# Maternal healthcare policies in India: A background paper

Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period (WHO, 2019). Over the decades, much effort has been exerted to improve maternal health world over. However, maternal healthcare remains a major challenge to the global public health system, especially in developing countries (Aliyu, 2018). Moreover, the gap in the risk of maternal deaths between developed and developing countries is considered as the most significant health divide in the world (UNICEF, 2021). In the years since independence, the Indian government too has taken measures to address maternal health. The present paper attempts to trace the evolution of Indian maternal health policies over the years, and present a critical reflection of the impact and effectiveness of the same.

The paper adopts the definition of maternal health put forth by the World Health Organization (2019), and focuses on women’s experiences during pregnancy or antenatal period, childbirth, and the postnatal period. However, the paper also touches upon the aspects of contraception and abortion. When adopting a lifecycle approach to maternal health which emphasizes on prevention of morbidity and mortality, early intervention, and overall wellbeing at every stage of life, access to contraception and safe abortion also form important aspects of maternal health albeit not falling within the purview of the definition by the World Health Organization.

## 1. An overview of global maternal health policies

In the 1960s, as mortality rates declined around the world, researchers and policymakers came to the conclusion that expanding family planning programmes and lowering fertility rates was the only solution to prevent population growth from outstripping natural resources, thus leading to famine and societal collapse.

In their influential paper titled *Maternal Mortality: A Neglected Tragedy. Where is the M in MCH?,* Rosenfield & Maine (1985) argued that despite increasing attention to maternal and child health programs most did little to reduce maternal mortality. Prior to the ICPD, the conference on Safe Motherhood held in Nairobi, Kenya in 1987 discussed the beginning of a safe motherhood initiative to reduce maternal mortality by 50% by the year 2000.

The International Conference on Population and Development (ICPD) held in Cairo, Egypt, in September 1994 is considered the turning point for women’s reproductive health and rights to take centre stage in national and global development efforts. The ICPD led Programme of Action created a shift from a narrow focus on population and fertility reduction to a broadened agenda addressing the range of sexual and reproductive health issues that constitute the individual lives of men and women (UNFPA, 2019). Sexual and reproductive health and rights were defined to include services and information relating to, for example, family planning, prevention and treatment of HIV and other sexually transmitted diseases, safe abortion, and safe pregnancy, all to be provided in a rights-based approach without coercion, discrimination, or violence (UNFPA, 2019).

In the year 2000, the Millennium Development Goals (MDG), which were eight global development objectives, were ratified by governments of 189 countries of the world; the fifth MDG contained the aim to improve the healthcare of mothers (United Nations, 2000). However, the MDG set maternal mortality as the indicator for assessing maternal health. Through this global decision, the discourse of maternal health hence recidivated to a target-based one, similar to what was extant in the era before the ICPD. Evaluations of the MDG Goal 5 found that whereas there had been important progress in identifying interventions to reduce maternal mortality, gaps remained. The greatest challenge lay in providing equitable access to life-saving interventions at the community level (Bryce et al., 2013). In especially low-income countries, coverage was lowest among the socioeconomically weakest women and families (Bryce et al., 2013).

Following the end of the term of the MDG, Sustainable Development Goals (SDG) adopted by the United Nations General Assembly in September 2015 laid down 17 developmental goals to be achieved by the year 2030. Goal 3 of the SDG aims to “ensure healthy lives and promote well-being for all at all ages”. Target 3.1 of SDG 3 specifically aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births. There are two major indicators for measuring this target, viz.: (i) maternal mortality ratio (MMR), i.e., the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births; and (ii) percentage of births attended by trained personnel.

With regard to these SDG targets, some researchers have pointed out the need to measure and monitor maternal health beyond mortality. Maternal mortality accounts for only a part of the overall burden of poor maternal health; maternal morbidity, i.e., the health problems borne by women during pregnancy, childbirth and the postpartum period contribute much to this burden, and yet, the true extent of maternal morbidity is unknown owing to lack of a common definition and identification criteria, standardized assessment tools especially at primary health care level, and common indicators to measure morbidity (Chou et al., 2016). Furthermore, these indicators of maternal health overlook the quality of maternal healthcare provided to the woman.

