

**A Civil Society Dialogue towards Action towards realizing the Right to Maternal
Health
New Delhi, 21 April 2009
Background Note**

It is estimated that around half a million women die each year all over the world of preventable causes related to pregnancy, of which half are in sub-Saharan Africa and the other half almost entirely in South Asia. In Asia, India is estimated to have close to a hundred thousand maternal deaths each year. The WHO estimates for maternal mortality in India came up with a ratio of 570 deaths every 100,000 live births, which was brought down in the Registrar General's report (2006) to 301. Yet at almost 80,000 deaths each year, and possibly around 20 to 30 times that figure suffering ill-health and near-misses, maternal health remains a huge challenge for the country.

India has made global commitments to reduce maternal mortality at Alma Ata, many years ago, and more recently at the ICPD in 1994, the MDGs in 2000 and the WHO 'Delhi Declaration' in 2005. India has put in place national programmes that address maternal mortality over the last two decades; such as the CSSM (Child Survival and Safe Motherhood) in 1992 the RCH (Reproductive and Child Health) programme in 1997 and the NRHM (National Rural Health Mission) in 2005. India does not lack for skilled personnel as it exports a large medically trained workforce to many countries. The country has become a hub of 'medical tourism' as its highly-skilled and comparatively less expensive curative health services attract users from all over the world. Very advanced technologies for information and communication have spread to remote corners of the country. Despite all this, each year many thousands of women continue to lose their lives or suffer ill-health due to causes¹ such as excessive bleeding (38%), sepsis (11%) and abortions (8%), all of which are preventable or can be managed by known interventions.

Maternal death is an important indicator of the reach of effective clinical health services to the poor, in this case poor women. Poor maternal health also reflects the aggravating factors for all ill-health, such as poor nutrition, lack of clean water and the incidence of infectious diseases. Since households bear the lion's share of health expenditure in India (currently estimated at 70%) as compared to the government, maternal health often accounts for unaffordable out-of-pocket expenditure that pushes poor families into the debt-trap. The continuing high levels of maternal mortality also indicate neglect over many years in favour of other vertical programmes and priorities². Poorer women and women from marginalized communities face higher rates of maternal deaths due to lack of proper monitoring at grassroots level, and lack of effective health systems review.

What emerges as a burning need is the improvement of health systems to be more responsive to healthcare needs of poor women, and to provide comprehensive,

¹ As set out in SRS report of the Registrar General 2006

² In contrast to other countries such as Sri Lanka that have made maternal mortality reduction their main public health priority for many years

accessible, acceptable and affordable high-quality care. Short-term and vertical policy solutions lead to more problems for poor women instead of improving health outcomes. The rampant corruption and poor standards of care faced by women are aggravated by the lack of proper mechanisms for accountability or effective grievance redressal.

For many decades now, Civil Society Organisations (CSO's), doctors, researchers, lawyers and others have been pro-actively making diverse efforts across the country to address this issue, using a wide range of approaches:

- Many organizations have contributed to strengthening women's right to maternal healthcare while working with broader agendas, while some have remained focused specifically on the issue
- A large number of NGOs have actually provided maternal health services and information to millions of poor women in marginal and under-served areas, or built capacities of grassroots workers
- Other organizations or researchers have used strategies such as building evidence on what works, or monitoring the current situation and presenting the findings with suggestions to the government
- A strong role has been played by networks and large mass-based organizations, which have run campaigns and even advocated at political platforms for the right to health and nutrition, which includes improved maternal health
- Some organizations have specialized activities like legal methods (case-work) or media advocacy or budget analysis or raising international standards.

This brief list cannot do justice to the diversity and invaluable contribution of all these efforts in trying to reduce maternal deaths. There is much to learn from each others' work across the country, both in terms of local realities, and in terms of effective strategies for realizing women's right to health: the achievements and the challenges faced. There may be opportunities for us to contribute to each others' strategies and campaigns, or to strengthen each others' research capacities. There is also a need for more sustained dialogue among us: to share recent findings and to debate the nuances of current policies in the light of women's experiences and their struggles in claiming the right to health care.

Towards building such a supportive space where we can have exchanges about our efforts and our learning, and to move towards a long-term broad-based alliance of organizations and networks already working on issues around maternal health, a national civil society dialogue on women's right to maternal health is being organized on 21 April 2009.

The meeting is being organized on behalf of the Healthwatch Forum³ and the Steering Committee for ICPD+15 in India, at the Indian Social Institute, New Delhi. We expect

³ Healthwatch Forum is an unregistered civil society platform to raise issues of women's health and rights, and communicates mainly through the e-group "reprohealth_india"

to have with us participants working on maternal health from at least 12 states of India, as well as researchers and representatives of national networks.

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Draft Agenda (as on 7 April 2009)

9.30	Registration	Tea/Coffee, setting up display tables for materials
10.00-10.45	Welcome, context and introductions	Maternal health in India: the need for working on women's rights to health
	<p>Plenary that lays the ground on rt to mat h, looks at progress</p> <p>Parallel round tables -10 min on each strategy</p> <p>Report back to plenary</p>	<p>Where is community monitoring:</p> <p>MSAM grassroots action?</p> <p>Address state, rts holders</p> <p>EVIDENCE SESSION ON RESPECT PROTECT FULFILL?</p>
10.45-12	<p>Panel One on strategies for women's right to health</p> <p>Chair - Dr. Imrana Qadeer</p> <p>Discussant - N.B. Sarojini</p>	<ul style="list-style-type: none"> • Drafting the Bill on the Right to Health for all - Jan Swasthya Abhiyan • Putting right to health issues in the election agenda - <ul style="list-style-type: none"> ○ Wada na Todo Abhiyan, ○ Jan Swasthya Abhiyan, ○ Centre for Legislative Research and Advocacy (CLRA) • Scanning health budgets - Centre for Budget Governance & Accountability (CBGA) <p>Discussion</p> <p>Summary by Chair</p>
12-1.30	<p>Panel Two on strategies for women's right to health</p> <p>Chair - Indu Kapoor</p> <p>Discussant - Leila Caleb Varkey</p>	<ul style="list-style-type: none"> • Using legal strategies in Orissa and Madhya Pradesh - Human Rights Law Network • Public hearings with guardianship institutions - <ul style="list-style-type: none"> ○ Jan Swasthya Abhiyan regional hearings ○ White Ribbon Alliance India in Orissa (WRAI) • Mission of the Special Rapporteur on the Right to Health and the UN Human Rights Council - SAHAYOG <p>Discussion</p> <p>Summary by Chair</p>
1.30	Lunch	
2.30- 4	<p>Panel Three on strategies for women's right to health</p> <p>Chair - Renu Khanna</p> <p>Discussant - Aparajita Gogoi</p>	<ul style="list-style-type: none"> • Evidence gathering on quality of care, access and inclusion - <ul style="list-style-type: none"> ○ Dr. S. Iyengar - Rajasthan ○ Smita Bajpai - Gujarat ○ Jayeeta - Study on Institutional delivery in 6 states • Capacity building - Creating a cadre of Skilled Birth Attendants in Andhra Pradesh (Dr. Prakasamma) • Information dissemination - Work with the

		media in Uttar Pradesh (Shakuntala) Discussion Summary by Chair
4-4.30	Tea/Coffee	
4.30-5.30	Ways forward Chair/Moderator - Jashodhara	Plenary discussion on why (and how) do we need to work together?
6.00	Close for the day	Announcements for dinner, for transport and check-out from rooms