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ARROWs For Change

Women's, Gender and Rights Perspectives in Health Policies and Programmes

Health Systems and Women's Rights:

Key Elements in Effectively Averting Maternal Death and Disability

Every day, thousands of women die from pregnancy and childbirth in Asia and the Pacific. 75% of these deaths are from complications directly associated with the process of pregnancy and childbirth, i.e. direct maternal death, such as from bleeding, hypertension-with-convulsion, infection, and unsafe abortion. The rest are from the aggravation of the maternal state by concomitant medical conditions, i.e. indirect maternal death, such as malaria, TB, malnutrition, and HIV/AIDS.[1]

Of the total 529,000 deaths estimated in 2000, 253,000 are attributed to Asia.[2] The chance of dying in pregnancy and childbirth is especially high in Nepal, Timor-Leste, Lao PDR, India, Pakistan, and Cambodia. Many of the women who die are poor, from minority groups, not well educated, and unable to fight for their own survival. They embrace the notion that harm and death are inextricable parts of pregnancy and birth.

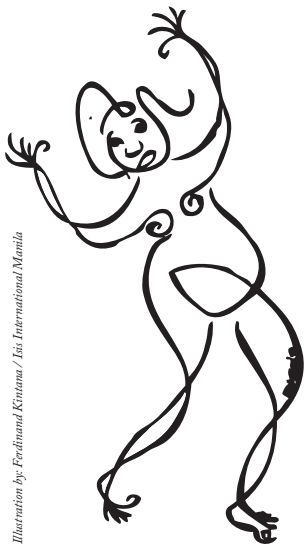

Illustration by: Ferdinand Kintanar / Isis International Manila

The fatalism, however, is totally unfounded. The development of medical and surgical remedies in the last century has gradually mitigated the harm due to the complications inherent in pregnancy and delivery. The array of life-saving treatments includes simple procedures like intravenous fluids and medicines, removal of retained afterbirth products and forceps delivery. In the case of more serious complications, there is blood transfusion and delivery by surgery (caesarean section).[3] This constellation of remedies is now called Emergency Obstetric Care or EmOC and where readily available and of good quality, the incidence of maternal death is low or reduced. This is the situation in middle economy countries like Japan, South Korea, Singapore, Malaysia, and Thailand. But this is also the case in poorer countries like Sri Lanka and North Korea, so obviously prosperity is not a key element.

If the solution to the maternal mortality problem is known, why is it then that many Asian countries are unable to stem the tide of this tragedy?

Here are two key elements:

1) The first element is the persistence and pervasiveness of what is known as the "risk assessment approach"[4] to maternal care.

In many countries, the standard of maternal care is to screen pregnant women for risks attributed to certain factors, mainly their age, the number and order of the pregnancy, the time interval with preceding pregnancy, the baby's position in the womb and others. Risks are predicted for women deemed 'too young' or 'too old' or have had 'too many pregnancies' or are having their 'first pregnancy', or had 'too short intervals' between pregnancies. 'High risk' pregnancies are referred for management by professional providers – e.g. nurse, doctor or midwife – or in health facilities. Those viewed to be 'low risk' or 'without 'risk' are relegated to non-professional attendants, such as traditional birth attendants (TBAs) or delivery outside health facilities.

The problem is that these predictions do not coincide with the actual delivery outcomes: many 'high risk' pregnancies end up without complication, while many 'low risk' ones encounter life-threatening complications that require skilled and professional help.[5] The scientific explanation for this is that life-threatening complications could develop in 15% of all pregnancies; complications which "cannot be predicted or prevented," but can be treated by EmOC.[f] With this evidence, the World Health Organisation (WHO) issued an urgent call in April 1997 that "all pregnancies be considered at risk."[6] This new approach calls for the presence of skilled providers who are not only able to deliver babies safely, but also able to diagnose and respond to emergency complications appropriately.[7] In the same breath, the new approach also calls for the availability and accessibility of referral facilities with EmOC capacity.[8]

This new approach requires many things. It requires the availability of an adequate number of capable and

well-motivated health professionals who can be available at any time, in the most remote of places. It requires sustained technical, financial and organisational support to these personnel, as well as working and integrated referral facilities. In other words, it requires a health system that is functional, adequately funded and able to respond quickly to the emergency needs of women in the throes of pregnancy and childbirth complications.

There are also specific reproductive health services, not designed to treat complications, but to avert them before they can even emerge. Two of these are contraception and safe abortion. Successful contraception basically prevents pregnancy and, by this effect, nullifies the possibility of pregnancy complications.[9] Moreover, successful contraception extinguishes the recourse to unsafe abortion that happens with many unwanted pregnancies. Contraception is estimated to prevent 20-35% of maternal deaths.[10]

2) A second element would be women's reproductive freedom and their ability to make and enforce decisions on their fertility and reproduction "free from discrimination, coercion and violence."[11]

This is a woman's ability to decide whether or not they want to be pregnant, which includes their having access to the information and technology that will help them enforce their decisions safely. This also implies the elimination of reproductive coercion and prohibition in culture, norms and policies and people's day-to-day practice. This requires the government to have a strong role in the promotion and enforcement of reproductive rights. At present, there are significant gaps in women's decision-making regarding reproduction in the Asia-Pacific region. One sees this in the persistence of arranged child marriages and the pervasive idealisation of pregnancy and childbirth that disregards the dangers to women. In some countries like the Philippines, powerful cultural institutions, like the Catholic Church, are allowed to control government policies on contraception and abortion.

Where governments fails to protect women through access to vital reproductive health care and safe abortion services, they will likely die or suffer permanent disabilities from pregnancy and childbirth. Every woman's death in motherhood depletes society. Infants orphaned by their mothers are unlikely to survive infanthood itself,[12] especially in the critical first month of life. Older children's nutrition and education are compromised with the loss of a primary caregiver. Moreover, the massive scale of death and disability from preventable causes strikes a discordant and discomfiting note in the time of global economic opulence and scientific advance. What human dignity are we talking about if we allow over half a million women to die yearly without the most basic protection?

