arrow
asian-pacific resource & research centre for women

Stories of CHANGE

Sharing Success Stories of Women's Health and Rights Advocacy Partnership - South Asia

Stories of CHANGE

Sharing Success Stories of Women's Health and Rights Advocacy Partnership - South Asia

Asian-Pacific Resource and Research Centre for Women (ARROW)

ISBN 978-967-0339-24-5
2016

Asian-Pacific Resource and Research Centre for Women (ARROW)
1 & 2 Jalan Scott, Brickfields 50470, Kuala Lumpur, Malaysia
Telephone: (603) 2273 9913 to 15
Fax: (603) 2273 9916
E-mail: arrow@arrow.org.my
Web: www.arrow.org.my
Facebook: https://www.facebook.com/ARROW.Women
Twitter: @ARROW_Women
Youtube: ARROWomen
Pinterest: arrowomen

Production Team

Story Tellers and Writers: Anju Shrestha and Ruby Shakya from Beyond Beijing Committee (BBC) in Nepal; Smita Bajpai from Centre for Health, Education, Training and Nutrition Awareness (CHETNA), Naresh Kumar Madawat from Shrushti Seva Samiti, Y.K. Sandhya and Sangeeta Maurya from SAHAYOG in India; Samia Afrin from Naripokkho and Monirujjaman Heru from Sangkalpa Trust in Bangladesh; Ahmed Raza Khan and Sajida Parveen from Shirkat Gah in Pakistan; and Nalini Singh from ARROW.

Copy Editor: Paroma Sadhana

Reviewed and Edited by: Sameer Thakur (external facilitator of the write-shop where the stories were first shared and written), Nalini Singh, Biplabi Shrestha, Maria Melinda Ando, Pooja Badarinath, Y.K. Sandhya, Smita Bajpai, Samia Afrin, Ruby Shakya and Ahmed Raza Khan.

Overall Coordinators: Biplabi Shrestha and Pooja Badarinath

Graphic Design: Nicolette Mallari
Cover Photo Credit: Shutterstock
Printer: CYF Contracts & Marketing

CONTENTS

PREFACE

The idea for a Women's Health and Rights Advocacy Partnership was sparked off in an ARROW's partners meeting in 2001. It was conceived as a partnership where grassroots concerns would impact and shape national and global policy on women's sexual and reproductive health and rights. (SRHR). These national and global policies would in turn impact and shape the lives of women and girls in ways that were necessary and needed. Although this idea was pertinent to all countries in the region, funding was obtained for four South Asian countries – Bangladesh, India, Nepal, and Pakistan. The partnership was anchored and coordinated in the region by ARROW, and linked to the international platform by the Danish Family Planning Association (DFPA). This year the partnership celebrates 13 years.

In the spirit of the WHRAP partnership and what it embodies, we wanted to bring out a publication which would carry the stories of change through the voices of marginalized women, activists, advocates and programme implementers who were involved in the work over the years. Truly, the changes have been at all levels: individual, community, media, local hospitals, national and regional policy-makers. This publication gives us a glimpse into the type of changes that occurred throughout the years.

In the era of the SDGs which we live in, accountability has become a buzzword, and yet it is sometimes difficult to pin down what accountability in action looks like. Holding our peers accountable, holding our community leaders accountable, holding service providers accountable, holding politicians accountable, holding ourselves accountable – all of these are the links that are fundamental when we wish to create a society based on integrity. These stories of change tell the stories of the links that form the chain of accountability.

By sharing these stories to a wider audience and varied stakeholders we are also aiming to strengthen the advocacy of WHRAP-South Asia for increased and improved accountability from duty bearers, guardian institutions as well as service providers for women's SRHR. We also wish to continue positing that if we are looking for lasting change with regards SRHR, we must first and foremost continue investing in local communities because indeed these are the frontlines where sexual and reproductive rights are realized or denied. The publication is a timely and strategic reminder of this truth.

We would like to acknowledge the passion, commitment and contributions of all the partners; local, national, regional and international; the community women and other individuals and groups who have been part of the WHRAP-South Asia initiative directly and indirectly. Change is only possible when we all play our part.

Sivananthi Thanenthiran
Executive Director, ARROW

Tania Dethlefsen
Deputy Director, DFPA

INTRODUCTION

About Women's Health and Rights Advocacy Partnership - South Asia

The Women's Health and Rights Advocacy Partnership (WHRAP)-South Asia positions itself as an international partnership with a regional voice. The partnership brings together women-led organisations and other civil society actors for evidence based advocacy on sexual and reproductive health and rights (SRHR). Over the last 13 years, WHRAP-South Asia has facilitated and contributed to processes aimed at improving the quality of life of marginalised women in Bangladesh, India, Nepal and Pakistan through empowerment, strengthening civil society engagement and public support leading to better accountability for health governance.

In South Asia, social determinants such as poverty, educational status, food and nutrition and water and sanitation affect health outcomes. Discrimination and inequalities based on gender, caste, class, religion, disability, age and geographical location entrenched in society and institutions adversely impact access of rights including the enjoyment of the highest attainable standard of physical and mental health. In this context, WHRAP-South Asia's rights-based approach includes the recognition that marginalised women in South Asia are rights-holders vis-à-vis the duty-bearers, the state authorities represented by government officials, health care providers, representatives of health facility based oversight mechanisms (OMs)[1] and human rights guardian institutions (GIs).[2] WHRAP-South Asia employs an approach whereby evidence is gathered locally and transformed into local, national, regional and international advocacy initiatives.

WHRAP-South Asia is implemented as a partnership programme between five leading national women's organisations including Beyond Beijing Committee (BBC) in Nepal, Naripokkho in Bangladesh, Shirkat Gah in Pakistan, Centre for Health Education, Training and Nutrition Awareness (CHETNA) and SAHAYOG in India as national partners; their selected community-based partners that work directly with the women on the ground; and the Asian Pacific Resource and Research Centre for Women (ARROW) as its regional partner. The programme has been carried

1 Oversight Mechanisms refer to Hospital Management Committees that have the function of supervising the management of hospital finances, approving hospital budgets, monitoring the performance of hospitals against the budgets, etc. Nepal - Health Facility Management Committees (HFMC); Bangladesh - Union Parishad Standing Committee, Health and Family Planning Committee, Union & Divisional Level Hospital Management Committee; India - Rogi Kalyan Samiti (Patient Welfare Committee), Facility-based Planning and Monitoring Committee; and Pakistan - Oversight Committee on Health and Population.

2 This includes various UN Human Rights Accountability Mechanisms such as the Universal Period Review process, CEDAW reporting, UN Special Rapporteur mechanisms, national human rights institutions, etc.

out in cooperation with and funded by the Danish Family Planning Association (DFPA).

WHRAP-South Asia began as a project in 2003. Currently in its fourth phase, it aims to promote marginalised women's SRHR. It calls for a context- specific and rights-based continuum of quality care (CQC) for women's reproductive health in South Asia which spans across a woman's life-cycle – before and during pregnancy to postpartum/post-abortion and menopause – and across various locations, for example, the home, community and health facilities.[3] CQC is crucial in order to reduce adolescent, maternal, newborn, and child mortality and morbidity and improve women's SRHR.

