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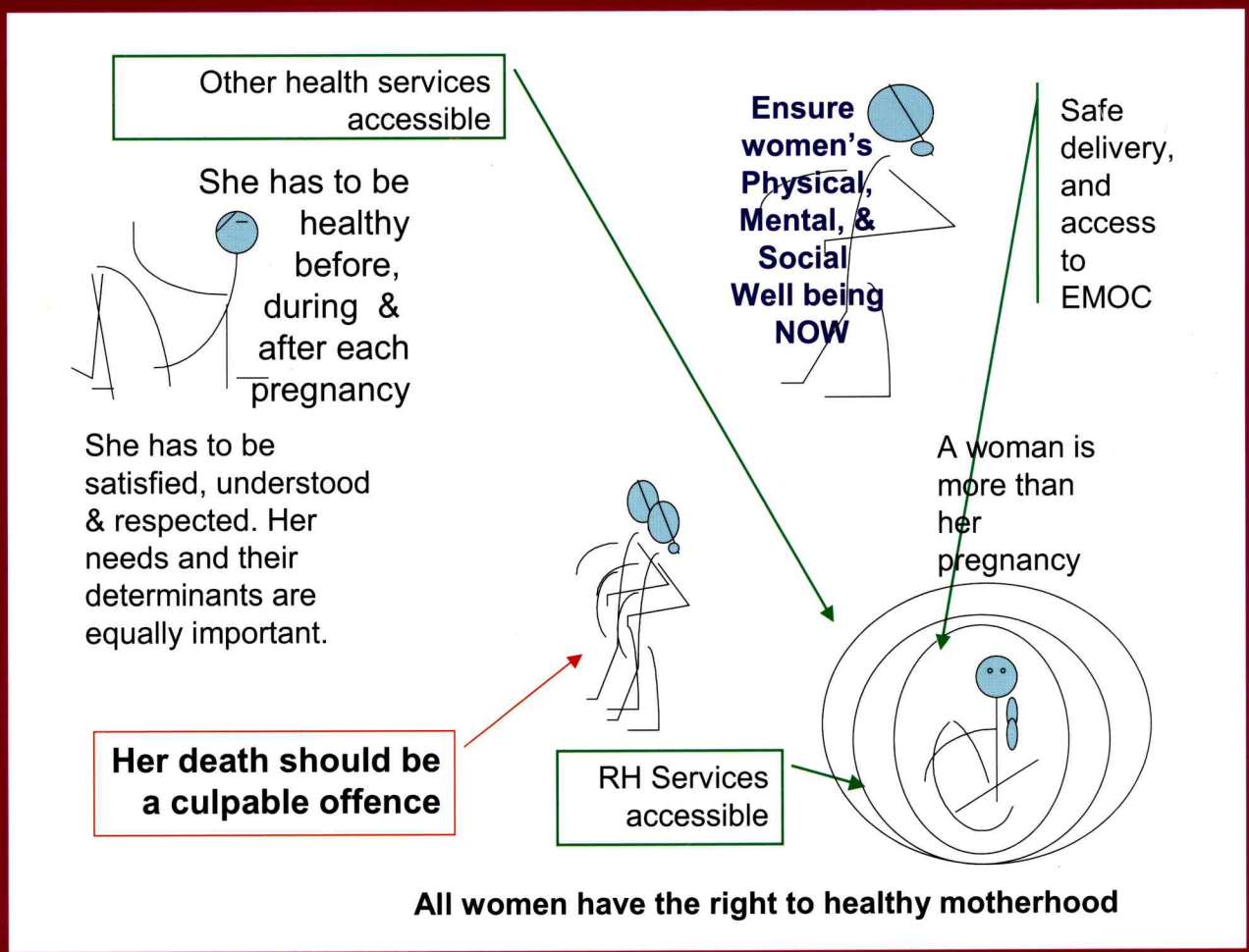
SID-SAN and Shirkat Gah

Regional Conference on Maternal Health and Well-being in South Asia: Strategies for Meeting the Millennium Development Goals, February 3-5, 2005



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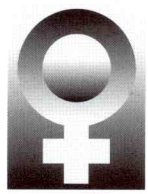

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Preface

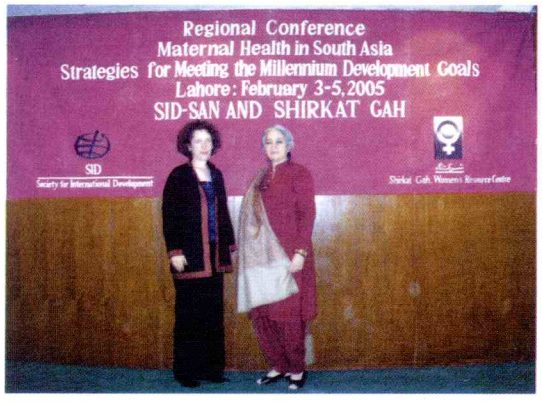
The Society for International Development -South Asia Network (SID-SAN) together with Shirkat Gah, the Women's Resource Centre in Lahore, Pakistan, hosted the Regional Conference on 'Maternal Health and Well-being in South Asia: strategies for meeting the Millennium Development Goals'. The aim was to use the framework of the MDGs to build important and timely partnerships in the region to promote women's sexual and reproductive health and rights. The partnership enabled on the one hand the knowledge of an established and committed women's NGO working on the ground, and on the other hand a region-wide network with the political awareness of an established civil society group with links to policy makers and development and health professionals to create a dynamic and engaging space for over 80 participants.

The full and rich discussion that ensued during the two days in Lahore not only reflected the excellence of the presentations and high calibre of the participants from Bangladesh, India, Nepal, Pakistan and Sri Lanka but also indicated how maternal health and well-being is critical to gender human rights and development in South Asia. The meeting brought together regional women's NGO and research communities, health and medical associations, the private sector, civil society networks, UN regional bodies research institutes and media associations in South Asia. Together they mapped out the different levels of partnerships needed to prevent maternal mortality and morbidity and to promote gender justice, women's rights health and well-being with a focus on poor communities in South Asian countries.

This brief report summarizes the Conference findings and recommendations to carry on the work in the region. In such a short space it can only sketch out some of the key issues identified by the 24 presentations made, including 6 expert papers, however we hope it will be of interest and use for all of those working to meet the major challenges that we face in our collective goal to reduce the unacceptable level of maternal deaths and morbidities in South Asia.

We would like to thank all the participants who joined us in Lahore, the hard working staff of Shirkat Gah and the Global Fund for Women and the Mailman School for Public Health for their generous support.

Khawar Mumtaz and Wendy Harcourt on behalf of SID-SAN and Shirkat Gah.



Wendy Harcourt and Khawar Mumtaz

SID-SAN

The SID South Asia Network (SID-SAN), is an influential group of civil society leaders in the SID network formed in 2002 to work on 'Political Conflict, Women and Well-being in South Asia'. The core concern of the SID-SAN network is to address the structural causes of political conflict in order to bring an end to the region's injustice, poverty, ill-health and gender inequalities that inhibit women's security, livelihoods and well-being. Since 2003 SID-SAN supports a regional alliance to promote women's reproductive health and rights with UN, government, civil society, religious leaders and political parties.

