Breaking the Silence

Voices from the Ground

A study on MMR

Action India

Supported by Global Fund for Women

India's Silent Tragedy

Maternal Mortality is not just about women dying at child birth, it is an indicator of the value placed on the life and well being of a woman by our society. High maternal mortality, indicates that a large number of women go through repeated pregnancies in life threatening conditions of poor nutrition and ill health. Maternal Mortality serves as an indicator not just of pregnancy outcomes, but also of a woman's health status.

Pregnancy and child birth are natural processes in a woman's life. **Motherhood**

should be a time of expectation and joy for a woman, her family and her community but they are by no means risk-free rather the reality of motherhood is often grim in India. For those women, motherhood is often marred by unforeseen complications or even a loss. Some women lose the foetus even before being born or shortly after child birth; while some lose their own life and that of the baby.

Maternal mortality is significant in the context of **Human Rights Violation** as many of them are preventable, and as a result of various difficulties in accessing maternal health services. Since many deaths happen in the seclusion of women's home or on the way to seek help at a medical facility, they often go unrecorded. India's Silent Tragedy……..

Women's Health and Reproductive Rights have been the foundation of Action India's Gender Equality Program. The "Women Centered Self Help Health Program", evolved a grassroots perspective to address Women's Reproductive Rights and Needs. The program focused on demystifying scientific knowledge of body and women's health, drawing out the tangled and interconnected layers of poverty, neglect, abuse, gender-based violence, discrimination, and subordination in the family that render women highly vulnerable at the time of their pregnancy.

Working with a Self Help approach enabled every woman perceive her body and health in a holistic manner. The approach was introduced in the year 1990 with a focus of expanding self reflection and self examination of one's own body. Collective sharing and helping each other induced innate compassion and willingness and strengthened the bonding between women.

Area of Intervention
Over 3 years, the Action India team covered 750 mothers in the 14 urban slum communities where Action India worked in close association with **Dais and 36 pregnant mother's groups**. This was followed by interviews of 450 mothers, in groups spread over 15 villages of Hapur block (UP).

The Pregnant Mother's Program involved an interaction from the third month of pregnancy to birth of the child and lasted till six months after the baby was born. We explored and heard their experiences of birthing at home and hospitals, and learned of their perceptions of how public and private health facilities function. We learnt that the health system grossly lacks accountability, in contradiction to a central human rights principle, integral to the realization of **Women's Right to Sexual and Reproductive Health**.

One of our unique experiences was recording the birthing experiences of community women working with Action India which was recorded and compiled to make the booklet titled, **"*Janam*"**. The booklet raises a discourse on traditional ways of birthing in the hands of experienced dais and the trained ANMs working in Govt.'s Health Centers. We found there was an overlap in the use of the term TBA- 'Trained Birth Attendants'. The 'Traditional Birth Attendants' who were fast disappearing and whose skills were not

adequately transferred to the next generation of Dais were often persecuted for lack of certification. Ironically private nursing homes and hospitals left the actual delivery in their hands and the qualified doctors were only called for Cesareans and complicated deliveries.

We also found that TBAs were referred to as ANMs who are supposed to undertake the birthing of child at health centers in rural areas. They were most often not available and the family would call the local traditional Dai and only in the severest of situations were compelled to take the pregnant mother to the nearest available hospital often reaching too late. Our health workers found that hemorrhage was the most common cause of maternal death as a result of being anemic or having high blood pressure. In both the situations the public health centers were not equipped enough to measure blood pressure or even provide blood from their blood banks to a woman on the brink of life and death. Often the family has to donate blood before a pregnant mother was admitted and here comes the Big Gender Question. Who would donate blood from the family? Not the husband, he could not risk losing blood. Women in his or her family in general are too anemic. At such a crucial moment of life and death blood has to be purchased at a cost of Rs. 8000 from a blood bank in order to replace the hospital supply. In reality, the pregnant woman is not admitted for delivery in the most critical of situations without the 'mandatory contribution of blood'. Our years of experience of working with the economically underprivileged and underserved women had led us to prioritize maternal health services and focus on the MDG goals to address maternal mortality by institutionalization of child birth. The target set by GOI to achieve 100% institutional births by 2015 seemed improbable.

