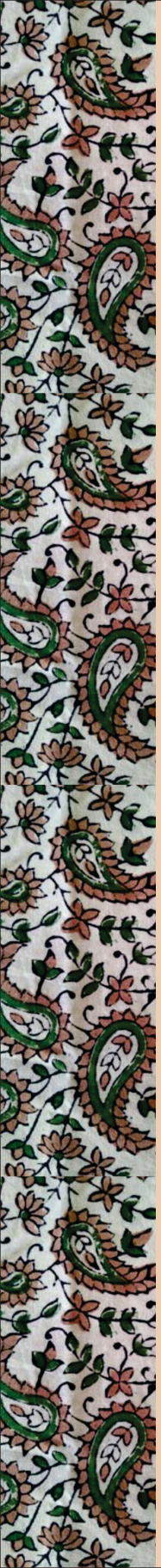

MISTREATMENT OF WOMEN IN LABOUR ROOMS

PERCEPTIONS OF HEALTHCARE PROVIDERS

Durga A. Vernekar & Sangeeta Rege

Cehat

Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

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Preface

India has made huge progress in terms of achieving MDGs in maternal health. Seeing the current progress, we will be able to achieve SDG targets in relation to maternal mortality ratio earlier than 2030. WHO has highlighted that it is important not only to provide the provision of care but also the experience of care to pregnant women. In this direction, a number of steps are being taken, and one of the interventions that has been developed is the layout design of the "Labour room". It has been advocated that the lay out design to be labour delivery recovery (LDR) and under it labour birthing bed is being promoted instead of labour table.

Laqshya guidelines issued by Government of India comprise key component- "Respectful maternity care" (RMC). In this direction allowing "birth companions" in the labour room has already been initiated. A few medical colleges in India have already introduced the choice of birthing positions for women in labour. Lately, midwifery has also been implemented. While RMC has drawn attention of all HCP; the support from the fraternity has been lukewarm. As we move forward to reduce the MMR to a level of developed countries, these interventions will be crucial. Some of the skills lacking in current health care workers are communication skills, and how to manage a unit efficiently. All out efforts should be made to address these issues. HCP should be recruited who have the requisite skill. Continuous capacity building of health care workers through the basic skill labs & advanced skill labs is the need of the hour.

The research study "Mistreatment of women in labour-Perceptions of Health care Providers" outlines key issues related to information asymmetry and dearth of communication by health providers with those seeking care. I am glad to note the good practices of Hospital B and how they have established protocols for RMC. This study also shows that one of the Hospitals had implemented it effectively with the given infrastructure and personnel.

Under Laqshya there is also a provision of supplementing the Human resources. All high case load facilities should do a detailed study on the requirement of Human resources required in Labour rooms. In this Covid-19 time Triage has become a norm. Triaging of women in labour has to be uniformly implemented across all health facilities conducting deliveries.

At the academic level, I recommend inclusion of Respectful Maternity Care (RMC) as a chapter in undergraduate curriculum of both nurses and doctors. This has already been included in the Midwifery curriculum. While progress has been made, I sense some reluctance with regard to introduction of the birth companion intervention. I must emphasise here that the birth companion should be identified during the antenatal period, and should be trained well so that they are able to provide relief to the woman in labour. I must reiterate that the RMC is a behaviour change and will be a long drawn process and should be supported by evidence-building studies every 2-3 years to monitor its progress.

Lastly, I must compliment CEHAT for carrying out a study on perceptions of Health care providers towards labour room mistreatment of women in labour. Majority of the studies in India are from the beneficiary point of view. This study has been from the providers' point of view. The study should be widely disseminated, so that health staff across the hospitals can learn from it and improve their behavior. We know from evidence that a woman who comes to our facility for delivery once does not want to revisit the facility given her experience of birthing. It is time we collectively work to change these perceptions of women, so that every woman is able to receive high quality of care & can have a positive child birth experience.

Dr. Dinesh Baswal
Former Joint Commissioner
Maternal Health Govt. of India Health and Family Welfare

Executive Summary

There is mounting evidence, both globally and in India, of mistreatment of women at the time of childbirth in health facilities. This comprises physical abuse, non-consented care, non-confidential care (including denial of privacy), non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities or financial abuse. These forms of mistreatment also constitute human rights violations of women in labour, with the World Health Organization in 2014 releasing a statement calling for prevention and elimination of disrespect and abuse during childbirth. Numerous studies exploring this phenomenon have been carried out globally. Most of these are prevalence studies, and have predominantly been carried out with women who have self-reported facing abuse in health facilities during childbirth, and are facility-based studies largely using the survey method. There are scant Indian studies examining disrespect and abuse of women during childbirth, and there are no Indian studies examining healthcare providers' perceptions of mistreatment occurring in labour rooms. The present study aimed to understand healthcare providers' perceptions of behaviours constituting disrespect and abuse in labour rooms, and to document their recommendations to prevent and stop disrespect and abuse in labour rooms.

A qualitative approach to enquiry was adopted wherein in-depth interviews were conducted with 18 healthcare providers from two public health facilities in Maharashtra, India. Hospital A is one of the hospitals which has a crisis intervention centre to respond to violence against women, the presence of which could assist in changing labour room practices. Hospital B was known to have recently initiated practices to inculcate respectful maternity care, exploring which could inform efforts to transform labour room practices. Healthcare providers from three cadres: doctors, nurses, and class-four workers (i.e. the hospital orderlies) were selected as respondents so as to elicit the unique experiences and perspectives of the different cadres. Participants were asked questions about their work profile and training, perceptions and practices of privacy, confidentiality and consent-taking,

perceptions of mistreatment in labour rooms, perceptions and practices of the birth companion policy and offering different birth positions, recommendations to prevent violence in labour rooms, and implementation of respectful maternity care practices (for Hospital B).

Key findings

- Providers dismissed the importance of maintaining privacy stating that it is only women inside the labour room besides doctors and nurses.

- The practice of highlighting the sero-status of a woman on the OPD file was common as that was the procedure for informing HCPs who may come into contact with her. Universal precautions for dealing with HIV positive pregnant women were understood as wearing complete protective gear only when attending to seropositive women.

- While "informed consent" was acknowledged as an important practice by all respondents, it was not implemented in its spirit; especially with regard to contraceptive counselling and decisions related to procedures such as C-sections, deliveries using forceps, and so on.

- A commonly expressed sentiment was that of socioeconomic backgrounds of women playing a role in their failure to plan pregnancies; biases were held particularly against multiparous women and women belonging to religious minorities.

- Healthcare providers unanimously rejected the term "labour room violence" and justified acts such as restraining the woman, shouting at and scolding her, as a necessity for better birth outcomes.

- Respondents stated being helpless when women displayed "un-cooperative" behaviours, i.e. not bearing down adequately during labour, walking around when in active labour, acting dramatic, and even lying about their medical histories.

- None of the respondents were aware of the LaQshya Guidelines released by the Indian government aimed at reducing maternal and newborn mortality morbidity, which also comprises a section on the provision of respectful maternity care.

- Healthcare providers cited infrastructural shortages, lack of training, and lack of patient-education as challenges giving rise to adverse interactions at the time of childbirth.

- The study also documented institutionalisation of respectful maternity care practice under an able leadership of the Head of Department and support of a medical college, indicating that champions from within the hospital can effectively bring about change when motivated to do so.

1. Introduction

The period of childbirth places women at a particular vulnerability (WHO, 2014). There is burgeoning evidence from across countries for the mistreatment of women at the time of childbirth (Bohren et al., 2015; Bowser & Hill, 2010). There is evidence to show that many women choose to not avail of health facility services for childbirth in spite of recognizing the health benefits of the same; these decisions often stem from past experiences of poor quality care, which include being hit, slapped, physically restrained, and abandoned (e.g. Adinew & Assefa, 2017; Khan, Hazra & Bhatnagar, 2010).

Although gaining traction only over the past few years, the occurrence of women being subjected to abuse during institutionalized childbirths has nevertheless been recorded in history. In the 1950s, the magazine *Ladies Home Journal* of the United States of America published an article titled 'Cruelty in Maternity Wards' which reported that pregnant women were routinely sedated, handcuffed, hit, and threatened to make them comply with healthcare providers' directives (in Goer, 2010). Brazil was the pioneer in bringing the issue of mistreatment of women in childbirth to the forefront. In 1981, an ethnographic description of women's agonizing experiences during institutionalized childbirths published in the book *Espelho de Vênus- Identidade Social e Sexual da Mulher* by the Ceres Group brought the phenomenon under sharp focus (Diniz et al., 2015).

The issue gained momentum with the childbirth activism movement in Latin America in the 1990s, beginning with the founding of the influential *Network for the Humanization of Labour and Birth* (ReHuNa) in Brazil in 1993 (Diniz et al., 2015). This was followed by the establishment of the Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN) in the year 2000 (Hodin, 2017). In 2007 Venezuela coined the term 'obstetric violence', which was defined as *"the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about*

their bodies and sexuality, negatively impacting the quality of life of women" (Pérez D'Gregorio, 2010).

Defining mistreatment of women during childbirth

The mistreatment of women during childbirth has been termed and defined variously such as: "mistreatment of women in childbirth at health facilities", "obstetric violence", "disrespect and abuse" and "dehumanized birth," among others, the typologies of "disrespect and abuse" and "mistreatment during facility-based childbirth" being the most frequently employed in global studies (Savage & Castro, 2017). However, all the terms share commonalities in underscoring the medicalization of the natural childbirth process, the mistreatment of women being rooted in gender inequities, drawing parallels with violence against women, the potential for harm, and the threat to women's rights (Savage & Castro, 2017). In 2010, Bowser and Hill undertook a landscape analysis to encapsulate available knowledge and evidence on the phenomenon, this being the first major synthesis of evidence on the issue. Their report titled *Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth,* through in-depth searches of published and technical literature along with interviews and discussions with experts, described seven major categories of disrespect and abuse that women encountered during childbirth in health facilities (Bowser & Hill, 2010):

i. **Physical abuse** comprises acts such as beating, pinching, slapping, tying up or physically restraining the woman in labour, pushing on the woman's abdomen, using excessive force to pull the baby out, and stitching post-partum sutures without the use of anaesthesia (e.g. d'Oliveira, Diniz & Schraiber, 2002; Khayat & Campbell, 2000). It also includes sexual abuse of the woman through acts such as performing vaginal examinations using excessive force or pulling the woman's legs apart roughly (e.g. Center for Reproductive Rights & Federation of Women Lawyers Kenya (FIDA), 2007).

ii. **Non-consented clinical care** refers to carrying out birth-related procedures such as caesarean sections, episiotomies, hysterectomies, blood transfusions, and sterilization, without the consent of the woman (e.g. Miller et al., 2003).

iii. **Non-confidential care (including denial of privacy)** refers to denying the woman physical privacy wherein she is compelled to give birth in public view, as well as lack of confidentiality with regard to sensitive patient information such as HIV status, age, marital status, medical history, and so on (Bowser & Hill, 2010).

iv. **Non-dignified care (including verbal abuse)** comprises acts such as blaming, scolding, insulting or threatening the woman (e.g. Kruk, Paczkowski, Mbaruku, Pinho & Galea, 2009; d'Ambruoso, Abbey & Hussein, 2005).

v. **Discrimination based on specific patient attributes** refers to providing the woman differential care, or poor treatment, on the basis of attributes such as race, ethnicity, educational level, socioeconomic status, and HIV status among others (e.g. Ezedinachi et al., 2002; Stangl et al., 2010).

vi. **Abandonment or denial of care** refers to women being left alone during labour and birth, as well as failing to monitor the woman during the course of labour, and intervening in situations which may threaten her health (e.g. Misago et al., 2001).

vii. **Detention in facilities** refers to detaining women and/or their babies in health facilities owing to the women's inability to pay the hospital bills (e.g. Human Rights Watch, 2009).

Numerous studies have since been carried out using this classification. Most of these studies have measured the prevalence of disrespect and abuse in health facilities during childbirth, and have largely been carried out in African nations (e.g. Asefa, Bekele, Morgan & Kermode, 2018; Rosen et al., 2015; Abuya et al., 2015). These studies have predominantly been carried out with women who have self-reported facing abuse in health facilities during childbirth, and are facility-based studies largely using the survey method. Verbal abuse and abandonment or neglecting to care have emerged as the most prevalent forms of abuse women are subjected to (e.g. Kruk et al., 2014; Abuya et al., Sando et al., 2016).

Factors contributing to mistreatment of women during childbirth

Some studies have explored the factors influencing the disrespect and abuse of women during childbirth. At the individual level, women's lack of awareness about their rights at the time of childbirth was seen to contribute to their mistreatment (Warren et al., 2017). Studies examining the association between disrespect and abuse during childbirth and individual factors of women found that women were more likely to be mistreated during childbirth if they were of higher parity, had HIV positive status, had lower socioeconomic status, or had complications during delivery (e.g. Kruk et al., 2014; Abuya et al., 2015).

The power differential between healthcare providers and patients was seen to contribute to the mistreatment of women at the interpersonal level; women accepted the mistreatment meted out to them owing to the perceived authority healthcare providers held over them (Warren et al., 2017).

At the health facility level, poor treatment of women at the time of childbirth was attributed to the shortage of staff, lack of resources and poor supervision (e.g. Warren et al., 2017).

At the policy level, lack of legal systems to safeguard women against mistreatment during childbirth, lengthy and costly legal redressal procedures, and lack of accountability among healthcare staff were seen to contribute to the abuse of women at the time of childbirth (Warren et al., 2017; Madhiwalla et al., 2018). Warren et al. (2017) also put forth that lack of or inadequate emphasis on communication skills in medical training is a factor leading to poor attitudes of healthcare providers towards women availing of delivery services from health facilities.

Mistreatment of women during childbirth and human rights

In 2011, the forms of disrespect and abuse of women during childbirth identified by Bowser & Hill (2010) were conceptualized as human rights violations by the

White Ribbon Alliance. This conceptualization was presented in the 'Respectful Maternity Care Charter', wherein different forms of disrespect and abuse in the labour room were associated with the corresponding human right violation (White Ribbon Alliance, 2011):

- Physical abuse as a violation of the right to freedom from harm an ill treatment.

- Non-consented care as a violation of the right to information, informed consent and refusal, and respect for choices and preferences including companionship during maternity care.

- Non-confidential care as a violation of the right to confidentiality and privacy.

- Non-dignified care (including verbal abuse) as a violation of the right to dignity and respect.

- Discrimination based on specific attributes as a violation of the right to equality, equitable care and freedom from discrimination.

- Abandonment or denial of care as a violation of the right to timely healthcare and to the highest attainable level of health.

This violation of women's rights has gained global urgency, with the World Health Organization in 2014 releasing a statement calling for prevention and elimination of disrespect and abuse during childbirth, declaring that every woman has the right to the highest attainable standards of health, which includes the right to dignified, respectful healthcare (WHO, 2014).

The Indian context

Historically, Indian policies and schemes to address maternal health have been chiefly directed towards curbing the maternal mortality rate and enhancing birth outcomes by encouraging facility deliveries. However, the quality of care meted

out to women availing of these institutional deliveries has always remained a peripheral theme, owing to which the surge in institutional deliveries has not translated into good quality care for women (Srivastava, Bhattacharyya, Clar & Avan, 2014). The Janani Suraksha Yojana under the National Rural Health Mission (NRHM) is a flagship programme to increase the rate of institutional deliveries (Ministry of Health and Family Welfare, Government of India, 2016). An evaluation of the program found that while there was an increase in the numbers of facility-based childbirths following the scheme, women narrated being subjected to abusive practices such as denial of privacy, verbal abuse, administration of fundal pressure, and being made to lie on floors immediately after delivery resulting in their dissatisfaction with the services; examples provided by women indicated that they were subjected to violence at the time of availing childbirth services in health facilities. (Khan, Hazra & Bhatnagar, 2010).

