A Qualitative Study of Physical and Verbal Abuse Experienced by Women During Labor and Childbirth in Dili Municipality, Timor-Leste

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A QUALITATIVE STUDY OF PHYSICAL AND VERBAL ABUSE EXPERIENCED BY WOMEN DURING LABOR AND CHILDBIRTH IN DILI MUNICIPALITY, TIMOR-LESTE

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ABSTRACT

Background: Timor-Leste has made good progress in reducing maternal and infant mortality in the last decade, but major challenges remain, with 51% of women giving birth at home and 43% without a skilled provider. There are many barriers that affect access to and use of health facilities for birth. An underexplored aspect in Timor-Leste is the role of disrespect and abuse during childbirth. This study aimed to explore the types of physical and verbal abuse experienced by women in urban health facilities, and at what stage of the birthing process these types of abuse are most likely to occur.
Subjects and Method: This was a qualitative study used in-depth interviews. A sample of 10 women who had recently given birth at two urban birth facilities in Dili, Timor-Leste. Women were asked about their treatment and adverse experiences during labor and birth. Notes were taken during the interviews, transcribed and coded, and themes were analyzed around types of abuse and when they occurred. The data were analyzed by narratively.
Results: Women experienced many different forms verbal and physical abuse from their birth attendant. Verbal abuse tended to occur earlier in labor, largely in response to women crying out in pain during contractions. Physical abuse was more likely to occur during the birth as well as during delivery of the placenta and perineal suturing.
Conclusion: Women described verbal abuse most often during labor and birth, and physical abuse during birth, placenta expulsion and perineal suturing.

Keywords: physical abuse, verbal abuse, mistreatment, childbirth, quality of care

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BACKGROUND

Sustainable Development Goals (SDG) five aims to achieve gender equality and eliminate all forms of discrimination and violence against women in public and private spheres (Johnston, 2016). The World Health Organization (WHO, 2018) has called for an end to preventable deaths and increase in health and well-being through universal health coverage, by emphasizing equity in access to quality health services where everyone is treated equally regardless of their attributes.

Timor-Leste has made good progress in reducing maternal and infant mortality over the past decade. Between 2009-2016 pregnancy-related mortality declined from 557 to 218 deaths per 100,000 live births, and infant mortality declined from 45 to 30

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deaths per 1,000 live births (GDS et al., 2017; GDS et al., 2018).

Total fertility rate also declined in that period, from 5.7 to 4.2 births per woman (GDS et al., 2017). However, maternal and infant mortality are still high compared to global figures and major challenges remain in increasing women's access to skilled attendants for birth. According to the latest Demographic and Health Survey, 51% of women gave birth at home compared to 49% in health facilities (GDS et al., 2018). Only 57% of women had assistance from a skilled health provider, and this was much higher for women in urban areas (86%) compared to women in rural areas (45%) (GDS et al., 2018).

There are many barriers that affect access to skilled attendance and use of health facilities for birth. Wild et al. (2010) have outlined the individual, social, political and health system issues that affect the way in which maternal health services are utilized by women in Timor-Leste. Khanal et al. (2014) found that women in rural areas, with low education and low household wealth were more likely to birth at home without a skilled provider. Furthermore, 56% of women in the Demographic and Health Survey said they had concerns about being treated respectfully when accessing healthcare (GDS et al., 2018). An underexplored aspect in Timor-Leste is the role of disrespect and abuse toward women by their health providers during birth and how this might affect willingness to seek care. Disrespect and abuse include physical and verbal abuse, discrimination and non-consented procedures, with physical and verbal abuse being the most common in a study in four low-income countries (Bohren et al., 2019).

Physical abuse includes hitting or slapping, either with an open hand or instrument, pinching, kicking or being physically restrained. Verbal abuse includes the use of harsh or rude language, judgmental or accusatory comments, or threats of poor outcomes or withholding treatment (Bohren et al., 2015).

Surveys conducted around the world show that disrespect and abuse toward women in childbirth is extremely common. A survey of disrespect and abuse in four countries, Nigeria, Ghana, Guinea and Myanmar, found that 41·6% of observed women and 35.4% of surveyed women experienced physical or verbal abuse, or stigma or discrimination during birth (Bohren et al., 2019). While there is large variation in prevalence of disrespect and abuse between surveys in different countries, it is concerning that some studies report extremely high rates, such as the study in 14 hospitals in Peru, which found 97.4% had experienced at least one category of disrespect and abuse (Montesinos-Segura et al., 2018).

