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Beyond Maternal Mortality: A Systematic Review of Evidences on Mistreatment and Disrespect During Childbirth in Health Facilities in India

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Abstract

The aim of this systematic review is to examine current evidence on the nature and extent of disrespect and abuse (D&A), mistreatment and practices of respectful maternity care of women during childbirth in India. Electronic databases were searched for published studies relevant to the topic. The search was conducted from May to September 2018. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used to conduct the review. A results synthesis was done using the Bowser and Hill landscape analytical framework for D&A of women during childbirth. Eleven studies are included in this review of which six were cross-sectional, four were qualitative, and one used a mixed-method approach. The type of abuse most frequently reported was the lack of respect and dignity (nondignified care) experienced by the women, usually in the form of negative and unfriendly attitudes of the providers. The least frequent form of mistreatment was physical abuse and detention in the facilities. The frequency of reported D&A was high, ranging from 10% to 77.3%. These behaviors were influenced by lack of education and empowerment of the women, their low socioeconomic status, poor training of providers and supervision, and a lack of accountability. Overall, disrespectful and abusive behavior had adverse impact on the utilization of health facilities for childbirth. It created a psychological distance between women and health providers. To our knowledge, this is the first systematic literature review to be conducted on respectful maternity care in India.

Keywords

mistreatment, disrespect and abuse (D&A), childbirth, dignity, health facility, India, quality of care

Background

Mistreatment of women in health facilities during childbirth has drawn public attention and is a growing area of interest for researchers (Bohren et al., 2015; Miller et al., 2016; World Health Organization [WHO], 2014). Worldwide, many women experience disrespectful, abusive, or neglect during treatment at childbirth. These practices violate a woman's basic human rights. They deter women from seeking maternal health-care services and can have serious implications for their health and well-being. Recently, many studies reported mistreatment of women in India during childbirth, which ranged from physical abuse, mistreatment, verbal abuse and nondignified care (Bhattacharya & Ravindran, 2018; Saxena, Srivastava, Dwivedi, & Bhattacharyya, 2018; Sen, Reddy, & Iyer, 2018).

Giving birth to child is a significant life event for women. However, motherhood also brings many challenges to new mothers. Giving birth is sometimes a traumatic experience, resulting in post-traumatic stress for a few women. Most health-care providers tend to think of birth trauma in terms of physical injury, often overlooking the psychological effects. Up to one third of women view their labor and delivery as traumatic. An estimated 2–6% of women experience the full range of symptoms of post-traumatic stress disorder (PTSD).

It is estimated that about 20–50% of women view labor and the delivery of their children as a traumatic birth experience (Ayers, Bond, Bertullies, & Wijma, 2016; Ayers, Joseph, McKenzie-McHarg, Slade, & Wijma, 2008; Slade, 2006). Further, globally, the percentage of women who experience the full constellation of traumatic births ranges from 1% to 9% (Bell & Andersson, 2016; Soet, Brack, & DiIorio, 2003; Waldenström, Hildingsson, Rubertsson, & Rådestad, 2004). There have been a substantial number of studies that reported neglect during childbirth and lack of health care which can lead to a traumatic birth experience (Beck, 2006; Waldenström

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et al., 2004). Other factors in traumatic birth experiences were the complicated deliveries and lack of support from family and partner (Grekin & O'Hara, 2014; Seng, Low, Sperlich, Ronis, & Liberzon, 2011). A traumatic birth experience can have several negative health outcomes for both mother and infant. Women who have had a traumatic birth experience report having fewer subsequent children and reduced breastfeeding (Beck, 2018). Childbirth-related post-traumatic stress disorders impact relationship between partners (Campbell & Renshaw, 2016; Fredman et al., 2016).

Of an estimated 303,000 maternal deaths that occurred worldwide in 2015, nearly 99% occurred in low-and middle-income countries or LMICs (Ishola, Owolabi, & Filippi, 2017). About 830 women die from pregnancy or childbirth-related complications every day. Pregnancy-related complications remain the foremost cause of deaths among women in the reproductive age-group. Most of these deaths are preventable if the women are provided appropriate and timely care (The White Ribbon Alliance [WRA]). In 2015, the United Nations launched the global strategy for women's, children's, and adolescents' health for the years 2016 to 2030 with the aim of reducing the global maternal mortality ratio (MMR) to fewer than 70 per 100,000 live births (Shakibazadeh et al., 2018).

India contributed 17% to the global burden of maternal deaths (WHO, 2016). The WHO estimates that each hour, nearly five women die in India due to childbirth-related complications, meaning 45,000 women die annually during childbirth. MMR is high, estimated at 130 maternal deaths per 100,000 live births (Registrar General of India, 2018). Commitment to Goal 5 of the Millennium Development Goals has led the Indian government to introduce several health system reforms with the aim of reducing MMR by 75% to 100 per 100,000 live births and creating universal access to reproductive health (Chattopadhyay et al., 2018). However, the review study of Balakrishnan and Khanna (2016) found that the risks of maternal deaths are worsened by inadequate health-promoting practices and institutional regimes of care that do not support quality in maternal health care, including inadequate antenatal care which increases obstetric risks.

The experience of giving birth has a lifelong impact on the overall health and well-being of women. It can either be an empowering life event or the cause of a traumatic syndrome (Halperin, Sarid, & Cwikel, 2015). Several programs have been implemented by the Government of India to accelerate utilization of institutional birth facilities. These have resulted in more than 75% of births taking place in institution in India (International Institute for Population Sciences & ICF, 2017). Experiences of previous births affect subsequent birth experiences: The fear of pain and negative experiences with the providers often dominate women's experiences of labor (Nilsson & Lundgren, 2009).

Quality of care provided during childbirth is a critical determinant of increasing utilization of maternal health-care services and preventing maternal mortality and morbidity (Jha et al., 2016). Overemphasis on institutional delivery conceals women's experiences with the health system, which is manifested in the poor quality of their interactions with staff and their engagement with biomedical technologies and practices and the continuum of care (or the lack of it) according to Melberg, Diallo, Ruano, Tylleskär, and Moland (2016) and Jha et al. (2016). Moreover, the notion of a successful childbirth cannot be solely demarcated as the survival of the infant and the mother. It should also include practices that are safe and human, such as appropriate place of birth, the presence of supportive kin, and respect and dignity of women during labor (Chattopadhyay et al., 2018; McCourt, Rayment, Rance, & Sandall, 2016).

India has a diverse population. The country is made up of various kinds of geographical locations which are home to multiple caste groups and religions. Health inequalities among these groups are evident. Women from the lower social caste groups are discriminated against and deprived of basic health services (Haddad, Mohindra, Siekmans, Màk, & Narayana, 2012; Jungari & Bomble, 2013; Vart, Jaglan, & Shafique, 2015). Women from the scheduled castes and scheduled tribes experience greater morbidities and mortality than other caste groups in India (Jungari & Chauhan, 2017; Mohindra, Haddad, & Narayana, 2006). Muslim women tend to receive less attention and more negligence from health-care providers and face higher odds of disrespect during childbirth. However, it must be mentioned here that the experiences of other religious minority groups in India were not studied.

