

Why do some health care providers disrespect and abuse women during childbirth?

Kaveri Mayra¹, Zoë Matthews¹, Sabu S Padmadas¹

¹Global Health Research Institute, Department of Social Statistics and Demography, University of Southampton

Abstract

Background: Disrespect and abuse during childbirth can result in fear of childbirth.

Consequently, women may be discouraged to seek care, increasing the likelihood for women to choose elective cesarean section in order to avoid humiliation, postnatal depression and even maternal mortality. This study investigates the causes underlying mistreatment of women during childbirth by health care providers in India, where evidence of disrespect and abuse has been reported.

Methods: Qualitative research was undertaken involving 34 in-depth interviews with midwifery and nursing leaders from India who represent administration, advocacy, education, regulation, research and service provision at state and national levels. Data are analysed thematically with NVivo12. The analysis added value by bringing an international perspective from interviews with midwifery leaders from Switzerland and the United Kingdom.

Findings: The factors leading to disrespect and abuse of women relate to characteristics of both women and their midwives. Relevant woman-related attributes include her age, gender, physical appearance and education, extending to the social environment including her social status, family support, culture of abuse, myths around childbirth and sex-based discrimination. Midwife-related factors include gender, workload, medical hierarchy, bullying and powerlessness.

Discussion: The intersectionality of factors associated with mistreatment during childbirth operate at individual, infrastructural, social and policy levels for both the women and nurse-midwives, and these factors could exacerbate existing gender-based inequalities. Maternal health policies should address the complex interplay of these factors to ensure a positive birthing experience for women in India.

Conclusion: Maternal health interventions could improve by integrating women-centred protocols and monitoring measures to ensure respectful and dignified care during childbirth.

Key words: Midwifery and nursing leaders, respectful maternity care, disrespect and abuse during childbirth, obstetric violence, India

Statement of problem

Problem or issue	Evidence of mistreatment of women during labour and childbirth by maternal health care providers in institutional birthing environments in India and globally.
What is already known	Various typologies have been developed that categorise disrespect and abuse during childbirth. This issue is often addressed as 'mistreatment during childbirth' or 'disrespect and abuse of women during childbirth' or 'obstetric violence'. Researchers have made efforts to define each of these terminologies. Emerging studies have reported the impact of mistreatment during childbirth. Respectful care during childbirth has gained more attention in recent years as a key dimension of quality maternal health services. The absence of it is deemed a violation of the fundamental human rights of women.
What this paper adds	This study contributes to the evidence base by identifying the causes underlying mistreatment of women during childbirth, based on perceptions and experiences from midwifery and nursing leaders. As primary maternal health care provider, midwives and nurses have an in-depth understanding of these challenges and associated factors. This study highlights the unheard voices from senior midwifery and nursing leaders, which have implications for the provision of quality of care and positive birthing experiences for women.

1. Introduction

Disrespect and abuse of women during childbirth is a human rights violation and a recognised global phenomenon that may vary across different cultural and socio-economic settings. Sen et al. defines disrespect and abuse during childbirth as a violation of women's dignity and reflects on it from an intersectional angle, stating that race, ethnicity, economic status, marital status, disability, gender identity and sexual orientation may increase women's vulnerability to mistreatment ^[1]. Additionally, abusive and sexist comments that health workers make to women at the time of childbirth may be normalised, endured, and tolerated as part of low expectations around care at birth. Clearly such comments are disrespectful to birthing women. Intentional actions to harm women's health and wellbeing in this context are specifically referred to as abuse during childbirth ^[1]. Studies report evidence of a range of mistreatment globally from an absence of greeting on arrival, a common disrespect many women experience, to extreme forms of abuse including physical violence, reported from developing and developed countries alike ^[2-3].

In India, there is evidence of mistreatment during childbirth that include a violation of privacy, verbal, physical and sexual abuse, unconsented procedures, detainment and extortion ^[4-10]. Extreme forms of abuse include routine episiotomy without anaesthesia, hitting with a stick as punishment for soiling the bed, verbal abuse and neglect, as reported in a study conducted in the north-eastern state of Assam^[7]. A study in Uttar Pradesh reported vaginal examinations without any information or consent; physical violence in public hospitals; routine perineal shaving and denial of a birth companion in private hospitals^[9]. Bohren et al. present a detailed typology of mistreatment during childbirth with seven categories of abuse: 1) verbal; 2) physical; 3) sexual; 4) stigma and discrimination; 5) failure to meet professional standards of care; 6) poor rapport between women and providers and; 7) health system conditions and constraints^[11]. There is evidence of mistreatment under all these seven categories in India^[35]. Despite growing evidence on the prevalence and extent of disrespect and abuse during childbirth, the underlying reasons have not been systematically understood in the Indian context. These could be cultural, social or

health system-related factors that may explain why women are disrespected and abused during childbirth by their care providers.

Discriminatory health care provision on the basis of background characteristics, including gender, race, socio-economic status, is a violation of human rights^[12]. India is uniquely diverse in terms of class, caste, socio-economic status and religion. Social determinants of respectfulness in care around childbirth remains to be thoroughly understood in India, though there is evidence suggesting that quality of maternal health care is influenced by a woman's background characteristics in some contexts^[13-14]. Narratives of women state they receive treatment in the facility after the women from the upper caste have received care^[1]. Disrespectful comments by care providers often target women's physical appearance, socio-economic status, parity and age^[9]. In a recent study, untouchability and casteism were mentioned as reasons for poor care provider attitudes^[15]. Inequality leads to lack of access to information and decision making power which may in turn lead to poorer health outcomes. Along with caste and class, these include reproductive history, age, marital status and parity^[15]. A study done in India reported that the highest mistreatment scores were for women who were older than 35 years^[9]. Another study found that older women were more likely to report about mistreatment during childbirth including reporting requests for a bribe^[16]. Studies conducted in Jordan^[17], Ghana^[18] and Ethiopia^[19] also reported that uneducated and unemployed women were found more likely to be abused.

