Maternal Death and Disability in India

Welcome Kit for Parliamentarians 2009

SAHAYOG
Centre for Legislative Research and Advocacy

Welcome Kit for Parliamentarians 2009

Maternal Death and Disability in India

SAHAYOG
Centre for Legislative Research and Advocacy

Published by:

SAHAYOG
A-240, Indira Nagar, Lucknow - 226016, Uttar Pradesh, India
Ph: +91- 0522-2310747, 2310860, Fax: +91- 0522-2341319
Website: www.sahayogindia.org

Conttributors:

Dr. Abhijit Das
Asha Kilaru
Jayeeta Chowdhury
Jashodhara Dasgupta
Dr. Prasanta Tripathy
Dr. Sebanti Ghosh
Vd Smita Bajpai
Dr Imrana Qadeer
Leila C. Varkey

Editor:

Jashodhara Dasgupta, SAHAYOG

Acknowledgments:

We are grateful to Dr Imrana Qadeer for the review of the first draft.
Shailey Hingorani of CLRA provided editorial inputs.
The costs for printing were supported by the International Initiative on Maternal Mortality and Human Rights

Disseminated by:

Centre for Legislative Research (CLRA), 9 Ferozeshah Road, New Delhi- 110001.
Ph No: 23070756, Telefax: +91-11-23070756, Website: www.clraindia.org

Cover Design and Layout: Anju Sah

Printed at: Drishti Vision, 117 Rajpur Khurd, Post Office IGNOU, New Delhi-68

For private circulation only

Maternal Death and Disability in India

1. The problem

a. The extent of global maternal mortality and morbidity

The burden of maternal deaths and illnesses borne by women of reproductive age is quite unacceptable in the twenty-first century, because these are largely preventable given the progress of medical science. Around half a million women are losing their lives each year due to causes related to maternity, and many millions more suffer acute ill-health and long-term health problems - with the result that having a child remains among the most serious health risks for women. On average, each day around 1,500 women die from complications related to pregnancy and childbirth, most of them in sub-Saharan Africa and South Asia (UNICEF).

Unfortunately, within South Asia, India leads in terms of the number of women losing their lives each year (22% of the total, according to UNICEF), despite the fact that India is becoming a global destination for the best quality healthcare! Although India trains large numbers of medical personnel, there is a huge shortfall in the availability of skilled providers who can save poor women's lives. This is a matter of national concern as it also affects our global reputation.

"More than one woman dies every minute from preventable causes in childbirth, and for every woman who dies as many as 30 others are left with lifelong, debilitating complications. Moreover, when mothers die, children are at greater risk of dropping out of school, becoming malnourished, and simply not surviving. Not only is maternal mortality and morbidity a global health emergency, but it triggers and aggravates cycles of poverty" (M. Robinson and A. Yamin, 2009).

b. The magnitude of the problem in India

Despite the rapid economic growth in India, maternal death figures continue to be high. The World Health Organization estimates in 2005 for maternal mortality in India came up with a Maternal Mortality Ratio(MMR) of 570 deaths every 100,000 live births, which was brought down in the Registrar General's SRS report (2004-06) to 254. Yet **at almost 60-70 thousand deaths each year, and possibly around 20 to 30 times that figure suffering ill-health and near-misses, maternal health remains a huge challenge for the country.** The recent UNICEF (2008) report revealed that the maternal deaths in India can be attributed to heavy bleeding (hemorrhage), infections (sepsis), unsafe abortions, obstructed labour, and high blood pressure (hypertensive disorder). These are the direct causes of maternal mortality. The indirect causes include TB, malaria, viral hepatitis and anaemia, which put women at great risk of complications and death during pregnancy, according to the WHO. Most of these are related to poverty which causes greater exposure to certain environmental factors that increase the risk for infectious and non-communicable disease, such as poor sanitation, poor working conditions, polluted air and water, violence stress and poor diet.

Direct Causes	Indirect Causes
Hemorrhage (38%)	TB
Sepsis (11%)	Malaria
Unsafe abortions (8%)	Viral Hepatitis
Obstructed labour (5%)	Anaemia
Hypertensive Disorder (5%)	