Learn More about us at: **www.arrow.org.my**

3 More about Continuum of Quality Care (CQC) can be found at http://arrow.org.my/wp-content/uploads/2015/04/Fulfilling-Womens-Right-to-Continuum-of-Quality-Care_Advocacy-Brief_2014.pdf).

ABOUT STORIES of CHANGE

Over the years, WHRAP-South Asia has contributed to various changes that brought about positive impact to the lives of women in general and marginalised women in particular. WHRAP-South Asia implements a complex modality where advocacy is at various levels – at the community, sub-national, national and international, and by various actors – women, CBOs, civil society groups and health alliances, media, national, regional and international partners and allies.

Over the course of 13 years, through WRHAP-South Asia's strategic interventions, women in the implementation areas are able to articulate their needs and demands for quality sexual and reproductive health services and seek improvement in the quality of health services provided. The community and national partners have garnered more support for their issues with other civil society groups and health alliances as well as media. In the implementation areas, community-based partners have reactivated and improved the functioning of various OMs where now they are taking up issues related to women's health in their regular discussions and actions. At the national level, through concerted advocacy there have been positive commitments and responses from GIs towards the improvement of women's health and rights. At the regional and international levels, CQC issues have been raised as the missing component in the current global SRHR and health strategies and commitments.

With this publication, WHRAP-South Asia documents the types of changes that are brought about as a result of its implementation in Bangladesh, India, Nepal and Pakistan.

These stories of change evolved through a process which was jointly decided by the partners. A format was designed where the partners narrated and wrote these stories at a write-shop organized by ARROW in Colombo, Sri Lanka from 17-20 May 2015. The write-shop allowed the partners an opportunity to qualitatively analyse the results they had achieved over the years.

This publication begins with the stories of brave women and men who found their voices to articulate SRHR concerns in their area. This is followed by stories of allies who have championed WHRAP issues. Subsequently there are stories to highlight the change brought about by community mobilisation towards effective functioning of OMs and of GIs taking note of grave SRHR violations. Finally, it documents examples of effective use of the evidence gathered at the local level for international advocacy.

Altogether, the nine stories, two from each of the countries, and one from the regional partner, ARROW, have captured not only the changes and successes but also the processes that have led to the successes which WHRAP-South Asia has been instrumental in. Generating such stories are imperative in order to have evidence to support the advocacy and strengthen the visibility of WHRAP-South Asia.

I. INDIVIDUAL STORIES OF CHANGE

The stories in this section describe an individual's journey on sexual and reproductive health and rights due to their engagement with WHRAP-South Asia at the local level.

Each of these stories show the result of continuous work of WHRAP's community-based partners with members of the community including media. As a result we have women in communities who are aware of their rights and entitlements and have the capacity to voice out their demands to duty bearers. These efforts are also supported by champions in media.

First, She Changed Herself

Overcoming Abortion Stigma

Story by
Ruby Shakya

Written by
Anju Shreshta

Location
Nepal

Partner Organisation
Beyond Beijing Committee

CQC Framework Highlight
Safe abortion services should be readily available and affordable to all women. This means that services should be available at all levels of health facilities which should be equipped with counseling services for safe abortion and use of contraception to prevent unwanted pregnancy.

Katahari is a village in Morang District located in the Koshi Zone of southeastern Nepal. It is situated in a semi-urban area and is inhabited by people from various caste groups. Shanti Chaudhary who is 41 years old now, was living with her happy family in Katahari. She had two sons and a daughter. She was a member of the community and used to take a lead role in its activities despite not being able to read and write.

Shanti's 20-year-old son, her eldest, married a 19-year-old girl. They were young and planning to continue their studies in order to establish their careers, and had no plans of having children. But after one year of their marriage her daughter-in-law got pregnant accidentally and the couple decided to have an abortion without consulting their parents. After a few days Shanti got to know about the abortion. The news stunned her as she was scared of being discriminated by the community, which stigmatised abortion. She believed that abortion was a sin and was against their cultural and societal norms. She had basic knowledge about contraception but did not know that abortion is legal in Nepal.

After a few days Shanti met Anita, a district focal person for the WHRAP-South Asia initiative in Nepal, who was seeking a community leader from her village. Anita proposed Shanti be the village focal person in the district as part of WHRAP-South Asia to advocate on sexual and reproductive health and rights (SRHR) in their village. Shanti agreed and as a consequence got opportunities to participate in capacity building trainings, meetings, and dialogues on issues related to SRHR. Working with WHRAP-South Asia made her aware

that abortion is a choice and a woman's right. Now she regrets her initial reaction and behavior towards her son and daughter-in-law when she got to know about their abortion.

With the enhanced capacity, knowledge, and a changed attitude towards abortion, Shanti now conducts community sessions in the village with mothers' groups, and shares her knowledge and experiences with them, disseminating information on issues related to safe abortion. Shanti visits all the wards of the village to spread awareness among the community women's groups. She also meets the village health post to get information about their services. She is also able to guide other women in her community about their choices with regards to SRHR.

Shanti is now not only aware of SRHR, of a woman's right to make decisions about her body, and of the importance of safe abortion services, but also strong in her advocacy on these issues. She has gained the trust of local women as well. She helps women who are worried about their unwanted pregnancies with her knowledge and advice.

In the absence of female community health volunteers, women visit Shanti for support and information regarding abortion services. Abortion is still not a familiar or easily acceptable concept in the Nepali society. Even though safe abortion has been legalized in Nepal since 2002, people believe abortion is a crime and an immoral action. Thus it is not easy for Shanti to convince people and reduce negative attitudes toward abortion in order to exercise it safely without the fear of getting stigmatised. Sometimes she faces challenges such as mockery and hatred from her peers for her social work, uncooperative government offices etc. Despite these barriers, she does not lose hope. She is passionate and motivated towards her work and is able to understand people's contexts.

People in the community also now understand SRHR, as well as safe abortion issues. They are not just talking about it, but are also supportive in her demands for quality sexual and reproductive health services from concerned stakeholders. This makes Shanti happy and satisfied with her work.

Shanti is now not only aware of SRHR, of a woman's right to make decisions about her body, and of the importance of safe abortion services, but also strong in her advocacy on these issues. She has gained the trust of local women as well. She helps women who are worried about their unwanted pregnancies with her knowledge and advice. The learning process within WHRAP-South Asia has changed her mind and perception. People in the community also now understand SRHR, as well as safe abortion issues. They are not just talking about it, but are also supportive in her demands for quality sexual and reproductive health services from concerned stakeholders. This makes Shanti happy and satisfied with her work.

Community leader, Shanti Choudhary. Source: BBC

The Bold One!

How one woman stepped beyond the traditional boundaries to make health services more accessible for her community

Story by
Sajida Parveen

Written by
Y.K. Sandhya

Location
Pakistan

Partner Organisation
Shirkat Gah

CQC Framework Highlight
Free screening with full quality, antenatal routine care/services and services for postpartum/post abortion complications. This should also be provided for screening of other situations such as violence, malaria, uterine prolapse, blood grouping, HIV, Sickle Cell anaemia, etc.