The Human Rights Council in the year 2013 recognized that applying a human rights-based approach to the reduction of maternal mortality and morbidity was the key to making meaningful progress in the area (UN Human Rights Office of High Commissioner, 2013). The human-rights based approach placed responsibility on the State for ensuring available, accessible, acceptable and quality facilities, goods and services to address barriers to maternal health; for example, delays in seeking care are treated not as idiosyncratic, personal choices or immutable cultural preferences, but as human rights failures which are affected by the inequitable and discriminatory distribution of health-care facilities which makes emergency obstetric care both unavailable and physically inaccessible (UN Human Rights Office of High Commissioner, 2014).

However, studies suggest that there is a long way to go before maternal health becomes a reality for women globally. For example, a study by Toppo et al. (2019) exploring maternal mortality in of Madhya Pradesh, India using a human rights lens found that poor antenatal care and lack of human resources posed major reasons for death in all facilities. The study found various violations of human rights of women, such as: failure to be given treatment for profuse bleeding leading to death of the mother, not being issued a death certificate by district hospital authorities to avoid blame, and women referred from one health facility to another and being neglected by the healthcare providers (Toppo et al., 2019).

### 1.1. The global discourse on “skilled birth attendance”

Between the 1970s and 1990s, the World Health Organization promoted traditional birth attendant (TBA) training as one strategy to reduce maternal and neonatal mortality. This movement can be said to have begun at the 1937 Inter-Governmental Conference of Far-Eastern countries, Bangkok, which called for the integration of TBA into rural health programmes. By 1952, the United Nations Children's Fund (UNICEF) began to supply trained TBAs with delivery-kits. These initiatives were taken to improve perinatal healthcare.

Nearly 20 years later, the UNICEF and WHO sponsored a technical consultation on TBA training owing to the growing interest in primary healthcare and the role of traditional healthcare. By the time of the 1978 Alma Ata Declaration, the WHO was fully in support of training TBAs to extend the reach of primary healthcare services. The WHO actively promoted the training and recognition of TBAs throughout the 70s and 80s. In 1972, 24 countries had some form of TBA training and by 1982, fifty-two countries were providing training programs for TBA. In 1982, WHO was confident that with stronger and expanded programmes, trained health workers (which included TBAs) would attend two-thirds of births by 1989 (Kruske & Barclay, 2004).

However, with the global advent of Safe Motherhood initiative (WHO, 1998) launched at the Nairobi Safe Motherhood Conference in 1987, which put its thrust on “safe deliveries” to reduce maternal mortality, the “non-medical or scientifically not proven” approach of TBA was relegated. Policy makers assumed that practical difficulties such as poor literacy and lack of “scientific knowledge” was preventing trained TBA from effectively lowering the MMR in countries that had invested in TBA training (Kruske & Barclay, 2004). This assumption appears to have led to the 1992 Joint WHO/UNFPA/MCH statement that declared TBA training and use be considered only an interim measure until ‘all women and children have access to acceptable, professional, modern health services’. The traditional birth attendant came to be defined as “a person who assists the mother during childbirth and who initially acquires skills by delivering babies herself or through an apprenticeship to other TBA” (World Health Organization et al., 1992).

In this period, skilled birth attendants (SBA) gained the forefront. WHO defined a skilled birth attendant as: *an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns* (WHO, 2004). Though TBA provide essential maternal and infant health care services during delivery and ongoing community care in developing countries, this policy shift in the 1990s which excluded TBA from the pool of skilled birth attendants led to many donor agencies funding TBA training programmes redirecting funds to providing skilled attendants during delivery (Saravanan et al., 2011). Today, the global thrust lies on skilled birth attendance which is to be provided by trained medical professionals such as nurses and doctors – the role of TBA in carrying out deliveries has been increasingly seen as irrelevant or ineffective. This is in spite of the fact that in countries like India, TBA, also known as *dais* play a vital role during childbirth, especially in rural and low-resource settings – they not only carry out the delivery, but also provide emotional support and comfort to the woman in labour (Gutschow et al., 2020).

## 2. A brief historical perspective of maternal health policies in India

At independence from colonial rule (1947), India inherited a health system marred by inequity and poor coverage. Hence, maternal and child health (MCH) services were planned to be expanded through training of doctors, nurses and midwives. However, little progress was made in real terms; and poor infrastructure and shortage of human resources emerged as prime concerns (Ministry of Health Government of India, 1961). Maternal health was generally viewed under the umbrella of child health programmes.

