FORMATIVE RESEARCH

Respectful Maternity Care (RMC) in Pakistan

THE WHITE RIBBON ALLIANCE
PAKISTAN
HEALTHY MOTHERS HEALTHY WORLD

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Dr Amanuallah Khan

President WRAP

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EXECUTIVE SUMMARY

The study in hand provides an overview of the practices of abuse and disrespect that women have to face while they seek maternity care services from public sector facilities. Qualitative in design, Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) with maternal health experts were the key tools of data collection used in the study. The FGDs were conducted in 5 districts (2 in Sindh province, 2 in KP and 1 in Punjab) purposively selected. IDIs were conducted with experts in all 3 provinces.

Formative in nature, the study was driven by Borwser and Hill (2010) framework for exploring the various dimensions of the Respectful Maternity Care. A number of practices have been identified that characterize maternity care services delivery in public sector health facilities in Pakistan. Most of the practices fall in the category of abandonment and denial of care, followed by non-dignified care including verbal abuse and non-consented and non-confidential care. Physical abuse and discriminatory practices were also mentioned but to an extent lesser than the aforementioned practices. Detention in facilities appeared to be almost absent probably because of the services being provided free in public sector.

The key drivers of these practices appeared to lack of accountability in the system, gaps in the trainings of the health care providers and high client load vis-à-vis facilities. On the demand side, lack of awareness of rights of women coupled with hopelessness with respect to result of any efforts of raising voice, fear of denial of care in case of complaining and lack of any effective grievance redress mechanisms were the key reasons found to producing this sorry state of affairs.

A multi-pronged strategy using public awareness and pressure campaigns as well as strategic advocacy to capitalize on the low hanging fruits such Right to Services Act, Right to Information Act, Health Care Commission and Citizen feedback Models that have recently been introduced in the governance of the provinces could be a way forward to promote RMC in Pakistan. This is a high time that such initiatives are taken given that Pakistan is exhibiting a trend of increase in facility based births which if capitalized can expedite Pakistan's progress towards reducing maternal mortality.

INTRODUCTION AND BACKGROUND

Respectful Maternity Care (RMC) refers to several important aspects of maternity care services. It describes the interpersonal interaction, embraces the fundamental rights of mothers, newborns and their families, and recognizes that all childbearing women need and deserve respectful care and protection of the women's rights to choice and preferences. It is an approach that centers on the individual, builds upon principles of ethics and respect for human rights, and upholds practices that recognize women's preferences and women's and newborns' needs. In 2010, Browser and Hill explored the evidence of disrespect and abuse in facility based childbirths in their Landscape Analysis and identified seven categories of disrespect and abuse: physical abuse, non-consented care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific attributes, abandonment or denial of care and detention in facilities. The analysis further found that disrespect and abuse might sometimes act as more powerful deterrents to skilled birth care utilization than other more commonly recognized deterrents such as geographic and financial obstacles.

Respectful Maternity Care (RMC) addresses these issues with a lens of rights expressed as the Universal Rights of Childbearing Women extracted from international covenants, laws and instruments of human rights and embodied in Charter of Respectful Care. Vis-à-vis the seven categories of disrespect and abuse identified by Browser and Hill, these rights include:

- Freedom from harm and ill treatment
- Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care.
- Confidentiality, privacy
- Dignity, respect
- Equality, freedom from discrimination, equitable care
- Right to timely health care and to the highest attainable level of health
- Liberty, autonomy, self determination, freedom from coercion

White Ribbon Alliance (WRA) is a torchbearer of safe motherhood across the globe and functions through its national alliances for policy and practice changes at global and country levels that can help make childbearing a safe and respectful experience for mothers. In partnership with the USAID funded Healthy Policy Project (HPP), WRA aims to make the seven aspects of the Universal Rights of Childbearing Women Charter the basis of maternity care systems around the world, including Pakistan.

The Health Policy Project supported WRA Pakistan to undertake a concerted campaign on Respectful Maternity Care (RMC) in Pakistan which is evidence based and targets specific gaps in the policies and programs of maternity services. Being a new approach, the diffusion of this instrument of improving the maternal health services delivery will take some time. Targeted efforts will be required to popularize this approach, both amongst citizens and decision makers, at the initial stage. The lack of RMC must be recognized as a problem area amongst the key decision makers and their influencers, and support is created around RMC as a priority in maternity care services delivery.

To this end, WRA Pakistan commissioned this study to develop insights about the state of disrespect and abuse around facility based births that can inform its campaign for the promotion of RMC. The study timing is critical given that Pakistan is experiencing an increase in facility-based childbirths which can be a window of opportunity for expediting Pakistan's progress on reducing maternal mortality. The findings of the study may also be useful given the citizens based accountability drive being witnessed in the overall governance of the country and manifested in media activism, the announcement of pro-citizen legislative measures such as Right to Information Act, Right to Services Act, and increased attention to citizen feedback models.

RESEARCH DESIGN

OBJECTIVES

The overall purpose of the research is to contextualize RMC with respect to Pakistan, the specific objectives are:

- To identify practices of disrespect and abuse that women face while seeking maternity care services at public sector facilities
- To gauge users' perceptions about the state of RMC in services delivery at public sector health facilities
- To determine key supply and supply-side barriers to the delivery of RMC by the public sector

METHODOLOGY

The research framework was grounded in the Respectful Care Charter[1]. Both quantitative and qualitative data was collected.

TOOLS, DATA SOURCES, SITES

Qualitative information on users' perspectives was collected through Focus Groups Discussions (FGDs) with mothers who have delivered at least once in any health facility; public and/or private. FGDs were conducted using an FGD guide based on the seven categories of disrespect and abuse identified by Browser and Hill (2010). A total of six FGDs were conducted in the rural union councils of Hyderabad (2), Rawalpindi (2), Swabi (1) and Abbottabad (1).

In addition, In-depth Interviews (IDIs) were conducted with maternal health experts with a mix of backgrounds (academicians, practitioners, managers, advisors) both from public and private sector across the three provinces i.e. Sindh, Punjab and KP. IDIs were conducted using a semi-structured guide.

The principal investigator collected most of the data and conducted all IDIs, four out of six FGDs (two in Punjab, one in KP and one in Sindh).

INFORMED CONSENT

The participants were informed about the objectives of the study and informed verbal consent was obtained before administering any tool. The participants/respondents were informed about their right of participation and right to provide information and confidentiality. The questions asked by the respondents within the scope of the study were answered.

DATA RECORDING AND ENTRY

All FGDs and IDIs were recorded through both note taking and audio recording. The respondents' consent was solicited for audio recording. The audio recordings were transcribed into notes and combined with hand written notes for analysis purposes.

DATA ANALYSIS

The data analysis was done manually. The hand written notes were read over three times in order to group the responses into the seven categories identified in Charter of Care founded in Browser and Hill Landscape Analysis. Effort was also made to ascertain the strength of each theme vis-à-vis other categories through a tally method. Interesting quotes from the field have been included for substantiating the findings.

[1] www.whiteribbonalliance.org/respectfulcare

FINDINGS

FOCUS GROUP DISCUSSIONS

PHYSICAL ABUSE

Physical abuse is one of the seven categories of disrespect and abuse. It is corresponded by the right to freedom from harm and ill treatment. Physical abuse was mentioned by FGD participants in all of the locations of data collection. However as compared to other categories it was mentioned less often. Of the various locations, in Abbottabad, it was described by FGD participants as "practiced mostly". Important manifestations of physical abuse mentioned by the participants included slapping on legs, episiotomy without anesthesia, pinching.

A participant from FGD in Pindi, while narrating her experience with seeking maternity care for her daughter, tells her story of how a nurse hit her daughter when she could not understand the nurse's question about the changing of the sanitary pads.

> *A nurse came over there and asked me whether I have changed the pad of my daughter (the pregnant woman). I could not understand that because we use cloth for this and did not know about pads. I confused pad with par (foot) and said that her foot was fine. On my reply, the nurse slapped my daughter so forcefully that I also could not help raising my hand to hit the nurse. She said if you could not understand why didn't she (pregnant woman) reply. My daughter was having her first baby and we used cloth instead so how could she tell. She was dying with pain and knew nothing at that time.*

Another participant from the same FGD mentioned about not using anesthesia while undertaking episiotomy.

> *Jab meri delivery thee to sunn ker kay chota aperation kertay hain. Unhon nay sunn kiaye bagair mujay cut lagaya.*
>
> *(Anesthesia is used before doing episiotomy. When I was having delivery they gave me cut without giving anesthesia)*

In Abbotabad one of the participants mentioned about the tying of legs during labor. She said:

> *They tied the feet of my sister-in-law to the stretcher and said that this was for everyone so nothing to worry about. And they were doing it with everyone.*

Physical abuse was usually related to women screaming or moving their legs during labor. For instance, a participant in the Abbottabad FGD mentioned the physical abuse as a reaction towards screaming. This was also mentioned by one of participants in Rawalpindi FGD in the following words:

> *Jo bohat ziada shor machahaty hain aur paon marty hain unhain thappar bhi parrtay hain.*
>
> *more noise and move their feet around get sla*

> *Raat ko sarkari haspatal main ziada jagnay ki waja say wo time nahi ho to drip taiz ker kay jaldi delivery kerwati hain or neend ki waja say operation bhi ziada kerty hain taa kay ziada na jagna parray.*
>
> *(In the night, in public sector hospitals due to lack of sleep they do not give more time, administer the infusions at higher speed to get the woman deliver early and also do more C sections so that they can go to sleep early) Rawalpindi*

NON–CONSENTED CARE

Non-consented care is the second category of abuse and disrespect. It is violation of the right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care. Non-consented maternity care appears to be practiced quite frequently in the public sector health facilities. Different responses related to non-consented care when grouped together were found to be the second most mentioned practice. A number of manifestations of non-consented care were mentioned during the FGDs.

"Doctors do not listen to the women and their attendants" was the most mentioned practice in this regard. This was related to the practice of merely writing prescriptions and investigations without any history taking and knowing the condition of the patient. In the words of one participant in the FGD in Rawalpindi:

> *Sunty nahin, bass dwayee likh dety hain or kehty hain chalain jayen uthain.*
>
> *(They do not listen, just prescribe medicines and say go now)*

Participants in FGDs in Sind also cited similar practices. For instance one of the participants said:

> *Asan wanyoon ta Asan gee budhandayoon ie kon Asan galhaindan wanyoon ho bas ha ha ha kandyoon ahan*
>
> *(When we go they do not listen to us at all, we keep speaking and they keep ignoring)*

When the care seekers try to say something they face being snubbed. For example, in one of the FGDs in Pindi the participant shared:

> *Gussay say baat kerty hain aur sunty nahin. Main doctor ko apny pain kay barray main bata rahy thee to kehnay lagi, jitna poocha hay utna hi batao aur na batao.*
>
> *(They talk angrily and do not listen. I was telling the doctor about my pain and she said "Tell me only what I have asked")*

The attendants were also frequently mentioned as experiencing snubbing while trying to convey any information about the pregnant woman. In Swabi one of the FGD participants said:

> *Mareez kaysath jo mujood hota hay wo agar bataya to doctor dantaty hain kay wo khud kion nahin batatin.*
>
> *(Those who accompany the woman if they try to tell something about the woman are snubbed by the doctor)*

Another participant from one of the FGDs in Sindh described a similar experience in the following words:

> *Main apni dewarani ko Civil lay gayee. Wo Khud bohat nervous hoty hay. Jab ham doctor kay pass gaya to nurse nay kah tum andar sath nahi ja sakty. Main nay kaha kay main iski halat bataun gee. Wo dantnay lagi or kaha kay ye itni barri aurat hay iskay mun main zuban nahi hay*
>
> *(I took my sister in law to Civil Hospital. She gets nervous. When we were to see the doctor, the staff nurse told me to stay back and that I could not go inside. I said that I could tell about her conditions. She snubbed me saying "she is a such a big woman, doesn't she possess a tongue in her mouth")*

The women and/or caretakers were snubbed not only while they tried to convey any information proactively but also when they tried to seek any information or ask questions. For instance, one participant in FGD in Rawalpindi mentioned:

> *Agar poochain to kehty hain bibi chup kero.*
>
> *(If we ask something they tell us to shut up)*

Another participant from the same FGD shared:

> *Sarkari main to apis main batain kerty rehty hain or hamain kehty hain chup ho jao.*
>
> *(In pubic sector hospitals they keep talking amongst themselves and order us to keep shut).*

> *Whahan to jo doctor bethy hoty hain wo to kat khanay ko dorrty hain (Rawalpindi).*
>
> *(The doctors sitting over there usually yell at women)*

The other practice mentioned with the same strength was that attendants were not allowed to accompany the women. A participant from Swabi said:

> *Attendant ko labour room main janay ki ijzat nahi daitay.*
>
> *(Attendant is not allowed to go into the labor room)*

Another participant in the Sindh FGD also mentioned the practice in the following words:

> *Aik banda labor room say bahar tak ho sakta hay laikan andar janay ki izazat nahi hoty.*
>
> *(One person can stand outside the room but no one is allowed to go inside)*

A participant in the Rawalpindi FGD while expressing the need for attendant's presence said:

> *Labor room main bilkul nahi janay daitay, Andar jo hamara mareez hay marr raha hay ya jee raha hay, uko kia problem hay, uskay sath kia ho raha hay. Pooch lo to agay say daant hay.*
>
> *(Do not at all allow going into labor room. Inside what is happening with our patient, is she dying or surviving, what problem is she passing through, how is she being treated, we never know. If we ask something we are snubbed)*

Another participant in the FGD in Rawalpindi related it to the doctor's own absence from the labor room.

