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'Safe', yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India

Sreeparna Chattopadhyay^a , Arima Mishra^b and Suraj Jacob^{c†}

^aSchool of Advanced Studies and Research, Srishti Institute of Art, Design and Technology, Bangalore, India;

^bSchool of Development, Azim Premji University, Bangalore, India; ^cVidya Bhavan, Udaipur, India

ABSTRACT

The majority of maternal health interventions in India focus on increasing institutional deliveries to reduce maternal mortality, typically by incentivising village health workers to register births and making conditional cash transfers to mothers for hospital births. Based on over 15 months of ethnographically informed fieldwork conducted between 2015 and 2017 in rural Assam, the Indian state with the highest recorded rate of maternal deaths, we find that while there has been an expansion in institutional deliveries, the experience of childbirth in government facilities is characterised by obstetric violence. Poor and indigenous women who disproportionately use state facilities report both tangible and symbolic violence including iatrogenic procedures such as episiotomies, in some instances done without anaesthesia, improper pelvic examinations, beating and verbal abuse during labour, with sometimes the shouting directed at accompanying relatives. While the expansion of institutional deliveries and access to emergency obstetric care is likely to reduce maternal mortality, in the absence of humane care during labour, institutional deliveries will continue to be characterised by the paradox of "safe" births (defined as simply reducing maternal deaths) and the deployment of violent practices during labour, underscoring the unequal and complex relationship between the bodies of the poor and reproductive governance.

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Introduction

The World Health Organization (WHO) estimates that 45,000 women die in India annually during childbirth, constituting 17% of the global burden of maternal deaths (WHO 2016). Motivated by Goal 5 of the Millennium Development Goals (MDGs), the Indian government has introduced several health system reforms with the aim of reducing the maternal mortality ratio by 75% to 100 per 100,000 live births and creating universal access to reproductive health (Government of India 2015, 2016). By 2013, the maternal mortality ratio had reduced to 167 per 100,000 live births from a high of 254 a decade earlier. After 2015, the MDGs' successor, the Sustainable Development Goals (SDGs), have continued to emphasise the importance of maternal health (WHO 2016) in both domestic and international discourses.

CONTACT Sreeparna Chattopadhyay  sreeparna@srishti.ac.in, sreeparna19@gmail.com

[†]Visiting Faculty, School of Development, Azim Premji University, Bangalore, India.

While in principle such universalistic, aspirational goals are welcome developments, they have been accompanied by problematic outcomes and discourses. For instance, Chatterjee and Paily (2011) find that the MDGs have pressured and incentivised much of the world, including India, to take up efforts to improve specific development indicators. The goal of improved maternal health is accompanied by a discourse of safe motherhood through biomedical institutional forms of care, which has further narrowed to an emphasis on 'institutional delivery' (Storeng and Béhague 2014).

Hospital births are not, however, an epithet for safe births. Melberg et al. (2016) and Jha et al. (2016) find that an overemphasis on institutional delivery conceals women's experiences of their encounters with the health system, manifested in the poor quality of their interactions with staff, engagement with biomedical technologies and practices, and the continuum of care, or the lack of it. Further, the notion of a successful childbirth cannot be solely defined as the survival of the infant and the mother. It should also include practices that are safe and humane, such as the presence of supportive kin, appropriate place of birth and respect and dignity during labour (McCourt et al. 2016). In India and other parts of the Global South, structural violence unequally distributes the risks associated with childbirth with poor women disproportionately bearing these risks. Balakrishnan and Khanna (2016), in their review of maternal deaths in India, find that these risks are heightened by inadequate health promoting practices and institutional (and other) regimes of care that do not support quality in maternal healthcare including inadequate ante-natal care, which increases obstetric risks. George, Iyer, and Sen (2005) have reported a near absence of post-natal care in many Indian states despite the majority of deaths occurring in the post-partum period. We argue that the imperative for 'safe' delivery, reduced to institutional delivery, hides what is often poor quality of institutional care and indeed violent practices during labour, producing the seeming paradox of 'safe, yet violent' referenced in the title of this paper.