During the mid-1970s in India, immunization of children received high priority. However, in keeping with the global shift of attention towards maternal health (viz. the Nairobi Conference of 1987), by 1992, the immunization programme in India evolved into the national Child Survival and Safe Motherhood Programme (CSSM) programme. It was designed to provide both child survival (e.g., immunization, diarrhoea, and acute respiratory infection control), and safe motherhood services (e.g., setting up first referral units, tetanus immunization, prevention of anaemia, antenatal care, delivery by trained personnel, etc.) through the primary healthcare system in India. Of its eight goals, one was for maternal health, viz. reduction of maternal mortality from 4 to 2 per 1,000 livebirths. Although the package specified care at birth as a service, the workplan of ANM at the sub-centre did not specify conducting deliveries in the list of critical activities (Vora, 2009). This was consonant with the global policy in the early years of the Safe Motherhood Initiative, wherein many programmes focused exclusively on a single component such as training traditional birth attendants or providing antenatal care. It was only in 1997 at the Sri Lanka Safe Motherhood Conference that a consensus emerged that making motherhood safer required a wide range of interventions comprising health care for women throughout pregnancy and delivery, and including access to skilled medical care for complications (AbouZahr, 2003).

Following the International Conference on Population and Development in 1994, the Indian Government started the process of re-orienting the family-planning and MCH programmes into a novel one: the Reproductive and Child Health-I (RCH-I) (Ministry of Health and Family Welfare India, 2015). The RCH-I programme added further interventions to those of the CSSM, including treatment of reproductive tract infections, sexually transmitted diseases, establishment of blood-storage units, referral transport, access to safe abortion, and additional nursing staff for the PHC for round-the-clock maternal health services.

These new efforts however were added without increasing human resources in management at the central or lower levels (Vora, 2009). Moreover, the programme was fraught with challenges such as inadequate linkages between components such as family planning, maternal health, and child health, lack of availability of specialist like anaesthetists and obstetricians, and haphazard implementation, e.g., unequal staffing and funding among different villages (Ministry of Health and Family Welfare India, 2005).

In 2005, with the assistance of World Bank and other donors, the RCH-II programme was started as a follow-on to the RCH-I programme and placed under a new government initiative – the National Rural Health Mission (NRHM). Under the NRHM, the main strategy of the Government for reduction in maternal mortality focused on institutional deliveries, rather than focusing on providing equitable access to quality emergency obstetric care. One of the important components of the NHRM was the ‘Janani Suraksha Yojana’ (JSY), a cash-transfer programme, which provided financial support to enable women from lower socio-economic groups to give birth in a health facility (Government of India, 2005).

### 2.1. The role of *dais* and auxiliary nurse midwives

In keeping with the global discourse that skilled birth attendants were more effective at lowering the MMR than TBA like *dais*, the training of TBA was eventually discontinued. With the foundation of the National Rural Health Mission (NRHM) in 2005, improved primary health care gradually became more accessible to the majority of Indians who live in rural areas, and from this increased accessibility to hospitals came a trend of increased institutional deliveries. Hence, while the traditional *dais* were ignored, concurrently, women and ASHA workers (Accredited Social Health Activist) were monetarily incentivized for every institutional birth. The popular international discourse led to the RCH-II Programme excluding *dais* completely as skilled birth attendants. This subsequent marginalization of dais included not only encouraging women monetarily to avoid their services, but more importantly included a gradual halt of the TBA training program and provision of TBA kits (Kruske & Barclay, 2004). There is however evidence to show that women, especially from rural and underserved areas prefer availing the services of TBA during childbirth owing to the traditional and long-standing bond they share with them (Sang, 2017). Studies dating as far back as 1994 have found women hailing from lower socioeconomic groups or backward castes in the society face discrimination and disrespect at the hands of healthcare providers when they approach health facilities for childbirth services (Ram, 1994) – a finding which holds true even today (elaborated upon in a latter section). Traditional birth attendants provide a stark contrast to this treatment, who not only carry out the delivery but also provide emotional and physical comfort to the woman in pain. Owing to the TBA hailing from the same community, women share a special level of comfort and trust with them, which is absent when availing of institutional childbirths (Sang, 2017).

