



Women's Health and Rights Advocacy Partnership

– South Asia (WHRAP-SA)

Rights Based Continuum of Quality Care for Women's Reproductive Health in South Asia

championing
women's sexual and
reproductive rights



WHRAP

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WOMEN'S HEALTH & RIGHTS ADVOCACY PARTNERSHIP -SOUTH ASIA

WHRAP- South Asia positions itself as an international partnership with a regional voice. The partnership brings together women led organisations and other civil society actors for evidence based advocacy on Sexual and Reproductive Health and Rights (SRHR). Over the last ten years our partnership has facilitated and contributed to processes aimed at improving quality of life of marginalised women in South Asia through strengthened civil society engagement and accountability for health governance.

WHRAP in the South Asian sub-region is implemented as a partnership program between five leading national women's organizations including Beyond Beijing Committee (BBC) in Nepal, Naripokkho in Bangladesh, ShirkatGah in Pakistan, Centre for Health Education, Training and Nutrition Awareness (CHETNA) and SAHAYOG in India as national partners; and their forty (40) Community Based partners who work directly with the women on the ground; the Danish Family Planning Association (DFPA) as the international partner; and the Asian-Pacific Resource and Research Centre for Women (ARROW) as its regional partner.

WHRAP was first implemented in 2003 in four South Asian countries (Bangladesh, India, Nepal and Pakistan). In Phase

II (from 2006-2010), WHRAP-South Asia reached out to nine broad categories of stakeholders from local to the global level to achieve results which include marginalised grassroots women beginning to demand accountability based on the right to reproductive and sexual health; increased responsiveness of the health care providers and health systems for quality SRH services; greater public visibility of SRHR and maternal health issues; a monitoring role of health rights violations being played by media; formation of alliances and partnerships at various levels for SRHR, maternal health and many others.

In the same phase it has reached out to more than 160,000 women at the grassroots level building their capacity in monitoring the health systems and their ability to articulate their demands for quality SRH more confidently. This has forced duty bearers to begin to respect these community groups and women and start paying attention to the issues that they are raising.

The following position paper outlines our advocacy stance on promoting a context specific rights based framework for Continuum of Quality Care for Women's Reproductive Health in four South Asian Countries (Bangladesh, India, Nepal and Pakistan).

CONTINUUM OF QUALITY CARE:

A Statement from the Asian-Pacific Resource and Research Centre for Women (ARROW) and the Danish Family Planning Association (DFPA)

Continuum of care has recently been highlighted by the Partnership for Maternal and Neo-Natal and Child Health (PMNCH) and UNICEF as a core principle of programmes for reproductive, maternal, adolescent, newborn, and child health. This modality of care is necessary throughout one's lifecycle - adolescence, preconception, pregnancy, childbirth, the postnatal period, and childhood - regardless of location. Care can be given in households and communities, through outpatient and outreach services, and public health institutions. Continuum of care also accounts for the need to address the impact of long distances and travelling time from one point of service to another, financial constraints, poor communication and transport, weak referral links and low-quality care in health facilities.

ARROW and DFPA with partners in South Asia are building on these policy directives. Through the Women's Health and Rights Advocacy Partnership (WHRAP) in South Asia. Based on careful analysis and evidence from the ground, WHRAP-South Asia believes that this initiative is extremely important but needs to be contextualised to the capacities of existing health systems and must be grounded in a rights based approach. Therefore we are calling for a context specific rights based continuum of quality care for reproductive health to be implemented by governments in the sub-region.

At a time when increased funding is directed towards specific interventions, this position is a timely and strategic one, drawing on the concepts established in 1994 and agreed upon by more than 170 governments which follows the lifecycle approach to women's sexual and reproductive health needs in the International Conference on Population and Development (ICPD). Specific interventions, however well-intentioned, are able to only support women, especially the most vulnerable, during one or two specific points in their lives. Access to comprehensive, quality sexual and reproductive health services throughout the lifecycle needs of women, encapsulated in the 'continuum of quality care' modality, is an essential intervention that enables women - especially the poor, marginalized and vulnerable - to access the services they need. WHRAP began as an initiative of ARROW and

partners in an endeavor to create a platform which was able to make visible the issues of the most marginalized women in our region and ensure that funding for these frontlines was secured. This partnership started in 2003 with ARROW and leading South Asian national women's organisations and community based organisations (CBOs) in Bangladesh, Nepal, India and Pakistan. A few years later the Danish Family Planning Association (DFPA) became an international partner. In 2012, the partnership expanded to include Maldives and Sri Lanka.

The partnership has been able to support and strengthen the sexual and reproductive health and rights (SRHR) agenda especially for the most marginalized and most vulnerable women in the region. This modality enables joint strategic planning and evidence-based advocacy on government commitments to bring about real changes in the lives of women, young people, their families and communities. WHRAP has created new advocacy opportunities that heighten the demand for better health governance and accountability.

In the more recent phases of WHRAP-South Asia, the partnership, is calling for renewed attention and political and financial commitment by governments and the international community to the agenda of providing a continuum of quality care for women's sexual and reproductive health. A comprehensive context-specific continuum of quality care package would ensure that appropriate care is available wherever and whenever it is needed and linked, where necessary, to other levels of care.

This is what women need. This is what they deserve. This is what will make the difference in their lives. WHRAP-South Asia is committed to making this a reality.

Sivananthi Thanenthiran
Executive Director
ARROW

Tania Dethlefsen
International Director
DFPA

INTRODUCTION

SHAMA DOSSA (ARROW)

The South Asian sub-region accounts for a substantial part of **preventable maternal deaths** in the world. Maternal mortality estimates remain high particularly in Bangladesh, India, Nepal and Pakistan. The maternal mortality ratio (MMR) of Bangladesh stands at 194¹, India 212², Nepal 281³, and Pakistan 276⁴. As many countries in South Asia do not have a reliable registration system for births and deaths, MMR estimates can be significantly higher. The national figures for MMR also do not capture the large inter-state and regional variations within these countries.

Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions which begin in youth⁵. Maternal mortality in girls under eighteen is estimated to be two to five times higher than in women between 18 and 25⁶. Nearly one in four people living in South Asia is an adolescent or a child between the ages of 10 and 19⁷. One in four adolescent girls in South Asia is too thin and one in five was stunted during her childhood due to inadequate nutrition⁸. While there is an emerging body of evidence on the impact of child marriage, adolescent nutrition and education on adolescent pregnancy and maternal and infant deaths and disability, this evidence rarely translates into adolescent-sensitive health programmes and budgets. Neither does new information on sexual abuse and sexual exploitation of adolescents and its health consequences taken into account.

Globally, about 19–20 million abortions are done by individuals without the requisite skills, or in environments below minimum medical standards annually. Nearly all unsafe abortions (97%) are in developing countries, leading to the deaths of 68,000 women and the development of permanent complications among millions of women. More than a third of these deaths occur in South Asia, where it is estimated that 37% of all maternal deaths are attributed to unsafe abortion. Between 10–50 per cent of women who undergo unsafe abortion in the region need medical care for complications, which contribute to approximately 29,000 deaths per year⁹. Leading causes of death include haemorrhage, infection, and poisoning¹⁰. Legalisation of abortion on request is a necessary but insufficient step toward improving women's health, especially when effective infrastructure, coordination processes, personnel, ancillary services and adequate budget are not in place. In India, for instance, access to competent care remains restricted because of other barriers¹¹.

In addition, multiple levels of discrimination and marginalisation are experienced more by women and adolescent girls in South

Asia within communities where the maternal mortality rates are highest. These communities are typically those below poverty line, where access to education is limited, where under-nutrition is common, and where issues around access to land and food security are ongoing. Such situations can be aggravated by the growing trend of privatisation in overtaking social services including health care. This means that there will be more out-of-pocket instances, which are usually experienced by the poor. Ultimately, this will amount to a denial not only of the basic right to health but also social and economic rights of the poor.

According to the 2009 Human Rights Council resolution these **high rates of maternal mortality and morbidity are unacceptable and preventable. Maternal mortality and morbidity is a matter of human rights**. At its core are one's right to health and life, that one's access to resources - including benefits from scientific progress - which can ensure a healthy and dignified living must be informed by equality and non-discrimination. Ensuring a **Continuum of Quality Care (CQC)** across a woman's lifecycle - from preconception to pregnancy to post partum/ post-abortion to menopause - and across various locations -home, community and health facilities - is important to reduce adolescent, maternal, newborn and child mortality and morbidity and improve women's reproductive health.

Quality of care can be defined as the "ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/well-being for the whole population"¹². Dimensions of quality of care can be reduced to two key questions: Can an individual get the care they need when they need it? And when they get care, is it effective and acceptable both in terms of clinical effectiveness and interpersonal relationships?¹³. Quality of care thus adds value to the casual understanding of the right to health.

Women and adolescent girls have the right to quality available, accessible, affordable, appropriate and acceptable services to help them plan and space their pregnancies and to avoid or address sexually transmitted diseases (STDs). If women and adolescents girls experience complications or illness at any point, continuity of quality care from household to hospital, with referral and timely emergency management, is crucial¹⁴.

This publication aims to reflect the context specific realities in four South Asian countries Bangladesh, Nepal, India and Pakistan towards affirming a rights based continuum of quality care

approach. It is divided into five main sections. The first section articulates WHRAP-South Asia's advocacy position providing a regional perspective and key recommendations for policymakers across the region. This is followed by four country papers each documenting evidence from the ground to support WHRAP-South Asia's regional position and providing key recommendations to policy makers.

The paper on Bangladesh by Naripokkho highlights the gap in the national health information system in Bangladesh in documenting maternal deaths and their causes. The authors claim that this under reporting of maternal deaths indicates both a violation of rights and a weak accountability system that cannot guarantee continuum of quality care for women's reproductive health in the country. Addressing this gap requires institutionalisation of a maternal death surveillance and review mechanism along with a number of policy and program implementation changes.

Abortion in Nepal was legalised in 2002. As a consequence of a number of progressive reproductive health policy initiatives and the pro-abortion law Nepal may be able to meet many of its MDG targets. However Beyond Beijing Committee (BBC) highlights the issue of policy implementation and public awareness about the law. Legalisation has not reduced the stigma of abortion and years after legalization only one in three women in Nepal is aware that abortion is legal¹⁵ and only one in two women know a place where the procedure is performed¹⁶. This is reflected in experiences in BBCs field sites where public service provision is extremely limited for both comprehensive abortion care and post abortion care and many women prefer to go to private providers or across the border if they can afford it.

CHETNA and SAHAYOG's paper on India highlights the need for independent maternal death reviews with community involvement where the national figures hide state specific reproductive health rights violations. They demonstrate through civil society collected data across several states the gap in service delivery and quality of care, and how many avoidable maternal deaths are the result of a lack of continuum of quality care in the country.

Pakistan has recently voted in a new government and is grappling with the 18th Amendment to the Constitution which has led to the devolution of the Ministries of Population Welfare and Health to the provinces in 2010. Shirkat Gah's paper highlights the dilemma of devolving a sick health care system which has resulted in extremely poor reproductive health outcomes for marginalised women. The authors raise the question of how to ensure continuum of quality care when poverty is increasing, violence against women is a major threat to reproductive health and rights, where threats to health workers by fundamentalists are frequent and where maternal mortality rates although dropping are still significantly high.

To conclude this publication aims to articulate WHRAP-South Asia's rights-based continuum of quality care framework for women's reproductive health. The work is supported by evidence from the ground from all partners in the sub-region and is informed by the experience of marginalized women who wish to seek access to non-discriminatory, affordable, appropriate and timely intervention for their sexual and reproductive health concerns.

Endnotes

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WOMEN'S REPRODUCTIVE HEALTH IN SOUTH ASIA: Calling for a Rights Based Continuum of Quality Care Approach

Shama Dossa (ARROW)

1. Introduction: Fulfilling MDG 5

A 2009 Human Rights Council resolution affirmed that **high rates of maternal mortality and morbidity are unacceptable and preventable and that maternal mortality and morbidity is a human rights issue**. The present rates of maternal mortality signify a violation of the rights to life, equality and non-discrimination, benefits from scientific progress, and the highest attainable standard of health, including sexual and reproductive health. The South Asian sub-region accounts for a substantial part of **preventable maternal deaths** in the world. Maternal mortality estimates remain high particularly in Bangladesh, India, Nepal and Pakistan. The maternal mortality ratio (MMR) of Bangladesh stands at 194¹, India 212², Nepal 281³, and Pakistan 276⁴. As many countries in South Asia do not have a reliable registration system for births and deaths, MMR estimates can be significantly higher. The national figures for MMR also do not capture the large inter-state and regional variations within these countries.

Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions which begin in youth⁵. Maternal mortality in girls under eighteen is estimated to be two to five times higher than in women between the ages of 18 and 25⁶. Nearly one in four people living in South

Asia is an adolescent or a child between the ages of 10 and 19⁷. One in four adolescent girls in South Asia is too thin and one in five was stunted during her childhood due to inadequate nutrition⁸. While there is an emerging body of evidence on the impact of child marriage, adolescent nutrition and education on adolescent pregnancy and maternal and infant deaths and disability, this evidence rarely translates into adolescent-sensitive health programmes and budgets. Neither does new information on sexual abuse and sexual exploitation of adolescents and its health consequences take this into account.

Not all adolescent girls experience risks equally. Poverty, caste, culture, ethnicity and geography create widespread inequities in the region. They are experienced differently across and within genders and ages. These and other factors contribute to the unacceptably high rates of maternal, child and infant mortality rates, as well as pronounced socioeconomic and gender disparities in South Asia.

Globally, about 19–20 million abortions are done by individuals without the requisite skills, or in environments below minimum medical standards annually. Nearly all unsafe abortions (97%) are in developing countries, leading to the deaths of 68,000 women and the development of permanent complications among millions of women. More than a third of these deaths occur in

South Asia, where it is estimated that 37% of all maternal deaths are attributed to unsafe abortion. Between 10-50 per cent of women who undergo unsafe abortion in the region need medical care for complications, which contribute to approximately 29,000 deaths per year⁹. Leading causes of death include haemorrhage, infection, and poisoning¹⁰. Legalisation of abortion on request is a necessary but insufficient step toward improving women's health, especially when effective infrastructure, coordination processes, personnel, ancillary services and adequate budget are not in place. In India, for instance, access to competent care remains restricted because of some of these barriers¹¹.

It is estimated that 37% of all maternal deaths result from unsafe abortion. Between 10-50% of women who undergo unsafe abortion in South Asia need medical care for complications, resulting in approximately 29,000 deaths per year¹². The lifetime risk of maternal death in Bangladesh is 1 in 110, India 1 in 140, Nepal 1 in 80 and Pakistan 1 in 93¹³. According to WHO and UNICEF reasons for maternal deaths in South Asia during 1997-2007 by percentage include hemorrhage 35%, hypertension 17%, indirect causes 19%, other direct causes 19%, embolism 1%, sepsis 7%¹⁴. Presently 80 percent of the population in these four countries still lives in rural areas without safe delivery services. Most countries cannot meet the minimum threshold of 23 physicians, nurses, and midwives per 10,000 people that was established by WHO as necessary to deliver essential health services¹⁵.

The past decade has seen a major emphasis on maternal, newborn, and child mortality with the Millennium Development Goals (MDGs). MDG Goal 5 targets the reduction of MMR by three-quarters and provision for universal access to reproductive health by 2015. But with two years left before 2015, South Asia is nowhere near the target indicators for maternal health interventions such as skilled birth attendance, antenatal care, and family planning. The contraceptive prevalence rate although improving shows that much needs to be done to reach targets A and B for MDG 5¹⁶.

2. Continuum of Care in Context

Continuum of care has recently been highlighted as a core principle of programmes for reproductive, maternal, adolescent, newborn, and child health. It is seen as a mechanism which can reduce the burden of half a million maternal deaths¹⁷. Continuum for care refers to the continuity of care that is necessary throughout one's life-cycle - adolescence, preconception, pregnancy, childbirth, the postnatal period, and childhood - regardless of location. Care can be given in households and communities, through outpatient and outreach services, and various public health institutions¹⁸. Every year 50 million women deliver at home. In developing countries most cases of mortality and morbidity happen at home due to delays in reaching the nearest health care facility¹⁹.

