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Research Article

A Legal Frame Work Of Maternity Health Care In India

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ABSTRACT

Better quality of care around the time of childbirth can significantly improve maternal and new-born survival. In countries like India, where the private sector contributes to a considerable proportion of institutional deliveries, it is important to assess the quality of maternity care offered by private sector healthcare facilities. This study seeks to fill that information gap by analysing baseline assessments conducted for the Manyata program, which aims to improve the quality of maternity care at private facilities.Human Rights Watch had hoped to include the perspectives of doctors or health workers who were suspended, dismissed, or arrested following complaints about maternal health care in Tamilnadu. Unfortunately, we were able to trace only one such health worker, a hospital staff nurse.Health workers and nongovernmental organizations providing services to villagers assisted Human Rights Watch in identifying pregnant women and families to interview.This report's focus is on the last of these three prongs, the state's internal monitoring of policies, practices, and performance. While the arguments presented in this report address the specific issue of preventable maternal mortality and morbidity, accountability as a human rights principle is central to the right to the highest obtainable standard of health more generally.

KEY WORDS: Maternity Health Care, Mortality, Human Rights.

INTRODUCTION

Prior to examining inequalities in maternal health care in the state, it is imperative to understand the maternal health scenario in the state.The concept of quality in maternal health services has broadened over time in India. During the early 1970s, the notion of quality in maternal health began with a focus on improving capacity and capabilities in human resources. Consequently, health committees made recommendations about medical education and support for clinical manpower (Srivastava et al. 2014). In the next decade, the emphasis on quality tied to clinical delivery of care continued, and policies and programs addressed the need for adequate supplies, better medical training, and efficient clinical operations. As advocacy and dialogue on patient rights in reproductive health increased their influence in the 1990s, perspectives on quality extended to include implementation and outcomes, such as effectiveness, equitability, and accessibility. The focus on quality outcomes is consistent with the growing visibility in this

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period of the Donabedian model for quality of medical care, which viewed health services in terms of its structure, process, and outcomes (Donabedian 1978, 1988).

Since the 2000s, viewpoints on quality expanded further to introduce patient-centered care, and mechanisms for quality assurance moved to the forefront. For family planning, the BruceJain framework rose to prominence, highlighting the importance of provider–patient interactions and defining quality as "the way individuals and clients are treated by the system providing services" (Bruce 1990; Jain 1989). In addition, programs such as RCH-II included provisions to establish quality assurance committees at district and state levels and provided guidelines for maternal death reviews (Srivastava et al. 2014). The GOI also began funding patient welfare committees for communities to improve the accountability among facilities. That is not to say, however, that quality framed within the context of clinical care became less important; in fact, the GOI set up the National Health Systems Resource Center to provide technical assistance and capacity building for quality improvement in the health system. As the evolution in the concept of quality demonstrates, quality is multidimensional and complex. Not surprisingly, there is no universally accepted framework for or definition of quality today (Nair and Panda 2011; Raven et al. 2012; Karvande et al. 2016). This review relies on the World Health Organization's (WHO's) commonly accepted paradigm for understanding and assessing quality of health care (WHO 2006). It also aligns with a framework developed by Hulton et al. (2007) for assessing quality of maternal health services in India. Both frameworks influenced the MacArthur Foundation in conceptualizing its maternal health quality of care grant making strategy. Therefore, this review examines quality of care across the WHO quality of care framework dimensions: effectiveness, efficiency, accessibility, patient-centeredness, equitability, and safety (Figure 5). Because many of these dimensions are related, this review further combines them into three key components: clinical (safe and effective), experiential (patient-centered), and contextual (accessible, efficient, and equitable). In the remainder of this chapter, we discuss maternal health quality of care in India within these three components.

In Tamil Nadu

Nine activists, including grassroots-level workers and a professor who participates in the maternal mortality review meetings. Human Rights Watch had hoped to include the perspectives of doctors or health workers who were suspended, dismissed, or arrested following complaints about maternal health care in Tamilnadu. Unfortunately, we were able to trace only one such health worker, a hospital staff nurse.Health workers and nongovernmental organizations providing services to villagers assisted Human Rights Watch in identifying pregnant women and families to interview.

