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RESEARCH ARTICLE

Women's narratives of disrespect and abuse during facility-based childbirth in Kolkata, India

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Abstract

Quality of care during childbirth is crucial to maternal health outcomes. Studies from India that report on women's experiences of disrespect and abuse by healthcare providers during facility-based childbirth are limited to high-fertility states and predominantly focus on public hospitals. However, the quality of maternal care in states with low fertility rates like West Bengal needs further examination. This study aimed to understand women's experiences of disrespect and abuse and their perceptions of facility-based childbirth. The study focused on public, private, and charitable hospitals in Kolkata district of West Bengal that presents a higher institutional birth rate than the national average. The findings derive from a qualitative study using in-depth interviews with 17 postpartum women who had facility-based births within one year before data collection in May 2019. Grounded theory approach was used to iteratively code the interview transcripts, identify reappearing categories, and generate themes through abstraction. The participants' narratives revealed experiences of verbal abuse, neglect and abandonment, poor rapport between providers and women, improper conduct of procedures, health facility conditions and constraints, and instances of overlapping forms of disrespect and abuse. The findings demonstrate the nature of disrespect and abuse across different hospital types in a major metropolis of India. Normalisation of poor-quality care manifested in women's lack of expectations of patient education and attention from providers. Health system conditions and constraints can impact the quality of care that problematise the push for institutional deliveries as a panacea for poor maternal health outcomes. The findings add to long-standing calls for improving maternal experiences of birth with an emphasis on promoting autonomy. National and state guidelines related to maternal health need to be aligned with accepted standards of care. West Bengal must establish ways to assess the implementation of such guidelines on the ground.

Keywords: facility-based childbirth; disrespect and abuse; health system conditions

Introduction

The process of childbirth and women's experience of maternal care are emerging as crucial determinants of health outcomes that were previously based primarily on health metrics (Tunçalp *et al.,* 2015; Perrotte *et al.,* 2020). India has a large population of birthing women and has seen a nearly 68% decline in its maternal mortality rate (MMR) between 2001 and 2020 (Office of the Registrar General & Census Commissioner, India, 2022). State-subsidised safe motherhood financing schemes that facilitate institutional childbirth, like Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram, have contributed to the decline in MMR in India (Ministry of Health & Family Welfare, 2022). However, the decline in India's maternal deaths is not without issues of

poor-quality care in birth facilities that can have direct and indirect implications for maternal mortality and morbidity.

Evidence from India and globally has reported several forms of violence against women (VAW) during childbirth by healthcare providers (HCPs). The literature has variously described this phenomenon as 'dehumanised care', 'disrespect and abuse (DA)', 'mistreatment', and 'obstetric violence' (Misago *et al.,* 2001; Bowser and Hill, 2010; Pérez D'Gregorio, 2010; Bohren *et al.,* 2015). Specifically, DA is defined as 'interactions or facility conditions that local consensus deem to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified' (Freedman *et al.,* 2014). While studies record a high prevalence of DA during childbirth in low- and middle-income countries like India, the experiences of DA in different contexts and settings within the country need further inquiry (Khosla *et al.,* 2016; Shrivastava and Sivakami, 2019).

The literature on VAW during childbirth in India is growing, albeit with certain limitations. A majority of the studies have focused on births in public healthcare facilities (Shrivastava and Sivakami, 2019) and on Uttar Pradesh and Bihar, states with high fertility rates (over the replacement level of 2.1) (Faheem, 2021). A rationale behind this focus is that public sector facilities and states with poor sociodemographic indicators but high birth rates face challenges in ensuring quality of care during childbirth (Chaturvedi *et al.,* 2015; Sharma *et al.,* 2019). Moreover, high levels of gender discrimination and the low status of women in these states can seep into the process of childbirth as a culture of VAW (Mayra *et al.,* 2024). On the contrary, West Bengal has a low fertility rate of 1.6 (Ministry of Health and Family Welfare, 2021b), and its capital, Kolkata, reported that 97.5% of all births in 2019-20 were in institutional facilities (Ministry of Health and Family Welfare, 2021a). Yet, in 2019-20, Kolkata reported an MMR of 80 per 100,000 live births, the second highest among all districts in West Bengal (Government of India, 2020). While advancement in the status of women is evident through sociodemographic indicators, West Bengal ranks high in terms of VAW (Biswas *et al.,* 2022). Journalistic reporting from Kolkata also shows evidence of violent and poor quality childbirth care (Chattopadhyay, 2015). Based on these reasons, the current study explored women's experiences of DA during childbirth in public, private, and charitable[1] healthcare facilities in Kolkata district, West Bengal, India.

Methods

Design, setting, and participants

This is a qualitative study of facility-based birth experiences among women in Kolkata, West Bengal. Three paediatric clinics were purposively contacted based on proximity in south Kolkata. After approval from the paediatricians and clinic authorities, women who visited these clinics for consultation regarding their new-borns' health were approached for the study. The study recruited women who had facility-based birth within one year prior to data collection in May 2019 to minimise recall bias. In-depth interviews were conducted with 17 women who gave birth in public, private, and charitable healthcare facilities located in Kolkata district.