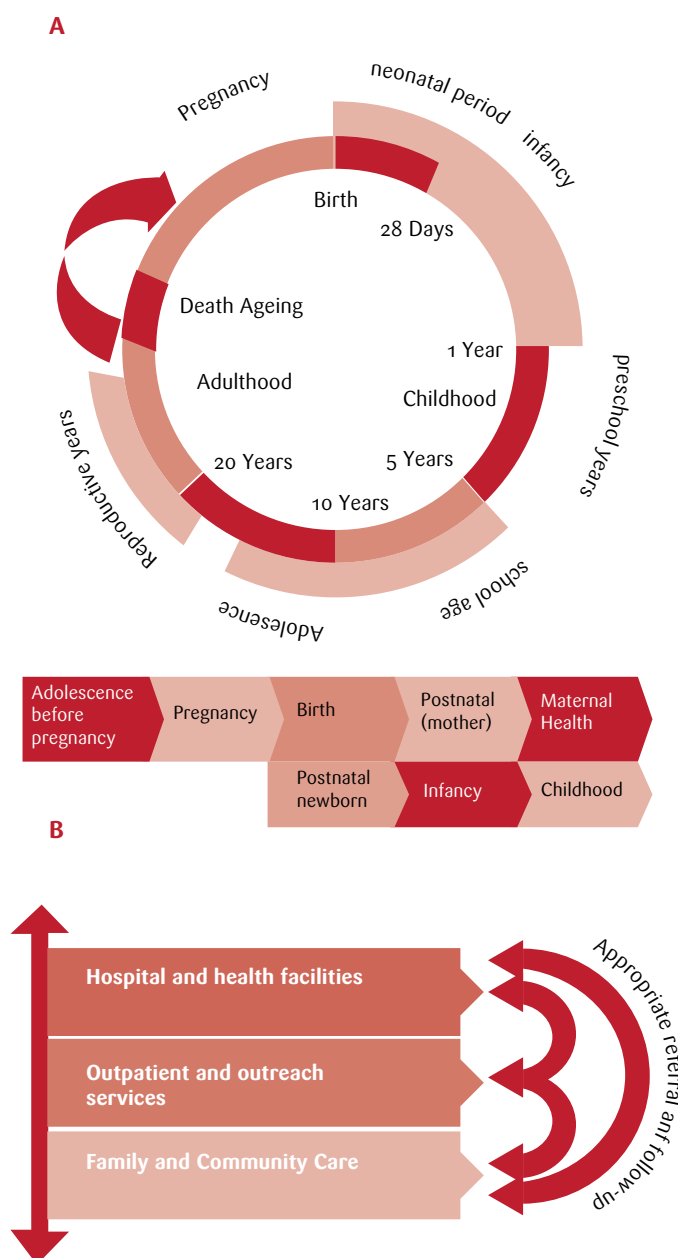


Figure 1: Continuum of Care

Connecting care during the lifecycle (A) and at places of caregiving (B).
Adapted from PMNCH and Kerber (2007, p. 1360)

The continuum of care over time includes care before pregnancy such as family-planning services, education, and empowerment for adolescent girls; during pregnancy and immediately after delivery; after pregnancy when complications may arise for both mother and child as well as the onset of menopause (ref. to Fig 1

drawn from Kerber et al 2007, p. 1360). Those who are pregnant require antenatal care that is linked to safe childbirth care. Both mothers and babies need postnatal care during the crucial first six weeks after birth. During childbirth and the days immediately afterwards, mothers and babies are at the highest risk of death and illness. In fact, over half of all maternal and neonatal deaths occur during this period. Postnatal care needs are also linked to family-planning services. It is their right to have access to education and services for nutritional, sexual, and reproductive health.

Continuum of care also accounts for the need to address the impact of long distances and travelling time from one point of service to another, financial constraints, poor communication and transport, weak referral links, and at times, low-quality care in health facilities²⁰. A comprehensive context-specific continuum of quality care package would ensure that appropriate care is available wherever and whenever it is needed and linked, where necessary, to other levels of care²¹.

There are a number of international initiatives which focus on continuum of care and which are relevant to the South Asia. These include the “**Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health: A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH)**” produced by the Partnership for Maternal, Newborn and Child Health (PMNCH) in 2011 and the 2010 UNICEF framework, “**A continuum of care for adolescent girls in South Asia: defining the issues, synthesizing evidence, and working towards a policy agenda**”^{22,23}. The PMNCH framework takes a primary health care approach as it articulates the issue of unsafe abortion, which can be remedied effectively remedied by a context-specific continuum of care. Meanwhile, the UNICEF framework includes the special needs of adolescent girls. This framework presents data from Nepal and Bangladesh and at the same time identifies key strategies and recommendations which are relevant to South Asian adolescent girls. These promising frameworks must be monitored and implemented. We also urge governments to consider our own recommendations towards a rights-based comprehensive continuum of quality care.

3. WHRAP-SA's Position on a Rights-Based Continuum of Quality Care in Bangladesh, Nepal, India and Pakistan

a) Why will a focus on delivery by Skilled Birth Attendants alone not reduce Maternal Mortality?

While the deployment of skilled birth attendants can help prevent maternal mortality, this modality is not always the ideal strategy for a continuum of care. Moreover, it may not be realistic for South Asia. Instead the region can have a continuum of care approach by building on its own resources such as the traditional

birth attendants who can fill in the gap between the patients who are poor and far from health facilities.

Continuum of care is the basis of healthcare in many wealthy countries, especially those with government-funded health-care systems with near universal coverage. The countries which rank as the ten best in terms of maternal health indicators all have an effective continuum of care for the health of mothers, neonates, and children²⁴. **However a continuum of care framework in the context of South Asian countries such as Bangladesh, Nepal, India and Pakistan must differ from the ones promoted in wealthier countries with strong well funded health systems; infrastructure and sufficient healthcare providers to meet population needs are present.**

Such a framework in our context requires consideration of the ground realities; acknowledging shortages in human and financial resources; and the inadequate health-system infrastructure, where care is neither continuous nor integrated. A skilled attendant, according to WHO, refers to “an accredited health professional-such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.”²⁵

Traditional Birth Attendants (TBA) either trained or untrained are excluded from this definition of skilled health workers. Due to these shifts in understanding there continues to be lack of clarity on what constitutes a skilled birth attendant in many countries. It appears that due to the push to meet this target, home deliveries are being forgotten.

In addition, the target of having 90 per cent of births in low and middle income countries to be assisted by skilled birth attendant (SBA) by 2015 is not realistic in South Asia²⁶. In fact, it is estimated that the deployment of SBA will remain limited to 50 per cent, with 90 per cent of the unattended births taking place in rural areas. This important finding substantiates WHRAP-SA claim that there is a need to pay attention to policies that will prevent deaths among women who give birth unattended and which affirms a continuum of care framework²⁷.

In the context of the four countries, Bangladesh, Nepal, India and Pakistan, home deliveries are a reality despite the increase in institutional deliveries. In Bangladesh in 2007, only 18 per cent of women were reported delivering with professional care and 15 per cent of these took place in facilities²⁸. Use-rates of skilled birth attendants in rural areas have increased from six per cent from 1991-1993 to 13 per cent in 2005-2007. Rates in urban areas have risen to 37 per cent in 2005-2007, from a plateau at about 30 per cent between 1991-1993²⁹.

Meanwhile, India's 2009 survey shows an increasing trend of institutional deliveries. Data from the survey claims that

as of 2010, 73 per cent of deliveries took place in institution. However in probing into these statistics, it appears that there is a significant variation by state. For example institutional deliveries were as low as 45 per cent in Chattisgar and 48 per cent in Bihar and as high as 99.9 per cent in Kerala and 99.8 per cent in Goa³⁰. Evidence therefore suggests that strategies to meet the MDG goal of having 80 percent skilled birth attendants have not been extremely successful.

In addition, a qualitative study in Rajasthan reveals that in a majority of deliveries, especially at home, the role of the visiting modern care provider such as the skilled birth attendant can be largely restricted to giving injections or IV drips during labour. Thus, even in the presence of a professionally-qualified birth attendant, women and newborns are bound to be subjected to a range of “unskilled” practices in both homes and facilities³¹ therefore challenging the utility and appropriateness of this MDG indicator itself.

In Nepal, more than 80 per cent of women give birth at home without the presence of a health professional who can recognise and manage complications³². In rural areas, the proportion of institutional deliveries is as low as 4 per cent³³.

Moreover, according to NFHS-3, more than half the births in India take place at the woman's own home and nine per cent at a parent's home³⁴. In Pakistan, nearly half of women in small urban areas reported that dais (traditional birth attendants lacking formal health training) assisted them in home deliveries³⁵.

Given the MDG target, there has been a large push for governments to train SBA as defined by WHO to manage deliveries and for women to opt for institutional deliveries. For example in 2005, Nepal introduced an innovative financing scheme, known as the Safe Delivery Incentive Programme (SDIP), as part of its strategy to increase the use of maternity services. The SDIP provides cash to women who deliver in a health facility and an incentive to health workers for attending deliveries³⁶.

Pakistan and Bangladesh have also been experimenting with similar voucher and cash transfer schemes, moving away from previous strategies of training traditional birth attendants^{37,38}. Some outcomes of these national policies and the challenges in their implementations are outlined below.

The debate on facility based-versus community-based care for improving women's and children's health perpetuates a false dichotomy. The **correct balance really depends on local contexts**. A better knowledge of the local context would thus help national policy makers to find the right balance between investing in formal facilities or in community-based MNCH approaches³⁹. This approach is substantiated by Bhutta et al 2008⁴⁰, based on their review of multiple intervention studies in developing countries. District health services need to consider

carefully the gains from developing a cadre of community health workers versus alternative approaches.

In circumstances where the primary care health system is reasonably functional and care-seeking is the norm, strengthening of facility-based health services, incentives and support (such as transport) to encourage use is likely to be more cost effective than the development of a new cadre of workers. In other instances, making the most of existing opportunities for delivering interventions through existing health workers and contacts should be a priority. However, in populations with very low coverage, a cadre of community health workers working in tandem with facility-based health staff (both public and private), may be the most effective way to reach families and households in greatest need.

There is now evidence proving that a large proportion of newborn death and disease can be reduced by implementing simple, low-cost interventions during delivery and in the vulnerable days and week post-partum, both in the facility and at home⁴¹. The majority of essential interventions are home care practices that families can provide themselves. Families can also tap the community health worker (CHW) who could be present at delivery to care for the newborn and/or visit within the first 24 hours and again, one to two additional times during the first week.

Chaudhary and Chowdhury (2008)⁴² argue that in a context where there is a shortage of skilled birth attendants, doctors and nurses, a strategy of using trained traditional birth attendants for service delivery is a viable option. Drawing on the Gonoshasthya Kendra (GK) model in Bangladesh, they claim that it is possible to upscale the model to the national level. This would entail the training of grassroots-level health and family welfare workers (family welfare assistants, sub-assistant community medical officers and health assistants) in basic health for six months and improving the skills of traditional birth attendants in pregnancy management through continuing in-service training, linked with the existing reproductive-health-care systems. An analysis of the GK model clearly shows that over 80 per cent of births are being delivered safely by trained birth attendants at home in GK villages. This clearly indicates that much can be achieved in the absence of skilled birth attendants or doctors in rural settings if well-trained low-cost traditional birth attendants are available⁴³.

WHRAP-SA Position

WHRAP-SA calls for the safe delivery for all births that take place at home and in institutions supported by an effective referral system including EMOc. The MDG era has seen a vertical approach in policy-making and budgeting to address issues of maternal mortality and morbidity. Consequently there has been a shift towards a focus on “delivery” as opposed to a more holistic focus on the situation of women/adolescent girls before and after childbirth/ abortion.

This myopic approach has led to an increased focus on institutional delivery rather than on safe delivery. Due to the shortfall in health budgets and skilled health personnel as well as the lack of strong health systems, a singular focus on institutional delivery cannot ensure comprehensive maternal health. SBAs are unable to provide coverage for all births which do not all take place in institutions.

Therefore what the current situation requires is the implementation of a context specific rights based framework for continuum of quality care for reproductive health across a woman's life cycle (preconception to post partum/ post-abortion) and across locations (home, community and health facilities). This must be considered by governments and donors in South Asia to reduce maternal mortality and morbidity. This includes a reorientation of continuum of care strategies which acknowledge the role of trained TBAs.

b) Why is the inclusion of Adolescent girls as well as a consideration for their nutrition important in a rights-based Continuum of Quality Care framework?

Nearly one in four people living in South Asia is an adolescent, defined by the UN as a child between the ages of 10 and 19⁴⁴. In a region with unacceptably high maternal mortality, however, nearly one in two South Asian women aged 20-24 was married before her 18th birthday and nearly one in three adolescent girls is either pregnant or already a mother⁴⁵. One in four adolescent girls in South Asia is too thin and one in five was stunted during her childhood due to inadequate nutrition⁴⁶. Despite rapidly improving education systems, more than half of adolescent girls miss school regularly during their menstrual periods because of social norms and the lack appropriate sanitation facilities in their schools⁴⁷. Not all adolescent girls equally face risks.

Poverty, caste, culture, ethnicity and geography create widespread inequities in South Asia that can be experienced with varying intensity during adolescence. These and other factors contribute to the unacceptably high rates of maternal, child and infant mortality rates, as well as pronounced socio-economic and gender disparities in South Asia. Nepal alone loses an estimated 10,000 adolescent girls a year to trafficking, mostly to brothels in India⁴⁸. Fourteen per cent of girls in Nepal and 11 per cent in Bangladesh are married before the age of 15, despite laws in both countries that prohibit marriage until after a girl's 18th birthday⁴⁹. Meanwhile, thirteen per cent of girls aged five-14 years are engaged in child labour in South Asia.

Although reliable numbers concerning sexual exploitation and sexual abuse of adolescent girls are a major challenge, it is likely that numbers are in the millions. Apart from the trauma and missed opportunity for schooling, adolescent girl survivors are exposed to the risk of sexually transmitted infections, HIV and unwanted pregnancy as well physical injury and threats. Given the stigma attached to these illnesses and conditions, survivors

often do not report any abnormal health experience.

While there is an emerging body of evidence about the impact of child marriage, adolescent nutrition and education on adolescent pregnancy and maternal and infant deaths and disability, this evidence rarely translates into adolescent-sensitive health programmes and budgets. Neither does new information on sexual abuse and sexual exploitation of adolescents and its health consequences, which are a major concern for all countries in South Asia. In most countries, surveys and planning documents group adolescent girls and young women to women of reproductive age, meaning, 15 to 49 years. Their health needs are consequently expressed as relating to their potential to bear children or spread sexually transmitted infections, rather than their own inherent rights as children, and later as women⁵⁰. Adolescents are likewise prone to anemia whose prevalence in more than 10 per cent of the population is considered a public health emergency. Evidence from micro-studies reveals anemia among the adolescents is disproportionately high in South Asian and other developing countries.

The prevalence of anemia can be traced to malnutrition due to poverty but it can be aggravated by discriminatory cultural practices towards adolescent girls. In South Asia, girls receive less food of lower quality. This was true in the field observation of a CHETNA team in rural India where a girl's food consumption is informed by fear that they will grow too fast and will be married off early by parents in need of dowry⁵¹.

Anemia is a particular concern for girls because during pregnancy, it is associated with premature births, low birth weight, and peri-natal and maternal mortality. Anemia is one of the primary contributors to maternal mortality (20-25%) and is significantly associated with a compromised pubertal growth spurt and cognitive development among girls aged 10-19 years in South Asia. Overall, 60% of South Asian women of childbearing age are underweight and malnourished⁵².

In pursuing to achieve MDG5, the reduction of socio-economic inequities should be viewed as a key challenge that policies and programmes must address. Greater focus is needed on implementation and evaluation of interventions that are efficient especially for the poor⁵³. Inadequate nutrition and its outcomes are related to food security issues which include food availability, distribution, quality and cost as well as women's knowledge of nutrition. Food availability in South Asia is also linked with the cost of food based on agricultural policies and trade mechanisms. Hence, in many developing countries of South Asia issues related to food and nutrition need to be included in a COC strategy.

WHRAP-SA Position

Adolescence is an extremely critical period in a woman's life cycle. Adolescent girls must be recognised as a group

with special needs in relation to their health, nutrition and empowerment (decision-making, leadership & self esteem) in continuum of care strategies/ frameworks.

CoC frameworks should not consider the needs of adolescent girls based on their potential reproductive roles alone. Instead, these must be based on the potentials which adolescent girls see for themselves. Therefore, we urge that a special focus be given to out of school adolescent girls.

Adolescent girls have a right to information about their bodies and means of protecting them. Hence we urge policy makers to mandate comprehensive reproductive health education for in-school and out-of-school adolescent girls. Given the current nutritional statistics, supplementary nutrition programmes need to be part of CoC strategies in South Asia with adequate budget allocations for this purpose.

We also suggest that since the mandate for adolescent girls continuum of quality care be shared by multiple government departments, an integrated approach must be ensured in implementing CoC strategies.

c) Why are issues of equity and non-discrimination important in the implementation of a rights based Continuum of Quality Care Framework?

