

**Concept Paper for Civil Society Dialogue with the  
UN Special Rapporteur Mission on Maternal Mortality in India,  
1 Dec 2007, New Delhi**

**Background of visit of the Special Rapporteur on the Right to Health**

The current Special Rapporteur on the Right to Health, Paul Hunt, is coming with on mission to report on Maternal Mortality in India, from 22 November to 3 December 2007. He is likely to be accompanied by Dr. Lynn Freedman of Mailman School of Public Health, Columbia University, NY (USA) a senior task force advisor-Child Health and Maternal Health 2005.

The Special Rapporteur on the Right to Health has the mandate from the UN High Commission on Human Rights to “focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as reflected in article 25 (1) of the Universal Declaration of Human Rights (UDHR), article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), article 24 of the Convention on the Rights of the Child (CRC) and article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), as well as on the right to non-discrimination as reflected in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).”

The Special Rapporteur is requested to:

- (a) Gather, request, receive and exchange right to health information from all relevant sources;
- (b) Dialogue and discuss possible areas of cooperation with all relevant actors, including Governments, relevant United Nations bodies, specialized agencies and programmes, in particular the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS, as well as **non-governmental organizations(NGOs)(emphasis ours)** and international financial institutions;
- (c) Report on the status, throughout the world, of the right to health, including laws, policies, good practices and obstacles;
- (d) Make recommendations on appropriate measures that promote and protect the right to health.

The Special Rapporteur is further asked to apply a gender perspective ...

(<http://www.ohchr.org/english/issues/health/right/index.htm> )

**Background Information on Maternal Mortality in India**

*Figures:*

There are an approximate 26 million births occurring in India each year (GOI, 2006). Out of these, the high number of maternal deaths and millions of women facing illness and disability related to maternal causes has become a matter of global concern, especially with reference to Goal Five of the MDGs. Between 70,000 and 130,000 Indian women lose their lives every single year (GOI, 2006; WHO, 2005); dying during pregnancy, during childbirth or even after, or killed by unsafe abortion complications. In numbers, this translates to one woman dying every 3 to 6 minutes. The most current Sample Registration Survey (SRS) 1997 to 2003 reported a Maternal Mortality Ratio of 301 per hundred thousand live births. While

India has 16% of the world's population, more than one fifth of the world's maternal deaths occur in India, the highest figures for a single country. As this preventable burden of morbidity and mortality is borne by women in their most productive years (age-group of 20 - 34), and often concentrated among the poorest communities, it is also a major development concern.

#### *Policy Goals:*

While the overall maternal mortality ratio for the country as a whole is considered to be between 300 to 500 maternal deaths per hundred thousand live births, the National Population Policy (NPP 2000) and the National Health Policy (NHP 2002) set the goal of reducing MMR to below 100 by 2010 and the MDGs request reducing it by three quarters between 1990 and 2015. The Tenth Five Year Plan and the National Rural Health Mission (NRHM) delayed the first of these slightly to 2012. The Registrar General of India (GOI, 2006) while noting a 'substantial decline in maternal mortality' from 1991 to 2003 also acknowledges a wide variation among states, with states like UP having a maternal mortality ratio of over 600, translating to over 30,000 preventable maternal deaths annually in that state alone.

#### *Measuring:*

It is difficult to get reliable local estimates of deaths since registration of births and deaths are still not universal in India.<sup>1</sup> Fairly wide ranges have results from different estimation methodologies and time periods used. Local enumeration of maternal death can be unreliable since many such deaths do not occur in hospitals and there is often no record kept by local health providers of deaths occurring in the community. According to cases recorded by NGOs in Uttar Pradesh, Andhra Pradesh, Orissa and Jharkhand, maternal deaths occur more among rural women, women without access to education, low-income Adivasi and Dalit women. This is clearly an issue of equity and social justice, as well as a grave violation of women's human rights because these deaths and illnesses/injuries are solely due to women's role in reproduction and the lack of value ascribed to their well-being and survival.

#### *Access to services*

The RCH Facility Survey<sup>1</sup> indicates that the basic level of personnel and essential supplies is seriously lacking in government CHCs and PHCs (IIPS 2003). Within the private sector, the location of facilities is heavily tilted to the urban side, thereby not serving the needs of rural poor women. According to recent studies, health expenditure is the second biggest cause for rural indebtedness in India, and hospitalized Indians spend on an average 58% of their total annual expenditure on health care. Over 40% of hospitalized persons borrow heavily or sell assets to cover health care expenses and 25% of Indians fall below the poverty line because of hospital expenses. Many poor women and religious minorities, specifically Muslim women, prefer not to go to government hospitals and clinics, not only because they cannot afford it, but also because of the abusive and callous behaviour they have to face (ref Jeffery, Jeffery & Rao). A large proportion of deliveries among the poor still take place at home with the support of traditional birth attendants and older women (ref. NFHS -3, lowest wealth quintile=79.4%) .

#### *Policy solutions*

Maternal Health Services have largely been considered a part of the Family Welfare work under India's Ministry of Health and Family Welfare and have suffered from their close

identification with the Government's population control programmes. But components related to antenatal and postnatal care have an overlap with the ICDS programme which falls under the purview of the Ministry of Women and Child Development.