Data collection and analysis

The authors used a semi-structured interview guide based on a literature review. The guide was prepared in English in consultation between the authors and then translated to the local language, Bengali. The interview guide was restructured based on pilot interviews and the final guide included open-ended questions on women's demographic characteristics, details about the birth, perceived healthcare quality during institutional birth, experiences and perceptions of DA during

[1]Not-for-profit hospitals that are owned by charitable organisations where fees for services are generally lower than private, for-profit hospitals, and the revenue are reinvested in the hospital (Sarwal *et al.,* 2021).

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birth, and future healthcare utilisation for birth care. Women who consented to participate were interviewed in a secure location at the clinic. Most interviews were conducted in Bengali except one which was conducted in English.

Prior to analysis, interview recordings were transcribed and translated to English. The interview transcripts were reviewed for coherence, completeness, and data accuracy. Each transcript was read individually and coded using abstraction in consultation between the authors. Using the grounded theory approach, the transcripts were iteratively coded to find similarities and dissimilarities among women's interactions with the health system during their childbirth (Corbin and Strauss, 1990). Concepts reappearing through the dataset were considered for further analysis and grouped as categories. Finally, the categories were abstracted into seven themes to structure the findings of DA among women across public, private, and charitable healthcare facilities in Kolkata. The authors resolved differences in opinions about coding by referring to Bowser and Hill (2010) and Bohren *et al.*, (2015) that provide two prominent typologies of VAW during childbirth used in the literature.

Results

The study reports the birth experiences of 17 postpartum women in Kolkata, West Bengal. Table 1 gives the participants' sociodemographic and birth-related characteristics, including details about the birth facilities. Participants were aged between 18 and 34 years, with a mean age of 25. One participant gave birth at the age of 17 years. More than half the participants had 12 or more years of formal education. Most women were homemakers, lived in extended family units, and had given birth to their first child. A majority of women gave birth in public facilities and through caesarean section (CS). The private and charitable facilities were a mix of multi-specialty general hospitals or nursing homes of variable sizes, with some offering specialised maternity and paediatric services. Figure 1 outlines the multi-level categorisation of DA captured in participants' narratives.

Verbal abuse

The most overt but seldom-reported form of DA was women's experience of harsh or rude language and judgemental comments from HCPs during their stay in the hospital. Sometimes these experiences involved chasms between patients' families and HCPs, which resulted in verbal comments directed towards the birthing women. Such interactions can enforce power hierarchies where the medical staff appear in opposition to the birthing women.

> *'When I was admitted for delivery, some other woman's family was quarrelling with the hospital staff asking for their daughter to be discharged. The doctor thought that was my family and shouted at me, "Your parents have come, and they are saying they will take the patient away. Why did you people get admitted here? You can leave. Who told you to come here?"'* [Bharti, 23-year-old, public hospital]

In addition to family-related comments, providers used judgemental language aimed at women's reproductive choices. However, the blurred lines between medical advice for women's welfare and judgements about their reproductive decisions can make interpretation of such comments difficult. Women may re-interpret the language used towards them as ultimately acceptable when framed under the rationale of their better health.

> *'They (HCPs) scolded me once because a lot of people had come to see me together in the hospital. So, it was natural that they would scold. One time I was scolded because I am young, and the doctor said that it is not right for me to conceive at this age. I told the doctor that what*

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Table 1. Participant Characteristics and Birth-Related Details (n = 17)

S. No.	Pseudonym	Age (Years)	Education	Employment	No. of Children	Type of Birth	Facility Type for Birth
1	Sheetal	22	9 years	Homemaker	1	Caesarean	Public tertiary care hospital
2	Kamala	18	10 years	Homemaker	1	Vaginal	Public tertiary care hospital
3	Nidhi	26	Bachelor's degree	Homemaker	1	Caesarean	Private hospital
4	Surashmi	25	Bachelor's degree	Homemaker	1	Caesarean	Private nursing home
5	Ananya	34	Bachelor's degree	Homemaker	1	Vaginal	Charitable tertiary care hospital; 684-bed
6	Kriti	26	No schooling	Homemaker	1	Caesarean	Public tertiary care hospital
7	Sneha	28	6 years	Homemaker	2	Caesarean	Public tertiary care hospital
8	Anandi	21	11 years	Self-employed	1	Caesarean	Public tertiary care hospital
9	Priya	27	8 years	Homemaker	2	Caesarean	Public tertiary care hospital
10	Janvi	25	8 years	Homemaker	1	Caesarean	Public tertiary care hospital
11	Deeksha	21	8 years	Homemaker	1	Caesarean	Public tertiary care hospital
12	Garima	32	Master's degree	Organised Sector	1	Caesarean	Private specialised maternity and paediatric hospital
13	Bharti	23	12 or more years	Self-employed	1	Vaginal	Public hospital
14	Leela	27	Bachelor's degree	Homemaker	1	Caesarean	Public tertiary referral hospital and medical college
15	Parul	27	Master's degree	Homemaker	1	Vaginal	Charitable specialised maternity and paediatric hospital
16	Ritu	19	12 or more years	Homemaker	2	Caesarean	Private multi-specialty hospital
17	Charita	25	Master's degree	Homemaker	1	Vaginal	Charitable multi-specialty hospital