Located in the Sheikhupura district of Pakistan is a village called Shamkey, home to about 3,000 people. In this village, like in many areas of Pakistan, women and girls are given differential treatment when compared to men and boys. Girls are usually discriminated against in terms of food and are given much less to eat both in quantity and quality, which often leads to health complications during pregnancy due to malnutrition.

Living in Shamkey in a joint family home is Shazia Imran, 28, a mother of two. Like most women and girls in the village, Shazia's access to basic health services was limited due to the restrictions on her mobility. Shazia's life would have probably continued in that same manner if it was not for her meeting the staff of Shirkat Gah and their partner *Nai Umeed* who are implementing the WHRAP-South Asia initiative.

In September 2014, *Nai Umeed* launched a local initiative to work on maternal health issues among vulnerable and poor households using a framework that employed community champions in order to enable a sustainable community accountability model. The idea was to train the champions on issues related to maternal and reproductive health and provide them with the opportunity to build strong links with various health facilities and government functionaries, such as the Lady Health Visitor, Lady Health Workers, and the Vaccinator, in order to facilitate women's access to maternal health services. They would also be linked with the Secretary of the Union Council to facilitate birth, marriage and death registrations.

Community women at an awareness raising session on maternal health in Sheikhupura district, Punjab, Pakistan. Source: Shirkat Gah

Initially, *Nai Umeed* struggled to find a friendly household that would give her space and time to sit and converse. Finally, the general secretary of *Nai Umeed*, Venus, met Shazia and her sister-in-law in their house. Shazia was impressive and showed potential to be a champion. It took multiple visits for Shazia's family to be comfortable with Venus and not have objections to Shazia accompanying Venus to visit other households in the village to select a cohort of champions.

During her initial visits to the village, Venus realised that birth registrations were not being done.[1] Previously, there was a government post of a *Chowkidar* (gatekeeper or watchman), who was responsible for recording the names of the children and submitting it to the office of the Union Council for registration. However, for reasons unknown, this was no longer happening and the onus of registering births lay with the people.

1 In Pakistan, registering births remains a challenge and this poses many administrative problems including difficulties to track age of marriage, as it is not possible to ascertain whether girls are marrying before the legal age of 16 for females in the absence of a birth certificate.

Shazia now spearheads a birth registration campaign, and over a short span of six months, compiled a list of all the children in her muhalla who had not been registered. In one of her visits to the office of the Union Council, she suggested that registrations would be easier if they could send a mobile van to the villages. The Council accepted the suggestion and plan to buy a van for this purpose.

Shazia, despite being educated up to the tenth standard, and married to a government employee, was not aware of the importance of birth registrations and as such did not register her children's birth. *Nai Umeed*, during the course of their meetings with the champions, aside from discussing the concept of quality health care for women, also raised the issue of lack of birth registration in the village. They explained the importance of registration to the women and encouraged the champions to list all the children in their *muhallas* (communities) and submit it to the office of the Secretary of the Union Council. Shazia now spearheads a birth registration campaign, and over a short span of six months, compiled a list of all the children in her *muhalla* who had not been registered. In one of her visits to the office of the Union Council, she suggested that registrations would be easier if they could send a mobile van to the villages. The Council accepted the suggestion and plan to buy a van for this purpose.

Over several interactions through *Nai Umeed*, Shazia has built a strong relationship with a Female Welfare Worker (FWW) from the Population Department who is trained in various family planning methods. Shazia would take her village women to consult the FWW for family planning

As a result of her work, Shazia's personal life has changed too. Now, she is more mobile, aware, and much more confident. This confidence is visible in her ability to communicate with service providers and others, winning the appreciation and admiration of the community. She is also able to negotiate and assert her rights in her domestic life as well.

services and other reproductive health issues, and if required, the women would be referred to the gynaecologist. The women learned that a referral from the FWW meant that the treatments would be faster and better than when they sought services on their own. This encouraged them to use public health facilities more than ever before. She also convinced reluctant mothers to vaccinate their children by addressing their fears related to vaccinations.

Shazia also noticed that there were a large number of people with disabilities in her village. So, with the help of Venus, she sought the services of another NGO which works with people with disabilities. She compiled a list of people with disabilities in her village who made use of the health camp to get hearing aids and wheel chairs.

As a result of her work, Shazia's personal life has changed too. Now, she is more mobile, aware, and much more confident. This confidence is visible in her ability to communicate with service providers and others, winning the appreciation and admiration of the community. She is also able to negotiate and assert her rights in her domestic life as well.

On being asked what her plans for the future are, Shazia says, "I think we must work harder to change the attitude of the hospital staff in district hospitals. We have had success with the Union Council and birth registrations, and have made them accountable though our perseverance and pro-activeness. I am hopeful that we will eventually bring about this change in our hospitals too."

Community women listening intently at an awareness raising session on maternal health in Sheikhupura district, Punjab, Pakistan Source: Shirkat Gah

Making News Matter

Using media to hold local authorities accountable for reproductive health

Story by
Ahmed Raza Khan

Written by
Sangeeta Maurya

Location
Pakistan

Partner Organisation
Shirkat Gah

CQC Framework Highlight
Respecting a woman's dignity, right to privacy and sensitivity to her needs and perspectives is paramount at all times. This includes the provision of safe abortion services, contraception, counselling and media reporting. In addition, attention should be given to the special needs of poor, adolescents and other vulnerable and marginalised women.

Sajjad Ahmed Jan, 45, lives in Charsadda district in the province of Khyber Pakhtunkhwa (KPK), Pakistan. He has been a news editor at a local newspaper, Charsadda News, for the last seven years. However, he admitted, "like other news reporters and news editors in the area, I too had no knowledge and awareness about women's reproductive health or rights. Like other parts of Pakistan, in my area too, the custom is that women are not allowed to go outside. In this situation, it's very difficult - especially for men, to talk about women's reproductive health and rights. This is even more difficult in Khyber Pakhtunkhwa (KPK) as majority of the people are still very conservative."

In 2014, Sajjad, along with some other media members, participated in a workshop on reproductive health (RH) organised by the Shirkat Gah Women's Resource Centre. During the orientation, he watched a documentary called *Mumtaz Bach Sakati Thi* (Mumtaz could have been saved). Watching this film shook him deeply and for the first time, he realised the poor state of women's health in his region. He felt it was a serious and flagrant issue and decided to work on it.

Sajjad explains further, "In our area, people refuse the Polio vaccination because they think that in the guise of the Polio vaccine, western countries were trying to control the fertility of the people. In such a situation, it is very difficult to write about family planning and other RH issues of women. There is also the possibility of threat. Despite this and because it is such a very serious issue, I decided to work on it."

