

## Araştırma / Research Article



# Hindistan'ın Kerala kentinde gerçekleşen kurumsal doğumlardaki uygunsuzluklar: Bir izleme mekanizması ihtiyacı

## Indignities in Institutional deliveries in Kerala, India: Need for a monitoring mechanism

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### ÖZET

Bu makalede , hamile kadınların hastanelerdeki doğumhanelerde ve emzirme odalarında mahremiyetini sağlamaya yönelik uygulanan müdahaleler tartışılmıştır. Kaliteli sağlık hizmetlerinin sağlanması çabalarında, hasta mahremiyetinin dikkate alınmaması önemli bir sorundur, hatta insan haklarına ilişkin sorunlardır. Aslında hasta mahremiyeti sağlık hizmetlerinde kalitenin sağlanmasında en önemli boyutlardan biridir. Bu nedenle, kurumlarda gerçekleştirilen doğumlarda hasta mahremiyetine verilen önemi ortaya çıkarmak amacıyla Kerala, Hindistan'da niteliksel bir araştırma gerçekleştirilmiştir. Kullanılan veri toplama yöntemleri, uzman kişilerle mülakatlar, doğum yapan kadın ve yakınları ile görüşmeler ve altı ay süresince doğumhanelerin gözlemlenmesidir. Bu süreç sonunda sağlık çalışanlarının ve kurumların doğum yapan kadının mahremiyetini önemsemediği ve kadınların onurlarına yönelik hak ihlallerinin olduğu gözlemlenmiştir. Araştırmanın gerçekleştirildiği hastanelerde onur ihlalinin yaygın olduğu öğrenilmiştir. Halbuki doğum sürecinde hamile kadının özgünlüğünü ve mahremiyetini koruma kabiliyeti söz konusu değildir. Sonraki süreçte de bu durum entelektüel ve manevi olarak kadının fiziksel iyileşmesini dahi etkileyebilir. Dolayısıyla bu hassas dönemde hekimler , hemşireler ve diğer sağlık çalışanları doğum yapan kadının mahremiyetine yönelik gerekli hassasiyeti göstermeli ve kurumlar bu durumun iyileştirilmesine yönelik müdahale programları geliştirmelidirler.

### ABSTRACT

In this paper, we present situations in the hospitals and labour rooms where women give birth and analyse how women's dignity is lost/ decreased and it cannot be restored without a professional intervention. In the endeavour to ensuring quality health care services, various issues arise that are linked to human dignity and human rights. Human dignity in health care is recognized as the most important non-clinical and intangible dimension. In a qualitative research that is based on grounded theory, we have explored the dignity violations in institutional childbirths in Kerala, India. Key informants interviews, interviews with birthing women and participant observation of six months in labour rooms / wards are the data collection methods employed. It is found out that dignity violation is rampant in these institutions. A woman with dignity related issues has no abilities to emphasize her own uniqueness and authenticity; she stops to progress physically, intellectually and spiritually. A public health intervention should be based on continuous monitoring of the labour process by a team which should include doctors, social workers and nurses. This intervention in maternity wards/ labour rooms can only help the woman-in-birth to go through an engendering, empowering experience of child birth.

## INTRODUCTION

Human dignity is recognized as the most important non-clinical and subtle element in health care. Dignity cannot be maintained only by the individual's effort as societal, structural systems also play a crucial role. Therefore, human dignity has a relational/ interactive dimension. The main purpose of every person is to understand her/his own essence and maintain the dignity in interpersonal relations with the aim to be

recognized and respected (Virbalienė & Žydzūnaitė, 2010). Lack of respect for human dignity obstructs effective reach of public health programs. Research has demonstrated that people who believe that they have been treated with dignity are more likely to complete the treatment and have a positive attitude towards seeking preventive health care in future (Beach et al 2005). The Universal Declaration of Human Rights gives the actual credibility and context to dignity/human rights (Morsink J 1999; Pagels E, 1979). Taking the case

of institutional child birth, this paper explores how birthing women constructed their notion of human dignity and what they consider as dignity violation. The paper further explores the scope of public health interventions in the maternity wards/ hospitals.

