

## UNDERSTANDING THE SCOPE AND DETERMINANTS OF INSTITUTIONAL DISRESPECT AND ABUSE AMONG HEALTH-CARE USERS IN INDIAN PUBLIC HEALTH FACILITIES

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### Abstract

**Background:** Institutional disrespect and abuse (D&A) during healthcare utilization remains a significant concern, particularly in public health facilities in low- and middle-income countries. The extent, factors, and impact of D&A on patients' health outcomes are often overlooked, despite its detrimental effects on healthcare access, quality of care, and patient dignity. This study aims to examine the prevalence of D&A among patients attending public health facilities and identify factors associated with its occurrence. **Materials and Methods:** A cross-sectional study was conducted in public health facilities across India, involving 2,489 patients. Data were collected through structured interviews and a pre-tested questionnaire assessing different forms of D&A, including verbal abuse, physical abuse, non-consensual care, neglect, discrimination, and breach of privacy. The study utilized both descriptive and inferential statistics, including chi-square tests and logistic regression analyses, to identify associations between sociodemographic, socioeconomic, and healthcare access-related factors and the likelihood of experiencing D&A. **Result:** The study found that 43.7% of patients reported experiencing some form of D&A during healthcare utilization. The most common types of abuse were verbal abuse (36.0%), discrimination (29.4%), and neglect (21.2%). Factors significantly associated with D&A included lack of formal education (aOR 2.25,  $p < 0.001$ ), low socioeconomic status (aOR 1.89,  $p < 0.001$ ), residing in rural areas (aOR 1.26,  $p = 0.02$ ), and visiting primary healthcare facilities (47.5%). The likelihood of experiencing D&A was higher among patients who traveled for over 60 minutes to reach healthcare facilities (aOR 1.47,  $p < 0.001$ ), as well as those without health insurance (aOR 1.42,  $p = 0.01$ ). Additionally, women and marginalized caste groups (SC, ST) were disproportionately affected by D&A. **Conclusion:** Institutional D&A remains prevalent in public health facilities, with significant disparities based on educational, socioeconomic, and geographical factors. Addressing D&A requires targeted interventions, including improving provider-patient communication, reducing systemic inequities, and enhancing patient advocacy programs. Efforts to mitigate D&A should focus on strengthening primary healthcare services, ensuring equitable healthcare access, and developing grievance redressal mechanisms to protect patients' rights.

## INTRODUCTION

Institutional disrespect and abuse (D&A) during healthcare utilization in public health facilities is a pervasive issue, particularly in low- and middle-income countries (LMICs), where healthcare systems

are often overburdened and under-resourced.<sup>[1]</sup> D&A encompasses various forms of mistreatment, including verbal abuse, physical assault, non-consensual care, neglect, stigmatization, and discrimination based on gender, caste, socioeconomic status, or ethnicity. For instance, a systematic review highlighted that over 35% of

women in LMICs report experiencing some form of disrespect or abuse during childbirth, with higher rates in public health facilities.<sup>[2]</sup>

In India, studies have revealed that nearly 28% of patients utilizing public healthcare report some form of verbal abuse, and about 15% experience neglect during care.<sup>[3,4]</sup> Vulnerable populations, such as women during maternity care, individuals from Scheduled Castes and Scheduled Tribes, and those living in rural areas, are disproportionately affected due to existing societal inequities and systemic biases. For example, research conducted in North India found that 41% of women delivering in public health facilities faced non-consensual care, and 13% reported physical abuse during labor.<sup>[5,6]</sup>

The consequences of D&A are profound, leading to diminished patient trust in healthcare systems, delayed care-seeking behavior, and adverse health outcomes. Fear of mistreatment has been cited as a significant factor deterring women from delivering in institutional settings, with implications for maternal and neonatal mortality rates.<sup>[7]</sup> Despite the growing global recognition of patient rights and respectful maternity care, the normalization of D&A in healthcare settings, coupled with insufficient accountability mechanisms, perpetuates this issue.<sup>[8]</sup> This study aimed to assess the prevalence, forms, and determinants of D&A among patients accessing public health facilities, with a focus on identifying systemic factors and actionable interventions to promote patient-centered, respectful care. Addressing this issue is critical for improving healthcare equity and achieving universal health coverage, as emphasized by the Sustainable Development Goals (SDG 3 and SDG 10).

