnerability especially when the woman is uneducated, poor, not appearing a certain way, old or young, married or not. The way she is treated by care providers in the labour room while giving birth is an indication of how society and her family values her, and treats her. This shapes her expectations, as she is conditioned to be treated in a certain way, with a certain level of respectfulness. Whether she asks questions or communicates with care providers and the response she receives, depends on how she is conditioned to be treated. In fact, gender-based discrimination begins at birth. The birth of a boy often means more money for care providers. The birth of a girl invites verbal abuse and discrimination for the new mother. The way she experiences being valued or not in general, is how she expects to be valued in the labour room by care providers. Gender is a cross-cutting issue which can be seen at the individual level, in the community and in the social environment.

"Globally women are of low status, not treated with respect or regarded as equal citizens, not valued. Little girls grow up thinking she is not as important as her brother, not likely to get educated, not encouraged to question. Women accept their lower place in the society. When they

come to give birth, many of them did not choose to be pregnant, they did not have access to birth control, married off very young. Arranged marriages, child brides. These all take away their empowerment. You find it difficult to stand up for yourself. When she is in labour, the last thing you want is fighting for yourself. You are so caught up in the psychological process that is happening. That makes you vulnerable as well." (GL05)

8.5.2.2 Nurse-midwife related factors

The nurse-midwife related factors have been organised into three levels too: (i) individual- includes personal and professional attributes; (ii) the birthing environment- includes the birthing room ('labour room'); and (iii) the policy environment- that determines the quality of care and service provision through policies at state, national and global levels.

Individual factors

Participants felt that workload often made nurse-midwives angry and frustrated, as they are overburdened. At a tertiary level health facility, for example, births have increased from 400 to 1000 per month over the last few years, though the number of staff remains same.

"We have 1 nurse for 100 patients, that is why this happens. Workload!" (OD02)

"Staff's confidence breaks as soon as they see the crowd. They worry how to provide care to so many." (RJ06)

"We used to give more psychological support back then." (OD03)

Respondents feel that the lack of promotions and stagnant salary is demotivating. The added workload without incentives makes them feel under-appreciated and under-valued.

"Nurse-midwives' are not getting enough salary, recognition. No one checks on us." (CL01)

"...they are discriminated with other professions. Physiotherapists and pharmacists are all going up (in their career) *and nursing* (and midwifery) *is going down." (O03).*

"...since roman times, women were not respected and then Christianity came in and women started being disrespected, which increased as the male medical model slowly installed itself into the profession. At one point, nurses and midwives were being held as witches. Its like a trail of under- representation that leads to disrespect and abuse of women and midwives. This increased in the 80's and 90's as the male medical model marginalised midwives." (GL06)

Working conditions are often demotivating in a hierarchical structure where doctors have better facilities than nurse-midwives. Such discrimination leaves nurse-midwives powerless and taken

for granted. One respondent felt that this learned helplessness is an outcome of continued oppression, which makes midwives' powerless to bring any changes in the system. Being voiceless in planning care provision leads to assertion of power on the women who are further down in the social hierarchy.

"They take these women for granted. They feel I am taking care of you and I have this power over you to provide care to you, so you have to listen to me. This is my territory and you are bound to listen to me." (WB02)

Many stakeholders mentioned that nurses and midwives are often bullied by doctors. With the lack of a supervisor, who is a nurse-midwife, the doctor as the head of any institution, overpowers everyone leading to mismanagement of midwifery and nursing services. Nurse-midwives are ill-treated; and their welfare and working environment is not considered.

"*Gynae ward does not have toilet, so if the nurses go to a different ward to use the toilet and the doctor comes for a round at that time… marks her absent for the day. Sometimes we quietly use the toilet in the cabin* (meant for wealthy patients) *when no ones watching. We are not respected. The medical superintendent does not respect us."* (BH01)

Stakeholders explain that the nurse-midwives' work involves dealing with births and deaths. Due to an increasing workload, they have less time to communicate with their patients. There is frustration from being overburdened and no time to process emotions related to vital events like births and deaths.

"They do not get attached. They call them by bed number or colour of saree." (RJ04)

Birthing environment

Participants mentioned the lack of infrastructure as an intervening factor in the birthing environment that is disrespectful to women. Screens are important to maintain privacy during childbirth. Lack of injectable anaesthetics and analgesics adds to a disrespectful birthing experience. It leads to women enduring more pain when they undergo an episiotomy and repair without anaesthesia. The cleanliness of the labour room is an issue, resulting in women birthing in an unhygienic environment.

"The doctors are tall, so their height needs to be considered, hence the labour table is so tall." (B02)

The 'team culture' includes how care providers collectively perceive respectful care based on existing work-place norms. This makes certain practices and even extents of disrespect and abuse during childbirth acceptable, thus adding to normalisation of disrespect and abuse during childbirth.

"There are 12 labour tables in the labour room, separated by curtains. We don't let men enter, so their privacy is protected. Then it is all women." (RJ01)

Extortion is often part of a team culture. The money gets divided by the whole team even though the non-health care providers, such as cleaners, are at the forefront of asking for it. There are many unethical practices that are part of team culture, including augmentation of labour.

"They will scream 'push, push' if their duty is ending at 1:45 pm. They will make sure the woman gives birth within one's duty time so that care provider gets the money… so they will induce with oxytocin sometimes." (RJ04)

Task shifting between care providers at different levels of care is based on the hierarchy of care providers, which stems from the centralisation of power and mismanagement of the increasing workload. Respondents share examples of systematic shifting of duties from doctors, which is not a part of nurse-midwives' role, followed by nurse-midwives' transferring their role in assisting births, to non-health care workers such as Mamta[16], ASHA and traditional *dais.*

"He (medical superintendent) *is running the hospital in any way he wants. Nurse-midwives' are posted in non-nursing roles even with an existing shortage. There are nurse-midwives' posted in the fire extinguishing department. Six nurses ready in their uniform, two for each shift. They are not involved in patient care anymore. Ten nurses are working in pharmacy distributing drugs while the pharmacists chill in a room. Nurses are working in pathology while technicians are roaming free. The telephone control room is run by nurses and so is the reception and housekeeping. The nurse patient ratio is 1:50-75."* (BH01)

Stakeholders describe that with increasing level of care provision, disrespect and abuse of women during childbirth increases. Women are more vulnerable to be abused at a tertiary level of care provision than a primary or secondary level. This is related to many factors, for instance, workload increases at a higher level of care, reducing patient-health worker interaction time and increasing workload related frustration. Many stakeholders feel that doctors at tertiary level are engaged in

[16] Mamta is a non health care provider who works provides some counseling to women on breastfeeding and the importance of cleanliness after women give birth in an institution in Bihar. She also maintains cleanliness in the labour room and receives incentives for her work.

more severe forms of abuse. Being further up in the level of care provision also means that women are not known to anyone in the team of care, where experiences are further over-medicalised than at a lower level of care. The tertiary level includes teaching hospitals, where women become subjects of 'case discussion' as part of the medical education.

"Everyone looks at her as someone you can perform cases on. They see that this is a case in my logbook… they want to give an episiotomy so one can get an episiotomy repair done and write about it in logbook." (CL04)

Disrespect and abuse of women during childbirth often stems from a lack of compassionate leadership at the centre of the management system or hierarchy, which also influences the team culture.

"Its like a ripple in the pond. You have got an abusive person at the centre of that. The person who is abusive in nature, may be of psychopathic tendencies. The person at the centre becomes powerful and in order to maintain that power, builds relationships, and slowly people change their behaviour to fit into that way of being. The longer that person is able to stay in one place (centre), *the culture* (of abuse) *grows stronger."* (GL06)

A participant in India called this a '*domino effect*' where one care provider learns to abuse from another, establishing an abusive team culture in the process, this peer influence slowly turns everyone into an abuser.

Policy environment

Some national policies indirectly contribute to a disrespectful birthing experience. The JSY policy incentivises women for giving birth in an institution and incentivises the community based motivators, ASHAs. This policy is criticised by participants as insensitive, as it does not uphold women's rights or facilitate their choices and decision making about childbirth.

"*It makes no sense to have a government policy to move women to hospitals when the hospitals treat them so badly. The response will be 'oh but you should see how they are treated* (at home) *in India, at least they get food in the hospital'."* (GL07)

Participants also identified that the dehumanisation of women begins in the pre-service education as a learned behaviour, where the medical, nursing and midwifery students imbibe how the care providers deal with women. Obstetric violence during birth has been a norm, which normalises it, thus reducing the importance of this problem.

"*I have seen the Head of the Department verbally abuse in around 1977-78. They are not properly educated. The government did not care back then about respectfulness as they are enforcing it now."* (WB01)

Birthing is explained as '*dirty work'* by an international participant (GL03), who shares that since birth work stems from unpaid women's work, it may have a negative impact on the profession which further entrenches medical domination of midwifery, nursing and birthing.

The provider-client ratio needs to be maintained to ensure respectful care. Under-recruitment is an indicator of lack of the women-centric policies. It is common in hospitals to rotate nurse-midwives, respondents perceive this practice as discouraging and deterrent to maintaining midwifery and nursing skills. The amount of documentation work is an additional burden that takes over direct care provision.