Shirkat Gah

Shirkat Gah -Women's Resource Centre, formed almost two and a half decades ago, is an institutional member of SID and has been working with SID since 1993 on various global and regional projects related to reproductive rights and health. Shirkat Gah has been one of the organizations in the forefront of defending women's rights besides providing solidarity to individual women in specific instances. One of Shirkat Gah's central tasks is to enhance the capacity of women's community based organizations to deal with women's issues and challenges as they arise in their communities with a focus on women's health and rights.

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Saman Yazdani Khan and Darakshan Badar

Imran Zafar and Saman Yazdani Khan

Kausar Khan, Darini Rajasingham and Jashodhara S. Gupta

Opening Plenary

Introduction

For 50 million women globally maternity means unnecessary suffering ill health or death. More than half a million women die annually of pregnancy related complications, 99 percent of them in developing countries a vast majority in South Asia. Maternal morbidity affects many millions more. Women and adolescent girls, living in desperately poor communities, continue to face overwhelming sexual and reproductive health problems. In addition, each year millions of infants die as a direct result of poorly managed pregnancies and deliveries. The tragedy is that most of these deaths and disabilities are preventable.

These figures tell a sorry tale, but also at the same time they are themselves difficult to estimate and can even hide what is really happening. Behind the figures is a complex story. The issue is not just bio-medical, nor simply the lack of resources, it is a complex mix of economic and socio-cultural factors that lead to gender discrimination, neglect and deprivation and ultimately the denial of women's rights to well-being. The prevention of maternal mortality and morbidity and better child survival demands more than access to better services and medicines. What is needed is a focused attention to the human rights of girls and women through a multi-sectoral endeavour and a concerted global effort. But while easy to state on paper, the current economic climate, religious and social beliefs, makes this a highly challenging task, particularly in South Asia.

The focus of the Millennium Development Agenda set by the series of 1990s UN Conferences (in particular the Programme of Action of the International Conference on Population and Development (ICPD) in 1994 and the Fourth UN World Conference on Women in Beijing in 1995 and the +five reviews in 1999 and 2000) gives an important concrete set of goals to tackle the issue. The MD Goal 3 to promote gender equality and empower women, aims to address the gender inequalities that continue to be pervasive and the strategies for women's empowerment and Goal 5 to improve maternal health addresses the problem of the millions of women who suffer from poor reproductive health and pregnancy-related illness and disability.

What the MDG process is revealing is that reducing maternal mortality and ensuring women's well-being, health and rights will require fundamental transformations in all spheres: in individual relationships, households and communities, in health facilities and care systems, in funding priorities, and in national and international policies. It will require the commitment of a broad range of social actors including health professionals, advocacy groups, women's groups, other community-based movements, legislators, policymakers and the deliberate creation of an environment responsive to this change. It needs fundamental social, economic and political change to enable women to overcome their current subordinate status in society and put an end to the violations of their rights, including reproductive rights. Most of all it will require activities that show operational results, resources and dedication and strong lasting partnerships.

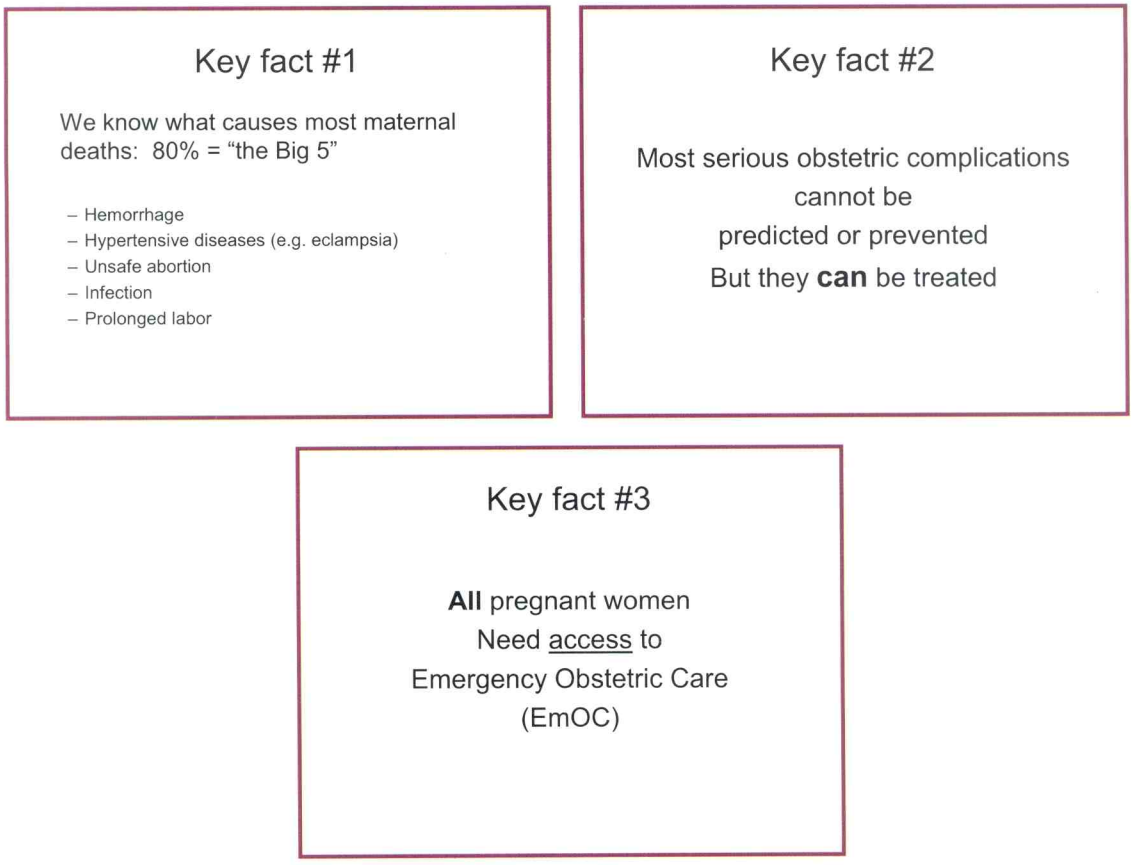
Taking up these challenges, the Society for International Development South Asia Network and Shirkat Gah Regional Conference on 'Maternal Health and Well-being in South Asia: Strategies for Meeting the Millennium Development Goals' explored how the MDG process can support women's reproductive rights and health agenda in South Asia, with a specific focus on maternal health and women's well-being as critical to gender human rights and development in the region.

The meeting focused on the political opportunity the MDGs present for the region to put in place the policies, resources and actions needed to reduce maternal mortality and morbidity and child mortality. The discussion took a pragmatic approach (while

acknowledging the lack of knowledge about the MDG process and the cynicism around it by many NGOs) looking at the MDG process as a way to push a South Asian women's rights and comprehensive maternal health agenda. The Conference adopted a radical critique of medical and development interventions by looking at the underlying economic and social factors that need to be taken into account. The participants worked from an analysis grounded in experience at the local level as well as technical knowledge on the subjects discussed.

