Experiences and impacts of Obstetric violence on Indian women within the Public healthcare system

Experiencias e impactos de la violencia obstétrica en las mujeres de la India dentro del sistema de salud pública

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Abstract
Obstetric violence is an often-overlooked obstacle to quality of health care service during childbearing and it has not received much attention in India. In this paper, our aim is to study the experiences and impacts of Obstetric violence on Indian women during the period of childbearing. A total of 256 women were interviewed in two districts (Sambalpur and Bargarh) of Odisha, India in between the age of 18 and 35 years in their latest childbirth within the last 5 years. We found that 83 women (32.4 percent) have experienced obstetric violence (Non-dignified care and physical abuses) and the prevalence is more among the women of lower caste and lower socioeconomic groups. Results also indicate that obstetric violence has long-lasting, chronic and fatal health consequences and many victims also reported serious deterioration in spousal and family relationship. It is a human rights problem that must be prevented and eradicated.

Keywords: Obstetric violence, non-dignified care, physical abuse, childbearing, violence against women, India.

Resumen
Violencia obstétrica es un obstáculo que a menudo se pasa por alto para la calidad del servicio de atención médica durante la maternidad y no ha recibido mucha atención en la India. En este artículo, nuestro objetivo es estudiar las experiencias y los impactos de la violencia obstétrica en mujeres de la India durante el período de maternidad. Se entrevistó a un total de 256 mujeres en dos distritos (Sambalpur y Bargarh) en el estado de Odisha, India, entre las edades de 18 y 35 años que han tenido su último parto en los últimos 5 años. Encontramos que 83 mujeres (32.4 por ciento) han experimentado violencia obstétrica (indigna atención médica y abusos físicos), y la prevalencia es mayor entre las mujeres de castas inferiores y grupos socioeconómicos más bajos. Los resultados también indican que la violencia obstétrica tiene consecuencias duraderas, crónicas y fatales para la salud y muchas víctimas también informaron un grave deterioro en la relación conyugal y familiar. Es un problema de derechos humanos que debe prevenirse y erradicarse.

Palabras clave: Violencia obstétrica, indigna atención médica, abuso físico, maternidad, violencia contra la mujer, India.

INTRODUCTION

Violence against women is undeniably a cross cultural phenomenon and it is being assisted in a violent manner everywhere in world (Watts and Zimmnerman, 2002). They experience situations of mistreatment, disrespect, abuse, negligence, violation of human rights by health professionals, especially during delivery and birth (WHO, 2015). Many studies have reported various forms abuses during childbirth in different parts of the world (Chadwick, 2017; Raj et al., 2017; Castro and Erviti, 2003; Dixon, 2015; Junqueira de Souza et al., 2017; Smith-Oka, 2015). It is frequent to observe in obstetrical rooms that women suffer different types of harassment, unethical action, presence of strangers and alone in unfriendly settings (Regis and Resende, 2015).

The denial of the presence of the companion of the women's choice; lack of information about the different procedures performed during care; unnecessary cesarean sections; deprivation of the right to food and walking; routine and repetitive vaginal exams without justification; frequent use of oxytocin to accelerate labor; episiotomy without the consent of the women (Bellón, 2015; WHO, 2015).

The World Health Organization (WHO) in its Organic Law on Women's Right to a Violence-free Life defines "obstetric violence" (OV) in Article 15(13) as: "… the appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanizing treatment, abusive medicalization and pathologization of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life[1]. This terminology was proposed for the identification of any act of violence directed against women during pregnancy, childbirth and the postpartum period both in private and public medical institution. Mistreatment of women in health facilities is rooted in pervasive gender inequalities and power imbalance between health providers and women (Chadwick, 2017; Raj et al., 2017). Therefore, disrespect and abuse can be viewed as a consequence of structural violence (Raj et al., 2017; Acharya, 2019).