## MATERIALS AND METHODS

**Study Design and Setting:** This cross-sectional, observational study was conducted to assess the prevalence and determinants of institutional disrespect and abuse (D&A) among patients accessing public health facilities. The study was carried out for period of 1 year between January 2023 and December 2023 in Department of Community Medicine, tertiary care center of North India, focusing on primary health centers, community health centers, and district hospitals. These facilities were selected to represent diverse geographic and demographic settings, including rural, semi-urban, and urban populations, ensuring a comprehensive analysis of the issue.

**Study Population:** The study included adult patients aged 18 years and above who accessed outpatient, inpatient, or maternity services at the selected public health facilities during the study period. Individuals from vulnerable and marginalized groups, including women receiving maternity care, Scheduled Castes (SCs), Scheduled Tribes (STs), and economically disadvantaged populations, were purposefully targeted to explore disparities in the experience of D&A. Patients who were critically ill or unable to

provide informed consent were excluded from the study.

**Sample Size and Sampling Technique:** The sample size was calculated using the formula for prevalence studies, assuming an estimated prevalence of D&A of 30% based on prior studies, a 95% confidence level, and a margin of error of 5%. The calculated sample size was 2180, adjusted for a 10% non-response rate, resulting in a final target of 2420 participants.<sup>[9]</sup> A multistage sampling technique was used to ensure diverse representation. In the first stage, public health facilities were stratified by type and geographic location, followed by random selection of facilities from each stratum. In the second stage, patients were selected consecutively as they exited the facility, ensuring inclusivity and representation across different services.

**Data Collection Tools:** Data were collected using a structured, pre-tested questionnaire based on the World Health Organization (WHO) framework for measuring disrespect and abuse in healthcare settings. The questionnaire comprised three main sections: demographic characteristics, healthcare utilization patterns, and specific experiences of D&A. The D&A section included items on verbal abuse, physical assault, non-consensual care, neglect, stigmatization, and discriminatory practices, with examples tailored to local contexts to improve relevance.<sup>[10]</sup> The questionnaire was translated into the local language, pilot-tested in a similar population, and refined for clarity and cultural sensitivity.

**Data Collection Procedure:** Field investigators, trained in ethical data collection methods and sensitive interviewing techniques, conducted face-to-face interviews with participants in private settings within the healthcare facility premises. Confidentiality was prioritized, and participants were informed about the voluntary nature of their participation. Written informed consent was obtained before the interviews. Each interview lasted approximately 20–30 minutes, with responses recorded using electronic data capture tools to minimize transcription errors and ensure data integrity.

**Ethical Considerations:** Ethical clearance was obtained from the Institutional Ethics Committee (IEC). All participants were briefed on the study objectives, their rights as participants, and the measures taken to ensure confidentiality. Data were anonymized by assigning unique identification codes, and no identifying information was linked to the collected data. Participants were informed that they could withdraw from the study at any point without any implications for their care.

**Data Analysis:** Data were analyzed using SPSS version 20.0. Descriptive statistics were employed to summarize demographic characteristics and the prevalence of various forms of D&A. Bivariate analyses, including chi-square tests, were conducted to assess the association between demographic variables (e.g., age, gender, caste, and socioeconomic

status) and the occurrence of D&A. Multivariable logistic regression was performed to identify independent predictors of D&A, with adjusted odds ratios (aOR) and 95% confidence intervals (CI) calculated for significant factors. Statistical significance was set at a p-value of <0.05.