> *Labor room main hamaray kissi ko bhi nahi janay daiteen. Khud bhi nahin hoteen, kam az kam hamain to ijazzat dainy chahya.*
>
> *(No one from the attendants is allowed in the labor room. The doctor herself is also not there. At least we should be allowed to be with our patient)*

Doctors do not seek permission while doing check-ups was the second most mentioned practice by the participants across all FGDs. Following are some of the expressions from FGDs that reflect the presence of this practice:

> *Check up kaylia ijazzat nahi laitin, direct kehty hain lait jao. (Swabi FGD)*
>
> *(Do not seek permission while checking up. Directly tell us to lie down on the bed)*

> *Check up say pehlay ijazat nahi laitin, bas kehty hain chalo lait jao, bas janwaron ki tarha salook hay or kia hay. (Rawalpindi FGD)*
>
> *(They do not seek permission before doing check up, only say to lie down, treat us like animals what else!)*

Along with the practice of not seeking permission of the woman for general check up, the practice of not seeking the consent of the woman while doing procedures especially C-Section was also mentioned frequently during the FGDs. Important in this regard was the observation recorded by the participants that consent was probably taken from the husband or family members but not from the woman who has to undertake the procedure. The consent taken from the husbands/caretakers was also mentioned to be very superficial. The staff just get signatures from them without describing or explaining anything.

> *Operation agar kerna ho to pehlay say nahi batatin, achanak kehty hain kay operation hay. FGD Swabi*
>
> *(If they have to do C Section, they do not tell us in advance. They suddenly say that C Section will be done)*

> *Doctor check kerty hay or kehty hay jaldi say wheel chair lao, operation ki tayyari kero, koi idhar ja raha hay or koi udher. Sirf husband say sign laity hain kay apkay mareez ka operation kerna hay, kuch hua to apki zimadari hay or sign laiker chali jaty hain. Aurat say na poochty hain na hi ussay bataty or samajhaty hain. (FGD Rawalpindi)*
>
> *(Doctor checks and says bring the wheel chair and start preparing for operation and people start moving here and there. Only take signatures from husband saying that your patient is to be operated upon and if something happens to her we are not be held responsible, get signatures and go away. The woman is never told, asked or briefed about anything)*

> *Barray operation kaylia sirf shohar say sign laity hain kay operation kerna hay magar tafseel say kuch nahi batatin, hamla aurat ko bhi kuch nahi batatin. FGD Abbotabad*
>
> *(For C Section only take signatures from husband saying that operation will be done and do not tell details. The pregnant woman is also not told anything)*

Doctors do not explain, do not counsel, do not describe were some of the other frequently said expressions in the FGDs reflecting the non-dispensation of the right to information of the patient. For example, one of the FGD participant in Sind while describing this situation said:

> *Tawaja nahi daitin, jatin hain to, hamian kia masla hay, kuch nahi batatin, whan koi suntan hi nahi.*
>
> *(Do not pay attention, when we go they do not tell what is wrong with us, no one listens)*

In words of another participant in FGD in Rawalpindi:

> *When the woman returns home, she is not told about what to do, what not to do, nothing is told!*

Along with not informing the patient, a participant in the Rawalpindi FGD also mentioned about the practice of misinforming in the following words:

> *Mujay golian bata din kaha ye khao or kaha kay sassti hain bahar say lay laina. Ghar aa ker mera shohar laya to 600 ki ayeen.*
>
> *(They prescribed me pills saying that these were cheap and you get it from outside. When my husband bought those, they were quite expensive)*

Respect of patients' choices and preferences is another dimension of the consented care. Important in this regard is the choice of the provider. While discussing this aspect of care, the participants mentioned that they never get any chance to make choice of doctor. The participants did not mention this proactively in the discussion partly for the reason that in the context of the acute shortage of care, the choice of care probably gets meaningless. When prompted one of the participants in the Rawalpindi FGDs

> *Agar ham udhar ja kay ye bolain kay hamin falan doctor say check kerwana hay to wo to hamara hasher ker day gee.*
>
> *(If we ask for the doctor of our choice then probably we will be doomed and not get even what little we would have received without asking)*

One participant in the Rawalpindi FGD mentioned about the practice of ultrasound by male in the following words:

> *I went to Civil Hospital for my first pregnancy. I was very young then. Male did ultrasound. I thought males would also be there at delivery time so I went back without delivering and never went to hospital for maternity care again and had my all deliveries at home.*

Permission to move around is another aspect of respect for patients' choice and preferences. The participants in the Rawalpindi FGD mentioned not being allowed to move around after admission.

> *Apni marzi say nahi chal phir saktin. Agar chalain to wo sunany party hain kay Allah Maafi (FGD Rawalpindi)*
>
> *(We can not move around on our wish. If we walk then have to bear the brunt that God forbid)*

However, another respondent from the same FGD mentioned that:

> *They allow us to go out of labour room if there is time.*

Participants in the FGDs in Sindh and Swabi also described being permitted to move around:

> *Wo chlanay phirnay kaylia khud bhi kehty hain or ijazat bhi daity hain magar compound kay ander tak. (FGD Hyderabad)*
>
> *(They encourage us to move around and also permit us to do so though limited to the compound of the hospital only)*

> *Chalnay phirnay ki ijazat hoty hay (FGD Swabi)*
>
> *(They allow us to move around)*

NON-CONFIDENTIAL CARE AND PRIVACY

Practices compromising the right to confidentiality and privacy of the women were also frequently mentioned during the FGDs in all six locations. “Parday ka intezam nahi hota” (there is no system of privacy), was the frequently mentioned expression of the participants in the FGDs in all locations. The participants mentioned several important aspects of lack of privacy. The most mentioned manifestation was women lying uncovered in waiting areas adjacent to labor rooms followed by the practice of the presence of other women in waiting areas adjacent to the labor rooms and presence of ward boys in the same areas. A participant in Abbottabad FGD depicted the situation as follows:

> *Parday ka koi intezam nahi hota, sab aisay hi parry hoty hain*
>
> *(There is no system of privacy; all women are lying in front of each other)*

A participant in the Swabi FGD mentioned this practice in the following words:

Parday ka intezam nahi hota, doosry aurtain bhi maujood hoty hain (FGD Swabi)

(There is no system of privacy, other women are also present over there)

A participant in the Rawalpindi FGD said:

Wo Table per laity hoty hain shalwarain utary hoty hain, sari laity hoty hain, dardain lay rahi hoty hain.

(They are lying on the table without trousers together and taking pains)

The participants in Rawalpindi FGDs also mentioned about deliveries happening outside the labor room. One participant mentioned the situation in the following words:

Saary bahurmaty ho rahy hoty hay. Parday ka bilkulkoi intezam nahi hota. Bahar Table per hi wo laity dardain lay rahy hoty hain. Mery bhabhi ko mery man nai apna dopata utar ker uss per dia, uski delivery bahar table per hi ho gaye thee. (FGD Rawalpindi)

(It is all so disgraceful. There is no system of privacy at all. Women are taking labor pains lying on tables outside the labor room. My mother covered my sister in law with her veil, she delivered on the table outside the labor room)

Another participant also mentioned the lack of privacy during the care as she narrated her observation of a woman whose privacy was violated by the doctor when the doctor asked the woman to show her sanitary pads in front of others.

Meray samnay aik larki ki bohat bleeding ho rahyee thee, wo keh rahee thee mujay bohat bleeding hay, doctor nay kaha pehlay pad check kerwao, main to whan say bhag aye (FGD Rawalpindi)

(I could see a woman having severe bleeding. She was herself saying that I am having severe bleeding, the doctor said to her that first get me your pad checked. I could not bear that and just went back to my home)

Another important factor that was mentioned by participants as compromising the privacy of the women was the presence of men in the areas where women stay before going into labor rooms and in the wards also. For instance one woman in the Rawalpindi FGD mentioned:

Sarkari hasptal main niche baygairty hoty hay, aik tang ooper hoty hay or aik neechay, har banda andar aa jaa raha hota hay, jo dard aya hota hay wo bhi ooper chala jata hay.

(Public sector hospital is so disgusting. One leg is up and one is down and every Tom Dick and Harry is coming inside. In such environment, whatever labor pains are coming they also wither away)

Another participant in the Hyderabad FGD also mentioned the similar practice in following words:

Parday ka intezam kahan hota hay, koi lehaz nahi hota. Compounder larkay wahin ghoom phir rahay hotay hain. Parday wali cheezain hoty hain magar wo usko khainch ker agay kernay ki bhi zehmat nahi kertin. FGD Hyderabad

(There is no system of privacy. There is no respect. Compound boys are roaming in the same area)

The presence of men in the check up room was also mentioned by one of the participant in the FGD in Hyderabad in the following words:

> *Once the staff took me inside the room of the senior doctor for check up. There was standing a group of doctors including male doctors. I asked why are males here and the staff replied that they were there to have meetings with madam (the doctor). Why the Hell were they having meeting here, I thought. There was no special consideration of privacy.*

A participant in the Rawalpindi FGD related her unwillingness to deliver in a public sector facility with the lack of privacy and care in the following words:

> *Meray samnay uss lady ko unhon nay bahar wash room main bhej dia. Uska bacha wahin washrrom main ho gia. Hazaro mard uss aurat ka scene dekh rahay thay. Ussay kuch mard or aurtain utha kay itnay buray tareeqa say ander lay gaya. Mera uss waqat nawn maheena tha. Main wapis aa gayee ghar per. Main nay kaha main nay to idher nahi kerana, ghar hi theek hay.*
>
> *(They sent a woman to the washroom outside. She delivered over there. Thousands of men were seeing her. A few men and women took her inside in a very bad manner. I was having my ninth month of pregnancy. Having seen this I returned home and decided not to go to hospital for delivery and get my babies delivered at home)*

Another practice quoted regarding the lack of privacy was the bed sharing. This was expressed more frequently in the Rawalpindi FGDs as compared to other locations probably because of the big population and high client load in tertiary care hospitals. One of the participants from Rawalpindi FGD shared:

> *Aik aik bed per teen teen aurtain hoty hain. Check up bhi samnay hi kerty hain aik hi bed per.*
>
> *(Three women are lying on each bed. They also do the check up of each one in others presence)*

NON–DIGNIFIED CARE (INCLUDING VERBAL ABUSE)

Non-dignified care refers to violations of the right to dignity and respect of women, including verbal abuse. Of all the seven categories, non-dignified care practices appears to be the most prevalent in Pakistan's public sector maternity care system. Of the various observations made by the participants, the most mentioned area in this regard was verbal abuse. Doctors were frequently mentioned to talk harshly, abuse, pass sarcastic remarks, scold and yell both at women and at their attendants across all locations of the FGDs.

