

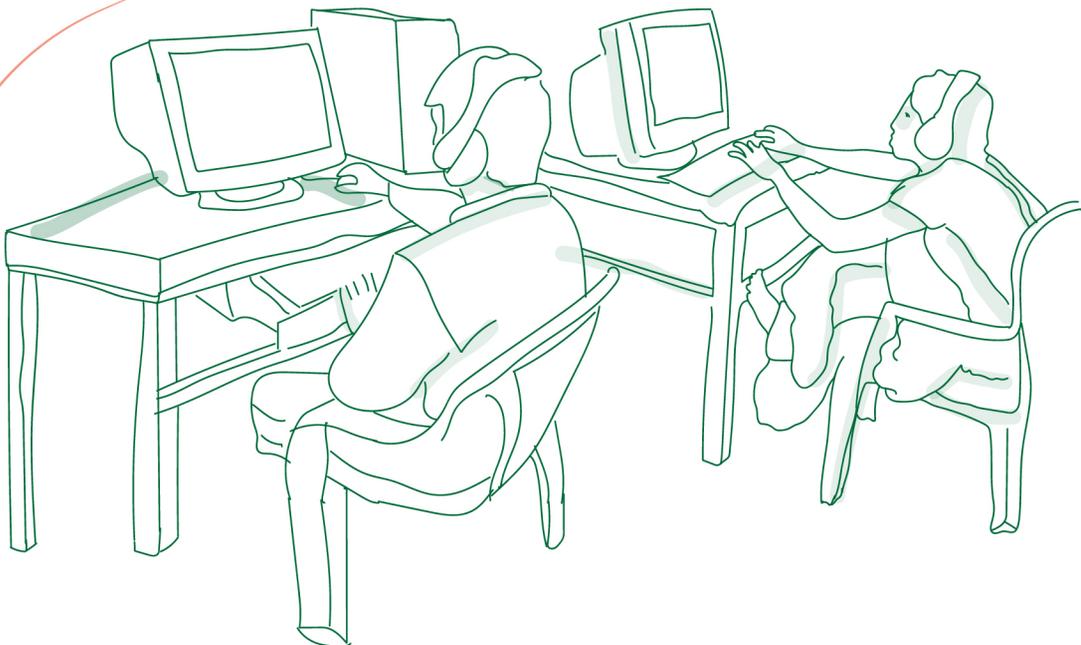


STORIES OF CHANGE

— 2019-2020

Case Studies on
Development Action and Impact

Azim Premji University Publication





Stories of Change: Case Study Challenge

Azim Premji University
2019-2020



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Stories of Change: Case Study Challenge

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Modern India has a history of a vibrant and active social sector. Many local development organisations, community organizations, social movements and non-governmental organisations populate the space of social action. Such organisations imagine a different future and plan and implement social interventions at different scales, many of which have lasting impact on the lives of people and society. However, their efforts and, more importantly, the learning from these initiatives remains largely unknown not only in the public sphere but also in the worlds of ‘development practice’ and ‘development education’. This shortfall impedes the process of learning and growth across interventions, organizations and time.

While most social sector organizations acknowledge this deficiency in documentation and knowledge creation, they find themselves strapped for time and motivation to embark on such efforts. Writing with a sense of reflection and self-analysis which goes beyond mere documentation and creates a platform for learning requires time and space. As a result, their writing is usually limited to documentation captured in grant proposals or project updates or ‘good practices’ literature with inadequate focus on capturing the nuances, boundaries and limitations of action.

Recognizing this need, the Azim Premji University launched ‘Stories of Change: Case Study Challenge’ with the objective of encouraging social sector organisations to invest in developing a grounded knowledge base for the sector. We are delighted to report

that in the inaugural year of this challenge (2018 – 19) we received 95 cases, covering interventions from education, sustainability, livelihoods, preservation of culture and community health. The target groups included adivasis, small farmers, children, women, youth and differently abled persons, among others. Through a two-stage evaluation process, the university selected 3 winners and 3 special mentions for the 2018-19 Stories of Change Challenge. In addition, we have selected 4 additional submissions, which together with the cited winners, is appearing in this jointly published compendium.

We hope that educators and practitioners alike find these stories valuable in their multiple engagements: influencing policy, building capacity of practitioners, documenting good practices for future learners, providing space to practitioners in teaching, collaborative research and even incubating new ideas for social change.

Acknowledgments



This compendium is a result of Azim Premji University's 2018 – 19 'Stories of Change: Case Study Challenge'. We thank all the organizations who submitted their stories from the field for this initiative. We appreciate the time and effort they have spent in developing the cases.

We had a two – stage evaluation process to select the ten submissions included in this compendium. We deeply appreciate the 19 colleagues from Azim Premji Foundation who agreed to review all the 95 submissions and shortlist the best ones. Their names, in alphabetical order, are: Anchal Chomal; Annapurna Neti; Aparna Sundar; Arima Mishra; Ashok Sircar; Geetisha Dasgupta; Himanshu Upadhyay; John Kurien; Kade Finnoff; Malini Bhattacharjee; Manjunath SV; Manu Mathai; Nazrul Haque; Puja Guha; Rahul Mukhopadhyay; Rajesh Josph; Richa Govil; Saswati Paik and Shreelata Rao Seshadri.

Annapurna Neti, Ashok Sircar, Malini Bhattacharjee, Rajesh Joseph, Rahul Mukhopadhyay and Shreelata Rao Seshadri are also the authors of the introductions for the 5 themes in this compendium.

Multiple individuals from the 10 organizations selected for this compendium worked closely with University team as well as with the copy editor, Malini Sood, to arrive at the final print-ready versions of their cases. All of them took out time from their busy schedules and were always very prompt and serious in their engagement. This compendium is a reality only because of each of those individuals. We are also grateful to Malini for her very professional and careful language editing.

Throughout the entire initiative – from publicity and outreach about the case study challenge to final design and page layout of this book – our colleagues from the Communication Team supported and helped at every step. Thank you, Sachin Mulay, Radhika and Nanit for making this happen.

Finally, Anurag Behar, the Vice Chancellor of Azim Premji University, has been very supportive of the Stories of Change initiative. Our Registrar, Manoj P was, as always, enthusiastic and encouraged us to imagine the task at a bigger scale than we had planned earlier. We want to thank Anurag and Manoj for their continuous support.

This is the first Volume of our proposed ‘Stories of Change: Case Studies on Development Action and Impact’ series and we want to continue this effort in the future as well. We hope this book will reach the intended audience – educators, researchers, practitioners, policy makers as well as students of development – and will be regarded as a persuasive and authentic account of the Indian social impact ecosystem. Readers can write to us at case.study@apu.edu. in with their valuable comments, suggestions and reviews so that we can improve our next editions. Thank you for reading and look forward to hear from you.

2.1 Integrating Gender in Medical Education and Clinical Practice:

The transformation of the Department of Obstetrics and Gynecology, Government Medical College, Aurangabad, Maharashtra



Centre for Enquiry into Health and Allied Themes (CEHAT), Maharashtra¹



Abstract

Despite the established role of social determinants in healthcare, neither medical education nor public health services in India have taken cognizance of it. Non-recognition of these social determinants has led to several biases in the dispensing of treatment and care to patients in general and to patients from re marginalized communities and sections in particular. Scholars have critiqued the field of medicine as being gender-blind and male-biased because the body of medical knowledge views the male body as the norm, with men's experiences forming the basis for describing the signs and symptoms of illness. This is a case study of the Department of Gynaecology and Obstetrics (OBGYN) in the Government Medical College, Aurangabad, Maharashtra (henceforth Aurangabad Medical College) which succeeded in facilitating gender perspectives in the teaching of



¹ Contributors from CEHAT: Sangeeta Rege, Padma Deosthali, Amruta Bavdekar, Priya John, and Ameerah Hasnain.



undergraduate medical students and transformed clinical practice by making it gender informed as well as gender sensitive to the needs of women. Some of the radical changes made in the functioning of the OBGYN department are renaming the Family Planning Department as the Comprehensive Contraceptive Services for All Department, introducing the concept of respectful maternity care, establishing medico-legal care for the survivors of sexual violence, and integrating first-line care for pregnant women facing violence. This evidence-based practice has not only enhanced the patient-provider relationship but has also led to positive health experiences and outcomes for the users of these services.



Integrating Gender in Medical Education and clinical practice: The context

The last two decades have witnessed the emergence of social determinants approaches in the field of public health. The World Health Organization's Commission on Social Determinants of Health, 2005– 2008 has defined the social determinants of health (SDH) as “the conditions in which people are born, grow, live, work and age” and as “the fundamental drivers of these conditions.” (p. 26). In other words, these are the factors apart from medical care that influence the health outcomes of the population. A huge body of literature supports the direct and indirect causal relationships between various socioeconomic factors and health. Health inequity, which is the unjust and systemic difference in the health status of different population groups, can be addressed or eliminated by taking reasonable action (WHO, Commission on Social Determinants, 2008); it is the consequence of social factors. It is important to address these factors to achieve the equitable distribution of various health targets across diverse population groups. It has been well established that public health interventions that fail to consider the social context and conditions of patients do not contribute to the reduction of mortality and morbidity rates. National-level data (National Family Health Survey [NFHS]) clearly indicate that diarrhoea, anaemia, infant mortality, and maternal mortality are far more prevalent in households with low socio- economic indicators (International Institute for Population Sciences [IIPS] and ICF, 2017).