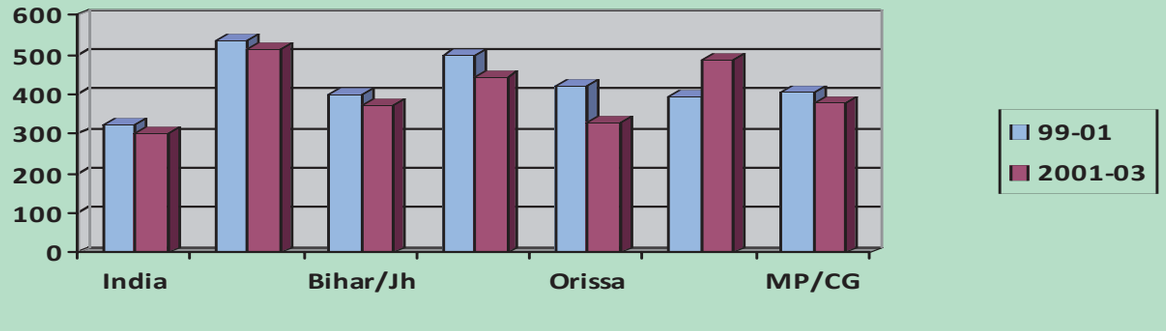
The social determinants of maternal mortality in India are critical factors in determining whether or not a woman will receive care, and they contribute significantly to the problems like hemorrhage, sepsis and unsafe abortions and obstructed labour. These include status of women in family and society, early marriage and early pregnancy, poor nutritional status, low literacy level, poor decision making power of women, socio-cultural and religious beliefs poverty and poor access to health care services, owing to their status in society and various forms of discrimination based on their identities.

The table below indicates that NFHS-3 data on women's nutrition, education and reproductive decision-making is alarming and draws association with high maternal mortality in these states.

Social Indicators	India	Assam	Bihar	Raj	UP	MP	Jhk	Ukh
Women's aged 20-24 years married by 18 years	44.5%	38%	60%	57.1%	53%	53%	16%	22.6%
Women aged 15-19 years who were already pregnant during the Survey	16%	16.4%	25%	16.1%	14.3%	13.6%	61.2%	6.2%
Women's literacy	23% < 8years	27%	16%	18%	15%	24%	27.5%	17%
Total Unmet Need	13.2%	10%	23.1%	14.7%	21.9%	11.8%	23.7%	11.3%
Anaemia among pregnant women (15-49 years)	57.9%	72%	60.2%	61.2%	51.6%	57.9%	68.4%	45.2%
Women's participation in household decision making	52.5%	70.1%	46.3%	40.2%	48.2%	46.7%	59.%	47.9%

All of these can be addressed politically, medically and socially with high commitment from government, health care providers and people themselves.

UNICEF(2008) estimates point out that two-thirds of maternal deaths in India occur in the backward states of Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh. The SRS data from 1999-2001 to 2001-2003 shows that overall maternal deaths have reduced in India, however in the poorer and backward states there is a very low rate of decline in deaths. (see table below).



The above table shows a downward trend in maternal deaths in 2003 compared to the data of 2001 in the more poorer states. However the alarming part is that in most of these states, the maternal mortality

ratios are already much higher than the national average. This means **that it is only states which have been performing well in the last decade that create the impression based on averages, that maternal deaths have greatly reduced in India.**

Maternal mortality and morbidity can be averted and tackled if the real problems are indentified and appropriate strategies are adopted. The Government of India has displayed its commitment by emphasizing on maternal mortality reduction in the National Rural Health Mission (NRHM), which was introduced in 2005 with focus on the poorer states with high maternal deaths.

Push for Institutional Delivery and Introduction of Janani Suraksha Yojna

The journey of maternal health, if divided into four stages, i.e., pre-conception, pregnancy (ANC), delivery or abortion, and post partum (PNC), should ideally have integrated strategies to provide a continuum of care, designed with women's involvement in the planning and implementing programmes. At the pre-conception stage, girls and women need education, nutrition, good health and support to make their own decisions. During pregnancy and after delivery, women need routine care and support from family members. During or after childbirth, abortion or any complication of pregnancy, women may need specialized health services that will ensure that they survive.

But in India, the maternal health programme implementation is emphasizing institutional delivery without adequately strengthening all the four components. NRHM gave an impetus to escalate institutional deliveries through financial incentives to the women. However, despite the increasing trend in institutional deliveries under NRHM, unfortunately there has not been enough improvement in infrastructure, health staffing or quality of service delivery.

Current Status of Health Care Services in the Poorer States

The DLHS 3 data from some of the states indicate that inadequate facilities and staff at Sub Centres, PHCs and CHCs prevent them from providing life saving services for pregnant women. These institutions are largely incapable of handling complicated maternal health conditions, which require not only specialized medical skills but also specialized services like Emergency Obstetric Services (EmOC), rapid referral mechanisms, blood banks, etc. The tables below highlight the plight of health care infrastructure and low availability of skilled staff.

