Welcome Kit for Parliamentarians 2009

Maternal Death and Disability in India
1.1. The problem

The problem of maternal mortality and morbidity

The burden of maternal deaths and disabilities 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.

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 estimated 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 and lack of access to quality healthcare, nutrition, clean water, and sanitation.

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<table>
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<tr>
<th>Direct Causes</th>
<th>Indirect Causes</th>
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<tr>
<td>Hemorrhage (38%)</td>
<td>TB</td>
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<tr>
<td>Sepsis (11%)</td>
<td>Malaria</td>
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<tr>
<td>Unsafe abortions (8%)</td>
<td>Viral Hepatitis</td>
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<td>Obstructed labour (5%)</td>
<td>Anaemia</td>
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<td>Hypertensive Disorder (5%)</td>
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Not only do these deaths take a toll on the health of women and their families, but also on the economy of the country. The loss of productive women is a significant burden on the country's economic growth.

The problem of maternal mortality and morbidity is a complex issue that requires a multi-sectoral approach involving government, healthcare providers, and society at large. It is a matter of urgency for the country to take strong measures to address this issue and ensure that every woman has access to quality healthcare and support systems to prevent these deaths and disabilities.
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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.

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 rate remains high. (see table below).
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ratios are already much higher than the national average. This means that for every 100,000 women
who become pregnant, 35 die during delivery. The situation is much worse in rural areas. The
Indian government has some new initiatives that could reduce maternal deaths in the near
future. These include promoting institutional delivery and improving the quality of health
services. However, 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.
Under-developed 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, all programs can take home some hard truths. First, maternal health is a right for all women, and across the socioeconomic spectrum, achievement of targets by the government must benefit all sections of the population. Second, it will require a marked change in our attitude, as well as the attitude of our elected representatives. It is high time that every representative made it a priority to reach health care to the poor and underserved.

Social Support

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. Under 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.

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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%) 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.
  - Eighty percent of women have received antenatal care until 20 weeks of gestation.
  - Only 6% of women received antenatal care between 20 and 36 weeks of gestation.
  - While 60% women have received antenatal care in rural areas, only 30% women from urban areas receive antenatal care during the first trimester.
  - 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.
- 69.4% births are in health facilities in urban areas, compared to only 31% in rural areas.
- About 45% births are in health facilities in urban areas, compared to only 15% in rural areas.
- About 16% births are in health facilities in urban areas, compared to only 6% in rural areas.
- About 26% births are in health facilities in urban areas, compared to only 10% in rural areas.
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- 80.6% of women with 10 or more years of education deliver in institutions, while only 19.8% women with no education do so.

- While 85% women from the highest wealth quintile deliver in institutional care, only 13.8% of women in the lowest wealth quintile seek institutional 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 a health facility.

- Institutional delivery is 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. 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 a home birth 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. There is no disaggregated data 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. Women with disabilities are less likely to receive antenatal care than those without disabilities, and are even less likely to access delivery care. Women with disabilities face additional barriers in accessing quality postnatal care, which can delay recovery and increase the risk of complications.

- 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 have at least one live birth.
Maternal Death & Disability in India 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 primary human rights issue.” UN Women (2011) further stressed that “In many places, women are unable to seek care for reproductive health complications and, in the case of maternal deaths, families may be forced to pay for the costs of care and wake up to unmet need.”

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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%.

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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. Health structures and networks were in place, including community participation, and clinical management, were good. This was achieved with the support and involvement of the Government and non-government agencies. The observed decline was due to increased awareness of maternal health, better organization and clinical management, and political commitment.

States like Tamil Nadu, Karnataka and Andhra Pradesh have also used regular audit or verbal autopsy to study reasons of maternal death and identify effective interventions to prevent them in the 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 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 biomedical and non-medical causes that led to these deaths. Both community-based and facility-based reviews were carried out to ensure that different circumstances leading to maternal deaths were identified and corrective actions were taken to avoid them.
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P., a poor daily-wage earning woman belongs to the Scheduled Tribes in Bihar. During her second pregnancy, she 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 pushed him and said he had to sign on a paper, which made him angry. He was not able to sign on paper and went to report to the local police.

However, the local police took him to the hospital. The doctor refused to sign the papers and said he had to sign before releasing the body. Later a local political leader and the ANM tried to strike a compromise and offered him money, but he refused.
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 followed it. It was intended to improve health services to poor women by providing replacement and granting for commissioned work.
- 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 included various steps 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.
- 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 on health as a percentage of GDP is only 1.1%, which is among the lowest in the world. However, 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 some of these are pushed into the informal sector, leading to debt and further marginalization.

d. There is a strong push for privatizing healthcare 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 decreases 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 approach to overcoming the epidemic.
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g. The continued emphasis on vertical programmes 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 preoccupied 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 population 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 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 and trained in case of complications.

• 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.
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 information disaggregated by poverty level, education, 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, every woman in India must have access to quality health care to ensure a healthy and productive life. Until a special focus is given to the poor and unreached women, who are often the victims of neglect,

♦ Raise questions regarding the high rates of maternal deaths in many states of India. Initiate a process of maternal death inquiry both from the national to the local level or vice 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 into 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 constituents. In fact, it is the elected representatives duty to ensure that the voice of women is heard and to avoid all interventions in health staff posting, salaries or projected wages.

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 information disaggregated by poverty level, education, 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, every woman in India must have access to quality health care to ensure a healthy and productive life. Until a special focus is given to the poor and unreached women, who are often the victims of neglect,

♦ Raise questions regarding the high rates of maternal deaths in many states of India. Initiate a process of maternal death inquiry both from the national to the local level or vice 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 into 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 constituents. In fact, it is the elected representatives duty to ensure that the voice of women is heard and to avoid all interventions in health staff posting, salaries or projected wages.
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:

1. Inform your voters regarding their entitlements and service guarantees from the public health system.
2. Monitor cases of neglect that appear in the media, support the victims and survivors to gain medical and legal support and justice.
3. Initiate a process of dialogue with MLA 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 and take action and corrective measures accordingly.
4. 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.
5. 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 to a common platform to discuss ways for improving maternal service delivery at government facilities.
6. Ensure that all posts in the health facilities are filled, the human resource is in place as per the requirements and that the concerns of the posted staff are addressed.
7. 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 have temporary exclusion during monsoon, snowfall etc.
8. 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.
About us

This group was developed by a group working on women’s
right to sexual 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 1990, entitled ‘Experiences of
Institutional Delivery: An Experiences Report.’ The
research group consists of researchers and activists affiliated
with women’s and organizations working in several states of
India.

This group is investigating how maternal health policies
impact on poor communities, especially from socially
vulnerable or deprived groups. Members of the group are
working on issues such as maternal mortality, with
particular focus on women’s right to comprehensive healthcare
without any discrimination.

For any further information, please contact SAVOG.

SAVOG
3/80A, Juhu, Mumbai 400049, India
Ph: 022-26550404/41
Ph: 022-26550410
Website: www.savogonline.org

Center for Legislative Research and Advocacy
& Research
New Delhi 110071
Ph: 011-23316837
Website: www.claraonline.org