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SRI LANKA

THE RIGHT TO MATERNAL HEALTH
CASE STUDIES OF NEPAL AND SRI LANKA

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Abstract

This report examines the legal frameworks and challenges of maternal health in Nepal and Sri Lanka in the context of international treaties and WHO priorities. The report aims to highlight issues such as inadequate pregnancy preparation, financial barriers, insufficient health related resources and infrastructure and address the importance of women's participation in decision-making process.The study analyses data from national and international reports, including sources like Ministry of Health, WHO, World Bank, and health-related journals, in order to investigate the problems associated with maternal mortality in Nepal and Sri Lanka. With the aim of identifying trends and key factors influencing maternal mortality, the study design thoroughly analyses both quantitative and qualitative data. Maternal fatalities in Nepal are frequently caused by delays in receiving referral services while in Sri Lanka, lack of awareness and failure to detect warning signs contribute in seeking care. Finding of this study demonstrate the need for enhanced health information systems particularly in rural areas, better health care access and reproductive health knowledge.

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Abbreviations

1. - Act - Act of Parliament
2. - ANC - Antenatal Care visits
3. - Ayur. – Ayurvedic
4. - CEDAW - Convention on Elimination of all forms of Discrimination against Women
5. - CEmOC - Comprehensive Emergency Obstetric care
6. - COVID-19 - Coronavirus Disease 2019
7. - CSC - Community Scoreboard
8. - GDP – Gross domestic product
9. - GoN - Government of Nepal
10. - GP - General Practitioner
11. - HDU - High Dependency Unit
12. - ICU - Intensive Care Unit
13. - ICESCR - International Covenant of Economic, Social and Cultural Rights
14. - ICCPR - International Covenant on Civil and Political Rights
15. - LMC - Lactation Management Centers
16. - MCH - Maternal and Child health
17. - MDR - Maternal Death Review
18. - MDT - Multidisciplinary Team
19. - MDHR - Maternal Perinatal Death Review
20. - MDSR - Maternal Death Surveillance and Response
21. - MMR - Maternal Mortality Ratio
22. - MOEWS - Modified Obstetric Early Warning Signs
23. - MoHP - Ministry of Health and Population
24. - MPDSR – Maternal and Perinatal Death Surveillance and Response
25. - NGO - Non-Governmental Organization
26. - NPP – Nepal Rupees
27. - SDGs - Sustainable Development Goals
28. - UNICEF – United Nations International Children's Emergency Fund
29. - USD – United States dollar
30. - WHO - World Health Organization

1. Introduction

Maternal health is a crucial part of healthcare systems worldwide, guaranteeing the well-being of women during pregnancy, delivery and postnatal period. In Nepal, constitutional provisions have protected the right of women to health care services, motherhood and reproductive health while Sri-Lanka underscore the significance of maternal health in its health policies. These legal frameworks place a strong emphasis on the state's obligation to guarantee equal access to health facilities and promote the welfare of women within a broader international context. Both Nepal and Sri Lanka are signatories to the International Covenant of Economic, Social and Cultural Rights(ICESCR) , the International Covenant on Civil and Political Rights(ICCPR) and Convention on Elimination of all forms of Discrimination against Women. These international treaties emphasise the importance of reducing maternal mortality and guaranteeing rights of individuals to the highest attainable standard of physical and mental health and guaranteeing access to medical care during illness.

Both countries are members of the World Health Organization which recognized maternal and child health MCH as one of the priority areas.

Despite these legal frameworks and international commitments, maternal health issues continue to be problematic in both nations. Factors such as poverty, inadequate healthcare infrastructure, geographicals barriers and cultural stereotypes contribute to delays in seeking health care and accessing high-quality maternal health services. Addressing these problems requires a comprehensive strategy which includes legal reforms, healthcare investments, proper utilisation of budgets, community engagement and awareness programs to ensure that women receive prompt and high-quality treatment during pregnancy and childbirth.

The purpose of this report is to examine the legislative frameworks pertaining to maternal health in Sri Lanka and Nepal, taking into account the international context provided by agreements like ICESCR, ICCPR , WHO and CEDAW. This report aims to provide insight into the status of maternal health governance on a national level while adhering to international standards for maternal health care by analysing current laws, policies, initiatives, maternal health indicators and obstacles faced by women in accessing healthcare service in both countries within an international legal context. Through this report both Nepal and Sri-Lanka can work towards strengthening their maternal health systems, lower their rates of maternal

mortality rates and guarantee that women receive high-quality prenatal and postpartum care by exchanging best practices, policies and initiatives. This might help in improving material health conditions in both countries by sharing knowledge of each other's achievement and difficulties.

2. Methodology and Study Design

This research aims to comprehensively explore the maternal mortality related challenges faced by Nepal and Sri Lanka, delving into their intricate impact on the lives of their respective population. The study will meticulously investigate and analyse data collected from both countries, employing a comprehensive approach that combines national and international reports. In Nepal data will be extracted from sources such as the Ministry of health, WHO,World Bank and health related journals. Complemented by insight from NGOs actively involved in maternal health initiatives. Similarly in Sri Lanka, national data sourced from the Family Health Bureau under Ministry of Health, alongside interviews with the Maternal Mobility and Mortality Surveillance Head and insights from relevant NGO reports.

2.1 Study Design

The collected data undergo comprehensive analysis, incorporating statistical methods for quantitative data and analysis for qualitative insights from interviews and reports. The goal is to identify trends, disparities and key factors contributing to maternal mortality in both counties. Building on these findings, the study will formulate evidence based recommendations, considering the unique cultural and health care context of Nepal and Sri Lanka. Collaboration with existing maternal health programs and innovative strategies will be proposed to address specific challenges identified in the analysis.

The research will broaden its scope by exploring the international background of Nepal and Sri lanka, Assessing the conventions ratified by these counties in relation to maternal health. An assessment of their adherence to international standards will provide context to the local findings. The synthesis phase will involve a meticulous comparison of data from both nations, utilising visual aid for clarity. This comparative approach will shed light on commonalities, differences and potential shared solutions.

2.2 Study Summary

The study will conclude by summarising key findings and emphasising their practical implication for policy makers and the healthcare profession. Acknowledging potential limitations in data availability and interview processes, ethical considerations surrounding participation confidentiality and responsible data handling will be outlined. Lastly, to ensure the robustness of the methodology, the research will consider seeking validation through peer review or consultation with experts in maternal health and epidemiology, adhering to ethical research standards.

3. Limitations

Reliable health-related statistics are crucial for understanding reproductive health and guiding policy decisions, funding, and research agendas.Health trends change rapidly, and ongoing efforts are needed to improve availability, quality, and use of health information. Asian countries like Sri Lanka and Nepal lack the necessary health information systems. Moreover governments are not publish very sensitive and secret information to public because of governmental policy issues. Mental health related problems that postpartum women encounter are not addressed in this study.This report does not include intensive comparative study between Nepal and Sri Lanka. This paper delves deeper into the socioeconomic aspects that contribute to maternal fatalities.

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4. International Legal Frameworks

International commitments of Nepal and Sri Lanka

4.1 International Covenants on Economic, Social and Cultural Rights, ICESCR (1966)

The Democratic Socialist Republic of Sri Lanka became a party to International Covenants on Economic, Social and Cultural Rights(ICESCR) in 1980 by the way of accession and the Government of Nepal acceded to the Covenant in1991.

Article 12 of ICESCR states that States Parties to the present Covenant recognise the right of everyone t;o the enjoyment of the highest attainable standard of physical and mental health where States Parties should be taken necessary steps to achieve the full realisation of these rights which includes:

a. Provision for the reduction of still-birth and of infant mortality and for the healthy development of children;
b. Improvement of all aspects of environment and industrial hygiene;
c. Prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d. Creation of conditions which would assure all medical service and medical attention in the event of sickness.

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Both countries as a state party have an international obligation to respect, protect and fulfil all human rights enunciated in the ICCPR.

4.2 Sustainable Development Goals (SDGs)

By 2030 , both Nepal and Sri-Lanka aims to reduce the global maternal mortality to less than 70 per 100,000 live births under SDGS target 3.1[1]The national development frameworks of Nepal have effectively incorporated the SDGs. Under the overarching national goal of "Prosperous Nepal, Happy Nepali," the SDGS have been a mainstreamed in the 15th Development plan (2019/20-2023-24). The 2030 agenda's objectives, benchmarks and ambitions are also incorporated into the 25-year Long-Term Vision 2100. All national development programs are given specific SDG codes through the Medium Term Expenditure Framework. Furthermore, the Sub-National Government's periodic plans now include the SDGs along with useful guidelines for monitoring and assessment[2]

Similarly, in line with the 2039 Agenda, Sri-Lanka aims to achieve a "Inclusive Transformation towards a Sustainably Developed Nation for All," where social inclusion and green growth serve as the cornerstones of economic change. The incorporation of the 2030 Agenda and SDGs into frameworks like the Public Investment Programme 2021-2024 and the National Policy Framework- Visions of Prosperity and splendour to this transition.[3]

4.3 Convention on the Elimination all forms of Discrimination against women (CEDAW)

Sri Lanka having ratified CEDAW, is subject to periodic reviews by the committee. Article 12 of CEDAW emphasises the importance of eliminating discrimination against women in healthcare ensuring equal access to health service including family planning. Sri Lanka's commitment to these principles reflects in its

[1] "Sustainable Development Goal 3: Good Health and Well-being | the United Nations in Nepal," Sustainable Development Goal 3: Good Health and Well-being | the United Nations in Nepal, n.d., https://nepal.un.org/en/sdgs/3.

