SUBMISSION FOR CONTRIBUTION TO THE UNITED NATIONS OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS' FOLLOW-UP REPORT ON GOOD PRACTICE AND CHALLENGES IN IMPLEMENTING A HUMAN RIGHTS-BASED APPROACH TO ELIMINATE PREVENTABLE MATERNAL MORTALITY AND MORBIDITY

Association for Women's Right to Health in Development (Türkiye)

This submission has been prepared by the Association for Women's Right to Health in Development in Turkey, in accordance with the United Nations Human Rights Council resolution 47/25, in an attempt to identify the current situation in Türkiye in the field of good practices and challenges in implementing a human rights-based approach towards eliminating preventable maternal deaths and morbidity.

What steps has your government or organization taken to utilize a human rights-based approach in policies and programs to eliminate preventable maternal mortality and morbidity? How has the technical guidance assisted your government or organization in designing, implementing, revising, and/or evaluating such policies and programs?

The primary concern for women in terms of sexual and reproductive health in Türkiye is maternal mortality. One of the UN's 2030 Sustainable Development Goals is to reduce maternal deaths to below 75 per 100,000 live births between 2015 and 2030 period, and to eliminate preventable maternal deaths (1). Türkiye is considered among the countries that have achieved this goal where the institution responsible for ensuring women and their maternal health through laws and regulations is the Ministry of Health. The Ministry carries out activities aimed at protecting women and women's maternal health by collaborating with provincial health directorates, public health directorates, universities, local governments, and non-governmental organizations. According to data from the World Health Organization, Türkiye has managed to reduce maternal mortality rates by 83.5% (1). Bringing maternal mortality rates to the desired level is one of the Ministry of Health's primary objectives.

The related efforts towards women's health in Türkiye gained momentum during the Republican era. With the 1950s, maternal mortality rates increased, leading to the establishment of Maternal and Child Health Centers (MCH) due to high fertility rates and illegal abortions. In 1965, the Population Planning Law was passed, and in 1978, the Basic Health Services (BHS) Law was enacted. In 1982, the General Directorate of Maternal and Child Health and Family Planning (MCH/FP) was established. Legalization of voluntary surgical sterilization and optional abortion up to the 10th week of pregnancy with the "Law on Population Planning" No. 2827 dated May 27, 1983, the National Strategic Action Plan for the Sexual and Reproductive Health and Health Sector (2005-2015), and the bylaw of restructuring the activities of the directorate for the Turkish Mother, Child, and Adolescent Health Institute is among the milestones of women's health (2-3).

In 1998, the National Strategic Plan for Women's Health and Family Planning (WS/FP-NSP) was prepared in Turkey, taking into account the improvement of women's health as a key objective and the provision of safe maternity care (4?). Additionally, in December 2001, the government of the Republic of Türkiye and the European Commission signed the Türkiye Reproductive Health Program (TRHP) Financing Agreement (5). The program, launched in January 2003, aims to contribute to the improvement of sexual and reproductive health (SRH) in Turkish society, particularly in terms of women and adolescents. The Turkish Reproductive Health Program (TRHP) involves many interrelated

studies ranging from training components to the establishment of youth counselling centres, from material procurement to small/large-scale research, and from the development of health managers' management capacities to information-education-communication (IEC) activities. Safe maternity care, family planning, sexually transmitted infections, and services for young people, including emergency obstetric care, are among the priorities in these studies.