"We are engaged in multiple things, a staff nurse in the labour room can not maintain care and quality service, they just can not. Such a huge log book they have to fill. So many records to maintain. How will she conduct so many deliveries? 1:1 ratio is required for assisting births… tertiary level staff just does paperwork." (WB05)

8.5.3 Participant's recommendations for respectful maternity care

Participant's recommendations are context-specific and are based on best practices. Preventing disrespect and abuse during childbirth and promoting respectful maternity is a deep-rooted, and an age-old problem, which requires a paradigm shift in culture to address challenges at various level. Participants suggest involving women and nurse-midwives in policy-making, as two key stakeholders in maternal health care.

"It's about really strong partnerships." (GL03)

Participants suggested a multi-sector approach to involve stakeholders from community and health systems for a lasting impact. Participants feel the need to decentralise power, from the medical model of care, to make care provision inclusive. Collaborations with women's rights organisations and nursing and midwifery associations will increase accountability. Global international organisations have a role in advocacy, setting standards and funding initiatives with a sustainable approach. These recommendations are summarised in a framework for midwifery model for women centred-care with changes suggested at different levels (Figure 8.2), similar to the levels discussed for the factors of disrespect and abuse during childbirth.

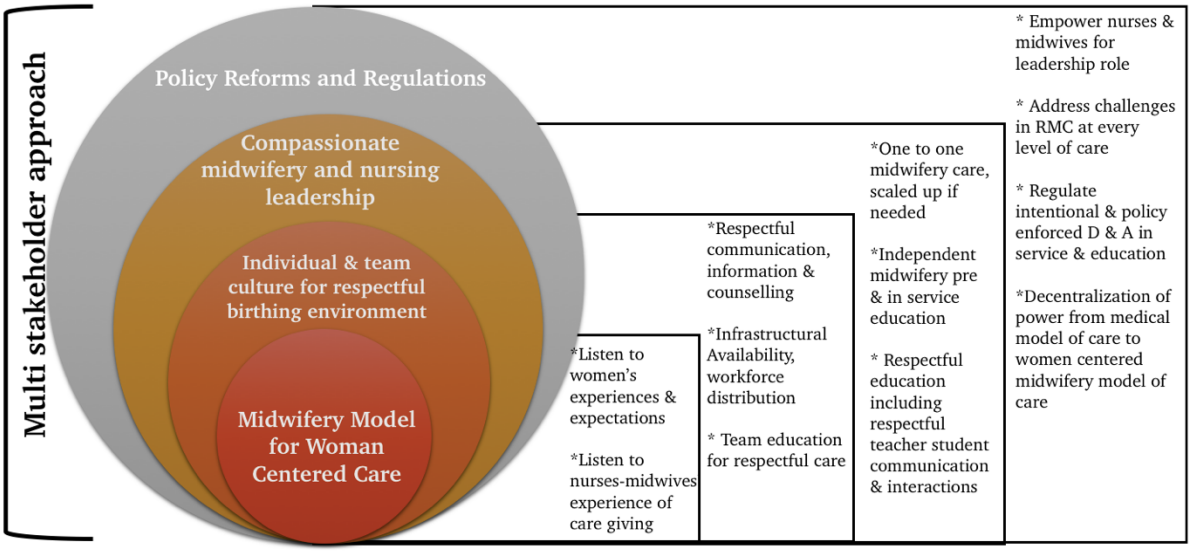

Figure 8.2 Recommendations for respectful maternity care in India (*Author's own*)

Level 1- Midwifery model for women centred care- It is imperative to hear women's expectations and experiences of care to understand what is respectful and good quality care for them and ensure a person centred positive birthing experience.

"The voice of people is one of the biggest motives behind change… you can regulate that there has to be a woman in the discussion but they will find a thousand ways around to not adhere to that. In changing values and norms of societies, not much changes. Women need to stand up and say 'I need respectful care!'. Those are the ways to make change happen." (GL01)

Participants felt that sharing information and counselling should begin in the antenatal period, to help pregnant women understand the process of birthing and explain procedures beforehand. They also felt it is difficult to communicate many things while the woman is bearing labour pain. Procedures need to be explained to gain the women's trust. Continued communication and psychological support during childbirth is considered of utmost importance.

"…tell them how much it will hurt. The number of hours it will take. We should tell them before PV and when starting a bottle to increase pain." (R01)

Midwifery and nursing is considered emotional work and participants felt it is important for care providers to take time out for themselves and take care of their wellbeing.

"…taking time to get a good work life balance. Doing what they enjoy, switching off from workplace, getting support from colleagues. Getting a perspective and being aware of oneself." (GL03)

The role of nurses and midwives is recommended to be envisioned as advocates for women's right for quality and respectful care. This will include standing against disrespect and abuse of women during childbirth in their facility and finding innovative ways to prevent it.

Level 2- Individual and team culture for the ideal birthing environment care provider: Perceptions around quality and respectfulness need to align with women's perception.

"*We look at India and see women in beautiful sarees in rural areas and feel everything is fine. One has to look beyond that and see what they feel, what they need, what they want and serve them well."* (GL02)

To ensure an appropriate team behaviour towards women under their care, it is necessary that steps be taken to improve the team's attitude. Being respectful towards each other in the team regardless of gender and profession is recommended.

*"The team needs to be trained together!" (*WB04)

"Facilities need to improve their collective behaviour." (WB03)

Respectful communication is strongly recommended. Respondents felt that care providers could be educated in what to say, what not to say and how to communicate with women, as they acknowledge that *'their words can hurt'.*

Changes are needed at the primary, secondary and tertiary level of care, which can be different based on the issues that exist at each level of care. Infrastructural availability and workload distribution need to be ensured at each level for an ideal birthing environment.

Home birth was suggested by many stakeholders, with scaling up of home-based care. They felt there is a lesser cultural difference between the care provider and women when care is home-based, where family members get involved as birth companions, making birthing more culturally acceptable and satisfying.

"Let's just change the physical environment, its not that difficult to do. It will have privacy. Does not need a bed. Lot of women do not need a bed. They want to birth standing up, on a mat, sitting down, on a little chair. They want it clean… and warm…" (GL02)

"*Ideal birthing environment is the environment for love making. Both psychological activities release oxytocin and endorphin on stimulation and obstructed when in fear, embarrassed or in doubt."* (WB03)

Level 3- Compassionate nursing and midwifery leadership: Midwifery and nursing leadership is considered key to ensure that a midwifery model of care is implemented in India. Participants strongly felt the need for one-to-one midwifery care for women. Advanced care is needed if complications arise. Therefore, efforts are needed to establish a midwifery model of care.

"Midwifery model of care is in conflict between trying to balance care based on institutional hierarchies, where you are accepted to intervene and if you do not, then you are professionally in trouble." (GL03)

The tertiary level of care, including teaching hospitals, which are responsible for the education of care providers, needs to adopt measures that comprise respectful maternity care while students can learn and practice. The importance of students to imbibe values of respectfulness in their behaviour needs to start in their pre-service education. The student nurse-midwives often suffer the consequences of being at the bottom of the medical hierarchy. Medical students were often prioritised in terms of practice in teaching hospital, whereas nursing and midwifery students do not get a chance. The student nurse-midwives are often treated disrespectfully. Respectful communication is encouraged for every interaction with the students, even when they make mistakes. The way tasks are delegated to students need to change.

"...teachers should be compassionate to the students. I am shocked sometimes to see in the global work how the midwifery students are treated... the hierarchy is knock on. Everybody is abusing the other who is lower in status than them... we need deep cultural change." (GL05)

"The actual relationship between the clinical instructor and the student should be respectful." (CL02)

Midwives and nurses need to be empowered so that they can take up leadership roles and participate in decision making at every level. Midwifery and nursing supervisors can realistically plan care and manage midwives and nurses. A participant felt that compassionate leadership at the centre could positively influence the team towards respectful behaviour, as a ripple effect, but this depends on the kind of leadership at the centre.

Level 4- Policy reforms and regulation: With increasing evidence of disrespect and abuse, midwifery and nursing leaders suggested several recommendations for policy changes in health service provision that can make birthing respectful and dignified. These include workplace policies

to have compassionate leadership by influencing norms at workplace that could foster respectful care and policies that govern care provision at the states and country level. Many participants recommend to address the increasing workload by implementing 1:1 ratio for nurse-midwife and women, which will directly influence care provision for the better. Proper management of workforce and development of leadership in nursing and midwifery is essential.

Regulatory bodies have a key role to play in education, practice, maintaining standards of care and upholding professions. Regulatory bodies need to make changes to discourage the individual and infrastructural disrespect and abuse of women during childbirth by setting standards.

"Indian Nursing Council should provide best examples, showcasing what it looks like to have a safe birth. SNCs are members of INC and can do it in their own states." (GL02)

Leaders have divided opinions on whether there should be regulatory reforms to address disrespect and abuse during childbirth. They feel that penalising care providers is not a solution, as they themselves are subjected to harsh working conditions. They also mention the need to discourage any kind of intentional disrespectful and abusive behaviour within a team and towards the birthing women. There should be zero tolerance of intentional abuse of women by all health care providers, and non-health care providers should not be allowed to assist births.

8.5.4 Respectful maternity care education for the next generation of care providers

Respect student- Nursing and midwifery leaders feel that the student nurse-midwives often suffer the consequence of being at the bottom of the medical hierarchy. Medical students are often prioritised to allow practice in teaching hospital, whereas *"nurses do not get a chance*". Respectful communication is encouraged for every interaction one has with the students even when the students make mistakes. A participant felt that the way tasks are delegated to students need to change.