[2] "Voluntary Reveiw 2020" (High-level Political Forum on Sustainable Development), accessed March 14, 2024, https://sustainabledevelopment.un.org/memberstates/nepal.

[3] "Voluntary Review 2020" (High-level Political Forum on Sustainable Development), accessed March 14, 2024, https://sustainabledevelopment.un.org/memberstates/srilanka.

efforts to address maternal mortality through healthcare initiatives, policies, and ongoing improvements in maternal care services[4].

Nepal became a state party to CEDAW in 1991, signalling its commitment to promoting gender equality in healthcare. Article 12(1) of CEDAW underscores the necessity of eliminating discrimination against women in healthcare, emphasising equality in access to health services. Over the years, Nepal has made strides in improving maternal healthcare, although challenges persist. The country's commitment to CEDAW has been a catalyst for policy changes and healthcare initiatives[5].

4.4 Constitution of World Health Organisation

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition..Moreover Sri Lanka and Nepal are members of WHO Article 2 of the constitution mentioned about promoting maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;

WHO pushes for health planning that prioritises women's interests and preferences in their own care. Meaningful engagement and empowerment of women, families, communities, and providers is critical for quality improvement efforts.WHO is responsible for monitoring progress towards the global objective of reducing maternal mortality (SDG target 3.1). WHO generates data, research, clinical guidelines, and programming tools.World Health Organization recognized maternal and child health MCH as one of the priority areas. In 1978 when the Primary Health policy was greatly promoted by the WHO and maternal and child health been included into the strategies and first Line Health Service were expanded as well as antenatal and delivery care, and training maternal and child health workers focusing on the survival of the child.

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[4] "Sri Lanka Shadow Report," *To The Commission on the Elimination of All Forms of Discrimination Against Women* (The Women and Media Collective,Colombo, n.d.), 8.

[5] "Universal Periodic Review - Nepal" ,August 4.2021. https://reproductiverights.org/nepal-abortion-decriminalization-un-upr,16.

5. Case Study 1-NEPAL

5.1 Background

Maternal and child health(MCH) related causes of death were the leading causes of death till 2000 but due to the improvement in nutrition initiatives by the government with assistance from international organisations like UNICEF AND WHO,MCH indicators gradually decreased[6].The Maternal Mortality Rate (MMR) in 2016 was 239 per 100,000 live births.The global target is to reduce maternal mortality ratio to fewer than 70 deaths per 100,000 live births. Nepal pledged to reduce its maternal mortality rate (MMR) from 81 per 100,000 live births in 2006 to 116 by 2022, 99 by 2025, and 70 by 2030[7].In Fiscal Year 2021/2022, the government of Nepal allocated NPR 179.5 billion to the health sector of which NPR 179.5 billion to the health sector, of which NPR 100.9 billion was a conditional grants to Ministry of Health and Population(MoHP). The federal government sent NPR 10.6 billion in fiscal transfers to the provincial governments,while provincial governments set aside NPR 18.3 billion as internal resources for the health sector. Local governments provided NPR 18.3 billion as internal resources for the health sector in addition to receiving NPR 29.3 billion in fiscal transfers from the federal government and NPR 970 million from the provincial governments.[8]

During the reference period(census 2021), 653 pregnancy-related deaths were documented. 622 of the 653 pregnancy-related fatalities were identified as maternal in nature.Among these nearly 0ne third of the deaths were of group 20 to 24 years(30%), whereas 10% of the deaths were of adolescents.[9]

5.1.1 Background Characteristic of the deceased women

A high proportion of maternal deaths (38%) was reported among the women with no formal schooling compared to women who have completed their college degree or above (6%). Nearly half of all maternal deaths occurred in the relatively densely

[6] Japan International Cooperation Agency, "Data Collection Survey on Health Sector in Nepal" (Yakuzemi Informative Education Center Co.Ltd, Japan development Co.Ltd, May 2023), 35.

[7] "National Population and Housing Census 2021:Nepal Maternal Mortality Study 2021" (Government of Nepal,Ministry of Health and Population; National Statistics Office, January 2023), 1.

[8] Japan International Cooperation Agency, "Data Collection Survey on Health Sector in Nepal.",85.

[9] "National Population and Housing Census 2021:Nepal Maternal Mortality Study 2021," 11

populated Terai region (55%) This was followed by the hilly region with 39% and mountains with 6%. In every ecological belt, the rate of maternal mortality during the delivery period is almost the same. But a greater proportion of deaths during the delivery period (19%) was reported in the mountainous region.[10]

5.1.2 Place of delivery and death

Among the women who had died during the delivery and in the post-partum period , three out of four women 76% had delivered in health facilities during the index pregnancy and one in five had delivered at home while 3% had delivered on the way to medical facilities. Majority of maternal deaths 57% had occurred in medical facilities and 26% in private households. Approximately 17% of the women had died while travelling from their homes to the medical facilities.p-13 Among the deceased women who died during the delivery in a health facilities ,62% gave birth in government facilities and 38% gave birth in non-governmental hospitals[11].

5.1.3 Utilisation of Health Service

There are four Antenatal Care visits which are recommended by the safe motherhood service protocol which includes the first ANC visit in 4th month, second in the 6th month,third in the 8th month and fourth in the 9th month. So among the women who died during pregnancy, delivery or postpartum period 85% had attended only one ANC visit. Only 53% of the 412 women who died during delivery and postpartum period had gone to all antenatal care visits[12].

[10] "National Population and Housing Census 2021:Nepal Maternal Mortality Study 2021," 11.

[11] "National Population and Housing Census 2021:Nepal Maternal Mortality Study 2021," 18.

[12] "National Population and Housing Census 2021:Nepal Maternal Mortality Study 2021," 21.

5.2 Causes of Maternal deaths

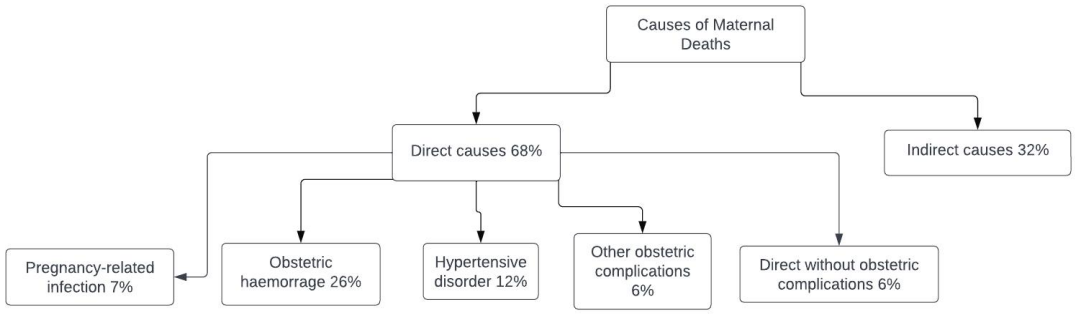

Fig.1 (Jasmina Shrestha, causes of maternal deaths)

According to the above mentioned figure 68% of maternal deaths are due to haemorrhage,infection, unsafe abortion, hypertensive disorders and obstructed labour. As per previously conducted studies in So, in Nepal hypertensive disorder of pregnancy,obstetric haemorrhage, sepsis and anaemia are identified as the common and preventable causes of MMR.[13] And major factors contributing to maternal mortality are:

1. Poverty
2. Inadequate and inaccessible health care
3. Unaffordable health services
4. Low status of women
5. Illiteracy

[13] Sitaula, Sarita, Tulasa Basnet, Ajay Agrawal, Tara Manandhar, Dipti Das, and Prezma Shrestha. "Prevalence and risk factors for maternal mortality at a tertiary care centre in Eastern Nepal- retrospective cross sectional study." *BMC Pregnancy and Childbirth* 21, no. 1 (2021): 2. https://doi.org/10.1186/s12884-021-03920-4.

5.2.1 Poverty

The majority of deceased women are from marginalised and impoverished backgrounds.They refrained from seeking treatment at higher-level hospitals or from arriving on time due financial constraints and fear of the associated cost[14].) The use of traditional birth attendant is a custom which is more prevalent among marginalised and impoverished groups. This is due to availability of traditional birth attendants locally and there is no need to travel to medical institutions which are often perceived as unfriendly by the women. But these attendants cannot handle problems or complications which lead to maternal deaths[15].

A normal delivery for a woman from a low to middle-class family costs almost 3 months of household income compared to just over a month in a high income family. Poverty and maternal mortality (MMR) have long been recognized to be closely related[16].

5.2.2 Inadequate and inaccessible health care- budget

Three Delays

The 'Three Delays' model is defined as critical phases which can have direct consequences on the survival of the mother: First delay: delay in the decision to seek care, Second delay: delay in identifying and reaching the health facility and Third delay: delay in receiving appropriate treatment at the facility. So , on the basis of this model , a majority of (74%) of deceased women had encountered at least one kind of delay while 17% of deceased women had experienced all three delays. The most frequent was waiting to seek medical attention (57% first delay) followed by delay in receiving care (40% third delay) and and delay in reaching facility care (33% second delay)The most common reasons for delays at health facility are[17]

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[14] Sitaula et al., "Prevalence and Risk Factors for Maternal Mortality at a Tertiary Care Centre in Eastern Nepal- Retrospective Cross Sectional Study," 6.

[15] Sitaula et al., "Prevalence and Risk Factors for Maternal Mortality at a Tertiary Care Centre in Eastern Nepal- Retrospective Cross Sectional Study," 9.

