

Equity and quality in maternal health services

Asha Kilaru, Francis Raj, Smita Bajpai
and others

Civil Society Dialogue with UN SR

Clustering of maternal deaths

- Majority of the deaths are among
 - Illiterate women or women with low education
 - Women who conceive early
 - Women from SC and ST communities
 - Daily wage labourers
 - Other marginalized groups – e.g. tribal populations, migrants, rural, young/unmarried people, HIV+, Religious minorities
 - Maternal deaths are under-reported by the civil registration system; even hospital deaths are not inquired into

Socioeconomic inequities persist in service *provision* and *uptake*

- inefficient and uncaring hospitals and providers, many of whom perpetuate existing caste, class and cultural biases
- unregulated and harmful medical practice

Exacerbated by

- Weak community capacity to negotiate health care
- weakened and often non-existent primary health care system

Social Exclusion and ANC

- From NFHS - 3, The proportion of SC/ST women who have two or more TT (or were given IFA) injections is much lower than other group (61 for SC to 82% for other; 17% for SC opposed to 30% for other)
- NFHS -3 data shows disparities in maternal care indicators across many groups

Weak primary health care system

- Women from marginal groups are most affected by a weak primary health care system that lacks staff, equipment, skills, supplies, drugs, and that does not treat them with dignity
- There is a lack of sensitivity to poor women and their rights
- Corruption at all levels – informal payments, ‘speed money’
- User charges – many poor families are not considered BPL because they lack certificate
- Unregulated and harmful private medical practice

Ineffective and uncaring service provision

- No continuum of care for maternal health from pre-pregnancy, through pregnancy and postpartum (incl. Abortion services), including linkages from home to referral facilities
- Persisting vertical programme priorities and often single-shot solutions for complex problems

Are institutional deliveries safe, safer?

- If facilities are open and providers are available
- If action is taken immediately
- If all women are treated equally
- If quality is maintained
- If continuity of care is ensured

Childbirth should be safe whether at home or hospital – this requires delivery services at home linked to emergency care at institutions

Successful examples of reduced maternal mortality for rural / tribal areas of India

Building capacities and skills of Dais, supported by continuum of care (Gujarat, Karnataka, AP, Rajasthan, Tamil Nadu)

- Technical skills on her core role during labour and childbirth,
- Her expanded role in Post childbirth and newborn care, linking with the health services for ANC/ referrals, Primary Health Care, Reproductive health issues, health issues.
- Leadership/coordination skills to establish linkages between community and public health systems
- Attitudinal aspects to deal with class, caste, gender issues
- Social aspects to act as a social change facilitator

Understanding Maternal Mortality in India

Social Determinants and Contextual Factors

Abhijit Das
Healthwatch Forum

Maternal Mortality :Immediate Causes

- *Haemorrhage*
- *Sepsis*
- *Anaemia*
- *Infection – Malaria*
- *Pregnancy Induced Hypertension*

Lack of skilled attendance at birth

Lack of emergency services

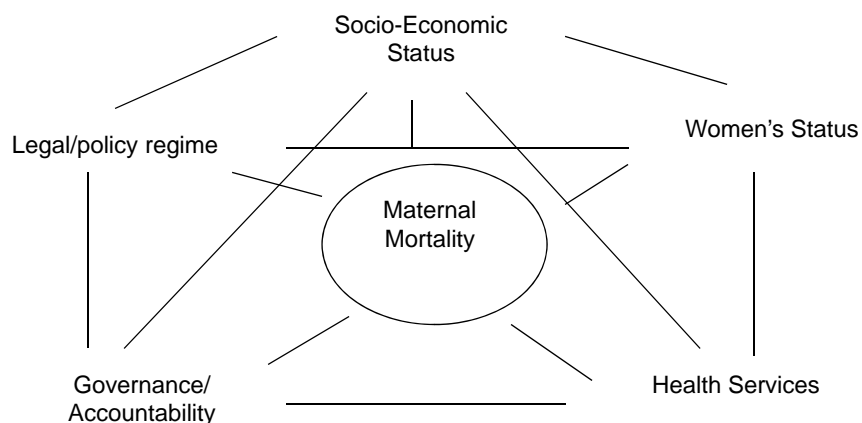
Delays.....