Conditions for Safe Delivery DLHS3

Conditions for safe delivery	Bihar	MP	Ori	Raj	UP
SC with additional ANM	27.6	8.2	51.5	21.8	3.3
ANM living in SC	20.3	48.5	43.3	55.1	37.2
PHCs functioning on 24 hours basis	64.5	73	49.1	56.9	45.5
PHCs having new born care services	9	23	8.7	13.6	11
PHCs having referral services	44	49	18	18	17
PHCs conducted at least 10 del last one month	20	52	12	24	19.4

Conditions for EmOC – DLHS3

	Bihar	MP	Ori	Raj	UP
CHCs having Ob/Gyn	43.9	20.8	88.2	31.5	29.9
CHCs having functional OT	86.4	70.7	59.4	60.3	88.5
CHCs designated as FRUs	87.9	61.4	53.7	52.7	55.8
CHCs offering caesarean section	13.6	8.1	8.3	9.6	3.2
CHCs having 24*7 new born care services	63.6	52.9	28.3	46.5	40.1
CHCs having blood storage facility	0	3.9	8.3	7.9	0.7

Of more concern is that most CHCs visited are still functioning at the level of PHCs, unable to make the transition to regular full occupancy in patient care and a wide range of specialist services. CRM 1 (2007)

Skilled Birth Attendants

State	Sk pers at home DLHS 3	Sk pers at home DLHS 2
Bihar	5.9%	7.9%
MP	5.7%	11.8%
Orissa	12.2%	14.3%
Rajasthan	13.4%	20%
UP	7.4%	8.3%

NO EVIDENCE OF SBA TRAINING WAS AVAILABLE FROM NRHM-MIS

Underdeveloped states of India have an urgent need for the conditions of the health care facilities to be improved and upgraded, skilled health staff put in place at any location of delivery, quality of health care improved and accountability mechanisms set up.

As NRHM is mid way and MDG goals only 5 years away, it is a huge task before the government, civil society and affected people to join hands and take steady and effective actions to save women's lives. It is high time that a burgeoning global economic power like India puts maternal health as a basic right of women and among the top state priority. With a new government in place, this is the right time for taking the leap forward.

c. Which women die - a question of equity

Despite improvements in maternal health indicators over the last decade, the progress has not been uniform in India. While the maternal mortality ratio (MMR) is currently 254 as per Registrar General of India, (2004-06 estimates), however MMR is as high as 480 in Assam and 440 in Uttar Pradesh /Uttaranchal, and as low as 95 in Kerala and 111 in Tamil Nadu. Thus, a woman's chance of dying in pregnancy or childbirth depends very much on where she is located.

Other factors also put women at risk of dying during pregnancy and childbirth: for example, women from vulnerable population groups and in those located in geographically remote or vulnerable areas have remained marginalized and excluded from the government health service delivery system. They face multiple barriers - physical, economic, socio-cultural, and political. These barriers impact women's capacity of accessing relevant and accurate information and compromise their capacity to negotiate family dynamics and decision-making power. Poverty, of nutrition and basic facilities put them more at risk of infectious diseases that severely affect their maternal health. At health centres and hospitals, the health workers treat women with these same discriminating attitudes that prevail in our society.

Social Support has been provided to pregnant women from BPL families with less than Rs 12,000 annual income by the Tamil Nadu government from 2006, under the Dr. Muthulakshmi Reddy Social Assistance Scheme. Within this scheme, pregnant women can apply through a form to the local medical officer and will receive Rs 1000 from the seventh month of pregnancy to three months after delivery, adding up to Rs 6000. This is meant to compensate for their loss of income and ensure their food security during maternity.

There is an urgent need for policy-makers and elected representatives to correct these imbalances in health services and health planning. We must rigorously commit to guaranteeing quality health services to the poor and un-reached. We must go beyond numbers and average figures for the country and state to understand where the problem lies. If every elected political representative and appointed bureaucrat made it a priority to reach healthcare to the poor and underserved, this would dramatically improve the

health of the country. **Today if we really want to improve our maternal health status, we need to ensure a special focus towards women who face exclusion** owing to their poverty, social status - caste, ethnicity or religion, number of children, and their location -urban slums or remote rural areas. The data from NFHS III clearly shows the disparities in health care.

-Antenatal Care - Over half of the women (50.7%) women received 3 or more antenatal checkups across India as per NFHS III. However, this average hides wide variations across socio-economic situation, and different states have very different standards of care, leading to inequitable healthcare for the women concerned. Availing of some form of antenatal care is almost universal in Kerala, Goa, Tamil Nadu and over 90%in Andhra Pradesh, Maharashtra, West Bengal, Karnataka, Delhi & Punjab. On the other hand 17 % women in Bihar and 26.6% women in Uttar Pradesh have 3 or more antenatal checkups.

