

Submission on behalf of Women's Health and Rights Advocacy Partnership- South Asia

(WHRAP-SA)

May 2012

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

WHRAP in the South Asian sub-region is implemented as a partnership program between five leading national women's organizations including, Naripokkho in Bangladesh, Beyond Beijing Committee (BBC) in Nepal, Centre for Health Education, Training and Nutrition Awareness (CHETNA) and SAHAYOG in India and Shirkat Gah in Pakistan as national partners; and their forty (40) Community Based partners who work directly with the women on the ground; the Danish Family Planning Association (DFPA) as the international partner; and the Asian-Pacific Resource and Research Centre for Women (ARROW) as its regional partner¹.

WHRAP-SA partners are interested in improving the formulation, quality, implementation and monitoring of sexual and reproductive health policies and programs in South Asia based on context specific needs of marginalized women. Our experiences of working with women's groups from a rights perspective have allowed us to document evidence of health right violations from our field site, raise issues of accountability and propose recommendations to address gaps identified. This includes cases of avoidable maternal mortality and morbidity; issues of adolescent reproductive health and nutrition; access to safe comprehensive abortion; and safe delivery - all under the umbrella of the need for implementation of a rights based continuum of quality care.

We believe that what is required in our countries is a needs based comprehensive approach that will ensure access to information and quality care at all stages of a woman's lifecycle and across location (home, community and health facilities), given the difficulties faced by marginalised women in accessing affordable skilled care in South Asia. Consequently a rights based continuum of quality care approach must facilitate available and equitable access to essential quality health and reproductive services which should be affordable and acceptable for women from adolescence through pregnancy, delivery, and beyond. However until effective maternal mortality reduction strategies are achieved community-based interventions could promote and avert preventable mortalities and morbidities. This could include training community based birth attendants (including Traditional Birth Attendants).

In this submission we present evidence from our national partners including two country research studies from Nepal and Pakistan conducted by WHRAP –SA partners and partners of ARROW². (Note the studies are attached as separate documents).

¹ www.whrap.org

² Thanenthiran, S; Racherla S.J. (2009). Thematic Study Series 4: Maternal Mortality and Morbidity in Asia. Reclaiming & Redefining Rights – ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

1. Socio-Cultural Determinants of Utrine Prolapse Prevalence among OPD Gynaecology Patients in Tribuvan University Teaching Hospital – Kathmandu, Nepal
2. “Barriers to Safe Motherhood in Pakistan: A Study in Selected Sites in Rural Sindh and Punjab”

We see the iERG call for submissions of evidence and best practices as an important opportunity to share our experiences and findings in an attempt to inform Maternal and Child Health policy development and implementation. Based on our experience we see a number of obstacles to implementation of the Global Strategy. In particular our focus is on continuum of quality care. We hope our submission will support the important work of the iERG.

The research case studies included in our submission were developed as part of the regular Asia Pacific monitoring of ICDP PoA coordinated by ARROW. Evidence generation was supported by funds from SIDA and Ford Foundation and the studies were launched in April 2012 in Kuala Lumpur, Malaysia. Findings of these studies support our key position on encouraging South Asian Governments to implement a rights based continuum of quality care approach to sexual and reproductive health.



WHRAP-SA Position on implementing a Rights Based Continuum of Quality Care Approach to Sexual and Reproductive Health in South Asia

1.1 Maternal Mortality

The South Asian sub-region accounts for a substantial part of maternal deaths in the world. Despite progress in the region, maternal mortality estimates continue to remain high particularly in Bangladesh, India, Nepal and Pakistan. According to national statistics for the region MMR is estimated at 194 for Bangladeshⁱ, 212 for Indiaⁱⁱ, 281 for Nepalⁱⁱⁱ, and 276 for Pakistan^{iv}. However as many countries in South Asia do not have a vital registration system for births and deaths MMR estimates suffer from wide confidence intervals. The national numbers for MMR also do not capture the large inter-state and regional variations within these countries^v.