## CONCEPTUALISING HUMAN DIGNITY

The word 'dignity' comes from the Latin word *dingus* meaning worthy (Mani 2011). Chaskalson (2002), Dicke (2002), Meyer (2002) and Donnelly (2009) state the complexity of human dignity as a phenomenon in their researches. Dignity is worthiness, high repute or honour, self-possession and self-respect and is linked to the respect and the recognition of another individual's worth (Schachter 1983). The disciplines of medicine, sociology, social work and nursing have used the concept of human dignity by linking it to social justice. Besides this, the constitutional law, the multilateral organisations protecting and working for marginalized population etc., also promote human dignity framework to gain credibility (Feldman D, 2000; Sacks J 2002; McDogal et al 1980). Despite such extensive use of the concept in various practice-oriented fields, International documents and scholarly literature, human dignity is also criticised as vague and contradictory because what constitute dignity is not clearly explored (Speigelberg H 1970; Hailer M, Ritschl D 1996). A short history of dignity has three stages of its evolution. In the first, dignity is conceptualized as a spiritual concept and places human beings superior to the rest of the godly creations. (Dales RC 1977, Lutz 1995, Pullman 2001). In the second stage, dignity resides in social hierarchy and is closely tied to a system of ranking. Dignity is both relative and absolute (Johnson JP 1971, Grant 2007). In the third stage, it was Kant who took on the great challenge of integrating the religious notion of dignity with expanding scientific knowledge to develop a secular notion of dignity. Kant's focus was on autonomy shifting the focus from 'respecting the dignity of people' to 'respecting the choices of people' (Pullman 2001, Somerville & Chan 2001).

Social work as a profession had a major role in monitoring dignity in hospital settings. The concept of human dignity in social work practice is applied in gerontology or disability based services (Lothian & Philip, 2001; Hall et al., 2009, Vorhaus, 2015). Chronic deprivation of rights, denial of the inviolability of human life, attacks on identity, subjection to suffering and humiliation all violate the subjective dimensions of human dignity. On the other hand, when the State restricts the freedom of an individual because the unlimited freedom of one individual may interfere

with the dignity of another, it can be considered as the objective dimension of human dignity (Malby 2002). Having a sense of dignity includes concern to achieve and maintain various forms of integrity as well as attitudes of self-respect, pride and self-esteem (Pritchard 1972). Many of these dimensions are relevant in institutional child birth and this is what the present paper would explore in order to alleviate and prevent such violations in such settings. This documentation is extremely important given the priority attached to institutional child birth and the international support extended to developing countries to enhance institutional child birth.

## METHODS

Grounded theory approach (Charmaz 2006; Strauss 1987; Glaser & Strauss 1967) is used to develop an understanding about the meaning, language, forms and context of human dignity. Grounded theory approach focuses on variations, complexity and links it to the contextual conditions. Grounded theory "fosters [the integration of] subjective experience with social conditions," it is a valuable tool for social justice research (Charmaz K 2005)

This paper has used four methods for data collection. It began with an exploratory and analytical review of the concept of human dignity, which evidently was interdisciplinary in nature. The participants of this study were women who visited public and private hospitals in Kerala for childbirth. Key informants interview also helped to contextualise dignity related issues in the Indian context. Academicians and political scientists who worked extensively on this area, three human right activists, three health activists who specialised in women's health issues were contacted via email and telephone as these people were known as human dignity and rights champions.

The next step involved interview of 200 pregnant women who attended one public and one private hospital in Kerala, India for their prenatal check-ups. They were interviewed to develop an understanding about health issues, pregnancy related issues and quality of care they received in the hospital. The third and important steps of data collection consisted of selecting 40 pregnant women who were willing to have in-depth interviews on the issue of dignity, birth experiences and were willing to accommodate the researcher in the labour room to observe the childbirth. The third stage involved in-depth interviews with 40 women at the eighth month of pregnancy, observation of childbirth in the labour room and a follow-up interview after three weeks of childbirth. Participant observation in the labour room was used as a method

of data collection to gain firsthand experience about dignity violation in the labour room.

