

Chapter – III

GOAL 5: IMPROVE MATERNAL HEALTH

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

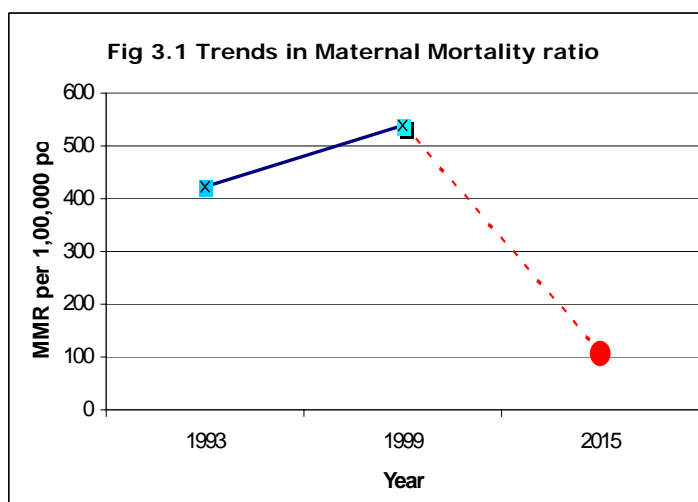
Indicators:

- Maternal mortality ratio
- Percentage of births attended by skilled health personnel

STATUS AND TRENDS

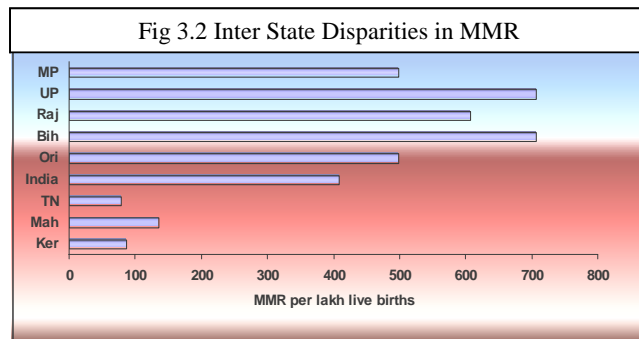
Maternal Mortality Ratio (MMR)

3.1 Maternal mortality in India continues to be a major concern given the reduced social, cultural and economic status of Indian women that inhibits them from adequate access to health facilities. Though it is a major social concern, there are no reliable estimates available on maternal mortality. The estimates available are from the National Family Health Surveys (I and II) and by the Sample Registration System (SRS) for few years. The average maternal mortality ratio at the national level estimated for 1998-99 in NFHS II was 540 per 100,000 live births which was higher than the previous estimate of 424 maternal deaths for 1992-93 (NFHS I). Though estimates are indicative, they reflect the relative neglect of women's health in India.



Regional Variations

3.2 There is clear evidence of high interstate variations in MMR. As is reflected in the figure, the estimates of MMR in the weaker states in the north and central India are very high compared to southern and western region states.



Births Attended by Skilled Health Personnel

3.3 Safe deliveries which is greatly reflected by births attended by skilled personnel though have been increasing, are still much below the desired level. NFHS II estimates that the proportion of births attended by skilled health personnel was at 42 per cent during 1998-99, an increase from 33 per cent during NFHS I (1992-92). A further drill down reflects a wide gap in the proportion between rural and urban. While the proportion of births attended by skilled health personnel in urban area is 73 per cent the same in rural is only 34 per cent. The vulnerable groups such as schedule castes and schedule tribes are the most affected with only 39 per cent and 23 per cent of births are attended by skilled health personnel respectively.

Causes of Maternal Deaths

3.4 There are several causes attributed to maternal deaths. Some of the direct causes, such as haemorrhage, puerperal sepsis, obstructed labour, abortions and toxemia account for more than three fourth of the maternal deaths while other related causes such as anaemia, pregnancy with TB/malaria, viral hepatitis and others account for rest of the deaths. Studies have shown that haemorrhage, sepsis and severe anaemia are the major causes of maternal deaths more so in rural areas. NFHS II reveals that moderate and severe anaemia among pregnant women (28 %) is almost double that of non-pregnant women (16 %).

3.5 These apart there are several other intangible factors associated with maternal deaths. They are overall health status, reproductive status, access to health services and extent of utilisation of health services. Adoption and non-adoption of family planning service also in a way has an effect on maternal mortality. The high maternal death ratio is further reflected with the performance of pregnancy related indicators. According to NFHS II only 65 per cent of mother received antenatal check-up, 67 per cent received two or more doses of tetanus toxoid and 58 per cent received IFA supplements. Only 48 per cent of currently married women use some method of contraception as compared to about 62 per cent in the Asia.

CHALLENGES

Establishing Database on MMR

3.6 Lack of information on maternal mortality levels in the states is the major detrimental factor in assessing the gravity of the issue and bringing in awareness on the maternal mortality. A reliable database is critical to planning, priority setting, and advocacy for political commitment. Dissemination of regular and reliable statistics on maternal deaths at national and state levels will increase sensitivity to the issue. A good civil registration system recording all births and deaths is essential.

