Obstetric Violence: A Critical Perspective on Maternal Healthcare

Ms. Geetika Sachdeva
Assistant Professor, J.D. Birla Institute, Kolkata.
Ms. Shereen Naaz
Research Scholar, J.D. Birla Institute, Kolkata.

Abstract

Obstetric violence has emerged as a critical yet under-recognized issue within maternal healthcare systems worldwide. It encompasses a range of practices—including physical abuse, verbal humiliation, coercive medical interventions, neglect, and denial of autonomy—perpetrated against women during pregnancy, childbirth, and the postpartum period. Despite significant advances in obstetric science and increased institutional deliveries, the persistence of disrespectful and abusive maternity care reflects deep structural, cultural, and gender-based inequities embedded within healthcare systems. This chapter critically examines obstetric violence as a form of gender-based violence and a violation of reproductive and human rights. Drawing on global and Indian contexts, it explores the forms, causes, and consequences of obstetric violence, highlighting its physical, psychological, and social impacts on women and families. The chapter further analyses legal and policy frameworks, the role of healthcare providers and midwives, and the need for systemic reforms rooted in respectful maternity care. By situating obstetric violence within public health, ethics, and human rights discourses, this chapter argues for an urgent transformation toward woman-centered, dignified, and accountable maternal healthcare.

Keywords: Childbirth, Gender-based violence, Maternal health, Obstetric violence, Reproductive rights, Respectful maternity care

1. Introduction:

Childbirth is widely portrayed as a moment of fulfillment and transition; however, for a substantial number of women, it is marked by experiences of humiliation, coercion, neglect, and abuse within healthcare settings. These experiences, collectively termed obstetric violence, challenge the assumption that institutional deliveries inherently

ensure safety and quality of care. While global maternal health initiatives have focused primarily on reducing maternal mortality, insufficient attention has been paid to women lived experiences of care, dignity, and autonomy during childbirth.

Obstetric violence reflects a broader systemic failure rooted in medical paternalism, gender inequality, and structural inadequacies in healthcare delivery. Women are frequently treated as passive subjects rather than informed decision-makers, particularly during labor, when vulnerability is heightened. This chapter critically examines obstetric violence as a multidimensional phenomenon that intersects with public health, medical ethics, and human rights.

2. Conceptualizing Obstetric Violence

2.1 Definition and Scope

Obstetric violence refers to acts or omissions by healthcare professionals or institutions that cause physical, psychological, emotional, or symbolic harm to women during pregnancy, childbirth, or the postpartum period. It includes non-consensual medical procedures, verbal abuse, neglect, denial of pain relief, and disregard for women's autonomy and preferences. International organizations increasingly recognize obstetric violence as a form of gender-based violence and a violation of reproductive rights (Bohren et al., 2015).

`The World Health Organization (WHO) defines respectful maternity care as care that maintains dignity, privacy, confidentiality, informed choice, and freedom from harm and mistreatment. The absence of these elements constitutes disrespect and abuse, which undermines trust in healthcare systems and negatively impacts maternal and neonatal outcomes (WHO, 2014).

2.2 Medicalization of Childbirth

The excessive Medicalization of childbirth has significantly contributed to obstetric violence. While medical interventions such as cesarean sections, episiotomies, and labor induction are essential in specific clinical contexts, their routine and non-consensual use transforms childbirth into a mechanized and dehumanized process. Women's bodies are often framed as inherently risky, justifying unnecessary interventions that prioritize institutional convenience over women's preferences and well-being (Diniz et al., 2018).

3. Obstetric Violence in the Indian Context

In India, obstetric violence remains widespread yet largely invisible within public discourse. Government initiatives such as Janani Suraksha Yojana have successfully increased institutional deliveries; however, improvements in infrastructure, workforce capacity, and quality of care have not kept pace. Reports from public and private

hospitals document routine verbal abuse, coercive practices, denial of birth companions, and non-consensual procedures, particularly affecting women from lower socioeconomic backgrounds, rural areas, and marginalized castes.

Although the Indian Constitution guarantees the right to life and dignity under Article 21, obstetric violence is not explicitly recognized in statutory law. Judicial interventions and human rights advocacy have addressed individual cases, but systemic accountability remains limited. The persistence of such practices underscores the gap between policy intent and lived realities of maternal care.

4. Forms and Manifestations of Obstetric Violence

4.1 Physical Violence

Physical obstetric violence includes unnecessary or harmful interventions such as routine episiotomies, excessive vaginal examinations, forceful fungal pressure, unjustified cesarean sections, and denial of pain relief. These practices can result in long-term complications including chronic pelvic pain, infections, infertility, obstetric fistula, and delayed recovery.