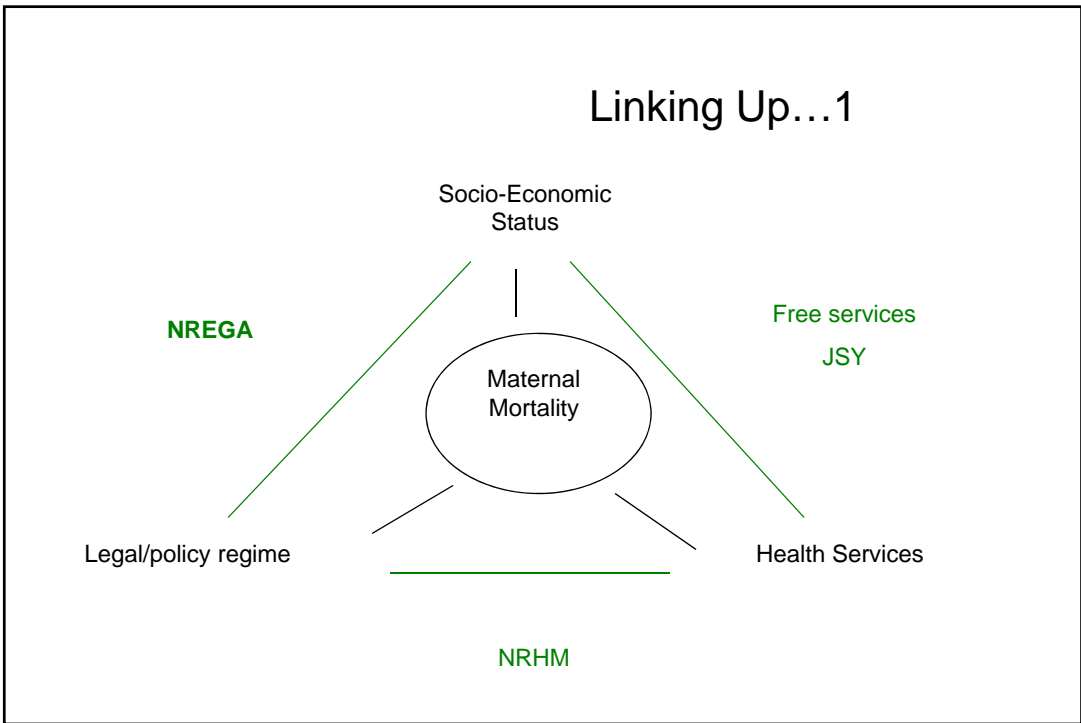
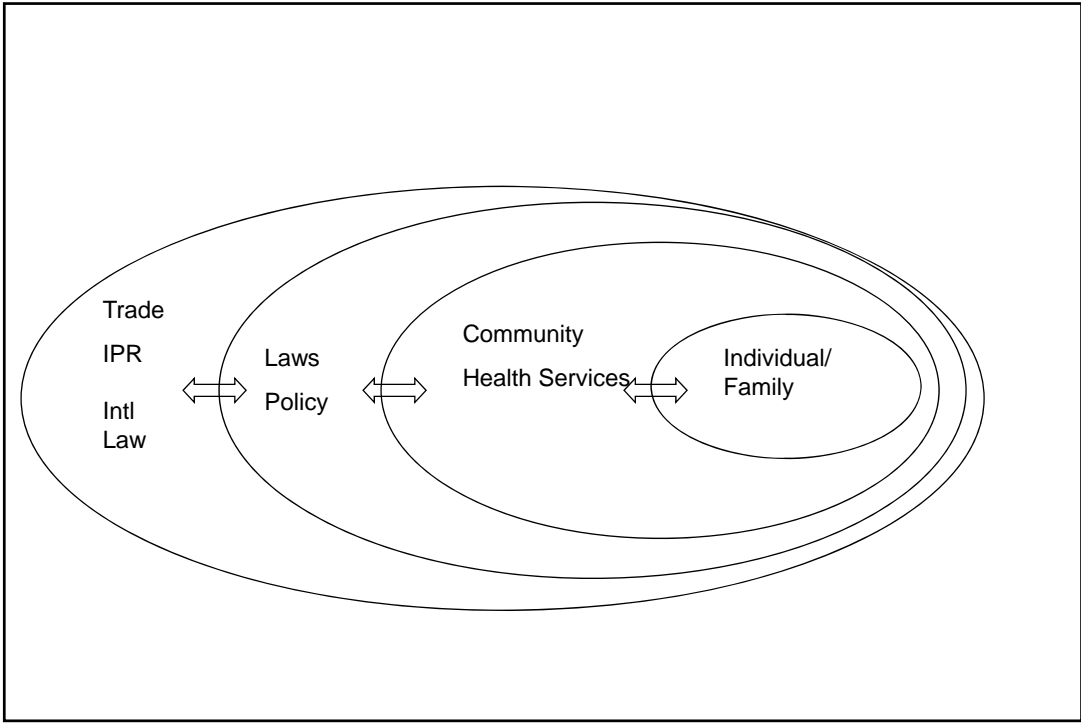
Maternal Mortality : Socio-economic Determinants

