FULFILLING WOMEN'S RIGHT TO CONTINUUM OF QUALITY CARE!

Context-Specific, Rights-Based Continuum of Quality Care for Women's Reproductive Health in South Asia

Women's Health and Rights Advocacy Partnership (WHRAP)-South Asia

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1.0
Continuum of Quality Care: A reflection 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 inthe 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) and
Tania Dethlefsen
(International Director, DFPA)

2.0
Glossary of Terms

Abortion: In the present context, 'abortion' refers to 'induced' abortion, which is the intentional termination of a pregnancy before the foetus can live independently. An abortion may be elective (based on women's personal choice) or therapeutic (to preserve the health or save the life of a pregnant woman).[1]

Ancillary Services: The healthcare services provided exclusive of room and board. Supplies and laboratory tests provided under home care, audiology, durable medical equipment (DME), ambulatory surgical centers (ASC), home infusion, hospice care, skilled nursing facility (SNF), cardiac testing, mobile lithotripsy, fitness center, radiology, pulmonary testing, sleep centers, and kidney dialysis are examples of ancillary services. Without ancillary services, doctors, dentists, and nurses will not be able to function effectively.[2]

Antenatal Care: 'Antenatal care' refers to routine health check-ups and treatment for health problems related to pregnancy received during the pregnancy period. A comprehensive package of antenatal care services includes identification and management of obstetric complications, such as pre-eclampsia, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy (IPTp) in malaria-endemic regions, and identification and management of infections including HIV, syphilis, and other sexually transmitted infections (STIs) (The Partnership for Maternal, Newborn and Child Health, 2006).[3]

Emergency Obstetric Care (EmOC): It refers to the care of women and newborns during pregnancy, delivery, and the time after delivery.

[1] ARROW. (2013). An Advocate's Guide: *Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights.* Kuala Lumpur: Asian-Pacific Resource & Research Centre For Women.
[2] http://definitions.uslegal.com/a/ancillary-services-health-care/
[3] ARROW. (2013).

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Live Birth: "The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life—e.g., beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles—whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born." [4]

Malnutrition: An abnormal physiological condition caused by inadequate, unbalanced, or excessive consumption of macronutrients and/or micronutrients. Malnutrition includes undernutrition and overnutrition as well as micronutrient deficiencies.[5]

Maternal Death: Maternal death is the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. The term 'after termination of pregnancy' indicates that if the pregnancy does not end in delivery, but ends in miscarriage or abortion, the resulting death is a maternal death. The term, 'irrespective of the site of pregnancy' means that a death during or following the termination of the pregnancy is a maternal death even if the site of the pregnancy was not the uterus but the fallopian tube, as what happens in ectopic pregnancy. If a woman dies of malaria or hepatitis during pregnancy, this is to be counted as maternal death because these conditions are more likely to be fatal in pregnant than in non-pregnant women. Such cases are known as the 'indirect' causes of maternal mortality.[6]

Maternal Mortality Ratio: "Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births. The data are estimated with a regression model using information on fertility, birth attendants, and HIV prevalence."[7]

Out-of-pocket Expenditure: "[It] is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure."[8]

Poor (Multidimensional): Up until recently, poverty has been measured in terms of income or consumption at the household level, and expenditure. In 2010, the Multidimensional Poverty Index (MPI), an international poverty measure, was developed for the United Nations Development Programme's Human Development Report by the Oxford Poverty and Human Development Initiative (OPHI). The index reflects the multi deprivations that a poor person faces with respect to education, health, and living standards. These three dimensions are measured using 10 indicators such as for education (e.g., years of schooling, school attendance); health-child mortality (nutrition); living standards (electricity, drinking water, sanitation, flooring, cooking fuel); and assets. A person is identified as multidimensionally poor if he or she is deprived in one-third or more of the dimensions. The MPIs can be deconstructed by region, ethnicity, and other groupings and dimensions, making it a useful tool to measure poverty.[9]

Postpartum Period and Care: Postpartum period begins immediately after the birth of the baby and extends up to six weeks (42 days) after birth. 'Postpartum / postnatal care' includes care for the mother and newborn. Detailed guidelines on what such care includes are given in the WHO Technical Consultation on Postpartum and Postnatal Care (WHO, 2010).[10]

Reproductive Health (RH): Reproductive health is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity"; it "addresses the reproductive processes, functions, and system at all stages of life." It "implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women [as well as gender non-conforming people] to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant." [11]

Reproductive Rights (RR): Reproductive rights "recognise that the sexual and reproductive health of both women and men [as well as gender nonconforming people] requires more than scientific knowledge or biomedical intervention." Rather, they require "recognition and respect for the inherent dignity of the individual." They "refer to the composite of human rights that protect against the causes of ill health and promote sexual and reproductive wellbeing." They "embrace certain human rights that are already recognised in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents."[13] RR include the right to safe, legal, and accessible abortion services.[14]

Sexual Health: "Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and

[4] WHO. http://www.who.int/healthinfo/statistics/indmaternalmortality/en/
[5] ARROW. (2014). *ARROWs for Change: Linking Poverty, Food Sovereignty and Security, and Sexual and Reproductive Health and Rights* Vol. 20, No. 1.
[5] ARROW. (2013).
[7] WHO, UNICEF, UNFPA, The World Bank, and the United Nations Population Division. (2014). *Trends in Maternal Mortality*: 1990 to 2013. Geneva: World Health Organization.[2]http://definitions.uslegal.com/a/ancillary-services-health-care/
[8] ARROW. (2013).

[9] Alkire, S., Roche, J.M., Santos, M.E., & Seth, S. (2011). *Multidimensional Poverty Index 2011.Oxford: Poverty and Human Development Initiative,* University of Oxford. Retrieved from www.ophi.org.uk/wp-content/uploads/OPHI-MPI-Brief-2011.pdf and cited in *ARROWs for Change*, 2014.
[10] ARROW.(2013).
[11] Adapted, "Reproductive Health." World Health Organization. www.who.int/topics/reproductive_health/en/, cited in *ARROWs for Change: 15 Years after Cairo* Vol. 15, Nos. 2 & 3, 2009.
[12] Erdman, J.N., & Cook, R. (2008). "Reproductive rights." Elsevier Inc. pp. 532-538, cited in *ARROWs for Change,* 2009.
[13] ICPD PoA, paragraph 7.3, www.unfpa.org/icpd/icpd-programme.cfm#ch7, cited in *ARROWs for Change*, 2009.
[14] ARROW. (2009). *ARROWs for Change: 15 Years after Cairo* Vol. 15, Nos. 2 & 3.

sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence."[15] The purpose of sexual healthcare should be "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[16] "For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled."[17]

Sexual Rights: "Sexual rights embrace human rights that are already recognised in national laws, international human rights documents, and other consensus documents. They include the right of all persons, free of coercion, discrimination, and violence, to: the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; seek, receive, and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when to have children; and pursue a satisfying, safe, and pleasurable sexual life."[18] Sexual rights also include the "right to personhood (the right to make one's own choices), equality (between and among men, women, and transgender people), and respect for diversity (in the context of culture, provided the first three principles are not violated)."[19] Moreover, "a human rights approach to sexuality and sexual policy implies the principle of indivisibility—meaning that sexual rights are inextricable from economic, social, cultural, and political rights. Freedom to express one's sexual or gender orientation or to be who one is as a sexual person, to experience erotic justice, is interdependent with a whole series of other rights, including healthcare, decent housing, food security, freedom from violence and intimidation, and to be in public space without shame."[20]

Skilled Birth Attendant: A skilled birth attendant (sometimes referred to as skilled attendant) is defined as "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 (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns." This definition excludes traditional birth attendants whether trained or not, from the category of skilled health workers (WHO, ICM, FIGO, 2004: p. 1).[21]

Supplements: Supplements include vitamins, minerals, herbs, meal supplements, sports nutrition products, natural food supplements, and other related products used to boost the nutritional content of a person's diet.

The Millennium Development: "At the Millennium Summit in September 2000 the largest gathering of world leaders in history adopted the UN Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound targets, with a deadline of 2015 that have become known as the Millennium Development Goals (MDGs). The MDGs are the world's time-bound and quantified targets for addressing extreme poverty in its many dimensions—income poverty, hunger, disease, lack of adequate shelter, and exclusion—while promoting gender equality, education, and environmental sustainability. They are also basic human rights—the rights of each person on the planet to health, education, shelter, and security."[22]

Total Health Expenditure: This is the sum of general government expenditure and private expenditure on health in a given year (in international dollars).[23]

Undernutrition: The outcome of undernourishment, and /or poor absorption and/ or poor biological use of nutrients consumed as a result of repeated infectious disease. It includes being underweight for one's age, too short for one's age (stunted), dangerously thin for one's height (wasted), and/or deficient in vitamins and minerals (micronutrient malnutrition).[24]

Universal Access to Sexual and Reproductive Health Services: This is "[t]he equal ability of all persons according to their need to receive appropriate information, screening, treatment, and care in a timely manner, across the reproductive life course, that will ensure their capacity, regardless of age, sex, social class, place of living, or ethnicity [other factors include caste, citizenship, (dis)ability, marital status, sexual orientation, gender identity, and religion, among others] to decide freely how many and when to have children and to delay or to prevent [or to terminate] pregnancy; conceive, deliver safely, and raise healthy children and manage problems of infertility; prevent, treat, and manage reproductive tract infections and sexually transmitted infections including HIV/AIDS, and other reproductive tract morbidities, such as cancer; and enjoy a healthy, safe and satisfying sexual relationship which contributes to the enhancement of life and personal relations."[25]

3.0 Introduction

About Women's Health and Rights Advocacy Partnership (WHRAP) - Asia

The Women's Health and Rights Advocacy Partnership (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

[15] WHO. "Gender and Human Rights." www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html, cited in *ARROWs for Change*, 2009.
[16] ICPD PoA, paragraph 7.2, cited in *ARROWs for Change*, 2009.
[17] WHO. "Gender and Human Rights." www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/index.html, cited in ARROWs for Change, 2009.
[18] Asian Communities for Reproductive Justice (ACRJ). (2005). *A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice*. California, USA: ACRJ. Retrieved from www.reproductivejustice.org/reproductive.html, cited in *ARROWs for Change*, 2009.
[19] Chandiramani, R. (2007). "Why affirm sexuality?" In ARROWs for Change Vol. 13, No. 2, pp. 1-2, cited in *ARROWs for Change*, 2009.
[20] Petchesky, R. (2006). "Introduction: Sexual rights policies across countries and cultures: Conceptual frameworks and minefields." In Parker, R., Petchesky, R., & Sember, R. (2006). SexPolitics: Reports from the Front Lines. Sexuality Policy Watch. Retrieved from www.sxpolitics.org/frontlines/book/pdf/sexpolitics.pdf, cited in *ARROWs for Change*, 2009.
[21] Cited in ARROW. (2013).
[22] http://www.unmillenniumproject.org/goals/
[23] ARROW. (2013).
[24] Basic definitions from FAO's Hunger Portal, retrieved from www.fao.org/hunger/en/, cited in ARROWs for Change, 2014.
[25] WHO. (2011). *Universal Access to Reproductive Health: Accelerated Actions to Enhance Progress on Millennium Development Goal 5 Through Advancing Target 5B. Geneva: WHO, cited in ARROWs for Change: The MDGs: A Critical Look and Some Proposals for the Post -2015 Development Framework Vol.16, No. 1, 2010.*

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last ten years, WHRAP-South Asia has facilitated and contributed to processes aimed at improving the quality of life of marginalised women in South Asia through strengthened civil society engagement and accountability for health governance.

