

Stop early marriages. Don't discriminate. Peace and security. Solar power. Conservation of environment. Free wi-fi. Food. Paved roads. LGBTQIA+ rights. Good housing. Job opportunities for women. Availability of wheelchairs. Garden materials. Bednets. Schools for girls. Stop early marriages. Don't discriminate. Peace and security. Solar power. Food. Conservation of environment. Free wi-fi. Food. Paved roads. LGBTQIA+ rights. Good housing. Job opportunities for women. Availability of wheelchairs. Garden materials. Bednets. Schools for girls. Peace and security. Stop early marriages. LGBTQIA+ rights.

*Another  
Listen*



In the aftermath  
the dust will settle into new places  
on the surface of a world forever changed

And we who remain will gather  
what is misplaced  
we will mend what is broken  
and make our peace  
with what is lost

We will find ourselves  
beyond language already stretched to its limits  
beyond our facts and figures bent to breaking

When the roar of a ruthless storm  
turns into the silence of a world in mourning  
let us hold this stillness as an offering  
as an invitation to take another listen  
find another lesson

When we are brought to our knees  
let it be at the feet of women

their wisdom as ageless as time  
their stories are the bridge  
between what was  
what is  
and what could be

Let us hold space  
for the silenced and unseen  
who show us new ways of being  
new ways of seeing even ourselves

Let us borrow the courage of these women  
for whom the world is always raging  
those who show us the power of creation  
how their hands transform crumbs into lifelines  
that reach across communities  
the girls who have howled into the wind  
and silence answered back  
let us hear them now  
and turn our hearing into doing  
for the ones who contain multitudes  
whose dreams expand  
beyond the boundaries of prison bars  
beyond our understanding of home  
beyond the margins of a world built  
without them in mind

let us see them a little clearer  
more than babies birthed or buried  
alone or with the wolves at their heels  
more than bodies braced or broken  
by people or policies or poverty

There is a truth beyond the numbers  
a world where every dream the hand can touch  
is accounted for  
where one wish granted makes room for another  
and life is lived in full  
at the intersection of all desire

Now,  
when we are called to reimagine  
let us build up and around  
with these real lives at the centre  
in their flawed yet deserving  
in their raw and dazzling

When the women speak,  
their voices ringing out  
from every corner of the earth  
let us lay down  
everything we once knew

let us ask again  
and this time  
ask more

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## ANOTHER LESSON

### What we have learned

*A letter from Aparajita Gogoi and Kristy Kade,  
Co-chairs of the What Women Want campaign*

It is impossible to separate women's health from women's equality. As such, *What Women Want* was conceived, in large part, as a challenge to the power structures that hinder women's maternal and reproductive health, just as much as it was a call for better quality women's health services writ large.

**Too often, women are discouraged from saying—and seeking—what we want. Too often, the world responds with criticism when we do.**

In addition to promoting better health policies, programs and services, *What Women Want* was meant to inspire women and girls to come together to assert their individual needs and wishes. It was meant to galvanize acceptance and appreciation of women and girls who advocate for others and themselves!

**We have challenged many of you—advocates, donors, journalists, policymakers, providers, who are also often our colleagues, friends, and families—**

**to put aside your assumptions, expertise, and interests and really listen to women about their needs.**

We have suggested that as the proverbial powers that be, you do not always know best, and to act on what women say. Otherwise, we risk women and girls believing that voicing their concerns is a hopeless strategy.

We stand by our challenge and are bolstered by gains resulting from *What Women Want*. These include the adoption of standards on respectful and dignified care, to the hiring of midwives, to the installation of working toilets in health facilities and the funding of contraceptives in countries as disparate as Mexico to Pakistan, and others in between.

We are inspired by women like [Luseshelo Simwinga](#)—a midwife and now an activist—from Blantyre City, Malawi, who, buoyed by the calls of 80,000 of her fellow country women, continuously demands her workplace be better, both to her and to the women and girls in her care. Luseshelo's

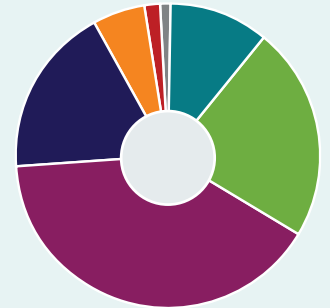
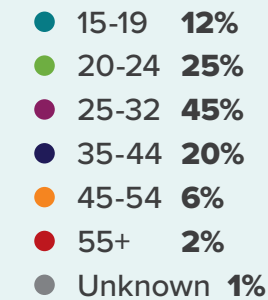
## What Women Want

### A SNAPSHOT

# 1,197,006

### DEMANDS

#### Breakdown by age





asks and actions secured personal protective equipment to provide for her and her patient's safety, and curtains to secure their privacy.

We envision and are excited for a future when we talk less about what women want, and more about what they got. Yet, we are also humbled.

**After a long overdue reckoning, in the form of COVID-19 and global protests highlighting both the legacies and ongoing perpetuation of oppression in our sector, we recognize the need to interrogate ourselves in the same way we asked of you.**

When we shared the initial *What Women Want* results in June 2019, we celebrated how the open-ended question let women and girls set the agenda, as opposed to beginning with a premise of what is important or asking them to decide among a set of options. When we announced that the number one response globally was respectful and dignified care with more than 100,000 responses, we remarked how that may seem like a small number out of 1.2 million, but with an open-ended survey, imagine how many varied responses we received, some having nothing to do with reproductive and maternal health at all! Looking back, who were we to say some women's and girls' answers were not as relevant?



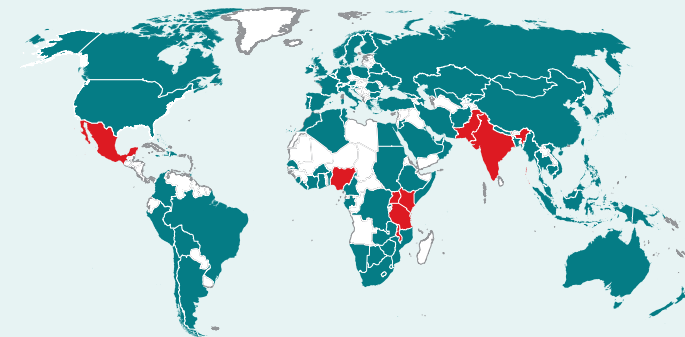
**As the COVID-19 pandemic has made abundantly clear, hunger, jobs, safety, schooling and shelter are all intimately connected to women's health.**

The announcement reflected our own interests and priorities in sexual and reproductive health and rights, and a lack of appreciation that for many women the "choice debate" is having to decide between which of their basic needs they will have met.

We described how the answers we received were far from simple, because women's lives are not simple. Yet, we advocated the top agenda items become everyone's agenda by highlighting how they resonated

**114**  
COUNTRIES

**359**  
PARTNERS



- Participating countries
- Most responses



across countries and age groups. In doing so, we missed pointing out how race, ethnicity, class, citizenship, gender fluidity, sexuality and disability influence a person's priority wants and needs.

For a campaign meant to listen to women and girls, we summarized, we generalized, and in doing so, many voices were lost in the din. We have since gone back to many of the campaigners to better understand the demands categorized as "other." Many such demands came from women and girls on the outer circles of typical, societal privilege. *Another Listen* centers some of their concerns and stories.

**We know it is nowhere near enough.**



We plan to revisit our efforts with new members and partners, that have different perspective and scope, to ask more women, in more in places, from more walks of life, what it is they want—full stop. We will invite women and girls, too often left out of the conversation, to share their own stories for their own purposes. Because having spoken to 1.2 million women and girls already, one thing is certain.

**To be an inclusive movement for women's health and rights, it means not only fighting for access to abortion, contraception, or emergency obstetric services, it means fighting for access to education, employment, food, housing, and environmental and personal security.**

It means fighting against oppression and discrimination in all its forms. It means fighting for all the things that influence whether a women or girl ever even makes it to a health facility and how she is likely to be treated if or when she arrives.

**The *What Women Want* campaign can only end once we reach where we thought we began,**

**refusing to separate health from equality for all women and girls.**



In solidarity,

*Aparajita Gogoi*

**Aparajita Gogoi**

*Kristy Kade*

**Kristy Kade**

Co-chairs, *What Women Want: Demands for Quality Healthcare from Women and Girls*

## OUR EVOLVING APPROACH

### Every voice counted, every voice heard

This was the *What Women Want* campaign mantra from its inception. Putting it on paper, however, is far easier than putting it into practice. Between 2018 and 2019, campaign mobilizers asked nearly 1.2 million women and girls from 114 countries, “What is your one request for quality maternal and reproductive healthcare services?” We then recorded, confirmed the meaning, and categorized each, and every, demand. In June 2019, we shared the top responses. Women and girls worldwide called for respectful and dignified care; water, sanitation, and hygiene (WASH); medicines and supplies; midwives and nurses; and health facilities.

#### Still, for many women and girls, their asks had yet to see the light of day.

We decided then, in early 2021, to launch the *What Women Want Dashboard*, a public demand repository. Now anyone, anywhere, anytime can search what women want in their own words, while protecting individual privacy. Do not just take it from us, “hear” from women and girls directly. The possibilities of their responses to improve multi-sector policy and program development, along with changes within facilities and communities, are endless.

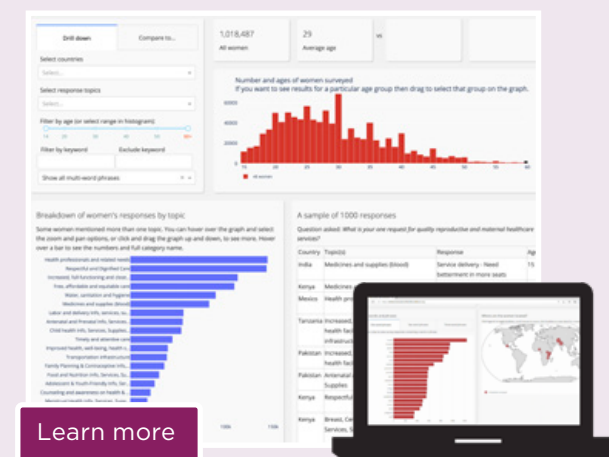
Building a dashboard that is both easily navigable and able to absorb new demands in real time—including topics far beyond reproductive and maternal health—took us to the cutting edge of natural language processing (NLP) techniques. Women’s and girls’ demands are now automatically categorized using a neural network informed by a subset of coded responses and then generalized across.

To strengthen the algorithm’s ability to correctly categorize women’s and girls’ responses, we consolidated 60 codes from the 2019 *What Women Want Global Report* to 36 ([Annex 1: Updated \*What Women Want\* categories](#)). For example, women’s and girls’ demands once categorized as part of *ethical, lawful, non-abusive and secure care* have merged with demands for *respectful and dignified care*.

The algorithm also enables double coding—and even triple coding—of responses. An example is the wish for ‘a birth companion of choice’. Given this right is enshrined within the *Respectful Maternity Care Charter: the Universal Rights of Women and Newborns*, such a request is now coded as both *respectful*

## Explore women’s demands

The *What Women Want* Interactive Dashboard offers an unprecedented level of access to women’s demands to allow anyone, anywhere to see exactly what women want when it comes to their healthcare.



and dignified care, and as *labor and delivery information, personnel, services, and supplies*. If a woman specified wanting her birth companion to be a male partner, this was also coded as *male engagement and shifts in family/partner dynamics*. The collapsing of codes and multiple coding was done in consultation with country and technical experts who confirmed the updated categories work in the digital sphere and reflect the real world ([Annex 1: Updated \*What Women Want\* categories](#)).

Reducing categories may seem to eliminate nuance. However, the opposite is true. Dashboard users can now easily filter responses by sub-categories, as well as search common terms and multi-word expressions to garner greater insights into women's wants, and make comparisons between geographies, age groups, and other factors. Drawing from the in-progress dashboard, we released the [Behind the Demands Report](#) in 2020. The report looks more closely at women's top demands, providing specifics about what women want. Consider WASH. 65 percent of requests are related to basic facility cleanliness. Without digging deeper, you may have presumed women's largest pre-occupation or concern was the availability of safe water.

The dashboard also provides opportunity to examine those asks focused on educational and economic opportunity, among others. In fact, the dashboard development made clear the need to spotlight asks beyond the top five and inspired this report.

**DEMAND: Adequate SP (sulfadoxine-pyrimethamine) to prevent malaria in pregnancy, proper infrastructure that has capacity to provide RMC and transport to facilities**

## Luseshelo Simwinga

Blantyre City, Malawi

Midwife at Queen Elizabeth Central Hospital (QECH)

When I see pregnant women, when I've helped them have their babies, and then they go back home happy, healthy and with healthy babies, that brings me so much satisfaction. I love my work and am passionate about being a midwife.

But I need adequate resources. Human and material resources can help so much in my role as a midwife because sometimes when you're working without the proper resources, or without enough resources, it is difficult to manage the range of women's conditions and risks. If there are essential drugs, if there are adequate staff working at the facility and if there is every resource that you need to help pregnant women or their babies, my job becomes more efficient and easier, and I get to provide the high-quality healthcare and respectful care that is my job.

At the beginning of the pandemic, we fell short of a lot of resources to be used in RMNCH (reproductive, maternal, newborn and child health). The cord clamps we use when babies are born—we ran out of these clamps completely. In one delivery, I helped a woman and her baby by using a yard of string in place of the clamp, and of course, it was not properly secured. The baby had to go to a referral facility and get a transfusion. Luckily, both the baby and mother survived. My colleague and I immediately ran a campaign to source out the proper cord clamps and our campaign was broadcasted on TV, radio, and in newspapers. We kept pushing and pushing, and when the news outlets amplified our story, that's when the government came in and cord clamps were finally procured.

I have also been involved in advocating for respectful care and curtains to be placed in my hospital. With support from the [International Confederation of Midwives](#), I hung up posters of the RMC (Respectful Maternity Care) charter and trained 80 of my fellow health care workers on RMC. I spoke to women after their services, asking them how they were treated. Most said they wanted privacy and confidentiality—they wanted curtains. I made some, but it wasn't enough.

It was my using the *What Women Want* results that convinced the District Officer to install curtains. We have about 350 deliveries a month, so those curtains helped provide women with privacy and confidentiality. I'll say 100% of my effort was based on the *What Women Want* campaign results; it is a great source of evidence which everyone can now access through the Dashboard.