Quality of care can be defined as the “ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/well-being for the whole population”⁵⁴.

Dimensions of quality of care can be reduced to two questions: a) can an individual get the care one needs when and where one needs it? (i.e. is the care accessible? Affordable?) b) when they get care, is it effective and acceptable both in terms of clinical effectiveness and interpersonal relationships?⁵⁵ Inequity in health refers to inequalities that are unjust according to social-justice theories. Inequities in maternal death and access to maternal services exist everywhere, both between and within countries. Increasing the supply of quality services seems important but it is not sufficient to improve access⁵⁶

Evidence from all four countries reflects that care is neither accessible nor is it equitable. A review of DHS data by Motague et al (2011)⁵⁷ similarly reveals that home births are most common among the poor. Half of these births were unattended even by a TBA. Meanwhile, women in the upper income quintile are more likely to give birth in a private health facility. These findings are further substantiated by country-specific data. For example only 13 per cent of the lowest income quintile in India delivers their babies in a hospital, even though all services are free for them. While many women feel that institutional delivery was not necessary, a quarter interviewed expressed that they could not afford to deliver in a health facility (International Institute for Population Science NFHS 3, 2007 in Devadasan, Elias et al 2008)⁵⁸. For example the DLHS-3 data from India reveals that

the rural-urban gap for safe deliveries remains wide as ever in the northern Indian states⁵⁹. Similarly in Pakistan, 38 per cent of women who did not have their last birth in a health facility cite the high cost of care as the reason for not doing so⁶⁰.

A study on delivery cost and the patients' willingness to pay in 9 districts in Nepal found that **not only were the costs of facility-based delivery considerable but, unlike home delivery, they varied considerably**⁶¹. Variation in costs was greatest for transport and additional items. Furthermore, **households face considerable uncertainty regarding the total amount of money they would likely to need, due to the uncertainty of clinical need. Health facilities tend not to publish tariffs**. None of the facilities examined provided package services with a standard price for the entire episode of care. There is also little consistency in pricing among pharmacies.

The willingness-to-pay survey indicated that **most women (56%) preferred to give birth at home, in the absence of complications**. The main reasons given were: the low cost and flexible payment mechanism allowed by informal attendants, no need to travel, and the familiarity of attendants with the home environment⁶². In the same study a third of all women preferred to deliver at a comprehensive obstetric facility. Safety and staff experience were highlighted as the main reasons for this preference. It is important to note that out of the women who cited these preferences, 34 per cent were from the highest wealth quintile, compared to only eight per cent from the lowest⁶³.

In an impact evaluation study of the cash transfer scheme in Makhwanpur district in Nepal claims that the implementation of the programme has led to a substantial increase in accessing maternity services and skilled attendants at delivery. However the cash incentive has reached disproportionately wealthier families. The study asserts that the Safe Delivery Incentive Programme (SDIP) **offers little protection against catastrophic payments** (representing over 10% of their total income)⁶⁴.

In the case of Bangladesh, studies show that a major constraint to the use of maternal healthcare is the cost of delivery, the fear of costs (especially for a complicated delivery), and the inability to find money when needed⁶⁵. Findings from evaluation of two home-based SBA programs in Bangladesh reveal that inequities in service utilization by income quintile and mother's education are substantial. **Although national figures may reflect an increase in deliveries by SBAs and MDG targets could be met, this does not mean the needs of the poorest are being met**⁶⁶. In fact it is not just the poor who face the double burden of poverty and ill health, the financial burden of ill health can even push the non-poor into poverty.

It is not only the gaps in the strategy itself that need to be considered but the **ability of national policy makers to implement the policy into practice**. For example, in the case

of Pakistan, the 1999 Reproductive Health Service Package emphasized maternal health care through the language of safe motherhood, pre/post abortion care and EmOC. However, overall progress has been slow due to poor implementation, governance issues and human resource constraints. It is marked principally by the inability to ensure delivery of quality obstetric services and the lack of evidence to support policy and programs⁶⁷. This is also reflected in the case of India where a study of the Janani Suraksha Yojana (JSY) cash transfer scheme in four Indian states showed that although institutional deliveries had increased, poor women were not aware of the programme. The documentation processes had become very cumbersome that there was a considerable delay before women could claim their cash benefit. Some women also mentioned that they received only partial amounts - the rest being pocketed by the health staff⁶⁸. Anecdotal evidence suggests that the quality of care has suffered in institutions because of the inability of the staff to absorb an increasing number of deliveries⁶⁹.

A evaluation study of the program in the state of Orissa found that the "manifold increase in the institutional deliveries, quality of care has become an issue, for instance, women were discharged on average, 16 hours after normal delivery and there were instances of being discharged even within 3-4 hours after delivery. This is risky to the life of both mother and the newborn and would not serve the purpose of reducing maternal and neonatal mortality"⁷⁰. Mothers tend to be in institutions less than a day in most cases and that quality of care needs to improve in a large proportion of the health facilities.

According to Berer (2010)⁷¹ the continuing recourse to home deliveries with a TBA among women who say they would deliver in a facility if they could, or who reject going to a clinic or hospital because the conditions are so poor, is an important example of the failure of both the public and private formal sectors to make delivery and post-partum services, let alone emergency obstetric care, accessible and affordable in the world's poorest countries. Unless the health system is able to ensure good quality care translating into continued and sustained use of maternal health services throughout the country, achievement of MDG-5 goal will likely remain out of reach for a long time⁷².

WHRAP-SA Position

In South Asia, social determinants such as poverty, educational status, food and nutrition, water and sanitation affect health outcomes. Caste, class, religion, gender-based inequalities, disability and geographical location further exacerbate the condition and adversely impact the health of women, children and young people. In addition, geographical terrain also limits access to health services. We argue that there are no shortcuts to achieving equitable access to good quality comprehensive reproductive health services. We urge that policy makers take a rights-based approach that incorporates equitable and non-

discriminatory access to continuum of quality care.

This requires an acknowledgment of the context-specific needs of these vulnerable groups; specific resource allocations (budget; human resources; infrastructure); and the development of context-specific implementation models for continuum of quality care that meet the needs of these groups.

d) Why are issues of accountability and good governance important in implementation of a rights-based Continuum of Quality Care Framework?

National governments are accountable to fulfil their obligations and commitments as signatories to CEDAW; ICPD Plan of Action; Beijing Platform of Action and the Human Rights Council's 2009 Resolution which states that **high rates of maternal mortality and morbidity are unacceptable and preventable maternal mortality and morbidity is a human rights issue** in addition to their own constitutional obligations to ensure the right to health. In addition, the state as a duty bearer must fulfill its obligations to its tax payers therefore it must provide health care services for all with a set of minimum standards. National budgetary expenditure needs to be reviewed within this context. A review of recent budgetary allocation for healthcare in Bangladesh, India and Pakistan reveal the paucity of resources allocated to health care. The budgetary allocation for the health sector in Bangladesh for the fiscal year 2011-12 is Tk 8,889 crore (including development and non-development budget), which is 5.43 per cent of the total budget⁷³. In the case of Pakistan, its health expenditure used to be around three per cent of the GDP in 2000 but fell to 2.7 per cent in 2007, with donors funding 3.5 per cent of total health expenditure⁷⁴. Public expenditures on healthcare in India are about Rs 310 billion or nearly seven per cent of GDP⁷⁵. **The rest is all made up from out-of-pocket financing.**

Out of Pocket or self-financing is the largest source of healthcare financing in South Asia. This has been **both regressive and inequitable**, especially for poorer households at the threshold of subsistence⁷⁶. Furthermore, a very large proportion of this financing does not come from current incomes but from debt and the sale of assets.

Out-of-pocket expenditure by households accounted for 70 per cent of total health expenditure in 2007 in Pakistan. Latest estimates based on national accounts statistics (Central Statistical Organisation, 2004) indicate that private expenditures on healthcare in India are about Rs 1,650 billion, of which 99 per cent is out-of-pocket. Nearly half the bottom two quintiles get into debt and/or sell assets, in contrast to one-third of the top quintile⁷⁷.

Unfortunately out-of-pocket expenditures are likely to become more frequent with the increasing trend towards privatisation. Many governments have already reneged from

their responsibility to provide and maintain public services, including for health⁷⁸. **Privatisation in healthcare according to Ravindran (2010) “refers not to the existence of a private sector in health, which is a universal phenomenon. It refers to deliberate interventions through policies and funding support to expand private sector provision of health care services; to introduce or expand private financing of health care (e.g. out-of-pocket expenditure, private insurance) and other market mechanisms within public sector health services; and to the gradual withdrawal of the state from taking responsibility for universal access to health care services.”⁷⁹.**

Privatisation could happen in one or more of government sectors including financing, service delivery, capacity-building, management and investment. Privatisation, then, is about governments handing over responsibility for the health of the people of their country to a whole range of different organisations and agencies, who may or may not work together, and who may or may not agree to and then implement a common plan to achieve a set of coherent, comprehensive public health goals and universal coverage. Rather, by definition, as private entities, these organisations and agencies are more interested to develop their own “market segment” and serve “their clients”⁸⁰.

According to Berer (2010) part of the **problem is that countries have not invested enough money in their people**. Added to this is the reduction of what is already inadequate domestic health expenditure when external aid and loans are provided. Accepting foreign loans and aid leads to additional problems such as external funders exercising control over a country's policies and practice and massive deficits when aid is reduced or revoked. There has also been a tendency to delegate responsibility to local governments for health care funding⁸¹.

It is important to challenge the assumption that privatisation is the panacea for improving quality and accessibility of healthcare. A recent study of three large-scale privatisation initiatives in service delivery, management and capacity building functions in the health sector reveal that privatisation in Pakistan's health sector is not delivering good quality, comprehensive reproductive health services⁸².

Instead, privatisation has created a limited range of fragmented services of often sub-optimal quality, available mainly to urban dwellers, and giving poor returns in terms of women's reproductive health needs⁸³. We therefore argue that ...it is not possible to tinker with and improve a limited section of the health system while leaving unaddressed deep-rooted systemic malaise, including: issues of staffing and remuneration; availability of equipment and supplies; and lack of coordination between health programmes, different tiers of health facilities and different government departments. These pose major hurdles to making health facilities functional at any level, irrespective of who runs them”⁸⁴.

WHRAP-SA Position

Health is a basic fundamental right of people and all governments in South Asia have ratified major conventions and are signatories to Plans of Actions (ICPD, BPFA, MDGs, CEDAW etc) which oblige them to ensure the right to health of their people, and in particular women's reproductive rights. The Human Rights Council's 2009 Resolution also states that **high rates of maternal mortality and morbidity are unacceptable and preventable and that maternal mortality and morbidity are human rights issues**.

In addition the state as a duty bearer must fulfill its obligations to its tax payers by providing health care services for all with a set of minimum standards and ensure accountability of the health system (public and private). We urge that states fulfill these obligations in their implementation of a continuum of quality care frameworks/strategies for reproductive health. We further urge that they all provide mechanisms for grievance and redress in cases where these health rights have been violated.

Although there have been improvements in maternal mortality indicators, the increasing trend towards privatisation has led to increased exclusion of marginalised groups from access to continuum of quality reproductive health care. The state in its stewardship role must regulate the entire private sector (formal and informal) to ensure that the right to health of its people is not violated. Further, it is essential that the hidden costs of services at government facilities are minimized if not eliminated so that women and adolescent girls can gain better access to quality services.

Conclusion

According to the 2009 Human Rights Council resolution these **high rates of maternal mortality and morbidity are unacceptable and preventable; and maternal mortality and morbidity according to the Council is a human rights issue**. It affects women's and girls' rights to life, health, equality and non-discrimination, the right to benefit from scientific progress, and the right to the highest attainable standard of health, including sexual and reproductive health. Ensuring Continuum of Quality Care (CQC) across a woman's lifecycle (preconception to pregnancy, post partum/ post-abortion and menopause) and across locations (home, community and health facilities) is important to reduce adolescent, maternal, newborn and child mortality and improve women's reproductive health.

Women and adolescent girls have the right to quality services to help them plan and space their pregnancies and to avoid or treat sexually transmitted infections. If women, babies, children, or adolescents girls experience complications or illness at any point, continuity of quality care from household to hospital, with referral and timely emergency management, is crucial⁸⁵.

We believe that what is required is a comprehensive approach that will ensure access to information and quality care at all stages of a woman's lifecycle and across location (home, community and health facilities), given the difficulties faced by marginalised women in accessing affordable skilled care in South Asia. Consequently a continuum of quality care framework must call for availability and access to essential quality health and reproductive services that should be affordable and acceptable for women from adolescence through pregnancy, delivery, and beyond; as well as for newborns and children.

*We feel that there are a number of international initiatives which focus continuum of care in the South Asian context such as the recent framework published by PMNCH (2011) **Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health: A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health (RMNCH)**, and the 2010 UNICEF framework titled **"A continuum of care for adolescent girls in South Asia: defining the issues, synthesizing evidence, and working towards a policy agenda"**. The PMNCH framework is important because it takes a primary health care approach; it acknowledges and clearly articulates the issue of unsafe abortion and suggests that the approach to continuum of care needs to be designed based on context specific needs. The UNICEF proposed framework is also significant because most continuum of care frameworks do not acknowledge or articulate the special needs of adolescent girls. This framework not only presents data from Nepal and Bangladesh but also identifies key strategies/recommendations for Continuum of Care with a focus on South Asian adolescent girls. We also advocate for monitoring the implementation of these recommendations in the region in tandem with implementation of our recommendations to comprehensive continuum of quality care to policy makers as articulated below.*

Recommendations for Continuum of Quality Care (CQC) Services

- All pregnant women at any time during pregnancy, delivery or postpartum must have access to Emergency Obstetric Care (EMoC), a package of critical health services which when provided immediately and competently can save women's lives.¹
- Pre and post delivery services must be included in the public health system package. Caring for women only at the time of child birth does not account for complications which may emerge later and which may put women's lives at risk.
- TBA training must be re-established to supplement SBA programmes.
- Role of Trained Traditional Birth Attendants (TTBA) must be extended to delivery in places where there is a poor and partially functional health system.

- SBA training must include modules on SRHR in line with ICPD and CEDAW commitments. This training must also be extended to include alternative medicine practices which proved to be beneficial for maternal health.
- Contraceptive services must equally target men with a specific focus on temporary methods as opposed to permanent methods. As partners, husbands and fathers, men have a role to play.
- Screening with full quality, ante-natal routine care/services and services for post-partum complications must be made available free of cost.
- Pre-referral management stabilization; treatment of mild to moderate complications such as eclampsia, HIV, and tuberculosis; and nutrition supplement from the public system must be included in the screening protocol.
- Pre-conception birth planning must be included in CQC programmes.
- Maternity benefits must be unconditional and crèche for children must be part of public health services.
- Public health system must take responsibility in registering ante-natal check-ups and developing a follow-up system.

Recommendations for the Development and Implementation of Public Monitoring Systems for CQC Strategies

- Monitoring systems for CQC must include specific continuous tracking of services which are available and accessible to vulnerable groups such as migrants, internally displaced, persons with disabilities, socially excluded, people living with HIV, and women. Their access to SRH information and services including EMoC and referral must also be tracked.
- Maternal death audits to identify the existing gaps in CQC must be conducted and included in the monitoring system.
- An annual report must be produced out of this monitoring system.
- A comprehensive reproductive education to in-school and out-of-school adolescents must be developed and monitored.
- Effective regulation systems for private providers and pharmaceuticals must be developed and implemented.
- The healthcare system must be subjected to continuous public/community monitoring. Social audits as part of a regulatory mechanism must ensure the accountability of all the stakeholders involved.
- A budgetary analysis of health allocations must be included as part of the monitoring system, with clear indications on resources spent on each program in compliance with the recommendations of WHO.