Between 2005 and 2016, India has seen an unprecedented increase in institutional births from 39% to 79%, yet there has been little improvement in the provision of quality maternal care services^[20]. Positioning nurse-midwives¹ in an independent midwifery role has become more important in such circumstances, because they are becoming the closest care provider

¹ India does not have an independent midwifery cadre as per the standards of International Confederation of Midwives. The Indian system of education enables practicing midwifery with nursing through a dual registration of registered midwives and registered nurses. Hence they are referred to as nurse-midwives in this study to acknowledge their dual role and absence of independent midwives in India.

that women come in contact with during pregnancy and childbirth. In India, every year, approximately 27 million births are reported, and of these, nurse-midwives attend one in four in rural areas and one in six in urban areas^[20]. There is a parallel increase in unnecessary medical interventions such as episiotomy, augmentation and cesarean sections (CS), in most states of India^[20]. The prevalence of CS at the national level is 17.2% in 2015-16, which is more than twice the level reported in 2005-06. It ranges from 5.7% in Nagaland to 58% in Telangana^[20]. Studies report that the increasing CS may be a result of financial motives in private sector hospitals^[20], which can also explain the variation in CS between public and private hospitals in both urban and rural areas. Mistreatment during childbirth may also lead to women choosing elective CS to avoid the humiliation they may have experienced in a previous vaginal birth or heard about from peers^[10].

Studies show that, globally, midwives face significant professional barriers because they are part of a profession dominated by women. Midwives have historically been compared with 'witches'^[21] and labelled 'half taught', 'totally ignorant'^[22] and blamed for negative birth outcomes. From a feminist perspective, this represents a double context of powerlessness attributed to social hierarchies for both women in their socially prescribed roles and nurse-midwives at a low level in the medical hierarchy^[23-25]. Furthermore, a lack of leadership opportunities among nurse-midwives in decision-making prevent them from advocating effectively for women in the provision of quality, respectful and dignified maternity care. Midwives argue that their role in care provision is unrecognised and they are often discriminated against and suppressed by physicians^[24-25]. Such challenges can lead to burnout, workplace harassment and bullying, causing care providers to show reduced empathy and compassion^[26-27] thereby increasing the care seekers' vulnerability to disrespect and abuse.

The literature suggests that poor working conditions leading to burnout in care providers may lead to poor maternal health outcomes^[26-28]. Midwives' work has been described as emotional work^[28]. The resulting depersonalisation, cynicism and detachment are used as coping mechanisms to deal with workload and job stressors^[26-27]. This is evident in many

aspects of care during childbirth that includes addressing women by the colour of their attire or bed number; that displays a lack of empathy when intentionally mistreating women during childbirth. Midwives report 'switching off' and putting on their 'masks' or 'happy faces' to appear dignified, which leads to emotional withdrawal and physical distancing from women they are caring for^[28]. They feel the need to 'don their emotional armour' which some refer to as 'surface action' or 'impression management', to be able to perform what the job requires,^[28-29] while inside they might be feeling like a 'food mixer'^[30]. Potential abuse of the midwife and a lack of opportunity for them to process the emotions in a job that involves dealing with vital events, such as births and deaths regularly, may add to women's vulnerability to mistreatment.

The 'What Women Want' survey asked women and girls globally their one key demand for improvement in maternal and reproductive health services and the top ranking demand from 1.2 million participants in 114 countries was respectful maternity care^[31]. The need for respectful care can be better understood by unravelling the underlying causes of disrespect and abuse during childbirth, which remain a key gap in the obstetric violence literature. Clearly, midwifery, nursing and medical students should be provided with education free of hierarchy, gender and status based differences, and they should be sufficiently mentored to provide care without any form of bias or discrimination. The abuse of hierarchy in medical education is a significant barrier to respectful maternity care^[5,12]. A recent study conducted in two tertiary level hospitals in Maharashtra, India looked specifically at structural violence through interviews with care providers and found normalisation of disrespect and abuse during childbirth and medical students engaging in such practices^[5]. Furthermore, respectful education, students observing respectful care and practicing it in their pre service-education is crucial, so that they are not conditioned to provide care that is disrespectful and abusive^[32-33]. Evidently, these underlying causes may be perceived differently by women (as care seekers) compared with the perceptions of midwives, nurses, doctors and other (as care providers)^[34]. This study bridges the gap by documenting the nurse-midwives care provider perspective by exploring the reasons behind mistreatment of women during childbirth in the context of India.

2. Methods

Our study participants are the nursing and midwifery leaders in India holding key leadership roles in the domains of education, administration, research, advocacy and service provision. Some of the selected participants represented more than one domain. These leaders have years of experience at the frontline providing care to women before taking various leadership positions. The selected leaders have reached a level of prominence in terms of their official position, (though in India, many of them have reported limited decision and policy-making power even at the highest attainable posts). They understand the challenges inherent in care provision and how these challenges may be tackled. The perceptions and experiences of these leaders are useful in developing practical solutions to ensure respectful care during childbirth in India.

We used qualitative methods to understand the reasons underlying disrespect and abuse from the care providers' perceptions. We selected participants through purposive and snowball sampling in five states in India, namely Bihar (BH), Rajasthan (RJ), Odisha (OD), Madhya Pradesh (MP) and West Bengal (WB) and at a national level (NL). These states represent diverse contexts with unfavourable maternal health indicators including high maternal mortality. The leaders were selected in three categories comprising the state level and the national level in India and a third category from other countries with advanced healthcare systems for a global policy making perspective.

In India, health is a state subject, therefore policy-making and governance is divided between the states and the centre. The states represent a wide range of health care contexts that are different in geography, culture and health outcomes, yet they share the similar health system infrastructure and face similar challenges. The selection of nurse-midwife leaders at a national level facilitates the understanding of the larger picture of health policy and governance structure in India. Additionally, we considered respondents in two other countries to gather an external perspective since mistreatment of women is of global concern. In-depth interviews were conducted among nurse-midwife leaders from two culturally different western settings: Switzerland and United Kingdom. These 'global' respondents have international experience, having worked in many countries including the

global south and north. Switzerland is the hub of the international development organisations that play a key role in global midwifery, nursing and health advocacy and governance. The United Kingdom has a multicultural society with over 14% Black, Asian and minority ethnic communities predominantly Indians and it represents a successful model of midwifery care and have made commendable progress in respectful maternity care.