I'm now talking to midwives about what type of respect that they want and what would help them give RMC to patients. Most women don't come to hospital because they're not respected enough.





## ANOTHER LISTEN

### Women's updated demands



Increased, full-functioning, and close health facilities, including WASH  
**202,738 responses**



Increased, competent and better supported health care workers  
**144,129 responses**



Respectful and dignified care  
**143,112 responses**



Free and affordable services and supplies  
**109,343 responses**



Medicines and supplies  
**82,833 responses**

While categories have morphed, women's answers have not. In fact, the updated algorithm has served to reinforce women's top demands, with some slight shifts and reordering. One adjustment the algorithm made was to integrate requests for specific facility improvements—such as *electricity, beds, and laboratories*—within the general code *increased, full-functioning, and close health facilities*. Also included in this category now are many of women's WASH-related demands. With the growing focus on WASH in healthcare facilities, this change is expedient. It is also logical—given the absurdity of calling a place with no water or sanitation a functional health center. The enhanced algorithm moved facilities from fifth to first, with WASH accounting for nearly 50 percent of women's demands in the updated category.<sup>1</sup>

Previously, *What Women Want* disaggregated by type of health provider, with nurses and midwives cracking the top five and even top three for women aged 20 to 24. The dashboard algorithm merged each of the healthcare provider categories: nurses and midwives, doctors, female providers, male providers, general health professionals, specialists, and community health workers.

## Timely and attentive care

Women want better from healthcare workers, but they also want better for healthcare workers. The more than 44,447 requests in the timely and attentive care code demonstrate women's appreciation for the significant relationship among the practicing environment, providers and ultimately the respect afforded to patients. While all women and girls deserve compassionate care no matter the circumstance, they are aptly calling out how the deterioration of one erodes the other. Specifically, women link dilapidated and understaffed facilities with poor treatment, such as abandonment or being rushed out.

Women and girls themselves often did the same. They regularly asked for various types of health care workers together (e.g., I want more midwives, nurses, and doctors). Healthcare providers are now the number two demand, closely followed by respectful and dignified care. These topics are separated by little more than 1,000 demands and are intimately connected. In fact, health workers in some form appeared more than 90,000 times in women's and girls' requests for respect and dignity.

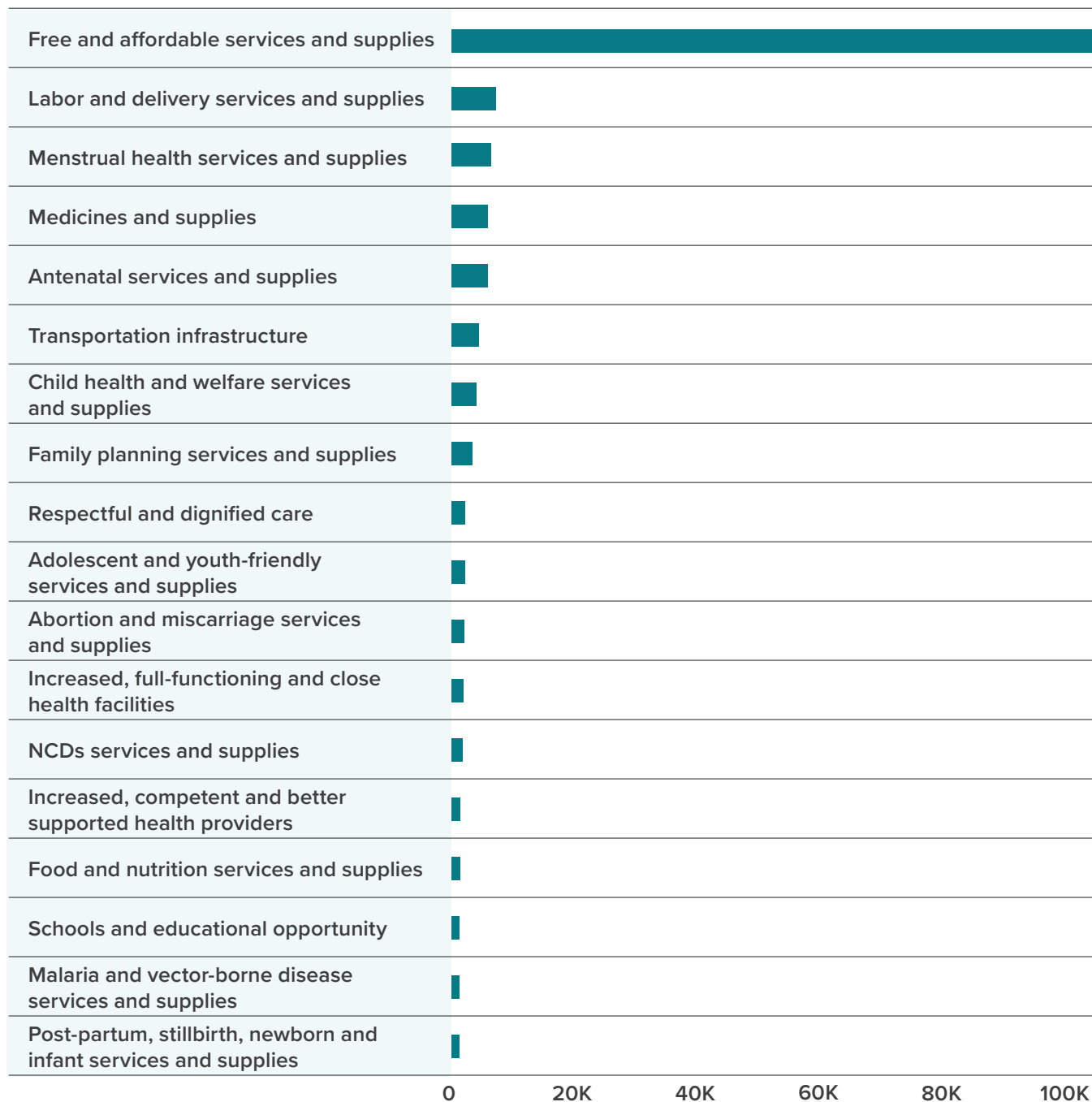
The medicines and supplies category remains the same. It includes the demands simply for "drugs" or "equipment," as well as blood,

<sup>1</sup> Demands related to broader WASH are coded separately, as are demands related to menstrual health.

cotton, gloves, scissors, safety pins, cloth, etc. Many women and girls often named the supply they want for specific health concerns (e.g., mama kits). The algorithm continues to categorize these demands under their corresponding health topic area (e.g., labor and delivery) without double-coding. With 19 health topic specific categories in all, the algorithm can only handle so much. However, old-fashion arithmetic has the request for supplies across all categories totaling more than 270,000. The new algorithm created one significant change within the top five, moving *free and affordable services and supplies* from the seventh most popular demand to the fourth. Previously, the *free and affordable services and supplies* code only contained general requests. However, some women and girls often named the free supply they want for specific health concerns (e.g., free IUD). The algorithm now ensures both demands are accounted for, coding a request for ‘free IUD’ under both *free and affordable services and supplies*, as well as *family planning information, personnel, services and supplies*.

Free and affordable care being a top demand is a good reminder that if a woman is not cared for in a clean facility and by the hands of a kind and capable health provider, she may rightly choose to go elsewhere or even opt out of services altogether. However, if care is not free, affordable, or reachable for a woman with limited means, she may not even have the luxury of a weighted choice. Access and quality must be equal priorities. Fair is often free and free is often fair.

**Figure 1. Demands for *free and affordable services and supplies***



## AN-OTHER LISTEN

### Women’s broader demands

When we hand-coded women’s and girls’ responses in 2019, we developed 50 categories related to maternal and reproductive health and an all-encompassing “other” category. Categories drew from *Hamara Swasthya Hamari Awaaz (Our Health, Our Voice)*—*What Women Want’s* precursor campaign conceptualized and implemented by WRA India. However, women’s and girls’ demands took us unimagined places. Overtime, we expanded and then consolidated several of the “traditional” maternal and reproductive health demands, and disentangled the “other.” The *What Women Want* dashboard now includes 36 categories, of which 17 are classified as maternal and reproductive health according to today’s standard policy and program parameters. The remaining categories reflect broader health and social determinants.

Obviously, there is a great deal of overlap. For example, many of the individual responses included in the categories of disability and LGBTQIA+ information, personnel, services and supplies, demand the right of people to control their fertility and sexuality and to seek and receive related services.

**Table 1. Maternal and Reproductive Health vs. Other Health and Social Determinants**

MATERNAL AND REPRODUCTIVE HEALTH	OTHER HEALTH AND SOCIAL DETERMINANTS
<ul style="list-style-type: none"> <li>• Abortion/miscarriage information, personnel, services, and supplies</li> <li>• Adolescent &amp; youth-friendly information, personnel, services, and supplies</li> <li>• Antenatal information, personnel, services, and supplies</li> <li>• Counseling and awareness on maternal, reproductive, and general health and services</li> <li>• Family planning information, personnel, services, and supplies</li> <li>• Free and affordable services and supplies</li> <li>• Improved health, well-being and maternal, reproductive, or general health services</li> <li>• Increased, competent and better supported health providers</li> <li>• Increased, full-functioning and close health facilities (including WASH)</li> <li>• Infertility information, personnel, services, and supplies</li> <li>• Labor and delivery information, personnel, services, and supplies</li> <li>• Medicines and supplies</li> <li>• Menstrual health information, personnel, services, and supplies</li> <li>• Post-partum, stillbirth, newborn and infant information, personnel, services, and supplies</li> <li>• Reduced medicalization or do not want service</li> <li>• Respectful and dignified care</li> <li>• Timely and attentive care</li> </ul>	<ul style="list-style-type: none"> <li>• Child health and welfare information, personnel, services, and supplies</li> <li>• Disability information, personnel, services, and supplies</li> <li>• Economic opportunity and financial support</li> <li>• Environmental health and agricultural support</li> <li>• Evidence, research, innovation, and technology</li> <li>• Fitness and recreation</li> <li>• Food and nutrition information, personnel, services, and supplies</li> <li>• HIV, hepatitis, STI and TB information, personnel, services, and supplies</li> <li>• LGBTQIA+ information, personnel, services, and supplies</li> <li>• Malaria and vector-borne disease information, personnel, services, and supplies</li> <li>• Male engagement and shifts in family/partner dynamics</li> <li>• NCDs information, personnel, services, and supplies</li> <li>• No demand</li> <li>• Other specific services (e.g., dentistry, eye care)</li> <li>• Power, policy/politics and rights</li> <li>• Post-menopausal and elderly information, personnel, services, and supplies</li> <li>• Religious support</li> <li>• Schools and educational opportunity</li> <li>• Transportation infrastructure</li> </ul>



**Responses underscore the impossibility of isolating reproductive and maternal health from other obstacles limiting the agency, autonomy, and general wellbeing of lesbian, gay, bisexual, transgender, non-binary, intersex and/or differently abled people. Responses also illustrate how difficult it can be to make just one demand when it is so intimately connected to larger system failures.**

Demands in these categories stress the importance of overall infrastructure and resources, including wheelchairs, accessible beds and ramps, and sign language translators. Demands also include economic and financial support, such as disability cards and benefits, not only as part of Universal Health Coverage, but wider social services.



In places where such benefits exist and are available, demands are for accountability of those who deny entitlements. Demands also include education to combat the bias, ignorance, and lack of appreciation or understanding that contributes to treating people like outsiders, whether intended or not.

*What Women Want* is also guilty of this. The demands in these categories, while still relatively few in comparison to the total number, spoke volumes. They made us realize how encouraging people to “stand up” and “speak out” may isolate—instead of inspire—individuals who are unable to walk or communicate verbally. They made us appreciate how someone who identifies as a birthing “person,” versus a “woman” will wonder whether their demand was even of concern or interest. They made us ask ourselves an uncomfortable question. Are our efforts meant to encourage participation also stifling it, and even perpetuating existing power dynamics?



Unfortunately, despite many NGO missions to the contrary, it is well-understood that existing and newly emerging health initiatives tend to reach the socio-economically advantaged, with the poor, and those marginalized due to age, disability, race/ethnicity, gender fluidity and sexuality, or geographic and migratory status, benefiting much later, if at all. Take our own quest to reach one million responses, the vast majority came from the general population.

**True reproductive justice flips the paradigm and first prioritizes the voices and concerns of those traditionally excluded from power, appreciating a system that works for them is more likely to work for everyone.**



## Joyce Ndulu

**Makueni county, KENYA**

Disability activist and mobilizer

### **DEMAND: Good reception by doctors and nurses**

I want most good reception by doctors and nurses, how they receive me when I walk in to seek treatment. Being received with respect. Delivery time is very sensitive for women, and they are vulnerable at that time and how they are treated is very key. Giving birth is a very difficult process for women, when you are received well, and treated well, it will make you confident of the process. If women are not respected in hospitals, they will not go to facilities in the future and that could lead to risks.

You can go to the hospital, and you are told doctors are not available. They go for very long tea and lunch breaks and all this time the women are waiting. Some health workers also abuse women, most during delivery. They do not sympathize with women. Some are abusive and ask, “who made you pregnant?” I am the one who decided, for myself and my children. So please stop shouting here.

There is a time I went to the hospital, not once, many times. I waited for a whole day. I went home disappointed. There is one day I was waiting and there was a woman waiting. I heard she died later, she waited for a whole day, and she was in so much pain. No one at the facility was bothering, by the time they were attending to her it was too late. I was heartbroken and I lost trust for that facility. Most times if you are perceived poor, you will be treated so badly and that is what happens most times.

Most women choose to deliver at home because they are not treated well at hospital, or they cannot afford the services. There are cases also where some say the facilities are very far, sometimes the only option for the women will be motorbike, and at that stage it is too risky, so they choose to deliver at home. The roads are very bad, during rainy seasons women suffer a lot, the riverbanks break, and it becomes impassable. If there is an emergency, one must use a route that is longer and that can be risky.

Women living with disability, for example, those who have challenge for walking, they go to hospital, there are no toilets for people living with disability, no ramps, no delivery beds fit for them,

they are forced to deliver in normal beds, which in most times can be risky.

There are women who are deaf, when they express themselves no one understands them, so they get frustrated. The blind also suffer, no one to guide them.