An article highlighting a WHRAP workshop to the media in Pakistan highlighting right to information and reproductive health. Source: Shirkat Gah

He also found out that in the district hospital, women were not treated with dignity. So he discussed it with the duty bearers and lodged a complaint with the District Complaint Cell. Since Sajjad was well known and had good relations with the official within the Complaint Cell as a journalist, immediate action was taken against the concerned staff. Now the behaviour of the staff has improved towards the people, especially women.


The Daily Charsadda News

روزنامہ چارسدہ نیوز

چارسدہ (نمائندہ چارسدہ نیوز) شرکت گاہ (WHRAP) پراجیکٹ کی تعاون سے دی گئی ورکشاپ میں معلومات تک رسائی کے قانون پر صحافیوں کو معلومات فراہم کی گئیں

WHRAP workshop with media personnel in Charsadda District, KPK, Pakistan. Source: Shirkat Gah

After returning from the session and exposure visit, Sajjad wrote several articles on anaemia, family planning, early marriage, and on the use of the Khyber Pakhtunkhwa Right to Information (RTI) Act.[1] "After getting an orientation on the RTI process, I have realised its power and have used it to file an RTI to get details of health budgets. When I get the replies, I plan to use the information to write articles on the gaps and raise questions to make duty bearers accountable," he says. Motivated by conversations with Sajjad, two of his friends have also filed RTIs. These were published not only by his newspaper, but by other local newspapers too.

Aside from being involved in improving the situation, Sajjad has also played a significant role in motivating the grassroots local champions under the WHRAP-South Asia project. For instance, in the Basic Health Unit (BHU), staff members were charging illegal informal fees for pregnancy test services. Sajjad used his influence as a journalist to help the local champion lodge a complaint with the district complaint cell, resulting in the termination of the norm of charging these illegal informal fees.

He also found out that in the district hospital, women were not treated with dignity. So he discussed it with the duty bearers and lodged a complaint with the District Complaint Cell. Since Sajjad was well known and had good relations with the official within the Complaint Cell as a journalist, immediate action was taken against the concerned staff. Now the behaviour of the staff has improved towards the people, especially women.

Aside from being involved in improving the situation, Sajjad has also played a significant role in motivating the grassroots local champion[2] under the WHRAP-South Asia project. For instance, in the Basic Health Unit (BHU), staff members were charging illegal informal fees for pregnancy test services. Sajjad used his influence as a journalist to help the local champion lodge a complaint with the district complaint cell, resulting in the termination of the norm of charging these illegal informal fees.

At a more personal level, Sajjad says he now discusses reproductive health issues with his wife and motivates her to share her knowledge with other women. Additionally, he has shared all his newfound knowledge with his friends and colleagues and encourages them to use it for the benefit of the women in their area.

1 The act was signed into law on November 4, 2013, and provides citizens "the right to access to information in all matters of public importance," including public documents and records. Khyber Pakhtunkhwa Government website, accessed November 30, 2015, http://www.khyberpakhtunkhwa.gov.pk/Rti-updated.pdf

2 Champions are local community activist. Most of the champions are between the age of 22-35 years. Shirkat Gah identified these champions with the help of local CBO United Youth Welfare organization Charsadda. Now these champions are trained to conduct community sessions, identify local RH issues, share with media and coordinate with district complaint cell Charsadda.

II. COMMUNITY MONITORING TO CHANGE LOCAL HEALTH SYSTEMS

The stories in this section describe the work of WHRAP-South Asia with community-based organisations and civil society alliances. Successes from advocacy at the local level is time and resource intensive.

For WHRAP our community-based partners and local level alliances have been key in ensuring that duty bearers, which include members of facility-based oversight mechanisms, are held accountable.

The following stories highlight the creative forms of advocacy undertaken in restrictive settings at the local levels despite good policies.

Bringing the Good Doctor Back

Advocacy to ensure the provision of comprehensive abortion services

Story by
Anju Shreshta

Written by
Ruby Shakya

Location
Nepal

Partner Organisation
Beyond Beijing Committee

CQC Framework Highlights
Guarantee women's safety in child birth whether in facility – based or home delivery. Having broad-based health care providers, such as Auxillary Nurse Midwives (ANM), Trained Birth Attendants (TBA), community midwives etc., is important. This should also be backed by emergency transport especially for complicated cases.

Manahari is a beautiful village in Makwanpur district of southern Nepal. The village includes people of various cultures and religions with different lifestyles. They are fortunate enough to have drinking water, electricity, mobile towers, cable services, and a primary health centre available in their village.

In the primary health centre (PHC), they also have comprehensive abortion services (CAS), which started in 2009. However, due to the stigma and discrimination attached to abortion in the society, as well as low awareness on availability of services, only two to three women access these services in a month. The fear of being disclosed forces women to seek backstreet abortion services. Due to under utilization of abortion services provided at the health centre, it is less prioritised even by trained health personnel. Anita's story below illustrates this:

> *"Anita, a 32-year-old woman has four children – two sons and two daughters – all born at home. When she learnt that she was pregnant again, she decided to have an abortion as she did not want to have more children. She was unaware of the services offered in the primary health centre, so she went to a village* sudeni *(a traditional birth attendant) to have an abortion. Soon after the procedure, Anita experienced heavy bleeding. She was first taken to the nearest primary health centre, but due to their lack of services, she was referred to a district hospital. She died during the transfer."*

Anita's story is experienced by many women, due to poor knowledge and inadequate services in the village. Many women have gone through unsafe abortions, or travelled long distances to avail comprehensive abortion services.

Based on this situation, community-based organisations (CBOs) in the district strengthened their awareness activities on sexual and reproductive health issues through the WHRAP-South Asia initiative. Women from the community were involved in these programmes, and realised that abortion services are available and important. With that being said, awareness is just one aspect of sexual and reproductive health.

Ultimately, sustained advocacy efforts led to re-functioning of the CAC centre; which had been closed for the past three years, providing women's right to safe abortion services within their community. Now, people are able to take advantage of the services.

Realising the need for services in the village, staff from the CBO Youth Welfare Society (YWS) decided to talk with the District Public Health Officer (DPHO) for re-recruitment of trained health personnel. Before the meeting with the DPHO and YWS, women from the community gathered strong evidence from the ground to highlight their issues. The study indicated that pregnant girls and women resorted to unsafe medication from local pharmacies to terminate the unwanted pregnancies; resulting in an adverse impacts on their health. There were many cases of women using unsafe methods resulting in incomplete abortions thereby necessitating hospitalisation for post-abortion care. This was solely the consequence of the non-functional Comprehensive Abortion Care (CAC) centre at the Manahari PHC. This health centre is a hub for people from the surrounding rural areas seeking health care.

Meeting with HFOMC that led to the restoration of services at Manahari PHC. Source: BBC

After identifying the core problem, YWS members took up the issue. They strategically raised the issue at the Health Facility Operation and Management Committee (HFOMC) meetings, with the medical doctor of the PHC, and at District Public Health Office (DPHO) of Makwanpur. YWS also conducted various bilateral meetings with the Public Health Nurse of DPHO to take the issue forward. The women from the community, who participated in HFOMC meetings, also concretely demanded the re-functioning of the CAC in Manahari. The medical doctor at the PHC, being a listed CAC provider, supported the demand to recruit trained personnel and make services available again. Ultimately, sustained advocacy efforts led to re-functioning of the CAC centre; which had been closed for the past three years, providing women's right to safe abortion services within their community. Now, people are able to take advantage of the services.

