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MATERNAL HEALTH IN INDIA

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Abstract
The concept of women's health today has become a major concern in India because of the high prevalence of infant, child, maternal mortality and deteriorating quality of life. India has come a long way in improving the health indicators since independence, but progress in reducing maternal mortality has been slow and largely unmeasured or documented. Since the beginning of the Safe Motherhood Initiative, India has accounted for at least a quarter of maternal deaths reported globally. India's goal is to lower maternal mortality to less than 100 per 100,000 live births but it is still far away despite its programmatic efforts and rapid economic progress over the past two decades. Therefore, the present paper is carried out to understand the maternal health in rural India so as to suggest some policy interventions for improving rural maternal health in India.

Keywords: Health, Maternal Mortality, Maternal Health, National Rural Health Mission, Janani Suraksha Jojana, Rashtriya Swasthya Bima Yojana.

Introduction

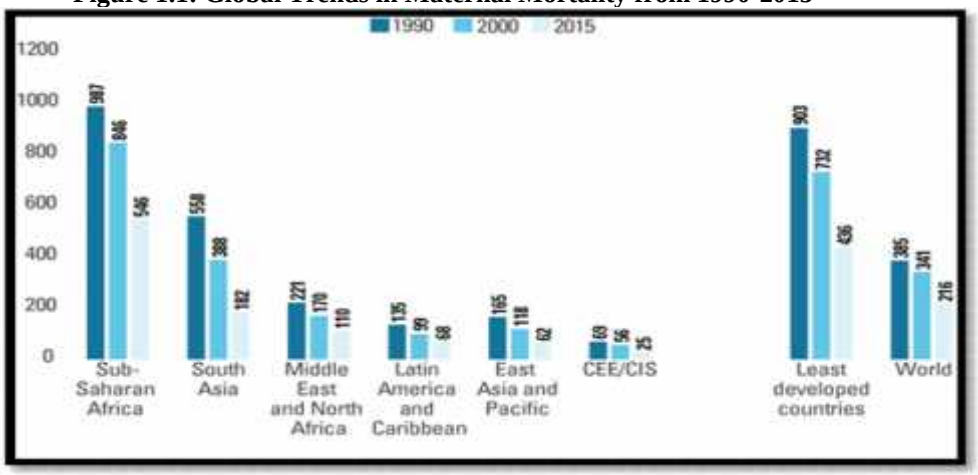
According to World Health Organization maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. It is a key indicator of women's health and status. Although motherhood is often a positive and fulfilling experience, for many women, it is associated with suffering, ill health and even death. Throughout human history, pregnancy and childbearing have caused death and disability in both women and neonates. Pregnancy and childbirth are not diseases (WHO, 2009). But, they carry risks because of the varying and embedded complications, practices, processes, beliefs, life conditions and the immediate environment.

Maternal mortality is an important indicator of maternal health. The maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given period per 100,000 live births during the same period. Most maternal deaths occur just before, during or just after delivery, often from complications that cannot be predicted and are difficult to prevent. Many times survival rates depend on the distance and time a woman must travel to get skilled emergency care. Delay in seeking care, arriving at an emergency care facility and receiving care from providers, raises mortality rates (Akram, 2014). Socio-economic such as patterns of gender politics that result in early marriage and high fertility, and compromise of access to nutrition, health care and contraception, especially amongst poor i.e. villagers and marginalized communities is also another major factor contributing to maternal mortality (Jeffery and Jeffery, 2010). Understanding of the knowledge and practices regarding maternity care during pregnancy, delivery and postnatal period is required for program implementation. Therefore, the present paper was carried out to understand the maternal health status in India.

Status of Maternal Health in Global Scenario

Globally, approximately 800 women die every day from preventable causes related to pregnancy and childbirth (WHO, 2014). Reducing maternal death and morbidity has been a major focus for the developing world since the launch of the Safe Motherhood Initiatives in 1987 (WHO, 1996). Although there have been great strides in countries like Sub-Saharan Africa and Asia, where maternal mortality has declined between half and two-thirds respectively, maternal mortality ratios in developing countries still remain 14 times higher than those in developed countries (UN, 2015). The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births while the maternal mortality ratio of developed countries is 12 per 100 000 live births (WHO, 2015). It was estimated that in 2015, roughly 303 000 women died during pregnancy and childbirth. More than half of these deaths occur in sub-Saharan Africa and almost one third occur in South Asia. Almost all of these deaths occurred in low-resource settings, and most could have been prevented (Alkema et al., 2016). The major causes of maternal deaths are complications that account for nearly 75% of all maternal deaths such as severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), and high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications from delivery and unsafe abortion (Say, 2014).