There are scant Indian studies examining disrespect and abuse of women during childbirth. However, there is some evidence available on mistreatment during childbirth from women's perspectives. Bhattacharya & Ravindran (2018) surveyed 410 rural women from Varanasi, India, and found that 28.8 per cent of them had faced some form of abusive behaviour during childbirth at the hands of healthcare providers, with verbal insults and physical abuse being the most commonly reported forms of abuse experienced by 19.3 per cent and 13.4 per cent of respondents respectively. The researchers also found that most mothers and their family members (90.5 per cent) were forced to pay class-four staff for carrying out duties such as cleaning up after the delivery in spite of government health services being free, and were at times also told to clean the beds themselves. Patel, Makadia & Kedia (2015) in their study exploring the extent of disrespect and abuse in facility-based childbirths among women residing in the urban slum area of Ahmedabad found that 57.7 per cent of 300 respondents had faced at least one form of disrespectful and abusive care, the most common being non-consented services and verbal abuse.

Perhaps one of the earliest Indian studies to shed light on mistreatment of women during childbirth was one by Ram (1994). The researcher explored the experiences of maternity among women residing on the coastal fishing belt in Tamil Nadu,

India. One of the findings of the study was that healthcare providers perceived women belonging to lower castes adversely, thus subjecting them to disrespectful treatment when they approached health facilities for delivery.

Efforts to address mistreatment of women during childbirth in health facilities

Globally, efforts in the form of health facility and community level interventions have been documented to address this phenomenon (e.g. Abuya et al., 2015; Ratcliffe et al., 2016). Provider-centric interventions have primarily aimed to increase the knowledge of healthcare providers with respect to childbirth-related rights of women, and improving client-provider communication (e.g. Ratcliffe et al., 2016; Abuya et al., 2017). Women-centric interventions too have largely focused on improving women's knowledge of their rights during childbirth, such as the right to be free from abuse during childbirth and the right to have a birth companion, and also on providing them information about health facility procedures related to childbirth (e.g. Brown et al., 2007; Ratcliffe et al., 2016).

Some Latin American countries have enacted laws to uphold the rights of women during childbirth, and to provide them with a dignified childbirth experience which is free from harm and abuse. Venezuela became the first Latin American country to develop legislation against 'obstetric violence' in 2007 (Pérez D'Gregorio, 2010). Argentina's National Law preventing gender-based violence has come to include a specific article on obstetric violence (Williams et al., 2018). Bolivia, Panama, and Mexico too, have enacted laws which embody violence against women during childbirth within the broader domain of gender-based violence (Williams et al., 2018).

In India, the Ministry of Health and Family Welfare launched the LaQshya (Labour Room Quality Improvement Initiative) guidelines in 2018, of which respectful treatment of women during childbirth forms an integral part (Ministry of Health and Family Welfare, Government of India, 2018). The guidelines include provisions for privacy to pregnant women during childbirth, presence of a birth companion, providing women the freedom to choose the position they want to

give birth in, using labour beds instead of tables, early skin-to-skin contact between the mother and baby, and initiating breastfeeding within one hour of birth, and adherence to all clinical protocols for management of labour. The guidelines also prohibit acts such as inducing or augmenting labour without sound clinical indications, verbally or physically abusing the woman in labour, insisting on a particular position for delivery, and making the woman or her caregivers incur out-of-pocket expenditures. Vicent & Saha (2019) evaluated the implementation of LaQshya in Andaman, India, and found that out of 185 women availing of delivery services from a public health facility, none were allowed to have birth companions. Further, 30 per cent of the women had experienced physical or verbal abuse during delivery, 56.7 per cent reported being subjected to fundal pressure, and 95 per cent of the women were not allowed to walk or take the birth position of their choice at the time of childbirth, indicating poor adherence to the LaQshya guidelines.

Rationale of the present study

There is extensive global evidence on the occurrence of violence in labour rooms. However, most of these research studies have sought women's perspectives and experiences (e.g. Asefa, Bekele, Morgan & Kermode, 2018; Maya et al., 2018; Adinew & Assefa, 2017; Rosen et al., 2015; Abuya et al., 2015). There is a dearth of studies exploring healthcare providers' perspectives on this phenomenon. Indian studies exploring this phenomenon too have primarily assessed the prevalence rates of disrespect and abuse in labour rooms (Bhatacharya & Ravindran, 2018; Patel, Makadia & Kedia, 2015). No Indian study, to the best of the authors' knowledge has examined healthcare providers' perceptions of violence occurring in labour rooms. The need to understand provider perspectives of labour room violence also arose from CEHAT's close engagement with the public health system. On numerous occasions, women availing of the services of Dilaasa[1], a hospital-based crisis intervention centre, have spoken to counsellors about the mistreatment they were meted out at the time of childbirth; such mistreatment has ranged from rude behaviour and negative remarks, to physical

[1] Dilaasas are hospital based crisis centres, a joint initiative of the MCGM and supported by the NUHM, established to provide support for women survivors of violence by sensitising healthcare providers and training them to understand domestic violence as a health issue.

and verbal abuse. CEHAT's program on integrating gender perspectives in medical education also threw light on specific practices in labour rooms (CEHAT, 2017). Being exposed to gender concerns in medical education, medical educators discussed that there was a lack of exposure to gender-sensitive care in labour rooms as well in their interface with pregnant women, since medical education did not focus on gender concerns. Hence shouting, scolding, and use of restraints was not uncommon in labour rooms. Recognising this gap, the gender integrated module for Gynaecology and Obstetrics for the undergraduate medical course (MBBS) was developed, which included steps to prevent labour room violence. The present study was conceptualized with the understanding that in order to bring about a positive change in maternity care practices, it is important to understand how healthcare providers view behaviours constituting disrespect and abuse of women at the time of childbirth. The results of the study would hence help to address the issue by inculcating positive attitudes and practices among healthcare providers working in the labour room.

Objectives of the present study

The objectives of the present study are:

i. To understand healthcare providers' perceptions of behaviours constituting disrespect and abuse in labour rooms

ii. To document their recommendations to prevent and stop disrespect and abuse in labour rooms

2. Methodology

This chapter describes the research design, the study settings, the tool, the sample, and the various procedures undertaken for the study.

Research design

As the prime objective of the study was to capture healthcare providers' perceptions of labour room violence, a qualitative approach to enquiry was adopted. The in-depth interview approach was hence selected as the method for data collection.

Study settings

The present study was carried out in two government health facilities (Hospital A and Hospital B) in the Indian state of Maharashtra. Hospital A is a mid-sized urban hospital, and Hospital B is a medical college in an urban setting. Both the hospitals provide healthcare services in the major departments of medicine, surgery, obstetrics and gynaecology, paediatrics, orthopaedics, ear-nose-throat, dermatology, psychiatry, and dentistry. These hospital settings were selected so that the study findings could enable in developing a response to prevent labour room violence. Hospital A is one of the hospitals which have a Dilaasa crisis intervention centre, the presence of which could assist in changing labour room practices. Hospital B was known to have recently initiated practices to inculcate respectful maternity care, exploring which could inform efforts to transform labour room practices.

Study tool

A semi-structured interview guide was developed based on the study objectives. The tool covered the following domains of enquiry:

1. Work profile and training
2. Perceptions and practices of privacy, confidentiality and consent-taking (including consent for contraceptive counselling)
3. Perceptions of violence in labour rooms
4. Perceptions and practices of the birth companion policy and offering different birth positions
5. Recommendations to prevent violence in labour rooms
6. Case example - Implementation of respectful maternity care (RMC) practices

Sampling and profile of respondents

The purposive sampling method was implemented for the study. Healthcare providers from three cadres: doctors, nurses, and class-four workers were selected as respondents. This was done to elicit the unique experiences and perspectives of the different cadres. It was surmised that the differentiation in the roles of the different cadres of healthcare providers would shape their interactions with women in their own unique manner, and therefore it would be useful to understand the dynamics of each. Three healthcare providers were selected from each cadre, from each hospital. The following table provides an overview of the respondents who participated in the study.

Cadre	**Hospital A**	**Hospital B**
Doctors	3 (one male and two female)	3 (one female and two male)
Nurses	3 (all female)	3 (one male and two female)
Class-four workers	3 (all female)	3 (all female)

Among the doctors interviewed, three were resident doctors, whereas three were senior doctors (consultant or professor). Among the nurses interviewed, three were senior nurses (matron or in-charge), and three were junior nursing staff. This selection of respondents was carried out to include the representation of doctors and nurses of all designations.

Ethical considerations

The study was reviewed by the Institutional Ethics Committee of Anusandhan Trust, to which CEHAT is affiliated. In order to carry out the interviews for the study, permissions were obtained from the Medical Superintendents and the Heads of Department of both the hospitals. Potential respondents were approached by the researchers, and requested participation in the study. They were explained the nature of the study, and provided an information sheet which gave an overview of the present study. Those who consented to take part in the study were asked for a convenient date and time for the interview.

Participants were informed at the beginning of each interview that no information regarding their personal practices would be sought, i.e. whether they themselves inflicted abuse upon women, in order to avoid any discomfort they may perceive because of the same. The interviewers stressed that the respondents were representatives of the medical fraternity, and that they were being asked to reflect upon the general perceptions of disrespect and abuse of women in labour rooms at their facility.

The interviews were carried out in hospital rooms which were otherwise unoccupied, thus ensuring reasonable confidentiality of the information shared by the respondent and convenience for the respondents. The respondents were provided a consent form which outlined their rights as study participants; the terms of anonymity, confidentiality and voluntary participation were put forth. Respondents signed two copies of the consent form; one copy of the form remained with the respondent whereas the other was handed to the researchers. Oral consent was obtained from those respondents who could not sign their names. Permission for audio-recording the interviews was sought from respondents; they were assured that the recordings would be used only for the purpose of transcribing the interviews, following which the audio files would be deleted. All participants consented to the interview being audio-recorded.

Data collection

The team sought permissions from authorities to get acquainted with the hospital labour room settings, understand a regular day in the labour room, and know the different procedures with regard to handling deliveries. This exercise helped ground the present research study within its context, thereby lending a better-informed perspective to the data collection process.

Two researchers were present at the time of each interview. While one researcher conducted the interview, the other researcher documented the same by hand; the presence of the other researcher was also to ensure that they could fill any gaps in information which were missed by the interviewing researcher. Additionally, field notes in the form of observations about the environment, the note-taker's impressions during the interview, and non-verbal communication were maintained in the course of data collection, which provided critical contexts to place the data in, and helped supplement the data derived from the interviews.

When requested to participate in the study, we noticed that class-four workers did not wish to speak to us individually, but voiced that they wanted to give the interview in pairs or as a group. We overcame this aspect by explaining to them that we wished to speak to each one of them individually because each of their responses were valuable to us, but wished to do it separately only because their views may differ from each other, and we wished to document each individual's experiences and responses comprehensively and to the best of our abilities so as to do them justice.

Data entry

Each interview lasted about 45 minutes. The audio-recorded interviews were translated and transcribed in English by one researcher. The recordings were supplemented by hand-written notes taken at the time of the interviews. The transcripts were checked and rechecked independently by three researchers.

Data analysis

The transcripts were read and re-read thoroughly by two researchers. Data was arranged according to domains derived from emerging patterns in the respondents' narratives. Thematic analysis was employed for analysing the data obtained from the interviews with healthcare providers. Further, in order to understand providers' perceptions of disrespectful and abusive behaviour, their narratives were analysed to sieve out underlying elements which dictated their stance towards such behaviour. The data was arranged according to super-ordinate and sub-themes, and the findings thus presented.

Chapterisation

The present report is divided into nine chapters.

1. **Introduction:** This chapter provides evidence from literature on the phenomenon of disrespect and abuse during childbirth and establishes the context of the study, providing the study rationale and objectives.

2. **Methodology:** This chapter describes the methods undertaken for the implementation of the research study, which includes details about the study settings, the sample and sampling procedure, the study tool, the ethical considerations in the course of the study, and the various procedures involved in carrying out the study.

3. **Management of labour processes:** This chapter speaks of the different procedures carried out during labour and the roles and responsibilities of the different cadres of healthcare providers in the course of labour; it also speaks of the training or preparation that the healthcare providers are given prior to taking up their duties in the labour room.

4. **Privacy, confidentiality and consent-taking:** This chapter describes the perceptions and practices related to privacy, confidentiality and consent-taking at the time of childbirth.

5. **Healthcare providers' perceptions of violence in labour rooms:** This chapter describes healthcare providers' perceptions of violence and their views on why such violence occurs.

6. **Notions of practices aimed at preventing labour room violence:** This chapter describes healthcare providers' perceptions of certain practices (i.e. the birth companion policy, offering different birth positions) mentioned in the LaQshya guidelines which aim to prevent labour room violence.

7. **Challenges and recommendations:** This chapter describes the challenges which, according to healthcare providers, give rise to adverse disrespect and abuse of women in labour rooms, and providers' recommendations to prevent the same.

8. **Exploring efforts to prevent violence in labour rooms and improve maternity care:** This chapter explores the efforts to prevent violence in labour rooms in Hospital B.

9. **Discussion, implications and conclusion:** The last chapter discusses the key findings of the present study, and their implications in practice.

3. Management of labour processes

In order to better understand the context of the labour room, we asked the respondents about what their roles and responsibilities entailed, the training they had received for the same, and what their typical day looked like. The figure below illustrates the roles and responsibilities of the different cadres of healthcare providers in the course of labour, followed by a detailed explanation of the same.

	Early stages of labour	During labour	After delivery
Nurses	Checking if woman in labour shaving and administering enema, administering IV fluids monitoring the woman and the foetus.	Assisting the doctors with the delivery, at times reported carrying out the delivery.	Checking upon the woman's condition, giving woman tea and biscuits preparing woman for breastfeeding.
	(record-keeping looking after sterilization of instruments)		
Doctors	**Senior doctors:** deciding course of treatment **Resident doctors:** monitoring the woman and the foetus.	**Resident doctors:** conducting the delivery. **Senior doctors:** conducting the delivery in complicated cases.	–
Class four workers	Clearing of the labour table	Sometimes called upon to physically restrain the woman	Taking the baby on a tray and giving the number, cleaning the woman, shifting her to the PNC ward
	(cleaning of the ward)		

Figure 1 : Roles and responsibilities of the different cadres of healthcare providers

Roles and responsibilities of nurses

Nurses stated that their interaction with the woman lasted through the entire duration of labour, from the time she entered the ward in initial stages of labour, until the post-natal period. Their responsibilities broadly encompassed preparing the woman for delivery, assisting the doctor at the time of delivery, and providing postnatal care.

Duties in early stages of labour

When the woman arrived in the labour ward, not only the doctors, but the nurses too were reported to check whether the woman was in labour. Shaving as well as administration of enema was carried out by staff nurses. In the early stages of labour, the nurses administered injections like oxytocin, if required, to intensify contractions. Additionally, any administration of medication and intravenous fluids was also carried out by them. They were also reported to monitor the foetal heart rate using the fetoscope. These tasks of examining the woman, monitoring the foetus, and administering injections and medication were carried out as per doctors' instructions. The nursing staff were also responsible for preparing the woman for a c-section if so indicated.

Duties at the time of delivery

The duties at the time of delivery comprised assisting the doctors by handing them the necessary equipment as and when required, and by providing any other miscellaneous assistance. For example, they were responsible for preparing the tray for administration of episiotomies, and for providing any assistance during suturing. Nevertheless, nurses also reported that at times, they were required to carry out deliveries if a doctor was not available.

Duties post-delivery

After delivery, the staff nurses reported of being responsible for checking the APGAR score. Depending on the condition of the baby (e.g. whether it has cried or not) it was either placed in the warmer or taken for further treatment if required. Nurses also said that it was they who took the baby to be shown first to the mother (where the mother was made aware of the sex of her baby), and then to the relatives along with female class-four workers. After the woman had been shifted to the Post Natal Care (PNC) ward, the nurses checked aspects such as whether the woman was bleeding, whether she had passed urine, and if she required any medication. The nursing staff also looked after providing the woman tea and biscuits after delivery. With regard to breastfeeding, the nurses took care

of appropriate placement of the baby during feeding, correcting inverted nipples, and providing stimulation for suckling.