Table 1: Differentials in TFR and the Mean Number of Children Ever Born(MCEB)toWomenacrossSocio-economicClassification in India

Classification	TFR NFHS3(2000-19)		MCEBDLHS 3(2000-19)	
	Tamilnadu	India	Tamilnadu	India
Residence				
Rural	2.03	2.06	2.45	4.22
Urban	1.73	2.98	2.29	3.42
Religion				
Hindu	1.53	2.59	2.15	3.84
Muslim	2.46	3.40	3.26	5.03

Christian	2.11	2.34	2.14	3.72
Caste				
Scheduledcaste	1.32	2.92	2.32	4.30
Scheduledtribe	NA	3.12	2.31	4.19
Otherbackward castes	1.74	2.75	2.61	4.06
Others	2.17	2.35	2.08	3.49
WealthIndex				
Lowest	NA	3.89	2.50	4.98
Second	NA	3.17	2.41	4.69
Third	1.75	2.58	2.35	4.28
Fourth	1.87	2.24	2.48	3.83
Highest	2.04	1.78	2.37	3.07

Note: NA, not available due to lack of sufficient numbers. Corresponds to womenattheend oftheir reproductivespan(40-49years).

Source:NFHS2005-06(NFHS3),IIPS&MacroInternational,2020.

DLHS2007-08(DLHS3),IIPS,2020.

Though theredoes not exist much difference among most ofthedistrictswithrespecttoTFR,itwashigherthanthereplacementlevelonlyin the care that a women and baby receives in the first few weeks in post-delivery is important for the health and survival of the women In addition to the rural health programme, the state has also given importance to the urban health programme to look after the health of 27 million urban people settled in the six metropolitan cities. There are various urban health centres in the state, including the Postpartum Units, which are usually attached to the district hospitals or CHCs. There are 65 urban health centres to take care of the needs of urban people. The Chennai Municipal Corporation runs its own urban welfare clinic, which functions like a sub district hospital.

MATERNALMORTALITY

Asdiscussedearlier,oneofthemostadverseoutcomesofapregnancyis thedeathof the motherand thereductionof maternaldeaths should be aprimeconcern for all health authorities and policy makers.TheWHO initsInternational Statistical Classification of Diseases and Related Health Problems,Tenth Revision, 1992(ICD-10),definesmaternaldeathor maternal mortality,as "the death of a woman while pregnant or within 42 days of termination ofpregnancy,irrespectiveofthedurationandsiteof thepregnancy,fromanycause related to or aggravated by the pregnancy or its management but not fromaccidental or incidental causes" (WHO, 2019).It is estimated that around 830womendieeverydayacrosstheworld,duetoreasonsassociatedwithmaternity, resulting in the death of around 3,03,000 women in 2019. Almost theentire burden of maternal deaths is being borne by the developing countries.

Table2:EstimatesofMaternalDeathsacrossRegions; 2000and2019

	Maternaldeaths		
	2000	**2019**	

Region	Number	Share inglobal deaths(%)	Number	Sharei ngloba ldeaths (%)	Changef rom19 90 levels
World	532000	-	303000	-	43.0
Developedregion	3500	0.6	1700	0.5	51.4
Developingregion	529000	99.4	302000	99.5	42.9
South-easternAsia	210000	39.5	66000	21.8	68.6
India	152200	28.6	45000	14.9	70.4

Source:WorldHealthStatistics,WHO,2019

At the country level, India accounted for the maximum number of maternal deaths 15 per cent (45000), followed by Nigeria and together they comprise around 30 per cent of the total global maternal deaths. At the other extreme, countries such as France, Malta, Puerto Rico and Albania did not report even a single maternal death. Around 50 countries (34 %) reported 10 or lesser number of deaths (World Bank, 2014). However, India also reported impressive decrease in maternal deaths from the 1990 levels, in comparison to other regions.

A major problem in a developing country like India is the poor quality of data with respect to maternal deaths. Developed countries have a robust registration system where the births and deaths are automatically registered. The hospital records are also reliable source of data. In India, though it is mandatory for all births and deaths to be registered, deaths are not registered as promptly as births (GoK, 2012). This is especially the case with maternal deaths as deaths which occur only in institutions are registered while domiciliary deaths go unregistered and in some cases they remain unknown as the reason for death may not be attributed to maternity, per se.

The available data sources in the state with respect to maternal deaths are the Health Management Information System (HMIS) information published by the Directorate of Health Services and the annual vital statistics bulletin published by the Directorate of Economics and Statistics. The Kerala Federation of Obstetricians and Gynecologists (KFOG) also attempted to enumerate the maternal deaths in the state.

