APPEAL
SAVE MOTHER & CHILD

Promote Safe Deliveries By Taking Them To Health Institutions

"Do You Know About The Initiatives Taken By The Government To Promote The Institutional/safe Deliveries & To Decrease The Morbidity / Mortality In Mother & Child ?"

A. Under JSY Scheme
   I) For Delivering In Govt. Hospital Mother Gets Incentive Of Rs 1400/- In Rural Areas And Rs 1000/- In Urban Areas.
   II) For Motivating Pregnant Mothers For Institutional Deliveries And Escorting Her To The Govt. Institutions The ASHA Is Getting Incentive Of Rs 600.00 Per Case

B. For Referral Transport
   For Referral Transport Of Sick Pregnant Women & Sick Newly Born Child The Amount Upto Rs 1000/- Per Case Is Placed At The Disposal Of The In-charge Health Institutions.

C. For Tracking Of Mothers
   For Tracking Of Mothers From Early Registration To Deliveries & Full Immunization For The Child, The Incentive Of Rs 1000/- Per Case In Being Paid To ASHA.
   I) Rs 200/- For Early Registration.
   II) Rs 400/- For Antenatal Check Up, Deliveries And Postnatal Care Upto 42 Days.
   III) Rs 400/- Full Immunization Of Child (up To Measles)

"Helps Us In Our Commitment To Save The Mother & Child For The Brighter Future"

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14 Global policies and local implementation: maternal mortality in rural India

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1 The burden of maternal mortality

Pregnancy or childbirth remains a leading cause of death, disease, or disability for women of reproductive age across the developing world (WHO 2010; Gill, Pande and Malhotra 2007). In fact, the fifth Millennium Development Goal (MDG)—whose stated goal is to “improve maternal health” by reducing maternal mortality and providing universal access to reproductive health—is now regarded as the most off-target of the eight Millennium Development Goals (Graham 2009). Every year, global pregnancies result in over 10 million maternal disabilities, 368,000 maternal deaths, 46 million abortions, 2.6 million stillbirths, and 3.8 million neonatal deaths (WHO 2010; Lawn et al. 2009, 2011). Many of these deaths can be collectively prevented with basic care around pregnancy and childbirth. India, our focus below, provides an excellent vantage point for studying these intertwined deaths as it accounts for more maternal deaths (63,000), more neonatal deaths (1.1 million), and more births (27 million) than any other nation in the world (WHO 2010; Lawn et al. 2009).

These deaths are not without economic costs. Conservative estimates suggest that global maternal and neonatal mortality alone results in $15 billion in lost productivity each year (Gill, Pande, and Malhotra 2007). Despite these costs, a lack of political and financial will around maternal and neonatal mortality remains. The 4.3 million mothers and newborns that die each year far outnumber the number of
people who die from HIV alone (2.9 million) or TB and malaria combined (1.7 million and 1.3 million respectively). Yet global assistance still lags for maternal and neonatal health, which was $1.2 billion in 2006 compared with the $10 billion allotted for HIV/AIDS in 2007 (Shiffman and Smith 2007). Repeated calls to prioritize maternal health have led to suggestions that The Global Fund to Fight AIDS, TB and Malaria should include maternal and neonatal health under its rubric (Horton 2010, Costello 2005). After repeated concern about lack of progress on MDG 5, the Secretary General of the United Nations proudly announced a pledge of over $40 billion towards the Global Strategy for Women’s and Children’s Health in September 2010.

The twists and turns of what was first known as the Safe Motherhood Initiative (SMI) and later branded as Making Pregnancy Safer (MPS) have been summarized elsewhere (AbouZahr 2003; Shiffman and Smith 2007). The SMI was founded when three major multilateral aid organizations—the World Bank, the World Health Organization (WHO), and the United Nations Fund for Population Activities (UNFPA)—met in 1987 with the stated goal of reducing maternal mortality. This focus on maternal conditions arose after a landmark essay (Rosenfield and Maine, 1985) subtitled “Where is the M in MCH?” had argued that the focus on child health in MCH initiatives had come at the cost of women’s and maternal health. Yet progress would remain out of reach for some time due to the challenges of bringing different agendas—mother versus child, community-based versus clinical care, and primary health versus vertical programs—and different agencies under one initiative (Lawn et al. 2006; Starrs 2006; McCoy et al. 2010). By 2005, donors sought to combine funding by merging the SMI with other initiatives to create The Partnership for Maternal, Newborn & Child Health (PMNCH). The PMNCH strategically linked maternal survival with newborn and child survival in order to better promote the linked MDGs 4 and 5 (McCoy et al. 2010).