Although there have been some reports of lack of respect when accessing general health services in Timor-Leste (GDS et al., 2018; Price et al., 2016), to date there has been no research examining the prevalence of disrespect and abuse during birth in Timor-Leste, nor any qualitative research specifically exploring women's experiences of mistreatment during childbirth. This study aimed to explore the types of physical and verbal abuse experienced by women in urban.

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health facilities, and at what stage of the birthing process these types of abuse are most likely to occur

SUBJECTS AND METHOD

1. Study Design

This was a qualitative study, used in-depth interviews. So that, we can obtain new information, free from the expectations set by authors to learn about types of physical and verbal abuse experienced by women in urban health facilities, and at what stage of the birthing process these types of abuse are most likely to occur.

This study was conducted in Dili, Timor-Leste, from October to November 2019.

2. Study Informants

The selection of informants in this study uses purposive sampling, which is the technique of determining samples with certain considerations/ criteria:

Inclusion criteria:

1. Women who had given birth in the pas two days
2. Women in postnatal ward.

A total of 10 women whohad recently given birth at two urban facilities in Dili were selected for this study.

3. Data Analysis

The interview notes were coded according to the categories of disrespect and abuse. We used the typology of mistreatment during childbirth proposed by (Bohren et al., 2015) with a specific focus on physical and verbal abuse as the most common types of mistreatments.

The coding was done manually using Microsoft Word. A thematic analysis approach was used, as described by Braun and Clarke (2006). Themes were analysed around types of abuse and the stages of labour in which the abuse was most likely to occur.

RESULT S

Sociodemographic characteristics of the study subjects

The data of sociodemographic syudy subjects will showed in the table 1. Sociodemographic study subjects included: 1) age, 2) marital status, 3) location, 4) time to reach facility, 5) religion, 5) education, 6) employeement, and 7) number of living children.

Table 1. showed that sociodemographic characteristics of the women. All women in the study were unemployed or worked in the informal sector (for example, housewife, subsistence gardening).

Their age ranged from 25-34 years, and all were Catholic and married. More than half of the women had received formal education after high school. Most women with their first birth gave birth at the hospital. Almost all the women lived in an urban area and the average travel time to the health facility was 45 minutes.

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Table 1. Sociodemographic characteristics of participants

Characteristics	Health Facilities			
	CHC		Hospital	
	n	%	n	%
Age (years)				
25–29	1	20	2	40
30–34	4	80	3	60
Marital status				
Single				
Married	5	100	5	100
Divorced/Widowed				
Location				
Urban	4	80	5	100
Peri-urban	1			
Time to reach facility				
20 minutes			1	20
30 minutes	2	40	2	40
45 minutes			2	40
60 minutes	2	40		
90 minutes	1	20		
Religion				
Catholic	5	100	5	100
Christian				
Muslim				
Education				
None				
Primary	1	20		
Secondary	2	40		
Tertiary	2	40	2	40
Vocational			3	60
Employment				
Business/private sector				
Civil servant				
Unemployed/informal work	5	100	5	100
Number of living children				
1 (first birth)			4	80
2–3	1	20		
4–5			1	20
6+	4	80		

Verbal abuse

Half of the women (respondents 1-3,5,7) reported some form of verbal abuse from their birth attendant. Verbal abuse was most likely to occur during the first stage of labour. The verbal abuse women experienced included being shouted at, being hissed at and mocked, being threatened with a bad outcome if she disobeys or derogatory comments about the woman's hygiene.

> *"The midwife made negative comments about my personal hygiene, why I didn't take a shower and smelled bad when she was checking me in the delivery room.* -Respondent 7.

Most of the women who experienced verbal abuse said it was in response to them calling out in pain during con-

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tractions. Two participants said the birth attendant hissed at them, mocked them and ridiculed them because they were making too much noise.

> *The midwife shouted "don't scream when you feel pain, the mother who is in the next room is about to give birth and you have only just* entered.*" Respondent 1 and 3."*

Two participants (respondents 2,5) said the midwife threatened that if they continued to shout and did not be quiet that bad things would happen to the baby or they would not be attended to. Half of the women (respondents 2,6,8-10) said they were actually left unattended. Women with their first birth were particularly prone to being left without a skilled birth attendant for the majority of their labour.

