Chapter 11
Respectful Maternity Care: A Methodological Journey from Research to Policy and Action

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11.1 Introduction

Health promotion relates to behaviours within social and physical environments. However, human behaviour has been mostly linked to biological and psychological traits, and the role that society plays in shaping the behaviours has largely been ignored (Cacioppo et al., 2000). Psychological theories have predominated in explaining human behaviours, but power relations in society cannot be ignored as determinants of behaviour (Guinote, 2007). Power does not necessarily come from personality, but from knowledge and skills, broadly in line with an individual's socio-economic standing in society (Gaventa & Cornwall, 2008).

Power relations also play an important role in the healthcare system, irrespective of the clamour for ethics and rights (Nimmon & Stenfors-Hayes, 2016; Miller & Lalonde, 2015). Often, although health service providers use the power of knowledge, they fail to provide the space for health service users to express their needs. Power relations are also visible in the maternity care provided to women in a healthcare facility setting where disrespect and abuse are prevalent across the globe (Miller & Lalonde, 2015). According to World Health Organization, Respectful Maternity Care (RMC) means "care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour" (WHO, 2018). It indicates that respect in maternity care is the responsibility of the service provider.

As a result, the RMC research was envisaged to help understand the behaviours of service providers, advocate with policymakers to review and revise policies and

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L. Potvin, D. Jourdan (eds.), *Global Handbook of Health Promotion Research, Vol. 1*,
https://doi.org/10.1007/978-3-030-97212-7_11

programmes and engage with service providers for participatory action for RMC in a tertiary care hospital in North India. Several theoretical and methodological issues were encountered during the conceptualization and implementation phases of this project, particularly while linking the research to advocacy, a process that is at the heart of health promotion.

11.2 The Context

In India, many women die while giving birth. Birthing at home was a common practice in India until recently, but, by 2015, 70% of women were presenting themselves for childbirth at health institutions (MoH&FW, 2017a). Birthing at a health facility has been considered a key intervention to save mothers and newborns in India where the maternal mortality ratio per 100,000 live births is still 113. However, the increase in the institutional delivery rate has not led to the expected decline in maternal and newborn mortality. Both policymakers and researchers have raised concerns about the "quality of care" available to women birthing in public health facilities. Some of the observed disrespect and violence to which women were subjected during delivery at such facilities was considered to be a factor that discouraged women from approaching health institutions for birthing, even when facing complications or needing specialized care.

As the Government of India had already initiated a programme for improving the quality of maternity care by improving the hospital infrastructure and technical capacities of health service providers, we initiated a project on respectful maternity care with financial support from the MacArthur Foundation, the Centre for Catalyzing Change (C3) and the White Ribbon Alliance.

11.3 Project Conceptualization

The fundamental question we needed to answer was how disrespect has emerged between the service user and service provider, and, so, the first call was to understand the unequal relationship between service providers and service users. The scientific literature on this question was scanty. We reviewed the history of medicine and public health and realized that the balance in power relations between a service user and a service provider has been contextual, i.e. different in different political and economic structures (Addicott & Ferlie, 2007).

In the Indian context, incidents of violence were reported in healthcare institutions. Although the vast majority of incidents involved disrespect or abuse of patients by service providers, it should be noted that there have also been cases of service users using violence against service providers who were perceived to be providing low-quality services or were perceived to be negligent (Kumar et al.,

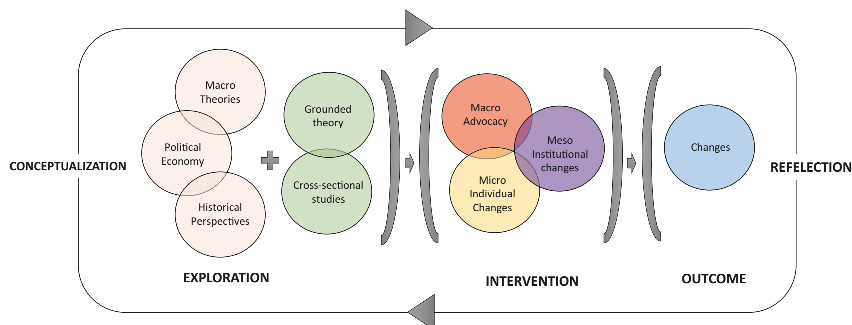

Fig. 11.1 RMC: paradigms of change

2016). This indicated that the power of knowledge (of service providers) can be challenged by those who are most vulnerable (the users of service).