Figure 1.1: Global Trends in Maternal Mortality from 1990-2015



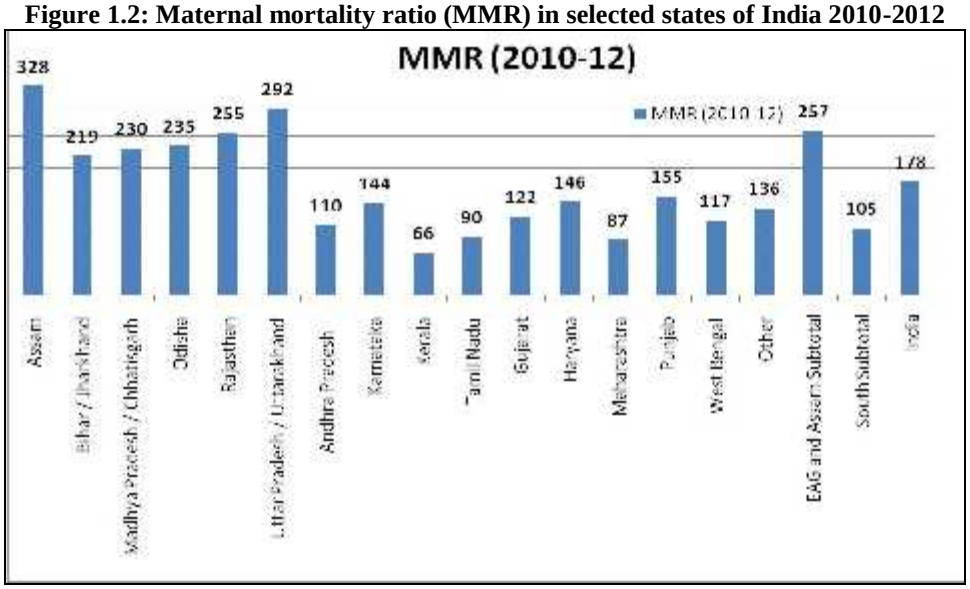
Source: World Health Organization, UNICEF, United Nations Population Fund and The World Bank, *Trends in Maternal Mortality: 1990 to 2015*, WHO, Geneva, 2015.

It is observed that there exists a wide gap in the maternal mortality ratio between the developing countries and developed countries. Even though there is a decreasing trend in maternal mortality from 1990-2015, in some developing countries like Sub-Saharan Africa, South Asia, Middle East and North Africa the rate of Maternal mortality still exists to be high followed by Latin America and Caribbean and Central Eastern Europe or Commonwealth of Independent States (fig 1.1).

Status of Maternal Health in Indian Scenario

Maternal mortality and morbidity are two health concerns that are related to high levels of fertility. In 2010, 19 per cent of the 287,000 maternal deaths estimated worldwide took place in India (WHO 2012). India has a high mortality ratio 178 deaths per 100,000 live births in 2012 (RGI 2012). Annually, it is estimated that 55,000 women die due to preventable pregnancy-related causes in India. Mothers in the lowest economic bracket have about a two and a half times higher mortality rate (UNICEF, 2014). It has been estimated that an Indian women is 300 times more likely to die in childbirth from pregnancy-related complications than women in the USA or UK (UNICEF, 2009). Within India, there is marked variation in MMR and healthcare access between regions and in socioeconomic factors (IIPS, 2010; Barros, 2012). In India the causes of maternal death is continue to be associated with determinants such as nutrition, poverty, and socioeconomic marginalization, over which policies have had little or no impact (World Bank, 2012). Most maternal deaths can be prevented if women have access to basic medical care during pregnancy, childbirth and postpartum period (WHO, 1994).

Figure 1.2: Maternal mortality ratio (MMR) in selected states of India 2010-2012



Source: Office of Registrar General, Sample Registration System (2010-12)

As per the data in figure 1.2, MMR is lowest in Kerala (66) and highest in Assam (328). During 2010-12, MMR is higher than the national level estimate in Bihar/ Jharkhand, Madhya Pradesh/ Chhattisgarh, Odisha, Rajasthan, Uttar Pradesh/ Uttarakhand and Assam.
India in recent past, is witnessing a gradual decline in both maternal and neonatal mortalities because of several planned interventions. But such decline is not uniform among various social and spatial categories. Further, decline in maternal mortality cannot be taken as the absolute indicator of sound maternal health as reproductive concerns and overall health conditions of women have important bearing upon maternal health.

