Call for submissions: Mistreatment and violence against women during reproductive health care with a focus on childbirth

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This submission is made by the Asian Pacific Resource and Research Centre for Women (ARROW), Malaysia and the Beyond Beijing Committee (BBC), Nepal, ECOSOC accredited organisations. BBC is a feminist network organisation working on the issue of women's SRHR based in Nepal. ARROW is a regional organisation working on improving evidence-based advocacy to ensure SRHR in Asia-Pacific region in partnership with national organisations. BBC and ARROW are partner organisations and welcomes this call for submissions.

It aims to draw attention to initial examples from Nepal while presenting broader regionally specific issues and gaps in the context of reproductive health in Asia. In the Asia region, there is a dearth of information on mistreatment and violence against women during reproductive healthcare in any context, including in the context of childbirth. This aspect is also relevant in the context of ensuring reproductive health and rights in the context of universal health coverage (UHC) and in relation to deciding essential service packages within the framework of UHC.

The submission is organised into the key areas under the call, presented in the following sections as much as possible.

1. **Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, 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;**

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination.[1] Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.[2] The concept of "safe motherhood" is usually restricted to physical safety, but childbearing is a rite of passage in Nepal, with deep personal and cultural significance for a woman and her family.[3] As motherhood is specific to women, issues of gender equity, non-discrimination and gender violence are also at the core of maternity care.[4]

Quality of care received forms an integral part of reproductive healthcare and lack of quality care can be affected in many ways, including through mistreatment and violence. Overcrowding of normal delivery services at referral hospitals in Nepal has contributed to poor quality care of the services that hinders women from attaining adequate services. The lack of complete and accurate information has women making uninformed decision about their pregnancy and related care. BBC's experience and related anecdotal evidence is that many women are not informed about the importance of check-ups prior to deliveries and post-natal care; thus, not many women attain ANC or post-natal visits. Additionally, during the consultation services are inadequate and the treatment of health care providers has been insensitive and, in some cases, women have faced verbal and

[1] World Health Organization, 2015: The prevention and elimination of disrespect and abuse during facility-based childbirth; Department of Reproductive Health and Research, World Health Organization. http://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf;jsessionid=196DE4F9CA0AF94F3F1F6B460106B1E1?sequence=1

[2] Ibid.

[3] Respectful Maternity Care: The Universal Rights of Childbearing Women

[4] Ibid.

physical abuse. The insensitivity of service providers is more reflected to mothers of young age, mother with HIV status, education level and mother with disability indicating that stigma towards women who have become pregnant outside the institution of marriage is also a potential driver of violence. This impact on women's obstetric health can have adverse consequences to their mental and physical health and that of the infant as well as overall wellbeing.

Anecdotal evidence shows that partners of the pregnant women are not allowed during the delivery, prohibiting the emotional support during the child birth and make any promote decision during a delivery and in the case of an emergency. Additionally, mistreatment during the childbirth by the service providers has been noted. Many women have experienced verbal and physical abuse during child birth and are not provided with complete and comprehensive information to make an informed choices during the course of their pregnancy and after. A related factor that can be observed with the number of caesarean sections. According to World Health Organization (WHO) there can be 10-15% caesarean section in saving lives of babies and mothers in any given settings[5]; exceeding this threshold implies that obstetricians are conducting unnecessary procedures. Unnecessarily performing C-section without medically justified is the issue of human rights violence of childbearing women.[6] The linkage between these procedures, women deciding to have these procedures and their experience require further exploration.

Similar trends have been observed in another study in Sri Lanka. The study found that younger women, poorer women, and women who did not speak Sinhala seemed to experience more obstetric violence than those with relevant social connections and better economic positions.[7] In India, in government hospitals inhuman practices such as negligence, physical abuse (such as slapping and episiotomies) and emotional/verbal abuse (such as scolding, shaming, yelling, not allowing husbands by the women's side) have been noted as being common. In private hospitals, the incidence of (unnecessary) caesarean childbirths have also been noted in relation to mistreatment during reproductive healthcare.[8]

2. **Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;**

Further exploration is required on this angle and in-depth study is recommended. Also see 4.3 below. The implementation of such polices requires further exploration and is a critical barrier as with numerous other policies and regulations.