In 2010, a landscape report by Bowser and Hill, "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth," summarized the available knowledge and evidence on the topic. While the review revealed a relative lack of formal research on the topic, the authors' in-depth search of published and technical literature, as well as interviews and discussions with content experts, led to the definition of seven major categories of disrespect and abuse (D&A) that childbearing women encounter during maternity care. These categories overlap and occur along a continuum—from subtle disrespect and humiliation to overt violence. They include physical abuse, nonconsented clinical care, nonconfidential care, nondignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities.

Recent studies have used different methodologies and conceptual frameworks to highlight the global prevalence and nature of D&A in health facilities during childbirth (Sando et al., 2017; Warren et al., 2013). However, the Bowser and Hill landscape analytical framework is the most frequently applied for reporting systematic reviews in developing countries (Ishola et al., 2017). Therefore, this study uses the Bowser and Hill landscape analytical framework to present the results.

To date, there has been no effort to summarize the evidence of experiences of disrespect, mistreatment, and abuse of women during childbirth in the health facilities of India. To our knowledge, this is the first formal review which has synthesized evidence of respectful maternity practices in Indian settings. In this context, the aim of current review is to examine

current evidences on the nature and extent of D&A of women during childbirth in health facilities in India.

Method

A systematic review of published quantitative and qualitative literature between January 2008 to September 2018 was conducted. The Bowser and Hill, a landscape report (Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth, 2010) classification formed the basis of synthesis in this review because it provided a framework for the classification, contributing factors and consequences of D&A during childbirth. Our analyses were conducted using Bowser and Hill's framework dimensions to describe and understand the nature of D&A faced by women during childbirth.

Search Strategy

Potentially relevant articles for systematic review were identified by searching bibliographical databases (PubMed, Embase, MEDLINE, Scopus, ScienceDirect, and Web of Science), the WHO, Cumulative Index of Nursing and Allied Health (provided by EBSCO Information Service). Also accessed were reports of WRA, U.S. Agency International Development (USAID), Health Policy Project, and Google Scholar resources. These platforms helped in the search for citations for this review. A full-search strategy for each database was developed using key words or free text terms in various combinations for the concepts: quality of care, disrespect or abuse, mistreatment during labor, providers' attitude, experience of women during intrapartum care, and childbirth. Medical Subject Heading or equivalent indexing terms were used to capture all relevant terms used by authors.

Inclusion and Exclusion Criteria

First, we screened the titles and abstracts of identified citations for potential inclusion in the review. Full texts were sought only for the relevant articles. Studies were eligible for inclusion if they were conducted in India and reported on indicators and contributing factors as well as consequences or investigated quality of care which was, directly or indirectly, related to the D&A of women during childbirth. Studies which aimed to understand and explore actual experiences of women during childbirth and reported any form of D&A or reported reasons for nonutilization or delayed utilization of skilled delivery services involving any form of D&A were also included. Studies published prior to 2008 were excluded from this review.

Appraisal of Quality

The studies include in the review were subjected to an appraisal process to assess their relevance, reliability, and accuracy. The Critical Appraisal Skills Programme tool was used for this purpose. The studies were assessed as being of high, medium, or low quality. Some studies were excluded from the appraisal because they did not satisfy the norms.

Data Extraction

Data were extracted using a standardized form for information such as the name of first author, year of publication, location of the study and its settings, study design, description of the study, sample size, demographics, type and characteristics of D&A experienced by the women, type of analysis carried out, results of analysis, and the limitations of the study.

Data Synthesis

The Bowser and Hill framework, a landscape report (Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth, 2010) was used for data synthesis. The framework categorized the D&A into seven domains as mentioned earlier. The contributing factors were categorized into individual and community, policy, governance, providers and service delivery factors and underutilization of skilled delivery services. The results were collated and analyzed with respect to these categories to fulfill the key objectives of the review. For quantitative synthesis, we reported the type of D&A experienced under each category in percentages. For qualitative synthesis, we quoted the participants followed by the authors' analysis to fit the report of D&A in the appropriate theme.

Results

The initial search yielded 302 citations and the updated search provided an additional 49, making it a total of 351. From these, 46 were removed because they were duplicates. After screening the titles and abstract of the 305 studies which remained, 284 records were removed because they did not satisfy the eligibility criteria for this review. Thus, 21 potentially relevant articles were identified for a full-text review of which 11 studies met the inclusion criteria (Figure 1).

Of these 11 studies, included, 6 were cross-sectional, 4 qualitative, and 1 used mixed methods (qualitative and quantitative). Seven of the 11 studies were conducted in Uttar Pradesh in North India (Bhattacharyya, Issac, Rajbangshi, Srivastava, & Avan, 2015; Bhattacharya & Ravindran, 2018; Dey et al., 2017; Diamouund-smith et al., 2017; Raj et al., 2017; Sudhinaraset, Treleaven, Melo, Singh, & Diamond-Smith, 2016); 2 in Chhattisgarh, East of Central India (Jha et al., 2016; Jha, Larsson, Christensson, & Skoog Svanberg, 2017); 1 study was done in Jharkhand, Eastern India (Bhattacharyya, Srivastava, & Avan, 2013); and 1 study was done in Assam in Northeast India (Chattopadhyay, Mishra, & Jacob, 2017). Two of the studies were done in a rural setting (Chattopadhyay et al., 2017; Bhattacharyya et al., 2013) and three in slums (Diamond-Smith, Treleaven, Murthy, & Sudhinaraset, 2017; Sudhinaraset et al., 2016).

About 57% of the women reported experiencing any form of mistreatment during pregnancy (Sudhinaraset et al., 2016). Most of participants (77.3%) self-reported their mistreatment, and the remaining were reported by observers who were witness to the mistreatment of the women (Dey et al., 2017). One in five (20.9%) reported mistreatment by their providers during childbirth which