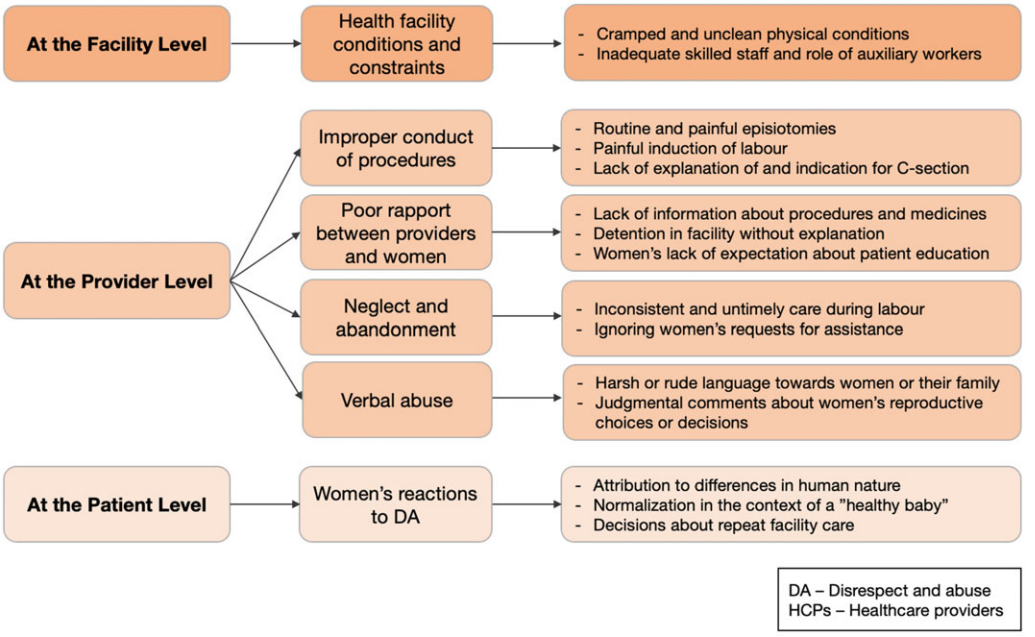

Figure 1. Multi-level categorisation of disrespect and abuse during facility-based childbirth in Kolkata, India.

can I do now that the baby is already here. It is not right to throw it away and we have accepted it as God's wish. The doctor said that I should tell people around me not to conceive at such a tender age because it is very harmful for the body to have a child before 18 years. He has said that it is alright to get married but not to have a child. I would say he said it in a good way'. [Kamala, 18-year-old, public hospital]

Neglect and abandonment

This theme captures women's experiences of 'delays in receiving their care or HCPs being inattentive to their requests' (Bohren *et al.*, 2015). The onset and progression of labour are variable processes and delays are expected. However, inconsistent and untimely care during these stages increased participants' anxiety and pain. Sheetal shares that multiple HCPs offered her conflicting advice, and she experienced excessive delays between admission to the facility and birth.

'I went to the hospital for a check-up and had pain in my abdomen. A doctor first told me my child would be born soon and instructed me to get admitted. Then the head doctor came and told me there is still time for my birth, so I came back home. I went back the same day since walking was painful. The doctor told me to sit down and drink some water, but I continued feeling pain. Then the doctor told me to go to the emergency department, take an injection, and see what happens. When I went to the emergency department, they checked and said the baby might be born that day. It was a junior doctor. So, I got admitted. Then the senior doctor came and confirmed that the child will be born soon. The next day passed by, and this continued till 8 days, and nothing happened . . . I was uncomfortable. My belly was getting tighter. Then on the 8th day they decided to do CS because they were not able to detect the child's heartbeat. When my child was finally born, he was in the Newborn Care Unit'. [Sheetal, 22-year-old, public hospital]

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This form of DA was also seen in private facilities where HCPs ignored women's requests for assistance. Charita was admitted to a non-profit multi-specialty private hospital where she had a prolonged normal labour that culminated in a forceps delivery, and she received 12 stitches. She shared instances of neglect and abandonment that extended to her newborn child as well.

> *'When I used to call the nurses, they would not come on time. I would keep ringing the bell, but they would come much later. They would not give me anything I asked for. They would not assist me to go anywhere. They should have helped me go to the toilet, but they did not. They did not clean my child properly as well. When I took my baby home, there was blood all over my baby's body and she had to be cleaned properly at home. If the baby defecated, they would come after 1-2 hours to clean her'.* [Charita, 25-year-old, private hospital]

Poor rapport between providers and women

Lack of information or ineffective communication from HCPs pertained to medications, medical procedures and questions from women and their families. Returning to Sheetal's experience, the delay in her care was accompanied with lack of information about the procedures, medications and why she was held in the facility despite no clarity on her delivery.

