

MATERNAL HEALTH POLICY IN INDIA

From Institutional Deliveries to Safe Deliveries
A position paper

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MATERNAL HEALTH POLICY IN INDIA

FROM INSTITUTIONAL DELIVERIES TO SAFE DELIVERIES

Introduction

Health activists and programme implementers from the non government sector have been feeling increasingly dissatisfied with the maternal health care situation on the ground in India. Many women continue to die around child birth because health facilities in many parts of the country are not equipped to provide Emergency Obstetric Care, the quality of antenatal care provided is inadequate. Government reports, however, project that the programme is improving mainly because the Janani Suraksha Yojana disbursements are increasing (1). Groups like the Jan Swasthya Abhiyan and CommonHealth have been expressing that the maternal health policy in India needs to move away from the paradigm of institutional deliveries to a paradigm of safe deliveries. What is a safe delivery? How do the Jan Swasthya Abhiyan and CommonHealth envision safe delivery? This paper explores these questions and offers an understanding that has evolved through collective discussions amongst these networks*.

What is our Conceptual Framework?

We believe that women have the right to the highest attainable standards of maternal health and maternal health care. Maternal health services have to be available, accessible, acceptable, and of good quality.

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women, it is associated with suffering, ill-health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour and birth injuries (2). Indirect causes in many settings include undernutrition, repeated pregnancies, anaemia, malaria, hepatitis and diabetes (3, 4).

A society's maternal well being, (or lack of it) depends on a range of underlying determinants, including social, cultural, health system, and economic factors. These have a profound effect on maternal health and, ultimately, on maternal mortality. The indirect and underlying determinants are best examined from both a demand and supply perspective, organized into pathways at the following levels:

- ▶ **individual** - age, parity, marital status, nutritional status, dietary, sanitary, sexual practices, access to safe and suitable contraception
- ▶ **household** - class, caste, income/assets, education, knowledge, gender power relations
- ▶ **community** - cultural, gender norms, community institutions, social capital, environment, and infrastructure
- ▶ **health system** - availability, accessibility, quality of health services
- ▶ **related sectors** - transport, water and sanitation, communication, food security
- ▶ **government policies and action.**

Thus maternal health is more than maternal deaths. However, maternal mortality ratio (MMR) is an accepted indicator of maternal health globally. Maternal deaths are recognised as the most visible proxy indicator of maternal health.

* We have not been able to address maternal health needs of women living with HIV/AIDS; and other women with special needs such as women with disabilities.

Evolution of maternal health policy

International policy

India's maternal health policy has to some extent been guided by the developments on the international maternal health arena. With the formation of the World Health Organization in 1948, although maternal health was on the agenda, there was no real attention to maternal health in international policy. Maternal mortality was thought to be a problem of poor countries and the poor within those countries. If there was any attention paid at all to maternal health, it was because of its connection with children's health. There was no concrete information on the extent of the health burden because of the problems of measurement of maternal deaths. In the 1970s WHO adopted a focus on family planning and the 1978 Alma Ata Conference drew international commitment to primary health care and situated maternal and child health within the comprehensive primary health care approach. In 1985, Rosenfield and Maine called for more attention to maternal health care in their landmark paper "Where is the M in MCH?" (5). It was only in 1987 that the Safe Motherhood Initiative was launched in Nairobi by an Interagency Group (sponsored by UNICEF, UNFPA, World Bank, WHO, IPPF, Population Council) (6). The stated aim of this initiative was to draw attention to dimensions and consequences of poor maternal health and to mobilize action to address high rates of maternal deaths and disability. The goal was to reduce maternal mortality by half by the year 2000. The Safe Motherhood Initiative was based on the theories that high risk pregnancies can be detected in advance, and that training traditional birth attendants (TBAs) would result in safe deliveries. The strategies recommended included risk screening during antenatal care and large-scale training of TBAs.

The International Conference on Population and Development (ICPD) at Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 signified the next shift in the understanding of maternal and women's health. The ICPD initiated a global change in policy towards reproductive health and in family planning by placing people's needs above demographic targets. It also drew focus on maternal mortality - as a visible sign of the historical neglect of women's health and needs. The ICPD also redeemed the position of abortion within the range of reproductive health priorities and called for efforts to 'achieve a rapid and substantial reduction in maternal mortality and morbidity and greatly reduce the number of deaths ... from unsafe abortion'. The Beijing Conference built on the ICPD momentum for women's health and reproductive and sexual health rights.

The next milestone in the evolution of the maternal health policy was the 1994 WHO package on Mother–Baby comprising of antenatal care, clean deliveries, Emergency Obstetric Care (EmOC), and family planning (7). Meanwhile in 1996 the Inter Agency Group intensified its efforts and launched a campaign that resulted in the 1998 Call to Action for Safe Motherhood and the Safe Motherhood Technical Consultation in 1997 in Sri Lanka (8). A review of key lessons from Safe Motherhood Initiative's first ten years showed that

- ▶ Maternal deaths were not declining in most developing countries.
- ▶ Improvements in collection of maternal health data led to, in some cases, higher estimates of maternal mortality.

Interrogating why there had not been more progress in reducing maternal mortality indicated that

- ▶ Priorities were not clearly defined, interventions were not always focused and effective.
- ▶ Political commitment and resources were inadequate.

The Sri Lanka Technical Consultation concluded with the following key lessons:

1. Every pregnancy faces risk. There is no reliable way to predict which women will develop complications.
2. Time between complication and death is very short (e.g., 2 hours in postpartum haemorrhage).
3. Therefore, skilled care should be available to all women during the maternal period, especially during childbirth.
4. Antenatal high-risk screening approach and TBA training alone are not effective in reducing maternal mortality.
5. Improved access to good quality maternal health services is necessary.
6. There is a need to prevent unwanted pregnancy and address unsafe abortion.