Other responsibilities of nursing staff

In addition to provision of clinical care to the woman in labour, the nursing staff was tasked with monitoring the cleaning and tidying of the labour ward, and the sterilization of instruments. Nurses also reported record-keeping to be an important part of their duties. They had to maintain records of admissions, of the medicines, injections, and treatment given to the woman, as well as of details of the baby such as the time of birth, the baby's weight, and its sex. This view was echoed by doctors who stated that most of nurses' time was taken up by "paperwork" than other tasks. One of the doctors also stated that at times, the nurses' duties of tending to the woman were overshadowed by their duty of record-keeping. This, he voiced, led to the neglect of women who were in need of medical attention.

> *They* (the nurses) *assist with the delivery... But the paperwork is more, so they are just at their desks. One sister is at the desk, and one sister is giving IV fluids. So here, basically bookkeeping is more important. Let anything happen, you cannot miss a record. Because that responsibility ultimately comes upon the sister. Here the sisters, they do not interact nicely... 'Properly' I would not say because they do not have the time. They have been assigned a different duty, a different job altogether. They have a book for everything. If they give an injection they have to write it down. And nowadays they have started a new book. Nowadays patients are getting Huggies diapers. So they have to keep a book for that, to maintain a record of the stock for Huggies diapers. So every patient they give this to after delivery, they have to write the patient's name, and the patients have to sign against their name, that she has received it. They are involved in all this. Rather than checking a patient when she is bleeding, while going to the PNC ward, they are doing this.*
>
> Senior doctor (male)

Training provided to nursing staff

All the nurses reported having completed 3.5 years of the B.Sc. Nursing course including 6 months of internship. They said that whereas the course comprised theoretical knowledge, the nurses got practical training during their internship. It comprised aspects such as preparing cases studies of patient management (e.g. case study for a pregnant patient with hypertension), as well as observing other staff members as they carried out their duties. This included observations of preparations for labour, conducting a normal delivery, and administering post-natal care. Once the nurses joined duty, they were supervised by senior nurses. In due course of time, they were entrusted with more complex tasks. One of the senior nurses narrated how the nature of nursing training and roles had changed over time; in earlier times, whereas nurses were trained to, and also performed tasks, such as carrying out per-vaginal examinations and deliveries, the nurses in the present times did not receive training for the same.

> *We used to carry out deliveries earlier. The protocol has changed now. We used to carry out all these tasks, of conducting PV examinations, carrying out episiotomies, carrying out deliveries... In earlier times, all this was known to us. But now what has happened is that the doctors are exposed to all these things in their first posting. They are made to carry out PV exams and episiotomies, so that they are trained. So the new nurses who join miss out on this, these opportunities of learning and doing these things. They haven't received this training...*
>
> Senior nurse (female)

Roles and responsibilities of doctors

The doctors said that their primary duty was to determine the course of treatment for pregnant women and to carry out deliveries. Doctors who had completed their undergraduate studies and had joined the hospital as postgraduate students were the resident doctors. The senior-most resident was the chief resident (CR). The roles and responsibilities of doctors differed as per their seniority. Resident doctors were reported to be the primary persons responsible for carrying out

deliveries under the instructions of senior doctors. Resident doctors carried out the tasks of monitoring the woman and the foetus, performing vaginal examinations, and carrying out the actual delivery. The labour ward was generally supervised by the chief resident. A resident doctor narrated what her roles and responsibilities entailed, and her daily routine, which alternated between the outpatient department and the emergency room:

> *Typical day, our day begins at 8 in the morning. Our duty is from 8 to 8. We have work in the OPD and in the emergency room. We have two units, so our duties alternate everyday. We are in the OPD on one day and in the emergency room on another. If there are any cases or referrals, we are informed from the ANC clinic or the gynaecology ward. We have to report on the progress of cases. While in labour, there are a few parameters that we check. First come the vital parameters: the BP, then we check for abdominal palpitations and the foetal heart rate, and per vaginal examinations.... We conduct deliveries. We work in the operation theatre, after the baby is born, we immediately call the paediatrician. The paediatrician then comes to check on the baby. In case there is any treatment or medication to be given then that is done. The baby is then given to the mother for feeding.*

Decisions regarding each patient's treatment were taken by the senior doctors. When women were admitted in the labour ward, senior doctors came on rounds, and assessed each woman's condition. They also classified the cases according to their risk levels (e.g. cases of hypertension, foetal malformation, changes in blood supply in the uterus). The delivery of complicated cases was also usually carried out by senior doctors, e.g. deliveries using forceps, cases of prolonged labour, breech birth, case of twins, or patients with heart disease or eclampsia. The senior doctors reported carrying out the duty of teaching the residents. This included teaching aspects such as decision-making, e.g. which case was high risk and which was not, signs and symptoms of different underlying conditions, and how to conduct normal deliveries, instrument-assisted deliveries, per vaginal examinations and c-sections.

Training and supervision for doctors

Training was termed as being supervised by senior doctors; the seniors explained to the juniors the different procedures such as case history taking, conducting examinations, and conducting deliveries. An "observe-and-learn" method was followed wherein the senior doctor first carried out a task or procedure which was observed by the juniors, who then gradually began carrying it out themselves.

> *The senior doctors check upon the work of junior doctors. My supervisor will check my work. So when I carry out some procedure, like the PV exam, my senior checks whether I have done it properly. And for my junior, when she conducts it, I check if she is doing it correctly.*
>
> Resident doctor (female)

> *Junior doctors, first few days we give them training in only pulse, BP, the basics. So the first few months they are just checking the BP, carrying out blood collection. Then slowly, slowly we tell them to deliver patients.* (We give them) *easy deliveries, when the head is on the perineum and they are just about to deliver, they deliver such babies. Then, later we teach them how to take episiotomies, and suturing. Slowly slowly we give them MTPs. Then tubal ligation, then LSCS. They assist us, they assist. And after one year they are trained. After one-one and a half years they are doctors who have passed. So we supervise them* (when they are doing it for the first time).
>
> Senior doctor (male)

Roles and responsibilities of class-four workers

Class-four employees in hospitals comprise of ward boys, ayah bais, and labourers. They are the support staff at the level of hospitals. All respondents from the class-four worker group unanimously stated that their duties primarily comprised cleaning anything that was dirty. All the class-four workers who were interviewed

stated that they were not literate. They had not undergone any formal training in their job, and were oriented to their duties by the nurses. The class-four workers reported to the nursing staff.

> *We clean dirty floors, clean up everything dirty which has fallen down. I sweep the floor. After sweeping I will mop. If there are some clothes in the bathroom I wash it, hang it to dry, and after it dries I will take it. Whatever rubbish* (gandha) *has fallen down, we pick it up that we take to the bathroom and clean it.*
>
> Class-four worker (female)

They stated that their role included taking the baby in the tray immediately once it was born and cleaning the baby. After this was done, the class-four workers weighed the baby, took the foot impression, and tied its identifying number. The baby was first shown to the woman/mother, after which it was shown to the relatives by the nurses along with the class-four workers. Following delivery, the class-four workers cleaned the floor and labour table, as well as tended to the cleaning of the woman, shifting her to the PNC ward, and helping her lie on the bed.

They stated that at times, they were sometimes called upon to physically restrain the woman. One of the respondents stated that at times, she has carried out the delivery if a doctor or nurse is busy in another delivery and the baby's head is crowning in case of another woman's delivery; they have helped with the baby coming out, after which they rush to the doctor to inform about it. This is because they are the ones always standing next to women in labour at the time of delivery.

The study hence found that whereas doctors were responsible for carrying out the delivery, women arriving for delivery were most in contact with nurses in the labour ward, who attended to them from their arrival till after delivery. Though class-four workers mainly tended to the aspect of cleaning up of the ward, and also of the woman after delivery, they too, were in contact with the woman throughout the course of her stay in the labour ward, with them sometimes being called upon to assist with labour. None of the cadres

had received any training on how to communicate the stages of labour to women at the time they joined hospitals, explain to them the frequency at which they would experience pain, and prepare them for delivery.

4. Privacy, confidentiality and consent-taking

Privacy and confidentiality

When asked about procedures for maintaining privacy and confidentiality of patients in the labour room, respondents from all cadres, both male and female unanimously declared that their institutions took required measures for the same. They held the belief that since the labour ward could not be accessed directly from the outside, no relatives of the patients could view the inside of the ward. Furthermore, the presence of security ensured that individuals did not enter the ward freely. Another commonly echoed response was that most working in the labour ward were female personnel and hencewomen in thelabour would not face a concern with regard to privacy, as well as confidentiality.

> *See, first of all not all are allowed to enter the labour room. Relatives are not allowed to enter. Only the staff is present, and the doctor is present, and the working mama* (male class-4 worker) *... no maushi* (female class-4 worker), *only maushi is there, even mama is not allowed to enter. So there are only females. …So we can also take the history confidentially.*
>
> Resident doctor (female)

On the discussions related to private space, respondents felt that curtains proved to be a barrier; this is because doctors could not see women from a distance from where they sat at their desks. If curtains were to be drawn, it would hinder the monitoring of labour. Our observation of the labour room indicated that there were no curtains between labour tables. Some respondents voiced that such a facility would not be feasible in a government set-up and is best suited for private hospitals. Further, according to healthcare providers:

> *We cannot have curtains drawn. This has to be done as when staff is less we cannot see all women in labour and neither can*

the doctor. So monitoring women is made possible without curtains.

Nurse (female)

But if women specifically asked for curtains to be drawn, then the same was carried out. For example, a staff nurse stated that though not drawn during monitoring the woman, curtains were drawn once she had dilated enough. This was also narrated by a woman doctor:

Now, only while examination (do we draw curtains). *While we conduct her PV examination, that is the time some patients who are first time pregnant, primi patients, think they want privacy. So that time they have* (privacy). *But once the PV examination is done, they can be there without curtains, because anyway nobody from outside is going to enter.*

Resident doctor (female)

While most women may not be able to voice their discomfort with regard to privacy, one of the respondents, a female doctor, stated that at times women did appear uncomfortable when male doctors attended to them, but this discomfort was short-lived and the women eventually "got used to it". On the other hand, another healthcare provider stated that while women did not have a problem, their husbands appeared to have a problem with the lack of privacy. Husbands were seen as reacting adversely especially to male doctors examining their wives.

There are very few patients (who have a problem)... *Rather, I think that their husbands are more hyper. They don't want males* (male doctors). *Patients don't have any problem as such. Husbands have a problem. Yes, it has happened at times. The husband has to understand that whatever doctor is available, only he can examine.*

Senior doctor (male)

We were informed of protocols related to maintaining confidentiality of sensitive medical information. According to respondents, this was kept confidential from

"other women patients". However, they had their own mechanisms of communicating about HIV status amongst the team of health providers. They reported that if the serostatus of a pregnant woman was found positive at the time of ante-natal check-ups, the word "Seropositive" was written in clear, bold letters on the OPD report so that healthcare providers who came in contact with the woman were aware of it and would take the required precautions. Furthermore, the antiretroviral therapy department of the hospital generated a list of seropositive cases every month, which was maintained with the labour ward at all times; this also ensured that new staff members were informed of which woman was seropositive. The last labour table in the ward was reserved for seropositive cases, and respondents reported taking special precautions while attending to women on that table. The term universal precautions seem to have a different meaning with healthcare providers as is evident in the excerpt below:

> *Yes we are at a risk, we and the staff, and other patients too. When we operate we use double gloves for these patients. It is universal precautions. It is available in the hospital, a kit. We use that kit, everybody wears that kit. Goggles, double gloves, the full kit which we wear, and they we do the operation. We know that she is* (seropositive), *so we try to minimize the blood loss in all these cases. …The instruments are sterilized in a different way, all the clothing used in the surgery are sterilized in a different way. Those are the special precautions, because if I do a vaginal examination, sometimes we have unsterilized gloves, and we do the PV, there are chances that if I have a cut, and I perform the examination, I can get that. Many times when we operate, there are chances of getting a cut, an accidental cut. So many of the staff, many of the doctors do get HIV or HbSAg, and then we have to take the post-exposure injections. I myself have taken post-exposure injections twice. So that's the thing, we have to take precautions.*
>
> Resident doctor (female)

Universal precautions is an approach to controlling infections with the belief that human blood as well as fluids can be infectious and hence these precautions have to be taken by HCPs for all patients. But this is not really being done.

Consent-taking

Doctors and nurses reported that consent was sought for delivery-related procedures such as caesarean section, blood transfusion, and delivery using instruments (e.g. forceps delivery). There was conflicting information from respondents on who provided consent. Whereas some healthcare providers reported that such consent was taken from both, the woman and her relatives, other providers reported that consent was taken only from the relatives. Efforts were made to explain consent procedures in language understood by the woman and her family.

> *We take consent for everything. Whenever there is a diversion in the path, you have to take consent. If I am doing an operative delivery, an instrument delivery, I have to take consent, from the patients of the relative. I have to explain to them in the best possible language they understand. …Because many a time the relatives are not ready even for a C-section. So you have to explain to them that it is necessary. …And even for a high risk patient, if it is an anaemic patient, I have to take her consent, that I need to give blood, I need to send her to an ICU, I need to do a section... If it is a high risk case it has to be explained well before to the patient and the relatives. Relatives most importantly, because just giving them a shock and telling them afterwards that now your patient is bad* (in a bad condition), *leads to difficult interactions between relatives and the doctors.*
>
> Resident doctor (female)

However one of the doctors reported that relatives did not always understand the implications of what they were being told.

A few do and a few don't (understand). *But we try to explain to them in their own language. ...Might be* (that they do not understand), *because the time we get for one patient is very less. This is not a private hospital that you can give half an hour to one patient and explain consent procedures. In the ANC OPD, there are 200 patients, and we have three hours. So it is only 2 to 3 minutes for each patient.*

Senior doctor (male)

Respondents also mentioned the term "negative consent". This was a term used by them when a woman (or her relatives) refused a particular procedure to be performed. Such a documentation protected healthcare providers in case of any adverse health event for the woman or the foetus.

We motivate them, that they have to get it (per vaginal examination) *done, that there are no female doctors, there are only male doctors. If the delivery has to happen then you shall have to get yourself examined. So sometimes they don't allow it, they give us in writing that they do not want to get it done from male doctor. This, they have to give in writing, because if something happens on the way, if they deliver on the way, then they doctor will be blamed, that you let her go* (without being examined). *So the doctor tells her to give it in writing, or to wait till a female doctor arrives. So they do give it to us in writing like that.*

Nurse (female)

Consent for administration of contraceptives

It is a well known fact that contraceptive counselling should be initiated in the period of antenatal care and services. This enables women to take informed decisions about spacing methods. When asked about hospital protocol for such counselling, respondents had varied responses. A majority of the respondents shared that women were spoken to about contraception immediately after delivery; this was considered to be the most conducive time women would agree

to having an intrauterine contraceptive device inserted, as elaborated upon by a doctor:

> *Yes... rather it* (PPIUCD insertion) *is stressed upon more during labour I think. Immediately post-delivery we do stress. PPIUCD or puerperal TL. Because the patient is now tired delivering.* (She has) *two children. She is more receptive during labour.*
>
> Senior doctor (male)

Respondents across cadres stated "making patients" use contraceptives was challenging. They complained of multiparous women refusing to use contraceptives despite becoming pregnant repeatedly. They largely attributed this to reasons such as the patients' inability to understand the importance of contraception - a result of the women's socioeconomic backgrounds.

> *There is nothing like family planning in this community, or even among the relatives. Yesterday a woman had come. This is her third abortion. The husbands do not use a condom, and women do not use a copper-T. She says I have been telling my husband but he does not listen. But both are ready for an abortion. I told her to speak to her husband, she went out, then she came back again saying I cannot insert a 'loop' because he does not agree. I and the doctor were so angry we felt we should conduct a vasectomy for him. He does not understand the health of his own wife. They still will not use pills or copper-T. Even after telling them so many times about the adverse effects, they continue to do this. She says it is okay, my husband has asked me to abort. They cannot understand the effects it has on the body.*
>
> Nurse (female)

In another case example a doctor reported trying to coerce patients into PPIUCD administration. She said that Muslim women generally refused to use contraceptives stating that it was against their religion to do so.

