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A Comprehensive Strategy to Check Maternal Mortality

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Abstract

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. Researches and Health activists have come up with dissatisfactory findings in the maternal health care situation on the ground in the state of Uttar Pradesh as well as 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. However, they only give quantitative details of the number of deliveries are now taking place in the institutions and quality of care is no where mentioned or evaluated. The present paper is an analysis of the quality of maternal health care available in two selected districts of Uttar Pradesh. The paper concludes that mere conducting delivery at a health facility need not necessarily ensure a safe delivery since quite a good number of facilities are ill-equipped to give proper care. Also, it was found that nearly 67percent women leave the health facility within 5 hours of delivery, instead of 48 hours stay required for safety of mother and child.

Keywords: Maternal Mortality, Janani Suraksha Yojana, Obstetric Care, Maternal Death Review.

Introduction

Context of Maternal Health and Maternal Mortality

An estimated 293,000 women died globally in 2013 as a result of pregnancy-related conditions. Although maternal mortality ratios remain elevated in many areas, the maternal mortality ratio has decreased by 1.3 percent per year globally since 1990, with the greatest annualized rate of reduction in developed countries (-3.1 percent versus -1.4 percent in developing countries). Globally, reduction in maternal mortality has been attributed to reduction in the total fertility rate, increase in maternal education, and increased access to skilled birth attendants. Other factors associated with maternal mortality reduction include the promotion of policies to reduce anemia and malnutrition, prevent malaria in pregnancy, provide calcium and micronutrient supplementation, encourage delivery in facilities properly resourced for emergency obstetric care, discourage early motherhood, and reduce unsafe pregnancy termination. Most (62 percent) maternal deaths occurred in sub-Saharan Africa (179,000 deaths) . Nearly a third of maternal deaths worldwide occurred in two countries: 17 percent in India (50,000 deaths in 2013) and 14 percent in Nigeria (40,000 deaths). That is an alarming level of mortality, considering a relatively successful implementation of Janani Suraksha Yojana in India.

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 maternal health policy in India needs to move away from the paradigm of institutional deliveries to a paradigm of safe deliveries. The approach to addressing maternal health in India is fragmented and focussed on promoting institutional deliveries alone, while overlooking the broader framework of sexual and reproductive rights. 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 in accessing antenatal care, in some cases leading to the death of the woman. 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 reaching the planning tables. 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. 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 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.

Literature Review

The women health needs special consideration today as during the fertile years (between the ages of 15 and 49 years), the women's health is relevant not only to women themselves, but also has an impact on health and development of the upcoming generations. Researches till date have examined that the social and structural patterning of illness and well-being is still in its infancy.

In instances where women were studied, the focus of investigation traditionally has been restricted to their reproductive capabilities.

Interestingly, according to Walters and Denton (1997), "in seeking to reveal the implications of medication and medical dominance, the agendas of feminist scholars have often been shaped by the focus of medicine, that is, reproductive issues."

But, when we talk about a women and her health, it's not just the reproductive health, rather we deal with the health of a women in totality, i.e. a women's maternal health dealt along with the political and socio-economic dynamics around her.

Hence, several contrasting studies emerged in the health and social sciences literature concerning association between the multiple dimensions, multiple roles and women's well-being (Waldron & Jacobs, 1989). Here, multiple dimensions may include the social, political, economic, psychological, cultural and demographic factors affecting the women's well-being. And, by multiple roles, Waldron & Jacobs, bring into light the need of investigating the influence of multiple roles being performed by a woman on her health, for instance, the marital status, the structure of family, the parental status and the employment status which affects the women's physical as well as mental health at large.

Thus, when we discuss about women's health, the major concerns as identified by Astbury and White (1998) were six key themes relevant to women's health information needs. These themes, based on a review of research findings, policy documents, and the content of women's common requests to health information services, were:

1. Age-related issues
2. Emotional and mental health
3. Reproductive health
4. Violence and women
5. Women as carers
6. Emerging health issues (including women and alcohol; older women and low income etc.).

Astbury and White emphasize that "the health issues facing women are complex and diverse" (1998), and that women are heterogeneous in nature. Even within specific subgroups defined, for example, by age, geographic location, ethnicity, or education level, there is much heterogeneity, which demands "modes of information dissemination which are flexible enough to address individual women's circumstances and preferences" (Astbury & White 1998).

Women need not die in childbirth. We must give a young woman the information and support she needs to control her reproductive health, help her through a pregnancy, and care for her and her newborn well into childhood.

Present Study

A Facility Survey of 30 PHCs, CHCs and District Hospitals of two districts of Uttar Pradesh, namely Aligarh and Hamirpur was undertaken to assess the quality of maternal care. Along with infrastructural status, the period of stay at the facility was also considered. The maternal death review undertaken by these facilities was also reviewed.

Data and Methodology

The study has used both quantitative and qualitative techniques for assessment and analysis. In depth interviews of stakeholders and focus group discussions were also organized for qualitative analysis. Although, the study is based on primary survey, secondary data available with districts ie District HMIS, and monthly reports available at the health facilities were also used.

