Woman-centred Maternal Health Care

What does it mean and how can it be achieved –

A position paper based on women's voices

Authors:

Subha Sri B, Renu Khanna, TK Sundari Ravindran, Sanjeeta Gawri, Swati Shinde

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Contact email ID: cmnhsa@gmail.com

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Executive summary

For several decades, countries worldwide, including India, have worked to ensure the availability of safe maternal and child health services. However, their focus has been on efficient technical/clinical interventions such as emergency obstetric care. Social determinants, and especially gender discrimination, even when acknowledged, are only tangentially addressed and rarely translated into interventions.

Feminist critiques of the medicalisation of childbirth and professional control over the childbirth process led to the emergence of the concept of 'woman-centred' maternal health care. Woman-centred care is also a cornerstone of good midwifery practice and in initiatives for 'Respectful Maternity Care'. However, even after three decades since woman-centred maternal healthcare was acknowledged as a policy priority, the definitions of woman-centred maternal healthcare have often been informed by the perspectives of health professionals and experts and seldom by the perspectives of women, especially those from the most marginalised groups, who are most affected by policies and programs.

This paper draws from a study conducted by CommonHealth and its partners that set out to develop a discourse on woman-centred maternal health care and its different components by listening to and foregrounding the voices of women, especially those from disadvantaged and vulnerable communities.

What does it mean to put women at the centre of maternal health care?

The principles of woman-centred maternal health care

Woman-Centred Maternal Health care is based on a set of principles listed below. We believe that 'woman-centeredness' has to be applied ***not only to women receivers of services but also providers of services.***

1) *Human Rights Based Approach*
2) *Positive pregnancy experience*
3) *Midwifery philosophy*
4) *Respect and Dignity of Women Healthcare Providers*
5) *Gender Power Relations and an Intersectional Analysis*

Key human rights principles that should underlie maternal health care

1. Right to non-discrimination and equality in maternal health information and services
2. Right to availability of maternal health information and services
3. Right to accessibility of maternal health information and services
4. Right to acceptability of maternal health information and services
5. Right to quality of maternal health information and services
6. Right to informed decision-making in maternal health information and services
7. Right to privacy and confidentiality of maternal health information and services
8. Right to participation in maternal health information and services
9. Right to accountability of maternal health information and services
10. Right to life and right to health
11. Right to freedom from harm and ill-treatment and right to respect and dignity
12. Right to the benefits of scientific progress

The components of woman-centred maternal health care

We detail below the different components that need to be in place in order to operationalize the principles mentioned above.

1) Technical quality of care

2) Care with respect and dignity

3) Continuum of care

4) Enabling environment at home and in the community

5) Enabling health system environment

How do we move toward woman-centred maternal health care in the Indian setting?

We focus here on some high level and overarching areas that need to be addressed in order to move towards woman-centred maternal health care.

1) *Reorienting the health system to a human rights-based focus*
2) *Higher allocation of public funds for health system strengthening*
3) *Participation and accountability for woman-centredness*
4) *Addressing gender as a determinant*
5) *Addressing social determinants*
6) *Addressing health care providers' needs*

What would be indicators to measure progress?

We list in the paper a few indicators, including at family and community level and at health system level, that can be used to measure progress and to check if maternal health care is woman-centred.

Background

For several decades, countries all over the world have made efforts to make safe maternal and child health services available. However, as famously questioned by Rosenfield and Maine in "Where is the M in MCH?", these programmes focused largely on the child at the expense of the woman[1]. It was not until the launch of the Safe Motherhood Initiative in Nairobi in 1987 that a global maternal health policy was articulated and prioritised[2]. Reduction of maternal mortality was featured as one of the Millennium Development Goals. It has also been included as a target (3.1) for Sustainable Development Goal 3 to ensure healthy lives and promote well-being for all ages [3] [4].

In India, in keeping with the global shift of attention towards maternal health (viz. the Nairobi Conference of 1987), by 1992, the immunization programme evolved into the national Child Survival and Safe Motherhood Programme (CSSM) programme[5]. Of its eight goals, one was for maternal health, viz. reduction of maternal mortality from 4 to 2 per 1,000 [6]. 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, 2015) [7].

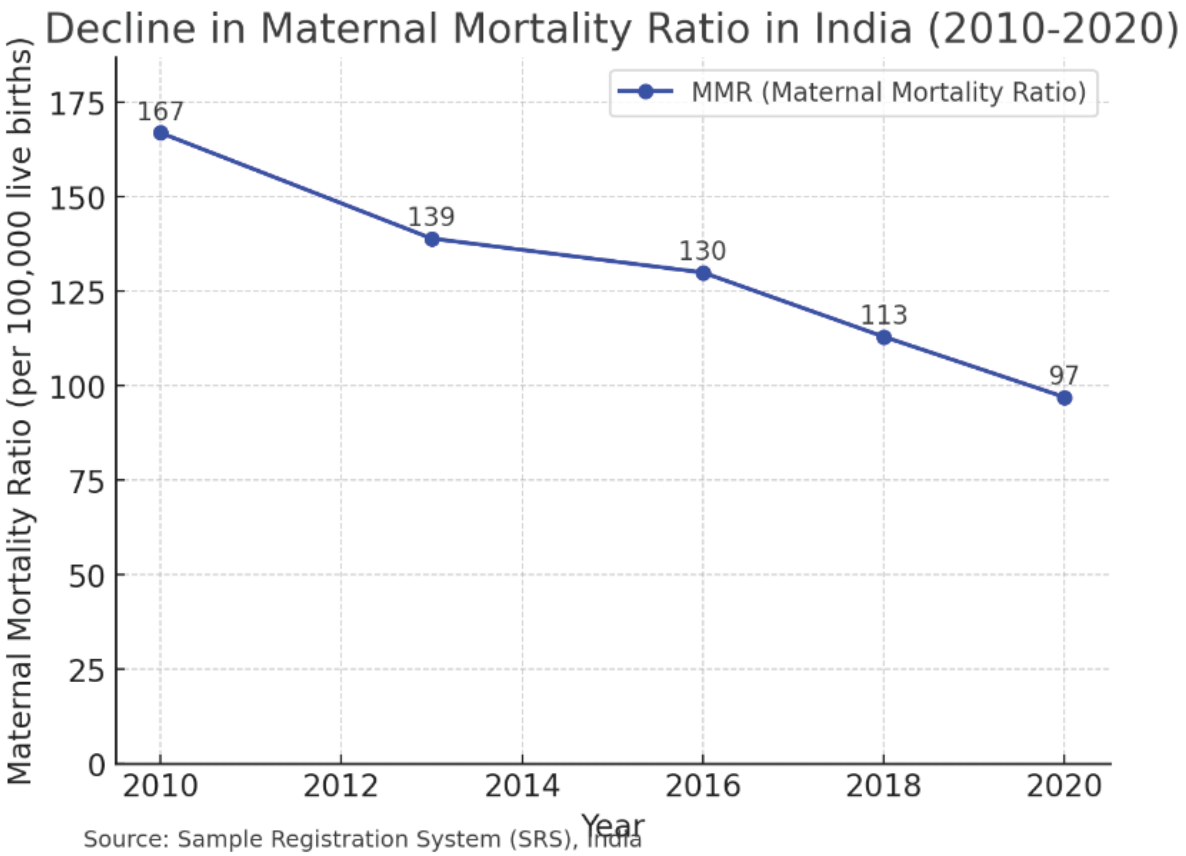
In 2005, with the assistance of World Bank and other donors, the concept of a Skilled Birth Attendant (SBA) was mooted as per WHO recommendations and key aspects of Emergency Obstetric Care were included in training provided to Auxiliary Nurse Midwives (ANM), Primary Health Centre (PHC) based staff nurses and medical officers. This was part of the RCH-II programme, started as a follow-on to the RCH-I programme and placed under a new government initiative – the National Rural Health Mission (NRHM, later the National Health Mission, NHM) [8].