1.2 Maternal Mortality and Adolescent Health

Nearly two thirds of premature deaths and one third of the total disease burden in adults is associated with conditions or behaviours that begin in youth^{vi}. Maternal mortality in girls under 18 is estimated to be two to five times higher than in women between 18 and 25^{vii}. Nearly one in four people living in South Asia is an adolescent, defined by the UN as a child between the ages of 10 and 19^{viii}.

Example from Shirkat Gah (Pakistan) - Early Marriages and Maternal Mortality

Early age marriages: the practice of early age marriage continues to be widespread in the impoverished sections of remote rural areas (a fact reconfirmed by Shirkat Gah teams during the recent floods in South Punjab, interior Sindh, Baluchistan and Khyber Pukhtunkhwa). While the minimum age of marriage for girls is 16 years under the law, it is not uncommon for girls to be married earlier. This is usually in conjunction with not taking a daughters' consent or forcing young into marriage. Parents' preference in these areas is usually to marry daughters soon after reaching puberty. Not surprisingly, half of Pakistani women are married by the age of about 19 years (PDHS 2007) with 13% married by the time they are 15 and 40% by age 18. In the absence of mandatory birth registration it is almost impossible to determine a girl's age. The marriage registrars who are supposed to make sure that all legal requirements are fulfilled fail to/are not interested in establishing the real age. Shirkat Gah is presently involved in an extensive advocacy campaign with provincial governments to raise the legal age of marriage to eighteen.

Early pregnancies: A direct consequence of young age marriage is early childbirth and greater vulnerability to related complications especially morbidities (like fistula) that do not get reported or counted. 18% of Pakistani women have had their first birth by age 18; 9% have begun child bearing between 15-19 years and 7% are already mothers in those ages. Pakistan's high maternal mortality ratio (276/100,000) includes deaths due to early pregnancies as well as unsafe abortion resorted to by women for limiting fertility. A low contraceptive prevalence rate of 33% and a high unmet need for contraception 26% (PDHS 2007) force women to seek abortions as a means of family planning.

Example from Centre for Health Education, Training and Nutrition Awareness CHETNA (India) Adolescent Anemia

One in four adolescent girls in South Asia is too thin and one in five was stunted during her childhood due to inadequate nutrition¹. Despite rapidly improving education systems, more than half of adolescent girls in South Asia miss school regularly during their menstrual periods because of social norms and a lack appropriate sanitation facilities in their schools. While there is an emerging body of evidence about the impact of child marriage, adolescent nutrition and education on adolescent pregnancy and maternal and infant deaths and disability, this evidence rarely translates into adolescent-sensitive health programs and budgets. Neither does new information on sexual abuse and sexual exploitation of adolescents and its health consequences gain recognition in national policies.

According to CHETNA's experience in the states of Gujarat and Rajasthan, anemia is of particular concern for girls because during pregnancy, anemia is associated with premature births, low birth weight, and perinatal and maternal mortality. In South Asian region a large number of pregnancies occur among adolescents and young people and anemia is the most common indirect cause of "maternal death". Anemia is one of the primary contributors to maternal mortality and is significantly associated with a compromised pubertal growth spurt and cognitive development among girls aged 10-19 years in South Asia.

The field observation of CHETNA team in rural India (Gujarat and Rajasthan) reveals that poverty is a main reason for adolescent malnutrition and anemia but it is usually accelerated by many discriminatory cultural practices towards adolescent girls. CHETNA found that girl's food consumption is controlled due to the fear that they will grow too rapidly so they receive less food and lower quality food. We found that parents did not want the girls to look older as this leads to a tremendous pressure on parents to arrange an early marriage and also to prepare a dowry.

1.3 Abortion

Every year, 19–20 million abortions are done by individuals without the requisite skills, or in environments below minimum medical standards, or both^{ix}. Nearly all unsafe abortions are in developing countries. An estimated 68,000 women die as a result, and millions more have complications, many permanent. Important causes of death include haemorrhage, infection, and poisoning^x. More than one third of these deaths occur in South Asia, where it is estimated that 37% of all maternal deaths result from unsafe abortion. Between 10-50% of women who undergo unsafe abortion in the region need medical care for complications, resulting in approximately 29,000 deaths per year^{xi}. Legalisation of abortion on request is a necessary but insufficient step toward improving women's health; in some countries, such as India, where abortion has been legal for decades, access to competent care remains restricted because of other barriers^{xii}

Example from Beyond Beijing Committee (Nepal) Policy Implementation

Based on current national policy, the Nepal government has made provision for free delivery services at health institutions for both normal and complicated cases; an incentives scheme for institutional delivery and referral and 4 free ANC check ups and Comprehensive Abortion Care. However in BBCs experience in its field sites, many women do not access these services due to lack of awareness and poor quality of services.

