SUBMISSION FOR CALL BY UN SPECIAL RAPPORTEUR ON VIOLENCE AGAINST WOMEN BY CEHAT (CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES)

1. **Please indicate whether in your country there are cases of mistreatment and violence against women (VAW) during reproductive healthcare, particularly facility-based childbirth. If so, please specify what kind of cases, and describe your country's response and any good practices, including protection of human rights.**
2. **Please specify if full and informed consent is administered for any type of reproductive healthcare, and if these include childbirth care.**

FORMS OF DISRESPECT AND ABUSE OF WOMEN DURING FACILITY-BASED CHILDBIRTH

CEHAT (Centre for Enquiry into Health and Allied Themes) is a not-for-profit research organization based in Mumbai, India. It has four key domains of work namely: (I) health services and financing, (II) health legislation and patients' rights, (III) women's health, and (IV) violence and health. Gender-based violence is one of its central areas of work, and CEHAT undertakes research and interventional work to address the same. The present submission is based on information derived from various research studies and intervention programs undertaken by CEHAT over the past decade as follows:

Research studies

1. Exploring Religion based Discrimination in Health Facilities in Mumbai (2013)
2. Perceptions of behaviour: Violence and labour rooms (ongoing)
3. Responding to Domestic Violence for Improving Maternal Health Outcomes: An Evaluation of a Counselling Intervention for Pregnant Women in Mumbai (2018)

Intervention programs

1. Integrating gender perspectives in undergraduate medical education
2. Public hospital-based crisis intervention centres, Dilaasa, for providing psychosocial and referral services to survivors of violence

RESEARCH STUDIES

1. Exploring Religion based Discrimination in Health Facilities in Mumbai (2013)[1]

This qualitative study explored religion-based discrimination in health facilities by healthcare providers. Among other findings, women also revealed abusive practices of healthcare providers towards women who availed of facility services for childbirth. Female class four workers (hospital orderlies) verbally and physically abused women in labour.

Verbal abuse included derogatory remarks, abusive language, and comments on women's character and sexuality; these comments were passed with the intention to discourage reproduction, and were targeted specifically at women from religious minorities.

Women were slapped on their thighs and across their faces to stop them from shouting in pain; this abuse was also ignored by doctors. Pregnant women were often made to clean dirty floors, and in the post-partum recovery period, asked to clean their utensils without any concern for their health.

The positioning of the beds in the labour ward, and the non-usage of curtains in the ward led to denial of women's privacy. Women lay facing one another minimally covered, which they found very

[1]Khanday, Z., &Tanwar, Y. (2013). *Exploring Religion based Discrimination in Health Facilities in Mumbai*. Mumbai: CEHAT. Retrieved from http://www.cehat.org/cehat/uploads/files/R%2091%20Exploring%20religion%20based%20discrimination.pdf

humiliating as they were in full view of whoever passed through the ward; this also included ward boys and doctors on rounds, which they deemed completely unacceptable.
Some women reported that they had never returned to the health facility owing to bad behaviour of healthcare providers during childbirth to the extent that they even preferred going to their villages for childbirth rather than returning to the public hospital.

2. **Perceptions of behaviour: Violence and labour rooms (ongoing)**[2]

The study attempted to explore provider perspectives of disrespect and abuse occurring in labour rooms, as few Indian studies have explored providers' perceptions of abusive behaviours during childbirth. Healthcare providers openly acknowledged the occurrence of verbal and physical abuse (including restraining the woman and administering fundal pressure) in labour rooms. The interviews revealed the normalization of such abuse; providers reported that such acts such as scolding the labouring woman, restraining her, and also at times applying fundal pressure, were necessary for better birth outcomes.
Issues of consent: Consent was understood by HCP as merely seeking signatures on different forms for procedures that may be required if there was a complication. However, the "informed" aspect of consent was not practised; providers reported that patients and their families at times did not understand what they were consenting to, regardless of which their signatures were taken. For procedures such as c-sections, the consent of family members overrode that of the woman. Episiotomies were considered the norm for primigravida women, and hence HCP stated that the same did not require any consent to be sought; episiotomies were also at times administered without the use of local anaesthesia.
Informed consent plays an important role in contraceptive counselling. Though the National Health Mission mandates women to be provided the 'basket of choices' for contraception, the study found that women were not provided all contraceptive options during antenatal check-ups. Rather, providers decided which contraceptives were to be offered to the woman; if the woman had two or more, children permanent methods were recommended, whereas if she had only one child, the PPIUCD was recommended. There was hence the assumption that a woman with one child would want another one, or that those with two or more would not, hence denying the woman reproductive control. Moreover, 'consent' was sought from women for insertion of the intrauterine contraceptive device (IUCD) at the time of delivery, when they were not in a position to give their consent, the act hence bordering on coercion.