THE GAPS IN POLICIES AND PRACTICES:

For India to achieve the Millennium Development Goal of reducing maternal mortality ratio, seems to be a milestone hard to reach. The family welfare programmes are concerned with meeting demographic goals and targets, which view women primarily as reproducers. Review of 8th and 9th Five year plan shows that there were hardly any descriptions of strategies or achievements related to maternal care and maternal mortality reduction goals. Even the 9th and 10th plan, which for the first time have included gender budgeting, do not include women's health other than reproductive health and family planning. Promotion of maternal and child health has been one of the most important objectives and integral part of the Family Welfare Programme in India since 1st and 2nd Five-Year Plans(1951-56 and 1956-61) when the GOI took steps to strengthen maternal and child health services.

Gradually the focus shifted from individualized interventions to attention to the reproductive health care, which includes skilled attendance at birth, operationalizing Referral Units and 24 hours delivery services at Primary Health Centers. The current Reproductive and Child Health Programme (RCH) launched in October 1997 and Integrated Child Development Scheme (ICDS) are other programmatic interventions by the state to provide services through PHCs and ICDS.

For better availability of and access to quality health care, in the year 2005 the government launched the flagship program "National Rural Health Mission" for the 2005-2012 periods. NRHM envisages providing services through strengthening public health system, making decentralization process more robust and increasing the overall financial outlays. In order to provide access to improved health care at the household level, female **Accredited Social Health Activists (ASHA),** were appointed to act as an interface between the community and the public health system. They are expected not only to generate demands for services but are also supposed to promote referrals for universal immunization, escort services for RCH, construction of household toilets, and other health care delivery program (Ministry of Health and Family Welfare, 2006). From our study and focus group discussions it was found that within such comprehensive health care paradigm like NRHM, the ASHAs have gained recognition whereas the local traditional birth attendants have gradually lost their legitimacy. However, according to the latest NFHS (Round 3 2005-06) an overwhelming number of childbirths took place at home.

National Population Policy 2000: The need for bringing down maternal mortality rate significantly and improving maternal health in general has been stressed in the NPP. However the main objective of the population policy was targeted population control without any regard to the human rights, privacy and dignity of the individuals. The two main aspects which were considered under this policy were sterilization operations and the two child norms.[1]

Uttar Pradesh Population Policy (UPPP)

After having NPP, Uttar Pradesh state government took initiative and formulated a state specific population policy and tried to set realistic objectives, integrate family planning services with maternal and child health services, encourage informed choice, address

gender issues and decentralize the programme implementation to a large extent.

Major Goals of the Uttar Pradesh Population Policy (2000)

Later age at Marriage. Increase the median age at marriage for women from 16.4 years in the late 1990s to 19.5 years by 2016.

Smaller family size. Reduce the total fertility rate from 4.3 children per woman in 1997 to 2.6 children in 2011 and 2.1 children in 2016.

Fewer maternal deaths. Reduce the maternal mortality ratio from 707 pregnancy-related deaths per 100,000 births in 1997 to a maternal mortality ratio of 394 in 2010 and to below 250 in 2016.

Fewer infant deaths. Reduce the infant mortality rate (IMR) from 85 deaths among infants less than one year of age per 1,000 births in 1997 to an IMR of 73 in 2006, 67 in 2011, and 61 in 2016.

Fewer child deaths. Reduce deaths among children under five from 125 deaths per 1,000 children in 1997 to 105 deaths in 2006, 94 in 2011, and below 84 in 2016.

Source: USAID report on population policy initiative in UP

Despite the clear policy intentions the progress on the ground has been very slow because of excessive emphasis on achieving targets, especially family planning targets; sometimes at the cost of providing basic services. The strategies were all directed towards penetrating the remote villages of UP and achieve targeted population control. Specialists claim that UPPP violates other crucial aspects of government policy. It re-introduced method-specific contraceptive targets, to the extent of 10 lakh sterilizations and 30 lakh spacing method users per year by 2005. This was a complete reversal of the government's target-free approach. It also violates Article 2 of the United Nations Convention on the Eradication of Discrimination Against Women (CEDAW), which underscores the right of individuals to freely decide the timing and spacing of their children[2] .

The other major lacuna is the inadequate and unequal distribution of resources. The ratio of hospital, functional sub centers, and beds to population in rural areas is much lower than that for urban areas. The ratio of doctors to population in rural areas is almost six times lower than that in the urban population. Per capita expenditure on public health is even much lower in rural areas, compared to government health spending for urban areas.