"…the actual relationship between the clinical instructor and the student should be respectful." (NL02)

Role modelling- Participants convey the importance of ensuring that the next generation of nurse-midwives' need to be respectful in care provision. Some of them feel that respectfulness can not be taught through a few days training. They understand it as a process, that ensure that the personality trait or value system is embedded in the student, so that they are capable of respectful care and to stand against disrespect and abuse during childbirth when required. Role modelling is mentioned a few times to achieve this. Participants feel that teachers have a key role to play in this. This role should begin in the teaching institution for them to demonstrate

respectfulness, but it is also important to show in the interactions with women in the teaching hospital. The importance of good communication, addressing the client by name, explaining every procedure and taking consent before engaging in any care provision is mentioned. It is important to stand against disrespect and abuse towards women when teachers see anyone in the team of care providers engaging in it, as NL03 explains.

"…when they see disrespect and abuse, teachers should point out and call the staff out later and discourage this behaviour. They should help them to perform better and be an advocate for the mother." (NL03)

The first challenge is to let the nursing and midwifery students practice, which is a key hurdle described by participants.

"Head of the department says my medical students will practice first. The nursing students observe cases and request them to give a chance. Hundred percent cases are done by medical students and we have complained about this many times but who will listen to us." (B02)

The challenge is greater for male students persuing nursing and midwifery, who try to get a little practice by assisting doctors. The gap in what is taught in the institution from the practice scenario in labour room can be reduced by proper supervision from the nursing and midwifery supervisors. Participants feel it is important for continuity of care, starting from the pre service education, as NL06 explains.

"I never allowed any student to practice without learning properly. They had to identify the woman, give antenatal care, provide care during childbirth followed by immediate postnatal care for 48 hours, if possible. Otherwise, I did not sign their casebook." (NL06)

Clinical instructors are usually assigned in the morning shift to supervise students, although a participant reports encouraging results of assigning teachers in all the three shifts, where students practiced.

Proper selection- Participants feel that students who join nursing and midwifery are not always ready for the role. They feel, students should be counselled on what the professional course entails.

"…some people join midwifery who can not function independently. There is a lot of independence in this area and one needs to make decisions. Everyone can not do that. Some prefer following orders, they should work in other areas like medical surgical nursing. If you can not function independently, don't work in midwifery." (WB03)

The participant also feels that candidates should be selected based on an aptitude test which will ensure willingness in the students from the beginning.

8.5.5 Do midwives have respectful births?

Among the nursing and midwifery leaders interviewed, twelve have shared stories of their own childbirth. Participants narrate both respectful and disrespectful birthing experiences. Some of them share that being a nurse and a midwife is a position of privilege, because they know the process and have the knowledge of birth. These participants have the experience of birthing in public and private health care facilities and at home.

Power of midwifery knowledge- Many midwives feel they had a better and respectful birth because they are midwives, even when they did not give birth in the labour room they worked in. As O03 shares, she guided her own birth with an understanding of the complications involved.

"… my husband brought the midwife on cycle and I told her to bring the catheter. Her skills and my knowledge worked together. I told her to boil the catheter first. I wanted to give birth in sitting position, so I did… so skillfully she delivered that I was very impressed." (O03)

Nurse midwives often shared about their own designation that ensured they have a good birth. Participant B02's birthing experience is an example of this.

"nurses did not behave properly… she was listening to foetal heart sound and I refused asking 'why are you listening to FHS when I am in pain, can't you wait till the contraction is over?'. I complained to the nursing superintendent. She saw my name and realised who I am… she called the staff and said 'where have you learnt midwifery, don't you know she is a teacher?' She apologised and then everyone cooperated." (B02)

Being a nurse and a midwife also means they sometimes knew the staff, which provided infrastructural benefits and the advantage of having someone assisting their birth whom they trusted as GL02 describes it.

"…its okay to feel out of control because you are having a completely out of body experience, but you need to trust the people birthing with you." Being a care provider often has extended benefits for their family and relatives as WB03 puts it, *"this is a communal feeling which we have, where we get better care because we provide care all our lives and we feel we have earned it."* (GL02)

Birthing in the workplace- In one case the participant giving birth in her own place of work ensured that every one was very respectful to her. But she also tried to be *"in her best behaviour"* as she did not want to be made fun of the way she was screaming or crying during childbirth. She

(NL04) further adds that her doctor encouraged her by saying *'she is very brave and we have not seen any woman with so much patience'* but she has also seen the same doctor sexually abusing other women in labour saying *'this is all you can do at home, and then you come here.'* Not all experiences were as good, GL06 shared how she was bullied in her workplace, which extended to her birthing space. She feels that her birth could be managed normally, but due to augmentation her contractions grew stronger and led to *'difficult forceps'* without any epidural or pain relief. The experience of birthing in her own workplace was traumatic for GL08 too as she describes it.

"I was slapped on my buttocks in my first birth cause my labour meant delay in her (midwife's) *leaving for home. She also forced me to have an enema even after I refused to have it. … She knew I am a midwife, we worked together. … I was powerless to refuse anything. Since then I have been frightened of midwives and doctors."* (GL08)

In the subsequent births, the participant ensured to have a midwife she trusted, who provided continuity of care. Also, she established her own home birth practice to ensure women in her area had respectful births.

8.6 Discussion

The midwifery and nursing leaders perceived that the painting (Figure 8.1) depicted the woman being abused during childbirth. They pointed out many unacceptable actions from the people around the birthing woman, in the obstetric environment. Though there is a difference in the perception of participants in India and elsewhere, about the severity of obstetric violence the woman in the painting is being subjected to. This difference in perspectives could be a result of the participant's context, the culture of violence they are exposed to, progress in the discussions about obstetric violence, the level of efforts to ensure respectful care and women's varied expectation of quality and respectful care in different contexts and countries. Participant's own context of shared oppressions and powerlessness may have an impact on their perception of violence as well. Indian participant's perspective conveys normalisation of obstetric violence to an extent where unless the act of abuse is extreme, it is unnoticeable and is side-lined. A participant from India felt that the picture shows good quality of care while another believed that some amount of shouting at the woman during childbirth is completely justifiable, as women are unable to hear due to pain and follow the instructions during childbirth. This could be fuelled also by the low expectations of women and the conditioning about birthing, that a live baby and a live woman are considered good enough outcomes of childbirth (Shakibazadeh et al., 2018).

Participants touched upon different types of factors associated with obstetric violence and increase women's vulnerability. These factors are not limited to women but also the nurse-

midwives as the primary care provider. Women and nurse-midwives are at the intersections of different individual, structural and policy related attributes in the larger context of oppression of women (Sen, Reddy & Iyer, 2018). All the factors discussed in this paper should be addressed to ensure that care is respectful and person centred. Freedman et al. (2014) discussed individual, structural and policy levels in their understanding of mistreatment of women during childbirth. I created a framework based on the patterns I learnt from the different factors from the midwifery and nursing leader's standpoint for the care-seeking woman and the care providers themselves. Some of these factors, such as gender, are cross-cutting for both the women and the nurse-midwives that goes against them and leads to disrespected women and disrespected care provider.

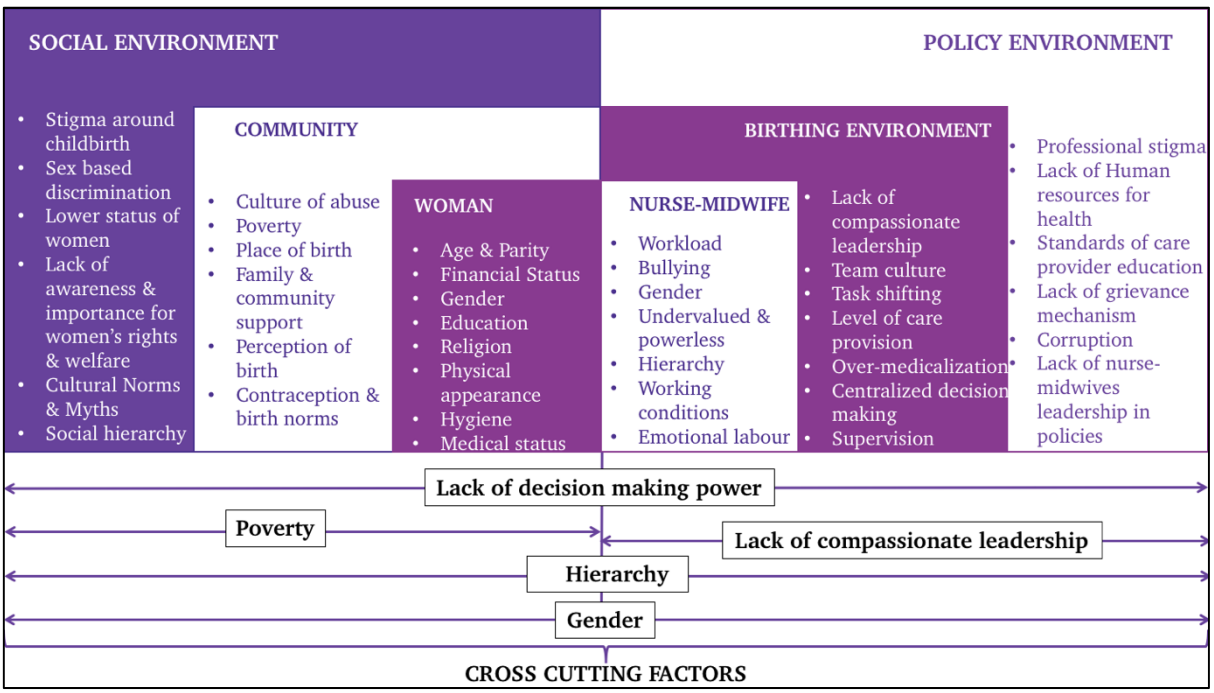

Figure 8.3 Midwifery leaders' perceptions of obstetric violence (*Author's own*)