3. **Responding to Domestic Violence for Improving Maternal Health Outcomes: An Evaluation of a Counselling Intervention for Pregnant Women in Mumbai (2018)**[3]

This intervention study involved providing psychosocial counselling for pregnant women facing violence when they visited the public health facility for antenatal check-ups. It aimed to improve their physical and psychological wellbeing and birth outcomes. This study also brought to light mistreatment faced by pregnant women while accessing reproductive healthcare services.
Obstacles in accessing abortion services: Pregnant women facing domestic violence were stripped of their autonomy with regard to the decision to have an abortion. Their access to MTP services was conditional; only upon agreeing to have an IUCD inserted did these women receive abortion

[2]CEHAT. (Ongoing). *Perceptions of Behaviour: Violence and Labour Rooms*.
[3]Arora, S., Deosthali, P., & Rege, S. (2018). *Responding to Domestic Violence for Improving Maternal Health Outcomes: An Evaluation of a Counselling Intervention for Pregnant Women in Mumbai*. Mumbai: CEHAT. Retrieved from http://www.cehat.org/uploads/files/Responding%20to%20Domestic%20Violence%20in%20Pregnancy.pdf

services. First-time pregnant women were denied abortions on the stated grounds that they would experience secondary infertility; women were also denied abortions owing to provider notions that a pregnancy had to be carried to term even if it was unwanted. Furthermore, healthcare providers (HCP) also insisted upon having the signature of 'the husband' when the Medical Termination of Pregnancy Act (1971) of India asks for only the woman's consent for an abortion.

Fear of doctors: Women also reported providing false obstetric histories to doctors fearing verbal abuse from them (e.g. providing false information about the gap between the previous and current pregnancies); these adverse behaviours of doctors also made women reluctant to ask them about future appointments and timings of medicine administration written on their hospital papers.

INTERVENTIONS

1. **Public hospital-based crisis intervention centres, Dilaasa, for providing psychosocial and referral services to survivors of violence**[4]

The Dilaasa project is a joint initiative of CEHAT and the Municipal Corporation of Mumbai (BMC) aimed at providing comprehensive healthcare for survivors of violence. These centres operate in 11 public hospitals of Mumbai and are presently being scaled up in other states of India. This initiative has also brought to light various forms of mistreatment against women in the ambit of reproductive healthcare in facilities.

Challenges faced by adolescents while accessing abortions: Adolescents seeking abortions face challenges owing to conflicts between government regulations. For a survivor of sexual violence, Indian laws namely the Protection of Children from Sexual Offences (POCSO) Act (2012) and the Criminal Law (Amendment) Act (2013) mandate the consent of the survivor to be sought for examination, treatment, examination for the collection of evidence and provision of information to the police if the survivor is above 12 years of age. However, the age of consent differs in the Medical Termination of Pregnancy Act (1971); in the case of those below the age of 18 years, abortion requires the written consent of the legal guardian as it is an invasive procedure. Moreover, the POCSO Act which considers individuals below 18 years of age children also makes consensual sexual activity among individuals below 18 years criminal, and mandates the reporting of the resulting pregnancy. Hence, for females below the age of 18 who are pregnant from a consensual sexual relationship, a medico-legal case is filed, wherein the partner is often charged for the 'sexual offence'. This leads to the incriminating of the girl's partner against her wishes, or the girl turning away from the hospital and accessing unsafe abortions, or even having to deliver the child, leading to deleterious consequences.

Denial of contraceptive needs of adolescents: Conflicts in the government's laws and policies hinder adolescents' access to contraceptives. The Rashtriya Kishor Swasthya Karyakram (RKSK) scheme for adolescents (aged 10 to 19) targeting nutrition, reproductive health and substance abuse, among other areas, has provisions for enabling adolescents' access to contraceptives However, the POCSO Act which deems any sexual activity by individuals below the age of 18 criminal prevents their access to the same.

[4]CEHAT. Cehat | Research Areas: Dilaasa: Intervention with the Health Sector for Responding to Violence Against Women. Retrieved from http://www.cehat.org/researchareas/project/1489666774

2. Review of undergraduate medical textbooks for the project on integrating gender in medical education[5]

Gender biases pervade many aspects of medical education in India such as clinical practice, research, health programme delivery, and medical education. CEHAT in collaboration with the Department of Medical Education and Research (DMER) led an initiative in Maharashtra, India to systematically integrate gender perspectives in undergraduate (UG) medical education. For the project, a review of popular obstetrics and gynaecology (ObGyn) textbooks used in the UG curriculum was first undertaken.