It was expected that understanding the drivers of disrespect and abuse, as well as changing behaviours and advocating for the rights of women seeking maternity care, might be another phase in the history of medicine and public health, and a multidisciplinary approach would be required to understand the phenomenon of power relations in a medical setting. Therefore, a team comprising an epidemiologist, a sociologist, a social psychologist, an anthropologist, a gynaecologist and a lawyer was put together to work on the RMC project, for providing both theoretical and methodological inputs. According to Davies, "a discipline needs the ability to attract like-minded individuals and groups with similar beliefs, goals and vision" (Davies, 2013). Hence, the RMC project adopted a multidisciplinary approach.

After extensive deliberations, a novel approach of linking research to policy and action was agreed. It differed from most of the earlier approaches, which focused on individual behaviour change and usually ignored organizational and social changes (Baum & Fisher, 2014). After considering the chaos theory (Gleick, 1987), the use of social structural theories was considered to be apt for the RMC project. A critical realist approach advocated by Bhaskar (Bhaskar, 1975), in which there is space for being critical, was used to help understand the whole of society in the context of its history. This was useful in planning the paradigms of change for the RMC project from exploration to intervention and outcome (Fig. 11.1). The intervention strategy was kept flexible for policy, institutional and individual contexts.

11.4 Research Strategy

In scientific disciplines, a conventionally positivist approach is used to provide evidence that is based on experiments, e.g. randomized controlled trials (RCTs). However, science is a product of historical development. The constructivist approach has broken the boundaries and limits of the rules on what evidence means. Therefore,

in the RMC study, we carefully followed both positivist and constructivist approaches in the various phases of the project.

The RMC project was carried out in three phases. The methods used in all three phases were selected to fill the gap between theory and empirical learning, as according to Charmaz:

> neither data nor theories are discovered but are constructed by the researcher as a result of their interactions with the field and its participants (Charmaz, 2000).

We ensured that each phase had its own specific methodology and that a separate protocol was submitted for financial support and ethical approval for each phase. However, each phase is linked with other phases starting from the conceptualization through to outcomes and reflections on changes made in policies and practices.

11.4.1 Phase I: Evidence for Advocacy

The aim in the first phase of the RMC study was to provide evidence on the extent and pattern of disrespectful behaviours (if any), to identify drivers of disrespect and draw lessons for policy changes and actions to be implemented in the programme. The research questions were: 1) What are the perceptions of service providers on RMC and the rights of women in the antenatal, natal and postnatal phases? 2) What are the gaps in the perceptions of service providers and users about RMC? 3) What are women's experiences of RMC? 4) What are the drivers of disrespect in care?

The specific objectives were to measure the prevalence of RMC and identify the factors leading to disrespect during the antenatal, natal and postnatal periods.

In this phase, a concurrent exploratory mixed methods (Creswell et al., 2003) study design was used. Random sampling strategy to collect quantitative data and purposive sampling to collect qualitative data from different levels of health institutions were harnessed. The data were collected using a structured questionnaire for the quantitative component, a topic guide for in-depth interviews and focus group discussions (FGDs) and a checklist for non-participatory observations. While observations and in-depth interviews with mothers and service providers were conducted in health institutions, in-depth interviews with postnatal mothers and FGDs with community members were held in a community setting. Health care providers working at different levels of public health facilities (primary, secondary and tertiary) were interviewed and observed in their own settings.