Within the scope of the program, financial support is provided to the efforts by non-governmental organizations in order to increase the demand for high-quality reproductive health (FHTP) and the Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO) (5). Serious efforts were made to expand and strengthen SRH service provision in Turkey. Some progress has been made, however, studies on these issues need to be furthered in order to better address the reproductive health issues more effectively services. In addition, support was also received from the U.S. Agency for International Development (USAID) and its subordinate organizations, the International Family Health Education Program and to replace traditional approaches in service delivery with comprehensive SRH and FP. Some objectives have been determined by the Turkish Ministry of Health, ranging from providing iron support during lactation, to increasing in-hospital births, building mother-baby friendly hospitals, providing vitamin D support to pregnant women, providing the necessary counselling services to all pregnant women in prenatal care, and reducing the caesarean delivery rate and maternal mortality. In addition to these, the objectives also involve preventing unwanted pregnancies, encouraging the use of modern contraceptives, and ensuring that pregnant women living in unsuitable conditions benefit from the guest mother practices (6,7,8). In the 11th development plan (2019-2023), there are principles of family planning and protecting the right to health in Articles 41 and 56 of the Turkish Constitution, aiming at strengthening maternal health. Although the rights-based service approach is increasingly integrated into health personnel training in maternal and women's health studies, there are still disruptions in its full implementation in field studies. When the structural documents that shape the policy and service areas of women's health are analysed in the context of transparency, accountability, participation, empowerment, equality and non-discrimination, gender equality, accessibility, and legality (with reference to international human rights law), it can be seen that the technical guidance provided to the respective states for reducing preventable maternal deaths and illnesses is not being applied at the intended level.

-It has been observed that all documents prepared in the field of maternal and women's health, including laws and regulations, are in line with the views shared by WHO and its guidelines, but are far from being participatory, as can be obtained from the content of the documents and the views of the experts working in the field.

- When the guidelines prepared to reduce maternal deaths and diseases are examined, it is seen that the guides and action plans neither include a cyclical revision nor an innovative and rights-based approach, despite the professional team work presented.

- Although the right to health is protected by the constitution and laws in general, the right to sexual and reproductive health in particular has not found a basis in the laws and regulations at a desired level.

- Even though the training and capacity building programs to strengthen maternal and women's health by the public tend to increase the success rate of in-service training and modules, these programs are addressed more to health workers, meaning that the trainings do not reach the affected subjects, especially the women and mothers living in non-metropolitan regions may not participate in these trainings, which needs to be further complemented.

-Data on maternal deaths are collected through the Maternal Mortality Notification System of the Ministry of Health. The system was launched in 2003, following the publication of the results of the Maternal Mortality and Causes in Hospital Records Survey in Turkey, which was carried out in 1998-1999 by the Ministry of Health, General Directorate of Maternal-Child Health and Family Planning (MCHSP) and published in 2002. Supporting it with practices such as "Preliminary Maternal Mortality Investigation Commission" and the "Central Investigation Commission", "Provincial Maternal Mortality Detection and Prevention Unit" and the "Provincial Investigation Commission" remains a good practice in reducing maternal mortality in Turkey. Looking at the content of the system, the absence of parsed data and the inaccessibility of system outputs cause a loss of rights. The inadequacies in monitoring and controlling the mechanisms of the maternal death notification system and the structure of these mechanisms, far from being participatory, are expressed as the shortcomings of the practice.

-Following a thorough examination of the system, it has been seen that principles including human rights approaches such as accessibility, gender equality, and inclusiveness are insufficient.

-Unfortunately, many recommendations and opinions concerning sexual and reproductive health, especially the United Nations Convention on Economic, Social, and Cultural Rights, to which Türkiye is a party, and the Convention on the Elimination of All Forms of Discrimination Against Women, were not addressed at the desired level in these documents.

-All programs prepared with the aim of reducing maternal mortality and diseases and strengthening women's health lack autonomous budgets. The required budgets for these services are allocated from the general budget of the Ministry of Health.

Although guiding services and policies that can be considered as good practice examples in many areas related to sexual and reproductive health (SRH), including maternal health, are available, it has been seen that the technical guidance prepared by the United Nations is not always implemented. The approach aiming towards SRH services in public administration lacks an inclusive, participatory, and accessible pattern and seems to be not taking measures against intersectional discrimination, with an insufficient budget, and related data on the services and policies not being transparently shared. Therefore, based on the opinions of public representatives and academics working in the field of maternal and women's health, as well as representatives of the Türkiye Family Health Planning Foundation and the Sexual Health and Reproductive Rights Platform, it can be seen that the technical guidance has not been implemented to the desired level and SRH services have not been taken into consideration in maternal and women's health programs.