The National Family Health Survey NFHS-3 found that women in India lack quality care during pregnancy and childbirth. Almost one in four women (23 percent) who gave birth in the last 10 years, received no antenatal care, ranging from 1 percent or less in Kerala and Tamil Nadu to 66 percent in Bihar. At least 40 percent of pregnant did not get any antenatal care in Jharkhand, Arunachal Pradesh and Nagaland. Only 65 percent of women receiving antenatal care received iron and folic acid supplements for at least 90 days. Only 4 percent of expectant mothers took a de-worming drug during pregnancy. Failure to take an iron supplement and de-worming drugs increases the risk of anemia, a major problem for mothers and children in India.

Table 1.1: Maternal Health Status of Indian Women

S. No	Maternal Health Status of Indian Women	Total	Urban	Rural
1.	Women aged 20-24 married by 18 (%)	47.4	29.3	56.2
2.	Total fertility rate (children per women)	2.7	2.1	3.0
3.	Women age 15-19 who were already mothers or pregnant at the time of the survey (%)	16.0	8.7	19.1
4.	Married women using any method of family planning, age 15-49 (%)	56.3	64.0	53.0
5.	Mothers who had at least 3 antenatal care visits for their last birth (%)	50.7	73.8	42.8
6.	Mothers who received postnatal care from health personnel within 2 days of delivery for their last birth (%)	36.8	60.8	28.5
7.	Institutional births (%)	40.8	69.4	31.1
8.	Pregnant women age 15-49 who are anemic (%)	57.9	54.6	59.0
9.	Women who have knowledge of HIV/AIDS among ever-married adults, age 15-49 (%)	57.0	80.7	46.4
10.	Currently married women who usually participate in household decisions (%)	36.7	45.0	33.0
11.	Ever-married women who have ever experienced spousal violence (%)	37.2	30.4	40.2

Source: NFHS-3 (2005-2006)

The data from table 1.1 reveal that 47.4 per cent of women aged between 20-24 years got married by the legal minimum age of 18 years. It is observed that there is a wide range of gap between rural (56.2 percent) and urban (29.3) women who got married by the legal minimum age. As per current fertility rate, Indian women have an average rate of 2.7 children in her life time.

At national level, 16 per cent of Indian women aged between 15-19 years have already become mothers. The percentage of rural women (19.1) bearing children at an early age are more than half than that of the urban women (8.7).
As per the data, 56.3 per cent of the currently married women in the age group of 15-49 years are currently using contraceptive methods. The percentage of the urban women (64 per cent) is higher than that of the rural women (53 per cent).

There are wide gaps in antenatal care in rural and urban areas. The percentage of women who received proper antenatal care in urban areas is 73.8 percent while that in rural areas is 42.8 per cent. The coverage of antenatal check up has been found to be low in rural areas.

As per the survey institutional deliveries in rural areas is still very low i.e. 31.1 percent and that of urban area is 69.4 percent. There is a huge difference regarding institutional deliveries between urban and rural area

In India, as a whole, only 36.8 percent of the Indian mothers received post-natal care from health professionals. The percentage of urban mothers who received proper post-natal care from health professionals is 60.8 percent. However, only

28.5 percent of the rural mothers received the same from health professionals and the percentage is lower than that of national average.

More than half of the Indian women i.e. 57.9 percent suffer from anemia where rural and urban mothers constitute 59.0 per cent and 54.6 percent respectively.
At national level, only 57 per cent of the mothers have heard of AIDS. Awareness about AIDS among women in urban areas is 80.7 percent and 46.7 per cent in rural areas. As less than half of the rural mothers do aware of AIDS, steps should be taken to improve the same.

More than a third of married women (36.7 percent) participate in household decision making where the performance of urban mothers (45.0 percent) is somewhat better than that of the rural mothers (33.0 per cent).
The data indicate that more than one third of married women in India experienced spousal violence (37.2 percent). The prevalence of domestic violence is high among rural women (40.2 per cent) than the urban women (30.4 percent).

The overall analysis from the NFHS-3 data shows that strategies and programs followed till now have not yielded desirable result on the health of Indian women. Especially rural women show poor performance than urban women.

Programmes and Initiatives for Maternal Health Development in India
National Rural Health Mission (2005-12)
The Government of India, Ministry of Health and Family Welfare, launched National Rural Health Mission (NRHM) in 2005. It recognizes the importance of health as a contributor of social and economic development and adopts the synergistic approach by relating health to the determinants of good health. It seeks to provide effective health care to rural population with special focus on 18 states, which have weak public indicators. The core strategies are (i) to train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services; (ii) promote health care at household through female health activist (Accredited Social Health Activist or ASHA); (iii) health plan for each village through Village Health Committee of the Panchayat; (iv) strengthening sub-centers through unified fund; and (v) implementation of an inter-sectoral District Health Plan. The supplementary strategies are (i) to regulate private sector including the informal rural practitioners; (ii) to ensure availability of quality services to citizens at reasonable cost; (iii) to promote public-private partnerships; (iv) mainstreaming Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy (AYUSH); (v) reorienting medical education to support rural health; and (vi) pooling and social health insurance to provide health security.

