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# Moving Beyond Disrespect and Abuse: A Mixed Method Study to Explore the Prevalence and Experiences of Postnatal Mothers on Disrespect and Abuse during Childbirth in Selected Urban Slums of Udaipur City (Rajasthan)

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## Abstract

Obstetric violence, encompassing disrespect and abuse during childbirth, poses a significant barrier to equitable healthcare and maternal mortality reduction. Understanding postnatal mothers' experiences is essential for promoting respectful maternity care (RMC). This mixed-methods study explored the prevalence and experiences of disrespect and abuse during childbirth among 16 postnatal mothers in urban slums of Udaipur, Rajasthan, using an explanatory sequential design. Quantitative data revealed that physical abuse (43.75%), poor communication with healthcare providers (35.42%), and lack of dignified care (34.09%) were prevalent issues. Verbal abuse (12.5%) and stigma/discrimination (16.67%) were less common but significant. Sociodemographic factors, particularly maternal age and age of the last child, influenced these experiences. Qualitative findings highlighted systemic gaps, including neglect, unconsented procedures, overcrowding, lack of privacy, and discrimination based on caste, hygiene, and socioeconomic status. The study underscores the urgent need for healthcare system strengthening, staff training, and policy reforms to promote equitable and RMC. By integrating quantitative patterns with qualitative narratives, this mixed-methods approach provides actionable insights for addressing complex healthcare challenges. Strengthening RMC practices is critical for reducing maternal trauma and achieving better maternal health outcomes.

**Keywords:** Childbirth experiences, Disrespect and abuse, Obstetric violence, Postnatal mothers, Respectful maternity care
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## Introduction

Obstetric violence, encompassing disrespect and abuse during childbirth, is a serious issue that undermines women's entitlement to respectful maternity care (RMC). It contributes significantly to poor maternal health outcomes, obstructing progress toward the achievement of Sustainable Development Goal 3, which aims to reduce maternal mortality globally. While maternal healthcare has improved in many regions, disrespectful and abusive practices in healthcare facilities remain prevalent, particularly in low- and middle-income countries.[1,2] In India, where 12% of global maternal deaths occur, these issues are exacerbated by a poorly resourced healthcare system, unequal access to quality care, and social determinants such as caste, income, and education.[3,4] Addressing obstetric violence is essential to reducing maternal trauma, improving care experiences, and ensuring equitable access to quality care.[5]

While the issue is increasingly recognized worldwide, the prevalence and nature of disrespect and abuse during childbirth remain underexplored, especially in rural and underserved areas such as Rajasthan. Studies in India have identified gaps in the quality of care, with instances of verbal and physical abuse, poor communication, and lack of dignity in healthcare facilities being reported.[6,7] Despite growing attention to RMC in India, systematic research is still limited, particularly regarding the intersection of socioeconomic factors and experiences of abuse during childbirth.[8,9] This study aims to contribute to this critical gap by examining postnatal mothers' experiences in urban slums of Udaipur, Rajasthan.

### Need for the Study

The issue of disrespect and abuse during childbirth has long been a concern in maternal healthcare, with growing recognition of its impact on women's physical and psychological well-being. Globally, the "What Women Want" campaign, which surveyed over 1.2 million women and girls across 114 countries, found that RMC was one of the highest demands from women.[10] In India, the campaign, known as "Hamara Swasthya Hamari Awaaz," garnered over 350,000 responses, further highlighting the urgent need for policy and practice reforms in maternal healthcare.[11]

Despite the significant global and national demand for respectful care, the prevalence of disrespect and abuse during childbirth remains largely undocumented, especially in rural and underserved areas. In Rajasthan, where the healthcare system is under-resourced and maternal mortality rates remain high, research on the prevalence and sociodemographic correlates of obstetric violence is scarce.[3,12] Previous studies have indicated

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that factors such as ethnicity, socioeconomic status, education, and healthcare facility type may influence women's experiences of disrespect and abuse, but comprehensive data from the region are lacking.[4,6] This study aims to fill this gap by exploring the lived experiences of postnatal mothers in Udaipur, Rajasthan, with a particular focus on identifying patterns of abuse and factors contributing to these experiences.