The paper explores this paradox in institutional deliveries through a qualitative study in a rural area of Assam state in northeast India. While the goal of the study was initially to identify a broad set of factors that affect maternal health, women reported considerable symbolic and tangible forms of violence during institutional deliveries. Therefore, we sharpened our focus to obstetric violence, a form of violence deployed during childbirth against women, reflective of other forms of marginalisation, contingent on their location within the larger political economy (Sadler et al. 2016). McKenzie-McHarg et al. (2015) have documented the negative physical and psychological consequences of obstetric violence that may be temporary, permanent or both. Our contention is not that the state's emphasis on increasing institutional deliveries is directly responsible for obstetric violence. Instead we argue that the narratives of violence and neglect that young mothers report need to be situated in the broader context of the state's focus on increasing institutional deliveries. Privileging the voices of women and locating our findings within a feminist analysis of health systems, we argue that obstetric violence is a particular form of violence that is gendered and intersects with other axes of structural inequalities such as caste/ethnicity, class and region in India, producing a negative and often violent experience of pregnancy and childbirth in India.

Situating obstetric violence

A global view of obstetric violence

It is only in the last decade that the term obstetric violence has come to be recognised as both a legal and social category. A rights-based approach to addressing obstetric violence

such as the WHO's stance that '[a]buse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights' (World Health Organization 2014), has been helpful in bringing public attention to this issue. However, Vacaflor (2016) finds that changing the discourse from a violation of human rights to making salient the issue of violence during childbirth, has helped some countries pass legislation to criminalise violence during childbirth. Notwithstanding legislation, even where obstetric violence is criminalised, for instance in Venezuela, Argentina, Mexico and South Africa, significant problems remain with implementing these laws (D'Gregorio 2010; cited by Dixon 2015; Pickles 2015).

Several studies including Bohren et al. (2015), Bradley et al. (2016) and Molina et al. (2016) have highlighted different types of obstetric violence prevalent across the globe. In a historical overview, Da Silva et al. (2014) catalogue three different types of obstetric violence found in Brazil: violent and aggressive speech by doctors, nurses and other health personnel; unnecessary/negligent medical procedures (iatrogenic procedures); and institutional unpreparedness such as inadequate physical facilities, equipment, ambience and management. The latter includes non-compliance with obstetric protocols for the humanisation of assistance during pregnancy. Our study finds evidence of all these practices.

Shabot (2016, 233), based on research with Euro-American women in the USA, views obstetric violence as a specific form of gender-based violence – 'violence directed at women because they are women'. Diaz-Tello (2016) and Jordan (1992) find that women's disempowerment and lack of autonomy in the health system is more common in settings where childbirth is highly medicalised and embedded within a hyper-capitalist and a deeply patriarchal society. In the Global South too, obstetric violence should be viewed as a specific type of gender-based violence that is systemic and systematic and embedded within the larger context of discrimination against women, particularly women who are also marginalised due to structural inequities (Smith-Oka 2015). For instance, Chadwick (2017, 6), based on South African research, notes that 'Obstetric violence is an assemblage of disciplinary, bodily, and material relations that are shaped by racialised, medicalised, and classed norms about "good patients," "good women," and "good birthing bodies"'. This view finds resonance in the work of Latina midwives who have used the term 'obstetric violence' (*violencia obstétrica* in Spanish) to effectively resist medicalisation and harmful medical procedures as well as abusive and dehumanising practices deployed against economically and socially marginalised women in Latin America (Dixon 2015).

In India, access to good quality medical care is mediated by class and caste membership, and interactions between medical staff and users of state facilities are characterised by large power asymmetries (Baru et al. 2010). In a landmark study on gender in medical education John et al. (2015, 25) find significant problems with curriculum, pedagogy and training of physicians in India. The study reveals that doctors hold negative gender stereotypes, including beliefs that women are weaker and have a lower pain threshold, they are difficult patients and that they exaggerate their pain and symptoms, compared to men. The present study also finds that physicians seldom acknowledge women's claims of pain during invasive medical interventions in childbirth as well as pain experienced during labour. Relatedly, childbirth has become increasingly medicalised in India, with a singular focus on institutional deliveries in state hospitals, which has displaced more supportive kin-based home birth practices without concomitant hospital-based supportive practices. While hospital births are the norm among Indian upper-middle class women, their experiences are starkly different from those of their working-class peers (Hamid 2016). However, these facilities offered to upper class

women are prohibitively expensive and therefore beyond the reach of the majority of Indian women.

