Ensuring maternal health and rights in Pakistan

In South Asia women and youth face serious problems as regards their sexual and reproductive health: maternal and infant mortality rates are high, the HIV/AIDS epidemic is rapidly spreading, the use of contraceptives is scant, and young people lack access to information and health services. In largely all respects, the region is lagging far behind the goals that their own governments set themselves in connection with the UN International Conference on Population and Development (ICPD) in 1994, and later in the Millennium Development Goals (MDG) at the turn of the century.

Particularly in Pakistan, the dismal state of women's reproductive health and rights raises serious concerns: women are excluded from health services, social activities and public spaces, which are compounded by their physical insecurity and class, caste, rural-urban, regional and provincial differentiation. They are also unable to exercise their reproductive rights within their families and communities and demand effective and timely services from health care providers especially in the public sector. To make the situation worse there is a serious lack of accountability towards clients by the health providers.

Among reasons for poor health, other than women's social status, are the quality and accessibility of health services. About 71 % of deliveries in 2004-2005 took place at home. Of these, 24 % had a doctor or LHV in attendance. In 2001-2002, 21 % of government facilities did not have female staff and there were only 18 % rural households with BHUs in their villages across the country.

Unsafe abortions remain a significant cause of poor reproductive health and rights thus affecting maternal mortality and morbidity in Pakistan. The estimated number of women who experience serious health complications each year as a result of unsafe abortions is almost 197,000.

Abortion is considered to be legal only when it is carried out to save the life of the woman or to provide necessary treatment to her. An estimated 890,000 abortions are performed annually in Pakistan. The country has an abortion rate of 29 abortions per 1000 women of reproductive age. An estimated 1 pregnancy out of six ends in abortion.

Pregnant women who wish to have an abortion are forced to visit illegal clinics run by midwives. Women generally do not use contraception because of inaccessibility, financial constraints, and objections by their husbands on religious grounds. Interestingly many men have objections to their wives using contraception but do not object to abortion. Consequently there are a high number of unplanned pregnancies which end in abortions.

Additionally, there are a high number of women having clandestine abortions and who remain invisible because they do not present themselves at hospitals for treatment.

Learning from Sri Lanka: Roles and responsibilities of midwives
Maternal Mortality Audit

Inside

Women's Resource Centre
Learning from Sri Lanka

Roles and responsibilities of midwives

The Sri Lankan health system has a good and timely outreach at the field level. The field level family health officers (midwives) are the pillars of Sri Lanka’s public health services.

- Midwives get a year and half-long training before serving in the community.
- They receive good support from the system: better salaries, opening clinics at the community level, providing them scooters free of cost are some examples.
- The midwives are in charge of the registration of couples eligible for reproductive health services; identify pregnant women in communities; encourage women to go for ante-natal care; do post-partum care and deliver family planning services and report to the maternity centre which can be accessed from anywhere in Sri Lanka with a distance of 7.5 kms.

Maternal Mortality Audit

Maternal Mortality Audit (MMA) is one of the critical ways to ensure system improvement and thereby reduce maternal mortality. Sir Lanka initiated this learning process in 1950 through an informal investigation. Today, the country has institutionalized mechanisms for maternal death audits from community to the national levels.

Importance of MMA

While maternal mortality ratio and rates give us the numbers of maternal deaths, they do not inform us about the factors that lead to death. Dr. Anoma Jayathilaka says that MMA inform us about, "Whose faces are behind the numbers? What were their stories? What were their dreams? They left behind children and families. They also left behind clues as to why their lives ended so early."

What Sri Lanka did

- Brought down its MMR despite sharing a similar economy and culture with other South Asian countries and experiencing a persistent conflict situation.
- Able to do it with less than 2% of GDP expenditure in health.

Objectives

MMA is conducted with the following objectives:

- Confirmation of the probable cause of death
- Analysis of the circumstances that lead to maternal death
- Identification of attributable service factors, not fault finding
- Identification of factors relevant to care receivers
- Review quantity and quality of service provision at all levels
- Implementation of corrective action at various levels (Divisional, Institutional, District, Provincial and National level)
- Review Policies and their implementation at national and sub-national level
- Linking of different sources of reporting of maternal death

Methodology

To begin with MMA is done at two levels — within the institutions, by service providers and at the community level by the field staff. Information is collected and verified from multiple sources — records, service providers as well as family members.
Steps involved in MMA

Investigation of MM involves five steps:
1. Identification of death
2. Notification of death as event occurs (within 24 hours, includes hospital and field notification)
3. Hospital and field investigation done separately (within seven days after death)
4. District maternal mortality review (each district every quarter)
5. National maternal mortality review (annually in each district)

Procedures

The first level of notification and investigation occurs at the community level. The purpose of this investigation is to identify gaps in the system. The second level of investigation occurs at the district level to take corrective actions/follow up and administrative decisions. The third level of investigation occurs at the national level to analyse factors that lead to death such as resources, policies, quality of care, and family and community factors, assess preventability of death, analyze actions taken at institutional and field level to prevent further deaths. Policy makers analyze actions and make suggestions to prevent deaths in future as a next step.