Each woman was interviewed separately and interaction lasted for about 45-60 minutes where focus was on addressing some issues and questions such as - do women have a dignified interaction with the healthcare system when they give birth in a hospital? ; what does dignity mean? ; what happens to women if their dignity is not respected during the birthing process? Almost in all the cases, it was observed that women from different classes conceptualise human dignity differently. Women were eager to talk about human dignity because in most of the cases their dignity was under threat at some point during the interaction with the health care system. Getting access to the labour room of any hospital was not an easy task and personal contacts had to be used to get access to hospitals for three months and therefore purposive sampling was used to select the participants. Similarly, the respondents' willingness to continue with the study for three months was crucial, which was possible only with this method of sampling. All the interviews were recorded with the written consent of the participant and confidentiality of all stakeholders was maintained. Necessary institutional ethical clearances and permissions were obtained. These include ethical clearance from Ethics Committee of the University (where the study was supervised and submitted) and Ethics Committee of both the hospitals gave permissions after necessary clarifications and modifications in the methodology and the process of data collection.

The data was analysed and interpreted manually. A content analysis of the interviews was done to identify main themes and concepts around which women articulated about human dignity in childbirth. Later, the themes were organised around central concepts like humiliation, neglect, autonomy etc. The field noting from participant observation method was used to supplement and triangulate the data which was collected using the interview schedule.

## **SOCIO-ECONOMIC BACKGROUND OF THE RESPONDENTS**

In the public hospital, there were two groups of women. Taking caste (social category in India) as the primary identifier, one group included Brahmins, Nairs and Syrian Christians<sup>1</sup> (considered upper castes), while another comprised Pulaya, Kudumbi and Dheevara (considered lower caste and constitutionally classified

as Scheduled Castes). In addition, Paraiyan women (untouchables from Tamil Nadu, Scheduled Castes) used the public hospital. All the forty respondents were between the age 19 to 35 years.

All the public hospital respondents could be considered as belonging to lower class since had an annual income of less than Rs. 50,000/-. Most of the upper caste respondents had their own house, whereas all of the Scheduled Caste respondents were living in rented accommodation. The Scheduled Caste respondents had migrated to the city in search of employment and lived in the most congested areas. The women usually worked, as did their husbands – in fishing (men), fish-selling (women), construction and domestic work (women), and working in small hotels (men). On the whole, they were either daily wage earners or self-employed (with working capital of up to Rs. 8,000/-). By contrast, the upper caste respondents were mostly housewives. Their husbands were engaged in work such as street vending and tailoring, while three were Class D government servants. In addition, there were a number of Muslim housewives whose husbands mainly worked in hotels as helpers. They did not own a house or any other property – they lived in slums. Their annual income came to less than Rs. 40,000/-. None of the women owned any immovable property – it was either registered in their husband's name or held jointly. The age of the respondents vary from 19 to 35 years. Education varied from the 8<sup>th</sup> standard to a Bachelors' Degree. Nair and Brahmins were educated to university level, while the Kudumbi women were educated mostly up to the 12<sup>th</sup> standard and the Muslim women had studied till 8<sup>th</sup> or 10<sup>th</sup> standard. Amongst twenty women, ten were primagravida whereas rest were multigravida. Six had some minor complications during pregnancy like bleeding and were advised bed rest. Three conceived through infertility treatment whereas rest 17 conceived naturally.

The social background of the private hospital respondents is as follows. Looking at their caste, we can see that the upper caste respondents were Brahmins, Vermas, Nairs and Syrian Christians, while the other respondents belonged to the Pulaya (Scheduled Caste) and Eezhava (Other Backward Castes) communities. The Scheduled Caste and Other Backward Caste respondents were from the creamy layer of their groups – those who had flourished and moved up in the hierarchy because of their education and collective struggles led by the SNDP<sup>2</sup>, enabling them to establish and successfully manage business ventures.

1. Although there is no caste system among Christians, it is followed implicitly. Syrian Christians consider themselves as upper caste, while Latin Christians and Converted Dalits are considered to be lower castes.

2. .SNDP is Sree Narayana Darma Paripalana Sangam, an organization which was established by Sree Narayana Guru to unite Eezhava community people.