> *'On the day my child was born, they gave me injections in the early hours of the morning. They did not tell me for what they are giving me these injections. They did not tell me even once what kind of delivery I will have. My family members were requesting them (hospital staff) to discharge me so that they could take me to some other hospital, but they said they would not. When my family requested to know what the problem with me was, they wouldn't say anything'.* [Sheetal, 22-year-old, public hospital]

Even when medical procedures are common, they warrant patient education. Episiotomies are conducted routinely in hospitals in India and CS births may be the predominant mode of delivery in some health facilities. Women with vaginal deliveries across facility types were given episiotomies without explanation of the procedure. Similarly, for CS, information was limited to the HCPs seeking consent from women and their family members but did not extend to what the procedure would entail. Some women articulated that they did not expect an explanation either due to how common the procedure is or because their perception of HCPs is that they would not talk about the details of a medical procedure.

> *'No, they did not explain the stitches to me. But the doctors expect that the patients will already know . . . that they would have the knowledge that during normal delivery they (doctors) would give stitches there (perineum)'.* [Ananya, 34-year-old, charitable hospital]

> *'No (laughing), they did not say anything about the (caesarean) delivery. And they would never say such things anyway'.* [Priya, 27-year-old, public hospital]

Improper conduct of procedures

This theme pertains to instances of HCPs' failure to meet professional standards of care established by state and national guidelines and evidence-based medicine. Participants' narratives included their experiences of improper conduct of medical procedures such as routine and painful episiotomies and painful induction of labour.

> *'They had taken me to the hospital for check-up in the last month. My (blood) pressure was excessively high and my feet had swelled up. Because of this, they got me admitted to the*

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hospital early. I was admitted for around 18 days. But I did not get labour pain. So, they tried to induce pain through injections—throughout the day, from the morning almost till the night. This was a pathetic situation. Even then I did not have normal birth. Since I did not have pain (natural labour) and they had given me injections since morning, I developed some other problems. Since it was artificial (induced labour) pain, I was suffering. I was suffering a lot'. [Parul, 27-year-old, charitable hospital]

A majority of the participants in this study had a CS birth and shared their narratives about their interactions with the HCPs before and during the surgery. For some women, a history of CS birth begot another CS, whereas for others the reasons were related to a breech presentation or inability to detect the foetal heartbeat after the women were admitted for birth. Only one participant shared that she had an elective CS birth because she had heard from a lot of people around her that, 'normal delivery . . . it takes a lot'. This participant chose a private facility for birth based on what her gynaecologist suggested and the reviews she had heard. However, for several women, HCPs did not explain the rationale behind a CS birth. In some cases, the reasons provided to women for a CS were not consistent with medical indications for the procedure.

'I used to visit the hospital during the pregnancy. During this time, I became familiar with one of the doctors and I went to his private clinic separately because I had heavy bleeding. The doctors there examined me and did some tests. They said my baby was alright but travelling in a car to the hospital could worsen the condition. So, I continued to consult the doctors at the clinic and told them I had breathing troubles. The doctor told me there are ways for me to have a normal delivery but since I have breathing trouble, I you won't be able to bear the pain of a normal delivery. For this reason, they told me that I will have a caesarean delivery'. [Anandi, 21-year-old, public hospital]

Health facility conditions and constraints

The physical conditions of facilities that the participants accessed varied greatly. In public hospitals in India, large general labour wards where multiple women give birth are common. The lack of privacy in addition to hospital regulations in these rooms may exacerbate the impact of other forms of DA, such as neglect and abandonment. Inadequate staffing at healthcare facilities also contribute to experiences of DA and subsequent ill-health among women during childbirth.

'They laid us down, side by side, on the beds in the same room . . . as in everybody can see everybody else. One hand distance away . . . one hand. Moreover, males are not allowed to enter there. They don't even allow them to come and see us for 5 minutes. But I could not share my problems with anybody else apart from him (husband). How much should I talk with him over the phone? And you cannot talk freely over the phone there. There were many patients lying there . . . on the bed, even on the floor. My mother-in-law and I told her (the doctor), "Do you see that person is suffering? It (the crowning head of the baby) went back inside (retracted)". But she said, 'What can I do? I am the only person here.' We said, 'When you have two people on the table then there should be two doctors.' She replied, "It is not possible to know when they will give birth. We could not estimate that both births will take place simultaneously"'. [Bharti, 23-year-old, public hospital]

In addition to HCPs, auxiliary workers in the health facilities may play a role in women's childbirth experience. For instance, the presence of a *dai* or traditional birth attendant can offset the problems associated with inadequate staffing. Women may also receive support from *ayahs* or female informal workers when hospital constraints and regulations do not allow family members to stay with women after birth.