There is also a big gap in family planning knowledge, women and girls are not informed about it and the myths take the day. They believe in these myths more than the facts. This education is needed for women and girls living in rural areas.

If women can be empowered with knowledge to know their rights, then they can voice it through the suggestion boxes in facilities. They will write the complaints and what they want with hopes the management will open and read their requests.

Some leaders only promise change by talking and no action, especially politicians. The hospital management is aware because women do keep complaining and there are so many cases of mishandling women. They just choose not to act. There are public hearings where women are supposed to voice their demands, but most times the leaders do not turn up. The ones we voted for are not concerned with us until the next election.

My greatest dream is for women with disabilities to be economically empowered. If only women can get means to make little money that they can save and use for their health needs and those of their children, the world will be so different. If they could have small businesses to sell vegetables, or chicken this would be great for women.





## Elicah Sanya

**Bungoma county, KENYA**

Disability activist and mobilizer

**DEMAND: Free maternity and women who are empowered economically**

Women are told to pay for [sterile] gloves when they go to hospital when giving birth or family planning services, yet most expect it to be free. The health facilities are very far from the villages and the roads are not good. Most women will not even have money to go to the hospital either to deliver or take their sick children. Most men assume the responsibility of children is for women. So, for example if baby is sick the mother is responsible. So, the mother will decide where to take the baby and look for money. Women choose to give birth at home with TBAs (traditional birth attendants) to avoid going to hospital because they will not be discharged [if they can't pay]. Most women then end up not getting quality services and sometimes some have had serious health complications—like bleeding too much—then a mother becomes too weak.

There are many times I go to hospital and leave unattended because there is no doctor at the clinic, this is very common. I feel sad because I would not have come to the hospital without feeling sick or requiring service and now, I must use more money to go another day. Services should be free so that women can go to hospital without worry, or women could have small businesses or jobs to make money to pay for services. But there is the challenge, most women do not have jobs. Their husbands are not really concerned about them or children. With women's empowerment, this will sort a lot of problems for women. Women will be able to pay for services, they will buy food for their children, they will pay for family planning.

Also, there is urgent need for attention on women with disabilities, like the deaf, there are no translators in hospitals, no special beds, even the doctors don't have the skills to accommodate our needs. You know, doctors think women with disabilities should not be getting pregnant. Doctors verbally abuse us, asking, "Who is it that made you pregnant?"

Politicians know about these issues, because they campaign on promises to women for hospitals and so on. Most people expect political leaders to do something because they promise during elections, but after election the politicians never come back to the people. There have been some efforts by county governments, I have seen some renovations in facilities but there is still more to be done.

Women need to be empowered to speak out more and ask for better services. My demand is free maternity and if not possible, women who are empowered economically so that they can afford to pay when they go to hospitals.

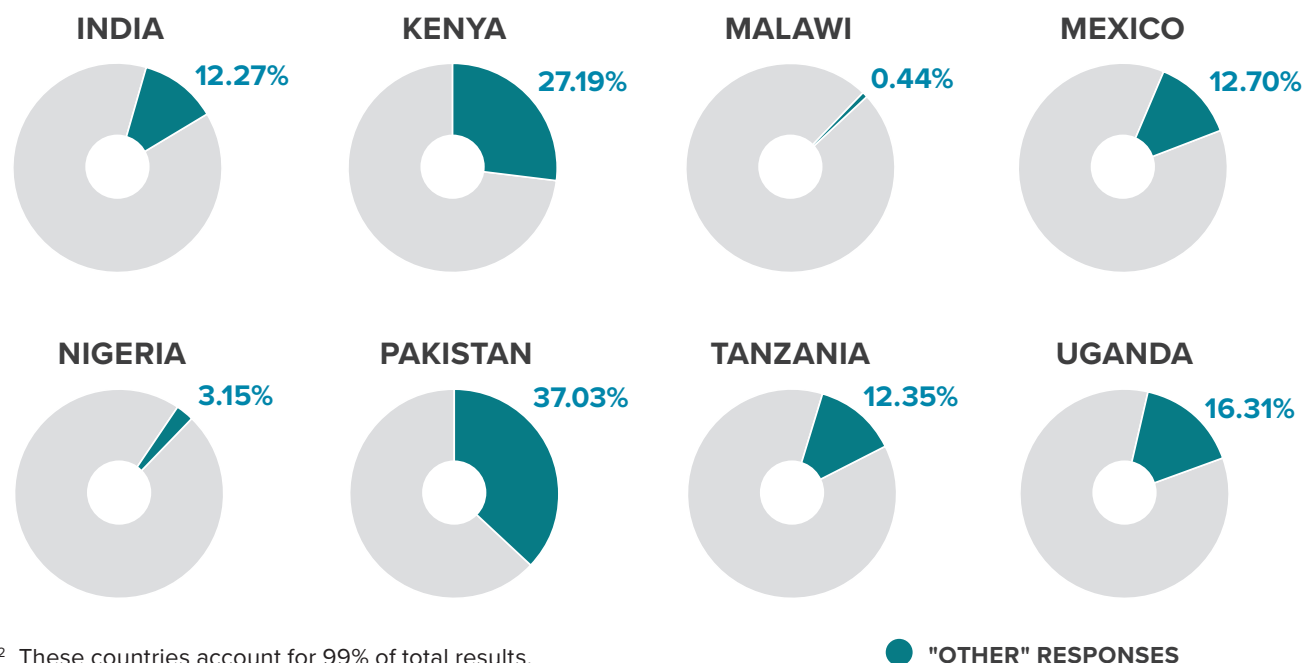
*As told to Angel Katusia, White Ribbon Alliance, Kenya.*



## How different might our results have been if we had been more deliberate in our mobilization?

Globally, nearly 20% of responses fell into the broader health and social determinant categories. Interestingly, of the eight countries that mobilized the most responses, those that we are aware made concentrated efforts to reach women and girls society often treats as “others” had higher percentages of “other” asks. In Kenya, outreach emphasized adolescent girls and included persons with disabilities, while Mexico deployed mobilizers to query indigenous and migrant women and women in prison. Both India and Pakistan prioritized reaching rural women. Tanzania also highlighted young women, and in Uganda, the country with the third highest number of refugees in the world, efforts were made to reach adolescent refugee girls.

Figure 2. Percentage of “other” responses by country<sup>2</sup>

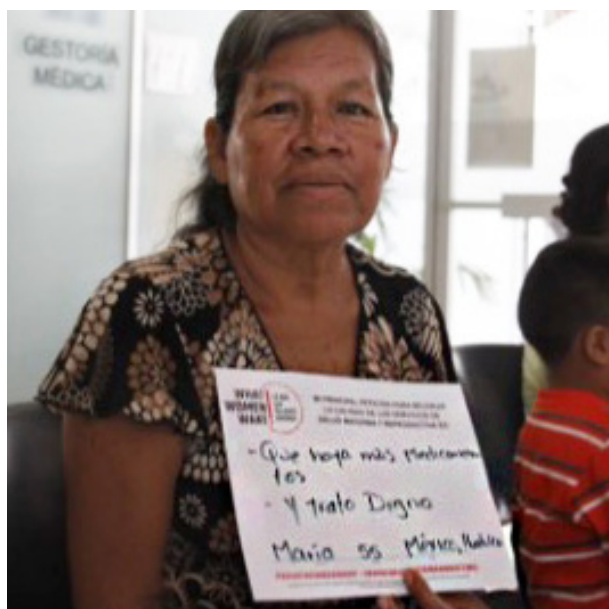


<sup>2</sup> These countries account for 99% of total results.

It is notable that over one-third of responses in Pakistan focused on broader health and social determinants, with their top demand overall being *child health information, personnel services, and supplies*.

Women and girls also expressed concerns about air pollution—particularly the effect of pollution on their own and their children’s health. WASH requests extended far beyond healthcare facilities to include water, sewers and cleanliness for the entire village, with a special plea for washrooms within households.

Other requests focused on the agriculture economy. In Sindh province, where many communities only grow wheat and rice, women asked for fruit trees and garden vegetable seeds. They wanted high-quality soil and to know the latest techniques in farming practice, in many instances to feed themselves and their children. Not only in Sindh, but across Khyber Pakhtunkhwa and Punjab provinces too—whether it was stitching, cloth dyeing, animal husbandry or support in opening small shops—women asked for vocational training to earn their own income, often to support their families’ health.



None of these requests were due to women's and girls' misunderstanding of the question: what is your one request for quality maternal and reproductive healthcare services?

**Their answers instead reflect an acute appreciation of how reproductive and maternal health is deeply influenced by social and environmental factors—because they live these realities, every day.**

In fact, the misunderstanding was ours. Admittedly, we judged their number one priority. We assumed it was child health because of a discomfort asking for themselves, when it was simply, for many reasons, what is most important to them. They were not concerned with what we wanted to know, but what they needed to say.

Over the next pages, you will meet the mobilizers from Pakistan's Rural Support Programme Network. These hard-working and inspiring women made their own demands while asking hundreds of thousands of others what they want. You are already acquainted with some of the mobilizers from the original *What Women Want Global Report*. This time, you will hear from many more, in



their own words, as they deserve. As many will tell you—some in a sentence or two, others in words spanning several paragraphs—it was often schooling and incomes that paved the way for their eventual reproductive and maternal health activism.

Hopefully, as you read, it becomes as clear to you as it is now for us that economics, education, and the environment are all connected to maternal and reproductive health. You may think it obvious. Why then do so many health advocates, donors and implementers narrow our focus to technical,



*If you don't have educational opportunity, you can't acquire skills, and then how can you have opportunity for jobs—if you don't have education, how can you be part of any decision-making process?"*

• **Talha Rasheed**, Fire Communications, mobilized 10,000+ responses across Pakistan

treatment, and/or provider interventions to improve quality, clinical care? Why do we not work in tandem with others to confront broader societal challenges?

**Why are we too often silent or look the other way regarding abuses of power, discrimination, and violations of human rights by leaders who “champion” reproductive, maternal, newborn, and child health?**

**Are we being pragmatic or are we being complicit? Truthful answers should make us uncomfortable and make us act, ideally in different ways.**

*“Women talked with me about open area toilets and shared, unclean water sources. They asked for village cleanliness because of diseases in the area. About 8 out of 10 people in my community have hepatitis. Our money goes to treatment and not our future health like family planning.”*

• **Naeem Akhtar**, Punjab, community resource person, mobilized 1,000+ responses in her local community

## COUNTRY IN FOCUS: Pakistan's Rural Support Programme Network mobilizers

Photos taken by, and stories as told to, Fatima Shahryar, Research and Development Forum for Safe Motherhood, Pakistan, a local affiliate of the global White Ribbon Alliance. Minimally edited for clarity.

### Zeenat

Swabi district, Khyber Pakhtunkhwa province

My life is a tale of constant struggles, but I am determined that no other woman living under same circumstances should suffer. I was 15-years old, when I was married to a man double my age. I was too young to fulfill my responsibilities as a housewife, but every other girl I knew was doing so, and therefore, I too continued. My mother-in-law was very strict, and I had to follow her instructions in performing all household chores.

Soon after I gave birth to a daughter and life continued. My daughter, Sidra, was 14 when my brother proposed that she be married to his wife's cousin. In our tribe, once a girl is promised, no one can go back on his or her word. Sidra was married, but the groom was not a young man. He was a 60-year-old uncle of my sister-in-law. Sidra had to live with grown up kids of her husband and was subjected to domestic violence quite often. Since she was married in a different city, we could not check on her very often. Last year, they sent her back along with her eight-year-old son. They have not divorced her, but seeing her condition, I have decided that I will not let her go back. She is mentally not in a state anymore, to look after her son or herself. I am getting her treated at a local hospital.

To pay for her medical expenses, and to support my family, I have opened a small shop in my house. I maintain a regular account of my sales that helps me also analyze what sells well.



**DEMAND: Women should be made aware of their rights and essentials of maternal and newborn health care**



## Zarina

Jacobabad district, Sindh province

I believe that no struggle goes in vain. If you have a will, you will find a way, no matter the obstacles. We were very poor and could hardly afford two meals per day. I started stitching clothes and my husband worked as a laborer. It was my passion to ensure that all my children go to school. I had to stand for my children's right and fight the family, our tribe and community.

Little by little, we continued our efforts and enrolled all our children in school. As the time passed, and being recognized by my community members, I was offered by a local organization to work as a community mobilizer. Our community was very conservative; so much so that women were not even allowed to talk to men. However, I accepted the job and convinced my husband that if we do not change ourselves, our lives will not change either.

I started going out to visit other families in my village, to inform them on the importance of maternal and child health and rights. My in-laws, living in a different village, found out about it and came to our house. They beat me and threatened my husband. But knowing that what I am doing is not just for myself and it is a great service to the people of my community, especially women, I continued despite threats from them and some of the community members.

Today, I not only work for my own village but also the neighboring villages. There are no health workers or health facilities available and so I am their only source. The change has been slow, but we have all witnessed it. I also have a small shop at my home, which I run together with my son and husband. I chose a different path, but with each life that I touch and empower, I feel I am fulfilling the purpose of my life.



**DEMAND: Trained staff available to provide information and health services for women**



## Shahnaz

Shikarpur District, Sindh province

I have three children and I want to make sure that they lead a completely healthy and prosperous life. My husband works as a clerk at a local office and supports me like a partner should. We both decided soon after marriage that we would not have more than three children. He always supports me, and I share all my health concerns with him. I make embroideries at home, to help generate income and contribute to our household. Our community also nominated us as the Bright Star couple. My ask for the *What Women Want* campaign is that we should have a health facility nearby, with a gynecologist and provision of oxygen for emergency cases. I attend all our community group meetings and inform other mothers about important steps in maternal health care.

**DEMAND: A health facility nearby, with a gynecologist and provision of oxygen for emergency cases**



## Nayab Mehreen

Mardan district, Khyber Pakhtunkhwa province

Soon after the birth of my first baby boy, my husband left me at my mother's home. He promised to come back but later sent a message that he is marrying someone else and cannot keep my son and me anymore. I did not know what to do, but as the time passed, I started making wedding accessories with my sister-in-law. I also help my family with the household chores.

If I were to demand one thing for quality health care, it would be access to a health facility. The nearest health facility in our area is one hour away, by rickshaw, which is not easily available, so we must walk to the facility. It is the inaccessibility that keeps people from visiting a health facility and therefore unaware of the importance of maternal and child health, especially during pregnancy and the postnatal period.