The 2000 Millennium Development Goals (MDG) then adopted the goal of improving maternal health and reducing by three-quarters the MMR between 1990 and 2015 (9). The key indicator decided to measure progress towards MDG 5 was proportion of deliveries conducted by Skilled Birth Attendants (SBA).

While the ICPD had succeeded in garnering global acceptance for the concept of reproductive health and reproductive rights, the MDG 5, once again reduced the larger goal of improving reproductive health to improving maternal health and improvement of maternal health was further reduced to reduction of maternal mortality through the internationally accepted strategies of universal access to skilled birth attendance and EMOC. It was only after efforts by the global women's health movement to expand the purview of MDG 5 that the indicator of universal access to reproductive health, with its limited targets, was added.

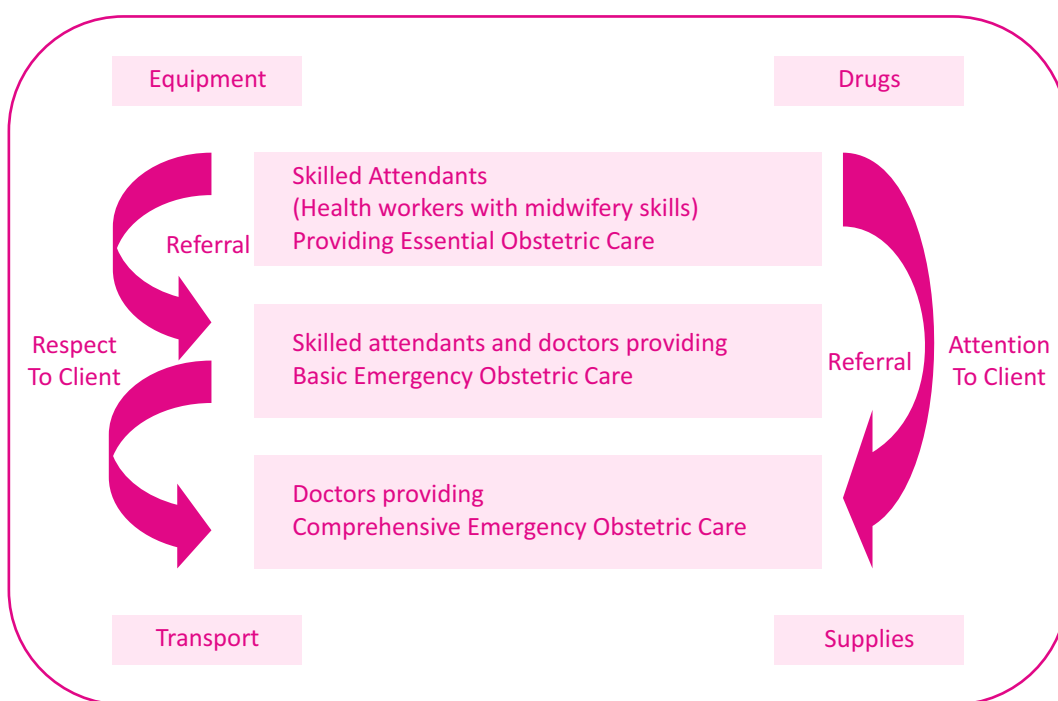
Skilled Birth Attendance

The Safe Motherhood Initiative (10) defines a ***skilled birth attendant*** as a health worker with midwifery skills who is proficient in managing a normal delivery and who is able to recognize the onset of complications, provide essential obstetric care, and supervise the referral of mothers and their babies for interventions that are either beyond the attendant's competency or not possible in a particular setting. However, a skilled attendant who does not have access to supplies, equipment, drugs and a referral system will have less effect on maternal mortality. The support provided by the health-care system to the skilled attendants is essential. ***Skilled attendance*** refers to the process wherein the attendant with the necessary skills is supported by an enabling environment that ensures adequate supplies, equipment, and infrastructure as well as an efficient and effective system of communication, referral, and transport. Other features of a supportive health-care system include in-service and on-the-job training, supervision, accountability, and equitable distribution and deployment of skilled attendants.

Emergency Obstetric Care (11)

Basic EmOC Services	Comprehensive EmOC Services
(1) Administer parenteral* antibiotics	(1–6) All those included in Basic EmOC
(2) Administer parenteral oxytocic drugs	(7) Perform Surgery (Cesarean section)
(3) Administer parenteral anticonvulsants for pre-eclampsia and eclampsia, including magnesium sulphate	(8) Perform blood transfusion
(4) Perform manual removal of placenta	
(5) Perform removal of retained products (e.g., manual vacuum aspiration)	
(6) Perform assisted vaginal delivery	
* Parenteral administration of drugs include injections or intravenous fluids	

Finger 1: Conceptual Frame work for Skilled Attendance at Delivery



Source: Adapted from Can Skilled attendance at Delivery Reduce Maternal Mortality in Developing Countries? By W. Graham, J. Bell, and C. Bullough, 2001, page 106, in V. De Brouwere and W. Van Lerberghe (Eds.), *Studies in Health Organization and Policy: Vol.17. Safe Motherhood Strategies: A Review of the Evidence*, Antwerp, Belgium: ITG Press

In India, maternal health policy followed some of the international trajectory as described above. For many decades beginning from the 1950s, India had a Family Planning and Maternal and Child Health Programme. In 1984, this was renamed the Family Welfare Programme. In the 1980s, the maternal health strategy focused on antenatal care, risk approach for detection of complications and training of TBAs, following the international launch of the Safe Motherhood Initiative. In 1992, with the launch of the Child Survival and Safe Motherhood (CSSM) programme (12), the maternal health strategies were: universalising antenatal care, delivery by trained persons and establishment of comprehensive essential obstetric care facilities, called first referral units (FRUs). The programme strategy did not distinguish basic and comprehensive EmOC facilities - an FRU was meant to provide the entire range of essential obstetric functions, including blood transfusions, anaesthesia and caesarean sections. The CSSM programme was silent on safe abortion.