Of the various expressions that doctors were mentioned to use, one was particularly mentioned and in all FGDs that was about referring to marital relationships of women. One woman in Rawalpindi FGD was said the following:

> *Main apni behan kay sath gayee thee aur labour room kay samany kharri thee. Aik aurat shor ker rahyee thee kay meray mian ko bula do. Doctor nay kaha jab mian kay paas laitaty ho uss waqat khial nahi ata ab main mian kay paas nahi choorron gee. (Rawalpindi FGD)*
>
> *(I had gone with my sister and was standing in front of a labor room where a woman was crying that "call my husband". The doctor said, "Don't you think about this when you sleep with your husband, now I will not let you go to your husband")*

Another participant in the Abbottabad FGD also referred to the similar kind of verbal abuse by doctors in following words:

> *Pehlay sharam nahi aye, ab cheekh rahy ho.*
>
> *(You were not shy while having marital activities and now why are you screaming)*

Doctors and staff were observed to be more abusive when women screamed while during delivery. A participant in the same FGD quoted this kind of verbal abuse in the following words:

> *Agar delivery ky doran aurat cheekhay to kehti hain kia pehlay nahin pata tha k ye hoga. (Abbotabad FGD)*
>
> *(If a woman screams during delivery, they say, "didn't you know this earlier?")*

Similar observation was made in the FGDs in Rawalpindi. A participant said:

> *Jo shor karti hain unhain kehti hain har sal a jati hain or aisay bhi kehti hain k Pehlay mazay laity ho ab a jaty ho yahan cheekhain marti ho. Iss tarah ki zuban har doctor ki hoty hay. (Pindi DH FGD)*
>
> *(Those who make noise, the doctors say to them, "you come here every year" and also say, "first you enjoy and then scream over here". Every doctor uses this kind of language)*

In addition to referring to the sexual relationship, the doctors were also mentioned as referring to the family making aspect of the woman. For instance in Hyderabad FGD, one of the participant said:

> *Mera ye teesra bara operation tha mujhay doctor dant kar kehnay lagi tumhain kia lachari thi phir bacha paida karnay ki. Ghusay say bol rahi thi. (Hyderabad FGD)*
>
> *(I was having my third C Section; the doctor scolded me saying that what was your problem that you are having third childbirth. Was talking angrily)*

No one cares, treats very disrespectfully especially when one screams, scolds when one is pregnant, no respect, no dignity for pregnant women, inhuman treatment, were the frequently used expressions of participants in all FGDs while mentioning their experiences of treatment in public sector hospitals during seeking maternity care.

> *Doctor bilkul pagal huyee bethy thee. Kehnay lagi kia masla hay bibi. Tumhein thorry see bhi takleef hoty hay to bhag ker aa jaty ho, zara see bhi bardasht nahi hay tum main. (Hyderabad FGD)*
>
> *(Doctor was mad. She said to me, "What is your problem, you feel little pain and run to hospital, don't you have little tolerance)*

> *Sarkari haspatal main to buhat bura hal hay. Yahan to aurat ko kutoon wali ihmiat nahin di jati . Rawalpindi FGD*
>
> *(The situation is very bad in public sector hospitals, Here the women are treated not even like dogs)*

> *Sarakari hasptal main hamain izzat nahi milty. Main to kehty hun mar jaun to mar jaun per civil na jaun. Hyderabad FGD*
>
> *(There is no respect in public hospital. I say better die rather than going to public sector hospital)*

A participant in the Jamshoro FGD mentioned slightly better behavior of doctors in the Outpatient Department (OPD) as compared to in labor room.

> *OPD main kuch behtar hay. Andar doctors bohat danataty hain. Gareeb ki koi izzat nahi isslia ham wahan nahi jatay.*
>
> *(It is little better in OPD. Inside the labor room the doctors scold a lot. Poors are not given any respect that is why we don't go there)*

A similar difference between OPD and labour room was also mentioned in the FGD in Swabi in the words of one participant:

> *OPD main rawaya behtar hota hay. Labor room main jo shor machahty hain unhain dant party hay.*
>
> *(It is little better in OPD. In labor room those who make noise face scolding)*

Disrespectful and abusive treatment was mentioned at all the different levels a woman undergoes while seeking care in hospital. For example one participant in the Rawalpindi FGD said:

> *Jab check up kaylia jaty hain to pehlay to jo bahar kharri hoty hain wo bohat zaleel kerty hain.*
>
> *(When we go for check ups first those staff who are sitting outside treat us in non-dignified manner)*

Staff other than doctors were also mentioned to be very disrespectful with women seeking maternity care in public sector hospitals. For example, a participant in the FGD in Rawalpindi shared that the aya (midwife) viewed her with suspicion. She described the behavior of midwife in the following words:

> *Wahan tau aya bhi bohat dantaty hay,kehty hay, zaroor tum nai kuch kia hoga, isslia zaya ho gia. Ab idher aa gayee ho. Main ayenda nahi gayee.*
>
> *(The midwife in public hospital also scolds a lot, says, "you must have done something wrong that you had miscarriage, and landed in here now". I never went there again)*

A participant in the Rawalpindi FGD while narrating her observation at hospital mentioned the disrespectful behavior of the doctor in following words:

> *Abhi jab main haspatal main thee, meray samnay aik aurat dardain lay rahy thee. Doctors or staff ko bula rahy thee or uska wahin zameen per baithay hi bacha ho gia. Staff nay aa ker ussay ulta danta or kaha tum neechay say uthy kion nahi, ab yahan per hi parry raho or chalay gayee. Ham do char aurton nay milkar ussay uthaya or ooper bed per laitaya. Sarkar hasptalon main gair insanni salook hota hay. Isslia main nay apnay donon bachay sarkari hasptal ki bajay ghar main paida kiay.*
>
> *(When I was in hospital, a woman was undergoing labor pains and calling for doctors and staff and delivered on the ground. Staff came and shouted at her instead of helping her and said, "why didn't you get up from the ground, now keep lying here on the ground" and she went away. I along with some other women around her helped her and got to bed. There is inhumane treatment in public sector hospitals, thus I got my two kids delivered at home)*

In the Abbottabad FGD, a participant mentioned the similar kind of disrespectful treatment of women in the following words:

> *Hamla aurat ki koi izzat nahi hoty. Doctor hamesha hamla aurat kaysath badtameezi say paish aty hain.*
>
> *(There is no respect of pregnant woman. Doctors always treat pregnant women disrespectfully)*

Doctors were also mentioned to scold when women could not push with labor pains. For example one woman in the Rawalpindi FGD mentioned:

> *Main do dafa gayee hon. Meray sath dono dafa hi aisa hua kay bohat dantaty hain. Kehty hain pain lo. Ab pain nahi hota to kaisay lun.*
>
> *(I have twice been to hospital and had the same experience every time. They scold a lot. Say that push, now if I don't have labor pain how can I push)*

DISCRIMINATION BASED ON SPECIFIC ATTRIBUTES

Discrimination based non specific attributes was also mentioned by participants across all sites. Poverty was the attribute mentioned in this regard. For instance a participant in the Swabi FGD mentioned:

> *Gareeb ki koi izzat nahi hoty, koi acha khata peeta chal jayay to uss say bohat izzat say bat kerty hain or treat kerty hain - Swabi*
>
> *(There is no respect for the poor, if some well off person goes then they talk and treat in a very respectful manner to her)*

A similar impression was conveyed in the other FGDs. Clothing and appearance was the manifestation of social status that was noted to be affecting the behavior of providers. For example, one participant in the Hyderabad FGD said:

> *Agar apnay achay kappray pehnay hain to wo kuch behtar tareeqay say paish aty hain - Aap kabhi hulia badal ker jayen bilkul gaon ki luty phuty aurat kay roop main phir unka salook or rawayeea aapko pata chal jayega*
>
> *(If you are well dressed then they behave with you in better manner - if you ever go there like a poor devastated rural women then you will realize how bad their behavior can be)*

Similary another participant in the Abbottabad FGD mentioned the same practice in the following words:

> *Agar aap hulyay say gareeb lagtay hain to wo acha salook nahi kertin, or agar koi achay status wala ho to uss say achi tarah paish aty hain*
>
> *(If you look like poor by your apparel etc then they will not treat you in good manner, if someone has a better social status then they will treat in better manner)*

Another participant in Hyderabad mentioned that doctors even tell poor to sit away from them:

> *Sarkari mainkoi izzat nahi milty, ham gareeb jayen to kehty hain door betho door, tum log naha ker nahi aty*
>
> *(There is no respect in public sector hospital, when we poor go they say us to sit at a distance from them and that you don't come after taking bath)*

Another participant in the Rawalpindi FGD expressed that respectful treatment is more certain if you have better status:

> *Status say bohat faraq parrta hay zahir hay wo phir achy tarah bat kerty hain*
>
> *(Status causes a lot of difference; obviously they talk in better manner then)*

Whereas status/poverty was repeatedly mentioned to deprive the women of respectful treatment and care, an interesting observation noted in the Rawalpindi FGD was the ill effect of looking better i.e. staff/doctors being skeptical of the those seeking care from the public sector who were well off:

> *Magar ye bhi aksar hota hay agar ham achay khasay huliya main hain to kehty hain kam az kam jo paisay wali hain wo to yahan na aya kerain, jo afford ker sakty hain wo to hamaray sir na charrhain - Pindi*
>
> *(This also happens quite often that if we are in good apparel then they say, "at least you should not come here, those who can afford should at least not burden us")*

ABANDONMENT OR DENIAL OF CARE AND DETENTION IN FACILITIES

Several sub-categories of practices emerged from responses grouped under the abandonment and denial of care category. Leaving the woman alone/absence of doctors/staff around the woman was the most mentioned practice by participants in all the FGDs. Staff going away with the newborn to the attendants from recently delivered woman to collect gifts, leaving the woman alone after administering the drip were the practices mentioned by participants in this regard. A participant mentioned this practice in the Abbottabad FGD in the following words:

> *Hamala aurat ko labor room main akaila chorr daity hain or jab delivery ka waqat ata hay to phir aty hain.*
>
> *(They leave the pregnant woman alone in labor room and come only when she is about to deliver)*

Another participant in the Abbottabad FGD mentioned a similar situation in the following words:

> *Staff shru main drip laga ker chaly jaty hay or phir jab aty hain jab aurat deliver kernay wali hoty hay. Iss doran wo nahi atin kay dekhain mareez ki kia halat hay.*
>
> *(Staff gives drip in the beginning and goes away. They come again when the woman is about to deliver and does not come during this time)*

A participant in the Swabi FGD said:

> *Labor room main akela chorr daity hain thorry dair kaylia or phir aa jaty hain.*
>
> *(Leave the woman alone in labor room for sometime and then come back after sometime)*

A participant in the FGD in Hyderabad mentioned the same practice in following words:

> *Akela chorr daity hain or chaly jaty hain.*
>
> *(Leave alone and go away)*

A participant in the FGD in Rawalpindi mentioned this practice in the following words:

> *Wo chalay jaty hain or aurtain aik doosray ko dekhty rehty hain dardain laty hain or cheekhty rehty hain.*
>
> *(They go and women keep looking at each other, keep bearing pains and keep screaming)*

Another woman in the Rawalpindi FGD narrated her observation about this practice as follows:

> *Aik dafa main delivery kaylia gayee to labor room main pehlay say aik aurat akely birth position main bagair kappron kay laity huyee thee. Jab main ander gayee to uss nay mujay kaha please meray kissi jannaay walay ko bahar say bula dain kay mujay shlwar to pehna day. Sara blood aur sara hissab kitab waisay hi neechay parra tha. Aya bachay ko lay gayee thee, rishtay daron say paisay lainay, phir nursery lay gayee, wor aurat beechary kitny dair akely waisay hi pary rahy. Rat ka sarrahay giara bara ka time tha. Pindi*
>
> *(Once I went for delivery, a woman was already lying uncovered in delivered position. When I went inside, she said to me, "Please call someone from my attendants outside so that at least they can make me wear trousers. The blood and other stuff from delivery were lying there. The midwife had gone with the newborn to receive gift (money) from the attendants and then took the baby to nursery. That poor woman kept lying alone there for quite a time. It was midnight)*

Staff appearing only when head of the baby appears during labor, staff/doctor not coming despite being called by the women herself and their attendants, were the other practices mentioned by participants while describing their experiences in hospital. A participant in the Swabi FGD mentioned:

> *Main jab sarkari haspatal gayee, whan mery delivery honay wali thee, bohat dard ho raha tha, mera shohar nurson or doctoron kay peechay bhagh raha tha magar koi twaja nahi day raha tha.*
>
> *(When I went to a public sector hospital and I was about to deliver and having severe pains, my husband was running after the nurses and doctors but no one was paying any attention)*

A participant in the same FGD mentioned about staff coming on their own willingness and not considering the patients' needs in the following words:

> *Doctor or staff apnay time per aty hain, jam hamain zroorat ho ya bulain to nahi aty hain.*
>
> *(Doctor and staff only come on their own time, they will never come when we need them or when we call them)*

A participant in the Hyderabad FGD mentioned a denial of care because of the shift change in following words:

> *Mujay dard ho raha tha, main nay nurse say kaha kay mujay dard ho raha hay to kehnay lagi keh hamari duty nahi hay or ab doosry ayaegee to dekhay gee. Mery behan unkay peechay ghoomti rahy kay injection to laga do dard ka magar unhon nay nahi suna.*
>
> *(I was having pains, I said this to nurse. She said that I am no longer on duty now the second nurse will come and check you. My sister kept running after them that give her injection for pain but they never listened to her)*