Making Change Happen, One Village at a Time

Advocacy to hold village committees accountable for women's health and rights

Story by
Naresh Madawat

Written by
Smita Bajpai

Location
India

Partner Organisation
CHETNA

CQC Framework Highlights
Open the healthcare systems to continuous public/community monitoring. Social reviews, as part of a regulatory mechanism, must ensure the accountability of all duty bearers involved.

After working in a programme for improvement in the public education system in the state of Rajasthan for eight years, I started Shrusti in 1999. It was intended as a space to independently implement my ideas and to fulfil my desire for interacting with the rural communities of the Jhadol Block in the Udaipur district of the state of Rajasthan, India. We started focussing on education and then moved on to address other issues, such as livelihood and health.

In 2013, one of my team members asked me to join Rajasthan White Ribbon Alliance for Safe Motherhood (SUMA) anchored by CHETNA, which is a network working for the reduction of maternal and newborn mortality in the state of Rajasthan. Realising the importance of this issue, we joined SUMA and participated in the trainings which were organised to build our capacities.

To begin with, we held discussions with women's groups in five villages to learn about their experiences of accessing maternal health services from the public health system. Women from interior villages shared that they were not treated properly, they were not respected, they had to make several visits, and not all women got all of the benefits and services that they are entitled to. Each woman had a different story to tell.

In order to collect better evidence for advocacy, we carried out an assessment of the services provided by the public health facilities, using tools provided by CHETNA. Although

there were some challenges, such as understanding difficult technical terms and uncooperative government authorities, we were able to complete the assessment. We understood the roles that the Village Health Sanitation and Nutrition Committees (VHSNC), facility-based committees, the *Anganwadi* (crèche) worker (AWW) of the Integrated Child Development Scheme (ICDS) which is India's Supplementary Nutrition Project, and the Auxiliary Nurse Midwife (ANM) at the sub-centre, were supposed to provide for quality services. Additionally, the assessment allowed us to see which areas needed work, and motivated us to work on them.

To begin with, we held discussions with women's groups in five villages to learn about their experiences of accessing maternal health services from the public health system. Women from interior villages shared that they were not treated properly, they were not respected, they had to make several visits, and not all women got all of the benefits and services that they are entitled to. Each woman had a different story to tell.

Based on the result of the assessment, CHETNA prepared a citizens' report card. The card was a blueprint of the health services of the area. It provided information on the strengths and gaps of maternal health services on aspects such as availability of providers, accessibility, infrastructure, and supplies.

We shared the findings from the Citizen's Report Card with women's groups from the five villages. The women agreed to join us in taking up the issue at the *Gram Sabha* (a constitutionally mandated space in the Panchayat System for soliciting citizens' voices in local governance). The meeting identified three issues to be proposed: repairs towards a building at the *Anganwadi* centre, filling up the vacant post of AWW and constructing a labour room at the Jamun sub-centre.

We shared the Citizens' Report Card with key decision makers from the *Gram Panchayats*, (Local Self Government Bodies), the Health Department, and the members of the facility-based committee–Rajasthan Medicare Relief Society (RMRS),[1] to which mixed responses were received. While some appreciated the initiative, others found loopholes. The Chief Medical Officer of Jhadol Block dismissed the issue right away. Though we were disappointed with his reaction, we did not lose hope. We approached the *Sarpanch* (head) of Madla *Gram Panchayat*, who was more compassionate and agreed to bring this matter up at the upcoming *Gram Sabha*.

Though this sounded hopeful, we were unsure of our next step and how to proceed with it as we had never made proposals at the *Gram Sabhas*. The training organised by CHETNA helped us gain clarity on the Panchayat system and ways to present proposals at *Gram Sabhas*. The discussions made us more hopeful about potential positive results as a result of advocacy at the *Gram Sabhas*. The training ended with a plan to engage with the upcoming *Gram Sabhas*. People from the community were motivated to participate in *Gram Sabhas* to support our call.

We were pleasantly surprised when our proposal to fill up the vacant post of the *Anganwadi* worker resulted in the selection of a worker on the spot. The *Gram Sabha* also resolved to take action on the two other issues we proposed.

1 Since November 1995, the government of Rajasthan has created RMRS, a society aimed to provide various diagnostic and treatment facilities at nominal cost to general patients and free of cost to below poverty line (BPL) and dependent patients. Source: http://medicaleducation.rajasthan.gov.in/ajmer/RMS.asp

This was taken up at the general house (which is a meeting of the *Sarpanch* from all the Panchayats of a block level) and the proposals were included in the priority list for action. Due to sustained follow-up by the former *Sarpanch*, the required budget was passed for construction of a labour room and repairs of *Anganwadi*.

Further, following the Panchayat elections, the newly elected *Sarpanch* informed us that funds for building the labour room have been transferred to the Panchayat and the construction process will start soon.

The land for construction of a labour room has been allocated and has been levelled. The road to the sub-centre has also been levelled for easy access. I am happy that our efforts have yielded results. We have been able to fulfil the expectations of women and communities, and are also pleased that women will not have to travel far to seek delivery services. Women from the villages have shared that they are hopeful that the services will be available soon, and are happy to see the change happening.

Health and Happiness Across River Islands

Holding authorities accountable for quality health services

Story by
Monirujjaman Heru

Written by
Samia Afrin

Location
Bangladesh

Partner Organisation
Naripokkho

CQC Framework Highlight
CQC monitoring systems must include continuous tracking of services for vulnerable groups including migrants, internally displaced, persons with disabilities, socially excluded, people living with HIV and women. Their access to SRH information and services including EmOC and referrals must also be tracked.

Sangkalpa Trust is a community-based organisation (CBO) of Naripokkho that is working as part of the WHRAP-South Asia initiative toward decreasing maternal death and is advocating for Continuum of Quality Care (CQC)[1] in Bangladesh. As part of this project, Sangkalpa Trust formed the Right to Health Alliance,[2] and its members visited five *chor*[3] areas in the Barguna and Patuakhali districts of Barisal Division in December 2014 to learn about the standards of living of the people there and their access to health services.

During this visit, the alliance members saw that these *chors* are situated 20-30 km from the mainland and there is no other communication or transportation system from a *chor* to the mainland or to other *chors* aside from boats, and these are also poorly available. There are 3,000-10,000 people living in each *chor*, but most of them are illiterate due to inadequate access to education. There is only one educational institution, a primary school, in a *chor*. There

1 CQC is a context specific and rights-based approach that will ensure Continuum of Quality Care across a woman's lifecycle, including adolescence, pregnancy, postpartum/post-abortion, and menopause.
2 The Right to Alliance was formed in 2014. It was an initiative taken by Executive Director of Sangkalpa Trust according to the guidance of Naripokkho for proper implementation of the WHRAP project.
3 *Chor* or alluvion is an area in the midst of a river that is formed by the accumulation of alluvium through river flow. There are many *chors* in the project implementation area and five were visited in 2014.

is little opportunity of employment; most people sustain themselves by farming and fishing. For this reason, their monthly income is less than BDT 5,000 (USD 65) and their standard of living is very low.