### Objectives of the Study

1. To assess the prevention of disrespect and abuse during childbirth among postnatal mothers
2. To explore the experiences of disrespect and abuse during childbirth among postnatal mothers
3. To find out the association between experiences of disrespect and abuse with selected sociodemographic variables.

### Hypotheses

$H_{01}$: There is no significant prevalence of disrespect and abuse among postnatal mothers during childbirth.

$H_{02}$: There is no significant association between experience regarding disrespect and abuse with selected sociodemographic variables.

## Methodology

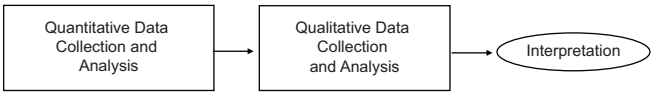
### Research Approach

Mixed-methods research approach.

### Study Design

This study adopted an explanatory sequential mixed-methods design. The purpose was to assess the prevalence of disrespect and abuse during childbirth (quantitative phase) and explore underlying contextual factors through in-depth narratives (qualitative phase). Quantitative data collection was prioritized to establish statistical trends, followed by qualitative data collection to provide context and interpretation, and integration of the findings.

Explanatory sequential research design under the mixed-method research approach.




### Research Setting

The study was conducted in urban slums (Machla Magra, Savina Kacchi Basti) of Udaipur city, Rajasthan.

### Population of Study

Postnatal mothers.

### Target Population

Postnatal mothers residing in Machla Magra and Savina Kacchi Basti slum areas of Udaipur city, Rajasthan.

### Sampling Technique

The purposive sampling technique was used to collect quantitative data, and a case study design was used to collect qualitative data from the same population.

### Sample Size

A total of 16 postnatal mothers.

### Sampling Criteria

*Inclusion criteria*

Every consenting woman who underwent a normal vaginal delivery in the healthcare facilities was included in the study.

### Exclusion Criteria

- Women who had undergone a cesarean section
- Postnatal high-risk condition
- Mothers with poor fetal outcomes.

### Ethical Considerations

Ethical permission obtained from the Human Research Ethics Committee of Geetanjali University, vide letter number GU/HREC/EC/2023/2195.

### Variables Under Study

*Research variable*

Experiences of postnatal women about disrespect and abuse during childbirth.

*Sociodemographic variables*

Selected sociodemographic variables were age in years, religion, educational qualification, occupation of mothers, occupation of husband, marital status, number of previous births, age of last child, socioeconomic status, and type of healthcare facility.

### Tool for Data Collection

- Section I: Sociodemographic variables
- Section II: Structured interview on items related to
  A. Physical abuse
  B. Verbal abuse
  C. Stigma and discrimination
  D. Dignified maternity care
  E. Communication between women and the healthcare provider
- Section III: Semi-structured interview schedule was used to explore the experiences of postnatal mothers regarding disrespect and abuse during childbirth.

### Content Validity and Reliability

The experts from the nursing and obstetrics, and gynecology departments were requested to judge the items for relevance, clarity, consistency, continuity, and appropriateness of the tool. The final tool was formed with necessary modifications as per the

expert's suggestions. The tool was checked with Cronbach's Alpha for the reliability (r value = 0.766), which found it reliable.

## Results

### Section A

Table 1 describes that the respondents were evenly distributed across all age groups, with 25%. All participants were Hindu, with no representation from other religions. The majority (37.5%) had higher secondary education or above, whereas 12.5% had non-formal education. The majority of mothers were homemakers (75%), and none were farmers. Husbands of postnatal mothers, as per occupation, equal percentage (37.5%) were government employees and self-employed, respectively, (25%) were doing private jobs. The majority were married (87.5%), and 12.5% were widowed. An equal percentage (50%) each had one or two previous births. The majority (37.5%) had children aged 2–3 years, whereas 12.5% had children aged 1–2 years. Most participants belong to the middle class (75%), and 25% belong to the higher class. A significant majority (87.5%) live in rural areas, with 12.5% living in urban areas. Healthcare usage was equally split between public and private facilities (50% each), with none delivered in non-profit hospital services.