Post ICPD, the Government of India implemented a target-free approach to do away with the family planning targets. In 1997, the Reproductive and Child Health programme (13) replaced the CSSM programme and sought to integrate the principles of the ICPD Programme of Action: men's involvement, promoting adolescent reproductive and sexual health, in addition to the target-free approach to family planning. The second phase of the RCH Programme (14) (2005 to 2010) sought to build on the lessons learnt from the first phase.

The National Rural Health Mission (NRHM) (15), the flagship programme of the Government of India launched in 2005, states improvements in maternal health as one of its key focus areas. Reducing the MMR to 100 deaths per 100,000 live births is one of the goals of the NRHM. Key maternal health strategies that the GOI has stated in its documents on the supply side are:

- Universal access to Skilled Birth Attendant (SBA)
- Essential Emergency Obstetric Care (EmOC) through network of First Referral Unit (FRU) and 24x7 Primary Health Centres (PHCs)
- Improving Access to EmOC services through Public Private Partnership (PPP) - eg. Chiranjivi Yojana
- Access to early and safe abortion services
- Strengthening Referral Systems; e.g., 108 Ambulance service, Janani Express

The NRHM simultaneously invests in improving public sector facilities in terms of infrastructure, human resource and skills. NRHM also provides service guarantees the minimum standards laid down by the Indian Public Health Standard (IPHS) (16) regarding infrastructure and facilities for various levels of public sector health institutions.

However, the major strategy on which disproportionate attention has been focused is the Janani Suraksha Yojana (JSY) (17). The JSY aims to promote institutional deliveries by providing pregnant women with a financial incentive for delivering in institutions. After demands from health and women's groups, home deliveries also get financial assistance in high-focus states, but this amount is much lower. This differential is expected to promote behaviour change with pregnant women opting for deliveries at institutions. The assumption behind this programme is that institutional deliveries will automatically result in access to skilled birth attendance and EmOC, thus improving the MMR.

The earlier National Maternity Benefit Scheme (18) was seen as an entitlement that enabled support for pregnant women's nutrition and transport. By linking a financial package to the woman accessing an institution for delivery, the JSY saw a shift in the policy perspective to that of a conditional cash transfer, to promote 'good behaviour'.

Trends in Maternal Mortality Ratios in India

In order to understand the interventions necessary to reduce maternal mortality in India, we first need to analyze the causes and trends of maternal deaths in the country.

Table 1 - Estimated MMR in India (19)

1990	1995	2000	2005	2008	2009 (SRS)
570	470	390	280	230	212

The table above shows that maternal mortality has decreased in the country as a whole from 1990 to 2008. However, not all states have performed uniformly well.

The GOI report on the midterm review of the MDGs (20) points out that Kerala and West Bengal are set to achieve their targets of reducing MMR by three-fourths before 2015, and that Bihar/Jharkhand starting from high MMR of 531 have also achieved a rapid rate of reduction of maternal deaths. What is of concern however, is the increase in maternal deaths in Haryana and Punjab, states which are considered to be developed, well performing states. MMRs in 2004-06 for Assam, Uttar Pradesh, Uttaranchal and Rajasthan are also worrisome. In fact these are amongst the states in India that account for as many as two-thirds of maternal deaths, with Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Uttaranchal and Uttar Pradesh being the others.

In the four southern states, Kerala and Tamil Nadu have already achieved the goal of a MMR of 100/100000 live births but, within the group, Karnataka lags significantly behind with a MMR of 178/100000 live births. In the sub-group of Empowered Action Group states including Assam, based on the annual decline of 22 points per year, the 2012 MMR figure is estimated to be around 220 / 100000 live births. Many of these states have shown acceleration in improvements in the latest three year period notably Assam, Madhya Pradesh and Rajasthan. Assam, where MMR declined at only 3 per 100,000 in the previous three years, now reports a decline of 30 points per year. Still, at a MMR of 390/100000 live births, Assam remains India's most maternal death prone states.

Another important feature is the comparisons between the maternal mortality ratio and the maternal mortality rate. West Bengal and Gujarat for example have the same ratio, 148 and 145, respectively. However, the Gujarat maternal mortality rate at 12.8 is 30% higher than the West Bengal rate at 9.2. At the other end Assam has an MMR of 390 versus Uttar Pradesh (359), Rajasthan (318) or Bihar (261) - but the maternal mortality rate of Assam is 27.5 against rates of 40.0, 35.9 and 30.1 for the latter. This indicates that the lifetime risk is much higher in the latter states due to the much higher fertility rates for these states – which points out to the tremendous reduction in total number of maternal deaths brought about by lower fertility rates by themselves.

While a state-wise disaggregation and analysis is done of states with high and low MMRs, an analysis of who are the women who die has not been included in the GOI MDG Midterm Review Report, though the information in fact exists. For example, the National Family Health Survey 3 (NFHS-3) data (21) show that the indicators for scheduled tribe and scheduled caste women are worse than those of 'other caste women' (the women who are higher up in the caste hierarchy). Many health indicators reflect this disparity - 23.7 % scheduled tribe women and 19% scheduled caste women are moderately to severely anaemic compared to 14% 'other caste women'. Similar differences are seen in nutritional status – 21.2% scheduled tribe women and 18% scheduled caste women are moderately/severely thin compared to 13.1% 'other caste women'. Women not receiving any antenatal care tend disproportionately to be women with no education, those in households with lower wealth index, and those who belong to a scheduled tribe.