The auxiliary nurse midwife or ANM, is a village-level female health worker in India who is known as the first contact person between healthcare services and the community. The ANM cadre was created in the 1950s to focus on basic maternal health including midwifery and child health within the first two years of life (Malik, 2009). At the time the ANM program was launched, ANM received two years of training on maternal and child health, with midwifery being the focus of nine out of the 24 months of training. However, by 1975, following the recommendations by the Kartar Singh Committee (1974) ANM became designated as “multipurpose workers” that were required to provide child health services and primary curative care to the communities which included family planning, immunization, sanitation, and infectious disease control, among others. These changes in roles and responsibilities of ANM were further compounded by changes in the duration of ANM training from two years to 18 months, with a reduction in the midwifery component since 1977 (Pyone et al., 2019). During 1980s and 1990s, the stress on family planning and immunization alienated ANM from maternal and child health, deskilling her and converting her into a multipurpose worker (Sheikh & George, 2010). In the present day, there is little clarity among ANM about their role within the health system; their time is not utilized effectively, with most of their time being spent on record-keeping activities (Bhombe, 2019).

## 3. Maternal health policies in India today

The Government of India adopted the Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A) framework in 2013, which essentially aims to address the major causes of mortality and morbidity among women and children. The National Health Policy of 2017 also endorses the same framework for addressing maternal health.

The major government flagship programmes under this framework are Janani Suraksha Yojana (2005) and the Janani Shishu Suraksha Karyakram (2011). Under Janani Suraksha Yojana (JSY), eligible pregnant women are entitled to get JSY benefit directly into their bank accounts. ASHA workers, too, get a cash incentive for facilitating the pregnant women to avail a facility-based childbirth.

In 2011, an evaluation of the JSY was conducted by the National Health Systems Resource Centre (NHSRC). The evaluation revealed that whereas the JSY had clearly increased the number of institutional deliveries, around 40% of the women delivered at home; the chief reason for this was cited as inability to afford transport costs to the health facility. Further, poor quality service and high out-of-pocket expenditures in institutions were also reported as deterrents to institutional delivery.

In order to address these issues emerging from the JSY evaluation, the Janani Shishu Suraksha Karyakram (JSSK) was launched in 2011. JSSK entitles all pregnant women delivering in public health institutions to free deliveries including Caesarean sections. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home.

In 2016 and 2019, the government launched the Pradhan Mantri Surakshit Matritva Abhiyan and the Surakshit Matritva Aashwasan schemes respectively. The former aims to provide comprehensive antenatal care to all pregnant women (in 2nd and 3rd trimester) on the 9th of every month detect and high-risk pregnancies in a timely manner. The latter aims to provide dignified, respectful and quality healthcare, at no cost and zero tolerance for denial of services.

Whereas the initial thrust on institutional childbirths did lead to an increase in the rate of facility-based childbirths, it did not lead to any significant reduction in the MMR owing to the poor quality of intra-partum care (Randive et al., 2013). The Indian government hence also launched training programmes with regard to maternal health so as to improve the quality of clinical care provided. The Dakshata Programme was introduced in 2015 to strengthen the competency of the providers of the labour room through skill-based trainings, and to improve the availability of essential supplies and commodities in the labour room and the postpartum wards. The LaQshya Labour Room Quality Improvement Initiative was launched in 2018 with the aim of strengthening key processes related to the labour rooms and maternity operation theatres and improving the quality of care around birth by organizing the infrastructure and protocol of labour rooms and maternity operation theatres.

In 2018, the Government of India introduced the concept of midwifery services throughout the country. The Midwifery services initiatives aims to create a cadre for Nurse Practitioners in Midwifery who are skilled in accordance to ICM competencies, knowledge and capable of providing compassionate women-centric pregnancy care. Currently, this programme has been piloted in Telangana where the training programme has been completed (Kumar, 2019). The project has been developed as a public-private partnership. Telangana has created 126 new posts for midwives and offers an additional Rs 15,000 as salary to nurses who complete the 18-month training (one year of combined classroom/hands-on training and a six months of clinical internship). This is seen as the initiation of a “midwifery-led” model of childbirth in the country. Whereas this program is still in its inception stage, it raises concerns about overburdening the already overworked nursing staff in the country and altogether ignoring the roles of TBA and ANM in childbirth care.