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;**

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[5] Tamang. L, 2016: Obstetric Violence like Caesarean Section linked to chronic non-communicable health problems, Maternal Health, Gender-power relations, Midwifery, Sexual and Reproductive Health, Social Entrepreneur, Social Work. http://laxmitamang.blogspot.com/2016/05/obstetric-violence-like-caesarean.html

[6] Tamang Laxmi, 2016: Obstetric Violence like Caesarean Section linked to chronic non-communicable health problems, Maternal Health, Gender-power relations, Midwifery, Sexual and Reproductive Health, Social Entrepreneur, Social Work. http://laxmitamang.blogspot.com/2016/05/obstetric-violence-like-caesarean.html

[7] Perera D, Lund R, Swahnberg K, Schei B, Infanti JJ; ADVANCE study team. 'When helpers hurt': women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka. *BMC Pregnancy Childbirth*. 2018;18(1):211. Published 2018 Jun 7. doi:10.1186/s12884-018-1869-z. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5991468/

[8] Nayak, A. K. and Nath, S. There is an Urgent Need to Humanise Childbirth in India. Economic and Pollitical Weekly. Vol. 53, Issue No. 2, 13 Jan, 2018. https://www.epw.in/engage/article/urgent-need-to-humanise-childbirth-in-india

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However, some evidence does suggest that such mechanisms may be limited. In Sri Lanka, instead of having access to complaint mechanisms they would find obstetric care, particularly for childbirth, in other state hospitals in subsequent pregnancies. They rarely reported such violence to legal or institutional authorities, nor within their informal social support networks.[9] Related to this, there is a need to recognise that this negative experience for women comes from a position of power and a power relationship between the women seeking services and those providing the service. Thus ethics of providing care needs to be considered not just in delivery but also in training of service providers. Further, the normalisation of such violence has to be tackled so that women do not consider it part of the experience of accessing a service and thus unquestionable. In Kerala, India many women that face obstetric violence are poor and are forced to seek less expensive public facilities for birth. They did not consider it abnormal, illegal or ethically wrong.[10]

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, see: 1 | 2

In addition to being signatory to a number of international commitments, Nepal has various laws and policies focusing on women's reproductive health and rights. These include:
1) The Constitution promulgated in 2015 in its article 38(b) states that "every woman shall have the right to safe motherhood and reproductive health".[11]
2) Safe Motherhood and Reproductive Health Right Act 2018, has ensure the respectful maternity care at all the non-government as well as private health facility that has followed the government criteria.[12] Safe motherhood and Reproductive health right act 2018 has addressed that if the women is denied of the safe motherhood and reproductive health services recognised by the government at the health facilities or discriminated because of the caste, religion , marital status, sexual orientation, disability morbidity, the service provider will be subjected to punishment and payment of financial compensation.
3) The Public Health Act 2018 reaffirms non-discrimination based on sex or sexual orientation in providing medical care, and maternity services free of cost. Public health act, 2018 has addressed different approach to make the service providers accountable. They are subjected to punishment in case of denial of the services, breaching of confidentiality, providing service without informed consent and informed choice and discrimination because of the caste, religion, marital status, sexual orientation, disability morbidity. Additionally, all health facilities should get informed consent (verbal or written consent) from service seekers before providing service.[13] However, in following conditions health services can be provided without service seeker's consent:

1. If the person is not in the state of providing consent and has given no immediate authority to anyone else, until his/her family members provide the consent.
2. In accordance with current laws or court's order, service can be provided without consent
3. If not providing the treatment can generate a public health threat.
4. If delayed service can cause death or have a chance of greater health risks.

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[9] Perera D, Lund R, Swahnberg K, Schei B, Infanti JJ; ADVANCE study team. 'When helpers hurt': women's and midwives' stories of obstetric violence in state health institutions, Colombo district, Sri Lanka. *BMC Pregnancy Childbirth*. 2018;18(1):211. Published 2018 Jun 7. doi:10.1186/s12884-018-1869-z. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5991468/
[10] The embarrassing state of Kerala's maternal healthcare: Effect of the Kerala model. Bulbul Prakash. March 2019. Counter Currents.org. https://countercurrents.org/2019/03/the-embarassing-state-of-keralas-maternal-health-care-effect-of-the-kerala-model
[11] Government of Nepal, Secretariat, and Constituent Assembly. 2015. The Constitution of Nepal 2015.
[12] Federal Parliament Secretariat. 2018. Safe Motherhood and Reproductive Health Right Act 2018. Nepal.
[13] Federal Parliament Secretariat. 2018. Public Health Act 2018. Nepal