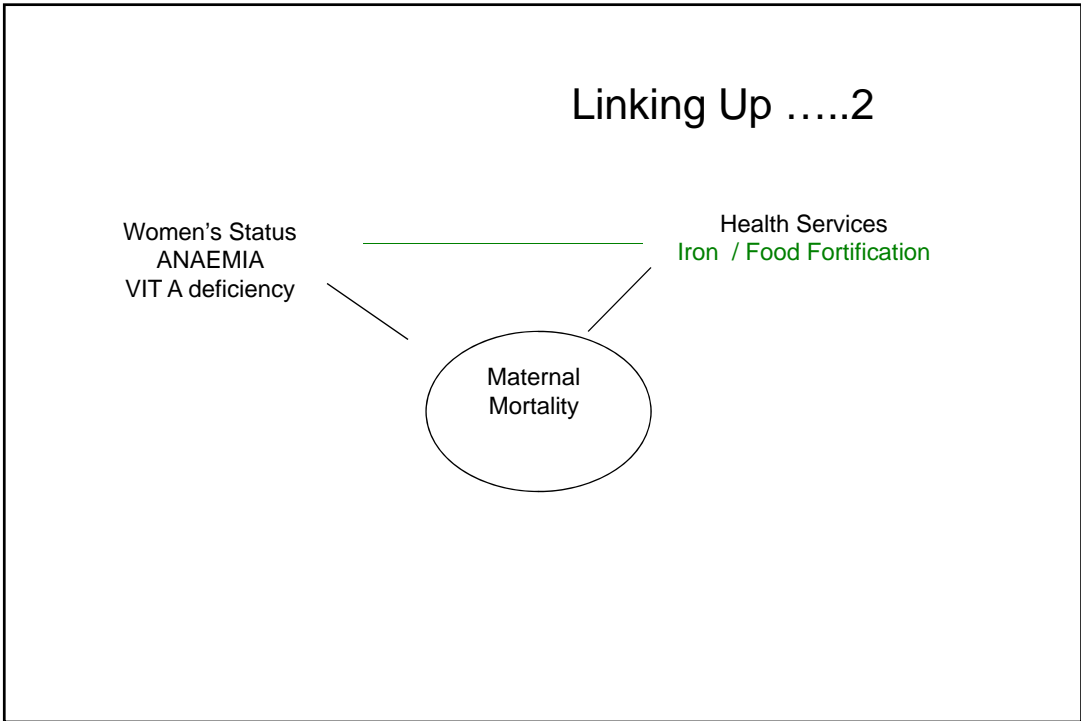
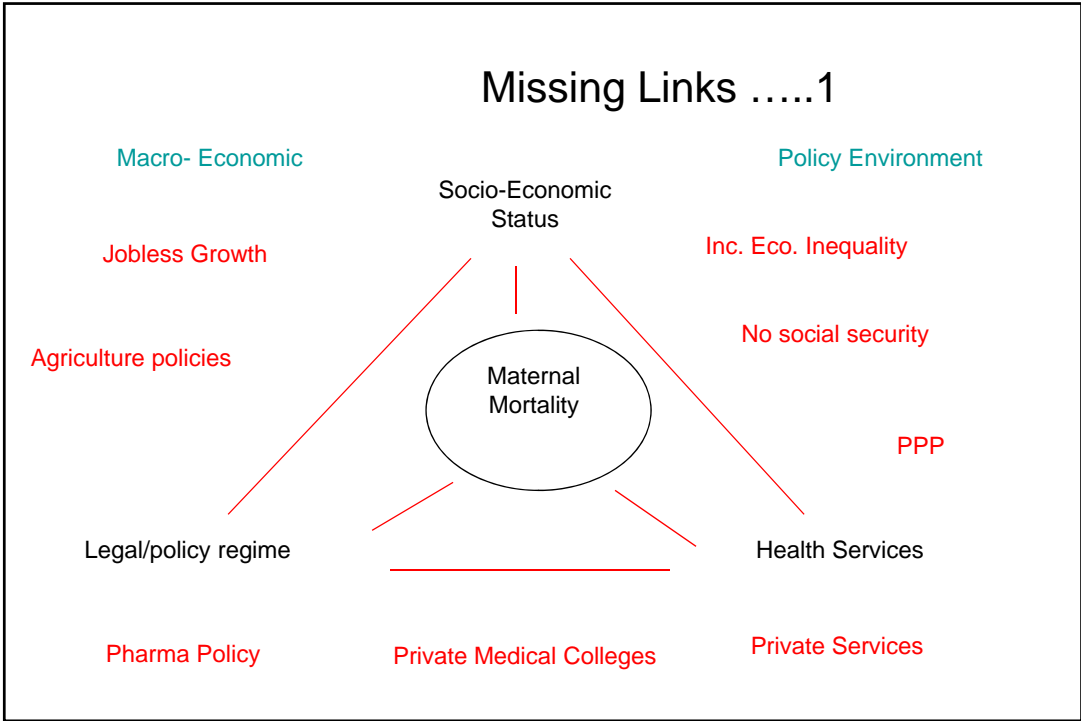
Evidence and Community level experience Show that Maternal Mortality is influenced by