2 Recent shifts in policy

Maternal health policy has undergone a considerable shift in recent years towards privileging strategic adaptation to local context over global policies and solutions. As a key editorial (Costello et al. 2006: 1477) in the *Lancet’s Maternal Survival Series* warned: “We are concerned about the one-size fits-all core strategy and believe the policies need to be context-specific.” Another essay summing up maternal health policy noted without irony that policies should not be copied from one

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1 The PMNCH was launched in 2005 to supercede three partnerships: (1) the Partnership for Safe Motherhood and Newborn Health hosted by the WHO, (2) the Healthy Newborn Partnership hosted by Save the Children, and (3) the Child Survival Partnership hosted by UNICEF. The first partnership itself grew out of the Safe Motherhood Interagency Group, which was comprised of the three founding agencies of the SMI—the WHO, the World Bank, and the UNFPA—along with UNICEF, UNDP, the Population Council, and the International Planned Parenthood Foundation (IPPF).
country to the next because, “the devil is in the detail” and “context matters” (Penn-Kekana et al. 2007: 34). A key essay on the eve of the twenty-year anniversary of the founding of the SMI summarizing decades of research on maternal mortality called for a renewed emphasis on implementation and context rather than a continued focus on global causes or solutions:

“Implementation of maternal health services on the ground has been woefully neglected in the global safe motherhood community.... We are not advocating a single universal approach to implementation, but neither are we suggesting that every situation is so unique that it has to start from scratch. In short, we know what to do, but how to do it varies by context. Understanding context entails an appreciation of the relation between supply and demand within the district level health system—ie, the continuum from home or community, up through health posts and health centres, to the first referral level facility” (Freedman et al. 2007: 1384, my emphasis).

The tack from „what to do“ to „how to do it“ shifts concern from broad causes and solutions towards local strategies of prevention and treatment. However, the focus on supply and demand still emphasizes the reductionist views of economists and policy makers that frequently shortchange the role of culture, power, and agency. In short, the language of efficacy can elide the complex intersection of power, gender, culture, and social hierarchy that are central to critical medical anthropology (Pfeiffer and Nichter 2008; Inhorn 2006, 2007). Yet there are signs that policy makers and researchers are recognizing the role of quality and agency in determining access to obstetric care.

“Ensuring the availability of a package of effective intrapartum interventions in health facilities does not guarantee an effect on maternal mortality, which is contingent on uptake by the target population, the quality of implementation, and the avoidance of harm introduction” (Campbell and Graham 2006: 1292).

Campbell and Graham critically isolate the uptake of services to quality of services and avoidance of harm, while others (Thaddeus and Maine 1994) have shown the importance of transport, costs, and other social barriers to uptake. Quality of care has emerged as a key concern that must be balanced against the overwhelming drive to increase coverage. As Graham and Varghese (2011: 378, citing Godlee 2009) recently argued, “the global insanity—continuing over and over again to deliver poor-quality health services for women and children and yet expecting results...” must give way to sustained efforts to provide high quality care, namely care that is “effective, safe, and a good experience for the patient”. The emphasis on quality of care draws on growing evidence that a significant fraction of maternal deaths are caused by clinical delays, omissions, and failures.
“Confidential enquiries into maternal deaths in a diverse range of countries, together with findings from clinical audits, suggest that the proportion of which substandard care played a substantial role is often more than a third. (Ronsmans and Graham 2006: 1196).

The emphasis on quality of care is linked to the overwhelming push towards increasing skilled attendance at birth across the globe. While institutional deliveries may appear to fulfill one core safe motherhood strategy—access to skilled intrapartum care—they only do so if the staff, the clinics, and the protocols at such institutions actually deliver emergency obstetric care (Gabrysch et al. 2011). Safe motherhood policies have had to account for both high risk and low risk pregnancies. After years of privileging either low risk or high-risk pregnancies/deliveries—often at the expense of the other—it is now recognized that most deliveries and pregnancies fall along a risk continuum that can change in sudden and unpredictable ways. Most importantly, it is difficult to predict which pregnancies will wind up as a high risk or low risk delivery. Although antenatal care does correlate with improved neonatal and maternal outcomes, studies have yet to show direct causal links between antenatal care and reductions in maternal mortality (Maine and Rosenfield 1999, Miller et al. 2003).