Has the technical guidance assisted your Government or organization in building enhanced understanding of the requirements of a human rights-based approach? If so, please expand upon the impact that such enhanced understanding has for the design and implementation of policies and programmes in this area.

In Turkey, services related to the regulations on fertility aimed at sexual and reproductive health (SRH) started in the 1960s, and significant gains have so far been achieved. However, data based on field studies and qualitative interviews indicate that contraceptive materials have become inaccessible in the majority of primary and secondary healthcare institutions in recent years. The unmet need for family planning in Türkiye decreased regularly from 1993 to 2013, from 15% to 6%, thanks to the continuous increase in the use of modern methods (10). However, the current findings from the 2018 TDHS revealed that the unmet need for family planning unexpectedly increased to 12%. (11), which also showed that 21% of Syrian migrant women living in Türkiye had an unmet need for family planning (12). Through qualitative interviews conducted in the field, it has been reported that women have difficulty accessing "protective services such as family planning/contraception, and prevention of risky

pregnancies" offered by the Ministry of Health in the field of women's health. Problems in accessing family planning services, based on preventive health services, give rise to an increased rate of maternal mortality. The tendency of women to terminate pregnancy through traditional methods in unintended pregnancies exhibits an area of interest worthy of consideration as it may contribute to the increase in maternal mortality rate.

According to TDHS (Türkiye Demographic and Health Survey) 2018 data, 4 percent of adolescent girls (15-19 age group) and 1.3 percent of girls aged 15-17 have been observed to have a baby in Turkey. Although it is pleasing to see a one percent decrease in the first rate compared to 2013, due to the negative health consequences of pregnancy in adolescence and other damaging effects on gender equality, there is a need for public policies to rapidly reduce these rates in Turkey. The fact that the percentage of unintended pregnancies among women aged 15-49 displayed a five-point decrease compared to 1993 is a pleasing development in terms of realizing SRH rights in Turkey. Despite this development, the TDHS 2018 study finding that 15 percent of births in the last five years were unintended births indicates that current FP counselling and services are far from meeting the need. Among the key groups, which are left behind with their needs unmet, are particularly older women and women with more than one child, about which we get informed by the fact that the rate of unintended births increases as the age of the woman and the number of children increase. Women living in rural areas, women with disabilities, and refugee women appear to be another key group. While the difference between the total desired fertility rate and the total real fertility rate is 0.3 across the country, the increase in this difference to 0.5 for rural women indicates that rural women have a higher level of unmet needs for FP counselling and services.

In 2018 TDHS data, it is seen that the unmet need for family planning, which was 6% in previous years, doubled in that year, reaching to 12%. If those who do not want children anymore or who are protected by the traditional birth control modalities even if they still do not want children are added to this percentage (12% + 21% = 33%), it turns out that one out of every three families in Türkiye cannot benefit from family planning services. When the women protected by the withdrawal method with low effectiveness are added to this data, it is seen that one out of every 3 women does not want to get pregnant but cannot access an effective contraceptive method, revealing the existence of the problem in accessing the service. Access to family planning services, which should be accessible in primary care, family health centres, healthy life centres and community health centres within the scope of preventive health services, is gradually decreasing. Lack of access to fertility tools causes health problems ending up with risky motherhood. On the other hand, the situation in maternal health and obstetrics services seems to be somewhat more positive compared to other SRH fields. It has been determined that 96 percent of women aged 15-49 who had a live birth in the last five years received prenatal care from a specialist and 99 percent of live births were performed in a health institution. 96 percent of women who gave birth in the two years before the survey stated that they also received postnatal care within the post-delivery 41 days. Despite this generally positive picture, it should be kept in mind that the rate of women who stated that they did not receive any prenatal or postnatal health care is 3.5 percent. Given that some community members are not reached by TDHS, such as nomads and seasonal workers who change places constantly within the country who are also not registered in the address-based population registry system, some special interventions aimed at these groups in pregnancy health and maternity services might be needed.