The key strategy of the Indian Government today to address maternal health hence revolves around institutionalizing childbirths – this approach hence encompasses the aspects of incentivizing facility-births, skills training medical and nursing professionals, and providing of free services. It once again takes into account a narrow definition of maternal health, i.e., measuring the same through maternal mortality rates. It fails to take aspects of quality of care into its ambit. In its pursuit to optimize institutional births, it focuses on training the nursing staff as midwives, ignoring the already prevalent acute shortage of nursing staff in the country. Moreover, it ignores the role of the ANM and traditional birth attendants (TBA), who have been supporting women during childbirth especially in areas which are not well-resourced.

## 4. How effective are the present maternal health policies in India?

As outlined in the previous section, the RMNCH+A programme is currently in operation today. Even though the framework envisages addressing reproductive, maternal and child health in association with one another, and aims to adopt a life cycle view of the health status of the population, it nevertheless aims to maternal health by solely decreasing maternal mortality – for which it puts its thrust on institutionalizing childbirths.

### 4.1. Increase in institutional childbirths: the purported advancement in maternal health

Many studies have concluded that the introduction of the JSY scheme has been followed by an increase in institutional deliveries. For example, Khan and colleagues (2010) found that in 2010, the percentage of women delivering in an institution had risen to 44, from 17% and 23% in NFHS-3 (2005-06) and DLHS-3 (2007-08) respectively; these percentages were 7 and 11 for the NFHS-1 (1992-93) and NFHS-2 (1998-99) respectively. The study by Lim et al. (2010) which evaluated the impact on increase in births in health facilities too found that JSY had a significant effect on increasing antenatal care and in-facility births. However, this influential study also pointed out that the implementation of JSY in 2007-08 was highly variable by state, from less than 5% to 44% of women giving birth receiving cash payments from JSY; the poorest and least educated women did not always have the highest odds of receiving JSY payments (Lim et al., 2010). The study concluded that there was a need for improved targeting of the poorest women and attention to quality of obstetric care in health facilities. Moreover, the study conducted by Randive et al. (2013) found that whereas JSY had succeeded in raising institutional births significantly, no significant association between institutional birth proportion and MMR was detected. The study concluded that high institutional birth proportions of themselves were inadequate to reduce MMR, and other factors including improved quality of care at institutions were required for the intended effect (Randive et al., 2013).

### 4.2. Maternal health schemes and financial burden of childbirth

The JSY has been in operation since the year 2005. Several studies have been conducted to evaluate the effectiveness of the scheme in reducing childbirth-related costs. Sidney and colleagues in their 2016 study conducted in the state of Madhya Pradesh found that 91% of 2172 women reported out-of-pocket expenditures (OOPE) despite the JSY scheme; women who had had a caesarean section had incurred more than 6 times the OOPE incurred by women who had had a vaginal delivery. Moreover, among the women who delivered in a JSY public facility, only a quarter received the cash incentive upon discharge, whereas the remaining were told to come back to receive the money (Sidney et al., 2016). Govil et al. (2016) too found that the JSY covered only 77% of the cost for normal delivery and 23% of the cost of complicated delivery; these figures are higher than those derived by Gopalan & Varatharajan (2012), who found that JSY could cover only 25.5% of the maternal healthcare cost of the beneficiaries in rural areas and 14.3% in urban areas of Rajasthan. Women have reported incurring OOPE chiefly on medicines, followed by sonography and tests, and transportation (Sidney et al., 2016). Goel et al. (2016) found that sub-optimal incentives, delayed payments to women, problems in arranging for a residence proof and extensive administrative paper work contributed to decreased uptake of the JSY scheme in Chandigarh.

Evaluations of the JSSK scheme – which was introduced to off-set the shortcomings of the JSY – also revealed similar results. Issac et al. (2016) in their study conducted in Uttar Pradesh found that women paid almost half of their mandated cash incentives to obtain delivery care. Along similar lines, the survey conducted Sharma & Bothra (2016) of women who had availed benefits under the JSSK revealed that even under the JSSK, beneficiaries incurred substantial out-of-pocket expenditure on services. Studies evaluating the JSSK have had a common underlying finding, that of lack of awareness among women about the JSSK scheme and free childbirth-related healthcare in public health facilities (Mondal et al., 2015; Issac et al., 2016; Sharma & Bothra, 2016).