The World Health Organization (WHO) recently recognized that obstetric violence, remains largely undocumented and unspoken about and the study led by WHO in Ghana, Guinea, Myanmar, and Nigeria between Sept 19, 2016, and Jan 18, 2018 concluded that around 42 percent of women experienced physical or verbal abuse or discrimination during childbirth in health centers, with some of the women being punched, slapped, shouted at, mocked, or forcibly held down (Bohren et.al, 2019). The State is responsible for institutional violence when women are denied access to health care, treated inhumanely, forced into unnecessary medical procedures during child birth period (WHO, 2015, Saini et al, 2017, Junqueira de Souza et al., 2017; Montesinos-Segura et al., 2018). In India, the institutional deliveries are 79 percent and Skilled birth attendance (SBA) deliveries is 81 percent in 2015–16 which are lower than 100 percent as envisioned by Sustainable Development Goals (Goli et al., 2019), however, the prevalence of obstetric violence is unknown in India, but according studies of Sudhinaraset et al. (2016), Khubchandani et al. (2018), women those living in rural areas, and women of lower caste are more likely to experience abusive treatment.

Saini et al. (2017), Sharma (2016), Raj et al., (2017) have identified that deprived health care system including purposeful neglect, purposeful economic harassment, disrespectful, verbal and physical abuses and discriminatory languages are some of the common daily events that pregnant women face in public health institution. This type of behaviors most of the time limits the instructional services and many women experiences the health complication during the pregnancy, during and after the child birth. Although, the reasons for this rise are not entirely known, but the statistics are indicative of underlying problems within Indian maternity care that deserves research and investigation. Thus, in the present paper we aim to study the experiences and impacts of Obstetric violence on women during childbearing in India.

UNDERSTANDING OBSTETRIC VIOLENCE

The problems of obstetric violence during childbearing have received much interest in many countries globally. In 2015, the World Health Organization acknowledged the severity of the mistreatment of women during childbearing when it released a statement on the prevention and elimination of disrespect and abuse during facility-based childbirth, calling abuse, neglect, or disrespect during childbirth a "violation of women's fundamental human rights" (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015). The statement also points out the link between maternal mortality rates and ensuring access to high-quality, respectful maternity care. According to the studies of United Nations Agencies women are denied high-quality care, and are subjected to disrespect and abuse at the hands of their care providers, there can be "direct adverse consequences" for both the mother and child (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015).

The Obstetric violence is also categorized as gender-based violence and discrimination against women and targeting specifically women, this shows inequality in our society (Savage and Castro, 2017; Sadler et al., 2016). Disrespectful and abusive treatment during child birth is a violation of women's fundamental human rights and can be viewed as a consequence of women's lives not being valued by larger social, economic and political structures (Sando et al., 2017, Acharya, 2019). Social norms play an important role in the acceptance of violence against women, and usually women remain silent about the violence they face in hospitals because they consider it "normal". This is because of the stereotype of how midwives are rude and violent, and getting screamed at or beaten by a midwife is normal and no one usually talks about it. In addition, women are ignorant about their rights as patients (AMNA, 2019).

On the other hand, women's silence about their experiences and ignorance about their rights gives the medical staff, specially the midwives the chance to be abusive (Lokugamage and Pathberiya, 2017; Diaz-Tello, 2016). In this paradigm, women are subjected to different practices that can be conceptualized as violence in their relations with

1 https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth-govnts-support/en/

health care services providers and these practices have been termed abuse and mistreatment. In 2015, Bohren and colleagues created a typology of mistreatment of women during facility-based childbirth. This typology consisted of seven domains: (1) physical abuse, (2) sexual abuse, (3) verbal abuse, (4) stigma and discrimination, (5) failure to meet professional standards of care, (6) poor rapport between women and providers, and (7) health system conditions and constraints. This typology recognizes two important underlying dimensions of the mistreatment of women during childbearing: that violence can occur on an interpersonal level as well as on a structural level (Bohren et.al, 2015).