2.1. Participant profile: Thirty-four participants were interviewed aged between 46 and 83 years with 24 to 60 years of general experience. All participants had previously received midwifery education except one who was a registered nurse, and 32 participants were registered as both a midwife and a nurse. Eleven participants had a PhD level qualification. Four male participants were interviewed in Rajasthan, which is one of the few states in India that provides midwifery education to male candidates. The remaining thirty participants were women.

The midwifery experience of participants ranged from 0 to 41 years. They were asked about the total number of vaginal births assisted including during their nursing-midwifery education. The responses ranged from 0 to approximately 40,000 births. Four of them assisted less than 25 vaginal births, even though it is an essential criteria of pre-service curriculum before registering as a midwife, and four of the respondents could not cite a number.

2.2. Study instruments: A semi-structured guide was used for in-depth interviews. The interview guide had three sections; 1) background information; 2) participant's role and responsibilities; and 3) perception of quality and respectfulness in care around childbirth. Given the sensitivity in discussing mistreatment of women during childbirth by care providers, an illustrated painting of a woman giving birth was used to initiate the conversation (Figure 1). The artwork was used with consent of the artist who is an Indian nurse-midwife. The theme and contents of the painting reflected the lead researcher's experience and observation of a childbirth in a public hospital setting in India.

The questionnaire was developed based on a literature review on disrespect and abuse of women during childbirth in multiple settings^[35]. The open-ended questions were aimed

toward understanding participants' reflection and judgement of the features covered on the painting. The guide further explored participants' perceptions of why some women experience mistreatment during childbirth, how that is related to care provider behaviour and what can be done to ensure respectful and dignified care during childbirth.

2.3. Ethics approval: The study sought full ethical approval from the Research Ethics Review Board of the University of Southampton (Reference No: 41164). All respondents were provided with a participant information sheet with details about the research, and they provided written consent to participate in the study. The interviews were audio recorded with consent. To ensure confidentiality, study respondents were anonymised in both the analysis and presentation of results.

2.4. Data collection: Data collection activities were conducted between July 2018 and January 2019. All interviews were conducted in person, except three which were conducted over a video call. The in-depth interviews were conducted in English by the female lead researcher, except in Hindi and Bengali for a few cases. The researcher is fluent in these three languages and is adept in qualitative data collection with over ten years experience. Participants provided written consent overall, and specific consent for audio recording. When participants did not consent to audio recording, notes were taken.

Participants were initially contacted by email with a request to take part in the study. The researcher has professional acquaintance with 11 of the 34 participants, prior to initiating the study. Most interviews were conducted in the participant's office or residence, and were free from any interruptions. However, interviews with participants representing regulatory bodies experienced some disruptions. Each interview lasted between 30 minutes and 1.5 hours. The interviewer's reflexive notes describe the interview environments. Participants were informed about the study objectives prior to the scheduled interview and of the researcher's qualifications and professional background. Nine prospective participants either refused to participate or dropped out from the study due to lack of time for the interview.

2.5. Data analysis: Data were analysed using thematic analysis ^[36]. The codebook consisted of apriori codes supplemented by deductive codes as analysis progressed. The initial codes were decided based on what made most analytic sense and appeared frequently across data. Further codes were generated based on code properties and refined using sub-codes. Qualitative data analysis software NVivo 12 was used to aid in analysis. Coding was undertaken by the lead researcher concurrently with data collection to identify emerging themes from the upcoming interviews.

3. Findings

The findings are presented under three sections. First, the midwifery and nursing leaders' reactions to the painting of a woman giving birth are presented. Second, an examination of their experience and perceptions of childbirth is presented along with the factors that make women vulnerable to mistreatment during childbirth. Third, recommendations are presented to inform policies for respectful care during childbirth in India.

3.1. Reaction to the painting of a woman giving birth

The participants from India used the words 'terrible', 'bad', 'wrong', 'not right', 'familiar', 'uncomfortable', 'stressful', 'not conducive', 'horrible', 'extreme disrespect and abuse' and 'concerning' to describe the painting (Figure 1). Here are responses from two participants who shared their perspectives of negative and positive aspects of care in the painting:

"...the position she is in, the woman is not comfortable. People around her are stressful... look at the strained faces around her. The environment is not conducive for her. This looks like a rural facility. In a hospital labour room so many people will not be around. The assistant, doctor and maximum 4 people will be around. Students will be allowed. A screen is lacking, for privacy. This looks like a private facility as situations are deteriorating in the private sector." (OD03)

"She (care provider) is massaging the uterus for contraction and to reduce the chance of PPH. This looks like PPH. She (labouring woman) must be unconscious, that is why the staff is pinching the thigh with forceps." (RJ01)

****Insert Figure 1****

Most respondents acknowledged observing aspects of disrespect and abuse in care during childbirth in the painting (Figure 1) although many confide they have not seen but have only heard about this from others. A few participants assumed that the painting is set in a private hospital, while others referred to a public tertiary hospital, but denied that nurse-midwives engage in such behaviour as seen in the following responses:

"Doctors engage in this kind of treatment" (NL01)

"Staff nurses' don't do that, only untrained dais (do)." (OD02)

Participants from other countries reflected how similar the situation seemed in many parts of the world. They find it 'horrifying' and 'shocking'. A participant also found it hard to believe that the labouring woman consented to have so many people around her when giving birth.

"...the women are not looking at her but at the baby. This woman is struck with horror... blood pouring from her. She is lying on a flat bed with no sheet... the fundal pressure is very hard... I see a woman who is being tortured! She is in grave pain and is screaming... there is one woman with her arm around her and she has her hand on her heart. It indicates some kind of compassion for the woman. But because of the system of the care and place, she is flat on her back, in the worst position possible without any comfort at the time of her life... this is a picture of extreme dehumanisation!". (GL07)

3.2. Factors behind disrespect and abuse of women during childbirth

Factors behind disrespect and abuse during childbirth related to characteristics of women are organised into a three level framework including individual, community and social

environment. Factors that relate to nurse-midwives, as identified by the study participants, were categorised into individual, structural and policy levels, in line with Freedman et al's [39] explanation of mistreatment during childbirth along with reference to the birthing environment. Figure 2, summarises these factors underlying disrespect and abuse of women during childbirth from midwifery leaders' perceptions, also highlighting the crosscutting nature of these factors.

