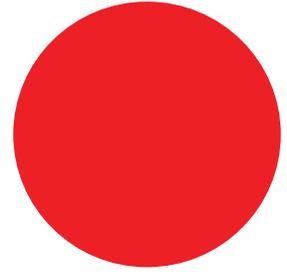


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medico friend circle bulletin



February 2026

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Schedule of 52nd Annual Meet

Editors' note

The theme of the 52nd annual meet of the mfc, to be held from 20 to 22 February 2026 at Raipur, is **Understanding and Addressing Systemic Violence in Healthcare**. The meet offers a space for collective reflection, dialogue, and exploration of ways to address these challenges meaningfully.

The following are the sub-themes:

- Concept of 'Violence'
- Violence experienced by Healthcare Workers
- Violence experienced by Healthcare Users
- Reasons underlying Violence in Healthcare
- Initiatives to Mitigate Violence in Healthcare
- Concept of 'Non-violence', 'Dialogue' and 'Justice'

In preparation to the annual meet three webinars were held.

1. Violence against frontline doctors in India: Understanding the structural and systemic factors (21st January 2026)
2. Seeking Healthcare amidst Structural Violence: Experience, Solutions and Way Forward through Community Voices (5th February 2026)
3. Truth, Non-violence and Justice: Reflections on Addressing Violence in Healthcare (11th February 2026)

The recording of these webinars may be accessed on the mfc website (mfcindia.org).

This issue of the bulletin carries the background note and the background papers prepared for the meet. The background note is also available in Hindi (translated by Anil Bamne), Malayalam (translated by P Premnath), and Marathi (translated by Maya Nirmala) and is available on the mfc website (mfcindia.org).

We also note with a saddened heart the passing away of two friends: Anil Pilgaokar and T. Vijayendra. Anil was the mfc convenor from 1990 to 1992 and was instrumental in steering mfc through one of its crisis periods. Mfc remembers them with great fondness and in gratitude for their contribution.

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Convenor: Mohit P. Gandhi; **Co-convenors:** Dharendra Arya and Juned Kamal

Obstetric Violence and Respectful Maternity Care in India

A Review of the Evidence

- *Amruta Bavadekar, Jashodhara Dasgupta and Renu Khanna*

Keywords: respectful maternity care, obstetric violence, reproductive health, LaQshya, institutional delivery

Over the past two decades, India has witnessed a significant push towards institutional childbirth, particularly following the introduction of demand-side financing schemes such as the Janani Suraksha Yojana (JSY). These efforts have been successful in increasing institutional delivery rates across states and socioeconomic groups. However, a growing body of research suggests that increased coverage has not consistently translated into positive childbirth experiences for women (Srivastava et al., 2020). Instead, many studies point to a troubling gap between access to facilities and quality of care, particularly in terms of dignity, communication, autonomy, and respectful treatment during labour and delivery (Saini et al., 2025).

This disconnect has prompted closer examination of women's experiences within maternity care institutions, giving rise to Indian scholarship on obstetric violence, disrespect and abuse during childbirth, and respectful maternity care (RMC). Together, these studies highlight that childbirth in institutions can be marked not only by clinical interventions but also by coercion, fear, humiliation, neglect, and silencing of women's voices. This essay will focus on such disconnections and experiences of violence experienced by women during the course of pregnancy and childbirth, using a secondary review and documented case studies.

Conceptualising Disrespect and Obstetric Violence

Much of the Indian literature draws implicitly or explicitly on the classification of disrespect and abuse proposed by Bowser and Hill (2010), which identifies seven forms of mistreatment during childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination,

abandonment or neglect, and detention in facilities. Subsequently a review of 65 studies across 34 countries by Bohren et al (2015) led to a typology of seven domains of mistreatment of women during childbirth: including physical abuse (for example, slapping or pinching during delivery); sexual abuse; verbal abuse such as harsh or rude language; stigma and discrimination based on age, ethnicity, socioeconomic status, or medical conditions; failure to meet professional standards of care (for example, neglect during delivery); poor rapport between women and providers, including ineffective communication, lack of supportive care, and loss of autonomy; and health system conditions and constraints such as the lack of the resources needed to provide women with privacy.