The following themes were discussed:

- How to 'unpack' the concept of Maternal Mortality and Morbidity,
- How to place the MDGs 'in context',
- How to find more appropriate and accurate ways to measure the maternal mortality ratio,
- How to redefine maternal mortality to include morbidity and non medical indicators, moving away from highly medicalized and expensive obstetric care as the only approach,
- How to train of TBA and doctors to ensure safe delivery taking a life cycle health systems training approach, and
- How to redefine health NGO and government collaboration (in the light of public/private partnerships).



Gender, Poverty and Health Systems

The Conference agreed that the MDGs are an important set of tools to end poverty, improve health systems, give greater access to women to appropriate health services and empower them to use reproductive health services with a sense of dignity and pride and a say in what goes on. On the other hand, it was felt that a critical approach to the MDGs needed to be taken particularly given the difficult context in which they were being proposed.

First of all, poverty needs to be understood as more than income poverty. In order to address poverty given the existing power structures it was not enough to set up goals and measurements, fundamentally radical economic, political and social reforms are needed. It was important to ensure well-being through health systems that work in a holistic sense for poor women. Health systems have to provide care throughout a women's life cycle from early age including antenatal care. In this sense maternal mortality and morbidity as a 'health' issue has to be seen not just in relation to disease but in relation to cross cutting concerns around 'human resources for health', 'ensuring access to health' and 'finance for health'. Maternal health has to be considered at the heart of the political and economic policy discussions, not put to one side as a technical 'medical' issue.

> Women's health is inextricably linked to their social status. Social disparities underlie the inequalities that deny health and rights to the poorest and most vulnerable women as well as those in special need – living under conflict, as refugees and in prisons.

A second concern is how to establish health systems that could provide the care, nutrition and medical treatment that can tackle the millions of women who continue to die in child birth and related diseases in South Asia. The knowledge and technical know-how is there, but the political will and equitable distribution of resources to make it happen is not. The required reduction in maternal mortality can only be achieved if the structures, resources and women's rights are also taken into consideration, particularly women's reproductive rights and health.

The meeting underlined that the MDGs are not neutral policy tools, they are part of an interventionist development policy that has impacted on health systems and thereby on women's demand for and access to primary health as well as reproductive health care. Reducing maternal mortality requires funding and a reform of health systems that addresses the problems of the decimation of the public health system through privatization and structural adjustment policies. Beyond financial provisions a strong health system recovery must also include further outreach and education of the population in ways that take into account how neglected health is the 'norm' for poor people – therefore health systems have to be seen as more than just delivery systems, but a core social institution that can tackle the complex issues around equity, social exclusion and gender bias.

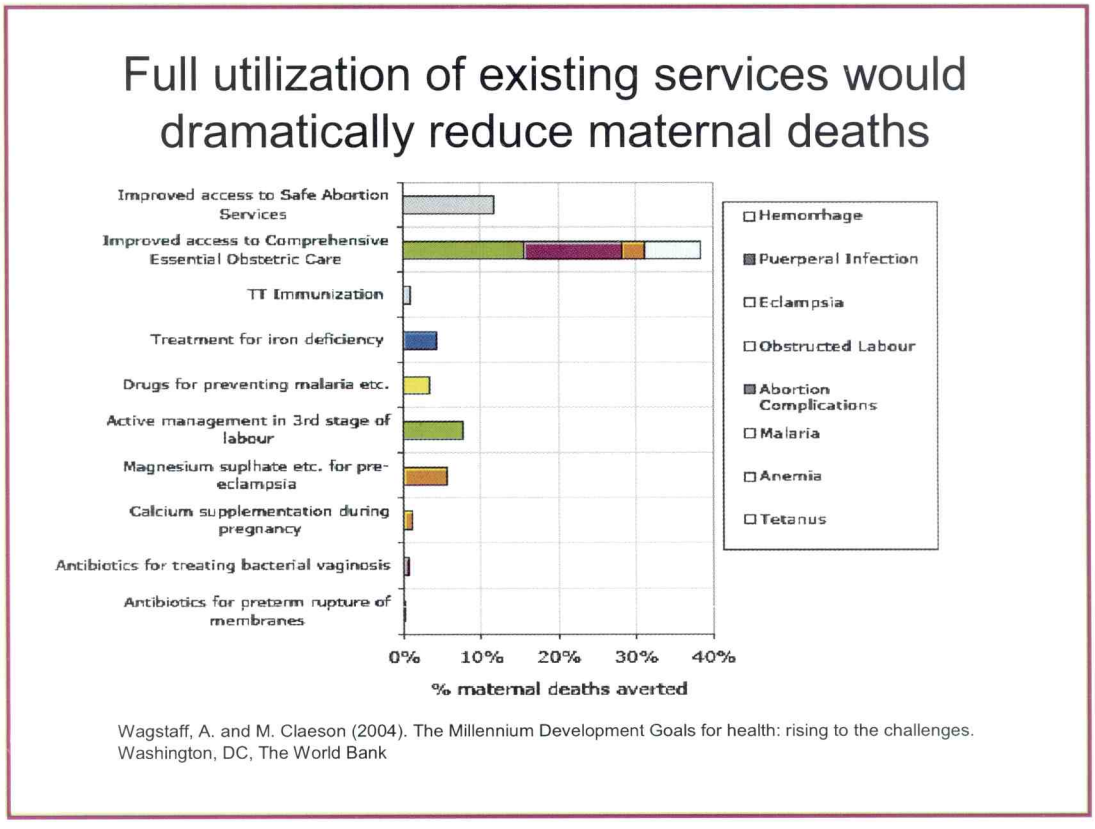
The MDGs: the broader context

The meeting drew attention to the broader political context and asked about the type of enabling environment needed to bring existing international agreements and instruments into the MDGs. Participants underlined that MDGs are as much about building political will as finding the resources. In addition the MDGs are not taking place in isolation, the policies of the IMF, World Bank and the poverty reduction strategies are all playing a major role in determining maternal health and also how the MDGs across the board will be met. There is an unequal playing field internationally that those putting the MDGs into action have to take into account. The MDGs do not adequately reflect the disparities between North and South or among countries in the South.

It was recognized that the MDGs had put back maternal mortality on the agendas of South Asian governments but it was important to highlight the 'M' that is missing i.e. morbidity. There was also strong concern raised that sexual and reproductive health and rights has to be put back in the MDGs.

The Conference benefited from the key note address of Lynn Freedman who presented the findings of the Millennium Project Task Force 4 and argued that strategies for meeting the MDGs should be premised on an understanding of health systems as core social institutions that help define the very experience of poverty and citizenship. She suggested that MDG 5 on maternal mortality provides a strategic entry point for addressing health systems.