-Socio-economic and geographic inequities Younger women, women who are better off economically, educated women, and women having their first child tend to receive more antenatal care compared to older women, poor or illiterate women and women with several children. For example,

- In Bihar almost 2/3rd women do not get any form of antenatal care.
- Less than half of women receive antenatal care during the first trimester of pregnancy.
- 73.8% urban women receive 3 or more antenatal checkups while only 42.8% rural women have 3 or more antenatal checkups.
- 85.3% of women with 10 or more years of education receive 3 or more antenatal checkups while 29.8% illiterate women receive 3 or more antenatal checkups.
- Only 40.2% scheduled tribe (ST) women receive 3 or more antenatal checkups.
- While 86% women from highest quintile avail 3 or more antenatal checkups, only 26% women from lowest wealth quintile receive 3 or more antenatal checkups
- 88% of mothers of first -order births received some form of antenatal care compared to only 48% mothers with several children, of birth order six or higher.

Quality of care in pregnancy- In India only 15% of women receive all the required components of antenatal care (3 or more antenatal visits with first visit in first trimester, two doses of tetanus toxoid and 100 IFA tablets). This indicator ranges from a high of 64% in Kerala and 56% in Goa to a low of only 2% in Nagaland and 4% in Uttar Pradesh

Delivery Care- Three out of every five births in India take place at home.40.7% births occur in institutions as per NFHS III. Despite major progress in institutional care coverage in the country, women from marginalized socio-economic groups and in rural or geographically remote areas still tend to deliver at home. Home births are more common among women who received no antenatal checkups, older women, women with no education, women in lowest wealth quintile and women with more than three previous births.

- 69.4% births are in health facilities in urban areas, compared to only 31%in rural areas.

- 80.6% of women with 10 or more years of education deliver in institutions, while only 19.8% women with no education go for institutional delivery.
- While 85% women from the highest wealth quintile deliver in the hospital, 13.8% of women in the lowest wealth quintile seek institutional care during delivery.
- Compared to 53.2% of births to mothers who do not belong to SC, ST or other backward class, Only 19.6% of births to scheduled tribe mothers occur in health facilities.
- Births to Jain mothers (93%), Buddhist/neo-Buddhist mothers (59%) and Sikh mothers (58%) are most likely to occur in a health facility and births to Muslim mothers (33%) are least likely to occur in health facilities.
- Institutional deliveries are least prevalent (10%) among mothers who do not seek antenatal care.
- Women having their first child are more likely to attempt institutional deliveries.

- State variations in Delivery Care - Kerala (99.3%), Goa,(92.3%) Tamil Nadu (87.8%) have almost all deliveries in health facilities while only 12-20% deliveries are institutional in Nagaland (11.6%), Chhattisgarh(14.3%), Uttar Pradesh(20.6%), Jharkhand(18.3%) and Bihar(19.9%).

-Post natal care - Only 36.4% women received postnatal care within 2 days of delivery from a doctor, nurse or ANM in India as a whole. But here too, there are wide variations among states: Tamil Nadu has 87% mothers having a postnatal checkup within two days of birth while in Uttar Pradesh 13.3% mothers have a postnatal checkup within 2 days of birth.

- Only 15% of women who had home births were followed by a postnatal check-up.
- 60.7% mothers received the same in urban areas, while 8% mothers received postnatal care within 2 weeks of delivery in rural areas.
- Births to Jain women are most likely to be followed by postnatal checkup, while births among Muslim women are least likely to be followed up by postnatal check up.
- Three fourths of women in highest wealth quintile receive postnatal care, compared to only 13% women in lowest wealth quintile.

Single women or unmarried women remain totally excluded from maternal health service provision owing to social conditioning of a patriarchal society. There is no disaggregated data avaialble to show whether they are able to access maternal health care services during pregnancy. Similar discrimination is seen in the case of women with more than two children. Neither families nor health providers consider them worthy of complete care during and after pregnancy. Similarly, women with special needs and disabilities are often treated poorly by service providers of all kinds. Again, the needs of these women