**Table 1:** Sociodemographic variables

| *S. No.* | *Variable* | *Frequency* | *Percentage* |
|---|---|---|---|
| 1. | Age in years | | |
| | 21–25 | 4 | 25 |
| | 26–30 | 4 | 25 |
| | 31–35 | 4 | 25 |
| | 35 and above | 4 | 25 |
| 2. | Religion | | |
| | Hindu | 16 | 100 |
| | Muslim | 0 | |
| | Christian | 0 | |
| | Others | 0 | |
| 3. | Educational qualification | | |
| | Non-formal education | 2 | 12.5 |
| | Primary | 4 | 25 |
| | Secondary | 4 | 25 |
| | Higher secondary and above | 6 | 37.5 |
| 4. | Occupation of mother | | |
| | Homemaker | 12 | 75 |
| | Farmer | 0 | 0 |
| | Employee | 2 | 12.5 |
| | Self-employed/business | 2 | 12.5 |
| 5. | Occupation of husband | | |
| | Government employee | 6 | 37.5 |
| | Private job | 4 | 25 |
| | Self employed | 6 | 37.5 |
| | Laborer | 0 | 0 |
| 6. | Marital status | | |
| | Married | 14 | 87.5 |
| | Unmarried | 0 | 0 |
| | Divorced | 0 | 0 |
| | Widow | 2 | 12.5 |
| 7. | Number of previous births | | |
| | 1 | 8 | 50 |
| | 2 | 8 | 50 |
| | 3 and above | 0 | 0 |
| 8. | Age of last child | | |
| | <1 year | 4 | 25 |
| | 1–2 years | 2 | 12.5 |
| | 2–3 years | 6 | 37.5 |
| | >3 years | 4 | 25 |
| 9. | Socioeconomic status | | |
| | Higher class | 4 | 25 |
| | Middle class | 12 | 75 |
| | Lower class | 0 | 0 |
| 10. | Type of health care facility | | |
| | Public | 8 | 50 |
| | Private | 8 | 50 |
| | Non-profit hospitals (Trusts) | 0 | 0 |

### Section B

Section B presents the quantitative findings related to the prevalence of disrespect and abuse experienced by postnatal mothers during childbirth. The results summarize the distribution of physical, verbal, and emotional forms of mistreatment as captured through structured interviews and are presented in Table 2.

### Experiences of Postnatal Mothers during Childbirth

Table 2: Reveals the quantitative findings as follows

- The highest percentage (43.75%) of abuse was physical, with many women experiencing rough physical touch, slapping, pinching, and being physically restrained during labor
- Verbal abuse (12.5%) was less common, but some women were subjected to accusatory comments or blamed for the slow progress of labor
- Discrimination and stigma (16.67%) were also relatively low but still significant. Some women faced bias based on their caste, religion, or hygiene, and experienced issues such as requests for bribes or being treated unfairly due to their marital status or disability
- Dignified maternity care (34.09%) was a significant issue, with many women facing poor physical conditions in healthcare facilities and not receiving proper informed consent for procedures
- Poor communication (35.42%) between women and healthcare providers was a major concern. Many women faced delays, a lack of explanation for procedures, and the denial of birth companions, making them feel unsupported during childbirth.

### Interpretation

The quantitative findings revealed that there was significant level of disrespect and abuse experience ($P < 0.05$) found for physical abuse (rough handling, slapping, pinching, and physical restraint during labor), verbal abuse (accusatory comments and blaming for slow labor progress), discrimination and stigma (bias based on caste, religion, hygiene, disability, marital status, and requests for bribes), dignified maternity care (poor physical conditions and lack of informed consent), Communication (denial of a birth companion). Whereas some areas of abuse, discrimination, and care quality were reported, they did not reach a statistically significant level ($P > 0.05$) across specific items.

It was found that there was significant evidence of disrespect and abuse experienced by postnatal mothers during childbirth, especially in above mentioned areas. Therefore, the null hypothesis (that there is no significant level of disrespect and abuse) should be rejected based on the binomial test results.