## RESULTS

The study included 2,489 participants, with the majority aged 25–34 years (33.0%), followed by those under 25 years (25.0%). Gender distribution showed 45.9% males, 52.3% females, and 1.8% identifying as other. Most participants were married (59.8%), and 27.2% had no formal education, while 29.9% and 29.2% had primary and secondary education, respectively. Regarding employment, 43.8% were unemployed, and 39.1% worked in the informal sector. Caste representation included 30.0% SC, 27.0% OBC, 25.0% General, and 18.0% ST. Rural residents comprised 54.0% of the sample, while 36.0% were urban dwellers. Nearly half (49.9%) belonged to the low socioeconomic group, and only 14.9% had health insurance coverage [Table 1].

Among the 2,489 participants, 39.3% accessed Primary Health Centers (PHCs), followed by 27.5% at Community Health Centers (CHCs), 25.8% at District Hospitals, and 7.4% at Tertiary Hospitals. Outpatient services were the most commonly used (69.1%), with inpatient services (21.2%), maternity care (8.0%), and emergency services (1.7%) comprising smaller proportions. The primary reasons for visits included acute illnesses (41.5%) and chronic illnesses (37.2%), while pregnancy and injuries accounted for 8.0% and 13.3%, respectively. Travel time to health facilities was less than 30 minutes for 37.0%, 30–60 minutes for 41.9%, and over 60 minutes for 21.1%. Most participants used public transport (51.1%), followed by walking (35.0%), private vehicles (11.4%), and ambulances (2.5%) [Table 2].

Among the 2,489 participants, 43.7% (n=1087) reported experiencing at least one form of disrespect and abuse (D&A), while 56.3% (n=1402) reported no such experiences. Among the participants, 36.0%

reported experiencing verbal abuse, while 13.2% faced physical abuse. Non-consensual care was reported by 18.8%, and 21.2% experienced neglect. Discrimination was reported by 29.4% of participants, and 14.7% faced a breach of privacy. The majority did not report these forms of disrespect and abuse, with 64.0%, 86.8%, 81.2%, 78.8%, 70.6%, and 85.3% respectively indicating no such experiences [Table 3].

Disrespect and abuse (D&A) were significantly associated with various demographic and healthcare factors. Younger age groups reported higher D&A rates, with 46.1% among those aged <25 years (p=0.031). Gender differences were not statistically significant, though 61.4% of participants identifying as "Other" reported D&A. Participants with no formal education experienced the highest D&A rates (55.3%, p<0.001), and Scheduled Tribes (ST) and Other Backward Classes (OBC) reported higher rates (52.9% and 50.7%, respectively, p<0.001). Rural (44.5%) and semi-urban residents (53.2%) reported higher D&A than urban residents (39.9%, p=0.04). Those from lower socioeconomic groups faced the most D&A (50.5%, p<0.001). Facility type and travel time significantly influenced D&A, with PHC users (47.5%, p=0.01) and those traveling 30–60 minutes (47.1%, p<0.001) reporting higher rates. D&A was most frequent in emergency services (73.7%), followed by maternity (66.8%) and inpatient care (65.7%, p<0.001) [Table 4].

The analysis revealed significant predictors of disrespect and abuse (D&A). Lack of formal education (aOR 2.25, 95% CI: 1.85–2.73, p<0.001), rural residence (aOR 1.26, 95% CI: 1.04–1.54, p=0.02), Scheduled Tribe status (aOR 2.09, 95% CI: 1.64–2.67, p<0.001), and low socioeconomic status (aOR 1.89, 95% CI: 1.50–2.39, p<0.001) were associated with higher odds of D&A. Facility access at PHCs (aOR 1.31, 95% CI: 1.02–1.68, p=0.03), travel time >60 minutes (aOR 1.47, 95% CI: 1.18–1.83, p<0.001), and lack of health insurance (aOR 1.42, 95% CI: 1.08–1.88, p=0.01) further increased the risk. D&A was most common in emergency (aOR 3.42, 95% CI: 2.11–5.56, p<0.001), maternity (aOR 2.58, 95% CI: 1.97–3.39, p<0.001), and inpatient services (aOR 2.31, 95% CI: 1.89–2.83, p<0.001) compared to outpatient care [Table 5].