Outcomes/Results

MMA were conducted using a participatory approach. The entire team was involved in the investigation irrespective of hierarchies. This resulted in shared responsibility and team building.

Maternal death investigation has become a routine activity in the Mother and Child Health (MCH) monitoring and evaluation system at every level and generates high quality data.

MMA has lead to improved practices and it serves as a tool to prevent future deaths.

MMA has helped to identify factors responsible for modifying ‘3 DELAYS’ model

Identify the shortcomings in case of management as well as health care system.

Non-fault finding approach indicated successes, participation and quality of data.

Developed commitment at policy level, resulted in high priority program. The policy makers and administrators were convinced about the important program issues and deficiencies that led to death (Case history. Evidence based).

Perception of women

‘Free and safe services are available in government hospitals’

Jayanthi lives 30 kilometres from Colombo, but she chose to follow the doctors’ advice as the service is free and the quality of care is good at the Castle Street Hospital. During the check-up, the doctor found some problem in her pregnancy and had to perform an induced abortion. Jayanthi feels very sad and disappointed. However, she is very happy with the government public health set up and the attitude and behaviour of everyone there.

‘To be a doctor in a government hospital is a privilege’

Lakhamani is a doctor working at a general hospital 30 kilometers away from Colombo. She just delivered her baby at Castle Street Hospital. When asked why she did not go to a private hospital, she said the government provides good service and benefits for public health doctors. During delivery, they are provided a three-month maternity leave with full pay. If they want another 3-month leave, they can also have it at half pay. The government also provides her a separate room as a privilege. She considers herself happy to be a doctor in Sri Lanka.

How they did it

- Focusing on improving rural health care before working on the urban or tertiary health care.
- With an organized system of delivery of maternal care, through both field and institutional based systems.
- Provision of a comprehensive package of health care for women in the reproductive age group.
- Provision of free state sector services are provided.
- Having the state as the main provider of maternal health care.
- Having a high degree of antenatal care coverage and trained assistance at delivery.
- With a maternal death surveillance system to identify system failures.
Lailla came from a poor family. Although she knew before her marriage that she had fibroids in the uterus, her family could not afford to have her treated. Her husband was very poor as well. Her first baby died of epilepsy at two months. In the second pregnancy when she had pains in the seventh month she could not consult a doctor as she could not afford it. This baby also died after birth.

In the seventh month of her third pregnancy she stopped feeling movements of the baby, and started having abdominal pain, together with foul smelling discharge. She pleaded with her family members to take her to a hospital, but they did not do so. When in the ninth month she began labour pains, a dai was called in. She said that the baby had died and they should see a doctor. But again her husband did not have money for the treatment. When the baby was half delivered and was stuck in the birth passage, her pains ceased.

Her family then put her in a donkey cart to take her to a hospital but on the way because of the jumps and jerks she delivered in the cart! The dead baby was rotten and smelling badly.

Later Laila gave birth to five children, had one abortion and was pregnant again. Repeated pregnancies had made her very weak over the years. The doctor advised her to have drips, but they never had enough money to follow the doctor's instructions. She said that her husband never allowed her to have intervals between pregnancies.

"I delivered the dead baby in a donkey cart" — Laila

In a recent study conducted by Shirkat Gah - Women’s Resource Centre on reproductive rights and health in partnership with WHRAP some predicaments of local women were highlighted. Their sufferings were a true reflection of the existing poor maternal health facilities available to them across the country.

"My husband and I have lost confidence in daia" — Razia

"Dai’s malpractices cause complications" — Deeba

"I got proper care at the hospital" — Saghira

"I fear hospitals. I remember how a relative screamed in the hospital when the doctor tried to stitch her wound. I will never go to the hospital" — Asifa

"I want to get myself treated but can’t afford the high cost of hospital treatment" — Waheeda

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Common voices

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<td>155</td>
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<td>63</td>
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<td>80</td>
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<td>GNI per capita (US$) 2004</td>
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<td>Health expenditure 2004</td>
<td>2.4 % of GDP</td>
<td>1.8% of GDP (0.23 of which is for maternal and child health)</td>
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<td>Gender-related development index (GDI) 2004</td>
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<td>Maternal mortality rate adjusted (per 100,000 live births) 2004</td>
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