Actually there are roadside patients who do not understand anything we tell them. That becomes an issue. Even Muslims, they say that TL (tubal ligation) *is not allowed in our religion. When we are faced with such things, we have to display aggressive behaviour. We tell them this is bad for health, and we sometimes ask them to bring their family members, husband and mother-in-law, but then no one turns up. …Sometimes we force them to insert an IUCD. Some agree but others don't. They say they will consult their relatives, and then they just don't come.*

Resident doctor (female)

The way most doctors employed a cafeteria approach to contraceptive counselling was putting forth contraceptive choices to the woman depending on her parity; healthcare providers presented / only those options to women which they felt were best suited for them.

You have to counsel them according to the patient status. If she is not a compatible patient, if she is not going to come to you every three months, then the contraception (injectable contraceptive which has to be administered once every three months) *is going to be a failure. Because you know that this lady is not going to come to you, you have to insert the copper-T for ten years - then you are free, tension-free that yes she will not conceive for 10 years. …We offer her copper-T, if she says no to copper-T, then we see. If she has completed her family, her first child is of 5 years, then we ask her to get a TL, the sterilization operation. If not then we say copper-T, if not copper-T then the injectable. We give her all the options. We start from whichever is the best, which suits her best.*

Resident doctor (female)

Most providers favoured the postpartum intrauterine contraceptive device (PPIUCD); other methods such as male condoms and injectable contraceptives were seldom discussed. Whereas Maharashtra has introduced the injectable

contraceptive (Antara) which has been made available at public hospitals, doctors largely did not mention this as one of the contraceptive options which women were provided. Upon probing, only a few respondents mentioned offering the same. PPIUCDs were associated with higher success rates and preferred by healthcare providers as they do not require close follow-ups. Healthcare providers voiced various reasons for non-recommendation of methods such as condoms, injectables and sterilization. The widely held notion among respondents was that women would not carry through the procedures required for effective usage of other contraceptive methods such as using condoms at the time of intercourse, or coming for follow-ups for injectable contraceptives; they also feared being blamed for the failure of methods other than the PPIUCD. The following narrative illustrates the respondents' points of view.

> *Antara requires follow ups, it has to be administered every three months. If they don't come for these follow-ups, then how will they use it? If they don't agree to use IUCD and pills, how will they use injections? With regard to contraceptives, they only know about the 'loop', they associate contraceptives with that. And all they say is that they will not agree to having it inserted.*
>
> Resident doctor (female)

On a similar note, another doctor stated that not only did condoms have a higher failure rate, but couples failed to use them consistently.

> *Condoms, if you see, have a large failure rate. We don't advice condoms, male condoms. Female condoms are very rarely used in India. Male condoms, if they are not used properly, they can fail. Secondly they don't use it consistently. And mostly if you see, the patients after they deliver, 4-5 months she is breastfeeding, so she doesn't get her menses properly, and the same time they have sex, so she has a six-month-old child, and is pregnant with a three-month-old baby. So to avoid these things* (we recommend the PPIUCD).
>
> Resident doctor (female)

Healthcare providers said that the husband and the relatives of the woman played a larger role in the decision-making process related to contraceptives. They reported that there were times when the woman agreed to use contraception, but her husband and family members dissuaded her from doing so. Yet none of the respondents had called partners / husbands of these women in antenatal period or post natal period to discuss contraceptives.

> *Actually the women who come here say that they don't want it* (contraceptives) *because they will have problems, because their family at home is refusing, that they want more children. The main reason is that they want a boy. So we tell them to space them. But even C-section patients get pregnant within 7 months and come back to us. Because of this we insist for a copper-T....*
>
> Nurse (female)

Consent-taking for episiotomies

All respondents unanimously stated that administering episiotomies was considered a part of the normal delivery process, and that it was required for most primiparous women. Some questioned relevance of asking for consent for "episiotomies" as they stated that it lies within clinical domain. Some stated that if such a procedure is not carried out it may lead to second or third degree tears and hence it was better to carry out such a procedure.

> *Episiotomies are carried out for all primis, it is compulsory for them. It is compulsory because the os does not open as much for primis. After the first delivery, it is not required. If we do not give episiotomies, the vagina can tear, this tear can extend upto the urethra. So it is always better to carry out an episiotomy.*
>
> Nurse (female)

Conflicting narratives emerged about administration of local anaesthesia. While some said it was administered at the time of performing episiotomies, a senior doctor however stated that since performing an episiotomy was a decision taken

at the labour table, women could not be informed about it in advance, and local anaesthesia was not always required as the woman would not realize the pain.

> *No we don't* (inform the woman about administering the episiotomy). *It is a last moment decision. The head is just abutting, and it has to be done within one or two seconds. And even without anaesthesia, she doesn't come to know. Usually we give local anaesthesia. But even without that, the intensity of pain is very high. She will not get to know. Many times this happens.*
>
> Senior doctor (male)

To summarise, healthcare providers understood privacy as being restricted to physical examination per se. While there were procedures for maintaining confidentiality of seropositive women, there were practices of writing the serostatus in bold on a woman's OPD file to ensure that other HCPs knew about it. Donning protective gear was restricted only while attending to seropositive women. Practice of informed consent was only understood as healthcare providers informing women about medical procedures and taking their signatures, thus indicating a narrow view of consent seeking. This was especially seen with regard to contraceptive counselling as well as deciding on elective procedures such as C-section, deliveries using forceps, and so on. A commonly expressed sentiment was that of socioeconomic backgrounds of women playing a role in their failure to plan pregnancies.

5. Healthcare providers' perceptions of mistreatment of women in labour rooms

This chapter captures how healthcare providers across both the hospitals understand the term "mistreatment and violence in labour rooms", and presents their perceptions of behaviours which constitute the same.

Reactions to the term "mistreatment and violence in labour rooms"

"Nothing like that happens here"

Healthcare providers across cadres rejected the terminology of "mistreatment and violence" at the outset. For example, a doctor stated: *You have written 'violence' here* (in the consent form). *But there is nothing like that which happens here* (laughs). They said that behaviours such as scolding or restraining the woman during childbirth were an integral part of the childbirth process, and were a necessity for better birth outcomes. These actions taken by them were soon forgotten by women once the baby was born. One of the doctors also said that certain acts on the part of the health provider were justified during labour, once the woman had delivered the baby, she should be explained why the health providers behaved the way they did. In this regard doctors and nurses acknowledged these acts such as shouting at the woman, but class-four workers stated that such behaviours never occurred in the labour room.

> *See, the baby has to be delivered within that short period of time. The baby has to come out within 2 minutes, otherwise it will get asphyxiated and can even die. Especially primi women, it is difficult to make them understand, we have trouble with delivering their babies. …At that moment, it becomes necessary... But after the baby is delivered, they say sorry, and we say sorry. Once the baby is out, everyone is relaxed.*
>
> Senior doctor (female)

"Women have unrealistic expectations"

A few respondents dismissed occurrence of labour room mistreatment or violence. They said that women held unrealistic expectations from healthcare providers; e.g they demanded a female doctor only attend to them, which may not be available. This resulted in theirs complaining about having been mistreated during childbirth.

> *Sometimes the patients directly go out and tell the relatives that they don't want to get the delivery conducted here. If they don't want to do it they are given DAMA* (discharge against medical advice). *But then they are upset because some patients think that the sisters or the doctors have to wait only with them. They are of such mentality. And here it is like this that there are many deliveries at night. And if we wait next to them... it is not possible, is it? ...And some of them feel that they are not being given good care here, because they feel that they are in pain and no one is attending to them. Now she herself has to bear the pain. But she thinks that the sister has to stand next to her, and the doctor must too. So we directly give them a DAMA.*
>
> Nurse (female)

Perceptions of empowered patients

Some respondents felt that patients in the present times were "smart" and prone to complaining against healthcare providers at the slightest inconvenience. Some would even threaten healthcare providers with dire consequences in case of poor birth outcomes. Such patients were well-aware about their rights to complain to grievance redressal. This aspect put providers under strain, and they harboured a constant wariness of patients.

> *Earlier, the patients were simpler. Now the patients have started answering back. For example, if you are walking, just leaving the room, and a woman stands right at the entrance, and if you*

ask her to stand to one side, she will immediately answer back, 'Where else should I stand?' They will then go and complain against us.

Nurse (female)

Another respondent voiced challenges in handling patients who were "Google-informed". They stated that these patients interfered in matters of their own treatment and questioned doctors when the doctors knew best what course of treatment was to be carried out. This was in contrast with patients who were less educated and accepted the treatment they were provided without any objections or questions.

If patients are uneducated, or less educated, then they are not too concerned. So when we explain to patients, we explain to every patient. Now if we say (to the educated population) *that your delivery is now overdue by seven days, and the delivery must be conducted now, they are concerned, will it be normal or a Caesarean, how will it be? Now if you say it to uneducated women, they say 'Okay doctor sahib you do whatever is required'. So that is a concern - the education makes a difference. Because they* (the educated population) *know that it can be normal or it can be a caesarean, what complications can arise in a normal delivery, what complications can arise in a caesarean delivery. So the Google population we have, that is a little difficult to counsel. Yes they surf Google, and it is difficult to tackle them compared to the normal population, and regarding labour too... they have many concerns. If it cannot be a normal delivery, then what can be done? If there is a problem with the normal delivery, then what can be done? Can you comment on the prognosis of the baby? So they are concerned about that.*

Senior doctor (male)

One of the staff nurses also stated that working in the labour ward was a risk in itself, and that any act of theirs could be misconstrued: *We are blamed from both*

sides. If we do something to save the baby, we are blamed, if something happens to the baby, we are blamed again.

Legitimising aggressive conduct

"Women are not co-operative"

Reacting to the term, respondents widely stated that adverse interactions between healthcare providers and women arose primarily owing to women "not being co-operative" at the time of labour.

> *I think sometimes it is required. Not violence as in hitting the patient. But you have to be stern with the patient. Unless you are stern, every patient will land up in LSCS... The patient even kicks you when she is in delivery.*
>
> Senior doctor (male)

"Women do not follow instructions"

Respondents cited behaviours such as getting up from the labour table, sitting down on the floor, or running to the bathroom during active labour, where healthcare providers had no choice but to shout at them or restrain them.

> *Some patients do not co-operate at all.* (In a lowered tone-) *They even kick us. Women even kick us if we say something. We tell them that the baby will die if they do not co-operate. What these women do is that in the course of labour, midway they relax, they stop bearing down. In such a case the child will get stuck. Sometimes the baby has the cord wrapped around its neck, this is very dangerous. Women stop bearing down. In such a case if we do something, say something, the patient registers a complaint against us. Some ask us 'How much more should we bear down?'*
>
> Nurse (female)

There was an undertone that women coming for delivery should know that they must be shaved when they arrived at the hospital, know how to climb the labour table and take the lithotomy position for delivery, and also carry items such as a government identification proof and an extra set of clothes. When women did not carry such documentation, healthcare providers blamed them for it. Respondents believed that multiparous women must be well-versed with the delivery process, and hence should require minimal assistance at the time of labour. One of the nurses said that it was unfortunate even the mothers of pregnant women did not physically or mentally prepare their daughters for labour, which increased the burden on healthcare providers as they had to teach women basic aspects such as bearing down adequately at the time of delivery.

Respondents stated that women hailing from small villages had to be scolded in order to make them comply with medical instructions as they did not understand labour related instructions. But this was perceived as abuse by women according to providers.

> *See now the women are not educated. They come from small villages. They don't understand anything. How the procedures are, what to do. Now even if the doctors get a bit angry - the woman nearby is also delivering. We will say 'Move!' So they will say 'They pushed me! Why did they push?' It is like that. Now if it is a new staff member, sometimes they say something to the woman, like move a little to the side. But you are not saying this angrily. You are just telling them to move aside. So people don't like being told even this. They come from khedegaon, meaning from small villages. Now they don't know anything, they don't allow us to touch them! We have to touch them!* (Laughing) *Sir has to touch them. Madam has to touch them. Now if we say move this way, then her body is exposed. They don't know that they have to lift their saree up, they don't like it.*
>
> Class-four worker (female)

"Women do not give correct obstetric histories"

Doctors and nurses explained that women did not disclose their medical histories, which created stress for healthcare providers and affected the labour process. Hence, sometimes they had to be aggressive in their approach towards women who hide obstetric histories.

> *The issue is that we see a lot of patients who come from slums. They do not come for any follow-ups. This causes a lot of problems. They come directly for their delivery. Sometimes there are women who are 4 and 5 gravida. Women who are hepatitis B positive also come to hospital. We do not have their reports or their HIV status, we have the quick HIV kits but they are not reliable, what to do? We go ahead with delivery, we cannot wait, it is the question of the baby. My colleague carried out a delivery without any gloves or precautionary gear, and then her reports came to us that she had a HPV infection.*
>
> Resident doctor (female)

> *Sometimes they do not tell us, they are not ready for revealing their history. Some women even wear false mangalsutras... We ask questions like can we speak to your husband, we require his signature. We even ask for the Aadhaar card... So when we enquire this way, we get to know that they are lying* (about their marriage).
>
> Senior nurse (female)

Justifying the use of physical restraint

Providers across cadres stated that use of physical restraint was important in the process of delivery.

> *Sometimes the patients do not co-operate. They do not bear down. At such times, we have to tell the maushi to sit down and bind*

their legs so that they make efforts to push. We have to do this because we want to facilitate a normal delivery. When there is no indication for a C-section, why should we carry one out?

Senior doctor (female)

One of the nurses voiced that at the time of labour even restraining the woman for the good of the foetus was misconstrued by the woman, who labelled it as abuse.

If the baby's head is at the perineum, and the woman rests, does not push, then it becomes a problem… Sometimes patients even cross their legs during labour. (Gesturing-) *If we even try to separate their legs like this, women say look the sister pushed us hard.*

Nurse (female)

Justifying scolding women

All respondents stated that women had to be "spoken to sternly" if the baby had to be delivered safely. In a staff nurse's words: You can't call this "abuse". But we have to explain to her in a raised voice, and even at times shout at her because they simply don't understand. Another respondent stated:

There are one or two patients who require that (being shouted at) *sometimes. They are very notorious. There are patients who cannot tolerate pain at all. Nowadays it is more common. It is very common. We have this sedentary lifestyle. So it is said that patients who work, they deliver normally easily. Other not sedentary work, but farmers and all, they deliver normally.*

Senior doctor (male)

According to them women largely belonged to slums and were illiterate, and this was the language and manner they understood. Certain women were non-cooperative in labour than others; these were primiparous women.

We tell them not to bear down so early in the process of labour, that there is time. You have to do it only when you are dilated optimally. This happens especially with primis. They watch these movies and try to behave the same way. They will hold the bedposts and scream and bear down. At such times the doctor tells us to scold them, to keep them in check and tell them all this is not required.

Senior staff nurse (female)

Legitimising non-use of pain-relief procedures

When asked about availability of epidural, a procedure related to pain management, i.e. the usage of epidural, respondents mentioned shortage of trained medical staff to carry out the procedure, especially anaesthetists. Some added that epidurals were a relatively new concept, and may not be accepted by women and their relatives for fear of being taken to an operation theatre for epidural administration. Hence none of the hospitals had a procedure for offering epidural, neither had women patients asked for the same according to the respondents.

Use of fundal pressure

Doctors and nurses unanimously stated that administering fundal pressure to hasten delivery was no longer practised as it was unscientific and could harm the foetus. One of the respondents recalled that the practice of applying fundal pressure stopped following a complaint from a patient, and was now rarely carried out. Class-four workers however stated that applying fundal pressure was an ongoing practice, but it was only doctors who usually carried out the same lest it should harm the foetus if anyone else carried it out incorrectly.