Ekjut in eastern India has been collecting robust data on women's/maternal deaths in the last 6 years from roughly 6 lakhs population and has found that about 79% of the deaths are of women from indigenous (scheduled tribe) communities (22). Research has shown that an indigenous person in India is 1.2 times more likely to experience excess mortality compared to a non-indigenous person with the same standard of living (23).

Table 2: Trends and place of birth and assistance during delivery

	NFHS 1 (1992-93)	NFHS 2 (1998-99)	NFHS 3
Assistance Skilled birth attendants (SBAs)	34.2	42.3	46.6
Traditional birth attendants (TBAs)	35.2	35	36.5
Home births	73.5	65.4	61
Institutional deliveries	26.1	33.6	38.6

Source: IIPS and Macro International

Table 2 shows that institutional births have indeed increased over the years along with a rise in assistance by SBAs. However, Figure 2 shows that improved population-wide trends do not translate to improved access for all. When the data are disaggregated by social factors as in Figure 2, we see that women delivering at institutions are more likely to be urban-dwelling, in the highest wealth quintile, and tribal (21). A similar picture can be seen regarding deliveries assisted by an SBA (please see Figure 3).

Social grouping, education and economic class are thus important social determinants of maternal health and access to public policy benefits in India which the official MDGs monitoring effort ignores.

Figure 2

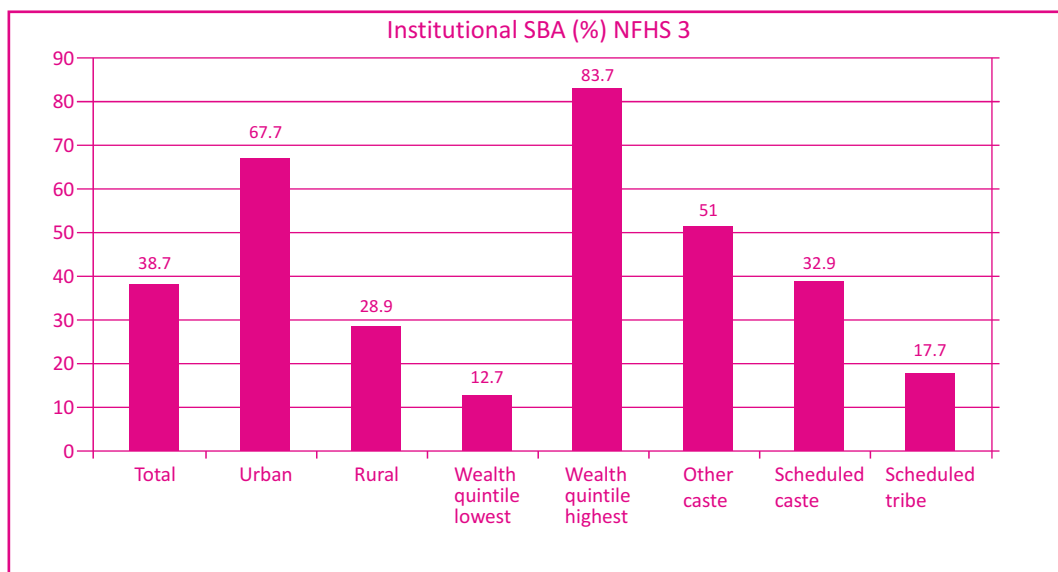


Figure 3

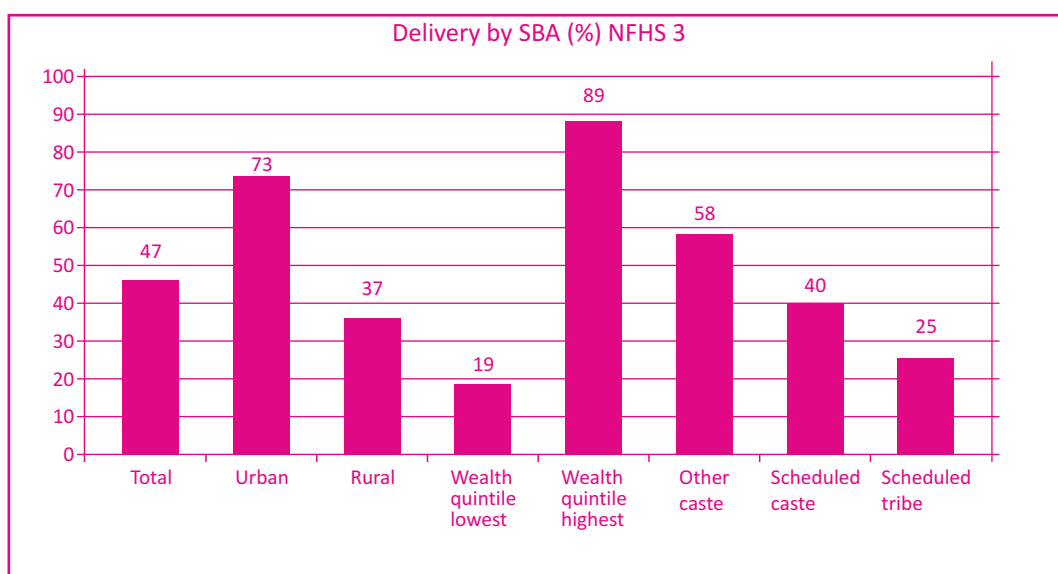


Table 3: Maternal Health Indicators over NFHS Rounds

	NFHS 3			NFHS 2	NFHS 1
	Total	Urban	Rural	Total	Total
Mothers who had at least 3 antenatal care visits for their last birth (%)	50.7	73.8	42.8	44.2	43.9
Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	48.8	75.3	39.9	42.4	33
Institutional births (%)	40.8	69.4	31.1	33.6	26.1
Mothers who received postnatal care from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their last birth (%)	36.8	60.8	28.5	NA	NA
Women whose Body Mass Index is below normal (%)	33	19.8	38.8	36.2	NA
Ever-married women aged 15-49 who are anaemic (%)	56.2	51.5	58.2	51.8	NA
Pregnant women aged 15-49 who are anaemic (%)	57.9	54.6	59	49.7	NA