Subsequent Indian studies have emphasised that obstetric violence is not only interpersonal, but also structural, arising from health-system constraints, professional hierarchies, and deeply gendered norms that shape how women's pain, behaviour, and compliance are judged during childbirth (Shrivastava & Sivakami, 2019). This perspective shifts attention away from "bad providers" towards systems that enable and legitimise mistreatment.

Prevalence and Patterns of Disrespectful Maternity Care

Quantitative evidence from India consistently shows that disrespect and abuse during facility-based childbirth are widespread. A systematic review and meta-analysis of Indian studies reported that nearly three-quarters of women experienced at least one form of disrespectful maternity care, with non-consented procedures, verbal abuse, and threats among the most frequently reported forms (Ansari & Yeravdekar, 2020). Importantly, the review noted wide variation across settings, suggesting

that institutional culture and local practices play a significant role.

Large-scale primary studies echo these findings. A longitudinal study of pregnancy and childbirth in Uttar Pradesh documented multiple forms of labour room violence, including shouting, slapping, coercion during procedures, and neglect, often occurring simultaneously (Goli et al., 2019). The study showed that mistreatment was not episodic but systematic, cutting across different stages of labour and postpartum care. Women from poorer households and those with lower levels of education reported significantly higher exposure to such practices, highlighting the role of social and economic vulnerability.

Facility-based cross-sectional studies from central and northern India similarly report high prevalence of verbal abuse, lack of privacy, denial of birth companions, and procedures performed without explanation or consent (Sharma et al., 2022; Yadav et al., 2025). Together, these studies underscore that disrespect is not limited to overcrowded or poorly resourced settings alone but is embedded in routine obstetric care across contexts.

Insights from Qualitative Research: Normalisation, Fear, and Silencing

While quantitative studies establish the scale of the problem, qualitative research provides critical insight into how women experience, interpret, and internalise mistreatment. Across diverse settings, women's narratives reveal that disrespect and abuse are often anticipated, normalised, and rationalised as part of institutional childbirth.

Qualitative studies from northern India document how women frequently describe being shouted at, threatened, or ignored during labour, yet frame these experiences as unavoidable or even necessary for a "safe delivery" (Bhattacharya & Ravindran, 2018). Many women reported that they did not expect explanations or emotional support, and some felt that questioning providers could invite further mistreatment. This internalisation of power asymmetry points to how institutional authority and gender norms intersect to silence women.

Non-participant observation of labour rooms in

Madhya Pradesh brought out that staff do not provide skilled care routinely, there was a lack of readiness to provide key elements of care, and harmful/unnecessary practices were coupled with poor techniques; staff sometimes threatened, abused, or ignored women during delivery (Chaturvedi et al, 2015). In Assam Chattopadhyay et al (2017) found substantial evidence of obstetric violence reflected in iatrogenic procedures such as episiotomies performed without anaesthesia, inadequate diagnosis of obstetric risks, undignified physical examinations, medical negligence, institutional unpreparedness and verbal and physical abuse during labour.

A set of over a hundred case studies documented by the civil society coalition Healthwatch Forum Uttar Pradesh with the organization SAHAYOG over 2005-2015 (Dasgupta, forthcoming; Dasgupta 2024) brings out patterns of obstetric violence experienced by women of rural Uttar Pradesh, mainly from marginalized social groups. These include denial of care or delays, demands for excessive payments and bribes based on which care may be withheld, women turned out during labour or the baby held hostage after the birth. In addition, the labouring woman faced abusive remarks and actions, negligence or provision of unskilled care during labour. For instance, health providers appear to rely heavily on repeated intra-muscular injections to speed up labour, often leading to delivery within half an hour, which indicates perhaps oxytocin is used without supervision. After the birth, women may not spend the rest of the night at the health facility and are turned out even after midnight, to make their own way back. There have been documented instances of nurses refusing to cut the cord and women returning to the village for a Dai to do the needful. Nurses have refused to clean up after birth, expecting women themselves or family members to do that.