The World Health Organization stressed that certain types of women (women of low socioeconomic status, women belonging to ethnic minorities) are at a higher risk of experiencing obstetric violence (WHO, 2015). In obstetric violence there is a clear individual perpetrator that is physical abuse of patients and intentional emotional abuse and structural forms of violence that is demeaning attitudes towards women, authoritative power of obstetric knowledge, infrastructural problemsthat create the conditions for individual abuse (Hennig, 2016).Quality of healthcare doesn't mean that a medical institution only has high quality clinical components, but also giving good and positive health care facility to the patients (Shabot, 2016). All women have right to dignified, respectful health care throughout pregnancy and childbirth as well as freedom from violence and discrimination. A growing number of evidence, however, shows that women are being mistreated during childbearing in health facilities across the world (Betron et al., 2018; Bellón Sánchez, 2015; Shabot, 2016).

In India, since 2006, the Government of India has promoted skilled attendance at birth through Janani Suraksha Yojana (JSY)[2] programme, however, the National Family Health Survey (NFHS-4) data shows that only 21 percent of women have received full antenatal care[3] (IIPS, 2017) and 52 percent of women have institutional births in public facility (IIPS, 2017). The National Family Health Survey data also indicates that approximately 20 percent of women had given birth at their home and only 2.5 percent children born at home were taken to a health facility for check-up within 24 hours of birth (IIPS, 2017). Researches of Goli et al. (2019), Sharma et al. (2019) and Pomeroy et al. (2014) indicates that poor quality of care in public hospital including inappropriate care practices, harassment, mistreatment, abuses and in most of the cases violence (sexual and physical), tend to choose private health sector or abundant antenatal care facilities.

There is now increasing evidence on obstetric violence against women during childbearing in all section of the Indian society (Sudhinaraset et al., 2016; Sharma et al., 2019) to document the authoritarian attitudes of obstetrics and gynecology health care personnel (Sharma, 2016). Available literatures indicate that women with lower socioeconomic status especially of Scheduled caste and tribe are most affected group of the obstetric violence (Chaturvedi et al., 2015; Sharma et al., 2017) and most of the time they have been left unsupported, were abused verbally, slapped and were not given information on treatment in public health sectors. Although, there is growing interest to improve quality of care during child bearing by the public agencies, however the growing incidence of obstetric violence many pregnant women forced to leave antenatal care which need to be study and analyzed obstetric violence experiences by Indian women.

METHODS

The study was conducted in Bargarh and Sambalpur districts of Odisha, India. According to National Family Health Survey data (NFHS 4) nearly 27 percent and 35 percent of women from Bargarh and Sambalpur districts respectively received full antenatal care during the period of child bearing (IIPS, 2017). Despite the government has tried to improve the quality of health care, the rate of institutional antenatal care has not shown improvement in the region. For this study we randomly selected 256 women (140 women from Bargarh district and 116 from Sambalpur district who have become mother during last 5 years) of the age between 18-35 years and visited public health care institutions for services during the pregnancy and during or after the child birth. Mothers were identified through the Accredited Social Health Activist (ASHA) workers and after that they were interviewed in a semi-structured questionnaire. Also, we have conducted 10 in-depth interviews (five women from each district)

The questionnaire included both quantitative and qualitative data information. The first section of the questionnaire included information on socioeconomic and demographic of women. The second section questions related to obstetric violence faced by the women during the pregnancy and during and after the child birth.

Ethics statement

The principal investigator's home institution obtained approval from the Institutional Review Board (IRB). Before and during the interviews, we followed the relevant ethical and methodological procedures such as safeguarding participants' confidentiality, anonymity, and safety. It must be noted that, while the participants agreed to be interviewed via ASHA health workers, we obtained their consent and repeatedly explained to them the purpose of our study and subject to be discussed. We never asked their names, avoided any questions could be interpreted as discrimination, and did not question their sentiments or judge their decisions or character.