### 4.3. Health system barriers: Why do women not want to deliver government health facilities?

There is much evidence about the poor treatment receive women receive at the hands of healthcare providers when they visit public health facilities for maternal health services in India. Ansari & Yeravdekar (2020) in their systematic review and meta-analysis of respectful maternity care during childbirth in India found that the overall prevalence of disrespectful maternity care was 71.31%, ranging from ranged from 20.9% to 100% among individual studies. This disrespect comprised various forms of ill-treatment such as physical and verbal abuse, denial of confidentiality and privacy, demand for informal payments, and lack of basic infrastructure, hygiene, and sanitation.

The study conducted by Khan et al. (2010) to assess the impact of Janani Suraksha Yojana in rural Uttar Pradesh found that more than half (56%) of women had experienced abusive practices such as being administered fundal pressure to hasten the delivery. Further, after childbirth, 9% of the women were moved to cots without mattresses, 6% to the corridors, and 6% to the floors (Khan et al., 2010).

Chaturvedi and colleagues in their 2015 study carried out in Madhya Pradesh explored whether the JSY ensured skilled birth attendance. They found that the delivery rooms were generally poorly maintained with regard to staffing, infrastructure, equipment and supplies, and cleanliness. The hospital staff did not provide skilled care routinely, e.g., monitoring was limited to assessment of cervical dilatation. The attendants took labouring women to the delivery room based on their judgements of increased severity of contractions, and hence owing to an absence of professional monitoring of progress of labour, deliveries often occurred unanticipated leading to chaotic situations around the time of delivery. This study too found that hospital staff threatened, abused, or ignored women at the time of delivery (Chaturvedi et al., 2015).

The first referral units or community centres are often found lacking requisite expertise and facilities in terms of competent staff or specialists, equipment, and supplies. This lack of services often results in a high number of referrals of women with an obstetric emergency that in turn led to further delay in receiving appropriate care (Yadav & Kesarwani, 2016; Mahapatro, 2013). These referrals are often unassisted, and the responsibility for arranging vehicles rests with the families who then spend a significant amount of time and money in arranging a vehicle for the travel and the treatment costs at health facilities, which are often at great distances (Nair et al., 2012). Health professionals have also been reported as not adhering to standard protocols while providing obstetric care or referrals (Hamal et al., 2020). Studies have also highlighted cases of referrals when the women were not even stabilized or given any first aid before referrals (Tey & Lai, 2013).

### 4.4. State of midwifery in India

Currently, India does not have a cadre of midwives educated to international standards (McFadden et al., 2020). There exists a lack of national standards for midwifery education and accreditation systems to monitor the quality of education (Sharma et al., 2015). Maternity services are provided by obstetricians, general physicians, and staff nurses in hospitals in India. The midwifery scope of practice of staff nurses is not clearly defined but “circumstance driven,” depending on several factors; one of these factors being the availability of doctors (Sharma et al., 2013). The Government of India launched the Guidelines on Midwifery Services in December 2018 with the aim of creating a cohort of Nurse Practitioners in Midwifery, capable of providing positive birth experiences to women by promoting physiological birth (thus reducing over-medicalization), providing respectful maternity care, and decongesting higher-level health facilities by providing services in midwife-led care units. This initiative, however, fails to take into the account the severe shortage of nursing professionals in the country (Saikia, 2018). It hence overburdens the already overworked nurses who have to take on multiple roles within the hospital, including that of a doctor in case of the absence of one. Moreover, this model ignores the role of the traditional birth attendants who have been assisting in deliveries especially in rural and under-resourced areas of the country. It also overlooks the potential contributions of auxiliary nurse midwives, who ae already grappling with unclear roles within the hospital (UNFPA, 2021; Bhombe, 2019), and can be trained to provide midwifery services instead of nurses as laid down by these guidelines.

## 5. Inequalities in the utilisation of maternal healthcare: Who are most overlooked by the maternal health policies?

Lim and colleagues in their 2010 evaluation of the JSY carried out through nationwide district-level household surveys conducted in 2002-04 and 2007-09 had emphasised the need for improved targeting of the poorest women by maternal health schemes. These findings hold true till the present date. Studies have consistently found inequities in maternal healthcare uptake based on socioeconomic status and caste. Mishra et al. in their 2021 paper exploring socio-economic inequity in access to JSY benefits using NFHS data found that even a decade after its inception, its national coverage stood at 36.4% in 2015-16. The national share of women belonging to the scheduled castes (SC) and scheduled tribes (ST) was lower (at 38%) than that of non-SC and ST women (at 62%). The JSY is also seen to favour wealthier groups, with poorer women having lesser access to JSY cash benefits (Thongkong et al., 2017).