WHRAP-South Asia is implemented as a partnership programme between five leading national women's organizations including Beyond Beijing Committee (BBC) in Nepal, Naripokkho in Bangladesh, Shirkat Gah in Pakistan, Centre for Health Education, Training and Nutrition Awareness (CHETNA) and SAHAYOG in India as national partners; their forty (40) Community-Based partners that work directly with the women on the ground; and the Asian Pacific Resource and Research Centre for Women (ARROW) as its regional partner. The programme has been carried out in cooperation with Danish Family Planning Association (DFPA) and financed by Danish International Development Agency (Danida).

WHRAP-South Asia as a project began in 2003. Currently in its Phase IV, it aims to promote marginalised women's sexual and reproductive health and rights and calls for context-specific and 'Rights-Based Continuum of Quality Care (CQC) for Women's Reproductive Health in South Asia' across a woman's lifecycle—from preconception and pregnancy, to postpartum/ post-abortion and menopause—and across various locations, e.g., home, community, and health facilities. Based on their over ten years of experience, WHRAP-South Asia argues that CQC is crucial in order to reduce adolescent, maternal, newborn, and child mortality and morbidity and improve women's reproductive health.

About the Paper

This position paper is a summarised and simplified version of a technical paper entitled Rights *Based Continuum of Quality Care for Women's Reproductive Health in South Asia* published by ARROW in 2013. It is intended for all who are working in the field of women's health, specifically for the improvement of maternal health in Bangladesh, India, Nepal, and Pakistan. The paper also speaks to NGO workers; civil society groups at local, national, regional, and international levels; and relevant government officials, as well as other national and international decision and policymakers who are not necessarily technically versed on the issue of maternal health, and maternal mortality and morbidity. For technical information, the full version of the paper is available at http://www.whrap.org/resource/arrow/rights-based-continnum-of-quality-care-for-womens-reproductive-health-in-south-asia/.

The paper aims to reflect the context-specific realities in Bangladesh, India, Nepal, and Pakistan towards affirming a rights-based framework for Continuum of Quality Care for Women's Reproductive Health in four WHRAP-South implementing countries. It is divided into five main sections. The work for the paper is supported by evidence from the ground from all the WHRAP-South Asia national partners and is informed by the experience of marginalised women who wish to seek access to non-discriminatory, affordable, appropriate, and timely intervention for their sexual and reproductive health concerns.

The first section of the paper articulates WHRAP-South Asia's 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 policymakers.

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 underreporting 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.

The paper on Nepal by Beyond Beijing Committee (BBC) highlights the issue of policy implementation and public awareness about the abortion law that was legalised in 2002. Legalisation has not reduced the stigma of abortion and even after years of legalisation, the awareness level is still very low, causing women to access clandestine services resulting to death and lifelong complications. In addition, public service provision is extremely limited for both comprehensive abortion care and post-abortion care.

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 results of a lack of continuum of quality care in the country.

Shirkat Gah's paper on Pakistan discusses the devolution of the Ministries of Population Welfare and Health to provinces, and its impact on the healthcare system with 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.

Women's Reproductive Health in South Asia
Calling for a Rights-Based Continuum of Quality Care Approach

4.0
Women's Reproductive Health in South Asia
Calling for a Rights-Based Continuum of Quality Care Approach[i]

Maternal Mortality in South Asia

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 194,[1] India 212,[2] Nepal 281,[3] and Pakistan 276.[4] The lifetime risk of maternal death in Bangladesh is 1 in 250, in India 1 in 190, in Nepal 1 in 200 and, in Pakistan it is 1 in 179.[5]

Poverty, caste, culture, ethnicity, and geography create widespread inequities in the region. Presently, 80 percent of the population in these four countries still lives in rural areas without safe delivery services.[6] Every year, at least 50 million women deliver at home. In developing countries, majority of cases of mortality and morbidity take place at home due to delays in reaching the nearest healthcare facility.[7]

According to the World Health Organization and UNICEF, the top reasons for maternal deaths in South Asia in 1997-2007 include hemorrhage (35%), hypertension (17%), indirect causes (19%), other direct causes (19%), embolism (1%), and sepsis (7%).[8]

Globally, there are about 19-20 million abortions done every year by individuals without prerequisite skills or in environments with below minimum medical standards. One-third of all maternal deaths are due to haemorrhage, infection, and poisoning[9] caused by unsafe abortions. Legalisation of abortion is a necessary but insufficient step toward improving women's health, especially when effective infrastructure, personnel, ancillary services, and adequate budget are not in place.

The Millennium Development Goal 5 focuses on maternal, newborn, and child mortality. It aims for the reduction of maternal mortality ratio by three-quarters and the provision of universal access to reproductive health by 2015. With just a year left, South Asia is nowhere near the target indicators for maternal health interventions such as skilled birth attendance, antenatal care, and family planning.

There is an emerging body of evidence of the impact of child marriage, adolescent nutrition and education on adolescent pregnancy, and maternal and infant deaths and disability. However, in a region where nearly one in four people is an adolescent (a child between the age of 10 and 19[10]), this rarely translates into adolescent-sensitive health programmes.

Statistics show one in four adolescent girls in South Asia is too thin and one in five was stunted during her childhood due to inadequate nutrition.[11] Maternal mortality in girls under 18 is estimated to be two to five times higher than in women between the ages of 18 and 25.[12]

[i]The original paper was authored by Dr. Shama Dossa. This Popular version is refined and updated by Nalini Singh and Biplabi Shrestha.

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According to the 2009 Human Rights Council resolution, the 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, and 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.

Initiatives to Reduce Maternal Mortality

There are a number of international initiatives which focus on the Continuum of Care (CoC) for maternal health which is relevant to South Asia. In 2011, WHO, through the Partnership for Maternal, Newborn and Child Health (PMNCH) framework, suggested that CoC be designed according to context-specific needs. Similarly, the 2010 UNICEF proposed framework includes special needs of adolescent girls. Both these promising frameworks must be monitored and implemented.

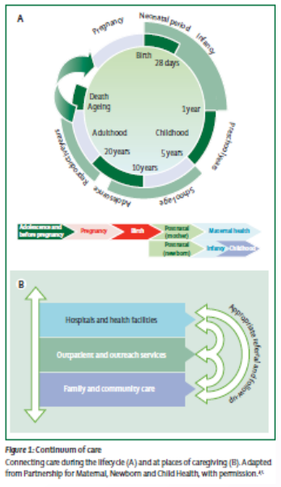

Figure 1: Continuum of care
Connecting care during the lifecycle (A) and at places of caregiving (B). Adapted from Partnership for Maternal, Newborn and Child Health, with permission.[45]

CoC 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 mother and child, as well as the onset of menopause.

The CoC accounts for 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 facilities.[13]

In the context of South Asia, however, using only the CoC approach is insufficient 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 conditions and adversely impact the health of women, children, and young people in the region.

WHRAP-South Asia's Call

WHRAP-South Asia then calls for universal access to rights- and context-based continuum of quality care (CQC) for women's reproductive health across a woman's lifecycle—from preconception and pregnancy, to postpartum/post-abortion and menopause —and across various locations, e.g., home, community, and health facilities.

Ensuring a Continuum of Quality Care (CQC) across a woman's lifecycle—from preconception and pregnancy, to postpartum/post-abortion and menopause, and across various locations, e.g., home, community, and health facilities—is important to reduce adolescent, maternal, newborn, and child mortality and morbidity and improve women's reproductive health.

The following section of the paper discusses gaps in the strategies to reduce maternal mortality introduced by MDGs and highlights of CQC to promote maternal health and to reduce and end maternal mortality.

Why will a focus on delivery by Skilled Birth Attendants (SBAs) alone not reduce maternal mortality?

The MDG era has seen 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 narrow approach has led to an increased focus on institutional delivery rather than on safe delivery.

There has been a large push for governments to train SBAs 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.[14] Pakistan and Bangladesh have also experimented with similar voucher and cash transfer schemes, moving away from previous strategies of training traditional birth attendants (TBAs).[15,16]

However, in the context of the four WHRAP-South Asia countries, home deliveries are a reality despite the increase in institutional deliveries. Due to the push to meet the MDG targets, home deliveries are being forgotten. Hence, aiming to reduce maternal mortality only through SBAs at institutions is unrealistic. In fact, it is estimated that the deployment of SBA will remain limited to 50 percent, with 90 percent of the unattended births taking place in rural areas.[17]

In India, while institutional deliveries have increased, there is a significant variation by state. A qualitative study also revealed that in the majority of deliveries, especially at home, the role of the SBA can be largely restricted to giving injections or Intravenous (IV) drips during labour.[18]

Thus, even in the presence of a professionally qualified birth attendant, women and newborns are subjected to a range of "unskilled" practices in both homes and facilities[19] which challenge the utility and appropriateness of this MDG indicator. For a greater impact, the countries can instead have a CQC approach by building on its own resources such as traditional birth attendants who can fill in the gap between the patients who are poor and far from health facilities.

There is now evidence proving that a large proportion of newborn deaths and disease can be reduced by implementing simple, low-cost interventions during delivery and in the vulnerable postpartum period, both in the facility and at home.[20] The majority of essential interventions are homecare practices that families can provide themselves. Families can also tap the services of the community health worker 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.

The Bangladesh Gonoshasthya Kendra (GK) model shows that over 80 percent of births are being delivered safely by trained birth attendants (TBAs) 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 TBAs are available.[21]

It is crucial, however, to note that the debate here is not about choosing between institutional or home-

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based delivery but about safe and unsafe delivery. In circumstances where the primary healthcare 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. 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.

WHRAP-Asia's Position

WHRAP-South Asia calls for the safe delivery for all births that take place at home and in institutions, supported by an effective referral system including Emergency Obstetric Care (EmOC). A context-specific rights-based framework for continuum of quality care for reproductive health across a woman's lifecycle (preconception to postpartum/post-abortion) and across locations (home, community, and health facilities) is needed. This includes acknowledging the role of trained TBAs to reduce maternal mortality and morbidity.

Why is the inclusion of adolescent girls and their nutrition important in a rights-based Continuum of Quality Care framework?

In South Asia, nearly one in two women aged 20-24 was married before her 18th birthday and nearly one in three adolescent girls is either pregnant or already a mother.[22] Around 14 percent of girls in Nepal and 11 percent in Bangladesh are married before the age of 15, despite laws in both countries that prohibit marriage before 18 years.[23] Nepal alone loses an estimated 10,000 adolescent girls a year to trafficking, mostly to brothels in India.[24] Meanwhile, 13 percent of girls aged 5-14 years are engaged in child labour in South Asia.

Since reliable numbers concerning sexual exploitation and sexual abuse of adolescent girls are a major challenge, it is likely that the 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.

Anaemia among the adolescents is disproportionately high in South Asia and can be traced to malnutrition due to poverty and aggravated by discriminatory cultural practices towards adolescent girls. Anaemia during pregnancy is associated with premature births, low birth weight, and perinatal mortality. It 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 percent of South Asian women of childbearing age are underweight and malnourished.[25]

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 South Asia, issues related to food and nutrition needs to be included in maternal health strategies.

WHRAP-South Asia's Position

Adolescence is an extremely critical period in a woman's lifecycle. Adolescent girls must be recognised as a group with special needs in relation to their health, nutrition, and empowerment (decision-making, leadership, and self-esteem) in CQC strategies/ frameworks.

Adolescent girls have a right to information about their bodies and means of protecting them. Hence, policymakers must mandate comprehensive reproductive health education for in-school and out-of-school adolescent girls. Further, supplementary nutrition programmes with adequate budget allocations need to be part of CQC strategies given the current nutrition statistics in South Asia. Thus, multiple government departments can share implementation of CoC strategies by adopting an integrated approach.

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

Evidences from all four countries reflect that care is neither fully accessible nor equitable. Homebirths are most common among the poor. Half of these births were unattended even by a TBA. Meanwhile, women in rich facilities are more likely to give birth in a private health facility.