Policy and Programme Implementation Recommendations specific to Adolescent Girls

- Special attention on the vulnerability of adolescents to rape, sexual abuse and sexual violence as well as adolescent girls being trafficked and internally displaced must be placed in policies and programmes.
 - A comprehensive reproductive health and rights education curriculum must be developed and implemented for school-going adolescents. This includes information on how an adolescent's body functions along with other RHR information such as access to contraceptives for both married and unmarried adolescent's girls. This is not part of life-skills curriculums in the four countries.
 - A system for tracking out-of-school adolescent girls and ensuring comprehensive reproductive health and rights education must be developed and provided. SRHR education modules are usually only targeted to in-school adolescents yet South Asia has a large population of out of school adolescents.
 - Adolescent friendly services such as counselling and health care must be integrated into general health services.
 - Policies on supplementary nutritious food must developed and implemented for all girl child/adolescent girls including those out of school.
 - Legislation to prevent early marriage resulting in early pregnancy must be enacted and implemented.
 - Birth registration systems must be in place especially for girls (this is linked to the ability to determine a girl's age at marriage).
- resources must be channelled to achieve health equity within a cohesive policy framework.
- Governments must not disengage from its regulatory role. Instead reforms in social services must be part of a political agenda that balances economic growth with equity and ensures the meaningful participation civil society and other stakeholders in the public health system.
 - Policies and programmes must account for the inter-relationship of social conditions which inform people's access to health services. These include those around poverty, food security; safe water, sanitation, gender equity; violence against women and male involvement in family life.
 - Adequate budgets must be allocated for home based services. Capacity of service providers need to be built by the health system to ensure recognition of complications and timely referral, ensure timely transport services.
 - Adequate budget must also be allocated for school feeding and supplementary nutrition for out of school adolescent girls.
 - Monitoring and accountability for cash incentive programs for institutional delivery schemes need to be strengthened and assessed periodically based on a rights based continuum of quality of care framework.
 - Governments must ensure that insurance schemes are transparent in the services they offer.

Recommendations for the States based on its obligation in providing CQC

- Governments must fulfil their obligations and commitments as signatories to CEDAW; ICPD Plan of Action; Beijing Platform of Action and the Human Rights Council's 2009 Resolution. National governments must recognize that the **high rates of maternal mortality and morbidity are unacceptable and preventable and maternal mortality and morbidity is a human rights issue.**
- Governments must provide quality health care services for all. Further, it is essential that hidden costs of services at government facilities are minimised if not eliminated so that women and adolescents can gain better access to these services.
- Sustained investment in strengthening the health system must happen under government stewardship.
- The benefit of public private partnerships (PPPs) implementing CQC models must be reassessed to support claims that they benefit the public. Public and private

Endnotes

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MATERNAL DEATHS IN BANGLADESH: Are We Getting the Right Picture?

Samia Afrin, Nashir Uddin and Shireen Huq (Naripokkho)

In September 2010, Prime Minister Sheikh Hasina announced during a UN Summit that Bangladesh will provide some more services and incentives towards reaching its MDG5 target:

- 3,000 midwives will be trained by 2015, and another 7,000 in a few years.
- Maternal health care service will be provided round the clock from 427 *Upazila* Health Complexes.
- 59 district hospitals will be updated for EmOC, preparing them as Women Friendly Health Service Centres.

A national action plan and a strategy for adolescent reproductive health will be formulated to increase awareness on reproductive matters and prevent adolescent pregnancies. Improve the adolescent health services to international standard in one third of all hospitals by 2015

(<http://www.unbconnect.com/component/news/task-show/id-59253/format-raw> Access Date 18 May 2013)

1. Context

Reproductive health and in particular maternal health has been a key concern in several international summits since the 1980s. One of the more recent indicators of its significance are the Millennium Development Goals (MDG) as they target a sweeping reduction of maternal mortality rates (MDG Goal 5a and b) by 2015.

A year after the MDGs were formalised, Bangladesh launched a "National Strategy for Maternal Health" in 2001. Later, the Health, Nutrition, Population Sector Programme for 2003-2010 adopted a national strategy for maternal health with a focus on Emergency Obstetric Care (EmOC) by Ministry of Health¹. As a consequence of the strategy, the Ministry of Health and Family Welfare has scaled up services for emergency obstetric care especially for the third stage of labour.

It has also approved the distribution of Misoprostol tablets to all pregnant women shortly after delivery to prevent postpartum haemorrhage. There is also increasing availability of Magnesium Sulphate for management of pre-eclampsia². As in other countries in the sub-region, haemorrhage and eclampsia are the leading causes of maternal deaths, accounting for 31 per cent and 20 per cent respectively³.

By 2010, the government reported that the country's Maternal Mortality Ratio (MMR) has declined by 60 per cent, from 322 in 2001 to 194 in 2010, suggesting a year on year reduction rate of around 5.5 per cent. The reduction rate per year is at an average of 5.5%. Bangladesh aims to reduce MMR to 143 by 2015⁴. It seems then that Bangladesh is on track in achieving MDG Goal 5 in time. However a second look at the practices in communities suggests otherwise, disputing the progress that has been officially reported and contradicting a national policy of reporting a maternal death within 24 hours.

2. Evidence from the ground

The following analysis on maternal deaths is informed by a 2011 study by Naripokkho in 14 Upazilas and 111 unions in 5 districts in the Barisal Division namely Patuakhali, Barguna, Barisal, Jhalakathi and Pirojpur. Data collected on maternal deaths in these five districts reveals that there were a total of 184 maternal deaths during the period of January-December 2011. These findings are a summary of data collected from government facilities which include: Barisal Sher-e- Bangla Medical College Hospital; two district hospitals in Patuakhali and Barguna; two Mother & Child Welfare Centres (MCWC); 11 Upazila (sub-districts) Health Complexes and Upazila Family Planning Offices and 111 Union Parishads (smallest rural administrative and local government unit) and Union Health & Family Welfare Centres (UHFWC).

The data and its analysis were validated in a workshops held in Barguna, Patuakhali and Barisal. These workshops were attended by civil surgeons (district head of health administration), Deputy Directors (DD Family planning), Upazila family planning officers, Statisticians (responsible to collect and process necessary government statistics), Residential Medical Officers, Sub-assistant Medical Officers (Medical assistants, provide primary health care services at government health care centres) and Family Welfare Visitors (FWV).

This study however is only based on reported cases and does not cover non reported cases of deaths that occurred at home or on the way to the hospital. Existing data on deaths in transit could not be cross-checked with other data mostly due to non reporting. Moreover, all districts under the Barisal divisions could not be covered due to fund constraints.

2.1 Present scenario of maternal mortality

Based on different government sources, this study notes that there were a total of 184 deaths from January to December, 2011.

Table 1: Source of Information on maternal deaths

Source of Information	Number of deaths	Percentage
Government hospitals	120	65.22
Birth & Death Registers at Union Parishad	47	25.54
Office of Upazila Family Planning Officer	4	2.17
Personally collected by CBO and project staffs and members of Women's Groups	13	7.07
Total	184	100

Note: Records of every death were checked and cross-checked with the name, age, address of the dead women. This was done by Naripokkho's project, CBO partner staffs and members of Women's Group.

Out of 184 deaths 111 were from study area, working area of the project.

Table 2: Source of Information on maternal deaths

Source of Information	Number of deaths	Percentage
Government hospitals	40	36.04
Office of Upazila Family Planning Office	5	4.50
Birth & Death Registers at Union Parishad	57	51.35
Personally collected by CBO and project staffs and members of Women's Groups	9	8.11
Total	111	100

About two-thirds of the deaths happened in government health facilities while 29 percent died at home, three percent died on their way to the hospital and around 2 percent in private clinics.

Fig 1: Places of maternal deaths

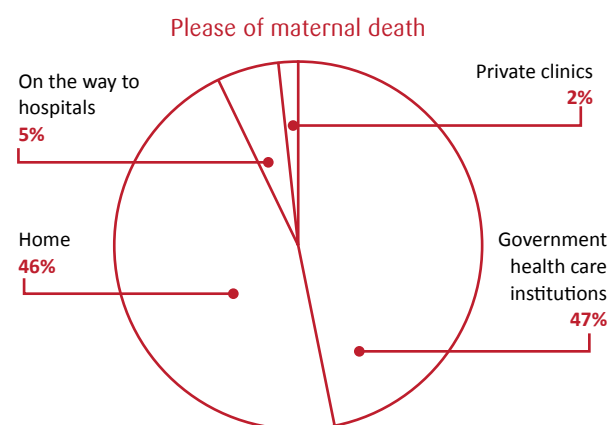


Table 3: Age distribution of deceased women

Age groups (Years)	Number of deceased women	Percentage (%)
Less than 20	5	4.5
20-24	31	27.9
25-29	28	25.2
30-34	24	21.6
35-39	10	9.0
40 and above	2	1.8
Missing	11	9.9
Total	111	100

The women who died were between the ages of 18 to 45, with 74.7 per cent of them coming from the age group 20-34 years. Average age at death was 26.68 years.

Table 4: Causes of maternal deaths as recorded in government registers

Reported cause of maternal death	Number of deaths	Present study (%)
Eclampsia	41	36.94
Haemorrhage	33	29.73
Obstructed or Prolonged Labour	10	9.01
Indirect causes*	15	13.51
Undetermined	12	10.81
Total	111	100

*High blood pressure, Infection after delivery, heart disease, anaemia during pregnancy etc.

Causes for maternal death in the present study vary from official data published on Bangladesh in Bangladesh Maternal Mortality and Health Service Survey 2010. In this study, eclampsia was the leading cause of death, accounting for 37 percent, followed by haemorrhage with 30 percent. Meanwhile the Bangladesh Maternal Mortality & Health Care Survey (BMMHCS), 2010 places haemorrhage as responsible for 31 percent of maternal deaths, followed by eclampsia with 20 percent.

2.2 Authenticity of government records

Table 5: Lapse in the compilation of maternal death information

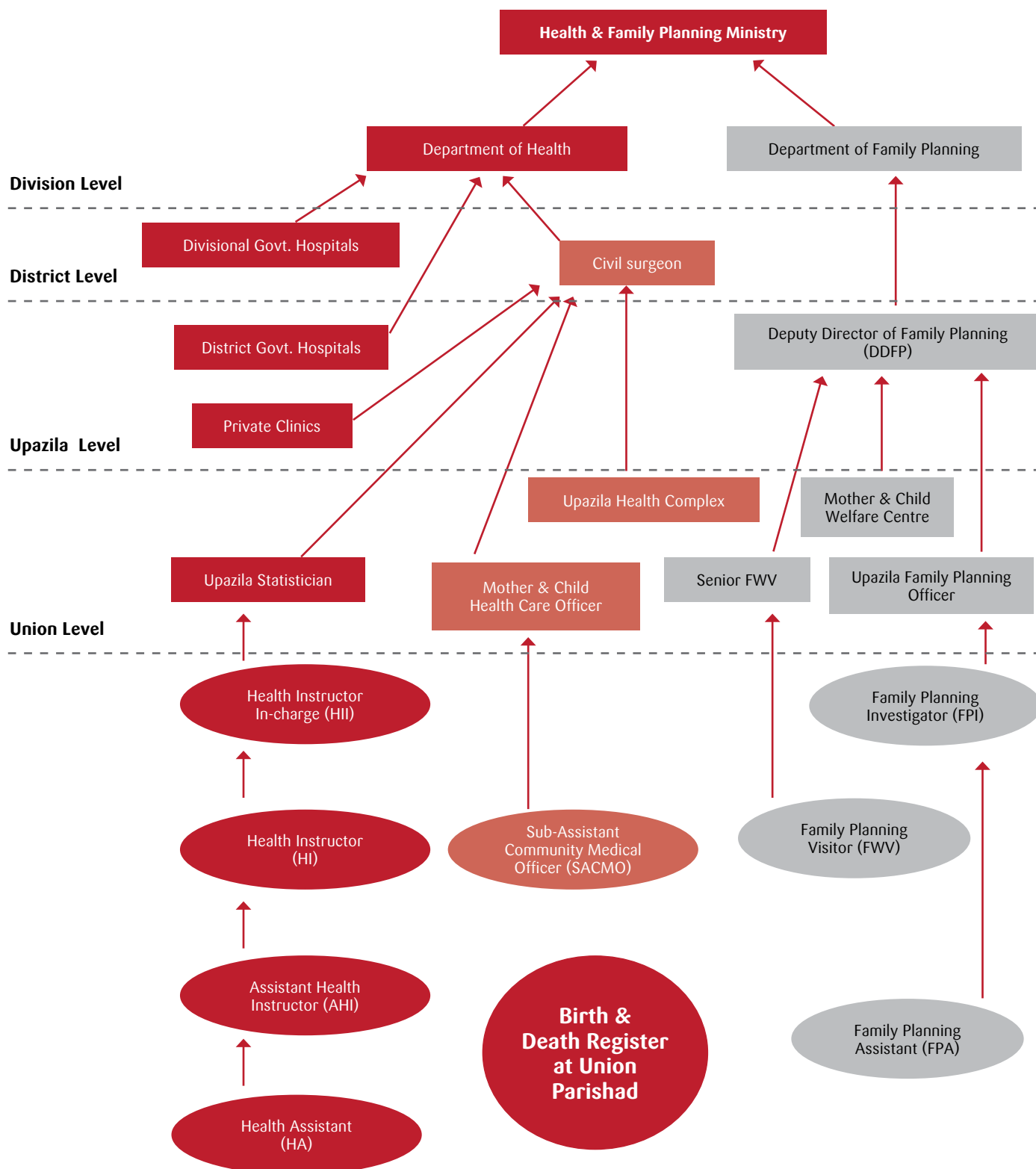
Sources of information	Real number of deaths	Number of deaths accounted for accumulation
Government hospitals	40	40
Office of Upazila Family Planning Officer	5	5
Birth & Death Registers at Union Parishad	57	-
Personally collected by project staffs and Women's Group members	9	-
Total	111	45 (59.46%)

Maternal deaths are recorded in the birth and death registries at the Union Parishad. Forty five deaths were recorded in Upazila Family Planning Office and registers at Union Parishad. However these are not reported to the relevant national agencies, which are the primary source of national surveys. The present study finds **45 unaccounted deaths in the national data (59.46 per cent)**. In addition, some **9 more deaths were discovered to be unreported**. This means that in total 48.64 per cent or 54 out of the 111 maternal deaths were omitted from national records.

Case Study

Amena, 20 and her husband Joynal, 30, a rickshawpuller in Barguna district, planned to wait for two years before having a child. At the end of her first trimester, Amena went to the Barguna civil surgeon's office for check-up while on her fourth month, she went to the Ailapata Union Health & Family Welfare Centre. She did not undergo any follow-up check up since then. Nearly a week before her expected delivery date, Amena's legs started swelling. Her husband wanted to rush her to the civil surgeon's office but her mother said that the swelling is normal and brought Amena to her father's house instead. Amena later gave birth with the assistance of a *dai* or a traditional birth attendant. Both mother and her baby boy were fine. But after four hours, Amena started vomiting with blood, prompting her father to call a village doctor. However Amena died before she could be treated. Her death was recorded in the registry of the Union Parishad but the information was not forwarded to a national office. Hence resulting in underreporting and missing data in national statistics.

Fig 2: Information Flow Chart for Maternal Death Reporting



The chart (page 6) shows the flow of records from one health care facility to another, until these records reach the Ministry of Health and Family Planning. The coloured boxes indicate the agencies which are in charge of family planning services. Square boxes are the agencies which record deaths, without collecting the details of each deceased individual such as name, age and address. The latter is done by agencies inside the oval figures. The Union Parishad, records maternal deaths but does not forward these pieces of information to agencies which compile information on maternal death nationwide.

Aside from the apparent lack of coordination among health service providers in data collection, there are also practices which deliberately mar attempts to correct the system's failures. One of the alarming findings from this study is that pieces of information relating to maternal death in the lower tier of health and family planning service are lost for the following reasons based on our observations and interviews:

1. Persons responsible for keeping records of maternal deaths are instructed unofficially and sometimes pressured to "keep" the number as low as possible.
2. Record keepers, who are part of the health service delivery system, fear that the numbers as might reflect on their professional performance.

These issues on reporting suggest a violation of human rights and a resistance against transparency in governance. By neglecting the need for accurate data, health interventions cannot be planned and implemented in ways which can prevent maternal deaths and exact accountability from erring agencies.

There are other issues and concerns which this study revealed. Eclampsia, the leading cause of maternal health is usually managed by an injection of magnesium sulphate. But physicians refuse this method as the latter requires continuous monitoring of the patient's blood pressure. Instead physicians inject tranquilizers as an immediate and temporary solution while referring the patients to tertiary hospitals. It is also telling that the government does not supply hospitals at Upazila level with magnesium sulphate. Meanwhile, haemorrhage, another leading cause of maternal health is also inadequately addressed. In most cases, a patient's blood type is not identified early and potential blood donors are not prepared. EmOC is also not available in all Upazila Health Complexes.

Case History

Tajinur, 23, became pregnant after two years of being married. She had four ante-natal check-up from nearest Union Health & Family Welfare Centre in Pathargata. As Tajinur did not experience labour pains during the expected date of delivery, relatives advised her to go to Pathargata Upazila Health Complex. Upon reaching the Health Complex on 28 June 2011, Ibrahim, an assistant community medical officer, took Tajinur to his own private clinic, the Pathargata Surgical Clinic. Ibrahim led the caesarian operation. Tajinur's relatives heard the baby's loud cry. Since Tajinur remained unconscious, Ibrahim and his assistant brought the baby back to Tajinur's abdomen and called an ambulance which took Tajinur and her relatives to the Barisal Sher-e-Bangla Medical College Hospital. The duty doctor at the hospital declared Tajinur dead on arrival. This death was not recorded and thus never became part of official statistics.