Under the NRHM, the main strategy of the Government for reduction in maternal mortality focused on institutionalizing births through the Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) [9][10] programmes, rather than focusing on providing equitable access to quality emergency obstetric care. Alongside, the simultaneous shift in policy of converting community midwives (ANMs) to multi-purpose health workers with responsibilities for several national programmes had a lasting negative impact on home based maternity services [11]. The active discouragement of Traditional Birth Attendants (TBAs/dais) also left a vacuum in maternal services that the Accredited Social Health Activist (ASHA) could not fill [12][13][14][15].

The Government of India adopted the Reproductive, Maternal, Newborn, 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 [16]. The National Health Policy of 2017 also endorses the same framework for addressing maternal health [17] In 2016, the government launched the Pradhan

Mantri Surakshit Matritva Abhiyan [18] to provide comprehensive antenatal care to all pregnant women and in 2019, the Surakshit Matritva Aashwasan (SUMAN)[19] scheme to provide dignified, respectful and quality healthcare at no cost.

Figure 1: Maternal Mortality in India (2010-2020)



With wide interstate variation and evidence pointing to increasing institutional births not contributing to a commensurate reduction in maternal mortality[20], more recent programmes have focused on improving quality of care in health facilities. The Dakshata Programme was introduced in 2015 to strengthen the competency of the providers of the labour room through skill-based trainings [21]. The LaQshya Labour Room Quality Improvement Initiative was launched in 2018 with the aim of strengthening key processes related to labour rooms and maternity operation theatres and improving the quality of care around birth [22].

In 2018, at the Partnership for Maternal, Newborn & Child Health Summit in New Delhi, the Government of India introduced the concept of midwifery services throughout the **c**ountry, with the goal of introducing 86,000 specially trained midwives in the country working at Midwifery led care units alongside obstetric units [23]. The Midwifery services initiative aims to create a cadre of Nurse Practitioners in Midwifery who are skilled in accordance with International Confederation of Midwives (ICM) competencies and knowledge, and capable of providing compassionate woman-centred pregnancy care. Notably, the programme only recognizes and

trains registered-nurse midwives (graduate nurses) as midwives and ignores from its ambit the cadre of ANMs who have been providing care during pregnancy and birth for several decades. GOI's policy on midwifery also ignores midwifery as an independent profession - the principles of which focus on being with the woman and providing woman centred care. By attempting to convert nurses who are clinical and patient oriented professionals into midwives, it further shifts maternal services into the arena of clinical and medical services. The power dynamics of patient centred care that nurses and doctors focus on is diametrically opposed to woman centred care. Similarly, the programme for training the Community Health Officer cadre introduced to run Health and Wellness Centres also does not consider ANMs as eligible for upgradation and training to become Community Health Officers [24].

While the consistent policy and programmatic attention to maternal health care over the past three and a half decades is commendable, their focus has been on efficient technical/clinical interventions such as emergency obstetric care. Social determinants, and especially gender discrimination, even when acknowledged, are only tangentially addressed and rarely translated into interventions. For e.g. the Women and Child Development ministry, through its ICDS programme, is expected to improve nutrition in women. However, anaemia in women in general and in pregnant women in particular continues to be a major concern[25]. Similarly, while legal protections are available to address domestic and intimate partner violence, mechanisms to operationalize these on the ground to support women facing IPV, especially during pregnancy, are not functional [26].

Parallel to these mainstream developments, the feminist health movement engaged centrally with issues such as the medicalisation of childbirth and professional control over the birthing process. With the greater engagement of feminists from LMICs in the movement, attention turned to maternal mortality and morbidity. The International Women and Health Meeting (IWHM) held in Costa Rica in 1987 denounced the death of more than half a million women globally from avoidable causes related to pregnancy, unsafe abortion, and childbirth [27]. The Call for Action issued by the Women's Global Network for Reproductive Rights foregrounded gender discrimination and violation of reproductive rights as contributors to maternal mortality and morbidity [27]. Several subsequent civil society initiatives, including the Network for Humanization of Birth (REHUNA) in Latin America since 1993 [28] have campaigned to put women at the centre of maternal healthcare. India hosted the Human Rights in Childbirth Conference in 2016 in Mumbai and various networks took up these issues prominently in their activities.

Feminist critiques of the medicalisation of childbirth led to the emergence of the concept of 'woman-centred' maternal health care. Definitions in the literature of what constitutes woman-centred care vary, but many present it as one that offers the woman choice, control, and empowerment [29][30][31]. Soon, the term woman-centred maternal healthcare found its way into national and international

policy documents. The 1993 *Changing Child Birth* report in the UK resulted from wide consultations with women about the care they desired during pregnancy and childbirth and informed subsequent maternal health interventions [32]. WHO's recommendation on antenatal care for a positive pregnancy experience mentions evidence suggesting that women valued genuine 'woman-centred care' [33], while another guideline on intrapartum care for a positive childbirth experience calls on health systems to provide woman-centred intrapartum care:

> *Health systems should aim to implement this WHO model of intrapartum care to empower all women to access the type of woman-centred care they want and need and to provide a sound foundation for such care in accordance with a human rights-based approach* [34].