West Bengal is one of the better performing states with a low MMR of 141. Yet the state is characterized by inequities in health service provision and uptake, resulting in disparities in maternal health outcomes across different socio-economic groups and geographical areas. It is the more educated women in urban areas who push up the averages: 79.2% women in urban areas have delivered in hospitals compared to 33.8% in rural areas. Only 19.3% Muslim women delivered in health facilities compared to 56.3% Hindu women. There is also a wide disparity among the districts, with Uttar Dinajpur reporting 27.6% hospital deliveries while Hooghly is 80.1%. Despite the high levels of antenatal coverage in West Bengal, 25% of older women aged 35-49 years, 21% women from Scheduled tribes, 18% women having fourth or higher order birth, 15% women in the lowest wealth quintile and 14% women with no education did not receive any antenatal care for their last birth. JSY benefits are meant for certified BPL and SC/ST women, who must be aged 19 years and above, and only up to two live births.

are rarely acknowledged or studied. Women who are known to be HIV + VE are after considered "untouchable" and may be denied health care in hospitals.

d. It's a human rights concern

According to Mary Robinson, the former UN High Commissioner on Human Rights (UNHCHR), "We know what is needed to save women's lives; we have known for 60 years what care women need when they face obstetric complications. **The reason that women are still dying is because women's lives are not valued, because their voices are not listened to, and because they are discriminated against and excluded in their communities and by healthcare systems that fail to prioritize their needs.** This is a matter of global shame, and a pressing human rights concern." (M. Robinson and A. Yamin) UNICEF also emphasizes an overall environment supportive of women's rights is needed, in order to enhance healthcare provision, address gender discrimination and remove inequities in society through human rights approaches. (UNICEF, 2008) In September 2008, the European Parliament passed a resolution recognizing maternal deaths as a human rights issue . In June 2009, the UN Human Rights Council has passed a resolution recognizing that preventable maternal deaths are indeed a violation of women's human rights. In India too, the time has come to view the unacceptably high maternal mortality as a serious human rights concerns.

e. Change is possible!

The good news is that it's possible for countries to make maternal health a priority and make a difference, and this does not need limitless resources.

Nepal's MMR is already better than that of neighbouring India, Pakistan and Bangladesh. Impoverished Nepal has dramatically reduced maternal mortality cases from 540 per 100,000 live births in 2001 to 280 in 2009 - which can be partly attributed to the legalization of abortion in 2002, through an Amendment in Nepal's Civil Code. From early 2004, the Nepali government began providing comprehensive care, training doctors and approving clinics all over the country where women could have abortion safely. Today, more than 177 approved government and private clinics in 71 districts provide abortion services to women. Other interventions include immunisation, reduction in fertility rate, iron supplementation, better skilled birth attendance, and substantial increase in the coverage of antenatal care, according to the United Nations Children's Fund (UNICEF). The government has made provisions for iron supplements to cut anaemia in pregnant women since women so often died of fatal bleeding after delivery. Today, just a third of Nepali women are anaemic, down from 75% five years ago. Vitamin A supplements, given after birth to boost immunity, have reduced infections in new mothers. Through education campaigns and expanded clinic networks Nepal also has managed to boost births at hospitals from 10% to 20% and increase the number of postnatal visits to clinics by more than 30%.

The key to **Sri Lanka's** outstanding improvements in maternal health was the expansion of a synergistic package of health and social services to reach the poor. The country's health system first targeted universal provision of improved health care, sanitation and disease management, then added specific interventions to improve the health of women and children. Over the years, successive governments have prioritized health-care services to mothers and the poor while spending economic and human resources judiciously. This has been supported by measures to empower women socially and politically through education, employment and social engagement. Clear mandatory competencies helped to make midwives into professionals, and a

no-blame policy helped regular inquiries into maternal deaths. The results are dramatic - maternal mortality was halved between 1947 and 1950 and again thirteen years later. Once health structures and networks were in place, increasingly better organization and clinical management have allowed Sri Lanka to cut the maternal mortality ratio by 50 per cent every 6 to 11 years. The rates of skilled attendance at birth and institutional delivery also grew. Sri Lanka's development of its health system has long been a model for other developing countries, demonstrating the degree of success that can be achieved in maternal and child health with a combination of sound strategies, sufficient resources and political commitment.

States like Tamil Nadu, Karnataka and Andhra Pradesh have also used regular audit or verbal autopsy to **study causes of maternal deaths** and identify effective interventions to prevent them in future. All these states have developed formats and guidelines for the process. Tamil Nadu has used surveillance of maternal deaths in combination with other strategies such as shortening of the delays in referral and access to emergency obstetric care. As a result of the system of audit, the reporting of maternal deaths increased from 640 deaths in 1994 to 1636 in 2001, coming down to 1219 in 2004. The investigations revealed both bio-medical and non-medical causes that led to these deaths. Both community-based and facility based reviews were carried out to ensure that different circumstances could be studied and avoidable factors identified for remedial action.