Moreover, all informants were also told before the interview that they were in no way required to answer all of the questions if they did not feel comfortable, and if during the interview they feel timid or uncomfortable to continue, they can discretely end the interview.

2 Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The programme, launched on 12th April 2005 and is being implemented in all states and UTs with special focus on low performing states.

3 Full antenatal care is at least four antenatal visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup taken for 100 or more days.

Data analysis

In this study we have analyzed the fieldwork information in two ways. The first was by using SPSS version 17 software, which systemized the socio demographic data of interviewed. Secondly, using Critical Discourse Analysis (CDA), we analyzed the words (discourses) of the victims of obstetric violence. From the discourses of victims, we analyzed how aggressor treat or control victims, how they coerced into situations, what kind of violence persists against the victims and different types of health problems suffered by victims. This qualitative information was analyzed together with the quantitative information to understand the magnitude and seriousness of the obstetric violence problem and its future implications. In the paper pseudonyms are used to protect women identity.

RESULTS

Socio-demographic characteristics of women

We first report on women's socio-demographic characteristics, as it is mentioned in the methodology section that 256 women of age between 18-35 years were interviewed to understand the prevalence of obstetric violence in two districts of Odisha, India. The socio-demographic profiles indicates that majority of interviewed women (45.7%, n=117) are below the age of 20 years and 36 percent women (n=93) are at the ages of 20 to 30 years and 18 percent women (n=46) said their current age is 30 to 35 years. When it comes to their educational status, nearly 57 percent women (n=145) have completed elementary or primary education, whereas 32.4 percent (n=83) said they never enrolled for a formal education (see table 1).

Amongst our 256 interviewed women, when we analyzed on the basis of caste, it is seen that 63 percent (n=162) women belongs to Scheduled caste (SC)[4], 8 percent (n=21) are Scheduled tribe (ST)[5], nearly 18 percent (n=45) are Other Backward Class[6] and 11 percent (n=28) said they belongs to other castes. When it comes to women's socioeconomic background, nearly 72 percent (n=183) identified themselves a very low socioeconomic group, whereas around 22 percent women (n=56) specified their status is low and only 6.6 percent women (n=17) belongs to medium socioeconomic status. On number of children (see table 1), we observed that only 4.7 percent (n=12) do not have any children, whereas majority of women (74.6 percent, n=191) said they have only one child and 20.7 percent (n=53) said of having two children.

On current occupational status of interviewed women, majority (76.5 percent, n=196) of them are not working and they identified themselves as housewife, 19 percent (n=49) are working as daily wage labourer, two women said they are working as school teacher (see table 1).

During the interviews among married women, we asked them; whether they have used public health care system during child bearing period in last five years, followed by whether they have personally observed or suffered any obstetric violence during the period of child bearing. As observed from the data analysis in table 2, nearly 74 percent women (n=189) mentioned that they have utilized public health care system during the period of the pregnancy and during and after the child birth, and 67 women (26 percent) have never utilized public health care system. On our question on obstetric violence, of 256 interviewed women, 83 women (32.4 percent) said they have suffered at least one type of obstetric violence in public health centre during the period of child bearing.

	Number	Percent
Current Age		
Less than 20 years	117	45.7
20-30 years	93	36.3
More than 30 years	46	18.0
Education		
ılliterate	83	32.4
Upto Primary	145	56.6
Upto Secondary	28	11.0
Caste		
Scheduled caste	162	63.3
Scheduled tribe	21	8.2
Other backward class	45	17.5
Other	28	11.0
Socioeconomic status		
Very low	183	71.5
Low	56	21.9
Medium	17	6.6
Number of children		
No children	12	4.7
1	191	74.6
2	53	20.7
Occupation		
No job/housewife	196	76.5
Daily wage labour	49	19.0
School teacher	02	1.0
Others	09	3.5

Table 1. Socio demographic characteristics of surveyed women, Odisha, India (N=256). Source: Fieldwork, 2019-20.