Using class as the primary identifier, the divisions coincided with those of caste even in the case of private hospital. The Eezhavas and the Nairs and Brahmins were better off than the Pulayas, with their annual income varying between six and twenty lakhs. All of the women had their own house and land. There was no strict division in terms of occupation. The women were either professionals (information technology specialists, teachers, bank employees and Class B government servants) or housewives. All of them were educated to at least degree level. Many respondents were Non Resident Indians, either working as or married to a man who was working in information technology or hotel management in the US/EU/Australia. There were also Muslim respondents who had their own land and house – the women were housewives and their husbands were employed in the Middle East at a managerial level. The respondents were between 19 and 35 years of age. Amongst twenty women, eight were primagravida whereas rest were multigravida. Nine had some minor complications during pregnancy like bleeding, high BP and gestational diabetes. Six conceived thorough infertility treatment whereas rest 14 conceived naturally.

## DIGNITY VIOLATION/ PROMOTION IN INSTITUTIONAL CHILDBIRTH- WOMEN'S EXPERIENCES

When two people involved in an interaction are in a hierarchical relationship, then the chances of dignity encounters and dignity violations are more. In health care system, *position of vulnerability* of the health care seekers (here pregnant women) and *position of knowledge and power* of the health care providers define and decide the level and intensity of dignity violation. The relationship is of hierarchy and asymmetric in nature. In the Indian context, apart from knowledge, power and authority, the structural/ social determinants like caste, religion and class also play important roles in this dignity encounter which is one of the most important, sensitive and joyful but at the same time painful experience in a woman's life. Analyses of participants' narratives show that the women could verbalize their dignity encounters/ violations in the labour room. During our field work, all the women irrespective of their social background mentioned four variables as the most important:

- **Recognition as a human being** with autonomy, rationality and thinking capacity- A generalized sense of disrespect and a gratuitous nastiness was widely observed in the labour rooms which demean the human worthiness of women.
- **Recognition as an individual rather than a tool/**

**machine-** Ideally, dignity is absolute and no social forces should be able to take it away. Women appreciated the health care system when the doctors showed a genuine concern rather than using them as tools to meet targets assigned to them by the management or insurance companies.

- **Ensuring an equal consideration/ priority-** Only the medical condition of the woman should be the basis on which priority is accorded to her. In actual health care setting factors like ability to pay bribes, caste and religion decided who get access to the resources available in the public health care facilities.
- **Freedom from exploitation-** The humiliating experiences and injustice faced are considered as exploitation which is clearly violating human dignity. The feeling that doctors *used them as objects* for training was also regarded as exploitation.

The women belonging to the lower class who accessed public health care facilities used the following constructs to explain dignity violation

- **Absence of discrimination in the hospital-** When the respondents experienced some kind of discrimination in the services they received, they challenged it using the concept of equality. Discrimination was in bed allotment, access to doctor, availability of drugs/ free food.

One respondent (from the Dheevera (fishing) community) shared her experience of being denied access to the free food that the hospital provides to all those who are admitted.

*"I asked the nurse why the food is rotten and she answered, "You people are always eating fish and you are engaged all the time in fish processing, so you yourself are stinking. The food is alright. Take if you want or move away." I did not reply, just came back to my bed. I skipped two meals, and in the evening when my husband came, he carried some food for me."* (X, second time pregnant, 27 years old)

- **Language of indignity and humiliation-** Shouting and brutal speech, usage of number, name of the caste and body shape to identify the woman, contempt, rudeness and indifference shown and reflected in the behaviour and interaction were regarded as highly demeaning ways.

One respondent explained, *"After seven hours of labour pains, the doctor decided that the labour is not progressing and decided to go for a caesarean section. My husband was asked to sign the consent form and the staff did not explain to him the reasons. I was in the labour room. They were preparing me for the caesarean and a nurse*



was injecting me. I had my last ultrasound report in my hand. With natural curiosity, I asked her the weight of my baby. Her action scared me. She blasted me and said that I am trying to act too smart by asking questions. She threw the injected needle onto my stomach and walked off. I was shocked and scared. After some moments she came back again uttering abusive words and took the needle and threw it in waste bin."