Insert Figure 2

3.2.1. Woman-related factors

Woman-related factors have been organised into three levels: (i) individual, which includes personal attributes of women; (ii) community environment, the women's immediate context including home, the place of birth, neighbourhood and community; and (iii) social environment, the state women come from in India and their country. The differentiation between these levels is not just geographic but also in terms of context and impact that a certain factor has, that may cut across levels.

3.2.1.1. Individual attributes: Women's background and physical appearance could make them vulnerable to disrespect and abuse during childbirth. Age and parity are frequently stated reasons for predisposition to poor treatment as well. One respondent mentioned that women with four or more children are often verbally abused:

"What do you plan, to score a century?" (NL03)

A woman had come to the health care facility with her 16-year-old daughter, may have provoked the conversation suggesting that she should have stopped childbearing at a certain age:

"A multigravida should not come to a labour room so many times." (WB03)

Parity may be associated with religion. One respondent mentioned that it is common to have many children in some religions and cultures:

"Muslim women are multi para." (RJ04)

Other respondents said that older women inevitably hear judgemental comments for having too many children or having them too late. Young girls were subjected to derogatory comments for becoming pregnant at an early age.

Illiteracy increases a woman's vulnerability. According to respondents, judgemental comments about uneducated women having frequent births are common. A woman's cooperation during labour often depends on how educated she is. This has a strong influence on her knowledge and expectations for care around childbirth. Interestingly, many respondents assume that the onus is on the woman to communicate, and not the care provider on how to talk to women from different backgrounds. The difference in care provider and women's background can lead to mistreatment, which includes their language, religion, caste and culture.

Women's physical appearance is the first thing that the care providers notice. The way a woman dresses, smells, weighs, maintains her personal hygiene, including how her genitals appear may determine how she will be treated during childbirth. Obesity attracts judgemental comments. Women who present with poor personal hygiene, in visibly dirty clothes and smelling bad, are considered unpleasant to care for according to this participant:

"It is easy to abuse obese women. Personal hygiene is a factor too. They come with skin diseases at times. No one wants to touch them. They have to hear a lot of bad comments lying on the labour table... they do not bathe and we have to clean everything as the baby will be born in the unhygienic passage... wood sellers, coal sellers, Bihari women are very dirty. We do not care if one has shaved or not. Many mothers come after trimming. Looks like they have come straight from the parlour, freshly waxed. They get good care, we like touching them." (WB03)

3.2.1.2. Community attributes: Women's immediate environment includes her home, family and neighbourhood and the people she comes in routine contact with, who may share the same background, values and culture in the community.

Poverty increases women's vulnerability to disrespect and abuse. It is a cross cutting factor, which is associated to her caste and socio-economic status. Respondents opined that poor women have no option but to seek care in public hospitals. Many respondents commented that staff members have a tendency to ask for unofficial payments (bribe) from the family after birth. These can be learned from the following responses:

"She will have to listen to a lot of comments if she is poor. There is a lot of ignorance too. If someone is rich or from better income society, then every staff behaves very patiently and respectful maternity care pours out of them. They know how to do it, just depends on whether you are worthy of respect." (RJ04)

"This is the cultural construct of birthing in India which to me is where the issue is. When women accept that this is okay, that is what they will get. Women in India pass on this cultural construct as birth preparedness. When we think about abuse of women in health care, we need to be very clear that in societies where abuse is normal it's going to be very difficult to change that in a health environment. Do the people around her feel that its not okay to pinch, hit women giving birth?" (GL02)

The stereotype about Muslim women having more children is also a norm about birthing and contraception in some cultures, from the participant's point of view.

3.2.1.3. Social environment: Being a woman increases her vulnerability especially if she is uneducated, poor, not appearing a certain desirable way, old or young, married or not. The way she is treated by care providers in the labour room while giving birth is an indication of how the society and her family values and treats her. This shapes her expectations, as she is conditioned to be treated in a particular way, with a certain level of respectfulness. Whether she asks questions or communicates with care providers and the response she receives, depends on how she is conditioned to be treated. This is a result of gender discrimination,

which begins at birth. The birth of a boy raises expectations for a bigger bribe for care providers. The birth of a girl often leads to verbal abuse and discrimination for the new mother. The way a woman giving birth experiences being valued or not in general, is often how she expects to be valued in the labour room by care providers. Gender is a cross-cutting issue which can be seen at the individual level, in the community and the social environment as illustrated by this participant:

"Globally, women are of low status, not treated with respect or regarded as equal citizens, not valued. Little girls grow up thinking she is not as important as her brother, not likely to get educated, not encouraged to question. Women accept their lower place in the society. When they come to give birth, many of them did not choose to be pregnant, they did not have access to birth control. Married off very young. Arranged marriages, child brides. These all take away their empowerment. You find it difficult to stand up for yourself. When she is in labour, the last thing you want is fighting for yourself. You are so caught up in the psychological process that is happening, that makes you vulnerable as well." (GL05)

3.2.2. Nurse-midwife related factors

The nurse-midwife related factors have been organised into three levels: (i) individual, includes personal and professional attributes; (ii) the birthing environment, includes the birthing room ('labour room') or at home or any room where women give birth; and (iii) the policy environment, includes policies that determine the quality of care and service provision.

3.2.2.1. Individual factors: Participants felt that workload often made the nurse-midwives angry and frustrated, as they are overburdened. One participant reports that in her hospital births have increased from 400 to 1000 per month over the last few years, but the number of staff remains the same. Participants share about the workload and its associated impact in the following responses:

"We have 1 nurse for 100 patients, that is why this happens. Workload!" (OD02)

"Staff's confidence breaks as soon as they see the crowd. They worry how to provide care to so many." (RJ06)

"We used to give more psychological support back then." (OD03)

Respondents feel that the lack of promotions and stagnant salary is demotivating. The added workload without incentives makes them feel under-appreciated, under-valued and discriminated, as stated here:

"Nurse-midwives' are not getting enough salary, recognition. No one checks on us." (NL01)

"...they are discriminated with other professions. Physiotherapists and pharmacists are all going up (in their career) and nursing is going down." (OD03).