These findings are further substantiated by country-specific data. For example, only 13 percent of the poor women in India deliver their babies in a hospital, even though all services are free for them.[26] Similarly in Pakistan, delivery at a health facility is markedly lower among births of the poorest (27%).[27] A study on delivery cost and the patients' willingness to pay in nine districts in Nepal found that not only were the costs of facility-based delivery considerable but unlike home delivery, they varied considerably. Most women (56%) preferred to give birth at home, in the absence of complications. The main reasons given were: the low cost, no need to travel, and the familiarity of attendants with the home environment.[28]

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 percent were wealthy, compared to only eight percent of poor women.[29]

An impact evaluation study of the cash transfer scheme (SDIP) in Makhwanpur district, Nepal, found implementation of the programme had led to a substantial increase in accessing maternity services and skilled attendants at delivery. However, the cash incentive reached disproportionately to wealthier families. The study asserts that the SDIP offers little protection against catastrophic payments (representing over 10% of their total income).[30]

In the case of Bangladesh, studies show that a major constraint in 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 needed.[31] Findings from evaluation of two home-based SBA programmes in Bangladesh reveal that inequities in service utilisation by amount of income and mother's education are substantial. [32]

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Figures Hide Real Story

Gaps still exist between policy and its implementation. **So although national figures may reflect an increase in deliveries by SBAs and MDG targets could be achieved, this does not mean the needs of the poorest are being met.**[33] Poor implementation, governance issues, and human resource constraints slowed the progress of Pakistan's 1999 Reproductive Health Service Package which focused on maternal health, safe motherhood, pre/post abortion care, and EmOC.[34] In India, a study of the Janani Suraksha Yojana, a cash transfer scheme, in four Indian states showed that although institutional deliveries had increased, majority of poor women were ignorant of the programme. Also, delays in payment of their cash benefits were compounded by a portion being pocketed by the health staff.[35]

Some evidence suggests that the quality of care has suffered in institutions because of the inability of the staff to absorb an increasing number of deliveries.[36] An evaluation study of the programme in Odisha, India, found women were discharged on average 16 hours after normal delivery and in some cases, even within 3 to 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.[37] Unless the health system is able to ensure good quality care translating into continued and sustained use of maternal health services for all, achievement of MDG 5 goal will remain out of reach for a long time.[38]

WHRAP-South Asia's 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 worsens the condition and adversely impact the health of women, children, and young people. In addition, difficult geographical terrain also limits access to health services. There are no shortcuts to achieving equitable access to good quality comprehensive reproductive health services.

Policymakers must take a rights-based approach that incorporates equitable and non-discriminatory access to continuum of quality care. This requires recognition of the specific needs of these vulnerable groups, specific resource allocations (budget, human resources, infrastructure), and the development of context-specific implementation of health models for continuum of quality care that meet the needs of these groups.

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 own constitutional obligations to ensure the right to health in addition to commitments made as signatories to Convention on the Elimination of All forms of Discrimination Against Women (CEDAW); International Conference on Population Development (ICPD) Plan of Action; Beijing Platform of Action; and the Human Rights Council's 2009 resolution. Moreover, the state must provide healthcare 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 insufficient allocation of resources to healthcare. The budgetary allocation for the health sector in Bangladesh for 2014-2015 is 4.2 percent of the total budget.[39] In Pakistan, health expenditure fell from three percent of the GDP in 2000 to 2.7 percent in 2007. Public expenditure on healthcare in India is nearly seven percent of GDP.[41]

Out-of-pocket (OOP) or self-financing is the largest source of healthcare financing in South Asia. In Pakistan, OOP expenditure by households accounted for 70 percent of total health expenditure in 2007. Latest estimates (Central Statistical Organisation, 2004) indicate that 99 percent of private expenditures on healthcare in India are out-of-pocket. For this, nearly half the extremely poor get into debt and/or sell assets.[42] Unfortunately, OOP expenditures are likely to become more frequent with the increasing trend towards privatisation.

It is important to challenge the assumption that privatisation is the solution 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 services.[43] 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 needs.[44]

WHRAP-South Asia's Position

Health is a basic fundamental right of people, and all governments in South Asia have ratified major conventions and are signatories to international plans of actions. 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 healthcare. The state 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 minimised, if not eliminated, so that women and adolescent girls can gain better access to quality services.

Conclusion

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 crucial.

Given the difficulties faced by marginalised women in accessing affordable skilled care in South Asia, ensuring a context-specific and rights-based continuum of quality care across a woman's lifecycle and across locations is critical to reduce adolescent, maternal, newborn, and child mortality and improve women's reproductive health. Implementations of the existing in tandem with that of WHRAP-South Asia for comprehensive continuum of quality care can make a difference in the region.

Recommendations for Continuum of Quality Care (CQC) Services

- All pregnant women should have access to Emergency Obstetric Care (EmOC), a package of critical health services which, when provided, can immediately and competently save women's lives at any time during pregnancy, delivery, postpartum/post abortion.[ii]

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- Guarantee women's safety in child birth delivery whether in facility-based or home delivery. Having a broad base health care provider is important such as ANM, TBAs, community midwives, etc. This should also be backed by emergency transport especially on complicated cased.
- Include pre and post-delivery/abortion services in the public health system package to account for complications which may emerge later and put women's lives at risk.
- Safe abortion services should be readily available and affordable to all women. This means that services should be available at all levels of health facilities which should be equipped with counselling services for safe abortion and use of contraception to prevent unwanted pregnancy.
- Services for safe abortion including counselling should be delivered in a way that respects a woman's dignity, guarantees her right to privacy, and is sensitive to her needs and perspectives. In addition, attention should be given to the special needs of the poor, adolescents, and other vulnerable and marginalised women.
- Re-establish TBA training to supplement SBA programmes. Definition of SBAs should be expanded to also include TBA.
- Extend role of trained traditional birth attendants (TTBA) to delivery where there is a poor and partially functional health system.
- A provision for an access to wholesome nutrition package for adolescents should be made. The wholesome package includes supplement; awareness; counselling; monitoring of health status and progress; Information dissemination with inclusion in the curriculum and the community outreach programs).
- SBA training must include modules on SRHR in line with ICPD, CEDAW and CRC commitments. This training must also be extended to include alternative medicine practices which proved to be beneficial for maternal health.
- Contraceptive services must equally focus on men with a specific focus on temporary methods as opposed to permanent methods. As partners, husbands, and fathers, men have a vital role to play.
- Free screening with full quality, antenatal routine care/services and services for postpartum/post abortion complications. This should also be provided for screening of other situations such as violence, malaria, uterine prolapse, blood grouping, HIV, Sickle Cell anaemia, etc.
- Pre-referral management stabilisation; treatment of mild to moderate complications such as eclampsia, HIV, and TB; and nutrition supplement from the public system must be included in screening protocol.
- Pre-conception birth planning is a must in all safe motherhood programmes.
- Maternity benefits must be unconditional and be part of public health services.
- Public health system must take responsibility in registering antenatal check-ups and developing a follow-up system.

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

- CQC monitoring systems must include continuous tracking of services for vulnerable groups including 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.
- Conduct in-depth and accurate maternal death review to identify the existing gaps in CQC and include in the monitoring system. The report of the review should be disseminated and made available to public.
- All countries must produce annual reports out of this monitoring system.
- Data monitoring should include disaggregated data based on age including teenage pregnancy.
- Develop and monitor a comprehensive reproductive education to in-school and out-of-school adolescents.
- Develop and implement an effective regulation system for private providers and pharmaceuticals.
- Open the healthcare system to continuous public/community monitoring. Social reviews as part of a regulatory mechanism must ensure the accountability of all duty bearers involved.
- A budgetary analysis of health allocations must be included as part of the monitoring system, with clear indications on resources spent on each programme in compliance with WHO recommendations.
- Organise public dialogue which brings the public health functionaries/providers, local self-government representatives and the users in a multi-stakeholder dialogue. This should also allow health providers spaces to discuss challenges they face.
- Community monitoring should be entrenched into the community action.
- Establish a well thought out functioning grievance redress mechanism with adequate participation/inclusion of non-system people at the grass root level which addresses grievance which is time bound. The action taken should be monitored.
- Existing mechanisms should be activated and empowered which should include an element of capacity enhancement of the officials/ members of the grievance redress committee.

Policy and Programme Implementation Recommendations Specific to Adolescent Girls

- Special attention should be given to health of young mother and 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.
- Special attention should also be given on the vulnerability of adolescents to internal and external migration that are forced due to various situation and must be placed in policies and programmes.
- Develop and implement comprehensive policies for adolescents that address SRHR as a part of the focus.
- Develop and implement a Life Skills Based Education/comprehensive sexuality education (CSE) curriculum for in and out of school adolescents. Such education and information on services should be accessed to all adolescents irrespective of marital status, gender, sex, sexual orientation, gender identity, sexual expression, etc. This is not part of life skills curriculums in the WHRAP-South Asia implementing countries.
- Develop and implement a system for tracking out-of-school adolescent girls and ensuring comprehensive sexual and reproductive health and rights (SRHR) education, considering the large population of out-of-school adolescents in South Asia.

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- Adolescent friendly services such as counselling and healthcare must be integrated into general health services. This should also address the issue of teenage pregnancies in and out of marriage and availability of adolescent friendly contraceptives availability, access to information and counselling for all adolescents.
- Policies on supplementary nutritious food must be developed and implemented for all girl child/adolescent girls including those out of school.
- Enact and implement legislation to prevent early, child and forced marriage with focus on social transformation.
- Birth registration systems must be in place especially for girls to help determine her age at marriage.
- Ensure adolescent active participation in designing, planning, implementation and monitoring policies and programmes.

Recommendations for the States based on its obligation in providing CQC

- States have an obligation 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.
- States have an obligation provide quality healthcare services for all and that health services should be provided through tax based finances.
- States have an obligation to provide budgets/ resources in accordance with WHO standards, skill mix adequate staff, essential medical supplies, blood and infrastructure to ensure CQC/ transparency of budgets expenditure.
- Sustained investment in strengthening the health system must happen under government supervision and management.
- The benefit of public private partnerships (PPP) implementing health models must be reassessed and its resources should be directed to achieve health equity within a cohesive policy framework.
- States must not disengage from its regulatory role. Reforms in social services must be part of a political agenda that balances economic growth with equity and ensures meaningful participation of all stakeholders in the public health system.
- Policies and programmes must account for social conditions which inform people's access to health services.
- States have an obligation to allocate adequate budgets for home-based services and increase capacity of service providers to ensure recognition of complications, timely referral and timely transport services.
- Allocate adequate budgets for school feeding and supplementary nutrition for out-of-school adolescent girls.
- States have an obligation to ensure that health insurance schemes are transparent in their services.
- Strengthen monitoring and accountability for cash incentive programmes for institutional delivery schemes and ensure periodic assessment based on a rights based CQC framework. States have an obligation to set standards and protocols to enable monitoring against it which is applicable across the entire country and should be made public.
- Ensure that ODA resource flows are transparent and that the most vulnerable sections of society are included.
- States have an obligation to strengthen the vital registration system.

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Maternal Deaths in Bangladesh: Are We Getting the Right Picture?

5.0
Maternal Deaths in Bangladesh: Are We Getting the Right Picture?[1]

Context

Reproductive health, particularly maternal health, has been a key concern in Bangladesh especially with the Millennium Development Goals (MDGs) targeting a reduction of maternal mortality rates by 2015.[1]

In 2001, a year after the MDGs were introduced, Bangladesh launched a "National Strategy for Maternal Health" with the Health, Nutrition, Population Sector Programme (2003-2010) focusing on Emergency Obstetric Care (EmOC).[2] Consequently, the Ministry of Health and Family Welfare scaled up EmOC services especially for the third stage of labour. With haemorrhage and eclampsia being leading causes of maternal deaths, accounting for 31 percent and 20 percent respectively,[3] it also approved the distribution of Misoprostol tablets after delivery to prevent postpartum haemorrhage. The supply of magnesium sulphate necessary for management of pre-eclampsia[4] was also increased.