- **Physical Violence and assault as a threat to dignity-** Using physical force to damage or demean an actor's body and the spirit was common. Women reported cases of physical violence, wherein they were pinched and beaten, hit on their cheeks and face, and they were pinched in between their legs. Sometimes, a small needle was used to strike their feet.

"I was screaming in pain. I was sitting on a chair and suddenly I felt my baby's head outside me. I again called for help and told the nurse. She told me to move to the bed. I was holding my stomach and vagina area with my hands. Somehow, I reached and lay down on the table. She checked me and declared that no head was to be seen. Her reaction was to give me two slaps on my face, with a rude comment that I was telling lies to get the bed. This was the worst humiliation I had ever faced in my life. Later, I was told by her that my thighs are full of "black marks" and so I am not clean. She pinched me, saying that I am not following her instructions (about breathing and pushing the baby out). More than labour pain, her presence was terrifying." (Y, First time pregnant, 29 years old)

- **Objectification of body and violating bodily integrity-** The consideration of woman as one without a self, treating a birthing woman as though she is disgusting or tainted. The intrusion and transgressing a person's bodily boundaries was not appreciated.

- **Rest during pregnancy and after childbirth, maternity benefits and job security post childbirth- Issues normally not part of dignity in other circumstances are also considered as part of human dignity by the women.**

- **Contempt and Disregard-** Treating the person as a thing rather than as an individual and without any value as if she has no existence / make the person voiceless and less confident.

- **Objectification and Intrusion-** Women also experienced violating the bodily integrity and personal boundaries at the level not commonly expected in the society.

**The women belonging to the upper class who accessed private health care facilities used the following constructs to explain dignity violation**

- **Appreciating the fact that a birthing woman is unique and complete individual-** The feeling of being abandoned, indifferent attitude of medical staff, not allowing speaking and clearing doubts, labelling and groups etc., were unacceptable.

- **Information Sharing and Being Part of Decision-making-** By "information sharing", the respondent meant sharing information after each check-up, allowing the woman to ask questions and clarify her doubts. When women are informed they feel more confident to face the birthing process. By restricting the information that reaches the patient, people are left to assumptions and ideas without rationality (Sered and Tabory 1999).

"The information is all about "me" and "my baby", so why are they so hesitant to share the information?"

- **Autonomy and Dignity-** Talking down to" someone or speaking to an adult "like a child was unacceptable to most of the women. Ignoring or discounting birthing woman's knowledge, skills, perceptions, concerns, needs, and feelings resulted in her being passive in the birthing process.

"I was very comfortable to walk around and my mother instructed me to walk around as far as possible. Suddenly a nurse came and asked me to lie down and said that this walking and so on are very old methods. When the pain proceeded and I was in active labour, I told the doctor that I wanted to give birth in a sitting position. She did not even reply to me. Later, when I repeated my request, the nurse told me that it is not possible and it is not good for "all". Who are these "all"? I did not understand. So I asked again, and she replied, "You see, the doctor's job is a dignified job. After so much training and hard work they reach here, and you expect her to sit on the floor and watch you? Are you of sound mind?" (P, Third time pregnant, 32 years old)

- **Use of unwanted / avoidable medical technology as an attack on dignity-** Considering women as weak and promoting painless labour/ caesarean sections were widely practiced. The excessive and unnecessary use of medical technology on their bodies created many physical problems for the women in the postnatal period. This included severe backache, nausea and infection in the vagina.

"I was never told or consulted what they were doing. Whenever I expressed doubts about what injection they were giving and so on, they remained very formal and replied, "We are trying to give you and the baby the best care possible." I never understood the relevance of and need for many of the medical procedures they followed. The only thing I understood in the end was that the cost

of my normal childbirth was Rs. 70,000.” (N, First time pregnant, 28 years old)

- **Privacy, Confidentiality-** Women considered maintaining privacy and confidentiality as utmost important to ensure dignity in the process of interaction.
- **Abjection and culture specific insensitivity-** in some cases, women were humiliated by making fun of their closely held beliefs or practices.

It was common practice in the labour room when a girl child was born to show a lot of sympathy, with nurses saying, “*Oh! Poor lady, not blessed this time.*” Such a tone was very humiliating for the woman and affected her self-confidence.