Descriptive analyses were carried out to find the prevalence of disrespect and to identify the factors involved. Thematic analyses of qualitative data were carried out manually as the team wanted to make a continuous comparison of data to find the links between themes. Grounded theory (Glaser & Strauss, 1967), in which a constant comparison within the data was applied to identify themes and defining categories, was used for the analyses. The QUAN and QUAL data were triangulated at the time of analyses, and QUAL findings were used to explain the reasons for disrespect (Fig. 11.2).

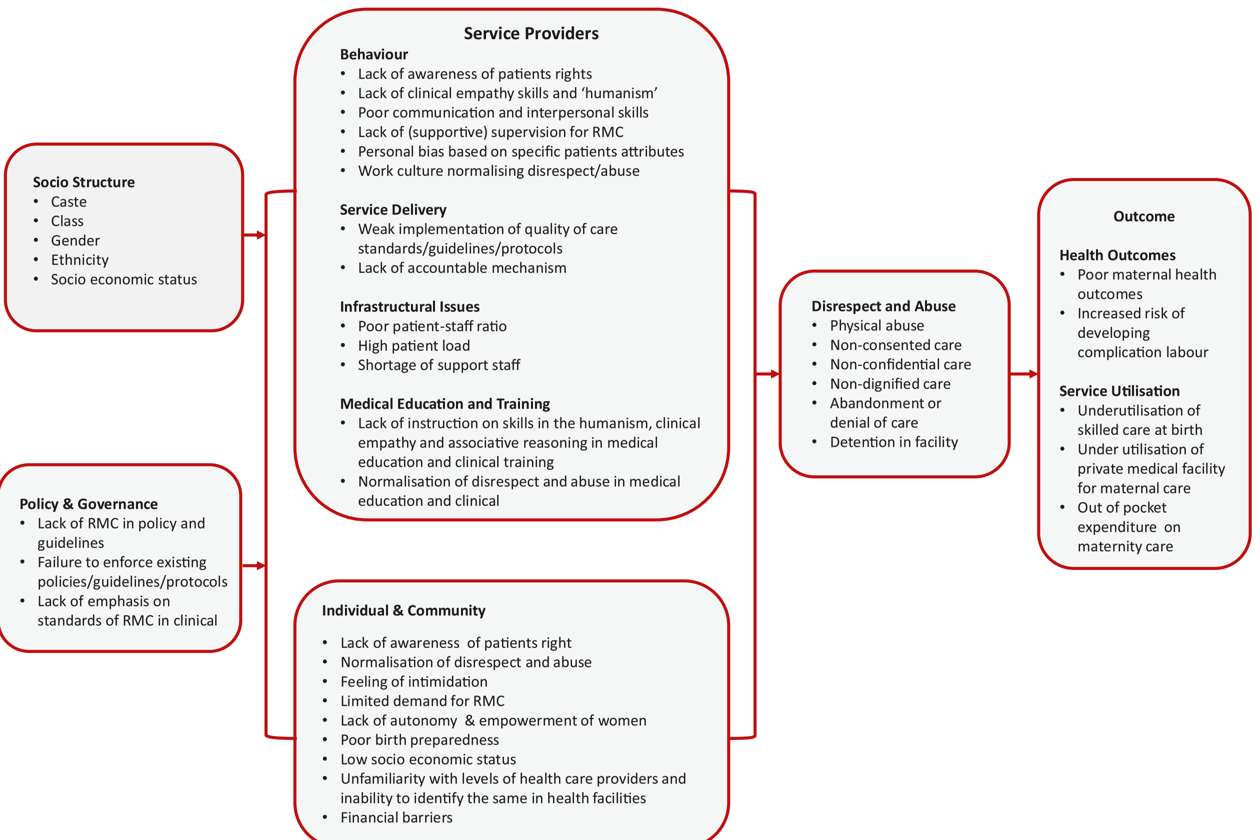

Fig. 11.2 Contributors to disrespect and abuse: findings from the RMC study

The interactions with service providers and service users at different levels of service delivery made it extremely clear that the medical education system has made service delivery more outcome-oriented, and this has led to the "normalization" of disrespect while providing care. Therefore, the issues of inequality within the health system must be addressed using policy spaces.