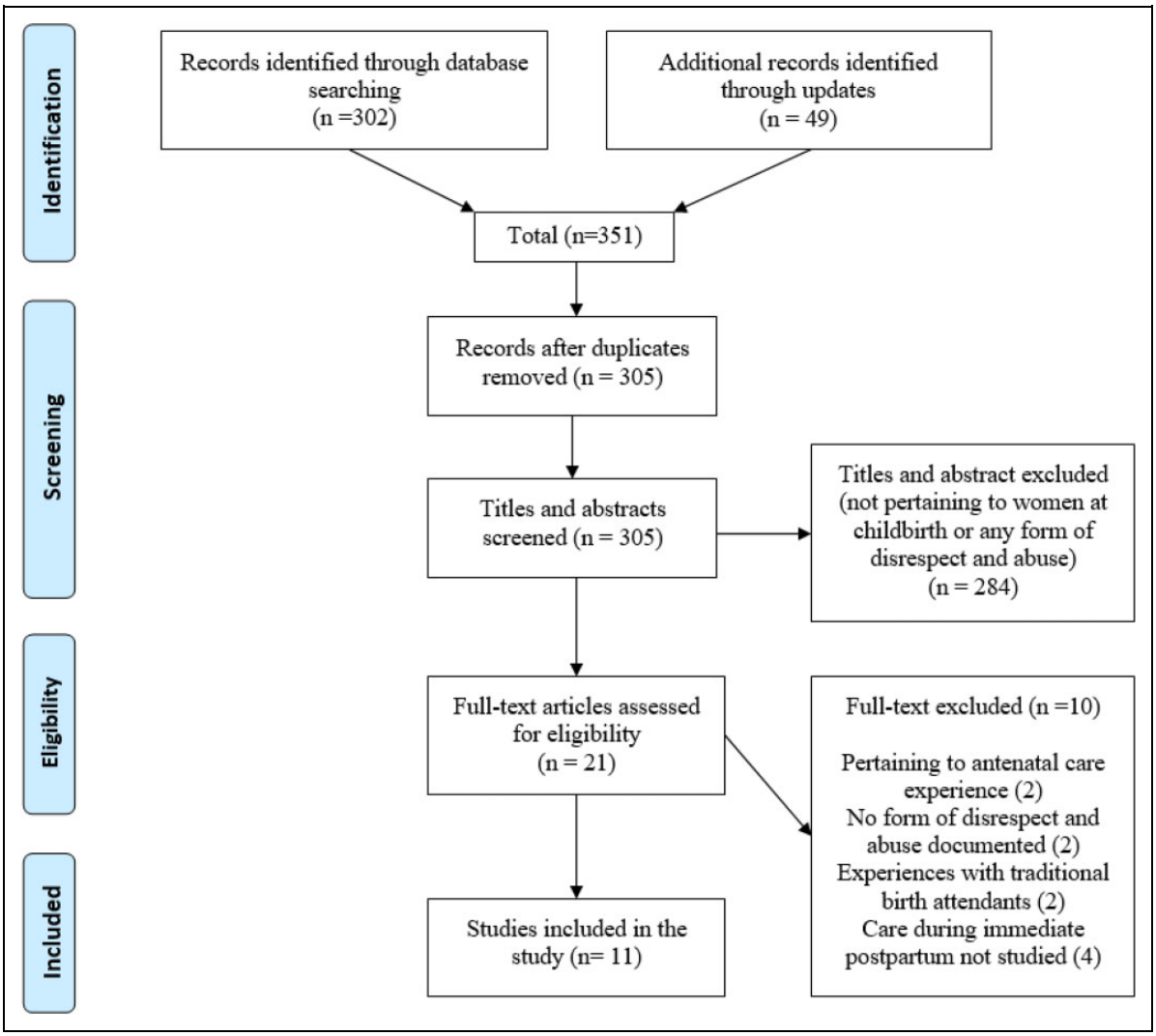

Figure 1. PRISMA flowchart of search and study inclusion process.

included discrimination and abuse. Women were significantly more likely to report mistreatment when their provider was a nurse instead of physician or midwife (Raj et al., 2017). As reported by Jha, Larsson, Christensson, and Skoog Svanberg (2017), women who had vaginal births at Community Health Centres were least satisfied with services pertaining to "Meeting with the baby" (mean score 1.4, *SD* .6). The study Diamond-Smith, Treleaven, Murthy, and Sudhinaraset (2017) reported that 24.2% of the providers expected payment or bribes and 4.3% of the women reported unnecessary separation from their babies. With the help of the Bowser and Hill framework, the results of our analysis are reported under the following subdomains. A summary of study characteristics presented in Table 1.

Physical and Verbal Abuse

Physical abuse is any nonaccidental act or behavior causing injury, trauma, or other physical suffering or bodily harm, while verbal abuse is a form of abusive behavior involving the use of wrong language. Verbal abuse occurs when a person forcefully criticizes, insults, or denounces someone else, the act characterized by underlying anger and hostility. It is a destructive form of communication intended to harm the self-respect of the other person and produce negative emotions. A qualitative study found that most commonly type of abuse reported by focus group participants was verbal abuse, which included "scolding" of patients and shouting at them (Sudhinaraset et al., 2016).

Diamond-Smith et al. (2017) reported physical abuse (15.5% of study population) and verbal abuse (28.6%). Beating and verbal abuse occur during labor which also sometimes directed at the accompanying relatives (Chattopadhyay et al., 2017). The participants described a range of provider's behaviors inside the labor room: from being polite and considerate to being abusive and cruel. The women's description of the treatment revealed use of discourteous language, insinuations about sex and babies, threats of physical injury, and, sometimes, even assault by the providers. The respondent women also recalled how some care providers tried to stop other providers in engaging in such (abusive) behavior.

Table 1. The Summary Characteristics of the Included Studies in the Review.

Authors (Year)	Study Location and Setting	Study Design and Description	Sample Size	Demographics	Type and Characteristics of Disrespect and Abuse	Results	Type of Analysis Done	Bias/Limitations
Bhattacharyya, Srivastava, and Avan (2013)	Rural area of Jamtara district in Jharkhand, a state in Eastern India	Qualitative study. Individual in-depth interviews (IDIS) and focus group discussion (FGDS) with women who recently delivered	Participants in individual in-depth interviews (IDIS; $N = 17$) and focus group discussion (FGDS; $N = 32$), women who had delivered in the 42 days prior to the study	Women respondents age-group of 18–25 years old	Lack of privacy and faith, extra money was asked apart from main expenditure for their pocket	Aspects of care most commonly cited by women to be important were availability of health providers and appropriate medical care (primarily drugs) in case of complications, emotional support, privacy, clean place after delivery, availability of transport to reach the institution, monetary incentives that exceed expenses, and prompt care	Using the transcripts of interviews, the data were analyzed thematically	Small sample, younger age-group
Bhattacharyya, Issac, Rajbangshi, Srivastava, and Avan (2015)	District of Uttar Pradesh, India	A qualitative descriptive study, semistructured, in-depth interview (IDI)	Women who recently delivered ($N = 24$)	Women age-group of 20–30 years old and one above 30 years.	Difficulty in maintaining privacy, physical access, cleanliness, interpersonal behavior, information sharing, and out-of-pocket expenditure	The common challenges experienced regarding provision of care were inadequate physical infrastructure; irregular supply of water, electricity, shortage of medicines, supplies, and gynecologist and anesthetist to manage; complications, difficulty in maintaining privacy, and lack of skill for postdelivery counseling	The data were analyzed thematically	Younger age-group, with low education and lower economic status which can have an implication on their perception selection bias
Sudhinaraset, Treleaven, Melo, Singh, and Diamond-Smith (2016)	Slums of Lucknow city of Uttar Pradesh, India (selected 38 slums randomly)	Mixed (qualitative and quantitative) surveys and focus group discussions	For quantitative ($N = 392$), for qualitative ($N = 26$)	Women had to be between 18 and 30 years of age, have at least one child currently under the age of five, and live in the slum area	Discrimination, physical abuse, verbal abuse, threats to withhold treatment, lack of information, abandoned or ignored, delivered alone, choice of position denied, companion not allowed, requested out-of-pocket-expenditure, unnecessary separation from baby	Quantitative results suggest high levels of mistreatment (over 57% of women reported any form of mistreatment). Qualitative findings suggest that lack of cultural health capital in Patient–provider relationships, lack of knowledge, and poor health outcomes. Of importance, however, patients also blame themselves for their own lack of knowledge.	Quantitative analysis—descriptive and bivariate statistics—qualitative, using the transcripts of interviews, the data were analyzed thematically	Urban slum populations
Jha et al. (2016)	One district of Chhattisgarh, state in India,	Qualitative in-depth interviews	Women who had given vaginal birth to a healthy newborn infant ($N = 13$)	Twenty-one women were invited to participate in the study, out of which 15 women, agreed to participate, and 13 completed an interview	Verbal and physical abuse, out-of-pocket expenditure, nonconcerned care	The women's descriptions show that the labor rooms seem to be well equipped and functional; however, availability of infrastructure may not necessarily reflect the quality of care. Women seek the health care due to cashless and safe intrapartum care, however, the hidden costs they bear involves a damage to personal dignity, feeling shame and guilt, and having	Grounded theory approach	Conducting interviews in women's homes where they held no authority and the quality of the interviewing skills of one no vice interviewer may perhaps be other confounding factors

