

## Overview and Key Findings

Paul Hunt's Report on Mission to  
India – Nov. 22 to Dec.3 2007

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## Overview information

- Objective of visit: to examine Maternal Mortality through the lens of Right to Health (RtH)
- Particular attention to maternal mortality in Rajasthan and Maharashtra
- Generalisable recommendations
- Focus on
  - Health workforce: availability and accessibility
  - Accountability

## Methodology

- Meetings with
  - Ministers of Health and Family Welfare, Women and Child Devlt, External Affairs
  - Chairpersons - National Human Rights Commission, National Commission for Women
  - Senior officials – Rajasthan and Maharashtra
  - UN Country team
  - Senior judges and lawyers
  - Civil society organisations including medical associations
- Visits to rural and urban clinics and hospitals in both states

## Contents of Supplementary Note

- Features of global maternal mortality: biological, social and structural causes
- Contextual information about India, Rajasthan and Maharashtra
- India's constitutional arrangements, international commitments, national human rights institutions, recent progress in health sector
- Govt. health policies and programmes, NRHM

### Right to Health Approach to Maternal Mortality

- Identifying right to health values and principles: equity, non discrimination, transparency, quality, participation
- Identifying right to health processes and mechanisms
- Applying the above two to 6 essential building blocks of functioning health system: *services, workforce, information system, products and technologies, financing, governance*

### RtH Approach to MM requires...

- Countries to prioritise interventions that are best available to them based on
  - Epidemiological evidence
  - Resource availability
  - Other human rights considerations.
- 4 cornerstone interventions to reduce MM
  - Contraceptives
  - Skilled birth attendance
  - Effective referral
  - EmOC, and others depending on context

### Key Findings: Health Workforce 1

- '*massive, crippling crisis*': lifesaving care unavailable in rural, disadvantaged areas
- Public facilities without providers
- Private sector impoverishing women and families
- '*Access is profoundly inequitable*'
- Report focuses on SBAs, senior technical managers, providers of EmOC and anaesthesia

### Key Findings: Health Workforce 2

- FRUs and CHCs – acute shortage of specialists and anesthetists as well as inequities in access
  - 75% to 83% posts of obstetricians vacant in tribal areas in Rajasthan
  - 79% anesthetists' posts vacant in Rajasthan
  - 17 week course for MOs but legal challenge by professional association and irrational management of trained MOs.

### Key Findings: Health Workforce 3

- Availability of SBAs
  - Enough ANMs, but....
  - Problems like...
    - absence from the place of work,
    - required competencies not present,
    - reduced training period
    - pre service training not skill based

*“M’ has almost disappeared from the job title of the ANM!”*

### Key Findings: Health Workforce 4

- Senior technical managers
  - *‘extremely weak technical capacity for managing MH programmes’*
  - Cost of increasing technical senior managers only a small fraction of total resources for MH
  - India needs 110 senior technical MH managers at national and state levels, Raj. 5-6, Mah. 9-10
  - MH Technical Advisory Committees at national and state levels (Recommendation)

### Key Findings: Health Workforce 5

- EmOC
  - ‘6000 doctors needed in 2000 rural FRUs’ (GOI estimates)
  - In 1999, only 800 Obs in rural FRUs in public facilities to do Caesarian sections
  - 25,000 rural GPs to be trained in CEmOC
  - Evaluation of pilot program – *‘only one piece of the puzzle’*
  - Lack of anesthetists biggest obstacle for EmOC
  - Training of MOs –33 against target of 377 (Raj 2009).

### Key Findings: Health Workforce 5

- Janani Suraksha Yojana
  - Increased institutional deliveries but.....
  - Problems like
    - Conditionality
    - BPL card
    - Actual costs more than cash benefit
    - Including ‘informal’ costs due to corruption
    - Quality of services in institutions

*‘....offensive, unethical and violation of Rt H’*

### Key Findings: Health Workforce 6

- Public Private Partnerships, eg Chiranjeevi
  - Problems.....
  - 700 specialist Obs in govt. service, 20,000 in private sector

Discourse needs to shift from Institutional delivery to Safe delivery – CH position

### Key Findings: Monitoring Accountability and Redress 1

- Growing recognition about importance as well as inadequacies
- Community monitoring processes '*patchy*', '*minimal participation from health officials*'
- Issues in counting maternal deaths – under reporting, yearly rates not generated by SRS
- Verbal autopsies done, but not analysed and used
- Punishment of individual health workers a deterrent

### Key Findings: Monitoring Accountability and Redress 2

- Indicators for EmOC not established
- Enormous and rapidly growing private sector – 25 % women in Raj. Use pvt sector for delivery services
- Large informal sector mainly used for abortion services
- No significant process by NRHM for regulating private sector

### Conclusion

- State's obligations in relation to determinants of maternal health - poverty, gender, social positioning – also
  - Anaemia in 55% women and increasing. Higher amongst disadvantaged groups
  - 16% girls become mothers while in their teens
- Maternal mortality tip of the iceberg – maternal morbidities need focus too
- Macro economic policies – eg. medical tourism?

## Finally.....

- Occasion of MDGs review, need to emphasise:
  - Reductionist approach to SRHR,
  - Verticalisation and compartmentalisation of the MDGs
  - Inadequacy of indicators to capture nuances

*Thank you*