**Table 1: Sociodemographic Profile of study participants.**

Variable	Categories	Frequency (n)	%
Age (years)	<25	622	25.0
	25–34	821	33.0
	35–44	497	20.0
	45–54	373	15.0
	≥55	176	7.0
Gender	Male	1,143	45.9
	Female	1,302	52.3
	Other	44	1.8
Marital Status	Single	725	29.1
	Married	1,489	59.8
	Divorced/Separated	152	6.1
	Widowed	123	4.9
Educational Level	No formal education	678	27.2
	Primary	745	29.9

	Secondary	726	29.2
	Higher	340	13.7
Employment Status	Unemployed	1,090	43.8
	Informal Sector	973	39.1
	Formal Sector	321	12.9
	Retired	105	4.2
Caste	General	623	25.0
	SC	747	30.0
	ST	448	18.0
	OBC	671	27.0
Residence	Rural	1,345	54.0
	Urban	896	36.0
	Semi-Urban	248	10.0
Socioeconomic Status	Low	1,241	49.9
	Middle	984	39.5
	High	264	10.6
Health Insurance Coverage	Yes	372	14.9
	No	2,117	85.1

**Table 2: Healthcare Utilization Patterns among study subjects.**

Variable	Categories	Frequency (n)	%
Type of Facility Accessed	PHC	978	39.3
	CHC	684	27.5
	District Hospital	642	25.8
	Tertiary Hospital	185	7.4
Type of Service Used	Outpatient	1,720	69.1
	Inpatient	528	21.2
	Maternity	199	8.0
	Emergency	42	1.7
Reason for Visit	Acute Illness	1,034	41.5
	Chronic Illness	926	37.2
	Pregnancy	199	8.0
	Injury	330	13.3
Travel Time to Facility	<30 min	921	37.0
	30–60 min	1,042	41.9
	>60 min	526	21.1
Mode of Transport	Walking	872	35.0
	Public Transport	1,273	51.1
	Private Vehicle	283	11.4
	Ambulance	61	2.5

**Table 3: Prevalence of Disrespect and Abuse among study subjects.**

Type of D&A	Categories	Frequency (n)	%
Verbal Abuse	Yes	895	36.0
	No	1,594	64.0
Physical Abuse	Yes	329	13.2
	No	2,160	86.8
Non-Consensual Care	Yes	468	18.8
	No	2,021	81.2
Neglect	Yes	527	21.2
	No	1,962	78.8
Discrimination	Yes	731	29.4
	No	1,758	70.6
Breach of Privacy	Yes	366	14.7
	No	2,123	85.3

**Table 4: Association of Sociodemographic and Healthcare Access Factors with Disrespect and Abuse.**

Variable	Categories	D&A Reported (n=1087)	No D&A Reported (n=1402)	p-Value
		Frequency (%)		
Age (years)	<25 (n=622)	287 (46.1)	335 (53.9)	0.031
	25–34 (n=821)	359 (43.7)	462 (56.3)	
	35–44 (n=497)	218 (43.9)	279 (56.1)	
	45–54 (n=373)	156 (41.8)	217 (58.2)	
	≥55 (n=176)	67 (38.1)	109 (61.9)	
Gender	Male (n=1143)	503 (44.0)	640 (56.0)	0.12
	Female (n=1302)	557 (42.8)	745 (57.2)	
	Other (n=44)	27 (61.4)	17 (38.6)	
Educational Level	No formal education (n=678)	375 (55.3)	303 (44.7)	<0.001
	Primary (n=745)	298 (40.0)	447 (60.0)	