[16] Jeevan Acharya et al., "Hidden Costs of Hospital Based Delivery From Two Tertiary Hospitals in Western Nepal," *PLOS ONE* 11, no. 6 (June 16, 2016): 1, https://doi.org/10.1371/journal.pone.0157746.

[17] "National Population and Housing Census 2021:Nepal Maternal Mortality Study 2021," 21-25.

- 24% of delays are due to finding risks for timely referral from the referring facilities
- 17 % delays are due to administrative delays in referred facilities
- 12% delays while scheduling transportation from the referring health facilities to the referred facilities
- 11% of delays happened due to inadequate communication between health facilities
- Delays in receiving treatment after admission 14%
- 11% of delays happened due to lack of essential equipment
- 9% of delays due to inadequate number of skilled health care personnel
- 9 % of delays due to delay in arranging blood
- 7% due to shortage of medicine.

The study which was conducted in six district of Nepal in 2021 of three different provinces identified that health post or primary healthcare centres were the available facility for the delivery service and it was the nearest health facility for majority households while zonal or regional hospitals were the nearest Comprehensive Emergency Obstetric care(CEmOC) sites. Neary three-fourth of women were referred to higher facilities with CEmOC services. Majority of patients faced difficulty in getting bed, drugs or health workers in time. The median cost of treatment was Nepalese Rs 40000(302.13 USD).[18]

In hilly and mountain regions, health facilities with CEmOC sites are located in distance and difficult to access locations. It is challenging to bring mothers to hospitals, even in plain areas because it is limited, especially at night. Due to this patients arrive at the referral hospitals quite late or die on the way,either after a failed attempt at a home for delivery or even the onset of labour pain. In some areas of the remote villages patients and their families have to walk across the river because vehicles cannot cross the river.[19]

[18] Sitaula et al., "Prevalence and Risk Factors for Maternal Mortality at a Tertiary Care Centre in Eastern Nepal- Retrospective Cross Sectional Study,"2-6.
[19] Sitaula et al., "Prevalence and Risk Factors for Maternal Mortality at a Tertiary Care Centre in Eastern Nepal- Retrospective Cross Sectional Study,"7.

5.2.3 Unaffordable health services

Nepal has one of the lowest GDP per capita levels in South Asia in 2022 at 1,336.5 USD.In Nepal, the maternal financing scheme was rationalised based on research indicating that financial obstacles prevent two thirds of women from accessing healthcare facilities. The Government of Nepal launched a financing scheme to encourage institutional births and lower financial barriers for women giving birth in medical facilities[20].

The Government of Nepal launched a Maternal Incentive Scheme in 25 least developed districts in 2005. This initiative was later renamed the 'Safe Motherhood Program' in 2007. This program includes the cost of a health worker's transportation to the health centre. Financial incentives offered by the Safe Motherhood program (transportation incentive) based on various geographic areas. Despite of these efforts by the Government of Nepal to address concerns about Out of Pocket Expenditure OOPE, in the last decade , the inequity gap for utilising health facilities for birthing has grown even more.According to a nationwide survey, a safe motherhood program could not increase the health care uptake by pregnant women particularly in rural areas. Geographical constraints were the primary reason for the lack of uptake of health facilities in rural regions. A prospective cohort study was conducted in 12 hospitals of Nepal in 2021, according to which the out of pocket expenditure was high despite the near universal maternal incentive scheme.[21]
The elements that contributed to the hidden cost of the hospital-based delivery were the education of mothers, the occupation of the home head, the monthly income of the family, the mode and place of delivery, distance from home to hospitals, and the length of the hospital stay[22]. Despite free maternity services,

[20] Kc, Ashish, Mats Målqvist, Amit Bhandari, Rejina Gurung, Omkar Basnet, and Avinash K Sunny. "Payment Mechanism for Institutional Births in Nepal." *Archives of Public Health* 79, no. 1 (September 9, 2021): https://doi.org/10.1186/s13690-021-00680-7.

[21] Kc et al., "Payment Mechanism for Institutional Births in Nepal," 5.

[22] Acharya et al., "Hidden Costs of Hospital Based Delivery From Two Tertiary Hospitals in Western Nepal," 10.

Nepalese women hesitate to visit hospitals for deliveries was shown to be mostly caused by hidden expenses.[23]

5.2.4 Low status of women

For decades, women have been denied equal rights to property, education, political participation, reproductive rights,livelihoods and so on. Structural barriers and social exclusion cause gender discrimination and inequalities.[24]The apparent requirement or benefit of utilising the delivery services is ignored by the family members of deceased women. Women were not provided with adequate information regarding the possible seriousness of pregnancy, delivery and postpartum and they did not share their issues which resulted in inadequate birth preparation which includes late antenatal check-up, long wait at homes unless life-threatening complications arise.Traditional practices and women's status can play a significant role in first delay. In Nepal, males make most of the decisions in households and men often don't participate in the delivery process either they are not alerted to the issues in time or they do not give proper attention towards the pregnant women. This is due to the low status of women in society and daughter in laws having to face discrimination in the husband's house and an absence of demand for obstetric care. This is a prevalent feature of patriarchal societies , particularly in low-income and marginalised households in Nepal's rural areas.[25]

5.2.5 Illiteracy

The literacy rate for women is 60.5 for females whereas the male literacy rate is 76.2 percent in Nepal.[26] The majority of maternal deaths are found from poor and marginalised family where most of women that passed away were

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[23] Acharya et al., "Hidden Costs of Hospital Based Delivery From Two Tertiary Hospitals in Western Nepal," 3.

[24] "Nepal Human Development Report 2020: Beyond Graduation: Productive Transformation and Prosperity" (Nepal: National Planning Commission, United Development Programme, 2020), 32.

[25] Rajendra Karkee et al., "Who Are Dying and Why? A Case Series Study of Maternal Deaths in Nepal," BMJ Open 11, no. 5 (May 1, 2021): 6–8, https://doi.org/10.1136/bmjopen-2020-042840.

[26] "Nepal Human Development Report 2020: Beyond Graduation: Productive Transformation and Prosperity," 37.

from lower castes and were illiterate,jobless. The majority of women experienced labour pain or difficulties that began at home when they attempted home delivery expecting normal delivery which demonstrates lack of awareness and knowledge to change institutional deliveries as there are other enabling causes such as transportation, social status, distance, money and quality health care[27].

5.3 Legal Frameworks addressing Maternal Health

5.3.1 The Constitution of Nepal, 2072

Article 32(1)(2)(3)of the Constitution of Nepal guarantees "the right relating to health" which provides to free basic health services from the State, and no one shall be deprived of emergency health services , the right to get information about his or her medical treatment and have equal access to health services.[28]

Article 38 of the Constitution guarantees the right of Women to have safe motherhood and reproductive health. Sub-section 4 of article 38 guaranteed the right of women to participate in all bodies of the State on the basis of the principle of proportional inclusion and sub-section 5 of this article ensures women's right to obtain special opportunity in education, health, employment and social security, on the basis of positive discrimination[29]

5.3.2 The Public Health Service Act,2075(2018)

This Act was enacted for making necessary provisions for implementing the right to get free basic health service and emergency health service ensured by the Constitution of Nepal.

Chapter 2 of this Act mentioned the rights, duties of service recipients and responsibilities of health institutions. Under this chapter, Section 3(1) provides every citizen to have the right to obtain quality health service in an easy and convenient manner. Section 3(4) of this chapter ensures the right to get free basic health related to motherhood , infant and paediatric health service[30].

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[27]Karkee et al., "Who Are Dying and Why? A Case Series Study of Maternal Deaths in Nepal," 8.

[28] Constitution of Nepal 2015, art.32(1)(2)(3)
[29] Constitution of Nepal 2015,art.38(4)(8)
[30] The Public Health Act,2018,Section3(1)(4)

Section 6 of this act provides every health institution shall, after providing service available in its institution, if there is no possibility to provide further treatment to the patient who comes for treatment due to the structure, equipment of its health institution, lack of specialist's service or any other appropriate cause, refer immediately to the health institution that can provide additional treatment to such a patient.

(2) While referring pursuant to Sub-section (1), the health institution shall fulfil the methods and procedures as prescribed

(3) After establishing necessary referral system among health institutions that provide specialist's service and basic health service, the Government of Nepal, Provincial Government and Local Level shall make necessary arrangements to make the service effective[31].

Section 5 of this act provides that the Government of Nepal shall provide specialised services prescribed as necessary on the basis of nature of service, geographical condition and the rate of epidemic of the disease[32].

Section 7 (1)provides ,Government of Nepal to make arrangement for providing every citizen with quality health service from a health Institution. Sub-section 3 of section 7 provides that the federation, province and local level shall make arrangements for human resources, technology and equipment in order to implement this act[33].

5.3.3 The Right to Safe Motherhood and Reproductive Health Act 2075(2018)

This Act is to make necessary provisions on making motherhood and reproductive health service safe, qualitative, easily available and accessible , in order to respect, protect and fulfil the right to safe motherhood and reproductive health of the women conferred by the Constitution of Nepal.

Chapter 2 , Section 2(1)(2)(3)(9) of this Act provides the right of women and teenager to obtain education, information, counselling and service relating to sexual and reproductive health and the right to nutritious, balanced diet and physical rest during the condition of pregnancy and childbirth and morbidity. Incorporates the right

[31] The Public Health Act, Section 6
[32] The Public Health Act, Section 5

[33] The Public Health Act, Section 7

to get reproductive health service needed during different situations of his/her lifecycle, in easily available, acceptable and safe manner[34].

