Civil Society Suggestions to Implement the Recommendations of the Report on Maternal Mortality in India by the UN Special Rapporteur on the Right to Health[i]

Developed during the Public Dialogue[ii] , 13 August 2010, New Delhi
Organized by the National Alliance on Maternal Health and Human Rights

Regarding Policy and Budgets

- Fulfill the election promise of better GDP to health budget ratio[iii] through massive increase of resources - with clear indicators for accountability and monitoring (governance, human resource, grievance redress, community-based monitoring, etc)
- Combine increased resources with serious investment in building capacity for decentralized planning and management at district level; as well as removing finance-flow bottlenecks and correcting skewed allocation of resources
- The Planning Commission should monitor the MMR and the findings from analysis of Maternal Death Audit as they have set up the 11th Five Year Plan goals of reducing MMR. They must hold accountable the Health Dept and RGI to produce on annual basis (not 3 yearly basis) the correct data and rates in a timely fashion - within 3 months of the year being over (the last MMR estimate we have is of 2004-6, even now in 2010). The same should apply for Still-birth rate, Neonatal mortality and Infant Mortality Rate.
- States should make public annual Maternal Death Reports, with analysis of causes and followup action proposed, so that the Goals of the Five Year Plan are met.
- In order to meet the 11th Plan Goals, there must be more attention to examining maternal health Outcomes (such as the number of maternal deaths within 42 days, numbers of deliveries that had safe outcomes for both mother and baby, records of post-partum complications, or any other adverse outcomes). Currently the focus is on Inputs (like the JSY) and Outputs (like number of women who have received JSY, or number who have attended institutions during childbirth)

- There needs to be an objective re-examination of the role of "incentives" in reducing maternal deaths; instead the quality orientation of services should be tracked by monitoring maternal, fetal and neo-natal survival and extent of infection prevention or management of obstetric or post-partum complications[iv].
- Given the vast number of women dying[v], the government must assume greater accountability for each case. A reasonable amount of financial compensation for each maternal death, such as Rupees 2000-3000 may be paid in monthly instalments over 3 years - for child support if there are children, or for family support.
- Staff posting has to be rational & equitable. There has to be transparent transfer and posting policy and an annual report on T & P must be produced by each health department for enhanced acountability. Government should spend more on the training of midwives.
- Enacting National Health Act with comprehensive, free access to services without targeting; ensuring Right to Healthcare in public and private sectors (regulated).
- Universalization of rights: Moving towards participatory regulation of entire health sector in framework of publicly managed and funded universal access system, with no targeting at all.

Footnotes:

(i) The Report and the Supplementary note are available at http://www.essex.ac.uk/human_rights_centre/research/rth/index.aspx
(ii) 75 participants including academicians, NGOs, national networks, the UN-Special Rapporteur on the Right to Health, an MP from the Parliamentary Standing Committee on Health & Family Welfare, Members of the National Human Rights Commission and the Planning Commission, donors, and UN representatives.
(iii) India's current ratio of 0.89% of GDP spent on health is lower than many developing countries - Sri Lanka is 2%, Costa Rica is 5.3% and Cuba is 7.1%; Malaysia and China is 1.9%.
(iv) The CAG report on the NRHN shows the gaps in JSY records, meaning it cannot be always equated with either institutional delivery or safe delivery.
(v) Estimates range from 65,000 to 100,000; an unacceptable number for any country and more so for India.

Regarding Programme Implementation

- We need to urgently reconsider how safe motherhood may be ensured for the significant proportion of pregnant women still not reaching hospitals[vi]- it is not adequate to talk of only Institutional Delivery but the focus should be on Safe Delivery, even if it occurs at home. The first and second ANMs posted in the sub-centres should provide domiciliary care during childbirth and in the post-partum stage if the mother is not reaching the hospital. Those women who develop any danger signs must be visited at home by the PHC doctors and if needed, transported to the facility for further treatment.
- The JSY focus should be expanded from institutional care to continuum of care; towards this all treatment for obstetric or post-partum/ante-partum complications must be free with adequate follow-up at home, based on a protocol. There should be no cost-recovery for any level of maternal and child care.
- There is need for wide publicity regarding 'guaranteed free maternal and neonatal health services'; the name of the responsible centre should be communicated during ANC to all pregnant women who are registered to encourage them to seek life-saving care. The provision of free services should be monitored by the community and an independent body.
- Transportation of mothers and newborns must be state responsibility (since many lives can be saved during two-hour window), as well as transport for treatment during complications and all referrals.
- An accessible Grievance Redressal Mechanism needs to be urgently constituted for cases of denial of maternal health services. If the Rogi Kalyan Samitis are to play this role, special capacity building is required and protocols must be set up for this.
- It is necessary to weave in the element of social exclusion into our perception with a focus on the marginalized groups such as the Dalit, Muslims and tribals; staff orientation must include orientation to the realities of poor rural women.
- Lack of nutrition which is a major cause of anaemia and consequent maternal deaths needs to be addressed through effective implementation of food and nutrition programmes.

Regarding Programme Monitoring

- The monitoring of process and outcomes through maternal and neonatal death audits should be expanded to also include audit of severe morbidities and near-miss cases[vii]. Maternal death audit should have components of participatory community audit with inputs from involved person and community; adopting joint enquiry method. Families reporting maternal deaths and participating in audits should be compensated.
- Contact with any provider during pregnancy should lead to a Tracking System by which all complications, referrals, lab tests and all treatment are recorded along with outcomes; the record of this should be provided to the woman herself, as well as be available with the local ANM. This will be an essential tool for any post-facto audit
- Need for stronger commitment and support at National level and in all States to Community-based Monitoring (CBM) of health services, especially CBM of maternal health services. Progressive generalisation of CBM across the country based on civil society facilitation. Adequate resource provision for capacity building of VHSCs/ community groups to undertake CBM.

Regarding the Private Sector

- All Public Private Partnership (PPP) or private services for maternal care should be subject to the same minimum norms as the public sector, report outcomes and be under the purview of a common grievance redressal system as and when it is developed.
- All women delivering in private or public or NGO hospitals must be legally entitled to their rights to adequate information, dignity, privacy, informed consent, access to medical records, non-discrimination, free beds in trust hospitals etc. enabling them to receive better quality and access to maternal health care.
- To ensure this, the rules for the recently passed National Clinical Establishments (Registration and Regulation) Act should explicitly include protection of Patients rights as mandatory process standards.

Footnotes:

(vi) According to DLHS-3 (2007-08) it is 53% of approximately 25 million pregnant women, which would be roughly 13-14 million women in India each year.

(vii) DLHS -3: post-partum complications were reported by 39% of women with home deliveries and 31% with institutional deliveries.

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~Towards Attaining Highest Quality of Maternal Health for the Marginalized in India~

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