Call for Submissions: Mistreatment and Violence against Women during Reproductive Health Care with a focus on Childbirth

**Submission: Shirkat Gah – Women’s Resource Centre, Pakistan**

**Date: 17th May 2019**

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;**

Health is a devolved subject in Pakistan, meaning it is up to each provinceto initiate laws and policies related to health care, with direction from the Federal Government. In 2013, the Federal Government passed the Reproductive Healthcare and Rights Act Pakistan, with the intention to comply with CEDAW, as well as enshrine reproductive health care rights. However, there is no recognition or mention of protection against violence and mistreatment of women during access to reproductive health care services. Further, there has been no specific policy or programmatic to see through the implementation of this Act. Bills in Sindh and Punjab have been presented, mimicking the language of the Federal Bill however, with currently no movement seen in Balochistan or Khyber Pakhtunkwa.

**Statistics from the most recent Pakistan Demographic Health Survey (PDHS) 2017-18 reports that reproductive health care coverage is improving; 9 in 10 women between the ages 15-49 are receiving antenatal care from a skilled provider and more than half of women have their first antenatal care visit in the first trimester, as recommended. 50% women make four or more antenatal care visits, and 66% of women are accessing healthcare facilities for childbirth. Yet, 1 in 3 births are still delivered at home and problems abound.**

**Shirkat Gah, supported by the International Development Research Centre (IDRC), conducted a 4- year intervention (2013-2017) study in 7 districts of Pakistan, across the 4 provinces, on strengthening health governance systems. A component of the study was to analysis the quality of care women received from health care facilities, and whether it impacted their health seeking behaviour. Our findings from the said research provide clear instances of mistreatment of women, due to socio-cultural beliefs and patriarchal notions, at the hands of service providers. In several locations, complaints about attitudes were reported, of staff being rude, scolding, pushing and shoving patients and/or their families.**[[1]](#footnote-1)**Testimonies**[[2]](#footnote-2) **of sexual harassment by male staff, especially of girls and young unmarried women were also recorded in several places.**

**These complaints were largely against public hospital service providers – but it needs to be said that the study itself focused on the public health sector. Community women interviewed complained about negligence, inattentiveness and aggressive attitudes of doctors and nurses alike. One said that after witnessing a woman in labour helplessly crying out in pain and being ignored by all staff**[[3]](#footnote-3)**, she decided she would never to go to a government hospital for her deliveries.**

**Women are disrespected and treated poorly at healthcare facilities, particularly those seeking reproductive healthcare services. This includes: being subjected to physical violence or being rudely spoken to while giving birth as a commonplace occurence; women having to wait hours while in labour for attention from doctors; the lack of care of privacy and confidentiality included: being stripped naked in front of other patients; surgeries being performed while other patients are present..**

**Yearly, 3,500-5,000 new cases of obstetric fistula are reported in Pakistan, and Dr Shershah Syed, president of the Pakistan National Forum on Women’s Health (PNFWH), estimates that out of these, approximately 20-30 percent are attended to,while the rest do not receive the required intervention. The causes for obstetric fistula have been linked to a lack of timely emergency obstetric care and a lack of policy related to administration of treatment against the issue.**[[4]](#footnote-4) **A public litigation petition was filed in Sindh province, to ensure the provision of treatment for women suffering from obstetric fistula. The petition was disposed off by the Sindh High Court with clear instructions issued to the Sindh Health Department to allocate funds for treatment, establish centres for treatment and provide quarterly progress reports in on hiring required skilled professionals and establishing these facilities.**[[5]](#footnote-5)

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

The Reproductive Healthcare and Rights Act stipulates full and informed consent, with regards to reproductive health information, but does not expand on its coverage. The language of the Act suggests that policy makers intended to focus on informed consent regarding contraceptive practices, but the vague terminology could offer a more expanded interpretation. Nonetheless, childbirth care options are restricted in Pakistan, for a myriad of reasons, especially in rural areas. There is a dearth of skilled midwives and gynaecologists at public facilities, according to ShirkatGah’s research, resulting in a lack of access to antenatal and post-natal care. Women receive counselling mainly from Lady Health Workers, who are unable to cater to the workload and therefore, may not spend adequate time counselling pregnant women or new mothers. Lady health workers have also been involved in polio campaigns which is seen as an emergency issue, therefore further increasing their workload and limiting their ability to counsel pregnant women and new mothers effectively. It should be noted that Lady Health Workers often go months without pay, are not provided refresher trainings and thus are usually not updated with new methods or developments. Therefore, it could be argued that the counselling services that they provide may not fall under the definition and scope of full and informed consent.