Randive et al. (2014) in their study exploring inequalities in institutional delivery uptake and maternal mortality reduction in the context of JSY in nine Indian states found that compared to the richest division in nine states, the poorest division had 135 more maternal deaths per 100,000 live births in 2010. While MMR had decreased in all areas since JSY, it had declined four times faster in richest areas compared to the poorest, resulting in increased inequalities (Randive et al., 2014).

Studies which have explored maternal healthcare uptake based on the parameters of full antenatal care (full ANC), skilled attendants at birth (SBA), and postnatal care (PNC) have found that factors such as economic status, religion and caste play an important role in promoting inequalities in the utilization of these services. Women belonging to religious minorities, scheduled castes, scheduled castes, other backward castes, women with lower education levels, and non-exposure to mass media were less likely to utilize these maternal healthcare services (Ali & Chauhan, 2020). Furthermore, rural residence is consistently associated with a low use of maternal health services in India, while urban residence is associated with high use (Hamal et al., 2020).

## 6. Other issues related to maternal health: Access to safe abortion and contraception in India

### 6.1. Access to safe abortion in India

India was a pioneer in legalising induced abortion under the Medical Termination of Pregnancy (MTP) Act of 1971 (Medical Termination of Pregnancy Act, 1971). Under the Act a woman can legally have an abortion upto 20 weeks of pregnancy. In 2021, the MTP Amendment Act 2021 was passed with certain amendments in the MTP Act including: all women (i.e., including unmarried women) being allowed to seek safe abortion services on grounds of contraceptive failure, and increase in gestation limit to 24 weeks for special categories of women (Ministry of Law and Justice of India, 2021).

In spite of the passing of these liberal laws, access to abortion in India is fraught with challenges, leading to high rates of morbidity and mortality in pregnant women (Nazir, 2021). There are inadequate numbers of safe abortion facilities within reach of the majority of poor women in both rural and urban areas, as well as a dearth of medically approved abortion providers and registered facilities; post-abortion counselling and services are inadequate; unsafe abortion is often not perceived as a women’s health issue; and there are trends in some parts of the country towards sex-selective abortion.

Moreover, two other Indian laws have inadvertently led to restrictions on abortion access. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) (PCPNDT) Act, which forbids ultrasound for purposes of sex determination and has led to restrictions on all second-trimester abortion provision. The PCPNDT seeks to regulate technologies with the aim of preventing sex selection, a practice rampant in India. However, a vast majority of women wish to undergo abortion for reasons other than for sex selection. The misplaced positioning of sex selection versus access to abortion immensely harms women’s physical and emotional health whereby they are either forced to continue unintended pregnancies or have little choice but to access abortion in unsafe conditions that pose grave danger to their health and well-being (Nadimpally et al., 2017).

The Protection of Children from Sexual Offences (POCSO) Act requires reporting of underage sex, so that minors who become pregnant cannot feel safe if they seek an abortion. The POCSO Act criminalises sexual activity (including consensual) among individuals below 18 years of age, and makes reporting mandatory for healthcare providers, curtailing girls’ access to safe abortion (Nadimpally et al., 2017). Hence, through the Rashtriya Kishor Swasthya Karyakram (RKSK) programme aims to improve the sexual and reproductive health of adolescents, it does not take into purview this aspect, hence being unable to wholly fulfil its aim of providing comprehensive services to adolescents including access to safe abortions and contraceptives.

### 6.2. Access to contraception in India

In India, access to contraception is conflated with family planning. According to the National Health Survey 2019-21, the need for contraception stands at 9.4% and the use of modern contraceptive methods stands at 56.5% (IIPS & ICF, 2021). The overall contraceptive prevalence rate (CPR) was 66.7% of currently married women aged 15-49. Female sterilization was the most commonly used contraceptive form. Among currently married women aged 15-49, 37.9% used female sterilization, followed by male condoms (9.5%) and pills (5.1%); 6% used a traditional method, mostly the rhythm method.