11.4.2 Phase II: Advocacy for Policy Change

The advocacy strategy included coalition building with allies, public awareness campaigns through mass media and meetings with policymakers. For agenda setting, a short documentary was aired on national TV (Deb, 2018), and several meetings were held with stakeholders.

A window of opportunity to communicate our work on RMC that emerged as the National Program on Quality of Care for Maternal and Child Health was to be launched on 11 December 2017 (MoH&FW, 2017b). As part of this event, we were able to share the findings of phase I with policymakers and programme managers. Based on these findings, RMC was included as an important component of the Labour Room Quality Improvement Initiative (LaQSHYA) program. The training for LaQSHYA included a session on RMC to sensitize service providers.

Although the service providers were sensitized during the programme implementation across the country, this capacity-building exercise was not without challenges. Resource persons for sensitization sessions on RMC reported that the service providers were in a denial mode regarding their disrespectful behaviours and remained defensive for quite some time. In the initial sessions, it was emphasized that though obstetricians save many lives despite this disrespectful behaviour, it needed to be changed in order to encourage more women to seek care in hospitals.

Advocacy with stakeholders and training workshops with health service providers helped in finding programme partners to take the RMC work forward. The experiences of other stakeholders who were also trying to implement RMC in their health institutions were especially useful. However, most of these institutions were following a top-down approach, i.e. change would be led by the authorities in power.

It was apparent that service providers themselves are bound by hierarchies in society and in the health system, and they automatically follow the instructions of the authorities without considering their own rights, the rights of the women they care for or the needs of the service users. Service providers appeared to remain distant from their own realities and keep their minds closed as everyone followed the existing routines and maintained the status quo. They often do not ask for improvements in the health infrastructure but rather make compromises on quality. There is no space for critical analysis of the environment in their personal or professional lives. The experts justify their behaviour by saying that they use their expertise to save mothers and babies, offering this as a rationale for not changing disrespectful behaviours.

11.4.3 Phase III: Participatory Action

Experiences from the training workshops and from other organizations, with both positive and not so positive outcomes, indicated that a top-down approach may not be sustainable. The research team also admitted bringing about changes in practice at tertiary care hospitals, where experts are recognized for their knowledge and skills, is a big challenge. Therefore, we decided to use a participatory action approach (Lewin, 1946) to change the behaviours of health service providers and to draw lessons for future health promotion research.

The purpose of the intervention in this phase was to learn and change together to realize the rights of childbearing women. The intervention was designed, implemented and evaluated by the study participants, i.e. the service providers; the research team only facilitated the processes.

The intervention was initiated in December 2018 in a tertiary care hospital. As there is no midwifery practice in India, women receive antenatal care at the primary care level, but, for birthing, they approach secondary or tertiary care facilities.

Participatory action is a continuous process, and spirals of change are followed. In the RMC programme, most of the planning and implementation of activities for change shifted from the facilitator of change, the researcher, to the service providers themselves. The service providers, particularly the residents and consultants, were able to change the hospital infrastructure and the behaviours by involving partners including institutional authorities, funding agencies and government representatives. They started to provide respectful services to pregnant and birthing women using their own innovations (such as drawing up a chart to observe their own behaviour and identifying what they could do differently, even during the COVID-19 crisis and periods of lockdown.

However, involvement of the service providers in the RMC programme implementation was quite complex. Deciding on the level of support required by the research participants, especially the senior obstetricians, was the biggest challenge. Achieving the dynamism and flexibility required in the use of research methods for data collection, intervention implementation and evaluation at different levels and integrating the qualitative findings and outcomes appropriately at different points in time without losing focus on the participants' needs sometimes presented difficulties for the team.