By 2010, the Maternal Mortality Ratio (MMR) declined by 60 percent, from 322 in 2001 to 194 for 100,000 live births in 2010. This annual reduction rate of around 5.5 percent suggests Bangladesh, which aims to reduce MMR to 143 by 2015,[5] is on track to achieve MDG Goal 5.

A closer look, however, shows non-compliance of the national policy to report maternal deaths within 24 hours. This could be behind the apparent decline in MMR.

At a UN Summit in September 2010, Bangladesh Prime Minister Sheikh Hasina announced more services and incentives would be provided towards reaching its MDG5 target. These included

- 3,000 midwives to be trained by 2015, followed by another 7,000
- Round-the-clock maternal healthcare service from 427 Upazila Health Complexes
- 59 district hospitals to be upgraded as Women Friendly Health Service Centres with inclusion of EmOC
- A national action plan and a strategy for adolescent reproductive health will be formulated to increase awareness and prevent adolescent pregnancies
- Adolescent health services are to be upgraded to international standards in one-third of all hospitals by 2015

Source: (http://www.unbconnect.com/component/news/task-show/id-59253/format-raw

[1]The authors and contributors of this paper are; Samia Afrin and Shireen Huq (Naripokkho)

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Evidence from the Ground

In 2011, Naripokkho conducted a study on reported cases of maternal deaths in 14 Upazilas (sub-districts) and 111 unions in five districts in the Barisal division. According to the data collected, of the total 184 maternal deaths recorded, 120 were recorded at government facilities, 47 at birth and death registers at the Union Parishad, four at the Upazila Family Planning office, and 13 by Naripokkho and its partners. These findings were validated in workshops with civil surgeons, family planning officers, statisticians, medical officers, and Family Welfare Visitors.

Findings

Women Die Young, Mostly in Government Facilities

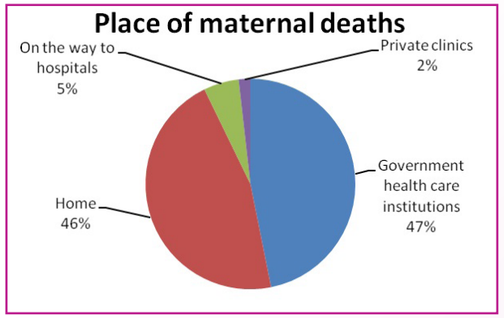
Naripokkho found 184 maternal deaths had taken place during January to December 2011 in five districts—Patuakhali, Barguna, Barisal, Jhalakathi, and Pirojpur. Of these, 111 were from the study area. Records of every death were checked by name, age, and address of the women by Naripokkho and its partners (Table 1).

Table: Source of Information on Maternal Deaths

Source of Information	Number of Deaths	Percent-age
Government Hospitals	40	36.04
Upazila Family Planning Office	5	4.50
Birth & Death Registers at Union Parishad	57	51.35
Personally collected by project staff and women's groups	9	8.11
Total	111	100

About two-thirds of the deaths took place in government health facilities while 29 percent died at home, three percent died on their way to the hospital and around two percent in private clinics (Figure 1).

Fig 1: Place of maternal deaths



These women were between 18-45 years, a majority between ages 20-34. The average age at death was 26.6 years (Table 2).

Table 2: Age of deceased women

Age group (Years)	Number of Deaths	Percent-age
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

Variance in Causes of Death

There were differences between the Naripokkho study and the official data published by the Bangladesh Maternal Mortality and Health Service Survey (BMMHCS, 2010) regarding the causes of these maternal deaths. Naripokkho found eclampsia as the leading cause of death, accounting for 37 percent, followed by haemorrhage, 30 percent. However, the BMMHCS held haemorrhage responsible for 31 percent of maternal deaths and eclampsia, 20 percent.

Maternal Mortality Underreported?

Maternal deaths are recorded at the Union Parishad. Forty-five deaths were recorded at the Upazila Family Planning Office and Union Parishad. However, these were not reported to the relevant national agencies considered for national surveys. Besides the exclusion of 45 deaths in the national data, nine more deaths tracked by Naripokkho were not reported at all. This means that 54 out of the 111 maternal deaths (48.64%) were omitted from national records.

Women Fall Through Gaps in Data Collection

While several departments are involved in recording maternal deaths, important information gets left out because of gaps in data collection. The Union Parishad, for example, which records maternal deaths, does not forward this information to agencies that compile country information on maternal deaths. This leads to underreporting.

The chart (Figure 2) shows the flow of records from a healthcare facility to the Ministry on Health and Family Planning. The coloured boxes indicate the agencies in charge of family planning services. The square boxes are the agencies which record deaths without the personal details of individuals, such as name, age, and address. Personal details are recorded by agencies shown in the oval figures.

THE MISSING MOTHER

Amena, 20, did not go for any antenatal check up after the fourth month of her pregnancy. Nearly a week before her expected delivery date, Amena's legs started swelling. Her mother did not consider this abnormal and brought her daughter to her natal home instead of taking her to the doctor as desired by Amena's husband. Four hours after giving birth with the assistance of a traditional birth attendant (Dai), Amena started vomiting 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.

Amena's is one of the many maternal deaths missing in national statistics.

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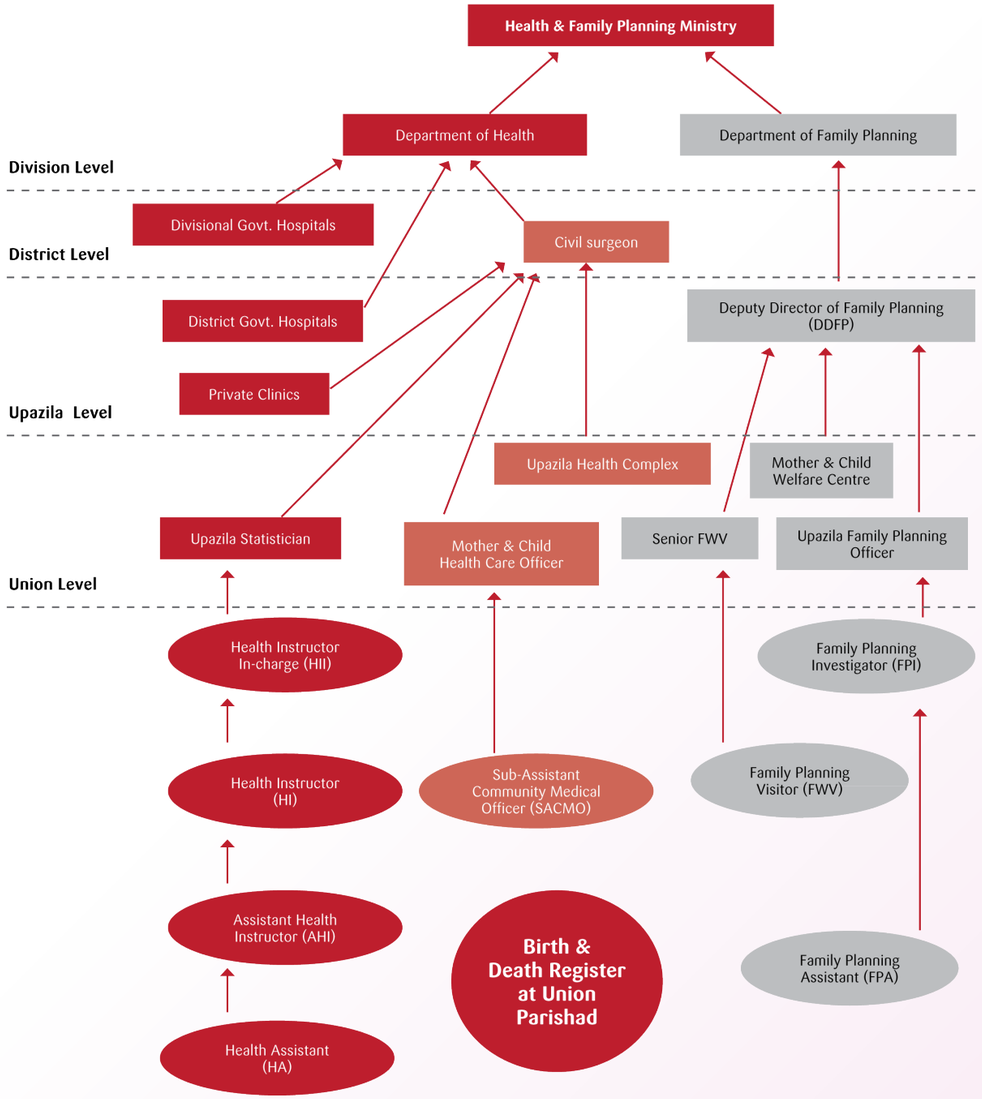
Fig 1: Information Flowchart for Maternal Death Reporting



Violation of Human Rights

Officials responsible for recording maternal deaths try to "keep" the number as low as possible. Similarly, record-keepers, who are a part of the health service delivery system, fear the numbers might reflect on their professional performance.

Naripokkho's findings on maternal death reporting indicate violation of human rights and reluctance for transparent governance. Unless data is accurate, health interventions to prevent maternal deaths and ensure accountability of health providers cannot be effective.

Protocols Ignored

Eclampsia management emerged as another issue of concern. Eclampsia, a leading cause of maternal death, is usually managed by an injection of magnesium sulphate. However, physicians usually don't follow this method as it requires continuous monitoring of the patient's blood pressure. Instead, they inject tranquilizers as an immediate and temporary solution while referring patients to tertiary hospitals. Magnesium sulphate is also not supplied by the government to hospitals at Upazila level.

Haemorrhage, another leading cause of maternal death, is also inadequately addressed. In most cases, neither the patient's blood group nor potential blood donors are identified in advance. EmOC is also not available in all Upazila health complexes.

Way Forward

The Naripokkho research reveals that anaemia, malaria, and tuberculosis are indirect causes of maternal mortality particularly among poor women who cannot access quality maternity care and trained health professionals. The distance to the nearest medical facilities for women living in remote areas also indirectly contributes to maternal deaths. These realities are not captured by official reports, leading to the belief that pregnancy complications alone cause significant number of maternal deaths. Hence, there is a need to reflect ground realities in official records.

Further, greater investments in community-based resources could prove to be life-saving. Traditional birth attendants, for example, could be trained to manage complications during and after delivery, thus reducing the risks rural women face in transit to medical facilities in towns.

DID TAJINUR DIE?

Tajinur, 23, had four antenatal check-ups from the Health and Family Welfare centre nearest to her. When she did not experience labour pains on the day she was due to deliver, she visited the Upazila Health Complex. Instead of tending to her there, Ibrahim, an assistant community medical officer, took Tajinur to his own private clinic and conducted a caesarian operation on her there. When Tajinur remained unconscious after delivery, Ibrahim sent her in an ambulance to the Barisal Sher-e-Bangla Medical College Hospital where she was declared dead on arrival.

Tajinur's death was not recorded and thus never became part of official statistics.