Lynn Freedman



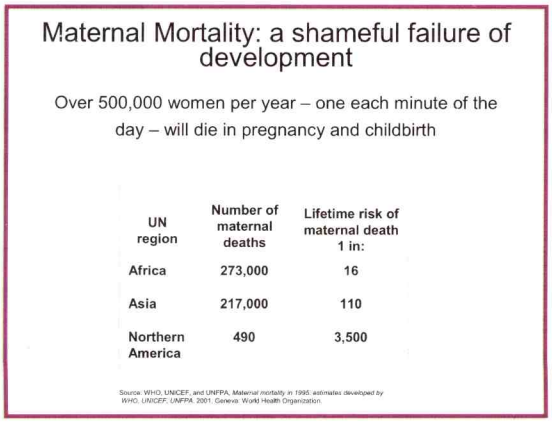
Wagstaff, A. and M. Claeson (2004). The Millennium Development Goals for health: rising to the challenges. Washington, DC, The World Bank

The MDGs, as they are framed fail to bring in the paradigm shift made in Cairo and in the Cairo review process that focus on women's sexual, reproductive health and rights. The issue is not just bio-medical, nor is it simply the lack of resources, it is a complex mix of economic and socio-cultural factors that lead to gender discrimination, neglect and deprivation and ultimately the denial of women's rights to well-being. The meeting was concerned as to how the MDGs could reinstate the ICPD paradigm shift, putting in place effective health systems, and ensure rich countries commitments to increase funding to reach the Goals, acutely aware of the economic and social requirements, equity and rights issues at stake. It was of particular concern of the project that the MDGs failed to take on board women's sexual and reproductive rights as a crucial indicator of progress under MDG 3, MDG 4, MDG 5 and MDG 6.

While seeing them as a tool to further women's health and empowerment agendas, the MDGs were seen by and large as inadequate as a complete strategy for maternal mortality prevention. The focus on targets meant that they ignored the critical role of socio-political context in achieving the targets.

Maternal Health

Maternal health is not only a concern during the reproductive age. Women's health is inextricably linked to their status in society – some of the critical indicators of their status are their participation in the political processes, safety and security from violence and exploitation, issues of work and wages, and particularly in urban slums water and sanitation.

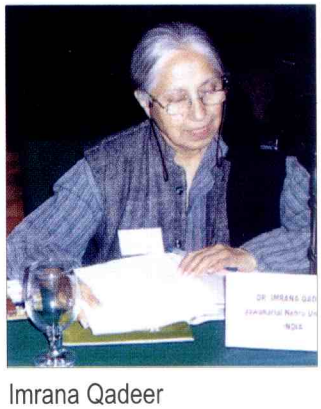


The reasons for women's mortality is embedded in more than biological and medical concerns, it is about protection from maternal depletion, about food/nutrition, water and sanitation, and combating communicable diseased, and decision-making by women. Empowerment of women specially, and communities in general are imperative, in order for women's health needs to be met with dignity.

12 Countries Account for 67% of Maternal Deaths

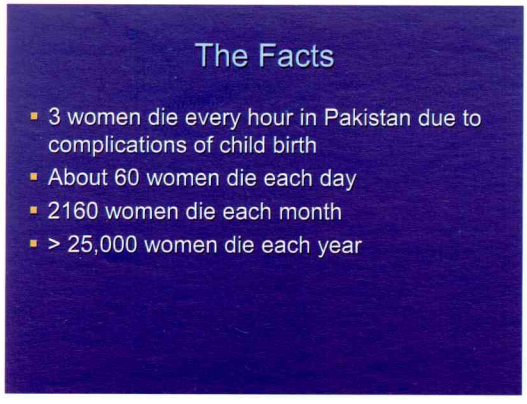
- India
- Nigeria
- Pakistan
- DR Congo
- Tanzania
- Afghanistan
- Bangladesh
- Angola
- China
- Kenya
- Indonesia
- Uganda

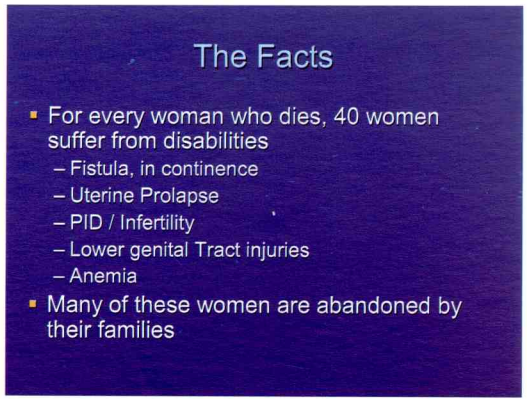
'Addressing maternal mortality calls for a socially sensitive developmental strategy that recognises women's role in production and the social determinants of reproduction. Such a strategy will inevitably address maternal mortality as a part of women's overall health, and her health as the central outcome of social and economic planning. The key requirements will be Comprehensive Primary Health Care, including necessary welfare services, employment, minimum wages, and food security. It would not only target reduction of extreme poverty and hunger, but would also address the very cause of the primary determinants of all mortality, including maternal mortality.' Imrana Qadeer



Imrana Qadeer

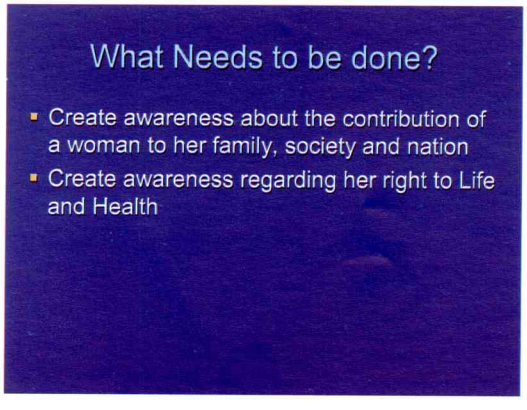
Underlying inequalities in health outcomes, are social disparities that must be recognized and addressed. Women in need must be reached, specially the most vulnerable and the poorest, and women in special circumstances – conflict, refugees, prison. Financial and non-financial barriers to health care must be part of the objectives to be addressed for ensuring access to health care including information on how power structures play out on the ground and impact health.

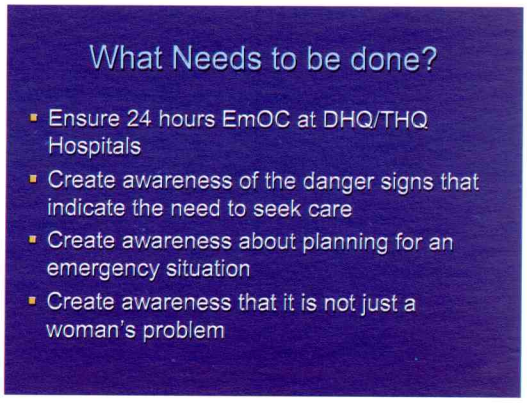




Abortion and its treatment was discussed in some detail, with a paper given on how abortion was legalized two years ago in Nepal. There were many challenges to be faced in the region as untreated complications due to abortion was one of the major causes of maternal death. In this context, abortion needs to be seen as a health issue not a human rights issue. It was important to reduce the need for abortion and to avoid its use as a contraceptive or female foeticide. There are still complex issues around abortion, and the growing religious fundamentalism is compounding these problems, however the general feeling was that the religious argument is not of high relevance in the region, it is more a question of ensuring women's health and the required services in relation to septic abortion. Most importantly it about providing appropriate preventive measures and ensuring that women know what is available and provided for legally.

Maternal health is not only a biological and medical concern, it is about women's empowerment, women's role in decision making, changing cultural bias to communicable disease including state responsibilities to prevent maternal debility, provide adequate food/nutrition, clean water and sanitation.