The literature on the role of social determinants in influencing health outcomes has identified gender as an important factor leading to inequities in health. Because the consequences of the gender gap are more deleterious for women, the literature has primarily focused on women. The distinction between sex and gender is increasingly being made by advocates of women's health to emphasize its consideration in the development of public health programmes and interventions. In general, women have a longer life expectancy than men because of biological factors. However, in South Asian settings, including India, this advantage is overridden

because the life expectancy of women is lower than or equal to the life expectancy of men. Several studies have highlighted the impact of gender roles on women's health (WHO, 2009). Pregnancy and childbirth are conditions that are unique to women and are normal biological processes, but carry a significant risk to women's health. The health conditions that affect both women and men have more severe consequences for women due to the latter's poor access to healthcare. Women are also less likely to have power to make decisions about healthcare utilization owing to their restricted gender roles and lower status in society (Senarath and Gunawardena, 2009). In the Indian context, several studies have highlighted gender disparities in the incidence of diseases and their treatment (Bhat and Zavier, 2003; Maharana and Ladusingh, 2014; Saikia, Moradhvaj and Bora, 2016). These studies have clearly pointed out the need to address gender disparities by public health interventions in order to improve the health of the population and to achieve global targets.

Gender inequity has significant implications for health in the field of medicine. Medicine as a field is frequently critiqued for not taking into account gender in clinical practice, research, health programme delivery, medical education, and other relevant domains. It is male biased, as the available knowledge is focused on males and is often generalized to women, thus ignoring women's unique physiological makeup. It does not consider the aspect of gender inequity that creates additional barriers for women in accessing health services. Women's health issues are often relegated to reproductive matters and pregnancy-related problems, thus ignoring the other health needs of women, including their mental health needs (Verdonk et al., 2008).

In short, there is no distinction between biological and social factors in terms of health disparities between men and women when seen through the lens of gender analysis. Gender role ideology, which is defined as the attitude of healthcare providers (HCPs) towards male and female patients, accentuates these disparities (Verdonk et al., 2009). Women patients are viewed as more demanding, as they are seen to seek too much information (Foss and Hofoss, 2004) and their health problems are attributed to uncontrollable factors like

behaviour and emotions (Benrud and Reddy, 1998). The negative attitude of HCPs towards women acts as a deterrent for women seeking healthcare. This lack of gender perspective in the field of medicine has a negative impact of the provision of, and access to, healthcare services to women. The family planning programme in India has not been able to integrate gender equity in its services because of the limited involvement of men (Garg and Singh, 2014). The negative attitude of HCPs towards women accessing abortion services is one of the major barriers faced by women in accessing safe abortion services (Sebastian, Khan and Sebastian, 2013).

Integrating Gender in Medical Education: The need for change

Revamping medical education provides an important opportunity to transform the provision of healthcare in India by integrating social determinants, and recognizing their relation to health, in the MBBS (Bachelor of Medicine, Bachelor of Surgery) curriculum. Gender-informed curricula would enable HCPs to be more aware of the impact of gender on health and encourage them to integrate gender considerations in their clinical practice (Zeleg, Phillips and Lefebvre, 1997). This change is crucial to enable HCPs to recognize the role of gender, class, caste, religion, and sexuality in relation to health, and subsequently to develop and integrate a gender-sensitive attitude in their medical practice. It is a prerequisite for gender-specific healthcare service delivery and for ushering in social change (Bickel, 2001). Despite the importance of this issue, the scope of undergraduate medical education in India is limited to a biomedical model of medicine with an emphasis on proximal determinants of health like pathogens and treatment modalities. In 2002, WHO made a commitment to implementing a gender policy to mitigate gender inequities in health. A consultative meeting of leaders in the field of medical education was convened which concluded that the key to achieving gender equity in health was to integrate gender considerations into pre-service training curricula. There was a consensus that the gender perspective should be integrated in all the disciplines of medical education and that continuous training should be provided throughout the professional life of medical

practitioners. Developed countries like the USA, Canada, and Australia adopted initiatives to integrate gender considerations in the pre-service training of HCPs. Developing countries, including the Philippines and Thailand, adopted similar initiatives.

These initiatives attempt to integrate undergraduate medical curricula (Australia and Thailand), introduce specific topics in the medical curriculum like sexual and reproductive health (Turkey), and address domestic violence against women (VAW) (the Philippines). One of the first initiatives to address gender in medical education was carried out in the USA by the Association of Professors of Gynecology and Obstetrics (APOG) in 2000. The objective of the programme was to optimize women's healthcare by teaching medical students to recognize gender and sex differences. The curriculum was designed in a manner so as to equip medical students with the knowledge to discuss pathophysiology, aetiology, and differential diagnosis and treatment for common, serious, and women-specific conditions, and efforts were made to build key health competencies in students. The common theme in the teaching of all these subjects was the importance of recognizing gender and cultural differences and to understand the impact of gender-based culturally sanctioned roles on the medical condition of patients.

Another example is the collaboration between Monash University in Melbourne, Australia and the Gender and Health Collaborative Curriculum Project (GHCCP) in Canada; the latter is the work of faculty and students from the six medical schools in the Canadian province of Ontario. Under this joint venture, similar efforts were made to integrate gender in the medical curriculum. The collaboration resulted in the creation of a repository of materials for medical educators, students, and those interested in gender and health. The course material was designed in a manner that it could be taught as a standalone set of modules as well as a gender-integrated medical course for students.

In 2002, the Philippines became one of the first Southeast Asian countries to integrate domestic and family violence concerns in its medical and nursing curricula. The disciplines of community

medicine, psychiatry, medicine, paediatrics, surgery, gynaecology, and legal medicine were called upon to integrate these concerns in their respective courses. At the end of the course, students were expected to have developed into culturally sensitive, gender-sensitive, and compassionate doctors and nurses possessing effective communication and counselling skills.

In 2003–04, Thailand decided to initiate gender-integrated medical teaching for undergraduate medical students for six years of the MBBS curriculum. Their medical curriculum now has topics such as ethnicity, sexual orientation, sexuality, and recognizing the health consequences of sexual abuse.

In India, an initiative to integrate gender in medical education was introduced by the Achutha Menon Centre for Health Science Studies of the Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum in 2002. CEHAT (Centre for Enquiry into Health and Allied Theme) was one of the partners in this initiative. Under this three-year project, different activities were undertaken, such as formulating training modules for gender sensitization, developing criteria for a gender-sensitive setting for imparting medical education, organizing gender-sensitive trainings for medical college teachers, and reviewing Indian medical textbooks through a gender lens. The project led to the creation of a pool of trained medical educators who carried out short trainings and orientations in their respective disciplines in medical colleges.

CEHAT has also led several initiatives on the in-service training of medical professionals to respond to the issue of VAW and demonstrated evidence-based health systems models for responding to domestic and sexual violence. Dilaasa, a hospital-based crisis centre, was a joint initiative of the MCGM and CEHAT, established to sensitize HCPs and to train them to consider domestic violence as a health issue. In 2014, the National Urban Health Mission (NUHM) replicated this model in 11 hospitals of Mumbai. Other states have also adopted the model of Dilaasa. This experience of working with the health system on handling gender-based violence was a crucial background for initiating the project on gender in medical education.

Building on these efforts, CEHAT, with support from the United Nations Population Fund (UNFPA) and in collaboration with the Directorate of Medical Education and Research (DMER), Government of Maharashtra, and Maharashtra University of Health Sciences (MUHS), based in Nashik, undertook a project on integrating gender in medical education in the MBBS curriculum in Maharashtra. The project was conceptualized differently so as to integrate gender in medical teaching by building the capacities of medical educators. The project was initiated with a workshop attended by key stakeholders such as DMER, MUHS, and other experts to seek their input. It was agreed that gender integration in medical education should be a joint initiative of CEHAT and DMER, that medical educators should be trained, and that the modules should be tested in select medical colleges to demonstrate the impact in terms of a change in attitude.

About the project

The Integrating Gender in Medical Education (GME) project was implemented in select medical colleges in Maharashtra. The aim was to sensitize medical faculty and medical students to gender equity in health which would subsequently lead to gender-informed health services. The aim was to achieve gender sensitization and awareness of public health issues such as gender/sex differences, sex selection, access to abortion, and VAW by integrating gender perspectives in the MBBS curriculum.

The main objectives of the project were to:

1. Build the capacity of medical faculty on gender perspectives and women's health issues through a training of trainers (TOT) programme.
2. Facilitate the teaching of gender perspectives to MBBS students who had undergone gender- sensitization trainings. An assessment of the feasibility of integrating gender issues and perspectives in medical education as well as bringing about changes in the knowledge and attitudes of medical

students who had undergone a gender-integrated curriculum was also expected to be carried out.

At the conceptualization stage, a consultation workshop on the GME project was organized in September 2011 with senior officials from the Department of Health and Family Welfare, DMER, MUHS, the State Women's Commission, and the Indian Council of Medical Research (ICMR) along with academics, activists, and organizations working on gender and health. At the workshop, several key recommendations regarding the GME projects emerged. One recommendation was the development of a ToT programme that focused on five departments: Forensic Medicine and Toxicology (FMT), Medicine, Preventive and Social Medicine (PSM), Obstetrics and Gynaecology (Ob-Gyn), and Psychiatry. These disciplines were chosen because they form a large part of the undergraduate education.