11.5 Methodological Rationale and Challenges

The following theoretical and methodological challenges had to be addressed while conducting the RMC project, especially linking the research evidence to advocacy and policy action.

11.5.1 Use of Theories and Models

Identifying and appropriately using theories and models for understanding the behaviours and environments of a variety of stakeholders, including pregnant women, service providers and political leaders, was a challenge. Health promotion has about 89 meso- and micro-level theories and models that explain how behaviours can be changed (Michie et al., 2014). The theory of change and the behaviour change wheel were both explored and the principles of both were applied, but, following the theory of critical realism, a concurrent mixed methods design (Michie et al., 2011) was used in the first phase. The capacity, opportunity and motivation (COM-B) part of the behaviour change wheel helped in understanding the capacity of participants. A trans-theoretical model was used to understand the stage of change of the study participants before starting with participatory actions, and, to find the drivers of mistreatment during childbirth, we used the conceptual framework of Bowser and Hill (Bowser & Hill, 2010; WHO, 2014).

There was a dilemma as to whether structural (Foucault, 1970; Althusser, 2009) or functional theories (Malinowski, 1944) should be used to help study participants understand how all relations are bound by power hierarchies. Structuralists are often critical of power and are in favour of change in power to bring about equality, whereas functionalists support maintaining the status quo by respecting the hierarchies and power. These theories help in understanding how domination by one class or social group provides space and opportunities for disrespectful behaviours to persist while the status quo is maintained. A review of the political economy of different countries indicates that inequities and power relations within systems are bound by political and economic structures, which also define the relationship between a health service provider and a user (Stuckler et al., 2010).

The use of social theories in deciding which research methods and intervention implementations are more effective and sustainable is now well established. There has been good use of theories in the health promotion research, but researchers mostly apply meso-level theories (Sabatier, 1988) for understanding or changing behaviours. Human behaviours are complex and dynamic; therefore, one theory or a set of theories cannot be advocated, and the choice of theories must be determined by the researcher's own philosophical underpinning, ideology and, at times, the need to be pragmatic according to the requirements of the setting in which they work.

11.5.2 Settings and Methods

The project was carried out in both community (phase I) and hospital (phase III) settings. Advocacy sessions, workshops and meetings were held with the policymakers and experts in an office setting (phase II). The intervention has currently only been implemented in a hospital setting, but, to change the behaviours of a community, there is also a need to develop interventions in that community after careful

consideration of the community context. Working in multiple settings is a challenge; however, the use of phasing helps.

Presently, the focus is more on changing the behaviours of service providers. There is also a need to change the behaviour of pregnant women who are vulnerable to abuse or violence as they are never made aware of their rights, knowledge that is essential when approaching a health institution to seek care. An intervention to change the behaviour of pregnant women should also be designed and implemented.

Appropriate choice of research design, sampling strategy and methods of data collection were difficult in the RMC study as it involved several phases with specific purposes. Research methods were borrowed from social science and epidemiology. The policy intervention development and implementation were also not easy; hence, it was necessary to maintain flexibility of approach during the different stages.

While deciding on which methods to consider for a specific setting for both data collection and intervention, it is important to recognize that health promotion research is complex and requires more than one method. Cross-sectional design can be used for measuring the prevalence of behaviours quantitatively. However, it should not be considered a complete method until it is supplemented by qualitative methods to identify the root causes of behaviours, which is essential when advocating for change. Therefore, a mixed methods design is appropriate, even for short or smaller health promotion studies.

11.5.3 Evidence for Advocacy

In the absence of local evidence on RMC, advocacy with the policymakers was difficult. Hence, the first phase was planned to provide data on actual behaviours performed at a given point in time and within the given context. Without understanding the drivers of the behaviours, the application of behaviour change models would not have been effective. Therefore, an exploratory concurrent mixed methods design was used for simultaneous collection and analysis of quantitative and qualitative methods. The learnings from thematic analyses of qualitative research provided information on not only the reasons for disrespect but also the circumstances under which disrespect occurs and on the kind of relationship that exists between service users and providers.