Yes, then help is needed (if the woman is not able to push adequately). *On the stomach like this* (indicates fundal pressure). *That's not our job! That, the doctor does. The doctors put pressure. We stand there with the tray. The doctor touches the stomach. The doctor helps if the woman does not have pain.*

Class-four worker (female)

Keeping women nil-by-mouth

The practice of keeping women nil-by-mouth was essential as stated by healthcare providers because it could not be predicted when a woman might need to be taken for c-section. In the words of a doctor: *They want to drink water. But usually during labour we don't give. We give IV fluids. We cannot tell when they may go into section.*

Perceptions of sexual violence

Respondents across cadres unequivocally stated that no sexual abuse of the woman in any form occurred in the labour room. In fact class-four workers felt that some women falsely accused male doctors of sexual abuse when the doctor was only performing his job of examining the woman.

> *Sometimes patients say things accusatorily. Doctors are scared to touch the patients. Yes, it happens. Patients cause disrepute* (Badnaami) *to doctors. So doctors are scared. Either we are called or sisters are called whenever they* (male doctors) *go near patients.* (Women have said) *the same thing, that they touched here, they touched there. Now where should he touch? If he has to do his work, then he is going to touch below only. The doctor needs to take the child out. If he doesn't, then you are the one who will have trouble. For this, you will accuse him? They go outside and accuse doctors. Because patients say this, even doctors don't approach patients. First we are called, only then will they touch patients.*
>
> Senior nurse (female)

Some providers also stated that women hailing from certain communities were more difficult than others to persuade to get an examination conducted from a male doctor.

Generally, Muslim community women, they are somewhat rigid, and do not allow a male to examine them. And sometimes it also happens that the male relative of the patient is with the patient, and he also insists the same - when they bring the patient into the labour in the receiving room, they say, 'No my wife should not be examined by a male.' Such things have also happened.

Senior doctor (male)

According to government regulations, medical examinations and interventions for women patients may be carried out only if a female service provider is also present, unless the user herself waives this right or unless it is not feasible at all in the given circumstances (MoHFW, 2011). In spite of this rule being in place, providers reported being "extra cautious" as they mentioned the looming fear of being falsely accused of sexual assault. A male doctor also disclosed that he avoided performing per vaginal examinations, and if he did, he ensured that a female staff member was present with him.

When a patient is taken for a C-section, and the baby is taken to the labour ward... the patient is on the trolley, until she comes out of the OT into the recovery room, until then, staff members stand inside the OT. Even when she is being shifted, we hold her feet, because she has been given a spinal (anaesthesia). *At night there are two male servants and a staff nurse* (female). *The servants take her, and we hold the feet. She is completely covered and brought outside. Hence misconduct doesn't happen... even we feel that because there are two servants, anything can happen. So this is the staff nurses' responsibility. This is a necessity for the staff to be present there. …We don't allow relatives or servants alone.*

Nurse (female)

Notions of demands made for money

Doctors and nurses admitted that asking for money from women and their relatives after the delivery of the baby was a widely prevalent practice, and that class-four workers demanded money from the women and their relatives. This was done without the knowledge of nurses or doctors, despite there being rules prohibiting the same. One of the nurses reported that they had introduced a form and women were made to sign it on admission. The form stated that patients and their relatives shall not give any money to any hospital employee, and if they did so, it was entirely their responsibility. Despite this the practice continues.

> *There have been complaints about this, against maushis, and so on. We are inside the labour room, we can't pay attention to all this that is happening outside the labour room. After we show the baby, we go inside as our duty ends there. Class 4 workers, maushis, they ask for* (money) *or they are given, I am not sure, but it has happened earlier in the labour ward. There have been complaints about this. …When we shift the patient to the PNC ward, they probably ask during that time. But in front of us or inside the labour ward, they do not ask. Because during shifting all their relatives are with them. While shifting to the PNC, or at the lift too they can ask. Because there isn't so much attention given to them at those times.*
>
> Nurse (female)

One of the staff nurses also spoke about changes she observed with respect to the practice of giving or taking money or gifts after childbirth, which also pointed towards deteriorating healthcare provider and patient relationship:

> *Earlier, 99 per cent of the patients gave something out of happiness. In 1992, there used to be a big pile of boxes of sweets, coconuts. All from patients and relatives who give it to us out of happiness. But now everything is different. Now this does not happen. We even get worried when something is given to us; even sweets, at*

first we used to distribute these sweets among patients but now we fear if there is poison in anything. There is a lot of change now, earlier the money was lesser, but happiness was more.

Nurse (female)

Class-four workers on the other hand vehemently denied demanding money from patients or their relatives. They stated that money was given by the patients themselves out of happiness, and was never demanded. They further stated that there were no rules prohibiting this act.

(We take money) *only if they give out of happiness. Some people give us money on their own out of happiness, at the time of showing the baby. That is happiness. No one puts their hand into another person's pocket deliberately, isn't that right?* (smiling) *Now if I put my hand into your pocket now you will shout, right? We don't take any money over here. And there are no rules. There are no rules and no money is taken. If someone gives out of happiness anyone will take the money. Now even if you give me something out of happiness I will take it.*

Class-four worker (female)

Healthcare providers unanimously rejected the term labour room violence and justified acts such as restraining the woman, shouting at and scolding her, as a necessity for better birth outcomes. They mentioned that they did not have a choice as women displayed "un-cooperative" behaviours, i.e. not bearing down adequately during labour, walking around in active labour, dramatising and even lying about their medical histories. They believed that women did not possess much knowledge about the labour process, and hence they had to behave the way they did, but women misconstrued it as being abusive.

6. Awareness about LaQshya guidelines

The government of India launched LaQshya - Labour Room Quality Improvement Initiative, in 2018, to be implemented nation-wide with the objective of reducing maternal and newborn mortality and morbidity, and enhancing the satisfaction of women availing childbirth service from public health facilities. LaQshya primarily lays down guidelines relating to facility level infrastructure and equipment, human resource management, and clinical practices to prevent maternal and neo-natal infection and morbidity. It also comprises a section on respectful maternity care which includes: the provision of privacy to pregnant women during childbirth, presence of a birth companion, providing women the freedom to choose the position they want to give birth in, using labour beds instead of tables, and adherence to all clinical protocols for management of labour; as well as prohibition of labour augmentation without sound clinical indications, verbally or physically abusing the woman in labour, insisting on a particular position for delivery, and making the woman or her caregivers incur out-of-pocket expenditures.

One year had elapsed since the guidelines were issued, hence we sought healthcare providers' views on the LaQshya guidelines and two of its provisions viz. the birth companion policy, and offering women birth positions of their choice. Most healthcare providers of Hospital A had not heard of the LaQshya guidelines. We decided to seek their views on these two specific practices.

Perceptions of the birth companion practice

Healthcare providers unanimously stated that the "birth companion practice" can only work in a private set-up, and not a government health facility; in an already cramped labour ward allowing relatives would be chaotic.

> *Actually not here, since it is a government set-up. So we carry out this companion* (practice) *in corporate or private set-ups where there is a lot of staff and one-to-one care is given. Here where we have a lot of patients and a limited number of doctors, it is quite*

impossible for us to give such facilities. Because if I allow one male to come in the labour room where I have 5-6 patients, it is not possible ...There it is like they have separate rooms for separate patients, each patient. One patient is in one room. So in that labour room her husband can come and sit beside her. Here it is not like that, it is a general one. In one room there are 5-6 beds, so here I can't allow. And in section, LSCS also, we have to maintain disinfection, the sterility. So here we can't allow that. We can't just waste the stock which we have. Like there are some OT clothes, and they are sufficient for the doctors. But if I allow the relative also to enter then he also has to change. Then it is difficult.

Resident doctor (female)

They also mentioned exceptional situations where a relative was allowed inside to provide the woman support, but was met with lack of success.

We have to allow for some patients who don't listen to us. We do allow their relatives inside. But sometimes the relative herself says 'kar do iska caesarean, woh mera bhi nahi sunti hai, ('Conduct a caesarean for her, she is not even listening to me'). *...Yes we have had such experiences. We have brought the relative of the woman inside, asking her to make her understand.*

Senior doctor (male)

There was also a belief that people availing of government health services were backward in their thinking, and having birth companions could actually hamper rather than facilitate the childbirth process.

No, it is of no use, not use at all. In India, the levels of education are so low, the mentality of the people is such. ...The mentality is such that they will have their own agendas, will want to settle their own scores. Imagine we live in the same locality, in a slum kind of area. And you and I have a fight over something like

water, while standing in the queue for water... Then when both women are admitted into the hospital for delivery and are lying on the bed, their husbands are also present, one woman will tell her husband that the other woman's husband was staring at her inappropriately. Then this starts a fight. This is what happens, and we have to handle all this. Even then we are the ones who are blamed. In fact the society is to be blamed for this.

Nurse (female)

There seemed a lack of understanding among the respondents on the role of birth companion as prescribed by WHO. A birth companion plays the role of emotional and practical anchor besides a competent healthcare provider. It is premised on the fact that most women seek physiological labour and birth to provide a sense of achievement and control through decision-making along with required medical interventions. A birth companion can play a role of effective companionship and handhold the woman through the labour process in presence of the healthcare provider.

Perceptions of offering different birth positions

Most providers showed great surprise about patients selecting or health providers recommending different birth positions. They held the stance that lithotomy position was the position of choice for healthcare providers, and this was followed in the hospital. This is because it was HCPs who had to facilitate various delivery-related procedures, such as administering episiotomies and giving sutures, so the position had to be suitable for them. In the words of a staff nurse: *They have to take the lithotomy position, because otherwise stitches cannot be given. How much tear there is inside, or how much the episiotomy should be,* (to understand this) *they have to take this position.*

Only one doctor agreed that there were varying positions a woman could take during labour. But he also said that such a need was never expressed by women in labour.

7. Challenges faced by healthcare providers and recommendations to prevent mistreatment of women during childbirth

This chapter puts forth the challenges voiced by healthcare providers, which according to them, gave rise to adverse interactions at the time of childbirth, and their recommendations for improving the working environment of labour rooms, thereby preventing disrespect and abuse during labour.

Infrastructure-related challenges and recommendations

Providers said that there was a shortage of staff. Having greater human resources would play a role in decreasing "stressful" patient-provider interactions as they will be able to devote more time to each patient. For example, one nurse mentioned that in post-natal care, staff members must ideally give instructions to every woman about the correct way to hold and feed the baby, but they preferred doing so only for primiparous women as there was a shortage of staff members for explaining this to all women.

> *Nothing can improve in the labour room* (laughs). *Because two staff members have to manage all this actually. So we inform the Matron or sister that this is the workload we have, so increase the manpower and get additional staff... Even staff members from other wards are brought in. Or if the operation theatre is free, then even the staff there helps, in the night, or if the workload is heavy.*
>
> Nurse (female)

Shortage of equipment, and specifically accessing resources was cited to be a concern.

> *See, all medications are available, but procuring them is a tough job. Sometimes there is shortage, then the sister has to identify*

them, then it goes for further signing, and by the time it comes it takes a long duration. …Equipment is there, but yes, gloves, medication... Facilities are very good here, but sometimes there is shortage, and then getting them is a big process.

Resident doctor (female)

Training-related challenges and recommendations

Only one nurse mentioned the need for training of healthcare providers in better communication skills, especially of doctors, as according to her, it was doctors who were in direct contact with patients. She also stated that training for medical personnel seldom included topics such as patient-provider communication and patient counselling which led to a lack of empathy towards the patient. Nurses however did not mention a need for training among their own cadre and for class-four workers. Doctors did not mention any training needs in their recommendations.

Patient education

Several healthcare providers suggested that women should be educated about not only aspects such as nutrition and care during pregnancy, but also about what is expected out of them at the time of labour, and the preparation for the same. According to them this could be done through outreach workers or community health volunteers who identify pregnant women in the community and counsel them, or at the time of antenatal visits in the hospitals.

When patients come for ANC visits, they must be told everything, counselled about what is expected out of them. This is important. ...Information must be given on how to hold the baby after birth and how to feed the baby, how to check if the baby is getting the feed, if the woman has had an episiotomy then she must be educated that she must not cross her legs but keep them straight. Some women just do not make effort, they have inverted nipples. That too we have to manage, and explain to them.

Nurse (female)

8. Exploring efforts to prevent violence in labour rooms and improve maternity care

Hospital B has been a part of a larger initiative at the state level to integrate gender-related aspects into the undergraduate medical curriculum in the subjects of: Obstetrics and Gynaecology, Psychiatry, Medicine, Forensic Medicine and Toxicology, and Community Medicine. Social determinants, including gender, affect health, health-related behaviours, and access to healthcare. The hospital's endeavour to positively transform labour room practices falls under the larger umbrella of integrating gender into the Obstetrics and Gynaecology curriculum which was introduced in the year 2016.

Introduction of the triage system

Doctors mentioned that triage system implemented in their department was found to be useful.This assists in prioritising high risk patients. An example is cited below

> *So triage, now generally this system is used during a situation of war. Mass casualty or war zone, you implement it there, that the ones who have the greater need, you lift them, provide service to them, then who needs it next, you lift them, provide them service. The ones who have the most minor* (condition), *if you attend to them later, then it is alright. So this hospital follows the triage system. And it has been tri-nomenclated too. There is a colour, there are ribbons with the colour code. The ribbon is applied to the paper, so that with the colour code itself everyone understands what category of patient it is. Now if it is red, the patient has to be attended to immediately. So the red is immediately sent inside, and an immediate decision is taken, whether a normal or caesarean has to be carried out, whether a blood transfusion is required, or if there are any other procedures. And because of effective triaging, the mortality and morbidity*

have reduced much. And (informative material) *on triage has been put up everywhere. So the new doctors who come also understand this soon, what triage is all about.*

Senior doctor (male)

Introducing birth companions

Introduction of the policy had led to a reduction in the instances of shouting at the woman and also in the lack of cooperation from them. This practice required involving a female relative of the woman, preferably one who had herself undergone the labour process in the past, to beallowed to be with the woman in the course of the labour. Providers voiced that this new practice had helped in the monitoring of women when there was a shortage of staff, as the companions could alert the doctors about the woman's condition. They saw that women felt more comforted owing to the presence of a relative with them.

So they (birth companions) *are given passes. Those who have passes, we only allow them inside. And for birth companions... we treat the patient in front of them. Mother, the patient's mother, mother-in-law and so on, sister-in-law, mostly they are the companions. When their relatives are close by, the patient feels comforted. Earlier all patients used to say 'Call our relatives', so when the relatives come inside they feel comforted. If a patient is in pain, then she is not too perceptive to the information being given to her. So if her mother or her companion is told, then they explain to them that it is like this...so there is improvement now, in their understanding.*

Nurse (female)

Class-four workers reported that having a birth companion in the process of labour helped reduce the constant questions of relatives to them outside of the labour room. Previously they would have to keep updating them about patient's status. They expressed that companions were useful for providers when IV fluids, gloves, etc. had to be bought for the patient, when these items were not available at the hospital.

In order to avoid overcrowding in the labour ward, sometimes providers had to prioritise companions for women who needed them the most.

> *So the high risk patients like those with heart disease, severe pre-eclampsia, or those who need them the most, we keep them* (the relatives) *selectively. So we keep only ten birth companions, ten to fifteen, those who are given I-cards. Because at a time if there are twenty patients inside, and if all twenty relatives go inside, there won't be any place at all isn't it? Who is on the bed, who is where, whose relative is where... so at such times we screen. If there aren't too many patients, if there are 5 or 7 patients, then all the relatives are allowed inside. But when there are many, it depends on the screening, who needs it the most, their relatives are called inside.*
>
> Senior doctor (female)

The initial experience of having birth companion practice created apprehensions in most HCPs, but more so in nurses. This was due to their past experiences of babies being stolen, or relatives conveying the incorrect sex of the child to those waiting outside. Further, they voiced that such a policy in their education or professional life was unheard of, which made them feel hesitant. Nurses and class-four workers' primary concern was that of maintaining cleanliness in the ward as labour rooms have to maintain highest standard of infection control; having more than one relative entering with the patient increases the staff's workload.