Methods

This paper draws from a larger study exploring maternal health in rural Assam. We employed primarily qualitative tools drawn from anthropology to collect data between December 2015 and April 2017. During fieldwork, two key findings shaped our subsequent course. Firstly, it became evident that institutional births had become the norm in Lalmati, the study hamlet. Secondly, the experiences of hospital births were frequently negative and marked by violence. In conversations with the project team, women spontaneously brought up their negative experiences with childbirth in hospitals, which required us to modify our topic guide significantly to ask specific questions around obstetric violence. While initially conceived as a one-year study, we extended the study by four additional months (November 2016–March 2017) to interview older women to unearth possible processes of biomedicalisation of childbirth, given that just a generation earlier, homebirths had been the norm.

Two research assistants trained in the social sciences collected most of the data with six visits by the authors during fieldwork. The material presented here includes interviews and conversations with women and their families, discussions and in-depth interviews with doctors and community health workers (Accredited Social Health Activists, ASHAs), nurses, as well as observations in state facilities. All interviews were conducted in Assamese with the exception of three interviews (two in Bengali and one in English). Interviews were transcribed and translated into English and then analysed for emerging themes by the authors both separately and collectively. The proposal for this study was peer-reviewed to ensure robustness and adherence to safety protocols for human subjects by the Azim Premji University, which funded our project. We secured written or oral informed consent from all participants. All the names used in this paper including the name of the hamlet are anonymised to protect the confidentiality and anonymity of participants. We also use pseudonyms for the names of the hospitals – a tertiary state hospital which also includes a teaching institute is referred to as the General Medical College, and the District Hospital refers to a mid-sized state facility which serves the district where our study is located.

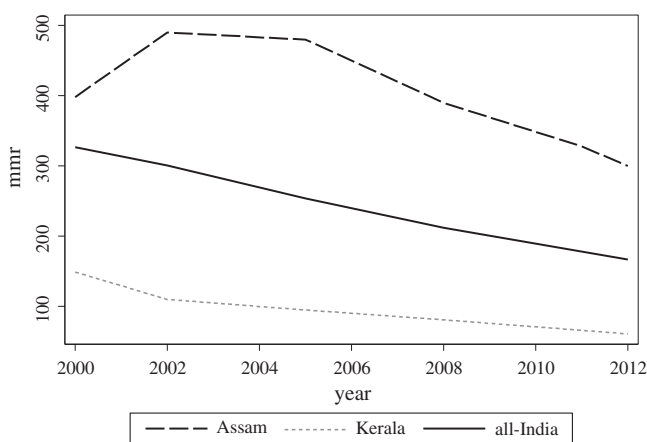


Figure 1. Maternal mortality ratio, India and selected states.

Study setting

Assam has the highest maternal mortality ratio in a country that already has a relatively high maternal mortality ratio (Cousins 2016; Montgomery et al. 2014). As Figure 1 shows, in the latest year for which data are available, Assam had a maternal mortality ratio of 300 per 100,000 births, which was *four-fifths* more than the all-India figure (167), almost *four times* more than the state with the lowest ratio (Kerala, 61), and three times the MDG 5 goal set for India for 2015 (100). Institutional deliveries in Assam have increased steadily over the last few years, although the rate is still lower than the Indian average (Annual Health Survey, Census of India 2015) with large disparities ranging from 40% to 90% in hospital births, ante-natal care and post-natal care across the state.

We chose a rural field site, 40 kilometres from the capital, Guwahati, to collect data. In January 2016, the single district of Kamrup split into Kamrup and Kamrup Metropolitan districts which are roughly equal sized with a total population of 2.8 million almost equally shared across the two districts, where 90% of the population are classified as rural (Government of India, Census Bureau 2011). This region was chosen for its heterogeneous populations consisting of tribal communities, Hindus and Muslims as well as the presence of several small primary health centres and a large government hospital, the District Hospital, with a 200-bed hospital that had been constructed just two months prior to the start of fieldwork and had a 10-bed maternity ward. Institutional births have become so common that in our study hamlet, which we call Lalmati (with about 100 households), of the 15 women who gave birth in the last two years, none had a home birth. The primary occupation is farming, although some households have diversified to poultry and pig farming and migration for work to other parts of India.

Participant information

A summary of respondent profiles is provided in Table 1.

Table 1. Participant information (in-depth interviews).