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'There were fewer people (HCPs) in the area they kept me. There was a dai who was very helpful. That is why I didn't face many problems. But I have seen a lot of patients whom the doctors didn't visit or didn't take proper care of. The madam who operated on me used to come regularly. But I used to hear other patients complain that doctors do not come for their check-up'. [Leela, 27-year-old, public hospital]

'For every patient they would allow one or two visitors. People from home would bring food so during the lunch hours they would open the gate, and my family member would feed me and then leave. But there was an ayah for me'. [Kamala, 18-year-old, public hospital]

Overlapping forms of DA

Incidents of DA may not fall exhaustively into one category or type, but instead can be interrelated and occur across a gamut (Bowser and Hill, 2010). Sneha's experience below illustrates how HCP's failure to meet professional standards of care during the time leading up to her childbirth intersected with poor rapport between providers and patients.

'When they admitted me, I informed the doctor that I had milk and biscuits before coming. The doctor told me that they will operate on me at 12 pm, so I should not eat anything till then. So, I did not eat anything and was feeling very hungry. At 2 pm, I told the doctor that I was very hungry but had not been operated yet. He said that I do not need to eat anymore, and my operation will take place at 8 pm. By then my daughter had already stopped moving in my belly. So, I went to the nurse and told her that my daughter has stopped moving. She told me to wait and that my operation will take place anytime now. Despite saying this, the operation finally took place at 8 pm. I did not tell my mother-in-law about how I was feeling because I feared that she might say something (to HCPs). Doctors have a particular time. Would they do it (CS) at a different time? No, they have their own time. I was scared that if my mother-in-law went and said something, the nurse would scold back that they will do it (CS) when they are supposed to do it'. [Sneha, 28-year-old, public hospital]

In another participant's narrative, there is overlap in unhygienic facility conditions, poor rapport between the provider and patient, and improper conduct of procedures that negatively impacted her childbirth experience and post-childbirth recovery.

'When I went to the hospital, the toilets and bathrooms were very dirty and unclean. After arriving at 3am, they took me to the room where the delivery happens, and I stayed there. They gave me saline because I was suffering, and they said I must lie down without turning or moving. But one cannot lie like that. When the pain starts one has to turn on their side or twist in pain. There was a female doctor there. She was not touching the body or even examining anything. My mother in law said, "look, she is in pain, do something." This person said, "After the baby comes out, I will go and hold it". But by the time she came to hold the baby, it had gone back inside [the baby was crowning but retracted without support]. They made a deep cut there (perineum) to bring the baby out. She even broke the needle while stitching (post-episiotomy) because of excessive force. I told her, "stitch properly". After the birth, I had burning pain there (pelvis). It took time to heal, which is why I also got a fever. This was a mistreatment'. [Bharti, 23-year-old, public hospital]

Women's reactions to DA

Participants' reactions to experience of DA during childbirth reflected power imbalances where women were at the bottom of the hierarchy. Their articulation of these experiences as

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mistreatment was not common. While some women shared their discontent with the behaviour of the HCPs, they did not voice these experiences as disrespectful or abusive. Other women feared negative consequences from HCPs if they complained about their experiences. They did not want to bother or irritate providers owing to their perceptions of how birthing women were expected to behave in a healthcare facility. Instead, they attributed these experiences to differences in human nature that are expected from the hospital staff.

> *'Their (HCPs) behaviour with me was alright, but people's nature varies. So that was it. Some people are good whereas some people are not. Actually, after my caesarean, there was a problem with changing pads (sanitary napkins). They (HCPs) had to change it frequently. This is not true for everybody, but some nurses would get irritated by this because they had to change pads multiple times a day for me'.* [Nidhi, 26-year-old, private hospital]

Women also articulated that experiences of DA may be normal and rationalised these instances in the context of a healthy baby, and all is well that ends well.

> *'The ayahs there didn't take proper care of me. Still, I would say the treatment in that hospital was good. The childcare was good. They cared for the child very well. Only the ayahs were cruel. During one's first childbirth, people usually feel emotional due to the release of various hormones. So, in such a time, the way they behaved was cruel to me. Maybe it was normal, but I felt it was cruel'.* [Parul, 27-year-old, charitable hospital]

> *The behaviour of the nurses was alright. But in between there was incident that I suddenly developed a gas problem. I suffered a lot. And the nurses had to care for my babies. But they were offended that they had to care for two babies. Because in the beginning I was familiar with the nurses . . . since the hospital was closer to my home, I had become familiar with them. They helped me a lot. But in the next shift, the nurses who had come might have thought that I was pretending to be sick so that I don't have to take care of the babies. But later on, they realised that I was really having problems. But that is alright. At the end everything was alright, and I could get back home healthy.* [Ritu, 19-year-old, private hospital]

A consequence of experiences of DA relates to whether women return to the same facilities for postnatal and future healthcare. Some women who did not receive proper information or felt mistreated shared that they would still return because they valued the doctor or the hospital. Some people resisted going back for postnatal care but also identified a lack of options for other facilities due to financial constraints. Other women shared that they would return to the hospital because it was near their residence and was easy to access. For women who shared that they would not return to the same facility for birth care in the future, the issues were related to lack of cleanliness, neglect, improper conduct of medical procedures, and verbal abuse from the HCPs.

