What Women Need - More effective policies and programmes

- Since maternal health policy directly affects women, problem identification and policy design must involve and consult women's organizations working on the issue.
- Women need a policy that emphasizes the responsibility of local providers for comprehensive and continuous care in pregnancy, abortion or childbirth and post-delivery stages.
- The emphasis needs to be on 'safe delivery' rather than 'institutional delivery'; women should have the choice of where they want to deliver, with a trained and skilled attendant available.
- There should be comprehensive training of community-based birth attendants who can support women with normal delivery and routine care in pregnancy and after childbirth. These may be daughters or daughters-in-law of older traditional birth attendants.
- The attendants should be strongly linked to referral institutions and transport, in case there is a complication. There must be a strong 'chain of referrals' system, so that families are not left to their own resources in seeking care for complications
- Referral institutions must be immediately strengthened to provide effective emergency care, through provision of skilled personnel, functioning equipment and regular supplies. This means first referral units within each development block.
- Health systems issues must be dealt with on a priority basis, especially human resource policies within the health system.
- All maternal deaths (and near-miss situations) need to be reviewed or 'audited' for a given time period, to determine how they could have been prevented by the health system. These audits should, however, not seek to immediately blame the health providers; they should investigate the lapses or gaps within the health system first.
- Until the health system improves, there should be an easily accessible Grievance Redressal Mechanism in case of maternal death or disability, with a no-fault compensation

References

i Features and Frequently asked questions - Janani Suraksha Yojana, As on October 2006, GOI, MOHFW, Maternal Health Division, Nirman Bhavan, New Delhi.

ii The findings of the study were shared in a draft presentation on 22 April 2009 at New Delhi, called 'Glimpses of Institutional Maternity Care - Some Food for Thought'; the relevant information is at http://www.sahayogindia.org/pages/programmes/maternal-health-and-rights/events.php

iii Case (name withheld) presented by Mahila Swasthya Adhikar Manch UP to the State Human Rights Commission of UP on 28 May 2009 at Lucknow.

iv Case documented by study partner in West Bengal.

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Maternal Death and Disability in India 2009

How can we strengthen current maternal health policy & programme in India?

Almost sixty to seventy thousand maternal deaths occur each year in India, and 20 to 30 times more women become very ill due to pregnancy, childbirth or abortions ~

In 2005, the government of India announced the National Rural Health Mission (NRHM) with a goal of reducing the healthcare inequity between urban and rural India, and providing integrated primary health care to the poor. In an effort to reduce maternal deaths by providing skilled care in hospitals, NRHM gave an impetus to escalate institutional deliveries through financial incentives to the women, called the Janani Suraksha Yojana (JSY) launched in April 2005.

Within the JSY, rural women in states with high maternal mortality (called Low Performing States) are provided with a financial incentive of Rs 1400, and urban women with Rs 1000, provided that they deliver their babies in government health centres or accredited private institutions. In other states, women would be eligible for this cash assistance if they are either Below Poverty Line (BPL) and above 19 years of age, or belong for the Scheduled Tribes or Scheduled Castes. There is also a promotional incentive for the link worker called ASHA, to accompany the woman in labour to the hospital, pay for her travel, stay with her in hospital and visit her after she gets back home. Additionally the ASHA workers are meant to encourage pregnant women to register with their local health centre and ensure immunization of both mother and baby. With this incentive, institutional deliveries have increased in India from less than 30% in 2003 to 40% during 2005-2006.

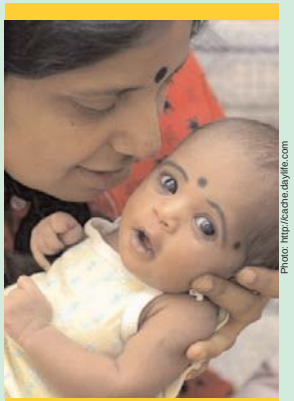
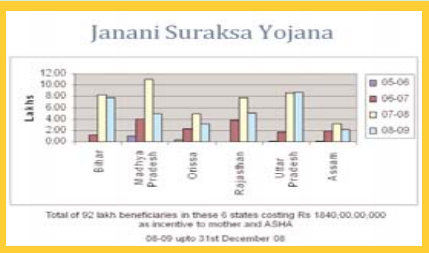


Photo: http://cache.daylife.com

The journey of child birth, if divided into four stages, i.e., pre-conception, pregnancy (ANC), delivery and post partum (PNC), should ideally have integrated strategies to provide a continuum of care, designed with women's involvement in the planning and implementing programmes. The JSY was meant to promote maternal health during at least three phases, but in India, the implementation strategies currently appear to be centred mostly on delivery without adequately strengthening all the four, as data and experiences show.

While attendance has increased in institutions during labour and childbirth, there has unfortunately not been enough improvement in infrastructure, health staffing or quality of service delivery. Although this was a goal within the RCH 2, recent data collected in the DLHS 3 shows that institutions are largely incapable of handling complicated maternal health conditions, which require not only specialized skills but also specialized serviced like Emergency Obstetric Care (EmOC) services, referral mechanisms and blood banks.

A recent study conducted by voluntary organizations and individuals in few blocks of UP, Uttarakhand, Bihar, Jharkhand, West Bengal and Karnataka revealed that increase in institutional deliveries in these states have not led to improvement in quality of maternal health care services. Women's own experiences have raised concerns over the poor quality of care, including poor infrastructure within institutions; the unsupportive, unprofessional and abusive behavior of the staff; poor staffing and low staff skills and competence; multiple referrals with no support for transportation; high costs, demand for bribes, irrational use of injections and in some instances lack of knowledge and non-receipt of JSY cash benefit. The diagram below reflects this experience, as it shows the changing number of beneficiaries over the last few years, with reductions in



MP, Orissa, Rajasthan and Assam.