4 The Scheduled Castes (SC) in traditional Indian society known as Dalit or Harijan or Untouchable. The traditional Indian society is divided into five main categories of castes - Brahmins, Kshatriyas, Vaishyas, Sudras and Dalit. Dalits are members of the lowest social group in the Hindu caste system. The word "Dalit", meaning "oppressed" or "broken". A Dalit actually is born below the caste system, which means below the four primary castes. In the year 1950 the Constitution of India (Constitution of India has 12 Scheduled) included Dalit castes people in one of the Schedule of the Constitution for their social, economical and political development.

5 Other Backward Class (OBC) is a collective term used by the Government of India to classify castes which are educationally or socially disadvantaged. It is one of several official classifications of the population of India, along with General Class, Scheduled Castes and Scheduled Tribes (SCs and STs).

6 The term 'Scheduled Tribes' first appeared in the Constitution of India. Article 366 (25) defined scheduled tribes as "such tribes or tribal communities or parts of or groups within such tribes or tribal communities as are deemed under Article 342 to be Scheduled Tribes for the purposes of this constitution".

	Number	Percent
Utilization of public health care (N=256)		
Utilized	189	73.8
Not utilized at all	67	26.2
Suffered obstetric violence in public health care centre (N=189)		
Yes	83	44.0
No	106	56.0

Table 2. Utilization of public health care system during childbearing periods. Source: Fieldwork, 2019-20.

Pattern of Obstetric Violence

In the present study we have classified obstetric violence in two categories: 1. Non-dignified care, and 2. Physical abuse. In non-dignified care, as shown in table 3, out of 83 women who reported suffered of obstetric violence in public health care during child bearing period, 43.4 percent women (n=36) have reported the medical personal shouted or scolded them during the check-up. Similarly, 41 percent women (n=34) said they were threatened by the medical staffs to withhold treatment during child birth and majority of women (88 percent, n=73) complained receiving of discriminatory racial comments. Fifty nine percent women (n=49) said medical staffs didn't provided them adequate medicine and 64 percent women (n=53) reported they waited for a long time to get medical care (see table 3). In this regards, Lata (21 years old) who became mother one half years back in Bargarh district said: *when I came to know from ASHA didi (ASHA sister) that I was pregnant, she recommended me to visit the hospital regularly. Every month, I tried to visit district hospital, however, when I was going, they were asking me to wait for awhile which goes upto more than two to three hours. Many times, they were unnecessarily shouted and scolded. When they came to know that I belong to Scheduled caste, doctor hesitated to attend me. Moreover, they were also charged money for free vitamins tablets which distributed by the government. Their behaviour is very ugly and rough…. They are very racist…. I have observed many times that they gives different treatment women of higher caste or class….. Even they never charge money for vitamins… Sometime I feel that it is misfortune to born in Scheduled caste… I am sure what I have seen during my pregnancy, many women of my caste also suffering the same, that's why now we all hesitate to visit district hospital….*

Regarding physical abuses, 28 percent women (n=23) disclosed being hit, slapped, pushed and pinched by the medical staffs during the care, whereas 37.3 percent women (n=31) received inappropriate physical touches without having been so informed or without

their having consented. A total of 41 percent women (n=34) and 13 percent (n=11) said they were forcefully pressed abdomen and vaginal examination during the check-up (see table 3). On physical violence one of our interviewee named Janki (27 years old, Sambalpur district) said: *on eighth months of my pregnancy, one day I had severed labour pain and I was taken to Sambalpur district hospital, doctor asked my husband that there is some complications in my pregnancy and normal delivery cannot be perform and caesarean is essential and for that he asked to shift to a private hospital, as district hospital is not fully equipped. However, my husband refuses to accept the suggestion and requested doctor that we do not have money to pay expenditure in a private hospital. Immediately doctor said:"then your wife and child will die and I cannot do anything". I was going through the severe pain and when I said doctor about this, he slapped me and shouted to be quiet. He also scolded in very bad language. Looking into the behaviour of doctor and nurses, later my husband and myself decided to move to private hospital and for that we borrowed money from a friend*.