To help the women of my community, I have started visiting the households along with a local community mobilizer and take part in community sessions, where I participate in group discussions and we learn from each other.

**DEMAND: Access to a health facility**



**DEMAND: An end to child marriages**

## Rehnaz

**Mardan district, Khyber  
Pakhtunkhwa province**

I was fourteen-years old, when I got married. My husband never worked, so I had to go out and look for work at an early age. I delivered my second child on my own. There was no one to help me, as my husband refused to take me to the hospital while I laid and bled on the ground. Me and my baby girl were completely on our own, while my son, two-years old at that time, sat near us and cried. It took time but I managed to help myself. The birth of my second child was a turning point in my life. It was then that I decided that I must help myself. I sold my gold earrings and bought a buffalo. I love it like my own children, as even in the hardest of days, I can earn my children a meal by selling the buffalo's milk.

Few months back, as I was expecting again, I decided to visit a health camp where I met with the local community resource person. She guided me on the antenatal check-ups and referred me to a health facility nearby. I was scared at first, but I was determined to stand up for my children and myself, so I followed my doctor's advice regularly. Two months back, I delivered a healthy baby girl named Noor.

I believe that no girl should be married at an early age. No child should have to go through what I did. Beginning with myself, I will fight for the right of my daughters to marry only when they are of the right age.



## Saima

**Mardan district, Khyber  
Pakhtunkhwa province**

I have been working as a Lady Health Visitor in my community for the past five years. I always wanted to help the women of my community, as living in a conservative setting further deprives them of their access to healthcare services.

I received training by Rural Support Programme Network's Sarhad Chapter last year, to work as a trained lady health worker. I met Rehnaz at one of the camps in our community and found her in a miserable condition. I helped her seek the services of a skilled birth attendant, despite resistance from her family and ensured that she delivers a healthy baby and has access to safe maternity. But Rehnaz is not the only one; she is one of the many women like her who continue to suffer. My ask from the *What Women Want* campaign is that families should be counseled for improved health of women, mothers and children, for they complete the family unit, and it is vital that every member of the family is healthy and is able to play their role in best of health. To enable this and play my part, I organize health camps in my community where women can reach me and my fellow Lady Health Visitors to seek information and health care services. We must not let any life be lost due to pregnancy and childbirth. A miracle as beautiful as this should not be a reason of anyone's suffering and death.

**DEMAND: Families should be counseled for improved health of women, mothers and children**

## Kalsoom

Swabi district, Khyber Pakhtunkhwa province

We live in a community where traditional values are strictly followed by all families. Women are not allowed to go out alone and therefore all matters outside the home are dealt with by the male members of our family. I was completely unaware of antenatal checkups and their importance during pregnancy, until I nearly lost my life and my baby due to eclampsia and blood loss during childbirth. To ensure that no other woman should suffer, I convinced my husband and received training for becoming a community resource person. I learnt important messages on mother and child health. I visit households now and ensure that all women and girls are aware of their health rights and importance of skilled health care. I do not want any other woman to go through what I had to endure.



**DEMAND: There should be a mechanism in place to ensure that all women and girls are aware of their rights and know where to seek health care services from**



## Bhaagbhari

Shikarpur district,  
Sindh province

**DEMAND: Women's health should always be the priority, for the household and for the community**

I stay at home and help my mother with taking care of my siblings and household chores. My aunt works as a community resource person and many women visit our home to discuss health related matters. I have learned a lot from my aunt and women who visit our home. We live with limited access to basic resources and must make do with whatever means available. Having been indirectly involved in the health campaigns and receiving the information, my ask from *What Women Want* is that despite the conditions, women's health should always be the priority, for the household and for the community.





## Sanam

Shikarpur District,  
Sindh province

It has been seven years since I began working as a community resource person, in my village. My work has been primarily the same, as I must go from one house to another and educate women of my community on maternal and child health. This past year, I received a training from the Rural Support Programme Network in which I learned about family planning and healthy birth spacing methods. It was new information for the women of my community. Initially it was difficult to share detailed information as they were not ready to listen, but with time, as I answered their queries, they started coming to me for advice, one after another. Soon after I conducted a campaign survey for *What Women Want* and learned how there are so many asks and so much that needs to be done to ensure quality health care for mothers and children. My ask from the campaign is to enable easy access to health care services, for every woman, everywhere. I am playing my part to inform and reach as many women as I can, but there are always some women left, who are deprived of health care and services that they deserve.

**DEMAND: Enable easy access to healthcare services, for every woman, everywhere**

## Bisma

Shikarpur District, Sindh province

It is not only about women or children. I feel that good health is a matter that concerns a community as a whole. I go to school so I can not only learn about educational subjects but also our society. I see my mother working and going to different households to inform women about key health messages and practices. I have learned that health is first and foremost our own responsibility. If we do not take care of ourselves, no other person will. My ask from *What Women Want* campaign is to provide clean drinking water so children can be safe from different diseases they catch from water supply. To ensure cleanliness, I also guide my class fellows and friends in the neighborhood to wash their hands before meal and after using the washrooms.

**DEMAND: Clean drinking water for children**



**DEMAND: A nearby and accessible health facility**

### Saima

Shikarpur district,  
Sindh province



I have a bachelor's degree and I have been working formally and informally, since the past five years for the women of my village. I received a formal training last year from Rural Support Programme Network, to become a community resource person. We were trained on the importance and methods of family planning and healthy birth spacing. In our part of the community, the education and health of women is still not given as much importance as it should be given. *What Women Want* helped me reflect and hear from women about how they want to have better access to health services but remain deprived of it. My ask from this campaign is that there should be a nearby and accessible health facility. I am doing my best to improve the standard of health care and aspire to help build a community where my people are healthy, and their well-being is looked after.

### Haseena

Jacobabad district,  
Sindh province



I am the only one educated amongst the women of my community. I received the formal training for becoming a community resource person from Rural Support Programme Network, Pakistan. The training helped me formally understand the key messages and counsel the women of my village on the importance of health and practicing positive health behaviors. I started family planning with myself—before advocating and asking other couples to practice it. Playing my part for the *What Women Want* campaign, I decided to lead with example, as I have eight children. My ask for the campaign is that an exclusive ambulance to transport pregnant women to hospitals in emergency should be available 24/7 at all places, for no mother should lose her life, while bringing life to the world.

**DEMAND: Exclusive ambulance to transport pregnant women to hospitals in emergencies should be available 24/7 at all places**

## Arbeli

Jacobabad district, Sindh province



We live in a small village, where houses are connected through walls. We often peak over the walls to check on each other. My husband does not work and so I am the breadwinner for my family. It has been nine years since I have been working as a community resource person in

my village. I mobilize and sensitize women on taking the lead and thus taking care of their own health. My ask from the *What Women Want* campaign is that every child and woman should get education. I have studied only till grade five, but even that has helped me. When communities are educated, they learn to ensure their health and well-being too. I am playing my part for the campaign by organizing village and community organizations, where members come together, discuss and seek solutions to their problems.

**DEMAND: Every child and woman should get education**

## Mai

Jacobabad district, Sindh province

I am not educated but I understand the critical importance of quality health care and services. I have two sons and live in an area where we do not even have a hospital nearby. I do not want my daughters-in-law or grandchildren to suffer because of unavailability of healthcare services. I have seen too many women lose their lives during childbirth while waiting for an ambulance. We always depend on a kind neighbor to lend his car so the pregnant women may be taken to a health facility that is an hour's distance by car, but they are not always available. My ask from the *What Women Want* campaign is that there should be a 24/7 ambulance and a female gynecologist, because we do not want a male doctor to deliver the babies of our women. Our values do not allow that. To serve this cause, I am advocating for girls to seek education and become doctors, so we can have our own doctors, from our community.

**DEMAND: 24/7 ambulance and a female gynecologist**



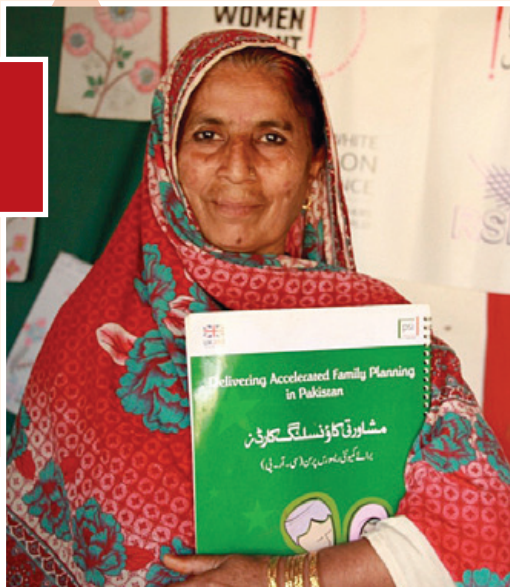


## Soomri

Jacobabad district, Sindh province

People trust me and count on me for advice on health. My husband is unemployed, but together with my sons, I try to manage the everyday expenses. I make embroidered clothes and décor pieces and sell them to manufacturers based in Karachi. I have been working since 2009, but it was during the *What Women Want* campaign that I truly got a chance to reflect as I heard other women's asks for the campaign survey. Some women wanted a solution to sewage problems, others demanded education, while some believed trained health workers could really make a difference. My ask from the campaign is to build a hospital with adequate facilities. Presence of a health facility and trained staff can turn lives around; although it may take time, people do start seeking the services. And being the need of the hour, as people travel miles and miles, I really believe that every community should have an independent and easily accessible healthcare facility.

**DEMAND: Build a hospital with adequate facilities**



ANOTHER LISTEN



## Shabana

Jacobabad district, Sindh province

I have been working as a community resource person for a long time now. Women of our communities have a lot of responsibilities that they are expected to fulfill. With changing times, women are also actively contributing

to the household income, in many cases being the only breadwinners for the family. Being a key member of the family unit, it is important that during pregnancy, childbirth and even afterwards, women receive quality healthcare services. If a mother is not healthy, she cannot nurture and look after the children in the best way either. My ask from the *What Women Want* campaign is that there should be extensive mother and child health programs that reach every woman, in every corner. To fulfill my responsibility toward this cause, I took part in the campaign and helped women become informed and reflect on their health needs.

**DEMAND: Extensive mother and child health programs that reach every woman, in every corner**

## Khursheed

Shikarpur district, Sindh province

It has been two years since I received a formal training to work as a community resource person. My husband works as a laborer and earns about 500 rupees (USD 5) per day. When I started working, initially people usually closed their doors and refused to let me in. However, with persistence and continued effort, I won the trust of my community and now I am usually the first point of contact for the women of my neighborhood. I had to work really hard to inform all women and sensitize them around the importance of maternal and child health, of going to a health facility and seeking services of trained healthcare provider. My ask from *What Women Want* campaign is that facilities, especially those concerning the three delays, should be enabled, so no mother reaches a point of losing her life. To play my part, I have

educated and mobilized all my community members to prepare well for pregnancy and childbirth, ahead of time. Now they start saving money as soon as they find out about the pregnancy.



**DEMAND: Facilities, especially concerning the three delays, should be enabled**



## Aasia

Jacobabad district, Sindh province

I learned about the importance of antenatal care from Khursheed, the community resource person of our village. My husband works as a daily wager in the outskirts of our village and occasionally earns about 3-400 rupees (USD 2). I stitch clothes and assist my neighbor in cattle-farming that helps me contribute to our household income. My ask from the *What Women Want* campaign is for a hospital with mother and child facilities, in our village. To do my part, I save 50-100 rupees every day, and am going for regular antenatal check-ups too. I am preparing well for the birth of my child. I am also the first woman in my family to see antenatal care services, and my husband accompanies me to the hospital, which is unusual for the community that we belong to.

## Farzana Shikarpur district, Sindh province

I had three kids, and my husband and I wanted to practice family planning, so we could lead a healthy life that balanced with our household income. We depended on natural methods to space between births, but then I became pregnant with my third baby. Last year, I heard about Khursheed, the community resource person and approached her to assist us with the process. She guided us well and we both could access the family planning services at the nearby health facility. My ask from *What Women Want* campaign is that 24/7 maternity care services should be available in our village. An expecting mother can need to transfer to hospital at any time, and travel to the main hospital is cumbersome and takes time. With a health facility accessible to every community member, we can also convince our families and adapt positive health behaviors.



**DEMAND: 24/7 maternity care services should be available in our village**

## COUNTRY IN FOCUS: India and COVID-19

In June 2020, as a follow on to *What Women Want*, WRA India asked 11,154 women in the states of Assam, Madhya Pradesh, Rajasthan, Uttar Pradesh, and West Bengal about their shifting RMNCH needs during lockdown.

**Three-fourths of women reported loss of livelihood by the earning member of their family and 63 percent were experiencing financial hardships.**

Compounding the situation were limitations on mobility. Three-fourths of women needed to go outside to get groceries, one-third for water and firewood, and one-fifth to use the toilet. Fear of COVID-19, the police and a lack of transportation kept women from going outside and taking care of their basic needs.

**Almost half of women reported both scarcity of food and inadequate access to healthcare services.**

“ I used to sell homemade spices (garam masala, badi, chilli powder, jira powder) before the lockdown. There is no income during lockdown which has impacted my livelihood adversely. We are unsure how lockdown has saved our life; rather the lockdown is killing us by impacting our income.”

• Arti Devi, Bareilly city, Uttar Pradesh

The one exception was a majority of women (92.4%) who delivered since lockdown, reporting they received postnatal check-ups. Forty-seven percent of these women (1199) said they received delivery assistance under various government schemes, 81 percent were from Janani Suraksha Yojana, followed by Pradhan Mantri Matru Vandana Yojana (PMMVY) with 17 percent.

**Thirteen percent of women also reported an increase in domestic and gender-based violence.**

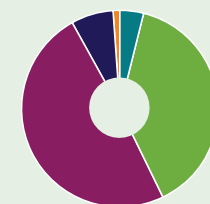
These women said lost access to female friends, relatives and neighbors prevented them from reaching out for help. Only one in three women knew of a helpline number.

Given India’s on-going COVID-19 crisis, we are compelled to act on what women have already told us and to help them survive the pandemic and ensuing lockdowns.