Attention to maternal health was first facilitated by the Child Survival and Safe Motherhood Programme, launched in 1992, which supported a risk approach to improved maternal health by concentrating on antenatal care. Subsequently, the Reproductive and Child Health (RCH 1997 and still ongoing) programmes also included a strong focus on maternal health with provisions to improve services for complications through setting up of first referral units (FRU).

Current policy solutions included in the National Rural Health Mission (NRHM, started in 2005) are meant to provide access to quality health care services including the setting up of 24 hour delivery services at half of the primary health centres to encourage institutional deliveries especially among poor and needy rural women on a priority basis. Women are being offered cash incentives to attend health centers and hospitals for childbirth through the Janani Suraksha Yojana (JSY) program, which is part of the National Rural Health Mission.

Despite these policy measures, at present there is a lack of adequate institutions, skilled providers and quality health care (IIPS 2003)<sup>ii</sup>. Although the rate of institutional delivery has been recorded as increasing, there are also increasing reports of poor quality of services and in some cases, deaths and serious disability among women despite their attending hospitals for delivery.

*Issues*

Drawing on the above, a comprehensive list of issues around maternal mortality arising from civil society analyses and evidence-based discussions of the past few years is given in the table below:

<b>Issues of Maternal Mortality</b>	<b>Sub-issues (that the presentations need to address OR the Mission could ask government for information)</b>
The problem	<ul style="list-style-type: none"> <li>• Extent</li> <li>• Causes, including socio-economic determinants of high maternal mortality</li> <li>• Populations most greatly affected (ie. Dalits, poor women, illiterate women, Muslim women)</li> <li>• Incidence; variations across states or regions or groups</li> </ul>
Technical aspects	<ul style="list-style-type: none"> <li>• Protocols followed for skilled assistance during normal labour and delivery</li> <li>• Emergency referral and transportation</li> <li>• Emergency services and skilled /qualified personnel</li> <li>• Anaemia and nutrition</li> <li>• Blood banks</li> <li>• Abortion care</li> <li>• Availability of life-saving drugs and their use/ cost</li> </ul>

	<ul style="list-style-type: none"> <li>• Availability of adequate medical equipment</li> <li>• Availability of beds/bed capacity at facilities</li> </ul>
Policy/ programme solutions	<ul style="list-style-type: none"> <li>• What have been the various packages of services since CSSM was launched 15 years ago?</li> <li>• What programme evaluations have been carried out and how are the learnings reflected; is accountability for programmes clear and has this been made public?</li> <li>• What mechanisms exist to ensure accountability and transparency by the government in creating these policies? (For example, are state and national governments required to post their planned budgets and expenditures on websites as soon as they are finalised?)</li> <li>• What are the relevant laws/and government rules and orders aimed at improving maternal health and health care?</li> <li>• How are these laws and policies being implemented on the ground?</li> <li>• What are the efforts being made by governments to demedicalize and mainstream access to abortion by ensuring manual vacuum aspiration in PHCs?</li> <li>• What are current approaches and what are their assumptions?</li> <li>• How have health systems been strengthened to provide improved services, and what has been the health outcome?</li> <li>• Has there been any equity mapping? How are services ensured for marginal populations like certain castes, tribes, urban poor, migrants, etc?</li> <li>• How do services reach young women (including teenaged mothers within or out of marriage?)</li> </ul>
Service provision	<ol style="list-style-type: none"> <li>1. How comprehensive are the maternal health services that women are receiving? Are women receiving the full range of maternal health services at each stage of pregnancy (Antenatal, Intranatal, Postnatal)?</li> <li>2. If the health system for maternal care includes staff from both family welfare and medical health, how are the Department's structure and services integrated and how is accountability established?</li> <li>3. What are the points of coordination with NACO to ensure that blood is available at FRUs for EmOC to function?</li> <li>4. With large numbers of women still accessing home-based services only, how have these services been supported or made more effective? How is quality of care ensured for home-based services? How are women treated by village-based health care workers?</li> <li>5. How have programme and policy differences for maternal and neonatal health care services been reconciled?</li> <li>6. How is the quality of maternal health care for women who attend health care facilities? How are women treated by institution-based health care workers?</li> <li>7. How is the increasingly-commercialized private sector contributing to negative maternal health care experiences and outcomes?</li> </ol> <p>What is the extent of access and barriers to:</p> <ul style="list-style-type: none"> <li>⇒ Life-saving maternal services?</li> <li>⇒ Abortion / post-abortion services?</li> <li>⇒ Services for younger women</li> <li>⇒ Services to women with lower mobility?</li> </ul> <ol style="list-style-type: none"> <li>8. Are women disadvantaged by location, class or any other factors while</li> </ol>