> *'I didn't take even one vaccine for my child from there (birth facility). There is a centre near my home where I got my child immunized. But to be honest we do not have the financial capacity to go elsewhere. At the most, we can choose to go to another government hospital, if not this one'.* [Sheetal, 22-year-old, public hospital]

> *'First, I had seen cockroaches roaming around the bed. Second, they (nurses) did not help me with anything. When I called them, they did not come, and they did not clean the baby properly. Because of these reasons, I would not like to go there again'.* [Charita, 25-year-old, private hospital]

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Discussion

This exploratory study thematically categorises experiences of DA during childbirth in public, private, and charitable hospitals of Kolkata and presents several key findings. Although quality of care is generally perceived as better in private hospitals of major cities like Kolkata, the study highlights that instances of DA are present in all types of facilities. Normalisation of experiences of DA can stem from other aspects related to the extent of patient education and individual attention that women expect from HCPs or women's inability to opt-out of a facility due to economic constraints. The study also reports on overlapping forms of DA that speak of the complex nature of causes and consequences of poor quality of childbirth care.

In the following section, the authors begin with considerations of power hierarchies and structural inequalities that underpin the discussion of the findings of this study. Against this backdrop, themes of DA presented in this study were connected with the typology of mistreatment outlined by Bohren *et al.,* (2015) since it comprehensively links specific events or instances to broader relations at the health system level. Finally, the authors suggest implications of the study findings for institutional births in Kolkata and, broadly, West Bengal and discuss the strengths and limitations of this study.

The themes of DA in this study capture experiences at the individual level but highlight structural inequalities that create conditions for such experiences and their normalisation (Freedman *et al.,* 2014). Feminist literature on VAW argues that women's actions during childbirth and their reactions to DA must be viewed from the lens of internalised violence and inherent power hierarchies in medical and social systems (Balde *et al.,* 2017; Cohen Shabot and Korem, 2018). Patriarchal norms globally that dictate women to be 'silent' and 'obedient' in public and private spaces can manifest in labour rooms and maternity wards (Cohen Shabot and Korem, 2018). Women in Cape Town, South Africa, reported trying to be obedient and docile to prevent angering HCPs and avoid being mistreated during childbirth at healthcare facilities (Chadwick, 2017). Through research on Black women's birthing experiences, Davis (2019) terms this construct 'obstetric hardiness' where women demonstrate ease in childbirth to avoid the experience of DA and violence. Similar sentiments prevail in Indian labour rooms where doctors are considered the most important people and amicable women fare better during birth (Mayra *et al.,* 2024).

Another aspect of power hierarchies during childbirth is the prioritisation of a healthy baby above all else. Providers, women, and their families may justify DA as the cost of ensuring the health and safety of the foetus (Chattopadhyay *et al.,* 2017; Cohen Shabot and Korem, 2018). van der Waal (2024) describes this as playing the 'dead baby card' where threats to the foetus's life, accurate or exaggerated, make birthing people comply with obstetric decisions and policies. In turn, women may describe their birthing experience as 'good' despite narrating disrespectful and abusive treatment, especially if they believed that such actions were taken to benefit their child's health (Balde *et al.,* 2017; Chattopadhyay *et al.,* 2017). With these considerations of power hierarchies, the study findings were contextualised within existing literature.

Verbal abuse of women during childbirth by HCPs has been recorded globally and across country income levels (Bohren *et al.,* 2015; Perrotte *et al.,* 2020). Research from India finds that 'scolding' and reprimands by doctors are routinely directed towards patients and their families (Chattopadhyay *et al.,* 2017; Rege *et al.,* 2024). In an autoethnography, a scholar trained as a midwife in a large tertiary-level hospital in West Bengal notes that derogatory and humiliating remarks towards birthing women were commonly used by junior and senior doctors alike (van der Waal *et al.,* 2023). Particularly, verbal abuse related to women's sexual behaviour may be used as a compliance measure when women express pain during childbirth (Barnes, 2007). Narratives of judgemental language about women's reproductive decisions during pregnancy and childbirth are also prevalent in India (Shrivastava and Sivakami, 2019; Faheem, 2021).

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Inadequate and improper treatments and procedures during childbirth constitute failure to meet professional standards of care (Bohren *et al.,* 2015). Participants' reports of extreme force during suturing of episiotomy incisions could be an indication of haste when performing procedures as a checklist exercise (Chattopadhyay *et al.,* 2017). Moreover, providers may feel justified in using force or coercion to obtain compliance from patients in a medical system that legitimises their power over labouring women (Cohen Shabot and Korem, 2018). This findings also bring forth the issue of high rate of routine episiotomies for vaginal births in India (Singh *et al.,* 2016). Episiotomies are the second most common surgery in obstetrics following CS births despite all current guidelines favouring selective use of this procedure (Ahmed *et al.,* 2023). For instance, recommendations for a positive experience of childbirth in facilities include selective use of episiotomy to avoid posterior perineal trauma, the need for suturing, and fewer complications related to healing (World Health Organization, 2016). The use of excessive force may also occur during vaginal examinations and procedures such as abdominal pressure and forceps birth (Dey *et al.,* 2017; Bhattacharya and Sundari Ravindran, 2018).