The nursing and midwifery workforce faces numerous gender-based and hierarchical challenges that impede their leadership and decision making powers (Sheikh 2012; Gupta et al., 2003; Langer et al; 2015). The social, economic and professional challenges lead to moral distress and burnout (Maslach & Leiter, 2009; Steege & Rainbow, 2009). Nurse-midwives' challenges such as unsafe working conditions, a lack of promotions, poor and delayed salaries, long working hours and a lack of supervision are well documented (Filby et al., 2016; Mayra, 2020b; Maslach & Leiter; 2016). However, using nurse-midwives for fire extinguishing services, is a definite new low. It is clear from the responses that nursing and midwifery leaders understand the challenge, and are capable of making reformative changes with multi-sectoral collaboration through administration, regulation, advocacy, research and service provision (Ratcliffe et al., 2016). Currently, participants

representing the education sector have no flexibility and little influence without a supportive regulatory framework. They also have limited power to make any change in the hospitals where the midwifery and nursing students practice. In a different study, I have published these changes required in education and regulation urgently in India which will be a key step towards ensuring respectful maternity care, in line with the recommendations that participants shared in this study (Mayra, Padmadas & Matthews, 2021). A midwifery model of care is crucial to ensuring respectful maternity care, which will be a cultural shift from the current medical model of care, that led to over-medicalisation of birth and has normalised obstetric violence during childbirth (Homer et al., 2014; Renfrew, McFadden & Bastos, 2014). This now seems possible, with India making strides to start midwifery in the country, which will increase accountability for respectful maternity care for women (Ratcliffe et al., 2016; GOI, 2018; Afulani & Moyer, 2019).

Health system management expects nurse-midwives to be 'super nurses' by providing them less than ideal work conditions while demanding good quality care. Policies come with an additional workload without increasing workforce, which leads to unmanageable fatigue (Steege & Rainbow, 2016; Lui, Andres & Johnston, 2018), as seen in the narratives (in section 3.2.2.3). The nurse-midwives' themselves are victims of poor workforce and health system policies, institutional mismanagement and hierarchy (Moridi et al., 2020). This is also why it is very important to learn from the discourse around intentionality of health care providers in obstetric violence that I have discussed at length in the literature review (section 2.3).

The policy environment is crucial to ensure long term changes. Though respectful maternity care is mentioned in the LAQSHYA guidelines in India, the content is not enough to ensure respectful care to women (GOI, 2017). Studies suggest that existing policies or initiatives targeted at improving maternal health care delivery, such as the JSY, are not underpinned by the essential infrastructure (Randive et al., 2014) to encourage respectful care and continuity of care. It is essential to call out actions of disrespect and abuse and state respectful care specifically to make it a norm (Morton & Simpkin, 2019). Recent studies have presented knowledge, skills and behaviours for respectful care which can be contextualised and adapted for India (Butler et al., 2020; Shakibazadeh et al., 29) which can be implemented with continued in-service training, birthing infrastructure and policy reforms (Moridi et al., 2020; Mselle et al., 2018).

Being a woman increases one's vulnerability to any kind of violence and victimisation (Jejeebhoy & Santhya, 2018) in India and a patriarchal culture increases this vulnerability especially during childbirth. Women's priorities are considered secondary, which ensures that the limited reports of obstetric violence shared by them, fall on deaf ears (Betron et al., 2018). Women are often blamed for poor birth outcomes and in some cultures the birth of a girl child is considered a poor

outcome (Sacks, 2017). Rules and regulations determine what women are allowed to do with their bodies and this control usually takes the power over their own bodies, away from then (Bradley et al., 2016). Any resistance is considered 'misbehaviour' and met with 'punishment'. Women are expected to quietly endure the labour pains, screaming or crying violates the social norms and calls for punishment in terms of scolding and many other forms of obstetric violence during childbirth, to discipline her body (Bradley et al., 2016; Sen, Reddy & Iyer, 2018). The control of the female body during childbirth in a hospital setting is a reflection of how society is conditioned to treat women at home, in the community and in general (Sen, Reddy & Iyer, 2018). The Indian participants did not mention gender as a factor, though there are some references to poor status or lack of women's awareness determining respectful care. Respondents shared that very few women ask any question. They just want to know how long it will take to give birth, even that is met with a rude response if the woman asks too many times.

It is clear from this study that midwives and nurses have an in-depth understanding of the factors underlying disrespect and abuse of women and can collaborate in bringing changes through advocacy, administration, education, regulation and service provision. This is the key strength of this study. These findings can be strengthened by understanding the experiences of midwifery care to further understand the challenges that care providers face routinely in direct care provision, including in the current time where newer forms of abuse and an increase of obstetric violence is being reported in media as a result of the COVID-19 pandemic (Sadler et al., 2020; Kumari et al., 2020). This is an added disadvantage along with the intersectionality of women's many attributes that gives rise to gender-based inequalities, thereby increasing women's vulnerabilities to abusive behaviour (Betron et al., 2018). However, collaborative efforts are required to ensure that all the factors are addressed at the three levels, for lasting changes, while keeping women and their nurse-midwives at the centre of the efforts and as key stakeholders.

8.7 Limitations

This study could benefit from the experiences of direct midwifery care providers to further understand the challenges that care providers face routinely in direct care provision at present. Given the study participants are all nurses and midwives, it may have some biased opinions against other members of the team of care providers. India does not have a separate cadre of midwives yet, hence the respondents have been addressed as nurse-midwives in the chapter. As a result, the responses are a mix of the respondents nursing and midwifery roles, but that is a challenge in itself. So long as these two streams of care are not separated, it would be difficult to filter out the midwifery related challenges from nursing when understanding and working towards respectful maternity care.

8.8 Conclusion

Obstetric violence during childbirth is driven by factors related to the care provider, birthing environment and policy environment and the woman as a care receiver. It is evident from this study that the nurses and midwives have in-depth understanding of what consists of respect during childbirth and what leads to disrespect and abuse of women. They face several challenges that make it difficult to sustain changes. Implementing midwifery practice and empowering the existing nurse-midwives in the current workforce, from the students to the leaders serving in the highest positions in the state and centre, is key to ensure good quality and respectful care for women in India.

Chapter 9 Expected respectability from an intersectional lens: discussion and conclusion

I aim to learn what makes women more vulnerable to obstetric violence in Bihar, India. To do this, I explored the nature of obstetric violence and factors that drive obstetric violence. I wanted to understand this from the experiences and perceptions of women who should be the key stakeholder in care seeking and as people who own this knowledge; and from the experiences and perceptions of leaders who are midwives, nurse-midwives and nurses, as primary stakeholders in maternal and reproductive health care provision, who own the knowledge from the care provider's position. These two standpoints are essential to ensure respectful maternity care for women. I used feminist methods to highlight women's voices and their experiences, supplemented by voices and narratives of their nurse-midwives.

I conclude my thesis by answering the question of 'what' and 'why' about obstetric violence through two constructs: 1) expected respectability- that explains why someone is considered respectable according to women's expectations of being respected, disrespected and abused based on the complex nature of their experiences during childbirth; and 2) intersectionality- that explains why women experience obstetric violence. Parallels can be drawn between both these constructs, to also understand midwives or nurse-midwives' experiences of respectability and what drives the violence and disrespect against them, through intersectionality. For women and midwives (predominantly women in the Indian context), these discourses in the birth environment are an extension of their lives in their social environment.

9.1 Expected respectability

Childbirth, as a narrative, is being passed on through generations as an experience that should be endured. Women's birthing experiences bring clarity about why it has been an experience that Indian women endure, and it can be understood as a continuum, which has aspects of respectfulness and obstetric violence which together decide whether women's birthing experience will be positive or traumatic. I have attempted to summarise and show this unique mix of respectful, disrespectful and abusive instances in women's experiences through the Continuum of Respectful Experiences (CORE) Model. I present an evolving prototype developed from Pairo's narrative, by plotting her experiences on the CORE model retrospectively to show aspects of respect, disrespect and abuse in her birthing experience (Figure 9.1). The CORE model enables visualisation of the complex, multi-layered nature of birthing experiences, which are not unidirectional and are long lasting. Some of these actions appear once, others appear multiple

times and many are 'ongoing behaviour' (shown vertically) that women experience throughout the duration of their stay in the hospital. The configurations of Pairo's identities and background help to understand her intersections. This model can be used as a tool for future research, to continue making progress and measure changing patterns of respectfulness in care provision. It can be operationalised for care providers to develop competencies and ways to address specific forms of obstetric violence; informed by participant's experiences and perceptions of respectful care, enabling person-centered decision-making informed by the different needs of people representing different identities. The goal is to make the continuum green all the way, to ensure a humanising birthing experience.