Source: IIPS and Macro International

Table 3 shows that while institutional births have indeed increased over time, there remains a large rural-urban differential. The table also shows that anaemia levels in women have increased substantially between NFHS 2 and 3; anaemia is known to be an important indirect cause of maternal death.

Causes of Maternal Deaths in India

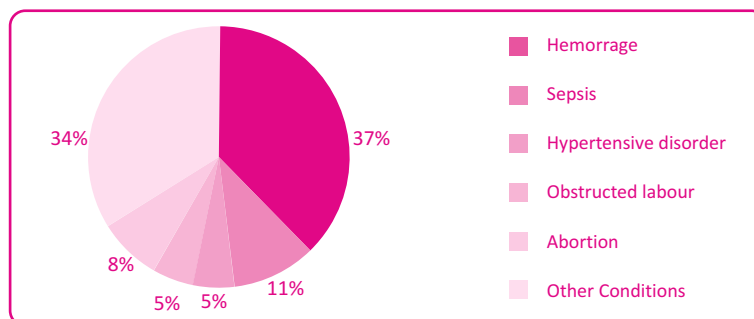


Figure 4

According to the Registrar General of India (24), main causes of maternal deaths are as follows: haemorrhage (38%), sepsis (11%) and abortions (8%), obstructed labour (5%), hypertensive disorder (5%) and other conditions (34%) (see figure 4). Other conditions include anaemia and other indirect causes like malaria.

Table 4 charts out the evidence-based interventions necessary to tackle each of the major direct causes of maternal mortality (25). Interventions ranging from detection and treatment of anaemia to family planning services are necessary for preventing maternal deaths. Delivering in an institution can only facilitate provision of some of these interventions, such as presence of a skilled attendant or operative delivery.


Table 4

Cause of maternal death	Proven interventions
Bleeding after delivery (postpartum haemorrhage)	Treat anaemia in pregnancy. Skilled attendant at birth: prevent or treat bleeding with correct drugs, replace fluid loss by intravenous drip or transfusion if sever.
Infection after delivery	Skilled attendant at birth: clean practices. treat with antibiotics if infection arises.
Unsafe abortion	Skilled attendant: give antibiotics, empty uterus, replace fluids if needed, counsel and provide family planning.
High blood pressure (hypertension) during pregnancy: most dangerous when sever (eclampsia)	Detect in pregnancy; refer to doctor or hospital. Treat eclampsia with appropriate anticonvulsive (MgSO ₄); refer unconscious woman for expert urgent delivery
Obstructed labour	Detect in time, refer for operative delivery.
Other direct obstetric causes	Refer ectopic pregnancy for operation.

Critique of the present maternal health policy and JSY

Several studies have shown that there has indeed been an increase in institutional deliveries across various states of the country over the last few years of implementation of JSY (26, 27). But when one looks at whether the rise in institutional deliveries has actually resulted in improvements in maternal health outcomes, the evidence from various studies is not encouraging.


One of the major areas of concerns emerging has been the readiness of facilities to handle the increased case loads. A study of JSY in eight high-focus states by the National Health Systems Resource Centre (NHSRC) (26) shows that facilities at block and higher levels take up disproportionately higher loads of deliveries compared to primary care facilities resulting in a stretching of their resources. Very often, facilities do not provide the level of care that they are supposed to. The 24 x 7 PHCs only provide round-the-clock delivery services, but not Basic EmOC (BEmOC) as they are supposed to. Many FRUs do not provide caesarean section facilities and very



few provide blood transfusion services. Quality of care was often found to be very poor. Studies by the National Institute of Health and Family Welfare in Orissa (28) and Rajasthan (29) also document that the shortage of human resource and poor infrastructure in facilities adversely affect the quality of care during delivery in BEmOC and Comprehensive EmOC (CEmOC) centres. A civil society fact finding into a large number of maternal deaths in Barwani district, Madhya Pradesh (30) found that standard treatment protocols were not followed. Harmful practices like irrational use of antibiotics and intravenous fluids and misuse of oxytocin to augment labour were widespread. Infection control practices were grossly inadequate. Even skilled birth attendance, that is presumed to happen automatically once women reach institutions, seemed inadequate; deliveries in labour rooms were often conducted by dais/traditional birth attendants; even where ANMs or nurses conducted deliveries, whether they were really skilled and had received adequate training for this, was questionable. Women often reported abuse and violence by providers in labour rooms. Another fact finding team to study the situation of maternal health in Jharkhand (31) found that even District Hospitals could not provide CEmOC – there were no gynaecologists, anaesthetists, no essential medicines for emergency obstetric care, no electricity or generators. As far as available obstetric facilities in the public health sector is concerned, District Level household Survey-3 (DLHS-3) (32) has revealed that only 24.3% PHCs have Lady Medical Officer, 53.1% PHCs function on 24 hours basis, 55.4% PHCs have referral services for complicated pregnancy/delivery, 25.1% CHCs have obstetrician/gynaecologist, 18.8% CHCs designated as FRUs offer caesarean section, and 9.2% FRUs have blood storage facility.