### THE CONSEQUENCES OF DIGNITY VIOLATIONS AND WOMEN’S STRUGGLES

Dignity violations bring in lot of consequences such as alienation, depression, stress, indebtedness, loss of self-confidence and serious post-partum depression. The initial emotions that developed due to dignity encounters include shock, fear, anger, helplessness, numbness, disbelief and frustration. Feeling of humiliation, feeling of anger, feeling of worthlessness and feeling of self-blame were commonly reported in our interviews. The long term consequences were feeling of passiveness, feeling of not seeking appropriate medical help on time, events of victimisation and abuse followed by feeling of disempowerment. People employed different strategies to cope with their undignified experiences. The behaviour and attitudes of healthcare professionals were considered as a norm and institutionalised. The care seekers did not question/raise their voices because they had previous experiences in which they were considered a “nuisance” and were abandoned. There were attempts in various ways to counter and question the inhumane treatment they received. The response was not very encouraging but they continued emphasising their rights. In the private hospital, there were cases where the woman’s relatives threatened the management with a legal complaint. Collective struggles were often seen in the public hospital. For example, when male visitors started using the toilet meant for women, the women immediately raised their voices and blocked entry to the ward.

Medical Social workers and other helping professions such as public health, irrespective of the field where they are employed work with people in distress. A professional, who is creating a help-based relationship with the client aims to reach to the person and protect his/her dignity. When such a professional works with a client, complete understanding of the innate human

worth and dignity plays an important role (Johnson 2001). From the data reported in this paper, it is evident that there is a need for more explicit and formal interventions in institutional child birth. Three actions can be proposed

#### 1) Avoid the instances of dignity violation as far as possible.

The issues many women raised include informed consent, sharing the information, and being part of the delivery process etc. Such issues which are very individual based can be successfully addressed by the professional. Once women have complete information about their pregnancy and birthing process, they can interact with other care givers and eventually can engage meaningfully with their birthing process. For instance, a social worker also has to work with other stake holders in the hospital so that they are sensitised about the issue of human dignity and dignity violation. A social worker can also facilitate sensitisation and mutual negotiation between the birthing women and the health care providers in association with other stakeholders in the institutional context.

A professional intervention can reinforce the strong sentiments among women who consider of birthing as a key life experience. They can help in nurturing and protecting a woman’s memory of birth. They can also help in recognizing the effects of emotions on the physiology of labour and provide comfort techniques and encourage positions that promote progress during labour. They can also help in promoting early breastfeeding and bonding.

Given the fact that the social inequality and its consequences are the main causes in violation of human dignity in Indian hospitals, social workers have an additional responsibility as social justice is one of the main values in the practice of social work (Grayet et al., 2012).

#### 2) Work with the women whose dignity is violated and are in stress.

The professional intervention can also help in motivating the client to change the perspective and again regain the self-confidence which she has lost during the interaction with the health care system. Moral principles such as humaneness, love, empathy, equality, tolerance, respect, courage, honour and honesty are extremely important in helping professions. Once women encounter dignity violation, importance has to be given to the above mentioned moral principles undertake repeated sessions with her to help her come out of the mental distress. The links between these

values constitute the content of dignity (Virbalienė & Žydzūnaitė, 2010). The continuous monitoring of such principles is necessary while recognizing the importance of right to make free choices and decisions during the helping process.

### 3) Further referral and follow up

The quality of post-natal experiences such as referral and professional help, legally claimable maternity leave and maternity benefits etc. has to be ensured. This is a long term service requirement which require intersectoral coordination.

## CONCLUSION

The pattern and extent of dignity violations that we have outlined in this paper based on our empirical observations of birthing in hospital settings show the need for a monitoring mechanism involving a multi-disciplinary team. Such a public health approach can create a helpful relationship from the beginning of the pregnancy and hospital visits, facilitate an engendering birthing experience by limiting the dignity encounters and enhancing the self-confidence and worthiness feeling of the birthing woman. A manual based on these empirical categories can be developed so that the team members are sensitized about the process. This is extremely important given the priority accorded to institutional child birth which would help in improving maternal-neonatal mortality in developing countries.

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