However, 8.4 percent women (n=7) said they were sexually abused by the medical staffs during the child bearing period and sixteen women (19 percent) cited other types of physical abuses. On sexual violence, Rati an eighteen years old woman from Bargarh district said: *after birth of my child, I visited district hospital for a check-up as I was having white discharge for more than a week. Although there were no patients, still doctor asked me awaited outside for an hour, and after that nurse called me to come inside the doctor's cabin. Without asking my health problem, doctor started shouting at me and asked why I am visiting regularly to the hospital.... he said.... you poor and Scheduled caste people just trying to utilize free services of government.... I tried to explain him about my problem but he didn't listen carefully and later asked me to sleep in a stretcher and forcefully examine my vagina... he put an instrument inside, when I complained about the pain, he scolded me in very bad language and forcefully pressed my stomach and asked me leave the hospital immediately...he also said if I complain any official, he is not going to check my health once again…*

	Number	Percent
Non-dignified care		
Shouting/Scolding from staffs	36	43.4
Threat to withhold treatment during child birth	34	41.0
Discriminatory racial comments	73	88.0
Refusing of providing medicine	49	59.0
Waiting for a longtime to get medical care	53	64.0
Physical Abuses		
Hitting, slapping, pushing and pinching from Staff	23	28.0
Inappropriate physical touches	31	37.3
Forcefully pressed abdomen	34	41.0
Forceful vaginal examination	11	13.2
Sexual abuse	07	8.4
Others	16	19.3

Table 3. Act comprising obstetric violence against women in India (N=83). Source: Fieldwork, 2019-20.

Among the women who reported non-dignified care and physical abuses in public health care centres, when we asked from whom they received the acts of obstetric

violence, majority of women (93 percent, n=77) said they were received mal treatment from administrative staffs of hospital, followed by the nurses (74.6 percent, n=62), as Lali (24 years, Sambalpur district) pointed out: *after delivering the child when doctor said we can go home, my hospital went to meet hospital warden for discharge certificate, at that time he asked for 10,000 rupees ($140 usd) for medicine and Salines. When my husband said medicines are free in Government hospital, the warden said: 'do not be smart….. everybody paid here….. if you will not pay we will not handover discharge certificate as well as birth certification…… after negotiating with him we paid 5000 rupess ($70usd) and then he gave all certificates….* Similarly, thirty five women (42.1 percent) said they have received non dignified care and physical abuses from doctors and 16.8 percent (n=14) said ANM (Auxiliary nurse midwife) abused them (see table 4).

Associated Factors	Number	Percent
Doctor	35	42.1
Nurses	62	74.6
ANM	14	16.8
Administrative staffs hospital	77	93.0

Table 4. Responsible Persons of Obstetric Violence against women in India (N=83). Source: Fieldwork, 2019-20.

Obstetric Violence: Associated Factors and Consequences

Obstetric violence is a common theme in observer's comments. As it can be assumed from the table 5, interviewed women were cited numbers of associated factors on prevalence of obstetric violence. As our quantitative information indicates, majority of women (81 percent, n=67) perceived being belongs to economically weaker section may be one of the causes that they suffer such kind of violence. Similarly, 68.6 percent women (n=57) said being belongs to Scheduled caste/tribe also other factor of suffering of obstetric violence. Interviewed women also cited other associated factors with relation to obstetric violence, such as illiterate (41 percent, n=34), ignored to visit the doctor's private clinic (76 percent, n=63), not paying of demanded money (73.5 percent, n=61) and 14.5 percent (n=12) said do not know the reasons behind the obstetric violence.

Associated Factors	Number	Percent
Being belongs to economically weaker section	67	81.0
Being belongs to Scheduled caste/tribe	57	68.6
Being illiterate	34	41.0
Ignoring to visit doctor's private clinic	63	76.0
Not paying of demanded money	61	73.5
Do not know reason	22	26.5

Table 5. Factors Associated with the Prevalence of Obstetric Violence against women in India (N=83) Source: Fieldwork, 2019-20.