Category	Description
Ethnicity/Religion	Tribals: Karbi, Boro, Tiwa <i>Adivasis</i> [Tea Tribe] Hindus (Assamese, Bengali, Bihari) Muslim (2, Bengalis)
Age range	17–36 years
Marital Status	All married except one widow
Years of education	4–15 years
Numbers of children	1–4
Reproductive Mishaps	5 reported a miscarriage or stillbirth; 1 reported death of an infant
Type of delivery	15 normal and 3 Caesarean sections; 6 pregnant when fieldwork concluded

Recruitment

Given the sensitive nature of the study, we used a snowball sampling methodology, selecting women who came to see an obstetrician in the District Hospital. We approached women with a short household survey to select those who had given birth in the last two years or were currently pregnant. This was to ensure that women could recollect details of their

childbirth experience, to track women who were close to their due date given the state’s recent emphasis on ante-natal care and to capture the experiences of those women who had given birth in the smaller centre or the large city hospital, before the District Hospital was built. We surveyed 66 women recruited either directly from the District Hospital or through women’s personal networks in Lalmati; of these we had prolonged interactions with 25 women.

Thematic exploration

The themes listed in Table 2 emerged either as a response to the questions in the topic guide, or organically during conversations with women. Of these, obstetric violence surfaced as an important theme after our initial interviews and we developed the questions on obstetric violence using open coding initially followed by axial coding (Strauss and Corbin 1990).

Table 2. List of themes.

Category	Description
Demographic and Personal Information	Age, numbers of children, husbands’ and respondents’ occupations, levels of education, home ownership, access to land, assets, information on natal family and in-laws
Individual, Household and Communal Regimes of Care	Nutrition during the pre- and the post-natal period, nature and types of support women received from kin and neighbours, birth rituals, women’s self-perceptions of their health and the overall experience of pregnancy and childbirth
Reproductive health	Birth history including history of infant loss or miscarriages, contraceptive use, menstrual hygiene, impacts of pregnancy and childbirth on their reproductive health
Health Systems	Women’s experiences with medical and non-medical staff, routine tests (urine, blood pressure, sonograms, iron-folic acid supplementation), out of pocket expenses associated with pregnancy, hospital-birth experience and receipt of government funds from various social entitlement programmes
Obstetric Violence	Details of childbirth, experience of episiotomies, reprimands, verbal or physical violence during childbirth, respect or privacy, neglect in the hospital, sharing of information at appropriate times during labour and the experiences of pain and trauma during childbirth

Findings

We use six case studies and discussions with physicians to highlight the different forms of obstetric violence that emerge from our study. These include physical violence that may be intentional, such as physical violence deployed during childbirth, and physical violence that may not be necessarily be viewed as violent by physicians, such as episiotomies, and therefore may be unintentional. We also include intentional emotional violence such as shouting, yelling and verbal reprimands issued to women and accompanying relatives. There are also instances of violence where intentionality is uncertain such as neglect, callousness and disrespect to highlight less overt but nevertheless significant and common forms of obstetric violence.

Iatrogenic procedures – episiotomies as a form of obstetric violence

Episiotomies constitute a form of obstetric violence and there is no medical evidence justifying their routine use (Melo et al. 2014). The WHO (1996) recommends that no more than 10% of women be given episiotomies since they can easily be avoided by a close monitoring of labour, and if performed should be done so using anaesthetics. Many Indian doctors know this and yet they continue to perform episiotomies routinely and often without anaesthesia. Our study suggests that this could be due to two reasons. Firstly, a significant aversion to what physicians deem 'risky' during childbirth, and secondly, gender-insensitive and out-dated medical training in India.

Conversations with Dr. Khan, a young doctor at the District Hospital, with a large patient load demonstrates physicians' constructions of medical risks in this context. Initially Dr. Khan refused to accept that episiotomies were performed incorrectly at the District Hospital, contradicting the narratives of our research participants. Later he admitted that this had indeed happened. Despite being aware of the international guidelines, he says that he continues to perform routine episiotomies in 90% of vaginal births because it is a low-risk process that prevents the possibility of spontaneous perineal tearing. He gave an example where episiotomy was not conducted and the outcome was tragic – '... one day I repaired one patient. And [with] her, everything was open. Rectum was completely open, was completely ripped'. He further explained that because episiotomies are 'planned incisions' if there is tearing, surgical suturing is possible. However, without episiotomies, '... if tear occurs and it has no boundary, there is no anatomy, everything is distorted'.