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Recommendations

- Record details (name, age, address) of every maternal death at each stage of data collection. These details must be publicly available, except when it violates the right to privacy
- Ensure accountability of record keepers and service providers through an effective monitoring system
- Ensure clear and effective coordination between Union Parishad and union level health service providers to ensure accurate data on maternal deaths
- Provide incentives for reporting maternal deaths
- Design a robust reporting system for maternal deaths which take place at home, outside of healthcare facilities, during referrals, and in transit
- Conduct a national maternal death review as soon as possible
- Include lessons learned, good practices, and gaps in the health system in the annual maternity death review
- Hold meetings between health service providers, public representatives, and family members of the woman within 48 hours after her death, convened by the Hospital Management Committees (HMC) and Union Parishad Standing Committees on Health
- Ensure antenatal check-up for all pregnant women at union level to identify eclampsia, anaemia, and other high-risk conditions
- Plan and implement a rights-based continuum of quality care for reproductive health needs.

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Access to Quality Health Services across Time and Place in India - A Right of All Women

Fulfilling Women's Right to Continuum of Quality Care!

Context-Specific, Rights-Based Continuum of Quality Care
for Women's Reproductive Health in South Asia

6.0
Access to Quality Health Services across Time and Place in India - A Right of All Women[1]

Context

Giving birth is one of the most joyful events in a woman's life. Sadly, a large number of women in India are unable to enjoy this blessing. Every year, around 56,000 women in India lose their lives due to pregnancy- and childbirth-related causes. The most common direct medical causes of maternal deaths include excessive bleeding, eclampsia, obstructed labour, unsafe abortion, and sepsis which are responsible of 75 percent of maternal deaths. Another 25 percent of maternal deaths are the result of indirect causes related to socio-economic factors such as anaemia, tuberculosis, and malaria.

Over the last decade, the estimated maternal deaths have declined,[2] but the progress is slow and uneven. Three states—Kerala, Tamil Nadu, and Maharashtra—have already reached the Millennium Development Goal (MDG) of bringing maternal mortality down to 109 as are several other states—Andhra Pradesh, West Bengal, Gujarat, and Haryana—which are close to achieving these targets. However, nine states including Assam, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Odisha, Rajasthan, Uttar Pradesh, and Uttarakhand, are far from achieving the MDGs and maternal deaths in these states range between 250 and 390 per 100,000 live births.

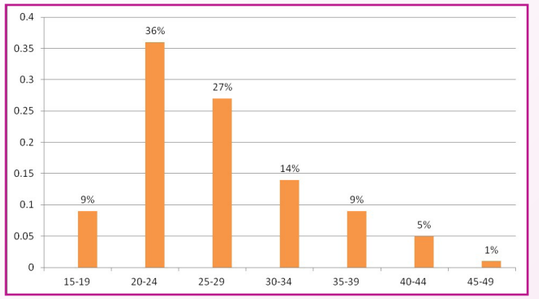
Ironically, most of these deaths could have been prevented by timely access to health services. A continued, complete, and comprehensive package of preventive, promotive, and curative quality health services including interventions to improve maternal nutrition needs to be made available, accessible, and affordable to all women at health facilities, in transit, and at home. Thus, continuum of quality care (CQC) needs to be ensured to prevent these needless maternal deaths.

Young Women's Access to Continuum of Care

National data indicates a grim scenario for young women in India. There is a steep decline in adolescent sex ratio from 933 at 13 years to 861 at 18 years.[3] More than half of adolescent girls are anaemic and the status has remained the same in the past three decades. Almost half of adolescent girls are totally thin to severely thin.[4] There is a need for specific interventions for addressing young women's health and nutrition needs, including their maternal health, before they become pregnant.

To compound the problem of widespread anaemia among these young girls is the problem of early marriage followed by early childbearing. The data shows that about 47 percent of girls are married by the age of 18—which is the legal age of marriage for women in India—and 16 percent of girls become pregnant or give birth between the ages of 15-19.[5i] The young age at which girls become pregnant and undergo childbirth increases the risk of facing life-threatening complications. This is borne out by data which shows that 9% of maternal deaths occur in the 15-19 years age group. The data also show that a majority of the maternal deaths (72 percent) are concentrated in the under 30 age group. .(Fig.1) Thus, a significant percentage of women die very young which is national loss in terms of youth energy.

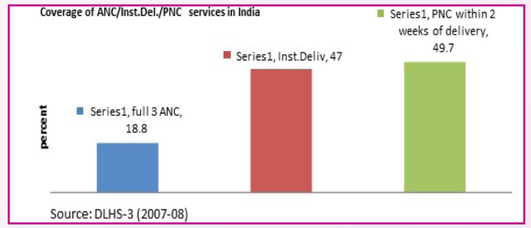
Figure 1: Age Distribution of Maternal Deaths in India Sample Registration System (SRS) Special Bulletin on Maternal Mortality 2010-2012; December 2013



Continuum of Care During Pregnancy, Childbirth and Postpartum

All women must receive a complete package of services during pregnancy, delivery, and after childbirth. Care during pregnancy, referred to as antenatal care (ANC), is necessary to detect risks that might lead to complications and prepare for delivery accordingly. The time after delivery up to 42 days is termed as the postnatal period. Care during this time is crucial as most maternal deaths occur in this period especially within 48 hours of delivery. Yet, national statistics indicate that few women receive complete care during pregnancy. The percentage of women delivering in health facilities and receiving postnatal checkups within 24 hours is comparatively higher. Only 2.7 percent of women who deliver at home or on the way received postpartum care within 24 hours after delivery. Thus, there are hardly any interventions to ensure safety of almost half of the women who deliver at home (Figure 2).

Figure 2



Care During Pregnancy

Documentation of maternal deaths by Civil Society Organisations (CSO) in India indicates that a significant number of women who died did not receive any ANCs. Those who did received mostly tetanus toxoid immunisation and iron folic acid tablets. Physical examination, particularly of the abdomen, was skipped. Incomplete ANCs meant that risks like severe anaemia, hypertension, malaria, and tuberculosis went largely undetected. These risks exacerbated obstetric complications (eclampsia and postpartum haemorrhage). Conversely, existing malaria, TB, and anaemia among women became aggravated by their pregnancy and increased their risk of maternal death.

CARE DELAYED IS CARE DENIED

No antenatal care was given to Chamelibai, 25, a brick kiln worker in Chhattisgarh despite suffering from oedema, blurring of vision, dizziness, and headaches during the seventh month of her second pregnancy. Only when Chamelibai had three seizures while working was she rushed to a health facility. She died on the way.

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Care During Childbirth

Care at Facilities

To meet the global thrust of 'skilled attendance at childbirt,' the Ministry of Health and Family Welfare introduced a conditional cash transfer scheme to encourage institutional deliveries. Called the Janani Suraksha Yojana (Mothers' Protection Scheme or JSY), the scheme has been successful in addressing the economic barrier to health services to some extent and has brought women to health facilities. However, there are concerns related to competencies and capacities of the facilities. Facility Survey[ii] data is a cause of worry particularly in states with high maternal mortality where public health facilities are understaffed, poorly equipped, and lack essential drugs. In health facilities where staff was present, they demonstrated a lack of skills and capacity to handle complications. This has an impact on the quality of care provided to women in these facilities.

Additionally, data (DLHS-3) shows that Primary Health Centres (PHCs) handle only a small number of deliveries whereas a large majority takes place in district and tertiary hospitals resulting in an overburdening of these facilities. The strategy of facility-based delivery services without ensuring adequate capacities and competencies and without adequate care during pregnancy raises safety concerns at health facilities.

Care at Home

More than half of the pregnant women risk losing their lives in the absence of a policy for safe homebirths. Traditionally, communities tap the services of Traditional Birth Attendants (TBAs/ *Dais*) who play a critical role in assisting women during childbirth at home. Despite contributing significantly in saving the lives of mothers and newborns, however, TBAs remain outside the public health system. This focus on institutional delivery has deflected attention from women who do not or cannot reach hospitals.

BLOOD, TEARS AND DEATH

When Durgabai, 32, experienced sudden and sharp pain in her back during her seventh pregnancy, she was taken to the nearest Community Health Centre several kilometres away from her village in Madhya Pradesh. After the nurse found her ready to give birth, Durgabai was made to lie on a bed and given an injection. Soon after, the legs and one hand of the baby emerged. However, when the baby's head did not follow, the nurse called the doctor. The doctor referred Durgabai to the district hospital, 22 kilometres away.

The nurse at the district hospital administered a saline bottle and tried to push the baby out. There was continuous bleeding during this time. The hospital did not make any provision for blood and instead asked the family to arrange it. Soon after receiving the first few drops of blood, Durgabai died. By the time the doctor arrived, it was already too late.

Continuum during Multiple Referrals

Multiple referrals are common for women who develop complications irrespective of the place of delivery. An analysis of maternal deaths by CSOs shows that women with complications were referred to at least four facilities and yet could not be saved. There is complete lack of communication between various levels of facilities and outreach work and lack of compliance to referral protocols. As a result, most providers are forced to work with limited information, increasing the risk to women's lives..

RUNNING AROUND IN CIRCLES SNUFFS OUT LIFE

When Sushila, 22, pregnant with her first child, suffered convulsions, she was carried in a cloth sling to a point accessible to an ambulance. On reaching the PHC two hours later, she was referred to the District Hospital (DH) without any examination or being taken out of the ambulance. However, her family took her to the Community Health Centre instead where Sushila was again referred to the DH without any medical care on the grounds that her cervix was not dilated. When Sushila finally reached the DH, 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 an ultrasound in an auto-rickshaw. None of these helped and she died, 40 hours after being admitted to the hospital..

Care after Childbirth

More than 50 percent of maternal deaths take place either within the first 24 hours or 42 days after childbirth. While the public health system guarantees three postnatal check-ups within 42 days of delivery, a majority of women receive it within two weeks of delivery. However, postnatal home visits are inadequate, irregular, and largely limited to child immunisation, increasing the risk of maternal and newborn death. Similarly, overcrowding of secondary and tertiary facilities reduces their ability to provide care in the face of postpartum complications, which is critical to the survival of mothers.

DID MALTI NEED TO DIE?

Malti, 26, pregnant for the third time, delivered a dead baby after two days of protracted labour. Five days later, Malti developed painful swelling in her abdomen and legs. Her family took her to a government hospital 40 kilometres away. Finding it closed when they arrived there at 10 pm, Malti was taken to a private hospital. There, the doctor prescribed medicines but did not admit her. The desperate family took Malti back to the government hospital but the gates were not opened and they had to wait outside. Although Malti was admitted when the hospital opened at 8 am and started on a drip, it was to no avail as she died within a few hours.

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

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Tracking Mothers Crucial to Survival

A lack of tracking of women who sometimes seek care from both public and private facilities widens the gaps in service delivery. Poor tracking and coordination between facilities in public and private sectors breaks the continuum of care and increases their vulnerability.

DEADLY TRACKING GAPS

Shakuntala Vasava, 22, accessed antenatal care in her marital home in Gujarat state, India. However, she went to her natal home in neighbouring state Maharashtra for delivery. There she was taken to a private nursing home where she delivered a stillborn baby. When Shakuntala started bleeding and complained of chest pain, she was referred to a public hospital in another town. This hospital refused to admit her, forcing Shakuntala's family to return to her natal home and then to her marital home. Although the Gujarat emergency transport service rushed her to a hospital, Shakumtala was unable to survive the journey and died on the way.

The Marginalised Remain Excluded

There is a direct correlation between a woman's economic status and her access to quality maternal health services. For example, only 59 percent of mothers in the lowest wealth quintile households received some ANC while 97 percent of those in the highest wealth quintile received antenatal care. Women most in need of these services like poor women who are older, have several children, belong to marginalised communities, and with no education are less likely to receive the same quality of treatment (NFHS-3). Maternal death reviews have shown poor women were abused and slapped in healthcare facilities for screaming in pain and even abandoned by nurses. Anecdotal evidence has illustrated how a poor pregnant woman suffering convulsions was asked to be shifted out to the corridor and a husband whose wife was critical was abused for inquiring about her condition. This callous behavior extended even after the women's death. Women's bodies were thrown off beds and out of hospitals.