3. Recommendations

1. Record details (name, age, address) of every death at every stage of data collection. These details must be publicly available, except those which may violate a person's right to privacy. Detail records of deceased women will be helpful to cross-check for avoiding over and under counting of deaths.
2. Ensure the accountability of record keepers through an effective monitoring system and clear coordination among health service providers.
3. Ensure clear and effective coordination between Union *Parishad* and union level health service providers to reconcile the figures and publish the accurate date on maternal deaths.
4. Design incentives for the reporting of maternal deaths.
5. Ensure a system of reporting for maternal deaths which take place at home, outside of health care facilities, during referral and in transit.
6. Conduct a nationwide maternal death review immediately.
7. Indicate the lessons learned, good practices, including the gaps in the health system in the annual maternity death review.
8. Conduct special meetings among health service providers, public representatives and family members of a deceased woman within 48 hours after her death, to be convened by the Hospital Management Committees (HMC) and Union Parishad Standing Committees on Health.
9. Monitor and ensure full ante-natal check-up for all pregnant women at Union level to identify eclampsia, anemia, and other high-risk conditions.
10. Integrate a context specific rights-based continuum of quality care framework into the existing RH programme.

Naripokkho's experiences and research in its fieldsites demonstrate that discrepancies on the ground lie in the more indirect causes of maternal mortality such as illnesses which arise from anaemia, malaria and tuberculosis and which can be correlated with the conditions of women who share a low status in society, live in poverty and have difficult access to high quality of maternity care services and trained health professionals. One typical indirect cause is the distance between the women's homes in remote areas and the nearest medical facilities. It is these realities which have not yet been captured by official reporting and as a result, suggest that there are actually a significant number of women who are dying because of pregnancy. Hence there is a need not only to focus on the situation in communities but also to shift strategies which can likewise make official reports more precise. For instance, there are community-based resources which can be enhanced to complement modern medical services which may take time to be scaled up. Traditional birth attendants, known as *Dais*, can be trained to manage complications during and after delivery. This can ease the risks patients face while in transit to medical facilities in towns.

Endnotes

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STATUS OF ABORTION IN NEPAL:

The need for a Continuum of Quality Care

Bidya Bhattarai, Rakshya Paudel, Laxmi Prabha Shrestha (Beyond Beijing Committee, Nepal) and Shubha Kayastha (ARROW)

Case Report

Anita, 32, lived in Makawanpur district with her family including four children, two sons and two daughters – all born at home. When she learned that she was one month pregnant, she decided to have an abortion as she did not want to have more children. She was unaware of the law so she went to a village sudeni or a traditional birth attendant. Soon after the procedure, Anita experienced heavy bleeding. She was first taken to the nearest health centre which referred her to a district hospital. She died while in transit.

1. Context

In the 1980's in Nepal, there was an improvement in the quality and availability of post-abortion care, including emergency treatment of complications which arise from unsafe abortion, post-abortion contraception and other reproductive health services¹. Later in the 1990s, with the efforts of different national stakeholders and Nepal's commitment to the International Conference on Population and Development (ICPD), access to safe abortion services also began to be presented as an issue of women's rights.²

In 2000, a joint study by the UN Fund for Children (UNICEF) and the Nepalese government estimated that 20 per cent of all maternal deaths were the result of unsafe abortion³. After nearly 30 years of persistent lobbying, the government of Nepal finally legalized abortion in 2002⁴. The law provides that **abortion services must be available on demand for the first three months. This period is extended for cases of rape or incest up to 18 weeks. When the life of a mother is under threat, abortion services can be accessed at any time.** However it is argued that one of the main reasons for legalizing abortion in 2002 was to regulate and control fertility rather than the protection of reproductive rights⁵.

The law on comprehensive abortion care is applicable in all 75 districts of Nepal.⁶ According to Samandari et al (2012) this has contributed to a large decline in the country's maternal mortality rate (MMR), cutting it down by nearly half by reducing the number of women who die from pregnancy related complications from a range of 539 to 281 per 100,000 live births in 2006 down to 281 to 229⁷. For this development, Nepal was cited by the United Nations for its contribution in achieving the UN Millennium Development Goal 5.8. **However much remains to be done to achieve the desired impact of the law for the most marginalized women, especially those who are not literate**

and who have no access to good sources of information about women's health, including the law and services it mandates.

1.1 Low awareness on safe abortion services and the law

Despite the law, only one in three women in Nepal is aware that abortion is legal⁹ and only one in two women know a place where the procedure is performed¹⁰. A 2010 study conducted among 200 women of reproductive age (15-49 years) and visiting obstetricians and gynecologists in the Nepal Medical teaching hospital, revealed that approximately 67 percent of women are aware about the law legalizing abortion, while most adolescents still have to be educated about it¹¹. The same study also stated that most women learned about the law and availability of services from the media. However, it is ironic that little investment has been made to popularize this otherwise significant legislation and its actual benefits for women and girls¹². Access to information on availability of services and benefits is central to ensuring continuum of quality care.

Among the follow up activities then which need to complement the law is the use of appropriate and strategic technologies in conveying the intention and highlights, including the services which ordinary women can access. One of the more effective media is video.

Nawaraj Subedi, Health Post personnel stated, "We provide information on safe abortion services to the pregnant women along with ANC check up. Pre and post counseling is also provided to the women visiting for abortion service."¹³

1.2 Unmet need for Contraception

One in four married Nepalese women has an unmet need for contraception.¹⁴ The Contraceptive prevalence rate (CPR) has risen in the last 30 years, from three per cent in 1976 to 48 per cent in 2006, with consistent increases in every five year period. Despite this growth in CPR, 25 percent of married women still need assistance in accessing contraception which again reflects a gap in the continuum of quality care¹⁵. There remains a limitation in the human resources for family planning counseling and in some areas, supplies. But a deeper reason lies in the cultural value given to having more children¹⁶. Moreover, there are still instances when family planning is compromised by the desire to have sons, who can increase a woman's status in the family and community.

Case Report

Mankumari Ghalan, 27 was already happy with her two sons who were both born at home. So when she got pregnant, Mankumari and her husband decided to have an abortion. Had they known about the family planning services given by the government, they could have prevented the pregnancy and the abortion procedure. But the nearest health facility is two hours away from their home. Mankumari eventually sought the services of a sudeni or a traditional birth attendant. After the procedure, she felt severe pain in her lower abdomen after two days. She was eventually taken to the district hospital, where she underwent two operations. She died three

*weeks later*¹⁷.

1.3 Continuing unsafe abortion practices

Despite the law, there are still women who continue with unsafe abortion practices. Approximately five per cent of maternal deaths can be attributed to complications arising from abortion and ante-partum hemorrhage.¹⁸ The stigma associated with abortion is also quite strong that some women ought to keep the procedure under wraps, even as this means unsafe abortion.¹⁹ In some cases, health services in rural areas are also limited that abortion can only be safely performed in district hospitals.²⁰ Sometimes because of the distance, women tend to visit district hospitals when the situation is already worse. It is important to note that once in a hospital, a patient is not always asked about the cause of bleeding nor is this always noted. This results in a loss of important data in analyzing unsafe abortion and subsequent planning for policies and programs which has implications for ensuring continuum of quality care.

Case Report

Sushila Ghimire, 38 lived with her two daughters and two sons in Makawanpur. She did not know anything about family planning methods. She conceived immediately after five and a half months of her last delivery. She was scared to let the community know her plans to have an abortion, so she went to neighboring India to have the procedure. A drug was placed inside her uterus, using a long thin metal stick. She cried in pain.. She started bleeding profusely after she returning home. Later, she was taken to the district hospital in Guleriya using a buffalocart. It took seven hours before she and her family arrived at the hospital. During this time, she bled profusely. The hospital could not provide her blood. In just an hour, Sushila died²¹.

1.4 Concerns on Post-abortion Care

Complications related to abortion constitute a third major cause of maternal mortality and morbidity in Nepal. They account for seven per cent of maternal deaths in the country, based on the Maternal Mortality and Morbidity Study for 2008-2009.²² The Post Abortion Care (PAC) Unit was established in May 1995 at the Maternity Hospital with the aim of treating and reducing unsafe abortion complications. There are now 78 PAC service sites in 50 districts, mainly in public sector health facilities. Family planning counseling and provision of FP services follow every Manual Vacuum Aspiration (MVA) procedure²³

Based on field visits by BBC and her partners we know that there is a PAC center in Letang VDC of Morang in our field site but until now only one woman accessed the center's services. Due to lack of human resource, the center is now closed.²⁴

One study on the evolution of post abortion care in Nepal reveals that only 56 per cent received counseling on contraception methods after abortion. This low usage rate can be attributed to the lack of decision making power of women. It was found also that some providers insist on delaying the start of some methods until after the client's next menstrual period starts. Instead, centres distribute condoms as an interim measure until the client returns. However, most clients do not return²⁵.

1.5 Male involvement in accessing abortion services

A 2007 study by civil society organizations shows only 50 percent of male respondents are aware about legal status of abortion yet husbands often think that they can decide over a woman's pregnancy²⁶. What is disturbing is that around 36 percent of married men said that they will either convince or force their wives to have an abortion in any situation. The same study also revealed that men rarely are informed about the hazards of unsafe abortion..

1.6 Trained Human Resources

More than 1200 service providers have been trained in Comprehensive Abortion Care (CAC) and 532 sites have been certified as CAC sites. Services have been expanded but still the number of trained human resource for abortion services is comparatively lower than the need. It does not help that the government has cut the budget for skills- building training of health personnel who are required for conducting safe abortion service. Service providers like in most countries prefer to be posted in the capital. Moreover there is less privacy and insufficient time allocated to patients in public CACs. The long waiting hours likewise discourage patients from using public facilities. To quote Sabitra Neupane of Tandi VDC of Morang, "Due to a lack of privacy, and the long waiting time in local government health institutes, women do not prefer to go there. Instead many visit private CAC centres where they get service with confidentiality."

1.7 Stigma and Discrimination

The general social and cultural attitudes still pose a significant barrier for women to access the benefits of the law. Women who had accessed abortion is usually stigmatized by the community since abortion signifies promiscuity and irresponsibility. The perception of service providers on abortion and the women seeking abortion affect the services to great extent. There have been very few studies carried out on this part.²⁷ Abortion is also difficult to access when one is unmarried. Some service providers seem to cast judgement. Pre-marital sex is strongly condemned in Nepalese society. Furthermore, there is been a of lot coverage by media on repeated abortions by teenagers using it as a method of contraceptive..²⁸

Case Report

After we decided to terminate pregnancy, I visited a pharmacy to take advice from the pharmacist. He gave me some medicine meant for abortion. However the medicine did not work. Afterward, we didn't seek any alternative sources as we were too embarrassed. In our community, if others come to know about the abortion, then it would be very embarrassing. Hence, we decided to continue with the pregnancy.
-Husband, 30 years old, agriculture, Saptari (CREPHA & PATH, 2007)

Case Report

"Though government has MVA/MA guidelines, the medicine of abortion used by teenagers is high. We should prevent it and raise awareness among teenagers regarding abortion."
- Tilak Prasad Ghautam, Health Post Incharge of Churiyamai VDC of Morang

Massive privatization in the health sector and the unregulated private clinics have contributed to increasing incidents of illegal abortions such as those performed because of son preference based on ultrasound results. This has a direct impact in the country's MMR. It has also raised many questions over the legality of abortion in Nepal.

Case Report

Suryadevi Jha of Mahottari district, already had four daughters. When she was pregnant for the fifth time, she along with her mother-in law decided to find out the sex of the foetus. After having an ultrasound in a private clinic, they found out that the foetus was female. To confirm this, the doctor of the clinic did the ultrasound again and confirmed the foetus as a female. Later Suryadevi decided to have an abortion and went to the same clinic. However, when she saw the aborted foetus, Suryadevi's mother in law found out that it was a male and started screaming at the doctor. But before she could do anything, one of the nurses cut off the penis to make it appear like a female foetus²⁹.

2. Recommendations to policy makers

1. Effectively monitor and facilitate the availability, accessibility and affordability of contraception services to all women, men and adolescents of reproductive age in the government facilities irrespective of marital status.
2. Popularize CAC policies and services through strategic information and communications plan and its effective implementation, utilizing the Citizen Charter in health centres, radio jingles and advertisements through electronic, print and other mass media campaigns.
3. Increase the number of trained health professionals in CAC centres, with proper monitoring of health centres and health care providers and ensure their presence in facilities by improving facility monitoring systems.
4. Increase the number of trained CAC providers and allocate the necessary budget for it.
5. Strengthen the training programs on post abortion care, such as those on counseling over the use of various contraceptive methods and follow up mechanisms and sessions with the patients.
6. Produce information and communication materials which target behaviour change among men who play a crucial role as partners and husbands.
7. Conduct a nationwide study on deaths caused by unsafe abortions, especially given the stigma attached to abortion. Design and implement asystematic data collection that includes histories of complications which arise from unsafe abortion.
8. Regulate and monitor the private health sector to ensure high health standards and to hold them accountable for their services.

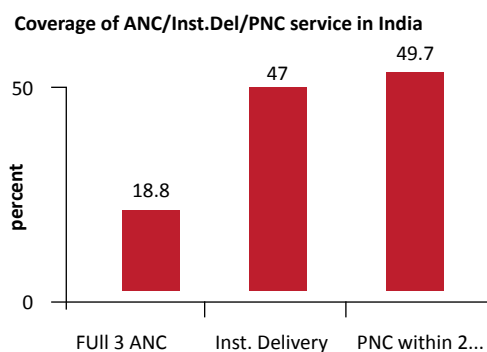
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CONTINUUM OF QUALITY CARE FOR MATERNAL HEALTH: A pre-requisite for Safeguarding Women's Health and lives in India

Vd. Smita Bajpai, CHETNA and Y.K.Sandhya, SAHAYOG

Fig 1: ANC, PNC Coverage and Institutional Delivery



Source: DLHS-3 (2007-2008)

1. Context

India's Maternal Mortality Ratio (MMR) has declined from 398 in 1997-98 to 212 per 100,000 live births in 2007-09 (SRS 2011)¹. However the rate of decline has been slow and uneven. Kerala, Tamil Nadu and Maharashtra have already reached the U.N. Millennium Development Goal of bringing their maternal mortality down to 109 women per 100,000 live births. Several other states — Andhra Pradesh, West Bengal, Gujarat and Haryana — are close to achieving these targets as well. However nine states namely - Assam, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand have MMR estimates ranging from 250-390 deaths per 100,000 live births. Since the most recent MMR estimates are available for the period 2007-2009 (*ibid*) the lack of accurate, disaggregated and updated report on Maternal Deaths in the public domain raises serious accountability issues.

1.1 Young Women's Right to Survival and Health

Almost half (45%) of maternal deaths occur during the age of 15-24 years in India (SRS,2011). Documentation by civil society organisations also indicates that most women who died were young. About 47 percent girls are married by the age of 18, the minimum legal age of marriage for females. Sixteen percent girls become pregnant or bear children between 15-19 years of age (NFHS-III,2005-2006)². Despite 51% of the total population of India belonging to this age-group, the outreach of public health programmes to this age group is limited. There is lack of inter-

"Chamelibai(Chattisgarh) was 25 years old woman pregnant for the second time and working in a brick kiln. Although she had oedema all over her body, blurring of vision, dizziness, and headaches in her 7th month, she received no antenatal care and continued working. When she suffered from three fits while in the brick kiln, she was rushed to a health facility but died en route."

sectoral convergence which is needed to address their health and nutrition needs. Lack of continuum of care to adolescents and young people increases their vulnerability to death and diseases.

1.2 Poor and inadequate care during pregnancy

Of the total women who register with the public health system, only 18.8 percent received complete antenatal check-ups.

Documentation by civil society groups (see end notes for comprehensive list of references of data sources from maternal death reviews) demonstrates evidence that;

- many of the women who died did not receive any antenatal check-ups;
- ante-natal care when provided to women was inadequate, often piecemeal and failed to detect risks and left women unprotected;
- antenatal registration did not give the woman any guarantee that the health system would take responsibility to ensure timely access to health services, particularly during complications;
- antenatal care was mostly limited to tetanus toxoid shots and distribution of 100 iron folic tablets. Physical examination and check-ups; abdomen examination although crucial were rarely conducted
- risks like severe anemia (including sickle cell anemia), hypertension, malaria, tuberculosis, etc. although widely prevalent were largely undetected;
- there was an absence/inadequate protocols/ compliance which prevented effective management of anemia;
- these risks exacerbate obstetric complications (anemia & PPH) or were exacerbated by pregnancy (malaria, tuberculosis);
- pregnancies were not tracked for adverse experiences such as still birth, maternal deaths, neonatal deaths, morbidities, disabilities etc.