> *"I felt pain with the contractions so I called the midwife, but she said "women with their first child take a* long *time to enter labour." She just waited in the midwives' room and didn't pay any attention to me. Only the practical students waited with me.* Respondent 2"

Physical abuse

Women reported experiencing physical violence such as being pinched, hit with instruments and having their legs forcibly pulled apart. Physical abuse most often occurred at the second stage of labor, during the birth of the baby. Five of the 10 participants (respondents 1-5) said that when they entered the delivery room, they had to obey the rules and lie on the bed (supine position). They said when they strained or held their thighs, or lifted their buttocks up the midwife got angry at them and either hit them, pinched their thighs or opened their thighs by force. Some said this happened two or three times. Four participants (respondents 1,6-8) said that when the midwife thought the baby was not moving down, that the midwife pressed directly on their abdomen when they were pushing, in an attempt to speed up the birth. These women said this happened one or two times during the birth, and occurred at both at the health centre and the hospital.

Physical abuse also occurred during the third stage of labour, when the placenta was being delivered. Five participants (respondents 1-5) said that, in an attempt to remove the rest of the placenta, the midwife inserted a finger into the birth canal which was very painful. Some women described not being given a chance to take a breath, the midwife not caring when they were obviously in pain, or closing their thighs because of the pain. When they closed their thighs a common reaction by the birth attendant was to hit them on the thighs, force their thighs open, or pull their legs up onto the bed. Two participants (respondents 7-8) said that when removing the placenta, the midwife inserted all her fingers into their birth canal which caused severe pain and they were not given time to breathe. They said this happened repeatedly two or three times.

Six participants (respondents 1-6) said they did not receive any pain relief during stitching of their perineal wound (perineal tear or episiotomy). The women described the suturing as extremely painful, that they screamed or closed their thighs or refused to be

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sutured. A common reaction by the midwife was to pinch them or hit their thighs with the sewing instrument.

> *"After I gave birth, the midwife said that my lower part had a tear. The midwife did the stitching on the torn part without giving me any pain relief, so it made me feel a lot of pain. – Respondent 1"*

One participant (respondent 3) felt that her pain was dismissed by the midwife, who shouted at her to calm down and stop screaming, and to just bite down on her clothes so she can finish the suturing quickly.

DISCUSSION

This preliminary study showed that women giving birth in Dili experienced multiple forms of physical and verbal abuse, discrimination and neglect. Women reported verbal abuse mostly during the first stage of labour when they were having painful contractions. This type of verbal abuse has been widely reported in other countries. Warren et al. (2017) reported that women in Kenya would be deemed 'uncontrollable' and receive worse care if they cried or screamed out in pain. Research by Hern and Rodr (2019) found that when women cried out during contractions the maternity staff yelled at them to be quiet and some women felt they were being treated like an animal. Similar to our study, women in high-income countries have also reported being shouted at, scolded and threatened with their babys welfare if they did not comply (Vedam et al., 2019; Reed, Sharman & Inglis, 2017).

Women in Guinea said that being yelled at by maternity staff created negative feelings and can affect the progress of labour (Balde et al., 2017). In contrast, women report that they prefer maternity workers who speak to them with encouraging and sympathetic words (Gebremichael et al., 2018).

One participant in our study reported humiliation and discrimination when staff made negative comments about her personal hygiene. In a study in India women said they felt humiliated because of the lack of cleanliness with the genital area (Bhattacharya, 2018). Women have also reported being ridiculed by comments from maternity staff that mock or pass judgement on their sexual history (Bohren *et al.*, 2017; Kruk *et al.*, 2018).

This type of humiliation has been reported in another qualitative study in Timor-Leste, which found that hospital staff denigrated their patients' hygiene and personal circumstances and that these were barriers to accessing health care (Price *et al.*, 2016).

Women having their first baby were more at risk of being left without a birth attendant during their labour. Neglect of women during birth has been reported in several studies, such as women being ignored, not being listened to, and not receiving any attention or treatment (Bohren *et al.*, 2019; Kassa & Husen, 2019; Gebremichael, 2018; Atai *et al.*, 2018).