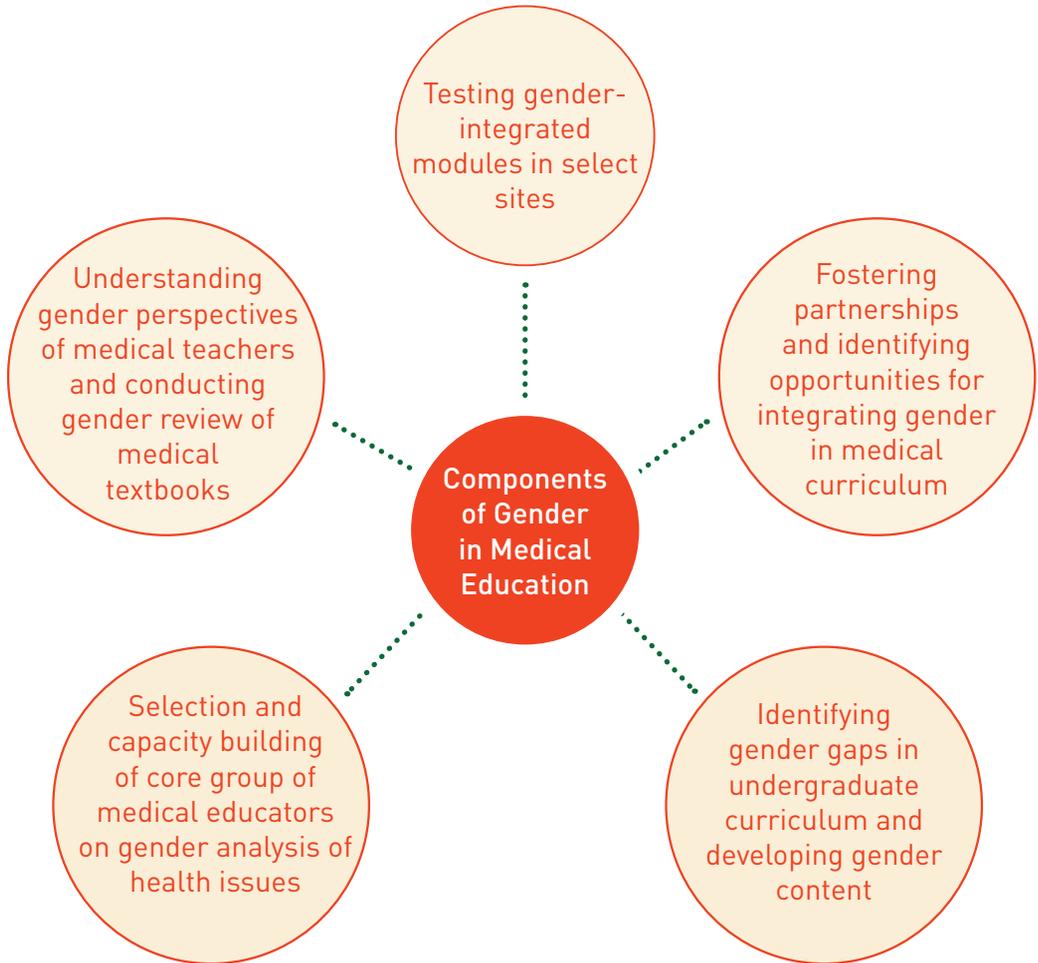
The conceptualization stage was followed by the intervention phase, which comprised the development of gender-integrated modules to facilitate the adoption of gender perspectives by MBBS students and a study to assess the feasibility of teaching these modules to students.

At the inception of the project, medical educators were trained on specific elements such as understanding the differences between sex and gender, recognizing the role of gender in health-seeking behaviour, and understanding how health is experienced differently by men, women, and marginalized groups of men and women (transgender, intersex, sexual minorities). The aim of the training was to understand the relationship between communicable diseases like sexually transmitted infections (STI), reproductive tract infection (RTI), and human immunodeficiency virus (HIV) and their links to gender. Considerable attention was also paid to recognizing the signs and symptoms of VAW and the many ways in which the consequences of VAW are reported to and within the health system. These critical components are currently missing in the MBBS curriculum despite their crucial linkages to health. In short, the following were the areas of training on gender issues:

1. Developing gender-based analytical tools for understanding and treating various diseases
2. Recognizing gender stereotypes held by HCPs and developing gender sensitivity in addressing health concerns
3. Developing an in-depth understanding of the concept of sexuality
4. Providing gender-sensitive reproductive health services for people from diverse groups (men, women, transgenders, people in same-sex relationships)
5. Inculcating gender sensitivity in abortion service delivery for women and girls
6. Being sensitive towards the sexual healthcare needs of different groups
7. Recognizing and responding to gender-based violence (GBV) in a sensitive manner

Components of the project

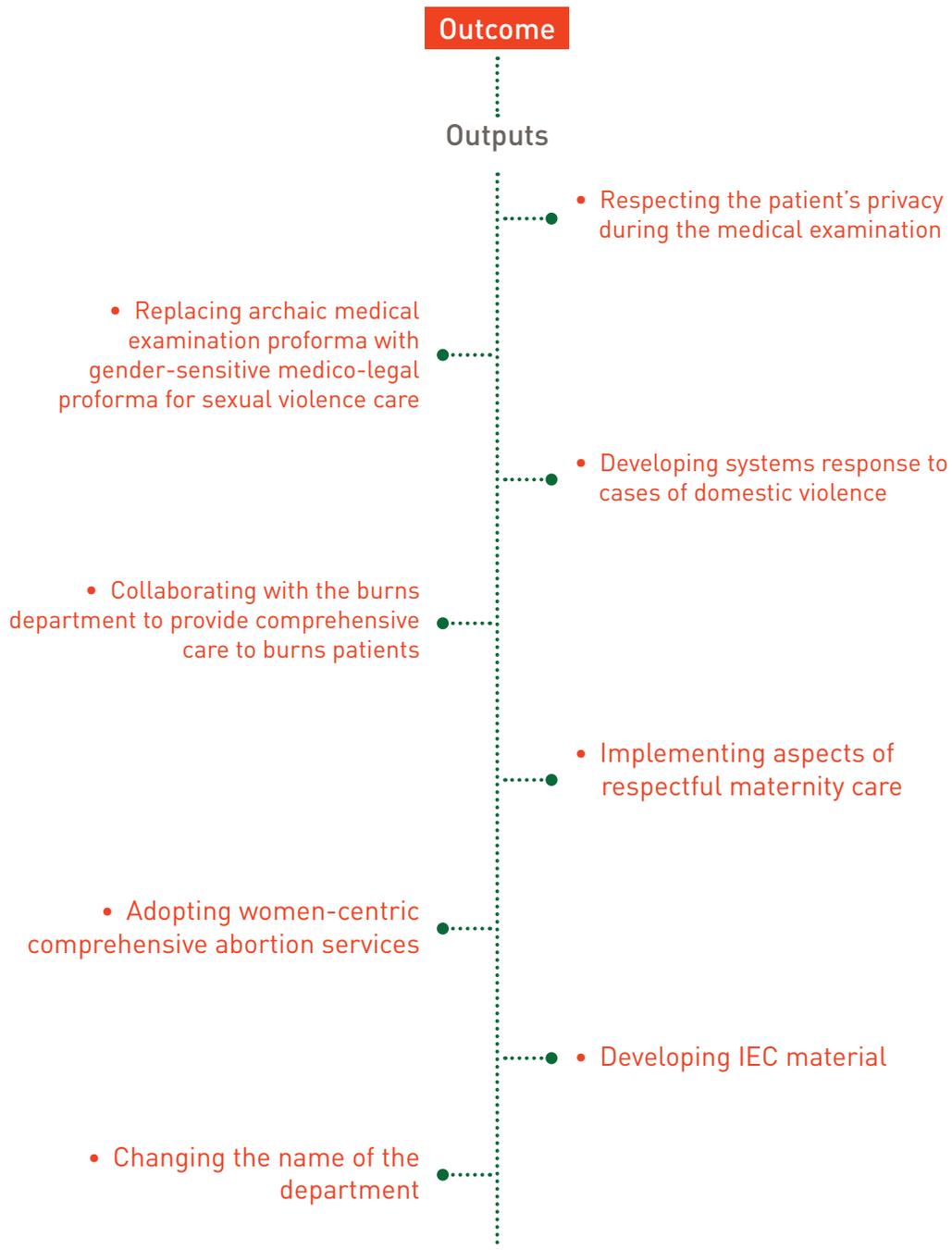
Post the training, medical educators along with experts reviewed the curriculum to assess how and where to include gender aspects in teaching undergraduate students. This humongous task was undertaken for all five disciplines, namely gynaecology and obstetrics, forensic science and toxicology, community medicine, psychiatry, and internal medicine. The medical educators were of the firm opinion that along with teaching the academic subjects to students, it would be critical to assess them in clinics and in their practical lessons where they interact with patients. This would allow for specific ways of determining whether students had understood and imbibed gender concerns.

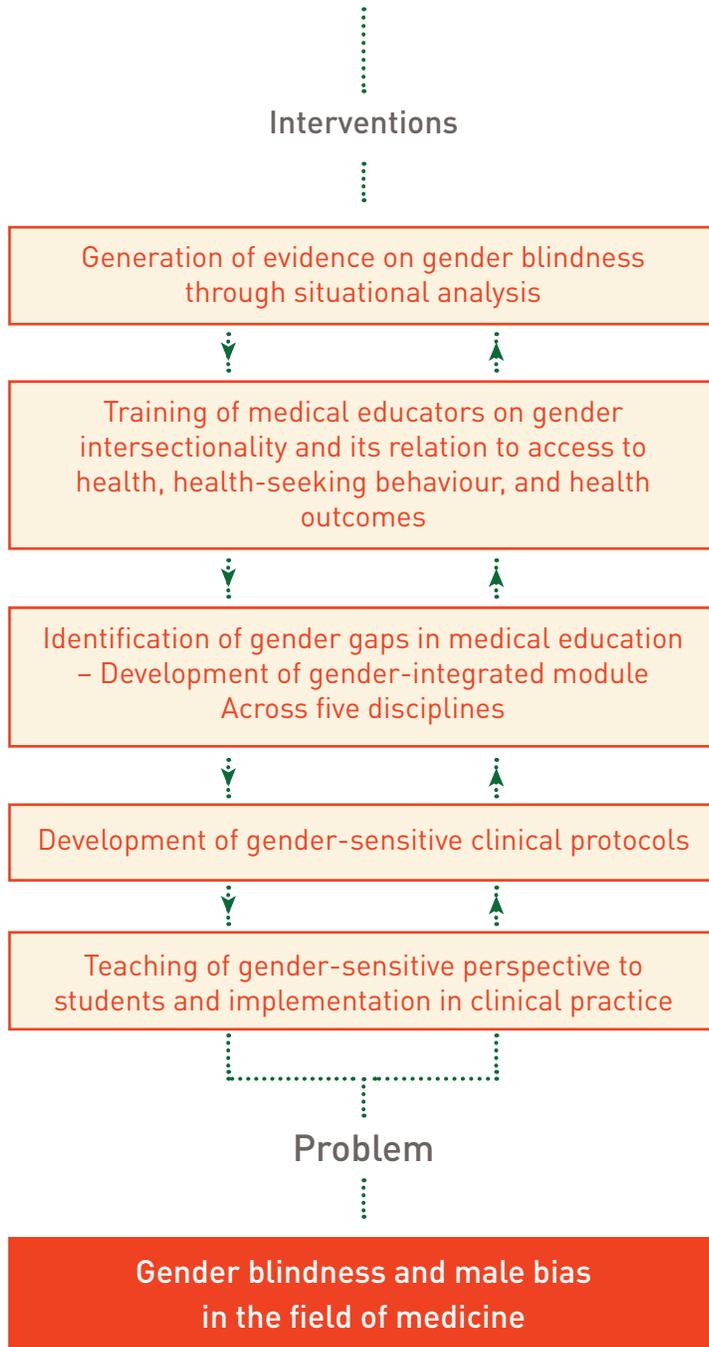


Theory of change

As a part of the GME project, gender-sensitive clinical protocols were introduced across five disciplines, including OBGYN (see Annexure 1). Beginning in 2015, trained educators sensitized and trained their colleagues in order to bring about changes in clinical practice.