- Poverty
- Women's Literacy
- Social Exclusion faced eg. dalit/tribal and minority section
- Better access to food and nutrition (anemia as a consequence)
- Age at marriage and childbirth
- Access to health services – including contraceptive and abortion services

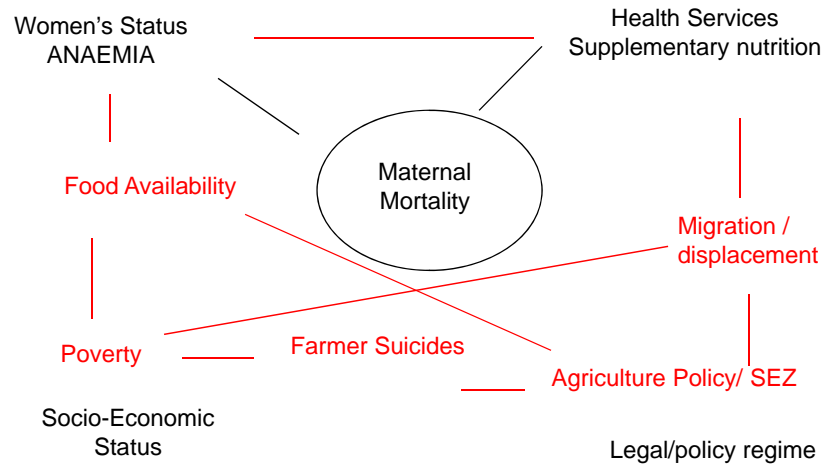
Maternal Mortality : Complex Causal Web







Missing Links2



A rights based approach to save lives needs to understand, operate within and change the context.

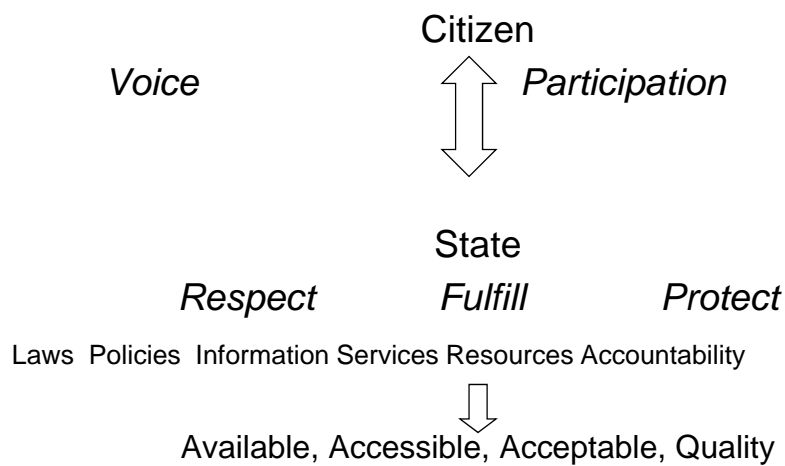
Thank you

Rights and Accountability

Women's right to maternal health in India

Presented at the Civil Society Dialogue
with the
UN Special Rapporteur on the Right to Health
1 Dec. 2007