Kausar Khan

> Although Primary Health Care has been misinterpreted it provides the basic framework for health and needs to be integral in the building of health systems that meet life long maternal health needs with dignity and understanding for all women

Comprehensive Primary Health Care

The meeting pointed to the Alma Ata as providing an important international agreement in 1978 that established Primary Health Care as a relevant and valuable framework. The meeting noted that although the primary health care agenda has become distorted in practice if its principle agreements were followed it provides the basic framework for health, and this needs to be retained as integral to the building of national and district level health systems that can meet maternal health needs, by ensuring universal health care that is to be guided by equity and community participation.

Primary health care is an agenda that needs to be revitalized to become again comprehensive. The meeting revisited the values of the PHC declaration of equity, justice, social transformation and social responsibility. Much interest was raised in how PHC can be brought together in convergence with human, financial and technical resources that connects communities to basic health system.

Status of Maternal Health in Pakistan

- A sex ratio of 108 men to 100 women

(*Economic Survey of Pakistan ,2001-2002*)

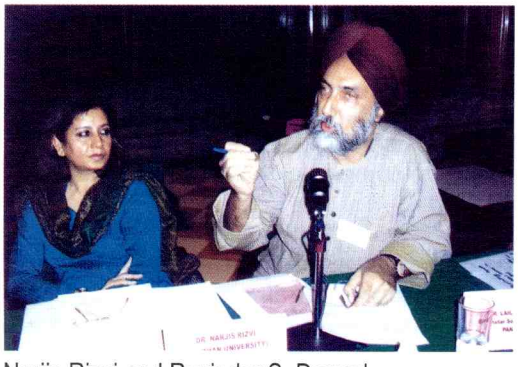
- Maternal mortality ratio is 300-700/1000 live births
- 20,000 women die each year due to pregnancy related complications
- About 60 mothers die each day from pregnancy and childbirth related complications every day (Pakistan Society of Gynecologists and Obstetricians, ICPD Review page -30)

The participants continually raised the issue about different approaches to health that are necessary if maternal mortality is to be reduced, underlying that essentially it is about health and well-being, not only about disease. Medicalizing pregnancy and birth is not the sole answer, in many contexts indigenous systems for example the *hakim* are important to take into account. Neither can the market be totally dismissed or blamed.

Therefore the meeting agreed that a focus on health systems in all their complexity is the strategy for reducing maternal mortality and installing maternal health in a comprehensive way. Such an approach moves away from targets and underlines the fact that averting death does not necessarily mean improving women's health. Access to the health system needs to be seen as an entitlement and structural change is required to ensure all women and men's rights to health care. MDGs are therefore an important opportunity to push women's health agenda, and can be welcomed in that context.

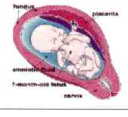
Issues related to maternal mortality

- Women
  - Poor nutritional status
  - High Fertility
  - Mishandled complications during delivery
  - No information
    - abortion
    - violence.
- Low utilization of
  - contraception
  - ante-natal
  - peripheral health facilities
- Information
  - MMR
  - Risk factors
  - Health information at every level
- Health delivery
  - Interaction with community
  - Skills of managers and health providers
  - Training guidelines and manuals



Narjis Rizvi and Ravinder S. Duggal

Maternal health agenda needs to focus.....



Status of women

Reproductive to women's health

Reaching the population

Conducive environment

Continuum of services

Health Awareness

Effective client provider interaction

Quality of services

Information system and indicators

Governmental Responsibility

There was a strong recognition in the meeting that the issue was not about new knowledge or new technology but rather political will and equitable provision that has to be the responsibility of the government. The participants underlined that Governments are responsible for providing health services (primary, secondary and tertiary). Universal coverage in reproductive health is imperative, and must be guided by principles of equity so that even the very poorest women can have the right to give birth with dignity and security. The government should be held accountable for high maternal mortality and morbidities.

In the comparison's across countries in the region Sri Lanka provides an excellent example of reduction in maternal mortality through relevant policies, programmes and research.

Key aspects relevant to orienting health systems for maternal health

Dulitha N. Fernando

Sri Lanka has developed an organized system for delivery of health care to its people, through field and institutional based programmes. Services are provided through a widespread network of institutions ranging from Central dispensaries, Rural Hospitals to General Hospitals/Teaching Hospitals and through a Health Unit system (MOH areas), responsible for providing preventive and promotive health services at the community/ domiciliary level.

Implementing simple targeted interventions focusing on major causes of maternal mortality through the state sector health services, has been the mainstay of the programme aimed at reducing maternal mortality in Sri Lanka. In the early post independence era, with a high MMR specially due to sepsis and haemorrhages, the need for provision of antenatal care and for trained assistance at delivery were focused on leading to an increased service outlets for antenatal care an increasing percentage of deliveries by trained personnel. In later years, with increasing demand for institutional services (contributed to by the higher literacy rates) and improvements in the quality of services, the institutional deliveries increased to 92% in 2001. With declining trends in MMR, focusing on improving the access and quality of care has paid dividends leading to further reduction in MMR. The experience of Sri Lanka shows that simple interventions aimed at effective reduction of the leading causes of maternal deaths could make substantial contributions to improvements in maternal care.

Provision of services free of charge to the consumer was a key decision that facilitated equity and accessibility of services by all socio economic groups. The high degree of coverage bears witness to this assumption. Other non-health interventions especially education of women contributed to a demand for health care and to the betterment of health status, in general.

Availability of a comprehensive health care package aimed at married women of the reproductive age group through a field based service delivery system which is labour intensive and relatively cost effective, supported by a widespread network of institutional facilities are the key factors in improving maternal health. In a situation where the MMR is relatively low, establishing a system to identify health system failures through a detailed maternal death investigation process has helped in further improvements in the system with special emphasis on quality of care.

However, inequities in service availability do exist specially in selected areas. Attention has been paid to reduce these inequalities which requires interventions with a wider scope. Political commitment to minimize inequities and improve quality of care has to be sustained in a setting where health sector reforms are being considered. Civil society has a major role to play in ensuring that political will remains and equity in health care is ensured.

Dulitha N. Fernando

One critical comment made was why in the South Asian context, are governments willing to put money into arms and not into social issues such as reducing maternal mortality? A fair health system approach, inclusive of inter-sectoral collaboration and community participation (as enshrined in the PHC Declaration of 1978) would cost far less than the amounts spent on the military and would enable the region to meet reproductive health and rights needs and other related health needs of women.

A key issue that arose in the context of reaching the very poor and providing proper attendance at the rural and slum level was how to ensure the proper training of traditional birth attendants. The meeting saw traditional birth attendants as a valuable resource, and as an integral part of the health system. There was concern that these women who have vast years of knowledge are being deskilled in the approach which gave priority solely to emergency obstetric care. Several doctors and activists who worked in the field pointed out that these women have technical skills which must be recognized and respected. Additional skills needed for reducing maternal mortality should be introduced without having to declare the TBAs as unskilled.

Traditional birth attendants are a valuable resource and must be seen as an integral part of the health system.

Planned interventions by the state were required to reorganize health systems, improve allocation professionalism and services. These all had to be government priorities. There was no reason for fees or expensive private health care in relation to meeting basic health needs of which maternal health is central. Governments have to prioritize health allocations in their budgets and also ensure that ending maternal mortality is seen in all its complexity and not just as a technical bio-medical problem. A too strong focus on EmOC can detract from other pressing issues that are determining maternal mortality and morbidity. The main causes of maternal mortality in South Asia: unsafe abortion, anaemia, haemorrhaging, malnutrition, lack of services, TB are more to do with widespread poverty and lack of education, services and good governance than lack of technical know how. It is important that Government is accountable to the community.