Doctors in the initial stages perceived birth companions as "relatives' interference in labour procedures".

> *So relatives are brought inside. But sometimes we have problems with the relatives as well. If one relative enters, instead of attending to her patient, she also interferes with other patients' management. Or conveys - means if some patient has delivered, and nobody is there, then she goes outside telling whether she*

has delivered a male or a female. That is the thing. Or giving messages to other patients. Or she interferes with our treatment also, 'Why you are giving this, why you are giving that?' So sometimes this happens. Sometimes with one patient they bring in two-three relatives at a time. We tell them that just one relative is allowed inside. But sometimes we have to keep two-three relatives too, if the patient is very un-cooperative, or the relatives are un-cooperative.

Senior doctor (male)

Introducing different birth positions

The respondents spoke about different birthing positions offered to women so that they may be more comfortable and less in pain during labour. They reported that rods had been affixed at the top of labour beds so that women may be able to hold them for support and take the birthing position most convenient for them. Women were informed about this provision when they arrived for antenatal check-ups, and hence were able to choose the position of their choice at the time of delivery.

Allowing intake of fluids during labour

As a part of bringing about changes in labour room, respondents shared that nil-by-mouth protocol has been eradicated and patients are allowed to have fluids. The woman's assessment for the need of operative procedures is carried out before the delivery, in the antenatal period, and instructions regarding fluid intake are thus determined. Class-four workers said that a practice of providing filled bottles of water at the bedside of patients was also introduced. 'Nil-by-mouth' was implemented on a case-to-case basis e.g. women with gestational hypertension, anaemia, etc. and who may need surgical intervention. These women are informed in advance about it.

Yes. Even if she is in active labour, we allow a liquid diet. Like juice, or coconut water, they can have such things. Not solid food.

Because during labour, there are chances of aspiration. So we allow fluids. It is not like we keep them NBM. They are allowed water, they are allowed a liquid diet. Like they can have tea and biscuits. Or they can soak biscuits in water and have. But they cannot have roti, dal, chawal, they can't have such things. Nil-by-mouth is for C sections. If the patient needs a section, we anticipate it, that she may need a section. So we administer IV fluids, like lactate or dextrose. We don't keep them NBM to prevent hypoglycaemia.

Senior doctor (female)

Provisions for privacy and confidentiality

The labour room, as well as the waiting room had curtains. Curtains separating examination tables were also seen. Respondents however stated that the curtains sometimes posed a problem while monitoring women in labour, and therefore were not drawn completely. Another respondent stated that in spite of having curtains or screens, it was not always possible to provide individual privacy to each patient:

There are screens in the waiting room. And inside too there are five tables, and no one comes inside. Only female relatives enter. And the sister who was sitting right now, we don't allow the relatives inside - male relatives. ...Yes there are screens there too, but there are five tables and we cannot have curtains enclosing labour room tables. The woman lying next to her can see her.. Over here, sometimes at night, there are 4-5 deliveries going on. There are 2-3 doctors, and there are 2 sisters. Meaning there is a screen. But there is not enough space. Sometimes deliveries are carried out on all the five tables. ...And sometimes when patients are experiencing pain they don't even look at the patient lying next to them. And no one else comes. And in front of the doctors and sisters they have to be (exposed).

Nurse (female)

The department has set up a separate ward for seropositive women and it was titled as a separate ward, which was reserved for high risk cases. This ensured that not only were they provided special care which they required, but that the confidentiality of their serostatus information also was not compromised. They further stated that for these women, special precautions were taken in the form of protective gear, and the by-products of their delivery were discarded separately.

Consent-taking protocol

Respondents mentioned that elaborate steps for consent have been created as against "blind consent-taking" for all procedures in the past. We were also shown the consent forms for different procedures, which were in English as well as in the regional language. Consent forms were customised based on high risk conditions such as heart diseases, anaemia, diabetes. Such consent was taken from both, the woman and her relatives because these conditions may warrant invasive procedures such as surgery.

Consent-taking for administration of contraceptives

Healthcare providers spoke of introduction of contraceptive counselling as a protocol right in the ANC period. However if the woman came to the hospital directly at the time of delivery, she was told about contraceptive options after she had delivered. A range of contraceptive options were offered to all women regardless of their parity. Respondents stated that contraceptive methods were administered only after obtaining informed consent from the woman; whereas some respondents stated that this consent was written in form, others stated that only oral consent was taken which sufficed. While efforts were made to speak to the woman and encourage her to make contraceptive decisions, at times women still insisted on asking a family member regarding contraceptive decisions, hence it was also recognized that many a times, the decision-making power did not lie with the women. At such times, the family member of the woman was informed of the same. Respondents reported that it was always the woman's wishes which were carried out regarding administration of contraceptive methods.

For contraceptives the relative's consent is not necessary. The patient has to be willing. And if the patient says, ask my relatives once, we ask. Otherwise we don't ask the relatives. Because it is about the mother's contraception. So she has the right. If she wants to get it (IUCD) *inserted, she can get it inserted. And if she says ask my mother, or ask my husband, we ask them, convey to them. ...When she comes for ANC visits, we counsel them since then. If they are multis, or even primis, we give them options - whether you want to get a copper-T inserted, or you want a TL. We ask each and every patient if you want to get a permanent sterilization or want a copper-T. So the counselling begins in the ANC, and we write on the OPD paper, that the patient is willing for this kind of contraception. We write that.*

...The women who come to us, they mostly do everything after having asked their husbands, whether a copper-T has to be inserted, whether a TL has to be carried out. Most of the times it is not their decision. We have to counsel them a lot. And if the husband says no, then we try to counsel the husband. If the mother is willing, if the woman is strongly willing, then we convey this, that she is willing, then what problem do you have. The fears they have, we try to rectify them.

Senior doctor (female)

Consent-taking for episiotomies

Respondents admitted that performing episiotomies had been a common practice in the hospital in earlier times, but now the practice was to administer an episiotomy only after a needs assessment, e.g. for conditions such as a rigid perineum or prolonged labour.

Episiotomies are administered whenever they are necessary. But the incidence and the percentage of episiotomies have reduced from before. Because many a time, patients deliver in the position

of their choice, so many episiotomies are not required. The earlier policy was to give an episiotomy to every patient. But now that is not the case. Wherever it is necessary, it is given.

Senior doctor (male)

All the providers reported that women were informed at the time of administering episiotomies that "stitches shall be given". Although this was a good practice, explaining the role of episiotomies and when they were supposed to be administered, was not being done.

Process of bringing about new practices

The introduction of new practices, such as, introducing birth companions, new birth positions and so on, was initiated by the head of the department. Respondents mentioned that his leadership played a key role in institutionalizing the new practices. All the doctors associated the changes with the term "Respectful Maternity Care", the concept under which it had been introduced, and stated that the endeavour concerned "imparting women their rights during childbirth". According to them, respectful maternity care entailed practices free of physical and verbal abuse of women, and which were judicious in their use of medical interventions (e.g. not administering episiotomies indiscriminately to every woman but only to those for whom it was indicated). Nurses and class-four workers referred to the initiative by individual practices which were carried out under it (e.g. allowing of birth companions, allowing different birth positions, etc.). All cadres of providers shared that these new practices had been introduced in a step-by-step manner, and after orienting all the cadres of healthcare providers through an initial training workshop. While there was initial resistance from all cadres, an open dialogue, communication, and hands-on training enabled bringing the entire team on board. This is an ongoing program, and changes are underway as mentioned by respondents. They called the process of respectful maternity care practice as ongoing process of continuous learning and teaching on the job from older to newer staff members. Most providers reported that patients' satisfaction and positive birth outcomes motivated them the most to keep up their efforts.

The results are good, isn't it? Meaning there is no need for any separate motivation. The patients' feedback is the most valuable. So they speak to us and go. Like the residents. The relatives meet all the residents before leaving, also give bouquets, so that feels good. In the end it is like this - everyone gets money (salary). *That is the primary aim. Meaning everyone has a source of income. There is no problem of that because we are a government set-up, whether we do something or not, we get the same amount of money. But if the person before you is appreciating you, that we liked such and such thing, or they did something well, then that is motivating. There is no need of any other* (external) *motivation. …Everything has its own shortcomings. But at the local level, how we can implement everything to the best of our abilities, we learn that. So by continuing the implementation of these aspects, now the process has been streamlined.*

Senior doctor (male)

This process of institutionalisation of respectful maternity care, such as the introduction of the birth companion policy, offering different birth positions, following the triage system by a team of healthcare providers under leadership of hospital and department looks encouraging.

9. Discussion, implications and conclusion

This study brings forth perceptions of healthcare providers about labour room practices, their perceptions about patients, and their recommendations for change. These findings are depicted in the following conceptual framework. The framework presents factors leading to disrespect and abuse, its perpetuation within hospital settings, and nature of interventions to prevent the mistreatment of women during childbirth.

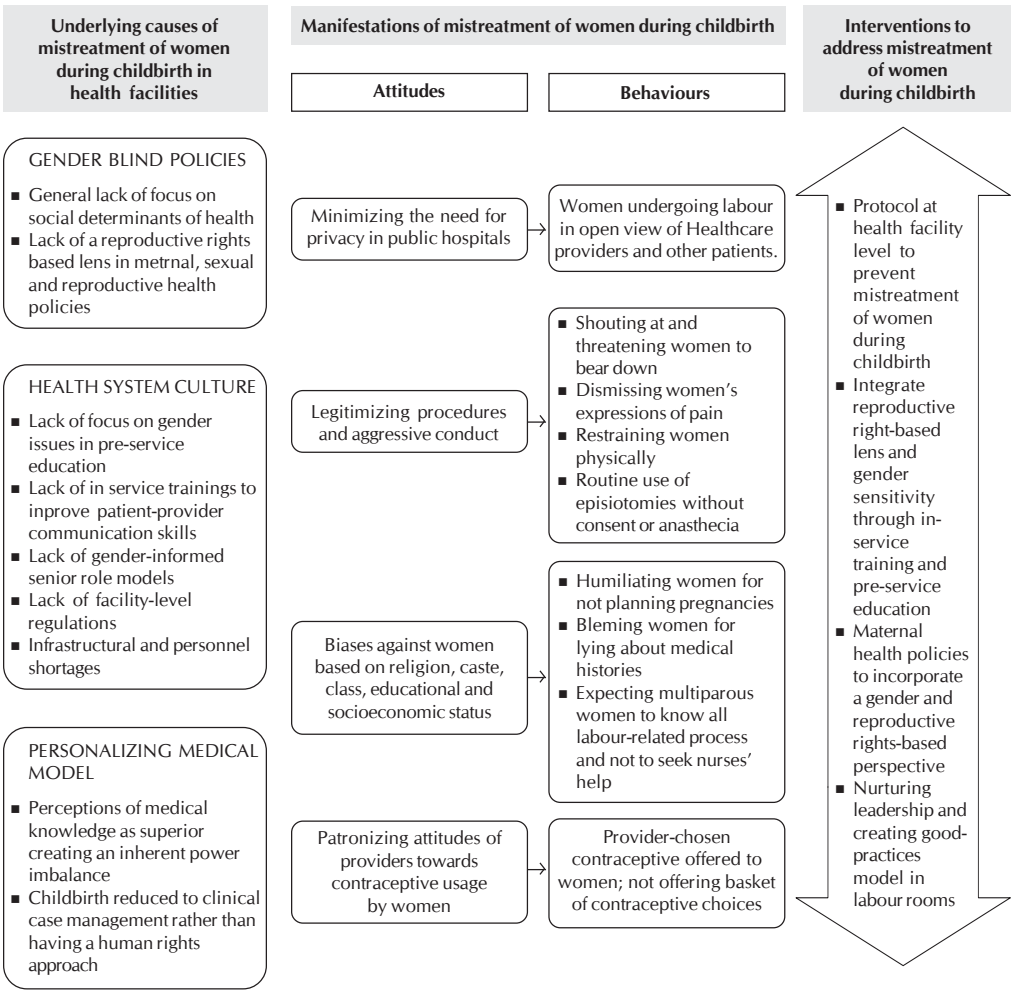

Figure 2: Conceptual framework presenting factors leading to mistreatment of women during childbirth, its manifestations, and interventions to prevent the same

It was found that healthcare providers in both hospitals generally held dismissive attitudes towards the lack of privacy and confidentiality, and informed consent-taking, with some exceptions in Hospital B, who spoke of positive changes in practice due to championing the cause of respectful maternity care by senior doctors of the gynaecology department. On one hand, providers acknowledged the importance of privacy in labour rooms, but on the other, contradicted themselves by stating that as majority of the staff working in the labour room were women, there was no need for specific protocol for maintaining privacy. It is hence evident from the findings that providers are unaware of women's expectations of privacy in labour room settings. There is evidence from studies carried out to document women's experiences in labour rooms that women perceive this lack of privacy acutely, and feel humiliated and disrespected at having to lie exposed in plain sight of others (Khanday & Tanwar, 2013; Amroussia, Hernandez, Vives-Cases & Goicolea, 2017). Discussion on confidentiality of sensitive information such as seropositive status brought forth patient-blaming attitudes amongst healthcare providers, who maintained that women deliberately provide false information about their medical histories such as their HIV status or the number of children they had, and felt that such confidentiality could be not be completely maintained at the cost of the health and life of providers lest they get infected.

While most healthcare providers maintained that "consent-taking" was an important procedure, its understanding was restricted to obtaining signatures of family members and/or the patient herself. Consent for episiotomies was dismissed by doctors and nurses stating that administering it was a medical need and hardly an issue of consent. The common belief across both hospitals was that episiotomies were a necessity for primiparous women. On the contrary, there is evidence to show that when administered episiotomies without anaesthesia, women are aware of the severe pain they experience, which has led to their gross dissatisfaction with the treatment received at the health facility (Diorgu & Steen, 2017). Moreover, the routine use of episiotomies has been termed as a non-evidence based practice, and guidelines by chief health organizations state that episiotomies must be given only when clinically indicated, its routine use for vaginal deliveries being unnecessary and not recommended (WHO, 2018).

Findings demonstrate that actions such as shouting at women in labour, using restraint, and in some cases applying fundal pressure, were considered useful to ensure positive outcomes for both, the baby and the woman in labour. There was a dismissal of the terms "mistreatment" and "violence" used by researchers to probe about these behaviours, and researchers were told that once the baby is born and the woman is out of danger, these behaviours were quickly forgotten. These findings are echoed in the study by Bohren et al. (2016) where providers considered slapping, pinching and shouting at women in labour as acceptable behaviours if they were carried out for positive birth outcomes.

Such behaviour and practices by healthcare providers were also rooted in preconceived notions about the women availing of public health facilities for childbirth. Particularly, biases were held against multiparous women and women belonging to religious minorities. The study hence illustrates how labour room violence, in effect, stems from provider biases and the inherent socioeconomic inequalities prevalent in the society, underscoring a culture of disrespect and abuse diffused within hospital settings.

The LaQshya guidelines were introduced with the aim of improving intra-partum and post-partum care for women and neonates. Their objective is to reduce maternal and new born mortality and morbidity associated with care around delivery in labour rooms. The LaQshya guidelines seek to enhance the satisfaction of beneficiaries i.e. women, by providing Respectful Maternity Care to all pregnant women attending the public health facilities in India. They have a specific set of cycles from Cycle 1 to Cycle 6 seeking toimprove facility level infrastructure and equipment, human resource management and clinical practices to prevent infection and morbidity, offer Respectful Maternity Care, ensure presence of birth companions during delivery, and enhance patient satisfaction. Subsequent cycles introduce assessment, triage and timely management of complications including protocols for referrals. While this is a welcome move, the guidelines do not specifically address ways to introduce Respectful Maternity Care and to carry out trainings related to introducing birth companions.