The other strategies, namely, increasing skilled birth attendants and attendance, and operationalising BEmOC and CEmOC are also far from satisfactory. Only 46.6 % of births in 2005-6 were attended by SBAs (33). The Fourth Common Review Mission Report (34) notes that 'access to emergency obstetric care has improved though nowhere near the scale that it was hoped for and the volume of complications managed within the public system is still suboptimal'. The failure of the supply side support in terms of increased finances, human resources and supplies to match the demand, as pointed out in Common Review Mission-3 (35), still remains a major issue. Several reports have also documented the total lack of focus on postnatal care (30, 36) although it is well known that the maximum number of deaths take place in the first two days postpartum.

At another level, the present maternal health policy completely dismisses the role of Traditional Birth Attendants in maternal health care. In keeping with international policy, only Auxiliary Nurse Midwives and cadres above are recognized as Skilled Birth Attendants. However, by its very definition, the term 'Skilled Birth Attendant' defines a person with a certain set of skills. Data shows that less than half of women delivering in the country have access to Skilled Birth Attendants as the term is now defined (21, 33). According to NFHS-3, TBAs conduct 36% of all deliveries. It is also well known that TBAs are accepted culturally in many parts of the country and are readily accessible to the woman when in need. Even in a state like Tamil Nadu where a majority of deliveries are in institutions, it has been documented that very often, the TBA remains the first point of contact for the pregnant woman and is preferred as a birth companion in institutions (37). Apart from promoting deliveries in institutions, the present policy does not have an alternative plan to make deliveries for women delivering at home and without SBAs safer. A recent peer-reviewed systematic review with meta analysis of studies assessing the effectiveness of strategies incorporating training and support of TBAs (38) found a significant reduction in adverse perinatal outcomes and a non-significant reduction in maternal deaths. Civil society reports from areas like Barwani (30) document that ANMs and other health care staff find it difficult to reach remote areas with difficult terrain even for regular




antenatal care, leave alone emergency care. Given such a scenario, the roles of local resources like the TBAs and ASHAs in providing maternal health care including delivery and postnatal care need to be reexamined. Of course, this would mean providing them with necessary skill-based training and back-up support in the form of Emergency Obstetric Care when needed.

The view of JSY providing financial support for women in accessing institutions is also to be questioned. The NHSRC study (26) documents an average out-of-pocket expenditure incurred of Rs. 1028 per delivery in an institution excluding transport costs. Assured referral transport systems like the EMRI service or Janani Express service were used only by 13% of women studied to reach institutions. Other reports also point to the problems in transportation services. NGOs working in Jharkhand report that the state has recently initiated the Mamta Vahan emergency transportation service, which is available only to bring women from their homes to the often ill-equipped PHC/CHC and not to the nearest appropriate health facility which may be a private hospital or in a neighbouring state. For women with complications, this leads to further delays, and has obvious life threatening consequences. Reports from NGOs in different parts of India indicate that women have to visit the hospital many times before they can get the JSY money and they need to spend each time for travel which discourages them further (22).

In the light of all of these observations, the whole focus on institutional deliveries and JSY needs to be questioned. Is it ethical to push women to institutions when adequate standards of care cannot be ensured? Is it not manipulative to use incentives to coerce women into accessing institutions when the state cannot ensure that they will receive adequate quality of care and dignity during childbirth and where the state has failed to ensure CEmOC even in District Hospitals?

It is also important to see who JSY is leaving out. In addition to incentivizing institutional deliveries, JSY attempts to disincentivize home deliveries. While the programme provides Rs 500 as a financial package for women delivering at home, several states have stipulated additional conditions on eligibility: the woman should be over 19 years of age, only for the first two deliveries, possess a BPL card. It is well known that poor, lower caste women, young women, and multiparous women are at higher risk for maternal mortality. It is also well known that in view of their social marginalization, and lack of decision making power, these women are more likely to have difficulties in accessing institutions and to have a home delivery. Devadasan et al (39) point out that only around 8.4% and 20.7% of all eligible BPL women in Chattisgarh and Maharashtra respectively got the JSY benefit in 2006-07. The NHSRC study (26) documents that many of these women are not even counted in the HMIS. By excluding them from the programme, JSY loses a valuable opportunity to bring them into contact with the health system. The state also thus fails in its role to provide social security in terms of maternal health care to these marginalized groups. The conditionality of age is blind to the Indian reality that 44% of the women in the age group 20 to 24 years were married before 18 years of age (21).


Gender issues in maternal health need to be acknowledged. It is well known that poverty and gender discrimination play key roles in influencing health of women - poor nutrition, anaemia, lack of education, lack of control over resources, poor decision making capacity are all various manifestations of these determinants that influence maternal health outcomes independently and in combination (40). The fact that maternal deaths continue to be unacceptably high is a reflection of the fact that women's status within families and society is low. Social beliefs and gender norms around early marriage and early pregnancy - having to prove one's fertility – affect maternal health of women. Low educational attainment by girls is associated with adverse maternal health outcomes



(NFHS-3). Pregnancy and childbirth are considered 'normal' phenomena not warranting any special care. Women continue to work as usual until late stages of pregnancy with no rest during the day. Gender power relations within the family play a huge role in determining women's access to ANC, safe deliveries and adequate nutrition at all stages of pregnancy, and postnatal periods. Gender discrimination and disparities result in weak control over economic resources and poor decision-making. The consequence is women having little say in matters of sexuality and reproduction including family planning, and unwanted pregnancies. There is increasing evidence that violence during pregnancy is high. A community-based case-control study of maternal mortality in the state of Maharashtra, reported that as many as 15% of maternal deaths were associated with the experience of violence (41). The issue of unsafe abortions is embedded within gender constructs. Why do women need abortions? Unwanted pregnancies due to failure or lack of contraceptive use are in turn related to gender factors – lack of awareness of body, of contraceptives, lack of control over her body and decision making on contraceptive use. Gender bias amongst service providers affect quality of maternal health care – labour room abuse is a recognized phenomenon.