Experiences of neglect and abandonment in health facilities also reveal HCPs' failure to meet professional standards of care (Bohren *et al.,* 2015). Earlier studies in India have captured similar experiences, such as women in urban slums of Gujarat sharing that 25.1% (n = 100) of them experienced abandonment during birth in hospitals (Patel *et al*., 2015). Globally, a study in Nigeria reported 29.1% women experienced neglect and abandonment during childbirth, whereas another study in Kenya found 14.3% of reported abandonment (Abuya *et al.,* 2015; Okafor *et al.,* 2014). Feminist analyses of similar frequent yet invisibalised forms of DA highlight that encounters marred by neglect and abandonment can affect women in the form of anxiety, shame, and diminishment that can have long-term psychological implications (Chadwick, 2017).

Poor rapport between providers and women can manifest in the form of ineffective communication, lack of supportive care, and women's loss of autonomy (Bohren *et al.,* 2015). Lack of communication can be related to loss of autonomy as well, such that participants are not involved in the decision-making process related to their care (Hulton *et al.,* 2007). While some participants voiced dissatisfaction over ineffective communication, other women did not expect HCPs to discuss medical information with them. A study in Uttar Pradesh found that 47.8% of the women accessing public health facilities had incomplete information on their birth procedures (Dey *et al.,* 2017). Another study from Uttar Pradesh compared women's perspectives to providers' perspectives where women reported valuing information about their labour status but providers opined they were unable to provide counselling due to work pressure (Bhattacharyya *et al.,* 2015). Women in this study also shared they were detained in health facilities against their and their family's will and faced restrictions on food and water intake during their stay at the hospital in anticipation of CS. Others have reported similar restrictions, termed nil-by-mouth, where women are not allowed to consume liquids or food justified by an unpredictable need for CS (Sharma *et al.,* 2019; Rege *et al.,* 2024).

Health systems conditions and constraints were related to several experiences of DA identified in the study. Constraints such as lack of human resources and inadequate medical supplies, inadequate policy guidelines regarding appropriate delivery of services, and facility culture promoting unfair practices can contribute to DA (Bohren *et al.,* 2015). Women giving vaginal birth were often adjacent to several other birthing women. This is common practice in government hospitals in Kolkata where, at times, two mothers with new-borns must share a single bed (Biswas, 2003). Additionally, unsanitary and unhygienic conditions contributed to women's negative childbirth experiences across private and public healthcare facilities. Several studies in India have reported instances of unhygienic conditions in public and private hospitals (Hulton *et al.,* 2007; Dey *et al.,* 2017; Marathe *et al.,* 2023). Poor physical conditions of facilities problematise the push towards institutional deliveries that contrasts home births as often taking place in dangerously unhygienic environments (Clark, 2016). While conversations on ensuring safe and hygienic home births are common (Sadgopal, 2009; Ou *et al.,* 2021), development of

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national guidelines for sanitation services in tertiary hospitals is recent (Siddharth *et al.,* 2021). Implementation of similar guidelines is crucial in states like West Bengal where institutional deliveries are higher than the national average.

Although the study characterised women's narratives into broader themes of DA for analysis, several instances showed overlapping themes. Narratives of lack of supportive care until the crowning of the foetus are a sign of poor rapport as well as failure to meet professional standards of care. This finding resonates with a study conducted in Tanzania where nurses may assume that women are calling them for help out of fear of pushing and they will start to help only when they see the head of the baby (Solnes Miltenburg *et al.,* 2018). While some participants received support from *dais* and *ayahs*, auxiliary care workers who can offset health system constraints, they are still placed above birthing women in a hierarchy of power relations (Mayra *et al.,* 2024). As such, women also experienced DA in the form of poor rapport and improper conduct from providers other than doctors and nurses. But these experiences need to be contextualised in the gendered and precarious care work conditions of auxiliary providers in West Bengal that point to the structural inequalities previously discussed (Basu, 2020). More research is needed on auxiliary health workers in different facility types and their role in childbirth care (Baru and Zafar, 2022).

This study also compares and contrasts experiences of DA across different facility types. India has a fragmented health system with significant variation in hospital types and a burgeoning private sector (Chatterjee *et al.,* 2013). People may perceive private facilities as better than public ones owing to better infrastructure, availability of resources, staff attitudes, and information availability (Swain, 2019). Yet, poor quality childbirth care is prevalent in public and private facilities of India (Bhate-Deosthali *et al.,* 2011; Sharma *et al.,* 2019), and this study contributes instances of DA across facility types in Kolkata. Importantly, the private sector is generally unregulated and may uphold lower standards that could otherwise come under scrutiny in a regulated public setting (O'Neil *et al.,* 2017). Comparing facility types is crucial because while quality of care is an important determinant of people's intention to revisit health facilities, socioeconomic factors may override the decision for people without the option to choose other facilities (Saini and Matta, 2014). The authors note in this study that women who were unwilling to access the same facility for subsequent childbirth cited unhygienic facility conditions, inadequate services, and untimely care as their reasons. However, women without the ability to pay or without access to alternative facilities reported that they would return to the same hospital or switch to another public hospital, primarily due to financial constraints or lack of transportation options.