(continued)

Table 1. (continued)

Authors (Year)	Study Location and Setting	Study Design and Description	Sample Size	Demographics	Type and Characteristics of Disrespect and Abuse	Results	Type of Analysis Done	Bias/Limitations
						to surrender themselves to the care providers: A trade-off that the women are willing to make but should not be required to do so.		
Diamond-Smith, Sudhinaraset, Melo, and Murthy (2016)	Slums of Lucknow, Uttar Pradesh, India	A cross-sectional study	A total of 759 young women This analysis is limited to the 392 women from that sample who had delivered in a health facility	Women of age 16–30 years who had delivered infants in a health facility in the previous 5 years and were living in slums of Lucknow, India.	Lack of support, lack of information	Only 53% health workers provide support, women who reported lack of support were more likely to report mistreatment. Lack of support in regard to discussions with providers and provider information were most strongly associated with a higher mistreatment score	Regression analyses	Restricted to slums so cannot be generalized for other strata women, recall bias
Diamond et al. (2017)	Slums of Lucknow, Uttar Pradesh, India	A cross-sectional study	392 Women from that sample who had delivered in a health facility, 21% delivered in a public primary health center, 50% in a government hospital, 21% in a private hospital, and 8% in a private clinic	Women of age 16–30 years who had delivered infants in a health facility in the previous 5 years and were living in slums of Lucknow, India	Discrimination, physical abuse, verbal abuse, threats to withhold treatment, lack of information, being abandoned or ignored, delivering alone, choice of delivery position ignored, companion not allowed, request, for payment or bribe, and unnecessary separation from the baby	16.8% Reported discrimination, 15.5% physical abuse, 28.6% verbal abuse, 12.2% threats to withhold treatment, 4.6% lack of information, 10.2% being abandoned or ignored, 10.5% delivering alone, 10.5% choice of delivery position ignored, 19.6% companion not allowed, 24.2% request for payment or bribe, and 4.3% unnecessary separation from the baby	Multivariate logistic regression model	Its cross-sectional nature does not allow to establish causality between women's views and their childbirth experiences
Dey et al. (2017)	Uttar Pradesh, India	A cross-sectional survey	Women ($N = 875$) delivering in 81 public health facilities in Uttar Pradesh	Women aged 15–49 years who had delivered at the selected public health facilities	Physical abuse, harsh delivery practices, and nonpresence of the provider ranged from fair to poor	Most participants (77.3%) self-reported mistreatment in at least 1 of the 17-item measures. For the 6 items included in both self-report and observations, 9.1% of women self-reported mistreatment, whereas observers reported 22.4% of women being mistreated	Regression model χ^2 analyses and t tests	Study conducted only in public health facilities in Uttar Pradesh
Raj et al. (2017)	Uttar Pradesh, India	A cross-sectional survey	Women ($N = 2,639$) who had delivered at 68 public health facilities in Uttar Pradesh	Participants were aged 17–48 years, and 30.3% were scheduled caste/ scheduled tribe	Abuse, failure to meet standard of care, and stigma and discrimination	One in five (20.9%) reported mistreatment by their provider during childbirth, including discrimination and abuse Women were significantly more likely to report mistreatment, when their provider was a nurse rather than a physician or midwife	Unadjusted and adjusted logistic regression models χ^2 analyses and t tests	A major limitation of this study is its reliance on women's self-report
Chattopadhyay, Mishra, and Jacob (2017)	Kamrup district, rural, Assam	In-depth interviews	The 15 women who gave birth in health-care facilities in the last 2 years	Women aged 17–36 years	Beating and verbal abuse during labor	There has been an expansion in institutional deliveries, the experience of childbirth in government facilities is	Analyzed thematically	

(continued)

Table 1. (continued)

Authors (Year)	Study Location and Setting	Study Design and Description	Sample Size	Demographics	Type and Characteristics of Disrespect and Abuse	Results	Type of Analysis Done	Bias/Limitations
						characterized 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 anesthesia, improper pelvic examinations, beating and verbal abuse during labor, with sometimes the shouting directed at accompanying relatives		
Jha, Larsson, Christensson, and Skoog Svanberg (2017)	Two districts of Chhattisgarh, India	A cross-sectional survey, consecutive nonrandom sampling method	All women ($N = 1,004$) who had had an uncomplicated vaginal birth as defined by WHO criteria, giving birth to healthy single neonate in one of the selected health facilities	Women's of two districts of Chhattisgarh State, India	Lack of privacy, improper handling, abandoned of care	Although most of the women (Vaginal Births 68.7%; Caesarean Births 79.2%) were satisfied with the overall childbirth services received, those who had VB were least satisfied with the processes on meeting their neonates (mean subscale score 1.8, *SD* 1.3), while women having CB were least satisfied with postpartum care received (mean subscale score 2.7, *SD* 1.2	Regression analyses, Richard Baker's pragmatic model, IBM software SPSS Version 24	Response bias, the findings may not be applicable to every public health facility from every part of India
Bhattacharya & Ravindran, 2018	Rural blocks of Varanasi district, Northern India	Community-based cross-sectional, multistage cluster random sampling	410 Rural women	Rural women who delivered between June, 2014 and August 2015 at any health facility of Varanasi district, Northern India	Nondignified care, verbal abuse, physical abuse, neglect, or abandonment, nonconfidential care	Frequency of any abusive behavior was 28.8%. The reported abuses were nondignified care including verbal abuse and derogatory insults related to the woman's sexual behavior (19.3%), physical abuse (13.4%), neglect or abandonment (8.5%), nonconfidential care (5.6%), and feeling humiliation due to lack of cleanliness bordering on filth (4.9%). Women were abused during labor or delivery irrespective of their sociodemographic background.	Bivariate analysis using χ^2, binary logistic regression	Smaller sample, recall bias

> They use dirty words (about sex leading to pregnancy and childbirth). This is a private matter, and everyone has to sleep with a man to have a baby. However, it should not be spoken like this in front of all to hear . . . But there are some good people too. One Sister (nurse-midwife) she immediately scolded this other Sister. She said, "This is no way to talk." So, it is mostly your luck, what kind of provider you get (laugh). (Jha et al., 2016)

Nonconsented Care

Consented care happens when an individual has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, test, or examination. The individual's decision must be respected. Violation of this right is called nonconsent care. Here, absence of information or processes for informed consent to common procedures around the time of childbirth in various settings (e.g., caesarean sections, episiotomies, hysterectomies, blood transfusions, sterilization, use of intrauterine device [IUD], or augmentation of labor) are referred to as nonconsented care (Bowser & Hill framework, 2010). Diamond-Smith et al. (2017), in their study, reported that 10.5% of the women were not given the choice of delivery position or were ignored if they asked.

