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# Women's health: poor services

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By Ayesha Khan | From the Newspaper March 1, 2011

**IT does not seem so long ago when the women's health movement marked a major victory in Cairo, as the United Nations Conference on Population and Development 1994 voted in favour of a broad-based reproductive health and development agenda to replace the narrow demographic-based obsession with using family planning to curb population growth rates.**

Countries were exhorted to widen their population control programmes to incorporate agendas such as sexual health and rights, poverty and health and reproductive health needs of women across their life-cycles not only those years devoted to child-bearing.

Benazir Bhutto, prime minister at the time, attended the Cairo conference and delivered an excellent speech in support of the new agenda. Pakistan worked as a moderate Muslim country negotiating with countries such as Saudi Arabia and Iran to win their support for the Conference Programme/Platform of Action. Donor funding for Pakistan became available for government organisations and NGOs alike to work on a variety of new areas, such as HIV/AIDS and other sexually transmitted diseases.

Now 17 years later, there is plenty of new information that has come to light that gives us pause to think and assess how far we have come. One such source of information is a recent study conducted by the Collective for Social Science Research on induced abortion in Pakistan. Interviews were held with 477 women distributed across 28 communities (mainly in Punjab and Sindh) who had induced abortions during the preceding five years. They answered a variety of questions exploring their entire pregnancy histories, related health-seeking behaviour and the reasons for and details of their induced abortions.

The women with induced abortions could be divided into two groups: the first (88 per cent) included all women who did not wish to become pregnant but nonetheless conceived, and the second (12 per cent) comprised those who decided after conception against keeping the pregnancy.

Another section of the survey focused on women being treated for post-abortion complications in a government district hospital in Karachi. They numbered 117 respondents over a month, and the cases represented all types of pregnancy loss. During the period they were in hospital (which ranged from a matter of hours to two days), some were referred for post-abortion family planning services to a

government outlet on the hospital premises, but a full 56 per cent were not given any counselling at all. Only 20 patients were counselled about family planning and its benefits, and 18 were sent to specific providers of contraceptive services.

Immediately following a pregnancy loss is the critical time for a woman to receive counselling on how best to plan for future pregnancies. If women leave a hospital without such information or without contraceptives in hand, an opportunity is lost to equip them with the resources needed to space or limit childbearing. Since it is a major achievement for women to come to hospitals in the first place to receive pregnancy-related treatment, doctors and nurses need to take full advantage of their brief interaction with patients.

This is not as easy as it sounds. Anyone who has spent time in the gynecology or labour wards of Karachi hospitals knows how large the caseload is on a given day. According to the administration department at one of the largest government hospitals in Karachi, the outpatient caseload is between 2,500 to 3,000 patients per day, and more than 1,000 patients admitted daily. At the obstetrics and gynaecology departments at the hospital, 20 to 25 deliveries are administered every day and the daily outpatient caseload is close to 200 patients. Doctors have reported they don't have time to counsel patients and even when a patient is referred to the family planning centre, which is within the hospital compound, there is no way to ensure the patient will follow this instruction. There are no waiting areas for women or their attendants and they usually have wait in hallways. At a district level hospital in Karachi, there may be as many as 9,000 women seen in the out-patient department in a one-month period, and 500 obstetrics patients admitted, along with over 100 gynaecology cases. Staff is rushed and overworked, and midwives or nurses may fill in for procedures that doctors are officially supposed to do.

There are government family planning centres in public hospitals, to which women are meant to be referred from out-patient clinics or by staff attending to admitted patients. But these are not always friendly and hospitable environments, sometimes only accessible to a woman after she waits in yet another endless queue, and sometimes so overflowing with women needing advice and understaffed with service providers that a patient will postpone the consultation and return home instead.

This turns out to be a costly mistake. The Collective research on induced abortion calculated the costs of this and the other alternatives to it: that is, spontaneous abortion or a pregnancy taken to term (delivery). Even including the expected cost of treating a complication, the out of pocket cost of an induced abortion was Rs4,600, a spontaneous abortion Rs3,062 and a delivery Rs7,273. In short, this makes having an induced abortion, with its risks, far cheaper than a delivery. And when these costs are compared to the out-of-pocket expenses of using contraception, the contrast is even more stark: one year on the oral pill costs less than Rs200, and a tubal ligation (which is permanent) costs Rs1,000. The numbers alone are an excellent reason for fixing our family planning services in Pakistan and making them accessible, user-friendly and widespread.

The writer works with the Collective for Social Science Research.

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