MATERNAL MORTALITY RATIO

Maternal health is most often discussed in terms of the Maternal Mortality Ratio or MMR; i.e. the indicator which presents the proportion of the number of maternal deaths to 1, 00,000 live births2. This, along with IMR is major indicators of the general health status of the society as well. The reduction of the MMR is a major objective of health and development programmes worldwide. It was in 2000, seeing the appalling low levels of human development across regions, that the UN launched the Millennium Development Goals (MDGs): a set of eight goals, each goal pertaining to improving a particular development dimension. Goal number five related to the improvement of maternal health. The first target was to reduce by three-fourths the global MMR of 1990, by 2015.

The global MMR has fallen from 380 deaths per 1, 00,000 live births in 1990 to 210 in 2013; i.e. a reduction of 45 per cent. However, as the envisaged reduction is 75 per cent, this points to the fact that much more remains to be done. There also exist wide inequalities in the world with respect to maternal health. The MMR in developing regions (230) was more than 10 times that in developed regions.

Table 3: MMR Estimates and Rate of Decline; World, Regions and India, 2000-2019

Region	MMR		Rate of decline
	1990	2015	
World total	380	216	43%
Developed	26	12	54%
Developing	430	239	44%
India	437	167	62%

Source: Trends in Maternal Mortality, 2000-2019, WHO, 2019
India –SRS (2019-20), Office of the RGI, 2019

Wide inequalities are also observed among countries. While Sierra Leone is estimated to have the highest MMR at 1100, Belarus has the lowest MMR at one. While mostly the Nordic and European countries are the best performers, countries from the African continent are the worst performing countries (WHO, 2015). As regards India, in 1990 the estimated MMR was 437 per 1, 00,000 live births. The target for attaining the MDG was to reduce the MMR to 109 by 2015. In line with the aim for attaining the MDG, NRHM as well as the Eleventh plan aimed at bringing down the MMR of India to around 110 (GoI, 2015). However, as per the most recently released SRS mortality estimate, the national MMR estimates is 167 per 1, 00,000 live births in 2013. Though India has recorded a rate of decline higher than the global rate, it has fallen far below its target under MDG.

CRITIQUES OF THE GOVERNMENT'S APPROACH TO MATERNAL HEALTH

NRHM has resulted in greater attention to maternal health but many Government officials and civil society groups have concerns about the government's approach. They argue that poor accountability adversely affects not only planning based on women's health needs but also the implementation of existing maternal healthcare interventions. These gaps in accountability manifest themselves in many ways, notably recurrent health system or programmatic gaps and a lack of government action to ensure that health programs are actually reaching pregnant women from marginalized communities including the poor, Dalit, other backward classes, religious minorities and tribal communities, or women in geographically remote areas. Furthermore, activists say that poor monitoring and attention to the supply-side coupled with the spurt in demand for institutional deliveries has resulted in substandard maternal health care at these facilities.

Moreover, state governments' pattern of unspent NRHM funds buttresses calls for better accountability by activists and doctors. For instance, millions of dollars in government funds for health care in Tamilnadu go unspent each year. A study for the Indian Planning Commission shows that roughly 40, 40, and 30 per cent of the amount allocated under the NRHM to the Tamilnadu government went unspent in fiscal years 2018-19, 2018-19, 2018-19. In February-March 2019, activists in Tamilnadu claimed that nearly "700 crore rupees [US$140 million]" remained unspent even though it was almost the end of fiscal year 2018-2019. In a January 2019 letter to 71 district chief medical officers, the Uttar Pradesh NRHM Mission Director urged each of them to spend "30 lakh rupees [US$60,000]" within two months, that is, by the end of March 2019.

Health experts and activists have also expressed concerns about the effectiveness of existing government strategies to improve maternal health. While the JSY has improved access to health care during deliveries, many groups argued that the Indian central and state governments are not taking adequate measures to address unsafe abortions-a significant cause of maternal mortality in India. Even though the NRHM guarantees safe abortion services

in public health facilities, and abortions are allowed in accordance with the Medical Termination of Pregnancy Act, in practice, little is being done to promote awareness and access to these services. Furthermore, health care to address maternal morbidities, which affect thousands more women leaving many disabled for life, is not given the attention it requires. What was intended to be a cash assistance integrated with antenatal and postnatal care, in practice, operates as a cash incentive to increase women's demand for facility-based deliveries without information on birth preparedness.