Woman-centred care is also a cornerstone of good midwifery practice [35]. According to Morgan (2015), the concept straddles "both the biomedical model and feminist healthcare aspirations" (p.10)[32] while the International Confederation of Midwives (ICM) considers woman-centred care as a fundamental philosophical approach for midwives, which has shaped the definitions of the role of a midwife and standards of care [36]. There have been civil society efforts in India to create models that centre around midwifery and provide woman-centred care – these include those by ANSWERS, ARTH, RUWSEC, Jan Chetna Manch and others [37][38][39]. The birth of SOMI (Society of Midwives, India) as an agency that brought awareness and raised a discourse on the midwifery model of maternal care is also notable here [40].

Another strand related to the focus on the woman in the birthing process is initiatives for 'Respectful Maternity Care' since 2011 to end the violence, abuse, and disrespect experienced by women during pregnancy and childbirth in health facilities (41]. Respectful maternity care has been broadened to 'Person-Centred Maternal Health Care' (PCMC), which includes dignity and respect, communication and autonomy, and supportive care [42].

It is three decades since woman-centred maternal healthcare was acknowledged as a policy priority. And yet, the definitions of woman-centred maternal healthcare have often been informed by the perspectives of health professionals and experts and seldom by the perspectives of women, especially those from the most marginalised groups, who are most affected by policies and programs.

This paper draws from a study conducted by CommonHealth and its partners that set out to develop a discourse on woman-centred maternal health care and its different components. The study sought to address a crucial gap by listening to and foregrounding the voices of women, especially those from disadvantaged and vulnerable communities, about what, in their view, constitutes pregnancy, childbirth, and postpartum care centred on the preferences and needs of the woman concerned.

The specific research questions for the study were:

1. *What is woman-centred maternal healthcare?*
2. *Do current maternal health policies and programmes provide for woman-centred care? Do they meet the maternal health needs of women?*
3. *What changes would be required to make maternal health policy and programmes woman-centred?*

The study employed a multi-phased approach to understand woman-centred maternal healthcare experiences through qualitative data collection using participatory methods. Phase I focused on grassroots-level consultations with women from marginalized communities (dalit, Adivasi, women from urban poor settlements) who had given birth in the last five years across different regions of India including Tamil Nadu, Maharashtra, Gujarat, Jharkhand, Uttar Pradesh, Madhya Pradesh, Odisha. These consultations were conducted in collaboration with local NGOs (also CommonHealth members) with experience in maternal health and engagement with marginalized communities. Frontline workers such as ASHAs and ANMs were also interviewed to gain their insights into woman-centred care practices. More details on what emerged from these consultations can be found here[43].

Phase II involved a consultative process with experts [44] in public health, sexual and reproductive health, and community health to gather specialised insights on maternal healthcare. These discussions formed a dual-layered foundation for policy recommendations. This intersectional approach enabled the capture of diverse experiences influenced by gender, caste, ethnicity, and socio-economic factors, contributing to a robust understanding of a woman-centred maternal healthcare framework.

What does it mean to put women at the centre of maternal health care?

This section describes **the principles** for woman-centred maternal health care emerging from the consultations with grassroots women, frontline workers, and experts described above, besides detailing **the key components** of woman-centred maternal health care.

The principles

Woman-Centred Maternal Health care is based on a set of principles. The principles draw from concepts related to ***human rights***, ***midwifery,*** **and** ***quality of care***. It may be noted that we believe that 'woman-centeredness' has to be applied ***not only to women receivers of services but also providers of services.***

Human Rights Based Approach

A human rights-based approach (HRBA) to health requires mainstreaming fundamental human rights principles as well as standards based on the 'right to highest attainable standards of health' (the AAAQ framework) across health services and health system policies. WHO has listed a set of human rights principles for contraceptive services in various guidance documents (Box 1) [45]. Similar principles have been applied in relation to access to safe abortion services [46].

Box 1 Human Rights-based Principles - WHO[1]

1. Non- discrimination
2. Availability of contraceptive information and services
3. Accessibility of contraceptive information and services
4. Acceptability of contraceptive information and services
5. Quality of contraceptive information and services
6. Informed decision-making
7. Privacy and confidentiality
8. Participation
9. Accountability

In this section, we adapt these principles to maternal health care. In addition, we expand the framework to include other human rights that have a bearing on maternal health and health care. For this, we draw from the Respectful Maternity Care charter of the White Ribbon Alliance [47] and various international human rights frameworks [48].

Non-discrimination: Women in all their diversity – across age groups, caste and religion, sexual orientation and gender identity, occupation, and health conditions – should be provided with all necessary maternal health services without any discrimination and any barriers. For example, mandatory reporting should not be required for those under 18 years, women in sex work who desire to be mothers should not be stigmatised and discriminated against because of their profession. There must be systems to prevent discrimination, to proactively monitor and to easily register any complaint of discrimination. Women who become mothers through adoption should be provided the same benefits under the law as those who become mothers biologically.

1 World Health Organisation. 2014. Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. https://iris.who.int/bitstream/handle/10665/102539/9789241506748_eng.pdf?sequence=1

Availability of maternal health services and information along the continuum (from contraceptive care to post-delivery care and comprehensive abortion care if required). Services should be close to women, provided through skilled health providers, and through Village Health, Sanitation and Nutrition Days, and available in sufficient quantities. Blood, in times of obstetric emergencies, as well as all other commodities should be readily available to enable good maternal health and well-being.

Accessibility of maternal health services, again across the continuum. Maternal health services should be accessible for all women, including those with specific vulnerabilities, for example, women living with disabilities, Dalit and tribal women, and others living in remote geographical areas. Services should be organized taking into account a maximum travel time to the nearest facilities for different levels of care. Financial accessibility should also be guaranteed. The language in which information related to different dimensions of maternal health is provided should be accessible to women with low literacy rates. Written, audio and video information on health should be provided in not just the state language but in all languages that are spoken in the state.

Acceptability of maternal health information and services. Attempts should be made to make services acceptable to different women according to their culture and traditions, as well as against the technical standards prescribed for different aspects of maternal health. It may be challenging to balance the negative aspects of certain cultural practices with good technical standards, but these challenges can be overcome by providing information in ways that women and their families understand, using their own metaphors.

Quality of maternal health information and services. Similarly, quality considerations should be based not only on the highest technical standards of maternal health care but also on women's concepts of quality of care, with respect and dignity of each woman at the core of the quality framework. Further detailing of how this balance can be achieved is in the section on technical quality of care below. Quality of maternal health care also means freedom from obstetric violence, disrespect, and abuse in the labour room.

Autonomy, Informed decision-making and Participation. Every woman's autonomy must be respected, which means that she must be enabled to make her own decisions after being provided complete information in ways that she understands what providers are seeking to convey to her. The pros and cons of all alternatives must be explained to her so that she can make the decision that she is comfortable with. While the family may need to be brought into the decision-making, healthcare providers should ensure that the woman herself has the space to think through and voice her point of view. This point is related to the principle of **Participation** – 'nothing about me, without me' – pregnant women must have the space and the enabling conditions to decide on the best course of their treatment, their birthing

options, their contraceptive decisions, and so on. Participation also means that users of services must have the opportunity to have a say in the design of programmes and policies affecting them. Thus, pregnant women in a community must have some platforms to be able to provide systematic feedback to health programme managers and service providers about how maternal health services must be structured and delivered.