The women in the study also said that a postpartum IUD to prevent further pregnancy was been inserted in their bodies after the birth of their baby without consulting the women or their families. The women were informed about it by the nurse-midwife only at the time of their discharge from the hospital.

> She (Nurse-midwife) told me at the time of discharge that copper-T was put for me immediately after childbirth. I was surprised because they had not asked me. I thought that maybe they asked my family, so I did not say anything. Now I know they did not ask anyone. They just put it themselves . . . That was very bad I think. I have to go to hospital for my check-up. I will go and tell them to remove it. (Jha et al., 2016)

Nonconfidential Care

Lack of privacy includes both lack of physical privacy in facilities where women who are in labor often deliver in public view (without any barriers to protect their privacy). Lack of privacy is also evident when patient-related information, such as the HIV status, age, marital status, medical history, and so on can be easily accessed by anyone. This is known as nonconfidential care in the Bowser and Hill framework (2010). The study by Jha et al. (2017) reported that 57% women were least satisfied with the privacy they were given while breastfeeding their children (mean score 1.3, *SD* .4). Most qualitative studies found that along with the care processes, women were also not granted privacy during childbirth, especially in labor rooms, which is an essential aspect for treatment of women during childbirth (Bhattacharyya et al., 2013).

Nondignified Care

Nondignified care during childbirth is described as intentional humiliation, blaming, rough treatment, scolding, shouting, and publicly divulging private patient information. It is important to note that a woman's description and perception of nondignified care may be very context-specific, so that an example of treatment given to one woman may not be relevant to others (Bowser & Hill framework, 2010). Qualitative study with grounded theory approach states that the women reported experiencing mild to severe compromise of their personal dignity during childbirth (Jha et al., 2016). The layout of the labor room was described by the women as tables being arranged in such a manner that the care providers could get a clear view of a woman's perineum, even from their seats. Even though there were curtains between two tables, they were always pushed aside. All the women could see each other. Once the women are inside the labor room, they were expected to uncover their lower bodies, irrespective of the advancement of labor. Although male relatives were not allowed to enter the labor rooms, male doctors and nurses were excused from this restriction. The women experienced deep shame.

> When I asked for some curtains to be pulled before I lifted my clothes for internal check-up, she (care provider) became very angry. She did not understand what value a woman attaches to her dignity. She said, "You think you are the only one with shyness, and shame? So many other women came, who were checked like this but did not complain. Lie down quietly." She did not even speak appropriately. I felt very bad. (Jha et al., 2016)

It was mostly the women who had delivery complications who reported that the doctors and other supporting staff behaved arrogantly with them. *They told us rudely about the difficulty in conducting normal delivery—they said if you want the mother and baby, agree to the surgery or take them somewhere else* (Bhattacharyya et al., 2015).

Discrimination

Discriminating against women or their families during childbirth on grounds of the woman's ethnicity, age, language, HIV/AIDS status, traditional beliefs and preferences, economic status, and educational level is referred as discrimination (Bowser & Hill framework, 2010). Diamond-Smith et al. (2017) found that 16.8% of the women surveyed reported discrimination during childbirth. One in five women (20.9%) experienced mistreatment by their health provider during their delivery. The mistreatment reported by them includes abuse, failure to meet the necessary standards of care, and stigma and discrimination (Raj et al., 2017).

A mixed-method study by Sudhinaraset, Treleaven, Melo, Singh, and Diamond-Smith (2016) reported that lower caste women were more likely to report various types of mistreatment—mostly in the form of discrimination—as compared to women of other castes. Several women felt the quality of care in government facilities, as experienced by the poor, are substandard when compared with the experiences of those from middle

Table 2. Concise Results of Included Studies.

Authors (Year)	Main Results
Sudhinaraset, Treleaven, Melo, Singh, and Diamond-Smith (2016)	Strong evidence on high levels of mistreatment, that is, over 57% of women reported any form of mistreatment. Lack of respectful patient–provider relationships. Providers set expectations and norms on behaviors during delivery, while women are often misinformed.
Diamond-Smith, Treleaven, Murthy, and Sudhinaraset (2017)	The women who were less empowered reported the highest level of mistreatment, whereas the women who had more equitable views about the role of women were less likely to report experiencing mistreatment during childbirth. Thus, there is a direct corelation between women's health and the women empowerment.
Chattopadhyay, Mishra, and Jacob (2017)	Poor and indigenous women who disproportionately use state facilities report obstetric violence, improper pelvic examinations, beating, and verbal abuse during labor, with sometimes the shouting directed at accompanying relatives (supporters).
Jha et al. (2016)	Although the labor rooms are functional, but there is a need for improvement of interpersonal processes, information sharing, and sensitive treatment of women seeking childbirth services in public health facilities.
Jha et al. (2017)	Lack of privacy, improper handling, abandoned of care, unnecessary separation from the baby, and lack of postpartum care.
Bhattacharyya, Srivastava, and Avan (2013)	Lack of faith, no privacy, and monetary incentives were asked that exceed the main expenditure.
Diamond-Smith, Sudhinaraset, Melo, and Murthy (2016)	Lack of support, lack of information, women were not allowed to accompany anybody to labor room for emotional support and encouragement.
Bhattacharyya, Issac, Rajbangshi, Srivastava, and Avan (2015)	Lack of skilled delivery due to physical infrastructure, irregular supply of water and electricity, shortage of medicines, supplies, poor access to gynecologist and anaesthetist, no confidentiality.
Bhattacharya & Ravindran, 2018	Any abusive behavior was 28.8%. Nondignified care including verbal abuse and derogatory insults related to the woman's sexual behavior (19.3%), physical abuse (13.4%), neglect or abandonment (8.5%), nonconfidential care (5.6%), and feeling humiliation due to lack of cleanliness bordering on filth (4.9%). Women were abused during labor or delivery irrespective of their sociodemographic background.
Raj et al. (2017)	There is strong evidence that one in five women (20.9%) reported mistreatment by their provider during childbirth, including discrimination and abuse. Women were significantly more likely to report mistreatment when their provider was a nurse rather than a physician or midwife.
Dey et al. (2017)	Around 77.3% of participants self-reported mistreatment and whereas observers reported 22.4% of women being mistreated. Physical abuse, harsh delivery practices, and absence of the provider at crucial stage ranged from fair to poor.