Currently, expert opinion is agreed on the effective approach to reducing maternal death and disability. Moreover, there are a lot of working models that demonstrate the feasibility of such a project.[13] Malaysia has a strong public health system predating its becoming an economic success. Sri Lanka is one country that, despite its poverty, has invested heavily on health and a core of professional midwives. China, despite its massive population, continues to prioritise health and has developed competent and well-supervised village health workers who are part of the formal health sector.

The effective approach will require a lot of effort, resources and political commitment. Retooling of the health system and human resource development will have to happen in the context of current global and national conditions. Health reforms will also require substantial investment, a tall order, given that regular health spending in many Asian countries are short of the WHO recommended expenditure of at least 5% of the GDP.[14] And, most importantly, it will require a drastic change of heart and mind regarding women and maternity:

- The appreciation of the intrinsic value of a women's life, especially in that critical period when they pregnant;
- The rejection of the belief that maternity, and especially maternal sacrifice, are necessary aspects of womanhood;
- An active embrace of the evidence-based notion that certain reproductive health services are life-saving and form part of women's entitlements; and
- The affirmation of women's reproductive freedom and agency and the full recognition of these rights.

Endnotes

1 *Maine, Deborah (ed.). 1993. Safe Motherhood Initiatives: Options and Issues. New York:Columbia University School of Public Health.*

2 *WHO. 2000. Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA, www.who.int/reproductive-health/publication/maternal_mortality_2000/*

3 *Maine, Deborah; Rosenfield, Allan. 2000. "The AMDD Program: History, Focus and Structure" International Journal of Gynecology and Obstetrics.*

4 *WHO. 7 April 1998. "Every Pregnancy Faces Risk", WHO Bulletin on Safe Motherhood for World Health Day.*

5 *Maine, Deborah (ed.). 1993.*

6 *Maine, Deborah; Rosenfield, Allan. 1999. "The Safe Motherhood Initiative: Why has it stalled?" American Journal of Public Health.*

7 *WHO. 7 April 1998.*

8 *UNFPA. 2004. World Population Report.*

9 *Freedman, Lynn et al. 2005. Who's Got the Power, Transforming Health Systems for Women and Children. New York: UN Millenium Project Task Force on Child Health and Maternal Health.*

10 *WHO. 2005. World Health Report.*

11 *UNFPA. 2004.*

12 *International Conference on Population and Development Programme of Action Para 7.2 m Panos. Birth Rights New Approaches to Safe Motherhood www. panos.org.uk/PDF/reports/ BirthRightsSafeMotherhood.pdf*

13 *Koblinsky,Marjorie. 2003. Reducing Maternal Mortality – Learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica, and Zimbabwe. The World Bank.*

14 *WHO. 2005. Annex Table 5, Selected national health accounts indicators: measured level of expenditures on health 1998 to 2002.*

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Sri Lanka's Success in Improving Maternal Health

Sri Lanka is a low income country which has achieved remarkable results in reducing maternal mortality. The maternal mortality ratio (MMR) was halved within three years between 1947 and 1950,[1] and at present the MMR stands at 92 deaths per 100, 000 live births[2] - far better than the MMR of 540 of nearby India.[3] This is an achievement for a country with a per capita gross national income around US$ 1,200, with one third of the population living below the poverty line in most provinces. The state offers free antenatal care through home visits and clinics, and there is an average of five clinic visits per pregnancy, with 92% of deliveries taking place in state run hospitals[4] Successive governments have invested in the development of a health structure that places equal emphasis on field and institutional care, resulting in services that cover every home through trained Family Health Workers and a network of hospitals providing simple but adequate emergency obstetric care facilities.

One of the key factors underlying this success story is the commitment of the policy makers, health care providers and educators. Sri Lanka has a legacy of stressing the importance of health and education, which has been instrumental in the development of its maternal health programmes and policies. With schooling made compulsory for all children in 1942, the literacy rates crossed the 70% mark by 1946 and reached 92% by 1992, with the gap between men and women starting to close early and reaching 2.5% at present.[5] Sri Lanka has the highest gender-related development index ranking of any South Asian country, and a number of government mechanisms, including the Ministry of Women's Affairs, the Women's Bureau and the National Committee on Women ensure that priority is given to women's needs and concerns.

Since the development of the Civil Medical Department in 1857, the Sri Lankan government has assumed the responsibility for providing health care. It set up the first maternity hospital, De Soysa Maternity Hospital, with a donation from a philanthropist, but it is entirely government run. The Ministry of Health (MoH) has also been active in gaining the support of NGOs and international agencies to initiate different maternal health programmes. The government used this external assistance as a launching pad, but subsequently mainstreamed programmes in such areas as family planning, nutrition and immunisation. Although Sri Lankan society is traditionally quite conservative, family planning was introduced as early as 1953 by a voluntary organisation, the Family Planning Association, which started a network of service delivery outlets, which were later incorporated into the MoH.[6] The decline of the total fertility rate (TFR) was slow until the early 1970s but accelerated in the early 1980s. Currently, Sri Lanka's TFR is 1.9, which is low compared to other South Asian countries, and is due in part to a contraceptive prevalence rate of 70%.[7]