3 India and the JSY scheme

The JSY scheme in India offers important lessons for the global attempt to increase institutional deliveries within the home-to-hospital continuum of care. Launched in 2005 with World Bank funding, India’s Janani Suraksha Yojana (JSY) scheme is the largest conditional cash transfer program in the world in terms of beneficiaries. At a cost of roughly $134 million (15.4 billion Rupees) in 2009-10, the scheme currently pays women in LPS (low performing states) like Jammu & Kashmir (our focus below) 1400 rupees per institutional delivery and 500 rupees for home births. The scheme also provides 600 rupees for the Accredited Social Health Activist (ASHA) who is supposed to accompany women to the hospital for delivery, 250 rupees to pay for emergency transport, and 1500 rupees to pay for an emergency cesarean if there are no free government services for cesareans. Plagued initially by bureaucratic inefficiencies and confusion over who qualified for the schema, the scheme soon dropped the stipulation that women have a marriage certificate, a BPL (below poverty line) certificate, and be below 19 years of age. Yet it continues to be underused across India. By 2009, less than 10% of eligible women benefitted in states that have high maternal mortality ratios such as Uttar Pradesh and Jharkhand (Lim et al 2010).

While the JSY program did achieve an increase in institutional deliveries across India, persistent worries remained about the lack of medical staff, supplies, and quality of care at government institutions (Jeffery and Jeffery 2010; Das, Rao, and
Hagopian 2010; Lahariya 2009). By including births in rural clinics or sub-centers in the definition of ‘institutional deliveries’, the JSY schema is paying women to deliver in a notoriously unreliable set of clinics at the bottom of India’s rural health care system. There is a serious danger in shifting births to clinics and hospitals that are underequipped to handle an increase in deliveries or emergencies (Jeffery and Jeffery 2010; Lahariya 2009). A recent study argued that if many obstetric wards in India are overwhelmed with two or more patients per bed, it is unclear how increasing deliveries will improve maternal outcomes or quality of obstetric care (Lahariya, 2009: 16). The JSY scheme has been correlated with improvements in perinatal and neonatal outcomes yet shows no correlation with improved maternal outcomes (Lim et al. 2010).

These studies indicate that the very institutions where women are sent may lack timely or integrated basic or comprehensive emergency obstetric care. If applied in a timely and integrated fashion, basic or comprehensive emergency obstetric care can treat all of the major causes of maternal mortality in India which are: hemorrhage (29.6%), anemia (19%), sepsis (16%), obstructed labor and ruptured uterus (9.5%), abortions (8.9%), and eclampsia (8.3%). The timing of interventions is critical, as the median time from onset to death of an untreated hemorrhage is just six hours (Costello et. al 2006). Moreover, a single complication—such as post-partum hemorrhage—may require a combination of interventions, such as oxytocin to increase contractions and stanch the blood flow, removal of placenta and uterine products to limit source of bleeding, blood transfusion to make up the lost blood, and finally surgical hysterectomy if all else fails. Jeffery et al. (2007: 175) starkly note that “government institutions in Uttar Pradesh are currently incapable of accommodating routine deliveries, leave aside dealing with complications that require emergency care”. The same study reports that one fifth of all community health centers in Uttar Pradesh were found to have even 60% of the equipment needed for handling basic obstetric emergency care and only a third of such centers had 60% of the medical staff required. Other studies have argued that the lack of timely transport or referral schemes constitute gross violations of obstetric care and human rights (Jeffery and Jeffery 2008, 2010; George 2007; Gutschow 2010).

Basic emergency obstetric care (BEOC) comprises six signal functions—parenteral antibiotics, parenteral anti-convulsants, parenteral oxytocin, manual vacuum aspiration, manual removal of retained placenta, and instrumental vaginal delivery (forceps or vacuum), while Comprehensive emergency obstetric care (CEOC) adds two more—cesarean sections and blood transfusion or blood products.

Rawal (2003) cites the major causes of maternal mortality recorded by the the Registrar General of India using the Sample Registration System (SRS). The Federation of Obstetric and Gynaecology Societies of India (FOGSI) finds a rather different breakdown of causes: anemia, eclampsia, sepsis, hemorrhage, and abortion in declining order.

Jeffery et al. (2007) also found inappropriate levels of injectable oxytocin use for the intrapartum period, without sufficient attention to the dangerous sequelae of such use. Compare Van Hollen (2003) and Jeffery, Jeffery, and Lyon’s earlier analyses of the shifting medicalization of birth in Tamil Nadu and North India (1989).
These anthropological critiques imply that the JSY schema may be doing little or nothing to reduce maternal deaths in some parts of India.