Obstetrics and Gynaecological Practice in Aurangabad Medical College





About the case study

This case study describes the efforts of medical educators of the Department of Obstetrics and Gynaecology of the Aurangabad Medical College to create gender-sensitive practices in patient management and to incorporate gender-sensitive attitudes amongst doctors at all levels, including professors, lecturers, residents, and interns. Nurses and the support staff were later included as well.

Aurangabad is the fifth largest city in Maharashtra, with a population of over one million. The Aurangabad Government Medical College Hospital (GMCH) is one of the premier medical colleges in Maharashtra and the biggest tertiary care hospital in the state, administered by the Directorate of Medical Education and Research (DMER). The hospital has 1,177 beds. The average monthly patient flow was approximately 58,000 outpatient visits in 2017.

The case study shows that medical educators when convinced of the need to incorporate gender considerations in medical practice can bring about major changes by establishing and providing gender-



Site of change

informed services, despite a large patient load, poor infrastructure, and inadequate staffing. Champions of the initiative such as the head of the department (HOD) and his ob-gyn team demonstrate how they have brought about remarkable changes in the functioning of the department.

Relevance of change

It is noteworthy that the Sustainable Development Goals (SDG), which constitute a global call to action, also address the health and well-being of all (Goal 3) and gender equality (Goal 5). Also, the mandate for Universal Health Coverage (UHC) proposes to ensure “equitable” access for all Indian citizens (Planning Commission, HLEG Report, 2011) and underscores the consideration of gender in the provision of healthcare services.

The need for gender sensitivity in the provision of obstetric care and abortion services, as well as care in responding to VAW, is evidenced by the following. The changes in clinical practice in the OBGYN department of the Aurangabad Medical College are significant for the following reasons.

1. ***Gender-sensitive obstetric care:*** There is a growing body of evidence that women receive poor care during pregnancy and childbirth, including abuse, disrespect, and neglect (Bohren et al., 2015). Such practices result in health services of poor quality, which impinge on the right to healthcare. Considering this evidence, WHO released a statement titled ‘The prevention and elimination of disrespect and abuse during facility-based childbirth’ to reiterate strongly the right of every woman to access dignified and respectful healthcare (WHO, 2014). It also released a set of recommendations titled ‘WHO recommendations: Intrapartum care for a positive childbirth experience’ in 2018 (WHO, 2018). These recommendations include not only clinical guidelines for the management of labour, but also aspects of respectful maternity care. They view childbirth from a woman- centred,

human rights-based lens, and put forth directives to ensure that the experience of childbirth for women is free from abuse and disrespect, and is a positive experience that takes place in a safe environment. In India, too, efforts have recently been undertaken by the government to ensure a positive childbirth experience. In March 2018, the Indian government released LaQshya – Labour Room Quality Improvement Initiative with the objective of reducing maternal and newborn mortality and morbidity, and enhancing the satisfaction of women availing maternity healthcare services.

In this context, the implementation of gender-sensitive services incorporating aspects of respectful maternity care at the level of the department is an important initiative to develop an evidence-based model that can be replicated at other health facilities.

2. **Abortion services:** Abortion has been legal in India since 1972, yet unsafe abortion is the third leading cause of maternal mortality in the country (Henshaw et al., 2009). Although the government has tried to improve the health infrastructure to increase access to abortion services, there are several barriers that compel women to seek abortion under unsafe conditions.

It is important to note that abortion is an essential component of sexual and reproductive health (SRH), and still service provision is not uniform across health facilities. In the Indian context, several studies on access to abortion have found various defensive practices at the hospital level that act as deterrents for women seeking abortion. These practices include lack of confidentiality and the insistence on securing the consent of the husband or a relative for abortion, even though abortion is mandated under the MTP law. Also, several public health facilities are known to provide abortion services only on the condition that women adopt either sterilization or copper intrauterine device (IUD) after the procedure (Iyengar et al. 2015). In addition, women are

not offered an abortion method of their choice by health facilities. Invariably, the most preferred method of abortion in public hospitals is dilation and curettage, which requires admission, and hence women seeking medical abortion are forced to go to private practitioners or to quacks (Duggal and Ramachandran, 2004).

To address these issues, it is important to build the capacity of HCPs to recognize the barriers faced by women in accessing these services and to improve access to safe abortion.

3. *Violence against women and health consequences*

Evidence from the literature indicates that domestic violence carries an immense disease burden owing to the fact that it has a profound impact on the physical and mental health of survivors. Many studies have established that domestic violence can lead to physical, psychological, and sexual health problems.

Violence results in injuries, bruises, fractures, burns, vaginal tears, psychiatric conditions, miscarriages, and so on. One of the largest killers of women of reproductive age in India is violence. Burning, poisoning, assaulting by knife, and abetting suicide are some of the ways in which women are killed within the family. The health effects range from low-birth-weight babies to anaemia, from depression to suicide, from vague bodily complaints to severe illnesses such as pelvic inflammatory diseases, from repeated abortions to chronic pain syndrome, from unwanted pregnancies and unsafe abortions to HIV/AIDS, from pregnancy complications to maternal mortality, from memory loss to heightened anxiety, from fear of sexuality to low self-esteem. Indeed, the psychological consequences of abuse often go unnoticed and unaddressed. These include depression, anxiety disorders, post-traumatic stress disorder, suicidal tendencies, and complaints of chronic pain (such as backache, which can be a psychological fallout of repeated abuse). In order to

obtain treatment for health complaints and injuries caused by violence, women approach the health facility. It is a well-known fact that women facing abuse are more likely to use health services as compared to women who are not facing violence. According to a multi-site study conducted in seven cities in India, almost half (45.3 per cent) of the women who faced violence reported injuries requiring treatment (INCLIN, 2000). Another study examining the cases of women recorded in the Emergency Police Register of the Casualty Department in a government-run urban hospital in Mumbai found that two-thirds of the women above 15 years of age (66.7 per cent or 497/745) were definitely or possibly cases of domestic violence (Daga et al., 1999). Health professionals are hence in a strategic position to reach out to women facing violence, being the most certain and probably the earliest contact available to a survivor of violence. Early identification of women facing violence and the provision of appropriate psychological first aid by healthcare givers can prevent the more severe health consequences faced by these women if they continue to be abused.

Further, the vital documentation of health complaints resulting from abuse can be done at the health facility. Such documentation can be used by the abused woman in a court of law as evidence if she chooses to pursue a legal course of action. The details about the documentation are shared in other sessions.

The change

As the teaching of the gender-integrated curriculum by medical educators was underway, medical educators of the OBGYN department began seeing their clinical practices more critically. They started questioning several existing clinical practices. There was a recognition that while the teaching of gender-integrated modules is underway, medical students would be able to imbibe such a

perspective only when they observed changes in clinical care offered to women at the department. This led to step-by-step changes made at the level of the department.

- I. ***Replacing the archaic medical examination proforma with a gender-sensitive medico-legal proforma for sexual violence care:*** Medical educators were convinced that they would not be able to go back to the old practice of rape examination where the patient's history is sought cursorily and only evidence is collected. As a part of gender integration, they had taught students to look at rape or sexual violence not merely as a legal issue but also as a critical health problem, because unwanted pregnancies, STIs, injuries, and other forms of trauma are a consequence of it. Hence, educators recognized the need to change this in practice. As a first step, they established a designated space away from the hustle and bustle of an outpatient department (OPD) to carry out the examination and provide care. The second step was to ensure the availability of a trained doctor at any time to carry out such an examination and provide treatment. In an extremely busy hospital, to keep a doctor on standby to conduct such an examination was impossible. Thus, the duty roster was changed to ensure the availability of a doctor who was already on duty and who would be supported by an additional doctor; the latter would take on the other duties of the former when the former carried out work related to sexual violence. A new protocol was laid down that stated that all investigations will be carried out on the same day and that the survivor of rape shall not be called upon again for further investigations. This was a radical change in the practice, as most hospitals in India continue to either admit the survivor or call her the next day. This practice is convenient to the hospital, but extremely distressing for the survivor. The department has also set up a counselling room called Dilaasa Kaksh to provide psychosocial services. As no counsellor is available to respond to such cases of violence, existing social service superintendents were trained to provide these services.

2. *Respecting the patient's privacy during the medical examination:*

The examination of patients in the presence of a group of medical students is a “given” in all medical colleges as this is how practical teaching has been conventionally carried out in India for several years. However, in all this, very little thought is given to the privacy of the patient. Gender-integrated training has enabled medical educators to entrench the notion of “privacy” across all arenas in their department. In the words of the HOD, “It is something I never thought about and now I realize that it was so simple to implement.” During an examination, the woman would be stripped after the doctor entered the room, but this practice has now been changed. A female attendant or nurse readies the woman in the room and exposes only that part of the body that is to be examined. Curtains have been installed at the level of each bed so that there is privacy for individual patients too. In the past, doctors often felt that since all the patients in the OBGYN department are women, there is no need for privacy, but when the situation was analysed through the gender lens, they realized the need to change this practice. The change is not a major infrastructural one but that of perspective and attitude, and that of valuing the privacy of a patient. The most common practice in training medical students was for a doctor to carry out a practical examination of the patient in front of students to indicate a physical condition and then demonstrate treatment. But this has now been replaced with the skill laboratory. Despite this being a Medical Council of India (MCI) requirement, many medical colleges do not have such skill labs in OBGYN departments where teachers train students in ways of examining on mannequins rather than women patients. The skill lab helps medical students sharpen their skills in conducting procedures like a genital examination.