Chapter 6, Section22(1)The Government of Nepal shall have to appropriate grant amount through its budget every year for every Local Level for the purpose of motherhood and reproductive health service. (2) The Provincial Government shall have to appropriate a certain amount through its budget as grant every year, as per the Provincial law, for the Local Level for the purpose of motherhood and reproductive health service. (3) The Local Level concerned shall have to spend the amount appropriated as per sub-sections (1) and (2) for the motherhood and reproductive health of the economically extremely destitute women as prescribed. 23. To appropriate budget by Local Level: (1) The Local Level shall have to appropriate the necessary budget from its annual budget for the purposes of motherhood and reproductive health service[35].

5.3.4 Nepal Treaty Act 2047(1990)

Section 9 In case of the provisions of a treaty, to which Nepal or Government of Nepal is a party upon its ratification accession, acceptance or approval by the Parliament, inconsistent with the provisions of prevailing laws, the inconsistent provision of the law shall be void for the purpose of that treaty, and the provisions of the treaty shall be enforceable as good as Nepalese laws[36].

[34] The Right to Safe Motherhood and Reproductive Health Act 2018,Section 2
[35] Right to Safe Motherhood and Reproductive Health Act , Section 22
[36] Nepal Treaty Act 1990, Section 9

5.4 Government initiatives

In an effort to enhance maternal and newborn outcomes, the Government of Nepal(GoN) initiated the Safe Motherhood Programme in 1997. The program specifically focused on removing financial barriers that prevent women and newborns from accessing institutional delivery,skilled birth attendants and maternity and newborn health facilities[37].

In 2009, the GoN launched a social audit to guarantee the effective execution of the 'Safe Motherhood Programme'. The intervention's goals were to raise community and women's awareness, encourage transparency in the health facility's decision-making process, hold decision-makers and healthcare professionals accountable and responsive to providing high-quality maternal health services, promote a culture of demand for information from the facility and strengthen mutual accountability between service providers and users.[38]

In Nepal, the community scoreboard (CSC) and community health scoreboard (CHSB) were introduced at the same time to encourage health sector accountability. With the assistance of the World Bank, the GoN piloted the CSC in 16 health posts in 2011. Although Csc was shown to provide useful information on facility performance, its high implementation cost and dearth of skilled human resources to support, the GoN was unable to expand it more. In the effort to enhance maternal health outcomes ,CARE-International implemented the community health scoreboard (CHSB) in Nepal,drawing on the successful CSC program in Malawi.[39]

Every public service centre has an information board called Citizen Charter. Since 2007 GoN has mandated that charters be placed in clearly visible areas within the public offices and infrastructure. Citizen Charter includes the information regarding the availability of services with cost, prerequisites for using the services, contact

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[37] Adweeti Nepal, Santa Kumar Dangol, and Anke Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," *Public Health Reviews* 41, no. 1 (December 1, 2020): 12, https://doi.org/10.1186/s40985-020-00147-0.

[38] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," 12.

[39] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," 12.

information,amount of the time needed and name of people to handle the grievances if any. [40]

Based on the idea of the monitor-review-act cycle, the Maternal Death Review(MDR) has been acknowledged by WHO as a relevant accountability tool for enhanced quality of the maternal health services. The GoN combined the MDR and 'Maternal Perinatal Death Review(MDHR)' programs to create the 'MPDSR' , a complete surveillance system. In Nepal, there are two types of MPDSR: community-based and facility-based.[41]A web-based system has been built by the MoHP to record maternal health deaths in Nepal and has been able to determine the causes of mortality deaths and MPDSR committee has developed action plans for various care levels.

5.5 Status of right of women to have safe motherhood and reproductive health

The Constitution of Nepal 2015 upholds the rights of women as fundamental rights,including the right to reproductive health and safety, education. While legal frameworks provide a strong foundation for advancing the rights of women and marginalised groups, there are still obstacles to converting legal equality into substantive equality for women.[42]Despite the positive government initiatives women in Nepal are still dying while giving birth due to preventable causes mainly. Women are not even allowed to make decisions about their own health which violates the rights of women to participate in decision making of their own health. Despite the government's emphasis on women's participation in each level of governance to improve social inclusion and gender equality, they tend to have less interest in accountability intervention due to unequal power dynamics, low education, excessive household chores and reproductive tasks. Women don't have much impact on the meetings because they only speak when specifically asked to. So the roles of women

[40] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," 11.

[41] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," 3.

[42] "Mapping Progress on Women's Rights in Nepal," UN Women – Asia-Pacific, n.d., 43, https://asiapacific.unwomen.org/en/digital-library/publications/2020/03/mapping-progress-on-womens-rights-in-nepal.

are limited to their physical attendance at the programmes while men are the ultimate decision makers. Evidence, however, indicates that increased female participation in participatory decision making process leads to noticeable improvement in maternal health services which ultimately reduces maternal mortality and morbidity[43]. In Nepal, a significant number of women's rights to be safe during delivery has been compromised[44].

The Public Health Act ensures the right to get free basic health related to motherhood and paediatric health service. The Government of Nepal is providing free maternity services but due to the hidden expenses Nepalese women hesitate to visit hospitals. This act has incorporated the provision about referral service where the Government of Nepal, Provincial Government and Local level should make necessary arrangements to make the referral service effective.Delays in referral services are the most frequent reason why mothers are dying due lack of transportation, administrative delays and late referral.

People who live in remote villages face difficulty in bringing mothers to the hospitals where in some areas they have to walk across the river. This act provides specialised service based on geographical condition, nature of services in section 5. The situation of people in remote village while getting health services and the provision in act doest seems to be matched.

Chapter 2, Section 9 of the Right to Safe Motherhood and Reproductive Health Act provides that women have the right to get reproductive health service needed during every situation of her lifecycle conveniently and in a safe manner.However, the majority of maternal fatalities were caused mostly by inadequate transportation, delayed referrals, a lack of necessary supplies, a deficit of qualified workers, and a shortage of medications. Chapter 6, section 22 of this act provides a provision regarding budget where an appropriate amount should be separated for Local level and Provincial government for the purpose of motherhood and reproductive health

[43] Adweeti Nepal, Santa Kumar Dangol, and Anke Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," Public Health Reviews 41, no. 1 (December 1, 2020): 15, https://doi.org/10.1186/s40985-020-00147-0.

[44] UKaid, Nepal Health Sector Support Programme, "National Medical Standard for Maternal and Newborn Care" (Ministry of health and Population, National Medical Standard for Maternal and Newborn care, 2220), 29.

services. Due to delayed release of funds , duplication in budgeting and underspend of health budgets at local level , the allocated budget is not being used which are separated for the motherhood and reproductive health services[45].

5.6 Solutions

5.6.1 Enhancing accessibility to health facilities

Birthing centres have been established by the Government of Nepal in rural areas to increase the institutional deliveries but usually these centres lack the capacity for timely diagnosis and management. So establishing these mid-level hospitals in rural areas is not feasible. Instead they should be built or upgraded from already existing health facilities at strategic locations in districts and regions of Nepal. For speedy transit, they should have good connections to villages and birthing centres.

The Safe Motherhood Programme can facilitate easy transportation access for the mothers in remote areas for reaching health facilities. Sometimes, they require helicopter rescue which poor people cannot afford[46].

5.6.2 Women's involvement in decision making process

The Government of Nepal explicitly highlighted accountability and governance as fundamental elements in its health policies to achieve the Sustainable Development Goals(SDGs) with regard to maternal health. Social accountability intervention plays an important role for progressive expansion while maintaining constant improvement in quality of health service and making service more affordable ,especially the poor and vulnerable groups[47].Research has demonstrated that increased participation of women in the decision making process, significant improvement in maternal health

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[45] Sharada Prasad Wasti et al., "Overcoming the Challenges Facing Nepal's Health System During Federalisation: An Analysis of Health System Building Blocks," *Health Research Policy and Systems* 21, no. 1 (November 2, 2023), https://doi.org/10.1186/s12961-023-01033-2.

[46] Rajendra Karkee et al., "Policies and Actions to Reduce Maternal Mortality in Nepal: Perspectives of Key Informants," *Sexual and Reproductive Health Matters* 29, no. 2 (April 6, 2021): 11, https://doi.org/10.1080/26410397.2021.1907026.

[47] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," December 1, 2020, 3.

care which ultimately reduces maternal death and morbidity. Mothers's groups are trustable representatives for women and intermediaries for social accountability interventions. But a clear directive at the policy level is needed[48].Researchers have highlighted that social accountability interventions can be successfully implemented in maternal health services if women are allowed to express their concerns and have access to channels for providing feedback and if health service providers are receptive to user feedback and willing for behavioural changes.[49]

5.6.3 Strengthening the capacity of health care services

Extension of 24-hour birthing centres alongside a safe motherhood program that encourages the continuation of antenatal care (ANC) to postnatal care (PNC). increasing the number of skilled health workers by providing training in obstetric drills and refresher courses, which might help in preventing,identifying and managing the main causes of maternal mortality. Inadequate instruments(delay 3) delay in providing intervention have caused maternal deaths in many studies which need to be addressed to reduce the maternal deaths[50].

5.6.4 Addressing financial barriers

Hidden costs must be decreased by concentrating on a number of socio-demographic parameters, including the pregnant women's educational attainment, the head of the household's occupation and the family's economic standing, in order to reduce the negative externalities associated with hospital-based delivery[51]. The Safe Motherhood program's maternal incentive scheme costs need to be reevaluated, and the compensation needs to be revised to lessen the financial burden[52].

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[48] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," December 1, 2020, 14.

[49] Nepal, Dangol, and Van Der Kwaak, "Improving Maternal Health Services Through Social Accountability Interventions in Nepal: An Analytical Review of Existing Literature," December 1, 2020, 20.