The fifth Millennium Development Goal (MDG) is committed to reduce the MMR worldwide by three-quarters by 2015. India continues to struggle with the alarming rate of maternal mortality. Over 22% of the world's reported maternal deaths occur in India, most of which are preventable, given the proper infrastructure and adequate resources. [3] According to the Govt. of India, 301 women die annually for every 100,000 live births. The state of Uttar Pradesh has one of the highest MMR at 440 deaths per 100,000 live births, which means that nearly 30,000 women lose their lives before, during or after childbirth or abortion every year in Uttar Pradesh alone

In order to meet the commitments spelled out in MDG, the GOI targets to reach 80 percent institutional birthing, 100 percent of deliveries to be attended by trained personnel, and reduce maternal mortality ratio to a level below 100 per 100,000 live births by initiating Janani Suraksha Yojana (JSY), which offers monetary rewards for mothers who have their deliveries in a government institution. These kind of state-sponsored interventions have exacerbated the problem and this approach neglects the lived reality of India's poor and vulnerable women. The Uttar Pradesh state government monitors the success of the JSY by setting and achieving "targets" for the number of facility-based deliveries, without monitoring or ensuring that such deliveries are really safe and include women who develop pregnancy-related complications. The government's push toward institutional births-roundly supported by the World Bank-has the negative result of displacing the centuries-old, traditional birthing methods developed by birthing attendants, or dais.

STATE ACCOUNTABILTY and MATERNAL MORTALITY

Legal Framework to Address MMR and Reproductive Rights:
Reproductive rights, even women's health rights are nowhere found within the Indian legal system. Over the years, through judicial interpretations numbers of rights have been held to be included within the right to life. The issue of maternal mortality has been taken under Right to health.[4] Full realization of the right to health, including maternal health, means progressive realization of both aspects of the right to health, that is, the rights to health care and underlying determinants of health. These determinants include food and nutrition, access to safe and potable water, adequate sanitation, sufficient quantity of hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.[5] However, most of these factors and discriminatory feeding practices, child marriage, early child bearing, gender and generational power dynamics in families, unwanted and unsafe abortions, lack of functioning public health facilities, lack of access to EmOS etc are all the rights denied in Indian scenario.

At its eleventh regular session in 2009, **Human Rights Council recognized Maternal Mortality as a pressing Human Rights Concern** and adopted a landmark resolution on **"Preventable maternal mortality and morbidity as human rights."** which is a step towards ensuring every woman's basic human right to a safe and healthy pregnancy and childbirth[6].

Article 12 of the ICESCR (International Covenant on Economic, Social and Cultural Rights) guarantees the right to the highest attainable standard of health. The UN Committee also affirms that states are required to take measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information. It recommends that states remove all barriers to women's access to reproductive health. [7]

The Indian Supreme Court has held that the implementation of the obligations in the international treaties is not conditional upon being incorporated in domestic legislation. Hence district level and state level authorities have the freedom to take measures to directly comply with India's international obligations. Likewise, Indian courts also have the freedom to direct governments to take measures to implement these binding international obligations.

The **CEDAW** committee in its General Recommendation no.24, Article 12 (para 17), places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care. It recommends the States to take "all appropriate measures" to eliminate discrimination against women in the field of health and ensure access to healthcare services in connection with pregnancy, confinement and postnatal care and ensure adequate nutrition during pregnancy and lactation as well. Moreover, according to article 12 para 31(c) the State parties should in particular prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. And, Article 24 of Child Rights Conventions particularly mentions that States shall take appropriate measures to ensure appropriate pre-natal and post-natal health care for mothers

Human Rights that can be applied to maternal mortality

- Right to life
- Right to the highest attainable standard of health
- Right to be free from cruel, inhuman or degrading treatment
- Right to equality
- Right to education
- Right to freedom from???????
- Right to information Discrimination
- Right to decide the number and spacing of children.

These rights are found in key human rights instruments including the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights and CEDAW.

Participatory Research Action: Objectives

· To do a comparative mapping of maternal health of pregnant women in urban slums and rural villages.

· To review access and delivery of public health services in rural areas and urban areas.

· To evolve strategies for improving comprehensive maternal health care and service delivery.

· To promote government accountability for the implementation of equitable policies and programs to reduce maternal mortality.

· To identify alternative ways to make birthing safer by giving greater control in the hands of the women themselves.