3. ***Collaboration with the burns department to provide comprehensive care to burns patients:***

Women reporting burns are kept in the surgery ward. In cases where women are pregnant and burnt, the gynaecologist is called upon. The earlier practice of gynaecologists consisted of assessing the pregnancy and providing a report. In short, the “burns” aspect was seen to by a surgeon while the “pregnancy” was seen to by the gynaecologist. There was no convergence on the management of treatment other than pharmacological treatment. Thanks to understanding and imbibing a gender perspective, medical educators of the OBGYN department now recognize the need to assess pregnant women reporting burns as possible cases of domestic violence. This has prompted doctors to develop a protocol for asking about the history of burns sustained by the patient and her experience of domestic violence, and to document the findings of the physical examination. This is an important contribution and significant step, as often women of reproductive age who report burns are regarded as having suffered “accidents”, without doctors and nurses enquiring into the possibility of domestic violence. This practice has now also been adopted by the burns unit where there is an inclination to develop a proforma for all burns patients.

4. ***Created a protocol for the identification of, and the response to, victims of domestic violence:*** Medical educators of the department are sensitized and trained to handle cases of violence. Violence in pregnancy has a profound impact on maternal health and pregnancy outcomes, and hence doctors now routinely enquire about it when providing antenatal care (ANC). Training has helped in raising the suspicion index of HCPs by teaching them to recognize the common health complaints of women that can be associated with violence. They ask women about violence at home in a sensitive manner and provide them first-line psychosocial

support. Medico-legal complaint (MLC), which has evidential value, is registered in all cases of domestic violence. One counsellor has been appointed in the department to provide services to survivors, and this counsellor has also been training nurses to provide psychosocial support to women.

5. ***Established women-centric comprehensive abortion services:***

In most government hospitals in India, access to medical termination of pregnancy (MTP), also known as abortion, is not easy. The MTP law allows adult women to access abortion services. Conditions such as obtaining the signature of the husband or the mother-in-law, making a police complaint if the woman is unmarried, and denial of abortion services to women under the age of 18 years are rampant. Additionally, women who reach the hospital in an advanced stage of pregnancy (second trimester) are suspected of seeking sex-selective abortion in a desire for a male child. Some hospitals even have an unwritten rule of “No contraception, no MTP”.

Aurangabad Medical College has adopted several positive changes and replaced archaic and defensive practices with more women-centred and gender-informed services.

There is no conditional access to abortion services in the OBGYN department. Sterilization or insertion of copper T or copper IUD is not compulsory when women seek MTP services. Women are counselled and given information about all the family planning choices available so that they can take informed decisions. With the consent of the woman, the husband is also spoken to about the need to use contraceptives and informed about the adverse impact of repeated pregnancies on the woman.

MPT is not linked to sex-selective abortion. HCPs take a comprehensive history to understand the reason for the delay in seeking abortion. This information is properly maintained in a given format in a register.

In the case of MTP, consent is taken only from the woman now. Earlier, there was an insistence on having the husband's signature on record and consequently in many cases the woman would never return. As HCPs have developed a greater understanding of the circumstances around a woman's decision regarding abortion, consent is taken from the woman only. In terms of the methods of abortion too, the team now recognizes the need to use medical abortion and Manual Vacuum Aspiration (MVA) instead of surgical methods. The department ensures that medical abortion drugs are routinely available, thus making access to safe abortion a reality for women.

Aurangabad Medical College has proactively provided MTP services in cases of sexual violence where the pregnancy has crossed 28 weeks. The department set up an expert committee and made efforts in several such cases as they realized the negative implications of continuing a pregnancy resulting from rape. In the last two years, eight pregnant women between 20 and 28 weeks obtained legal permission for undergoing abortion through a court order after seeking expert opinion from the department.

These women received safe abortion services from the department. It is important to note that many hospitals in India do not take proactive steps in the case of an advanced pregnancy even with the full knowledge that the pregnancy is an outcome of rape. In this context, Aurangabad Medical College has provided a clear example of how the matter should be handled.

6. *A significant and landmark change is the change in the name of the department:* One of the most significant changes was renaming the department. The name of the department was changed from the Family Planning Department to the Comprehensive Contraceptive Services for All Centre. This is an important step because the department believes

that contraception, including abortion services, is not restricted to only limiting the size of the family and that contraception is needed by all women. In the context of a human rights approach, the change in name is important because it replaces the term 'family planning' with the more inclusive term 'contraception', which addresses the contraception needs of all persons, including those who may fall outside the traditional family unit.

7. ***Implementing aspects of respectful maternity care:*** The GME project enables HCPs in the department to understand and address the issue of ongoing disrespect and abuse faced by women patients. They implemented the core components of respectful maternity care in a government hospital setting to ensure that women receive more skilled and respectful care during delivery.

Creating a sitting arrangement for women in the antenatal OPD: In the ANC OPD, there was no sitting arrangement earlier; pregnant women were made to stand for long hours. As soon as the doctor arrived, patients would rush into the doctor's room. This created a lot of friction between doctors and patients, with nurses scolding the patients for not queuing up and for generally being disruptive. This situation changed with the gender sensitization of HCPs, with the realization that women travel several hours to reach the hospital; the waiting period could be made bearable by introducing benches and sitting spaces so that women and their families were comfortable and that they also would not crowd the OPD. This arrangement has been found to be helpful to both doctors and women patients.

Introducing triaging of treatment: Triage is the initial or primary assessment to determine the urgency of care needed by a patient. Compared to the first come, first served basis, triage focuses on maximizing the benefits for each individual patient by giving treatment priority to those patients whose

needs are the most urgent. Triage is important especially in the labour room to distinguish between serious patients and routine patients. All women are examined at 0 hours to establish the triage index. Triage is also helpful in segregating the responsibilities of doctors and nurses when there is an excessive workload and a shortage of staff. The department has allocated an enclosed space near the labour and delivery ward for triaging. It has a reception area with some delivery beds. This has helped HCPs to provide timely care and also to distribute the workload evenly between doctors.

Integrating informed consent across all procedures in the labour room: In general, the obtaining of consent for various procedures during childbirth is often overlooked. If any attention is paid to it, it is regarded as a mere formality about obtaining the signature of a family member for performing some sort of invasive procedure. The resident doctors are trained to take consent from women by providing them all the relevant information pertaining to the procedure. Now, the consent for each procedure is taken separately and has been operationalized in an ethical manner.

Introducing evidence-based childbirth: Over-medicalization of childbirth, which includes excessive or inappropriate use of interventions like episiotomies and caesarean sections, can contribute to morbidity and mortality. The literature on maternity care has defined extensive episiotomies, postpartum suturing of tears, and episiotomy without anaesthesia as a form of physical abuse. In Aurangabad Medical College, the HCPs of the department are trained to practise evidence-based medicine. The focus is on curtailing unnecessary episiotomies and caesarean sections in pregnant women. The department undertakes regular caesarean audits to assess the need based on evidence-based parameters like obstetric history, onset of labour, foetal lie, number of neonates, and gestational age.

Modifying preexisting beds to birthing beds and allowing women in labour to adopt the position of their choice: The beds in the labour room have been modified so that women feel comfortable during childbirth. The freedom to choose labour and birth positions like kneeling on the floor has a positive effect on the woman's comfort level and helps speed the progress of labour. The choice of the birthing position also reduces the need for unnecessary induction of labour. It results in client-oriented maternity health services that are associated with higher satisfaction and increased utilization of facility-based health services. The department aims to encourage the adoption of the squatting position during delivery, which help in vaginal delivery without tears.

Keeping mother and newborn together after childbirth: The baby is placed on the mother's abdomen for two to three minutes and then the umbilical cord is clamped to improve the outcome for both baby and mother. Delayed cord clamping and putting the baby on the mother's abdomen soon after delivery reduce blood loss after delivery, thereby helping in reducing anaemia in mother and newborn.

Allowing women in labour to walk and consume food and fluids as per their wish: The earlier practice was to restrict food and fluid intake during labour due to concerns about the aspiration of stomach contents into the lungs during general anaesthesia. However, there is no medical evidence for this and hence the practice in the department was changed to respect women's choice.

Providing a birth companion: Usually labour rooms have a strict "no entry" policy and a sign stating this is posted for anyone outside of the department. The women in labour are inside while their families wait outside. Labour takes several hours, and the anxiety and stress of the woman inside and of her family waiting outside increase. Given the shortage of staff, nurses and doctors have to attend to a large number of labouring women and cannot provide one-to-one care. This

leads to a lot of anger and frustration. To address this issue, the concept of a birth companion was introduced where the labouring woman is provided support by an experienced woman from her family who stays by her side during the duration of labour and childbirth. Women are given the option of experiencing labour and childbirth, with a companion of their choice providing support and encouragement. There is strong evidence in the literature that the presence of a birth companion improves maternal and newborn health outcomes, including increasing the chances of a normal delivery, ensuring a shorter duration of labour, and encouraging the early initiation of breastfeeding. The birth companions are informed about the danger signs during labour so that they can alert HCPs on duty. The birth companions are provided with gloves and gowns to avoid infection. Women have described the experience of labour with a birth companion present to lend moral support as positive.