or higher socioeconomic status who received better treatment and faced fewer barriers to accessing care in the public sector. A 28-year-old respondent from Uttar Pradesh said,

> For [higher socio-economic status] government health facilities are very good. For us, poor people, it is not so good. We are abused. If you ask anything to them they would shout back at you. They think they are big shots and know each and everything. What would a poor man do in such situations? We have to keep mum. (Age 28, from rural Uttar Pradesh; Sudhinaraset et al., 2016)

Abandonment/Neglect

Abandonment means women being left alone during labor and birth, as well as the failure of providers to monitor the women's health and intervene in life-threatening situations (Bowser & Hill framework, 2010). Diamond-Smith et al. (2017) reported that 10.2% of women felt that they were abandoned or ignored by their providers. About 10% of the women reported experiencing threats of withholding treatment, being abandoned or ignored, delivering alone, or being denied their preferred choice of position for delivery (Sudhinaraset et al., 2016). However, abandonment and neglect were reported only in two studies. Neglect in a health-care setting is often difficult to report due the crowding in hospitals.

Detention in Facilities

Restraining women in the health facilities where they had recently delivered, as well as their babies, usually due to failure to pay is referred as detention in facilities (Bowser & Hill framework, 2010). About 24.2% of women reported demands for payment of bribe. Further, 12.2% of the women reported threats for withholding treatment and unnecessary separation from their babies (4.3%) when they failed to make payment on time. The women reported detention in facilities for failure to pay their bills and that of their babies (Diamond-Smith et al., 2017). The concise results and critical findings are presented in Table 2 and 3 respectively.

Discussion

Respectful maternity care (RMC) is a health-care topic that is receiving increasing attention globally. Our systematic review suggests that D&A and mistreatment of women during childbirth in health facilities is a regular occurrence in India. Overall, the nature of mistreatment reported was verbal and physical

Table 3. Critical Findings.

- Abuse and mistreatment in health facilities during delivery has been reported in both public and private health facilities in India.
- Most repeatedly reported was nondignified care and the least commonly reported were physical abuse and detention in facilities, mentioned only in one study.
- Lower caste women were more likely to report various types of mistreatment compared to women of other caste that chiefly include discrimination.
- Definitional and measurement of incidences of mistreatment and abuse during childbirth in facilities is lacking.

abuse, nonconsented care, nonconfidential care, nondignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Our review shows that the most common type of mistreatment was nondignified. Physical abuse and detention in health facilities were the least common (as reported in only one study). However, it needs mention here that there is a strong likelihood that cases of mistreatment of women in health facilities are underreported for various reason, including a perception among parents that such treatment is normal and hence should not be seen as mistreatment (Sen et al., 2018). These cases surface only when the women patients are specifically asked about it.

Evidence suggests that fear of D&A that women too often encounter in facility-based maternity care is a stronger deterrent to the use of skilled care in a country like India, which has a high burden of maternal mortality, than commonly recognized barriers, such as cost, distance or addressing unmet needs for family planning all of which also have the potential to significantly reduce maternal mortality.

The review also indicates that women from poor households and lower castes faced more discrimination and nondignified care than their counterparts from the richer and higher castes. Thus, the more disadvantaged women are more vulnerable in terms of health status and poor maternal and child health (Jungari & Bomble, 2013; Jungari & Chauhan, 2017; Mohindra et al., 2006; Thorat & Neuman, 2012). Mistreatment of poor and lower caste women exacerbates their deprivation of institutional services. Therefore, efforts are necessary to mitigate discrimination and mistreatment during childbirth.

The caste system is deeply rooted in India which is reflected in the country's health systems where lower caste women suffer more than women from the general category. Mistreatment of women is frequent in both private- and public-sector facilities. Hence, interventions must focus on both sectors in India's health-care system to improve behavior with patients.

India's primary health-care facilities are burdened by the patient load. The number of health-care personnel is not sufficient to cater to the numbers. The lack of health personnel in India's health facilities, especially in government-run hospitals, places a burden on the available personnel. This suboptimal human resources situation, as well as lack of proper training, may be one reason for the disrespect or mistreatment of women in health facilities. Previous studies have also reported poor infrastructure, lack of training for health workers, and shortage of trained health professionals in the government health sector (Iyer, Sidney, Mehta, & Mavalankar, 2016; Mavalankar, 2016). Improving primary health-care services and training to enhance the sensitivity of health-care personnel and health workers will contribute to the reduction in patient mistreatment.

In addition, mistreatment of women during labor and childbirth is not properly defined because of which it is difficult to measure the numbers and severity of mistreatment. No uniform methods or scales are available in India that can measure its prevalence. Issues pertaining to the measurement of D&A during pregnancy are critical in many ways. The review shows that different studies have adopted several approaches—qualitative and quantitative—to study the phenomena of D&A during pregnancy. But no scales have been used to measure them (Sen et al., 2018; Sharma, Powell-Jackson, Haldar, Bradley, & Filippi, 2017), which is why measuring the nature of mistreatment in health facilities is sometimes challenging (Afulani, Diamond-Smith, Phillips, Singhal, & Sudhinaraset, 2018; Sen et al., 2018).

D&A of women at childbirth in India has not been extensively researched and comprehensively documented. Studies available in the public domain do not examine the concept of RMC in substantial detail. Thus, more research is needed to fully understand the issue. To provide respectful and nonabusive care during childbirth, health systems must be responsive to the specific needs of women at childbirth and provide care in a manner that ensures respect for their sexual, reproductive health, and human rights.

This review revealed that there is a lack of formal studies on the subject of RMC in the Indian context. Thus, there is a need for studies, qualitative as well as qualitative, to generate more robust evidence of mistreatment. Further, more studies were conducted in Northern Indian and hence future research must focus on India's southern parts to obtain a comprehensive understanding of the issues related to mistreatment and violence experienced by women during childbirth in health facilities. Future research should also seek to understand the views and experiences of women, their families, and health-care providers. Such an approach will significantly contribute to the development and implementation of appropriate interventions and policies.

Limitations of the Study

The review may not be an adequate representation of India because most studies included in it were conducted in North India. The results and findings of this review may be slightly biased toward the north Indian context. The situation of south Indian childbearing women may be different from that of the counterparts in north India. Further, the studies included in this review do not use the same definitions. Hence, the differences in the prevalence of mistreatment and abuse of women patients in health facilities may be attributable to the absence of uniform definition and understanding. Although the study used the Bowser and Hill framework to present the results, we used only the first dimension of the framework. Other dimensions, which explore the factors and consequences of D&A, were not considered in this study.