A Rights Framework



The Right to (Maternal) Health

For health care and all underlying determinants of health (nutrition, sanitation, shelter, safety, etc):

- Are services available? Where are they available?
RCH Facility data ...
- Are services accessible? To whom, which social groups? On what payment and with what result? Is information accessible?
- Are services acceptable? By all? Gender sensitive?
- Are services of highest quality? How is that decided and monitored?

State obligations

- Fulfil the right to health: facilitate, provide and promote - through legislative, budgetary, administrative, judicial, promotional and other measures
- Respect the right to health: refrain from interference
- Protect the right to health: take measures to prevent third parties from interfering with the right to health

Normative level and actor-oriented perspectives

- **Normative** level – many laws and policies in India
There is a flawed assumption that the system will implement whatever is passed by policy makers
 - **Actor oriented perspectives:** Lived experience in claiming the right to health – very different realities depending on your class (paying capacity), gender, caste, location and level of political influence
- Rights claiming is fraught with contestation

Normative level

- Through Constitutional mention, (Directive Principles); **laws** on Abortion (MTP), age at marriage, Right to Information; SC rulings on right to food and qoc in FP operations; **policies** like NPP 2000 and NPEW 2001 and programmes like the NRHM (includes entitlement – Concrete Service Guarantees)
- Through participatory monitoring mechanisms (RKS, Community monitoring), Patients' Charters, public hearings
- Through institutional delivery with JSY, PPP, IPHS

Yet gaps do remain....

- AIDS and Polio eradication remain competing high priorities
- Women are seen as objects without their preference or choice
- Maternity services and benefits are debated as it is linked with 'irresponsible breeding';
- Abortion access being curtailed due to falling sex ratio
- Monitoring systems not in place to ensure quality compliance, not well-resourced yet

Weakening of state health sector

- Marketing tertiary level care globally while primary level collapses
- Vertical programmes continue, drawing attention away from regular health services
- Strong involvement and influence of international organizations as opposed to local public health experts
- Decimation and de-skilling of staff; lack of resources for preventive and promotive health
- Promoting roles of the private sector, without regulations in place, incl. privatization of medical education (affirming profit motives)
- Little dialogue with ISM practices

Actor Oriented perspectives

- ✓ Doctors as a professional class enjoy considerable local power and influence; they may have protection of local political forces and enjoy impunity
- ✓ There is a power/ class/ education differential between the poor, rural female users and the providers
- ✓ The poor are quite unimportant for the system and providers, since they have limited paying capacity
- ✓ There are vested interests in denying care at state facilities (to increase use of private facilities)
- ✓ There is a huge profit motive, and corruption at every level
- ✓ There has been no practice of participation of women or user communities

From rights to accountability

CASES SHOW – No documentation of deaths and near-misses, no grievance redressal, compensation, legal protection of victims; no liability at any level

- Articulation of the right to maternal health – to health (morbidity) and to life (deaths)
- Proactive measures to ensure services from an equity framework
- Ensuring liability in case of denial of care or negligence or malpractice
- Building up of 'voice' – women and men need to demand and monitor services

CS Good practice for Citizen Voice

- Documentation of Maternal Deaths
[AP, UP, Bihar, Jharkhand, Rajasthan, Karnataka]
- Maternal Health Social Audits
[Uttarakhand and UP]
- Women's Health Rights Forum as in UP
- Public hearings on MH with SCW as in Orissa WRAI
- Civil society networks around MH
[UP, AP, Jharkhand...]
- TBA Union/ Organisation – as in Gujarat
- Citizen's Watch Reports
[JSA, CHSJ, HW Forum ...]

Thank you!