Denial of care was also done as a reaction to a woman's or their attendants' complaints. In the Abbottabad FGD, a participant mentioned about this in following words:

> *Agar koi shikayat kerta hay tau wo mareez ka hath pakarr kay kehty hain kay lay jao issay yaha say.*
>
> *(If anyone complains, the doctors then give you the hands of your woman saying that take her away from here)*

Another woman mentioned the same aspect in the following words in the FGD in Rawalpindi:

> *Jo aurtain sahi illeaj na honay per larrty hain, gussa kerty hain unhain wo check hi nahi kertin, kehtyhain kay chaly jao.*
>
> *(The women who make noise and react on not having good care get themselves deprived of whatever care they could get earlier. The doctors ask them to leave without checking)*

The staff and doctor do not turn up even when they are called by attendants or women. A participant in Rawalpindi mentioned this state of affairs in the following words:

> *Check nahi kerty, baar baar unhain bulatay raho nahi atin, bilkul ain time ho phir aty hain.*
>
> *(Do not check, you may keep calling them again and again, only come on last moments)*

The practice of not providing the care is sometimes so strong that even the physical manifestation of the patient's worse conditions could not convince the doctors and providers to attend the patient. A respondent from the Rawalpindi FGD tells her story of the death of her first child in the following words:

> *Mera pehla bacha zayay ho gia tha. Mery bohat bleeding ho rahy thee, Main raat ko 12 bajay hospital chaly gayee. Whan koi tawaja nahi thee, main jab bayhosh ho ker gir gayee to wo bohat gussa huyee or kaha kay uth jao idher say. Subah 7 bajay tak kissi nay mujay check nahi kia. Mery halat mazeed kharab ho gayee. Main nay apni bhabhion say kaha mujay lay jao yahan say merna to hay hi. Phir mera shohar mujay qareeb private laygia.*
>
> *(I lost my first child. I was having a lot of bleeding. I reached hospital at around 12 in night. There was no one attending the patients, I fainted and fell down. The staff got angry at me and said go away from here. No one checked me till 7am and my conditions aggravated. I asked my sister in laws to take me from that place saying that I will die but why here. Then my husband took me to a private facility)*

The other frequently mentioned practice of denial of care was that doctors did not conduct the physical examination of women. The various frequently used expressions mentioning this form of denial of care included: **send** back without checking, checking only on last moments of delivery, not at all conducting physical examination in OPD, only writing Ultrasounds. Another related manifestation was the high reliance of senior doctors on junior doctors and nurses. The expressions frequently used to mention this state of affairs included: senior doctors not conducting examinations and only making juniors do so, doctors sending women to nurses saying that they would explain.

One participant in the Hyderabad FGD reflected upon this state of affairs in the following words:

> *Barry doctorny aty hay, choty doctorny ko bol ker chali jaty hay kay tum dekh lo mareezon ko, or jo choty doctorny ko takleef batain to wo phir uskay mutabiq likh dety hay magar hath laga kay check nahi kerty, sirf ultrasound likh dety hay.*
>
> *(The senior women doctor comes, pass directions to junior doctors that they may check the women and go. The junior doctors might write in the light of what we tell)*

Another participant in the same FGD said:

> *Doctor hath laga ker check bhi nahi kerty, aur tau aur hamain door bethaty hay or bohat dantaty hay kay bibi aisay to bibi waisay.*
>
> *(Doctors do not conduct physical examination, in addition that, they tell us to sit away from them and scold)*

In another response by one of the participant in Jamshoro, the doctor suggested the lack of bathing by the patient was the cause of doctors not conducting her physical examination:

> *Doctor kehty hay, door ho kay betho, tum naha ker nahi aty ho to hath say kia check kerain gee.*
>
> *(Doctor says stay away from me, you do not take bath so how can we check you physically)*

Another participant in Rawalpindi mentioned about staff writing numerous investigations without physically examining and the absence of any physical examination practices altogether in OPD in the following words:

> *Fata fat unki bat suny or kehty hain chalain jee agla mareez bhejain. Test to wo beshumar likh dety hain, hath laga ker bilkul check nahi kertin. Sirf delivery kay akhery waqt check kerty hain wo bhi kabhi kabhi. OPD main to bilkul nahi kertin.*
>
> *(Listen quickly and ask the staff to send the new patient. Write countless investigations and do not do phycial examination. Only check in the last moments of delivery and that too on a very few occasions. Do not check at all in OPD)*

A slight deviation was observed in the Swabi FGD when one of the participants mentioned doctors conducting physical examinations before doing ultrasound and other investigations. This may be due to the fact that Swabi is the constituency of the current health minister and is thus getting more attention:

> *Sarkari haspatal main pehlay doctor poora muayeena kerty hay phir ultrasound kerty hay or test kerty hay.*
>
> *(In public sector hospital, the doctor first conducts a complete physical examination, then does ultrasound and other investigations)*

A participant in the Rawalpindi FGD told of the fetal death of her fellow woman (who was also participating in the same FGD) whereby they attributed the death of child to the doctor not conducting the examination and misjudging the situation of the woman and fetal health.

> *Ye jo bethy hay iska pehla bacha zaya ho gia tha. Isko pehlay dardain lag gayeen theen or halka saa dag laga tha. Issay haspatal lay gaya whahn doctor nay kaha kuch bhi nahi hay na ander say check kia na bahar say bas ghar bhej dia or bacha ghar zaya ho gia. Wahan aisay hi kerty hain, kehty hain agar dag laga hay to pehlay pad check kerwao manty nahin hain.*
>
> *(She lost her first child. She had premature pains and had slight spots. We took her to hospital where the doctor said that there was nothing wrong. She said this without conducting any physical examination and sent her back home where the child died. The doctors commonly do this, they do not give value to what careseekers tell them. Regarding spotting, they ask to show the sanitary pads and would never listen to what careseeker says)*

The doctors were described making women wait for assistance during labour until the fetal head starts appearing. This was mentioned in the following words by a participant in the Rawalpindi FGD:

> *Jahan tak sarkari hasptal ki baat hay,wahan to jab tak bacha bahar nazar na aa raha ho hath hi nahi lagaty. Mery jab bachi paida huyee to main cheekh rahy thee, doctor nay kaha jab tak bacha bahar nazar nahi aye ga ham hath nahi lagayaengay tum cheekhain na maro, ladies ki koi respect hi nahi.*
>
> *(When we talk about public sector hospital, the doctors do not touch you until the head of the fetus appears. When I was giving birth to my daughter I was screaming, the doctor said that unless the head of the child appears we are not going to touch you so do not scream…there is no respect for women)*

Another malpractice observed by the participants was referring women without checking. This was mentioned with respect to Rural Health Centre staff. A participant narrated her story in the following words:

> *Meray pehlay do bachay dayee kay haton mar gaya thay (neelay parr gaya thay paida honay ka baad). Mera shohar hasptal nahi lay ker jata tha. Ab mujay dardain shru huyeen to main paidal ghar say nikal ayee. Yaha ghar say qareeb RHC hay. Wahan andar kissi tarah dardon main paidal chal ker pohanch gayee. Wahan gayee to doctor nay bola ham apka case nahi lay saktay, aap barray haspatal jayeen. Main nay bataya bhi kay main akeli aye hun paidal, phir bhi unhon nay nahi lia, jab main wapis murry derwazay per hee the RHC kay, mera bacha udher hi deliver ho gia.*
>
> *(My first two children died at the time of birth because of being delivered by a Traditional Birth Attendant (turned blue after birth). My husband did not take me to hospital. This time when I started to have pains I went to hospital on foot. RHC is near to my house. Somehow with pains I was able to reach inside of RHC. When I reached there the doctor said that we cannot take your case you have to go to the big hospital (THQ). I told her that I have come alone, this did not cause any effect on them and they still denied the care. When I returned and had barely reached the door of RHC, I delivered baby there)*

Another set of practices that were frequently mentioned by the participants, and broadly can be categorized under denial of care, were related to the time factor. Long queues, long waiting times, poor waiting arrangements and related conditions were frequently mentioned in this regard. A participant in the Rawalpindi FGD mentioned this situation in the following words:

> *Jab haspatal jayen to itny lmbi line hoty hay kay banda khara ho ho ker hi thak jata hay, itna barra pait uthaya huay aurton ko unhon nay kharra kia hota hay, baithnay ki koi jagga nahi hoty*
>
> *(When we go to hospital, there are long queues that we get tired by standing in those queues. They make women stand with such abdominal conditions; there are no places for sitting)*

A participant who had recently visited the district headquarter hospital shared her observation of the fight for seating as follows:

> *Main parson gayee thee, jo hamla aurtain hain kuch dhoop main bethy huyee theen or baqi kharry theen. Aik kursy say uthy to unhon nay kursy kaylia aik dosray kay balon main hath daldiya, larry itnay burray tareeqay say keh koi hisaab hi nahi Pindi*
>
> *(I was there day before yesterday, some of the pregnant women careseekers were sitting and others were standing. When one of the sitting women left the others fought ferociously for the chair that was left empty by her)*

Another woman in the Rawalpindi FGD mentioned the waiting duration of almost 10 hours after which they get a chance to see the doctors in following words:

> *Subah panch bajay jaty hain or dopehar ko teen sarrhay teen bajay wapsi hoty hay in hamla aurton ki*
>
> *(The pregnant women have to go at 5 in morning and return in 3 or 3.30 in the afternoon)*

The issue of long waiting times was even reported with respect to emergency services of the hospital. A participant in Rawalpindi mentioned:

> *Ham apni behan ko laikar Rat ko naun bajay hasptal ki emergency gaya itna rush tha log linain laga ker baithay thay, kehnay ko wo emergency hay magar sirf nam ki, linain lagy hoty hain.*
>
> *(We took our sister in an emergency to the hospital at 9pm, there was huge rush and long queues, this was emergency to be called only actually there was nothing sort of expected from emergency unit)*

A participant from the Jamshoro FGD mentioned the same issue as a necessary thing to happen when you go to seek care:

> *Agar dakhla day bhi dain to bohat intezar kerwatay hain*
>
> *(Even if we succeed in getting checked up, they would make us wait a lot)*

Another important factor that appears to be a barrier for pregnant women in accessing care is the registration pre-requisite for admission that is upheld by the staff to the level that it may even compromise the care. A participant in Abbottabad mentioned about this barrier in the following words:

> *Card kay bagair case nahi laitin, chahain mar bhi jayan agar card nahi bana hua to nahi laitin*
>
> *(They would not admit you for delivery even if you are dying when you are not already registered with them)*

Another participant in the Rawalpindi FGD mentioned the same situation even for an emergency in the following way:

> *Card kay bagair bhi aurat ka case nahi laitay chahay emergency main hi jayen, card kay bagair nahi laitay chahay kuch bhi ho, agar bacha ghar main paida ho jaya or koi masla ho phir bhi nahi laitay kehtay hain pehlay delivery idher kerty to laiatay ab nahi.*
>
> *(They do not take pregnant woman case without registration card even if we go to emergency. They would not take your case whatsoever happens if you don't have a card. They would not take the case when you have delivered at home no matter what worse situation you are facing at that time. They say that if you would have delivered here then we would have taken your case)*

A participant in the Rawalpindi FGD related the story of a fatal death due to antepartum hemorrhage of her cousin who was denied care by hospital due to the woman not being pre-registered with them. She narrated the story in the following words:

> *Mery jethany ka khoon jana shru ho gya tha delivery say pehlay, srkari haspatal walay nahi lay rahay thay, aik haspatal say dosray haspatal ghoomtay rahay , itnay haspatalon main ghumaya or phir bacha bhi marra hua paida hua*
>
> *(My sister in law had antepartum hemorrhage, public sector hospital administration was not taking the case, we kept roaming from one hospital to other and the child died)*

In addition to women being denied care due to not being registered with the facility, another important observation related to denial of admission card itself. For instance, one of the participants in the Hyderabad FGD mentioned that women are denied registration if they come to facility in the last trimester:

> *Chatay ya satwain maheenay kay baad card nahi banaty chahy kuch bhi ho jaya*
>
> *(Do not give registration card in sixth or seventh month what so ever happens)*

A similar denial of registration was mentioned in Jamshoro in the following words:

> *Pehlay dakhlay kaylia jatay hain to dakhla nahi daitay, number day datay hain- aj nahi kal ana,chahay poora time ho chukka ho*
>
> *(When we go for admission they do not give it, put us on turn - not today but come tomorrow even if you are on full term)*

Another reason of denial care at Rural Health Centre (RHC) level related to the women being primigravida as mentioned by one of the participants in the Rawalpindi FGD.