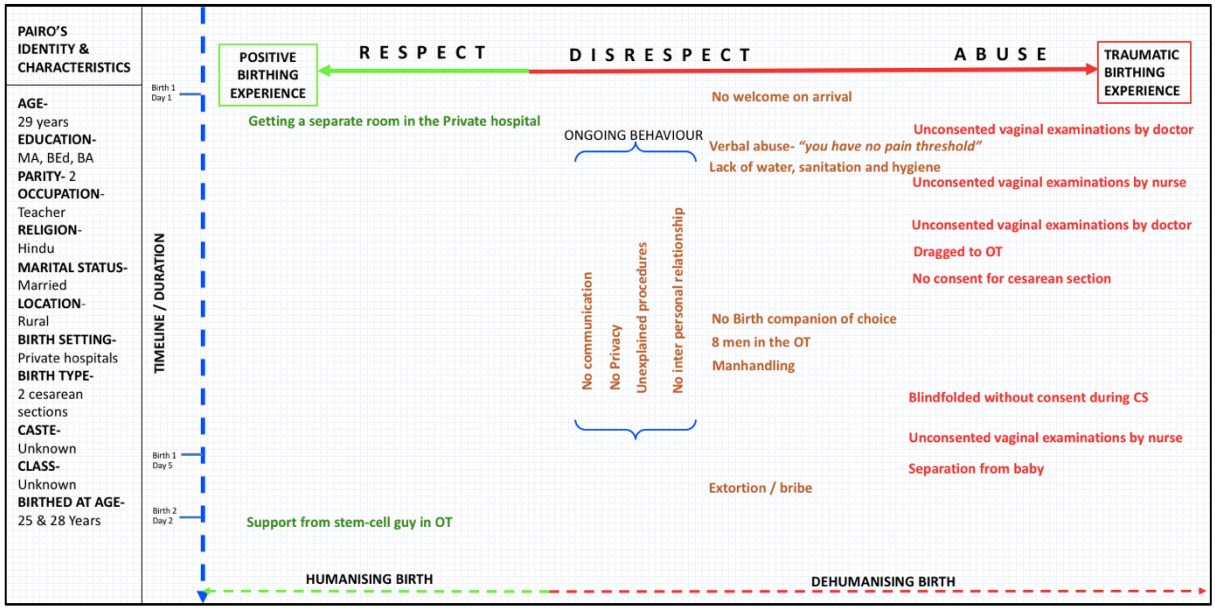

Figure 9.1 Continuum of Respectful Experiences (CORE) model (*Author's own*)

The findings from chapter 5 demonstrated evidence that every woman experienced at least two to three forms of abuse during childbirth ranging to a maximum of 17 forms of abuses making it an extremely traumatic childbirth experience for the participant (Appendix A). No woman reported experiencing sexual violence and being restrained during childbirth, and reports of physical (2%) and verbal abuse (5%) are at a minimum. This is in line with several studies that explain reasons behind underreporting of experiences of obstetric violence in resource constrained settings. The paper on determinants of obstetric violence during childbirth identified by the quantitative analysis, does not explain the number of accounts of violence under each of these forms, how many people these women were abused by and the nature of the obstetric violence with its diversity in the context and the impact on women. I, therefore, go deeper into women's embodied experiences in the following chapters through participatory arts-based feminist methods that put women's narratives at the centre, while cutting through the barriers of language, stigma and power.

A common thread in all the findings chapters (chapter 5, 6, 7 and 8), from the standpoint of women and their nurse-midwives, is that grievance reporting is unusual. Women's reporting of violence is influenced by their experience of reporting violence in their routine lives, driven by the context within its domains of sensitivity and stigma, that guides whether and what to talk about birthing experiences within the discourses around sexual, reproductive and maternal health and wellbeing.

In the quantitative study (chapter 5), no woman reported being restrained. Although, being restrained is one of the most traumatic anecdotes in most women's birthing stories in the qualitative study (chapter 6), because of its connectedness to unconsented vaginal examinations, to episiotomy, to unanesthetised episiotomy repairs, uterine explorations and fundal pressure. Women considered many of these interventions to be a part of quality health care provision, which is supposed to be endured. Sexual violence, as an Asian feminist theorist explains, is considered a fate worse than death, and has negative repercussions towards the women, instead of the perpetrator, as the current discourse in most parts of India goes. Women stand the chance of being disbelieved, as is seen in the global discourse and in India, concerning the incredulity surrounding domestic violence, intimate partner violence and now obstetric violence. It is therefore not surprising that no woman reported sexual violence in the quantitative study, although that changed in the birth mapping exercise which captured women's experiences from their unique ways of verbal and non-verbal expressions, such as Ria's reference to sexual violence as '*colourful things'*.

It is obvious from women's narratives that the attempt to discipline women bodies by health care providers, as is in the nature of obstetric systems, is well understood and obeyed by women and accepted as a culture leading to self-discipline in a display of obstetric hardiness, in line with the gendered expectations from women in general, more so from women representing particular background characteristics such as being multiparous. I also present reports from women's and nurse-midwives' narratives about how this guides women's expectation of being respected, disrespected and abused during childbirth, which I refer to as 'expected respectability'. It explains whether and how women expect to be treated by care providers treat them based on the societal and cultural norms, and women's positioning, defining their respectability from an outsider's perspective and in this case, care provider's perspective. I explain this from an intersectional lens in the following section.

9.2 Applying an intersectional lens

Intersectionality can help to understand why women experience obstetric violence and why some care providers engage in inflicting obstetric violence during childbirth. Women's narratives indicate how they are treated in the birthing environment, obstetric and non-obstetric, and how they expect to be treated during childbirth. Women are treated in a certain manner because of their positioning at the intersections of gender, parity, abilities/ disabilities, marital status, caste, financial status, physical appearance, language, religion, nationality, statehood, age, education and health status. I have attempted to present this through the intersectionality wheel, adapted for obstetric violence (Figure 9.2). These intersections are dynamic, based on people's context and background characteristics. They are flexible and can be fluid, because the intersections are constantly shifting in relation to the changes in women's background characteristics and context, as is explained by the theory and concept of configurations.

In the quantitative analysis presented in chapter 5, I found that age, parity and education were significant in determining women's vulnerability to obstetric violence. This, along with other determinants, were shared by women through their birth maps, although I did not directly explore the underlying factors driving obstetric violence in the qualitative study, but women completed their narratives sharing the reasons behind being treated respectfully, in general and in the birthing environment. This is more pronounced in Amrita's comment that although she is dark skinned but she prefers cleanliness, drawing the connection on how women's treatment in the society and birthing environment is dependent on the colour of their skin, while also indicating towards the discriminations women face, based on their skin colour and physical appearance. I saw a pattern in women's narratives, on how these determinants interact and influence each under the four key domains of gender, power, culture and structure while increasing women's vulnerability to obstetric violence in paper 3. Some of these determinants were missing from women's narrative but could be learnt from nurse-midwives' perspectives in paper 4. One of these about vulnerability of women particularly from Bihar could be noticed in a nurse-midwives' judgement ridden comment that Bihari women display poorer personal hygiene. This reflected the stereotypes related to women's geographical positioning in a state or country could also lead to obstetric violence.

Figure 9.2 Intersectionality wheel of obstetric violence (*Adapted from Simpson, 2009, p.3*)

The clarity on this comes from the nurse-midwives' standpoint, who reflect on the determinants of obstetric violence, as primary care providers and as a part of the health system. They have experienced the challenges of working in the medical model of care. It is often male-led and has remnants of patriarchy embedded in a postcolonial context. A pattern can be noticed in the important factors that nurse-midwife leaders mentioned, and could be divided into factors that are related to them and to women, in increasing boundaries of self, immediate surroundings and larger environment, that interact with each other while determining women's vulnerability to obstetric violence. Many of these factors are cross-cutting, between women and nurse-midwives, such as gender, which connected them in their shared vulnerabilities and drew parallels on how similar their stories are, for women being at the bottom of the social hierarchy and nurse-midwives' positioned at the bottom of the medical hierarchy. This positioning, influenced the other factors while constantly shifting the context of how women, nurse-midwives and other stakeholders in care provision and care seeking interact with each other respectfully, disrespectfully and in an abusive manner while constantly creating new discourses owing to their diversities.

Chapter 10 Summary, policy recommendations and way forward

I aimed to explore women and nurse-midwives' experiences and perceptions about the nature of obstetric violence and the underlying factors driving this issue in Bihar, India. In this final chapter, I summarise the findings from chapter 5, 6, 7 and 8, and conclude with the policy recommendations and suggestions for future work along with stating the limitations of the thesis.

10.1 Summary of research

Paper 1 (Chapter 5)-

- Women's experiences of obstetric violence are plural and multilayered, which may go on for the entire duration of their stay in the obstetric setting. Most of the participants of the study experienced at least 2-3 forms of obstetric violence during childbirth in Bihar, while the maximum forms of abuses experienced by a woman was 17.
- Bribery, extortion and unclear fee structure is the commonest form of abuse that every woman experienced, regardless of her background characteristics.
- Parity (number of births), age and education increased women's vulnerability to experience obstetric violence during childbirth in Bihar.
- No participant reported being sexually abused.
- Three types of obstetric violence emerge from the data in Bihar: 1) coercion; 2) poor communication; 3) physical and verbal abuse.
- The survey data does not necessarily elicit full disclosure or abuse from women. But the extent was considerable and is likely to be more.