During the interviews, may women also commented that in maternity care units nurses and other hospital staffs demanded money for doing activities, as they said it is kind of gratuity payments and in case a woman do not pay, they tried to harass and do not cooperate. In this sense Laxmi a 24 years old mother from Sambalpur district said: "when I delivered my baby in district hospital, after the child birth, medical staffs asked for money and said, they did lots of activities, such as drying and wrapping the newborn, weighing the newborn, cleaning blood spills on the delivery bed or labour room floor and cleaning up. My husband gave 2000 rupees ($30 usd), but they were not satisfied and asked for more money but we didn't give… immediately they said they are not going to change bed cover and they will not take proper care…also on the day of leaving hospital they asked for money, but we didn't pay, so they threaten us and said next time they will see us..... One nurse said we are very ungrateful people… only knows how to use free services of government…"

Similarly, Radha a twenty years old mother from Bargarh district said: *one day after my delivery, two nurses came to asked my health and after the check-up, they asked for 5000 rupees ($71 usd). They said: 'I had lots of complication; however, we have performed the delivery so well. If we had not done that, the child would have died inside you. I will take half of the money and will give the rest to doctor. In case we will not pay, then doctor may get upset and it may affect future health check-up'. It was too much money for us and we didn't pay asked amount and gave them 2000 rupees ($30 usd). Although they took the money but they were not happy. After that no one took my temperature, blood pressure and checked my stitches for rest of the days, they just left me without changing clothes. When we companied to the hospital official, they said they will look into this matter but it never happened. I feel so guilty for not having money and I also feel so guilty for being poor."*

In our analysis we have classified the consequences of obstetric violence into four different categorizes; 1. Self health, 2. Economic, 3. Family and, 4. Social. On self health consequences, it is observed that 32.5 percent women (n=27) have experienced physical health problem such as injuries, infection and pain after the abuses they suffered in public health care institution. Similarly, 53 percent women (n=44) said they suffered depression or stress after the event and 21.7 percent women (n=18) said they lost their appetite. On economic consequences, analysis indicates that, 61.4 percent women (n=51) have lost their saving during the child bearing period, majority of (83 percent, n=69) said they are in debt as they taken money from different sources for the health care and 17 percent women (n=14) said they and their husband have lost their job due to frequent absent with the employer (see table 6).

Women who have reported suffering of obstetric violence have also mentioned serious consequences on their family life. As it is perceived in table 6, nearly 45 percent women (n=37) and 19.2 percent (n=16) women said after suffering obstetric violence their spousal and parental relationship has worsen, similarly, 24 percent women (n=20) said they have observed distinct behaviours from their family members after the incidence of violence and 27.7 percent women (n=23) said they feel isolated in the family. In this sense, Rati an eighteen years old woman from Bargarh

district said: *"after my last check-up in hospital, my husband scolded me that why I allowed doctor to touch my private body part. I tried to explain him, that doctor forced me, however, he didn't understand and started fighting with me and said: I am a very bad lady....since then our relation has fragmented, although I have given thousands of explanation, but each day his behaviour is very strange....Very less time he talked with me…. He is not spending time with me…. When he returned from work, he never meets me…. The similar things also his other family members are doing…. I feel very isolated and have feeling that my spousal relation is over. I'd rather die at hospital than here".* On social consequences, data indicates that, 13.2 percent women (n=11) have observed discrimination in the society and 11 percent women (n=9) said their relationship in the community has degraded after the incidence of obstetric violence.