"...since Roman times women were not respected and then Christianity came in and women started being disrespected, which increased as the male medical model slowly installed itself into the profession. One time nurses and midwives were being held as witches. Its like a trail of under- representation that leads to disrespect and abuse of women and midwives. This increased in the 80's and 90's as the male medical model marginalised midwives." (GL06)

Working conditions are often demotivating in a hierarchical and patriarchal structure where doctors have better facilities than nurse-midwives. Such discrimination leaves nurse-midwives powerless and taken for granted. One respondent felt that learned helplessness is an outcome of this continued oppression, which makes nurse-midwives' powerless to bring any changes in the system. Being voiceless in planning care provision leads to an assertion of power over women who are further down in the social hierarchy as this participant shared:

"They take these women for granted. They feel I am taking care of you and I have this power over you to provide care to you, so you have to listen to me. This is my territory and you are bound to listen to me." (WB02)

Many respondents mentioned that nurse-midwives are often bullied by doctors. With the lack of a supervisor who is a nurse-midwife, the doctor as the head of the institution overpowers everyone, leading to mismanagement of midwifery and nursing services. Nurse-midwives are ill-treated; and their welfare and working environment not considered. A participant from Bihar highlighted this:

"Gynae ward does not have toilet, so if the nurses go to a different ward to use the toilet and the doctor comes for a round in that time... marks her absent for the day. Sometimes we quietly use the toilet in the cabin when no one's watching. We are not respected. The medical superintendent does not respect us." (BH01)

Stakeholders explain that the nurse-midwives' work involves dealing with birth and deaths. Due to an increasing workload, they have less time to communicate with women. There is frustration from being overburdened and no time to process emotions related to vital events such as births and deaths, as this participant shared:

"They do not get attached. They call them by bed number or colour of saree." (RJ04)

3.2.2.2. Birthing environment: Participants mentioned the lack of infrastructure as an intervening factor in the birthing environment that is disrespectful to women. Screens are important to maintain privacy during childbirth. Lack of injectable anaesthetics and analgesics adds to a disrespectful birthing experience. Women endure more pain and undergo an episiotomy and repair without anaesthesia. The cleanliness of the labour room is an issue, resulting women birthing in unhygienic environment. The preference to care providers comfort is shared by this participant by describing the labour table:

"The doctors are tall, so their height needs to be considered, hence the labour table is so tall." (BH02)

The 'team culture' includes how care providers collectively perceive respectful care based on existing work-place norms. This makes certain practices and even extents of disrespect and

abuse during childbirth acceptable, thus adding to normalisation of mistreatment during childbirth. This is reflected in the following participant's perception of privacy:

"There are 12 labour tables in the labour room separated by curtains. We don't let men enter, so the privacy is protected. Then it is all women present." (RJ01)

Extortion seems a part of team culture. The money gets divided in the whole team even though the non-health care providers, such as cleaners, are at the forefront of asking for it. There are many unethical practices that are part of the team culture, including augmentation of labour.

"They will scream 'push, push' if their duty is ending at 1:45 pm. They will make sure the woman gives birth within one's duty time (shift) so that care providers get the money... so they will induce with oxytocin sometimes." (RJ04)

Task shifting between care providers at different levels of care is based on the hierarchy of care providers, which stems from the centralisation of power and mismanagement of the increasing workload. Respondents share examples of systematic shifting of duties from doctors, which is not a part of nurse-midwives' role followed by nurse-midwives' transferring their role in assisting births, to non-health care workers such as Mamta², Accredited Social Health Activists (ASHA) and traditional *dai*:

"He (medical superintendent) is running the hospital in any way he wants. Nurse-midwives' are posted in non-nursing roles even with an existing shortage. There are nurse-midwives' posted in fire extinguishing department. Six nurses ready in their uniform, two for each shift. They are not involved in patient care anymore. Ten nurses are working in pharmacy distributing drugs while the pharmacists chill in a room. Nurses are working in pathology while technicians are roaming free. The telephone control room is run by nurses and so is the reception and housekeeping. The nurse patient ratio is 1:50-75." (BH01)

² Mamta is a non-health care provider who provides counseling to women on breastfeeding and the importance of cleanliness after women give birth in an institution in Bihar. She also maintains cleanliness in the labour room and receives incentives for her work.

Stakeholders describe that with increasing level of care provision, mistreatment of women during childbirth increases. Women are more vulnerable to be mistreated at a tertiary level of care provision than at a primary or secondary level. This is related to many factors, for instance, workload increases at a higher level of care, reducing interaction time between women and health care provider and increasing workload related frustration. Many stakeholders feel that doctors at tertiary level are engaged in more severe forms of abuse. Being further up in the level of care provision also means that women are not known to anyone in the team of care where experiences are more medicalised than at a lower level of care. The tertiary level includes teaching hospitals and often women become subjects of case discussion as part of the medical education system as the following participant noted:

"Everyone looks at her as someone you can perform cases on. They see that this is a case in my logbook... they want to give an episiotomy so one can get an episiotomy repair done and write about it in logbook." (NL04)

Mistreatment of women often stems from a lack of compassionate leadership at the centre of the management system and hierarchy which also influences the team culture:

"Its like a ripple in the pond. You have got an abusive person at the centre of that. The person who is abusive in nature, may be of psychopathic tendencies. The person at the centre becomes powerful and in order to maintain that power builds relationships and slowly people change their behaviour to fit into that way of being. The longer that person is able to stay in one place (centre) the culture (of abuse) grows stronger." (GL06)

A participant in India called this a '*domino effect*' where one care provider learns to abuse from another in a team culture and this peer influence slowly turns everyone into an abuser.

3.2.2.3. Policy environment: Some national policies indirectly contribute to a disrespectful birthing experience. The Janani Suraksha Yojana (JSY) that incentivises women for giving birth in an institution and incentivises the community based motivators called ASHAs, was

criticised by participants as a policy which is insensitive. It does not uphold women's rights or facilitate their choices and decision making about childbirth:

"It makes no sense to have a government policy to move women to hospitals when the hospitals treat them so badly. The response will be 'oh but you should see how they are treated (at home) in India, at least they get food in the hospital'." (GL07)

Participants also identified that dehumanisation of women begins in the pre-service education as a learned behaviour where the medical, nursing and midwifery students imbibe how the care providers deal with the women. Mistreatment of women during birth has been a norm which normalises it thereby reducing the importance of this problem. A participant shared that this has only been recognised in recent times:

"I have seen the Head of the Department verbally abuse in around 1977-78. They are not properly educated. The government did not care back then about respectfulness as they are enforcing it now." (WB01)

Birthing is explained as '*dirty work*' by a participant (GL03) as birth work stems from unpaid women's work, it may have a negative impact on the profession which further entrenches medical domination of midwifery, nursing and birthing.