	trying to access services? For example, what are ways of ensuring services to the 'informal' residents like urban poor or migrants?
Financing	<ol style="list-style-type: none"> <li>9. What are costs of services? What are the range and reasons for variations?</li> <li>10. Who bears the costs ( to system, and consumer), how is it borne, how are costs shared?</li> <li>11. What are provisions for ensuring access to services regardless of cost/ability to pay?</li> <li>12. How are women and their families affected by the costs of care?</li> <li>13. How has increased privatization affected women's access to services?</li> <li>14. Is insurance provided, with what restrictions, if covered who pays the premium and what are the rates of compensation?</li> </ol>
Monitoring	<ul style="list-style-type: none"> <li>• How are deaths tracked? Are the caste, religion, economic and location factors recorded?</li> <li>• Where are deaths on the way to facilities recorded and reported? By whom?</li> <li>• How are home-based births and deaths monitored?</li> <li>• What leads to care-seeking at hospitals? (?)</li> <li>• How are adverse outcomes/ deaths tracked</li> <li>• Are there any audits of deaths, if so then how are these audits used to feed-back into improving the system?</li> <li>• What regulations exist to ensure standards of care at maternity centres?</li> <li>• How are standards and regulations maintained at state-run and private hospitals/institutions?</li> <li>• How are grievances addressed?</li> <li>• How is medical malpractice or negligence monitored? Are there case histories of legal recourse for action?</li> </ul>
Equity and rights based approaches	<ol style="list-style-type: none"> <li>15. How are services/ providers held accountable?</li> <li>16. Are providers accountable to users through any mechanisms?</li> <li>17. How are family and social gender-based discrimination in utilization of services addressed?</li> <li>18. Are there conditionalities to accessing services or other maternal health benefits?</li> <li>19. To what extent are pregnancies planned or voluntary? Is there any coercion in relation to marriage/sex/conception/ abortion/ delivery interventions?</li> <li>20. How are women being empowered/ informed to advocate for themselves?</li> </ol>
<p>Published documents -</p> <ul style="list-style-type: none"> <li>▪ SRS report 1997-2003</li> <li>▪ NFHS 3</li> <li>▪ Indian Public Health Standards, GOI, RCH Facility Survey</li> <li>▪ National and State Government reports</li> <li>• Evaluations of the CSSM and RCH 1 by World Bank</li> <li>• CAG report on FW programme including RCH 1</li> <li>• Parliamentary committee/question reports</li> <li>• NRHM documents including JRMs</li> <li>• Analyses by CEHAT, CHSJ, JSA etc.</li> </ul>	

*Possible participants for Dialogue:*

The possible individuals/ groups who may attend or are already involved in the effort include –

<b>Name of key person involved</b>	<b>Organization</b>	<b>State/ location</b>
1. Dr. Prakasamma	ANS-WERS	AP
2. Asha Kilaru / Saras Ganapathy	Belaku Trust	Karantaka
3. Biswajit Padhi	WRAI-Orissa	Orissa
4. Dr. Narendra Gupta/ Tej Ram	PRAYAS	Rajasthan
5. Vd. Smita Bajpai	CHEटना	Gujarat
6. Renu Khanna	SAHAJ	Gujarat
7. Dr. Prasanta Tripathy/ Lindsay Barnes	Ekjut	Jharkhand
8. Sunita Shahi	PRAYAS	Uttarakhand
9. Subhash Mendhapurkar/ Sandhya	SUTRA	HP
10. Dr. Sundari Ravindran	Achutha Menon Centre, Trivandrum	Kerala
11. Rakesh/ Susheela Singh	Healthwatch Forum	Bihar
12. Sangeeta, Shakuntala and others	Mahila Swasthya Adhikar Manch	UP
13. Asha George	CMNHSA	
14. Kamayni	Mumbai JSA	Maharashtra
15. Gouri Chowdhury	Action India	Delhi
16. Patricia and Roger Jeffery	Researcher, Edinburgh Univ.	Delhi
17. Imrana Qadeer	Researcher, retd. JNU	Delhi
18. Priya Nanda	ICRW	Delhi
19. Shireen Jejeebhoy and Santhya	Population Council	Delhi
20. Bela Ganatra	IPAS	Delhi
21. Madhu Bala Nath	IPPF-SARO	Delhi
22. Aparajita Gogoi	WRAI	Delhi
23. Leila Caleb Varkey	Researcher	Delhi
24. Shruti Pandey	Supreme Court Lawyer	Delhi
25. Dr. Abhijit Das and others	Centre for Health and Social Justice	Delhi
26. Jashodhara Dasgupta	Healthwatch Forum, SAHAYOG	UP
27. Sharad Iyengar	ARTH	Rajasthan
28. Sunita Kujur	CREA	Delhi

Jashodhara Dasgupta, Leila Caleb Varkey, Asha George, Roger Jeffery and others.  
15 November 2007

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Endnotes

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<sup>i</sup> In this context, we would note that, while the recently released report that claims a substantial reduction in the MMR would be welcome news if it is accurate, there has to be a question mark about its reliability, since no indicators of the likely underlying causes of maternal mortality have shown such substantial changes in the same period.

<sup>ii</sup> International Institute for Population Studies, Facility Survey National Report under Reproductive and Child Health Project Phase II. 2003, IIPS. [http://www.rchindia.org/fs\\_india.htm](http://www.rchindia.org/fs_india.htm)