> *RHC main pehly delivery nahi laitin or waja bhi nahi batatin*
>
> *(Do not take primigravida in RHC and also do not tell the reason)*

Receiving the highest level of health care is the right of all women. Cleanliness is also one of the important elements of the quality of care. The participants made a number of observations about the lack of cleanliness in the health facilities where women receive maternity care, along the various stage of maternity cycle. One of the participants in the Hyderabad FGD said:

> *Safayee bilkul nahi hoty*
>
> *(There is no cleanliness at all)*

A similar situation was mentioned by participants in the Swabi FGD in the following words:

> *Safay ka intezam nahi hota, labor room or bath room bohat ganday hotay hain*
>
> *(There is no system of cleanliness, the labor rooms and wash rooms are very dirty)*

A participant in the Rawalpindi FGD expressed her dissatisfaction with the cleanliness in the health facility in the following words:

> *Hasptal main itny gandagi hoty hay kay wahan to beemar ho ker wapis ao*
>
> *(There is so much garbage in the hospital that you will return with sickness)*

Another participant added:

> *Wahan itni gandagi hay kay app kharray hon to qay anna shru ho jaty hay. Labor room main blood waisay hi parra hota hay, koi safayee nahi hoty*
>
> *(There is so much garbage in hospitals that you will start vomiting if you stand there for a while. The blood keeps lying on floor, no cleanliness)*

The time of day was also mentioned as affecting the delivery of care. In the evening and nights, participants described the absence of staff. For example, one participant in Swabi said:

> *Rat main or sham main doctor nahi hotin.*
>
> *(There is no doctor in evening and in night)*

The attitude of the staff was also seen to worsen in the night time, along with observation of some wrong practices. For example, in the Rawalpindi FGD one of the participants stated:

> *Raat main to jang ker kay baithay hotay hain. Choti umer ky hoty hain or mobilon per lagi hoty hain.Agar kahain kay drip wagaira check ker lain to agay say gussay say bolty hain kay apko pata hay ya hamain.*
>
> *(In night they are like ready to fight mode. The doctors are young and mostly busy chatting on mobile phones. If someone asks them to look at the drip etc, they reply that we know better than what you know)*

Relationships with society elites such as political representatives, with hospital staff along with bribes in different forms were also seen to affect the delivery of services. Those who were resourceful in this respect would get services. For example, one of the participants in an FGD mentioned about care being provided only with a reference in the following words:

> *Sifarish say sara kam ho jata hay. Mery nand ko dard ho rahay thay laikan ussay dakhla nahi day rahay thay. Phir jab reference gia unhon nay forum admit ker lia or operation bhi ho gia.*
>
> *(Everything gets done if you have a reference. My sister in law had pains but they were not giving admission to her. When we got a reference then they admitted her immediately and the operation was also conducted)*

Another participant in the Rawalpindi FGD mentioned how staff provided care only in return for a bribe.

> *Sifarish to bohat chalty hay. Agar sifarish ho to ap ka kam sab say pehlay ho ga- whan jo staff thee wo hamaray paas aty thee or kam kerty thee hamara agar ussay paisay daitay thay werna nahi kerty thee*
>
> *(Reference is used a lot. If you have a reference you will get services first of all- the staff over there used to come to us and provide us services when we gave her money, otherwise she would not do that)*

A similar observation came from a participant in the Hyderabad FGD in the following words:

> *Sifarish agar ho to kam jaldi ho jata hay, sifarish bohat chalty hay*
>
> *(If you have a reference you will get the services quickly, reference is used a lot)*

In Swabi, one of the participants referred to accessing medicines through reference as follows:

> *Sarkari dwayeean nahi miltin. Sirf jan pehchan walon ko daitay hain.*
>
> *(You will not get medicine from public sector. Only those who have references would get the medicine)*

In Abbottabad, an FGD participant mentioned getting checked up when having used some reference.

> *When use links than they check up*

GRIEVANCE REDRESS

An inevitable part of any system of service delivery is the grievance redress mechanism which require users to register their complaints at the appropriate forums provided in the system and for action to be taken in response to those complaints. Effort was also made to gain insights into this aspect of services delivery. Across all the data collection sites, participants predominantly reflected upon the ineffectiveness of any such system to the extent that it may be safe to draw the conclusion that any such system is practically non-existent and the careseekers have accepted it as a reality to a level of complacency. The doctors and **staff** were mentioned to be free of any fear of moral, ethical, or institutional accountability in this regard.

In government hospitals, complacency appears to exist that such things would happen, and society appears to have accepted this state of affairs. In some instances, the respondents mentioned the doctors' anger as a normal thing and recognized the right of doctors to misbehave with women. Internalization of the lack of trust in the system, hopelessness, fear of aggression, which can involve their males also in fight with staff, complacency that doctors getting angry is normal, the lack of opportunities to seek care from elsewhere, fear of denial of care due to raising their voice - and all these factors reinforced by socio-economic poverty - push women and their caretakers into the conspiracy of silence on the denial of care.

A participant in the Hyderabad FGD reflected upon this grey area in the following words:

> *Bas rotay hain, yahan sab aik jaisay hain koi muslaman nahi, doctor or amla ham say kehta hay jahan chahay wahan shikayat laga lo*
>
> *(Just cry, here all are same, no one is Muslim, the doctor and staff say that you may complain wherever you wish)*

In Swabi, one of the participants mentioned that all staff work in a network therefore rendering any such effort ineffective.

> *Agar unkay na dekhnay per ham awaz uthain to wo nahi suntay, in sab ka ander say setting hota hay - Swabi*
>
> *(If we raise any voice, no one would listen as they all are supporting each other in this system)*

The care seekers have to face denial of care if they raise any voice. One of the participants in the Abbottabad FGD mentioned this situation in the following words:

> *Agar illaj sahi na honay per ham awaz uthain to doctor hamla aurat ka hath uskay ghar walon ko day ker kehtay hain kay issay lay jao ham nahi dekhtay*
>
> *(If we complain about any services issues, the doctor hands over the pregnant woman to her family saying that we will not examine her and you may leave now)*

Another participant from the FGD in Rawalpindi also descrbed the same situation in the following words:

> *Agar koi aurat awaza uthahty hay, ussay wo check hi nahi kerty, kehty hay chaly jao*
>
> *(If some woman raises complaint, they do not check her, they ask her to leave)*

DIFFERENCE BETWEEN PRIVATE AND PUBLIC SECTOR

The private sector is also an important provider of maternity services. The services provided by private sector were more often described by participants as better than those being provided by the public sector. The better care in private sector was attributed to the high cost of such services. Patient-provider interaction was especially mentioned as being better by one participant in the Rawalpindi FGD in the following words.

> *Bohat faraq hay private or sarkari main. Pvt main bohat care hay, achay tareeqay say bolty hain, Zahir see baat hay agar paisay laitay hain to care to dayngay*
>
> *(There is big difference in private and public sector. There is lot of care in private sector, they talk in good manner. Obviously if they charge so high, they will also give better care)*

A similar observation was made by another participant when she talked about the better cleanliness and better frequency of check ups in the private sector:

> *Ab jab paisay day kay banda jaya to Jee Bismillah to hoty hay. Private main her panch minute baad safayee hoty hay. Nurse pad change kerty hay, baar baar check up hota hay. Private main care ziada hay*
>
> *(Now when you give so much money then naturally you will be welcomed. In private sector they clean after every five minutes. Nurse changes pad, the check up is done again and again. There is more care in private sector)*

A participant in the Hyderabad FGD also described the differences between private and public sector in the following words:

> *Bohat faraq hay - mujay barray operation ka bataya tha. Civil main mujay time hi nahi dia, mujay takleef ziada ho gayee thee, phir main nay private dekhayaa. Pvt main paisay laitay hain isslia achy tarah check kertay hain.*
>
> *(There is a lot of difference - I had to undergo C Section. The Civil Hospital did not give me appointment; my problem was worsening so I had to go to private sector. Private sector takes money so treat well)*

In KP, it appears that women prefer to deliver at home rather than delivering in private facilities:

> *Sarkari haspatal main acha salook nahi hota, ye sab sahoolatain or izzat nahi milty to ham kam jatay hain ghar per hi kerwa laiatay hain private nahi jatay.*
>
> *(The women do not get respect in public sector that's why we get delivered at home but do not go to private sector)*

In KP, it appears that women prefer to deliver at home rather than delivering in private facilities:

SUMMARY LIST OF KEY PRACTICES

PHYSICAL ABUSE PRACTICES
Episiotomy without anesthesia
Slapping, tying the legs to the stretcher
During the night, speeding up the drip for quick delivery, doing more operations rather than giving time

NON-CONSENTED CARE PRACTICES
Not seeking permission before check up
Not permitting the woman to move around, scolding if she does so
Misinformation
Allow to go out of labor room if there is time in delivery, women are allowed to move
Refusing permission for attendant
Doctors talk harshly, abuses, talk disrespectfully, sarcastically referring to the marital relationship, scolds, yells, talks ambiguously, snubs on questioning, scolds if attendant tells re patient
Ultrasound performed by male
Staff do not listen , do not value what patient is saying, just write prescription/investigations
Women not permitted to talk
Procedures not explained
Does not know where to go when comes to hospital
No choice of doctor

No counseling provided
Does not inform the woman about an operation, just gets consent from attendants who are outside
Attendant not informed about what is happening inside the delivery room

NON-CONFIDENTIAL CARE PRACTICES
Taking pains in the waiting area outside the labour room
No privacy, other women present, ward boy moving around, other male doctors present, all women lying uncovered in front of each other and others
Multiple women sharing a bed
Women lying uncovered
Deliveries happening on tables outside labor rooms, on the ground, at the door of the RHC, staff do not receive patients despite of emergencies, if the duty time is over the staff asks the women to come next day irrespective of her condition

NON-DIGNIFIED CARE (INCLUDING VERBAL ABUSE) PRACTICES
No seating areas, pregnant ladies standing, no shade for standing
Junior staff treat women badly, in non-dignified manner
No one cares, treat women very disrespectfully especially when one screams, scolds
Staff outside the labour room treat women with disrespect
Women sent out of the room, insulted and sent out of room

Junior staff (midwives) see bleeding with suspicion
Junior staff (midwives) scold patients
Doctors talk harshly, abuse, talk disrespectfully, sarcastically referring to the marital relationship, scold, yell, talk ambiguously, snub on questioning, scold if attendant tells them about the patient
Women scolded when screaming with pain

DISCRIMINATION BASED ON SPECIFIC ATTRIBUTES PRACTICES
Poor rural women made to sit at a distance
RHC does not take primigravida cases
Misbehave towards the poor, staff scold that those who have no money should not come here, no respect for the poor

ABANDONMENT OR DENIAL OF CARE PRACTICES
Long Queues, pushing, overcrowding, long waiting times
Admission not granted without prior registration
Gives medicine during the first visit only and not in the follow up visits
Senior doctors do not check patients, only tell the juniors to check
Doctor/Staff come in their own time but not when asked/requested
Steal and sell medicines from public facilities
Referral without properly examining

No seating areas, pregnant women standing, no shade for standing
Do not conduct physical examination, sent away without checking, sometimes check only at last moments of delivery, not at all in OPD, only writes ultrasound
First shift doctor will not check women if second shift staff is late in arriving
Doctors send to nurse saying she will describe the prescription
Does not attend a woman in labour without registration card of that hospital despite there being an emergency
Examinations performed very quickly
Women insulted and sent out of room
Deliveries happening on tables outside labor rooms, woman sent to outside wash room and delivered there, on ground, at the door of RHC, staff do not receive patients despite of emergencies, in case the duty time is over the staff will ask the woman to come next day irrespective of her condition
RHC does not take primigravida cases
No doctors /staff around , only come when head appears, do not come despite calling, midwife goes away for taking gifts from attendants, leave alone in labour room, give drip and go away and only come at the time of delivery,
Children lying without being attended to in the nursery, with oxygen masks slipped
3-4 children lying in one incubator
Those who makes more noise are attended less

Multiple women on each bed
Will not attend to a woman who has delivered at home
Do not make give registration cards after 6th and 7th month of pregnancy
Little care provided when shifted to ward (post op)
Blood not cleaned up in the labor room
No doctors available in the night and evening
Staff is in a fight mode in night, are busy on mobiles all the time, talk angrily when asked for something

IN-DEPTH INTERVIEWS WITH EXPERTS

EXISTENCE OF ABUSE AND DISRESPECT

The existence of abuse and disrespect in maternity care services delivery was mentioned by all of the IDI respondents from different backgrounds, both from public and private sector, academia, management, practitioners and civil society. While talking about the existence of abuse and disrespect practices, one of the respondents from KP said:

> *Disrespect and abuse exists. I have seen people slapped and hurt by the physicians.*

A similar situation was mentioned by another respondent in Punjab in the following words:

> *Health System's nucleus is patient s/he is most disrespected.*

Another respondent in Punjab mentioned the gravity of the situation:

> *Disrespect to bohat ziada hay.*
>
> *(There is a lot of disrespect)*

A respondent from Sindh described the situation in following words:

> *Respectful Maternity Care is not at all followed.*

One of the respondents was of the view that between respectful and disrespectful care there is a bigger proportion of practices that are neither disrespectful nor respectful but are exhibiting indifference. Such proportion is like 30:40:30.