While globally maternal health policy has focused on the proximate determinants of maternal health, namely management of obstetric complications, long-term sustained improvements in maternal health cannot be made unless the root causes of poverty and gender bias are addressed (40). Lack of focus on these root causes also affects the effectiveness of the immediate medical intervention. The experience in Barwani (30) is a classic example where the investigation revealed apathy at all levels of the system, including in facility-level providers towards adivasi women. Negligence and discriminatory attitude towards marginalized sections of society, particularly adivasis, was found to be responsible for a large number of maternal deaths. The framing of JSY as the flagship programme for maternal health under NRHM has resulted in a total lack of attention to these social determinants of maternal health. This has resulted in situations like in Barwani (30) and Jharkhand and Orissa where nutritional anaemia and malaria contribute to a large proportion of maternal deaths (e.g., in Jharkhand and Orissa (42), a study done by Ekjut attributes 23% of all maternal deaths to malaria) but are ignored in programmatic intervention. This has also resulted in very little, if any, attention to unsafe abortion as one of the five major causes of maternal mortality; safe abortion services are largely unavailable in the public sector except at the block / district level, even in well performing states like Tamil Nadu (43).

Accountability and governance also have been raised in several civil society reports as important issues affecting maternal health care. The Barwani fact finding (30) found governance in health systems falling short on many counts - the pervasive corruption at all levels of the health system, the total lack of attention to local problems like anaemia and malaria, the lack of adequate grievance redressal systems, the systemic neglect of resource poor tribal areas, the poor quality of care and apathy in health care institutions, and the frequent flouting of the ethical health care principles of beneficence, non maleficence and autonomy all substantiated this. A Human Rights Watch investigation into accountability in maternal health care in Uttar Pradesh (44) documents recurrent health system gaps in provision of maternal health care including barriers to emergency care, poor referral practices, gaps in continuity of care, and improper demands for payment as a condition for delivery of healthcare services. Monitoring of maternal deaths was also found to be poor including lack of adequate reporting of maternal deaths. The report also found that grievance redressal systems are non existent in public facilities.



In the larger context, the ICPD Programme of Action defined reproductive health and rights and saw a comprehensive package as necessary to achieve these. The MDGs singled out maternal mortality as the indicator for action as far as reproductive health was concerned. Maternal health policy has further reduced this to the technical intervention of skilled birth attendance as a proxy for better maternal health care. JSY further reduces this to institutional delivery to an extent where policy and programmes see this as an end in itself and not as a means to better maternal health outcomes. Institutional deliveries even in tertiary hospitals are far from the skilled birth attendance as conceptualized above.

Historical evidence from low and middle-income countries like Sri Lanka, Thailand, Costa Rica (40, 45, 46) that have managed significant reductions in maternal mortality in recent decades shows a strong political commitment to improving public health and other determinants like education and human development. Evidence from states like Tamil Nadu and Kerala (45, 47, 48) shows that women choose to go to institutions for delivery in the presence of an enabling environment including functional health care facilities, better quality of care, higher educational levels, better roads and transport and good governance; the increase in institutional deliveries in these states is seen much before the introduction of any financial incentive scheme. The use of a conditional cash transfer to bring women to institutions in the absence of such enabling environment is a failure to learn from this experience and a lost opportunity for systems to build such an environment.

A new programme – Janani Shishu Suraksha Karyakram

In June 2011, the Ministry of Health and Family Welfare launched the Janani Shishu Suraksha Karyakram (49) under the NRHM. This programme aims to provide free and cashless services for all pregnant women for normal deliveries as well as Caesarean section operations, and care for sick new born babies (up to 30 days) in all government health facilities – rural and urban – across the country. While this is a step towards universalizing an important aspect of maternal health care, it remains to be seen what barriers women will face in terms of elimination of 'informal payments' and provision of acceptable quality services.

Centre staging 'safe delivery'

In order that we bring the woman and the newborn back to the centre of the whole issue, overall wellbeing of the mother and newborn should replace mere institutional delivery as an indicator of quality maternal and child health services. Every delivery, regardless of where it takes place, should be safe for both the woman and newborn from both a technical perspective and a rights-based view. Necessary systemic changes need to be made to achieve this universally. Recent work in this area has shown results. A checklist of essential practices during delivery has been found to markedly improve the quality of practices during delivery in a recent study in Karnataka, India (50).

CommonHealth facilitated discussions with various groups of persons engaged in the issue of maternal health to understand the different dimensions of safe delivery. These included academics, members of civil society and community-based organizations, activists and medical experts.

Discussions were also conducted with grassroots women in rural Tamil Nadu to understand their perspectives on safety of delivery (51). The following dimensions of safe delivery emerged out of these discussions.


- Absence of morbidity and mortality
- Technical quality of care
- Continuum of care through antenatal, intranatal and postnatal period and through the life cycle of the woman
- Adequate support facilities at place of delivery like electricity, running water, toilets, cleanliness
- Enabling environment promoting physical and emotional health of the woman including nutrition, family support, social support
- Presence of a birth companion
- Safe contraception and safe abortion services
- Autonomy and decision making of the woman
- Dignity of the woman and absence of abuse and violence
- Absence of discrimination
- Special needs of marginalized groups to be addressed
- Accountability to the woman and to the community
- Absence of corruption.
- Safety at work places, maternity benefits and welfare schemes like crèches, child care facilities

Based on these dimensions, we propose the following criteria for defining a pregnancy and delivery as safe.