Privacy and confidentiality. Notions of privacy and confidentiality may differ in different contexts. The underlying value of these principles is that no harm should come to the woman because of compromised privacy and confidentiality. In many contexts, women prefer to have a companion with them to feel confident and safe. Providers need to ensure that there is no power play happening in such a situation. For example, if the mother-in-law involved in the domestic violence experienced by her daughter-in-law accompanies a pregnant woman for an antenatal checkup, as is customary and normal in many South Asian countries, the woman may find it difficult to respond to the provider's probing about the violence that she might be experiencing. In such a situation, the provider may need to find ways of removing the mother-in-law from the scene so that the pregnant woman can speak openly. Providers are bound by professional ethics to keep the medical history of every patient confidential. This applies to pregnant women's information also – providers must ensure that they do not cause any harm by revealing sensitive information about the pregnant woman.

Accountability. It is primarily the state's obligation to respect, protect, and fulfil human rights with regard to the provision of maternal health information and services. Duty bearers are responsible for establishing effective accountability measures. Effective accountability requires individuals, families, and groups, including women from vulnerable or marginalised populations, to be aware of their entitlements to SRH, and it empowers them to claim these entitlements. Healthcare providers must be trained about their accountability to communities and users, even as they are conscious about their accountability to their supervisors and those higher in the health system hierarchy. Platforms for dialogues between community users and service providers must be set up and used in the true spirit of answerability to communities. Redressal mechanisms must be established and honoured.

Right to life and right to health: Women engage in the act of social reproduction through pregnancy and giving birth. That thousands of women continue to die and face ill health during this is unacceptable and a gross violation of their right to life and health. All efforts must be made to ensure that women not only survive pregnancy with good outcomes for themselves and their newborns but also continue to enjoy good health and well being in the long term.

Right to freedom from harm and ill-treatment and right to respect and dignity: All women, irrespective of their social position, class, caste, religion or any other factors, should be treated with respect and dignity. This includes providing respectful and

compassionate care during labour and birth. All forms of violence and abuse during care provision are violations of these rights. This also includes freedom from violence at home including freedom from intimate partner violence.

Right to the benefits of scientific progress: Women should have access to the most current evidence-based interventions that impact their health and well-being. For example, presence of a birth companion is shown to result in better maternal and perinatal outcomes and therefore all women must be accompanied by a birth companion of their choice during labour and birth.

Right to the social determinants of health: It is well known that health goes much beyond health care alone. All women therefore should have access to all the determinants that impact their maternal health including good nutrition, clean water, sanitation, clean air, good living and working conditions.

Positive Pregnancy Experience

Women's expectations from maternal health care are centred around having a healthy pregnancy and a complication-free delivery within a safe and supportive environment, with positive outcome for the mother and the newborn. Women's expectations align with the human rights-based principles described in the section above, as well as the notion of a *positive pregnancy experience* and midwifery approach that are being discussed in the current discourse around maternal health and well-being.

A scoping review of what women want from ANC and what outcomes they value indicated that women from high-, medium- and low-resource settings valued having a 'positive pregnancy experience.' A [48] 'positive pregnancy experience' is defined as '*maintaining physical and sociocultural normality, maintaining a healthy pregnancy for mother and baby (including preventing or treating risks, illness, and death), having an effective transition to positive labour and birth, and achieving positive motherhood (including maternal self-esteem, competence, and autonomy).'*

Many of the components of a 'positive pregnancy experience' match the rights mentioned above - the provision of effective clinical practices (interventions and tests, including nutritional supplements – reflected in the right to quality maternal health care), relevant and timely information (including dietary and nutritional advice – reflected in the right to information) and psychosocial and emotional support, by knowledgeable, supportive and respectful healthcare practitioners (reflected in the right to acceptable services), to optimise maternal and newborn health. It is important to highlight that maternal health care providers must be cognizant of the fact that the emotional, psychological, and social needs of adolescent girls and vulnerable groups (including women with disabilities, women with mental health concerns, women living with HIV, sex workers, displaced and war-affected women, ethnic and racial minorities, among others) can be greater than for other women.

WHO recommendations on antenatal care for a positive pregnancy experience [33] state that countries must rethink and redesign their health systems to '*provide women with respectful, individualised, person-centred care at every contact by practitioners with good clinical and interpersonal skills*.'

Midwifery Approach

Many of the values and principles stated above are inherent in the philosophy of Midwifery [49]. The International Confederation of Midwives describes Midwifery as '*an approach to care for women, gender diverse people, and their newborn infants whereby midwives:*

- *Optimise the normal biological, psychological, social, and cultural processes of childbirth and the early life of the newborn;*
- *Work in partnership with women, respecting the individual circumstances and views of each woman*
- *Promote women's personal capabilities to care for themselves and their families*
- *Collaborate with midwives and other health professionals as necessary to provide holistic care that meets each woman's individual needs.'*

ICM states that Midwifery is 'a professional framework of autonomy, partnership, ethics and accountability'.

Respect and Dignity of Women Healthcare Providers

As we engaged in this study, it became clear to us in CommonHealth that while the concept of 'woman-centred maternal health care' converged with the notion of respect for and dignity of every woman seeking maternal health services, it could not ignore the dignity of the women who are providers of those services. The ASHAs and the ANMs in the study spoke about their own challenges and the difficulties that they face in discharging their duties towards pregnant women. It became clear that, as women, they negotiate power dynamics within their own family realities and balance these within their power-ridden professional spaces where they are at the bottom of the health system hierarchy. The working conditions of the ASHAs - as 'volunteers' paid on task-based incentives, often with inordinate delays, with little recognition within the formal health system and health facilities, and all kinds of extra work thrust on them - made it clear to us that we had to argue for 'woman-centeredness' with respect to the frontline women health care providers too.

Gender Power Relations and an Intersectional Analysis

As described above, an analysis of gender power relations and a recognition that all women are not 'one-class' is also a foundational principle in this initiative. There are diversities among women – there are women who are more vulnerable than others with multiple layers of marginalisations that have to be recognised and addressed. Kimberle Crenshaw defined the multiple layers of marginalisations as *intersectionality* - "Intersectionality is a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking"[50]. In a more recent interview, she stated "Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects" [51]. The women in our study who tell us about their experiences of pregnancy and childbirth are those who bear burdens of multiple marginalisations – they are young and migrant and tribal, dalit and rural and poor, and various other combinations.