Cost of Health Services

Free health services are guaranteed under the public health system in India. Women are entitled to free delivery services at the public health facilities. Yet, households contribute a significant portion—71.13 percent [iii]—to avail of healthcare services. Out-of-Pocket expenditure (OOP) on health continues to be a major concern, leading to increased debts, thereby further marginalising the poor and perpetuating the debt trap.

In Uttar Pradesh, money was demanded in 23 cases from pregnant women and their families for tests, medicines, supplies, equipment, and instruments, and even to see their newborns and for cleaning. They had to pay even when the mother or baby failed to survive. In many cases, treatment was not started until payments were made. A man from a marginalised community had to cycle 17 kilometres through forests at night to borrow money to pay the staff. By the time he returned, his wife was dead.

Poor Maternal Nutrition, High and Stagnant Levels of Anaemia

Maternal nutrition is the key to the survival of mothers and newborns. Thirty three percent of women are undernourished and more than half (56.2 percent) of the women in the reproductive age group (15-49 years) are anaemic. Anaemia during pregnancy and postpartum is almost universal. The coverage of nutrition supplementation and services during adolescence, pregnancy, and postpartum is poor and grossly inadequate. While the public health system promises iron folic acid tablets, the regularity of supply and compliance is a concern.

Way Forward

For most poor families, pregnancy and childbirth means loss of wages, reduction in family income, and steep increase in expenses. India's alternative health and healing systems can help in reducing costs while improving health and nutrition levels. This must be recognised and integrated in the public health system. Besides ensuring that essential drugs is available in primary health facilities and the storage of blood at secondary and tertiary facilities, adequate food, nutrition, and iron folic acid supplementation to prevent postpartum anaemia is also imperative. Establishing a rapid response mechanism to verify maternal death and violation of rights will help to promote greater accountability in the health system and deter demands for payments and abusive and unethical behaviour towards poor marginalised. omen:

Recommendations

1. The continuum of quality care approach needs to be adopted in design and implementation of maternal health programmes to include:
   - Health, nutrition, and development issues of adolescent girls and young women irrespective of their marital status and including their maternal health
   - Coverage of care during pregnancy, childbirth, and postpartum to all women irrespective of their location through individualised tracking and service provisioning by outreach workers
   - Track migrant population, mapping out places of work and provisioning off-season and on-season services at the workplace
   - Enhance capacities of ASHAs/TBAs/ frontline workers to provide women and families information on their entitlements, signs of obstetric complications, and where to address them
   - Ensure nutritious food supplements to all women throughout their pregnancy and postpartum period
   - Strengthen skills of providers and outreach workers to provide complete, quality ANC/ PNC for timely detection of severe anaemia, malnutrition, pre-eclampsia, and infectious diseases and individualised tracking to avoid breaking of the continuum of care

2. Increased budgetary allocations for strengthening of public health system up to three percent of Gross Domestic Product(GDP)

3. Improved coordination and convergence between the Ministry of Health and Family Welfare and the Ministry of Women and Child Development for combined action on maternal health and nutrition

4. Strengthen facility-based care
   - Monitor the Indian Public Health Standards and protocols for intra-partum care, including Basic EmOC and Comprehensive EmOC

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- Enable Rogi Kalyan Samiti and Village Health Sanitation and Nutrition Committees to carry out social audit of health facilities and community-based monitoring of maternal health services
- Support referrals with relevant documents and transportation. Institute a clear protocol to include stabilising the woman before referring her to the next appropriate level of care
- Enable trained TBAs to accompany woman in labour room
- Strengthen skills in public facilities for recognising and managing postpartum complications and sepsis, deep vein thrombosis, fistulas, and prolapsed uterus so that women don't depend on private facilities

5. Strengthen home-based care
   - Ensure local community-based attendants are trained for normal home deliveries and basic management of complications in remote areas
   - Train community-based attendants and ASHAs on postpartum danger signs and monitor health through home visits for six weeks after birth/abortion

6. Strengthen maternal death reviews
   - Encourage reportage of maternal deaths by incentives to frontline workers and elected representatives of the local self government (Panchayat)
   - Appoint a district and state level maternal health Ombudsperson to take action related to MDR and other maternal health issues
   - Bring civil society/women's organisations on board in district and state review committees and make public the action taken reports

7. Institutionalise accountability
   - Lack of accurate, disaggregated, and updated report on maternal deaths in the public domain raises serious accountability issues
   - Make MDR reports public through state annual reports stating remedial action taken to prevent similar deaths
   - Institute a simple and accessible grievance redressal mechanism for the poor/less literate.

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3. HealthWatch Forum Uttar Pradesh (2005-09): documented 15 deaths and 16 near-miss testimonies documented from 10 districts, Uttar Pradesh

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9. Jan Swasthya Sahyog documented 26 cases from their field area in Chhattisgarh

10. SEWA Rural (2007 onwards): documented 20 cases in the area of work in Bharuch district, Gujarat

11. Vd. Smita Bajpai; CHETNA (2012): documented eighteen cases from underserved areas in Gujarat,India

12. Gender and Health Equity project, IIM Bangalore (2005-11): documented 43 cases in Koppal district, Karnataka

13. ANSWERS (2008): documented 108 cases from 22 districts, Andhra Pradesh

Glossary:

1. MMR-Maternal Mortality Ratio
2. ANC – Ante Natal Care
3. ANM – Auxiliary Nurse Midwife
4. ASHA - Accredited Social Health Activist
5. BEmOC – Basic Emergency Obstetric Care
6. CEmOC – Comprehensive Emergency Obstetric Care
7. CHC – Community Health Centre (located at the sub-district level)
8. IPHS – Indian Public Health Standards
9. RKS – Rogi Kalyan Samiti or Hospital Management Committees
10. PRI – Panchayati Raj Institutions (Local Self Government bodies)
11. PNC – Post Natal Care
12. PPH – Postpartum Haemorrhage
13. VHSNC – Village Health Sanitation and Nutrition Committees

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Calling for Context-Specific, Rights-Based Continuum of Quality Care for Safe Abortion in Nepal

7.0
Calling for Context-Specific, Rights-Based Continuum of Quality Care for Safe Abortion in Nepal[i]

Background

World Health Organization (WHO) estimates that about 25 percent of all pregnancies worldwide end in induced abortion, approximately 50 million each year.[1] More than half of these abortions are performed under unsafe conditions resulting in high maternal mortality ratio especially in developing countries like Nepal.[2] The resolution CPD 47th session urges governments and development partners, including through international cooperation, to improve quality services by managing complications arising from abortion, giving access to reliable information, and providing compassionate counseling for women who have unwanted pregnancies. Using abortion as a family planning method can also be reduced through expanded and improved family planning services and in circumstances where abortion is not against the law, training and equipping health-service providers and implementing other measures to ensure that such abortion is safe and accessible.[3]

The abortion bill in Nepal was passed in 2002 (Muluki Ain 11th Amendment Bill) after almost three decades of lobbying, and it became a law in 2004.[4] This law states that comprehensive abortion care services must be available on demand for the first three months. This period is extended to 18 weeks for cases of rape or incest. If the life of the mother or foetus is endangered, abortion services can be accessed at any time. The legalisation was made possible by efforts from different national stakeholders who held the government accountable to its commitment to the International Conference on Population and Development (ICPD). 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 229.[5]

Despite the law, however, unsafe abortion in Nepal continues to take place. Women keep on dying or suffering from lifelong morbidities resulting from unsafe abortion.

In the run for achieving the Millennium Development Goals (MDGs) in 2015, we also find that the progress towards *MDG5a on Universal Access to Reproductive Health* has been unacceptably slow in Nepal, particularly for marginalised and illiterate women with no access to information or healthcare regarding safe abortion services and its legality.

Rights-based Continuum of Quality Care (CQC) for Safe abortion in Nepal

The Continuum of Quality Care (CQC) for safe abortion in Nepal refers to the provision of continuous quality care for safe abortion across a woman's lifecycle, either through increasing awareness via complete, accurate, and easy-to-

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Abortion is not just about some vulnerable women. It is about all of us.

understand information in family and community level on its legality and services, or providing comprehensive abortion care (CAC) including pre-counseling and post-counseling at health facilities level with monitoring and evaluation for quality improvement. Post-abortion care is also a vital part for safe abortion services. It includes family planning counseling and services to avoid future unwanted pregnancies and repeat abortions, as well as to adequately space a next desired pregnancy. The CQC on safe abortion care also includes respect for women's informed and voluntary decision-making, autonomy, privacy, confidentiality, and prompt and nonjudgmental service with attention to the poor and adolescents, and other vulnerable and marginalised women with special needs as well as access of care within walking distance along with short waiting time.

The Beyond Beijing Committee (BBC) in Nepal has been advocating for safe and legal abortion even before it was legalised. BBC supports safe abortion on two grounds: BBC recognises safe abortion as women's right to reproductive health choices, and safe abortion services should be available to women who choose to abort their pregnancy.

Evidence from the Ground

Low Awareness Impedes Access

Only one in three women in Nepal is aware that abortion is legal[6] and only one in two women know where the service is available.[7] A 2010 study conducted by Tulachan and Risal[8] and by visiting obstetricians and gynecologists in Nepal Medical Teaching Hospital revealed that approximately 67 percent of women were aware about the law legalising abortion. It also found that most women heard about the law and the availability of services from the media. Unfortunately, little investment has been made to popularise this significant legislation and its benefits for women and girls.[9] The law can be effective only when women are aware of it.

IGNORANCE PROVES FATAL

When Anita, 32, a mother of four children, learned she was pregnant again, she decided to have an abortion as she did not want to have more children. Ignorance of the law legalising abortion led her to a village sudeni or an untrained traditional birth attendant. The sudeni pricked Anita's uterus by a long stick for several times. Soon after the procedure, Anita experienced heavy bleeding. She was first taken to the nearest health centre where the health personnel was on study leave then was taken to a district hospital. She died on the way.

Unmet Need for Contraception

The contraceptive prevalence rate increased from three percent in 1976 to 48 percent in 2006. Yet, one in four married women has an unmet need for contraception[10] and 25 percent of them still need assistance in accessing contraception, reflecting a gap in the continuum of quality care.[11]

Further, the desire to plan families is reduced by the cultural perception that having more children[12], particularly sons, raises a woman's status in the family and community.

Unsafe Abortion Continues Despite Law

Despite the law, many women continue to have unsafe abortions. Approximately five percent of maternal deaths are caused by abortion complications and antepartum haemorrhage.[13] Legalising abortion is not enough for women to utilise abortion services efficiently. One of the main reasons behind the continuation of unsafe abortion is the inaccessibility of safe abortion services.

PAYING A HEAVY PRICE FOR UNWANTED PREGNANCY

Mankumari Ghalan, 27, was happily married with two sons. When she became pregnant again, Mankumari and her husband decided to have an abortion. The nearest health facility, however, was two hours away from their home, so she sought the help of an untrained traditional birth attendant. Two days after the abortion, Mankumari was taken to the district hospital after complaining of severe pain in her lower abdomen. She underwent two operations and died three weeks later.

If women had an access to safe abortion services provided by the government, Mankumari would have lived and stayed in good health.

Missing Data on Unsafe Abortion

In some cases, rural health services are limited, forcing women to seek abortion services in district hospitals.[14] With district hospitals being far from their villages, though, women tend to visit it only when their complications have worsened. Further, a client is not always asked about the cause of bleeding nor is it noted in their history. This results in a loss of important data useful in analysing unsafe abortion and planning subsequent policies and programmes for continuum of quality care.

Do Women Access Post-abortion Care?