The most frequently mentioned aspects of abuse and disrespect included lack of privacy and confidentiality, verbal abuse and lack of consented care by doctors. One of the respondents from Sindh, having background of both public and private sector, depicted the lack of privacy in the following words:

> *One patient is being examined and two or three other patients are talking there, there is no concept of privacy at community level health facilities. There is no set up for privacy, one patient is sitting here, other there, third one is lying, there is no privacy in small places*

A similar situation was mentioned by a respondent from KP in the following words:

> *Will perform a procedure anywhere, in front of anyone, non-consented care is also very high, privacy. Consented is absolutely not practiced*

The situation in Punjab was conveyed in the following words:

> *Aurtain wahan bay parda parry hoty hain. Aik aik bed per teen teen chaar chaar mareez post op main hoty hain.*
>
> *(The women are lying uncovered. There are three to four patients lying on each bed in post op)*

The same respondent shared the practice of obtaining superficial consent in the following words:

> *Consent laitay hain magar bas yeh keh ker kay operation kerna hay yahan sign ker dain or kuch nahi batatay, na mareez ko pata hota hay kay consent kay ander kia hay jaidad likhwa rahay hain ya kuch aur*
>
> *(They take consent but only say that "we have to do operation so sign here" and would never tell anything. The patient would never know about what is written in the form, is it an inheritance transfer deed or anything else)*

The other frequently mentioned aspect was the verbal abuse by doctors of the women who seek care from public sector hospitals. For example, one of the respondents shared his observation of verbal abuse in KP in the following words:

> *I have listened with my own ears such as jahil, ganwar (idiot, illiterate) what have you done.*

Another expert from Punjab conveyed the gravity of the situation in the following words:

> *Main apkay sath wo ilfaz share nahi ker sakta jo wo khwateen doctor labour room main bol rahy hoty hain. Main sun ker heran ho jata hun kay yar ye hamari parrhi likhy khawateen hain or doctors hain or ye ilfaz bol rahy hain*
>
> *(I cannot tell you the words that lady doctors use in the labour room. I get surprised that these women are the educated women of our society and they are saying such words)*

Another MNCH expert from Sindh, who has background of academia, civil society, public sector, conveyed the situation in the following words:

> *Jab patient ata hay to public sector main to greeting ka swal hi paida nahi hota.*
>
> *(When a patient comes, no way she will be greeted)*

Another respondent from Sindh described the situation in the following words:

> *Public hospital especially in tertiary care hospital there is no privacy at all. There is no sensitivity of dignity. Doctor always considers patients someone lower to them in social status and this is reflected in her tone, body language and even the way she uncovers the patients.*

With respect to denial of care, the IDI respondents mentioned the issue of lack of physical examination the most. The expert from Sindh depicted the situation in the following words:

> *Let me tell you, when a patient comes, she will be only asked about symptoms and investigations will be prescribed, no one will examine her. Examination to hota hi nahi (there is no examination).*

The respondents were also asked for their opinion about the difference in private and public sector with respect to abusive and disrespectful maternity care practices. Most of the respondents held the opinion that there is better services delivery in the private sector as compared to public. One of the respondents in Punjab shared his own experience of his wife's preference for private sector in the following words:

> *Biwi kehty hay mujay merwana hay jo sarkari hasptal lay jayengo*
>
> *(My wife said that if you want to kill me that you will take me to public sector hospital)*

Another respondent mentioned the difference in the behaviour of the providers who work in both private and public sector and attributed it to a lesser work burden and high accountability:

> *Same person behaves differently in public and private sector. There is a slight difference in attitude, and there is less pressure in private sector. If there comes a complaint in private sector then your services are terminated. In government it happens vice versa, when there is a complaint against doctor, the doctors go on strike.*

Another respondent depicted the difference in the following words:

> *The same patient if coming in private, I will give her all the services and I will be dealing with her very politely.*

Another respondent attributed the better status of private sector to its accountability mechanisms:

> *There is accountability in private sector. Patient can complain against nurse or doctor to the head.*

The lower incidence of disrespect and abuse in the private sector was also attributed to the commercial aspects associated with the private sector by one of the respondents in the following words:

> *Private sector may have lesser prevalence due to commercialism but regulatory checks do not exist there as well.*

Another respondent mentioned the poor being treated in the same manner in both the sectors. She said:

> *In private sector that deals with the poor, abuse and disrespect happens like that in public sector but not at other levels*

REASONS FOR DISRESPECT AND ABUSE

The experts were asked about the causes of disrespectful and abusive practices observed in the maternity care services delivery. Several reasons were mentioned both on demand and supply sides of the services.

DEMAND SIDE

On the demand side, the most mentioned factor was the lack of awareness of the careseeker about their right to respectful care that is free from abuse. In the words of one of the experts from Punjab:

> *Patient ko apnay right ki koi awareness nahi hay*
>
> *Patient does not have any awareness of her right). We at this level even don't know about our rights and even if someone knows no one has the will to exercise that.*

What kind of awareness is lacking? Another respondent from Punjab shared that:

> *The patients may have some awareness of their right to medicine and also somewhat aware of right to complain if she does not get medicine, but they do not know rights of respectful and free of abuse care, they may not know their right that doctor has to take consent before examining and that staff cannot treat them disrespectfully.*

The lack of awareness of the rights of the maternity care seekers appeared to be reinforced by acceptance of the doctors' poor behavior as normal practice. For example a respondent from Sindh mentioned:

> *Patients think that doctors have a right to tell them where to sit and where not to sit.*

A similar kind of complacency among careseekers with the system was mentioned by another respondent in the following words:

> *Ground reality samajh kar mareez sabar shukar ker laita hay*
>
> *A patient accepts the situation by considering it as ground reality.*

Another respondent mentioned the situation in the following words:

> *Hamari public to bohat achi hay jo her maamlay main kehty hai Allah ki marzi hay.*
>
> *The public is so good that it accepts every odd by taking it as their fate.*

Poverty, illiteracy, lack of education, lack of information about health issues, lack of information about grievance redress mechanisms, fear of deprivation were the factors mentioned by respondents to underpin the lack of demand for respectful and free of abuse maternity care. One of the respondents put these factors together very eloquently when he said:

> *Demand comes in when you are aware, secondly you know redress mechanisms, thirdly whether you like to accept your status in society or tend to challenge the norms. Most of these people are illiterate, poor and also have fear that if they said something then they may be deprived of the free services which they are going to get. The patient is in an extremely compromised position due to all of these issues.*

Another respondent from Sindh said:

> *They are not aware of their rights. Courage will come when there will be literacy.*

While mentioning the lack of information as a key driver of the lack of demand for RMC by women, one of the respondents said:

> *This is primarily due to predominant asymmetrical health information distribution whereby a provider possesses all the information while a patient does not possess any information that increases the chances of exploitation of patients at the hands of providers.*

Another respondent mentioned lack of community participation resulting in a lack of community ownership of the health services as a cause of the situation in the following words:

> *There is no community participation. Community hospital ko own hi nahi kerty.*
>
> *Community does not own hospital.*

SUPPLY SIDE

Respondents mentioned a number of factors that can be grouped together as the supply side factors responsible for disrespect and abuse practices in the maternity care services delivery. The most mentioned factor related to gaps in trainings of health care providers. It was repeatedly mentioned by respondents that the current training of doctors and other health care providers is highly deficient in aspects related to RMC. For instance, one of the respondents from KP pointed out the absence of any training in this regard in the following way:

> *There is no structural training on attitudes and behaviors. All specialists, practitioners, staff, paramedics do not have patient handling trainings, whatever they possess they get it on their own but there is no structural training.*

Another expert from Punjab referred to related gaps in theory as well as in practical trainings of health care providers at all levels in the following words:

> *This topic has never been under discussion, this is not taught, not told, so irrespective of level of care providers they don't have this concept building. They don't even know what to do and what not to do. Nothing is taught during pre-service and in-service.*

An academician from Sindh pointed out the superficial presence of any related content in the medical curriculum in the following words:

> *The trainings methodology does not include this. Neither is it in medical curricula. Students may read it only for examination purposes that they have to greet the patient and take permission but no training for practicing it. No one tells about in daily routine.*

Another respondent from Sindh mentioned about the gaps with respect to context specificity of the curriculum and training and lack of interest of students. She said:

> *It is not in the medical curriculum. The medical education being taught here is not linked with the socioeconomic context of the country. Postgraduates romanticize endoscopic surgeries, robotic surgery, and laparoscopy. We want to climb 100th step first and therefore fall like anything. Community health is nowhere in focus.*

The experts also related it with the overall lack of focus on public/community health in the curriculum. For example one of the respondents stated:

> *Nothing is taught in medical colleges about this and there is no concept of counseling in fact, doctors think that counseling is not their job. Doctors consider "healing" as their job and unfortunately we consider it as a procedure, writing prescriptions, they think their job starts here and ends here.*

Besides the formal curriculum, the students also learn certain things by observing the doings of their teachers, seniors and mentors. Gaps were pointed out with respect to the absence of role models to follow by students in this regard. For instance, one expert said:

> *Neither have they been taught on this nor have they any role model to follow.*

Another respondent traced this issue to the fact that public health is not a priority of the teachers.

> *Doctors and professors don't believe in public health*

The second most mentioned factor assumed by respondents to result into disrespectful and abuse practices during maternity care delivery was the Client Load. High turnover of clients in the public sector was mentioned as adversely affecting the quality of care delivered. In the words of one of the experts:

> *Agar mujay bhi din main 300 logon ko milna parray to shru main main theek bolon ga aur akhir main khud cheekhun ga*
>
> *(If I have to see 300 patients in a day, I will speak appropriately in beginning and by the end I will also be shouting)*

The same reason was quoted by another respondent in the following words:

> *The major reason is the number of patients and the time factor*

Another respondent mentioned the client load being more in gynae obs as compared to other departments, and thus resulting in more abuse and disrespectful practices for women.

> *Compared to other departments, gynae obs main labour main auroton kay sath disrespect ziada honay ki waja bohat ziada workload or pressure hay*
>
> *(Compared to other departments, the high extent of disrespectful practices in gynae obs department is due to huge workload)*
>
> *Providers say that in one time they have to attend 200 to 250 patients in OPD and there is lot of workload in the labour room and ward.*

High client load pushes health care practitioners into practices such as not taking history appropriately. For instance, one of the respondents said:

> *Doctors kehtay hain ham nay 200 mareez dekhnay hain to ham history main ye saray credentials kaisay note kerain gay*
>
> *(Doctors say that we have to examine 200 patients so how can we note all credentials during history taking)*

The respondents attributed high client load to client's high preference for secondary and tertiary care facilities resulting in the overuse of tertiary and secondary care facilities.

> *Jiska dil kerta hay munh utha ker barray hasptal chalay jata hay (Everyone comes to big hospital)*
>
> *(There is a lot of pressure due to many patients in tertiary care owing to patients' preference for going to secondary and tertiary health care facilities)*

Part of this problem was also attributed to the lack of proper referral systems.

> *We don't have proper referral system*

Lack of human resource and lack of infrastructure and seniors involvement in management was also referred to as creating more pressures on the health care providers, resulting in compromised quality of health care.