## ANOTHER LISTEN

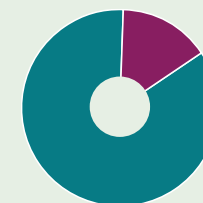
## KEY RMNCH

### survey findings



#### AGE

- 15-19 4%
- 20-24 39%
- 25-34 49%
- 35-44 7%
- 45+ 1%



#### SETTING

- Urban 15%
- Rural 85%

### Ability to use the preferred family planning method since lockdown



**YES**  
52%



**NO**  
44%



**DK**  
5%



**1 in 8 did not receive ANC during COVID-19**



**1 in 3 children did not receive vaccination**



## WRA INDIA'S COVID-19 *call to action*

**Amplify what works:** Greater use of television, mobile, and social media for interventions and community engagement.

**Policy shifts for improved agency, health, nutrition, and poverty alleviation:** Invest in skill building programs and interventions that build and increase women's income generation capacity.

**Community level intervention:** Launch initiatives such as community camps to provide support and guidance to women to avail government's maternal health schemes and entitlements.

**Support frontline workers:** Ensure that women are able to access services regularly.

**Cross sectoral interventions and programs:** Focus on increasing awareness and women's reach/access to helpline numbers for reporting domestic violence.

## Abanti Sahu

Balasore City, Odisha State

Husbands beating their wives is quite common in villages like ours. Ever since many men have returned home due to lockdown, husbands vent their anger and frustration on their wives. Though we are staying at home, we still feel insecure. There is a threat of physical violence from our own partners. Hitting and slapping women by men is most common in our society. As men are confined to home, going through mental tension and scarcity of food, there are conflicts between men and women over managing family finances. The women at home must slog throughout the day to arrange food, water and other necessities. But with the limited resources due to financial constraints, women bear the brunt of a difficult situation at home. We (women) are hit by men for giving them less to eat when there is shortage of food. All forms of physical violence have increased. It happens in our village every day since lockdown. Two-three days ago, there was an incident when a daughter-in-law was badly beaten up by her in-laws.

*As told to Bhagaban Mahopetra, WRA India*



## Anita

**Khandwa city, Madhya Pradesh State**

After lockdown, we were stuck in Aurangabad. No transportation was available and we had no work or means to earn money. We had to leave for our village in such difficult circumstances because we were asked to vacate the room by the landlord due to non-payment of the rent. We had to book a private car to return home which charged us a lot of money. We are cooking less and eating less amounts so that available food can last for a few extra days. In my village, there have been many fights between villagers. Now that there is some relaxations by government for alcohol, there are lots of fights between men. These men are agitated and frustrated due to joblessness and financial crisis. They come home drunk and beat their wives to take out their frustration. My husband comes home everyday and starts fighting with me on small issues. Women cannot do anything but suffer in silence and slog at home with increased burden of chores.

*As told to Varun Kumar, WRA India*



## Anupam Sharma

**Bareilly City,  
Uttar Pradesh State**

I had moved earlier this year with my children to Delhi to join my husband in earning money and supporting the family financially. However, due to lockdown, my husband lost his job and we were unable to get any work.

Thus, the crisis became unbearable without any means for rent, food and sustenance. We were stranded in Delhi for one and a half months without income. Children had to cope without milk. Our meals did not include curd, pulses, etc. Vegetables were prepared only once in two days because the prices of vegetables became very high and we could not afford them. The rotis (local bread) were given to children first and me and my husband ate leftovers. Children were refused savories and snacks. Children became very weak without proper food, milk, and fruits. After lockdown, my husband will go back first and approach his factory for work. If he does not get work there, it will be very difficult to search for a new job due to the influx of returning migrants.

*As told to Varun Kumar, WRA India*



## ANOTHER LOOK

# Women's invisible demands

COVID-19 brought into stark relief how much more must be done to shine light on those in the shadows. In the words of Alma Alizia Ochoa Moctezuma, *What Women Want's* lead mobilizer in Mexico, we must work harder to reach, “la invisibilidad, las que no miramos, las que no les preguntamos.” Or the invisible, the women we do not see, the women we do not ask. Often, these are women who are young, who are displaced or transient, who are imprisoned, who are indigenous, to name but a few.

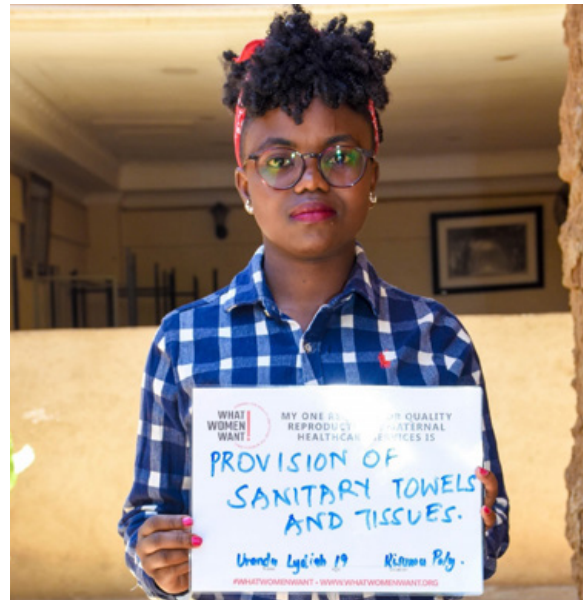
One of the limitations of the original campaign design was our inability to close the feedback loop with each and every woman about how her demand was met—or not. Then, over the last year, the pandemic complicated our planned community follow-up with imposed lockdowns and restricted travel. While at times necessary, it widened the already significant digital divide that often determines who is seen and heard.

Fortunately, we were able to connect with several mobilizers, such as Alma, still embedded and/or connected to *What Women Want* participating communities. They shared more about what was behind women's and girls' demands, making it obvious that we did not have the whole

picture. It is coming into sharper focus. Below, we share women's experiences from Kenya, Uganda and Mexico.

## Spotlight on adolescents in Kenya

Menstrual health, while the 20th demand among all age groups, was number four for women ages 15-19. In both Kenya and Uganda, where adolescents were a higher proportion of responses, it was the third demand overall. We highlighted this in the second *What Women*



“Ensure education for girls from 9 years to be able to make good decisions, provide sanitary pads to the needy in order to reduce teenage pregnancy.”

• Vivian, 18, Kenya

*Want* report *Behind the Demands*, pointing out that with 93% of all responses in this category, what girls want most are free sanitary napkins—“not pamphlets, but pads.”

However, when Kenyan mobilizers Sandra Mwarania and Angel Katusia met again with girls in Bungoma, Kajiado and Makueni counties they heard unequivocally, “Don't make this just a pad issue!” Girls did not want pamphlets, materials, or instructions on menstrual health either. What they want, what they need are income generating opportunities. Sandra explains, “Girls told us it's not just about whether they have sanitary napkins or not. It's about the difficult choices between basic needs.” Angel elaborates, “If I'm comparing the price of sanitary towels or napkins to a packet of flour for dinner—I'm thinking I need to eat first.”

Girls described being compelled to enter relationships or engage in transactional sex driven by need for sanitary napkins, let alone other necessities. Sanitary napkins are a short-term, band-aid that alone will not fix the underlying issue. Adolescent girls are asking



for supplies, but more than that, they are asking for the means to obtain them, and other essential items, by and for themselves over time.

Sandra and Angel also discussed how adolescents are in no way a monolith—school going and out of school; married and unmarried, but sometimes still heading homes. These differences inspire different demands. “Married adolescents and those heading homes want autonomy to make financial decisions. They want the right to make decisions about how and when to use their money,” says Sandra. Angel elaborates, “we heard many demands for mobile money to be registered under their names, so they have authority to access and use their money and so they can seek reproductive healthcare without limitation.”

Unmarried, pregnant teenage girls, also spoke to Sandra and Angel about the discrimination they face. “They don’t receive care until the day of their delivery when they go to a facility to have their babies. They are shamed when they seek

antenatal care because of their age or because they go without a husband,” Angel laments.

“COVID-19 has only exacerbated the situation. Funding for adolescent sexual and reproductive health programs has been redirected to fight the pandemic. Girls not only do not have access to contraceptives right now, but many also do not have the option to abstain even if they wanted to. They are trapped at home often with their abusers. They’re concerned about rises in early marriage and female genital cutting due to school closures that leave them more vulnerable,” says Sandra.

While Sandra and Angel offer an incredible amount of information, we must be careful not to make too many generalizations across the

East Africa Community and use the dashboard and ongoing conversations to compare and contrast countries. While many girls in Kenya said it is not foremost an information issue, those in Tanzania may feel quite differently. Counseling and awareness on maternal, reproductive, and general health and services was the fifth overall response in Tanzania—approximately 7% of the nearly 112,000 demands. However, these requests were almost exclusively from girls ages 15 to 19, who made up roughly 10% of respondents. Would it have been number one if more adolescents had been asked?

“

*Teenage mothers should not be discriminated against and stigmatized when they seek maternal services.”*

• **Anonymous**, Kenya, Age 19



**DEMAND: Increase investments and access to indigenous or culturally-centered maternal health services**

• **Sandra Mwarania**

**DEMAND: Dignity for all women and girls during their periods**

• **Angel Katusia**



**DEMAND: I want protection. Protection  
against rape and gender-based violence**

**M\***

**Kibera Neighborhood, Nairobi County**

I come from Kibera slums where every other day you hear a case of young girls being raped and no action is taken. If today I'm raped, I may get pregnant and I am still young, I could just die because I don't know anything about childbirth. If I have protection, I will be able to go to school without fear, I will be able to walk around without fear and I will achieve my goals and achieve my dream of becoming a doctor.

My friends also worry about themselves because of the stories around the slums; cases of girls being raped are many. The security police are aware, because most girls now report cases of rape, but the police don't follow up with speed.

My parents should always protect me, the government also should ensure we live in safe spaces. My parents should ensure they watch over me, who they leave me with, when I come home, not to send me out at night.

I should be free to go to the hospital, if I need help and when I get there, I should be attended to. When I go to hospital and I'm not attended to, for example, if I have infection, I feel bad, I'm lost because for me that's the safe place to go but most of us are turned away. My mother is the one who takes me to the hospital, sometimes I can sneak and go ask nurses questions by myself.

I have seen girls in my class suffering because they use pieces of clothes when they are on their periods. We usually get pads from school, but they also run out, some of us share with our sisters so you run out of the pads, and you have no option. It is usually embarrassing. Some girls decide not to come to school. Sometimes we may have pads, but we don't have panties, so it would be nice if we can access affordable panties too.

My dream is for girls to be free to go to school and achieve their goals with no interruption or fear. I want girls who are raped to be able to get justice.

*Story as told to Angel Katusia, White Ribbon Alliance, Kenya.*

*\* Name withheld to protect privacy.*

## **Spotlight on refugee women and girls living in Uganda**

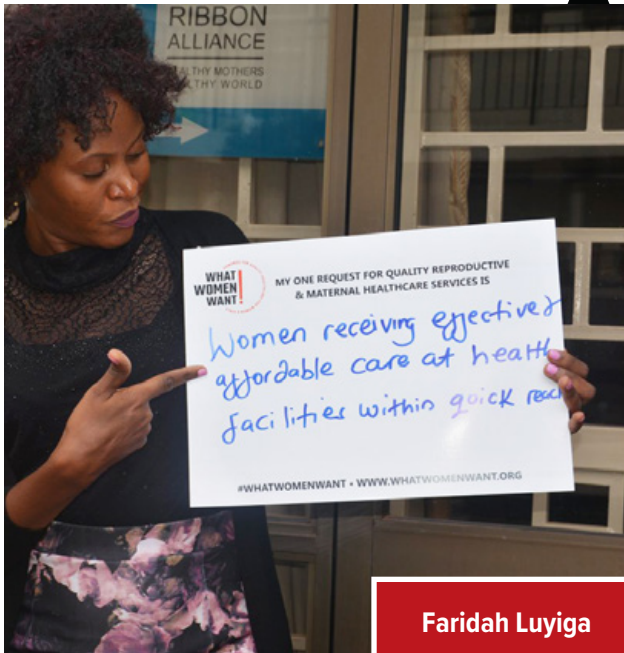
In Uganda, in the refugee-hosting districts of Adjumani, Lamwo and Yumbe specifically, the demands were startling in their straightforwardness and simplicity. They were almost always one-word answers and reflect a lack of the most basic necessities: blankets, buckets, sanitary towels for both menstruation and after birth, soap, and underwear. Mobilizers, Faridah Luyiga and David Ssebuggwawo, tell us how refugee women who live among the community and outside the camps often fall through the cracks. David laments, "Some NGOs or government agencies classify these demands as personal problems which should be solved by someone's own budget."

Women and girl refugees drove the number one request in Uganda, which was seen nowhere else: *labor and delivery information, personnel, services, and supplies*. This request boiled down to mama kits, which include plastic sheeting, razor blades, cotton, wool, gauze pad, soap, gloves and cord ties. The kits are a popular incentive for women and girls to deliver in Uganda's public health facilities. Yet, they remain out of grasp for many refugees when they go to deliver their children, often having to bring their own supplies.

"When you are a refugee, you have basic limitations on getting what you need—and these are things that every woman needs, not just refugee women. Some of the women, when they were responding to us, they had this hope that,

‘Finally! Maybe these people will provide these items to us.’ I remember being told by one woman in frustration, ‘You know, we don’t only bleed once!’,” admits David.

Faridah points to how populations in camps are increasing, and the diversity of languages within the camps is growing. “Women are increasingly unable to find people who can understand their needs, and that is if anyone is bothering to ask. And while implementing partners are providing some supplies, no one is thinking of postpartum pads or panties—and neither were we. The more I spoke to these women, the clearer it was that their requests were not only about supplies, but dignity.”



Faridah Luyiga

Along with mama kits, as part of the *labor and delivery information, personnel, services, and supplies* category, many refugee women also asked for their choice of birth position. Many refugee women say they prefer to squat to give birth, however health workers are unfamiliar with this position and do not permit it. Still, others asked for their choice in birth companion. When David and Faridah organized follow-up meetings with women to develop community action plans to realize their demands, they learned about the unintended consequences of well-meaning, but poorly implemented male engagement policies or initiatives that were driving these requests.

“Health providers and facilities have all gotten the memo on the importance of male engagement,” says David. “Unfortunately, for refugee women—whose husbands are often still in their home country or elsewhere seeking work—they find it hard to convince health workers that their husbands are not available and this causes delay in accessing services. In other parts of the country, they pay boda boda (motorcycle taxi) riders to pretend to be their husbands and attend antenatal care appointments with them. If they show up to centers alone or without a husband, they get put at the back of the line.”