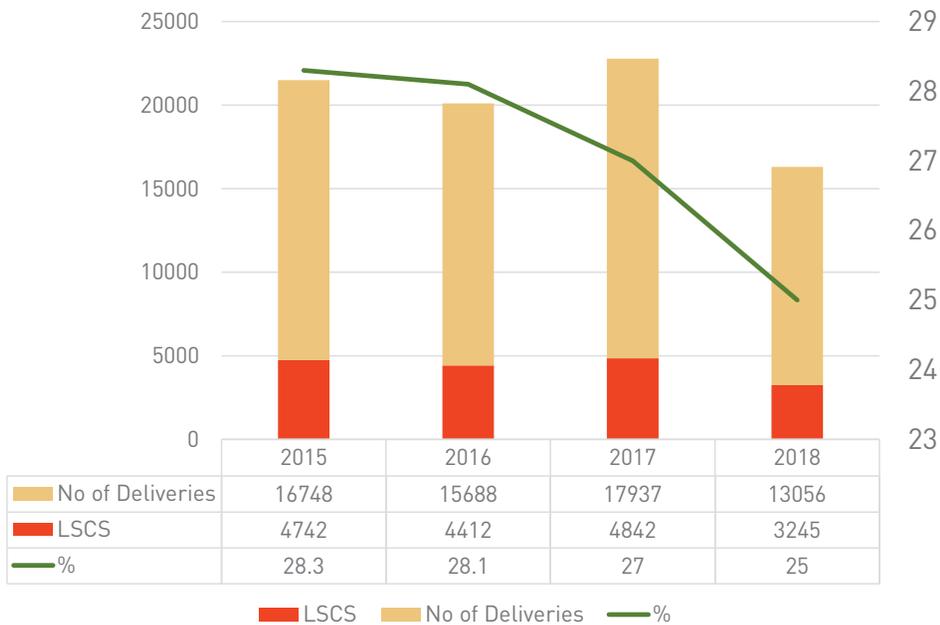
8. ***Development of information, education, and communication (ICE) material:*** The department has prepared different IEC material for patients waiting in the OPD. The IEC material includes early signs of complications during pregnancy like pre-eclampsia to raise awareness among women.

Outcomes of clinical practice changes:

1. ***Developing standard operating procedures (SOPs):*** This is an important reference manual for resident doctors who are at the forefront in terms of providing healthcare services to patients. The SOP manual has 44 chapters and includes detailed instructions on proceeding with or handling 45 situations. It provides insights not only into the field of clinical practice but also addresses problems relating to the management of one's workload, tackling violence against doctors, and understanding the working of government schemes. The SOP manual is instrumental in promoting better care and more effective patient outcomes. It provides

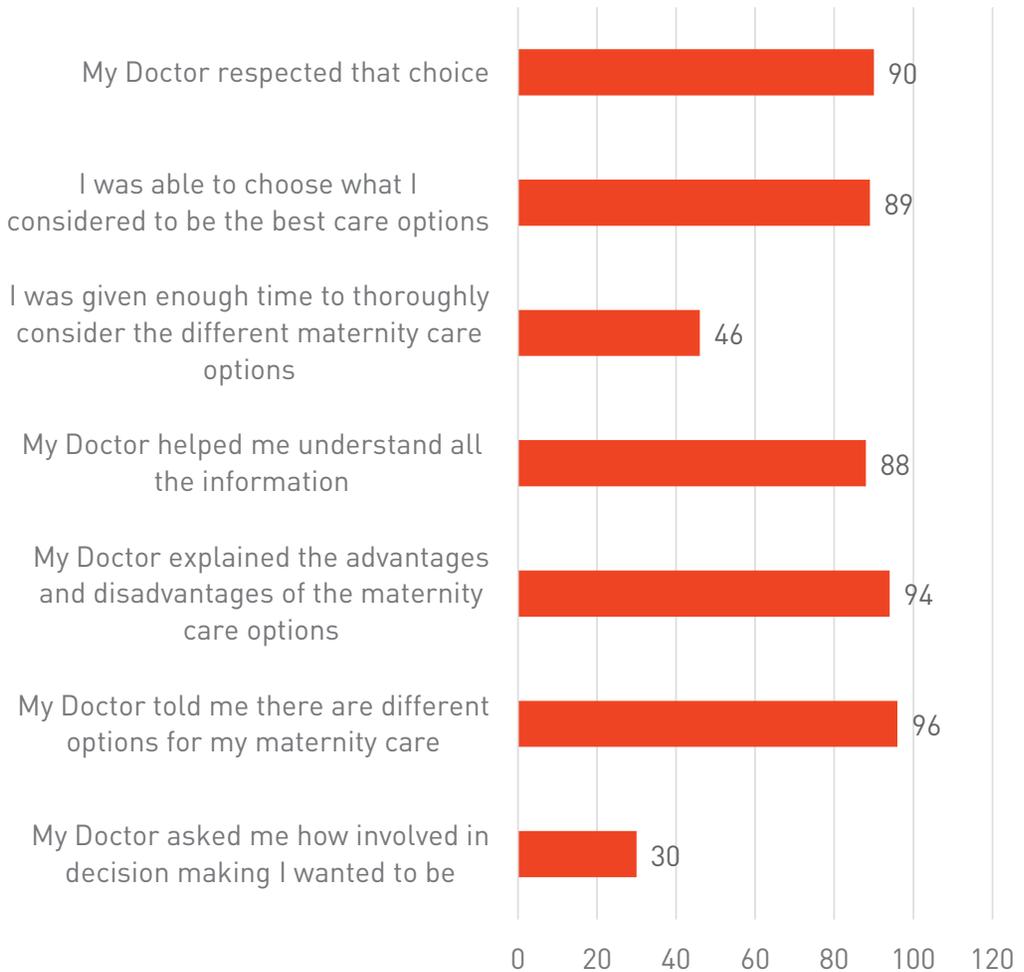
in-depth knowledge about the proper conduct of the antenatal OPD, labour room, operation theatre, and postnatal care (PNC) room.

2. **Promoting evidence-based practice:** The department has started maintaining separate records of special cases to promote evidence-based practice. These records help students to learn the intricacies of handling complicated cases. In addition, postgraduate students are encouraged to take up dissertation topics that examine social factors along with biomedical factors in treatment.
3. **Generating evidence to show impact:** The department routinely analyses its data to generate evidence on the impact of introducing changes in its clinical practice. It recently surveyed 300 women to learn about their experience of accessing services from the department.

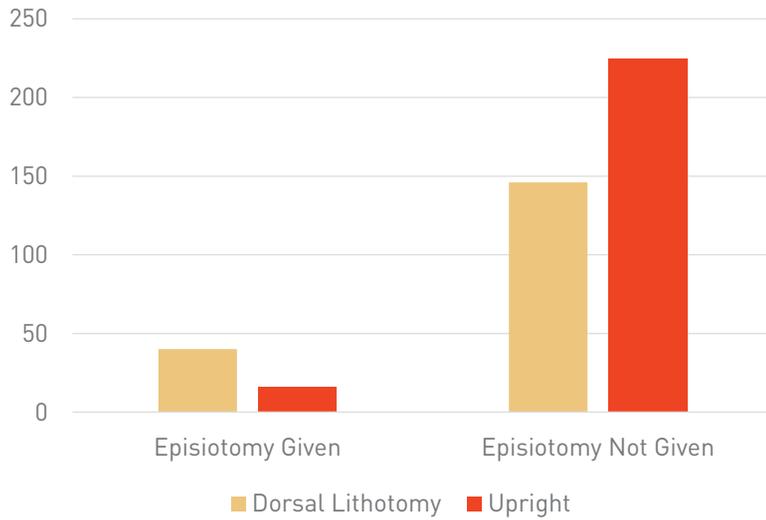


The rate of caesarean section has fallen from 28% to 25%.

% Agreed

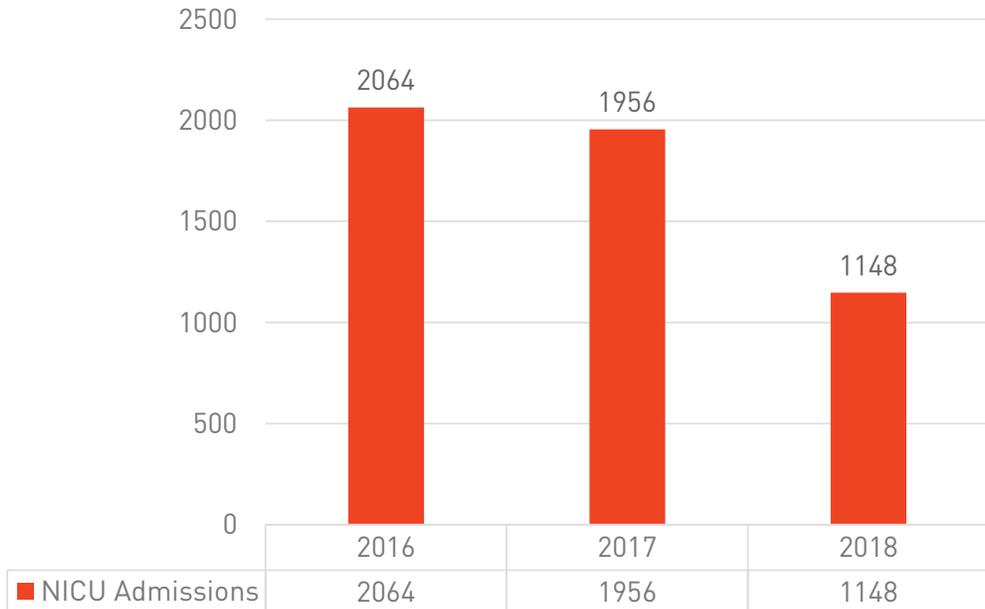


These are the results of the survey assessing women's experience of seeking care.



The graph shows that 22.5% women needed episiotomy in the dorsal lithotomy position whereas Only 7.2% women needed episiotomy in the upright position.

NICU Admissions



The admission rate of the Neonatal Intensive Care Unit has declined significantly due to practices like delayed cord clamping, skin-to-skin contact between mother and child, and initiation of early breastfeeding.