To conclude, there is an emerging framework of woman-centred maternal health care, which rests on the pillars of human rights and midwifery and considers the well-being of women service providers.

Components of woman-centred maternal health care

This section details the different components that need to be in place in order to operationalize the principles mentioned above in order that women receive maternal health care that is truly woman-centred. It draws from the experiences and expectations of the women who participated in this study and includes components within the health system as well as within women's families and communities. The components detailed here are: technical quality of care, care with respect and dignity, continuum of care, autonomy and participation, and enabling environment, both within families and communities, and within health systems.

Technical quality of care

After the introduction of the conditional cash incentive programmes under the Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram, institutional birth rates in the country have steadily increased to reach a national average of 89 per cent (NFHS 5). In our conversations with grassroots women, it emerged that almost all of them saw institutional births as a norm that they aspired to and gave birth at home only if circumstances prevented them from reaching institutions. This was with the trust that birthing in institutions would ensure the best possible outcomes for them and their babies.

However, their experiences belied their expectations and it seemed that the health system did not live up to these expectations of women to provide good quality care. Women across diverse settings reported multiple experiences of receiving poor quality care or not receiving standard interventions that are recognised as part of good quality care. This included being left alone during labour, absence of a birth companion, lack of pain relief during suturing of perineal wounds and episiotomy, and unnecessary referrals. Often, services such as measurement of blood pressure and abdominal examination were not provided at the VHSND during antenatal care contacts, or investigations like blood tests and ultrasound were unavailable in facilities. Postpartum care was unavailable in most settings. Women highlighted the lack of adequate ambulance facilities as a key concern.

Women in our study also reported concerns about the overmedicalization of pregnancy care. Their reports revealed immense misinformation related to pregnancy and birthing. There seemed to be an overuse of tests – for e.g. women reported having to undergo multiple ultrasound examinations during pregnancy seemingly without any medical indication. These seemed to play on the woman's and her family's fear for the well-being of the fetus. Since these services were often unavailable in the public sector or had long waiting periods even when available, women were forced to spend out of pocket and seek care in the private sector. They also expressed concerns over the overuse of caesarean section. They felt that caesarean sections were often carried out for non-medical reasons, e.g. commercial interests or for the convenience of health care providers.

The concerns expressed by women reflect the emerging narratives globally about the over-medicalisation of care during labour and birthing, including unnecessary caesarean sections [52]. Obstetric violence in the form of unnecessary interventions like episiotomy and caesarean and lack of pain relief has also emerged in the literature as a key form of abuse during labour and birth [53][54][55]. WHO's Quality of Care framework [56] highlights the importance of good technical quality of care, including the provision of evidence-based interventions, actionable information systems, and a functional referral system. The Government of India's LAQSHYA programme also invests in these domains in an attempt to improve the quality of care in labour rooms in public sector health facilities [22].

There is good scientific evidence that several interventions that are considered woman-centred are now also known to result in good maternal and perinatal outcomes. These include the provision of a birth companion, ensuring mobility during labour, adopting alternate positions of the woman's choice during birthing, and not practising routine episiotomy[34]. The midwifery philosophy promotes the adoption of these interventions, putting the woman at the centre of care. However in India, the midwifery model of care is still confined to a few educational and

demonstration sites in the public sector and the Nurse Practitioner in Midwifery training is limited to nurses working in the public sector. Expansion of this model of care requires formation of a cadre which has not yet taken place.

It is important to note here that by the 1970s, medicines and health technology had made sufficient progress to bring down the MMR to single digit levels in many countries. If a woman in labour reaches a health facility alive, there is enough technology and medicines to ensure her life - except in the rarest instance - if every labour and birth is seen as a potential emergency and if the emergency protocols are followed in any healthcare institution. However, it is well known that the technical quality of care in institutions continues to be poor despite efforts to improve it. Globally, it is estimated that between [57][58] 5.7 to 8.4 million deaths in low and middle-income countries take place due to poor quality of care in health facilities. Modelling studies [59] estimate that investing in good technical quality of care would result in a 28% reduction in maternal deaths, a 28% reduction in neonatal deaths, and a 22% reduction in stillbirths. In India, CommonHealth's past work has highlighted the effects of poor quality of care on maternal mortality [60]. Several studies have documented poor quality of care around childbirth in facilities [61][62] [63].

Thus, it is important to ensure that women receive the best possible technical quality of care when they reach institutions for birth. From a rights perspective, women have a right to the benefits of scientific progress, and access to the most current evidence-based interventions would help them realise this right.

What would such good quality technical care include in a woman-centred framework? WHO defines several of these interventions in its most recent guidelines for antenatal care, intrapartum care, and postnatal care to ensure a positive pregnancy and birthing experience[33][34][64]. Some of these include the presence of birth companion, ensuring adequate emotional support and pain relief during labour and birth, a more physiological and individualized management of labour than currently practised, ensuring immediate skin-to-skin care of the baby, and supporting breastfeeding. Ensuring, therefore, that a full set of evidence-based interventions are available and provided with assurance of good quality is key. This should include care during pregnancy and during the postpartum period including the provision of a full set of antenatal care interventions, identification of women who are at high risk for complications for specialized care, and provision of postpartum care including support for breastfeeding. This also means that interventions that do not have any evidence-base or are in fact known to cause harm should be avoided. This includes the whole ambit of overmedicalized interventions during pregnancy and birth, for e.g. routine episiotomy,

birthing in the supine position, multiple unindicated ultrasound examinations. Good technical quality of care also needs to include functional referral systems that provide appropriate and timely referrals for women who need them while avoiding unnecessary referrals. Timely transport services in times of referral need to be ensured.

- Ensure that a full set of evidence-based interventions are available and provided with assurance of good quality. This should include care during pregnancy, birth and during the postpartum period.
- Interventions that do not have any evidence-base or are known to cause harm should be avoided. This includes the whole ambit of overmedicalized interventions during pregnancy and birth, for e.g. routine episiotomy, birthing in the supine position, multiple unindicated ultrasound examinations.
- Ensure functional referral systems and timely tansport services that provide appropriate and timely referrals for women who need them while avoiding unnecessary referrals. Timely transport services in times of referral need to be ensured.

Care with respect and dignity

Disrespectful care in labour rooms has emerged in recent years as a key concern. The experiences of the women interviewed as part of our study show that disrespectful care remains rampant and widespread. Almost all women who participated recounted several instances of such care, including being left alone, physically and verbally abused, and emotionally harassed while going through labour and at the time of birth. This was also compounded by the discriminatory behaviour of healthcare providers based on caste and poverty. These seemed to be defining experiences of their care for women, with women narrating instances of such abusive behaviour even several years after the event. Experiences of such abuse resulted in women deciding not to seek further care in facilities, especially those in the public sector.