Paper 2 (Chapter 6)-

- Women's experience of birth is complex, multilayered and unique with their contrapuntal voices representing the diversity and the ups and downs, the respect, disrespect and abuse in their birthing experiences which are not unidirectional. These are a blend of their voices of silence, knowing, resistance, resilience, depression, sadness, trauma, isolation, powerlessness, determination, hopelessness, relief, satisfaction, struggle, conditioning, denial, anger, happiness and more.
- Obstetric violence is explored in several domains which includes, but is not limited to communication, touch, obstetric interventions, people around childbirth, birth setting and birthing environment to understand the nature of obstetric violence in order to ensure respectful maternity care in each of these domains.

- Feminist methods are essential when exploring issues born out of centuries of women's oppression.
- Arts-based research is an appropriate way of learning about sensitive issues around women's sexual, reproductive and maternal health care and wellness.
- Birth mapping is a feminist visual arts-based participatory method to enable learning from women's embodied birthing experiences.

Paper 3 (Chapter 7)-

- Gender, power, culture and structure based barriers drive obstetric violence and respectful maternity care. This is an extension of the how these factors drive other forms of violence such as sexual harassment, intimate partner violence and domestic violence, in the other routine phases of women's lives which may increase their vulnerability by normalising violence. This has been commonly seen in patriarchal cultures in post colonial settings.
- The factors under these four domains can be overlapping, this is in the fluid nature of these cross-cutting factors that makes them complex and are therefore essential to explore through unique approaches of research.

Paper 4 (Chapter 8)-

- There are many factors related to the nurse-midwives that function at the individual, birth environment and policy environment levels; similarly, there are factors related to women that function at the individual, community and social environment levels. These factors together determine women and birthing people's vulnerability to obstetric violence. Many of these factors, such as gender, are cross-cutting.
- Midwives and women are both victims of a violent birthing environment and an insensitive policy environment, as a result of midwives' being at the bottom of the medical hierarchy and women positioned at the bottom of the social hierarchy, experiencing a form of deep-rooted and continued oppression.
- Midwives' perception of respect, disrespect and abuse is based in their context and culture, and how they perceive it is crucial to ensure respectful maternity care through their recommendations around midwifery model of care, shifting from the current medical model of reproductive and maternal health care.

10.2 Research contributions

- Better understanding of social determinants of obstetric violence from women and nurse-midwives' experience and perspectives to ensure respectful maternity care in India.

- A detailed framework presenting the drivers of obstetric violence with recommendations for respectful care provision during childbirth.
- WHO's Essential Respectful Care Course (ERCC)- The findings of this PhD will guide education of midwives globally as primary care providers better understanding obstetric violence, its factors to provide respectful maternity care blended with research from other parts of the world, with the ERCC, that is under-development at WHO Academy, WHO, HQ.
- A policy framework reflecting on the experience of midwifery leaders and women to advocate for improved respectfulness in maternal health care provision and to thereby ensure quality of care.
- Birth mapping, a visual arts-based research method to understand sensitive issues such as respect, disrespect and abuse learnt from women's perspectives and experience of care during childbirth to guide care provision in India, which can be adopted to explore sensitive issues with sensitivity in other contexts.

10.3 Policy recommendations

- The central and state governments of India should collaborate with partners who play a key role in providing sexual, reproductive and maternal health care and develop a roadmap for a way forward to ensure person-centered compassionate care, guided by women and midwives'. They need to make systemic changes beginning at the top levels of policy making while staying engaged for continued learning from the ground realities from women and midwives as the two key stakeholders.
- Birth maps can be utilised in the curriculum for midwifery, nursing and medical students to learn about obstetric violence and ensure respectful maternity care to women from women's experiences and perspectives. Birth mapping is a unique way to learn women's embodied experiences and before students practice health care provision on people.
- Government of India should ensure implementation of professional midwifery cadre, independent of their nursing role to ensure compassionate respectful maternity care for all women and birthing people, regardless of their background, in an equitable manner.
- Governments should enact laws at the central and states, against obstetric violence in line with other countries such as in Latin America, who have laws in place against violence in obstetric settings.
- Large scale surveys are required to generate evidence for obstetric violence. Government can ensure inclusion of questions exploring nature and extent of obstetric violence in National Family Health Surveys just as it explores questions on intimate partner violence.

- Inclusion of nursing and midwives and nursing and midwifery leaders at every level of decision making and policy making, starting from the grassroots and primary level of care provision. This will have implications in education and practice.
- Empowerment has to be at all levels for midwifery, nursing and medicine students and care providers and teaching professionals on how to take a stand for women and people whose rights are being violated, on how to preserve their dignity, through role modelling.
- Every time there is an indicator falling behind in health care, nurses and midwives are on the firing line and interventions are particularly designed just to train or retrain them. This implies a shifting of blame on them, for being a pre-dominantly women dominated profession. This is a gender-based challenge and systemic bias that needs to be addressed through team-based inter-professional learning for respectful maternity care. This needs to be in the curriculum and educational standards so that the regulatory and accreditation systems of India can incorporate it.

10.4 Limitations

- Survey data does not capture everything about the nature of obstetric violence in Bihar, India.
- Surveys are subject to sampling errors which can not be underestimated.
- Underreporting could be a challenge in low resource settings such as Bihar, where women's expectations of care could low which may lead to acceptance of poor quality and disrespectful and abusive care.
- While body mapping captures women's embodied experiences, cultural understandings and social context could potentially influence the contents of mapping exercise.
- Although measures were in place to reduce response biases, the nursing and midwifery leaders' interviews could have been influenced by their roles as key policy makers and being a part of health care systems.
- Practicing midwives (nurse-midwives' in the Indian context) were not included in the study.

10.5 Future research

- Research aiming to create an atlas of birth maps from countries and contexts around the world to understand the diverse nature of women and birthing people's experiences of respectful maternity care and obstetric violence during childbirth.

- Research should explore the extent of obstetric violence within different forms of abuse which have been recognised and the ones that are context specific and remain to be identified in different states and in India.
- Research on women's experiences of all forms of violence along with obstetric violence through sensitive, feminist, embodied participatory methods to understand the construct of all forms of violence in women's lives without segregating the different forms of violence.
- Research and consultation based on learnings from systemic literature review to develop plans for a way forward to address the driver identified at all the levels, individual, birthing environment, social and policy levels, which can enable respectful maternity care provision.
- Research to understand obstetric violence in unique circumstances such as surrogacy, prison, conflict and humanitarian settings, natural calamities and pandemic to ensure respectful care in these contexts for sexual, reproductive and maternal health care.
- Research on overlapping territories and constructs such as reproductive violence, reproductive injustice, reproductive politics and governance etc. how they overlap with and differ from obstetric violence, to further understand the whole gamut of women's experience within sexual, reproductive and maternal health and health care.
- Research on midwives and nurse-midwives' experience of obstetric violence and respectful maternity care when they give birth, and how that influences health care provision.
- Research on team culture on obstetric violence and also on respectful maternity care, and how teams can be addressed together in initiatives to ensure compassionate care.
- Large scale quantitative research on care providers related barriers to ensure respectful maternity care in India.
- Research exploring pain and pleasure in women's sexual, reproductive and maternal health related embodiments to understand how they influence each other, and their experiences and expectations from health care.
- Research on obstetric violence and respectful maternity care from the perspective of sense of sight, smell, speech, sound and touch.
- Research on birthing environment infrastructure and architecture for low resource, high workload settings.
- Understanding the contrapuntal voices quantitatively to know the duration of these voices representing concord and discord in an attempt to make a shift towards more concord, in sensitive issues of birthing where women's may hesitate to share their experiences of obstetric violence.

- Research and implementation of the Continuum of Respectful Experiences (CORE) model.

Postscript: The story of my birth

My 1st family picture: Baba *(curly hair),* **Ma** *(wearing a saree cut from the cloth of the curtain),* **me** *(camouflaging on my mother's lap)* **and Didi** *(turtleneck)*

I was born in a military hospital in the western state of Rajasthan in India, at 10 am on a thursday, December 11th, 1986.

Soon after, my ma was shifted to a postnatal care room that she shared with a Rajasthani aunty.

Let's call her Binti.

Binti aunty gave birth to her 4th son and was very sad!

Mrs and Mr Binti always wanted a girl and had 4 sons while trying for a girl.

My ma had a daughter already, our beloved Keya.

I am her second girl, so Binti aunty drooled all over me from the second she saw me and had a brilliant idea.

"Let's exchange our babies, Kalpana" she said to my mother "*that way we will both complete our dream family with perfect male : female ratio and the secret will remain in this postnatal room*".

Let's call her son Dhinku.

Concerned, I looked at Dhinku and thought there's no way my ma will give me up for him.

(Please refer to me in the picture in Exhibit A: My first family picture)

Important detail - none of the fathers had seen their respective babies yet.

Binti kept pleading.

Ma said no.

She said please.

Ma said no.

0

Dhinku and I made eye contact and cried, undecided who's going to get a Bengali upbringing and who will be raised Rajasthani.