*Women refugees need good feeding, and for expectant and breastfeeding mothers, they need good nutritious feeding so they can gain strength and be healthy. They need strength since in the camp no one is available to help them. The lack of food also leads to conflict in the homes. My husband quarrels every time he finds no food at home. Women like me need money; they need an income. If I had money, I would not be quarreling with my husband over food.”*

• **Asozo Lilli**, South Sudanese refugee living in Uganda



## Spotlight on migrant imprisoned and indigenous women in Mexico

Stretching from the beaches of the Yucatan peninsula to Mexico City—one of the most densely populated and cosmopolitan capitals on the globe—to the indigenous zones of Chiapas, the mountainous, impoverished state of Guerrero, and the perilous route most migrants follow through Veracruz, the experiences of women within Mexico’s borders are often worlds apart. “At the beginning (of *What Women Want*), I was not very sensitive about the needs that could exist. I took it for granted that there was water everywhere. I visited clinics and spoke to women who arrived after walking for four or five hours and couldn’t have water. I never expected to find that one of the main answers was a drink of water,” confesses Alma Alizia Ochoa Moctezuma, who lives in Chiapas. “I understood we had inequalities, but, in fact, they are deeper than I imagined, especially for migrant women and women who were incarcerated.”

Alma explains that when a woman arrives in Mexico, whatever the circumstance or legal status, she has a right to care during pregnancy and delivery. However, organizations working on migrants’ rights are rarely focused on reproductive and

maternal health care, and vice versa. As women move from migrant hostel to hostel, they often fall through the cracks, as reflected by Mexico’s top demand of basic drugs and equipment. Also among the top asks in Mexico was midwives. However, these requests are different from demands for midwives in other countries. Women in Mexico are specifically requesting more and better supported “parterias” or traditional or indigenous midwives.

Parterias do not necessarily meet the standard International Confederation of Midwives (ICM) or WHO definition, but for migrant women, and especially indigenous women, in many parts of the country, they are often the first or only point of contact for any form of healthcare, including by women and girls who have been trafficked or experienced gender-based violence. With little resources or respect, these women do their best to fill some of the gaps, often becoming targets of violence themselves simply because they care for these women and girls.

Alma also highlights how, similar to migrant women, there is no protocol to address basic reproductive and maternal care for women in prison in Mexico. “A sentence doesn’t take away your fundamental human rights. This fact has been somehow made invisible, even for advocates like me who work in defense of women’s right to health. Just as the government makes these women invisible,



**DEMAND: Aborto legal y acceso equitativo a servicios de salud/ legal abortion and equitable access to health services**

• Alma Alizia Ochoa Moctezuma

so do we. I speak now in retrospect. I did not do enough at the time of the *What Women Want* campaign or in previous work—really, we omitted them. I know that the agenda is very complicated and that we work intensively on other issues. But I do believe that sometimes it becomes too easy to omit, and then to do it often. Migrant women, as well as women in prisons, are the most invisible. It’s like they do not exist, they simply do not exist”.

### **B\*** Veracruz State

I am traveling with my 3-year-old daughter from Honduras to the United States. We've journeyed by train, by road, we've walked many miles in the sun, rain and night, looking for the safest path away from the cartels that hunt us. The hardest part of my journey was the choice to leave. And not just leaving my country but leaving my two eldest daughters behind and only bringing my youngest with me. Since leaving, she has fevers and coughs, but there are no hospitals on our route. We've moved from hostel to hostel, and station to station, but I couldn't even find medicine or fever suppressants. I'm now here, and I have nowhere to go. I just hope I can get to the other side.

It would be good for me if they gave us the help of a doctor when we arrived at a hostel, to check us out and our children. Although we've been treated well here, there's no doctor.

**DEMAND: a doctor**

**DEMAND: Doctors who were kinder**

### **E\*** Veracruz State

I'm used to walking day and night and being strong for my two children. I want doctors who are kinder, when my little girl was sick with dehydration, they told me I had to be more careful, but what else can I do? In Honduras, I have nothing to go back to. If I go back now, I won't be able to do it again. I had a hard time making this decision and I know that there (in the US) my children have a better future ahead of them and I'm going to have a job. If my situation in Honduras were different, I would never have chosen to expose my children in this way. I had a hard time making this decision, but in Honduras I have nothing to go back to."

### **MJ\*** Veracruz State

I worked in a grocery store in Honduras, but it was not enough to support my parents and younger siblings. My mother was sick and my father prey to alcoholism. The best option I could see was trying to get to America.

I've had food and shelter, but the medical care is poor where I've stayed along the way. It is necessary to have doctors who are more respectful of women and have privacy during medical appointments. I had a medical review and I felt very uncomfortable, because the doctor who came to care for me was in a bad mood. It was also in the same room where everyone was and that also made me uncomfortable, because when the doctor examined me, there were more than 60 people around me.

Privacy in such an intimate matter is something necessary. Even if we are migrants and do not have papers, we should be treated with respect, especially when it comes to caring for our health.

**DEMAND: Doctors who are more respectful of women and privacy during medical appointments**



## Estela

**San Luis Potosi, Sampat community**  
Indigenous midwife

Since I was 15-years old, I accompanied my grandmother in her practice. More than anything, I decided to choose this path because seeing the love that my grandmother had for the women she

attended. It was very beautiful. It was a nice feeling of belonging and being heard. Seeing how my grandmother accompanied the women, how she talked to them—the connection that the women have with the midwives is what is special. What they have with us is that connection of being able to talk, of being able to speak about their lives, which makes them feel safe. From seeing that process and thinking that it is really we who save ourselves—that was it, I decided to become a midwife.

I now work with an organization called Mim Tsabal Parteras. We have worked in Estoril for three years. We organized to find a place to receive women and give them the attention they wanted. We as midwives are changing. In the past we, waited for the women to come find us. Now we are actively searching for those women who cannot come to town, who cannot seek us out, who do not have the same access. We go and look for them. Now they know that we're going to visit, so the women have started formally waiting for us. But at the end of the day, I feel like it's a quest.

Especially when COVID-19 started and the public transport no longer went to the communities. We started looking among ourselves to gather money to travel to the communities and bring groceries because we also had to bring food to pregnant women. We were carrying groceries for four months in a row. I do not know

how we did it, but we had to—otherwise, what could we say to a pregnant woman without food about caring for herself? Thank God there was a way for us to seek help eventually from collection centers. On top of these challenges in helping women, midwives at that time were forgotten. We were everywhere—many of us were in Oaxaca, Chiapas, Veracruz, Chihuahua—but nobody could see us; we didn't have equipment or any facemasks or PPE or anything.

I want the freedom to be able to work and be respected for my experience as a midwife. I can help a woman deliver safely in a place of her choosing and ensure that her newborn can still receive a birth certificate—despite her not delivering in a facility. I want the freedom to care for a woman and not be threatened with jail. I don't need the approval of a local health authority because I have the trust of my community and for me that's enough. But to be able to practice midwifery without fear, without fear of being singled out or put in jail—it would totally change our realities as midwives. Women would also feel safer in seeking us out for their home births and in having a fully free choice in the type of birth they want. So, it's that freedom for us that would really be freedom for everyone.

I want midwives to not be afraid to reclaim what is ours. Do not be afraid to accompany a woman. Let us remember that what we know or what we do, that we bring it from many centuries ago. Which is a right we have. And I'm not just talking about the midwives, I'm talking about all the women and families. We have a right. We have the power to decide about our body. Because at the end of the day, it's our duty, it's a service to the community.

My message is of respect, choice, strength, empowerment for women. We are free. We were born in this Mexico, where there are still certain freedoms. When those freedoms are not acknowledged, we must speak up. Because if we don't speak up, they won't ask, and they won't listen.

**DEMAND: Respect and freedom  
to provide without fear**



## S\* Oaxaca State

It's my first baby. A nurse came during my pregnancy to check on me, but on the day of my delivery, no one knew what to do. When I began to go into labor, there were no doctors, there was no nurse, there was no director of the prison, and no one to call to for help. By the time anyone realized I was in labor, it was night. It was an odyssey to just get me out of the prison and into medical care. The prison staff made calls and arranged for an ambulance to take me to the hospital and then brought me and my baby back a few hours after birth. In the end, I received care, but it was just luck. No matter I'm in prison, I should get care. It's still my right.

\* Name withheld to protect privacy.



*Freedom to work as midwives to care for pregnant women with a humanized birth, respected and quality."*

• Maria, Mexico, Age 36



*Right now, the world is attentive to the things that people have been screaming about for decades and if we are doing systems-justice work, we can't plug one hole in the wall and call it done."*

• Raven Freeborn

## Spotlight on Black mothers in the United States

In the United States (US), *What Women Want* mobilizers canvassed people attending [Women's March](#) and [March for Moms](#) events and made connections with many leading activists, including Raven Freeborn, Senior Policy and Advocacy Manager of [Mamatoto Village](#) and licensed clinical social worker in Washington, DC and Chanel L. Porchia-Albert, CEO and founder of [Ancient Song Doula Services](#) in Brooklyn, New York. Both Raven and Chanel are working to balance the scales of birth justice in the US, where Black women are over three times more likely than white women to die from a maternal complication. Their deaths place the US last among all high-income nations in terms of maternal mortality.

Mamatoto Village supports Black women and birthing persons to navigate and uphold their rights within the existing system, while at the

same time works to transform the system. "Our north star is thinking about the last person that gets served. Identifying the last person that would receive care if we continued in the model that we currently exist in and making that our starting point," says Raven. Raven believes community care models are key to eliminating the maternal mortality crisis for Black mothers, but that true birth justice goes beyond community engagement to community ownership.

Raven has initiated a 'village keepers' mechanism that engages and honors community members—particularly persons on Medicaid or who are Medicaid-eligible—with lived experience of harm as paid experts who set Mamatoto's advocacy agenda. "Village keepers need to define birthing justice for us," emphasizes Raven. They add, "If people are in the process of experiencing the pain or harm of food inequity or living in a food desert, we want to amplify that story in the way that they



**DEMAND: Quality of care increases in positive relationship to the lifespan, community resources, safe and meaningful relationships, and economic resilience of people living on the other side of the solutions we embed into the system**

• Raven Freeborn

talk about it, and we want to ask them about what reality they want to imagine instead, so that we can bring in our tools of advocacy and partnership to them and they are leading the solution, and can ensure that the solution is meaningful to them. Because nothing is viable if it's not meaningful to the community. And if it's not meaningful, we need to be prepared to start over."

For Chanel, whose journey as a doula began with her own birth experience, being community centered means employing a cultural humility framework that recognizes individuals as the experts on their own bodies, experiences, and care. Chanel explains, "It means for us to be humble and think maybe I'm not the expert. It means going into a situation, understanding that every time we

meet with someone, we're learning something new either about ourselves or someone else. And having appreciation for that. That's what the cultural humility framework teaches us to really understand." Chanel laments, however, that this approach is not widely practice, given it takes much more time per patient. Time that is not often allotted to healthcare providers under the current health system where they have patient quotas to meet, fixed and sterile checklists to assess family history rather than family stories, and no time to understand their patients' humanity, nor their own.

This leads to devastating consequences. Chanel has bore witness to widespread disenfranchisement of individuals, including non-consensual drug testing and threatening communities with Child Protective Services,

police, or immigration officers when they refuse medical procedures. Chanel recalls, "I started to see the ways in which people were treated at bedside...how low-income people of color—particularly Black, Brown, and Indigenous people—were treated when seeking out health care services. Where we don't even allow people to trust their bodies enough or center their voices enough so that they can birth their children in a healthy and affirming way."

Raven adds, "[When we talk about dignity] it is often focused on the moment of care, where the provider gets to determine what dignity looks like." Raven makes clear improving this dynamic is essential. From their perspective,

**DEMAND: Rebuilding systems in order to center women and birthing people**

• Chanel L. Porchia-Albert



an ideal world is one where people can show up and ask providers to facilitate decisions that they want to make for themselves. However, they also stress that truly respectful care secures a person's dignity and autonomy over their entire lifetime. Raven asserts for many 'village keepers' birthing justice equals housing justice—housing or higher quality housing comes up frequently among clients seeking perinatal services. Therefore, Mamatoto is now building a housing justice coalition and equipping housing advocates to speak about the harm poor quality housing poses for pregnant people, babies, and their families.

Chanel applauds efforts that include advancing sustainable solutions to inequitable housing, as she sees these same challenges in her own doula practice. Chanel expands, "There's other things that are happening and we're not paying attention to the social

determinants of health and housing and transportation and food insecurity and language. You're trying to tell someone to eat healthy, but then you're not giving them any kind of way to be able to do that. Where's the intentional partnering, right? We need to make those connections among community-based organizations. As a doula, I aim to connect people with these wider resources."

Raven acknowledges that this broader approach has challenges within the current health and funding environment. "It's hard to go to a funder and say, we don't have outcomes yet. Or to say, 'We're going this way, toward this vision, but I don't know how to tell you that we're going to get there.'" That said, Raven believes we must continue to push funders and shape their understanding of how best to support community-owned movements. "Right now, the world is

attentive to the things that people have been screaming about for decades and if we are doing systems-justice work, we can't plug one hole in the wall and call it done."

Chanel echoes the sentiment, "My number one ask is that we take the time to acknowledge our individual humanity so that we can see the humanity in other people, and we can move forward in our jobs, in the service of others, in a way that sets the foundation for future generations. We must acknowledge the traumas that we may have experienced in the past, the histories that we come with when we present ourselves, and the understanding that that DNA is very real in our cultural identity. We must honor those things in ways where we're meeting people where they are. Not where we expect them to be."





## Meet Brittany

Brittany, 23, lives with her two daughters, in an apartment provided through a two-year program run by the Salvation Army. She worked part-time as an aide in a senior home, paying 30 percent of her income toward rent, and is returning as soon as she can arrange care for her new baby.

Brittany became pregnant while participating in a Job Corps program to become a certified nursing assistant (CNA) in Pennsylvania. She had been using the contraceptive shot but missed a shot while working in PA and found out five months later she was pregnant. She explained that the staff in the program told her she would need to go back to her primary provider in Maryland where she had been living with her aunt to get care, but because she could not afford the bus ticket back, she didn't make the trip and missed her contraceptive shot.