Definition of safe delivery

Delivery whether at home or in an institution is 'safe' when

- Both the mother and the newborn survive.
- There is no maternal or neonatal morbidity, both short-term and long term.
- The woman and the newborn do not receive unnecessary/irrational procedures or drugs, and receive the essential/appropriate, timely care (both complicated and uncomplicated).
- The woman and the newborn receive a continuum of appropriate care from antenatal to intranatal to the postnatal period. This should include safe abortion services for those women who need them.
- The woman and the newborn have adequate support structures at place of delivery including running water, electricity, and clean toilets.
- The woman and newborn have an enabling environment to a safe pregnancy and delivery including adequate nutrition, family and social support, safety at work places, access to maternity benefit and welfare schemes, birth companion.
- Those with complication receive emergency care and referral and transport.
- Those with complication receive the appropriate technical standard of care.
- The woman receives all the relevant information and is consulted in care given to her.
- The woman and the newborn are treated with dignity.
- The woman and the newborn are not abused in any way.



The criteria listed in the above definition should form the basis for indicators to measure safety of a pregnancy and delivery in place of the present focus on institutional delivery alone as the sole criterion and indicator of maternal health services. Many aspects of safe delivery described above are consistent with the concept of skilled birth attendance, for example, the need to follow standard treatment protocols, availability of adequate facilities, availability of requisite equipments, supplies and medicines, emergency transport and so on. Indicators for these should be developed as a part of a package of indicators for safe delivery.

Conclusion and Recommendations

Maternal health policy in India needs to go beyond institutional delivery care to seriously and decisively addressing determinants like anaemia, malaria and tuberculosis. In addition, at the very least, a comprehensive maternal health package should consist of contraceptive services and safe abortion services to deal with unwanted pregnancies, as well as good quality antenatal care, skilled birth attendance and quality postnatal care for the woman and baby. Additionally, focus on adolescent sexual and reproductive health and rights can result in delaying marriages and childbirth and enhanced nutritional status and should therefore be considered as a part of a comprehensive maternal health package.

Comprehensive interventions are required to bring down maternal mortality ratios. The direct causes of maternal mortality – haemorrhage, pre-eclampsia/eclampsia, sepsis, obstructed labour – can be taken care of by skilled birth attendance and quality maternal health services. Utilizing the existing skills of the TBA at places where they are consolidated with some additional training on proper assistance at delivery and early identification of complications while using a standardized protocol used in midwifery practices will go a long way in catering to the needs of a large number of women who deliver at home out of choice or otherwise. But the root causes also need to be addressed through community-level interventions as well as making maternal health a political issue, which is of concern for society at large. The importance of dealing with the broader social determinants needs to be acknowledged by policy and programme makers and not expect narrow solutions to achieve sustainable results.

Maternal death audits have now been formalised and guidelines have been issued for the same. These must immediately be implemented. Reporting systems for maternal deaths must be made more robust with involvement of ASHAs and communities in reporting from multiple sources. Involvement of the Village Health and Sanitation Committees in community maternal death audits will help in sensitizing them to demand side issues of early transportation, improving road conditions and quality of care at institutions. In addition, facility level audits for different parameters of quality of care also should be put in place.

Indicators for maternal health have to move beyond the number of women who availed of the JSY to include the perspectives of the women who are actually being addressed by the programme. We need to collectively evolve indicators for 'safe delivery' that can be applied wherever the births take place. Several dimensions within the concept of skilled birth attendance match closely with the dimensions of safe delivery. Indicators for skilled birth attendance should be acceptable to health policy makers and programme managers and we should argue for broader safe delivery indicators within this framework of skilled birth attendance. Some of these indicators should also be introduced as a part of community monitoring efforts in the states where community monitoring is

taking place, as well as a part of village health planning. These will be concrete ways of making maternal health a concern of families and communities.

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CommonHealth Thematic Areas

Maternal Health

Make every instance of maternal morbidity and maternal death count.

Advocate for safety, quality and respect for women's rights in delivery care.

Promote health system strengthening and accountability through community mobilization.

Neonatal Health

Generate and disseminate information on neonatal health.

Encourage labour monitoring for improving perinatal and neonatal outcomes.

Advocate for right to health for newborns, through

- a. Counting of stillbirths and newborn deaths.
- b. Attention to newborn outcomes by promoting safety and quality in delivery.
- c. Legal, policy and economic measures to support newborn care.
- d. Greater participation of men, families and the community in essential newborn care.

Safe Abortion

Carry out sustained campaigns to promote access to safe and quality abortion services for all women irrespective of marital status, especially those from disadvantaged sections.

Support the prevention of sex-determination through stringent implementation of the PC-PNDT Act and campaigns against gender discrimination, without compromising on women's access to safe abortion services.





CommonHealth - a Coalition for Maternal - Neonatal Health and Safe Abortion

We are a coalition of concerned individuals and organizations from across India, who have come together to work towards changing the unacceptable situation around issues of maternal-neonatal health and safe abortion.

Vision

A society that ensures maternal-neonatal health care and safe abortion for all women, especially those from marginalised communities in India.

Mission

To raise visibility of the unacceptably high mortality, morbidity among mothers and newborns, and the lack of access to safe abortion services, especially among the disadvantaged.

To mobilise advocates from different constituencies to:

- a. ensure effective implementation of relevant policies and programmes.
- b. contribute to the development of new policies and changing of existing ones when needed.
- c. build a rights based and gender sensitive perspective within communities, health care providers, researchers, administrators, elected representatives and the media, among others.