Ethnographic and qualitative work conducted in public health facilities in Maharashtra and other states further illustrates how women's cooperation is actively enforced through fear and discipline. Being labelled "non-cooperative" — for crying out in pain, questioning procedures, or asking for support — often resulted in harsher treatment, delayed care, or verbal humiliation (Rege et al., 2013; subsequent CEHAT studies). These findings resonate strongly with women's own

descriptions of “having to cooperate” to receive care, even when in pain or distress. Participatory qualitative studies, including narrative interviews and body-mapping exercises, have shown that women experience obstetric violence not only as momentary events, but as deeply embodied experiences that shape their emotional wellbeing and future care-seeking (Mayra et al., 2022, CommonHealth 2025). Fear, anxiety, and loss of trust in public facilities often persisted long after childbirth, influencing decisions in subsequent pregnancies.

Health-System and Structural Determinants

Across both quantitative and qualitative studies, disrespect and obstetric violence are consistently linked to structural features of the health system. High patient loads, staff shortages, lack of privacy infrastructure, and rigid institutional protocols create environments where interpersonal care is deprioritised. Providers themselves report stress, burnout, and pressure to meet targets, which can translate into authoritarian or dismissive behaviour towards women. At the same time, feminist health scholarship from India has long argued that maternity care must be understood within broader political and economic contexts. Analyses of health sector reforms and reproductive health policies point to how women’s bodies become sites for achieving demographic and programmatic goals, often at the cost of autonomy and dignity (Sen & Iyer, 2017). In such contexts, practices like coercive sterilisation counselling, pressure for “timely” compliance, and moral judgement of women’s reproductive histories become normalised within facilities.

Since the public health system caters disproportionately to the poor, the experiences in state facilities symbolise the social devaluation of reproductive health of poor women (Gilson 2003 cited in Chattopadhyaya et al 2017). In India, the government health scheme (Janani Suraksha Yojana or JSY) incentivized pregnant women from 2005 onward to reach a health facility during labour so that they may have an institutional childbirth, providing a conditional cash transfer. In Uttar Pradesh, for example, this led to a situation where millions of women tried to access an under-resourced public health system, with under-equipped, understaffed health facilities

and health providers who are under-qualified and unsupervised. Their existing health vulnerabilities, such as malnutrition, anemia, infectious diseases or other high-risk factors, remained undetected during the tokenistic pregnancy care provided, which did not include services for any health problems, including miscarriage or post-abortion complications. The situation is exacerbated by the identity of the women, who may have little or no education, belong to Dalit/Adivasi/OBC/ minority communities and come from remote villages.

The increasing focus on target-driven institutional births seems to have coincided with increases in unnecessary technological and medical interventions during births (Chattopadhyaya et al 2017). A landmark case was that of a rural daily-wage worker Salenta/Snehlata, in Muzaffarnagar district, Uttar Pradesh, who attempted after five successful home births, to give birth in a Primary Health Centre, hoping to get the cash transfer JSY in her sixth pregnancy. Without getting her to empty her bladder, the Auxiliary Nurse Midwife (ANM) started an IV drip (possibly with the drug of popular choice, oxytocin) and left her unattended for three hours in labour. After the baby was born, the ANM harassed the poor family for informal payments, holding the mother and baby hostage, forcing them into debt. When Salenta finally got home, she was constantly leaking urine. Although she went back to the PHC for treatment and later visited six other hospitals over months, diagnosis of the vesicovaginal fistula was delayed, and no corrective surgery was offered until the activists of Healthwatch Forum arranged for it, ten months later (Centre for Reproductive Rights, 2011)

Rekha, a 29-year-old Dalit woman with two daughters, describes how she sought antenatal care from the local PHC and ultrasound scans from a local private clinic for all her deliveries, which took place in the medical college hospital. Rekha’s second pregnancy occurred within three months of an accident, in which she sustained a head injury and was hospitalised for over two months. She went to the PHC for her delivery, and the entire experience was traumatic, exemplifying several types of obstetric violence described above:

“The nurses asked me to take a deep breath and push the baby out. They pressed my stomach. I

had unbearable pain and shouted, “Let me go; if you press any further, I will die.” My parents (then) took me to the medical college hospital. There, they removed all my clothes and made me stand nude.... They did a c- section delivery. The baby was injured, with a cut across the face.” (Ravindran et al 2026)

Continuum of Violence

Sarala’s story (see Annexure) shows how the violence that women experience extends from the private to the public sphere and compounds based on their social location and context. Gender power relations between her husband, her mother-in-law, and herself and the domestic and sexual violence that she experienced, resulted in the trauma of the loss of two pregnancies, as well as unwanted and mistimed pregnancies. Sarala’s own disability and her husband’s visual impairment exacerbated the violence that she experienced at the hands of the health system. In addition to the violence of poor quality of antenatal and contraceptive care, she was humiliated and verbally abused because of her disability (Ravindran et al 2026).

Policy Responses and the Promise of Respectful Maternity Care (RMC)

In response to growing evidence of mistreatment, the Government of India launched the LaQshya initiative to improve the quality of care in labour rooms and maternity operation theatres. LaQshya explicitly incorporates principles of respectful maternity care, including privacy, consent, communication, and emotional support. Evaluations of RMC-oriented interventions under LaQshya present a mixed picture. Facility-level studies from Maharashtra and Madhya Pradesh report improvements in patient satisfaction, provider communication, and adherence to respectful practices following focused training and monitoring (Bangal et al., 2020; Shwetha et al., 2023). These findings suggest that respectful care is achievable when institutional commitment, training, and accountability mechanisms are aligned.

However, other studies caution that policy frameworks alone are insufficient to transform everyday maternity care practices. Observational studies and patient-reported accounts from India and other low- and middle-income settings indicate that despite initiatives

such as LaQshya certification, routine forms of disrespect—including verbal abuse, neglect, non-consented care, and denial of information—continue, particularly in high-volume public hospitals (Kruk et al., 2018; Chattopadhyay et al., 2022). Evaluations of RMC-oriented programmes highlight persistent gaps in implementation, weak and episodic supervision, and limited institutional accountability, which together constrain the transformative potential of such initiatives (Government of India, 2017; Sando et al., 2017). Importantly, several scholars argue that these limitations are not merely technical but deeply relational and structural.

Steep social hierarchies between doctors and patients—shaped by caste, class, gender, and educational asymmetries—produce care encounters marked by paternalism and coercive authority, where women, particularly from marginalised backgrounds, have little scope to question decisions or assert autonomy (Dasgupta et al., 2015; Jewkes & Penn-Kekana, 2015). Without explicitly engaging with these entrenched power relations within clinical settings, RMC frameworks risk becoming procedural checklists rather than catalysts for meaningful change in women’s experiences of childbirth care.

Implications and Gaps

Taken together, the literature and case documentation suggest that obstetric violence in India is not an aberration, but a systemic issue shaped by the interaction of gender norms, structural inequalities, institutional hierarchies, and health-system constraints. While recent policy initiatives signal important recognition of respectful care, sustained change requires attention to women’s voices, provider working conditions, and accountability structures.

There remains a need for more longitudinal and qualitative research that centres women’s lived experiences, particularly among marginalised communities, and examines how respectful care is negotiated — or denied — in everyday clinical practice. Integrating such evidence into policy and training is essential if institutional childbirth is to become not only safer, but also more humane and just.

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Mumbai, and a public health researcher. She is pursuing a PhD at Tata Institute of Social Sciences (TISS), focusing on respectful maternity care, with broader interests in gender, health systems, and rights-based policy research.

Jashodhara Dasgupta, an independent researcher on gender, health and rights, has co-founded and led feminist organizations and civil society advocacy networks on sexual and reproductive rights. She currently co-chairs a Lancet-Commission on Political Determinants of Health, is a Co-Convenor at Feminist Policy Collective and on the Board of SAHAYOG.