1.3 Poor and Inadequate care during Delivery

In congruence with the global push to achieve the MDGs and for achieving 'skilled attendance at childbirth', the government of India has laid emphasis through a conditional cash transfer scheme to encourage women to come to hospitals for childbirth. The scheme is called the Janani Suraksha Yojana (Mothers' Protection Scheme or JSY) and is part of the National Rural Health Mission (2005-12). The JSY is supported by a community-based link worker called the Accredited Social Health Activist (ASHA) to support pregnant women and ensure that women

register their pregnancy with the local health centres, as well as to accompany women to hospital during labour, and conduct post-partum home visits. However this focus on institutional delivery has deflected attention from what happens to women who do not or cannot reach hospitals (that is close to half the women in the states with higher MMR, adding up to several millions). There is also inadequate assessment of the capacity of hospitals to handle this large volume of cases, as well as whether providers actually manage to provide skilled attention to women who needed emergency obstetric care.

Facility Survey³ data is a cause of worry particularly in states like Madhya Pradesh, Uttar Pradesh, Rajasthan, Bihar and Jharkhand. Based on civil society reporting public health facilities are understaffed and poorly equipped health centres lack equipment and essential drugs. In health facilities, where staff was present, they demonstrated a lack of skills and capacity to handle complications. This situation is reflected in the case history provided below.

"DurgaBai (Madhya Pradesh) aged 32 years was undergoing her seventh pregnancy. She experienced sudden and sharp pain in her back. She was taken to the Community Health Centre (CHC) which was a few hours journey from her village. Upon examination, the nurse at the CHC found that DurgaBai was ready for delivery. DurgaBai was made to lie on a bed, and was given an injection soon after which both the legs and one hand of the baby were out. However, the baby's head was stuck inside, and the nurse sent for the doctor. The doctor saw the baby and referred DurgaBai to the District hospital which was 22 kms away. On reaching the district hospital DurgaBai was administered a saline bottle by the nurse. The nurse tried to force the baby out by pushing. There was continuous bleeding during this time. The hospital did not make any provision for blood and instead asked the family to arrange for it. After receiving only a couple of drops of blood, DurgaBai passed away. By the time the doctor, who was called by the nurse, arrived DurgaBai was dead."

Additionally, District Level Household Survey (DLHS-3) data shows Primary Health Centres handled only a small number of deliveries whereas a large majority of the deliveries occurred in district and tertiary hospitals resulting in an overburdening of these facilities. The high pressure on the facilities also reduces their ability to ensure post-partum observation and care; this is despite knowing that a high proportion of deaths occur in the post-partum period. Thus while there is certainly an increase in institutional delivery, it is questionable whether all women are going through 'safe delivery' or receiving continuity of care.

1.4 No Attention to Home Births

In the absence of a policy to make homebirths safe, more than half, 50% of women are at risk of losing their lives in absence of any assistance for timely recognition of complication and referral. In spite of this the government has failed to take steps to ensure that women who deliver at home are assisted by skilled providers. Traditionally, communities have accepted Traditional Birth Attendants (TBAs/Dais) and they continue to play a critical role in assisting women during childbirths. TBAs/Dais based on our experience can contribute significantly in saving mother's and new-born's lives if integrated in to the public health system. Therefore a policy for strengthening and supporting TBAs is needed.

1.5 Lack of continuum of care during referral

For women who develop complications irrespective of place of birth, multiple referrals are common. An analysis of cases documented in a district in the state of Jharkhand shows that sometimes women had referrals to at least four facilities before she died. The following case clearly brings out the lack of continuum of care during referral.

"Sushila was a 22 year old woman from a Scheduled Tribe. This was her first pregnancy. She had convulsions in the night and early next morning she was carried on a cloth sling by her relatives to the point where the Janani Express ambulance had arrived to pick her up. She reached the Primary Health Centre (PHC) two hours later. Here she was referred to the District hospital (DH) even before she was taken out of the vehicle without any examination. But her relatives took her to the Community Health Centre (CHC) where they arrived an hour later. Here the nurse claimed that her cervix was not dilated and so she was further referred to the DH without receiving any medical care. She arrived at the DH at 1 pm (3 hours later) where she was administered an intravenous drip and two injections. The family was told that they would have to wait for some hours before any intervention could be made. The following day she was sent to a private centre for ultrasound in an auto rickshaw. Eventually, after forty hours of being admitted at the District Hospital, she passed away. "

1.6 Poor and Inadequate Care after Childbirth

More than fifty percent of deaths take place during the first 24 hours and 42 days after childbirth. While the Public Health System guarantees three PNCs within 42 days of delivery, more than 50% of women receive a post natal check-up within 2 weeks of delivery. PNC visits at home are inadequate, irregular and largely limited to child immunisation. Lack of quality of the PNC visits increases the vulnerability of maternal and new-born deaths.

“Malti was a 26 Scheduled Caste woman from Uttar Pradesh was pregnant for the third time. She neither had any antenatal checkups nor had any immunization, but she was completely healthy. On 12th September 2008 at about 8:00pm, she started having labour pains and after protracted labour pain finally delivered a dead baby on the 14th of September at 9 am. After 5 days, on 19 September 2008, she developed swelling and pain in her abdomen and legs, then her family took her about 40kms away to a government hospital which was closed at around 10:00pm. From there they took her to a private hospital where the doctor gave medicines worth Rs.250 but did not admit her. So, they again took her to the government hospital, but since no one would open the gate, they waited outside till morning. She was admitted at around 8:00am and the doctor started a drip, but she died within few hours.”

Her death could have been prevented if adequate postpartum care was provided.

1.7 Lack of continuum across sectors, administrative blocks

One of the reasons of the gap in service delivery is due to mobility of women/families either due to livelihoods or due to social customs. There is lack of tracking and coordination among facilities across public and private sectors and across administrative blocks at various levels. As a result, there is a break in the continuum which increases the vulnerability of deaths.

“Shakuntala Vasava, 22 yrs, a resident of a village in South Gujarat passed away on 31/7/11. It was her first pregnancy and registered, provided with routine Ante Natal Care. As per the custom, she went to her natal home in the neighboring state of Maharashtra. When she went in to labour, she was taken to a private nursing home in a town. She delivered and it was a still birth. She started bleeding and complained of chest pain. She was referred to a public hospital in another town. The hospital refused to take her and so they returned to her natal home and then to her home in Gujarat. They called 108 (government financed emergency transport service) which took her to a hospital in Gujarat state. She passed away on the way.”

1.8 Exclusion of the Marginalised and the Poor

There is a direct correlation between the wealth index and access to maternal health services, particularly during pregnancy. For example, among mothers in lowest wealth quintile households, 59 percent received any antenatal care and only 23 percent received check-ups from a doctor. Among mothers in highest wealth quintile, 97 percent received any antenatal care and 86 percent received antenatal care from doctors. Women who are older, having several children, from schedule tribes, with no education and in household with low wealth index are less likely to receive the same quality of treatment (NFHS, 3, *op. cited*).

Maternal Death Reviews by civil society have shown that women who are the most marginalized and most in need of these

services- Dalits, tribals, minorities and poor women - are the first to be denied easy access to government health facilities. The reviews show that poor women were abused, slapped for screaming in pain and left alone by nurses. There was extreme callousness regarding their deaths - women's bodies were thrown down from beds, out of hospitals and asked to be taken to another hospital when already dead. This callousness is clearly illustrated by the language used by the staff with poor women and their families, for example the following statements were narrated by family members of deceased women

"Move to the verandah I have to close the ward" - an ANM to pregnant woman suffering convulsions at CHC;

"Are you too educated and wise? We have seen many like you" - a doctor to husband who enquired about his wife's condition which was critical

1.9 Cost of Health Services

Despite guarantee of free health services from the public health system, households contribute a significant portion at 71.13% (NHA-2004-05)⁴ of total health expenditure for availing health care services from different health care institutions (NHA, *ibid*). Out of Pocket Expenditure (OOP) on health continues to be a major concern, leading to increased debts thereby further marginalizing the economically poor and perpetuating the debt trap.

In 23 cases from Uttar Pradesh, demands for money were made by the staff in health facilities, women and their families had to pay for tests, medicines, supplies, equipment, instruments, for travel, to see their new-borns, to staff for cleaning and in one case a family had to pay Rs. 5000 after the woman had died. (Women are entitled to free delivery services at the public health facilities). Staff in many cases refused to commence treatment unless payments were made, as in the case of a Dalit man who had to cycle 17 kms through forest at night to borrow money but returned to find 35 year wife lying dead. In the absence of money, the staff verbally abused poor patients - for example the following statements were narrated by family members of deceased women:

"Do not step in my vehicle if you don't have money"
- Driver of Mamta Vahan to husband of pregnant woman;
"Pay up! Throw the baby in the ditch and get lost"
- Nurse yelling at a woman who had a still birth.

There is need to ensure free (no expenditure) services to the marginalized sections of the society.

10.0 Lack of continuum for maternal Nutrition and Anemia

Maternal nutrition is one of the key components that influence the health and lives of the mother and the newborn. However, undernutrition among women in India is alarming with 33

percent women having a Body Mass Index below normal (NFHS - 3, *op. cited*). More than half (56.2 percent) of women in the reproductive age group are anemic (*ibid*). Pregnancy and post partum anemia is almost universal. Haemorrhage is one of the leading causes of maternal deaths in India and anemia reduces the chances of survival. The coverage of nutrition services- during adolescence, pregnancy and postpartum is poor and grossly inadequate. While the public health system promises Iron Folic Acid Tablets, regularity of supply and compliance is a concern. For most poor families, pregnancy and childbirth means loss of wages, reduction in family income and steep increase in expenses. While India boasts of plural health and healing systems, their role in improving health and nutrition levels is seldom recognised.

Recommendations

We urge the Central Government to:

1. Improve services for primary health by:
 - i) Increasing budgetary allocations for health to at least 3% of GDP.
 - ii) Universalize access to healthcare and provide cashless services at the point of care.
 - iii) Increase focus on underserved and migrant populations during drawing plans and policies related to health care.

We urge the Ministry of Health and Family Welfare to:

2. Improve services during pregnancy by:
 - i) Ensuring complete ante-natal care to detect severe anemia, malnutrition, pre-eclampsia, infectious diseases, and other high-risk conditions on time.
 - ii) Strengthen links between Ministry of Health and Family Welfare and the Ministry of Women and Child Development to ensure improvement in health and nutrition status.
 - iii) Enhance capacities of ASHAs/TBAs to provide women and families information about their entitlements, routine care, Signs of Obstetric Complications and where to go if there are complications.
 - iv) Increase number of facilities providing safe abortion services and list them at CHC.
 - v) Ensure nutritious food supplementation to all women, throughout the pregnancy.
3. Improve services during delivery by:
 - i) Monitor the Indian Public Health Standards (IPHS) and protocols for intra-partum care, including Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC).
 - ii) Enable Rogi Kalyan Samiti (RKS) and VHSNCs to carry out social audit of health facilities and Community-based Monitoring of maternal health services.
 - iii) Rationalize referral supported with full set of documents and transportation. Institute a clear protocol which includes stabilizing the woman before referring her to next appropriate level of care.

- iv) Enable Birth Companions- Trained Traditional Birth Attendants where possible, to accompany woman in labour room for support.
 - v) In remote areas without all-weather roads, ensure that local community based attendants are trained for normal deliveries at home and basic management of complications.
4. Improve post-partum services by
 - i) Provide training to community based attendants and ASHA on postpartum danger signs and monitor her health by home visits for six weeks after birth/abortion.
 - ii) Strengthen skills in facilities for recognizing and managing post-partum complications - bleeding (post partum haemorrhage) and sepsis, deep vein thrombosis, fistulas, prolapsed uterus so that women do not turn to private sector for care.
 - iii) Blood storage must be ensured at CHC level to save women's lives and prevent delays
 - iv) Ensure adequate food and nutrition and iron folic acid supplementation to prevent postpartum anemia
 5. Maternal Death Review (MDR)
 - i) Make all maternal deaths notifiable through positive incentives to frontline workers and PRIs
 - ii) Institute a Rapid Response (like WHO instituted for Polio Eradication) to verify the maternal death and check if there was any rights violation involved
 - iii) Appoint a district and state level maternal health Ombudsperson to take action related to MDR and other maternal health issues.
 - iv) Conduct confidential MDR and bring civil society/ women's organizations on board in district and state review committees.
 - v) Make public MDR findings through an Annual Report in each state which announces remedial action taken to prevent similar deaths.
6. Improve accountability
 - i) Institute simple and easily accessible grievance redress mechanism for the poor/less literate.
 - ii) Abusive or unethical behaviour towards poor and socially marginalized women and their harassment for informal payments must be made punishable.

Sources of Data

The data used in this policy brief is based on Maternal Death Reviews conducted by the following Civil Society Organisations in India:

- I. Dr. Subha Sri, Sarojini N and Renu Khanna (2011): Maternal Deaths and Denial of Maternal Care in Barwani District, Madhya Pradesh: Issues and Concerns, Jan SwasthyaAbhiyan, Sama and CommonHealth http://www.commonhealth.in/resources/eglish_resources/Fact_Finding_Report_Final.pdf
- II. HealthWatch Forum Uttar Pradesh (2005 - 09): documented 15 deaths and 16 near-miss testimonies documented from 10 districts, Uttar Pradesh <http://www.sahayogindia.org/wp-content/uploads/2012/06/Quality-of-Maternal-Health-Services-IN-Uttar-Pradesh-A-Public-Hearing-in-Azamgarh-UP.pdf> <http://www.sahayogindia.org/wp-content/uploads/2012/06/Incidents-of-maternal-death-and-ill-health-in-nine-districts-of-UP4.pdf>
- III. IyengarKirti, Gupta, Narendra (2001): People's Accounts of Maternal Deaths in Jodhpur <http://www.hrln.org/hrln/images/stories/pdf/HRLN-Using-The-Law-For-Public-Health-dr%20Narendra%20Gupta.pdf> ARTH and PRAYAS (2011): documented 12 deaths in Umaid Hospital Jodhpur, Rajasthan in 2011
- IV. Ekjut and Soumik Banerjee (2011-12): documented 23 deaths in Godda district Jharkhand
- V. Jan SwasthyaSahyog documented 26 cases from their field area in Chhattisgarh
- VI. SEWA Rural (2007 onwards): documented 20 cases in the area of work in Bharuch district, Gujarat
- VII. Vd .Smita Bajpai; CHETNA (2012): documented nine cases from underserved areas in seven districts, Gujarat
- VIII. Gender and Health Equity project, IIM Bangalore (2005-11): documented 43 cases in Koppal district, Karnataka
- IX. ANSWERS (2008): documented 108 cases from 22 districts, Andhra Pradesh

Glossary:

1. ANC - Ante Natal Care
2. ANM - Auxiliary Nurse Midwife
3. ASHA - Accredited Social Health Activist.
She is a trained female health activist in the community who creates awareness on health and its social determinants and mobilizes the community towards local health planning and increased utilization and accountability of the existing health services. The ASHA covers a population of 1000.
4. BEmOC - Basic Emergency Obstetric Care.
This include the following : Parenteral administration of Antibiotics, Treatments for eclampsia (provision of anticonvulsants), Parenteral administration of Oxytocics, Assisted Vaginal delivery (vacuum extraction), Manual removal of Placenta and removal of retained products of conception (MVA)
5. CEmOC - Comprehensive Emergency Obstetric Care
Besides providing all the BEmOC services the following 24-hour services should be provided throughout the year: Availability of blood and blood transfusion facility, facility for Caesarian section for delivery of foetus in emergency cases.