Conclusion

Verbal and physical abuse, lack of privacy and confidentiality, maltreatment, detainment in facilities, and negative and unfriendly staff attitudes are barriers to utilization of skilled delivery services. This systematic review presents analyzed data on an extensive range of disrespectful and abusive behaviors experienced by women during childbirth in India, as well as the contributing factors and consequences. Although the strength of the evidence is not robust, the factors influencing disrespectful and abusive conduct, which were revealed in this review, suggest that interventions for empowering women and educating them on their rights, and strengthening health systems to respond to the specific needs of women during childbirth are essential. The study also highlighted the need for health-care quality-improvement programs in India to address nonclinical aspects of care because women want to be treated humanely during their stay in health facilities. They expect respectful treatment, privacy, and emotional support. Therefore, it is necessary that training programs for health-care personnel include elements of interpersonal care and communication skills. In addition, implementing and enforcing policies on RMC are vital.

Raising awareness among health-care providers about the need to exhibit respectful attitudes and behavior toward women is important for increasing a woman's confidence in the quality of care and treatment that she will receive. She must expect the same degree of comfort and emotional support at a health facility as she would get in her home.

The findings of this review contribute to knowledge about the barriers to the utilization of health facilities for delivery. Understanding women's perceptions about good care and addressing them in quality assurance programs can not only bridge the supply and demand gap but also increase facility-based delivery by assuring safe, affordable, and respectful care. Further research is required to provide a more rigorous and evidence-based understanding of the issue of D&A of women that women in India experience during childbirth.

Implications for Policy, Practice, and Research

- The prevalence of disrespect and abuse in the health facilities during delivery has been evident. Women from lower socioeconomic background and lower caste women are affected most. Hence, policies must address the health-care provider's issues at both private and public health facilities.
- Training health-care providers about the respective maternity practices and creating awareness among pregnant women about the healthy practices will be practical strategy.
- Identify the various forms of violence and abuse experienced by pregnant and delivering women.
- Exploring the health-care providers (midwives, doctors, and clinicians) opinion and perception about violence taking place in the labor rooms.
- More research is needed to find the complex factors affecting the violence during delivery.
- Both qualitative and quantitative studies should be undertaken to examine the various dimension of disrespect and abuse in health facilities during delivery.

Author Contribution

All authors contributed equally to preparing the article.

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References

Afulani, P. A., Diamond-Smith, N., Phillips, B., Singhal, S., & Sudhinaraset, M. (2018). Validation of the person-centered maternity care scale in India. *Reproductive Health*, *15*, 147. doi:10.1186/s12978-018-0591-7

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-traumatic stress following childbirth: A meta-analysis and theoretical framework. *Psychological Medicine*, *46*, 1121–1134.

Ayers, S., Joseph, S., McKenzie-McHarg, K., Slade, P., & Wijma, K. (2008). Post-traumatic stress disorder following childbirth: Current issues and recommendations for future research. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*, 240–250.

Balakrishnan, S. S., & Khanna, R. (2016). *Dead women talking: A civil society report*. Delhi, India: Common Health and Jan Swasthya Abhiyan. Retrieved from http://www.commonhealth.in/Dead%20Women%20Talking%20full%20report%20final.pdf

Beck, C. T. (2006). Pentadic cartography: Mapping birth trauma narratives. *Qualitative Health Research*, *16*, 453–466. doi:10.1177/1049732305285968

Beck, C. T. (2018). The slippery slope of birth trauma. In M. Muzik & K. Rosenblum (Eds.), *Motherhood in the face of trauma* (pp. 55–67). Cham, Switzerland: Springer.

Bell, A. F., & Andersson, E. (2016). The birth experience and women's postnatal depression: A systematic review. *Midwifery*, *39*, 112–123. doi:10.1016/j.midw.2016.04.014

Bhattacharyya, S., Issac, A., Rajbangshi, P., Srivastava, A., & Avan, B. I. (2015). "Neither we are satisfied nor they"—Users and provider's perspective: A qualitative study of maternity care in secondary level public health facilities, Uttar Pradesh, India.

BMC Health Services Research, *15*, 421. doi:10.1186/s12913-015-1077-8

Bhattacharya, S., & Ravindran, T. S. (2018). Silent voices: Institutional disrespect and abuse during delivery among women of Varanasi district, northern India. *BMC Pregnancy and Childbirth*, *18*, 338. doi:10.1186/s12884-018-1970-3

Bhattacharyya, S., Srivastava, A., & Avan, B. I. (2013). Delivery should happen soon and my pain will be reduced: Understanding women's perception of good delivery care in India. *Global Health Action*, *6*, 22635. doi:10.3402/gha.v6i0.22635

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., … Javadi, D. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Medicine*, *12*, e1001847. Retrieved from https://doi.org/10.1371/journal.pmed.1001847

Bowser, D., & Hill, K. (2010). *Exploring evidence for disrespect and abuse in facility-based childbirth*. Boston, MA: USAID-TRAction Project, Harvard School of Public Health. Retrieved from https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf

Campbell, S. B., & Renshaw, K. D. (2016). Military couples and posttraumatic stress: Interpersonally based behaviors and cognitions as mechanisms of individual and couple distress. In S. MacDermid Wadsworth & D. S. Riggs (Eds.), *War and family life* (pp. 55–75). Cham, Switzerland: Springer.

Chattopadhyay, S., Mishra, A., & Jacob, S. (2017). 'Safe', yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India. *Culture, Health & Sexuality*, *20*, 815–829. doi:10.1080/13691058.2017.1384572

Chattopadhyay, S. (2018). The shifting axes of marginalities: the politics of identities shaping women's experiences during childbirth in Northeast India. *Reproductive Health Matters*, *26*, 62–69. doi:10.1080/09688080.2018.1502022

Dey, A., Shakya, H. B., Chandurkar, D., Kumar, S., Das, A. K., Anthony, J., … Raj, A. (2017). Discordance in self-report and observation data on mistreatment of women by providers during childbirth in Uttar Pradesh, India. *Reproductive Health*, *14*, 149. doi:10.1186/s12978-017-0409-z

Diamond-Smith, N., Sudhinaraset, M., Melo, J., & Murthy, N. (2016). The relationship between women's experiences of mistreatment at facilities during childbirth, types of support received and person providing the support in Lucknow, India. *Midwifery*, *40*, 114–123. doi:10.1016/j.midw.2016.06.014

Diamond-Smith, N., Treleaven, E., Murthy, N., & Sudhinaraset, M. (2017). Women's empowerment and experiences of mistreatment during childbirth in facilities in Lucknow, India: Results from a cross-sectional study. *BMC Pregnancy and Childbirth*, *17*, 335. doi:10.1186/s12884-017-1501-7

Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., Wagner, A. C., Vorstenbosch, V., & Monson, C. M. (2016). Partner accommodation moderates treatment outcomes for couple therapy for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *84*, 79.

Grekin, R., & O'Hara, M. W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review*, *34*, 389–401.

Haddad, S., Mohindra, K. S., Siekmans, K., Màk, G., & Narayana, D. (2012). "Health divide" between indigenous and non-indigenous populations in Kerala, India: Population based study. *BMC Public Health*, *12*, 390.

Halperin, O., Sarid, O., & Cwikel, J. (2015). The influence of childbirth experiences on women's postpartum traumatic stress symptoms: A comparison between Israeli Jewish and Arab women. *Midwifery*, *31*, 625–632.