This review revealed a complete absence of content on social determinants of health, which includes gender, and their interplay with health conditions, health-seeking behaviours, and health outcomes. Content on informed consent for different medical procedures was conspicuous by its absence; textbooks advised written consent of the husband along with the wife's for female sterilisation. Within teachings on reproductive healthcare, the concept of informed consent was not an area of focus; and was relegated to a few lectures on medical ethics. ObGyn curriculum also did not include concepts related to obstetric violence in topics such as *normal labour*, *obstructed la*bour, *urinary disorders*, and *genital fistulae* among others, which are conditions where mistreatment of women can occur, or result from such mistreatment. Medical students were also not exposed to the concerns of overmedicalisation of birthing e.g. with unnecessary C-sections and episiotomies.

COUNTRY RESPONSE AND GOOD PRACTICES

Integrating gender in medical education[6]

Integrating gender in medical education is a collaborative project between CEHAT, DMER and the Maharashtra University of Health Sciences to train medical educators in inculcating gender perspectives to medicine in their teachings. Under this project, in the ObGyn curriculum, 31 topics across five years of medical education were identified, and gender perspectives were systematically integrated within the same. The curriculum was tested for efficacy and feasibility through a quasi-experimental research design. Positive results of the study enabled this curriculum to be adopted by the Academic Council of Maharashtra in the state-wide medical curriculum.

Government Medical College of Aurangabad, Maharashtra took this project further, and expanded the scope of gender integrated teaching to gender-sensitive clinical practices. Inclusion of curtains in labour rooms to enable privacy, introduction of birth companions in labour rooms, enabling women to take different positions to ease labour pain, customising consent forms for a range of reproductive health services, and identifying and caring for pregnant women facing domestic violence are some of the positive clinical practices introduced. There is hence the need for the Medical Council of India to take cognizance of women's reproductive health rights and implement this evidence-based curriculum across the country.

[5]CEHAT. Gender in Medical Education. Retrieved from http://www.gme-cehat.org/Resources/List_Resources.aspx.
[6]Bavadekar, A., Bhate-Deosthali, P. & Rege, S. (2017) Integrating Gender in Medical Education. *Quest in Education*, *41*(2).

Need to integrate routine enquiry for domestic violence for pregnant women in antenatal care settings: effectiveness of an intervention study3

CEHAT's study on responding to violence during pregnancy entailed providing pregnant women facing domestic violence a psychosocial intervention to mitigate the effects of violence on them. The intervention resulted in almost all participants adopting safety strategies in the event of an episode of violence, and also in steps such as taking up a job or moving out of the marital house; 84% of the participants reported better health following the intervention. The study also detected a 16% prevalence of domestic violence among 2515 pregnant women who participated in the study, highlighting the need for responding to violence during pregnancy.

This has led to an institutionalization of the practice of routine enquiry to identify VAW in pregnancy, and is integrated into 11 peripheral hospitals in Mumbai. This enquiry is carried out by both HCP and counsellors at Dilaasa centres. At centre, women receive psychosocial support and referral to other sources of help. This practice needs to be absorbed into health facilities across the country owing to the burden of violence in pregnant women, and the promising effects of intervention.

Gender-sensitive proforma for survivors of sexual violence[7]

In 2014, the Indian government released the *Guidelines and Examinations Proforma for Medico Legal Cases* of survivors of sexual violence. These guidelines were in keeping with the *Guidelines for medico-legal care for victims of sexual violence* released by the World Health Organization in 2002.[8] The 2014 guidelines abolished the 'two-finger test' for establishing the occurrence of sexual violence, and made it binding upon healthcare providers to provide medical treatment to the survivor free of cost. The guidelines operationalise informed consent and respect autonomy of survivors in making decisions about examination, treatment and police intimation. It calls for evidence-collection based on science, with specific guidance for taking only relevant samples for preservation of evidence, and doing away with unnecessary invasive procedures violating the woman's bodily integrity. However, it has been adopted only by 9 states of the country, and the awareness and implementation of these guidelines remain scant across medical facilities in the country.[9]

3. Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing, and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations.

Mistreatment of women at the time of childbirth is normalized within the health facility culture, and is divorced from the notions of quality of care. There is not recognition of the same as a violation of human rights. Furthermore, there are no provisions in the form of laws or regulations to safeguard the rights of women during childbirth. Hence currently, there are no redressal mechanisms to

[7] Ministry of Health & Family Welfare, India. (2014). *Guidelines and Protocol: Medico-legal care for survivors/victims of Sexual Violence*. New Delhi.