It however needs to be highlighted that from our experience of working with marginalized communities, such experiences of disrespect are in no way unique to women and are common experiences of anyone from disempowered rural communities seeking care in public facilities. This is probably a reflection in the health system of the general lack of sensitivity and empathy to the underprivileged in society at large. This is compounded by the fact that health care providers do not receive any training or sensitization to the different vulnerabilities that their patients face, including class, caste, or gender. They thus continue to carry forward the prejudices prevalent in society and exhibit them in their practice. Several initiatives, including rights-based maternal healthcare and a charter of women's and newborn's rights in labour rooms, have been proposed to address disrespectful care [65]. WHO's quality of care framework[56] places women's experience of care on par

with the provision of care. This includes effective communication, care with respect and dignity and emotional support.

Thus, good technical quality of care alone is insufficient and needs to be accompanied simultaneously by a good experience of care, provided with respect and dignity. At the minimum, this means that physical violence, verbal abuse, shaming, communal and casteist slurs, and humiliation should stop in all health facilities, public or private. Women should be cared for with sensitivity and empathy during pregnancy and labour and not be neglected during labour.

Another aspect of respectful care is the adherence to informed consent for contraceptive procedures. Women across multiple settings in our study narrated instances of coercion and non-consensual insertion of PPIUCD. This is a complete violation of women's right to informed choice and a violation of their bodily integrity. Women in our study had a very clear demand that such practices should stop.

- Good technical quality of care alone is insufficient and needs to be accompanied simultaneously by a good experience of care, provided with respect and dignity.
- At the minimum, this means that physical violence, verbal abuse, shaming, communal and casteist slurs, and humiliation should stop in all health facilities, public or private.
- Women should be cared for with sensitivity and empathy during pregnancy and labour and not be neglected during labour.
- Informed consent for contraceptive procedures should be adhered to. Coercion and non-consensual insertion of PPIUCD should stop immediately.

Continuum of care

Another key component of woman-centred maternal healthcare is the continuum of care. Women need healthcare services throughout their lives, from adolescence to old age. Women in our study reported that services only focus on the period of pregnancy and childbirth, and even the postpartum care services recommended in the programme were not uniformly available. These were also reflected in the interviews with FLWs where they saw their work as limited only to pregnancy and childbirth and family planning, not other aspects of women's health and lives. This is also borne out by the way the maternal health programme is designed - the current GOI programme regresses the 21 months of each childbearing (from conception to infancy) to 48 hours within an institution. The GOI midwifery guidelines do not stress on community midwifery services or service providers [66].

Our experiences of working with girls and women in several areas of the country over several decades have highlighted the continued absence of services beyond those for pregnancy, childbirth and contraception. There is very little comprehensive pregnancy related care (mostly limited to registration, cursory examination, TT, distribution of IFA). The focus is on intrapartum care alone and this is within a facility and ignores woman-centeredness most of the time. Postnatal care is almost absent. Newborn and infant care are limited to immunization. Postpartum contraceptive services are limited to PPIUCD largely. Studies have also shown that while women may survive pregnancy, they continue to face ill health and even mortality because of a lack of services beyond the postpartum period[67][68].

Healthcare conditions like anaemia, which is highly prevalent in pregnant women in the country, require interventions before and beyond the period of pregnancy and childbirth. Women also need gynaecological services for common conditions like menstrual disorders, uterine prolapse, reproductive tract infections and reproductive cancers. Several studies including CommonHealth's own[69] have reported on the cumulative effects of poor quality care during pregnancy on women's reproductive health and long term overall health. Absence of services when faced with such gynaecological morbidity pushes women into an exploitative private sector, leading to irrational procedures like unnecessary hysterectomy[70][71]. Thus, there is a need for woman-centred care to focus beyond just maternal health on women's overall health through all stages of their lives.

- Women need health care services beyond the period of pregnancy and childbirth, including for conditions like anaemia and for common gynaecological conditions like menstrual disorders, uterine prolapse, reproductive tract infections and reproductive cancers.
- Absence of services when faced with such gynaecological morbidity pushes women into an exploitative private sector, leading to irrational procedures like unnecessary hysterectomy.

Enabling environment at home and in the community

The women who participated in this study saw their care during pregnancy as starting from their families and communities. They wanted a nurturing and caring environment in the family. This included relief from their gender-defined roles of household chores and caregiving responsibilities. They did not want restrictions on food, snacks and sleep time imposed on them. They wanted the supportive care to continue even in the event of adverse pregnancy outcomes like miscarriage or stillbirth. They also wanted the home environment to be free of violence.

Women also expressed the desire to be able to make decisions about their own health and health care, including regarding their diets, work and rest. They also wanted the

agency to decide the place of birth, prescription adherence, and mode of transport. Some women also expressed a desire to have access to small amounts of money to spend on themselves. Women wanted their male partners to be supportive and respectful of their choices and to be active participants in their care – some women wanted their partner to accompany them on antenatal visits, while others wanted the freedom to be on their own. Nevertheless, almost all of them wanted their partners to take equal responsibility for contraception.

Son preference was seen by women as something that added mental and emotional stress for them. They wanted both their families and communities to not pressurise them to have sons. They also expected communities to provide physical and financial support to them when needed.

Thus, women saw a nurturing, supportive, violence free environment at home as a key component of woman-centred maternal health care.

- Women wanted a nurturing and caring environment in the family with relief from their gender-defined roles of household chores and caregiving responsibilities.
- Women wanted the home environment to be free of violence.
- Women also expressed the desire to be able to make decisions about their own health and health care, including regarding their diets, work and rest, and medical care.
- They wanted their partners to take equal responsibility for contraception.
- They wanted both their families and communities to not pressurise them to have sons.

Enabling health system environment

A well-functioning health system is necessary for women to receive quality maternal healthcare. Several of the frontline health workers we spoke to recounted challenges that they faced in providing care for women and their babies. One of the key challenges was a lack of sufficient human resources, resulting in their being overburdened with work and, therefore, unable to provide the care they were supposed to. They also recounted gaps in infrastructure, such as a lack of adequate resting rooms and waiting areas for frontline workers and women's families. Both frontline workers and women in our study narrated several instances of lack of supplies of essential medicines and equipment, resulting in their having to purchase these from the market paying out of pocket. They also reported being overburdened by the digital interventions put in place recently – they often had to face poor internet connectivity and malfunctioning devices, resulting in activities related to these interventions

becoming time consuming. They felt this took away time meant for actual care of women.