### Section C

Table 3 reveals the association between experiences with selected sociodemographic variables as follows:

**Table 2:** Experiences of postnatal mothers during childbirth

| S. No. | Areas | Yes (1) | No (0) | P-value | Interpretation |
|---|---|---|---|---|---|
| | Physical abuse | | | | |
| 1. | Experienced physical examination | 10 | 6 | 0.454 | NS |
| 2. | Rough physical touch during examinations | 14 | 2 | 0.004 | S |
| 3. | Slapped, pinched, or shouted at by HCP in the labor room | 2 | 14 | 0.004 | S |
| 4. | Physically restrained or tied during labor | 2 | 14 | 0.004 | S |
| | Verbal abuse | | | | |
| 5. | Used abusive words and rude language | 4 | 12 | 0.077 | NS |
| 6. | Personalized and accusatory comments | 2 | 14 | 0.004 | S |
| 7. | Blaming the poor progress of labor | 0 | 16 | 0.000 | S |
| | Stigma and discrimination | | | | |
| 8. | Discrimination based on caste, religion, and habitat | 2 | 14 | 0.004 | S |
| 9. | Discrimination based on socioeconomic Status | 6 | 10 | 0.454 | NS |
| 10. | Discrimination based on age | 6 | 10 | 0.454 | NS |
| 11. | Discrimination based on parity | 4 | 12 | 0.077 | NS |
| 12. | Stigma related to clothing and hygiene | 0 | 16 | 0.000 | S |
| 13. | Discrimination based on disability | 2 | 14 | 0.004 | S |
| 14. | Discrimination based on marital status | 2 | 14 | 0.004 | S |
| 15. | Discrimination and denial of safe traditional practices | 2 | 14 | 0.004 | S |
| 16. | Unreasonable request of bribery by HCP | 0 | 16 | 0.000 | S |
| | Dignified maternity care | | | | |
| 17. | Lack of informed consent | 4 | 12 | 0.077 | NS |
| 18. | Breaches the confidentiality of Information | 4 | 12 | 0.077 | NS |
| 19. | Painful/forced vaginal examination | 8 | 8 | 1.000 | NS |
| 20. | Refusal to provide appropriate obstetrical care | 6 | 10 | 0.454 | NS |
| 21. | Unconsented instrumental and surgical Procedures | 4 | 12 | 0.077 | NS |
| 22. | Neglect and long delays in the treatment | 4 | 12 | 0.077 | NS |
| 23. | Lack of observation during labor | 6 | 10 | 0.454 | NS |
| 24. | Lack of privacy and objectification of Women | 8 | 8 | 1.000 | NS |
| 25. | Long queues and detainment in health facilities | 6 | 10 | 0.454 | NS |
| 26. | Improper physical condition and facilities | 2 | 14 | 0.004 | S |
| 27. | Supply constraint related to bed linens, dressing, and other supplies | 8 | 8 | 1.000 | NS |
| | Poor communication between women and HCP | | | | |
| 28. | Lack of proper communication | 12 | 4 | 0.077 | NS |
| 29. | Unattending the concern during labor | 6 | 10 | 0.454 | NS |
| 30. | Use of technical language and lack of understanding | 6 | 10 | 0.454 | NS |
| 31. | Lack of supportive care from health Workers | 4 | 12 | 0.077 | NS |
| 32. | Denial or lack of a birth companion | 2 | 14 | 0.004 | S |
| 33. | Lack of preferred birth position | 4 | 12 | 0.077 | NS |

- The distribution of age groups (21–25, 26–30, 31–35, and 35+) significantly differs when divided by the median split. This suggests that age plays an important role in differentiating groups based on median, which could imply that age is a factor that influences certain outcomes in the study
- The age of the last child is significantly related to the median split. This suggests that the age of the last child is a differentiating factor in this study, potentially impacting the outcomes based on the mothers' experiences.

### Section D (Qualitative Analysis)

The qualitative analysis identified several critical themes based on postnatal mothers' experiences of disrespect and abuse during childbirth (Table 4). Each theme is supported by subthemes and direct responses from postnatal mothers. Key findings are summarized accordingly to the theme below:

## Discussion

This study explored the experiences of disrespect and abuse during childbirth among postnatal mothers in urban slums of Udaipur, Rajasthan, focusing on sociodemographic variables, quantitative analysis, and qualitative insights.