Sri Lanka resisted the strategy of training traditional birth attendants as a measure to reduce maternal mortality. Sri Lanka invested heavily in training midwives who are among the frontline health workers who provide family planning care in the community. There are approximately 5,000 such workers in service, each serving a population of 2,000 - 4,000. Their duties include distributing oral contraceptives and condoms, family planning education and counselling, and immunisation.[8] A milestone in monitoring maternal health in Sri Lanka was the establishment of the Maternal Mortality Review, which is a complete review taking place at three levels - institutional, regional and national - with the last review being conducted with the assistance of the Professional Colleges. The strategy of institutionalising deliveries has worked well in this geographically small country. Today, the institutional delivery rate is 97%, with 92% of the deliveries taking place in government institutions and 60% of women delivering in hospitals manned by specialists. Only 2% of births take place in the home, often with the assistance of a trained Family Health Worker; however, home deliveries were responsible for 22% of the maternal deaths that took place in 1996.[9]

Endnotes

1 *Liljestrand, Jerker; Pathmanathan, Indra (eds.). 2003. Investing in Maternal Health: Investing in Maternal Health: Learning from Malaysia and Sri Lanka. Washington, D.C, USA: The World Bank.*

2 *Family Health Bureau, Sri Lanka Ministry of Health. 2004. Maternal Mortality Review.*

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7 *World Health Organization. Core Health Indicators. http://www3.who.int/whosis/core/core_select_process.cfm*

8 *Center for Reproductive Rights. 2004. Women of the World: Laws and Policies Affecting Their Reproductive Lives, South Asia. New York, USA: CRR.*

9 *Family Health Bureau, Sri Lanka Ministry of Health. 2004.*

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Photo by Luciana Rodrigues

India: Including Women's Voices When Crafting Maternal Health Policies

Maternal health is almost always seen as a technical and health issue which means that the medical establishment is regarded as best qualified to speak on it. Policy making on maternal health has therefore never consulted those who are directly affected, that is the women who undergo pregnancy. Policies and Five Year Plans set ambitious targets to reduce maternal mortality, but programmes continue to look away from women. Women have never been consulted on where they prefer to give birth, what support they need for their choices, what happens when they seek help, and what their experience have been in seeking abortions. Neither have women been asked whether all their pregnancies are of choice, whether they need more support in making reproductive decisions and whether they can actually exercise sexual choices and sexual health protection.

Today, policy making is also largely dictated by concerns of cost, since health care is rapidly becoming a lucrative industry rather than a right. In the name of being 'cost effective', however, often highly technical, unrealistic and cost-intensive solutions may be promoted. One classic example is the promotion of compulsory 'institutional delivery' for every birth as the only solution for averting maternal deaths.[1] Despite the fact that women may see birth as a private activity to be carried out in the comfort of home or that there are birth attendants in most communities who can be given more training, policy makers insist that all women should deliver in hospitals. This is despite the knowledge that only 15% of all births lead to complications and the rest are normal deliveries and that complications can happen in the ninth month of pregnancy or up to six weeks after delivery. Policy makers set aside the evident fact that large numbers of women cannot afford the travel costs and informal payments for undergoing birth in state-run institutions: more importantly, that in large parts of India there are no institutions or referral systems to handle the complicated cases![2] Knowing all this, policy makers have preferred to promote institutional delivery through incentive payments and other means.[3]

A group of Indian NGOs working with directly affected women decided that they would take women to directly voice their concerns and their experiences regarding their right to maternal health to address the policy makers in the country's capital. A three-day policy dialogue took place in New Delhi on 27-29 December 2005, called "VOICES

FROM THE GROUND: Policy Dialogues on Women's Right to Maternal Health," organised by SAHAYOG (Lucknow), CHETNA (Ahmedabad) and the Centre for Health and Social Justice (New Delhi), which was attended by 100 participants from eight states of India (apart from local media persons).

These dialogues enabled rural and urban low-income women to directly address the media, Ministry and Planning Commission officials and donors regarding their demands for the improvement of maternal health services in India. The rural women presented testimonies of their experience of seeking maternal health care, denial of health services and described maternal deaths in their families Supporting the women were a number of NGOs who had jointly drafted a set of concrete recommendations for the government. The NGOs supporting the women gave evidence from various parts of the country to indicate that maternal health services were highly inequitable, with a 'clustering of deaths' in certain states, among poor rural women and among Dalit and tribal women.

The meeting also saw a debate on skilled attendance at childbirth between rural traditional birth attendants who had organised themselves into a "Dai Sangathan" and representatives of UN agencies. The Ministry of Health and Family Welfare (Government of India) responded to the women by asking for detailed descriptions of the maternal death cases so that some action could be taken, and this was followed up by a series of faxes from the participating NGOs to the Ministry. Fortunately, the officials have taken action and enquiry letters were issued in 2006. The Ministry also invited the organisers to present these testimonies at three state-level meetings on maternal health (in states with high maternal mortality), so as to bring home the immediacy of the problem to officials at the state level.

However, the rural women and NGOs from Uttar Pradesh wanted to create more pressure from the 'demand side', as they had been documenting denial of maternal health services, doing case work and carrying on the dialogue with state officials for two years already. They felt there was need for a more concerted state-level campaign to raise awareness within the community and the government regarding women's right to maternal health. Rural women decided to call the campaign Complete Citizens Total Rights Campaign (Puri Nagrik, Pura Haq) and this was carried out over several districts of Uttar Pradesh from 6th March to 28th May 2006.

The rural women and NGOs collected around 35,000 signatures supporting their demands and took them to the Minister of Family Welfare on the eve of 28 May 2006 (International Day of Action for Women's Health). They met the local health officials in their districts and presented their problems, indicating their demands for maternal health rights through a poster. Women also monitored the implementation of the government's Rural Health Mission and gave feedback to the state's Director General of Family Welfare at a meeting to celebrate the first anniversary of the Mission launch. The rural women also met members of the State Commission for Women and made presentations inside the State Legislative Assembly. They marched in colourful processions, carrying a 'woman's corpse' to symbolise maternal death, and they stood dressed in shrouds with candles to protest against the forty thousand maternal deaths in the Uttar Pradesh state each year.