Based on the findings stated in the 2018 TDHS, institutional structure needs to be implemented in order to provide widespread, easily accessible, free and high-quality contraception and FP services and counselling for all women with unmet family planning needs, particularly the old ones, those with several children, those settled in rural areas as well as the disabled and refugee women. In order to reduce maternal and infant mortality rate, prevent gender-based violence, reduce cases of sexually transmitted diseases such as HIV/AIDS, and ensure the sustainability of maternal health services, a Minimum Health Service Package (MHSP) aimed at sexual and reproductive health should be

implemented in times of disaster. The odds of seeing secondary health problems and serious threats exponentially increased in the determinants of health in the coming period due to the heavy destruction experienced and the damage to the health system, according to the reports published and qualitative interviews carried out after the earthquake Kahramanmaras zone on February 6, 2022. It has also been reported that at least three maternal deaths occurred in the last 1 month in the provinces affected by the earthquake, where difficulties were mostly encountered in pregnant care, childbirth assistance, postpartum care, and infant follow-up processes. (22) Gender inequality in the earthquake-affected regions has further deepened as there are no separate health tents for pregnant, puerperal and newborns in the cities. A holistic approach cannot be ensured towards such factors as communicable diseases, women's disability, pregnancy and puerperal examinations and follow-ups. It is reported in qualitative interviews that women cannot access family planning methods (hype, condom, morning-after pill, oral contraceptive, pregnancy test) and that prenatal and postnatal care services are not provided. In summary, it is seen that women cannot access SRH services in times of disaster and crisis.

Even though it is legal in Turkey, women who want to end their pregnancies through VTP on their own are limited in what they can do. Even though VTP can be done within the legal 10-week time limit, it is covered by the Social Security Institution, and public healthcare providers are required to offer it, it seems to have become much harder to get this service. The findings of the 2018 TDHS reveal that approximately half of voluntary termination of pregnancy services are provided by state hospitals, which also confirms the fragmented and scattered service structure in the field of reproductive health. Many of the healthcare professionals interviewed stated that they did not know where to refer patients who requested a VTP service. It is known that these restrictions on VTP services will have negative consequences for maternal health.

According to the "Report on Abortion Services in State Hospitals in Turkey," voluntary abortion services are provided without any conditions in 10 out of a total of 295 public hospitals (Ankara, Amasya, Bayburt, Burdur, Hakkari, Şanlıurfa, Tekirdağ, and Tunceli), while they are not provided in 185 hospitals (13). In another study conducted in Turkey, it was found that although 74 out of 184 public hospitals could perform abortion operations, only 9 hospitals in Ankara, Izmir, and Istanbul could perform voluntary abortions in line with the law (up to the 10th week of pregnancy, regardless of whether the woman is married or unmarried) As can be seen from the sample results, the principles in the law and the actual practice exhibit differences in essence. In our qualitative interviews, it was recorded that there could be an increase in self-discharge attempts by women who cannot access medical abortions and an increase in the use of unsafe abortion practices.

The technical guideline on maternal mortality and diseases in line with human rights obligations reveals that a comprehensive understanding in the relevant policy area is insufficient in Türkiye to improve women's status, provide sexual and reproductive health rights, strengthen health systems, and improve the monitoring and evaluation of unsafe abortions. The lack of special policy areas for adolescents, ethnic and racial minorities, indigenous women, refugees, disabled women, sex workers, HIV-positive women, displaced and war-affected women, women living in underserved areas, and other excluded and stigmatized populations, the inadequate budget allocation for preventing maternal health and illnesses, and the inability of women to have significant participatory roles in these processes show that the policy implementation towards preventing maternal health and illnesses in Türkiye needs to be restructured within the frame of a human rights approach.