The NRHM has identified specific goals and objectives to be completed within a time frame. The most important initiative related to maternal health is recruitment of a new category of health worker. According to the Mission Document of NRHM, every village/large habitat will have a female ASHA chosen by and accountable to the panchayat to act as the interface between the community and the public health system. ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat. She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets and other health care delivery programmes. She will be trained on pedagogy of public health developed and mentored through a Standing Mentoring Group at national level incorporating best practices and implemented through active involvement of community health resource organizations. She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker (AWW), ANM, functionaries of other departments and self-help group members, under the leadership of the Village Health Committee of the Panchayat.

ASHA will be promoted all over the country, with special emphasis on the 18 high focus states. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the states under the programme. She will be given a drug kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time. Induction training of ASHA will be for 23 days in all, spread over 12 months, and on-the-job training would continue throughout the year. It also talks about prototype training material and cascade model of training proposed through training of trainers including contract plus distance learning model. The training would require partnership with NGOs/ICDS Training Centers and State Health Institutes. According to a Ministry of Health and Family Welfare Report, 7.49 lakh ASHAs were selected and 7.05 lakh ASHAs were trained in the first module by 2010 (MoHFW, 2010).

Janani Suraksha Yojana (JSY)
Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. The scheme is under implementation in all states and Union Territories (UTs), with a special focus on Low Performing States (LPS).

Janani Suraksha Yojana was launched in April 2005 by modifying the National Maternity Benefit Scheme (NMBS). The NMBS came into effect in August 1995 as one of the components of the National Social Assistance Programme (NSAP). The scheme was transferred from the Ministry of Rural Development to the Department of Health & Family Welfare during the year 2001-02. The NMBS provides for financial assistance of Rs. 500/- per birth up to two live births to the pregnant women who have attained 19 years of age and belong to the below poverty line (BPL) households. When JSY was launched the financial assistance of Rs. 500/- , which was available uniformly throughout the country to BPL pregnant women under NMBS, was replaced by graded scale of assistance based on the categorization of States as well as whether beneficiary was from rural/urban area. States were classified into Low Performing States and High Performing States on the basis of institutional delivery rate i.e. states having institutional delivery 25% or less were termed as Low Performing States (LPS) and those which have institutional delivery rate more than 25% were classified as High Performing States (HPS). Accordingly, eight erstwhile EAG states namely Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Rajasthan, Odisha and the states of Assam & Jammu & Kashmir were classified as Low Performing States. The remaining States were grouped into High Performing States.

Rashtriya Swasthya Bima Yojana (RSBY)

Rashtriya Swasthya Bima Yojana (RSBY) was launched on 1 April 2008 by the Ministry of Labor and Employment, Government of India. It is a health insurance scheme that aims at providing health insurance coverage to the poor families of India. It provides cashless insurance coverage for hospitalization in both private and public hospitals. The cost of the insurance premium is borne by both the central (75 per cent) and state (25 per cent) governments. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most of the diseases that require hospitalization. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding.

Conclusion

Women are the half of human wealth of India. The health of women matters a lot for building healthy India. Right after the independence, under the Eleventh Five-Year Plans and three National Health Policies, Central as well as state authorities had taken different steps and initiated projects for the improvement of health for mothers as well children. Despite the large gains in health status since independence, many parts of India are still in the early part of health transition. Difference among states must be recognized and considered. The poor continue to suffer widely. The poorest quintile of Indians has more than double the mortality rates, malnutrition, and fertility of the richest quintile. The disadvantaged groups in India have consistently worse health outcomes as do people living in rural areas.

Recommendations

The following recommendations are given to improved maternal health in India.

- There is need to raise awareness among girls, parents, teachers and community leaders through school and community based programmes about the negative impact of early marriage and pregnancy on women and children.
- All existing primary health care infrastructure be strengthened while adequate supplies of drugs and kits be ensured for effective and efficient delivery of maternal health care services. The gaps in required health centers and existing health centers may be tackled through public/private partnerships and launching of mobile health clinics.
- Sub-centers should be strengthened in terms of improved facilities and infrastructure to provide services under RCH programmes.
- For controlling fertility and mortality, it would be appropriate to improve educational and developmental programmes in a coordinated manner for rationalizing programmes inputs and achieving benefits.
- Prenatal and postnatal checkup may be ensured through promoting public private partnership and mobilizing community.
- There should be more emphasis on traditional birth spacing methods while health professionals should be properly trained for providing health counseling regarding use of family planning methods and reducing its side effects on health.

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