The outcome was that the Minister of Family Welfare began to make announcements in the media regarding the importance of maternal health. In some districts, the local health officials developed improved relations with NGOs and enlisted their support in implementing the National Rural Health Mission. The rural women themselves declared the launch of a state-level organisation to continue working on the issue of women's right to maternal health.

These two efforts indicate that women are able to clearly articulate their needs and preferences on maternal health services despite being non-literate, rural and from low-income families. Women are directly affected by health policies, and their experiences and their choices should form the content of policy deliberations, rather than only the technical medical point of view, which often overlooks the social and economic context within which maternity occurs. As we move towards a rights-based approach in maternal health, women's voices need to be given more space, and women's choices need to be considered in decision making.

Endnotes

1 *The report of the Registrar General (2005) called Maternal Mortality in India 1997-2003 says that institutional delivery in India has risen from 24.3% in 1991 to 28.3% in 2003.*

2 *The data from reproductive and child health (RCH) Facility Survey mentioned in the RCH 2 document (2003) indicates that the government institutions equipped to provide essential and emergency obstetric care are rare since they either lack personnel, essential supplies or equipment. According to the RCH 2 document, the RCH Facility Survey revealed that first referral unit (FRU)/community health centre (CHC) and district hospitals attended only about 10 referred cases of delivery in a month.*

- *Only 36% of primary health centres (PHCs) had adequate physical infrastructure*
- *31% PHCs had adequate supplies*
- *Out of every 10 PHCs, 8 have no Essential Obstetric Care Drug kit*
- *34% PHCs offer delivery services, 3% offer abortions*
- *Only 10% of the CHCs and FRUs had adequate supplies*
- *Only 56 % PHCs, 49% CHCs and 89% District hospitals have all critical supplies (defined as 60% of critical inputs)*
- *38% PHCs had adequate staff in position*
- *Out of 10 CHCs, 7 have no obstetrician, 8 have no pediatrician*
- *25% of CHCs and 46% FRUs had adequate staff Details available at http://www.sahayogindia.org/what's%20new/main_complete_citizens.htm*

3 *The current health mission National Rural Health Mission (NRHM) will pay ASHA community animators to motivate women to have delivery in hospitals and pay for costs. The NRHM is a large scale effort by the current government to improve the basic healthcare delivery system in India, especially to improve the availability of and access to quality healthcare by the rural poor, women and children. Details are available at http://www.mohfw.nic.in/NRHM%20Mission%20Document.pdf*

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Regional

The Southeast Asian Consortium on Gender, Sexuality and Health held its 5th Leadership Course on Gender, Sexuality and Health in Southeast Asia and China in Hanoi, Vietnam from 27 August to 15 September 2006. The impetus for this annual 19-day leadership course stems from the fact that minimal attention is paid to the important linkages between gender, sexuality and health policy and programmes, mainly due to a lack of adequate financial and human resource constraints at the country level. As such, this course pools country-based resources into a collective, regional effort resulting in an exciting multi-disciplinary curriculum. It is an opportunity for key actors in the Asia-Pacific region working on issues of gender, sexuality and health to receive cross-disciplinary training and share perspectives.

Twenty-one participants from Cambodia, Hong Kong SAR, Indonesia, Lao PDR, Philippines, and Thailand attended the course from diverse backgrounds (e.g. UN, academia, union, NGO, and government). They were provided with context-specific and gender-sensitive knowledge about sexuality and the critical linkages between gender, sexuality and health policies and programmes in Southeast Asia and China. Time was also spent exploring how theories of gender and sexuality, along with different methodological approaches, can be applied to health policy and programmes to enhance health outcomes. For those interested in this course, it will be held again in 2007 (27 August – 15 September 2007) in Nakornpathom, Thailand.

Source: Southeast Asian Consortium on Gender, Sexuality and Health, c/o Center for Health Policy Studies, Faculty of Social Science and Humanities, Mahidol University, 25/25 Puttamonthon Road 4, Salaya, Nakornpathom, 73170, Thailand. Tel: 662-441-9184, 662-441-9515 (ext. 109) Fax: 662-441-9184, 662-441-9515 (ext. 112) E-mail: progassist@seaconsortium.org Website: www.seaconsortium.org

India

The 8th State Dalit Women's Conference was held in Palavoy Village, India on 27 – 28 August 2006, to strengthen the Dalit women's movement, raise awareness regarding Dalit women's political and land rights and voice a call to action to challenge untouchability, the caste system, globalisation processes, and religious fundamentalism. Over 1,000 Dalit women attended the 2-day event. Topics of discussion during the conference included the harmful effects of pesticides on the health of rural women involved in agricultural work, the negative impact of transnational corporations, the weak response of India's government to Dalit women's rights and concerns, the discriminatory treatment Dalit women endure, and the need for Dalit women to come together and act as a powerful, political unit. In Tamil Nadu, government laws and policies outline a number of rights for Dalits, including a guaranteed number of seats in the local government and the provision of two acres of land, but this is rarely implemented or enforced. Women leaders and activists spoke ardently about the pervasive practice of untouchability, with 40% of villages in India still involved in this practice, and the fact that 60% of sex workers are Dalits. Beyond confronting discrimination and inequality, it was felt that Dalit women's power in decision making and leadership must be championed. The second day of the conference closed with a passionate sharing of the resolutions from the conference.