[50] Sitaula et al., "Prevalence and Risk Factors for Maternal Mortality at a Tertiary Care Centre in Eastern Nepal- Retrospective Cross Sectional Study," 7.

[51] Acharya et al., "Hidden Costs of Hospital Based Delivery From Two Tertiary Hospitals in Western Nepal," 9.

[52] Kc et al., "Payment Mechanism for Institutional Births in Nepal," 6.

6. Case Study 2- SRI LANKA

6.1 Background

Sri Lanka, a South Asian island nation, boasts a unique and evolving healthcare system that has made commendable strides in recent decades. The country's commitment to achieving universal health coverage and improving health outcomes has resulted in a system characterized by a blend of traditional and modern healthcare practices.[53]

The roots of Sri Lanka's healthcare system can be traced back to ancient times when indigenous healing practices, Ayurveda, and traditional medicine were predominant. With colonial influences and the introduction of Western medicine during British rule, the foundations of a modern healthcare system were laid.[54]

Presently, Sri Lanka's healthcare infrastructure is organized into three main tiers: primary, secondary, and tertiary. Primary healthcare is delivered through an extensive network of public health units, including clinics and dispensaries, serving as the first point of contact for the majority of the population. Secondary care facilities, comprising district and base hospitals, cater to more complex medical needs, while tertiary care is provided by specialized hospitals in major urban centers.[55]

The Sri Lankan government plays a pivotal role in the healthcare sector, with the Ministry of Health overseeing policy formulation, planning, and implementation. Public healthcare services are predominantly funded and provided by the government, ensuring accessibility and affordability for a significant portion of the population.[56]

Sri Lanka has achieved notable successes in public health, particularly in the areas of maternal and child health, infectious disease control, and vaccination programs. The

[53] Rajapaksa L, De Silva P, Abeykoon A, Somatunga L, Sathasivam S, Perera S et al. Sri Lanka health system review. New Delhi: World Health Organization Regional Office for South-East Asia; 2021, https://apo.who.int/publications/i/item/sri-lanka-health-system-review

[54] Dr Margaret Jones1, The Sri Lankan Path to Health for All from the Colonial Period to Alma-Ata, University of York, United Kingdom, (2015), https://www.ncbi.nlm.nih.gov/books/NBK316260/

[55] Harsha aturupane, hideki higashi, roshini ebenezer, deepika attygalle, shobhana sosale, sangeeta dey, and rehana wijesinghe, *Sri Lanka Human Capital Development*, World Bank Publications 2021, (37)

[56] Harsha aturupane, hideki higashi, roshini ebenezer, deepika attygalle, shobhana sosale, sangeeta dey, and rehana wijesinghe, *Sri Lanka Human Capital Development*, World Bank Publications 2021, (37)

country's efforts in eradicating malaria and reducing maternal and child mortality have gained international acclaim.[57]

Once consider about the Sri Lanka healthcare system it's organised by the domestic laws and the regulations. Talking about the Sri Lanka maternal healthcare system initially we have to identify the domestic laws which related to the maternal health care system.[58] Certain of the domestic laws as follow:

6.2 Sri Lanka Domestic Laws which related to Maternal Health

6.2.1 Constitution of the Sri Lanka

CHAPTER VI

In the of Sri Lanka's constitution lies a commitment to fostering a society where every individual can thrive. Guided by these principles, the government envisions a nation where every citizen, regardless of background or circumstance, has the opportunity to lead a life of dignity and well-being. At the core of this vision is the belief that access to quality healthcare is not just a privilege but a fundamental right for every Sri Lankan. It's about ensuring that a mother in a remote village and a family in a bustling city alike have access to the care they need when they need it most. These principles underscore the government's dedication to building a healthcare system that is not only efficient and effective but also compassionate and inclusive, reflecting the values of a society that cares for its own.[59]

NINTH SCHEDULE (Provincial Council List)

The Ninth Schedule of the constitution incorporates a special focus on healthcare within Sri Lanka's provincial governance. This schedule explains the responsibilities assigned to provincial councils in terms of health and indigenous medicine. Provincial councils play a critical role in ensuring their constituents' well-being by establishing and managing public hospitals, rural healthcare facilities, and maternity homes, as well as providing essential public health services such as health education and environmental health. Furthermore, the schedule permits provincial governments to

[57] Rajapaksa L, De Silva P, Abeykoon A, Somatunga L, Sathasivam S, Perera S et al. Sri Lanka health system review. New Delhi: World Health Organization Regional Office for South-East Asia; 2021, https://apo.who.int/publications/i/item/sri-lanka-health-system-review

[58] Harsha aturupane, hideki higashi, roshini ebenezer, deepika attygalle, shobhana sosale, sangeeta dey, and rehana wijesinghe, *Sri Lanka Human Capital Development*, World Bank Publications 2021, (37)

[59] Sri Lanka Constitution, Chapter VI, Art 27

create and implement comprehensive health development plans that are tailored to the specific needs of respective regions.[60]

Furthermore, it emphasizes the importance of indigenous medicine by enabling the development of Ayurvedic dispensaries and hospitals, as well as the upkeep of herbaria, which illustrate the complex tapestry of ancient therapeutic techniques woven into Sri Lanka's healthcare system. The Ninth Schedule's provisions highlight the government's commitment to providing accessible, holistic healthcare that meets the different requirements of its population at the provincial level.[61]

Sri Lanka's constitution does not explicitly recognize the right to health, hindering direct legal action for health issues in the Supreme Court. However, individuals can still seek remedies in lower courts under existing healthcare laws and regulations.[62] While this limitation affects legal recourse at the highest level, it doesn't leave individuals entirely without legal protections in healthcare matters. Efforts to advocate for constitutional recognition of the right to health may enhance legal safeguards and access to justice for health-related grievances.

The lack of constitutional recognition of the right to health in Sri Lanka may have consequences for maternal health. Maternal health includes a variety of services and rights necessary for a safe pregnancy, childbirth, and postnatal care. Pregnant women may face barriers to getting timely and high-quality maternal healthcare treatments if their right to health is not explicitly guaranteed by the constitution.

6.2.2 Health services act

The Sri Lanka Health Service Act establishes the structure and responsibilities of the Department of Health, as well as the formation of regional hospital boards and hospital committees, with the goal of encouraging more efficient public health management on the local level. The Act establishes the Department of Health, which has three divisions: medical services, public health services, and laboratory services.[63]

The Department of Health is responsible for several key objectives under this Act, including providing essential healthcare services for disease prevention and treatment, promoting health education and research through scholarships and grants, and implementing measures to investigate and prevent diseases while

[60] Sri Lanka Constitution, Ninth Schedule
[61] Sri Lanka Constitution, Ninth Schedule
[62] Sri Lanka Constitution, Chapter III
[63] Health Service act no 12 of 1952, Sec 02

improving public health. By outlining these obligations, the Act establishes a comprehensive framework for the management and delivery of healthcare services in Sri Lanka, highlighting the government's commitment to protecting its residents' well-being through a strong healthcare system.[64]

6.2.3 MATERNITY BENEFITS (AMENDMENT) ACT, No. 15 of 2018

This act, makes changes to Section 3 of the Maternity Benefits Ordinance, changing the eligibility term for maternity benefits for female employees. The modified clause defines the period during which a woman worker is eligible to maternity benefits based on whether her confinement results in the birth of a living child or not. If the confinement results in a live birth, the entitlement period is twelve weeks, starting two weeks before and ending ten weeks after the confinement date. If the confinement does not result in a live birth, the entitlement period is decreased to six weeks, beginning two weeks before and ending four weeks after the day of confinement.[65]

The amendment also states that if the woman worker worked for the first two weeks before her confinement, she is entitled to maternity benefits for the same number of days after her confinement, beginning the day after the end of the ten-week or four-week period, as applicable. These modifications seek to give clarity and uniformity about maternity benefits rights for female employees, ensuring adequate support during the critical period preceding childbirth.[66]

6.2.4 MATERNITY BENEFITS ORDINANCE, No 32 of 1939

The Sri Lanka Maternity Benefit Ordinance defines a number of rules and regulations governing maternity health system offerings. First, Section 8 of the law requires the employer to pay the maternity benefit for the period up to and including the day of confinement within forty-eight hours of the woman worker producing the authorized proof of confinement. Furthermore, the sum due for the next term must be paid in two payments, at the end of the second and fourth weeks, respectively, following her confinement, regardless of whether she has told her employer of her confinement.[67]

In the case that a woman worker entitled to maternity benefit dies during the stipulated term, Section 9 requires the employer to pay the outstanding maternity

[64] Health Service act no 12 of 1952, Sec 05
[65] Maternity Benefit (Amendment) Act no 15 of 2018, Sec 02
[66] Maternity Benefit (Amendment) Act no 15 of 2018, Sec 03
[67] Maternity Benefits Ordinance no 32 of 1939, Sec 08

benefit to the person named in the notice submitted under Section 7(3). If no such person has been specified, the payment will be distributed to her heirs at law.[68]

Furthermore, Section 10 protects pregnant employees by preventing employers from issuing notice of dismissal during the woman worker's absence from work under the ordinance or on a day that would expire while she is absent. Similarly, Section 10A forbids termination of employment simply on the basis of pregnancy, confinement, or related illnesses. It shifts the burden of proof on the employer in the event of prosecution for violating this rule.[69]

Section 10B contains provisions concerning the employment of pregnant women. It prevents a woman worker from working from the date mentioned in her notification to the date preceding her confinement if she expects to be confined for a duration of three months or less. It also prevents a woman worker from working on any job that could endanger her or her child for three months after her confinement date.[70]