There is also the worrying trend of unnecessary expensive medicalization of birth practices. Mirroring rich countries there is the growth of c-sections, expensive drugs and private clinics for growing wealthy classes. The meeting was concerned that this indicated that technical solutions are being promoted by large corporations rather than decent and universal health for all. The running down of government services and inability of government to take up their responsibilities due to budget cuts led to a tiered health system where only the wealthy could afford proper services, even though the poor ended up paying often proportionally much more of their income for inadequate health services, that often were accessed too late and in ways that were inappropriate.

Even in Sri Lanka, which is the most successful in the South Asia region in relation to almost all health and gender indicators, is suffering from the roll back of the state.

Nighat S. Khan

Suggested Actions

- The Millennium Development Goals tell us where we need to go; case studies and research tell us what we need to do to get there. So how do we make it happen?
- Partnership at many levels are key to this issue. Governments need to make the political commitment to promoting women's health and status, and to allocate sufficient resources to appropriate health interventions

- Governments also need to develop appropriate policies – for example, rules authorizing midwives, nurses and other non-physicians to perform procedures they can do competently but are often barred from doing because of outdated policies and attitudes.
- But government cannot do it alone as with many other aspects of sexual and reproductive health, partnerships are key for achieving and sustaining improvement.

- Women's groups and NGOs need to make sure that policy-makers hear the voice of the community when they are making decisions about maternal and newborn health.

Missing points

1. Conceptualizing maternal well-being

Targeting the end results

About 5,000 mothers die in Nepal every year due to maternal causes,but many more suffer due to maternal cause and many more mothers die every year due to other causes

Techno-centric approach to maternal death

About 100,000 TBAs working in rural Nepal are totally discouraged.

Missing points

2. Exclusion and inequalities

Indicators	Poor	Rich
IMR	96.5	63.9
U5 MR	156.3	82.7
Immunization	32.4	71.1
ANC (TT +2)	16.6	57.4
Delivery by HW	2.9	33.7

Unfortunately because of the closing of the airport by King Gyanendra not all participants from Nepal could attend. Sharad Onta sent her presentation on "Missing Point in Nepal's Maternal Health Services".

Measuring and Monitoring Maternal Mortality

Given that the MDGs are about targets and numbers the participants raised many questions around the validity of the data (particularly given the inaccuracies of the census of rural populations) and about the methodology of data collection and the planning done on its basis. They stressed the importance of highlighting disparities among populations, given that averages hide inequity as well as the political use of figures. It was agreed that qualitative rather than quantitative figures were needed. Questions were also raised on the sisterhood method of collecting data and a proposal made based on a trial done in Nepal to work with mother's groups and community health systems.

Other important sources for health statistics which reflect what is happening on the ground are union councils and Health Management Information Systems (HMIS) as well as district level data particular in conflict areas. The important issue is that measurement can serve to strengthen the knowledge and capacity of local practitioners for local level action. In this good qualitative data is also important given that figures are often politicised and that renders standard measuring mechanisms inaccurate. So in reference to the MDGs the concern is not so much to become caught up in the numbers but rather look at the issues. It is important to have both local level and national analysis to make accurate targets, especially in conflict situations. Figures have to be de-bundled, and there is the challenge in up-scaling local units to the national level.

At the same time it is complex to render local concerns into figures and analysis readable at the global level. In this sense, problems are not necessarily local but reconstitute the national and the global preoccupations. Projecting goals on to quantitative data is highly problematic because the structure and form in which we reconstitute local knowledge becomes itemized and disconnected from the social, cultural and political contexts. Therefore, there is a need for embedded qualitative data.

Participants

Private-public Sector

The participants strongly recommended the responsibility (rather than the much more watered down concept of stewardship) of the state and there was a long discussion around the failures of the public sector. Why were charity hospitals turned into corporate hospitals in the 1990s, with subsidies, for example in India, being paid out by the government to corporate sector hospitals?

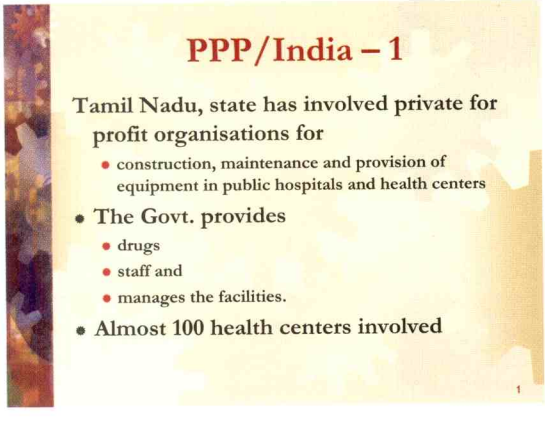
There was a debate as to whether there was a need to increase the support of public-private partnerships, particularly if NGOs were included as non-for-profit private sector. In this argument people felt there was a limited capacity of public sector to reach out and that the market was fulfilling a need. Nevertheless it was felt that it was important to monitor private sector health intervention and to have clear guidelines as to the responsibility, decision-making and affordability components of any PPP agreement.

The purpose of PPP is to reach the poor. If PPP fails to do that then the purpose is lost.

This required creating a rights base environment and a careful definition of 'partnership' in monitoring; ethics; standards; protocol; and capacity building. The key determinant needs to be the goal and objective of providing health care to the poor regardless of who is providing.

The example of how 40 percent of family planning services in Pakistan are provided by private sector is a cautionary one. A strong warning was made about quacks preying on the poor. Therefore it was felt that the government must retain its responsibility to deliver health services even if it contracts out where it is unable to deliver, possibly using NGOs as mediators that can monitor the safety and ethical behaviour of for-profit companies particularly in relation to over the counter drugs.

The principle of equality, mutuality, complimentarity and support are the essential for any successful private and public partnership. Both public and private sector need to be accountable and responsible and each utilized according to what it can offer.



Taken from Saman Yazdani Khan's presentation looking at successful models of PPP.

The discussions were very lively around the role of the private sector with major concerns being raised about whether the state has failed, is the best answer to turn over the job to the private sector? Does this allow the state to avoid their responsibilities? The private sector works according to the market and the people who need health care most are the poorest and they cannot afford private care. A major concern was that PPP may end up empowering the private not public sector, and thus not help poor women. We therefore need to define partnership on the terms of those in need to ensure equity, and

at the same time to strengthen the state. Another concerned raised was how to view the role of non-profit organizations or NGOs in this partnership.

Panel on Private/Public Sector

In slums and the rural areas, the poorest have little access to quality health service providers. The private service providers that do reach them are quacks, untrained people and overworked nurses.

The meeting felt the need to develop a much more comprehensive framework that looks at public health care beginning with an honest critique of South Asian public health systems. In a true health partnership significant things are shared - from vision to organizational structure, all planning is done together rather than sharing only infrastructure. There has to be an honest talk about regulation or deregulation.

If a mega city urban DOTS Project reaching the 8.3 million people in the Punjab can work why can we not reduce maternal mortality in the same districts?