Source: Michelle Rogers, an ARROW Programme Officer, attended the Conference on behalf of the Asia-Pacific Resource and Research Centre for Women (ARROW), No. 80 & 82, 3rd Floor, Jalan Tun Sambanthan, Brickfields, 50470 Kuala Lumpur, Malaysia. Tel: 603-2692-9913 Fax: 603-2692-9958 E-mail: arrow@arrow.po.my Website: www.arrow.org.my

Indonesia

The White Ribbon Alliance for Safe Motherhood, Indonesia held its first national meeting on 5 – 7 September 2006 in Jakarta. A total of 136 participants and 30 invitees were present at the meeting, including Her Excellency, the Minister for the Empowerment of Women, Dr. Meutia Hatta Swasono. The White Ribbon Alliance for Safe Motherhood unites individuals, organisations and communities – NGOs, UN agencies, professional associations, students, health service providers, midwives, and others – who are working to increase public awareness about the needless loss of life as a result pregnancy and childbirth related deaths and to promote safe motherhood around the world. The While Ribbon Alliance (WRA) of Indonesia was officially formed at a meeting of NGOs in October 1999, but this recent 2006 meeting is their first national meeting. WRA Indonesia has initiated several awareness raising activities, including the promotion of the white ribbon campaign and a campaign focused on birth and emergency preparedness at the community level. They adopted an official name Pita Putih (white ribbon in Bahasa Indonesia) and developed a slogan which translated into English means "The mother is safe, baby is health and family is happy." To further publicise their efforts, articles on WRA Indonesia have been submitted to local papers. For information on becoming a member of the White Ribbon Alliance, please visit: www.whiteribbonalliance.org/GetInvolved/

Source: Srihartati Pandi, Indonesian White Ribbon Alliance for Safe Motherhood (APPI), c/o Melati Foundation, Jalan Semangka Blok S – 37, Kalibata Indah, Jakarta Selatan, 12750, Indonesia. Tel: 62-21-7970593 Fax: 62-21-7970593 E-mail: shartatipandi@yahoo.com or appi@pitaputih.org

Pakistan

Shirkat Gah, in collaboration with two organisations, SUNGI Development Foundation and Omar Asghar Khan Foundation (OAKF), from August 2006 has put into operation a UNFPA supported project whereby six 'Women Friendly Spaces' (WFS) with hammams (bathing areas) are being set up for women in earthquake affected areas of Pakistan's North West Frontier Province (NWFP) and Azad Kashmir. A relatively new concept, it evolved out of the participatory rapid needs assessment carried out in nine relief camps by Shirkat Gah with other organisations in the aftermath of the devastating earthquake that struck the northern areas of Pakistan in October 2005.

No agency until that point had looked at women's special needs. The assessment revealed that besides security, reproductive health and psychosocial-related needs, women most of all wanted privacy for bathing and washing and just being by themselves. In light of these findings, WFS were conceptualised for the camps. However, the closure of the camps by April 2006 led to the adaptation of the concept to villages seriously affected by the earthquake.Each WFS will serve women in multiple villages around it and will be jointly managed by SUNGI, OAKF and the local women. These are planned as women's and adolescent girls' own spaces where they can come together around structured activities (health and reproductive health needs, skills training, lectures, talks, etc.), as well as unstructured ones (reading, playing games and coming together for relief and support). Already, women's priorities for each WFS, along with how they will be used, have been collectively set. At present, three WFS spaces with two bathing areas in Mansehra (NWFP) are under construction and should be ready by the end January 2007.

In Muzaffarabad (Azad Kashmir), the sites have been selected with construction to begin in early 2007, though local teams have rented space in the three project villages as an interim measure. Positively, these temporary spaces have begun to function as a place for women to meet. Overall, there is a great deal of excitement in the communities where the WFS are being established, as local women have volunteered to participate in running them.

Source: Khawar Mumtaz, Senior Coordinator, Shirkat Gah - Women's Resource Centre, 68-Tipu Block, New Garden Town, Lahore, Pakistan. Tel: 092-42-5836554, 5848815, 5832448 Fax: 092-42-5860185 E-mail: khawar@sgah.org.pk Website: www.sgah.org.pk

Vietnam

A capacity building session was held in Hanoi, Vietnam on 25 – 28 May 2006 on writing a shadow report on CEDAW (Convention on the Elimination of All Forms of Discrimination against Women) implementation. Organised by the Gender and Community Development Network (GENCOMNET) and the International Women's Rights Action Watch (IWRAW) Asia Pacific, this training session was held to equip NGOs in Vietnam with the skills to write a CEDAW shadow report. The creation of independent shadow reports by NGOs is a crucial step in bringing women's real concerns to national and international attention, as governments' assessments of their efforts to comply with CEDAW are frequently incomplete and tend to minimise problems and maximise accomplishments. The training aimed to: 1) build the capacity of Vietnamese NGOs regarding the significance, scope, content, and uses of CEDAW; 2) create a pool of resource persons on CEDAW, especially in the context of writing the report; and 3) build the capacity of NGOs to utilise the CEDAW framework in their work, whether in advocacy, services, research, and other programmes. In past years, Vietnam has presented CEDAW reports prepared by the National Committee for the Advancement of Women, but a shadow report has never been submitted. It is anticipated that this first shadow report will focus on six topics addressing women – health, politics, education, social rights, jobs and careers, and poverty reduction – and include recommendations on how to deal with women's needs and challenges through the vision of local NGOs. The report is to be completed by the first quarter of 2007 in preparation for the CEDAW conference in New York in 2007. For further information on producing NGO shadow reports, please visit IWRAW's webpage on this topic: www.iwraw.igc.org/shadow.htm

Source: Gender and Community Development Network (GENCOMNET), 113 D1, Trung Tu, Dong Da, Ha Noi, Vietnam. Tel/Fax: 84-4-5726789 E-mail: gencomnet@vnn.vn Website: www.english.gencomnet.org

International Women's Rights Action Watch (IWRAW) – Asia Pacific, 80-B Jalan Bangsar, 59200 Kuala Lumpur, Malaysia. Tel: (603)-2282-2255 Fax: (603)-2283-2552 E-mail: iwraw-ap@iwraw-ap.org Website: www.iwraw-ap.org