Free uterine prolapsed surgical camps are also arranged periodically by the state but there is little interest in post surgery care indicating poor quality of service again. Additionally, the government has a well designed monitoring mechanism for health facilities and services. However despite presence of these progressive government policies on reproductive health there is a large gap in effective implementation. At present these services are not functioning well in many government hospitals and monitoring is limited to utilization of the budget.

In Makawanpur district (one of BBC's field sites), the Comprehensive Abortion Care (CAC) service of the Hetauda district hospital is currently non functional. Many women have been choosing private clinics such as Nepal Family Planning Association, and Marie Stopes Centre, Makawanpur for abortion. There had been a total of 595 safe abortion services provided by the private clinics during the period of January to April 2012. Women are compelled to choose private clinics for abortion despite of the low abortion cost at the government hospital. The absence of trained doctors at the district hospital CAC centre resulted in its non functional state during the period.

"Abortion still beyond reach for most village women" an recent article published in a daily newspaper-The Himalayan Times, (21st May, 2012)

<http://www.thehimalayantimes.com/fullNews.php?headline=Abortion+still+beyond+reach+for+many&NewsID=332842>

The article states that although the Nepal court in May 2009 had ordered the government to secure women's access to safe and affordable abortion service through a comprehensive abortion law and creation of government fund to cover the cost of abortion for those unable to pay, abortion service provided by the government through CAC service is still beyond the reach of many women seeking the service.

1.5 The Right to Quality Care

According to the 2009 Human Rights Council resolution high rates of maternal mortality and morbidity are unacceptable and preventable; and maternal mortality and morbidity according to the Council is a human rights issue. It affects women's and girls' rights to life, health, equality and non-discrimination, the right to benefit from scientific progress, and the right to the highest attainable standard of health, including sexual and reproductive health. Ensuring Continuum of Quality Care (CQC) across a woman's lifecycle (preconception to pregnancy, post partum/ post-abortion and menopause) and across locations (home, community and health facilities) is important to reduce adolescent, maternal, newborn and child mortality and improve women's reproductive health. Women and adolescent girls have the right to quality services to help them plan and space their pregnancies and to avoid or treat sexually transmitted infections. If women, babies, children, or adolescents girls experience complications or illness at any point, continuity of quality care from household to hospital, with referral and timely emergency management, is crucial.

At a population level, quality of care can be defined as “ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/well-being for the whole population”^{xiii}. Dimensions of quality of care can be reduced to two questions:

- a) can an individual get the care they need when they need it (i.e. is the care accessible? affordable?)
- b) when they get care, is it effective and acceptable both in terms of clinical effectiveness and interpersonal relationships?^{xiv}

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Examples of Barriers to Accessing Quality Care

In reference to the supporting studies in the submission (see attached documents), both address issues and barriers to accessing quality of care.

Research Study 1 from Nepal on, “Socio-Cultural Determinants of Utrine Prolapse Prevalence among OPD Gynaecology Patients in Tribuvan University Teaching Hospital – Kathmandu, Nepal” re-enforces previous studies that have demonstrated that utrine prolapse is significant reproductive health and rights issue for women in Nepal. The study findings articulate barriers to seeking health services and reasons for delays in seeking care. Although the government of Nepal has designed policies and screening guidelines access to continuum of quality care for most women still remains a significant challenge.