[8] WHO. (2002). *Guidelines for medico-legal care for victims of sexual violence*. Geneva: WHO.

[9] CEHAT. (2018). Understanding Dynamics of Sexual Violence: Study of case records, CEHAT and MCGM, Mumbai, India.

address mistreatment of women during childbirth, and also in the broader context of reproductive healthcare.

Finally, the great majority of the evidence for mistreatment of women with regard to reproductive healthcare comes from public health facility settings. However, women are also mistreated in private healthcare settings e.g. in the form denial of abortions without any grounds. However, the private medical sector in India is in effect unregulated. Hence, even though the poor treatment meted out to women in public health facilities is brought to light, that within private facilities remains largely invisible. This is a significant loophole as there is evidence to show that the rates of procedures such as caesarean sections are much higher, almost thrice that of the rates in public health facilities.[10] There is hence the need to bring the private medical sector into the purview of accountability.

4. Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue?

India is a signatory to the Sustainable Development Goals (SDGs) (2015) Goal 3 and Goal 5 of which address health and gender equality respectively. Both these clauses aim to end VAW, violence adversely affecting women's health, as well as being a result of power imbalance and gender inequalities in the society. It is also a signatory to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979), and the Global Plan of Action agreed upon at the 67th World Health Assembly. This calls for the country to exert efforts to end gender-based violence within its borders.

The ***National Health Policy of India (2017)***[11] recognizes gender-based violence as a grave health concern, and states that all survivors of gender-based violence must be provided free treatment in public as well as private health facilities, and be treated with respect and dignity; it calls for the strengthening of the health sector response towards the issue through orientation towards gender-based issues.

LaQshya: Labour Room Quality Improvement Initiative: The Government of India released the LaQshya guidelines in 2017 with the aim of promoting safe and respectful childbirth practices.[12]These guidelines are applicable to all government-run medical colleges, district hospitals, community health centres, sub-district hospitals, and first referral units. LaQshya addresses the aspects of space, layout, equipment, human resources, and protocols with regard to labour rooms. It also includes a component of patients' rights, which encompasses the aspect of respectful care during childbirth. This component of LaQshya is however overshadowed by the other technical, skill-based and infrastructural aspects2, and the implementation of respectful and dignified treatment of women during childbirth remains to be seen.

[10] E.g. Singh, P., Hashmi, G., & Swain, P. (2018). High prevalence of cesarean section births in private sector health facilities-analysis of district level household survey-4 (DLHS-4) of India. *BMC Public Health*, *18*(1). doi: 10.1186/s12889-018-5533-3

[11]Ministry of Health and Family Welfare, India. (2017). *National Health Policy*.

[12]Ministry of Health and Family Welfare, India. (2017). *LaQshya: Labour Room Quality Improvement Initiative.*

Hospital-based crisis intervention centre for survivors of gender-based violence under the National/State Health Mission[13]:

Programme Implementation Plans (PIP) under various State Health Missions such as those of Kerala and Haryana have integrated evidence-based models to respond to VAW; these centres are founded on the hospital-based Dilaasa model. The Ministry of Women and Child Development (MWCD) has also opened independent one-stop-centres in various states. A review of these existing OSCs however found that these centres were cut-off from health system; there were lacunae in co-ordination among referral networks, and in clarity of roles of OSC staff.[13]

Strengthening the health sector response towards VAW[14]

In 2013, the World Health Organisation (WHO) developed clinical and policy guidelines on '*Responding to intimate partner violence and sexual violence against women*' for low and middle income countries. CEHAT in collaboration with the WHO has undertaken a study to implement these guidelines in order to generate evidence on the feasibility of their implementation, and also to test the possibility of developing a model healthcare response towards VAW in the tertiary healthcare setup. This includes the training of HCP in the various aspects of responding to VAW, such as the concept of gender, the social determinants of health, identifying the symptoms of violence, and providing appropriate medical and referral services. This initiative is being currently carried out in two medical colleges of Maharashtra, India, and is hoped to lend a sustainable model for responding to VAW in tertiary health facilities across the country.

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[13] Bhate-Deosthali, P., Rege, S., Pal, P., Nandi, S., Bhatla, N., & Kashyap, A. (2018). *Role of the Health Sector in Addressing Intimate Partner Violence in India*. ICRW. Retrieved from http://www.cehat.org/uploads/files/Role_of_the_health_sector_in_addressing_intimate_partner_violence_in_India.pdf

[14] CEHAT. Cehat | Research Areas: Implementation Research To Test Approaches To Rolling Out WHO Guidelines And Tools For The Health Sector Response To Violence Against Women. Retrieved from http://www.cehat.org/researchareas/project/1525069832