By citing an extreme case – something that could have been prevented at the outset by close monitoring – Dr. Khan presents a perverse justification for episiotomies. His rationalisation and conversations with other doctors suggest that the medical construction of what is 'risky', in fact has the impact of normalising obstetric violence, by not categorising those very procedures as violent or as iatrogenic practices. Dr. Khan was not a 'bad' doctor; the women we interviewed liked him and viewed him as more sympathetic than the other doctors. However, as with other doctors we spoke to, Dr. Khan does not appear to follow an evidence-driven approach to his work; however, this is not unique to him, but is characteristic of many physicians practising under difficult conditions in the Global South.

While risk mitigation could be one of the reasons for why episiotomies may have become routine, our study suggests that medical education may also influence the manner in which episiotomies are administered. Two of the doctors we had conversations with, reported that they are trained to not use an anaesthetic when making the incision. Dr. Kumar, a 50-year-old physician and a public health practitioner and also a health activist in Assam sympathetic to our arguments, said that he was taught to 'cut the patient (woman in labour) at the peak of her pain'. His teachers (mostly men) explained this away by saying that 'because they are already in pain, no anaesthetic is required because they (women) won't feel much'. Over the years, Dr. Kumar had become unconvinced about this owing to his interest, training and practice in preventive and public health in rural Assam. He did not administer episiotomies routinely and had helped his wife have a home-birth.

A female doctor in her 30s with several years of experience in government facilities across India, Dr. Pai explained that she had been instructed to 'cut all primis [first time mothers] and not use an anaesthetic when cutting, but use a local anaesthesia when stitching because by then the baby would be out, and then the mother will feel the pain'. Her training reflects

common medical (mis)understanding of the experience of pain. She reinforced her position by saying that it was her belief that many women screamed during labour not out of 'real pain' but because the screams of a woman on another bed compels women in the labour ward to join in communal screaming, 'whether or not there's real pain'.

Her understanding of labouring women's pain is emblematic of an absence of empathy, the systematic invalidation and non-recognition of women's pain within biomedical practices and also symptomatic of women's effacement of autonomy and their infantilisation within health systems. The women we interviewed who were told to keep quiet when they screamed in pain also corroborate this view. The disciplining of the body of the labouring woman by suppressing her screams is one of the more insidious yet common forms of violence inflicted through the practice of biomedical institutionalisation (Chadwick 2017; Foucault [1973] 2012; Shabot 2016). With the notable exception of one study, that found that empathy declines considerably among medical students, though more among men than women, as they progress through the semesters, suggesting that the nature of medical training could be responsible for it (Shashikumar et al. 2014), there is little critical scholarship on medical education in India that emphasises empathy.

Disrespectful treatment, physical and verbal violence and reprimands

Episiotomies are not the only examples of obstetric violence. Sumitra Rahang, a 30-year-old Karbi tribal woman with a history of multiple miscarriages gave specific examples of verbal abuse, which she termed 'scolding' by doctors at the primary health centre, which served the population prior to the establishment of the District Hospital. She reported that both women in labour and accompanying relatives including husbands were routinely reprimanded, a fact reinforced by our conversations with ASHAs accompanying the women to medical facilities from their villages. Sumitra commented on the patchiness of care saying, 'sometimes they [doctors, nurses and the medical system] care and sometimes they don't'. Having suffered several miscarriages earlier, she was grateful that medical personnel had saved her infant son, who did not cry at birth, by putting him in an incubator. However, the medical team's lack of care was evidenced in their treatment of the couple during childbirth. She reported that when she vocalised her pain during labour, the doctors wanted her to tolerate the pain and not twitch. She thought that the baby would be born soon, but that did not happen. She was left alone in pain. When her husband went to the doctor to ask for help, he was severely reprimanded. They told him – 'Don't talk too much! We will *refer* [transfer her to a different doctor if they deem it necessary] her'. Sumitra decided that rather than being insulted in this way, it would be simpler if she just endured the pain.

Sumitra's account suggests that reprimands are issued not only to women during labour but also to relatives who are trying to support them. She reported that her husband and the husbands of other women in the labour ward would 'turn crimson', indicating anger and embarrassment at being humiliated in this manner. Lupton (1997, 99) argues that the disciplining of the body in medical encounters is not always through violence, although that does happen; it is often through '...persuading its subjects that certain ways of thinking and behaving are appropriate for them'. The reprimands and 'scoldings' are thus consistent with ideas of disciplined bodies that ought to be presented in an appropriate fashion for institutional examinations, a view echoed by some of the physicians we interviewed in this study, discussed earlier.