Early marriage is a common reality within the *chors*. Often, parents marry off their daughters when they are between 10 and 14 years old. As a result, they become pregnant as adolescents, and suffer poor maternal health and complications, particularly as there is insufficient access to government health services in the *chors*. Due to a government mandate, there is only one community clinic in one *chor*, usually in those with a population of more than 6,000, and these clinics are only open for two to three days per month. Many smaller and more remote islands with lower populations are denied basic health services. People have very little idea about maternal health services and many pregnant women often take medicines from quacks and religious charlatans. There is no primary and emergency health services for women to depend on. Therefore, maternal death and child death rates are higher than mainland.[4] Moreover, there is no health facility in *chor* areas.

During the visit, alliance members collected crucial information about health service systems in the *chor* areas, made a report on the basis of that information, and presented and discussed it in the alliance meeting to develop a plan for advocating with local authorities to improve the situation.

4 The following statistics also reflect the same. According to the Bangladesh Maternal Mortality Survey (BMMS) 2010, the Maternal Mortality Rate (MMR) is 194 per 100,000 live births in Bangladesh and the divisional MMR for Baraisal is 168. However, in 2012 Naripokkho-WHRAP found that the MMR is 231 in 111 union of Barisal Division and those unions have several Chors as Barisal is surrounding by many rivers.

Due to the repeated efforts of the alliance members, the local authority finally took some steps to improve the condition of the health service system in the chors and things are changing. For example, a decision was made in the meeting with the Upzilla Health and Family Planning Officer that a second community clinic would be established in the comparatively smaller Majherchor*, which is now under implementation. Additionally, the Dashmina Upazila Alliance members came together to form a medical team consisting of volunteers from the locality and doctors of the Upazila health complex.*

Sangkalpa Trust staff travelling to river isalnds. Source: Naripokkho

An alliance member collecting information of MH in the Chor. Source: G M Badal

The information was used as evidence for lobbying with the local authorities, the administration of the hospital, the civil surgeon, the assistant director of the Family Planning Department at the district level, and the Health and Family Planning Officer at the *Upzila* (sub-district) level for improvement of health services at *chor* areas.

The alliance members also met with the *Upzila* chair and vice-chair, and with the Union *Parishad* chair to discuss the issues and how to provide better healthcare in these smaller *chors*. Additionally, they discussed with the health service provider of the community clinic about his responsibilities. They also sent the report to Naripokkho and the WHRAP-South Asia initiative.

Due to the repeated efforts of the alliance members, the local authority finally took some steps to improve the condition of the health service system in the *chors* and things are changing. For example, a decision was made in the meeting with the *Upzilla* Health and Family Planning Officer that a second community clinic would be established in the comparatively smaller *Majherchor*, which is now under implementation. Additionally, the Dashmina *Upzila* Alliance members came together to form a medical team consisting of volunteers from the locality and doctors of the *Upzila* health complex. Later, alliance members took the team to the *chor* Hadi (name of the area given by the people who built the locality) and held a one-day health camp that provided regular check-up and primary health service to the people. Another significant achievement by the *chor* visit of alliance members is the increased availability of primary health services at *chor* Borhan. Earlier, the Chor Borhan Community Clinic opened for only 2-4 days in a month, but now, after the visit, it remains open regularly.

As a result, people in these chors are getting primary health services. This has led to an improvement in the health situation of the chor area. Women in particular are getting better health services and they are very happy about it.

III. ADVOCACY FOR STATE ACCOUNTABILITY

The stories in this section describe the efforts put in by WHRAP-South Asia in ensuring that governments are accountable to their obligations and commitments.

The stories also highlight processes and actions taken to make human rights guardian institutions take responsible political action on SRHR violations and on governments' lack of compliance to international commitments and national laws.

Will the Real Member of Parliament Stand Up?

Community organisation holds an elected representative accountable for quality health services to his electorate

Story by
Samia Afrin

Narrated by
Monirujjaman Heru

Location
Bangladesh

Partner Organisation
Naripokkho

CQC Framework Highlight
Establish a well thought-out functioning grievance redress mechanism with adequate participation/inclusion of non-system people at the grassroots level which addresses grievances in a timely manner. The action taken should be monitored. Existing mechanisms should be activated and empowered which should include an element of capacity enhancement of the officials/members of the grievance redress committee.

Sangkalpa Trust, a community-based organisation (CBO) of Naripokkho, has been working since 2003 with the Women's Health and Rights Advocacy Partnership - South Asia initiative in order to ensure the accountability of service providers in Patharghata *Upzila*[1], in Barguna district of Barisal Division. It monitors services provided at government health facilities and advocates for quality health services through the activation of Hospital Management Committees (HMC)[2]. Sangkalpa Trust is also a member of the HMC of the Patharghata *Upzila*.

According to current government orders in Bangladesh, an HMC is to be headed by the local Member of Parliament (MP). Similarly, the *Upzila* Health and Family Planning Officer (UH&FPO) is the member secretary for HMC. According to government rules, HMC meetings should be held monthly in order to discuss issues related to the quality of health care services in hospitals, and to find ways to address the issues that require approval of a local MP. In 2014, Sangkalpa Trust found out that the HMC in Pathorghata Upzila Health Complex has not met in more than two years. This was because of the very infrequent visit of the MP in the *Upzila* due to his busy work schedule. The absence of HMC meetings led to a deterioration in

1 *Upzila* refers to a sub-district.

2 The Hospital Management Committees (HMCs) were formed by the Ministry of Health and Family Welfare to monitor the work of the *Upzila*, District and Divisional level hospitals. There are 21 members at the *Upzila* level. The Chairperson and the Co-Chair of the HMC are the local Member of Parliament and Chair of the elected *Upzila* Parishad respectively. Other members include the hospital staff, women leaders, government officials, local journalists, and local NGOs.

accountability mechanisms and services in the health complex. Doctors were not available even during the time of their duty, patients were charged illegal fees, the quality of the medicines and other services were compromised, and there was lack of running water in the health facility. In addition, the security at the hospital was poor, and failed to deter loitering drug abusers, who discouraged patients' use of the facilities.

Following the meeting, actions were taken in order to improve services at the health complex. These included the following: reduced absenteeism and frequent transfers of medical officers, increased visits by doctors, the organisation of health education for out-patient department (OPD) patients, increased OPD usage, a reduction in the demands for informal payments, improved sanitation, a regular water supply, and improved security at the campus. Moreover, the Committee members are now more proactive in identifying problems and taking measures to solve them.