Geographical Area of study:
The study was first done in the slums of Delhi and then in 15 villages of Hapur, Ghaziabad district in Uttar Pradesh. The villages covered under the study where: Katikhera, Kharkari, Sudna, Tiyala, Gaundi, Ubarpur, Nawada, Muradpur, Ayadnagar, Salai, Ghunghrala, Amarpura, Bhikhampur, Sultanpur and Mansurpur. **A brief interaction with 3 doctors and 8 ANMs in Hapur Tehsil revealed the pathetic conditions of the sub centers in the villages.** According to the ANMs a good percentage of women delivered at private nursing homes because of lack of available services at the health centers.

The Community Health Center (CHC) based in Hapur block operates with the minimum infrastructure and human resources. As reported by women and staff nurse, in the year 2007, owing to some wrong handling of a complicated case, and the resultant retaliation from the public, the lady gynecologist was suspended. Since then the hospital was running without a lady doctor. A doctor was coming from 8:00 am to 2:00 pm on contract basis. The equipments required for the emergency operations, facility for blood transfusion etc. were not available and the cases were referred to the district hospital, Ghaziabad. The scenario of Primary health center (PHC) situated in Nurpur was even worse as there the cases are totally in the hands of ANM. As regards the transport facility there was only one ambulance to cater to the whole of Hapur Tehsil.

Participatory Research Methodology:
· The research design includes observation of pregnant women over 18 months covering antenatal and post natal care.
· Monthly meetings with pregnant women's groups created awareness and educated them of the need for additional nutrition and exercise.
· The importance of registration at health care facilities was emphasized.
· In depth interviews and FGDs were conducted to assess the experience of birthing, both at home and institutional births.
· Reflections and recollection of cases of maternal mortality were attempted to be traced through collective memory as no records were available on the subject.

In-depth Interview:
A total of 426 women were interviewed in Hapur block. The interview schedule was designed in a way so as to address not only adverse experiences in institutional delivery but to get a holistic picture of the nutrition, rest and customary practices that go with pregnancy and in the way these affect the maternal health of women.

Secondary Respondents group included - ASHA, Aanganwadi workers, Action India Community Health workers, 17 Dai and ANMs, CHC staff nurse and doctors at PHC.

Focus Group Discussions: **8 FGDs** were conducted with pregnant women, Dai, ANM,

ASHA and Aanganwadi workers. An integral part of the FGD was to inquire into the schemes of the government, like the Janani Surkasha Yojana, Role of ASHA and ANM.
Case Documentations: Experiences of women who have delivered in hospital and had adverse experience not only in terms of availability of services also in terms of ill treatment by doctors and nurses.

Review of Literature:

Various studies have been done to study and measure the maternal mortality rate, changing role of ANM and its implication on maternal and child health. We referred to various study reports and the survey reports. The National Family Health Survey (NFHS 3) is a national level household survey to gather information on fertility, family planning, infant and child mortality, reproductive health, child health, nutrition of women and children, and the quality of health and family welfare services. The latest round conducted in 2005-06 (NFHS-3) samples represented more than 99 percent of India's population living in all 29 states. The NFHS reports present health indicators disaggregated by urban and rural areas mask the inherent differences which exist within urban areas.

Various articles from Newspapers and journals were referred, which helped us to understand the various policies, extent of political will, regional disparities and gaps in promises made by Govt. and ground realities.

A study "Sparing Lives"- Better Reproductive Health for Poor Women in South Asia, conducted by World Bank in five South Asian Countries to study the recent trends in maternal mortality and morbidity. Besides it examined the availability and utilization of existing health facilities and targeting poor and deprived section of the societies.

The studies and publications of Action India and the community based reports of Self Help Health Program helped a lot in developing perspective on public health and design interventions. the books like Janam,

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Evidence from the Field

In the course of study conducted in urban slums and villages of Hapur, it was found that maternal mortality is determined by a mixture of biological, socio-economic, cultural and contextual factors and their complex interactions. Therefore the study attempted to address maternal health and locate the other socio cultural factors that obstruct and underplay the importance of healthcare and lead to maternal death. Also some secondary sources interviews were conducted to collect the evidence to establish Human rights principles of entitlement and accountability and improve responsiveness and functioning of the public health systems.

As maternal mortality is affected by a range of socio-economic determinants, this study explores the various indicators that directly or indirectly relate with viz: domiciliary care practices, inadequacy and unequal distribution of emergency obstetric care services. Fertility, order of pregnancy, preference for place of delivery, nutrition, availability of skilled birth attendants and dais, use of primary health services, physical access to health care (transportation and finances) etc.