The provider-client ratio needs to be maintained to ensure respectful care. Under-recruitment of health care providers is an indicator of lack of women centred policies. It is common in hospitals to rotate nurse-midwives, respondents perceive this practice as discouraging and deterrent to maintain midwifery and nursing skills. The amount of documentation work is an additional burden that takes over direct care provision as participant WB05 shared:

"We are engaged in multiple things, a staff nurse in the labour room can not maintain care and quality service, they just can not. Such a huge log book they have to fill. So many records to maintain. How will she conduct so many deliveries? 1:1 ratio is required for assisting births... tertiary level staff just does paperwork." (WB05)

3.3. Participant's recommendations for respectful maternity care

Participants' recommendations were context-specific and based on best practices. Preventing disrespect and abuse during childbirth and promoting respectful maternity is a deep rooted, omnipresent problem which requires a paradigm shift in culture to address challenges at various level. Participants suggest that women and nurse-midwives' should be involved in policy making as two key stakeholders in maternal health care.

"It's about really strong partnerships." (GL03)

Participants suggested a multi-sector approach to involve stakeholders from community and health systems for a lasting impact. They indicate the need to decentralise power from the medical model of care to make care provision inclusive. Collaboration with women's rights organisations and, nursing and midwifery associations will increase accountability. Global international organisations have a role in advocacy, setting standards and funding initiatives with a sustainable approach. These recommendations are summarised in a framework of midwifery model for women centred-care (Figure 3), in line with the levels discussed for the factors of mistreatment during childbirth.

Insert Figure 3

Level 1- Midwifery model for women centred care: It is imperative to hear women's expectations and experiences of care to understand what is respectful and good quality care for them, to ensure a woman centred positive birthing experience:

"The voice of people is one of the biggest motives behind change... you can regulate that there has to be a woman in the discussion but they will find a thousand ways around to not to adhere to that. In changing values and norms of societies, not much changes. Women need to stand up and say 'I need respectful care'. Those are the ways to make change happen." (GL01)

Participants felt that information sharing and counselling should begin in the antenatal period, to help pregnant women understand the process of birthing and explain procedures beforehand. They also felt it is difficult to communicate many things while a woman is in labour. Procedures need to be explained to gain women's trust. Continued communication and psychological support during childbirth is considered of utmost importance as this participant recommended:

"...tell them how much it will hurt. The number of hours it will take. We should tell them before vaginal examination and when starting fluids to increase pain." (RJ01)

Midwifery and nursing is considered emotional work and participants felt it is important for care providers to take time out for themselves and take care of their wellbeing.

"...taking time to get a good work life balance. Doing what they enjoy, switching off from workplace, getting support from colleagues. Getting a perspective and being aware of oneself." (GL03)

The role of nurses and midwives is recommended to be envisioned as advocates for women's right for quality and respectful care. This will include standing against mistreatment of women during birth in their facility and finding innovative ways to prevent it.

Level 2- Individual and team culture for ideal birthing environment: Care providers' perceptions of quality and respectfulness in maternity care need to align with women's perceptions and needs.

"We look at India and see women in beautiful sarees in rural areas and feel everything is fine. One has to look beyond that and see what they feel, what they need, what they want and serve them well." (GL02)

To ensure an appropriate health care team behaviour towards women, it is necessary to make efforts to improve the team's attitude. Being respectful towards each other in the team regardless of gender and profession is recommended:

"The team needs to be trained together!" (WB04)

"Facilities need to improve their collective behaviour." (WB03)

The need for respectful communication is strongly recommended. Respondents felt that care providers could be educated in how to communicate with women as they feel that *'their words can hurt'*.

Changes are needed at the primary, secondary and tertiary level of care, which can be different based on the issues that exist at each level of care. Infrastructural availability and workload distribution need to be ensured for an ideal birthing environment.

Home birth is suggested by many respondents, along with the scaling up of home-based care. A participant felt there is a lesser cultural difference between the care provider and woman when care is home-based, and family members get involved as birth companions, making birthing more culturally acceptable and satisfying. Participants referred to home as an ideal birth environment as due to the privacy and comfort it provides which also aids in the release of essential hormones:

"Let's just change the physical environment, its not that difficult to do. It will have privacy. Does not need a bed. Lot of women do not need a bed. They want to birth standing up, on a mat, sitting down, on a little chair. They want it clean... and warm..." (GL02)

"Ideal birthing environment is the environment for love making. Both psychological activities release oxytocin and endorphin on stimulation and obstructed when in fear, embarrassed or in doubt." (WB03)

Level 3- Compassionate nursing and midwifery leadership: Midwifery and nursing leadership is considered key to ensure that midwifery model of care is implemented in India. Participants strongly felt the need for one-to-one midwifery care for women. Advanced care is needed in the event of complications.

"Midwifery model of care is in conflict between trying to balance care based on institutional hierarchies, where you are accepted to intervene and if you do not, then you are professionally in trouble." (GL03)

The tertiary level of care, including teaching hospitals responsible for education of care providers, needs to adopt measures that comprise of respectful maternity care where medical, midwifery and nursing students can learn and practice. It is important for students to imbibe values of respectfulness in their behaviour starting in their pre-service education. The student nurse-midwives often suffer the consequences of being at the bottom of the medical hierarchy. Medical students were often prioritised for practice opportunities in teaching hospital, whereas nursing and midwifery students do not get a chance. The student nurse-midwives are often treated disrespectfully. Respectful communication is encouraged for every interaction with the students, even when they make mistakes and the way tasks are delegated to students need to change, as shared by these participants:

"...the teachers should be compassionate to the students. I am shocked sometimes to see in the global work how the midwifery students are treated... the hierarchy is knock on. Everybody is abusing the other who is lower in status than them... we need deep cultural change." (GL05)

"The actual relationship between the clinical instructor and the student should be respectful." (NL02)

Midwives and nurses, when empowered, can take up leadership roles and participate in decision making at every level. Midwifery and nursing supervisors can realistically plan care and manage midwives and nurses. A participant felt that compassionate leadership at the

centre could positively influence the team towards respectful behaviour, as a ripple effect, but it depends on the kind of leadership at the centre.