 Misconceptions and myths continue to persist across communities, with women and girls accessing information from each other and repeating the practices of the older generations. Following tradition, women tend to not access post-natal care: they are often deterred by family members and further demotivated by the cost of health seeking behavior. The latter is especially important when women have little financial resources over which they exercise control. Most women are not counselled effectively on post pregnancy family planning, and neither are all options available to them at centres. Despite being trained, most service providers do not provide side effect management information or techniques, possibly due to lack of time, and also possibly due to the fact that providers do not want to discourage women from using contraception.

Decision making powers at a household level usually lie with the men (or mother–in-law); women generally are denied the right to make any decisions regarding their reproductive health, including child birth, and are made to follow through with whatever is decided by the husband and/or mother-in-law, especially in terms of health care. Women’s ability to act for themselves is further impeded by a lack of knowledge about reproductive health matters and existing services and know how (as well as finances) for accessing these.

1. **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;**

A variety of complaint mechanisms, including complaint boxes, telephonic and email based mechanisms to receive and address grievances, have been established across facilities and provinces. Effective upward communication within departments has helped to resolve complaints and, for example, PWD field offices forward serious complaints to the District offices and Secretary PWD, as well as to the(CM) Minister’s office, Chief Justice, and Ombudsman.

Complaint boxes however are not the most useful method for a country where women’s literacy is low, especially in rural areas and marginalised populations. When complaint boxes are in the custody of the senior-most facility in-charge, effectiveness and use is determined by the personal outlook of the official: some are encouraging others not. Limited abilities to write or communicate effectively, especially communities in rural areas, a lack of standardised forms to register complaint (and even a lack of tools to use to write out complaints) indicate the ineffectiveness of this mechanism. Many fear backlash and negative consequences of filing complaints and therefore, choose not to.

In some places Complaint Cells have been instituted, but the names of the members in the Cell and their telephone numbers have not been publicised. In any case, mobile telephone numbers are deemed to get better responses than landlines. Where these are available, they are used more frequently.

Electronic web-based complaint mechanisms are less effective/useful in rural areas with poor networkcoverage; they also tend to exclude the poor and women to a larger extent as their access to smart phones is limited.

The Citizens’ Portal in Khyber Pakhtunkhwa requires complainants to have an email account, which

further limits its usage by women.Punjab has the greatest number of mechanisms that include the CM Complaint Cell and DCO Office ComplaintCells. Telephone numbers for complaints are posted outside offices and publicised on banners at seminars, etc. Monthly reports are sent to the CM Secretariat, and meetings held with DCOs to ascertain actions taken and number of cases resolved.

The study found that the most effective changes have occurred when multi-stakeholder community committees have been established to receive complaints and oversee matters. These inlcude elected local councilors and civil society representatives, sometimes the media.

1. **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.**

**Currently, there are no clear SOPs developed that guide health responses to VAW, apart from those that are stipulated under the various violence laws (Domestic Violence, Anti Rape and so on). Health policies rarely discuss violence procedures and neither are Lady Health Workers or Midwives duly trained on sensitised trainings for survivors.**

1. Sukkur, village Kauro Khan Panhyar, focus Group Discussion with married women, 2016; Muzaffargarh, Focus Group Discussion with married women, 2016. [↑](#footnote-ref-1)
2. Focus Group Discussion with unmarried girls, Cattle farm, 2016 [↑](#footnote-ref-2)
3. Focus Group Discussion with married women, Qubo Saeed Khan, 2016. [↑](#footnote-ref-3)
4. “HEALTH: BROKEN BY CHILD BIRTH” Naqvi, Rizwana, DAWN News 2018 <https://epaper.dawn.com/DetailImage.php?StoryImage=13_05_2018_528_002> [↑](#footnote-ref-4)
5. C.P. No. D-4243 of 2015, Sindh High Court Petition [↑](#footnote-ref-5)