Overcoming challenges:

The story of change between 2014 and 2018 has not been an easy one. The changes introduced by the medical educators who participated in the GME initiative met with a lot of resistance. The department has a high patient load, with 16,000 deliveries per year, and also a high rate of referral from the neighbouring rural areas. The doctor–patient ratio in the department is very low. As a result, HCPs perceived such initiatives as an additional burden. To address this issue, the gender-trained medical educators adopted an interesting strategy; they designed a standard operating procedure (SOP) that assists doctors in handling routine and difficult situations. Such an SOP did not exist earlier and therefore the communication between different units was very cursory, with the heads of the units having their own ways of managing patients. The development and adoption of the SOP has led to uniformity in procedure. Seeking feedback from other doctors also has led to ownership of the SOP. It has created a healthy, collegial, and cooperative working environment between different departments.

The first challenge was to explain the need for, and the importance of, making clinical changes to the team of HCPs. HCPs often believe that their role is only to treat the disease and its physical manifestation.

Doctors often ask patients about their medical history but without understanding the underlying social factors and causes. Conventional medical training of HCPs does not equip them to address the social determinants of health in an effective or sensitive manner. In the initial phase, gender-trained medical educators were ridiculed by their peers who dismissed them as “gender” doctors who have too much time on their hands and so can indulge in “gender” issues. But the medical educators have slowly made some progress, by inviting their peers to look at the modules and to participate in trainings, resulting in gradual but steady changes.

The department has to function as a team, with doctors, nurses, and support staff working towards a common goal. However, there was a lot of resistance from nurses about certain aspects like allowing the presence of birth companions and allowing women to choose their position of birthing. Their objections were related to fears about overcrowding, apprehensions of babies being stolen from the ward, and also concerns about letting in untrained family members and others. After a dialogue between the entire staff, it was decided that the birth companion would be allowed based on risk assessment. The benefits of the presence of the birth companion in the ward next to the woman were also discussed; it would help nurses in monitoring any emergency and would facilitate early breastfeeding. Medical educators set up various WhatsApp groups so that nurses could alert them about any difficulties faced by them. Such groups were also made for residents to discuss their routine cases, including the challenges they faced. This group sharing has led to the exchange of a lot of information on good practices and has motivated HCPs to adopt evidence-based practices. The department's work has received international recognition from organizations like WHO, UNFPA, UNICEF, and the White Ribbon Alliance. The international acceptance of the initiative has drawn the attention of senior administrators of the health facility who are now also involved with the project.

Infrastructure: Government health facilities are often plagued by inadequate infrastructure, and this is also a contentious issue and a major problem at the Aurangabad health facility. The trained HCPs of the department have managed to bring about some changes with the limited resources at their disposal. They strategized the changes by prioritizing them and by using the available funds from the government efficiently. There is a fund for every surgeon, which is Rs 100 per case, but no doctor takes this money and instead contributes it towards the common fund which is used for various activities in the department. It is also critical to note that due to international recognition of the initiative, the department has been able to raise funds from various organizations.

Experience of implementing gender-sensitive clinical practices

Medical educators stated that they had to be true to the gender-integrated content taught by them to medical students. Hence, clinical changes were essential. Once they made changes in clinical practice, they saw that their peers and students accepted and imbibed them. The approach was not top-down, but rather it was inclusive. These are important lessons for introducing sustainable changes in clinical practice.

In this regard, the HOD, OBGYN, Aurangabad Medical College said, “In case of repeated reproductive infections, clinicians used to advise women hysterectomy or used to tell them that it is a psychological problem. Now these problems are viewed through the gender lens and students are taught to take women into confidence and explore the underlying reasons.”

He described his earlier practice when no attempt was made to look at clinical conditions through the gender lens: “I would often chide women seeking abortion more than once and ask them why they didn’t use contraceptives.”

The other educator from the department who is an associate professor said, “Earlier, I wouldn’t pay attention to the vague complaints made by some women. But I can now sense instances of domestic violence.”

The improvement in the quality of care can be measured by the impact of changes at the facility level. There has been a decrease in caesarian sections and unnecessary interventions during labour. There has been an increase in the number of deliveries, early initiation of breastfeeding, and better pregnancy outcomes.

Recognition of the initiative

The initiative to implement gender-sensitive clinical services has been acknowledged by various international organizations. It has also been recognized the Government of India. The deputy

commissioner, Ministry of Health and Family Welfare recently visited the department to study the initiative to provide respectful maternity care. The central government is planning to recognize it as a model that can be upscaled at other sites.

The initiative was also covered recently in a report by NDTV which documented the experience of doctors, nurses, and patients. See <https://www.ndtv.com/video/shows/ndtv-special-ndtv-india/motherhood-service-and-respect-482864>

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Annexure

Checklist to ensure gender-sensitive approach in obstetrics and gynaecology clinics items	Yes	No	NA
<p>Procedures in place to ensure privacy: Provide an enclosed space to talk to the patient that ensures auditory and visual privacy, e.g. curtains, some amount of soundproofing</p> <ul style="list-style-type: none"> • during history taking • during abdominal and pelvic examination <p>Ensure that you speak with the patient alone, apart from speaking in the presence of relatives or accompanying persons.</p>			

Checklist to ensure gender-sensitive approach in obstetrics and gynaecology clinics items	Yes	No	NA
<p>Treat information obtained from patient in a confidential manner: Ensure that information given by the patient in any form, whether verbal, written, recorded, or computer-stored, remains confidential and is not revealed to any person without the patient’s consent.</p> <p>Do not discuss the patient with other staff members, in front of other patients, with family members or friends.</p> <p>In the case of minors and individuals, in matters that involve legal issues, information has to be shared with their parents and/or guardians, and these patients also should be informed about the reason and necessity for the disclosure of this information.</p> <p>Make patients aware of, and the reasons for which the information given by them needs to be communicated to any other person and obtain their consent for sharing this information with:</p> <ul style="list-style-type: none"> • Other doctors • Partner and family members • Police/lawyers 			
<p>Information pertaining to HIV+ status, incidence of domestic violence or sexual abuse, and suicidal thoughts and/or previous attempts at suicide must be communicated to intimate persons in the family.</p> <p>Details of sexual and reproductive health, i.e. menstrual history, childbirth/pregnancy, should be obtained in a sensitive manner.</p>			

Checklist to ensure gender-sensitive approach in obstetrics and gynaecology clinics items	Yes	No	NA
<p>Maintain non-judgmental attitude, be sensitive, and maintain confidentiality of disclosures about abortion, sex selection, sexual orientation, sexual practices, and gender identity.</p> <p>Physical examination should be done in a manner that respects the patient’s privacy and dignity</p>			
<p>Ensure auditory and visual privacy. Ensure appropriate covering of patient.</p> <p>Ensure presence of chaperone wherever necessary.</p> <p>Obtain informed consent after explaining indication, details of procedure.</p> <p>Ensure adequate lubrication, instruments at comfortable temperature (avoid hot/cold instruments).</p>			
<p>Explain findings, discuss diagnosis and further management plans after conducting examination sensitively, and counter check to confirm that the patient understands.</p>			
<p>Be non-judgemental about patients/clients during examination irrespective of the clinical conditions they present, e.g. STI, pregnancy out of marriage. Be respectful in language and behaviour with all patients.</p>			

Checklist to ensure gender-sensitive approach in obstetrics and gynaecology clinics Items	Items	Yes	No
<p>Respect woman’s autonomy–her right to refuse examination Ensure a provider/doctor of a sex preferred by the patient</p>			
<p>During pregnancy–abortion Wantedness of pregnancy assessed</p> <ul style="list-style-type: none"> • If unwanted, discuss options for termination/continuation of pregnancy sensitively while allowing woman autonomy to choose. 			
<ul style="list-style-type: none"> • If woman desires termination of pregnancy, offer MTP or refer to appropriate services for the same. • Do not insist on spousal/other consent for MTP. • Do not make abortion service conditional on acceptance of contraception. <p>During pregnancy–antenatal care: All pregnant women to be screened for domestic viol</p> <p>During labour and childbirth</p> <p>Ensure auditory and visual privacy.</p> <p>Ensure appropriate covering of woman.</p> <p>Provide information on progress of labour, any complications in a sensitive manner and seek consent for any procedure/intervention.</p> <p>Treat woman with dignity and respect.</p> <p>Avoid unindicated procedures, e.g. enema, shaving, routine episiotomy. Allow birth</p>			

Checklist to ensure gender-sensitive approach in obstetrics and gynaecology clinics Items	Items	Yes	No
<p>companion into labour room at all times. Respect woman’s choice regarding position, pain relief, etc.</p>			
<p>Contraceptive services Discuss all available options with woman, and if she desires, also discuss these with her partner Seek informed consent and provide adequate information on advantages, side-effects, and complications.</p>			
<p>Ensure provision of contraceptive service of choice/referral to appropriate service for the same. Ensure that there is no coercion or conditional provision of contraceptive service.</p>			
<p>Adolescent services: Maintain non-judgemental attitude regarding marital status, sexual practices, sexual orientation, request for contraception. Provision of services–information, contraception, abortion, consent of adolescent regarding disclosure of information to parent/guardian</p>			

References

- Benrud, L. M., & Reddy, D. M. (1998). Differential explanations of illness in women and men. *Sex Roles, 38*(5–6), 375–386. <https://doi.org/10.1023/A:1018753720941>
- Bhat, P. N. M., & Zavier, A. J. F. (2003). Fertility decline and gender bias in northern India. *Demography, 40*(4), 637–657. <https://doi.org/10.2307/1515201>
- Bickel, J. (2001). Gender equity in undergraduate medical education: A status report. *Journal of Women's Health & Gender-Based Medicine, 10*(3), 261–270. <https://doi.org/10.1089/152460901300140013>
- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., et al. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLOS Medicine, 12*(6)(20150630): e1001847. <https://doi.org/10.1371/journal.pmed.1001847>
- Daga, A. S., Jejeebhoy, S. J., & Rajgopal, S. (1999) Domestic violence against women: An investigation of hospital casualty records, Mumbai. *Journal of Family Welfare, 45*(1), 1–11. <https://doi.org/10.1177%2F097206340100300114>
- Duggal, R., & Ramachandran, V. (2004). The abortion assessment project—India: Key findings and recommendations. *Reproductive Health Matters, 12*(24 Suppl), 122–129. DOI: 10.1016/S0968-8080(04)24009-5
- Foss, C., & Hofoss, D. (2004). Patients' voices on satisfaction: Unheeded women and maltreated men? *Scandinavian Journal of Caring Sciences, 18*(3), 273–280. <https://doi.org/10.1111/j.1471-6712.2004.00290.x>
- Garg, S., & Singh, R. (2014). Need for integration of gender equity in family planning services. *Indian Journal of Medical Research, 140*(Suppl1), 147–151.