What challenges does your Government or organization face in implementing a human rights-based approach in policies and programmes to eliminate preventable maternal mortality and morbidity? Please elaborate on the nature of these challenges and steps taken to address them.

In the current Turkish legislation, in the theoretical context, the "rights-based service approach rules and the provision of services with this approach are not reflected in the practices, even though they are available in writing. The first obstacle in this regard stands out as the political approach, while the second is that the current health system prioritizes the concept of "treatment" (especially since 2011). Therefore, the maternal mortality rate has not shown a decrease since 2011, but rather a plateau. In this context, universities, women's research and application centres of universities, the media, and non-governmental organizations continue their necessary advocacy activities without interruption.

Such issues as lack of inclusive laws and practices, difficulties in obtaining meaningful data, lack of financial and human resources, including specialist health professionals, and a lack of awareness and capacity for human rights-based practices are among the main challenges in the implementation of technical guidance in this regard. Obtaining significant data on sexual and reproductive health, including maternal health, remains a challenge. In many places, infrastructure-caused constraints and the distance to the healthcare facilities hinder the full application of technical guidance and human rights-based approaches.

The application of technical guidance and related tools should be encouraged as broadly as possible, particularly in the ministry of health and relevant public institutions at all levels, as well as beneficiaries, non-governmental organizations and local governments.

All laws and regulations should clearly state that maternal health services, including the services for the prevention and treatment of maternal diseases, should be of good quality, accessible, acceptable to all pregnant women and girls, and should be provided without discrimination.

Does your Government or organization regularly collect and analyse disaggregated data and information on maternal mortalities and morbidities, including in the context of COVID-19 pandemic? Please elaborate on good practices and challenges in this regard.

In Turkey, it has been a long-standing practice to keep track of this kind of information in different ways. A detailed registration notification application regarding maternal mortality has been initiated and still continues. In this system, the maternal mortality commissions at the provincial level review each mortality case and come to a decision in terms of cause and preventability of the case, and the centre reports it to the Ministry of Health. The collected data is analysed by the Ministry of Health and published from time to time. The maternal mortality monitoring program is carried out in order to prevent maternal deaths from preventable causes, examining each maternal death for its cause. The "preliminary maternal mortality detection and prevention unit" and a "provincial investigation commission" have been established at the provincial level, and a "preliminary maternal mortality commission and central inspection commission" have been established under the supervision of the Ministry of Health. (This can be shown as an example of good practice.) The disadvantage of the system, on the other hand, is that sometimes the publication of information flow analysis reports of the real situation is delayed on account of political concerns. For example, with which diagnosis were the maternal deaths occurring during the Covid period entered into the system? Is it possible to log in with a different code? As in the general maternal mortality data of WHO, data on maternal mortality rate due to Covid in Türkiye is not available (14). Again, the caesarean section rates associated with the increase in maternal mortality are not at the desired level in Turkey. While the 10-15% caesarean section rate recommended by WHO is 58.4% among live birth deliveries in the 2021 Health Statistics Yearbook, the rate of primary caesarean section can be seen to be 29.1%. Disaggregated data on maternal deaths are not shared with the public on a regular basis. This goes against the principles of accountability and transparency that are talked about in the technical guidance. Also, when important data isn't shared with the public, it makes it hard for civil society organizations to do enough monitoring and advocacy work to reduce maternal deaths and diseases. In the maternal mortality monitoring

program, there is still a question as to whether data is kept for disabled, refugees, and rural women, including seasonal agricultural workers.

Please elaborate on the main causes that may have led to poor maternal health outcomes in the context of COVID-19 pandemic in your country and/or context? Please also describe the impact of the COVID-19 pandemic response on the availability and accessibility and quality sexual and reproductive health, including maternal health services for women and girls.