Zofeen Ebrahim

Media and partnerships

Media could be very effectively used for helping to alert the public to the MDGs and in particular to reduce maternal mortality. But media needs to be sensitized and informed about maternal health and reporting on development issues is an uphill task. She concluded by stating that that communicating accurate news about maternal mortality and the MDGs is not easy – it is best achieved by developing partnerships between different organizations and groups. See www.ips.org

Recommendations for Public-Private Partnerships in Maternal Health

Indu Kapoor, Chetna

Through a people-centred rights based approach, the state is responsible for providing healthcare services to all its citizens through the public healthcare system. Strategic inputs in the public health system could be provided through meaningful public private partnerships, so that adequate resources and funds from the private sector, could be mobilised to ensure universal access to comprehensive healthcare, especially for the economically disadvantaged sections of the society in developing countries.

Enhancing awareness and empowering communities to access maternal health services
The empowerment of women, families and communities and a shared sense of responsibility for pregnancy and childbirth is needed so that women and communities are in a position to demand quality health care.

- Finance public interest advertisements in the mass media for educating communities about products and services for maternal health access
- Initiate and support trainings for midwives and community health workers in the public sector, especially in remote unserved and underserved areas.
- Enhance capabilities of community health workers and service providers through capacity building and enhancement programmes
- Implement campaigns for behaviour change communication strategies to save lives of mothers and newborns by recognizing their specific health problems

Strengthening infrastructure and human resources for providing basic and essential maternal health services

- Providing financial and technical assistance to improve basic facilities in remote impoverished areas like availability of water, housing, electricity, roads, transport, buildings of public health facilities, etc.
- Ensure presence of trained personnel, particularly in remote unserved and underserved areas for providing gender sensitive and quality healthcare
- Strengthen infrastructure by providing cost-effective facilities in underprivileged areas like – mobile obstetric van that can provide emergency services, ambulance services, telephone facilities linked to health centres, etc.
- Strengthen public health system through inputs from the private sector in providing emergency obstetric care, post partum care and post abortion care

Ensuring adequate supplies reach allocated areas

- Ensure adequate supplies of essential medicines like IFA, TT, etc. are stocked adequately and distributed to the disadvantaged sections in all the health centers
- Fill gaps in infrastructure by ensuring that support facilities like blood banks are available, accessible and affordable
- Ensure supplies of life saving medicines and drugs, tools and machines in public and trust hospitals

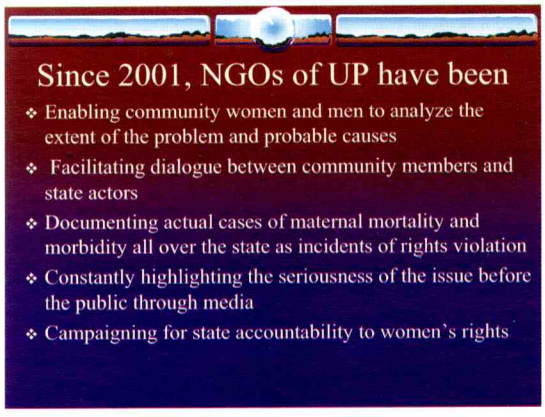
Ensure access to maternal health services implemented by Government Organizations, particularly for economically poor communities

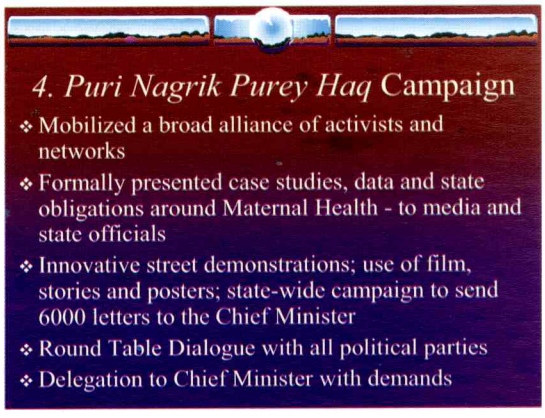
- Designing health insurance schemes to cover maternal services – normal and emergencies for the economically disadvantaged.
- Provide economic support through specially designed aids and schemes for the under privileged and backward population, especially in tribal areas.
- Provide financial assistance for expensive life-saving treatment to those who cannot afford it, through sponsorship schemes and aids.

Partnerships

Partnerships must be developed that the strengthen public sector, and not to replace it or duplicate it. Partnerships to be based on shared values, goals and concerns. All partners in health care must rigorously strive to pre-empt, prevent, challenge and change all forms of exploitation of those in need. Exploitation may come various sources – pharmaceutical companies; policies insensitive to those in need. All cases of exploitation must be made public and stringent actions taken against the exploiters. Political partnerships also need to be developed; just as all professional groups need to be sensitized and mobilized. Human, financial and technical resources should be mobilized through synergy and convergence. Linkages with other sectors should be maintained for that would help achieve the objectives for reducing and averting maternal deaths.

Effective partnerships need to advocate for sexual and reproductive health rights (SRHR) for promoting safe mother hood, young peoples health and strengthen the civil society's capacity to effectively advocate for SRHR need to be developed at the local/community level, national and international level. Media is clearly an important partnership to form, but it needs careful and skilled work to sensitize and inform the media about maternal health.





(Jashodhara S. Gupta presented how the Puri Nagrik Purey Haq campaign successfully used CEDAW to ensure women's maternal health rights in Uttar Pradesh.)

Conclusion and Strategies

There is a need for multi-tiered advocacy (community, regional international), raising women's voices, and building partnerships for reproductive health and rights within SAARC. This depends on maternal health for all, women's empowerment at the community level, maternal health being seen not as a medical concern but as part of the broader spectrum of social health and rights; intersectoral cooperation between the health sector and the community as enshrined in PHC declaration; emphasis on strengthening state capacity to be accountable to citizens in terms of the right to health care; influencing regional and national policies for increased spending on social sector; develop multi-tiered partnerships to influence policy at the global level; develop monitoring mechanisms for all stakeholders; mainstream the values that guide these strategies so that we are not made to 'adapt' to the environment, instead of 'changing' the environment.

- Keep raising the voices of those in need – specially the most vulnerable and poor women.
- Build partnerships for strengthening the public sector.
- Build alliances for monitoring progress, and keep a consistency check of all short-term and mid-term goals from the long-term goals.
- Monitor whether all interventions for women's health increase inclusion.
- Conduct analysis of critical issues like health sector reforms; impact of political decisions on maternal health; reasons for the failure of the public health sector.
- Find effective ways for advocacy at the regional level for example at SAARC
- Mobilization of media – find creative ways of persevering with attention on maternal health issues.
- Advocate nationally, regionally and globally for inclusion of SRHR in the MDGs through expansion of indicators.

Nandita Solomon

Indu Kapoor

Aruna Uprety and Khawar Mumtaz

Imran Zafar

Summary of Expert Papers

Achieving the MDGs: Health systems as core social institutions

Lynn Freedman Millennium Project Task Force 4

Lynn Freedman argued that strategies for meeting the MDGs should be premised on an understanding of health systems as core social institutions that help define the very experience of poverty and citizenship. MDG 5 on maternal mortality provides a strategic entry point for addressing health systems. Achieving the MDGs will require massive new investment in the health sector: domestic budget allocations and official development aid on a whole new scale. But the answer is not just money; it is the entire way in which we think about the connection between health and development – and the priority actions that result.