International Institute for Population Sciences (IIPS) and ICF. (2017). National Family Health Survey (NFHS-4), 2015–16: India. Mumbai: IIPS. <https://dhsprogram.com/pubs/pdf/FR339/FR339.pdf>

International Clinical Epidemiologists Network (INCLIN) (2000). Domestic violence in India, Part 3: Violence against women and girls. A summary report of a multi-site household survey. Washington, D.C.: International Centre for Research on Women and the Centre for Development and Population Activities.

Iyengar, K., Paul, M., Iyengar, S. D., Klingberg-Allvin, M., Essén, B., Bring, J., et al. (2015). Self-assessment of the outcome of early medical abortion versus clinic follow-up in India: A randomised, controlled, non-inferiority trial. *Lancet Global Health*, 3(9), PE537–E545. [https://doi.org/10.1016/S2214-109X\(15\)00150-3](https://doi.org/10.1016/S2214-109X(15)00150-3)

Maharana, B., & Ladusingh, L. (2014). Gender disparity in health and food expenditure in India among elderly. *International Journal of Population Research*, 2014, Article ID 150105, 8 pages. <https://doi.org/10.1155/2014/150105>

Planning Commission (2011). High Level Expert Group Report on Universal Health Coverage for India. Instituted by the Planning Commission of India. New Delhi: Government of India. Available from: http://planningcommission.nic.in/reports/genrep/rep_uhco812.pdf

Henshaw, S. K., Joyce, T. J., Dennis, A., Finer, L. B. & Blanchard, K. (2009). Restrictions on Medicaid funding for abortions: A literature review. Guttmacher Institute. Retrieved 30 August 2019 from <https://www.guttmacher.org/report/restrictions-medicaid-funding-abortions-literature-review>

Saikia, N., Moradhvaj, & Bora, J. K. (2016). Gender difference in health-care expenditure: Evidence from India Human Development Survey. *PLoS ONE*, 11(7), e0158332. <https://doi.org/10.1371/journal.pone.0158332>

Sebastian, M. P., Khan, M. E., & Sebastian, D. (2014). Unintended pregnancy and abortion in India: Country profile report. STEP UP Research Report. New Delhi: Population Council. <https://doi.org/10.31899/rh4.1052>

Senarath, U., & Gunawardena, N. S. (2009). Women's autonomy in decision making for health care in South Asia. *Asia-Pacific Journal of Public Health*, 21(2), 137–143. <https://doi.org/10.1177/1010539509331590>

Verdonk, P., Benschop, Y. W. M., De Haes, J. C. J. M., & Lagro-Janssen, A. L. M. (2008). Making a gender difference: Case studies of gender mainstreaming in medical education. *Medical Teacher*, 30(7), 194–201. <https://doi.org/10.1080/01421590802213206>

World Health Organization (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization.

World Health Organization (2009). *Women and health: Today's evidence tomorrow's agenda*. Geneva: World Health Organization.

World Health Organization (2014). *The prevention and elimination of disrespect and abuse during facility-based childbirth*. Geneva: World Health Organization.

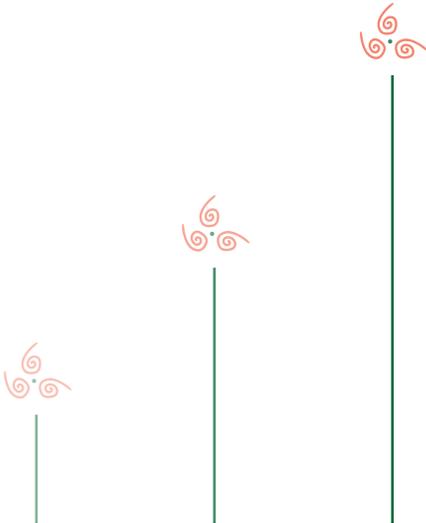
World Health Organization (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience*. Geneva: World Health Organization. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK513809/>

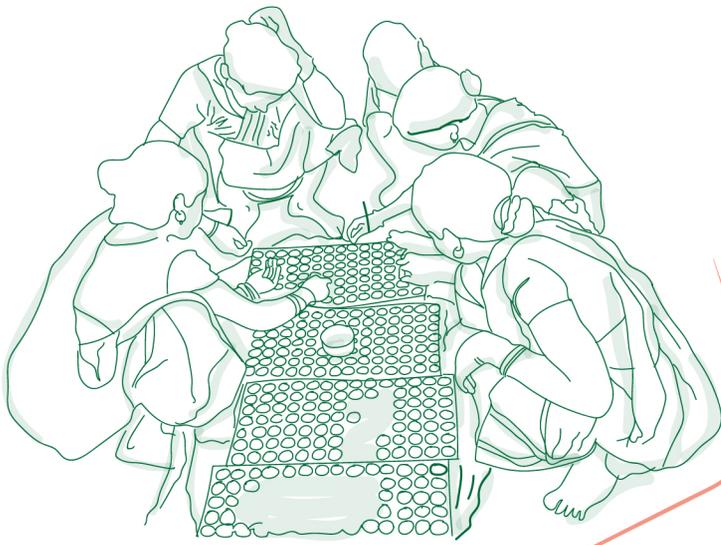
Zepek, B., Phillips, S. P., & Lefebvre, Y. (1997). Gender sensitivity in medical curricula. *Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, 156(9), 1297–1300.

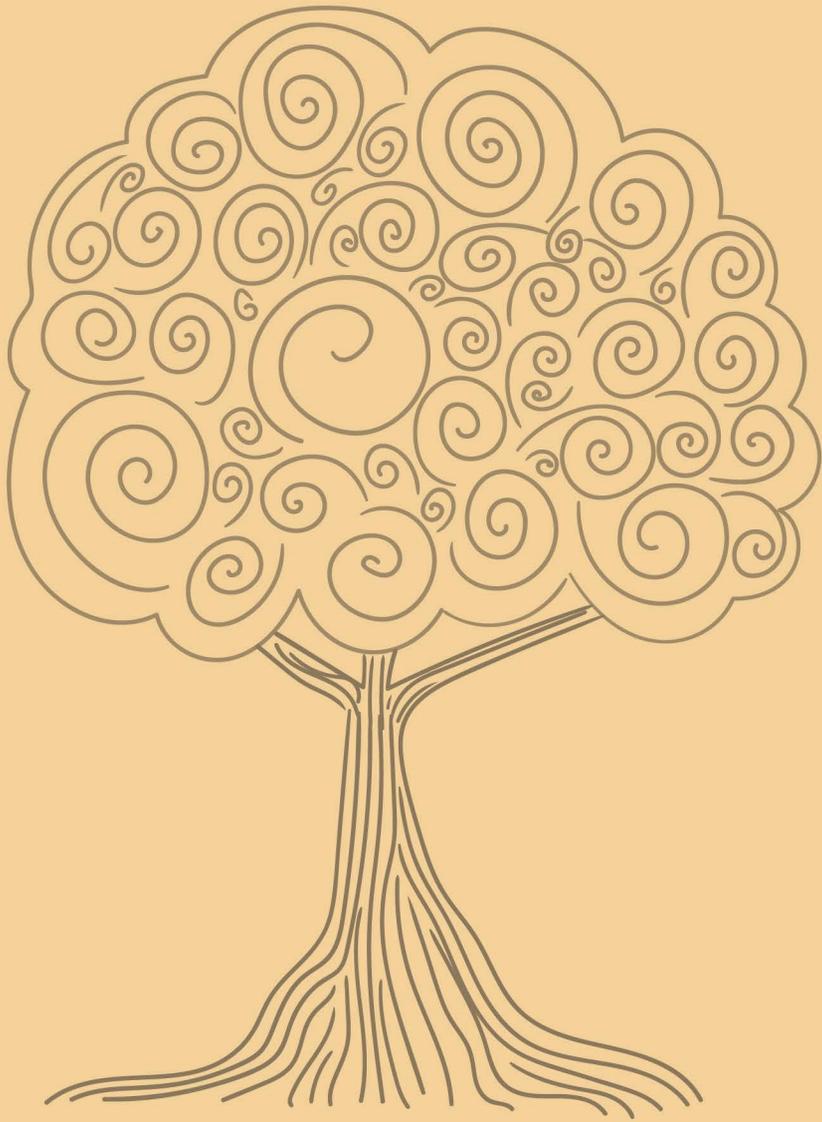
***Centre for Enquiry into Health and Allied Themes (CEHAT),
Maharashtra***

CEHAT (Centre for Enquiry into Health and Allied Themes) is the research centre of Anusandhan Trust established in 1994. CEHAT is involved in research, training, service and advocacy on health and allied themes. CEHAT's aim is to produce socially relevant and rigorous health policy research and action to promote the wellbeing of the poor and disadvantaged, strengthen people's health movements, and realize the right to health and health care. The organization's strategies include:

- 1) undertaking research and advocacy projects on various socio-political aspects of health;
- 2) establishing direct services and programs to demonstrate how health services can be made accessible and provided in an equitable and ethical manner;
- 3) disseminating health information through databases and relevant publications. Socially relevant and rigorous academic health research and health action at CEHAT is for the wellbeing of the disadvantaged masses, for strengthening people's health movements and for realising right to health and health care. All efforts in CEHAT endeavour to create space for the participation of people without compromising on academic rigour.







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