Another example of disrespectful treatment reported by some women was improper pelvic examinations – done hastily as a tick box exercise. Amita Tumung, a Karbi woman, had delivered her first baby at 35 after a series of miscarriages through a Caesarean section at the local General Medical College, which was 40 kilometres from her house, requiring two hours of travel by three different modes of transport. She said ‘...the nurses would come to check on me after every hour... but they would not ... what to say ... the examination they did was not proper’. Although Amita was not scolded or verbally abused, she did identify this as being ‘rough treatment’. Amita’s husband Hemanto reported that in General Medical College while her childbirth experience could not be characterised as either good or poor, his treatment was very poor. He felt that he was treated like an ‘animal’ and had to bribe the ward attendants to let him sleep outside or to stay close to his wife. He observed that he was not the only one who was treated this way in the hospital, but that people were treated inhumanely and hospital attendants and health workers acted authoritatively and insensitively. Amita reported that she did not receive hospital meals and had to wait until someone brought food for her from home.

One of the most egregious reports of intentional physical violence was reported by Rabia, an ASHA in East Kamrup district who had been taking care of Ayesha, a 20-year old Muslim woman and a first-time mother. Ayesha had been referred to General Medical College by the small health centre in her village, on discovering that the baby had died *in utero* at nine months. They felt ill equipped to handle the complicated case. An ambulance provided by the government transported Rabia and the heavily bleeding Ayesha to General Medical College. Even after two days post-admission, Ayesha received no medical attention. In Rabia’s opinion this was because the baby had died and Ayesha was not in the throes of labour, therefore staff felt there was no need to pay her any attention. Despite the fact that Ayesha’s stomach had swollen considerably, the doctors did not remove the baby. On the third day Ayesha started vomiting and could not control her stools and evacuated on the bed. The attending nurse hit her hard on her arms with a stick for not being able to control her bowels. As Rabia narrated the story, she became overwhelmed and broke down crying, ‘...forget about the money, is this the way to treat a human? This is her first baby!’ Ayesha survived her ordeal, but our study indicates that unfortunately her experience is not atypical of women’s experiences of childbirth in state facilities in India.

These conversations with women and caregivers are emblematic of attitudes towards poor and/or Indigenous groups, many of whom receive shoddy treatment precisely because of their socio-economic status. While not all birth experiences in public facilities are poor, negative experiences constitute the majority of such experiences. When a fraction of the women in the study reported experiences that were not negative, these appear to have been due to idiosyncratic factors, amplifying issues around routine health system negligence and callousness.

The narratives of younger women stand in sharp contrast to the older women – older women in our study described that just a generation earlier they gave birth at home, squatting or standing in the presence of supportive older female kin and a traditional birth attendant (*dai-ma*). The *dai-ma* would be called to relieve pain by herbal oil massages and physically manipulate the position of the baby. Even eight years after her death, older women in Lalmati spoke fondly about her, indicating that while they had other sources of suffering such as having to do hard labour linked to farming during pregnancy, the experience of child birth itself was not violent.

Koshto – accounts of pain as suffering

Junu Terong was a 26-year-old tribal woman with 14 years of education and a son aged 10 months. She was referred from the District Hospital to the General Medical College, although the reasons for her referral were unclear. Typically, patients were transferred in this way when they presented with complications, one of the most common being anaemia (particularly haemoglobin levels below nine), since the District Hospital did not have blood-banking facilities. She reported that she was referred because her amniotic sac broke and fluid had been leaking for a few hours. The doctor at the General Medical College performed an episiotomy twice on her, and without anaesthesia for the second time. While it is possible that she could have been anaemic, the baby's birth weight (normal at 3 kg) does not suggest this. After the episiotomy, the hospital suffered a power cut for 20 minutes. The doctor had to suture Junu using the torch on his mobile phone. Junu said that the stitches did not turn out well because a young, inexperienced doctor had sutured the incision and she had to be stitched again. She was surprised that the largest state facility did not have power back up. She told us that she had found the pain unbearable and asked the doctor '... how are you stitching? I suffered (*koshto*) a lot'.