The lack of human resources is also borne out by evidence from government data. Rural health statistics reveal a shocking level of vacancies in human resources in district hospitals, especially for specialists like gynaecologists[72]. Even states like Tamil Nadu, with well-functioning health systems report very high levels of gaps in specialist positions in CEmONC centres[73].

Healthcare workers need an enabling environment to be able to provide good quality care. Health facilities should be equipped to provide care for any emergency during pregnancy and birth, including blood transfusion. In the absence of such an enabling environment with adequate human resources, infrastructure, equipment and supplies, mere training sessions for healthcare workers will not result in closing the gaps in quality of care.

Another key aspect of health systems is governance. Poor governance repeatedly came up as a key barrier to both the provision and experience of woman-centred care in our study. Frontline health workers reported several instances of poor governance, including in their postings, monitoring and surveillance, and division of work burden. Women's experiences of care in our study included high out-of-pocket expenditures, either because of informal payments within the public sector where care was supposed to be free, or because of exploitatively high charges in the private sector. Women across different settings complained about having to pay informal payments at multiple points throughout their care during pregnancy and childbirth. It is well known that corruption breaks trust within the system and enables poor-quality care. Thus, ensuring that maternal health care is affordable and provided truly free of charge at the point of service provision in the public sector is important to improve women's experience of care. Also important is monitoring and regulating the prices in the private sector. Regular monitoring to ensure unnecessary interventions do not push up costs are also needed.

Frontline health workers also complained about not receiving salaries on time, while ASHAs get paid only an incentive and no salary. Experts we spoke to also highlighted the low budgetary allocation for health, poor recruitment practices to fill vacancies and contractualization of the health workforce.

Thus, focusing on ensuring health systems are able to provide an enabling environment for woman-centred care is important. It is essential that health systems are governed by robust mechanisms and a leadership that puts the focus on women and their needs. Identifying leaders with commitment and integrity within the health system and supporting them to bring about change is needed. Woman-centredness would require organization of services such that women receive good quality care close to home. Community and PHC level services would need to be strengthened. These services should include essential maternal health services like blood pressure

measurement and urine protein testing. Depots of essential commodities should be available with a depot holder in the village, for e.g. the ASHA or Anganwadi worker or ANM, to be available on days other than when the VHSND is held.

The women who participated in our study had very clear expectations of what they wanted in health facilities. They felt health facilities should have adequate human resources and infrastructure to avoid overcrowding and to cater to women's needs. There should be adequate space for checkups for pregnant women - enough space to sit, fans, drinking water, and clean toilets at a minimum. The facilities should have adequate numbers of doctors and specialists, including women doctors. All the drugs and diagnostics facilities should be available in one place at the PHC level. These services should be made available free of charge. In health facilities, all supplies and drugs should be procured and available at the institution and women and their families should not be asked to procure them from the market.

Women also wanted services close to their homes, without having to travel long distances for different services, and had several suggestions for strengthening the services of FLWs. They felt ANMs should conduct household visits and group sessions for women on various components of ANC care, such as rest, diet, checkups, danger signs, and mental and physical preparation for childbirth, and provide information on postpartum care, postpartum contraception, health insurance, free transport and other government schemes. They also wanted their male partners to take part in these sessions. They wanted FLWs to be responsive to their needs and send them regular reminders.

- Health systems should be governed by robust mechanisms and a leadership that puts the focus on women and their needs.
- Services should be organized such that women receive good quality care close to home.
- Health facilities should have adequate human resources and infrastructure to avoid overcrowding and to cater to women's needs. They should have adequate supplies.
- Services should be close to women's homes, without them having to travel long distances for different services.

How do we move toward woman-centred maternal health care in the Indian setting?

The present study is important in several respects. One, the study focused on maternal healthcare within medical settings and care received within the household and through frontline health and social care workers. Second, it covered women from different marginalised populations whose perspectives are not often documented. Third, the study covered different regions of India, capturing perspectives from diverse health systems and socio-economic and cultural settings. Fourth, the study was carried out by community-based organisations that had built a relationship of trust with the women included in the study, which enhanced the quality of information collected. Thus, the principles and components of woman-centred maternal health care described above and the policy recommendations detailed below emerge from the lived realities of women, especially those from marginalized communities. We focus here on some high level and overarching areas that need to be addressed in order to move towards woman-centred maternal health care.

Reorienting the health system to a human rights-based focus

The health system is currently designed on the principle of efficiency with the services organized based on the health system's needs and convenience. In order for care to be woman-centred, there needs to be a reorientation of the system to a focus based on human rights. This would mean the goal of the health system would be not only to not violate the rights of those who seek services, but rather protect and fulfil their human rights in the fullest possible manner. This would need changes in the design of the system to be able to address all of the human rights detailed in the earlier sections. This would also mean training and sensitization of all care providers, programme managers and policy makers to ensure they are able to effectively play the role of duty bearers for provision of services. In addition, efforts would need to be made to ensure women and patients who seek services are aware of their entitlements and rights so as to be able to claim them. This would need development and wide publicising of women's (patients') rights charters, involvement of civil society organizations in building knowledge amongst women on their rights, developing legal and policy frameworks to safeguard the human rights focus.

Higher allocation of public funds for health system strengthening

Strengthening different components of the health system is essential for the provision of woman-centred maternal health care of good technical quality. This would include investment in adequate human resources including specialists, providing them with necessary training to not only improve knowledge and skills but also change attitudes and behaviours, upgrading infrastructure of facilities, ensuring availability of essential equipment and supplies including blood. Investment will

also need to be made to improve governance in health systems – this would need building of leadership, setting up adequate monitoring mechanisms, and building learning systems.

Maternal health services cannot be improved in isolation. 'Silo'ed approaches that narrowly focus on one specific area such as maternal health will result in inefficient investment of resources and weakening of health systems. Maternal health services must be implemented within broader Universal Access to Health Care interventions. Maternal health care services have to be contextualized within the broader comprehensive primary health care approach - only then will social determinants of maternal health be addressed. This will also ensure addressing other health issues like anaemia and infectious diseases convergent with maternal health care. Maternal health services also need to be located within broader reproductive health services offered at primary health care level.

All of this would require resources. A consistent demand of health activists has been to increase budgetary allocation for health. Tax-revenue based funding aimed at universal rather than targeted coverage has been shown by international evidence to be the way forward. While overall allocation for health should increase, the resources also need to be spent appropriately towards measures that would increase woman-centredness. This would, for example, mean adequate allocation for resources for postpartum care, or for women's health needs beyond pregnancy and childbirth.

Participation and accountability for woman-centredness

Women's choice and autonomy are seen in the literature as key features of woman-centredness. Women in our study also echoed this. Women's participation would need to be ensured at different levels.