The COVID-19 epidemic that occurred in December 2019 affected many areas, with the health system being affected the most (16,17). In order to reduce the risk of transmission of the COVID-19 epidemic, many states had to impose such measures as travel restrictions and closing schools (18,19), leading an increase in the level of anxiety felt by pregnant women (20). This situation also affected the antenatal care services that allow women to have regular check-ups during pregnancy, which is an important period in human life (21). Due to the anxiety they experienced, the pregnant women experienced a dilemma as to whether to get the antenatal care they needed or to avoid the risk of infection. Although the urgency of the situation in Türkiye was perceived at the beginning of the Covid Pandemic process , the difficulty in obtaining vaccines, delays in delivering some protective measures to the public, and most importantly, the health institutions largely allocated to Covid patients, insufficient number of maternal and women's health polyclinics left open in this period adversely affected the health of mothers and women. Although many relative deficiencies were compensated later, the services towards prenatal care of pregnant women, termination of pregnancy, and contraception services during the Covid period could not serve properly for women's access. In-hospital birth services was one of the well-functioning services, especially in urban areas, due to the "Alo 112" system, a main emergency hotline led by the Ministry of Health.

It is seen that reproductive health services were particularly affected due to disruptions in routine health services and changing priorities during the COVID-19 pandemic process. Obligatory restrictions such as curfews, flexible working hours, and restrictions on the number of work items in health institutions made it difficult for individuals to access information, counselling, and family planning services related to contraception. Being subjected to physical violence during pregnancy, which was 10 percent according to the results of the 2008 research, was 8 percent according to the 2014 research results. (24) In times of disaster/war and crisis, women experience more violence. Women who were subjected to violence during the pandemic period also suffered violation of their rights to apply to the relevant institutions and receive the necessary service, as a result of the factors listed (such as going out, the risk of contamination, the fact that health institutions only serve for Covid, women's counselling centres run by NGOs are closed, etc.), which had an impact on both maternal and infant health and miscarriage.

It is important to implement the Minimum Health Care Package (MISP) for Sexual and Reproductive Health in Disasters (SRH) in such crisis times as pandemics. Although there are preparations for this application in Turkey, it has yet to be activated in the field. It is known that MISP principles were not applied in the field of reproductive health after the Kahramanmaraş-centered earthquake that affected 11 provinces of Türkiye on February 6, 2023. The minimum initial health service package must include SRH services in national disaster risk reduction strategies.

In addition to a significant portion of service and human resource capacity being directed towards combating the Covid-19 pandemic, the restrictions imposed to combat the pandemic, such as travel restrictions and curfews, were implemented without considering the access of individuals in need of SRH services, resulting in serious problems in accessing family planning services, healthcare services provided for pre-post-perinatal , childbirth, and postpartum periods, as well as diagnosis and

treatment services for sexually transmitted infections (STIs) for infected individuals, as expressed in qualitative interviews.

Please provide information on whether there is a particular group of women in your country and/or context who have been disproportionately affected by the pandemic and response measures when accessing sexual and reproductive health, including maternal health services. (For instance, adolescents, women living with HIV, indigenous women, racial and ethnic minority women, women from rural areas, persons with diverse sexual orientations, gender identities etc.)

During the pandemic, services were interrupted in Turkey, but before and during the pandemic, teenagers, women who had gone through menopause, people who lived in rural areas, LGBTI people, and women in general were already discriminated against in different ways. Recently, there has even been an attitude against the word "gender". It is seen that the basic SRH indicators of Syrian migrant women were even worse during the pandemic period, adolescent births were high, family planning methods were used less frequently, and the rate of not meeting the requirements for family planning services was quite high. Also, it is stated that seasonal agricultural worker women applied to health institutions by their own means and could not access basic health services such as prenatal and postnatal follow-up, SRH outpatient services. Even if health workers pay personal visits to the living quarters of seasonal agricultural workers, problems are still experienced in terms of benefiting from health services due to inconsistent time intervals (working in the field during the hours of service). It is seen that seasonal agricultural workers generally have problems in accessing health services, and risky pregnancies are more common, which were encountered more commonly during the pandemic period. The increase in the workload of the health professionals working in CHCs due to fieldwork such as affiliation and follow-up negatively affected the ability of mobile health teams to provide services to the areas where the workers were located. During the crisis, barriers to accessing health services increased as a result of quarantine measures, limiting access to support services such as rehabilitation services as well as basic necessities and medicines. It has been determined that the physiotherapy needs of disabled women could not be met due to the closure of rehabilitation centres during the pandemic period, caregivers left their jobs during this period, housekeepers did not come their works, and constantly used drugs could not be obtained from pharmacies. The problems and rights violations faced by LGBTI people in sexual health services continued to increase during the pandemic. Existing laws still force transgender people willing to go through the gender reconciliation process to give up their biological reproductive functions, and access to hormonal drugs is restricted for various reasons in this process.