Asymmetry in knowledge between the service user and provider was one of the major reasons for unequal relationships and subsequent abuse and disrespect during the provision of services. Most women acknowledged the occurrence of violence but always referred to other women who had experienced it. None of the women shared their own experience of violence that they might have encountered. It is possible that the women perceived a loss of dignity or a sense of shame in experiencing physical or verbal abuse.

Almost all the service providers acknowledged that violence has become a part of their care routines and it has been “normalized”, though it is not considered to be desirable. They admitted that they do not approach the powers that be in the health

system for an increase in resources but rather abuse the women who come to them in large numbers for availing themselves of services in resource-constrained situations. The insights gained from the multiphase mixed methods research were substantially effective in advocating for RMC. Therefore, while planning for health promotion, the research focus should be on generating evidence for advocacy for policy change interventions.

11.5.4 Intervention Development

Intervention research has been conceptualized by Rothman and Thomas (1994). It uses three facets: knowledge development, knowledge use and design and development (Rothman & Thomas, 1994). In the RMC research project, knowledge was generated in phase I; this was used for advocacy with the policymakers in phase II as well as for designing intervention for changing behaviours of service providers in phase III.

Advocacy, after the first phase, was intended to bring policy and programme-level changes. However, as the top-down approach was not found to be adequate, it was decided that the bottom-up approach would be used for co-development of the intervention, following the principles of participatory action research, i.e. the spiral approach of planning, action and evaluation.

It was considered beneficial to use a self-reflective approach with the practitioners who are experts in their own fields. Bogdan and Biklen have noted “practitioners marshal evidence or data to expose unjust practices or environmental dangers and recommend actions for change” (Bogdan & Biklen, 1992).

Therefore, practitioners were actively involved in the cause for which the research was being conducted. For others, such commitment is a necessary part of being a practitioner or a member of a community of practice. Thus, various projects designed to enhance practice could be referred to as “action research” (Goetschius et al., 1967).

The RMC project can be considered as action research, bringing need-based change in individuals, systems, organizations, communities and in the policies for changing structures. Thomas recognizes that the central idea is for “problem-solving in whatever way it is appropriate” (Thomas, 2007).

Whereas McNiff (2016) argues that it cannot be considered as a technique but should be viewed as a kind of conversation (McNiff, 2016). According to Thomas, action research is all about people:

> thinking for themselves and making their own choices, asking themselves what they should do and accepting the consequences of their own actions (Thomas, 2007).

11.5.5 Intervention Implementation

Implementation of action research in a tertiary care hospital is difficult as this hospital is a centre of excellence that provides care for women with complications of pregnancy and childbirth and has a load of 6,000–7,000 births per year; approximately 40% of these are caesarean section cases.

Disrespect towards pregnant and birthing women was found to be a "normalized" behaviour. Changing such behaviours has been a challenge. It calls for more than the issuing of guidelines and orders from the top authorities. Discriminatory and disrespectful behaviour was not only acceptable but also encouraged at times under the guise of saving the life of the mother and child. Discussions at all levels, during advocacy, raised questions in the minds of participants and provided opportunities for the researcher to understand how some behaviours in certain professions become normal when linked to service delivery outcomes or to targets for the reduction of maternal and newborn mortality.

The first demand that was raised by service providers during the advocacy session was that of hospital infrastructural development, e.g. one of the domains of respectful maternity care is privacy and access to the delivery room for a birth companion from the family. Service providers argued that this was not possible due to poor infrastructure. Lack of infrastructure or lack of resources was cited by service providers as a reason to avoid behaviour change, which provided another important lesson for the design of the intervention.