Through an initiative of the Executive Director at Sangkalpa Trust, these issues were discussed at the Right to Health Alliance[3] meetings. The members of the alliance decided to reach out to the MP to inform him of the situation and to stress the importance of activating the HMC. The alliance members met with the MP who made several promises but did not keep his word. Despite this, Sangkalpa Trust proactively put the agenda together. Unfortunately, the agenda was dismissed by the secretary of the committee, who failed to show up at a meeting that the MP did attend due to a fear that they would be held accountable for irregularities in the health complex. However, the health alliance under the leadership of Sangkalpa Trust did not give up, and continued lobbying with the MP and with the *Upzila* Executive Officer and *Upzila* Health and Family Planning Officer (UH&FPO).

HMC Meeting in Pathaoghata Upzila Health Complex. Source: Mirza Khaled

Finally, after a year of advocacy, the MP was convinced and assured that he would call for a meeting during his next visit. He called for the first HMC meeting in more than three years on 19 March 2015. The issues that were identified through the monitoring of the facility by Sangkalpa Trust and the alliance were discussed. When the importance of regularity of the HMC meeting was brought up, the MP affirmed it, and said that in his absence, the co-chairperson would chair the meeting.

Following the meeting, actions were taken in order to improve services at the health complex. These included the following: reduced absenteeism and frequent transfers of medical officers, increased visits by doctors, the organisation of health education for out-patient department (OPD) patients, increased OPD usage, a reduction in the demands for informal payments, improved sanitation, a regular water supply, and improved security at the campus. Moreover, the Committee members are now more proactive in identifying problems and taking measures to solve them.

These changes would not have materialised if not for the perseverance and commitment of Sangkalpa Trust and members of the Right to Health Alliance.

3 The Right to Health Alliance was formed in 2014. It was an initiative taken by Sangkalpa Trust with the guidance of Naripokkho for proper implementation of WHRAP project.

Digging Deep, Reaching High

Civil Society gathers evidence of SRHR violations to hold the government accountable

Story by
Y. K. Sandhya

Written by
Sajida Parveen

Location
India

Partner Organisation
SAHAYOG

CQC Framework Highlights
Contraceptive services must equally focus on men with a specific emphasis on temporary methods as opposed to permanent methods. Public dialogues must be organised which bring the public health functionaries/providers, local self-government representatives and the users in a multi–stakeholder dialogue. This should also allow health providers space to discuss the challenges they face.

Implementation of the Family Planning Programme in India began several decades ago in 1952,[1] when the growing population was often dubbed as a bomb that was about to explode. The national government believed that if population growth was not controlled, economic development would remain elusive. As a definite way of controlling population growth, targets were set in each state regarding the number of men and women to sterilise.[2] It should be noted that female sterilisation, a terminal method, has for decades, remained the mainstay of the national family planning programme. Although the programme talks about offering a basket of choices, modern spacing methods (IUCD, oral contraceptives, and condoms) account for a very small fraction of contraceptive use.

Sterilisation services are provided not just in hospital facilities but also in camps that are organised by the government and sometimes with the support of NGOs. A number of women are called for sterilisation in the camps. In many of these camps, doctors perform a large number of sterilisation operations in conditions that do not follow the standard quality norms mandated by the Supreme Court of India, which has led to the death and morbidity of many women. Furthermore, although mandated, it is very difficult for the affected women or the families of the dead women to receive the compensation they are entitled to.

SAHAYOG and other members of the Health Watch Forum (HWF) have observed several sterilisations camps and conducted case documentations of sterilisation failures and deaths. Based on them, in 2003, the HWF filed a public interest litigation (PIL) case[3] in the Supreme Court,

1 In 1952, India launched the world's first national programme emphasising family planning to the extent necessary for reducing birth rates "to stabilise the population at a level consistent with the requirement of national economy."

2 India has had a long and somewhat turbulent history with regard to family planning. It has, over the years, adopted a number of different approaches, including a coercive target approach, a policy articulating a reproductive health and rights paradigm, contraceptive-specific incentives, and a family planning camp approach, among others.

3 In collaboration with the Human Rights Law Network and the Centre for Reproductive Rights.

A member of the NHRC at the public hearing . Source: SAHAYOG

wherein it cited data from the States of Uttar Pradesh, Bihar, and Maharashtra, that provided evidence on government practices regarding female sterilisation. These included lack of counseling or informed consent, lack of pre- and post-operative care, and performing sterilisation in unhygienic and un-anesthetised operating conditions. The judgment was clear. The Supreme Court recognised the problem and formulated a set of guidelines that are required to be followed.

To deliver justice to the women, SAHAYOG mobilised networks and other CBOs. They held a public hearing in Delhi in 2014 where affected women and family members of those who had died shared their experiences. Members of the National Human Rights Commission (NHRC) and the Parliamentary Standing Committee (PSC) on Population were invited. After advocating for two weeks, SAHAYOG mobilised CBOs, women who had either failures or complications following a sterilization, and the families of the women from 14 states who had died during sterilisation to present testimonies before the panel.

In 2014, a camp was organised by an NGO in the Bilaspur district of Chhattisgarh state, in a charitable hospital that had been closed for some time. Among the women who were sterilised 140 reported complications within a few hours. Thirteen of the women died, and 70 were in critical condition. The sterilisations performed in the camp breached guidelines requiring surgeons to perform no more than 30 sterilisations per day. This problem is not only specific to Bilaspur, but happens in many of the camps organised across the country; however, it remains an issue that has been often ignored.

Following the Chhattisgarh sterilisation deaths, SAHAYOG and other civil society organisations working on the issue felt that the focus of the discussion around sterilisation should not just be limited to Chhattisgarh, as this was a problem prevalent across India. If the focus remained specific to Chhattisgarh, the impression would be that this is a localised issue and the national population policy and its programme budgeting would not come under question.

To deliver justice to the women, SAHAYOG mobilised networks and other CBOs. They held a public hearing in Delhi in 2014 where affected women and family members of those who had died shared their experiences. Members of the National Human Rights Commission (NHRC) and the Parliamentary Standing Committee (PSC) on Population were invited. After advocating for two weeks, SAHAYOG mobilised CBOs, women who had failures or complications following a sterilization, and the families of the women who had died during sterilisation to present testimonies before the panel. The NHRC members and the Secretariat of the PSC responded by asking what support was required from them. SAHAYOG was of the opinion that the issue was not localised to Bilaspur, but was an outcome of flaws in the National Population Policy and that the Committee could raise questions regarding the budget of Ministry of Family Welfare.

The hard work of SAHAYOG paid off when the questions they drafted were used by the Standing Committee to question the Ministry on their spending, and hold them accountable to women achieving their reproductive and sexual health. Having the attention of and commitment from the PSC members are great achievements, considering that the undue emphasis on female sterilisation was not even considered a problem earlier. The advocacy on this continues.

Connecting Local and Global Accountability

Accountability for Women's SRHR at the International Level: WHRAP-South Asia Strategies

Story by
Nalini Singh

Location
Malaysia

Partner Organisation
ARROW

CQC Framework Highlights
States have an obligation to fulfill their international commitments as signatories. They should provide quality healthcare services for all. Sustained investment in strengthening the health system must happen under government supervision and management.