Women's Experiences of Institutional Maternal Health Care

P., a poor daily-wage earning woman belongs to the Scheduled Tribes in Bihar. During her second pregnancy, P. realized that the foetus was not moving in her womb and others advised her to visit a private hospital but her husband was away and there was no money.

Sometime later, she went to government health facility where an agent (dalal) harassed her during ultrasound, asking for an informal payment of Rs. 1500 which she could not afford. Luckily, an Anganwadi worker helped her to get the ultrasound for Rs.300. However the agent stalled her report for 15 days. She was finally informed that her baby had got 'stuck', so she took the reports to the lady doctors at government hospital at block level, but did not receive any help.

A few days into her ninth month, she felt the pains at night, which subsided by morning. She took some days to arrange for money. At this time the lady doctor who works at the government hospital called P. to her private clinic and looked at her reports, to inform her that the baby was already dead.

Then the doctor admitted her and started an IV drip with two injections, and a day later she delivered her dead baby. They had to spend almost Rs. 4000, for which her family had to take loan. Demanding informal payments beyond the fees, the compounder refused to give her the discharge slip.

The very next day, P. started bleeding at home. She went back to the same clinic for treatment and was advised bed rest. She returned home after 2 days and continued to feel weak. She was informed about JSY money, but she had not received it at the time of the study interview.

J. was a 35 year-old Muslim woman of western UP, who was pregnant for the seventh time. Her labour pain started at 5am on 20th February, 2009, and her husband rented a private vehicle and took her to the CHC. They did not see a doctor, but an ANM admitted her and promised an early delivery.

The ANM began to push J's abdomen to get the baby out, and when J started screaming, the ANM slapped her and complained to her husband that J was very ill-mannered. The ANM asked J's husband to get an injection, gave it to J and went home around 8am. As J's pains stopped, her worried husband went to call the ANM, but she sent him away twice. Only after he had called her for the third time did she come back, and all the attendants started to apply strong pressure on J's abdomen
.
After an hour at round 9:30 the attendant came out of the room, announced that the baby had been born and demanded Rs. 5000. J's husband borrowed Rs.3500 and added Rs.1500 from his mother-in-law, and paid them Rs.5000. A doctor came with some papers and asked J's husband to sign on them. But he refused to sign on any paper without seeing his wife. When he forced himself into the room where J was, he found her dead.

The hospital staff used physical force and administered an injection on him which made him unconscious. Later a local political leader and the ANM tried to strike a compromise and offered him money, but he refused.

2. What steps are being taken through our national policies and programmes?

Since 1992, the government of India has formulated several schemes and policies to improve maternal health, with some amount of success. The ratio of maternal deaths to live births (known as MMR) reduced from 1997 to 2003 (SRS 2006), and again from 2003 to 2006 (SRS 2009).

- In 1992, there was a Child Survival and Safe Motherhood programme which aimed to address neglected aspects of maternal services including essential and emergency obstetric care, as well as trained birth attendants within communities
- In 1996, the government policy decided to free its health workers from family planning targets, which was a step in the right direction, although not all states actually follow this. It was intended to free up health workers to pay more attention to pregnancy registration and check-ups for women.
- In 1997, the government adopted an integrated "reproductive and child health (RCH)" approach, which was meant to include various reproductive health services for women, men and young people. It has completed one phase and currently the RCH-2 is being implemented.
- In 2000, the government passed the National Population Policy which was firmly against any forms of coercion in the name of population control and emphasized maternal health care.
- In 2005, the government announced the National Rural Health Mission with a goal of reducing the healthcare inequity between urban and rural India, and providing integrated primary health care to the poor.

Despite these progressive steps, some gaps still remain in terms of policy:

a. Health spending by the state is extremely low per capita. **Currently public spending in India on health care at 0.9% of gross domestic product (GDP) is among the lowest in the world** and ahead of only five countries-Burundi, Myanmar, Pakistan, Sudan, and Cambodia. This proportion has fallen from an already low 1.3% of GDP in 1991 when the economic reforms began.

b. Comprehensive primary care has been weakened over the years by vertical and uncoordinated health programmes and campaigns,_and health systems are further weakened by poor human resource management policies. Two-thirds of the PHCs in the country have one or no doctor, and the Community Health Centres are also understaffed in terms of specialists. The personnel posted in the government health centres are seen to be harsh towards the poor, and often demand informal payments.