4.2 Verbal and Emotional Abuse

Verbal humiliation, scolding, threats, and shaming during labor are frequently normalized within clinical settings. Such treatment reinforces hierarchical power relations between providers and patients, eroding women's dignity and agency. Emotional abuse has been strongly associated with trauma, anxiety, and long-term distrust of healthcare institutions.

4.3 Psychological Violence and Neglect

Psychological violence involves withholding information, denying informed consent, ignoring emotional distress, and restricting support persons during labor. Neglect, including delayed treatment or inadequate postnatal care, further exacerbates preventable morbidity and psychological harm.

4.4 Discrimination and Denial of Autonomy

Women from marginalized communities—based on caste, class, disability, age, or sexual orientation—experience disproportionately higher levels of mistreatment. Implicit biases among healthcare providers contribute to differential treatment, reinforcing structural inequalities and poorer health outcomes.

5. Causes and Contributing Factors

5.1 Structural Failures in Healthcare Systems

Healthcare systems are often characterized by inadequate infrastructure, workforce shortages, urban bias, and fragmented service delivery. Overcrowded facilities, lack of privacy, and resource constraints create environments where disrespectful care becomes normalized rather than challenged.

5.2 Gaps in Medical Education and Training

Medical education frequently emphasizes technical competence over ethical practice, communication skills, and empathy. Limited training in gender sensitivity, mental health, and social determinants of health leaves providers ill-equipped to deliver respectful and woman-centered care.

5.3 Patriarchy and Gender Inequality

Patriarchal norms profoundly shape healthcare interactions. Women's pain is often minimized, their decision-making capacity questioned, and their reproductive choices controlled. Gender inequality within medical institutions further perpetuates these dynamics.

6. Impact on Women and Families

6.1 Physical Health Consequences

Obstetric violence contributes to childbirth-related injuries, postpartum hemorrhage, puerperal infections, and long-term reproductive health problems. Inadequate postnatal follow-up exacerbates these risks, particularly in low-resource settings.

6.2 Psychological and Emotional Trauma

Women subjected to obstetric violence face increased risks of postpartum depression, anxiety disorders, post-traumatic stress disorder (PTSD), and tokophobia. Trauma can disrupt mother–infant bonding and negatively affect family relationships and child development.

6.3 Long-Term Effects on Trust and Health-Seeking Behavior

Traumatic childbirth experiences erode trust in healthcare systems, leading women to delay or avoid future medical care. This avoidance increases risks in subsequent pregnancies and undermines broader public health goals.

7. Legal and Policy Frameworks

Several Latin American countries have explicitly recognized obstetric violence in law, while other regions rely on broader human rights and medical ethics frameworks. In India, constitutional protections, professional medical regulations, and judicial precedents offer partial safeguards; however, enforcement and accountability mechanisms remain weak.

8. Role of Midwives and Support Networks

Midwife-led models and respectful maternity care (RMC) emphasize informed consent, emotional support, and continuity of care. Evidence suggests that such approaches reduce unnecessary interventions and improve maternal satisfaction and outcomes. Community support networks and the presence of birth companions further enhance accountability and women's empowerment.

9. Preventing Obstetric Violence: The Role of Healthcare Providers

Healthcare providers occupy a critical position in both perpetuating and preventing obstetric violence. Integrating respectful maternity care into medical curricula, promoting trauma-informed practice, addressing institutional power hierarchies, and ensuring ethical accountability are essential steps toward meaningful change.

10. Conclusion

Obstetric violence is not an isolated aberration but a systemic manifestation of medical paternalism, gender inequality, and institutional failure. Addressing it requires a paradigm shift from survival-focused maternal care to rights-based, woman-centered, and dignified care. Eliminating obstetric violence is essential not only for improving maternal health outcomes but also for upholding women's human rights and restoring trust in healthcare systems.

References

1. Bohren, M. A., Vogel, J. P., Hunter, E. C., et al. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. PLOS Medicine, 12(6), e1001847.
2. Diniz, S. G., Salgado, H. O., Andrezzo, H. F. A., et al. (2018). Abuse and disrespect in childbirth care as a violation of women's human rights. Reproductive Health Matters, 26 (53), 1–12.
3. Human Rights Watch. (2019). They want us exhausted: Women's experiences of childbirth in healthcare institutions.

4. World Health Organization. (2014). Prevention and elimination of disrespect and abuse during childbirth. WHO.