High Risk Pregnancy Behaviour

3.7 The pregnancy pattern in India – too early, too many, too close together – enhances the risk of maternal mortality. About one fifth of fertility is contributed by women in the age group of 15-19 years. The birth interval in about one fourth of this group is 18 months. Of the total births, about a quarter are higher order births, of order 4 or more.

Wide rural – urban variations

3.8 Rural ratios are typically two to three times higher than urban ratios. NFHS II estimates MMR at 619 for rural India as compared to 267 in urban India. This abnormal difference between rural and urban areas depicts the pathetic conditions prevailing in rural India requiring focused and increased attention and efforts.

Poor percentage of institutional deliveries

3.9 Institutional deliveries is a critical factor in determining maternal deaths. The NFH survey II indicates that the institutional deliveries are low in the country (33.6%) and very low in rural areas (24.6%). Various measures though have been under implementation under RCH programme for promoting institutional deliveries; they still need to be seen for the better results.

Poor programme implementation

3.10 The RCH programme though has various provisions such as emergency transportation, supply of emergency obstetric care equipment and IFA tablets, provision of hiring private gynaecologist by public health facilities; the RCH Facility Survey conducted in 2000 reveals poor availability and utilisation of these provisions. The programme implementation has to be improved for attaining set objectives.

POLICIES AND PROGRAMMES

Child Survival and Safe Motherhood/Reproductive and Child Health Programmes

3.11 Indian MCH Programmes from as early as 60s and 70s have focused on antenatal care and safe deliveries. Despite all these the MMR has remained high though there is an improvement. The major programme towards promoting safe motherhood and reducing maternal mortality in India is Child Survival and Safe motherhood (CSSM), now being integrated into Reproductive and Child Health programme. Prior to the CSSM, several programmes in various forms were under implementation aiming to control population, promote safe motherhood and child survival. While these programmes did have a beneficial impact, the discrete and separate identity of each programme was causing problems in its effective management besides somewhat reducing the outcome. In the nineties the Child Survival and Safe motherhood (CSSM) programme was, therefore, drawn up and implemented from 1992-93 onwards.

3.12 The process of integration of related programmes initiated with the implementation of the CSSM Programme was taken a step further in 1994 when the International Conference on Population and Development at Cairo, proposed the unification of programmes for Reproductive and Child Health (RCH). The RCH Programme incorporates the components of the Child Survival and safe Motherhood (CSSM) Programme and further includes two additional components – one relating to sexually transmitted diseases (STD) and the other relating to reproductive tract infection (RTI). The main highlights of the RCH programme are:

- interaction of all interventions for fertility regulation and maternal and child health with reproductive health programmes for both men and women;
- reorienting the provision of services to make these client centred, demand driven, high quality and based on the needs of the community assessed through decentralized participatory planning and the target free approach;
- upgradation of the level of facilities for providing various interventions with due care to quality. The First Referral Units (FRUs) being set up at sub-district level will hereafter provide comprehensive emergency obstetric and new born care. Similarly RCH facilities in PHCs will be substantially upgraded;
- all-round improvement in the access of the community to various services are commonly required by it. It is proposed to provide facilities for MTP at the PHCs counselling and IUD insertion at the sub-centres, in a phased manner;
- provision of greater access to out reach services, particularly for the vulnerable groups of the population who have, till now, been left out of the planning process. For this, special programmes will be taken up for urban slum-dwellers, the tribal population and the adolescents;
- NGOs and Voluntary Organisations will be involved in a much larger way to improve the out-reach and make it a people's programme;
- Practitioners of ISM will be trained and research and development in ISM will be supported to improve the range of RCH services; and
- Panchayati Raj System will be assisted to play greater role in planning, implementation and assessment of client satisfaction.

Maternal Health Component of RCH

3.13 The maternal health component of RCH services to be provided at the sub-centre, PHC, CHC/FRUs include the following:

I. Antenatal Care

- Registration of pregnancies
- Providing essential antenatal care (at least 3 visits)
- Iron prophylaxis to pregnant and lactating mothers
- Detection and treatment of anaemic mothers
- Management/referral of high risk pregnant mothers

II. Natal Care

- Increasing proportion of deliveries by midwifery trained personnel
- Increasing proportion of institutional deliveries

III. Post-Natal Care

- Provision of at least 3 post-natal visits
- Monitoring and care of the new born
- Referral/management of high risk new born

IV. Provision of care for unwanted pregnancies

Referral/management of unwanted pregnancies through MTPs and safe abortion

ATTAINING MDG TARGET

3.14 India's performance is poor even among the low and middle income countries in the region. Even based on conservative estimate of 407 per 100,000 by Sample Registration System in 1998, more than 100,000 women die of pregnancy related causes every year in India, which was about 18 per cent of global maternal deaths. With the current trends, both the national target 100 to be achieved by 2010 (National Health Policy – 2002) and the MDG target 106 by 2015 look unrealistic. Achieving these targets is largely dependent upon socio economic conditions of women besides efficient implementation of programme interventions. Among the others, the following are critical in achieving the target:

- Reduction in fertility levels
- Promoting comprehensive antenatal care
- Screening and identification of anaemic women
- Active promotion of institutional deliveries
- Effective screening for high risk delivery cases
- Effective availability of emergency transportation
- Increase in the number of approved facilities for Medical Termination of Pregnancy