India's Progress towards the health related Millennium Development Goals – Maternal Health

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ABSTRACT

With a significant percentage of world population in India, global emphasis on improving maternal health in India has increased. Though India has made some progress in reducing the maternal mortality rate, it is still far from the MDG target. From a structural perspective, the slow progress towards more efficient maternal health care is rooted in issues like inadequate manpower, infrastructure and other resources like medicines and emergency facilities. However, the problem may have deeper roots in the socio political environment in India. These may be manifested in the lack of political and social will to focus on maternal healthcare, social perceptions of grass root healthcare workers like 'auxiliary nurse midwives', and prioritized attention to population control initiatives like family planning. This article presents an overview and analysis of India's progress towards implementing maternal health initiative, and of cultural and socio political factors which may be influencing this progress.

Keywords: maternal health, MDGs, public sector, India, midwives

INTRODUCTION

MDG 5 aims to reduce the maternal mortality ratio (MMR) by 75% between 1990 and 2015. The indicators selected to measure this target were the MMR and the proportion of births attended by skilled health personnel. In India and other developing countries, measurement of these metrics is difficult and the error ranges are large. Given the relatively small improvements in maternal health believed to have occurred in the last few years and the large errors in measurement, it is difficult to precisely measure changes in the MMR. These errors are due to lack of standardized measurement techniques and data from variety of disparate sources[1]. According to MDG, India is required to attain MMR of 109 per 100,000 live births by 2015. India did make some progress towards this goal by bringing down MMR from 437 per 100,000 live births in 1990/91 to 254 per thousand live births in 2004-2006[2,3]. However, estimations from the current trends reflect that India might be able to attain an MMR of 135 per 100,000 live births by 2015 which is 26 points less than the MDG target of 109 per 100,000 [4,5,6,7]. Following sections present a discussion of progress made towards attainment of MDG 5.

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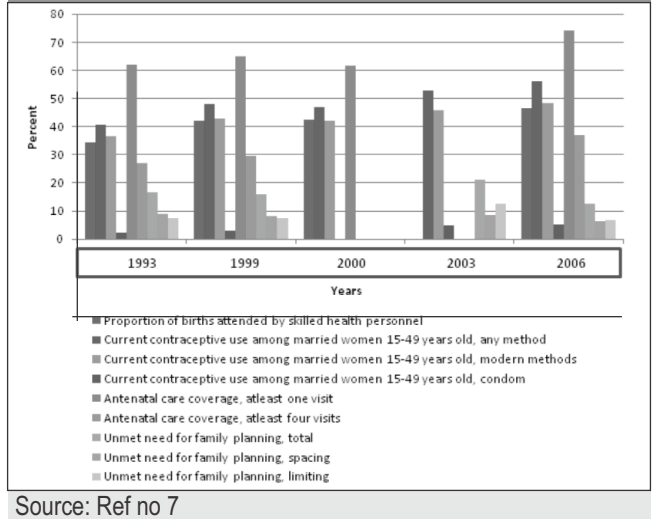
Fig.1: Trends observed in progress towards maternal health MDG indicators over the last 2 decades



Source: Ref no 7

Past measures:

India is a largely patriarchal society and maternal and reproductive health is not a large priority in the societal agenda. Furthermore, with a population over 1 billion, India's focus has been largely on family planning and maternal health has taken a back seat [1]. The government attempted to address maternal health issues by developing a nurse midwife workforce called "auxiliary nurse midwives" in the 1960s. However, due to the label "auxiliary," these health personnel were not given the appropriate credit for their work and they were not as effective as a skilled health workforce could have been [1]. More recently, since committing to working toward the MDGs, the government has sponsored several programs to tackle maternal mortality. For example, in 1992 the Child Survival and Safe Motherhood Project was co-financed by the World Bank and UNICEF to support child survival, prevent maternal mortality and morbidity, and increase effectiveness of service delivery[2]. The Reproductive and Child Health Initiative in 1997, financed by the World Bank, was also a similar government scheme, but it was inadequate in addressing MDG 5 due to problems with access to quality medical products and medicines. The National Rural Health Mission was established in 2005 to put increased focus on the problem of maternal and child health and work towards universal access to public health services [8,9]. The World Bank revised its plan for the Reproductive and Child Health Initiative and made a second injection of funds into the program after addressing deficiencies in the first attempt. Even with all of these efforts and policies, the MMR has only gone down from 437 deaths to about 300 deaths per 100,000 live births in a period of 16-18 years. This pace is not on track to meet MDG 5 by 2015. Clearly, while these programs may have identified the right problems, cultural implementation and challenges in the health system have interfered with the progress.