Level 4- Policy Reforms and Regulation: Participants recommend workplace policies to have compassionate leadership by influencing norms in the workplace that could foster respectful care and policies that govern care provision in the states and country. Many participants recommend addressing the increasing workload by implementing a 1:1 ratio for nurse-midwife and women, which will directly influence care provision for the better. Proper management of workforce and nursing and midwifery leadership is essential to mobilising change.

Regulatory bodies have a key role to play in education, practice, maintaining standards of care and upholding professions. Regulatory bodies need to make changes to discourage the individual and infrastructural disrespect and abuse of women during childbirth by setting standards.

“Indian Nursing Council should provide best examples, showcasing what it looks like to have safe birth. SNCs (State Nursing Council) are members of INC (Indian Nursing Council) and can do it in their own states.” (GL02)

Leaders have divided opinions on whether there should be regulatory reforms to address mistreatment during childbirth. They felt that penalising care providers is not a solution, as they themselves are subjected to harsh working conditions and insensitive workforce policies. They discouraged any kind of intentional disrespectful and abusive behaviour within care provider team and towards the birthing women, and called for a zero tolerance to intentional abuse of women by health care providers. They further opined that non-health care providers should not be allowed to assist births.

4. Discussion

The midwifery and nursing leaders perceived that the painting (Figure 1) depicted the manner in which a woman is being disrespected and abused during childbirth. They pointed

out many unacceptable actions from the people around the birthing woman, in her birthing environment. A difference is noticed in the perception of participants from India and elsewhere in terms of perceiving the severity of mistreatment that the woman in the picture is subjected to. This could be due to the difference in people's conditioning and exposure to the culture of violence, progress in the discussions about mistreatment, the level of efforts made to ensure respectful care and women's varied expectation of quality and respectful care in different contexts and countries that the participants come from. Indian participants' perspectives convey normalisation of mistreatment to an extent where, unless the act of abuse is extreme, it is side-lined. A participant from India even perceived that the picture shows good quality care while another felt some amount of shouting at the woman during childbirth is completely justifiable, as women are unable to hear through the pain and follow the instructions during childbirth. This could equally be fuelled by the lower expectations of women and the conditioning around birth where a live baby and live woman are considered good enough outcomes of childbirth^[37].

WHO guidelines for intrapartum care mention four new recommendations for a positive birthing experience: 1) respectful maternity care; 2) effective communication; 3) companionship during labour and childbirth and 4) continuity of care^[38]. All the factors discussed in this paper should be addressed to ensure that care is provided under these four recommendations. Freedman et al. discussed individual, structural and policy levels in their understanding of mistreatment of women during childbirth^[39]. The factors shared by midwifery and nursing leaders in this study are grouped into similar levels separately for the care-receiving woman and the care providers, mainly nurse-midwives. The findings also suggest that mistreatment at birth is often due to an intersection of various factors at different levels that make a woman vulnerable to face multiple forms of disrespect and abuse during childbirth^[1].

The nursing and midwifery workforce faces numerous gender-based and hierarchical challenges that impede their leadership and decision making power^[23, 40-41]. The social, economic and professional challenges lead to moral distress and burnout^[26-27]. Nurse-

midwives' challenges such as unsafe working conditions, lack of promotion, poor and delayed salaries, long working hours and lack of supervision are well documented^[24-26]. However, using nurse-midwives for fire extinguishing services, is a definite new low. It is clear from the responses that nursing and midwifery leaders understand the challenge, and strongly favour reformative changes with multi sector collaboration through administration, regulation, advocacy, research and service provision. Currently, participants representing the education sector have no flexibility and little influence, without a supportive regulatory framework^[42]. They also have limited power to make any change in the hospitals where the midwifery and nursing students practice^[23,42].

A midwifery model of care is crucial to ensuring respectful maternity care, which would be a cultural shift from the medical model of care, that led to over-medicalisation of birth and has normalised mistreatment during birth^[43-44]. This now seems possible, with India making strides to start midwifery in the country when efforts should be made to increase accountability for respectful maternity care towards women ^[45-47].

The health system management generally expects nurse-midwives to be 'super nurses' by providing them less than ideal work conditions while demanding good quality care. Policies come with an additional workload without increasing workforce, which leads to unmanageable fatigue^[27,48], as seen in the narratives (in section 3.2.2.3). The nurse-midwives' themselves are victims of poor workforce and health system policies, institutional mismanagement and hierarchy^[32,49].

The policy environment is crucial to ensure long term changes. Though respectful maternity care (RMC) is mentioned in the labour room quality improvement initiative guidelines in India, known as LAQSHYA, the content is not robust enough to ensure respectful birthing environment to women^[50]. Studies suggest that existing policies or initiatives targeted at improving maternal health care delivery, such as the JSY, are not underpinned by the essential infrastructure^[51] to encourage respectful care and continuity of care. It is essential

to call out actions of disrespect and abuse and instate respectful care specifically to make it a norm^[49]. Recent studies have presented knowledge, skills and behaviours for midwives for respectful care that can be contextualised and adapted for India^[37, 52] and be implemented with continued in-service education, improving the birthing infrastructure and bringing in policy reforms^[32, 53].

Being a woman increases one's vulnerability to any kind of violence and victimisation^[54] and the patriarchal culture increases this vulnerability to be mistreated during childbirth. Women's priorities are considered secondary, which ensure that the limited reports of mistreatment shared by them fall to deaf ears^[55]. Women themselves may be blamed for poor birth outcomes and in some cultures the birth of a girl child is considered an undesirable outcome^[56]. Rules and regulations determine women's agency over their bodies and this control usually results in disempowerment^[57]. Any resistance is considered 'misbehaviour' and meted with 'punishment'. Women are expected to quietly endure the labour pains. Screaming or crying violates the social norms and calls for punishment in terms of scolding and many other forms of mistreatment during childbirth to discipline her body^[57,1]. The control of the female body during childbirth in a hospital setting is a reflection of how society is conditioned to treat women at home, in the community and in general^[1]. The Indian participants did not mention gender as a factor, though there are some references to poor status and lack of women's awareness determining respectful care. Respondents shared that very few women ask questions to the care provider, and may receive a rude response even to simple questions, such as the duration of labour.