Junu had begun the narrative initially characterising her birth experience as 'fine' but ended it by using the word 'suffering'. Many women in our study used the Assamese word *koshto* as shorthand to describe a range of sufferings experienced during childbirth. Her narrative suggests at least two possibilities: firstly, there are extremely low expectations for institutional care, to the point that even tangible indicators of violence are considered to be trivial, particularly among the poor who access public facilities. While this does not seem evident from Junu's reporting, in the case of Bhagyasree discussed later, the link is more explicit. Secondly, it is possible that in a historical context with a high maternal mortality ratio and high infant mortality ratio, being alive itself is an achievement. Therefore, emic perceptions of extreme suffering may encompass worst possible outcomes such as maternal or infant deaths or incidents of prolonged suffering – including protracted labour, cotton/gauze being left behind causing infections and/or infant deaths.

Junu was not surprised at the ineptitude of the young doctor. She appreciated that the junior doctor was reprimanded by the senior doctor for her incompetency. However, it is unacceptable that the largest public hospital in a state of over 30 million people operates without uninterrupted access to electricity and, in fact, institutional unpreparedness is one type of obstetric violence. Further, in India it is public knowledge that at large state facilities which also function as teaching hospitals, patients are often used for clinical practice to refine the skills of young doctors, a pattern that we observed in three of our cases of episiotomies gone wrong, causing extreme pain and suffering.

Roshmina, a Bengali Muslim woman, who was so deeply traumatised by her childbirth experience and the death of her new-born that she had developed a deep fear of sexual intercourse and was seriously contemplating divorce when we interviewed her. In her early 20s, articulate and the daughter of a school principal, she lived in Nagaon, a district that was 100 kilometres from Kamrup. She was more affluent than most of our respondents and had finished high school. Two years earlier she had married a man with a successful rice trading business. She lamented that though there was no (financial) scarcity at home (*abhab*), she had no peace (*shanti*). She had come to the District Hospital for continuing problems with episiotomies done extremely poorly.

Roshmina did not report a difficult pregnancy. However, her baby had died soon after birth. She was initially admitted in a private hospital in Nagaon, which had recommended a Caesarean section, though the reason for this was unclear. She had completed 39 weeks of pregnancy but was not in active labour at the time of admission. She had been retained in the hospital overnight during which the hospital had prepared her body for surgery including the administration of an enema and shaving her private parts. After a while, her husband began to suspect the motives of the facility, believing that they had recommended a Caesarean not out of a legitimate medical need. This suspicion is not unfounded given that unnecessary medical procedures such as Caesarean sections are routinely recommended by private hospitals in order to profit from patients (Neuman et al. 2014; Ghosh 2010). He transported her in a private vehicle and got her admitted to the District Hospital since her parents lived nearby. The journey took about two hours.

At the hospital, Roshmina was induced and she gave birth, but her son died within 10 minutes, allowing her to barely catch a glimpse of her baby. She was coping not only with the loss of her infant but also the extreme physical and mental trauma she endured including episiotomies being performed without anaesthesia. She had been bleeding heavily and as a result the doctors at the District Hospital referred her to the General Medical College. What they did not tell her, and we surmised later, was that the District Hospital does not have a blood bank and therefore no transfusions were possible – a procedure that was possible at the General Medical College and in all likelihood saved her life. By the time she was referred, Roshimi had lost consciousness. She was then re-stitched at the General Medical College, again without anaesthesia, by a trainee doctor. The details of her birth were extremely harrowing to even hear, let alone suffer. She said there was a ‘bucket full of blood,’ in the District Hospital. In the General Medical College after the episiotomy, they had also left cotton and gauze inside her. She spent two weeks at the General Medical College and had to be given four units of blood during her stay there. Four months later, she continued to have pain, itching, a large blister, and other discomforts. She used the word corpse (*laash* in Bengali) to summarise the way she was treated. Her narrative also indicates that the physical and mental trauma sustained during traumatic labour can become so debilitating that it can impede a normal life (c.f. Stramrood and Slade 2017). Whether there is an intentionality to the violence or not, the impacts of obstetric violence clearly have long-term consequences and therefore it is even more urgent that these be addressed as more and more Indian women are being encouraged to have hospital births.

Suffering through neglect

Women’s experiences of labour were also characterised by neglect and carelessness. Bhagyasree was a middle-caste, Hindu Assamese woman and first-time mother, married to a *Tiwa* (tribal) man. With an undergraduate degree, she was more educated than the other respondents, which is reflected in her knowledge of antibiotics and her more critical analysis of the poor care she received.