The sociodemographic variables reveal equal distribution across age groups (21–25, 26–30, 31–35, and 35+), with all respondents belonging to the Hindu religion. Educational qualifications vary, with the majority (37.5%) having higher secondary or above education, whereas 12.5% have no formal education. Most mothers (75%) are homemakers, and husbands are primarily employed in government (37.5%) or self-employed roles (37.5%). Marital status shows that 87.5% of women are married, and 12.5% are widowed. Half of the respondents reported one or two previous births, and the child's age was predominantly between 2 and 3 years (37.5%). Socioeconomic status is mostly middle class (75%), and healthcare access is equally split between public (50%) and private facilities (50%). The National Family Health Survey 4 in India reports that women from middle and upper socioeconomic classes have better access to institutional deliveries compared to lower-income groups. This supports the observation that middle-class respondents dominated in our study (75%).[6]

Quantitative findings showed a significant prevalence of physical abuse (43.75%) and poor communication (35.42%), which were the most common issues reported by the participants. These concerns highlight systemic gaps in healthcare services, such as understaffing, overcrowding, and a lack of proper training for healthcare providers. The lack of dignified care (34.09%) also emerged as a major issue, with participants reporting poor physical conditions in hospitals and a lack of privacy.[6,7] Although verbal abuse

**Table 3:** Association between experiences with selected sociodemographic variables

| S. No. | Variables | Below median | Above median | Df | Chi-square value | Inference |
|---|---|---|---|---|---|---|
| 1. | Age in years | | | | | |
| | 21–25 | 4 | 0 | | | |
| | 26–30 | 0 | 4 | 3 | 0.046 | S |
| | 31–35 | 2 | 2 | | | |
| | 35 and above | 2 | 2 | | | |
| 2. | Religion | | | | | |
| | Hindu | 8 | 8 | -- | -- | --- |
| | Muslim | 0 | 0 | | | |
| | Christian | 0 | 0 | | | |
| | Others | 0 | 0 | | | |
| 3. | Educational qualification | | | | | |
| | Non-formal education | 0 | 2 | | | |
| | Primary | 2 | 2 | 3 | 0.446 | NS |
| | Secondary | 2 | 2 | | | |
| | Higher secondary and Above | 4 | 2 | | | |
| 4. | Occupation of the mother | | | | | |
| | Homemaker | 6 | 6 | | | |
| | Farmer | 0 | 0 | 2 | 0.135 | NS |
| | Employee | 2 | 0 | | | |
| | Self-employed/business | 0 | 2 | | | |
| 5. | Occupation of husband | | | | | |
| | Government employee | 4 | 2 | | | |
| | Private job | 0 | 4 | 2 | 0.069 | NS |
| | Laborer | 0 | 0 | | | |
| | Self employed | 4 | 2 | | | |
| 6. | Marital status | | | | | |
| | Married | 8 | 6 | | | |
| | Unmarried | 0 | 0 | 1 | 0.131 | NS |
| | Divorced | 0 | 0 | | | |
| | Widow | 0 | 2 | | | |
| 7. | Number of previous births | | | | | |
| | 1 | 1 | 0 | 2 | 0.565 | NS |
| | 2 | 3 | 4 | | | |
| | 3 and above | 4 | 4 | | | |
| 8. | Age of last child | | | | | |
| | <1 year | 4 | 0 | | | |
| | 1–2 years | 2 | 0 | 3 | 0.007 | S |
| | 2–3 years | 0 | 6 | | | |
| | >3 years | 2 | 2 | | | |
| 9. | Socioeconomic status | | | | | |
| | Higher class | 2 | 2 | | | |
| | Middle class | 6 | 6 | 1 | 1.000 | NS |
| | Lower class | 0 | 0 | | | |
| 10. | Type of health care facility | | | | | |
| | Public | 4 | 4 | | | |
| | Private | 4 | 4 | 1 | 1.000 | NS |
| | Non-profit hospitals (trusts) | 0 | 0 | | | |

(12.5%) and stigma (16.67%) were less common, they remain critical areas needing attention, particularly regarding discrimination based on caste, socioeconomic status, and hygiene.[8,9] A quantitative study by Kumar *et al.* (2019) found that women with higher education levels were significantly more likely to utilize antenatal care services, reflecting a positive correlation between maternal education and access to quality care. This aligns with the findings where 37.5% of participants with higher education accessed healthcare facilities better than those with limited education.[8]