Keith-Brown, Kimberli. 2005. Investing for Life: Making the Link between Public Spending and the Reduction of Maternal Mortality. Mexico City, Mexico: Fundar Center for Analysis and Research. *39p. http://www.internationalbudget.org/Investingforlife.pdf*

The report Investing for Life: Making the Link between Public Spending and the Reduction of Maternal Mortality captures the dialogue that took place at a 3-day meeting in November 2004, where a small group of maternal health and budget advocates and researchers met in Mexico City to explore the potential for using budget analysis to strengthen civil society efforts to reduce maternal mortality. Civil society budget work aims to understand, analyse and influence government budgets, paying particular attention to transparency, social justice and inclusive budgeting. The meeting took the form of a dialogue aimed at building the understanding of the two fields and looking at the possibility of developing a strategic, mutually beneficial alliance. The overarching intention of the report is to broaden the discussion and provide guidelines for other activists looking for new strategies to reduce maternal mortality. The report addresses the possibilities for combining the long-standing experience of the maternal health community with the analytical approaches used in applied budget work.

After the Executive Summary and the Introduction, the third section introduces the field of maternal mortality, addressing major policy issues, approaches for reducing maternal mortality, along with international conventions and commitments on the issue. The fourth section, Applied Budget Analysis, describes the growth of this field, the types of organisations that specialise in this area and the goals and methods that define this work. The fifth section is especially interesting in that three challenges to reducing maternal mortality are outlined: 1) human and infrastructure resources required for skilled care; 2) equity in access to services; and 3) effective and efficient service delivery. Each challenge is followed by a description of how budget analysis can be used to address maternal mortality challenges. The final section, New Strategies and Perspectives, delves further into the challenges, strategic choices and linkages associated with bringing the maternal health and civil society budget analysis fields together.

SAHAYOG. 2006. Voices from the Ground: Women Show the Way. *Lucknow, India: SAHAYOG. 34p. http://www.sahayogindia.org/what's%20new/Voices_book.pdf*

This publication takes as its point of departure the fact that policies and programmes on maternal health have traditionally been viewed through the lens of cost-effectiveness, technically viable solutions or medical appropriateness. As such, Voices from the Ground: Women Show the Way elegantly details the maternal health concerns of those who are actually on the receiving end of policies and programmes in India. This publication is the output of policy dialogues on maternal health organised by the Indian partners of the Women's Health and Rights Advocacy Partnership (WHRAP) in New Delhi on 27 – 29 December 2005, the goal of which was to create a direct interface between community women from different states, policymakers, programme planners, parliamentarians, and the media.

In the report, between sections that discuss women's rights to maternal health, community care and hospital care, the causes of maternal deaths, and the standardisation of care, are the harrowing narratives of the women themselves. Intimately detailed are the realities of pregnant women's lives who are at risk in India due to poverty, isolation, malnutrition, a lack of medicine, and having their basic rights denied. Also covered is the disconnect between health policy and what is actually happening on the ground, along with the fact that only a small segment of the population is able to benefit from a rapidly prospering and modernising India. The publication concludes with four useful boxes covering: 1) Recommendations of 'Voices from the Ground'; 2) Unsafe Motherhood: The Shameful Figures; 3) The Deadly Cocktail (the 'four delays'); and 4) Abortion Related Deaths.

Shirkat Gah; Society for International Development. 2005. Regional Conference on Maternal Health and Well-Being in South Asia: Strategies for Meeting the Millennium Development Goals, *February 3-5, 2005. Lahore, Pakistan: Shirkat Gah. 29p.*

This report succinctly outlines the findings and recommendations stemming from the Regional Conference on Maternal Health and Well-Being in South Asia: Strategies for Meeting the Millennium Development Goals held on 3 – 5 February, 2005 and organised by the Society for International Development together with Shirkat Gah. The conference aimed to critically explore how the MDG process can support women's reproductive rights and the health agenda in South Asia, with a specific focus on maternal health. The participants worked from an analysis grounded in experience at the local level as well as technical knowledge on the subject matter.

The first six sections of the report are useful in understanding: 1) the MGDs in the broader context and how they fail to bring in the ICPD's emphasis on women's SRHR; 2) primary health care, particularly how it needs to be revitalised to be more comprehensive; 3) government responsibility and how this issue is about political will, equitable provision and holding governments accountable for maternal mortality and morbidity; 4) the measurement and monitoring of maternal mortality and how there is too great a focus on targets and numbers, which can be inaccurate, and the need for more qualitative data on the disparities between groups; and 5) the relationship between the public and private sector and importance of monitoring private sector involvement in maternal health and the necessity for clear guidelines with respect to responsibility, decision-making and affordability in any private-public partnership. The

sixth section covers partnerships and, more specifically, how partnerships need to be actively sought, stressing that goals must be aligned and advocacy should play a decisive role in the work being done.

The Lancet Maternal Survival Series: Strategies Prioritized to Reduce Maternal Deaths. *Published Online September 28, 2006 http://www.womendeliver.org/downloads/Maternal_Lancet_series.pdf*

On 28 September 2006, The Lancet, the established British medical journal, published a series of papers entitled: The Lancet Maternal Survival Series: Strategies prioritized to reduce maternal deaths. The series, composed of five research papers and five comments, represents a call to action regarding the problem of maternal mortality around the world and aims to strengthen the evidence base to support advocacy messages on maternal survival. The first paper details the 'who, when, where, and why' of maternal mortality, drawing attention to the fact that the risk of a woman dying as a result of pregnancy or childbirth during her lifetime is about one in six in the poorest parts of the world, compared to the risk of about one in 30, 000 in Northern Europe.