Fertility Indicators:
Dig. 1.

Age at first conception and frequency of pregnancies is an important predictor of maternal mortality. As reproductive concerns begin in adolescence, it is essential to understand how much ready, physically and psychologically, the adolescent is for sex and reproduction. The demographic survey was focused on pregnant women from 15 to 44 yrs.. The survey found that 11% of women between 15 to 20 years were already mothers or were pregnant with their first babies. The data from the survey revealed that 58% of pregnant women were of 21 to 26 years age group and most of these were pregnant for the third time. This indicates the early marriage and fertility of young women.

Dig. 2

In the FGDs women said that they were married at early age of 14 or 15 and had two children age of 20. However this does not really gives the total no of number of pregnancies, as in between many of them said that they had miscarriage also. These

women in the village areas had not received any counseling on the use of contraceptives, importance of child spacing or health risks involved. A few women who were above 30 years age practiced periodic abstinence.

B. Contraceptive Use:
All most all the women knew at least one method of contraception. However, majority were unaware of the range of available contraceptives. Those who were aware of contraceptive pills feared the side effects. The low use of contraceptives among young women (between 15 to 19 years) is common; this may be due to lack of knowledge, inability to express their wish to delay conception and lack of opportunity to interact with the ANM. The situation is even worse in Muslim dominated villages. The religious beliefs keep the adolescent and young women away from any kind of information on reproductive process and contraceptives. In urban slums the women were aware of the methods of contraception; however the use of contraceptives is low both in urban and rural settings as women have women no decision making ability in this matter.

C. Domiciliary Care Practices:
To study the underlying socio cultural causes for maternal mortality, the domiciliary care practices for mothers in the community and the available primary services were studied in detail. **Hours of work and rest, nutrition and other practices were taken as indicators to understand the socio cultural practices that support the antenatal and postnatal care.** During the Action India study in Hapur, the community health workers formed groups and discussed the practices that directly or indirectly affected the reproductive health.

In the urban areas, though they migrate from the various parts of different states, they are better exposed to progressive trends. The women staying in nuclear family generally have more independence and they keep themselves open to both traditional practices and the modern pattern of antenatal and postnatal care.
Diag: 3

As the diagram shows in general the hrs spent on work is more than that of rest. In rural areas the majority of women appear to contribute most of the work in animal husbandry and make a 40-70% contribution to crop production.Some women and girls (especially in Muslim dominated villages like Sultanpur, Salaigaon and Gondi) are confined at home. These women are generally engaged either in household or do some bead work on piece rate. From the FGDs it was found that women engage in work during pregnancy with a belief that it helps in smooth and normal delivery, which is less expensive and can be done by Dai at home.

Postnatal Care at Home: Rest and Diet
In general the post partum period in villages or in urban areas is of 40 days. However it may vary in case of giving birth to a male or female child. Around 69 % women said that in case of male child they are more cared and get rest for full period of 40 days, but in case of girl child it may vary from 40 to 10 days. Especially in cases where 2nd girl child

is born. Son preference in urban areas is similar to the rural areas. Moreover period of rest also depends on where the women deliver; at natal place they take rest for a longer period than in in-laws place.

One of the ANM in Gondi village said that adolescent girls and young women are vulnerable to complications during delivery due to deteriorating health conditions. In the case they have given birth to a girl child, the pressure to produce a son is imminent to which they are bound to comply, thus they cant assert on spacing.

D. Nutrition:

A general observation of Aanganwadi and nutritional supplement through ICDS scheme was made to examine the links between the nutrition supplement to the pregnant women within community and its impact on their health. Several background factors were studied, whether they got enough food to eat, the volume of staple food consumed during and after pregnancy, number of days after which food is given, time of breast feeding etc were some of the aspects taken as primary indicators.

Though women and girls are meant to be served nutrition supplements through Aanganwadi centers in every village, and iron folic acid is meant to be distributed free to all pregnant women, the quality and amount of diet being provided hardly fulfilled their requirement.

Diag: 5

As regards the customary practices related to food, 88% women said that they were suggested to eat less. There was a common belief that rich and heavy diet may lead to enlarged fetus and consequent painful delivery, or the fetus may get crushed in the birth canal. Thus eating less and light food during pregnancy is a general customary practice in the villages.