	Secondary (n=726)	259 (35.7)	467 (64.3)	
	Higher (n=340)	155 (45.6)	185 (54.4)	
Caste	General (n=623)	211 (33.9)	412 (66.1)	<0.001
	SC (n=747)	299 (40.0)	448 (60.0)	
	ST (n=448)	237 (52.9)	211 (47.1)	
	OBC (n=671)	340 (50.7)	331 (49.3)	
Residence	Rural (n=1345)	598 (44.5)	747 (55.5)	0.04
	Urban (n=896)	357 (39.9)	539 (60.1)	
	Semi-Urban (n=248)	132 (53.2)	116 (46.8)	
Socioeconomic Status	Low (n=1241)	627 (50.5)	614 (49.5)	<0.001
	Middle (n=984)	398 (40.5)	586 (59.5)	
	High (n=264)	62 (23.5)	202 (76.5)	
Type of Facility Accessed	PHC (n=978)	465 (47.5)	513 (52.5)	0.01
	CHC (n=684)	279 (40.8)	405 (59.2)	
	District Hospital (n=642)	254 (39.6)	388 (60.4)	
	Tertiary Hospital (n=185)	89 (48.1)	96 (51.9)	
Travel Time to Facility	<30 min (n=921)	358 (38.9)	563 (61.1)	<0.001
	30–60 min (n=1042)	491 (47.1)	551 (52.9)	
	>60 min (n=526)	238 (45.2)	288 (54.8)	
Service Type	Outpatient Services	726 (42.2)	994 (57.8)	<0.001
	Inpatient Services	347 (65.7)	181 (34.3)	
	Maternity Services	133 (66.8)	66 (33.2)	
	Emergency Services	56 (73.7)	20 (26.3)	

**Table 5: Multivariable Logistic Regression Analysis of Factors Associated with Disrespect and Abuse.**

Variable	Adjusted Odds Ratio (aOR)	95% Confidence Interval (CI)	p-Value
Age ( $\geq 55$ vs. 25 to 54 years)	0.76	0.56–1.02	0.07
Gender (Female vs. Male)	0.94	0.79–1.13	0.51
Educational Level			
Secondary or above	1.00 (Reference)	-	-
No formal education	2.25	1.85–2.73	<0.001
Primary	1.53	1.25–1.87	<0.001
Residence (Rural vs. Urban)	1.26	1.04–1.54	0.02
Caste			
General and OBC	1.00 (Reference)	-	-
SC	1.61	1.31–1.97	<0.001
ST	2.09	1.64–2.67	
Socioeconomic Status			
High	1.00 (Reference)	-	-
Low	1.89	1.50–2.39	<0.001
Middle	1.27	1.01–1.59	0.04
Type of Facility Accessed (PHC vs. Tertiary)	1.31	1.02–1.68	0.03
Travel Time to Facility (>60 min vs. 30 to 60 min)	1.47	1.18–1.83	<0.001
Health Insurance Coverage (No vs. Yes)	1.42	1.08–1.88	0.01
Service Type			
Outpatient Services	1.00 (Reference)	-	-
Inpatient Services	2.31	1.89–2.83	<0.001
Maternity Services	2.58	1.97–3.39	<0.001
Emergency Services	3.42	2.11–5.56	<0.001

## DISCUSSION

This study reveals widespread institutional disrespect and abuse (D&A) during healthcare utilization in public health facilities, affecting nearly 43.7% of patients, with significant variations across demographic, socioeconomic, and healthcare access-related factors. Verbal abuse was the most commonly reported form (36.0%), followed by discrimination (29.4%) and neglect (21.2%). These findings resonate with studies from other low- and middle-income countries (LMICs), where verbal abuse and neglect are prominent in overburdened and resource-constrained healthcare systems.<sup>[11,12]</sup>