The study findings on women's experiences of DA during CS births have implications for Kolkata's context of low fertility. There is an increasing trend in CS births across India, and Kolkata reported a high rate of 44.7% CS births in 2019-20 (Ministry of Health and Family Welfare, 2021a). Ahamed *et al.,* (2023) argue that in rural West Bengal, women's perceptions about CS as being less risky, less painful, and more convenient against a backdrop of declining fertility may prompt CS on maternal request. Although this study did not explore the connection between CS and low fertility, a majority of the participants had this mode of delivery where only one was due to maternal request. Research from Kerala, a state that achieved below replacement level fertility in the 1990s and records high CS rates, indicates that the costs associated with CS can erode the quality of health care (Padmadas *et al.,* 2000). Women also reported being asked for consent without explanation of the CS procedure which is similar to findings from other research (Bhattacharyya *et al.,* 2015). High rates of CS in Kolkata indicate that more women may be exposed to similar experiences of CS and at a younger age since teenage pregnancy is a concern in West Bengal (International Institute for Population Sciences (IIPS) and ICF, 2017). Further research should explore if the association between low fertility and maternal request for CS in West Bengal belies a culture of silence, enduring pain, and restricted agency within the medical system as reasons for high CS births (Kuan, 2014; Mayra *et al.,* 2024).

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This study has certain limitations. Due to the sensitive nature of VAW during childbirth, participants may have underreported their experiences of DA. Moreover, although maternal recall of pregnancy-related events has been validated (Tomeo *et al.,* 1999; Ramos *et al.,* 2020), characteristics of memories for traumatic and non-traumatic birth may differ (Crawley *et al.,* 2018). The purposive recruitment strategy limited variation in participants' socioeconomic characteristics. The authors acknowledge this limitation while aligning with arguments in favour of capturing different cultures, contexts, and expectations even when the knowledge generated is not generalisable (Solnes Miltenburg *et al.,* 2018). Further, the study could not fully explore some aspects of women's childbirth experiences, such as one participant opting for a CS birth due to her perception of vaginal birth as 'a lot'. While this was an isolated finding in the current study, it overlaps with a growing body of research on India's increasing CS rate and should be explored in future studies. Despite these limitations, to the best of the authors' knowledge, this is the first systematic research study on VAW during childbirth in the state of West Bengal in India. Although participants were recruited from three clinics in proximity to each other, the study contrasts and compares findings from women who gave birth in public, private, and charitable hospitals in various parts of the Kolkata district. Women's relative homogeneity in socioeconomic backgrounds also allowed this study to capture the experiences of marginalised women in a major Indian city with high-income inequality. Findings from this research can inform large-scale survey and longitudinal studies that can capture the prevalence of DA in a wider population in resource-poor settings of West Bengal (Goli *et al*., 2020).

Conclusion

While research on DA in India has increased in the past decade, questions about quality of childbirth care have long accompanied the emphasis on institutional delivery (Sundari, 1992; George, 2007). Recent discourses around quality of childbirth care emphasise and promote autonomy, a perspective that forms the crux of the global movement towards respectful maternity care (RMC) (White Ribbon Alliance, 2022). The need for RMC is reiterated in the aftermath of the COVID-19 pandemic, which exacerbated the lacunae in health systems globally. India ranks high in RMC research globally (Shuman *et al.,* 2023) and hospitals in several states, including West Bengal, have assessed or adopted RMC (Yadav *et al.,* 2022; Das *et al.,* 2023). National-level policy guidelines, such as LaQshya, have also incorporated elements of RMC in their formulation (White Ribbon Alliance, 2025). However, the guidelines miss crucial elements like harmful labour practices and experiences of DA and the on-ground implementation of existing guidelines remains unassessed in West Bengal (Singh *et al.,* 2024). With a high proportion of institutional deliveries in Kolkata district and several regional disparities in rural areas, quality of childbirth care in hospitals of West Bengal needs improvement to align with policy objectives that fully incorporate RMC and human rights charters.

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Ethical standard. The authors protected participants' rights and confidentiality throughout the research. The informed consent form was translated to the local language, Bengali, and shared with participants before seeking their signatures. Research participants or a relative accompanying them were allowed sufficient time to go through the consent form before signing it. The participants were informed of their right to refuse to answer any question at their discretion and/or to withdraw their participation from the research process at any point during their interview. Once the research participants agreed to be interviewed, they were reassured that their identity would not be revealed during any study stage. The interviews were audio recorded with the participants' consent. During transcription, participants were assigned pseudonyms to maintain anonymity and a record of participants' pseudo-identifiers was maintained. This record was referenced at the time of analysis and manuscript development to ensure confidentiality. The authors also anonymised other identifiers, such as names of health facilities mentioned by participants during the interviews. Participants were also educated about the ways in which understanding women's experiences can contribute to the maternal healthcare landscape in India.

This study was approved by the Research Committee for the first author's master's degree at the School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai, India. The authors affirm that all procedures and processes contributing to this work comply with the ethical standards on human-participant research.

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