Furthermore, Section 11 protects a female employee from dismissal without cause within five months of her confinement. Dismissal during this period does not deprive her of any maternity benefits she is entitled to. Any argument over the sufficiency of cause for dismissal must be presented to the Commissioner for resolution, and his judgment is final.[71]

Finally, Section 12 states that the employer's duty to pay maternity benefits is a first charge on the assets of the trade in which the woman worker is employed, guaranteeing that such payments are prioritized.[72]

6.3 Background of the Sri Lanka System and Maternal Health System

Sri Lanka's maternal health landscape has evolved substantially, with historical records indicating improvements in maternal and child health dating back to the mid-20th century. The country's focus on healthcare, education, and family planning has contributed to a noteworthy decline in maternal mortality rates.[73]

Maternal health and mortality in Sri Lanka have undergone significant transformations over the years, reflecting both successes and ongoing challenges. The

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[68] Maternity Benefits Ordinance no 32 of 1939, Sec 09
[69] Maternity Benefits Ordinance no 32 of 1939, Sec 10
[70] Maternity Benefits Ordinance no 32 of 1939, Sec 10B
[71] Maternity Benefits Ordinance no 32 of 1939, Sec 11
[72] Maternity Benefits Ordinance no 32 of 1939, Sec 12
[73] Harsha aturupane, hideki higashi, roshini ebenezer, deepika attygalle, shobhana sosale, sangeeta dey, and rehana wijesinghe, *Sri Lanka Human Capital Development*, World Bank Publications 2021, (53)

Maternal Mortality Ratio (MMR), a critical indicator of maternal health, measures the number of maternal deaths per 100,000 live births. In Sri Lanka, the MMR has seen significant reductions over the years, reflecting the success of comprehensive healthcare programs and policies.[74]

6.4 Present Maternal Mortality Situation in Sri Lanka

The maternal mortality records from the year 2019 in Sri Lanka provides valuable insights into the country's maternal healthcare system and the factors contributing to maternal deaths. Sri Lanka has a well-established Maternal Death Surveillance and Response (MDSR) mechanism in operation since 1981.[75] This structured system involves the collaboration of field and hospital health staff, comprehensive case scenario development, and a detailed review process at both district and national levels. The MDSR mechanism aims to identify deficiencies in seeking healthcare, reaching care, and treating maternal complications, with the ultimate goal of translating lessons learned into practice, programs, and policies.[76]

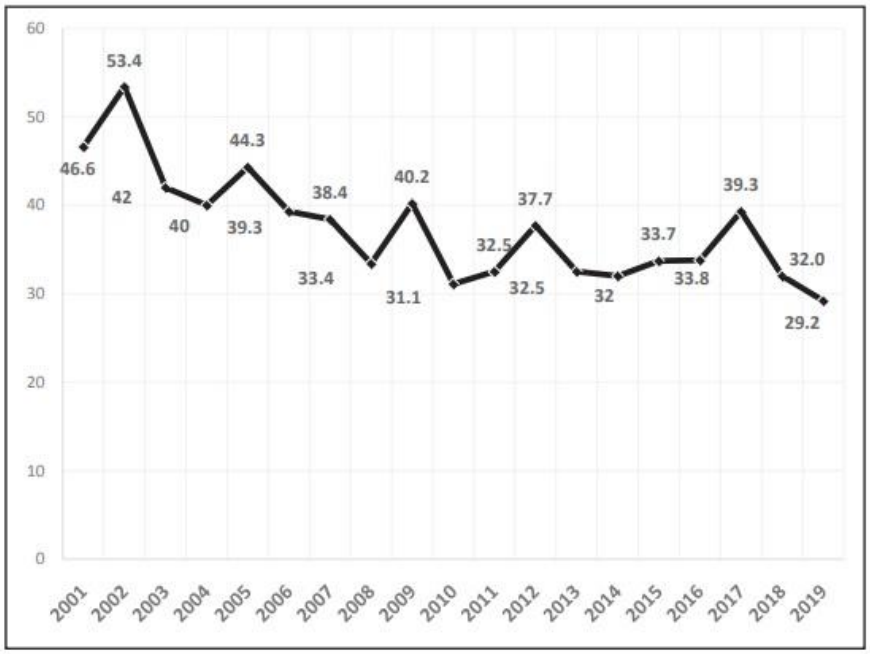

Fig.2 (Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019)*

[74] Harsha aturupane, hideki higashi, roshini ebenezer, deepika attygalle, shobhana sosale, sangeeta dey, and rehana wijesinghe, *Sri Lanka Human Capital Development*, World Bank Publications 2021, (53)
[75] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (43)
[76] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (43)

Maternal Mortality Ratio (MMR) a key indicator of maternal deaths, assesses the risk of maternal mortality once a woman is pregnant. Sri Lanka has shown a significant reduction in MMR over the decades, reaching commendable levels compared to other South Asian countries. In 2019, the MMR was reported as 29.2 per 100,000 live births. In 2019, the field health staff in Sri Lanka registered and provided care for over 3.9 million eligible families. Among the 341,745 pregnant mothers registered, 95.4% received antenatal care, and 99.9% delivered in a hospital, reflecting high rates of healthcare utilization during pregnancy.[77]

6.5 Classification of the Maternal Mortality

Maternal deaths are categorized into two groups: direct and indirect. Direct obstetric deaths result from complications during pregnancy, labor, and postpartum, while indirect deaths result from pre-existing conditions aggravated by pregnancy. In 2019, 56% of maternal deaths were classified as indirect, 43% as direct, and 1% as uncertain.[78]

6.6 Causes for Maternal Mortality in 2019

In the year 2019, Sri Lanka recorded a total of 93 maternal deaths, each with its own set of contributing factors. The causes of maternal deaths provide valuable insights into the challenges faced by pregnant individuals and the healthcare system. The leading causes of maternal deaths in Sri Lanka in 2019 were diverse, reflecting a range of medical conditions and complications associated with pregnancy.[79]

6.6.1 Heard Disease (16%)

In 2019, heart diseases emerged as a significant contributor to maternal mortality in Sri Lanka, accounting for 16% of the reported cases. The specific heart-related conditions leading to maternal deaths were diverse and posed unique challenges during pregnancy and childbirth.[80]

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[77] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (44)
[78] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (46)
[79] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (48)
[80] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (48)

Rheumatic Valvular Heart Disease and Ischaemic Heart Disease were identified as prominent causes within the broader category of heart diseases. Rheumatic Valvular Heart Disease refers to heart valve damage caused by rheumatic fever, an inflammatory condition that can result from untreated streptococcal infections. Ischaemic Heart Disease, on the other hand, involves reduced blood flow to the heart muscle, often due to the build up of plaque in the coronary arteries.[81]

The maternal deaths associated with heart diseases underscore the complexity of managing pre-existing cardiovascular conditions in the context of pregnancy. Pregnancy exerts additional strain on the cardiovascular system, and individuals with heart diseases may face increased risks and complications. The data does not provide detailed information on the specific circumstances or interventions related to each case, but it highlights the importance of specialized care and monitoring for pregnant individuals with pre-existing heart conditions.[82]

The role of healthcare providers in recognizing and managing cardiovascular risks during pregnancy is crucial. Adequate antenatal care, close monitoring of maternal health, and timely interventions are essential elements in mitigating the impact of heart diseases on maternal mortality. The categorization of heart diseases as a leading cause emphasizes the need for targeted strategies and interventions to address cardiovascular health in the maternal population, ultimately contributing to the reduction of maternal mortality rates in Sri Lanka.[83]

6.6.2 Respiratory Disease (13%)

Respiratory diseases accounted for 13% of maternal deaths in 2019. Within this category, pneumonia emerged as a primary concern, with 10 out of the 12 reported deaths attributed to this respiratory condition. Additionally, influenza virus was implicated in five pneumonia-related deaths. The data underscores the vulnerability of pregnant individuals to respiratory infections and highlights the importance of addressing respiratory health during pregnancy.[84]

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[81] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (49)
[82] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (49)
[83] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (49)
[84] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (49)

The impact of respiratory diseases on maternal mortality emphasizes the need for effective preventive measures, timely diagnosis, and appropriate management. Adequate antenatal care and interventions to prevent and manage respiratory infections can play a pivotal role in reducing maternal deaths associated with these conditions.

6.6.3 Obstetric haemorrhage (09%)[85]

Obstetric hemorrhage, or excessive bleeding during pregnancy, labor, or postpartum, represented another significant cause of maternal mortality, contributing to 9% of reported cases in 2019. The causes of obstetric hemorrhage included postpartum hemorrhage (including one case related to home delivery), uterine rupture, and abnormally-adherent placentae.

The prevention and management of obstetric hemorrhage require a multifaceted approach, including skilled obstetric care, access to emergency obstetric services, and timely interventions during childbirth. Antenatal education and preparedness for potential complications are crucial elements in reducing the incidence and impact of obstetric hemorrhage on maternal mortality.

6.6.4 Suicide (26%)[86]

Maternal suicides, totaling 24 cases, were included in the analysis. It's important to note that only cases fulfilling the maternal death definition were considered (3 out of the 24 suicides), emphasizing the complexity of mental health and its impact on maternal mortality.

6.6.5 Liver Disease[87]

There was a significant reduction in the number of deaths attributed to liver disease compared to previous years. The specific causes and nature of liver diseases were not detailed in the provided information.