c. In this situation, the costs of healthcare are disproportionately borne by the people (around 80%), resorting to private services in the absence of effective health provisioning by the state. According to NFHS 3, hardly 40% of rural communities use public sector, and close to 70% of urban users go to the private sector. However, this also means that lakhs of families are pushed into debt or below the poverty line in trying to access healthcare, and that a rising percentage of people do not seek healthcare even for serious problems, fearing the expense.

d. There is a strong push for privatizing health care services, and state resources are unfortunately being diverted to the private for-profit sector, with inadequate safety mechanisms and regulations in place to safeguard the interests of the poor and vulnerable groups. Proliferation of private medical colleges is leading to decrease in standards and ethics of medical practice.

e. The responsibility for financing healthcare costs, including health support to the poorest unorganized workers and compensation for poor quality of care, is gradually being shifted to private players such as insurance companies. Poor families are unable to negotiate payments from these companies.

f. The HIV/AIDS component of healthcare is still vertically separate from the rest of health and family welfare, preventing an integrated package of interventions.

g. The continued emphasis on vertical programmers such as Pulse Polio Campaign for the last decade or so has detracted attention from integrated health care and especially from maternal health care, since health department personnel at every level are frequently pre-occupied with stages of the polio campaign.

h. Maternal health programmes and services:
   - Unfortunately the maternal health programme has also become vertical, through the Janani Suraksha Yojana Scheme that monitors maternal health by the narrow indicator of how many women received money after delivering in an institution.
   - The total number of expected deliveries is roughly 25 million in India, so it is unrealistic to expect that an under-funded health system, providing poor quality of care, will be able to handle this burden and save women's lives.
   - The role of the ASHA is more as a 'motivator' for institutional delivery and less as a 'social health activist' working with a comprehensive approach on the socio-economic determinants of health.

What poor women need - some policy recommendations:

i. The Right to Health to be made justiciable by law. This will enable the weakest sections of the populations to access comprehensive quality healthcare without discrimination against those from remote rural areas, the less-educated, the poor, those from socially marginal sections, as well as those affected by conflict, violence and industrial pollution or displacement.

ii. Increase in budgets to 3% of the GDP within the next five years, to ensure adequate human resources and supplies; and monitor the reduction in private 'out-of-pocket' expenditure

iii. Strong policies for comprehensive and integrated primary healthcare, putting an end to vertical programmes that detract funding and attention from other important problems

iv. Robust human resource management policies with adequate pay, promotional avenues and secure employment; ensuring that all levels of providers receive skill-training and adequate supervision; also ensuring that doctors are not burdened with administrative roles; strict mechanisms to check corruption and demands for informal payments

v. Specific and effective regulation of the private sector in terms of pricing, rational therapies and informed consent of patients, while recognizing that the private sector is playing a role in providing health services today

vi. Promotion of service guarantees for poor people with local oversight (community monitoring and support) and accessible grievance redressal mechanisms, rather than promoting insurance as a substitute.

vii. Maternal health:
   - The emphasis needs to be on 'safe delivery' rather than 'institutional delivery'; women should have the choice of where they want to deliver, with a trained and skilled attendant available. The attendants should be linked to referral institutions an transport in case there is a complication
   - Referral institutions must be immediately strengthened to provide effective emergency care. There must be a strong 'chain of referrals' so that families are not left to their own resources in seeking care for complications
   - All maternal deaths (and near-miss situations) need to be reviewed or 'audited' for a given time period, to determine how they could have been prevented by the health system, but without seeking to immediately blame the health providers.

3. Key Recommendations for our Policy Makers:

You can make a difference!

Elected representatives play a critical role to protect the right of all women to a dignified life and the highest attainable standard of health.

Within Parliament we urge you to -

- Demand improved national surveillance of all maternal deaths, with all state-wise figures disaggregated by poverty level, education, caste, religion, age, and number of pregnancies.
- Examine how far the resources lead to improved services for the disadvantaged women, and emphasize government's accountability for guaranteeing quality health services to the poor and unreached. Today if we really want to improve our maternal health status, we need to ensure a special focus towards women who face exclusion owing to their poverty, social status - caste, ethnicity or religion, number of children, and their location -urban slums or remote rural areas.
- Raise questions regarding the high rates of maternal deaths in many states of India. Initiate a process of maternal death inquiry from the national to the local level or vice a versa to find out the factual reasons, and take corrective measures for strengthening of the public health service delivery system.
- Join specific parliamentary committees to look in to issues concerning maternal health.
- Initiate discussions on budget allocations and review the spending specifically on maternal health. Propose changes in allocations; demand process and quality indicators to monitor public spending of money. For example instead of questioning only the amount of money spent in Janani Suraksha Yojana, Parliament should also review the outcomes and the quality of service provided, the chain of referral and so forth.
- Review the current laws in context of maternal health and formulate or reform laws accordingly. For example, does the current legal system adequately deal with denial of healthcare to the poor? If complications and emergencies faced by women do not receive adequate services are there easily accessible forums where the poor may take their grievances?