Ishola, F., Owolabi, O., & Filippi, V. (2017). Disrespect and abuse of women during childbirth in Nigeria: A systematic review. *PLoS One*, *12*, e0174084. doi:10.1371/journal.pone.0174084

Iyer, V., Sidney, K., Mehta, R., & Mavalankar, D. (2016). Availability and provision of emergency obstetric care under a public–private partnership in three districts of Gujarat, India: Lessons for Universal Health Coverage. *BMJ Global Health*, *1*, e000019. doi:10.1136/bmjgh-2015-000019

Jha, P., Christensson, K., Svanberg, A. S., Larsson, M., Sharma, B., & Johansson, E. (2016). Cashless childbirth, but at a cost: A grounded theory study on quality of intrapartum care in public health facilities in India. *Midwifery*, *39*, 78–86. doi:10.1016/j.midw.2016.04.012

Jha, P., Larsson, M., Christensson, K., & Skoog Svanberg, A. (2017) Satisfaction with childbirth services provided in public health facilities: Results from a cross-sectional survey among postnatal women in Chhattisgarh, India. *Global Health Action*, *10*, 1386932. doi:10.1080/16549716.2017.1386932

Jungari, S., & Bomble, P. (2013). Caste-based social exclusion and health deprivation in India. *Journal of Exclusion Studies*, *3*, 84–91.

Jungari, S., & Chauhan, B. G. (2017). Caste, wealth and regional inequalities in health status of women and children in India. *Contemporary Voice of Dalit*, *9*, 87–100. doi:10.1177/2455328X17690644

International Institute for Population Sciences & ICF. (2017). National Family Health Survey (NFHS-4), 2015–16. Mumbai, India.

Mavalankar, D. (2016). Doctors for tribal areas: Issues and solutions. *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine*, *41*, 172. doi:10.4103/0970-0218.183587

McCourt, C., Rayment, J., Rance, S., & Sandall, J. (2016). Place of birth and concepts of wellbeing: An analysis from two ethnographic studies of midwifery units in England. *Anthropology in Action*, *23*, 17–29. doi:10.3167/aia.2016.230303

Melberg, A., Diallo, A. H., Ruano, A. L., Tylleskär, T., & Moland, K. M. (2016). Reflections on the unintended consequences of the promotion of institutional pregnancy and birth care in Burkina Faso. *PLoS One*, *11*, e0156503. doi:10.1371/journal.pone.0156503

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., … Manuelli, V. (2016). Beyond too little, too late and too much, too soon: A pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, *388*, 2176–2192. doi:10.1016/S0140-6736(16)31472-6

Mohindra, K. S., Haddad, S., & Narayana, D. (2006). Women's health in a rural community in Kerala, India: Do caste and socioeconomic position matter? *Journal of Epidemiology & Community Health*, *60*, 1020–1026. doi:10.1136/jech.2006.047647

Nilsson, C., & Lundgren, I. (2009). Women's lived experience of fear of childbirth. *Midwifery*, *25*, e1–e9. doi:10.1016/j.midw.2007.01.017

Raj, A., Dey, A., Boyce, S., Seth, A., Bora, S., Chandurkar, D., ... Ramakrishnan, A. (2017). Associations between mistreatment by a provider during childbirth and maternal health complications in Uttar Pradesh, India. *Maternal and Child Health Journal*, *21*, 1821–1833.

Registrar General of India. (2018). *Special Bulletin on maternal mortality in India: 2014-16*. New Delhi: Sample Registration System. Retrived from http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR%20Bulletin-2014-16.pdf

Sando, D., Abuya, T., Asefa, A., Banks, K. P., Freedman, L. P., Kujawski, S., ... Ugwu, E. O. (2017). Methods used in prevalence studies of disrespect and abuse during facility based childbirth: Lessons learned. *Reproductive Health*, *14*, 127. doi:10.1186/s12978-017-0389-z

Saxena, M., Srivastava, A., Dwivedi, P., & Bhattacharyya, S. (2018). Is quality of care during childbirth consistent from admission to discharge? A qualitative study of delivery care in Uttar Pradesh, India. *PLoS One*, *13*, e0204607. doi:10.1371/journal.pone.0204607

Sen, G., Reddy, B., & Iyer, A. (2018). Beyond measurement: The drivers of disrespect and abuse in obstetric care. *Reproductive Health Matters*, *26*, 6–18. doi:10.1080/09688080.2018.1508173

Seng, J. S., Low, L. K., Sperlich, M., Ronis, D. L., & Liberzon, I. (2011). Post-traumatic stress disorder, child abuse history, birthweight and gestational age: A prospective cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology*, *118*, 1329–1339.

Sharma, G., Powell-Jackson, T., Haldar, K., Bradley, J., & Filippi, V. (2017). Quality of routine essential care during childbirth: Clinical observations of uncomplicated births in Uttar Pradesh, India. *Environments*, *13*, 14. doi:10.2471/BLT.16.179291

Shakibazadeh, E., Namadian, M., Bohren, M. A., Vogel, J. P., Rashidian, A., Nogueira Pileggi, V., ... Souza, J. P. (2018). Respectful care during childbirth in health facilities globally: A qualitative evidence synthesis. *BJOG: An International Journal of Obstetrics & Gynaecology*, *125*, 932–942.

Slade, P. (2006). Towards a conceptual framework for understanding post-traumatic stress symptoms following childbirth and implications for further research. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*, 99–105.

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth*, *30*, 36–46. doi:10.1046/j.1523-536X.2003.00215.x

Sudhinaraset, M., Treleaven, E., Melo, J., Singh, K., & Diamond-Smith, N. (2016) Women's status and experiences of mistreatment during childbirth in Uttar Pradesh: A mixed methods study using cultural health capital theory. *BMC Pregnancy and Childbirth*, *16*, 332. doi:10.1186/s12884-016-1124-4

Thorat, S., & Neuman, K. S. (2012). *Blocked by caste: Economic discrimination in modern India*. Oxford, England: Oxford University Press.

Vart, P., Jaglan, A., & Shafique, K. (2015). Caste-based social inequalities and childhood anemia in India: Results from the National Family Health Survey (NFHS) 2005–2006. *BMC Public Health*, *15*, 537.

Waldenström, U., Hildingsson, I., Rubertsson, C., & Rådestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, *31*, 17–27. doi:10.1111/j.0730-7659.2004.0270.x

Warren, C., Njuki, R., Abuya, T., Ndwiga, C., Maingi, G., Serwanga, J., ... Olenja, J (2013) Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. *BMC Pregnancy and Childbirth*, *13*, 21. doi:10.1186/1471-2393-13-21

World Health Organization. (2014). *The prevention and elimination of disrespect and abuse during facility based childbirth: WHO statement*. Retrieved from http://www.who.int/reproductivehealth/topics/maternalperinatal/statement-childbirth/en/

World Health Organization. (2016). *Health in 2015: From MDGs, Millennium Development Goals to SDGS, sustainable development goals*. Retrieved from http://www.who.int/gho/publications/mdgs-sdgs/en/

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