Diag:6

The other important findings related to nutrition during survey and FGD were:

- Women take low calorie diet in the initial months of pregnancy. In poverty stricken families, the pregnant women could hardly manage a meal because of food shortage; however they take staple food which is rich in nutrients. This could be substantiated by the data which shows that 28% women take 2 to 3 chapattis and a bowl of rice throughout their pregnancy and only 2% women increased appetite in late pregnancy.
- 43 % women belonging to well off families consumed staple food and calorie rich diet as well. Whereas in the poor families the common expression was: **“we eat whatever we get, we don't have much option”.**
- Most women get calorie rich diet after delivery as it is customary to

supplement the lactating mother. 79 % women said that they start breast feeding after the third day of delivery. Only 9% were those who believed in feeding the same day. Also in FGD, we found that in the case of birth of a girl child the care of mother and child was not taken seriously and after giving birth to two consecutive girl child they are totally neglected.

· It was commonly observed that primary health staff belonging to higher castes is reluctant to visit Scheduled Caste households for immunizations and other primary health services. Asha, Aanganwadi workers and traditional birth attendants remain the only caretakers to attend to women from SC/ST castes.

Anemia:

While interacting with pregnant women, the community health workers found that most of the women were anemic and underweight. Low supplement of nutrients and the practice of "eating last and the least" gradually lead to poor health and anemia. There is a total neglect of a mother's health in India. A big chunk of adolescents, belonging to 15-19 yrs age group are more at risk as they usually have multiple deficiencies of iron and minerals. **Thus giving one iron tablet a day to a woman during her pregnancy is not always effective. The root of the problem is adequate quantity and quality of food continued over the period of antenatal care.** The pregnant women have to fetch water, make fuel, work in the fields and tame buffaloes, etc., all on the little amount of food they can afford. The ICDS aanganwadi scheme has not achieved much due to its limitation to food supplement for lactating mothers.

E. Pregnancies and Abortion:

As per our study, the rate of abortion and ultrasound is higher in urban areas in comparison to rural areas of Hapur. Out of 423 women interviewed in Hapur only 6 women accepted that they had undergone abortion, only 2 of them gave the reason and 4 of them did not respond. Though the reason for abortion was not revealed, in both rural urban areas generally abortions were conducted on the advice of doctor. Only a few women said that the doctor anticipated deformities or the woman was not in position to carry forward pregnancy. Most of the abortions were done in the first three to four months.

Ultrasound is not widely available in village areas. 20 to 21 percent of women had undergone ultrasound in Hapur block or Ghaziabad city. Apparently as it was reported, 80% women had an ultrasound to know the child position of placenta. Among these were those women who had accessibility to private nursing homes or those who had some problems like regular bleeding, low weight and had approached doctor either at district hospital or to the nursing homes.

However at the FGD, all women stated that women rarely have a say in the decision making .The decisions are jointly made by the mother-in-law and husband. Although some of the women reluctantly accepted that there is family pressure and son preference when they are sent for sex detection and consequent abortion in case the fetus is a female.

Backdoor abortions (both in urban and rural areas) are common which have negative consequences. From FGD in Sudna, it was clear that backdoor abortions are quite frequent which remain unreported and is given the name of miscarriage. Such unsafe abortions may be the cause of maternal mortality but is not reported. According to estimates 6 lakhs women die due to unsafe abortions every year.

Reproductive Health care Services: Role of ASHAs and Janai Suraksha Yojna

Diag: 7 **Diag: 8**

The overall rate of registration was 53%. Though at the sub center level it reached 76%. This was an outcome of frontline responsibility of ASHA to organize client side and take the Janani Suraksha Yojna under which pregnant women receive cash payments for undergoing antenatal check ups, T.T. immunizations and institutional delivery.

Diag 9:

To understand the major reason for not getting registered, it is necessary to ask 'who and why' these women were not getting registered. As the reasons from above diagram confirm, these women are those who are either from poor families or remote areas where the public health facilities have not yet been reached. Lack of awareness dissuaded them to register and more so they feared they would not be treated with respect if they went to hospital.

F. Antenatal Care:

As per our findings, despite the strong mandate of Govt. of India to launch NRHM as an umbrella of primary health services, antenatal care is centered only on T.T. immunization and IFA supplement. Blood pressure is often not measured, the reason that either there is no machine available at sub centers or ANMs do not want to carry the machine to the villages. In most of the villages sub centers are not functional. It was found that only 25% women received Iron Folic Acid supplements. The lack effort to distribute IFA is one of the reasons. According to the ASHAs complains the mothers did not value the importance of IFA. The antenatal coverage is also affected due to the religious beliefs and related non compliance with IFA supplementation.