Research Study 2, from Pakistan “Barriers to Safe Motherhood in Pakistan: A Study in Selected Sites in Rural Sindh and Punjab” provides more evidence on why women are not receiving quality care. The qualitative study using sentinel sites in the Provinces of Punjab and Sindh demonstrates that although there has been improvement in the knowledge, awareness and utilization of reproductive and family planning services, there is universal dissatisfaction with access and availability of quality services in all study sites. The study also captures the disturbing trend of privatization and inequity. Poor and marginalized sectors of the population continue to be denied access to quality care and have to resort to taking large loans or seeking care from unskilled and unsafe health practitioners to fulfilling their reproductive health care requirements.

1.4 Continuum of Quality Care

There is a buy-in from South Asian governments to adopt a continuum of care framework; however the experiences of marginalized women reveal that in practice, there are serious limitations in the quality of care provided and the systems of referral. For example, one of the targets for achieving MDG 5 is that 90% of births in low and middle income countries have a skilled birth attendant (SBA) by 2015^{xv}. However, due to the pressure to meet this target it appears from documented experiences of poor women that home deliveries are being forgotten. Skilled attendants can perform deliveries either at home or in hospitals. However in practice they tend to be placed in health centres making skilled attendance synonymous with facility delivery.

Example from SAHAYOG (India) - Women's Experiences of Institutional Delivery: Findings from two states in northern India – Uttar Pradesh and Uttarakhand

Within its current National Rural Health Mission (NRHM), India is currently promoting maternal health through institutional delivery. The poorer performing states have a scheme of cash incentive (Janani Suraksha Yojana or JSY) for all women who come to institutions for childbirth (for example in Uttar Pradesh and Uttarakhand). There is also a community-level link worker (ASHA) trained and paid to motivate women for pregnancy registration, check-ups and institutional delivery, as well as post-partum follow-up.

In a 2008 in study by SAHAYOG , 97 institutional delivery attempts were considered in government facilities studied in Uttar Pradesh and Uttarakhand – 29 women respondents were selected based on their consent to participate. Based on in-depth qualitative interviews women talked about their experience of quality of care including the behaviour of providers and cost of delivery. Here are some of the excerpts from the interviews...

Behaviour of providers

“The ANM (Auxiliary Nurse Midwife) asked my mother-in-law to take me to another hospital. It was only after my mother-in-law begged and pleaded pointing that it was midnight and that we had no male escort that the ANM relented and administered an injection.” (UPM 5 28 years, Kohar caste)

“I was made to lie on the floor, hanging onto a chair with one woman holding my abdomen, and the nurse holding my legs apart with my feet. I was so scared of being scolded by the nurse and her helper that I did not scream even once although I was in great pain. And because I did not scream the nurse did not scold me” (UK 5, 24yrs, ST)

Experiences with costs at government institutions

“If you do not have money, then the nurses will not treat you, in fact they will turn you away”. (UPM 8,22yrs, Tribal)

“The reason why the health personnel do not listen to us is that we are tribals and the health personnel have neither any compassion nor any respect for us” (Father-in-law of UPM 8)

“We were told that we would get facilities in the government hospital. But in reality we got no facilities; we were expected to buy the medicines from chemists.” (Husband of UK 8, 27yrs, Tribal)

Are institutions providing continuity of maternal care services?

- During complications in pregnancy, 11 women resorted to private providers although 22 had contact with a government nurse for TT (Tetnus Toxide) injection*
- Out of 14 women who had post-partum complications only 3 took medicines from the government hospital Women do not seem to perceive the government institutions as providing quality treatment or medicines in ill-health.*

Experiences with Costs

Poor women had to pay 200-500 Rupees as informal payments to the staff and up to 1500 for medicines. Out of 19 who were eligible, only 8 got the cash incentive (JSY).

Most received the money after repeated attempts "If the expenses in the government hospitals are so much then what was the use of going there? It is better to go to private hospitals instead. For the government health personnel, patients do not matter; they are not interested in saving their lives, the only thing that interests them is making money ... the government health services do not work for the benefit of the poor and needy people." (Husband of UPA 2, OBC)

'Culture' of service provision

- Poor rural women comply with the government programme for institutional delivery → which is the desired behaviour change. Yet once they manage to reach a facility, they may be faced with delays, lack of providers such as doctors, or may even be turned away. They may be sent back home or sent away to other hospitals without any proper referral support.
- If admitted, they may not be provided with basic documentation proving that they were admitted. Quality of care provided is extremely basic, and in cases even dangerous (unmonitored use of multiple intra-muscular oxytocin injections during labour). This is compounded by social discrimination, insensitivity to women's pain, and harassment for money.