4 The JSY in context: Ladakh

Slightly smaller than Norway, but home to only 270,000 people, Ladakh consists of two districts, Leh and Kargil. Each district has one government hospital based in the central towns, Leh and Kargil, from which the districts draw their names. These two hospitals currently provide the only comprehensive emergency obstetric care in the region. Yet many of community level health clinics and subcenters lack several measures of basic emergency obstetric care. While the auxiliary nurse midwives (ANM), who attend most of the home and clinic deliveries, can provide basic intrapartum care including injectable antibiotics and oxytocin, they often lack the instruments or the skills to perform manual vacuum aspiration, instrumental deliveries, and other signal functions of basic emergency obstetric care. In short, many rural clinics and midwives in Ladakh are ill prepared to save the mothers and neonates who suffer life-threatening complications. This is significant given the obstacles to accessing hospitals or clinics in this remote, rural Himalayan region. Many valleys lack access to the hospital except on foot for six months every winter when passes are blocked and emergency helicopter services are unreliable. Women who live in remote parts of Ladakh, who are due to deliver between November and May, must make the decision (and have the financial resources) to leave their homes months before their due date if they wish to deliver at a hospital.

This essay draws on fieldwork concentrated between 1994-2002 and 2006-2011 at Leh hospital and in rural parts of Kargil district. Besides collaborating with the two chief obstetricians of Leh hospital since 1994, Gutschow has conducted extensive interviews with the nurses, nurse-midwives, and medical assistants who provide institutional and home-based antepartum and intrapartum care across Ladakh. Between 1994 and 2011, Gutschow interviewed more than 200 women in Ladakh and a range of traditional ‘experts’ who deliver traditional healing in Ladakh including practitioners of Tibetan medicine, monks, nuns, and oracles about reproductive and maternal health (Gutschow 2004, 2006, 2010).
This chart shows a steady rise of deliveries, live births, and cesareans as well as the more variegated rise and fall of family planning services at the Leh government hospital over the last 3 decades. The shift of birth from home to hospital in Ladakh long precedes the introduction of the JSY scheme into Ladakh in 2006 and outpaces the trend towards institutional birth across India. By 1995, while almost half of all deliveries in Leh district were facility-based, only 20% of all births in India were institutional (Wiley 2002). By 2007, 74% of all deliveries in Leh district but only 45.5% of the deliveries in Kargil district were facility-based, even as the all-India rate of institutional deliveries remained less than 50% (Pathak et al 2010). What distinguishes Leh hospital from Kargil hospital has been the service of two obstetricians, aunt and niece who have dedicated their lives to providing quality obstetric care over the past three decades (Gutschow 2010). The different rates of institutional deliveries at Leh and Kargil hospitals imply that women prefer the quality of obstetric care at Leh hospital, which is born out by our interviews with patients at Leh hospital. Other studies indicate that rural women in India prefer home births to poor quality of care at institutions (Pathak et al. 2010; Jeffery and Jeffery 2008, 2010). Other major factors contributing to the rise in institutional deliveries in Ladakh as in the rest of India include the greater value placed on each birth in a context of lowered fertility and improved income, education, access, and transport facilities (Gutschow 2010, Chawla 2006, Van Hollen 2003, Pinto 2008, Jeffery, Jeffery, and Lyon 1989).

The perceived quality of care at Leh hospital is born out by maternal outcomes as well. Maternal mortality ratios (MMR) fell precipitously at Leh Hospital in the last 3 decades, from 746/100,000 in 1988 to 96/100,000 in 2006. There are no good statistics on neonatal and perinatal mortality at the Leh hospital, but the stillbirth rate ranged between 38 and 41/1000 between 2004 and 2007. In recent years, the MMR at Leh hospital was roughly half that found in the nearby but remote subdistrict of Zangskar and less than half that found in a government hospital in the state of Kerala, noted for its maternal health outcomes. Observations and interviews in the labor and delivery wards at Leh hospital in the past 15 years confirm that most medical staff are able to provide evidence-based and quality obstetric care in timely fashion.

Yet these indications of quality of care starkly contrast with the notable decline in both abortions and tubal ligations at Leh hospital after 2003. When Dr. Lahdol, who served as the Chief Obstetrician at Leh hospital from its founding in 1979, retired in 2003, the provision of family planning services at Leh hospital took a hit.