Physical abuse was a common experience among women in this study. This included hitting, pinching the thighs, opening the thighs by force, pulling the legs up, pressing directly on the abdomen to speed up labor, inserting fingers in the birth canal to

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remove remaining placenta and suturing the perineum without any pain relief. In Timor-Leste, women having a spontaneous vaginal birth are expected to adhere to the supine or lithotomy position on a delivery bed during birth.

Research has shown that this is not an optimal position because it does not allow for the psychological and physical mechanisms that reduce labor pain, and it may increase pain because there is more direct pressure from the fetal head on the vaginal wall in the supine position (Vedam *et al.*, 2019). Women in our study reported that due to the severity of the pain laying down they felt they had to hold their thighs or lift their buttocks up when pushing.

This was a common point where midwives would begin to use physical violence by hitting or pinching their thighs or opening their thighs by force. Other studies have reported similar practices to force women's compliance (Shimoda *et al.*, 2018; Ijadunola *et al.*, 2019; Hern & Rodr, 2019; Kassa & Husen, 2019).

The use of fundal pressure, or pushing on the abdomen in the direction of the birth canal, was similarly experienced as traumatic by women in Hern and Rod's (2019) study, especially when the birth attendant did not explain what he/she was doing. Women's experience of the practice as traumatic is important because a Cochrane systematic review found there is insufficient evidence for the routine use of fundal pressure on women in the second stage of labor (Hofmeyr *et al.*, 2017).

This study showed that women were more likely to experience physical violence as their labour progressed into the second and third stage. This is in line with direct observation of births conducted by (Bohren *et al.*, 2019) in three countries. They found physical and verbal abuse peaked 30 minutes before birth to 15 minutes after birth. A study with women in Ghana also found that poor treatment is generally experienced by women during the second stage of labor, especially among young women with their first child, women who were perceived as unable to push well, and women who were deemed as not complying with instructions (Maya *et al.*, 2018).

The ongoing use of physical violence and force into the third stage of labour and during perineal suturing was reported by participants in this study. Seven of the 10 participants said the birth attendant inserted a finger or hand into their birth canal to remove the rest of the placenta, that it was extremely painful and that they were physically forced to open their legs when they reacted to the pain. It was not possible to assess what proportion of the women had an actual retained placenta (placenta not expelled within 30 minutes of the birth of the baby) or were bleeding heavily. However, it is important to note that the incidence of retained placenta is around 3.3% and manual removal of the placenta should be done under sedation (WHO, UNFPA & UNICEF, 2017). Given the apparent routine nature of this type of mistreatment amongst women in our sample, this practice deserves further urgent atten-tion.

We found that almost all women who received perineal suturing did so without being offered any pain relief.

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This appears to be a common practice in low-resource settings and has been reported in studies from Nigeria, Ghana, Myanmar, and Tanzania (Bohren *et al.*, 2019, Shimoda *et al.*, 2018, Bowser & Hill, 2010). Suturing without pain relief can be extremely painful and the trauma associated with this is compounded by the use of physical force to make women comply. The direct and indirect impact of mistreatment on women and their babies is yet to be fully explored, but it has been associated with higher incidence of postpartum depression (Leite *et al.*, 2020). In addition, it can make women extremely fearful for subsequent births (Bhattacharya, 2018; Mehretie Adinew & Abera Assefa, 2017).

The findings show that disrespect and abuse toward women during all stages of labour and birth is occurring in Timor-Leste. This confirms that women in Timor-Leste are being negatively impacted by the widespread global phenomenon of disrespect and abuse that is deeply embedded in health systems and embodied by health providers in a diverse range of maternity settings around the world. This study contributes new knowledge about the specific types of abuse experienced by women in health facilities in Dili. It found that physical and verbal abuse are often inflicted on women to deter their physiological response to pain.

There appear to be several routine practices in place that increase pain for birthing women and have little evidence-base, such as lithotomy position for birth, applying fundal pressure, manual removal of placenta and suturing the perineum without pain relief. These findings demonstrate the urgent need for further research and action to understand the scale of the problem in different health settings in Timor-Leste, the impact on women's health and wellbeing and how respectful, woman-centred and evidence-based care can be improved throughout the health system.

AUTHOR CONTRIBUTION

The authors contributed equally.

CONFLICT OF INTEREST

There is no conflict of interest in this study.

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