While sociodemographic factors (age, education, socioeconomic status, etc.) did not show significant associations with disrespect and abuse, several underlying factors were identified that may explain this lack of clear correlation. Underreporting due to cultural stigma, hesitation to speak out against healthcare providers, and fear of repercussions may have led to less transparency in the responses. In addition, increased awareness of rights through various RMC campaigns might have made women more conscious of their treatment, but did not necessarily link these experiences to specific sociodemographic characteristics.[10,11] A study in the International Journal for Equity in Health (2018) found no direct association between education level and disrespect during childbirth, likely due to systemic normalization of abusive practices across socioeconomic strata. This matches the observation of a lack of significant correlation between sociodemographic variables and abuse.[6,7]

The qualitative analysis revealed significant challenges in maternity care, including inadequate communication, lack of privacy, and unconsented procedures. Participants reported stigma, verbal and physical abuse, and discriminatory practices based on socioeconomic and personal attributes. Systemic issues such as overcrowding, delays in care, and denial of family support further compounded their distress. These findings highlight the urgent need for respectful, patient-centered care and systemic reforms to improve maternal health experiences.[3,12]

**Table 4:** Thematic presentation of qualitative analysis

| S. No. | Theme | Subtheme | Responses |
|---|---|---|---|
| 1. | Concerns during hospital stay for delivery | • Not giving an opportunity to discuss concerns<br>• Lack of observation | R1: "I was never given a chance to talk about my concerns. I had so many questions, but was just told what to do without any explanation."<br>R3: "The staff didn't check on me as often as they should have. I had to remind them that I was in pain." |
| 2. | Care provided appropriate/ inappropriate | • Lack of privacy<br>• Forceful and painful examinations<br>• Unconsented procedures | R1: "There was no curtain or screen when they were examining me, and other people could see everything."<br>R2: "They kept doing vaginal exams without asking for my consent. I felt uncomfortable and violated."<br>R3: "They seemed to rush through the examination, and I felt like it was done in a very aggressive way." |
| 3. | Stigma and discriminatory care | • Blaming for poor labor progress<br>• Care based on hygiene, clothes, caste and socioeconomic status, age, and educational status) | R1: "The doctor kept blaming me for the slow progress of my labor, like I wasn't pushing enough."<br>R2: "They assumed I was uneducated because of my accent and made me feel uncomfortable asking questions."<br>R3: "A nurse said my 'poor hygiene' was causing complications during labor."<br>R4: "At one point, they delayed my treatment because I was unable to pay the hospital fee immediately." |
| 4. | Physical and verbal abuse | • Uses of abusive words<br>• Blaming for poor labor progress | R1,2: "They were all very rude. The midwife kept saying I was making a fuss over nothing."<br>R2,3: "They told me my body wasn't "working properly" and that it was my fault my labor was slow." |
| 5. | Poor rapport with health care provider | • Lack of communication<br>• Uses of technical language | R1,2: "No one told me what was going on, and I was left to wonder about every procedure."<br>R2,3,4: "My concerns about pain relief were ignored, and they kept telling me to 'wait and see.'"<br>R1,2,3,4: "They kept using medical terms without explaining them to me. I had no idea what was going on with my own body." |
| 6. | Denying of family support | • Disallowing birth companion<br>• Disallowing family visitors | R1,2,4: "I wanted my husband to be with me, but they wouldn't allow him in the delivery room."<br>R1,2,3,4: "They told my family that only one person could be with me during labor, and that was really hard for me." |
| 7. | Poor health system conditions and constraints | • Denial of safe traditional practices<br>• Choice of birth settings and birthing positions<br>• Overcrowded wards | R1,3: "They didn't respect my desire to use natural pain relief methods and kept pushing for medication."<br>R2,3,4: "I wanted to deliver in a position that was more comfortable for me, but they insisted I lay on my back."<br>R1,2,3,4: "The ward was so overcrowded that I had to share a bed with another patient, and there was no privacy." |

The White Ribbon Alliance's qualitative reports identify systemic discrimination against women from lower socioeconomic classes and less formal education. These women face barriers such as staff neglect and limited autonomy in decision-making, which align with the findings of systemic inequities.[6]

## Conclusion

This study highlights the significant issues of disrespect and abuse during childbirth in urban slums of Udaipur, Rajasthan. While sociodemographic factors did not show a direct association with the experiences of mistreatment, the findings from both quantitative and qualitative data reveal widespread concerns. The most prevalent issues were physical abuse, poor communication, and lack of dignified care, with physical abuse being the most commonly reported. Verbal abuse and stigma, poor communication, and forceful examination, though less frequent, also remain critical problems.