Renu Khanna is a gender, health and rights practitioner. She is a Co-Founder of SAHAJ and continues to be on its Governing Board. She is on the Gender Advisory Panel of WHO and has been a Commissioner on the Lancet Commission on Gender and Global Health (2020-2025). Renu continues to be active in several pro-people movements like the Jan Swasthya Abhiyan, CommonHealth and Feminist Policy Collective.

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Annexure - Sarala's story

25-year-old Sarala is now pregnant for the sixth time. She and her husband Franklin live with two of their three children – two boys, aged 3 and 1 – in a government-provided group house. Her five-year-old daughter lives with Sarala's parents. Sarala's family are Christian Dalits belonging to the Vettiyan sub-caste.

Sarala has a physical disability: she cannot stretch or fold the fingers of one hand; one of her legs is bent, and she walks leaning to her left. Franklin, a visually challenged person, is a lay preacher in the local church. Both have disability certificates that give them a monthly allowance of Rs. 1,000 each, their main source of income.

Despite her disability, Franklin expected her to do all the household work. She had to fetch water from the public tap, and had to ask for help to lift the pot to her hip. He did not seem to realise the pain she had to bear. Sarala would cook the food and complete all the household chores and then had to be at Franklin's beck and call:

“Get me the towel, fetch me the soap, get me my clothes, give me food, give me sambar.”

Any delay in her responding to his demands would make him very angry. This behaviour also extended to their sexual life:

“If he calls me, I should go immediately. If not, he will curse, scold me, and ask me, ‘With whom did you go and roam around that you cannot come soon?’. He will even call me a whore, he will not be patient even for a second.”

Franklin began beating her if she said she did not feel well. He would insist on having sex even within two months of childbirth. One pregnancy followed another, whether Sarala wanted it or not.

Violence and abuse also contributed to her poor pregnancy outcomes. Sarala lost her first baby after being beaten by her mother-in-law in an argument. A month after her miscarriage, Sarala conceived again. She went to the village health nurse and, on her advice, to the primary health centre (PHC) for monthly check-ups. She was not given any contraceptive advice during her ANC visits, but was advised to 'stay away from her husband' after delivery. Sarala gave birth to a baby girl at home, with a nurse conducting her delivery.

Sarala became pregnant again when her daughter was just over a year old, but her pregnancy resulted in a stillbirth due to her husband's violence: she had not been feeling well and hadn't cooked lunch, for which her husband beat her so severely that she bled profusely and went into labour immediately. Her husband took her to the government hospital immediately, but the baby was stillborn.

Her subsequent two babies were sons, both born in government hospitals. She had to depend on her husband to mobilise the money to take her for monthly antenatal check-ups and the deliveries, sometimes accompanied by her neighbouring *akka* (sister). When there was no money, she would have to borrow to get to the hospital. At the time of the stillbirth, she was taken on a bike to the PHC, and from there on to the government hospital.

“I was bleeding all the way. When the nurses and doctors (in the hospital) saw me, they rebuked me. ‘Why did you not come earlier? Could you not have called an ambulance?’”

Being blind, her husband could not negotiate the hospital when she was admitted. He left her there and went home, and she had to manage on her own.

Each time she reported a missed period to the village health nurse, the latter would scold her for getting pregnant so often.

After her fifth delivery, when her second son was born, she had a copper-T inserted, but it did not suit her. She had heavy bleeding during her periods, lasting for several days, to the extent that she could barely manage to get through the day. Eventually, she went to the hospital with her neighbour's help and had the copper-T removed. She has been told she is ineligible for female sterilisation because of her disability, so the doctors advised her husband to undergo a vasectomy. He keeps saying he would but has not done it so far. Within a month of removing the copper-T, Sarala's periods stopped, and she is now four months pregnant. Franklin would like her to terminate this pregnancy with tablets, but Sarala has refused. She wants to give birth to a healthy baby and give the baby to her brother for adoption.

Sarala has not yet gone for any check-ups; she is waiting for her husband to arrange for the money to take her for a scan and for pregnancy check-ups. She wants this to be her last pregnancy.

“I do not want to go on having children; how will I feed them? I cared for all the children without anyone's help and breastfed the babies with the support of just one hand and one leg.”