It appears that the Indian government focus is on 'universal institutional delivery' rather than 'improved maternal health'. This means less attention to routine care or emergency care in pregnancy or abortion or post-partum stages. India has roughly 25 million births each year; the already inadequate and over-stretched health facilities would be better used for complications, not for every delivery. An outcome of such a policy could be lack of attention to making home births safer. Most interventions in improving healthcare attempt to address what is seen as 'community-level barriers and delays'. What has not been studied adequately by health programme managers is the 'culture of service provision' and the 'social factors' affecting the quality of service provision

Recommendations

1. There is a need to understand that the current policy and programme direction is itself deeply rooted in a cultural perspective that favours bio-medical technical approaches to healthcare issues.
2. Since there is a privileging of external expertise regarding solutions to deep-rooted health problems, the reality on the ground within large parts of India needs to be better investigated.
3. Interventions have to be designed to deal with the challenging aspects of the 'culture of service provision' and there needs to be a concern for continuum of quality care provision.

In addition according to recent estimates the target of 90% of births in low and middle income countries to have a skilled birth attendant (SBA) by 2015 will not be met and in South Asia in particular the figure will remain around the 50% mark (with 90% of the unattended births taking place in rural areas)^{xvi}. This important finding substantiates WHRAP-SA's claim that the present strategy does not meet the safe-delivery needs of women. Hence there is a need to pay attention to policies that will prevent deaths among women giving birth at home, unattended by skilled personnel.

Example from Narripokkho (Bangladesh)- Training of Community Birth Attendants

According to the Bangladesh Maternal Mortality and Health Care Survey (BMMHCS), 2010, approximately 56.5 % of women giving birth are assisted by untrained traditional birth attendants. As a result many women are not referred in time and die of pregnancy related complications. In a context where there is a shortage of skilled birth attendants, doctors and nurses a strategy of using trained traditional birth attendants for service delivery is a viable option. An analysis of the Gonoshasthya Kendra (GK) model clearly shows that over 80% of births are being delivered safely by trained birth attendants at home in GK villages. Drawing on the GK model in Bangladesh it is possible to upscale the model to the national level. This would entail the training of grassroot-level health and family welfare workers (family welfare assistants, sub-assistant community medical officers and health assistants) in basic health for six months and improving the skills of traditional birth attendants in pregnancy management through continuing in-service training, linked with the existing reproductive-health-care systems. This clearly indicates that much can be achieved in the absence of skilled birth attendants or doctors in rural settings if well-trained low-cost traditional birth attendants are available (Chaudhary & Chowdhury, 2008).

Chaudhury, R. H., & Chowdhury, Z. (2008). Maternal Mortality in Rural Bangladesh: Lessons Learned from Gonoshasthya Kendra Programme Villages. Asia Pacific Population Journal, 23(1), 55-78

Multiple levels of discrimination and marginalization are experienced by women and adolescent girls in South Asia within communities where the maternal mortality ratio is highest. These are also communities that are invariably linked with poverty, lack of access to education; under-nutrition and issues of food security. We are therefore also concerned with the growing trend of privatization we are witnessing in South Asia where deliberate interventions through funding agencies and national policies are supporting expansion of the private sector and private financing of health care (e.g. out-of-pocket expenditure, private insurance) and other market mechanisms within public sector health services^{xvii}. This is leading to a gradual withdrawal of the state from taking responsibility for universal access to quality health care services and a further denial of social and economic rights contributing to spiralling poverty^{xviii}.

We believe that what is required in our countries is a needs based comprehensive continuum of quality care approach that will ensure access to information and quality care at all stages of a woman's lifecycle and across location (home, community and health facilities), given the difficulties faced by marginalised women in accessing affordable skilled care in South Asia. Consequently a rights based continuum of quality care approach must facilitate availability and equitable access to essential quality health and reproductive services which should be affordable and acceptable for women from adolescence through pregnancy, delivery, and beyond; as well as for newborns and children. However until effective maternal mortality reduction strategies are achieved community-based interventions could promote and avert preventable mortalities and morbidities by training community based birth attendants (including Traditional Birth Attendants).