Health promotion also relates to "providing environment for change". Infrastructure is an environmental issue, and, many a time, it is beyond the control of the service provider. There is always a cultural lag between material and non-material culture (Ogburn, 1922). In individual and family lives, material culture grows faster than non-material culture as it is based on technology and the marketing of products. In health systems, the indicators of performance are based either on service coverage or on lives saved in low-resource countries (WHO, 2000), and these do not have much impact on the environment. It raises another question: Does it mean that work be done on other behavioural issues until there is a conducive environment?

Although environmental requirements were discussed, the communications during the workshops and meetings led to the understanding that power relations are deeply rooted in society and in social systems such as the health system. It became clear that it is not only the physical infrastructure that needs to be changed but also the social and economic structure calls for bigger changes to address RMC and the larger issue of health inequity.

Several meetings, workshops and visits by the facilitator in the labour room had to be carried out. The facilitator helped the service providers understand the issues around disrespect and how to resolve them while being respectful. Initially, there was denial that there was a problem of disrespect and significant resistance to change from the service providers' side.

11.5.6 Measuring the Impact

Health promotion research need not always have a control group to test the hypothesis as in RCTs, but it can follow the spirals of change of action research. Evaluation of the change in action research is quite challenging, but the qualitative reflections of the stakeholders can reveal whether it leads to policy change and desired actions at both the institutional and individual levels. For example, evidence-based advocacy helped in providing a platform for following the RMC approach for pregnant women and newborns at the national level, and qualitative observation led to the discovery that there were some institutions where the change towards RMC was becoming visible. The change in the public sector institutions was found to depend on the leadership of the higher authorities as staff in subordinate roles often follow the guidelines provided for the change. This top-down approach led to some changes taking place without the service providers even realizing that there had been a change, what the change had been or who gained and who lost after the change. It was clear that imitation of the behaviour of others played a large part in the process of change, but it is important to recognize that evidence-based advocacy did lead to questioning the status quo.

In the second spiral of change, after 3 months, the obstetricians and resident doctors started to acknowledge the existence of disrespect and reflect on their behaviour. By the end of 1 year, they had started to address this issue on their own. They had begun to identify the issues, plan the steps needed to address them and present their plans during the workshops. This process is being followed more closely and more often by nurses and medical doctors rather than by other categories of staff.

The role of a facilitator was reduced as some service providers stepped into that role. The measurement of outcome was not how much change had happened quantitatively, as is the case for RCTs, but the qualitative measure that explains the extent and type of change and its effect on the well-being of service providers and users.

11.6 Conclusions

In the RMC project, the individual behaviour change concept had to be stretched to a wide range of social and environmental changes. Since a great deal of time had to be spent building the recognition, even among the research team, it is necessary to understand the social contexts and the root causes of the behaviours of both the service providers and the users so as to advocate for respectful maternity care service. It is imperative for health promotion researchers to recognize their own philosophical outlook before starting the research work. Critical realism, as well as historical and theoretical perspectives on the relationship between a health service provider and a user, was useful for designing a complex health promotion research project.

Field observations, along with in-depth interviews, helped in advocating and in negotiating with the political system to create a policy space for RMC. Various theories were used within the given context to understand the behaviours and to initiate change. The service providers were involved from the planning stage to implementation, evaluation and re-planning cycles to ensure continuity while making conscious efforts to improve quality of care. The RMC research experience suggests that change can be more acceptable, practicable and sustainable if the actors of change have been engaged in recognizing their beliefs and current behaviours. People themselves need to test and learn from their own change process; control of change needs to be in the hands of the people who are changing themselves. The researcher needs to be a facilitator. The journey of RMC is continuing, and change has become an internal rather than an external process.

RMC has emerged as a social phenomenon, which also has physical and psychological aspects. The RMC journey reveals that individual change needs to be understood within environmental changes and that change is a process. Hence, there is a need for a paradigm shift. Health promotion needs to be rooted in social science, socio-political and cultural contexts and systems. The core of health promotion lies in "change". The existing macro-, meso- and micro-level theories of change are relevant, but health promotion scientists need to be more realistic and at the same time more critical to bring about change not only in behaviours or systems but also in structures.

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