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5 The rates of institutional deliveries and skilled attendance at birth are quoted from the Leh District Health Plan (Government of India 2007b: 49) and Kargil District Health Plan (Government of India 2007a: 48). The report elsewhere mistakes the institutional delivery rate from pregnancies not live births; I have ignored those rates.

6 The MMR recorded at Leh hospital between 2005 and 2007 (93.5/100,000) was less than half that found in rural Zangskar between 2006 and 2009 (225/100,000). The Leh hospital’s MMR was less than half that found at a teaching hospital in Trivandrum (215/100,000) and a fraction of that recorded at a teaching hospital in Allahabad (3778/100,000) (Purandare 2007).
from which it is yet to recover. Although Dr. Lahdol was awarded a Padma Shri, one of the highest civilian honors in India, her concerted efforts on behalf of maternal and reproductive health earned her increasing attacks by right wing religious and political groups. Since her retirement, the attacks on family planning have not abated and the number of abortions has continued to decline. After nearly three decades of steady gains, the number of abortions reported in 2010-11 had sunk to a level not seen since 1979-80, even as the number of births increased fifteen-fold. This restriction on safe abortion services leaves women little choice but to travel days to reach a private hospital or clinic that in the nearby cities of Jammu, Srinagar, or risk an unregulated abortion in a private clinic. It is important to recall that abortion is one of the five leading causes of maternal mortality in India. Significantly, the JSY program seems to have had little impact on the provision of abortions in Ladakh, one of signal functions of basic emergency obstetric care.

The quality of care found at Leh hospital stands in contrast to the sub-standard care delivered across many rural centers. Currently, many of the block level clinics or community health centers in Kargil lack the basic functions of emergency obstetric care on a 24/7 basis. Official documents outlining district level provision of healthcare are littered with phrases such as: ‘capacity building in Emergency Obstetric Care’, “all CHC [community health centers] to be developed as FRU’s [first responder units]”, and “PHC to be developed as 24x7 facilities” (Government of India, 2007b: 44). Yet even five years after the JSY has been introduced, these same centers were still found to be closed at night or staff unavailable on a 24x7 basis. As such, women are being lured to deliver in facilities with limited or unavailable emergency obstetric care. This is born out by the following admission in the Kargil District Health Plan’s section on maternal health: “The community does not have enough confidence in the government facilities since the personnel are not always available and also adequate infrastructure, equipment, and drugs [sic].” (Government of India, 2007a: 49). The Padum Community Health Center (CHC) still lacks a functioning operation theater and an anesthesiologist despite spending millions of rupees in upgrading the facility to a CHC. In short, despite the best intentions, the JSY scheme has not provided the emergency obstetric care required to sustain reductions in maternal and neonatal mortality.

5 Conclusions

While it may be true that many home births in India lack access to skilled or emergency obstetric care, it does not necessarily follow that institutional births necessarily involve access to emergency obstetric care. Further research is needed to evaluate whether the JSY scheme is improving maternal and neonatal outcomes across India and whether hospitals, clinics, and staff can provide the quality emergency obstetric care they claim to. The experience in India and Ladakh suggests a degree of caution towards the inexorable push to institutionalize birth. Currently,
there simply are not enough facilities to accommodate India’s 27 million annual births. As Anthony Costello (2006: 1477) wrote in the Lancet’s Maternal Survival Series:

“Intrapartum care based in health centers is appropriate for all as a longer-term strategy, but it might not be the best option for reducing maternal mortality in all contexts in the shorter term. In many communities with high maternal mortality this strategy is simply not achievable with current resources and infrastructure.”

A health center strategy is only the ‘best option’ for reducing maternal mortality if one can guarantee the quality of obstetric care in those centers. It is unclear that the push towards institutionalizing birth across India and the globe has yet to fully account for quality of care or skill of health care providers at the relevant facilities. Until women are guaranteed quality and respectful care, they will continue to choose home births over institutional births (Campbell and Graham 2006). Until then, one needs more qualitative and systematic studies comparing quality of care across the continuum of care from home to hospital or those comparing low risk home and hospital births in low resource settings. Similar studies in high re-source settings comparing low risk home and hospital deliveries have shown lower rates of maternal interventions and similar rates of neonatal mortality and morbidity (Janssen et al. 2009, De Jonge et al. 2009, Johnson and Daviss 2005). Clearly, efforts to improve quality of care (Graham and Varghese 2011) must coexist with the ongoing efforts to institutionalize birth if we are to see progress in maternal and neonatal outcomes in India. There is a need to measure both the quality and quantity of obstetric care if the 5th MDG is to be met in time in India as elsewhere across the globe.

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References