6. CHC – Community Health Centre (located at the sub-district level)
7. IPHS – Indian Public Health Standards
The IPHS are a set of uniform standards envisaged to improve the quality of health care delivery in the country. These IPHS guidelines act as the main driver for continuous improvement in quality and serve as the bench mark for assessing the functional status of health facilities.
8. RKS – RogiKalyanSamiti or Hospital Management Committees
They are constituted and registered at the level of District hospital/ CHC/PHC for community management of public hospitals. It ensure compliance to minimal standard for facility and hospital care and protocols of treatment as issued by the Government and is a means for ensuring accountability of the public health providers to the community
9. PRI – Panchayati Raj Institutions (Local Self Government bodies)
Panchayati Raj system is a three-tier system in the State with elected bodies at the Village, sub-district and District levels. It ensures greater participation of people and more effective implementation of rural development programmes
10. PNC – Post Natal Care
11. PPH – Postpartum Haemorrhage
12. VHSNC – Village Health Sanitation and Nutrition Committees
They are established at the level of a revenue village. It serves as a forum for participation of the community and of the representatives of the Panchayati Raj Institutions. Its main functions include generating public awareness of health programmes and health entitlements and motivating the community to avail them; overseeing the work of public service functionaries and monitor health services being provided in terms of availability, quality, outreach, and reaching out to the marginalized sections.; conducting a needs assessment of the village health, sanitation and nutrition situation and make a village health plan.; maintain data on the total population of the village; assisting in infant and maternal death audits and planning how best to spend the 'untied fund' for the benefit of the village.

Endnotes

- 1 Sample Registration System (2009): *Special Bulletin On Maternal Mortality In India - 2004-06*, Office Of Registrar General, Ministry of Home Affairs, Government of India, http://censusindia.gov.in/Vital_Statistics/SRS_Bulletins/MMR-Bulletin-April 2009.pdf
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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR WOMEN IN PAKISTAN

Naureen Butt, Uzma Farooq, Tabinda Sarosh (ShirkatGah, Pakistan)
and Shama Dossa (ARROW)

1. Context

Recognition of reproductive health as a fundamental right alongside women's empowerment is an important contribution of the United Nation's International Conference on Population and Development (ICPD) and other international bodies such as the World Health Organization. However twenty years after ICPD, comprehensive reproductive health services are still beyond the reach of most women and adolescent girls in Pakistan. In recent years donors and governments have been putting resources into the overall strengthening of health systems in developing countries yet monitoring of key reproductive health and rights (RHR) indicators for Millennium Development Goals (MDG) 5¹ such as maternal mortality and morbidity have demonstrated that there is a clear gap between rhetoric and government actions (see Table 1 below). The fact that the targets of the maternal health MDG will not be reached by 2015 is evidence of the reality that gender inequality has not been sufficiently addressed, both within the structure of the goals and indicators of MDG 5, as well as within the overall MDG development framework itself. The issue points to lack of government attention reflected in poor resource allocation to issues that primarily and directly affect the female half of the population. As only women can die from maternal deaths, lack of access to life-saving procedures amounts to discrimination against women.

Hence, maternal mortality ratios despite improvements remain significantly high and lifetime risk of maternal death is 93 in Pakistan². Service delivery for antenatal care is only 60.9 percent for the first visit by a woman and drops dramatically to 28.4 by the fourth visit³. In terms of contraception there is also a significant gap between the total fertility rate and the wanted

Table 1: Pakistan Demographic Health Survey 2007

Indicators	Status	Target 2015
Maternal Mortality Ratio	276/100,000 live births	140
Proportion of births attended by SBAs	40	> 90
Contraceptive Prevalence Rate	30%	55%
Total Fertility Rate	4.1 live births/woman	2.1
Ante natal care (ANC)	56%	100%
Unmet need for Contraception	26%	

fertility rate. Contraceptive prevalence rates also reflect issues of access and lack of choice and data on skilled birth attendants at delivery reveals that the majority of births still take place at home and there are limited referral and EMOC services available for women to access.

Pakistan is one of the leading countries in South Asia, plagued by concerns on sexual and reproductive health and rights (SRHR). Like in most of the sub-region, the lives of Pakistani women tend to be conditioned by the patriarchal relationships at home which are aggravated in the bigger realms of politics, market, religion and culture. With minimal attention to girls and women compared with boys and men, less resources tend to be devoted for their reproductive and sexual well-being. The latter is typically the last in family priorities, except in otherwise grave situations.

Reproductive health service options are not available to most adolescent girls, especially in rural settings. The Lady Health Workers (LHWs) are accessible but not trained to help them and the other service providers like the BHU, hospitals, both public and private even where available, are denied to unmarried girls because of social and cultural reasons. There is no provision to cater to this important section of the population keeping these cultural and social sensitivities in mind. Nor is there any service for health education or awareness raising specifically for adolescents. Early age marriages are a major cause of adolescents suffering poor reproductive health⁴.

The National Population Policy 2010 has a greater focus on adolescent and male reproductive health. It also seems to have a comprehensive reproductive health services package for all stages in a woman's life cycle. However, the implementation of this package remains dubious given the public health sector's inconsistency. Moreover, the interim Population Sector Perspective Plan 2012 fails to even refer to a life cycle approach.

1.0 Devolution

Devolution of the health and population ministries in Pakistan took place two years ago. Shirkat Gah in its various advocacy efforts and engagement with the Pakistan Reproductive Health Network (PRHN) has analysed the sudden impact of the 18th Constitutional Amendment which led to completely abolishing the Health Ministry and Population Welfare Ministry. Our analysis shows that devolution has caused uncertainty and there is a lack of direction and uniformity among the different provincial Health and Population Welfare departments. As pointed out by Dr. Sania Nishtar⁵ provinces have long demonstrated a lack of capacity in terms of implementation and good governance. Also, a position paper on devolution of Population Welfare drafted by PRHN mentions that although many functions of the ministry had already been devolved to the provinces in 2002, there is a need at present to retain a national role in policy and planning development, human resource development, and advocacy and communication⁶.

A crucial point to consider is also that the 18th Amendment to the Constitution of Pakistan, among other things, gave greater autonomy to the provinces by "devolving" many subjects entirely to the provincial legislatures and governments, including health. Many questions are yet to be resolved such as: who then would be taking leadership in this area? What plans were in place to assist this transition? Provincial capacity (in terms of human resource, planning and financial management)? And whether the new structures (eight divisions, including the Ministry for Inter Provincial Coordination) had the mandate or the resources to ensure effective transition...⁷

It is also worth noting though that the Government of Pakistan has recently issued a Notification on the 4th of May 2013 that it has renamed the "Ministry of National Services and

Regulations" to "Ministry of National Health Services, Regulation and Coordination" and that this Ministry will be taking charge of medical service delivery and academic institutions, the drug regulatory agency and coordination of vertical health programmes, among other functions. This could bring the much desired coordination at the federal level but it is yet to be seen how this translates for Health Systems Governance.

2 Evidence from the Ground

In 2010, Shirkat Gah carried out a nationwide qualitative study, "Monitoring the Implementation of MDG5a and b" to assess progress towards MDG5a and b in Pakistan⁸ the results of which were published by Shirkat Gah in "Rising to the Challenge" (2012). The study captured the dismal condition of women's health in terms of lack of access to quality continuum of care and also unveiled the need for addressing social determinants of health, service delivery, and the need to build capacity of the health related duty bearers and service providers to understand and respond to the gender specific implications of poor health governance. Furthermore, the study found that marginalized communities suffer more and the needs of the adolescent population are completely overlooked despite the increasing demand for information and services about reproductive health and rights.

Shirkat Gah's above mentioned research also focused on reproductive health (RH) services (availability, accessibility, quality), unsafe abortion and its links to maternal mortality, family planning and emergency services, adolescent reproductive health and the link between secondary education and positive reproductive health outcomes in girls. The study concluded that RH services are poor where available and are not easily accessible to women. The findings below have all been drawn from Shirkat Gah's (2012) research "Monitoring MDG5a and b in Pakistan".

The key findings from Shirkat Gah's study were:

- Population welfare is a health and social justice issue
- No significant difference in RH services and issues for the poor between districts with RH specific interventions and those without
- Accessing services is dependent upon differences in socio-economic status, education, urban or rural location
- Violence and fear of violence are key deterrents for women in seeking RH/Family Planning services
- Poverty is a key determinant of public health facility utilization

Details of the Findings are as follows:

2.1 Maternal Deaths

Maternal deaths continue to remain a challenge in Pakistan (14,000 maternal deaths, MMR 276/100,000 live births)⁹. Access to emergency obstetric care family planning and post partum care is poor. Where women must step out of the house to avail health services a host of factors such as distance, transport, cost, permission, escort and knowledge of options come into play. People prefer to go to the public sector facilities because they are either free or subsidized but the salaries of the health providers are low and there are hardly any incentives for them to serve in difficult circumstances¹⁰.

The various service providers are tempted to increase their income by diverting public facilities, medicines, and their own time and expertise to the private sector. So even in areas where public sector facilities are present and staff and medicines provided, they are not functioning optimally because of lack of incentives, monitoring and regulation. The gaps in services left by the public sector are being filled by a variety of service providers who range from religious soothsayers and quacks to private doctors and clinics.

2.2 Unsafe Abortions:

890,000 abortions occur annually in Pakistan (Population Council of Pakistan and Guttmacher Institute, 2005) and given that this data was collected mostly through women hospitalised for post-abortion complications, the figure is considered to be an underestimate. Abortions are also said to account for 6 % of maternal deaths in the country (PDHS 2006-2007). Deaths resulting from abortion are mostly due to the fact that they are either self induced or carried out in an unsafe manner. In a country with high fertility rates, high unmet need for family planning and low contraceptive use, unwanted pregnancies are not uncommon.

Abortions are often used as a means of family planning¹¹. Reasons for resorting to an unsafe procedure include, but are not limited to, unavailability of appropriate health facilities in the vicinity, lack of awareness about how and where to access the appropriate health provider and the consequences of unsafe abortions, social restrictions on mobility and service providers who are biased and turn patients away.

Most of these findings are confirmed by Shirkat Gah's above mentioned research on MDG 5. Our study also found that unmarried women are at greater risk of death and morbidity

due to unsafe abortion as they are far less likely to find allies to guide them to the appropriate health professional. Cases of young unmarried girls committing suicide as they had could not found any help in terminating the pregnancy were also identified as major reproductive health and rights issue. Another research consultancy Shirkat Gah conducted in Sindh on child marriages found cases of child brides ingesting rat poison to terminate pregnancies, which even ended one young girl's life¹².

2.3 Barriers to accessing services

The burden of contraception largely lies with the women. The social norm is for large families, exacerbated by the need to produce sons. Early age marriage, women and girls' low status in society with limited education and employment opportunities are also driving factors of the low contraceptive use and high fertility rates¹³. Awareness of family planning is raised through word of mouth, LHWs, television and radio programmes, etc but this increase in demand is not being met with an increase in supply of services.

There is relatively more awareness and corresponding availability of services in urban areas as compared to rural. In rural areas, LHWs are greatly appreciated because of their provision of services at the doorstep but these services are limited to pills and condoms, indicating a dearth of commodity and choices available. As mentioned above, the gap left by the public health sector is often filled by unqualified persons and since there is no check on such persons administering family planning injections or inserting intrauterine devices without follow up or counseling, myths of side effects when things go wrong are further perpetuated.

2.3.1 Unskilled and Underskilled medical staff

Skilled Birth Attendants are unable to provide coverage for all births and as a matter of fact Traditional Birth Attendants (TBAs) assist over 50% of deliveries, while skilled providers assist just 39%. Government has expanded the operation of Lady Health Workers (LHWs) to all Districts, but LHWs fail to reach remote and under-developed districts¹⁴. Too often, the phenomenon of new life is transformed into an agonizing experience for survival. It has been ShirkatGah's experience that in field areas of WHRAP districts, coverage of LHWs is insufficient and none of the districts have 100% coverage and there exists a marginal gap in supply of population/health services and needs of the poor and marginalized groups. However, in all the locations where the LHWs are present they are well appreciated by the women because services at the doorstep are suited to the cultural, social and financial constraints.

In Shirkat Gah's experience in the WHRAP districts in both Punjab and Sindh is that the coverage of LHWs is quite limited. Not all cases of birth were facilitated by LHWs. Nonetheless the communities, especially women appreciate the presence of LHWs, whose services are suited to the women's cultural, social and financial constraints.

Farzana, 28 belongs to a poor household in the village of Rakh Boli in Sheikhpura in Punjab. She was married off at the age of 17 to a 38-year old daily labourer, with whom she has four children: two sons and two daughters. The birth of her first two children was spaced by one and a half years. But she became pregnant when her third child was only six months old. Her husband was not pleased. At that time her family was already struggling to make ends meet.

He blamed Farzana for not taking a drug which could have prevented another pregnancy. For her part, she also told her husband that he could have also used condoms. Later, her husband asked her to have her pregnancy terminated, even when she was already on her third month. She relented as she thought about the difficulty of caring for an infant and her rather weak condition.

Despite the opposition of her religiously devout mother-in-law, Farzana underwent a D & C procedure with a TBA in another village. The TBA performed the procedure in an hour and a half and later charged her Rs. 3000. Following the procedure, Farzana experienced bleeding. Two weeks later, the bleeding even increased, prompting her husband to take her to a medical doctor. An LWH, who administered her and other women in the village polio vaccines learned about Farzana's bleeding and directed the couple to visit a private clinic in Tehsil in Mureedke. The lady doctor who scolded her, saying: "you people spoil the case and then come to us to fix it." She performed an ultrasound and informed Farzana that the continuous bleeding was caused by severe infection in the uterus. She performed a D & C procedure which lasted for three hours and also prescribed some medication. This made the bleeding stop. Seeing that Farzana was from a poor family, the doctor had only charged her Rs. 2000. Farzana was able to leave the hospital within three hours of the procedure.

2.3.2 Limited access to correct and complete information

A key barrier in demanding accountability from public health institutions is the minimal data on service delivery performance and outcomes. The fragmented structure and relationships of these institutions necessarily renders the surveillance system weak and inefficient. These also make policy decisions less informed by realities and service providers, free from accountability.

The impact of misinformation trickles down to the community as services tend to be inconsistent, incomplete and inappropriate enough to put women's lives in danger. Complete and correct pieces of information as well as a conducive environment in asking more questions and sharing experiences are quite critical for women, whose bodies are subjected to the challenges and dangers of pregnancy and childbirth. Women also often take primary responsibility over family planning, even as this must be an obligation of two partners.

Information is one's primary defense to preserve and enhance one's sexual well-being especially in the critical stages of adolescence, pregnancy and post-pregnancy. The rate of clandestine and unsafe abortions cannot only be attributed to the legal restrictions but also to the lack of public information of when, how and where to access this procedure.

Among the areas where correct and complete information is not given importance are family planning and post-partum services. There are several stories which documented failures of procedures and even medication, resulting in excessive bleeding, infertility, obesity and back aches, among others. Meanwhile, post-partum care, which includes counseling is often lacking in both public and private health centres.

Nasreen, 28 comes from a poor family in a village in Chak Shah District Nankana Sahib in Punjab. At 13, she was married to her cousin in her father's side. Now a 28 year old mother of four children, she does not know how to read and write. Before, her husband, who works in the fields thought of having many children, assuming that they would be able to provide for themselves and make the family prosper. After her third child, Nasreen took oral contraceptives which were provided to her by the LHW but these caused her excessive bleeding and she practically ended up getting her menstrual cycle every two weeks. When she complained, the LHW assured her that this side effect would subside with continuous intake. But the LHW was wrong because five months later Nasreen was still experiencing excessive bleeding. Her body had swollen and she had become very weak from anemia. The LHW then told her to stop taking the pills. Just a month after, she became pregnant and later gave birth to a boy. By this time, the couple decided not to have any more children. The LHW in the village also provides condoms and injections but Nasreen was apprehensive with the feedback of other women who shared that the injectibles have not been effective and the intra uterine device Copper T also causes a lot of problems. Now her husband has begun using condoms, but only when he wishes to.

2.3.3 Low regard for women's mobility and privacy

Mobility and privacy are necessary in accessing information and consulting as many sources to learn about one's own body and sexuality. This is a challenge in a context where early and forced marriages are almost the norm and where unequal gender relationships leads to a woman's loss of control over her own body. Women's bodies are thus vulnerable to early and unplanned pregnancies and the risks associated with these, spread of sexually transmitted infections (STIs including HIV) and malnutrition.

Social and cultural sensitivities likewise discourage unmarried adolescents and women from consulting doctors over observations and concerns especially over sexual and reproductive health such as excessive menstrual pain and vaginal discharge. The mere presence of LHW is not enough especially when they are not trained enough to address these concerns otherwise taboo subjects.

2.3.4 Adolescent Girl's Access to SRH Services

During Shirkat Gah's awareness-raising session for adolescents in 40 villages covered by WHRAP, mothers insisted to sit with their children. While the mothers' fears and anxieties over the content of the session were relieved, their children were placed at a disadvantage. Daughters remained shy, discouraging them to ask questions and share more openly.

It is important to note that adolescents have an extremely low visibility in policy discussions, programme plans and surveys. Adolescent girls are grouped either with women of the age bracket of 15-49 years or with children between zero-five years.