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[85] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (49)
[86] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (50)
[87] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (50)

6.6.6 Other Causes:

Various other causes, including hypertensive disorders, and complications related to the pregnant state, contributed to maternal deaths. The causes of death evolved over the years, with notable reductions in some direct causes, such as obstetric hemorrhage.[88]

Furthermore, the data indicates that the majority of women (81%) received care at a hospital before succumbing to maternal death, reinforcing the importance of healthcare interventions in preventing and managing maternal complications. Delays in seeking, reaching, and treating (Three Delays) were identified in 69% of confirmed maternal deaths, emphasizing the need for timely and accessible healthcare services.

6.7 Causes for Maternal Mortality in year 2020

In 2020, Sri Lanka recorded 91 maternal deaths, providing a provisional national Maternal Mortality Ratio (MMR) of 30.2 for 100,000 live births. This result, based on live births reported by the Registrar General's Department (301,706 for 2020), showed a modest increase in MMR over the previous year, owing mostly to a significant fall in live births (17,304 fewer births) in the denominator.[89]

In 2020, maternal deaths were spread across three sectors: rural (77%), urban (21%), and estate (2%). The ethnic composition of the ladies was Sinhala (66%), Tamil (23%), and Muslim (11%). The bulk of the ladies (96%) were married, with three unmarried and one lady cohabiting. Three teenage maternal deaths occurred, with a considerable number (74%) falling between the ages of 20 to 35, with 23% of women older than 35.[90]

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[88] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021 (52)
[89] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Interim Analysis of Maternal Deaths - 2020 Annual Report*, Dec 2021, (03)
[90] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Interim Analysis of Maternal Deaths - 2020 Annual Report*, Dec 2021, (04)

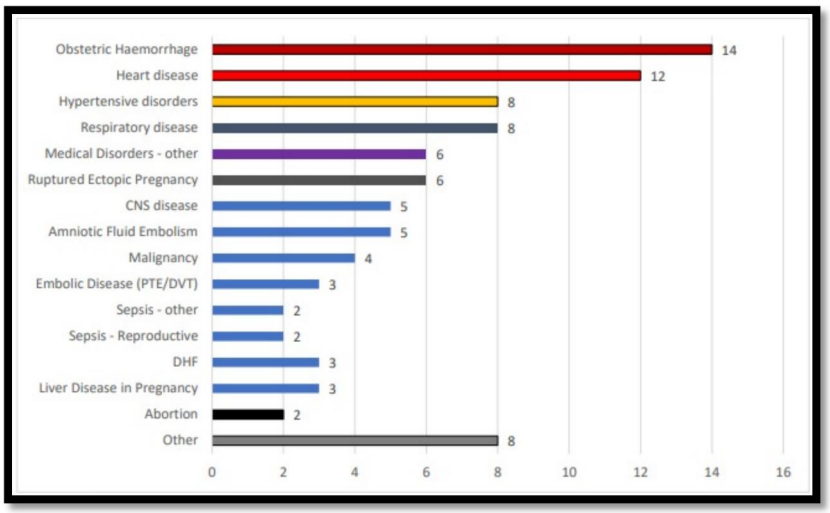

Fig.3 (Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Interim Analysis of Maternal Deaths - 2020)*

The causes of maternal deaths in 2020 (Figure 3) included obstetric hemorrhage (15%), heart disease (13%), hypertensive disorders (9%), and respiratory disease (9%). Hypertensive disorders assumed a leading cause after a prolonged duration, while the other three causes rotated as leading causes over the preceding years.[91]

Considering the particular causes of maternal fatalities in 2020 sheds light on the issues confronting Sri Lanka's maternal healthcare system, leading future measures and policies to further reduce maternal mortality.[92]

6.8 Causes for Maternal Mortality in year 2021

In 2021, Sri Lanka experienced an increase in maternal mortality, as seen by the Maternal Mortality Ratio (MMR) of 47.04 per 100,000 live births. This significant rise over previous years can be traced mostly to the increased impact of the COVID-19 pandemic, with 60 maternal deaths connected to virus-related complications. [93]

[91] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Interim Analysis of Maternal Deaths - 2020 Annual Report*, Dec 2021, (05)
[92] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Interim Analysis of Maternal Deaths - 2020 Annual Report*, Dec 2021, (06)
[93] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (03)

Fig.4(Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021)*

A under graphical representation of maternal deaths from 2001 to 2021 shows a steady decline until 2020, followed by a dramatic increase in 2021, corresponding with the peak of the COVID-19 epidemic. A district-by-district examination finds great variety, with Kilinochchi reporting the highest MMR of 103 per 100,000 live births.[94]

COVID-19 complications became the major cause of maternal death in 2021, accounting for 44.8% of all reported cases. Other significant reasons included heart disease (11.9%), obstetric embolism (6.7%), obstetric hemorrhage (6%), and abortion (4.5%). The impact of COVID-19 on maternal mortality is clear, with a dramatic shift in the major causes.[95]

The Sri Lanka multidisciplinary panel identified delays in seeking, reaching, and treating in a significant proportion of cases (81.3%). The COVID-19 pandemic and associated restrictions likely contributed to the increased presence of delays. Additionally, the panel deemed 73.9% of maternal deaths preventable.[96]

[94] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (05)
[95] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (06)
[96] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (08)

6.8 Analyse of Maternal Mortality

Maternal mortality in Sri Lanka is a complex issue influenced by a variety of factors, including delays in seeking treatment, a lack of awareness of pregnancy-related hazards, and shortcomings in healthcare facilities. According to Dr. Harendra Dassanayake,[97] a consultant with the Maternal Morbidity and Mortality Surveillance Unit, one of the leading causes of maternal mortality is a delay in receiving appropriate medical care. Many pregnant mothers are unaware of the potential risks connected with pregnancy or fail to detect warning signals of difficulties, causing delays in seeking necessary healthcare treatments.

Dr. Dassanayake highlights that significant amounts of maternal mortality can be avoided with immediate action and appropriate care. However, pregnant mothers must have an extensive understanding of pregnancy-related risks and the significance of seeking immediate medical assistance. Furthermore, healthcare institutions must be appropriately staffed with qualified specialists, such as obstetricians and anesthesiologists, as well as necessary resources, in order to effectively manage obstetric emergencies.[98]

The causes of maternal mortality in Sri Lanka are further underscored by data from the Maternal Morbidity, Mortality Surveillance Unit, which indicates that inadequate pre-pregnancy preparation and delays in treatment contribute to a significant number of preventable deaths. The surveillance data highlights the importance of educating expectant mothers about pregnancy-related risks and ensuring timely access to healthcare services.[99]

Furthermore, the availability of skilled healthcare professionals, particularly obstetricians and anesthesiologists, emerges as a critical factor in reducing maternal mortality rates. Emergency deliveries require qualified specialists on hand to improve maternal outcomes effectively. Additionally, investments in healthcare infrastructure and resources are essential to enhance the quality and accessibility of maternal healthcare services nationwide.[100]

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[97] Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician, 07 March 2023
[98] Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician, 07 March 2023
[99] Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician, 07 March 2023
[100] Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician, 07 March 2023

Addressing the maternal mortality rate in Sri Lanka requires a multifaceted approach that includes education, capacity building for healthcare workers, and ongoing investment in healthcare facilities. Sri Lanka can significantly reduce maternal mortality and provide healthier pregnancies for all women by resolving treatment delays, raising knowledge of pregnancy-related risks, and strengthening healthcare infrastructure.[101]

As per the Sri Lankan government reports evidently mentioned more than 70% of maternal deaths are in preventable in year 2021. Studying above mention causes and statistics recognize some common reasons which increase the maternal mortality.[102]

6.8.1 Inadequate and Inaccessible Health Care

In 2021, an extensive investigation of maternal deaths was carried out, with an emphasis on delays in searching, reaching, and treating. The findings, given by a multidisciplinary panel of specialists, provide substantial insight into the factors that contribute to maternal mortality.[103]

The data revealed that 81.3% of maternal deaths, equivalent to 121 cases, experienced some form of delay. This marks a significant increase from the 2020 figure of 51.7%, suggesting a potential correlation with the challenges posed by the COVID-19 pandemic, including associated lockdowns and travel restrictions. An alarming 77% of maternal deaths, totalling 103 cases, were associated with Type 1 delay, primarily related to issues in seeking care. The dominance of Type 1 delay underscores a critical area for improvement in the maternal healthcare system. Factors contributing to delayed healthcare seeking need thorough examination and targeted interventions.[104]

Type 3 delay connected to the provision of timely and appropriate treatment, exhibited a substantial increase, with 38% of all maternal deaths reporting this delay either independently or in conjunction with other delays. The noteworthy surge in Delay 3 indicates challenges in delivering timely and effective medical interventions.

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[101] Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician, 07 March 2023

[102] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (08)

[103] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (02)

[104] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (07)

The COVID-19 pandemic might have played a role in hindering treatment accessibility.[105]

The causative links between inadequate access and delayed treatment are evident, with one often acting as a precursor to the other. In scenarios where individuals face barriers in reaching healthcare facilities promptly, delays in seeking and receiving adequate medical attention become more pronounced. This interconnected nature creates a compounding effect, intensifying the overall risks associated with maternal health.[106]

Due to the inadequate and inaccessible health system following issues are found:[107]

a. Late or inadequate multidisciplinary team (MDT) approach to patient management:

Obstetricians, anesthesiologists, neonatologists, and nurses are frequently required to work together to provide maternal care. The delayed or insufficient involvement of these professionals in patient management might result in inadequate care and adverse consequences for pregnant women.

b. Lack of adequate resuscitation facilities, HDU, ICU, transport facilities in certain private healthcare institutes

Access to critical care facilities, such as resuscitation units, high dependency units (HDU), and intensive care units (ICU), is vital for successfully handling obstetric emergencies. Inadequate facilities, particularly in private healthcare institutions, might cause delays in appropriate interventions and increase maternal morbidity and death.

c. Unavailability of required medications, facilities, or logistics at the hospital level:

To effectively address obstetric emergencies, maternal healthcare facilities must be well-equipped with the required drugs, equipment, and logistical assistance. Shortages or unavailability of these resources can prevent timely and effective care, resulting in poor maternal outcomes.