With inputs from the entire group,
Jashodhara
(Healthwatch Forum)

RECOMMENDATIONS

From

CIVIL SOCIETY

**New Delhi
1 December 2007**

RIGHTS

- **Recognise right to maternal health**
- **Recognise right to safe and legal abortion**
- **Articulation of the right to maternal health (including abortion) should be linked with surrounding vital rights –**
 - **dignity,**
 - **self-determination/ choice,**
 - **Privacy, Confidentiality**
 - **Integrity – physical, mental, emotional**
 - **Information / education**
- **Enforce right to food and nutrition .**
 - **Take all measures necessary to reduce rural indebtedness, and eliminate hunger, malnutrition and starvation in the country.**

RIGHTS

- Regulation of health services to extend to both public and private sector with comparable norms
- Rights Based Approach in NRHM has to be strengthened through rigorous documentation, reporting and enquiry of adverse outcomes and denial/ violation of rights, fixing accountability along with liability – civil and criminal
- Strong strategic information campaigns to inform communities especially women about their entitlements
- Training providers & managers in a gender sensitive and rights based perspective so that they plan, deliver and monitor programmes that do not discriminate on basis of caste, class, gender and sexual orientation

SERVICES

- Maternal Health services must be free
- Maternal Health services must be universal
 - Ensure continuum of care which includes institutional delivery and home based care; maternal care must include prenatal, delivery and post natal care to ensure safety of mother and new born
 - Increase base of skilled providers for delivery and abortion – non-doctors/nurse –practitioners / midwives in the country
 - Essential drugs for pregnancy and childbirth must include illnesses that affect maternal mortality (e.g. Falciparum Malaria)
 - Participation of Traditional System of Medicine / AYUSH systems
 - Anaemia to be addressed within a nutritional support programmes
 - Affirmative action for marginalised/ vulnerable sections – the young, rural, tribal, dalits, HIV +ve

SERVICES

- Safe delivery must not be equated with JSY and delivery services be integrated for proper pre-natal and post-natal care to ensure continuum
- Incentivisation of institutional delivery should be stopped as it is leading to coercive approach and neglect of the quality services
- Instead the Government should concentrate to ensure 100 percent availability of critical infrastructure, staff, equipment and supply inputs at all levels of public health facilities for delivery and emergency care, especially in remote areas and prioritize provision of health care access to poor underserved and marginalized communities.
- Appropriate transport facilities must also be ensured for continuum of the referral chains

RESEARCH

- Further research into existing beliefs, values & practices surrounding maternity, the interventions during childbirth in homes and institutions (including ethnographic studies)
- Assessment of long-term morbidity due to pregnancy or delivery / abortion needs to be done and appropriately addressed
- Tracking the equity factors through disaggregated data gathering on maternal deaths and near-misses: by caste, religion, age, income and location (Urban/Rural)

GOVERNANCE & ACCOUNTABILITY

- Ensure participation of local communities and women in planning, social auditing /monitoring of services and evaluation through multiple strategies like Public Hearings. Enhance government capacities with effective participation of PRIs
- Rational allocation of resources with transparency and accountability safeguards at all levels
- Strengthening public health systems in all respects:
 - Skill-building and career development of health personnel
 - Transfer policy
 - Supplies of equipment and drugs
 - Policies to fill gaps in underserved areas

GOVERNANCE & ACCOUNTABILITY

- Develop a comprehensive health MIS system well integrated with the social /maternal death audit should be part of the government system & be done at both facility and community level – Action on findings should be legally binding
- Strengthen the monitoring mechanisms for all deliverables -integrate services with accountability indicators for all the concerned departments
- Stringent measures for financial accountability and against corruption, esp. demands for informal payments for delivery of health services
- Make mandatory the ongoing and end line evaluation for all programs based on well defined indicators, and fix accountability for ensuring compliance with recommendations thus drawn
- Stop project based data collection like registration of pregnancies for detecting sex-selective abortions
- Initiate measures for effective access to justice like waiver of court fee, effective remedies

POLICY

- Resist international pressures for institutional delivery or similar target driven programmes
- Enact Public Health Acts at central and state levels
- Increased, equitable and rational allocation of resources for health; with increased managerial capacity for complete utilization of the funds.
- Provide comprehensive integrated health services, also with complete integration of all vertical programmes like STI, HIV/AIDS programs
- Review public private partnerships to ensure strengthening of public health services, and that they do not lead to privatization
- JSY must be submitted to re-examination – quality services must be ensured rather than incentives. Policies of providing incentives and disincentives for achieving indicator goals should be scrapped
- Convergence of all laws and policies on issues around Maternal Health – abortion, 2-child norm, pre-birth sex-selection, child marriages