The second paper draws attention to the fact that while maternal death is a complex issue, there are a few strategic choices that can be made that have proven effective in reducing maternal mortality. The third article raises the issue of the scarcity of skilled health provides and health-system infrastructure and discusses what is needed to move forward from this dire situation. The fourth paper takes up the point of mobilising financial resources for maternal health, which includes a discussion of the lack of cost-effective maternal health services and how available evidence creates a strong case for the removal of user fees and the provision of universal coverage for pregnant women.

UNFPA. 2006. Maternal and Neonatal Health in East and South-East Asia. Bangkok, Thailand: UNFPA. *28p. http://www.unfpa.org/upload/lib_pub_file/613_filename_bkmaternal.pdf*

The publication Maternal and Neonatal Health in East and South-East Asia gives a useful overview of the maternal and newborn health situation in the region. This publications provides a clear articulation of the evidence needed to save women's and newborn's lives, as there is now a solid evidence base of the priority initiatives on maternal and newborn health which must be in place to avert maternal and neonatal mortality in resource-constrained settings. Though only 28 pages in length, it is able to cover, in six chapters, an overview of maternal and neonatal health and underserved groups in the region, international lessons learned in reducing maternal and neonatal mortality, strategies in countries with high MMRs, and aspects of monitoring and evaluation. One of the most useful elements of the publication is the extensive presentation figures and tables. Figures include such useful statistics as maternal mortality ratios, percentage of births attended by skilled birth attendants, percentage of maternal deaths averted by specific interventions, and contraceptive prevalence rates. The tables contain valuable information on maternal health indicators for East and South-East Asia, including MMR, SBA, EmOC, and community awareness.

White Ribbon Alliance of India; UNICEF. 2006. I Want to Live: An Advocacy Kit for Media Representatives. *India: WRAI and UNICEF. 36p.*

The White Ribbon Alliance of India (WRAI) and UNICEF have developed a safe motherhood advocacy kit for media representatives: *I Want to Live: An Advocacy Kit for Media Representatives.* The kit, which focuses on the Indian context, was launched at a meeting with Indian parliamentarians on the eve of India's National Safe Motherhood Day, 10 April 2006, in Delhi. This useful kit aims to increase the awareness among media and elected representatives on issues related to maternal mortality, with the ultimate goal of engaging them in advocacy for safe motherhood policies and programmes at national and state levels. Divided into 15 separate information sheets, it covers a range of practical topics, including "Frequently Asked Questions about Safe Motherhood," "Definitions," "The Causes of Maternal Mortality," and "The Consequences of Maternal Deaths." Especially useful are the sheets detailing concrete points where action can be taken: for example, one sheet outlines how media representatives can use unique and creative approaches to effectively and appropriately convey the message of safe motherhood; and another sheet explains how media representatives' stories and campaigns can inspire families and communities to encourage delayed marriage and childbearing; recognise, prevent or treat pregnancy-related complications; and ensure that women and children get proper nutrition.

Other Resources

AbouZahr, Carla. 2003. *Safe Motherhood: A Brief History of the Global Movement 1947–2002*. British Medical Bulletin. Vol. 67:13-25.

ACCESS. 2007. *Demystifying Community Mobilization: An Effective Strategy to Improve Maternal and Newborn Health. Baltimore, USA*: ACCESS. 30p. http://www.accesstohealth.org/toolres/pdfs/ACCESS_DemystCM.pdf

Center for Reproductive Rights. *Surviving Pregnancy and Childbirth: An International Human Right. New York, USA: Center for Reproductive Rights.*15p. http://www.reproductiverights.org/pdf/pub_bp_surviving_0105.pdf

de Bruyn, Maria; Packer, Sarah. 2004. *Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling and Clinical care. Chapel Hill, USA:* Ipas. 52p. http://www.ipas.org/publications/en/ADOLPOL_E04_en.pdf

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Espinoza, Henry; Camacho, Alma Virginia. 2005. *Maternal death due to domestic violence: an unrecognized critical component of maternal mortality.* Pan American Journal of Public Health. Vol. 17(2):123-129. http://www.scielo.br/pdf/rpsp/v17n2/a11v17n2.pdf

Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. 2004. *Obstetric Fistula: Ending the Silence, Easing the Suffering. Baltimore, USA*: JHBSPHCC. 12p. http://www.infoforhealth.org/inforeports/fistula/fistula.pdf

ARROW's Publications

ARROW. 2007. *Rights and Realities: Monitoring Reports on the Status of Indonesian Women's Sexual and Reproductive Health and Rights - Findings from the Indonesian Reproductive Health and Rights Monitoring & Advocacy (IRRMA) Project. Kuala Lumpur:* ARROW. 216p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2005. *Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015, Asian Country Reports. Kuala Lumpur:* ARROW. 384p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. CRR. 2005. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, East and Southeast Asia. New York: Center for Reproductive Rights.* 235p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research. Kuala Lumpur: ARROW.* 147p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2001. *Women's Health Needs and Rights in Southeast Asia: A Beijing Monitoring Report. Kuala Lumpur:* ARROW. 39p.
Price: US$ 10.00 plus US$ 3.00 postal charge

Abdullah, Rashidah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing. Kuala Lumpur:* ARROW. 30p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1-4 June 1998, Kuala Lumpur, Malaysia. Kuala Lumpur:* ARROW. 65p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 1999. *Taking up the Cairo Challenge: Country Studies in Asia-Pacific. Kuala Lumpur:* ARROW. 288p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 1997. *Gender and Women's Health: Information Package No. 2. Kuala Lumpur:* ARROW. v.p.
Price: US$ 10.00 plus US$ 3.00 postal charge

ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific. Health Resource Kit. Kuala Lumpur:* ARROW. v.p.
Differential Pricing. Contact ARROW for details.