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[105] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (06)
[106] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (07)
[107] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (11)

d. Delayed recognition, diagnosis, and treatment initiation for medical and obstetric emergencies:

Early detection and treatment of medical and obstetric problems, including as sepsis, preeclampsia, and amniotic fluid embolism, is crucial for reducing maternal mortality. Delays in diagnosis, treatment commencement, and escalation of management can have a major impact on maternal outcomes and increase the risk of death.

e. Inappropriate and inadequate management of critical symptoms at the GP level:

General practitioners (GPs) play an important role in the early detection and treatment of pregnancy-related problems. However, insufficient training, funding, and support for GPs may result in inefficient management of key symptoms, such as shortness of breath, which can contribute to poor maternal outcomes.

6.8.2 A Lack of Knowledge

In the context of the alarming rise in maternal mortality in Sri Lanka, effective educational strategies are paramount to address the identified delays and enhance overall maternal health outcomes. Recognizing the multifaceted challenges, particularly the significant increase in delays, a targeted approach that combines community education, healthcare provider training, and technological interventions can contribute to substantial improvements.[108]

The identified issues, such as inadequate pre-pregnancy preparation and inappropriate family planning methods leading to unwanted pregnancies, highlight the need for comprehensive and accessible education. As a recent records Sri Lankan maternal mortality can reduce more than 70% because in year 2021 records says 78% maternal death are preventable. Consequently lack of education also one of reason increasing maternal mortality.[109]

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[108] Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician, 07 March 2023

[109] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (11)

Due to the lack of knowledge following issues are found:[110]

a. Inadequate pre-pregnancy preparation and inappropriate family planning methods:

Effective family planning is critical for avoiding unplanned pregnancies and lowering maternal mortality. However, insufficient pre-pregnancy counseling and the use of improper family planning methods might raise the risk of difficulties during pregnancy and labor.

6.9 Government Initiatives

The Sri Lankan government has launched a series of measures to reduce maternal mortality, with a focus on maternal and newborn care. One major result is the promotion of hospital deliveries, with 92% taking place in hospitals with specialised facilities. This comprehensive approach guarantees that pregnant women receive care in settings capable of efficiently addressing any problems.[111]

To improve monitoring during delivery, all pregnant women are tracked using the partogram, a useful instrument that allows healthcare personnel to measure labor progress and intervene quickly if deviations occur. Furthermore, color-coded Modified Obstetric Early Warning Signs (MOEWS) charts make postpartum monitoring and identifying issues easier, ensuring prompt interventions.[112]

Mother Baby Centers and Lactation Management Centers (LMC) have been established at 31 and 68 specialty hospitals, respectively, to increase the emphasis on specialized care. The government aims to provide these critical facilities to all specialty institutions that care for babies, demonstrating their commitment to comprehensive maternal and neonatal health care.[113]

Consultative meetings and review sessions have been held to address congenital diseases such as congenital hypothyroidism screening, congenital deafness screening, and the Neonatal Retrieval System. These efforts aim to improve early detection and

[110] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Analysis of Maternal Deaths - 2021 Final Report*, 2023, (11)
[111] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021
[112] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021
[113] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021

intervention for congenital disorders, resulting in better maternal and newborn health.[114]

6.9 Solutions

6.9.1 Education on Danger Signs:

Providing broad education to pregnant women and their families is essential. This education should cover frequent danger indicators including extreme stomach discomfort, heavy bleeding, and a high temperature, which might suggest difficulties during pregnancy or after childbirth. Empowering women and their families with this knowledge allows them to recognize when medical intervention is required and seek care as soon as possible, lowering the risk of maternal mortality owing to treatment delays.

6.9.2 Increased Observation for High-Risk Mothers:

High-risk mothers, such as those with pre-existing medical disorders like diabetes or hypertension, require close monitoring throughout their pregnancy. Healthcare practitioners should conduct regular check-ups and offer individualized advice on how to manage their patients' specific health conditions. Negative outcomes can be avoided by constantly monitoring high-risk pregnancies and responding quickly to any issues that emerge.

6.9.3 Guideline Adherence and Training:

Developing and distributing specific guidelines and recommendations for addressing obstetric emergencies is critical. Healthcare personnel should attend regular training sessions to ensure that they have the essential skills and knowledge to handle emergencies efficiently. Healthcare facilities can improve maternal care quality and lower death rates by standardising treatment methods and ensuring adherence to recommendations.

6.9.4 Pre-Pregnancy Counseling:

Pre-pregnancy counseling is critical for identifying and resolving any risk factors prior to conception. Women with pre-existing medical issues or other risk factors should seek professional advice to improve their health before becoming pregnant. This may include lifestyle changes, medication

[114] Sri Lanka Government, Family Health Bureau Ministry of Health Sri Lanka, *Annual Report of the Family Health Bureau 2019*, May 2021

adjustments, and meetings with specialists in order to reduce risks and improve maternal outcomes.

6.9.5 Family Planning Services:

Access to comprehensive family planning services is critical for avoiding unplanned pregnancies and properly spacing newborns. Women should have access to a variety of contraceptive choices based on their own needs and preferences. Furthermore, continuing support and follow-up services are required to ensure that chosen contraceptive methods remain effective and satisfactory, fostering responsible family planning practices and lowering the occurrence of high-risk pregnancies.

By successfully adhering to these recommendations, Sri Lanka can strengthen its maternal healthcare system, improve maternal outcomes, and, eventually, lower maternal death rates. Investing in education, monitoring, guideline adherence, pre-pregnancy care, and family planning services has the potential to significantly improve maternal health and well-being throughout the country.

7. Findings

Despite legal frameworks upholding women's rights to reproductive health and safety in Nepal, challenges persist in converting legal equity into substantive equality for women whereas Sri Lanka does not consider health as right but the government has guaranteed Economic,Social and Cultural Rights (ESCR) through its legislation and policy.

Nepal and Sri-Lanka both of the country lacks adequate medical professionals, drugs and equipments.

In both Nepal and Sri-Lanka majority of the maternal deaths are due to preventable causes such as haemorrhage and hypertensive disorder during pregnancy.

Delays in referral services are a common reason for maternal deaths in Nepal with challenges in accessing hospitals and specialised services in remote areas and the most common reason for Sri-Lanka is lack of awareness of the potential risks connected with pregnancy or failure to detect warning signals of difficulties, causing delays in seeking necessary healthcare treatments.

8. Conclusion

In conclusion, women are dying during delivery due to preventable causes mostly in both countries and poverty, inadequate infrastructure, geographical barriers, and cultural stereotypes are the factors contributing these deaths. These factors underscore the need of enhancing healthcare services, improving women's participation in decision-making, need of health care investments and addressing financial barriers to ensure equitable access to quality health care. Despite of having legal provision, international treaties and commitments government of these two countries continues to face challenges to reduce maternal deaths. This report shows only guaranteeing rights, commitments and introducing health programs doesn't overcome the challenges. To achieve tangible improvements in maternal deaths comprehensive community engagement is needed.

9. Recommendations

To the Government of Nepal

- Improve transportation facilities for easier access to heath care services, particularly in remote areas and consider providing helicopter services where transportation is difficult and expensive for the population.
- Improve referral systems and focus on management of health institutions to reduce delays in seeking, reaching and treating pregnant women in need of emergency obstetric care.
- Ensure that women have a significant role in accountability interventions for enhancing social inclusion and gender equality in healthcare decision.
- Examine and address hidden costs related to hospital-based deliveries and take action to lower the cost barriers.

To the Sri Lanka Government

- Strengthen emergency obstetric care services in all districts, particularly in areas with high maternal mortality rates like Kilinochchi and ensure that medical institutions have necessary resources and trained staff to handle obstetric emergencies promptly and effectively.
- Organise public awareness campaigns about pregnancy related risks, warning signs and the importance of seeking timely healthcare services during pregnancy and child birth.
- Foster collaboration between legislators, community stakeholders and healthcare professionals to create all comprehensive strategies reducing maternal deaths.
- Strengthen coordination between primary, secondary and tertiary healthcare facilities to guarantee smooth referrals for high-risk pregnancies.

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Appendix

Interview questions - Dr Harendra Dassanayake, Family Health Bureau Ministry of Health Sri Lanka, Maternity, Mobility and surveillance unit, Consultant community physician

Introduction

1. Can you provide introduction about yourself?

Background and Overview:

1. Can you provide an overview of the current maternal mortality situation in Sri Lanka?
2. What are the key factors contributing to maternal mortality in Sri Lanka?

Causes of Maternal Mortality:

1. Could you elaborate on the primary causes of maternal mortality in Sri Lanka based on your surveillance findings?

Preventive Measures and Precautions:

1. In your opinion, what are the most effective preventive measures that can be implemented to reduce maternal mortality in Sri Lanka?

Future Strategies:

1. Looking forward, what strategies or innovations do you believe would be most impactful in further reducing maternal mortality in Sri Lanka?

Community Awareness and Education:

1. How is the unit involved in raising awareness and educating communities about maternal health and the risks associated with pregnancy?

Recommendations for Researchers:

1. For researchers interested in studying maternal mortality, what areas or aspects would you suggest focusing on to contribute to the existing knowledge base?