Associated Factors	Number	Percent
Self-health		
Physical health problem (Injury, infection, pain)	27	32.5
Depression/Stress	44	53.0
Loss of appetite	18	21.7
Economic		
Loss of saving	51	61.4
Debt	69	83.1
Problem of working	14	17.0
Family		
Deterioration in spousal relationship	37	44.5
Deterioration in parental relationship	16	19.2
Rejection by family member	20	24.0
Isolation	23	27.7
Social		
Discrimination	11	13.2
Deterioration of community relationship	09	11.0

Table 6. Consequence of Obstetric Violence against women in India (N=83). Source: Fieldwork, 2019-20.

DISCUSSION AND CONCLUSION

This study explored the nature and context of mistreatment amongst women attending public facilities in two districts of Odisha, India. All women in the study encountered at least one indicator of obstetric violence, and undoubtedly it is a significant problem in the context of human rights and the struggle against violence against women. The results of this study show that nearly fifty percent (44%, n=83) women aged 18 to 35 who have utilized the public health care in studied districts in last 5 years have experienced obstetric violence. Based on these results, we claim that millions of women in India have experienced this problem in public health care institutions.

The results also reveal, predominantly women are completed elementary level of schooling and majority belongs to Scheduled caste, Other Backward class and lower socioeconomic group. With total 256 interviewed, as result indicates, 83 women have suffered obstetric violence during the child bearing period. The prevalence of obstetric violence amongst Scheduled caste and tribe women is higher compared to other categories of women. The study of Sudhinaraset et al. (2016) reported that scheduled castes women receive inferior care and discrimination in all public health care institution compared to other categories of women, since these women are less empowered, health workers are more likely to think that they can get away with mistreatment of these women.

As of our study, the non-dignified care is mainly reported by the women belongs to Scheduled caste and tribes as well as other backward class women, however, the physical abuses is higher amongst women>25 years and Scheduled caste and tribes women. Overall, the obstetric violence also depends on service providers. Upon asking the responsible persons of obstetric violence, we found that it is hospital administrative staffs, nurses including doctors who are execute the violence.

As other studies have demonstrated, there is always difficulty of recognizing the experience of obstetric violence as it is influenced by the several factors. However, as we observed many women cited that economic and social status plays an important role in the process of access in quality of health care. In addition, the power relationship between professional and women is key factor for the obstetric violence. Saini et al. (2017) suggest that the primary drivers for poor care arise out of inequalities of information, wealth, and power relationship. Similarly, the study of Aguiar et al. (2013) indicates that the violent acts are practiced by health professionals based on their technical and scientific knowledge, by hierarchical and unequal power and authority relations, in a hegemonic and patriarchal biomedical model that segregates and illegitimates the power of females over their bodies, making them passive and disciplined.

Another important aspect for violent acts in obstetric care is the lack of knowledge of women about their sexual and reproductive rights and thus end up accepting procedures without any questioning, they do not express their desires, their doubts and they suffer in silence without even knowing they were violated (Zacher, 2015; Pickles, 2015) and this passivity allows the authoritarian imposition of derogatory norms and moral values by health professionals on women (Pickles, 2015).

The health consequences of obstetric violence can be long-lasting and chronic and fatal. Many studies have identified that more severe the abuse, the greater its impact on women's physical, psychological and socioeconomic health (Freedman et al., 2014; Sudhinaraset et al., 2016). Important finding of the study is that, women who experienced obstetric violence have reported many self-health, economic, family and social consequences, such as injury, infection, stress, deterioration in spousal relationship, discrimination among others.

This has clear implications for the overall health of women who experience obstetric violence, and also for health-care costs, since prevention is usually more cost effective than treatment. The Government of India has recommended under Suraksha Yojana (JSY) programme to

all public health care units to ensured safe motherhood intervention by promoting institutional delivery providing trained and qualified skilled birth attendants but it is necessary to ensure safe and respectful maternity care for all can help to accelerate progress to end obstetric violence. However, given the various context specific challenges in the state of Odisha, the prospect of all deliveries being cared for by qualified personnel at health facilities remains an important challenge. Thus, it is very much important create awareness among healthcare providers to eliminate disrespectful and abusive practices with emphasis on key ethical principles like autonomy, respect and dignity.

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