What measures have your Government or organization undertaken in order to mitigate the impact of COVID-19 pandemic on maternal health? Please elaborate on any lessons learned, good practices as well as challenges faced.

The Covid - 19 is now over, yet unfortunately, a major earthquake hitting not too long ago has adversely affected lives of 13 million people, claiming thousands of their lives. We have faith that those responsible for making decisions and policies, supervisors, and all members of the health care workforce, as well as communities, will recognize the importance of preventative measures and planned actions, among other things. While providing health services in general as well as services pertaining to reproductive health care ,the "three zero" targets that were discussed at the Nairobi Summit had a significant impact on Türkiye as well. At the very least, we employ all of the objectives and recommendations for "advocacy purposes" in our teaching activities with the goals of empowering women, preventing all preventable maternal deaths, and bringing the number of unmet needs in family planning down to zero. We have a strong belief that it will be impossible for Türkiye to meet

the United Nations Sustainable Development Goals by the year 2030 or any later if the position of women is not improved and gender-based violence is not eradicated in the country.

POLICY RECOMMENDATIONS

To improve maternal health and prevent maternal mortality, all current barriers to access to quality obstetric services should be identified and addressed at both the health system and community levels.

- Within the legal framework, it should be ensured that voluntary termination of pregnancy (VTP) services are provided widely, irrespective of judgements of the service providers, as in other health services.

-Monitoring bodies are needed to monitor and analyze disaggregated data and information on maternal health outcomes, including maternal morbidity and maternal mortality. In that respect, data collection efforts should be prioritized to facilitate the monitoring process. In order for non-governmental organizations to access data in the field of maternal health, public transparency is a must.

Simultaneous action and programs should be undertaken so that success implementation of human rights-based approach towards maternal health policies and programmes can be achieved and the already-established discrimination can be addressed and gender equality concept can be promoted.

- Recommendations made by human rights treaty bodies such as the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women should be observed.

-Minimum Health Service Package (MHSP) for Sexual and Reproductive Health (SRH) in Disasters should be involved in all policy making processes to protect maternal health in emergencies, reduce preventable deaths and diseases, and ensure a secure access to health services.

-Inclusive and holistic health plans should be developed to address inequalities resulting from structural discrimination in the health system of health interventions that focus on disadvantaged women and girls at high risk for maternal mortality and morbidity.

-Aside from the specific efforts to ensure that women and girls are empowered enough to claim their rights and have access to reliable information to make decisions about their health, efforts should also be made to reduce maternal mortality rates through holistic prevention strategies that will include the elimination of all barriers to access comprehensive sexual and reproductive health services.

- A political will should be displayed to abolish laws that restrict women's sexual and reproductive health and rights, including those related to family planning and abortion.

-In addition to gender discrimination, women are often less likely to access adequate health care and timely interventions and services, due to a variety of factors such as distance, cost, lack of information or cultural insensitivity. They may also be reluctant to access maternal health services because of language barriers or previous experiences of maltreatment and abuse in healthcare settings. Being subjected to bad mistreatment during childbirth and pregnancy makes disabled women and those living with HIV, who are already considered vulnerable, twice as disadvantaged. Attention should be paid to intersectional discrimination and this approach should be incorporated into all policy processes.

PERSONS & INDIVIDUALS COUNSULTED

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