Unpacking Politics for Controlling Maternal Mortality in South Asia

Imrana Qadeer Jawaharlal Nehru University, New Delhi, India

Imrana Qadeer stated that reduction in maternal mortality was only possible with socially sensitive developmental strategies, which understand the role of women in South Asian societies, and address a woman's key role in production and reproduction in these societies, and overall health, especially maternal mortality are addressed. It should deal with her health as a central outcome of social and economic planning and the key requirement for this is Comprehensive PHC. Furthermore MDGs can only succeed if they keep the interests of the marginalized in view too.

Square Pegs in Round Hole: Redefining Public Private Partnership

Indu Kapoor Chetna, India

Indu Kapoor discussed the growing global move towards utilizing the private sector as a partner of the public sector through health care reforms. She stated that PPP could help attain MDGs. She went on to describe an ideal PPP and possible partnerships between different organizations i.e. with not for profit organizations, partnership and with for profit organizations. She completed her presentation with exploring the idea of PPP in maternal health and left us with the thought that 'The principle of equality, mutuality, complimentarity and support are the essentials for effective partnership, together let us make it a reality'.

Measuring and Monitoring Maternal Mortality: The Motherhood Method

Mahesh Maskey University of Tribhuvan, Kathmandu, Nepal

Mahesh Maskey talked about the available methods of measuring maternal mortality and the limitations of the same. He proposed a new method to measure and monitor maternal mortality he is developing in Nepal called the motherhood method.

Orienting health systems for maternal health – Sri Lankan experience

Dulitha N. Fernando University of Colombo, Colombo, Sri Lanka

Dulitha N. Fernando gave an overview of the Sri Lankan health system, explaining that since independence Sri Lanka has had a welfare approach that has continued despite increase in private sector hospitals thanks to sustained political will. Maternal death in Sri Lanka has been thoroughly investigated and has experienced sustained reductions over the years. Sri Lanka retains an organized system of maternal health delivery, both field based and institutional based. There is provision of comprehensive package of health care even in the rural areas and the public sector is free of charge. There is in place a maternal death surveillance system, which identifies system failures. She closed by asking: Can Sri Lanka continue this welfare delivery system in an era of increased privatization and globalization?

MDGs and the Media, Space for Partnerships

Zofeen Ebrahim, IPS, Pakistan

Zofeen Ebrahim argued that media could be very effectively used for achieving the MDGs. But media needs to be sensitized and informed about maternal health and reporting on development issues is an uphill task. She concluded by stating that that communicating accurate news about maternal mortality and the MDGs is not easy – it is best achieved by developing partnerships between different organizations and groups.

SID-SAN and Shirkat Gah
Regional Conference
Maternal Health and Wellbeing in South Asia: Strategies for Meeting the Millennium Development Goals
February 3 – 5, 2005

From 09:00 – 17:00

Day I		February 3, 2005
Session I:	**Opening & Context Setting**	**Time**
	1. Registration	08:30 – 09:30
	2. Introduction to the Conference: Khawar Mumtaz	09:30 – 10:00
	3. Keynote Presentation: Achieving the MDGs: Health Systems as Core Social Institutions: Lynn Freedman	10:00 – 10:45
	TEA	**10:45 – 11:15**
	4. MDGs: A South Asian Perspective: Yasmin Qazi	11:15 – 11:45
	5. Defining an Enabling Environment: Wendy Harcourt	11:45- 12:00
	Discussion (Moderator: Wendy Harcourt)	12:00 – 13:00
	LUNCH	**13:00 – 14:00**
Session II:	**Reorienting the Health System: The Continuum of Care (from grassroots to the tertiary)**	
	6. Keynote Presentation: Orienting health systems for maternal health – Sri Lankan experience: Dulitha Fernando	14:00 – 14:45
	7. Maternal Health from Grassroots to Tertiary, Experience from the Aga Khan University: Narjis Rizvi	14:45 – 15:05
	8. The Indian Experience: Ravinder S. Duggal	15:05 – 15:25
	TEA	**15:45 – 16:15**
	9. The Nepal Experience: Mahesh Maskey/on behalf of Sharad Onta	16:15 – 16:35
	Discussion (Moderator: Laila Gardezi)	16:35 – 17:00

Day II		February 4, 2005
Session III:	**Unwrapping Maternal Mortality in South Asia**	**Time**
	1. Keynote Presentation: Unpacking Politics for Controlling Maternal Mortality in South Asia: Imrana Qadeer	09:00 – 09:45
	2. Health related factors/risks of Maternal Mortality: Sadequa Jafferey	09:45 – 10:15
	TEA	**10:15 – 10:45**
	3. Maternal Morbidities: Fistula: to prevent or treat: Sohail K. Lodhi	10:45 – 11:05
	4. Illegal/Unsafe Abortion: Impact on Maternal Mortality & Morbidity: Initiatives to Legalize Abortion in Nepal & its Impact: Aruna Uprety	11:05 – 11:45
	5. **Discussion** (Moderator: Poonam Muttreja)	11:45 – 13:00
	LUNCH	**13:00 – 14:00**
Session IV:	**Measuring and Monitoring Maternal Mortality**	
	6. Keynote: Measuring and Monitoring Maternal Mortality: Mahesh Maskey	14:00 – 14:45
	7. Some Thoughts on Measuring Maternal Mortality: Darini Rajasingham	14:45 – 15:15
	TEA	**15:15 – 15:45**
	8. Monitoring Maternal Mortality-Community Based Strategies from a Rights Approach: Jasodhara D. Gupta	15:45 – 16:05
	9. Benchmarks of Fairness in Health Care: Kausar S. Khan	16:05 – 16:25
	10. Situation of Maternal Health in Bangladesh: Sayyida Akhtar.	16:25 – 16:50
	11. **Discussion** (Moderator: Mahesh Maskey)	16:50 – 17:30

Day III		February 5, 2005
Session V:	**Redefining Public Private Partnership**	**Time**
	1. Keynote Presentation: Square Pegs in Round Hole: Redefining Public Private Partnership: Indu Capoor	09:00 – 09:45
	2. Perspective from the Private Sector: Imran Zafar	09:45 – 10:05
	3. Pakistan and South Asian Perspective: Saman Y. Khan	10:05 – 10:25
	TEA	**10:25 – 11:00**
	4. Government Perspective: Darakshan Badar	11:00 – 11:20
	5. **Discussion** (Moderator: Indu Capoor)	11:20 – 12:30
	LUNCH	**12:30 – 13:30**
Session VI:	**Strategies for Meeting the Millennium Development Goals**	
	6. Partnerships for Change: Nandita Solomon	13:30 – 13:50
	7. The Role of the Media: Zofeen T. Ebrahim	13:50 – 14:10
	8. Advocacy for Maternal Health: Nighat S. Khan	14:10 – 14:30
	TEA	**14:30 – 15:00**
	9. Women's Right to Life & Health: Talat Rizvi	15:00 – 15:40
	10. **Discussion** (Moderator: Kausar S. Khan)	15:40 – 16:15

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