The qualitative data provided deeper insights into the personal experiences of women, revealing neglect, overcrowding, unconsented procedures, and denial of birth companions, all of which contributed to a feeling of disempowerment. Discrimination based on caste, socioeconomic status, and hygiene was also identified as a significant issue.

These findings point to systemic gaps in healthcare delivery, including inadequate staff training, overcrowded facilities, and a lack of respect for women's autonomy and dignity. Despite increased awareness of RMC, the persistence of these issues underscores the urgent need for policy reforms, better healthcare infrastructure, and improved training for healthcare providers. Ensuring that all women receive respectful, dignified, and equitable care during childbirth is essential to reducing maternal trauma and improving overall maternal health outcomes.[4,6]

## Recommendations

- Future studies can be done to explore rural, urban, and metropolitan regions to understand how disrespect and abuse vary across different settings
- Research can investigate how caste, religion, education, and income interact to influence women's experiences of maternity care
- Researchers can assess the effectiveness of RMC policies and identify areas for improvement

- Future studies will explore the use of mobile apps or helplines to help women report abuse and hold healthcare providers accountable
- Researchers will examine the unique challenges faced by women with disabilities, teenagers, and those living in poverty
- Future research will explore how including husbands or family members during childbirth can improve care and reduce abuse.

## Insights Gained from Mix Method

The mixed-method approach revealed complementary insights. While quantitative data showed that physical abuse (43.75%) and poor communication (35.42%) were the most common experiences, qualitative data highlighted systemic gaps such as inadequate staffing, lack of privacy, and discriminatory practices. This integration underscored the need for improved healthcare policies and staff training to address these issues holistically.

## Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work, the author(s) used Artificial Intelligence tools to improve language and readability. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

## Key Points for Policy

- Strengthen national maternal healthcare policies to mandate RMC practices in all healthcare facilities
- Implement systematic monitoring mechanisms to track and address disrespect and abuse during childbirth
- Integrate culturally sensitive, anti-discriminatory practices into maternity care policies to address socioeconomic and caste-related disparities.

## References

1. Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwiga C, Warren CE, *et al*. Defining disrespect and abuse of women in childbirth: A research, policy and rights Agenda. Bull World Health Organ 2014;92:915-7.
2. White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Childbearing Women. Washington, DC: White Ribbon Alliance; 2011.
3. Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: A systematic analysis of amenable deaths in 137 countries. Lancet 2018;392:2203-12.
4. Sethi R, Gupta S, Osrin D, Ellis M, Langer A. Respectful maternity care and women's experiences in India: A literature review. Reprod Health 2017;14:44.
5. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, *et al*. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. PLoS Med 2015;12:e1001847.
6. Bowser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis. United States: USAID; 2010.
7. Kruk ME. The impact of health system quality on maternal outcomes in low-income and middle-income countries: A systematic review. Lancet 2017;389:1637-49.
8. Srivastava A, Avan BI, Rajbangshi P, Bhattacharyya S. Determinants of women's satisfaction with maternal health care: A review of literature from developing countries. BMC Pregnancy Childbirth 2015;15:97.
9. Kumar S, Kumar N, Vivekadhish S. Educational attainment and maternal health care utilization in India: A nationwide cross-sectional study. BMC Public Health 2019;19:1082.
10. White Ribbon Alliance. What Women Want: Demands for Quality Healthcare from Women and Girls. White Ribbon Alliance; 2019. Available from: https://www.whiteribbonalliance.org [Last accessed on 2025 Oct 05].
11. Ved R, Dua A, Kapoor SK, Sachdev HP. Improving maternal health in India: Insights from two decades of policy and program implementation. BMC Health Serv Res 2019;19:387.
12. UNICEF India. Maternal Mortality in India: Trends and Interventions. New Delhi: UNICEF India; 2020. Available from: https://www.unicef.org/india [Last accessed on 2025 Oct 05].