As a member of the political party you could -

- Educate fellow party men and women on the issue of high maternal mortality and morbidity rates in India.
- Raise awareness on the importance of protecting women's health as a part of their obligations towards their constituencies. Ensure that party colleagues support poor women victims in cases of denial of healthcare. Encourage them to avoid all interventions in health staff posting, transfers or punitive action.

- Prioritize 'Saving Women's Lives' in your party's agenda and ensure that the party is committed to make substantial efforts to work towards the goal of reducing MMR to less than 100 by 2012.

As a representative of your constituency, concrete improvements are possible if you:

- Inform your voters regarding their entitlements and service guarantees from the public health system.
- Monitor cases of neglect that appear in the media, support the victims and survivors to gain medical and legal support and justice
- Initiate a process of dialogue with MLAs of your constituencies who are members in the Rogi Kalyan Samitis. Encourage and motivate them to regularly review the functioning of public health service delivery system and take action and corrective measures accordingly.
- Listen to people, particularly women from the vulnerable sections of society and take action and corrective measures on their concerns and grievances related to quality of service delivery.
- Organize public dialogues to inform communities about their entitlements from the public health system and provide a forum to bring the service providers and those entitled to the service on a common platform to discuss ways for improving maternal service delivery at government facilities.
- Ensure that all posts in the health facilities are filled, the human resource is in place as per the requirements. Listen to the concerns of the posted staff and provide basis amenities and facilities for them at the place of residence.
- Mobilise investments for infrastructure strengthening in your constituencies to ensure that no woman dies due to lack of transport, adequate and quality roads , communication facilities. Particularly focus on areas unserved by the public system and areas which face temporary exclusion during monsoon, snow fall etc.
- For geographically difficult areas like mountains and deserts, devise local mechanisms and ways to reduce the delay in accessing health services when a woman faces life threatening complications- for example a rope-way in hills, free camel carts in deserts, or starting maternity 'waiting homes' so that women may stay near a road before labour begins.

References

1 All data from NSSO and World Bank reports, quoted by Jan Swasthya Abhiyan in their Manifesto for General Elections 2009.

2 Article on Nepal January 20, 2009 at http://southasia.oneworld.net/todaysheadlines/nepal-succeeds-in-improving-maternal-health

3 Article on Sri Lanka: I. Padmanathan, quoted in The State of the World's Children 2009 - Maternal and Newborn health, UNICEF, New York, 2008.

4 Let's stop women's suffering, by Mary Robinson and Alicia Yamin - http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2009/06/04/lets_stop_womens_suffering/

5 National Family Health Survey III (2005-2006), International Institute of Population Sciences, Mumbai, 2007.

6 "Preventable Maternal Mortality and Morbidity and Human Rights", A/HRC/11/L.16, United Nations Human Rights Council General Assembly, 12 June 2009.

7 Sample Registration System - Maternal Mortality in India:1997-2003, Trends, Causes and Risk Factors, Registrar General India, 2006.

8 Sample Registration System - Maternal Mortality in India: 2003-2006, Registrar General India, 2009.

9 Text of Resolution of European Parliament at http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2008-0406+0+DOC+XML+V0//EN&language=EN

10 The State of the World's Children 2009 - Maternal and Newborn health, UNICEF, New York, 2008.

About us

This brief was developed by a group working on women's rights to maternal health in the context of comprehensive primary healthcare. The group has recently completed a voluntary research study on women's experiences of institutional delivery in 2008, entitled "Glimpses of institutional maternity care- some food for thought." The group consists of researchers and activists affiliated with networks and organizations working in several states of India.

The group is investigating how maternal health policies impact on poor communities, especially from socially vulnerable or deprived groups. Members of the group are committed to a process of enquiry and advocacy, in order to promote all women's rights to comprehensive healthcare without any discrimination.

For any further information, please contact SAHAYOG.

SAHAYOG
A-240, Indira Nagar, Lucknow - 226016,
Uttar Pradesh, India
Ph: +91- 0522-2310747, 2310860,
Fax: +91- 0522-2341319
Website: www.sahayogindia.org

Centre for Legislative Research and Advocacy
9, Ferozeshah Road
New Delhi-110001
Ph No: 23070756,
Telefax: +91-11-23070756
Website: www.clraindia.org