> *Hamaray paas HR itna nahi hay.*
>
> *(We don't have enough human resource)*

The third most mentioned group of drivers of a lack of RMC in public sector health facilities was Poor Supervision and Lack of Accountability. For example, one of the respondents emphasized the situation in the following way:

> *There is no monitoring and no accountability, aap to khuda ban jatay hain (you become God). As a professor neither you examine patients nor you operate. Technicians operate and doctors give them money. Tech dependent surgeons and medical rep dependent physicians need to be made accountable.*

Another expert described the lack of accountability in the following words:

> *Koi accountability nahi hay, corruption hay, bad governance hay.*
>
> *(There is no accountability, there is corruption and bad governance)*

Another expert mentioned the duty negligence and lack of accountability in the following words:

> *There is no accountability, come hurriedly, do your work and go hurriedly. We have seen our seniors also doing the same.*

The issue of poor supervision was also mentioned by one of the respondent:

> *There is no supportive supervision. There is no reward, there is no supervision and your HR is not motivated*

The other factor with respect to lack of accountability mentioned by respondents was the lack of grievance redress mechanisms in the system. For example, one of the respondent said:

> *There is no proper grievance redress mechanism. Here staff grievances are not being addressed what to talk about patients grievances. In tertiary care there are drop boxes but no proper system.There is no proper grievance redress mechanism. Here staff grievances are not being addressed what to talk about patients grievances. In tertiary care there are drop boxes but no proper system.*

A related factor mentioned in this regard was the lack of knowledge of the public about the grievance redressal mechanisms which may sometimes result in direct aggression towards staff by careseekers.

> *Grievance redress mechanism is there especially in private sector, but people don't know about that. Public sector main medical superintendent hota hay, head of deppt hota hay .(In public sector there is medical superintendant, head of department) but general public may not know about that and therefore people hit doctors and nurses, cause damages*

The fourth most mentioned causes related to political interference, VVIP culture and bribery that were assumed to push doctors to compromise the quality of care for general care seekers. For example, one of the respondents mentioned the political interference in the following words:

> *The MNAs and MPAs have disrupted the system. There is a rush in OPD and those who are referred by these MPAs and MNAs have to be checked earlier which result in others grievances.*

Another respondent mentioned this grey area in the following words:

> *Jin kay paas sifarish hoty hay to unka kam to ho jata hay aur ziad tar mareez jikay paas koi sifarish nahi hoty unko sweeper say laikar doctor tak unhain zaleel kerta hay*
>
> *(Those who have some reference get their needs addressed, and those who do not have any reference are mistreated by all including and not limited to by janitors and doctors)*

Another respondent depicted the sorry state of affairs in the following words:

> *Ye to hamari training ka hissa hay kay jo VVIP hay wo patient hay chahy wo maternity department ka hay chahy wo cardiology ka hay*
>
> *(This is part of our training that VVIP is the patient whether s/he is of maternity department or cardiology department)*

Bribery was mentioned in relation to junior staff. For example, one respondent mentioned:

> *Sweeper to hamesha paisay kay chakar main hotay hain or jo unko paisay nahi daitay unkay sath bura salook kertay hain*
>
> *(Janitors always after money, and those who do not give him money to him have to face bad response from him)*

The fifth most mentioned reason related to the personality issues of doctors such as lack of sensitivity, attitudinal problems and the misuse of power and authority. For instance, one of the respondents mentioned the misuse of power by doctors in the following words:

> *Jo ooper ka level hay doctors ka unhun nay patients say laina kuch nahi hay magar wo whahan perr apni authority jattay hain or unkay sath kuton wala salook kertay hain especially in the labour room*
>
> *(The upper level doctors don't have to take anything from women but they want to show their authority and treat them like dogs especially in the labour room)*

The lack of sensitization was mentioned by a respondent in the following way:

> *Log to ab kisi ki bay izzati ker kay unko ihsaas bhi nahi hota kay unhon nau bayizzati ki hay.*
>
> *(There is no sensitization of providers about RMC. People insult anyone and don't even feel that they have insulted someone)*

Another respondent related the attitude gap with the patient load in the following words:

> *Attitude problem is there. Provider is in a psychological state of mind that she is examining so many patients together and on the other side the patient wishes to have more importance leads to aggravating of the situation.*

for one respondent the doctors had internalized the attitudinal gap and it had become their nature after they had inherited it from their seniors.

> *Ye inki genes main inherent hay.*
>
> *(This is inherent in their genes)*

Gender and social exclusion was also mentioned by respondents as a factor in poor practice of maternity care. For instance, one of the respondents attributed the lack of respect for women in maternity care to the low social status of women in society in general.

> *Either it is a hospital or a bank; being a woman you don't get respect. You are treated so disrespectfully especially in the public sector.*

Differences based on the urban or rural background of women was also mentioned to be a discrimination factor. In the words of one of the respondents:

> *A gynecologist will deal an urban woman differently and a rural woman differently*

RELEVANT POLICIES AND INSTRUMENTS PRESENCE

The experts were also asked about the existence of any relevant policies and tools that pertained to RMC. The only key element mentioned in this regard was the Medical Ethics that is included in the Oath of doctors. For example, one of the respondent mentioned:

> *RMC has usually been dealt under medical ethics*

Other expert expressed the policy vacuum in the following manner:

> *I don't think anything has been done at policy level in this regard. No one has this concept, not only in maternity care but in any other case also there is no such concept.*

Another respondent reinforced this:

> *Policy level per RMC per koi standard nahi banay huya*
>
> *(There are no standards in place at policy level on RMC)*

It appeared that some other instruments on patients' rights have been developed but the attitudinal and behavioral aspects of the client-provider interaction were not included in those. For example, a respondent from KP mentioned:

> *Policy has standards and strategies about rights of the patients but there is no such thing like attitudes and behaviours with patients in policies.*

A similar situation was described in Punjab:

> *Policy level per RMC per koi standard nahi banay huya,*
>
> *(There is no standard on policy level for RMC)*

The respondents also highlighted the non-availability of any such instruments in the system that can help reinforce the RMC practices. Wherever positive practices were being observed, they were attributed to individual interests and attitudes. For example, one of the respondents mentioned:

> *System wise there are no such checks and balances whereby you can say that people adopt RMC, there are individual responses/self practices of providers depending on their trainings, their backgrounds such as culture, morality etc.*

Why is RMC missing in the policies, strategies and instruments that are being used in the governance of health system? The respondents traced it to the lack of attention of the stakeholders in this regard. For example, one of the respondents from Punjab stated:

> *Politicians and bureaucrats are policy level people and they do talk that patients get all the services which include treatment, management and counseling but this is more often a slogan and also does not include attitude of the providers. When they inspect, they only ask whether you are getting medicines and, if a little more, then they will ask whether doctor comes to see you.*

Another respondent focused on the lack of seriousness and political will to resolve this issue:

> *Policy makers, politicians, bureaucrats all know this issue but they are not serious. This issue is not their priority.*

Lack of sensitivity of policy makers on this issue was also mentioned in terms of them not being personally affected:.

> *Policy makers are not personally affected so they don't have any sympathies with the public.*

In the words of another expert:

> *Politicians, policy makers and bureaucrats are not sensitized on this. There has been less work done by NGOs also in this regard.*

The Media is becoming a strong policy influencer in Pakistan. However, it was described by respondents as not covering such issues due to capacity gaps.

> *Media does cover such issues but randomly but they don't have the capacity to look at the things in that manner.*

The lack of focus on this aspect of care by the government was also thought to be missing because of the government struggling to meet wider health care needs:

> *Government is trying to meet the care delivery who would think to give respectful care.*

SUGGESTIONS FOR IMPROVEMENT

The experts were also asked for their suggestions to improve the situation.. When grouped together, it was found that highest number of suggestions related to monitoring, accountability and grievance redress, followed by suggestions to improve the trainings of the health care providers and with the third most suggested area being on client load management.

The need for accountability was emphasized by one of the respondents in the following words:

> *Accountability is extremely important. The same guy will drive differently in his street, the Mall road and motorway because he knows that he will be caught on motorway and not be able to get away.*

Another respondent mentioned the same need in the following words:

> *Rules and regulations should be made.*

How to improve accountability? The experts gave several important suggestions. One of the respondents suggested separating monitoring from accountability. This was with reference to the current context whereby the department of health monitors as well as undertakes accountability:

> *Alag hongay to monitoring assan ho hayegee*
>
> *(If monitoring would be separated from accountability then it would be easy)*

Another suggestion was to leverage support from local government structures, engaging with community based organizations and civil society involvement:

> *Local government structures, CBOs, can be utilized; LG has gone to village level. Civil society involvement is necessary.*

A related suggestion was about introducing citizen feedback forms for holding health care providers accountable:

> *Attitudes ko accountable kernay kayliay citizen feedback forms should be introduced. (Citizen feedback forms should be introduced to hold the attitudes accountable)*

Another suggestion related to introducing Closed Circuit TV Cameras (CCTV) in the OPD so as to improve accountability by having proof of misconduct.

> *There should be monitoring system in the hospitals. If a patient complains then you can at least review the CCTV footage as where has been the problem, otherwise there will be no proof.*

Another expert suggested exploiting ongoing changes in the governance of health system to get RMC and its standards introduced in the operational plans and strategies etc. Improving people's knowledge of the grievance redress mechanisms was a suggested focus in this regard:

> *If people know where they have to go for complaint such as phone numbers, hospital displays notices, they may not create troubles. What happens that seniors run away and juniors have to face the public and they are not properly trained?*

A related suggestion was about displaying Charter of Health Care in Hospitals that should include both providers' and patients' rights and responsibilities.

> *Charter of Health Care should be displayed in hospitals that should include charter of rights and responsibilities of the patients and charter of health care establishment.*

The training of Health Care Providers' was the other most mentioned area of suggestions by experts. Important areas of improvement in this regard included developing job descriptions of providers, introducing induction training for doctors, training of junior staff, and teaching by doing/role modelling by seniors, inclusion of Patient Counselling in the curriculum of all cadres, and holding regular drills. A few excerpts from discussions with experts in this regard are given below:

> *Sab say pehlay job description hony chahyay. Her department main orientation hoty hay, hamaray han jab medical doctor ko BHU main lagaya jata hay to he does not know how to manage and he becomes a puppet in the hand of class 4 staff*
>
> *(First of all there should be job descriptions. Every department gives orientation training, in health department when a doctor is posted in BHU she does not know how to manage and thus becomes puppet in the hands of lower staff)*

> *Uska 3 month induction training hony chahya*
>
> *There should be 3 months induction training.*

The need for junior staff training was expressed in the following words by an expert:

> *A patient gets at most 5 minutes from a doctor when s/he goes to a health facility but spends half a day there at the hands of lower staff such as peon, technician. Patients are manipulated by lower staff. These staff need to be trained on the medical ethics.*

Besides training of the junior staff, it was suggested that training also be provided to junior doctors on certain skills of counselling, obtaining consent and breaking the news etc.

> *Junior doctors need to be trained on how to obtain consent and how to break the news.*

Making seniors demonstrate the skills was highly recommended by the respondents.

> *Senior faculty should stay and give more time. Senior needs to do it herself and get it done by juniors.*

Regarding training of all levels of providers, one of the experts said:

> *Patient counseling training should be at all levels including paramedics. This should be included in medical curriculum as well as trainings.*

The third category of suggestions was related to reducing and managing the Client Load. For instance one of the expert said:

> *Workload needs to be drastically reduced. There is huge workload in tertiary care. If you are examining 200 patients in 6 hours then how will you justify that?*

The key strategy recommended by experts to cut down the workload was improving the referral system in a way that facilitates patients seeking and receiving the appropriate level of care delivery at relevant levels in contrast to the current high burden at tertiary and secondary care levels. For example, one of the experts mentioned:

> *In tertiary care hospital only problematic or high risk cases which are beyond the capacity of gynecologists at the lower levels such as BHU and RHC, THQ and DHQ should be dealt with. All normal cases and simple C sections without any complication problems should be dealt with in respective BHUs, RHCs, THQ and DHQs.*

A suggestion to improve this was to have filter clinics at lower levels:

> *BHU, RHC and THQ should have filtration clinic.*

It was also suggested to engage general physicians for referral:

> *Engage general physicians so that they can screen and refer the problem cases. If this cannot be done then make filter clinics. You can reduce the workload through filter clinics. This will also reduce quackery as quacks cannot refer and thus people will stop going to them.*

Another suggestion pertained to managing the workload through installing TV cameras and issuing electronic tokens:

> *Install TV cameras in OPD waiting area and issue electronic tokens which will tell as which patient has to go in which room.*

Expanding the availability of services and increasing the salaries of doctors to entice them to public sector were the other suggestions to manage the workload.