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1. Kuala Lumpur:* ARROW. v.p.
Price: US$ 10.00 plus US$ 3.00 postal charge

Definitions

Basic Emergency Obstetric Care (EmOC)

Basic EmOC includes the following functions:
- Parenteral (intravenous or intramuscular) antibiotics
- Parenteral oxytocics (drugs that induce uterine contractions to stop bleeding)
- Parenteral sedatives or anticonvulsant drugs
- Manual removal of the placenta (to stop haemorrhage)
- Removal of retained products (to prevent bleeding and infection)
- Assisted vaginal delivery with forceps or vacuum extractor (to alleviate prolonged labour)

UNFPA: http://www.unfpa.org/mothers/terms.htm

Maternal Death and Late Maternal Death

The Tenth Revision of the International Classification of Diseases (ICD-10) defines a maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." In recognition of the fact that the 42-day limit is somewhat arbitrary, given that modern life-sustaining procedures and technologies can prolong dying and delay death, the ICD-10 introduced a new category: late maternal death. Late maternal death is defined as the "death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy."

World Health Organization. International Statistical Classification of Diseases and Related Health Problems, 10th Revision (Version for 2007): http://www.who.int/classifications/apps/icd/icd10online/

Obstetric Fistula

Obstetric fistula is an injury of childbearing. It is a hole between the birth canal and one or more of a woman's internal organs, usually the bladder and/or the rectum. The hole develops after several days of obstructed labour when the pressure of the baby's head against the mother's pelvis cuts off the blood supply, causing the tissue to die and a hole to form. This can be avoided with timely medical interventions, such as a Caesarean section. Without treatment for obstetric fistula, the woman is left with chronic incontinence, unable to control her flow of urine or faeces, and is often ostracised by her family and community.

EngenderHealth: http://www.engenderhealth.org/ia/swh/mcf.html

The Right to Safe Pregnancy and Childbirth

…States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Convention on the Elimination of All forms of Discrimination against Women - Article 12 (2): http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm

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Addressing Unplanned Pregnancies Can Reduce Pregnancy and Childbirth Related Deaths

Every year, of the estimated 210 million women who become pregnant, 80 million of these pregnancies are unplanned, some of these are carried to term, while others end in spontaneous or induced abortions. In East Asia, 39% of the 40 million pregnancies that occur every year are unplanned, and 30% end in abortion. In the rest of Asia, 34% of 83 million pregnancies occurring each year are unplanned and 17% end in abortion.[1] Overall, a third of pregnancies worldwide do not end in motherhood for women. The data calls for a de-linking of the terms pregnancy and motherhood, since so many pregnancies do not result in maternity, and hence the need for strategies that take this fact into account effectively.

Avoiding unplanned pregnancies can reduce the alarmingly high pregnancy and childbirth related deaths in the Asia-Pacific region, where the largest numbers of women continue to die each year in India (136,000); Pakistan (26,000); Bangladesh (16,000); China (11,000); Indonesia (10,000); and Nepal (6,000).[2] A significant proportion these deaths – 14% for south-central Asia and 19% for south-eastern Asia – are the result of unsafe abortions.[3] The legal environment around abortion has a significant bearing on women's access to safe abortion services. Moreover, women in all parts of the world, whether young, old, married, unmarried, rich, and poor, have abortions; but often poor, young and unmarried women's access to safe services, even when legally entitled, is grossly limited.

A large proportion of married women in the region report they had a birth sooner than they wished to (a mistimed birth) or at a time when they had wanted no more children (an unwanted birth). The percentage of unplanned births among ever-married women aged 15-49 years is very high in the Philippines (44%); Bangladesh (32%); Thailand (31%); India (21%); and Pakistan (21%).

There is also a high unmet need for contraception in Asia – an estimated 63 million women in Asia (except China) have an unmet need for contraception.[4] Unfortunately, information on the unmet need for contraception of single, never married, divorced, separated, and widowed women in most Asia-Pacific countries is unknown. Women unable to access appropriate and comprehensive information about safe sex practices, sexuality and contraceptive choices, along with related services, are denied their basic sexual and reproductive rights. Without information and services, women are more vulnerable to having unplanned pregnancies, which elevates the likelihood of their having an unsafe abortion.

The Cairo Programme of Action calls for prevention of unwanted pregnancies to be given the highest priority and every attempt to be made to eliminate the need for abortion, while still recognising the importance of access to safe abortion services. Advocacy efforts need to be directed towards improving all women's access to affordable and appropriate contraceptive choices, irrespective of their marital status, along with ensuring access to safe abortion services. This needs to be coupled with empowering women to exercise control over when and under what circumstances they will become pregnant.

Endnotes

1 *The Alan Guttmacher Institute. 1999. Sharing Responsibility: Women, Society and Abortion Worldwide. New York, USA: The Alan Guttmacher Institute*

2 *Ross, John A.; Winfrey, William L. 2002. "Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate." International Family Planning Perspectives. Vol. 28 (3): 138-143*

3 *ARROW. 2005. Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015. Kuala Lumpur, Malaysia: ARROW*

4 *WHO. 2004. Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000. Geneva, Switzerland: World Health Organisation*

By Sai Jyothirmai Racherla, Programme Officer, ARROW

Country	Maternal Mortality Ratio[e] (Maternal deaths per 100,000 live births)	% of unplanned births among women (mistimed and unwanted birth) (ever-married women, 15-49 years)[f]	Unmet need for contraception[g] (%)
Bangladesh	380	32	18
Pakistan	500	21	32
Nepal	740	N/A	28
India	540	21	20
Cambodia	450	N/A	33
Laos PDR	650	N/A	N/A
Vietnam	130	N/A	7
Thailand	44	31	11
Philippines	200	44	26
Indonesia	230	17	14