Respresentatives from CBOs, National, Regional and International partners of WHRAP at a partners meeting held in 2015. Source: ARROW

Investment in building a strong Asia Pacific partnership for advocacy on SRHR was a strong collective call at an ARROW Regional Partners Meeting in 2001. This partnership would strengthen the linkages between the local, national and international advocacy so that the impact and efforts to influence policy and programme change is increased.

In moving this call forward, WHRAP began as a programme for ARROW in 2003. A new approach was needed as identified by ARROW and partners to ensure that SRHR remains a priority agenda for governments in the region as well as donors. The implementation of the Millennium Development Goals (MDGs) recognized improvement of reproductive health as part of the larger poverty eradication strategy but within its limited framework. Many of the policies driven by agencies and donors to reduce the maternal mortality ratio focused narrowly on institutional deliveries. However, these failed to recognize the context

marginalised women are in. In the four WHRAP-South Asia countries, home deliveries are a reality.

WHRAP in South Asia began against a backdrop of the sub-region with high maternal mortality and morbidity. The vertical approaches to end preventable maternal deaths are largely seen to be disconnected from the realities faced by marginalised women. WHRAP national partners, with their years of experience working for and with marginalised communities, highlight the fact that these policies and programmes are not working. Consequently, when there are failures or violations, there are no opportunities to seek redressal from authorities.

Consistent support from the Danish Family Planning Association (DFPA) has sustained the implementation of WHRAP for over a decade. ARROW and DFPA's commitment has ensured that there is an equal amount of resources emphasized for organisational and programmatic development. With this partnership, national partners are able to develop and adapt their programmes to their context and develop different strategies for the same goal. ARROW as part of WHRAP, is driving and supporting the processes for joint strategic planning, monitoring and evidence-based advocacy at all levels. At the local level, the aim is to empower marginalised women by building their capacity to generate evidence. Locally generated evidence is then integrated with national, regional and international advocacy which aim to change policies and programmes to accurately address the needs of these women.

As an international partnership with a regional and local voice, WHRAP-South Asia has been able to leverage spaces at the regional and international levels so that partners are able to present their evidence and positions in these spaces. ARROW also has been at the centre of developing the position paper on a Context-specific Rights-based Continuum of Quality Care (CQC) for Women's Reproductive Health in South Asia. This has enabled partners to move towards common and unifying advocacy goal despite addressing diverse populations and issues in each country. This position has formed a framework for WHRAP-South Asia's national and CBOs partners for their interventions. It has been translated and widely disseminated. It has also been the basis of submissions to the WHO Commission on Information and Accountability for women's and children's health through its Independent Expert Review Group.[1]

WHRAP in South Asia began against a backdrop of the sub-region with high maternal mortality and morbidity. The vertical approaches to end preventable maternal deaths are largely seen to be disconnected from the realities faced by marginalised women. WHRAP national partners, with their years of experience working for and with marginalised communities, highlight the fact that these policies and programmes are not working. Consequently, when there are failures or violations, there are no opportunities to seek redressal from authorities.

In recent years, ARROW has been able to raise joint positions through organizing regional advocacy dialogues, events and by engaging in key regional and international processes. One such highlight was the organisation of the Regional Advocacy Dialogue in 2012 on "Advancing Accountability: Raising the Issue of Maternal Deaths in South Asia" in New Delhi, India. This brought together 18 regional and national stakeholders, including representatives from WHO-SEARO, UNFPA, WRAP-South Asia partners and others to assess maternal health policies and their impact on the lives of marginalised women. It highlighted and addressed the gaps in care and services. The participants agreed on WHRAP-South Asia's CQC advocacy agenda and reflected on the need for broader alliance building for the partnership. The then 'UN Special

1 http://www.who.int/woman_child_accountability/ierg/en/

Rapporteur on the Right of Everyone for the Enjoyment of the Highest Attainable Standard of Physical and Mental Health', Anand Grover, who also joined the meeting, suggested use of the mechanism's complaints protocol for violation of rights.

ARROW also has been at the centre of developing the position paper on a Context-specific Rights-based Continuum of Quality Care (CQC) for Women's Reproductive Health in South Asia. This has enabled partners to move towards common and unifying advocacy goals despite addressing diverse populations and issues in each country.

Similarly, in 2014 ARROW/WHRAP-South Asia received support from a broader base of civil society for the CQC position. More than 50 representatives from 38 different CSOs in Asia Pacific deliberated and produced 'the call for action towards context specific rights-based continuum of quality care.[2] The call was formulated in the context of the new Sustainable Development Goals (SDGs) which were being decided and strategies for ending preventable maternal mortality were being finalised by WHO and other agencies. It reiterated that the ground level realities should be taken into account so that the final goals and strategies are reflective of the needs of, and can bring about real changes for, all women, particularly marginalized women.

In 2015 ARROW/DFPA/WHRAP-South Asia, organised a side event at the July session of Intergovernmental Negotiations (IGN) on the SDGs at the UN headquarters in New York. It was organised in collaboration with the DFPA, United Nations Non-Governmental Liaison Service (UN NGLS), AIDS Accountability International (Africa focus), and with official support from the government of Nepal. The side event showcased the lived realities of girls and women in South Asia. It provided an analysis of the region's persistent reproductive health challenges, 15 years after MDG implementation by highlighting the contextual differences, lack of accountability at the local level and the need to focus on quality health care especially on SRHR. The participants who included several member state representatives including Nepal and Denmark, staff of various UN agencies and other CSO representatives were presented with evidence that argued for the CQC approach. Representing WHRAP-South Asia's first-ever engagement at the UNHQ, the event proved to be an opportunity to forge relationships and strengthen support for our advocacy. Participants agreed that the CQC call was timely and was missing from the ongoing SDGs discussions.

With this sustained engagement as a partnership, we hope to ensure that the forthcoming global accountability framework recognises the urgent need for context-specific continuum of quality care for all women.

2 http://arrow.org.my/wp-content/uploads/2015/04/Continuum-of-Quality-Care_Call-for-Action_2014.pdf

PARTNERS IN WHRAP-SOUTH ASIA

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

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

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

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

Naripokkho, based in Bangladesh, is a membership-based, women's activist organization working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice since its founding in 1983. For more on Naripokkho, please visit: www.naripokkho.org

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

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

Learn More about us at: **www.arrow.org.my**

ISBN 9789670339245

arrow
asian-pacific resource & research centre for women

Asian-Pacific Resource and Research Centre for Women (ARROW)
1 & 2 Jalan Scott, Brickfields, Kuala Lumpur, Malaysia 50470

Telephone (603) 2273 9913 to 15
Fax (603) 2273 9916
E-mail arrow@arrow.org.my
Web www.arrow.org.my
Facebook https://www.facebook.com/ARROW.Women
Twitter @ARROW_Women
Youtube ARROWomen
Pinterest arrowomen

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building, and organisational development.

ARROW envisions an equal, just, and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

Published with the support of the Danish Family Planning Association (DFPA).

ARROW's work is also made possible through the core funding/support from

Sida

ARROW also receives institutional support from the **Ford Foundation**.

The content of this publication does not necessarily reflect the views and positions of these donors.