Abortion-related complications are the third major cause of maternal mortality and morbidity in Nepal. It accounts for seven percent of maternal deaths according to the Maternal Mortality and Morbidity Study in 2008-2009.[15]

The Post-Abortion Care (PAC) Unit was established in May 1995 to reduce unsafe abortion complications. Although 78 PAC units exist in 50 districts, mainly in public sector health facilities to provide family planning counseling and services after every Manual Vacuum Aspiration (MVA) procedure,[16] field visits by the Beyond Beijing Committee and its partners revealed that many were rarely accessed. This low usage rate can be attributed to the inability of women to make decisions regarding their bodies. Further, only 56 percent received counseling on contraception methods after abortion. When providers insisted that clients return at the onset of their next menstrual period and distributed condoms as an interim measure, most did not come back.[17]

Husbands Dominate Abortion Decisions

A 2007 study[18] showed that only 50 percent of male respondents were aware that abortion was legal. Although men knew little about the hazards of unsafe abortion, 36 percent said that they would convince, or if needed, force their wives to have an abortion. Clearly, they made the decisions regarding their wife's pregnancy.

Confidentiality and Privacy

According to a 2009 study, confidentiality in government facilities was compromised because of the lack of separate space for counseling and recovery and due to having only a few trained counselors. In Koshi Zonal Hospital, for example, the CAC service provider said that due to the lack of a separate counseling room for safe abortion service, most of their clients expressed no interest in having safe abortion in the hospital. In Lele Primary Health

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Centre of Lalitpur district, women of the VDC do not visit the PHC for safe abortion services, as health personnel used to leak stories of those accessing safe abortion services in the past.

Lack of Trained Human Resources

In 2012 to 2013, a total of 195 service providers have been trained in Comprehensive Abortion Care (CAC). There are 574 certified CAC sites and 179 MA listed sites.[20] It is less than what is required, and a cut in government funds to train health personnel conducting abortions has not helped. With service providers preferring to be posted in urban areas, public facilities in the rural areas have suffered. Moreover, long waiting hours, lack of privacy, and insufficient time given to patients in public CACs have discouraged its use.

Stigma and Discrimination Close Doors

Social and cultural attitudes still remain significant barriers for women seeking abortion. The stigma associated with abortion leads women to seek the service secretly, even if the procedure is unsafe.[21] Women who go in for abortion are considered promiscuous and irresponsible and stigmatised by the community. Perceptions of service providers of women seeking abortion affect provision of services leading to greater access of over-the-counter medication to terminate pregnancies. In one such case, a couple took some medicine from a trained birth attendant. And when the medicine given did not work, the couple chose to continue the pregnancy as they were afraid it would become known in their community and cause embarrassment.[22]

Pre-marital sex is frowned upon in Nepal, making abortion more difficult for unmarried women. Further, reports in the media on abortions being used by teenagers as a method of contraceptive has discouraged access of services.[23]

Negative Impact of Privatisation

Massive privatisations in the health sector and the growth of unregulated private clinics have contributed to increasing incidents of illegal sex-selective abortions and have had an impact on the country's MMR. There has been a lot of coverage by the media as well on repeated abortions by teenagers using it as a contraceptive. This has raised many informal discussions on the need to continue abortion as a right.

STIGMA FORCES UNSAFE ABORTION

Sushila Ghimire, 38, a mother of four, was ignorant about family planning. Her fifth pregnancy, five and a half months after her last delivery, was unwanted. However, she was afraid to have an abortion in her village lest it became known to the community. She went to neighboring country India where a medication was placed inside her uterus with the help of a long thin metal rod.

When Sushila started bleeding profusely after her return to Nepal, she was taken to the district hospital in a buffalo cart. She continued to bleed during the seven-hour journey. The hospital, however, did not have provisions for blood, leading to Sushila's death within an hour of arriving there.

Suryadevi Jha (name changed) of Mahottari district already had four daughters. As she was pregnant for the fifth time, she, along with her mother-in law, decided to find out the sex of the foetus. They went to a nearby private clinic and had the ultrasound done. They found that the foetus was a female. They requested to do the ultrasound again to confirm the sex of the foetus. The doctor of the clinic did so and confirmed the foetus as a female. It was suggested to Suryadevi to have an abortion so she went to the same clinic for the procedure. When they received the aborted foetus, however, Suryadevi's mother-in-law found that the foetus was a male and started screaming at the doctor. One of the nurses then cut the penis of the foetus to prove that it was female.

SOURCE: Naya Patrika Daily, *09 May 2013*.

Affordability is an Issue

According to a recent survey by the Center for Research on Environment, Health and Population Activities, 19 percent of women from disadvantaged communities said that lack of money to pay the abortion fee was a barrier to obtaining a safe abortion. For marginalised women, access to safe abortion is needed as a back-up method for unplanned pregnancies, which unfortunately occur often due to the lack of access to contraception, or even in cases of contraceptive failure. All governments have a fundamental responsibility to safeguard reproductive rights and any failure to do so is a serious violation to women's basic human rights.

Need of Comprehensive Law

The legal provisions for abortion currently reside in the chapter on life in the National Code (Muluki Ain). Punishments for crimes against human life such as murder are also found in this section, implicitly identifying abortion as a crime akin to murder. In Laksmi Dhikta vs Nepal Government case,[ii] based on the fact that the court has not recognised the foetus as a human life, the Supreme Court states that legal provisions on abortion must be contained in a separate law and disassociated from discussion of murder.[24] Therefore, the government must introduce a comprehensive abortion law that codifies the legal principles and establishes a concrete, rights-based legal framework for ensuring access to affordable and high-quality safe abortion services.

Way Forward

Affordable contraception choices must be made available and accessible to all women, men, and adolescents of reproductive age, irrespective of marital status, to ensure that no woman dies for want of family planning services. Access to information on the availability of services and benefits is central to ensuring a rights-based, context-specific continuum of quality care for safe abortion. The legal safe abortion is a service for marginalised women who need it as the last resource for them to survive with dignity. It is not a means of family planning.

[ii]Laksmi Dhikta vs Nepal Government: The case, which was filed by the Forum for Women, Law and Development, Pro-Public, and a group of human rights lawyers in February 2007, centres on Lakshmi Dhikta, an impoverished, rural woman. Lakshmi was unable to get a legal abortion when she became pregnant for the sixth time because she could not pay the required service fee – Nepali rupees 1130 (approximately 20 USD at the time). As a consequence, she was forced to carry her unintended pregnancy to term.

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Recommendations

Review of deaths caused by unsafe abortion

- Design and implement a systematic data collection system that includes histories of complications which arise from unsafe abortion
- Conduct a national study on deaths caused by unsafe abortions

Information dissemination

- Popularise CAC policies and services via Citizen Charters in health facilities of government and non-government offices, via electronic, print, and other media
- At the community level, the Female Community Health Volunteers (FCHVs[iii]) and TBAs[iv] can play an important role in helping women avoid unintended pregnancy through providing contraceptive information, counseling, and other methods, and informing them about the risks of unsafe abortion. They can also give information as to how to obtain safe and legal abortion care, and they can provide pregnancy tests and referrals as well to safe abortion services in the health facilities / CAC centres
- Produce information, education, and communication materials which target behavioural change among men who play a crucial role as partners and husbands
- Comprehensive services should always involve contraceptive information, services, and referrals, to help prevent repeat unintended pregnancy and reduce the need for another abortion

Training

- Increase the number of CAC providers and trained health professionals at CAC centres and ensure their presence in facilities by allocating the necessary budget and improving monitoring systems for quality care
- Strengthen training programmes on post-abortion care including counseling on the use of various contraceptive methods and follow-up mechanism

Access to quality services

- Ensuring good-quality abortion care requires ongoing supervision, quality assurance, monitoring, and evaluation
- To the full extent of the law, safe abortion services should be readily available and affordable to all women. This means services should be available at primary care level, with referral systems in place for all required higher-level care
- Services should be delivered in a way that respects a woman's dignity, guarantees her right to privacy, and sensitive to her needs and perspectives. Attention should be given to the special needs of the poor, adolescents, and other vulnerable and marginalised women
- Abortion services should be integrated into the health system, either as public services or through publicly-funded, nonprofit services, to acknowledge their status as legitimate health services and to protect against stigmatisation and discrimination of women and healthcare providers
- Regulate and monitor the private health sector to ensure accountability and high standards for safe abortion care

A separate comprehensive law

- The government must introduce a separate comprehensive abortion law that codifies the legal principles and establishes a concrete, rights-based legal framework for ensuring access to affordable and high-quality safe abortion services which will translate into real change for the health, lives, and rights of Nepali women

[iii] FCHVs are volunteers and are not paid for their services. Though they are not a health staff, they are a vital link between the public health services and community.

[iv] WHO has defined traditional birth attendants (TBAs) as "traditional, independent (of the health system), non-formally trained, and community-based providers of care during pregnancy, childbirth, and the postnatal period

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Sexual and Reproductive Health and Rights for Women in Pakistan: Still a Challenge

8.0
Sexual and Reproductive Health and Rights for Women in Pakistan: A Challenge[1]

Background

Women in Pakistan are conditioned by patriarchal attitudes. Thus, compared to boys and men, lesser resources tend to be devoted to girls and women for their reproductive and sexual health (RSH). In rural areas, RSH services are not available to most adolescent girls. The Lady Health Workers (LHWs) are accessible but not suitably trained. Hospitals, both public and private, deny services to unmarried girls because of social and cultural practices. There is no health education specifically for adolescents. In fact, adolescent girls are generally missing from policy discussions and programmes.

Early marriage is responsible for poor reproductive health amongst adolescents.[1] Hence, the maternal mortality ratio (MMR) remains significantly high at 276 for every 100,000 live births.[2] The low contraceptive prevalence rates reflect issues of access and lack of choice. Data on skilled birth attendants at delivery reveals majority of births still take place at home and access to referrals and EmOC services is limited.

With comprehensive reproductive health services still beyond the reach of most women and adolescent girls, Pakistan will be unable to achieve the Millennium Development Goal (MDG) 5 by 2015 (Table 1).

Table 1. Pakistan Demographic Health Survey 2012-2013

Indicator	Status	Target 2015
Maternal Mortality Ratio	276/100,000 live births	140
Birth & Death Registers at Union Parishad	Around 60%	> 90
Contraceptive Prevalence Rate	35% for any method and 26% for any modern method	55%
Total Fertility Rate	3.8 live births/ woman	2.1
Antenatal Care (ANC)	67%	100%
Unmet need for Contraception	26%	

Devolution of Responsibilities

The National Population Policy 2010 has a greater focus on adolescent and male reproductive health. While it also has a comprehensive reproductive health services package for all stages in a woman's lifecycle, its implementation remains poor.

[1]The original paper was contributed by Naureen Butt, Uzma Farooq, Dr.Tabinda Sarosh and Dr. Shama Dossa. This Popular version is refined and updated by Dr. Tabinda Sarosh.

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In 2011, the Health Ministry and Population Welfare Ministry was abolished through the 18th Constitutional Amendment. This led to uncertainty and a lack of direction amongst the different provincial health and population welfare departments. In May 2013, the Ministry of National Health Services, Regulation and Coordination was given charge of medical service delivery and academic institutions, the drug regulatory agency and coordination of vertical health programmes, amongst other functions. Hopefully, this will bring the much desired coordination at the federal level.

Evidence from the Ground

In 2010, Shirkat Gah carried out a national qualitative study to monitor the implementation of MDG5a and assess its progress. Published in 2012, the study[3] revealed the dismal condition of women's health. The needs of adolescents were completely overlooked and RH services, where available, were poor and not easily accessible to women, especially those from marginalised communities.

Maternal Deaths Remain a Challenge

Access to emergency obstetric care, family planning, and postpartum care is poor. One in every 89 women also dies from maternal causes.[4] Maternal deaths continue to remain a challenge as a host of factors such as distance, transport, costs, permission, escort, and knowledge of options shape women's health-seeking decisions.