5. If the person does not deny the service in direct or indirect manner.

4) National Health Policy 2018 addresses the issues of quality human resources focusing on midwifery and nurses to promote maternal new-born child and adolescent health.[14]
In addition to the laws and policies the government has developed programmes such as: the Maternity Incentive Scheme (Aama Programme), 2005 and the Nyano Jhola (Warm Bag) program (2012/2013), Female Community Health Volunteers (FCHV) program (1993/94), Prevention of Mother to Child Transmission (PMTCT) program in 2005 has been introduced by the government to address maternity and child birth care.[15]

The maternity incentive scheme (*Aama* Program) was developed as response to reduce maternal mortality. This scheme was developed during the MDG period and to increase the institutional delivery. Thus, the scheme provided transport incentives to women to deliver in health facilities. In 2006, user fees were removed from all types of delivery care in 25 low HDI districts and expanded to nationwide under the *Aama* Program in 2009. In 2012, the separate 4 antenatal care incentives program was merged with the *Aama* Programme. In 2016/17, the Free Newborn Care Program, in FY 2015/16, was merged with the *Aama* Programme. The *Nyano Jhola* (Warm Bag) Program was launched in 2012/13 to reduce protect new-borns from hypothermia and infections and to increase the use of peripheral health facilities (birthing centers); thus, reducing neonatal mortality. Two sets of clothes for newborns and mothers, and one set of wrapper, mat for baby and gown for mother are provided for women who give birth at birthing centers and district hospitals. The program was interrupted due to financial constraints, however MOH allocated extra budget for 2016/17 due to popular demand. FCHV program (1993/94) was one of the successful program launched by the government. The major role of FCHVs is to advocate healthy behavior by mothers and community people to promote safe motherhood, child health, and family planning and other community based health. Nepal started its Prevention of Mother to Child Transmission (PMTCT) program in 2005 and launched Community-Based PMTCT program in 2009, taking PMTCT services beyond hospitals and making the services accessible to pregnant women living in remote areas. Human resources, especially from maternal and child health care, have been trained in alignment with PMTCT services.[16]

Along with all the progressive and positive laws and policies, the government has also developed a mechanism for accountability, Maternal Perinatal Death Surveillance and Response (MPDSR) and Health facility Operation and Management Committee (HFOMC). This includes routine identification, notification, quantification and determination of causes and avoid ability of all maternal and perinatal deaths, as well as the use of this information to respond with actions that will prevent future deaths.[17] This has been expanded in 6 districts by the end of FY 2016/17 and Ministry of Health has planned to gradually expand this to all 75 districts. In addition, facility-based MPDSR has already started in 42 hospitals in FY 2016/717. HFOMC addresses the issue of local governance and accountability of the health service at the local level[18].

Additionally, the government has developed One Stop Crisis management (OCMCs) this is a mechanisms to address the gender based violence. 2010 National Action Plan against gender-based violence that intends to provide integrated services to survivors by establishing hospital-based one-

[14]Government of Nepal. 2017. National Health Policy 2017.
[15] Department of Health Services. 2018. Annual Report: Department of Health Services 2016/2017. Kathmandu, Nepal.
[16] Department of Health Services. 2018. Annual Report: Department of Health Services 2016/2017. Kathmandu, Nepal.
[17] Ministry of Health and Population, Department of Health Services, Family Health Division. 2015. Maternal and Perinatal Death Surveillance and Response (MPDSR) Guideline.
[18] Ministry of Health and Population, Department of Health Services. 2018.Health Facility Operation and Management Committee- A reference guideline for local level.

stop crisis management centres (OCMC).[19] As of now, the MOHP has established 21 OCMCs. However, due to lack of disability friendly service in terms of infrastructure and behaviour, some women lack the access to OCMC.[20]

Recommendations:

- Governments should develop evidence-based policies and guidelines for maternal care ensuring a continuum of quality care that also ensures respectful care.
- Governments should encourage natural childbirth and develop specific policies and measures, such as use of rate of cesarean section without medical necessities.
- Respectful maternity care must be ensuring to preserve women's reproductive rights.
- There needs to be greater investment in generating and capturing evidence on this form of violence as well as ascertaining it impact on women taking into account diversities and intersectionality.

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[19] Ministry of Health. 2017. Health Sectory Transition and Recovery Program. Case Study. Performance of Hospital Based One Stop Crisis Management Centers. NHSSP and UKaid

[20] Ministry of Law and Justice (MOLJ) Nepal. 2009. Domestic Violence (Offence and Punishment) A 2009. http://www.lawcommission.gov.np/en/documents/2015/08/domestic-violence-crime-andpunishment-act-2066-2009.pdf.