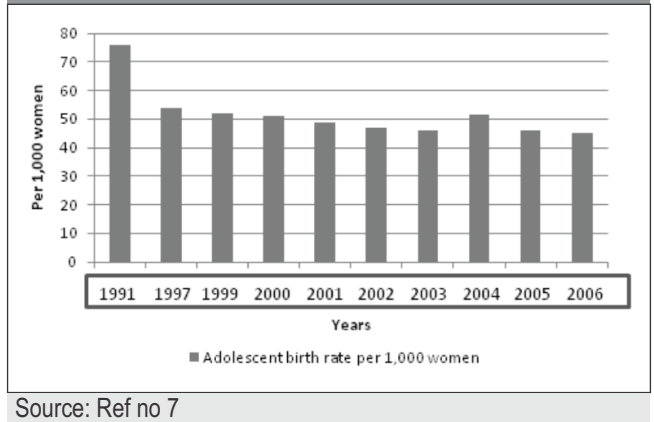
Fig. 2: Trend showing decline in maternal mortality ratio + over 2 decades

Source: Ref no 7

Present measures:

Current strategies for India as outlined in their 2005 MDG Report are wide in scope. They include prophylaxis and treatment of Anemia- a major cause of maternal mortality in India- through distribution of tablets with iron and folic acid, antenatal care to pre-register pregnant women before delivery to monitor pregnancy progress and any potential complications, provision of emergency obstetric care, and creation of a workforce of trained birth attendants to deliver the vast majority of births that occur in the home[10]. Other schemes include safe abortion kits, population control policies, and increased health personnel. Again, like past programs, present initiatives face system level and cultural level barriers. Although emergency obstetric care remains a priority, inadequate staffing remains a problem and prevents full utilization. Furthermore, inadequate infrastructure, medicines, and facilities for emergency care all contribute to the high maternal mortality ratio [11,12].

Fig. 3: Adolescent birth rates per 1,000 women over 2 decades:



Source: Ref no 7

Donor role:

The donor role in India has predominantly been working with the central and state governments to address several of these issues. The large, national programs have been funded primarily through World Bank, such as the two Reproductive and Child Health programs (8). UNICEF also conducts programs to assist in monitoring and evaluating efforts to prevent maternal and infant mortality (13,14). While these organizations have provided monetary and service assistance, India's government must address key barriers to move its maternal health program forward (15). The issue at hand remains more focused on problems with effective structuring and implementation rather than a lack of funds.

Major challenges:

Malavankar (2008)[1] and Vora (2009)[16] identify several areas that pose challenges for India to decrease their MMR. The

lack of targeted implementation of emergency obstetric care is an important shortfall in India's maternal health strategy. Although the Reproductive and Child Health program and more recently the National Rural Health Mission have stated commitments to improving maternal health, poor strategic planning and lack of focus with regards to emergency obstetric care are problems. With a majority of births occurring in the domiciliary setting, midwives and skilled health personnel are essential for lowering the MMR. Yet, partly from international pressure and cultural resistance, nurses trained for midwifery were converted to general nurses focusing on immunization and family planning. The current lack of qualified midwives is a major hindrance for reducing the MMR in India. Poor management of the health system leads to misallocation of resources, inadequate monitoring of quality of care, and slow implementation of programs. Without proper central planning, there is little coordination between government entities, NGOs, and village health workers, so care is not comprehensive and existing efforts are not as effective. Lack of political will has contributed to minimal expenditure on health, and little effort to provide comprehensive maternal health has been made (17).

Recommendations:

Given India's current situation, two main areas must be the focus for reform. Emergency obstetric care has been identified as a crucial part of a successful maternal health package (18,19). The government must ascertain which regions have the least access and address issues such as upkeep, staffing, and transportation to facility. This will certainly assist in reducing the major causes of maternal deaths in India, all of which can be averted with emergency obstetric care (20,21). In addition to emergency facilities, there is an absolute need for a competent, skilled, midwifery workforce that can provide services in rural areas. With about 60% home delivery rate, a majority of women do not have suitable care nearby at the time of delivery unless accompanied by a skilled birth attendant. Programs to train these workers, as well as providing them with the appropriate tools and rights to assist in complicated births will be immensely helpful (22). Besides emergency care and skilled birth attendants, a change in political focus to prioritize health is needed. Maternal health in particular must be a focus given its use as a benchmark for a nation's overall health status (23,24). India has set ambitious goals in its most recent MDG report, but there has been little improvement in the MMR. India must carry the same enthusiasm in setting these goals to changing policies and implementing programs to meeting these goals.

CONCLUSION

Overall, though India seems to have made some progress towards the MDG goals, lack of political and social will towards efforts to improve maternal health pose serious challenges. These challenges may be overcome only by connecting maternal health to population control and family planning measures, the key priority of the Indian government and health establishment. Increased emphasis on maternal health, a system to coordinate maternal health initiatives across various entities, and regionally focused efforts may also make these initiatives more efficient and effective.

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