People prefer to go to the public health facilities because they are either free or subsidised. Low salaries, the absence of incentives to serve in difficult circumstances[5] and the lack of monitoring and regulation prompts public health service providers to increase their income by using their time and expertise and even medicines, for private practice. Consequently, the gaps in services are exploited by religious soothsayers, quacks, and private doctors.

Unsafe Abortions

According to the population council (2013), there are around 790,000 abortions taking place in Pakistan every year.[6] Since this data was collected from women hospitalised for post-abortion complications, it does not reflect the actual number. Abortions, many of which are unsafe, account for six percent of maternal deaths in the country (PDHS 2006-2007).

In a country with high fertility rates, high unmet need for family planning, and low contraceptive use, unwanted pregnancies are common. Abortions are often used as a means of family planning but unavailability of appropriate health facilities in the vicinity and the lack of awareness about how and where to access the appropriate health provider leads to unsafe abortions. Ignorance of the consequences of unsafe abortions, social restrictions on mobility, and disapproving service providers all exacerbate the situation.

Shirkat Gah's study also found that unmarried women were at greater risk of death and morbidity due to unsafe abortions, being less likely to access appropriate health professionals. Cases of young unmarried girls committing suicide on being unable to access safe abortion services has emerged as a major reproductive health and rights issue. Shirkat Gah found cases of child brides in Sindh using rat poison to terminate pregnancies, with fatal consequences at times.[8]

Barriers to Accessing Services

A large family, pushed by the need to produce sons, is the social norm. The burden of contraception largely lies with the women. Early marriage, however, coupled with the low status of women, and limited education and employment opportunities lead to low contraceptive use and high fertility rates.[9] Although awareness of family planning has increased, services have not been expanded to meet this demand.

There is relatively more awareness and availability of services in urban as compared to rural areas. LHWs provide services at the doorstep in rural areas but these are limited to handing out pills and condoms. The dearth of choices allows unqualified persons to provide family planning injections or insert intrauterine devices without following necessary procedures. When things go wrong, family planning-related myths are perpetuated.

Unskilled Staff

In Pakistan, Traditional Birth Attendants (TBAs) assist in over 50 percent of deliveries while skilled providers (SBAs) just cover 39 percent. A shortage of SBAs led the government to expand the operational area of LHWs to all districts. Although LHWs are unable to reach remote districts, their services wherever available have been useful for women as it is delivered at the doorstep.

LADY HEALTH WORKERS COME TO THE RESCUE

Farzana, 28, has four children. Married at 17 to a 38-year old daily labourer, she became pregnant for the fourth time when her third child was only six months old. Her husband was not pleased and blamed Farzana for not taking preventive measures. He asked her to have an abortion although she was three months pregnant.

Farzana sought the help of a TBA in another village. The TBA performed the procedure in an hour and a half and charged her Rs. 3000. Farzana experienced bleeding afterwards. When this continued even two weeks later, her husband took her to a private clinic on the recommendation of the local LHW. There, the lady doctor found severe infection in her uterus. After performing the necessary procedure, she prescribed some medication which helped to stop the bleeding. Seeing that Farzana was from a poor family, the doctor charged her only Rs. 2000. Farzana was able to leave the hospital within three hours of the procedure.

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Limited Access to Correct Information

Complete and correct information is critical for women especially in the crucial stages of adolescence, pregnancy, and post-pregnancy. The rate of clandestine and unsafe abortions cannot be attributed only to legal restrictions but also to lack of relevant information.

The absence of accurate information related to family planning and postpartum services have led to failures of procedures, excessive bleeding, infertility, obesity, and backaches. Postpartum care, which includes counseling, is often lacking in both public and private health centres. Poor data on service delivery performance and outcomes impedes accountability of public health institutions.

Poor Mobility and Privacy

A lack of mobility and privacy necessary to access RSH information makes women more vulnerable especially when early and forced marriages are the norm. Unequal gender relations reduce a woman's control over her own body, leading to early and unplanned pregnancies. Chances of maternal mortality and morbidity, sexually transmitted infections (STIs), and HIV increase.

Adolescent Girls Need Attention

Rural adolescent girls are more likely to drop out of school as they grow older due to several reasons including the distance between the house and the school, lack of separate bathrooms in schools, and social disapproval. Limited education increases their chances of early marriages and pregnancy, prevalence of anaemia, and higher morbidity rate.

During Shirkat Gah's awareness campaign for adolescents in 40 project villages, mothers insisted on sitting with their children. While the mothers' fears and anxieties about the content of the interaction were assuaged, their presence prevented their daughters from asking personal questions.

MISINFORMATION MISLEADS

Nasreen, 28, a mother of four, started using oral contraceptives after her third child. Married at 13, Nasreen was uneducated and was dependent on the LHW for contraceptives. But when she complained the contraceptives caused excessive bleeding and the onset of menstrual cycle every two weeks, the LHW assured her the side effect would subside over time. However, Nasreen's bleeding continued over the next five months. Seeing her swollen body and highly anaemic condition, the LHW advised Nasreen to stop taking the pills. Barely a month later, Nasreen became pregnant and in due course gave birth to her fourth child.

When Nasreen and her husband decided not to have any more children, the LHW offered injectable contraception. However, Nasreen rejected it after receiving negative feedback from other women users who found injectables ineffective and Copper T, the intra uterine device, problematic. With her husband now using condoms only when he wants to, Nasreen's risks of another unwanted pregnancy have increased.

EDUCATION PAYS

Seema, 28, lives in the village of Parao Khas in Khyber Pakhtunkhwa. The eldest of eight siblings, Seema was able to complete secondary education thanks to her grandfather's encouragement. Seema's grandfather also permitted her to apply for the position of LHW in a local hospital. Fortunately, Seema's family was supportive. Now an LHW, Seema is economically independent and has a higher status within her family and community. Her opinion carries weight and this is why she has been able to turn down marriage proposals. Seema continues to study while working as an LHW. Her dream is to start her own clinic for the poor. Seema believes her example will encourage families to educate their daughters.

Violence against Women

Women have little or no decision-making powers in their natal and marital homes. The prevailing patriarchal system impacts poor and marginalised women more, increasing their vulnerability to physical and sexual abuse. Seen as mere objects for reproduction and household chores, women are less educated, less fed, and less valued. Discrimination is a form of violence and denies one's basic right to life.

Gaps in Health Systems Governance

Shirkat Gah's field-based projects highlighted a number of challenges in the health system. Inequitable health financing results in negligible amounts spent on general government health expenditures (Table 2). The government is constitutionally mandated to provide universal

WHO CARES FOR AYESHA?

As a child, Ayesha often suffered convulsions. When she was seven, instead of taking her to a doctor, Ayesha's parents took her to a faith healer as they believed she had been possessed by a spirit. She was given an amulet with Quranic verses.

When she turned 16, Ayesha was married to her cousin. Here she faced discrimination and torture by her husband and his family. Her mother-in-law refused to give her enough food and her husband would abuse her physically. The abuse continued even when she became pregnant. Her mother-in-law assisted in her delivery, despite not being a dai. The infant was born dead. A few weeks later, Ayesha became pregnant again. This child was also stillborn.

Yet, no one took Ayesha to certified medical professional. Her own family members wanted to but were too poor to seek medical help. Her in-laws, though just as poor, were not concerned enough to consult a doctor.

When Ayesha became pregnant for the third time, she was sent to her natal home. A village dai was called to assist her when she went into labour in the night. The third child was born dead, leaving Ayesha writhing in pain. But her parents could not take her to a medical facility in the absence of transport facilities. Ayesha did not survive the night. She was 20.

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healthcare, yet, there is an increasing trend of privatisation of services despite the lack of adequate regulatory mechanisms.[10]

Table 2 : Consolidated National Health Accounts	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: WHO. (2009). Health Expenditure Series. Geneva: World Health Organization. Latest updates are available on http://www.who.int/nha/country/en/index.html

The gap between policy and implementation are amplified by weak monitoring and evaluation systems, lack of transparency and accountability regarding resources allocated and spent on health, and their equitable distribution across provinces and districts. The severe shortage of human resources; their absenteeism in health facilities particularly in rural, remote, and underserved areas; and poor retention of high-quality staff worsens the situation. The health sector is plagued by a low standard of protocols and services which perpetuate corruption, complacency, favouritism, and insensitivity, particularly towards the poor and marginalised. The private health service providers are completely unregulated and are not bound to follow any quality and safety protocols. Unfortunately, significant budget cuts in public health are allowing greater privatisation with minimal government controls.

Way Forward

A continuum of care is critical to address all stages of a woman's lifecycle and across all locations. Special attention needs to be given to facilitate access to affordable skilled care. In this context, the community needs highlighted during district policy dialogues should be incorporated in health policies and programmes. Since social and cultural practices discourage unmarried adolescents and women from consulting doctors on sexual and reproductive health, their concerns must be addressed with appropriate sensitivity.

Recommendations

- Increase capacities of relevant officials in local and federal government (Health, Population Welfare, Local Government)
- Support safe delivery for all births (home and institutions) by an effective referral system including Emergency Obstetric Care (EmOC) through registered and trained TBAs
- Build awareness and capacity of service providers for young people's health needs while upholding privacy and confidentiality
- Formulate adolescent-sensitive health programmes with adequate budgets, making life skills-based education part of the school curriculum
- Institutionalise maternal death surveillance and reviews to identify gaps in the existing services and include monitoring systems and annual reporting
- Introduce a national policy on post-abortion care
- Ensure availability of affordable essential and non-essential drugs through regulatory mechanisms for quality, uniformity, pricing, and accountability of services
- Retain policy formulation at the federal level to ensure clarity at all levels, uniform training, and evaluation standards
- Develop National Population Policy Framework with adequate resources in consultation with provinces, civil society, academia, private sector, and other stakeholders
- Develop and adopt Provincial Population Policies within a stipulated time to ensure continuity after federal funding ends in June 2015
- Develop an effective communication and advocacy strategy with active involvement of all provinces and civil society organisations
- Tailor messages, videos, brochures, and other communication material for local context and translate in local dialects
- Use events like international conferences, seminars, and special events as awareness opportunities on the status of healthcare for women in Pakistan.

[1]Shirkat Gah. (2012). Rising to the Challenge. ___ (Complete the citations)
[2]Pakistan Demographic and Health Survey, 2006-2007.
[3]Shirkat Gah. (2012). Rising to the Challenge. ___ (Complete the citations)
[4]Pakistan Demographic and Health Survey, 2006-2007.
[5]Shirkat Gah. (2012). Rising to the Challenge. ___ (Complete the citations)
[6]Population Council of Pakistan and Guttmacher Institute. (2005).
[7]Shirkat Gah. (2009). *ICPD+15: Investigating Barriers to Achieve Safe Motherhood.* ___ (Complete the citations)
[8]WPF. (2012). "The Puppet and the Puppeteers." Rutgers.___ (Complete citations)
[9]Shirkat Gah. (2009). *ICPD+15: Investigating Barriers to Achieve Safe Motherhood.* ___ (Complete citations)
[10]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 healthcare services; to introduce or expand private financing of healthcare (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 healthcare services." (cited in Berer, 2010, p. 6).

Partners in WHRAP-South Asia

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

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

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

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

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

SAHAYOG in India works with the mission of promoting gender equality and women's health using human rights frameworks through strengthening partnershipbased advocacy. For more on Sahayog, please visit: www.sahayogindia.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 Learn More about us at www.whrap.org

Advocacy Brief

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CONTEXT-SPECIFIC, RIGHTS-BASED CONTINUUM OF QUALITY CARE FOR WOMEN'S REPRODUCTIVE HEALTH IN SOUTH ASIA

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