Major Findings

Maternal deaths are a significant cause of death in women in the 15–49 years age group, and they make up a larger proportion of all-cause deaths in the rural areas of the two districts. We found that the distribution of cause-specific mortality was the same across poorer and richer catagories of population, suggesting that the high burden of maternal death in poorer states is not due to an excess of one or more causes of direct obstetric deaths.

Use of healthcare was significantly lower in rural population compared with urban areas. Furthermore, emergency obstetric care (community

consultation and/or health-facility admission) was a significant point of access to care for most women in a critical medical state in both poorer and richer states.

Qualitative analysis shows that one-third of complications arose in pregnancy prior to the onset of labour. Narrative review lead to identify the timing of the complication relative to the onset of labour and we were able to identify the antepartum precedents of intrapartum mortality. The cesarean rate among delivered women is 7%, which is lower than the national average of less than 10%.

We were also able to differentiate between planned and actual place of birth, in order to differentiate between those seeking care for routine services and those seeking care in a critical medical condition. Routine care plays an important role in prevention and early identification of complications leading to maternal death.

Duration of stay at the facility was surprising and rather shocking : 67% women stayed in hospital less than 6 hours after the delivery, thus deprived of the monitoring, supervision and care needed for safe motherhood.

Discussion

1. In spite of the fact that the poorest and most vulnerable women are the most affected, the health system has fallen short in addressing maternal health with a comprehensive strategy and being accountable for it.
2. Maternal Death Reviews, though mandated since 2010, have not been institutionalised in the districts , and are not being carried out in several communities, especially in rural areas.
3. 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.
4. 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.
5. There is a lack of institutionalized systems of accountability to the community in the health system including for critical issues like maternal mortality.
6. Undignified treatment of women, especially those from marginalized communities, during childbirth has been reported from various parts of the state, 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.
7. 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.

1. For instance, screening for sickle cell anaemia in tribal populations, bed nets and malaria prophylaxis in malaria endemic areas.
2. Maternal health care needs to be placed in the context of all-round strengthening of health systems.
3. 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.
4. While the Janani Sishu 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.

5. Quality of care in the private sector needs to be monitored and regulated.

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

1. Needs of pregnant women should be prioritized in all social welfare programmes at all levels. (For example, adding maternity benefits in NREGA)
2. Specific interventions like one fresh cooked meal women in pregnancy and during lactation as demonstrated in Andhra Pradesh should be implemented.
3. 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.

1. Ensure social audits including provision of resources and setting up mechanisms.
2. Make Maternal Death Reviews transparent and accountable.

a) 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.
b) Broaden district and state MDR committees to include civil society representatives, PRIs and independent technical experts.
c) Include private sector deaths in MDR
d) Consolidated reports of MDRs should be made public with details of actions recommended and taken.
e) Tools should be modified to include better evidence for technical details and also social determinants.

3. Ensure grievance redressal mechanisms, including immediate response systems and district level ombudspersons.

References

1. World Health Organization. Evaluating the quality of care for severe pregnancy complications, The WHO Near-Miss Approach for Maternal Health, WHO, Geneva, Switzerland, 2011, http:// whqlibdoc.who.int/publications/2011/9789241502221_eng.pdf.
2. WHO. Ten leading causes of death in women aged 15–44 years by country income group, 2004. http://www.who.int/gender/women_health_report/womenandhealth_report_chart_chp4_table1.pdf.
3. State Maternal Mortality Review: Accomplishments of Nine states, Bacak SJ, Berg CJ, Desmaris J, Hutchins E, Locke E (Eds), CDC, Atlanta 2006.
4. Saving Mothers' Lives: Reviewing Maternal Deaths to Make Childhood Safer - 2003-2005. In: The Confidential Enquiry into Maternal and Child Health (CEMACH), Lewis G. (Ed), CEMACH, London 2007.
5. Maternal mortality and related concepts. VItal and Health Statistics. Dept of Health and Human Services. February 2007.
6. IIPS (2010) District level household and facility survey (DLHS-3) 2007–2008: India. Mumbai: International Institute for Population Sciences.
7. Jha P, Gajalakshmi V, Gupta PC, Kumar R, Mony P, et al. (2006) Prospective study of one million deaths in India: rationale, design, and validation results. PLoS Med 3: e18. doi: 10.1371/ journal.pmed.0030018
8. Jha P, Kumar R, Khera A, Bhattacharya M, Arora P, et al. (2010) HIV mortality and infection in India: estimates from nationally representative mortality survey of 1.1 million homes. BMJ 340: c621. doi: 10.1136/bmj.c62
9. Bhatia JC (1993) Levels and causes of maternal mortality in southern India. Stud Fam Plann 24: 310–8. doi: 10.2307/2939224
10. Nisar N, Sohoo NA (2010) Maternal mortality in rural community: a challenge for achieving millennium development goal. J Pak Med Assoc 60: 20–24.