While Hospital A was not aware of Lasqshya guidelines, Hospital B had introduced the entire scope of Laqshya guidelines-triage system and protocol for management of high risk pregnancies - besides the components of Respectful Maternity Care i.e. initiating birth companions for primiparous women and enabling women to choose birthing positions, amongst others, to prevent disrespect and abuse in the labour room. Training of providers to understand the concept of respectful maternity care, development of a handbook with standard operating protocols for women in labour, introduction of different birthing positions as well as birth companions were described as key components to inculcating respectful maternity care. The programme was an ongoing one, with respectful maternity care practices being passed on from older to newer staff through a system of continuous teaching and guidance on the job, hence institutionalizing these new practices through constant engagement, supervision and incremental.

The present study sheds light on gaps in medical and nursing education system which do not delve into the social determinants of health. This hinders healthcare providers from understanding the sociopolitical contexts of decisions related to pregnancy, birthing, access to healthcare, control a woman has over her own body, as well as the decision to use contraceptives. Moreover, despite the growing body of global evidence on respectful maternity care, the lack of integration of these new aspects in continuing medical education and nursing training prevents healthcare providers from practising humane and empathetic ways to manage childbirth. This finding hence holds much significance for directions for medical and nursing education and training, which must include the aspects of social determinants of health and positive patient-provider communication within their ambit.

Finally this study not only brings to fore the institutionalization of mistreatment of women, but also an example of efforts made to prevent such practice. The findings call for a holistic perspective towards quality of care during childbirth, taking into account patient-provider communication, and a childbirth experience free of discrimination, harm and ill-treatment. Nonetheless, a programme to inculcate respectful maternity care in Indian public health settings holds promise for efforts aiming to improve childbirth care.

References

1. Abuya, T., Ndwiga, C., Ritter, J., Kanya, L., Bellows, B., Binkin, N., & Warren, C. E. (2015). The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. *BMC Pregnancy and Childbirth, 15*(1). http://dx.doi.org/10.1186/s12884-015-0645-6
2. Abuya, T., Warren, C. E., Miller, N., Njuki, R., Ndwiga, C., Maranga, A. ... Bellows, B. (2015). Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *Plos One, 10*(4). http://dx.doi.org/10.1371/journal.pone.0123606
3. Adinew, Y. M., & Assefa, N. A. (2017). Experience of facility based childbirth in rural Ethiopia: An exploratory study of women's perspective. *Journal of Pregnancy*, 1-6. http://dx.doi.org/10.1155/2017/7938371
4. Amroussia, N., Hernandez, A., Vives-Cases, C., &Goicolea, I. (2017). "Is the doctor God to punish me?!" An intersectional examination of disrespectful and abusive care during childbirth against single mothers in Tunisia. *Reproductive Health*, *14*(1), 1-12. https://doi.org/10.1186/s12978-017-0290-9
5. Annan, K. (1999). Violence against women 'most shameful', pervasive human rights violation, says Secretary-General in remarks on International Women's Day. Retrieved from https://www.un.org/press/en/1999/19990308.sgsm6919.html
6. Arora, S., Bhate-Deosthali, P., & Rege, S. (2018). *Responding to domestic violence for improving maternal health outcomes: An evaluation of a counselling intervention for pregnant women in Mumbai*. Mumbai, India: Centre for Enquiry into Health and Allied Themes.
7. Asefa, A., Bekele, D., Morgan, A., & Kermode, M. (2018). Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. *Reproductive Health*, *15*(1), 1-8.https://doi.org/10.1186/s12978-017-0449-4
8. Bajpai, V. (2014). The challenges confronting public hospitals in India, their origins, and possible solutions. *Advances in Public Health*. https://doi.org/10.1155/2014/898502

9. Bhattacharya, S., & Ravindran, T. K. (2018). Silent voices: institutional disrespect and abuse during delivery among women of Varanasi district, northern India. *BMC Pregnancy and Childbirth*, *18*(1), 1-8. https://doi.org/10.1186/s12884-018-1970-3

10. Bishop, F. L., Barlow, F., Coghlan, B., Lee, P., & Lewith, G. T. (2011). Patients as healthcare consumers in the public and private sectors: A qualitative study of acupuncture in the UK. *BMC Health Services Research*, *11*, 1-11. https://doi.org/10.1186/1472-6963-11-129

11. Bohren, M. A., Hunter, E. C., Munthe-Kaas, H. M., Souza, J. P., Vogel, J. P., & Gülmezoglu, A. M. (2014). Facilitators and barriers to facility-based delivery in low - and middle-income countries: A qualitative evidence synthesis. *Reproductive Health*, *11*(1).

12. Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., … Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *Plos Medicine*, *12*(6). https://doi.org/10.1371/journal.pmed.1001847

13. Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., &Olutayo, A. O., ...Hindin, M. J. (2016). "By slapping their laps, the patient will know that you truly care for her": A qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria. *SSM - Population Health, 2*, 640-655. http://dx.doi.org/10.1016/j.ssmph.2016.07.003

14. Bowser, D., & Hill, K. (2010). *Exploring evidence for disrespect and abuse in facility based childbirth*. Boston: USAID-Traction Project, Harvard School of Public Health. Retrieved from https://www.ghdonline.org/uploads/Respectful_Care_at_Birth_9-20-101_Final1.pdf

15. Brown, H., Hofmeyr, G. J., Nikodem, V. C., Smith, H., & Garner, P. (2007). Promoting childbirth companions in South Africa: A randomised pilot study. *BMC Medicine*, *5*(1), 1-8. http://dx.doi.org/10.1186/1741-7015-5-7

16. Burrowes, S., Holcombe, S. J., Jara, D., Carter, D., & Smith, K. (2017). Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: A qualitative study. *BMC Pregnancy and Childbirth, 17*(1), 1-14. http://dx.doi.org/10.1186/s12884-017-1442-1

17. Centre for Enquiry into Health and Allied Themes. (2017). *Integrating gender in medical education: Obstetrics and gynecology: Gender integrated modules for MBBS. A guide for medical teachers*. Mumbai, India: CEHAT.
18. Centre for Enquiry into Health and Allied Themes, Seth G.S. Medical College and King Edward Memorial Hospital & Maharashtra Association of Resident Doctors (2018). *Exploring the phenomenon of violence faced by resident doctors in public hospitals of Maharashtra by patient/s and/or relative/s and/or escort/s: Factsheet*. Retrieved from http://www.cehat.org/uploads/files/VAD%20factsheet%2020%20Sept%202018.pdf
19. Center for Reproductive Rights & Federation of Women Lawyers Kenya (FIDA). (2007). *Failure to deliver: Violations of women's human rights in Kenyan health facilities*. Retrieved from https://reproductiverights.org/sites/default/files/documents/pub_bo_failuretodeliver.pdf
20. Chadwick, R. J., Cooper, D., & Harries, J. (2014). Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery*, *30*(7), 862–868. https://doi.org/10.1016/j.midw.2013.12.014
21. Chattopadhyay, S. (2015). *'I can't take it anymore': Sights and awful sounds from the labour room of an Indian public hospital*. Retrieved from https://scroll.in/article/729784/i-cant-take-it-anymore-sights-and-awful-sounds-from-the-labour-room-of-an-indian-public-hospital
22. D'Ambruoso, L., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health*, *5*(1), 140. https://doi.org/10.1186/1471-2458-5-140
23. d'Oliveira, A. F. P. L., Diniz, S. G., & Schraiber, L. B. (2002). Violence against women in health-care institutions: An emerging problem. *The Lancet*, *359*(9318), 1681–1685. https://doi.org/10.1016/S0140-6736(02)08592-6
24. Diniz, C. S. G., Rattner, D., d'Oliveira, A. F. P. L., de Aguiar, J. M., & Niy, D. Y. (2018). Disrespect and abuse in childbirth in Brazil: Social activism, public policies and providers' training. *Reproductive Health Matters*, *26*(53), 19–35. https://doi.org/10.1080/09688080.2018.1502019
25. Diniz, S. G., & Chacham, A. S. (2004). "The Cut Above" and "the Cut Below": The abuse of caesareans and episiotomy in São Paulo, Brazil. *Reproductive Health Matters*, *12*(23), 100–110. https://doi.org/10.1016/S0968-8080(04)23112-3

26. Diniz, S. G., de Oliveira Salgado, H. D., de Aguiar Andrezzo, H. F., de Carvalho, P. G. C., Carvalho, P. C. A., Aguiar, C. A., & Niy, D. Y. (2015). Abuse and disrespect in childbirth care as a public health issue in Brazil: origins, definitions, impacts on maternal health, and proposals for its prevention. *Journal of Human Growth and Development*, *25*(3), 377-382. https://doi.org/10.7322/jhgd.106080

27. Diorgu, F. C., & Steen, M. P. (2017). Nigerian mothers' perceived disrespectful care during labour and birth arising from lack of choices for birthing position and episiotomy. *Journal of Gynecology & Obstetrics*, *1*(3).

28. Donabedian, A. (1988). The quality of care: How can it be assessed?. *JAMA*, *260*(12), 1743. Retrieved from https://jamanetwork.com/journals/jama/article-abstract/374139

29. Ezedinachi, E. N. U., Ross, M. W., Meremiku, M., Essien, E. J., Edem, C. B., Ekure, E., & Ita, O. (2002). The impact of an intervention to change health workers' HIV/AIDS attitudes and knowledge in Nigeria: A controlled trial. *Public Health*, *116*(2), 106–112. https://doi.org/10.1038/sj.ph.1900834

30. Freedman, L. P., Ramsey, K., Abuya, T., Bellows, B., Ndwiga, C., Warren, C. E., ... Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: A research, policy and rights agenda. *Bulletin of the World Health Organization*, *92*(12), 915–917. https://doi.org/10.2471/BLT.14.137869

31. Garcia-Moreno, C., & Watts, C. (2011). Violence against women: an urgent public health priority. *Bulletin of the World Health Organization*, *89*(1), 2-2. Retrieved from https://www.scielosp.org/pdf/bwho/2011.v89n1/2-2/en

32. Glasman, L. R., & Albarracín, D. (2006). Forming attitudes that predict future behavior: A meta-analysis of the attitude–behavior relation. *Psychological Bulletin, 132*(5), 778-822. https://doi.org/10.1037/0033-2909.132.5.778

33. Goer, H. (2010). Cruelty in maternity wards: Fifty years later. *The Journal of Perinatal Education*, *19*(3), 33–42. https://doi.org/10.1624/105812410X514413

34. Goldberg, H. (2009). Informed decision making in maternity care. *The Journal of Perinatal Education*, *18*(1), 32–40. https://doi.org/10.1624/105812409X396219

35. Govender, V., & Penn-Kekana, L. (2008). Gender biases and discrimination: A review of health care interpersonal interactions. *Global Public Health*, *3*(S1), 90–103. https://doi.org/10.1080/17441690801892208

36. Hanefeld, J., Powell-Jackson, T., & Balabanova, D. (2017). Understanding and measuring quality of care: Dealing with complexity. *Bulletin of the World Health Organization*, *95*(5), 368-374. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5418826/

37. Hodges, S. (2009). Abuse in hospital-based birth settings?. *The Journal of Perinatal Education*, *18*(4), 8–11. https://doi.org/10.1624/105812409X474663

38. Hodin, S. (2017, April 11). Respectful maternity care: A basic human right [Blog post]. Retrieved from https://www.mhtf.org/2017/04/11/respectful-maternity-care-a-basic-human-right/

39. Hopkins, L., Saciragic, L., Kim, J. and Posner, G. (2016). The hidden curriculum: Exposing the unintended lessons of medical education. *Cureus, 8*(10). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5120972/

40. Human Rights Watch. (2009). *No tally of the anguish: Accountability in maternal health care in India*. India: Author.

41. Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*, *47*(11), 1781–1795. https://doi.org/10.1016/S0277-9536(98)00240-8

42. Jewkes, R., & Penn-Kekana, L. (2015). Mistreatment of women in childbirth: Time for action on this important dimension of violence against women. *PLOS Medicine*, *12*(6).https://doi.org/10.1371/journal.pmed.1001849

43. John, P., Bavadekar, A., Hasnain, A., & Karandikar, A. (2015). *Gender in medical education: Perceptions of medical educators: Study conducted among medical educators of seven medical colleges in Maharashtra*. Mumbai, India: Centre for Enquiry into Health and Allied Themes.

44. Khan, M. E., Hazra, A., & Bhatnagar, I. (2010). Impact of Janani Suraksha Yojana on selected family health behaviors in rural Uttar Pradesh. *The Journal of Family Welfare*, *56*, 9-22.

45. Khanday, Z., & Tanwar, Y. (2013). *Exploring religion based discrimination in health facilities in Mumbai*. Mumbai, India: Centre for Enquiry into Health and Allied Themes.

46. Khayat, R., & Campbell, O. (2000). Hospital practices in maternity wards in Lebanon. *Health Policy and Planning*, *15*(3), 270–278. https://doi.org/10.1093/heapol/15.3.270

47. Kincaid, D. L. (2000). Mass media, ideation, and behavior: A longitudinal analysis of contraceptive change in the Philippines. *Communication Research, 27*(6), 723-763. https://doi.org/10.1177/009365000027006003

48. Kruk, M. E., Paczkowski, M., Mbaruku, G., de Pinho, H., & Galea, S. (2009). Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *American Journal of Public Health*, *99*(9), 1666–1672. https://doi.org/10.2105/AJPH.2008.146209

49. Kruk, M. E., Kujawski, S., Mbaruku, G., Ramsey, K., Moyo, W., & Freedman, L. P. (2014). Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy and Planning*, *33*(1), e26-e33. https://doi.org/10.1093/heapol/czu079

50. Kujawski, S. A., Freedman, L. P., Ramsey, K., Mbaruku, G., Mbuyita, S., Moyo, W., & Kruk, M. E. (2017). Community and health system intervention to reduce disrespect and abuse during childbirth in Tanga Region, Tanzania: A comparative before-and-after study. *PLOS Medicine*, *14*(7). https://doi.org/10.1371/journal.pmed.1002341

51. Kurian, O. C., Wagle, S., & Raymus, P. (2011). *Mapping the flow of user fees in a public hospital*. Mumbai, India: Centre for Enquiry into Health and Allied Themes.

52. Leonard, K. L., & Masatu, M. C. (2010). Using the Hawthorne effect to examine the gap between a doctor's best possible practice and actual performance. *Journal of Development Economics*, *93*(2), 226–234. https://doi.org/10.1016/j.jdeveco.2009.11.001

53. Madhiwalla, N., Ghoshal, R., Mavani, P., & Roy, N. (2018). Identifying disrespect and abuse in organisational culture: A study of two hospitals in Mumbai, India. *Reproductive Health Matters*, *26*(53), 36–47. https://doi.org/10.1080/09688080.2018.1502021

54. Maya, E. T., Adu-Bonsaffoh, K., Dako-Gyeke, P., Badzi, C., Vogel, J. P., Bohren, M. A., & Adanu, R. (2018). Women's perspectives of mistreatment during childbirth at health facilities in Ghana: Findings from a qualitative study. *Reproductive Health Matters*, *26*(53), 70–87. https://doi.org/10.1080/09688080.2018.1502020

55. Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D., ...Althabe, F. (2016). Beyond too little, too late and too much, too soon: A pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, *388*(10056), 2176–2192. https://doi.org/10.1016/S0140-6736(16)31472-6

56. Miller, S., Cordero, M., Coleman, A. L., Figueroa, J., Brito-Anderson, S., Dabagh, R., ... Nunez, F. M. (2003). Quality of care in institutionalized deliveries: The paradox of the Dominican Republic. *International Journal of Gynecology and Obstetrics*, *82*(1), 89–103; discussion 87-88. https://doi.org/10.1016/s0020-7292(03)00148-6

57. Ministry of Health and Family Welfare, Government of India. (2011). *National Health Bill*. New Delhi, India: Author.

58. Ministry of Health and Family Welfare, Government of India. (2016). *National Rural Health Mission: National Health Mission*. Retrieved from https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=969&lid=49

59. Ministry of Health and Family Welfare, Government of India. (2018). *LaQshya: Labour Room Quality Improvement Initiative* (pp. 37-40). New Delhi, India: Author.

60. Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., ... Umenai, T. (2001). From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': Changes in five municipalities in north-east Brazil. *International Journal of Gynecology & Obstetrics*, *75*, S67–S72. https://doi.org/10.1016/S0020-7292(01)00511-2

61. Nandraj, S., Muraleedharan, V. R., Baru, R. V., Quadeer, I., & Priya, R. (2001). *Private health sector in India: Review and annotated bibliography*. Mumbai, India: Centre for Enquiry into Health and Allied Themes.

62. Oliveira, V. J., & Penna, C. M. de M. (2017). Discussing obstetric violence through the voices of women and health professionals. *Texto Contexto - Enfermagem*, *26*(2). https://doi.org/10.1590/0104-07072017006500015

63. Patel, P., Makadia, K., & Kedia, G. (2015). Study to assess the extent of disrespect and abuse in facility based child birth among women residing in urban slum area of Ahmedabad. *International Journal of Multidisciplinary Research and Development*, *2*(8), 25-27. Retrieved from http://www.allsubjectjournal.com/download/1089/159.pdf

64. Peabody, J. W., Taguiwalo, M. M., Robalino, D. A., & Frenk, J. (2006). Improving the quality of care in developing countries. In D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, ... P. Musgrove (Eds.), *Disease Control Priorities in Developing Countries* (2nd ed.). Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK11790/

65. Pérez D'Gregorio, R. (2010). Obstetric violence: A new legal term introduced in Venezuela. *International Journal of Gynecology and Obstetrics*, *111*(3), 201-202. https://doi.org/10.1016/j.ijgo.2010.09.002

66. Ram, K. (1994). Medical management and giving birth: Responses of coastal women in Tamil Nadu. *Reproductive Health Matters*, *2*(4), 20-26.https://doi.org/10.1016/0968-8080(94)90004-3

67. Rao, M. (2017, February 8). Uttar Pradesh has a free ambulance service for pregnant women but substandard hospitals [Blog post]. Retrieved from https://scroll.in/pulse/827874/uttar-pradesh-has-a-free-ambulance-service-for-pregnant-women-but-substandard-hospitals

68. Ratcliffe, H. L., Sando, D., Lyatuu, G. W., Emil, F., Mwanyika-Sando, M., Chalamilla, G., ... McDonald, K. P. (2016). Mitigating disrespect and abuse during childbirth in Tanzania: An exploratory study of the effects of two facility-based interventions in a large public hospital. *Reproductive Health*, *13*(1). http://dx.doi.org/10.1186/s12978-016-0187-z

69. Ravindran, T. & Kelkar-Khambete, A. (2007). Women's health policies and programmes and gender-mainstreaming in health policies, programmes and within health sector institutions. *Background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health*.

70. Rosen, H. E., Lynam, P. F, Carr, C., Reis, V., Ricca, J., Bazant, E. S., & Bartlett, L. A. (2015). Direct observation of respectful maternity care in five countries: A cross-sectional study of health facilities in East and Southern Africa. *BMC Pregnancy and Childbirth*, *15*(1). http://dx.doi.org/10.1186/s12884-015-0728-4

71. Sando, D., Ratcliffe, H., McDonald, K., Spiegelman, D., Lyatuu, G., Mwanyika-Sando, M. ... Langer, A. (2016). The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. *BMC Pregnancy and Childbirth*, *16*(1). http://dx.doi.org/10.1186/s12884-016-1019-4

72. Savage, V., & Castro, A. (2017). Measuring mistreatment of women during childbirth: A review of terminology and methodological approaches. *Reproductive Health*, *14*(1). https://doi.org/10.1186/s12978-017-0403-5

73. Sen, G., Reddy, B., & Iyer, A. (2018). Beyond measurement: The drivers of disrespect and abuse in obstetric care. *Reproductive Health Matters*, *26*(53), 6–18. https://doi.org/10.1080/09688080.2018.1508173

74. Sethi, R., Gupta, S., Oseni, L., Mtimuni, A., Rashidi, T., & Kachale, F. (2017). The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery. Reproductive Health, 14(1). http://dx.doi.org/10.1186/s12978-017-0370-x

75. Sharma, D. (2017). Rising violence against health workers in India. *The Lancet*, *389*(10080), 1685. https://doi.org/10.1016/S0140-6736(17)31142-X

76. 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. *Bulletin of The World Health Organization*, *95*(6), 419-429. http://dx.doi.org/10.2471/blt.16.179291

77. Srivastava, A., Bhattacharyya, S., Clar, C. & Avan, B. I. (2014). Evolution of quality in maternal health in India: Lessons and priorities. *International Journal of Medicine and Public Health, 4*(1), 33–39. Retrieved from http://www.ijmedph.org/sites/default/files/IntJMedPublicHealth2014_4_1_33_127120.pdf

78. Stangl, A., Carr, D., Brady, L., Eckhaus, T., Claeson, M., & Nyblade, L. (2010). *Tackling HIV-related stigma and discrimination in South Asia*. Washington DC: The World Bank.

79. The White Ribbon Alliance. (2011). Respectful maternity care: The universal rights of childbearing women.

80. United Nations. (2015). *Sustainable development goals*. Retrieved from https://www.undp.org/content/undp/en/home/sustainable-development-goals.html

81. Vacaflor, C. H. (2016). Obstetric violence: A new framework for identifying challenges to maternal healthcare in Argentina. *Reproductive Health Matters*, *24*(47), 65–73. https://doi.org/10.1016/j.rhm.2016.05.001

82. Vincent, V., & Saha, M. K. (2019). A study on evaluation of LaQshya in Andaman. *Recent Advances in Pathology & Laboratory Medicine*, *5*(3).

83. Vogel, J. P., Bohren, M. A., Tunçalp, O., Oladapo, O. T, & Gülmezoglu, A. M. (2016). Promoting respect and preventing mistreatment during childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology,123*(5), 671–674. https://doi.org/10.1111/1471-0528.13750

84. Vora, K. S., Mavalankar, D. V., Ramani, K. V., Upadhyaya, M., Sharma, B., Iyengar, S. ... Iyengar, K. (2009). Maternal health situation in India: A case study. *Journal of Health, Population and Nutrition*, *27*(2), 184-201. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761784/

85. World Health Organization. (2014). *The prevention and elimination of disrespect and abuse during facility-based childbirth*. Geneva, Switzerland: World Health Organization.

86. World Health Organization. (2017). *Density of physicians (total number per 1000 population, latest available year)*. Retrieved from https://www.who.int/gho/health_workforce/physicians_density/en/

87. World Health Organization. (2018). *WHO recommendation on episiotomy policy | RHL*. Who.Int. Retrieved from https://extranet.who.int/rhl/topics/preconception-pregnancy-childbirth-and-postpartum-care/care-during-childbirth/care-during-labour-2nd-stage/who-recommendation-episiotomy-policy-0

88. Williams, C. R., Jerez, C., Klein, K., Correa, M., Belizán, J., & Cormick, G. (2018). Obstetric violence: A Latin American legal response to mistreatment during childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology*, *125*(10), 1208-1211. https://doi.org/10.1111/1471-0528.15270

Annexures

Annexure 1: Interview guide used in Hospital A

Age:
Sex:
Education:
Profession:
Cadre and position:
Number of years of experience in the facility:
Number of years of experience in total:
Number of normal deliveries in a month in the facility that interviewee is involved in:

Domain	Questions
Work profile	1. Could you tell us about the nature of training you have received as a part of your MBBS course/nursing? 2. Could you share your experience of working in this department (OB/GYN)? 3. Can you share with us what your typical day in the labour room looks like? 4. What are the various challenges faced by you while working in this department?
Privacy and confidentiality	5. Could you describe labour room practices with respect to privacy? 6. Could you describe labour room practices with respect to confidentiality? 7. Can you tell us more about maintaining privacy and confidentiality when it comes to women in labour who are HIV+ or have hepatitis B, single women, rape survivors? (Is privacy and confidentiality maintained for these women? Issues with the same)

Domain	Questions
Consent and autonomy	1. For what medical procedures during delivery are consent required? When and how are these sought? What is the procedure for the same? 2. At what stage is contraceptive counselling offerred? What are the different options offered? What are the consent procedures for the same? 3. What do you think of having birth companions? Problems/ issues/challenges with implementing it? How do you think birth companions can help or cannot help the woman in labour? 4. What do you think of alternative birthing positions for women in labour? How have practices regarding alternative birthing positions changed over the years? (in the context of Aurangabad)
Verbal abuse	5. Several healthcare providers have shared that oftentimes the situation in labour room gets tensed with patients. Can you share some of these situations that you might have observed (do not have to be your personal experiences)? 6. (Probe: On what is shared - What happens then? Can you tell us more....? 7. Why do you think compels healthcare providers to raise their voices and scold the patients during labour? How often does this happen? 8. Can you share something about these situations and what was told to the patients? 9. Can such situations be prevented? What steps need to be taken at different levels- department, staff, patient , etc.?

Domain	Questions
Physical abuse	10. Several healthcare providers have also shared that oftentimes the situation in labour room is such that patients are slapped, restrained, pinched etc. Can you share circumstances under which these situations might happen? 11. Why do you think healthcare providers may slap, pinch or restrain patients during labour? (Probe: Can you share an incident that you might have witnessed?) 12. Can such situation be prevented? What would you recommend as necessary- at different levels- hospital, department, staff, patients?
Financial abuse	13. What are the various reasons why patients / their relatives may be required to pay during delivery and post natal care? 14. Besides cleaning, how else do ayah bais help healthcare providers with patients during labour? What are the policies regarding ayah bais and class IV employees interaction with families and the reasons behind the same? What are monetary gains, if any, which class IV employees, seek or expect from patients and their families?
Recommendations	15. What are your recommendations to prevent labour room violence? 16. What changes are needed to help HCPs during delivery? What aspects of policies and practices would you recommend changing to improve labour room practices and how? 17. There are some policies such as Laqshya of GoI. How do you think such policies can or cannot help better practices in the labour room?

Annexure 2: Interview guide used in Hospital B

Interview date _____
Interview start time _____
Interview end time _____
Interviewers _____

Age:
Sex:
Education:
Profession:
Cadre and position:
Number of years of experience in the facility:
Number of years of experience in total:

Domain	Questions
Work profile	1. Can you tell us about your education and work experience related to obstetrics? 2. Can you speak about the training process (for your job/ for juniors)? (Probes: practical training for procedures such as PVs, who performs it) 3. What does your typical day look like?
Questions on labour room violence	Have you heard about the term 'labour room violence'? (If not then explain: Any form of violence inflicted upon the woman in a labour room, such as women being scolded or hit). Can you tell us more about this? (Probes: the reasons for the same; who usually does this; practices or protocol in the hospital with regard to the same)

Domain	Questions
	We would like to understand how these practices have changed over the years. Could you please help us understand the same. (Probes: factors which led to the change; its different components; staff training; infrastructural changes) 1. **Consent-taking:** What is the consent-taking procedure followed in the hospital? (Probes: procedures now and the change over the past years; rationale and usage of different consent forms; whose signatures are required and why; challenges faced, challenges vis-à-vis relatives or the client; consent for episiotomies; training/ orientation received for the same) 2. **Privacy:** Could you describe labour room practices with respect to privacy? How have these changed over the years? (Probes: infrastructural changes; challenges and facilitators; training/orientation received for the same) 3. **Confidentiality:** What is the protocol for HIV or HB positive patients? (Probes: procedure for keeping records, universal health precautions; training/orientation received for the same) 4. **Birth companions:** Does the hospital have a system of birth companions? How does it work? (Probes: who are birth companions; what stage of labour are the birth companions called upon; their roles; training/orientation received for the same; perceived benefits or challenges of the same; challenges in implementation; effects on the delivery process) 5. **Birth positions:** What are the positions women take during labour? Could you elaborate upon the same? (Probes: different birth positions offered; to which women they are offered; infrastructural changes made

Domain	Questions
	for this; challenges in implementation; effects on the delivery process) 6. **Verbal abuse:** At times, the situation in the labour room gets tense such that it becomes essential to scold a woman or raise one's voice. Could you tell us more about this? (Probes: reason for the same, what is told to the woman); change over the years; training for the same) 7. **Physical abuse:** At times, the woman in labour had to be restrained, or even slapped. Could you tell us more about these situations? (Probes: reason for the same, who usually does this; change over the years; training for the same) 8. **Fluid intake (categorized under physical abuse):** Are women allowed to take fluids while in labour? Could you tell us more about this practice? (Probes: change over the years; which women are allowed and which are not; provisions made for the same, challenged faced in implementation) 9. **Financial abuse:** Economic demands are usually made post delivery. Could you tell us the reason for the same? (Probes: who does it; protocol regarding it)
Other processes with regard to labour	1. **TRIAGE system:** Is there a TRIAGE system in your hospital? Could you tell us more about it? (Probes: its working mechanism; what times it is practiced; change in practices; effect on HCP duties; family and patient responses)

Domain	Questions
Contraceptive counselling	1. Can you tell elaborate upon the procedures for contraceptive counselling followed in your hospital? (Probes: stage at which it is carried out; contraceptive options offered and preferences for different clients) 2. How are the decisions regarding contraceptive use made? (Probes: role of HCP, woman, husband, other relatives)
Concluding remarks	1. What are recommendations you may have to improve the functioning of labour rooms further? What are your recommendations for ending the phenomenon of labour room violence? 2. What are aspects other hospitals must attend to if they wish to adopt the model of maternity care your hospital currently follows? (Probes: sustainability; scalability; resources required)

Annexure 3: Information sheet

CEHAT (Centre for Enquiry into Health and Allied Themes) is the Mumbai-based research centre of Anusandhan Trust. CEHAT has been involved in research, training, service and advocacy on health and related themes for the past 2 decades. We focus on the research areas of health financing, health legislation and patient's rights, and gender, and closely work with the health system to develop comprehensive and sensitive mechanisms to respond to women and children. Currently, we are carrying out a study titled 'Perceptions of Behaviour: Healthcare providers and Violence in Labour Room'. We aim understand the phenomenon of labour room violence and reasons for its occurrence. We also aim to understand the current protocols and procedures with regard to pregnant women, challenges encountered by healthcare providers, and suggestions for improvement of responses. The information collected shall help understand the reasons for the occurrence of labour room violence, as well as assist in the development of protocol to prevent the same. This study shall be carried out in two government hospitals of Maharashtra.

For this study, we are conducting interviews with healthcare providers viz. doctors, nurses, and support staff groups. This interview shall take about 30 minutes. We shall not be asking about your individual clinical or nursing practice vis-a-vis pregnant women. The interview will seek to understand the general practices of each group with regard to pregnant women and childbirth.

In case you have any concerns or questions related to the research please contact the researchers:

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Or you can contact the Institutional Ethics Committee at iec@cehat.org

Thank you.

Annexure 4: Consent form

Hello and greetings

My name is _____. I work with CEHAT (Centre for Enquiry into Health and Allied Themes). CEHAT is a centre of Anusandhan Trust and has been involved in research, training, advocacy, and interventions related to health care and access to health for marginalized communities since 1994.

We are currently undertaking documentation on labour room practices in public hospitals. We wish to understand the current protocols for pregnant women, contraception, counselling and labour room practices. We specifically want to understand the reasons for labour room violence and challenges faced by healthcare providers vis-a-vis pregnant women.

While interviewing you, we will not be asking you questions about your individual clinical practice. We will speak to you to understand the general practice and protocols in labour room for doctors, nurses and support staff. The interview will take 30 to 45 minutes.

Participation in this interview is completely voluntary. You have the right to say no. You may change your mind at any time and withdraw in the course of the interview. You may choose not to answer specific questions or to stop participating at any time. There is no risk involved in participating in this study. There are no direct benefits and no compensation for participation in this study. Complete confidentiality and anonymity would be maintained in the study and while sharing the findings.

Your signature below means that you voluntarily agree to participate in this research study.

Signature _____ Date _____

In case you have any concerns or questions related to the research please contact the researcher:

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You can also contact the Institutional Ethics Committee at iec@cehat.org

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocavy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-polictical aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through database and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health.

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