In conclusion, we hope that iERG will review the evidence presented in our submission and use the information to support the commissions own analysis and review processes. As we believe that state governments need to be accountable and must take concrete actions to address the context specific sexual and reproductive health and rights needs of marginalized women in our countries.

Partners in WHRAP-South Asia



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



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



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



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



Naripokkho based in Bangladesh is a membership-based, women's activist organization working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice since its founding in 1983.



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



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

Learn More about us at www.whrap.org

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- ⁱ BMMHCS 2010
- ⁱⁱ Indian SRS Bulletin 2011
- ⁱⁱⁱ NDHS 2006
- ^{iv} PDHS2006-2007
- ^v Thanenthiran, S; Racherla S.J. (2009). Thematic Study Series 4: Maternal Mortality and Morbidity in Asia. Reclaiming & Redefining Rights – ICPD+15: Status of Sexual and Reproductive Health and Rights in Asia. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).
- ^{vi} World Health Organization Adolescent Health and Development (AHD) Unit, Department of Family and Community Health, Regional Office for South-East Asia, New Delhi India. "10 Facts on Adolescent Health" http://www.who.int/features/factfiles/adolescent_health/facts/en/index.html
- ^{vii} Programming for Adolescent Health and Development, WHO Technical Report Series: No. 886. World Health Organization, United Nations Population Fund and United Nations Children's Fund, 1999, p. 11.
- ^{viii} UNICEF (2010). A continuum of care for adolescent girls in South Asia: defining the issues, synthesizing evidence, and working towards a policy agenda, UNICEF Regional Office for South Asia. http://www.who.int/pmnch/media/membernews/2011/adolescent_health_rosa.pdf
- ^{ix} Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., et al. (2006). Unsafe abortion: the preventable pandemic. *The Lancet*, Volume 368, Issue 9550, Pages 1908 - 1919, 25 November 2006, 368(9550), 1908-1919.
- ^x Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., et al. (2006). Unsafe abortion: the preventable pandemic. *The Lancet*, Volume 368, Issue 9550, Pages 1908 - 1919, 25 November 2006, 368(9550), 1908-1919.
- ^{xi} IPPF-SARO. "Strategic Plan SARO: Abortion." Retrieved 22 November, 2011, from <http://www.ippfsar.org/en/What-we-do/Strategic+plan/abortionsaro.htm>.
- ^{xii} Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., et al. (2006). Unsafe abortion: the preventable pandemic. *The Lancet*, Volume 368, Issue 9550, Pages 1908 - 1919, 25 November 2006, 368(9550), 1908-1919.
- ^{xiii} Campbell SM, Roland MO, Buetow SA. Defining quality of care. *Soc Sci Med*. 2000;51:1611–1625
- ^{xiv} Nair, H., & Panda, R. (2011). Quality of maternal healthcare in India: Has the National Rural Health Mission made a difference? *Journal of Global Health*, 1(1), 79-86.
- ^{xv} *As it is believed that having a SBA in attendance during delivery will reduce the chances of maternal mortality by approximately 16% to 33%* Crowe, S., Utley, M., Costello, A., & Pagel, C. (2012). How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? . *BMC Pregnancy and Childbirth*, 12(4). Retrieved from <http://www.biomedcentral.com/1471-2393/12/4/abstract>
- ^{xvi} Crowe, S., Utley, M., Costello, A., & Pagel, C. (2012). How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? . *BMC Pregnancy and Childbirth*, 12(4). Retrieved from <http://www.biomedcentral.com/1471-2393/12/4/abstract>
- ^{xvii} Ravindran, T. K. S. (2009). "Privatization in SRHR: Glimpses from Some Countries of South and South East Asia." *ARROWS for Change*, 15(1 & 2): 4-6.
- ^{xviii} Ravindran, T. S. (2010). "Privatisation in reproductive health services in Pakistan: three case studies." *Reproductive Health Matters*, 18(36): 13-24.