When Brittany learned she was pregnant she said, "I thought how on earth am I going to do this? I was in school and working." She had to drop out of her job training program because she couldn't finish her clinicals while pregnant. Although she was only a few months from finishing the program, she couldn't complete it and receive her certificate needed to work in DC.

Brittany felt her prenatal care and delivery services were good; however, she did share several instances of feeling unheard by

providers. After her first delivery she noticed she was bleeding a lot and when she told her nurse "I'm still gushing a lot, is that normal," the nurse said it was. She was hemorrhaging, although they caught it early enough that she did not need a transfusion. Still, Brittany added that she had been telling the doctor about symptoms during the pregnancy such as blurry vision, feeling lightheaded, very swollen feet, and extreme sickness, but the doctor kept telling her "It's normal." It was only after arriving at the hospital that she learned she was at risk for preeclampsia.

After giving birth, Brittany opted for an arm implant contraceptive, but she had it removed after a year because of bleeding. She became pregnant the same year. After her second baby, Brittany opted for the contraceptive shot adding, "At my doctor's office, they only push two types of birth control: Nexplanon and the IUD."

For Brittany, factors outside the health care system pose some of the biggest challenges. Unable to live with her parents, who also experienced homelessness, Brittany has struggled to find an affordable place to live and generate enough income to support herself and her daughters.

"Some people think that when you're on benefits, they think you're lazy and don't want to work .... But I'm trying to work." The challenge for Brittany is that as a nursing aide in a senior home, she doesn't make enough to cover rent, and as soon as she reaches a certain threshold her other sources of assistance are cut off: "Once you start working, they cut off all your benefits ... It's really



hard .... Taking away food stamps was an eye-opener. There were times when we didn't have anything but snacks. We didn't have meat, or vegetables ... " Brittany plans to start working again as soon as she can find childcare but added "when [benefits] are turned off, that worry comes back."

*Story reprinted from [Human-Centered Solutions to Improve Reproductive and Maternal Health Outcomes in Washington, D.C.](#) with permission from the [District of Columbia Primary Care Association](#).*

### **The D.C. Women's Health Improvement**

**Project** is championed by the D.C. Primary Care Association and led by two Fellows. The project seeks to design human-centered policies and programmatic solutions to improve reproductive and maternal health outcomes in Washington, D.C.

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## Amber Rose Issac

*Amber was a 26-year-old Black woman, excited to be a first-time mother. She died in childbirth.*

*Amber's partner, Bruce McIntyre, shares her story.*



Amber would always talk to me about maternal mortality, and she would tell me these stories and I would tell her, “This isn’t going to happen to us.” It did.

My name is Bruce McIntyre, I am the partner to Amber Rose Isaac, and I live in the Bronx, New York.

Amber was an innovator, a game changer, who was going to change the world one way or another. She wanted to start an early-life program or open up a school to help underprivileged families and their children. She was phenomenal. We had a lot of big plans and they cut her [life] short for no reason.

Amber was facing incompetence very early on. With our OB-GYN, it started from the very first appointment. The OB-GYN seemed really distraught about our marital status. She asked if Amber and I were married. We told her no, but we have plans. After that, the OB-GYN was kind of just like giving us faces or huffing and I feel like after that she was less attentive to Amber.

OB-GYNs tried to tell Amber about her body instead of taking the time to figure out what was really going on with Amber. As we’re coming into March, we’re not getting any response. Amber is reaching out constantly about blood work or paperwork that she needs. Nobody is really reaching back out to her.

I’m getting aggravated. You know, I’m constantly telling Amber like, “We should do this with your mom. Let’s file another complaint. Let’s have your mom [a long-time hospital employee] reach out.” I feel like that was a constant thing.

Amber was tired of it. She wasn’t being seen. Coming into her third [trimester], she should have been seen every two weeks coming into every

week, but she wasn’t being seen at all. We were facing so much neglect that we decided that we were going to hire midwives.

When we got updated blood work back for our midwife, our midwife let us know, “Hey, we can’t accept you because you’re high risk” and made us aware that Amber’s platelet levels were dropping at a staggering rate. Her blood was unable to clot. Her OB-GYN and other doctors were signing off on her paperwork and they’re not telling us that her platelet levels are dropping like this, we had to find out through a midwife.

We go to get blood work done...I believe it was April 11th to see what was going on, but we’re not hearing anything back for the results. They finally scheduled a day for her to come in on April 17th. Amber was in there for over an hour and she’s calling me complaining like, “Hey, they don’t have my paperwork here, they don’t have my blood work here.”

They had told Amber they didn’t have any blood work. The people at the lab were trying to call the doctor, but the doctor’s not answering. The doctors are blaming the lab, the lab is blaming the doctors. That’s when Amber made that tweet that she wanted to write a tell-all about the incompetence and the negligence that she was dealing with from the medical system, the healthcare system.

They called us the next morning, like 8:30 in the morning saying that she needs to come in. The day that they induced her labor was the same day they found out that she had HELLP Syndrome—causing her platelet levels to be so low.

Amber is very scared because she knew that they were neglecting her and that they just weren't paying attention to her. She really didn't want to go by herself. She didn't trust them. She's asking me to come up with her or to have her mom or somebody, but because of COVID-19 hospital policy at the time, birth companions were not permitted.

Her COVID-19 test came back negative twice, but the head surgeon told Amber, we're still going to treat you as if you were a COVID-19 patient. They couldn't find out why her platelets were dropping. Her platelet levels were very low, very, very, very low, whenever we were in the hospital, and instead of bringing her platelets up, they were testing her for COVID-19.

Doctors came back like 30 minutes later, rushing a C-section. They were pushing it with a sense of urgency... telling her that they wanted to get the baby out before she became sick.

I was just standing there waiting for Amber and there were these double doors that I was looking through. I didn't know if Amber was in there or not, but I see them rushing my baby out. He's covered in blood and I'm just thinking, "Wow. He's here." Then right after that, I hear the intercoms go off and the announcers calling for all medical emergency staff to attend to Amber's room. They had to say that she was a non- COVID-19 patient three times before people really started rushing to her aid.

I'm hearing people at the front desk shout, "Hey, where is this at? This hasn't arrived from the blood bank yet? Where is this?" They're

having to go to the other side of the hospital to get blood, to rush blood. They told me that they had everything ready in her room, they told me that everyone that I would want to be in that room with Amber was going to be in that room. They weren't prepared.

They're working on Amber for maybe two and a half hours and I'm asking them, "Hey, have you guys at least closed her back up from the C-section?" They ended up cutting her some more. Mind you, her platelet levels are very low. Her blood is water-like. Her blood is not clotting.

We're still waiting around for updates. We see Black doctors leaving Amber's room shaking their head and looking at me like they want to come tell me something, but they can't. Then you have white doctors leaving her room coming up to me, patting me on my shoulder, "Oh, you're going to be fine. You're going to be okay."

If Amber would have received standard care, she would be here. Simple as that. What she had was 100% preventable, 100% treatable if caught early on. If Amber was a white woman, they would have definitely paid more attention to her. If this would have happened to a white woman, all hell would have broken loose. It would have been a state of emergency if it was a white woman.

When it comes to Black mothers, Indigenous mothers, Brown mothers, they're not being heard at all. I've heard Amber voice her concerns so many times. I've had to speak up.

Amber's mother has had to speak up. Amber left her own testimony before she passed. Black women just aren't being paid attention to. They're not being listened to.

*As told to Marissa Ware, as part of the [Brave Voices, Bold Actions Podcast](#).*

Honoring Amber's legacy, Bruce founded the SaveARose Foundation to raise awareness of maternal mortality amongst Black and minority women in the United States. The foundation has held rallies, conducted media interviews, and participated in panel discussions to raise awareness. The foundation is currently awaiting approval to become a registered 501c3 non-profit, and will accept donations once granted.

To support the Save A Rose Foundation and stay up to date with upcoming events, follow [@savearose.foundation](#) on Instagram.



## ANOTHER ASK

# What(sApp) women want

*What Women Want* activists worldwide are transforming women's and girls' demands into actionable agendas (Annex 2: *What Women Want: Advocacy Asks by Country*). The agendas differ based on individual country contexts, but there is one cross-cutting item among them. It is that asking, listening, and acting on what women say becomes the new norm for policy and program development across spheres—and not the purview of a one and done campaign. Women's and girls' wants and needs are dynamic and ever changing. We cannot assume we will continue to know and understand what they are, simply because we asked one question, one time.

**Imagine how different the COVID-19 recovery might have been if we had mechanisms in place to meaningfully engage communities from the start.**

Nearly overnight, governments and facilities around the world suspended maternal and reproductive health services. Curfews were in place without notification or exemption for those who were pregnant, or processes or plans to make sure women could still receive critical care. From places as far between as Narok county, Kenya to Chandigarh, India, *What Women Want* mobilizers shared reports of women and girls unable to access health

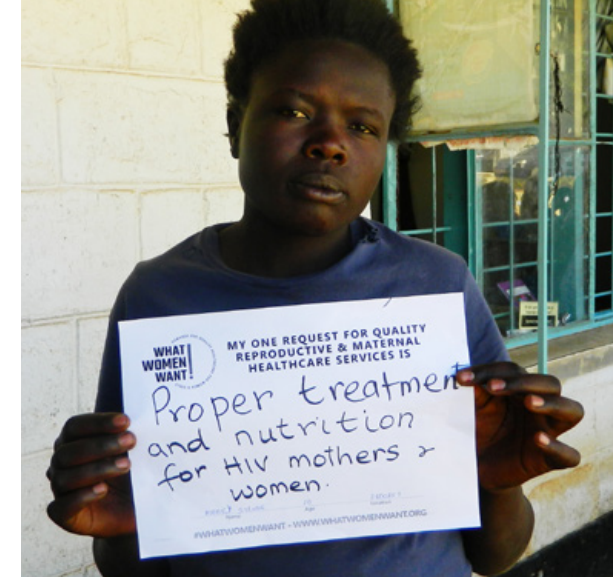


*And there the voice of women again is a step further ahead than those of us designing from behind a desk. Women said it to us in 2019, and then it became evident in the COVID-19 epidemic.”*

• **David Melendez Navarro**,  
Technical Secretary, CPMS

facilities while in labor. They conveyed stories of women and girls experiencing verbal and physical harassment by local police while trying to walk there and giving birth in quarantine centers, having returned home, or on the side of the road.

Women's and girls' experiences were often dismissed as some things are bound to be overlooked and missed during an emergency. What was missed were the rippling and crippling ramifications of such a policy decision and the myriad of other concerns and considerations women and girls needed addressed in real-time. Cancelling services and issuing curfews were viewed by many women, girls, and communities as top-down, misguided mandates that endangered their lives.



**Such decisions fostered skepticism about recommendations at-large as well as the appreciation by those in charge of the realities of everyday people's lives, undermining the overall pandemic response.**

Sexual and reproductive health and rights advocates, including White Ribbon Alliance, quickly mobilized to ensure maternal and reproductive health services were restored and deemed essential in Kenya, Malawi, Mexico, Pakistan, and other places. We successfully advocated for respectful maternity care procedures and provisions to be included in many of these same countries' COVID-19 response procedures. Yet, when we organized a virtual focus group with adolescent girls in Kajiado county, they asked about financial support and nutrition—their concerns about finding food far outweighing the parallel concern of accessing health services.

How many missteps could have been altogether avoided if we were prepared to listen or had been listening to women and girls all along?

**As part of a post-pandemic global reset, Global Count is querying women, non-binary, and transgender people from every country, culture, and racial background around the globe on their priorities for gender equality. So far more than 30,000 people have participated, with gender-based violence being the top concern.**

In addition to supporting Global Count's online survey, we are collaborating with MSD for Mothers and [Praekelt.org](https://praekelt.org) to place the means of asking in the hands of more activists and advocates, development partners, donors, policymakers, providers, and women and girls themselves—quite literally. In late 2021, we are launching *What(sApp) Women Want* utilizing smartphones. Either independently or through a mobilizer, women and girls will be able to routinely share their open-ended preferences and wishes for maternal and reproductive health, and other topics of interest.

*What(sApp) Women Want* will analyze answers in real-time. Participating women and girls, as well as other stakeholders, will learn immediately what is being collectively demanded at any moment, in any given place. *What(sApp) Women Want* will also connect women and girls to each other so they can collectively organize in their community, and with campaigners who can help elevate

their demands to national, regional, and global leaders while connecting them with opportunities and resources to advocate. The tool will also inform women about their impact, chronicling changes resulting from their demands.

Momentum is growing to ask women more of what they want. As part of their upcoming PUSH campaign, the [International Confederation of Midwives](https://www.internationalmidwives.org/) is using *What(sApp) Women Want* to ask midwives what it is they want. Their answers will inform their advocacy agenda going forward. Advocates in countries or regions where greater numbers of women and girls did not participate in the original *What Women Want* campaign, such as Francophone Africa, are now launching efforts in partnerships with others. Original mobilizers in Kenya and in Mexico are now going back to ask the women and girls who were not as visible as part of their first round what it is they want. They are also asking new questions about intersecting needs.