Public facilities offer predominantly permanent contraceptive methods whereas other modern spacing methods can only be obtained through private facilities; presenting compounded financial, social, and geographic barriers for the majority of women (Mewa, 2020). There also exist vast socioeconomic disparities in contraceptive access and use. A study on knowledge and contraception practices in women belonging to the low socio-economic strata in Delhi by Pandey et al. (2017) found that among 272 women attending a family planning clinic at a Delhi municipal corporation hospital, of whom 22.1% were illiterate, 47.8% were ignorant of contraception. Only 38.3% women were aware of emergency contraception. The main reasons cited for not using contraception was desire for male child (24.6%), fear of side effects (20%), desire for another child (20%), opposition from family members (15.4%), inaccessibility (4.6%) and inconvenience and lack of confidentiality (5.4%).

## 7. Discussion and conclusions

In 2016, the White Ribbon Alliance asked more than 143,500 women about their one “ask” to improve the quality of reproductive and maternal health. Five key areas emerged out of the women’s narratives viz.: (i) access to maternal health entitlements (including supplies and services), (ii) dignity and respectful care, (iii) availability of health providers, (iv) clean and hygienic health facilities, and (v) display of information on entitlements, schemes and services. When the current maternal health policies and schemes and their implementation are compared with these expectations voiced by women, they are found lacking in various respects.

Maternal mortality remains the key indicator for measuring maternal health in India. Merely incentivizing institutional births does not completely address maternal mortality and neither does it solve the problem of poor quality of maternal healthcare. There is an urgent need to strengthen emergency obstetric services along with the thrust on institutional deliveries if maternal deaths are to be stemmed.

Moreover, there is ample evidence to suggest that the very populations these maternal health benefit schemes aim to target are the same populations which are missed; women who hail from the most socioeconomically disadvantaged sections of the country are the ones who most require the financial support for childbirth services, but are the ones who lack access to the same. Maternal health cannot be addressed without taking into consideration the effects of poverty, caste, education, and other socioeconomic factors. As time and again pointed out by researcher, there must be concerted efforts made to reach the most vulnerable segments of the population.

The policies focus on training medical and nursing staff to be better skilled at childbirth care. However, the policies completely ignore the role of the auxiliary nurse midwives in carrying out deliveries. Moreover, they completely overlook the contributions of traditional birth attendants, who have been carrying out childbirths in especially rural and under-resourced areas. This aspect is especially significant in the context of acute shortage of nursing staff in the country. There hence must be an endeavour for capacity-building of these traditional birth attendants and auxiliary nurse midwives so as to reduce the burden on the already overworked nursing staff, and also hence add to the workforce. Moreover, there must be a clear enunciation of their roles and responsibilities so that their time and skills may be utilized effectively.

Women have voiced the need for receiving respectful and dignified healthcare when availing of childbirth services from public health facilities, and there is much evidence to show the disrespect and mistreatment women face at the hands of healthcare providers while availing of maternal health services. There is hence a need to broaden the indicators used to measure maternal health, which must also include the quality of care provided and women’s satisfaction with the same.

The present maternal health policies appear to work only at generating a demand for facility-based services without strengthening the quality and delivery of these services. Moreover, the policies are in effect, distancing women from environments familiar and comfortable to them (e.g., delivering wit the support of TBA), and placing them in health facility settings which they perceive as cold, distant and hostile. Policy makers should be cognizant of how policies unfold on the ground, which must be coupled with effective monitoring of implementation and measurement of progress.

### 7.1. The way forward: Discourse building around women-centred maternal health care

The current state of maternal healthcare in India and the prevailing policy scenario begs the following questions: *What is women-centred maternal healthcare? Do current maternal health policies and programmes provide for women-centred maternal healthcare? Do they meet the maternal health needs of women? What changes would be required to make maternal health policy and programmes women-centred?*

There is hence a need to understand what is it that women desire and expect out of maternal health services. This may be explored through consultations with women, grassroots organizations working with women, and also experts working in advancing maternal health in the country. This must include rural and urban women in different regions of the country, and must comprise groups of women facing different issues of marginalization such as women living with disability, women living with HIV, Dalit women, and tribal women.

Consultations can be held with experts from the field of medicine, public health, sexual and reproductive health, and community level practitioners, so as to gain their inputs on into building a technically sound, women-centred framework for maternal health care, exploring the questions put forth above.

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