Some of the suggestions related to the demand side. Most mentioned in this regard was increasing the awareness of public about their rights and entitlements:

> *Patients' awareness should be increased.*

Another expert emphasized the need for community awareness as a factor that could make practitioners behave properly:

> *It is most essential because when the community will make noise then demand will be created and the practitioners will have to think on it.*

It was, however, also mentioned that increasing awareness only will not be sufficient, this has to be in line with increased resource allocation to this area and also the overall socio-economic uplift of the society:

> *Awareness is an area that needs to be worked upon but will also require to work on the socioeconomic uplift of society as well.*

The Education system was mentioned as a way to improve awareness:

> *Education system can help address the lack of awareness, what's wrong if I am poor that does not deprive me of my rights, self-image of individuals need to be built.*

Media Capacity Building was also mentioned in this regard:

> *There will be a need to educate, train media for putting specific frame to it. Otherwise they create hype on such issues that triggers reaction. They also need to be educated on the way the patient care needs to be seen for improvement.*

Garnering Partnerships amongst different stakeholders was another suggestion in this regard:

> *A partnership needs to be developed amongst professional associations, civil society and media. When media creates hype they are seen as intruders and not as partners, someone which exaggerates. Regulatory bodies need to be involved for structured partnerships.*

Regulation, policy institutions creation, strategizing the functions of the government was also recommended:

> *3 pronged strategy is required: Formation of regulatory frameworks, strengthening Governments policy formulation mechanism, and strategizing its functions.*

Advocacy was suggested a way to bring the issue into limelight and focus on policy changes:

> *Mobilize policy makers, do advocacy so that they realize it as an important aspect of health care.*
> *Jitna zroori haspatal banan hay utna hi zroori ye hay kay logon ko respectable way main sari cheezain milain.*
>
> *(The way it is important to construct the hospital same is the importance of giving them respectful care)*
> *RMC issue needs to be brought into the notice of the employers of the public sector i.e. bureaucrats. They need to question those whom they pay.*

Presence of relevant protocols was also suggested to overcome this issue.

> *If protocols of patient handling exist then many issues will be resolved.*
> *Opper say standard guidelines ayan, law ho, instructions, iskay sath checklists any chahya.*
>
> *Standard guidelines should be provided by top management, there should be laws, there should be checklists.*

The respondents identified several opportunities that could be used to promote the cause of RMC. In this regard it is Important to note the Chief Minister Initiative in KP, Independent Monitoring Units (IMUs) in Punjab and KP, the Right to Services Commission in KP, the Right to Information Commission in KP and Punjab, and the Health Care Commissions in KP and Punjab.

CONCLUSIONS

This study provides interesting insights into the state of respectful maternity care in Pakistan. The key conclusions are:

- Women regularly face abuse and disrespect in public sector facilities when they are seeking childbirth services.
- Amongst the seven categories identified by Browser and Hill, the right to timely healthcare and to the highest attainable level of health appears to be most compromised as the majority of the practices relate to abandonment and denial of care.
- Non-dignified care (including verbal abuse) is the second category of abuse and disrespect which Pakistani women have to face while they seek maternity care services from the public sector.
- Non-consented and non-confidential care practices are the third most common practices.
- Physical abuse and discrimination based on specific attributes are the fourth most common practices, whereas detention in the health facilities is almost absent due to services being free in public sector.
- The key reasons for this sorry state of affairs include a lack of accountability, seen as the top reason, followed by gaps in the trainings of healthcare providers at all levels and for all cadres; in the curriculum as well as in the methodology of training. The third most important reason relates to high client load underpinned by the issues of ineffective referral system.
- On the demand side, the key reason is the lack of awareness among citizens about their rights and entitlements confounded by complacency and acceptance of existing practices due to fear of negative repercussions, perceptions of not getting any grievance redressed, and internalization of the superiority of the health staff, especially doctors.
- The grievance redress mechanism appears to be virtually non-existent and ineffective where if it does exist.
- The private sector appears to be better at delivering respectful care compared to the public sector. The key factor in this appears to be the commercial nature of the private sector along with a stronger accountability mechanism.
- The deficits in practice are underpinned by deficits in policy. There are no policies about this aspect of care delivery and policy makers are not sensitive enough to this issue. As a result, there has been no noticeable focus on RMC so far.
- Opportunities exist that can be leveraged to promote the cause of RMC. The opportunities lie in the governance instruments such as the Right to Information Act, the Right to Services Act, citizen feedback models being introduced by governments, and the Health Care Commission Standards.

RECOMMENDATIONS

- Formative in nature, the study in hand has documented key practices that reflect disrespect and abuse experienced by women in public sector health facilities. Whereas the study does not provides estimates of prevalence of these practices, it does however highlight the existence of such practices which have been described by the users of health facilities as well as experts such as managers, practitioners, academicians etc. as barriers to access of public sector maternity services especially by poor and marginalized. It opens the avenues of further research in this area. Important in this regard would be finding estimates of existence of such practices, more in-depth comparisons with private sector, study of different accountability mechanisms for their potential to contribute towards ensuring respectful care for women.
- The recent Pakistan Demographic and Health Survey (PDHS 2012-13) has documented an increase in the facility-based births that has long been pursued as a strategy to decrease maternal mortality. Decades of efforts on demand generation for skilled birth attendance have brought this window of opportunity. RMC is a key to capitalize on this. Government should focus on this aspect of maternity care for optimum utilization of the resources and translating demand into positive health outcomes.
- There is an urgent need for policy to be formulated to address this issue. Given the overall policy deficit, coupled with the demand side issues, it is recommended that a multipronged advocacy strategy is adopted by civil society especially the organizations working on RMNCH, human rights and accountability that targets all key policy stakeholders including decision makers, policy influencers and the beneficiaries.
- The media, civil society, NGOs, CBOs and others should join together to promote RMC.
- Along with a promotional campaign, targeted advocacy to include RMC into Health Care Charters, Right to Services offer, and Right to Information services can be a strategic entry points to introduce RMC into the health governance.
- Political representatives possess some sensitivity to this issue by virtue of their constituents' complaints. More can be done, however, to support them become effective champions of RMC. Targeting women caucuses can be useful in this regard.
- The RMC related indicators should be included in the monitoring framework of maternity health services monitoring mechanisms. The monitoring mechanism such as District Health Information System, Roadmap Stock takes by Independent Monitoring Units (IMUs) and the provincial and national surveys include RMC indicators and regularly capture data on this. Citizen feedback models can also be valuable entry points in this regard.
- The issue of RMC does sit well within Quality of Care approach and can be dealt under that accordingly. However, we believe it is important and strategic to not to lose the rights perspective that can be an unwanted outcome of dealing with it solely within the QoC paradigm.

- Public demand can be a fundamental driver of change in this regard. Public awareness of the rights of childbearing women must be increased to form the corner stone of the drive for change. A mass media campaign on the rights and entitlements of childbearing women, championed by societies well known figures, would be very effective in this regard.
- The practices of services delivery are usually internalized by doctors through their observations of their seniors' in House Job component of the medical training. Senior doctors should promote RMC at the practices level by being role models. An example to follow in this regard is the Head of Department of Gynecology in Liaqat University of Medical Sciences in Sindh. Besides, the professional associations that set standards of practices such as Society of Obstetricians and Gynecologists Pakistan (SOGP) and Pakistan Medical Association of Pakistan should come forward in promoting RMC standards.
- The curriculum of the medical staff including both doctors and non-doctors should be improved to include RMC in the teaching. The Medical Colleges, Pakistan Medical and Dental Council (PMDC), Federal Ministry of Health Services Regulation and public health teaching institutes such as Health Services Academy (HAS), Institute of Public Health (Lahore), Provincial Health Services Academies need to include RMC into the teaching curriculum under medical ethics and community medicine courses.
- The Right to Services Commission should include special provisions for pregnant women grievance redress and standards of waiting time and non-attendance by service provider be enhanced to include pregnant women needs.
- The governments should develop strategies to manage the workload that has been one of the key determinant of misconduct of health care providers. Resources need to be increased in proportion to the client load to have more facilities, improve the waiting areas, increasing the labor rooms, making referral system functional The primary health care utilization needs to strengthen in order to reduce burden on tertiary care.
- An effective referral system needs to be put in place at secondary health care facilities that can enable these facilities to accept primigravida and other high risk cases which can be referred in case of emergency.

ANNEXES

ANNEX A. FOCUS GROUP DISCUSSION GUIDE WITH MOTHERS

Q 1: Where do women usually go to seek maternity care services (ANC, Delivery and PNC)?

Q 2: How is a woman treated in health facility when she goes there for seeking maternity care (ANC, Delivery, PNC)?

Probe for:

- Physical abuse
- Non - consented care
- Non - confidential care
- Non - dignified care (including verbal abuse)
- Discrimination based on specific attributes
- Abandonment or denial of care
- Detention in facilities

Q 3: How differently is a woman treated in the private hospitals as compared to public sector when she goes there for seeking maternity care (ANC, Delivery, PNC)? What is different and why?

Probe for:

- Physical abuse
- Non - consented care
- Non - confidential care
- Non - dignified care (including verbal abuse)
- Discrimination based on specific attributes
- Abandonment or denial of care
- Detention in facilities

Q 4: What do you/your caretakers do when you are not treated properly in the health facility while you seek maternity services? (Accountability)

- Files a complaint
- Fight with the providers
- Goes to media
- Seek support from influential
- Bribe the provider for getting proper services

Q 4: How does this affect you when you are not treated respectfully in health facility?

Probe for:

- willingness to seek health services from the facility
- her health
- her care taking by others
- loss of resources (money/time, etc.).
- seeking services from traditional birth attendants and healers

Q 5: How should a woman be treated when she goes to seek maternity services from a facility?

Probe for:

- Freedom from harm and ill treatment
- Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care.
- Confidentiality, privacy
- Dignity, respect
- Equality , freedom from discrimination, equitable care
- Right to timely health care and to the highest attainable level of health
- Liberty, autonomy, self-determination, freedom from coercion

Q 6: What should be done to ensure that every woman gets respectful care during maternity?

ANNEX B: INDEPTH INTERVIEW GUIDE

Q 1: How is RMC being practiced in maternity services delivery?

Probe for:

- Physical abuse
- Non - consented care
- Non - confidential care
- Non - dignified care (including verbal abuse)
- Discrimination based on specific attributes
- Abandonment or denial of care
- Detention in facilities
- Differences in Public and Private Sector practices

Q 2: How is RMC being dealt with at policy level of health governance in your province? Probe for:

- Existence of guarantees (constitutional, conventional, cultural) for the following rights

  - o Freedom from harm and ill treatment
  - o Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care.
  - o Confidentiality, privacy
  - o Dignity, respect
  - o Equality , freedom from discrimination, equitable care
  - o Right to timely health care and to the highest attainable level of health
  - o Liberty, autonomy, self-determination, freedom from coercion

- Translation of these rights into health policies/strategies/legislation
- Policy debate/discourse on these rights
- Attention of the policy makers (parliamentarians, bureaucracy)
- Attention of the policy influencers (media, civil society, professional associations)
- Reasons for the policy deficits

  - o lack of evidence to bring this issue to light
  - o New concept
  - o Woman issue
  - o Overall low importance to health issues

Q 3: What is the status of RMC at implementation level?

  - o Presence/absence of any protocols
  - o Teaching about RMC in medical curriculum (pre-service and in-service)
  - o Existence of any standards of service delivery related to RMC
  - o Availability of any accountability/grievance redress mechanism

Q 4: What is status of demand for RMC at community level?

  - o Women/Peoples' awareness about their rights

    - Freedom from harm and ill treatment
    - Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care

- Confidentiality, privacy
- Dignity, respect
- Equality , freedom from discrimination, equitable care
- Right to timely health care and to the highest attainable level of health
- Liberty, autonomy, self-determination, freedom from coercion

o Women/Peoples' capacity to demand these rights
o Availability and accessibility of forums or systems of grievance redress in case of violation of these rights of women

Q 5: What should be done to promote RMC in the health system for improving safe motherhood? Probe for:

o At policy level
o At service delivery level
o For monitoring and accountability (indicators inclusion, role of media, role of communities)
o At community level for demand creation

ANNEX C: LIST OF EXPERTS INTERVIEWED

- Professor Dr Sadiqa Jaffery, President (National Committee on Maternal, Newborn and Child Health)
- Dr Azra Ahsan, (Private Practitioner Gynecologists)
- Dr Javed Bhutto (Department of Health, Sindh)
- Dr Rehman Khattak (Technical Resource Facility, Khyber Pakhtunkhwa)
- Dr Ahmed Ali (Director Health Services, Khyber Pakhtunkhwa)
- Professor Dr Raheel Sikander (Head of Department Gynae Department, Liaqat University of Medical Sciences, Jamshoro, Sindh)
- Dr Masood Anwar (Director Health, Management Information System, Punjab)
- Dr Mushtaq Suleri (Director Health Care Commission, Punjab)
- Dr Pervaiz (Program Manager, Integrated Reproductive, Maternal, Newborn and Child Health Program)