### Will you join them?

**Now with the ease of *What(sApp) Women Want*, the only reason not to ask women and girls what they want, is because we do not want to know the answer.**

**The question we then should be asking is... why not?**



To learn more or plan your own *What Women Want* effort using *What(sApp) Women Want* beginning 2022, contact:

[info@whatwomenwant.org](mailto:info@whatwomenwant.org)

## ANNEX 1

# Updated *What Women Want* categories

**1.** Abortion/miscarriage information, personnel, services, and supplies  
**Previous categories:** Abortion information, personnel, services, and supplies + Miscarriage information, personnel, services, and supplies

**2.** Adolescent & youth-friendly information, personnel, services, and supplies

**3.** Antenatal information, personnel, services, and supplies

**4.** Child health and welfare information, personnel, services, and supplies

**5.** Counseling and awareness on maternal, reproductive, and general health and services

**6.** Disability information, personnel, services, and supplies

**7.** Economic opportunity and financial support

**8.** Environmental health and agricultural support

**9.** Evidence, research, innovation, and technology

**10.** Family planning information, personnel, services, and supplies

**11.** Fitness and recreation

**12.** Food and nutrition information, personnel, services, and supplies

**13.** Free and affordable services and supplies  
**Previous categories:** Free and affordable services and Supplies + Equitable care and Universal Health Coverage

**14.** HIV, hepatitis, STI and TB information, personnel, services, and supplies

**15.** Improved health, well-being and maternal, reproductive, or general health services

**16.** Increased, competent and better supported health providers  
**Previous categories:** Increased, competent and better supported health providers (general) + Increased, competent, and better supported doctors + Increased competent and better supported midwives and nurses + Male health providers + More female health providers + Specialists

**17.** Increased, full-functioning and close health facilities  
**Previous categories:** Increased, full-functioning and close health facilities + Administration and record-keeping + Beds and bedding + Electricity + Laboratories + WASH

**18.** Infertility information, personnel, services, and supplies  
**Previous categories:** Infertility information, personnel, services and supplies + Want children

**19.** Labor and delivery information, personnel, services, and supplies

**20.** LGBTQIA+ information, personnel, services, and supplies

**21.** Malaria and vector-borne disease information, personnel, services, and supplies

**22.** Male engagement and shifts in family/partner dynamics

**23.** Medicines and supplies



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**24.** Menstrual health information, personnel, services, and supplies

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**25.** NCDs information, personnel, services, and supplies

**Previous categories:** NCDs information, personnel, services and supplies  
+ Breast and cervical cancer information, personnel, services and supplies

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**26.** No demand

**Previous categories:** No demand + Other/Non-determinable demand

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**27.** Power, policy/politics and rights

**Previous categories:** Community engagement and accountability +  
Empowerment and rights + End violence and harmful practices against  
women and girls + Peace, no conflict + Policy and political change

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**28.** Post-menopausal and elderly information, personnel, services,  
and supplies

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**29.** Post-partum, stillbirth, newborn and infant information, personnel,  
services, and supplies

**Previous categories:** Post-partum, stillbirth, newborn and infant  
information, personnel, services, and supplies + Mental health  
information, personnel, services, and supplies

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**30.** Other specific services (e.g., dentistry, eye care)

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**31.** Reduced medicalization or do not want service

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**32.** Religious support

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**33.** Respectful and dignified care

**Previous categories:** Respectful and dignified care + Complete and  
understandable communication + Confidentiality and privacy + Ethical,  
lawful non-abusive and secure care

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**34.** Schools and educational opportunity

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**35.** Timely and attentive care

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**36.** Transportation infrastructure

**Previous categories:** Transportation infrastructure + Referral system

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## ANNEX 2

# What Women Want advocacy asks by country

## India

### WOMEN & GIRLS DEMANDS

### ADVOCACY OBJECTIVES

#### Access to maternal health entitlements

- Invest in public education campaigns on entitlements and service guarantees including how and where to access free maternal and reproductive health supplies.
- Make the display of free services and entitlements mandatory at facilities to ensure easy access to information.
- Ensure timely allocation, disbursal, monitoring, and tracking of maternal health entitlements and schemes.
- Reduce out of pocket expenditure with zero tolerance for informal payments.

#### Access to health services, supplies and information

- Ensure that an essential package of reproductive and maternal health services are available at the lowest level facility, closest to where women and girls live.
- Ensure free health services, in private and public facilities, for women from economically weaker sections of society.
- Ensure that feedback and grievance redressal systems, at the community and facility level, are fully operational with a system for filing complaints and corrective action.
- Invest in up-gradation and maintenance of health facilities, including operationalizing of First Referral Units (FRUs), and improve the functionality of surgical and operational theatres in health facilities in underserved areas.

#### Equity, respect and dignity

- Commit to zero tolerance for disrespect and abuse during maternity care services.
- Adopt respectful and dignified care standards and corresponding monitoring, reporting, and redressal mechanisms.
- Endorse and display the Respectful Maternity and Newborn Care (RMNC) Charter, in the local language, in all health facilities
- Invest in respectful and dignified care training for health workers and rights education for communities.
- Ensure that all women are allowed a birth companion during labor and delivery.

#### Facility improvements

- Ensure cleanliness, functional toilet, handwashing facilities, and potable drinking water in healthcare centers in underserved areas.
- Invest in menstruation education, availability of free and/or affordable menstrual products, and menstrual waste management systems within schools and health facilities.
- Involve local elected representatives to monitor and ensure clean and functional health facilities.
- Form Swachh Bharat Abhiyan flying squads to conduct surprise visits to check cleanliness and hygiene in toilets, wards, and labour rooms.

#### Availability of health professionals

- Increase budget for health, especially for human resources, and fill vacant positions.
- Ensure that at least one General Nurse Midwife/Midwife is present at all PHCs.
- Ensure 24x7 availability of skilled doctors and specialists in underserved areas.
- Invest in improved working conditions for healthcare providers, including frontline workers, that includes training and leadership opportunities, appropriate salaries, housing, and security.

# Kenya

## WOMEN & GIRLS DEMANDS

## ADVOCACY OBJECTIVES

### Cross-cutting demand: Institutionalizing women's feedback

- Develop a citizen engagement strategy for Kenya's UHC implementation to formally capture and elevate the needs of women, girls and persons living with disabilities; advance quality of care; and promote community-led accountability.
- Incorporate menstrual health services and supplies—including free, quality sanitary towels to every girl registered and enrolled in a public education institution as well as soap, water and facilities for disposal of used menstrual management materials; adolescent sexual and reproductive health information and services; and safe motherhood provisions into Kenya's Reproductive Health Bill 2019.
- Drive the implementation of the National Adolescent Sexual Reproductive Health Policy (NASRHP) at the sub-national level to ensure health workers provide high quality ASRH services; security agencies enforce laws to protect adolescent girls from gender-based violence; and that adolescent girls and young women influence the delivery of quality sexual and reproductive health services in Narok and Nairobi counties.
- Advocate for increased resources for the Gender Mainstreaming Policy and the Anti-FGM Policy into county integrated developments plans and legal frameworks in Kajiado County, aligned with women's and girls' self-expressed reproductive and maternal health needs.

### Respectful and dignified care

- Improve health workers' knowledge and awareness to respectfully respond to needs of women, adolescents and persons living with disabilities in Bungoma, Makueni, Kakamega, Kisumu and Vihiga Counties.

### Water, sanitation and hygiene (WASH)

- Improve cleanliness, sanitation—including safe drinking water and waste bins - and availability of menstrual health information and supplies in five target health facilities in Bungoma, Kajiado, and Makueni counties.

### Medicines and supplies

- Increase availability of essential drugs and supplies for women, adolescents and persons living with disabilities in Bungoma, Makueni, Narok and Nairobi counties.

### Increased, competent and better supported midwives and nurses

- A clear scope of practice for midwives is developed by the Nursing Council of Kenya and an independent midwifery scheme of service is developed by the county public service boards of Kisumu, Kakamega and Vihiga counties.
- An independent midwifery organizational structure is formalized by the Ministry of Health.

### Increased, fully functional and closer health facilities

- Ensure four health facilities in Bungoma, Makueni, Narok and Nairobi counties are fully equipped with specialized outpatient and inpatient infrastructure that responds to the needs of women, adolescent and persons living with disabilities, including providing accessible ramps, maternity beds and translation services.



## Malawi

### WOMEN & GIRLS DEMANDS

### ADVOCACY OBJECTIVES

#### Respectful and dignified care

- Ministry of Health adopts the revised Respectful Maternity Care (RMC) Charter and integrates it into fully funded health worker in-service trainings by December 2021.
- Ministry of Health launches and operationalizes the web-based platform enabling Hospital Ombudsman to report, refer, monitor and follow up on complaints by women and girls about disrespect and abuse, negligence and non-attentiveness by July 2022.

#### Water, sanitation and hygiene (WASH)

- Ministry of Health creates a water, sanitation and hygiene budget line and ring-fences it to improve WASH in health facilities by 2022.

#### Increased, competent and better supported midwives and nurses

- The Ministry of Health hires 300 more midwives to ensure that the midwife to client ratio in the clinical area is improved by July 2022.
- Ministry of Health creates and fills the positions of deputy director for midwifery services at ministry headquarters level and midwifery officers in central and district hospitals to ensure coordinated and improved delivery of midwifery services in Malawi by July 2022.

#### Medicines and supplies

- Ministry of Health increases family planning budget line item in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) budget by over 10% annually for the next three years.

## Nigeria

### WOMEN & GIRLS DEMANDS

### ADVOCACY OBJECTIVES

#### Cross-cutting demand: Institutionalizing women's feedback

- The Niger State Primary Healthcare Development Agency embeds the routine collection and use of women's and girls' perspectives as a key criterion for fully functioning Ward Health Development Committees—a government recognized, citizen-led accountability mechanism for healthcare delivery.

#### Water, sanitation and hygiene (WASH)

- The Niger State Primary Healthcare Development Agency ensures installation of handwashing facilities and six toilets within each of the state's 274 focal primary health centers.

#### Respectful and dignified care

- The Federal Ministry of Health updates the *Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns* and the Niger State Ministry of Health domesticates it.

#### More female providers and increased, competent and better supported midwives and nurses

- The Niger State Government mobilizes resources to hire and deploy at least one midwife in each of the state's 274 focal primary health care centers.

#### Increased, fully functional and closer health facilities

- All of Niger State's focal primary health centers (PHCs) meet readiness criteria to receive Basic Health Care Provision Funds (BHCPF), and the Niger State Primary Healthcare Development Agency releases BHCPF to the entire 274 focal PHCs to expand community access to free primary healthcare services and supplies.

## Pakistan

### WOMEN & GIRLS DEMANDS

### ADVOCACY OBJECTIVES

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**Cross-cutting demand:  
Institutionalizing  
women's feedback**

- Provincial Government of Sindh includes "Listening Sessions" — a women engagement mechanism for improving family planning programming — in its Planning Commission Form 1 (PC-1) for FP2030.

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**Respectful and  
dignified care**

- Khyber Pakhtunkhwa Health Care Commission (KPHCC) adopts the Ethics, Guidelines and Standards of Respectful Maternal & Newborn Care in the Minimum Services Delivery Standards developed by the Healthcare Commission by 2022.

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**Medicines and supplies**

- Provincial Government of Khyber Pakhtunkhwa increases budgetary allocations for the Population Welfare Department for ensuring a continued supply of contraceptives at district level facilities by 2022.

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**Increased, competent  
and better supported  
midwives and nurses**

- Provincial Government of Sindh adopts the model of improved quality, capacity and supervision of community midwives<sup>3</sup> service delivery given the COVID-19 pandemic and other management challenges by 2022.

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<sup>3</sup> Community Midwives (CMWs) are the skilled birth attendants that provide maternal and newborn health services (including normal delivery and family planning services) at the community level. CMWs are trained by government under the maternal, newborn and child health (MNCH) Program, but there have been issues regarding their deployment which have been magnified in the ongoing COVID-19 crises.

## Uganda

### WOMEN & GIRLS DEMANDS

### ADVOCACY OBJECTIVES

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**Cross-cutting demand:  
Institutionalizing  
women's feedback**

- Government of Uganda institutes mechanisms to routinely capture the demands of women and girls within priority policy formulation and implementation processes, notably the National Health Insurance Bill, National Self-Care Guidelines, and the Sexual and Reproductive Health and Rights Guidelines.

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**Respectful and  
dignified care**

- Ministry of Health adopts the Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns, displays it in local languages at all health facilities, and routinely assesses health facilities on respectful maternity care provision and issues an annual report.

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**Water, sanitation and  
hygiene (WASH)**

- Ministry of Health and Ministry of Education and Sports, in partnership with the private sector, ensure availability of free and/or affordable reusable menstrual products and menstrual waste management systems within all schools and health facilities across the country.

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**Increased, competent  
and better supported  
midwives and nurses**

- Ministry of Health and Ministry of Internal Affairs finalize and implement the Human Resources for Health Migration Policy to provide a framework through which health workers' demands are addressed to enhance motivation, mitigate human resource gaps, and promote Universal Health Coverage.

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**Medicines and supplies**

- Ministry of Health provides free Mama Kits — the number one *What Women Want* demand in Uganda — for all pregnant women in the country, including refugees, at public health facilities.
- Ministry of Health revises the Postpartum Hemorrhage Management Guidelines and Essential Medicines List to include heat-stable carbetocin and trenexamic acid to tackle the number one killer of Ugandan women.
- Uganda Blood Transfusion Services to scale the Concentrated Session Segmentation Model and promote blood donation campaigns throughout the country to increase availability of blood and blood products.

## ANNEX 3

# Additional *What Women Want* resources

### **What Women Want Interactive Dashboard**

The 1.2 million open-ended responses categorized, analyzed, and now available at your fingertips.

[Visit dashboard](#)

### **Behind the Demands Report**

Reviews the top five demands in detail, including women's and girls' sub-demands.

[View PDF](#)

### **What Women Want Country Findings**

Provides analysis of women's demands in countries with highest numbers of demands.

[India](#) | [Kenya](#) | [Malawi](#) | [Mexico \(English\)](#) | [Mexico \(Spanish\)](#) | [Nigeria](#) | [Pakistan](#) | [Tanzania \(English\)](#) | [Tanzania \(Kiswahili\)](#) | [Uganda](#)

### **What Women Want Country Advocacy Agendas**

Outlines key advocacy asks based on women's demands.

[India](#) | [Kenya](#) | [Malawi](#) | [Nigeria](#) | [Pakistan](#) | [Uganda](#)

### **What Women Want Global Findings**

Reviews the top 20 demands globally and across age groups.

[View PDF](#)

### **What Women Want Global Advocacy Agenda**

Suggests key action items that can be adapted to drive change at all levels and are based on women's demands.

[View PDF](#)

### **Coming soon:**

- **What Women Want Mexico Advocacy Agenda**
- **What Women Want: Midwives' Demands Report**
- **What Women Want Interactive Map and Case Studies**
- **What(sApp) Women Want**

### **Learn more:**

[www.whiteribbonalliance.org/whatwomenwant/](http://www.whiteribbonalliance.org/whatwomenwant/)





# LISTEN **ACT** TASK...AGAIN

Listening to women is a radical act.

**Acting on what we hear is revolutionary.**

**Asking beyond is transformational.**

To learn more about this campaign, visit  
[whiteribbonalliance.org/whatwomenwant/](http://whiteribbonalliance.org/whatwomenwant/)



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