Although the positive impact of female secondary education on SRHR has been true in most cases around the world, it is unfortunate that education itself is a luxury for girls in rural areas. It is typical for them to drop out as they grow older because of the distance between the house and the school; the lack of washroom facilities in schools; transport and security issues and social disapproval. A limited education can be linked with early marriages, prevalence of anemia, higher morbidity rate, low status and less employment options among women and girls.

Even the more educated women are constrained by the same cultural norms. They have to abide by the strict customs of arranged marriages, stop working and even endure poor public services when resources are not available.

Seema, 28, is from the village Parao Khas in Khyber Pakhtunkhwa. She is the eldest of eight siblings. At five, she was admitted to the nearest primary school. She went on with high school in the town of Charsadda since there was no high school in her village.

People were not pleased with her going to school except her grandfather, who was a frequent visitor to Lahore and appreciated the trend of girls education. When she reached her final year of high school her grandfather allowed her to apply for the post of LHW in a local hospital.

Many people also dislike the job of the LHW because it requires women to travel and therefore, deem it unsuitable for women. Fortunately, Seema's family is supportive. Now an LHW, Seema professes the benefits of education to a woman. Because of this, she not only got a source of income but also esteem within her family and community.

Her opinion now carries weight. Her family received many marriage proposals and her opinion was always asked. Seema rejected all of them. Instead she would like to make a decision once she has sensed that the right man has come. While working, Seema is continuing her studies. Her greatest is to have her own clinic that would cater to the poor. When this happens, Seema believes that more families will be encouraged to educate their own daughters.

2.3.5 Violence against women, especially poor women and minorities

The previous cases show that while women have greater responsibilities, they have less decision-making power whether in their parents' or their husbands' households. Investments are not directed towards them, leaving them less educated, fed and valued.

The impact of this patriarchal system becomes more acute among poor and marginalized women, who are largely seen as a matter of economic exchange and who are more prone to physical and sexual abuses especially with a caste system. Their value lies solely on their reproductive labour, which means both labour within the household and ability to reproduce.

Discrimination is itself a form of violence. As such it can be said that Pakistani women and girls actually live a context of violence that can easily worsen into one that denies one's basic right to life.

Ayesha had not been well since her childhood. At around six or seven years, Ayesha was thought to have been possessed by a spirit that arms and legs would contract as she would scream whenever she had violent convulsions. Then when her breathing became laboured and eventually stopped, she would lose consciousness. She was taken to Pir-o-murshid, a faith healer who gave her Ta'weez that had Quranic verses. At that time, Ayesha's family did not consider bringing their daughter to a doctor. At only 16, Ayesha married her cousin, a peasant on her father's side as part of an exchange. In this new household, Ayesha experienced torment from her husband and in-laws. Her mother-in-law refused to give her enough food. Meanwhile, her husband would physically abuse her and send her outside the house at the behest of his mother. Ayesha endured this without telling her parents and brother so as not to complicate the relationship between the two families. The abuse continued even when she got pregnant. Her mother-in-law assisted her delivery, despite not being a dai. The infant was dead at birth. That very month Ayesha became pregnant again. This child was also stillborn. All this time, no one took Ayesha to certified medical professional. Her own family members were too poor to collect the resources necessary to seek medical help. Her in-laws were just as poor, but additionally had no desire to do so. When Ayesha became pregnant for the third time, her in-laws threw her out of the house and told her to go have her child at her parents' house because they could not pay for the possible complications. When she began to have contractions at night, a village dai assisted her as she gave birth to a stillborn baby girl. Unable to articulate her complaints, Ayesha just groaned in agony. Her family members desperately waited till dawn so they could arrange for transport to a medical facility. But she died at night. She was only 20.

2.4 Gaps in Health Systems Governance

Additional findings from Shirkat Gah's field based projects reveal a number of health system governance challenges.

2.4.1 Inequitable Health Financing

As pointed out in the Table 2 and marginalisation of health in financial and budgetary allocation processes results in negligible amounts spent on general government health expenditures . This closely connected to the increasing trend of **privatization** of service provision and the downloading of responsibility by national governments who are constitutionally mandated to provide universal health care; connected to this is also the lack of adequate mechanisms and implementation private sector regulation (Berer, 2010, p. 10; Kristiansen & Santoso 2007)¹⁵.

Table 2: Consolidated National Health Accounts - Pakistan

Expenditure	2005	2010
Total expenditure on health as % of Gross domestic product	3	2
General government expenditure on health as % of total expenditure	26	38
Per capita total expenditure on health (PPP int.\$)	59	59
General government expenditure on health as % of total government expenditure	3	4
Private expenditure on health as % of total expenditure on health	74	62
Out-of-Pocket expenditure as % of private expenditure on health	81	82

Source : Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on <http://www.who.int/nha/country/en/index.html>)

In addition the above mentioned issues, a number of indicators reflect poor governance of the health system in Pakistan. These include in no specific order: gaps in evidence generation; limited functional **mechanisms for wide participation and consensus of stakeholders** including the involvement of a civil society to aid accountability and transparency) The **gap between policy development and policy implementation** are exacerbated by **weak monitoring and evaluation systems, lack of transparency and accountability** in terms of resources allocated and spent on health and their equitable distribution across provinces and districts; (this includes issues of leakage and underutilization of funds. The severe **shortage and absenteeism of human resources** for health particularly in rural, remote, and underserved areas; challenges in deployment and retention of high quality staff in health facilities, programs and various management positions; and the development of mechanisms to monitor the responsiveness

of the health services that determine particularly the level of satisfaction of its users are all deterrents to progress towards the ICPD agenda. Reproductive Health and rights advocates need to engage with these health system challenges in order to achieve universal access to health care services, including comprehensive reproductive health services. It is therefore vital that reproductive health and rights are integral parts of health systems, and of policies and funding aimed at strengthening health systems.

2.4.2 Conflict of interest and corruption among medical practitioners

With the decreasing resources for public health, already existing problems are bound to worsen, making access to maternal care more difficult and planning for reforms and alternatives more urgent.

At present, the Pakistani health sector is plagued by a low standard of protocols and services which perpetuate corruption, complacency, insensitivity within its ranks and stories of disempowerment and tragedies for many women. The provision of health services is not only poor but it is also slow. Patients who previously know some medical practitioners in a hospital tend to be served first, than those who do not even as their case may be worse.

There are also several instances when government-employed medical professionals run their own private clinics and entice their patients to avail of private services instead. Cases where conflict of interest are overt erode the public's confidence over public health institutions.

It is important to note that private health service providers are completely unregulated that higher fees do not guarantee quality services, including skilled staff, who can be shielded from malpractice. Unfortunately the significant budget cuts in public health manifest an increasing orientation towards privatization with minimal government controls. Privatisation will not only exclude sectors which are in need of intervention but can further burden the public health system.

Recommendations

Shirkat Gah's field studies and experiences identify the following windows of opportunities for interventions:

- Increase capacities of Responsive officials (Health, Population Welfare, Local Government) -- to community demands/needs as evidenced during District policy dialogues
- Facilitate the capacities and support responsive and forthcoming communities who are aware of their needs and need the knowledge base and a platform to approach the government actors and demand and access their rights

Broadly from a Health systems perspective would like to propose that Provincial Population Welfare and Health Departments:

- Adopt a comprehensive approach to ensure access to information and quality care at all stages of a woman's lifecycle and across location (home, community and health facilities) to overcome difficulties faced by marginalized women in accessing affordable skilled care.
- Support safe delivery for all births at home and in institutions by an effective referral system including Emergency Obstetric Care through registered trained TBAs.
- Build awareness and capacity of service providers for young people's health needs such as counseling and health care. These services must be integrated into general health services. Privacy and confidentiality must be upheld at all time.
- Formulate adolescent-sensitive health programs with adequate budgets e.g. making Life Skills based education part of the educational curriculum.
- Adopt a coherent information dissemination policy of the Health and Population Welfare Departments to keep people abreast of the services which can be accessed. Increase funding for health and population policies and programs.
- Institutionalize maternal death surveillance and reviews to identify gaps in the existing services towards ensuring an efficient and effective continuum of care. This includes institutionalizing monitoring systems and annual reporting.
- Introduce a national policy on post-abortion care.
- Ensure the availability of affordable essential and non-essential drugs through mechanisms that regulate the quality, uniformity and accountability of services and pricing system of the private sector.
- Weaknesses in Pakistan's Health Governance System have been identified as lack of accountability and transparency mechanisms at central and implementation level, a lack of unison in the working of the bureaucracy and technocracy, less prioritization of the principles of health equity, lack of evidence-based decision making and weaknesses in policy, planning, health information and surveillance units which impact effectiveness and efficiency poorly. Therefore development capacities of health professionals and bureaucrats and measures to improve synergy among them is extremely important.

Recommendations in relation to the management of the Devolution process of the Ministries of Health and Population Welfare¹⁶.

1. Policy and Planning:-

- Policy formulation should remain a central function at the Federal level. For the sake of clarity and consistency at all levels, it is of crucial importance to have one National Population Policy Framework developed in consultation with the provinces, civil society, academia, private sector and other stakeholders. The Framework shall define precisely the relationship between Federal and the Provincial governments with reference to the execution and implementation of the Population Welfare Programme and the relationship between provincial components of the country-wide Population Welfare programme. Other essential components of the Framework should be:
- Continuation of Population Welfare Programme as a priority at the Provincial levels
- Allocation of adequate resources for the recurrent and expansion costs of the Programme
- Development and adoption of the Provincial Population Policies within a stipulated time to ensure that the Programme continues without any setback after stoppage of Federal funding in June, 2015

Provincial policies should adequately address the issues of HRD, Communication/ Community Mobilization/ Demand Generation, Service delivery, commodity security, research and others Drawing on the National Policy Framework, the Provincial Governments could develop their own policies. The population policies of all the provinces/regions and need to ensure (a) uniformity, consistency, standardization, as well as (b) adherence to Pakistan's internationally binding commitments (e.g. CEDAW, CRC, ICPD and FWCW). The policy must be in line with the national commitments made at the ICPD, like rights based and life cycle approach to reproductive health and should be the basis of a National Plan of action (NPA) for Reproductive Health and serve as a guideline for the preparation of programmes and projects at provincial level and for their implementation.

- International obligations and commitment regarding RH, that are to be honored and reported at federal level, must be incorporated in the Policy and National Plan of Action. Future plans and strategic directions emerge from the Policy and there should be a mechanism at federal level to act as the focal point for coordination of efforts at all levels. One possible mechanism could be the revitalization and strengthening of the Pakistan National Commission on Population.

2. Human Resource Development:-

The Human Resource Development (HRD) is of crucial importance for the successful implementation of the National Policy and Plan of Action. The technical wing of the former Ministry of Population Welfare along with Directorate of Clinical/ Non-clinical Training and its allied Regional Training Institutes and Population Welfare Training Institutes, have done some commendable work to ensure a constant supply of skilled personnel, through competency based training programs. It is important to retain HRD at the federal level for the following reasons:-

- To ensure uniform training standards through uniform need-based curricula
- Uniform and credible evaluation criteria
- Development and updating of curricula to keep abreast with new developments in knowledge, skills and technological advances
- Faculty training and mentoring
- Development, revision and updating of training resource material and evaluation protocols
- Ensuring transparency and validity of examination.
- Maintaining pool of trainers and examiners
- Directorate of Clinical Training (DoCT) should be restructured as PRHAFC (Pakistan Reproductive Health Accreditation Council), in line with Pakistan Medical and Dental Council and Pakistan Nursing Council.

3. Communication and Advocacy

- Communication and advocacy is a highly technical and sensitive issue. In order to develop an effective Advocacy and Communication Strategy, in line with the policy, it should remain as a Central function with active involvement of all provinces and civil society organizations.
- Proto type messages videos, brochures and other communication material be developed at central level and then tailored and translated into different languages, in line with local cultural environment.
- High profile events such as international conferences, seminars and World Population Day be arranged at federal level.

Endnotes

- 1 Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio & Target 5.B. Achieve, by 2015, universal access to reproductive health
- 2 Trends in maternal mortality estimates developed by WHO, UNICEF, UNFPA and World Bank 2010, Datasource 2008 http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf
- 3 UN MDG Indicators Database <http://mdgs.un.org/unsd/mdg/Data.aspx> Access Date 11 May 2013
- 4 Shirkat Gah publication, "Rising to the Challenge" (2012)
- 5 Health and the 18th Amendment: Retaining National Functions in Devolution (Heartfile, 2011)
- 6 Pakistan Reproductive Health Network (PRHN) Position Paper on 18th Amendment Devolution of Health and Population Welfare Ministries to Provinces 2013.
- 7 Dr. Sania Nishtar, "Devolving Health- A Way Forward", The News, 23 July 2011
- 8 Shirkat Gah publication, "Rising to the Challenge" (2012)
- 9 Pakistan Demographic and health Survey, 2006-7 (PDHS)
- 10 Shirkat Gah publication, "Rising to the Challenge" (2012)
- 11 "ICPD + 15: Investigating Barriers to Achieve Safe Motherhood"- Shirkat Gah, 2009
- 12 "The Puppet and the Puppeteers"- Rutgers WPF, 2012
- 13 ICPD + 15: Investigating Barriers to Achieve Safe Motherhood"- Shirkat Gah, 2009
- 14 WHO and Global Health Workforce Alliance, *Country Case Study: Pakistan's Lady Health Worker Programme: Scaling Up Education and Training for Health Workers*, 2 (2008), available at http://www.who.int/workforcealliance/knowledge/case_studies/CS_Pakistan_web_en.pdf.
- 15 Privatization in healthcare according to Ravindran (2010) "refers not to the existence of a private sector in health, which is a universal phenomenon. It refers to deliberate interventions through policies and funding support to expand private sector provision of health care services; to introduce or expand private financing of health care (e.g. out-of-pocket expenditure, private insurance) and other market mechanisms within public sector health services; and to the gradual withdrawal of the state from taking responsibility for universal access to health care services." (cited in Berer, 2010, p.6).
- 16 Pakistan Reproductive Health Network (PRHN) Position Paper on 18th Amendment Devolution of Health and Population Welfare Ministries to Provinces 2013.

Partners in WHRAP-South Asia



Danish Family Planning Association - DFPA based in Denmark is working to promote worldwide sexual well-being, wished-for-children and no sexually transmitted diseases for everyone. Health concerning sexuality, pregnancy and birth is a human right, regardless of nationality, age, gender, religion or marital and social status. For more on DFPA, please visit www.sexogsamfund.dk



Asian Pacific Resource and Research Centre for Women - ARROW based in Malaysia is committed to advocating and protecting women's health needs and rights, particularly in the area of women's sexual and reproductive health. ARROW relies on effective partnerships and collaborations. For more on ARROW, please visit www.arrow.org.my



Naripokkho based in Bangladesh is a membership-based, women's activist organization working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice since its founding in 1983. For more on Naripokkho, please visit: www.naripokkho.org



Centre for Health Education, Training and Nutrition Awareness - CHETNA in India raises nutrition and health consciousness among disadvantaged social groups through capacity enhancement of Government and Civil Society functionaries. For more on CHETNA, please visit: www.chetnaindia.org



SAHAYOG in India works with the mission of promoting gender equality and women's health using human rights frameworks through strengthening partnership-based advocacy. For more on Sahayog, please visit: www.sahayogindia.org



Beyond Beijing Committee- BBC in Nepal is dedicated towards a nationwide campaign to eliminate all forms of discrimination against women, and Sexual and Reproductive Health and Rights is one of the principal issues of the organisation. For more on BBC, please visit: www.beyondbeijing.org



ShirkatGah (SG) in Pakistan is a Women's Resource Centre formed in 1975 and aims to promote women's empowerment through a rights based approach that ensures that women have access to the rights and services they are entitled to. For more on ShirkatGah, please visit www.shirkatgah.org

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**RIGHTS BASED CONTINUUM OF QUALITY
CARE FOR WOMEN'S REPRODUCTIVE
HEALTH IN SOUTH ASIA**

2013

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1 & 2 Jalan Scott, Brickfields,
50470 Kuala Lumpur, Malaysia
tel+603 2273 9913
fax+603 2273 9916
emailarrow@arrow.com.my
webwww.arrow.org.my

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Editors

**Nina Somera
Nalini Singh
Shama Dossa**

Writers & Contributors:

**Anjana Shakya
Bidya Bhattarai
Indu Capoor
Jashodhara Dasgupta
Khawar Mumtaz
Laxmi Prabha Shrestha
Nalini Singh
Naureen Butt
Nashir Uddin
Pallavi Patel
Rakshya Paudel
Samia Afrin
Sivananthi Thanenthiran
Shireen Huq
Shubha Kayastha
Smita Bajpai
Uzma Farooq
YK Sandhya**

Layout Artist:
TM Ali Basir