Binti broke into tears, inconsolable.

Mr. Binti jumped in, said please.

Ma said no.

Everybody started crying!

They said ask Mr. Kalpana, he'll surely want Dhinku (2.5 kgs) in exchange of a 2nd daughter (4 kgs).

Keya, my didi, clueless, if her parents are bringing home a sister or a brother.

Mr. Kalpana heard about the deal of baby exchange on the table (in the crib) and got furious.

Mr. Kalpana ran his hand through his curly head full of hair and said no.

For whatever reason, together, Mrs and Mr Kalpana decided to keep their daughter (4 kgs) and they lived happily ever after.

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Appendix A Trahi's birthing experience

Trahi (pseudonym) is a 21-year-old homemaker. She has two children, and her last child was born 18 days ago. She is a Hindu by religion and belongs to schedule caste. She has received 4 years of formal education, belongs to a household from poor socio-economic background, who are all casual labourers in others farms. The household does not have access to electricity.

Trahi travelled with her mother-in-law and a relative to the health care centre. She made two visits for antenatal care at a public health care facility during her pregnancy and felt that she is treated very respectfully during her ante-natal visits. Going to this facility was her family member's decision. It was the same facility where she went for her antenatal care and felt the providers treat their clients well. She expected a well equipped facility, clean environment, good, affordable and specialised services. When she visited the health care centre to give birth the health care providers checked her blood pressure, the fetal heart rate and conducted an ultrasonography. Her birth was assisted by a doctor, nurse, mamta and ASHA. Her mother-in-law accompanied as her birth companion.

Trahi experienced many instances of obstetric violence during her stay at the healthcare facility during childbirth. She experienced physical abuse, verbal abuse, stigma, discrimination, there was poor rapport with health care providers, a failure to meet professional standards of care and health system constraints. The health care providers used rude language with her and made judgemental and accusatory comments. She was threatened to be hit because she was screaming from the painful contractions. They physically abused her by pulling her by her leg, she was also slapped or hit or pinched. There was poor communication and she felt like a passive participant because she was not informed the findings of her general and vaginal examinations. She was not communicated about the ward environment and the progress in her labour. She felt neglected and abandoned. Her privacy was not maintained and confidentiality was breached. Her consent was not sought when conducting interventions on her.

Trahi, or the baby were detained at the health care facility for the inability to make payment. Her family paid 500 rupees in bribe and 3500 rupees for medication at the government health care facility. She had not received the JSY money in the 18 days since birth, which she is supposed to receive immediately in her bank account. She felt that the staff attitude towards her was very poor. She was not allowed any food or fluid during labour and birth, and was not allowed to walk around. She was not allowed to give birth in a position of her choice and had to give birth standing. Her baby was put on her chest right after birth. She took no action about the obstetric

violence she experienced. She shares that she will not recommend this health care facility to others to give birth. Trahi rated the respectfulness shown to her during childbirth and stay in the facility as poor.

Appendix B Body mapping aided in-depth interview guide

Background

No.	Question	Response
A1	Participant code	
A2	Participant chosen pseudonym	
A3	Age	
A4	Number of children	
A5	Education (no. of years)	
A6	Occupation	

Household information

No.	Question	Response
B1	Is there water supply in the household?	
B2	Is there electricity in the household?	
B3	Does the participant have a bank account to her name?	
B4	Distance (kms) to the nearest health care facility? (PHC/ CHC/ DH/ Tertiary hospital)	
B5	Urban/ Rural	
B6	Duration of stay at current address	

Birth history

No.	Mother's age at birth	Place of birth (Hospital, Home, CS other)	Sex of newborn at birth	Birth companion	Any complications / comments / remarks
C1					
C2					
C3					
C4					
C5					

Appendix B

Experience, expectations and perceptions about childbirth

No.	Questions and probes	Reflexive Notes
Experience of childbirth		
D1	How was your birth experience? ***Probes****: She may talk about any birth experience of her choice and even mention experiences from different births she has had.*	
D2	How were you received at the health facility when you arrived and how was the experience? ***Probes****: Who received you, how many people were there, who said what, who did what, waiting time from arrival to labour room or ward*	
D3	What happened after admission? Were you taken to the labour room or a ward to wait? What happened in the antenatal room? ***Probes****: Were you allowed to move around? Was someone with you from family? Was there anything that you liked or did not like? Did you feel anything disrespectful or abusive?*	
D4	*How would you describe the **birthing environment**/ room where you gave birth? ***Probes:*** *what was around you? Curtains, air conditioning, other labour tables, cleanliness, monitor*	
D5	*How was your **privacy** maintained during labour and while giving birth? ***Probes:*** *What were people doing around you? Can you show on the map where around you they were standing? Did you feel you were properly covered? How did you feel about it?*	
D6	*What **position** did you give birth in and how did you feel about it? ***Probes****: lying down, restraints, people holding down, how was birthing on a labour table*	
D7	*What i**nterventions** were performed on you in the hospital from admission to discharge? How did you feel about it? ***Probes****: consent, information, communication*	
D8	Did the **same care provider** give care to you from antenatal period to childbirth? ***Probes:*** *Yes, no? why? What would you have liked? How would it have helped?*	
D9	*How did the person/ people from family around you help while you were in the health care facility (or home) and when you were giving birth?	
D10	*How did you decide about your **birth companion** and why?	
D11	How was the **behavior of the care provider** around you during childbirth?	
D12	What conversations did you have with the care provider? ***Probes:*** *Did anyone say anything to you that you did not like? Anything that you liked?*	

D13	How did you feel about asking questions to the care providers during childbirth? ***Probe****: Could you* ***talk freely*** *to your care provider?*	
D14	*What kind of touch is okay during childbirth? ***Probes****: How many people touched you in anyway? Care providers and family? Who touched you where and how many times? How did you feel about it?*	
D15	*What comforted you during **labour pains**? Who (family, care providers) helped you? How? ***Probes:*** *Walk around, drinking water, taking some food, using washroom, back massages; What was the most discomforting?*	
D16	*What are the things that you liked during childbirth? What are the things that you did not like? ***Probes****: was information about you shared with others that you did not want? Did you have to pay for any service?*	
D17	******How did you decide where to give birth and why? How did you feel about that decision?	
Hopes		
E1	*What did you already know about giving birth? What is the language you use to talk about birth? Who do you talk to about birth, questions, fears, doubts?	
E2	*What did you **hope** would happen when you give birth? ***Probes****: List all the things she says and keep asking specific questions based on her response, could be unrealistic*	
E3	*What services should be there in the hospital that will make your experience of childbirth **satisfactory and respectful**? ***Probes****: birth environment, privacy, cleanliness, behavior of care providers, way of talking*	
E4	**Multipara-**what is the difference in your experience of birthing in two settings? Good and bad? Which was more respectful & disrespectful? Why?	
F	**Concluding question**- How do you feel about this exercise? Is this a satisfying exercise? Why? ***Probes:*** *likes, dislikes about the process of body mapping*	

Note- **To be asked for **home births** as well.*

Appendix B

Body Map Key

Respondent ID/ Pseudonym-

Symbol or colour	Meaning or interpretation

Post interview debrief

Debrief
Reflexive notes
Interview environment

Appendix C Nurse midwives' perspectives on respect, disrespect & abuse during childbirth

A.	**Background information** (To be filled by participant if possible)		
A1	**Participant code**		
A2	**Age**		
A3	**Sex**		
A4	**Designation**		
A5	**Organisation/ department**		
A6	**State**		
A7	**Category (select all that applies)**	• MOHFW • INC/ SNC • Hospital • Teaching Institution • Civil Society Organization • Private • Others _____	
A8	**Number of years of service in urban and rural area**	Urban _____ Rural _____	
A9	**Educational background (select all that applies)**	• ANM • GNM • BSc Nursing • PBBSc Nursing • MSc Nursing in _____ • PhD in _____ • Other _____	
A10	**All the designations worked on with promotions (mention position and number of years worked on the same, Eg. Staff Nurses- 10 years)**	**Designation**	**Years of service**
A11	**Total years of experience**		
A12	**Have you ever done midwifery professionally?**	Professionally- Yes / No	
A13	**If yes, for how many years or months?**		
A14	**How many births have you conducted in total?** *(any in the last one year? Public/ Private)*		
B.	**Current Role and responsibilities**		
B1	How would you describe your nursing and/or midwifery career?		
B2	What is your current role and responsibilities?		