Women's rights and public health experts caution that the government's interventions to improve maternal health are too vertical, ignoring concerns about the overall health of women during their life-cycle, including the underlying determinants of girls' and women's health and their other rights including food, potable water, employment, and access to contraceptives of their choice. The underlying determinants of health influence maternal health care. Dr.SundariRavindran, a leading public health expert on the reproductive and sexual health of women, said that in many areas of India, women are likely to experience a far higher rate of pregnancy-related complications requiring emergency obstetric care than the global average of 15 per cent.This is because of their overall poor health resulting from poor nutrition and anemia and has implications for the number of facilities that need to be equipped with comprehensive emergency obstetric facilities.

Further, activists repeatedly emphasize that vertically run programs, notably polio eradication, have had negative outcomes, which should not be replicated in maternal healthcare programming. One of the main adverse outcomes of the polio eradication campaign is that field-based health workers spend a large part of their time on it, forcing other health concerns into the backseat. For instance, senior officials from the Uttar Pradesh Directorate of Family Welfare concede that "pulse polio-all focus is on this project and other programs are neglected. A study commissioned by the Uttar Pradesh Health Systems Development Project quotes a USAID study in Uttar Pradesh saying that one of the many challenges to maternal health care is that "National programmes such as Polio eradication are consuming half of health functionaries time.

Moreover, many feel that the government mistakenly continues to approach the reproductive and sexual health of women within an overarching framework of "population control or stabilization." The government has not taken measures empowering women to make informed, autonomous, health-related decisions, especially about use of contraceptives or facilitated use of contraceptives that encourage male participation. They point to the government's sterilization program, noting that field-based health workers spend a considerable amount of their time on sterilization without providing information about non-terminal contraceptive methods.

Several women and men from rural Tamilnadu reported seeing ASHAs or nurse-midwives only during polio drives or complained that they received prompt assistance only when they wanted to get themselves sterilized. For instance, Vimala V. died after delivering at home and Revati R., a relative who was present at the time of delivery, said she had died without assistance from any health worker. RevatiR. explained: "If you tell her health worker that it is for sterilization, then they will go to any length to help you-will arrange their own vehicle and take you to the hospital. But if you say that it is for something else, they will not even turn around and look at you."

The "population control" approach has found its way into the JSY as well. In the non-Empowered Action Group states, JSY benefits are restricted to women above age 19 for up to two live births. Likewise, cash assistance for home-based deliveries is restricted to women above

age 19 and up to two live births. This short-changes the medical needs of young mothers and pregnant women with multiple pregnancies.

Finally, the private sector continues to play a significant role in providing healthcare services, including obstetric services. About 64 per cent of women go to private healthcare providers for complete antenatal care and about 20 per cent of all deliveries occur in private health facilities.Many activists said that the absence of regulation of the private sector posed a significant challenge to ensuring affordable quality maternal health care to all women.

SCOPE AND LIMITATIONS

This report uses a human rights framework to examine maternal health care, setting out several specific steps we believe officials should take to better integrate accountability into maternal healthcare programs and ensure their implementation through the health system. It does not explore all available tools for accountability including external surveys assessing quality of health care, public hearings, social audits of budgets, or community-based monitoring. The NRHM, India's flagship rural healthcare program, sets out a three-pronged accountability framework of external surveys, community-based monitoring, and stringent internal monitoring. This report's focus is on the last of these three prongs, the state's internal monitoring of policies, practices, and performance. While the arguments presented in this report address the specific issue of preventable maternal mortality and morbidity, accountability as a human rights principle is central to the right to the highest obtainable standard of health more generally.

CONCLUSION

The model integrates existing information from quantitative and qualitative studies and provides a more comprehensive picture of structural and intermediary factors of maternal health service use and maternal mortality in India and their mechanisms of influence. Reducing maternal mortality continues to be a part of the India’s health agenda, and the NRHM maintains its prominence as a key government program. In addition, India’s commitment to UN Sustainable Development Goals along with pressure from global and local civil society organizations is likely to keep the government focused on this area. Given this climate, the efforts to improve maternal health will also likely persist in India. Given the limitations of this study, we indicate the areas for further research pertaining to the framework and maternal health.

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