At the level of individual care, women's agency needs to be respected through robust informed consent processes and ensuring of explicit consent for various procedures, for e.g. PPIUCD insertion. Over and above this, however, women's voices need to inform policies and programmes designed for them, and special efforts need to be made to ensure meaningful participation by women. Several initiatives are now being proposed to centralize childbirth services in the guise of efficiency and better quality of care[74] – ensuring women's inputs into the design of services will ensure that any such initiatives are informed by women's everyday realities rather than only by efficiency as a criterion.

Accountability is closely related to participation. Health systems need to build mechanisms for accountability including regular audits of select indicators and processes like maternal deaths, referrals, caesarean sections. In addition to accountability within the health system, community accountability mechanisms must be established and strengthened. There are several examples of such community accountability initiatives both nationally and globally that can serve as role models

for such programmes. CommonHealth has in the past explored initiatives for community accountability for maternal health. This included community monitoring of maternal health services in three districts of Gujarat along with social autopsies of maternal deaths[75]. Similar initiatives need to be upscaled to be part of regular activities of the health system.

A key component of accountability is grievance redressal. An effective Grievance Redressal System that includes both an immediate response system to provide immediate relief and a more medium-term review and systemic correction mechanism must be set up. These should be headed by independent ombudspersons who will be able to hold the health system accountable.

Addressing gender as a determinant

Gender continues to be a key social determinant of women's health. Health care providers must be trained and equipped with skills to address gender-based issues while providing care. There are initiatives like the Gender in Medical Education programme in Maharashtra [76][77] that have successful models of integrating gender into preservice education. Trainings on respectful care should also foreground gender as a social determinant and help health care providers recognize and overcome their own gender-based biases.

Our study also showed how gender continues to be a key factor in women's lives in their own families and communities. Addressing this would require more overarching programmes that include for example the education system and working with boys and young men.

Gender will need to be addressed from a perspective of intersectionality. The different axes of marginalization women face based on their caste, ethnicity, religion, age, disability, HIV status need to be recognized and addressed.

Addressing social determinants

Health systems need structural reforms to be able to increase the system's sensitivity to social determinants. This is essential for women and indeed all patients who seek care, especially those from marginalized communities, to be treated with empathy and compassion. One way to do this would be to increase the representation of those from marginalized communities in the health care workforce through affirmative action in pre service education and in recruitment. Medical and paramedical education should include specific curriculum on social determinants similar to the gender in medical education programme mentioned above and provide training on how health care providers can work to mitigate the effects of these in their everyday practice. All health facilities should have help desks staffed by community representatives to provide support for those from marginalized communities seeking care.

Addressing health care providers' needs

Addressing the needs of health care providers, especially women FLWs, emerges also as a key perspective from our study. Women FLWs, often from marginalized communities themselves, work under challenging circumstances and need the support of an enabling environment to provide services. Such an environment, in addition to addressing the health system components, should also ensure they have decent working conditions including fair wages paid on time, safe spaces for rest during duties or when accompanying women to facilities, access to water and toilets. Respectful treatment of FLWs by their superiors within the health system is another key area that needs addressing.

What would be indicators to measure progress?

We list below a few indicators that can be used to measure progress and to check if maternal health care is woman-centred.

At the family and community level

- Proportion of women whose haemoglobin is higher than 11 g/dL before birthing (a reflection of healthy diet given to them during pregnancy and preconception period)
- Proportion of women facing domestic violence during pregnancy and in the postpartum period
- Proportion of pregnant women accompanied by their male partner for antenatal checkup at least once during pregnancy and once after birth
- Proportion of male contraceptive use among total modern contraceptive use
- Proportion of women who had at least two years gap between the present and last childbirth

At the health system level

Services related

- Proportion of pregnant women who received complete information about pregnancy, antenatal care, danger signs during their antenatal visit
- Proportion of women who had full information about their own and their foetus's health condition and were informed about models and types of birthing
- Proportion of women and families who decided to have a natural birth or try for one with full information

- Proportion of health facilities with active promotion of natural birthing and woman centred practices with separate normal birthing units and wards for complicated births
- Proportion of women in labour who were accompanied by a birth companion of their choice
- Proportion of women in labour who were allowed to birth in a position of their choice
- Proportion of women giving birth in a facility who received episiotomy
- Proportion of women giving birth or their family members who report disrespectful care – disaggregated by caste, religion, Adivasi status
- Proportion of women giving birth in a facility or their family members who report being demanded informal payment
- Proportion of women who have given birth who receive complete postpartum care
- Proportion of women receiving PPIUCD who had provided informed consent during antenatal period

Health system related

- Proportion of women giving birth in a facility or their family members who report having to purchase drugs or supplies from outside
- Proportion of health facilities with adequate water and clean toilet facilities for pregnant women
- Proportion of health facilities where rest rooms for family and/or ASHA are available
- Proportion of health care providers who have received gender sensitization training

Programme and policy related

- Are there specific policies on the type, number and cadre of maternity service providers (midwives and others) in community, health centres, hospitals? Do these provide for qualified and regulated community and home based midwives?
- Do policies and programmes separate maternal care from hospitals and introduce normal birthing centres closer to homes including home-based maternity services?
- Are there community participation programmes in place? How functional are they? Are women part of structures for community participation? Are members of marginalized communities part of these structures? Is there representation from diverse groups, for e.g. religious or ethnic minorities, persons with disability, in these structures?
- Are there any grievance redress mechanisms in place? How functional are they? Is the ombudsperson independent of the health system?
- Are other reproductive health/women's health services available beyond the period of pregnancy and birth?
- What is the percentage of GDP allocated for health? How much of this is spent on maternal health care? How much is spent on other reproductive health care programmes (in addition to the family planning programme)? What percentage of specific PIPs are allocated for MCH, to training, drugs?

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About CommonHealth

CommonHealth - Coalition for Reproductive Health and Safe Abortion, constituted in 2006, is a rights-based, multi-state coalition of organisations and individuals that advocates for increased access to sexual and reproductive health care and services to improve health conditions of women and marginalized communities in India. Within sexual and reproductive health and rights, CommonHealth concentrates its efforts largely on maternal health and safe abortion. The coalition draws its membership from diverse disciplines, thematic areas and geographies within the country.

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SAHAJ on behalf of CommonHealth
SAHAJ, 1 Shri Hari Apartments, 13 Anandnagar Society,
Behind Express Hotel, Alkapuri, Vadodara,
Gujarat, India 390007
Tel: 91-265-2342539
Website: www.sahaj.org.in
Email: sahaj_sm2006@yahoo.co.in

Contact:
[Programme Manager cum Co-ordinator, CommonHealth]
Email: cmnhsa@gmail.com
CommonHealth website: http://www.commonhealth.in