B3	What supervisory role do you currently play? *(Probes: Visits to hospitals, teaching institutions, meetings with people etc.)*
B4	How are various nursing and midwifery policies made? How are those decisions made? *(Probes: regulation, deployment, transfer, etc.)*
B5	What role do you play in nursing & midwifery workforce governance? *Probe: recruitment, salary, posting & transfer, continued education, career progression, promotion Collect: policy documents, acts, etc. What percentage of them are with nursing and midwifery background? Who are the stakeholders involved in these decision making?*
B6	Do you feel nurse-midwives are playing an equal role at policy making? Do you feel they can contribute in any other way in improving nursing-midwifery workforce governance?
C. Perception of quality & respectfulness in care around birth	
Information: Here is a painting drawn by a midwife based on her and my experience of a delivery we had observed together. (Refer to image)	
C1	What is your reaction to the painting? *Probe: familiar or not, realistic or not,* type of facility, urban/ rural, home, private, public
C2	What do you feel are the essential components of good quality of care around childbirth?
C3	What does respect mean to you?
C4	How would you define respectful maternity care?
Information: There is some evidence coming up from states like Bihar, Uttar Pradesh, Jharkhand, West Bengal etc. that women have been physically abused (hit, slapped, pinched) or verbally abused (comments on sex life, discriminatory comments based on gender, religion or socio economic status, physical appearance) or there was lack of privacy during childbirth & confidentiality during or after.	
C5	Have you heard of childbearing women undergoing disrespect and abuse during childbirth? What kind of disrespect and abuse do you think women face? Could you share some examples from what you may have seen or heard?
C6	Why do you think some care providers abuse women during childbirth? *Probe: work environment, work pressure*
C7	How does this start? Why? *Probe: While they are students, later in profession*
C8	How do you think the childbearing woman's background characteristic plays any role in why she gets abused during childbirth, if any? *Probe: Gender, Socio economic status, education level, class, caste, religion, HIV status, number of children, age*
C9	How do you think a woman's physical appearance plays a role in why she get's abused? *Probe: Height, weight, age, color of skin, attire / clothing, personal hygiene level, genitals*
C10	How do you feel the transformation happens from a student who is learning to give care around birth to a professional some years later who abuses women around childbirth? *Probe: Medicine, midwifery, other staff*
C11	How can you ensure that respectful maternity care is provided? *Probe: Disrespect and abuse during childbirth is violation of human rights. How can it be regulated? Disincentive, punishment*
C12	Given you are nursing and / or midwifery leader (in India) how do you think nursing and / or midwifery leadership can help improve respectfulness of care around childbirth?

C13	How can our nursing & midwifery students be shown to provide RMC in their Pre service education?
C14	Can you list three things/ actions you can take from your level to see that care provision around childbirth is respectful? And what barriers and facilitators do you foresee for the same?
C15	Do you have any children? Would you mind sharing how your childbirth experience was? (*Probe: Respectful, disrespect & abuse, in control,* choice, what did you like or dislike)

Appendix D Knowledge translation

This PhD enables understanding of obstetric violence during childbirth. The findings highlight need for future research to promote and implement respectful maternity care and find short term and long term solutions to address obstetric violence during childbirth. My PhD began in January 2018 and the following activities helped in knowledge translation of my PhD research over the last four years.

Table D: Knowledge translation activities

Month, year	Event	Activity
2018		
August-September 2018	Seminar at WHO Head Quarters, Geneva, Switzerland	**Respectful Maternity Care: Definitions, typologies, evidence and policies** Presented to health and policy experts at an open to all seminar at the WHO HQ.
August-September 2018	Global guidelines for training midwives on respectful maternity care, WHO Toolkit (upcoming)	**Interned on Midwifery Leadership at WHO HQ** Prepared a cross cutting module on RMC for a global toolkit on midwifery education as a deliverable of the internship. This toolkit will be published when other modules will be ready.
December 2018	Partnership of Maternal Neonatal Child Health, Partner's Forum, New Delhi, India	**Midwives Voices, Women's Choices** Organised a side event to the partners' forum that brought midwives, women and adolescent girls from 13 states in India where they shared their experiences, needs and challenges. The audience of this event included international development organisers, policy makers, academicians and researchers from many countries. The Normal Birth Campaign in India was also launched in this event. https://www.change.org/p/government-of-india-promote-normal-birth-in-india-be-a-normal-birth-ambassador
2019		
March 2019	Department of Social Sciences Seminar, University of Southampton, UK	**Why do care providers abuse women during childbirth?** Presented findings from the first analysis based on midwifery leaders interviews
March 2019	What Women Want Campaign, UK	**Lead the global What Women Want campaign** in UK to collect women and girl's wants for reproductive and maternal health care.

April 2019	3 Minute Thesis University of Southampton	**Won the faculty level 3MT** Represented Faculty of Social Sciences at the University level competition. https://www.youtube.com/watch?v=LNA6cAfzDAE
May 2019	All Wales Student Nurses Conference, Cardiff, Wales	**How can student midwives ensure respectful maternity care?** Invited to speak on the role student midwives have in providing respectful care and how respectful communication in the teaching environment influences that.
May 2019	72nd World Health Assembly, Geneva, Switzerland	**WASH in HCF and Midwifery Strengthening** Represented ICM as a young midwifery leader and invited to speak at two panels alongside Director General Dr. Tedros A Ghebreyesus.
June 2019	What Women Want Report, White Ribbon Alliance	Got featured in the report as one of the 5 key influencers for the campaign that ran in 114 countries and found respectful maternity care as the 1st ranking demand from a total 1.2 million wants. https://www.whiteribbonalliance.org/wp-content/uploads/2019/06/What-Women-Want_Global-Results.pdf
June 2019	14th Normal Labour and Birth Research Conference, Lancashire, UK	**Empower midwives for respectful maternity care** Presented findings from first analysis chapter on drivers of disrespect and abuse during childbirth from midwifery leader's perspective.
July 2019	Parlay Parlour; White Ribbon Alliance, Glastonbury Festival 2019, UK	**Women's bodies, Women's rights** Spoke on a panel focusing on choices in birth and fertility revolving around pain and pleasure; alongside Jesse Phillips, MP Birmingham Yardley. https://www.theguardian.com/music/2019/jun/30/glastonbury-gender-balance-performers-headline-acts-men
August 2019	Respectful Maternity and Newborn Care Guidelines, Government of India	Reviewed and gave inputs to the national guidelines on Respectful maternity and neonatal care by Government of India.
September 2019	Resolution to revolution: WASH in health care facilities, Livingston, Zambia	**How does water, hygiene and sanitation services in health care facilities effect care provider's safety & dignity?** Presented at a three-day meeting organised by WHO HQ, UNICEF and Government of Zambia based on personal experiences and a quick survey of nurses and and midwives on social media from other lower middle income countries. https://www.youtube.com/watch?v=Su53NTLFkdA&feature=youtu.be
September 2019	14th Annual Society of Midwives India Conference, Raipur, India	**Do midwives have respectful births?** Invited to speak on a panel on Respectful Maternity Care (RMC) in India organised by White Ribbon Alliance India at the 14th SOMI conference.

September 2019	International Confederation of Midwives' (ICM)	**Midwifery educator's curriculum; and Nurse Practitioner in Midwifery Curriculum; Government of India** Consulted with ICM on a five-member team of midwifery experts led by Prof. Lesley Page to prepare two curriculums for midwifery educators and nurse practitioners in midwifery (NPM) in India. A new cadre of midwives is finally being trained in India to enable midwifery led care that is good quality and respectful.
2020		
February 2020	Birthing outside the system: The Canary in the Coalmine, Routledge	**Why South Asian women make extreme birth choices** (Book Chapter) Co-written with Bashi Kumar Hazard, from Human Rights in Childbirth who is editing this book with Hannah Dahlen and Virginia Schmied from Western Sydney University, Australia. https://www.routledge.com/Birthing-Outside-the-System-The-Canary-in-the-Coal-Mine-1st-Edition/Dahlen-Kumar-Hazard-Schmied/p/book/9781138592704
March 2020	Economic and Political Weekly (EPW)	**Docsplanation!** It's an opinion piece to highlight the domination and influence of medical profession on midwifery and nursing in India. https://www.epw.in/journal/2020/10/postscript/docsplanation.html
April 2020	Washington University of St. Louis	Gave a guest lecture to undergraduate students on **'Birth, gender and midwifery'**
May 2020	73rd WHA, Geneva	WASH for nurses and midwives' in COVID-19
June 2020	The Practicing Midwife Journal	**A starched cotton fluorescent yellow saree, khopa, belly button and safety pins: decoding the 'dignified Indian nurse-midwife'** https://www.all4maternity.com/a-starched-cotton-fluorescent-yellow-saree-khopa-belly-button-and-safety-pins-decoding-the-dignified-indian-nurse-midwife/
July 2020	College of Obstetrics, Argentina	Partería Intercultural Got featured in a South American midwifery magazine by the College of Midwives's in Argentina in their global intercultural midwifery section.
September 2020	GLOW Conference	Presented a poster titled why some care providers disrespect and abuse women during childbirth.
December 2020	15th Normal Labour and Birth Research Conference	
2021		

February 2021	University of Southampton, UK	
June 2021	International Confederation of Midwives Congress, Bali, Indonesia	Abstract selected for 3 Minute Thesis: 1. Disrespect and abuse of women during childbirth in India (3 minute thesis entry)
2021-22	Publications under review or in- print	The following papers are planned from the PhD: 1. Mayra K., Matthews Z., Sandall J. The case of surrogate decision makers for women competent to consent during childbirth in Bihar, India. *Agenda.* In print 2. Mayra K., Matthews Z., Sandall J., Padmadas SS. Women's experience of respect, disrespect and abuse in Bihar, India: a body mapping aided critical feminist study (under review with BMC Pregnancy and Childbirth) 3. Mayra K. Body Mapping: a participatory method to understand women's birthing experience (Under review with Qualitative Health Research) 4. Van der waal R., Mayra K. Obstetric violence as gender based violence (Book Chapter, Under review) 5. Van der waal R., Mayra K, Obstetric Violence: It's abolition (Under review with Feminist Anthropology)

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