Her doctor left cotton inside her vagina and forgot to tell her. She said a few days after giving birth, one night when she went to the toilet she noticed that the edge of a cloth was hanging down from inside. She pulled it out. However, she did not know that inside was yet another gauze. For two weeks, she continued to suffer from a burning sensation when she urinated and pain in the middle of her lower abdomen – all of which she initially attributed

to the childbirth. Two weeks later when she had to press forcefully to relieve constipation, she noticed another thread hanging out. After cleaning herself she decided to check using a mirror. She used a mirror daily to apply an ointment at the site of her stitches, a practice not suggested by the doctor, but one which came from her own repository of knowledge. When she pulled the thread hard, the second piece of cloth came out and she said, 'It started to stink so terribly! The stench was really unbelievable. I started praying to God and kept pulling'. Eventually she removed the festering cloth and went back to the doctor who prescribed a course of 14 days of injectable antibiotics to combat the infection that had begun to set in. Bhagyasree and her family felt she had very narrowly survived this ordeal.

This is a distinct act of medical negligence reflecting an uncaring and callous attitude on the part of her physician. Bhagyasree refused to absolve the doctor of his responsibility. She felt that his forgetting is in fact an amplification of the absence of care, something she continued to experience postnatally too, when he did not prescribe an ointment in her list of medicines, which she knew would speed her healing. Her level of health literacy was considerably higher than many of the other participants, obvious from the use of the mirror to apply medicines on her stitches, recognising that a fetid piece of gauze left inside the body is a cause for alarm and seeking timely medical help. We suspect that these are triumphs not because of the system, but despite of the system and that there could have easily been a more tragic outcome.

Conclusion

Through the narratives of women, we have highlighted their negative experiences of institutional deliveries in public facilities in a part of rural Assam. It is worth noting that the majority of study participants had low levels of education, were poor and rural, often indigenous (tribal) and felt disempowered in their interactions with medical personnel. Women reported both intentional violence, which included physical and verbal violence, reprimands to husbands and relatives, and unintentional violence including the use of iatrogenic procedures such as episiotomies performed without anaesthetics. These are consequences of a health system that fails to recognise women's, and especially poor women's suffering during childbirth and normalises it. We attribute this to a cluster of different factors including India's health system that is gender-biased and generally insensitive to women's needs.

We find substantial evidence of obstetric violence reflected in iatrogenic procedures such as episiotomies, inadequate diagnosis of obstetric risks, undignified physical examinations, medical negligence, institutional unpreparedness and verbal and physical abuse during labour. Such interactions with the public health system '...defines in critical ways poor women's experience of the state and their broader place in society' (Freedman 2005, 2). Since the public health system caters disproportionately to the poor, the experiences in state facilities symbolise the social devaluation of reproductive health of poor women (Gilson 2003). The normalisation of different forms of violence and women's descriptions of these acts without necessarily terming them as violent emanates from a systematic and systemic gender and class bias reflected in distinct and inequitable power relations between state health systems and women (George, Iyer, and Sen 2005).

Diamond-Smith et al. (2016) and McCourt et al. (2016) suggest that one way to reduce obstetric violence is through greater engagement with families and partnering with mid-wife-led units. While in the Global North the importance of the place of birth and support

during labour are acknowledged, this is less so in India. There are clear systemic issues, which allow for obstetric violence to occur: an insensitive medical education curriculum, provider constraints of time and resources, disempowerment of nurses and community health workers and a lack of accountability. While recent policies have sought to frame reproductive health in terms of equity, rights and access to comprehensive healthcare, the lived experiences of poor women indicate widespread experiences of neglect, abuse and violation of human rights. Measurable goals, such as the reduction of the maternal mortality ratio and the increase in institutional deliveries, become the yardstick for enumerating successes of interventions and the basis of planning, implementing and evaluating reproductive health programmes – rather than addressing complex processes that put women's health at risk in the first place (Austveg 2011).

Our findings suggest that while the system counts women's survival as a measure of success, it is often at the cost of their dignity and ruptures in the continuum of care. Moreover, the experiences of women like Roshmina who have been subjected to traumatic episiotomies suggests longitudinal negative impacts on both their physical, psychological and sexual well-being. The increasing focus on target-driven institutional births seems to have coincided with increases in unnecessary technological and medical interventions during births. The singular emphasis on institutional deliveries, but not on overall reproductive health, unless it is linked to motherhood, underscores the unequal and complex relationship between the bodies of poor women and the governance of reproduction in this context.

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ORCID

Sreeparna Chattopadhyay  <http://orcid.org/0000-0003-1077-2162>

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