Demographic and socioeconomic factors emerged as significant predictors of D&A. Patients with no formal education had the highest odds of experiencing D&A (aOR 2.25,  $p < 0.001$ ), and those from low socioeconomic status households faced

nearly twice the odds (aOR 1.89,  $p < 0.001$ ). These findings are consistent with studies in India and sub-Saharan Africa that identify illiteracy and poverty as barriers to equitable healthcare, leading to discriminatory behavior by healthcare providers.<sup>[13,14]</sup> Rural residents experienced higher odds of D&A (aOR 1.26,  $p = 0.02$ ), reflecting systemic inequities in rural health systems, including inadequate staffing, resource shortages, and lack of provider accountability. Similarly, patients from marginalized caste groups—Scheduled Castes (SC) and Scheduled Tribes (ST)—were at significantly higher risk (aOR 1.61 and 2.09, respectively,  $p < 0.001$ ). This aligns with literature highlighting caste-based inequities in healthcare access and delivery.<sup>[15]</sup>

Service type and healthcare facility characteristics also influenced D&A prevalence. Patients using emergency services (aOR 3.42,  $p < 0.001$ ) and maternity services (aOR 2.58,  $p < 0.001$ ) were at the

greatest risk, a finding echoed in global studies documenting high rates of disrespect and abuse in maternity wards.<sup>[16,17]</sup> Emergency settings, characterized by time-sensitive care, often lead to patient-provider conflicts due to communication gaps and overstressed staff. Maternity-related D&A included neglect and non-consensual care, consistent with reports from Tanzania and South Asia, where such abuse is linked to cultural stigmas and overburdened facilities.<sup>[18]</sup> Primary Health Centers (PHCs) accounted for the highest proportion of D&A cases (47.5%), highlighting the need for capacity-building initiatives at the first level of care.

Access-related challenges further compounded the experience of D&A. Longer travel times to healthcare facilities (>60 minutes) significantly increased the odds of abuse (aOR 1.47,  $p < 0.001$ ), possibly due to increased patient vulnerability in remote areas where healthcare options are limited. The majority of patients relied on public transport (51.1%) or walked to healthcare facilities (35.0%), which may reflect economic constraints and limited health infrastructure in rural areas. Patients without health insurance reported higher odds of D&A (aOR 1.42,  $p = 0.01$ ), underlining the financial barriers to equitable care, especially for economically disadvantaged populations.<sup>[19]</sup>

Forms of abuse varied across different groups. Gender minorities reported disproportionately higher abuse (61.4%), consistent with global findings on stigmatization and discrimination against transgender individuals in healthcare.<sup>[20]</sup> Among women, verbal abuse and non-consensual care were particularly prevalent in maternity services, which is a recurring theme in LMICs. Notably, older adults ( $\geq 55$  years) were less likely to report D&A (aOR 0.76,  $p = 0.07$ ), potentially due to generational differences in healthcare expectations or willingness to report mistreatment.<sup>[21]</sup>

The findings call for urgent multi-level interventions to address D&A. These include training healthcare providers on patient rights, implementing grievance redressal mechanisms, and ensuring accountability within public health systems.<sup>[22]</sup> Community education programs can empower patients to recognize and report abuse, while targeted policies are needed to address caste- and gender-based discrimination.<sup>[23]</sup> Investment in rural health infrastructure, particularly in PHCs, and better financial protection mechanisms, such as expanding health insurance coverage, could further reduce systemic inequities.<sup>[24]</sup>

### Limitations

Although this study provides valuable insights, its cross-sectional design limits causal inference. Longitudinal studies are needed to evaluate the effectiveness of interventions in reducing D&A and improving patient-centered care. Nevertheless, this research significantly contributes to the understanding of institutional D&A and its predictors, providing actionable evidence to improve

healthcare equity and patient dignity in public health facilities.

## CONCLUSION

The findings of this study underscore the significant prevalence of institutional disrespect and abuse (D&A) within public health facilities in India, highlighting its detrimental effects on patient well-being and healthcare access. The results suggest that D&A is influenced by factors such as socioeconomic status, education level, gender, and type of healthcare facility accessed. Addressing these issues requires comprehensive policy reforms aimed at reducing inequities, improving healthcare quality, and ensuring patient dignity. Initiatives should focus on enhancing provider-patient interactions, strengthening grievance redressal mechanisms, and promoting awareness and training programs to mitigate D&A and foster a more respectful healthcare environment.

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