Some gaps have been identified within current maternal health programmes and services in India:

- The total number of expected deliveries is roughly 25 million in India, so it is unrealistic to expect that an under-funded health system, providing poor quality of care, will be able to handle this burden and save women's lives.
- Currently the health system is unable to provide quality maternal care services in those states where most maternal deaths occur. The facilities in PHCs and Sub Centres are extremely basic, and FRU's are non-functional is many places. Blood banks are barely functioning in many districts. In this context, it becomes unethical to promote 100% institutional delivery, or to expect that the JSY payment will ensure maternal health and survival.
- When the poor women reach institutions during labour, they are compelled to purchase drugs and supplies from the market, and also have to provide informal payments to the staff. Some government doctors are engaged in private practice, and the families are compelled to pay steep rates there.
- Since infection prevention and hygiene is not of the best standard, women stand the risk of contracting hospital infections.
- Home births are being stigmatized as inherently 'unsafe' and training of community birth attendants has been neglected, thereby making home births even more risky.
- There is low attention to the continuum of care from pregnancy registration to a safe post-partum period. Institutional deliveries are assumed to be 'safe' despite the widespread lack of emergency care services.
- There is no support provided for referral to a higher level of care, and no responsibility taken by the institution for the next step of the woman's journey to seek emergency care. In fact the poor possess no documentation of even having attended an institution during labour.
- If women face ill-health, disability or death as a result of poor quality of care in government hospitals, the health system today has no accessible grievance redressal mechanism that the poor can use. This is a violation of their rights.
- After spending the energy and money on a hospital delivery, poor families are also unlikely to seek prompt care for post-partum complications, yet after delivery is the high-risk time when women can die of heavy bleeding or infections.
- Unfortunately the maternal health programme has become just like another narrow vertical public health intervention, through the Janani Suraksha Yojana Scheme that monitors maternal health only by the limited indicator of how many women received money after delivering in an institution. It does not monitor the continuum of care, the safe outcomes of pregnancy or abortion, or the quality of care provided.

Women's Experiences of Maternal Health Care

Death, despite all efforts

The story of M., a very poor woman of the Scheduled Caste, who died at the tragically young age of 26 in a district in eastern Uttar Pradesh, is a telling example of how maternal health care is unavailable and unaffordable for the rural poor, leading to fatal results.

M. was pregnant for the third time yet received no information to attend a clinic during pregnancy. On 12th September 2008 at about 8 pm in the night, she started having labor pains, and her family took her in a small cart to a CHC which was 2kms away, looking forward to the support of the Janani Suraksha Yojana money they would surely get. There she did not see any doctor, but a nurse (ANM) tried to force the baby out by putting pressure on the abdomen all night. The next day, the ANM asked the family to take her away to the district hospital without offering any referral support such as transportation.

Having no money, the family took her back home. But her situation got worse, so the next morning, they managed to get her on a tractor and took her to some private hospital. The private doctor refused to treat her, but the desperate family begged him until he relented and gave her an injection. This led to the birth but the baby was already dead; meanwhile M was bleeding dark clots when she came home.

Within five days she had pain and swelling in her abdomen and legs. She was so ill that this time her family travelled 40 Km with her, to reach a government hospital late at night. No one would even open the gate at 10 pm, so once again they took her to a private hospital, where the doctor once again refused to admit her. In a last-ditch effort the family took her back to the government hospital once again, and waited outside the gate all through the night.

At 8 am the hospital gates opened; they took her in and a doctor started her treatment. She died within a few hours. There was no post-mortem, no review of why the death had occurred and no compensation to the family for the lack of care that led to her death.

Poverty and Health Access: A Vicious Cycle

The inequity in access to health services is clear from this story in West Bengal. WB has fairly positive health indicators, but there are wide disparities among districts, castes, and religious groups:

The story of S. a rural, non-literate young woman from a northern district in West Bengal who is a home- based beedi roller, shows why women from poor marginal communities may decide never to go to a hospital for deliveries.
S. got married at 18 years to a daily labourer; their family income is around Rs 2000/- per month, and they have a BPL card. During her first pregnancy she was just nineteen, and stayed mostly at her natal home during pregnancy. She went for pregnancy registration to her village sub-center, and received tetanus injections but no examination was carried out, and no one checked her blood pressure.

Her family planned on a home delivery, so when she started labour pains, they called the local Dai. The pains went on for two days without delivery, and she became unconscious. The local Dai gave up the case; it was quite late at night and there was no health worker for them to consult. With great difficulty they arranged a vehicle and her uncle took the decision to take her to the Sub-Divisional Hospital 15 km away.

When she reached, the staff including the doctor and nurses on duty began to slap her. She regained consciousness and begged for some medicine to reduce her suffering, but they verbally abused her. They got her family to buy the IV fluids from the shops; it was not provided by the hospital even though she was so poor and had a BPL card.

After a while her son was born through normal delivery, but they gave her a cut (episiotomy) and stitched it up later. These stitches later got infected and she was in great pain. She could hardly sit up or take care of her newborn child. After coming home, as no government health worker provided her postnatal care or advice, she sought treatment from the local (unqualified) practitioner.

S. was so traumatized by the entire experience, that she feels that she would never go to the hospitals for delivery in future.

Her family spent Rs 700/- for medicines including IV fluids in hospital, and later for medicines given by local unqualified medical practitioner for the infected episiotomy stitches. Moreover some Rs 300/- was spent on transport, making a total of Rs 1000, or half their monthly family income. Her mother-in -law became aware of JSY benefits from the local health worker and NGO field worker. They received Rs 500/- after one month of delivery from the local sub-center. This was used to buy a goat for the family. However, they did not receive the remaining Rs 200/- because there was some error in the paperwork.