Policy Recommendations for Maternal Health in India

The Delhi statement

Context of maternal health and maternal mortality in India

Maternal mortality continues to be an unjustifiably significant problem in India in spite of the issue garnering a lot of attention and being the focus of policy and programme by the Government of India and international bodies. Health activists have been feeling increasingly dissatisfied with the maternal health care situation on the ground in India. Many women continue to die around child birth because health facilities in many parts of the country are not equipped to provide Emergency Obstetric Care, the quality of antenatal care provided is inadequate, and safe abortion services in the public sector are inaccessible for the majority of women. Government reports, however, project that the maternal health situation is improving mainly because the Janani Suraksha Yojana disbursements are increasing.

We believe that women have the right to the highest attainable standards of maternal health and maternal health care. Maternal health services have to be available, accessible, acceptable, and of good quality. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.

The approach to addressing maternal health in India is fragmented and focused on promoting institutional deliveries alone, while overlooking the broader framework of sexual and reproductive rights. The maternal health policy in India needs to move away from the paradigm of *institutional deliveries* to a paradigm of *safe deliveries.* Several issues that affect maternal health - such as access to safe abortion services, access to choice of contraception, dignified childbirth, poverty, nutrition remain blind spots in policy.

Similarly, gender based violence is a crucial factor that has major health implications and even death. This is the result of physical injuries and also of barriers created by domestic violence to women seeking appropriate care during pregnancy and delivery. The situation is exacerbated by the state's regressive demographic goals and coercive population policies that have dictated health policies and programmes for women especially in terms of financing and resource allocation. There is enough evidence to suggest that attention to ante natal and post natal care has suffered because of the priority accorded to the family planning programme in the country.

Thus, the solutions proposed often fail to capture or be relevant to the lived realities of women. Approaches to reduction of maternal mortality have for too long been driven by experts, funders and international bilateral organizations, with the voices of the women of India and the activists working among them, hardly ever being included in policy and programme planning. Maternal mortality reduction strategies have been target oriented and treat maternal mortality as a simple input - output problem. In the past year or so, there have been a number of documentations of maternal deaths by civil society groups from different parts of India including from the so called 'developed' states like Tamilnadu, Karnataka and Kerala. All of these reports bring out the inadequacy of purely technical and narrow indicator-oriented approaches, without concurrent attention to the social determinants, health systems and other broader aspects surrounding these deaths.

While Maternal Death Reviews are mandated and are being done in several states, many maternal deaths still fail to get reported, especially those that occur outside hospital settings. There is no public disclosure of the analysis of maternal deaths, or of the measures planned to address the causes of maternal deaths. Neither is there an

accurate and disaggregated database from which the especially vulnerable groups can be identified.

In order to focus more political attention to maternal health in the country and to suggest recommendations for policy and programmes, a group of public health specialists and civil society activists from different networks and organizations including CommonHealth, NAMHHR and Jan Swasthya Abhiyan, SAMA, CEHAT, SOCHARA and SAHAJ met in Delhi on the 12th and 13th August, 2013. The meeting saw the participation of nearly forty persons working closely at the grassroots on issues related to maternal health. On the second day, Dr Syeda Hameed, Member, Planning Commission and Mr Keshav Desiraju, Secretary, MoHFW, interacted with civil society members at a policy dialogue session. The sessions saw several concerns and recommendations emerging from the consultation.

Our concerns

- In spite of the fact that the poorest and most vulnerable women are the most affected, the government has fallen short in addressing maternal health with a comprehensive strategy and being accountable for it.
- Maternal Death Reviews, though mandated since 2010, have not been institutionalised in many districts across various states, and are not being carried out in several communities, especially in rural areas.
- Even where maternal death reporting and reviews are being done, this information is not available in the public domain so as to ensure transparency and accountability of the process.
- Important social determinants like poverty, caste and gender including violence against women that have been shown repeatedly by civil society documentations to be intimately related to maternal health and maternal mortality, are not being addressed in any manner by existing programmes.
- There is a lack of institutionalized systems of accountability to the community in the health system including for critical issues like maternal mortality.
- Undignified treatment of women, especially those from marginalized communities, during childbirth has been reported from various parts of the country, but is not acknowledged as a problem. Women report facing physical abuse and verbal abuse, particularly use of derogatory, sexually explicit language. This makes them reluctant to use public health facilities thus impacting access.
- Gender based violence, including domestic violence, which is known to have an impact on women's control over their fertility, as well as pre and post partum health of mothers is not even addressed as an issue of concern.
- Unsafe abortion which is a major cause of maternal mortality is not adequately addressed in maternal health programmes.