It is clear from this study that midwives and nurses have an in-depth understanding of the factors underlying mistreatment of women and can collaborate in bringing changes through advocacy, administration, education, regulation and service provision. This is the key strength of this study. These findings can be strengthened by understanding the experiences of direct midwifery care providers who are serving at the frontline to further understand the challenges that care providers face routinely in direct care provision including at the current time where newer forms of mistreatment and an increase of obstetric violence is being

reported as a result of the COVID-19 pandemic ^[58-59]. This adds to the disadvantage along with the intersectionality of women's many attributes that gives rise to gender-based inequalities, increasing women's vulnerability to abusive behaviour^[60]. Collaborative efforts are required to ensure all the factors at the three levels are addressed for lasting changes, while keeping women and their midwives in the centre of the efforts and as key stakeholders.

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Figures



Figure 1: Flash card showing a birthing environment in India

(Source courtesy: Art work by S. Karmakar; lead researcher sought consent to use the image for research and publication purposes)

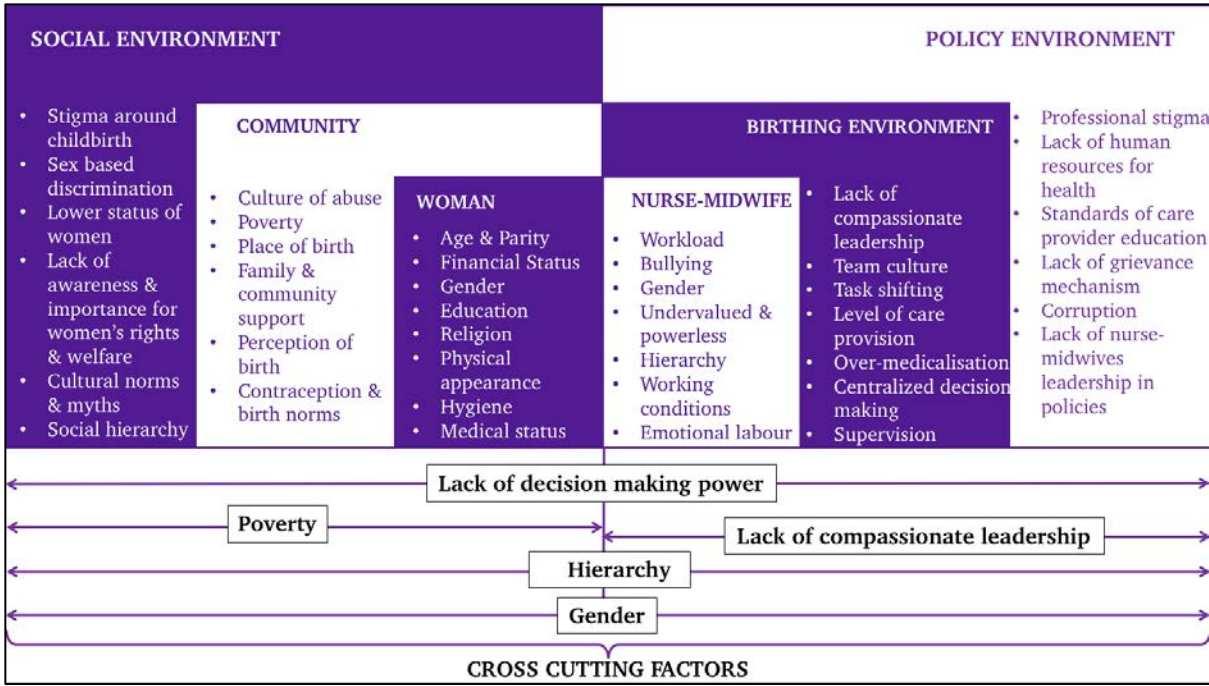


Figure 2: Factors influencing disrespect and abuse of women during childbirth (Authors' original)

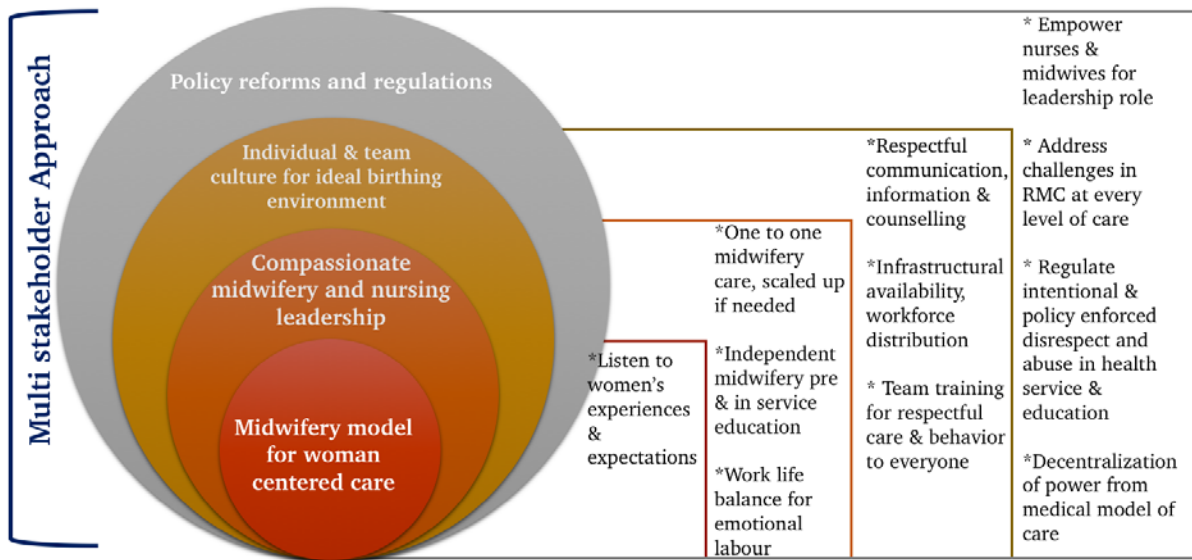


Figure 3: Recommendations for respectful maternity care (RMC) in India

(Authors' original)