Key Recommendations

✓ In spite of the increase in the number of institutional deliveries in recent years, **quality of care remains a serious concern.** Marginalized women from vulnerable caste groups and geographically remote areas continue to be excluded from programmes. Therefore, we recommend that

- **Ensuring SAFETY must be the priority in ALL deliveries** irrespective of where they occur and who conducts them.

- **Outcome indicators** should go beyond JSY disbursements and number of institutional deliveries **to include indicators of Safety** such as, completeness of antenatal care, technical aspects of care like Active Management of Third Stage of Labour and provision of postpartum care.
- **Blood availability** continues to be an important issue. Blood storage units should be operationalized at every FRU.
- **Referrals** are often done unnecessarily and to facilities that do not have the capacity to manage specific complications. Availability of emergency transport during such referrals is also an important issue. Accountability during referrals must be ensured and continuity of care provided during transit between facilities during referrals. Ensuring that women are accompanied by appropriately trained health personnel during such referrals, providing free emergency transport, and instituting audits of referral protocols and outcomes are some mechanisms to ensure accountability during referrals.
- **Verbal and physical abuse by health care providers**, during labour in public health facilities must be stopped and action taken against health care providers who indulge in it. Mechanisms to address grievances particularly related to abuse must be put in place in health systems.

✓ **Policies and programmes must respond to women's needs** that go beyond quality health care during pregnancy, delivery and post partum period to include nutrition, contraception, access to safe abortion, freedom from violence, dignity during care and access to information and care, from adolescence throughout their life span.

- Documentations of maternal deaths show that non-obstetric causes are becoming an important contributor to maternal deaths. **Services for tuberculosis, malaria and rheumatic heart disease during pregnancy must be strengthened and integrated with existing vertical programmes** for these diseases.
- **Availability and access to abortion services in the public health sector** need to be ensured. Information on number of abortion services provided in public sector facilities should be collected and analysed.

✓ **Policies and programmes need to be more nuanced and tailored to the needs of women in different situations.**

- For instance, **screening for sickle cell anaemia in tribal populations, bed nets and malaria prophylaxis in malaria endemic areas.**
- Maternal health care needs to be placed in the context of **all-round strengthening of health systems.**
- Maternal health care can be strengthened only within a **functioning primary health care system and Universal Access to Health Care** that is publicly provisioned and tax-financed.
- While the **Janani Shishu Suraksha Karyakram** is a step towards Universal Maternity Care, this **should be monitored rigorously** both from within the system and through communities to ensure that no out of pocket expenditures are being incurred.

✓ Maternal health is dependant on a range of **social determinants** like nutrition, gender, poverty, caste, religion.

- Needs of pregnant women should be prioritized in all social welfare programmes at all levels. (For example, adding maternity benefits in NREGA)
- Specific interventions like one fresh cooked meal women in pregnancy and during lactation as demonstrated in Andhra Pradesh should be implemented.
- Screening of **gender based violence** during pregnancy should become an integral part of antenatal care.

✓ **The state has to be accountable for ensuring the health of every woman** during pregnancy and delivery including access to safe abortion services if necessary.

- **Ensure social audits** including provision of resources and setting up mechanisms.
- **Quality of care in the private sector needs to be monitored and regulated.**
- Make **Maternal Death Reviews transparent and accountable**. **Strengthen reporting systems** for maternal deaths by including reporting from persons outside the health system like Anganwadi workers, teachers, PRI members and self help group members.
  - **Broaden district and state MDR committee**s to include civil society representatives, PRIs and independent technical experts.
  - **Include private sector deaths in MDR**
  - **Consolidated reports of MDRs should be made public** with details of actions recommended and taken.
  - **Tools should be modified** to include better evidence for technical details and also social determinants.
- Ensure **grievance redress mechanisms,** including immediate response systems and district level ombudspersons.

This statement is an outcome of discussions during the National Consultation on Maternal Health in India, held in Delhi on August 12 and 13, 2013 organized by the undersigned organizations.

CommonHealth

Coalition for Maternal-Neonatal Health and Safe Abortion

www.commonhealth.in

Cehat

Health For All Now! People's Health Movement

JSA

NAMHHR

Sahaj

Sama

sochara building community health

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