Diag: 8

At the time of in-depth interviews majority of the Muslim women were disinterested in undergoing any kind of medication during antenatal care as they consider pregnancy as a natural process and their religion does not allow medication during pregnancy. Women in general lacked knowledge about reproductive health risks and were not

aware of importance of additional requirement of IFA during pregnancy.

G. Infant Mortality:
Responding to the reasons behind the infant deaths. 58% women said it was miscarriage, 13 % were still born and around 18% of women did not respond. The period of these deaths were 30% within 24 hrs and 39% within a month or so. In Muslim dominated villages like Salaigaon and Sultanpur, the occurrence of still birth was more frequent.

The other major reasons of birth related IFR as identified from FGDs were (i) Socio-economic and geographic problems like poverty, inadequate information among people, lack of access to health care (ii) anemia among women, malnutrition, low birth weight (iii) poor availability of health services(both preventive and curative) to reach the targeted population effectively.

Diag: 9 **Diag: 10**

Diag: 11

From FGD with ANM, Asha and aanganwadi workers it was found that majority of children are born with low birth weight. These children are at a higher risk of mortality. One of the major causes of low birth weight is the poor nutritional status of the mother before and during pregnancy. They also said that, early child bearing and low spacing among the pregnancies lead to still birth. As the study reflects, female infant mortality figures are higher than male. As visible from the above chart, in a few families the number of dead female children is more than 3.

H. Delivery: Institutional or Home based?
With an aim to understand the need and choice of women residing in rural areas, the health workers of Action India collected information from the pregnant women groups formed for the purpose of observation and maternal health awareness.

Diag: 12

Despite the efforts made by govt. to strengthen institutional deliveries, majority of the

women prefer to deliver at home. Especially in villages where the health facilities are not accessible. Dais are still easily available. However some women have moved towards hospital and private nursing homes which suggest that the efforts of ASHA to implement JSY scheme under NRHM is having effect.

In order to locate the clients who go for institutional deliveries and to understand the changing trends in preference for birthing, pregnant women were classified into two categories.

- A. Those who were young and first time pregnant
- B. Those who were second or third time pregnant

Diag: 13 **Diag: 14**

Among both the categories preference for home based delivery was maximum; however among those who were 2nd or 3rd time pregnant 85% women preferred home based delivery with the help of “Dai”. The economic constraints distance and location of hospitals and poor transportation facility was cited as causes. Fear of cesarean delivery and misbehavior of doctors and nurses were the major reasons behind the preference for home based delivery. It would appear more women wanted home births in spite of the decline of the experienced "Dai Maa", and relied on the support systems of the family and village. Preference for delivery in hospitals was minimal. In the FGDs, women said that, driven by monetary incentives under Janani Suraksha Yojna, families have started choosing institutional birthing over home birthing.

I. Maternal Health Care and Traditional Birth attendants:

Various persons are engaged in care during home based child birth; this includes senior family members, persons skilled in conducting child birth, person who works as cord cutters, masseurs and so on. However, Irrespective of caste and class 'dais' are found to be socially and emotionally connected to the pregnant mother.

Diag: 15

The “Dai” is locally available or called from the nearby villages. They see her role beyond conducting childbirth, in continuum of care and support of mother and child health. Unfortunately the trained ANMs are not available when needed at night. Most of the ANMs are posted in villages but stay in other parts of Hapur Block and thereby not easily accessible.

Diag: 16

The 8 FGDs and interviews with 426 women revealed that most traditional “Dais” were not formally trained by the Government. They were respected in the society for their birthing skills, and their role in post partum care. Also, they served as a bridge between

the clients and health system, sometimes accompanying women to health facilities in case of complications which they could not handle. They had enough experience to identify the risks early and refer the pregnant woman to the hospital or take her to a doctor.

Diag: 17

Of the 17 Dais interviewed, 15 had learnt their skills over the years through working with other Dais or elderly women in the community. The experienced Dais are old and dying out. The new generation dais does not have sufficient skills or experience. They are dependant on the local RMP (Registered Medical Practitioner) to give pitocin injection which as a practice is controversial.

The Dais, said that they faced non cooperation and disrespectful attitudes of their counterparts in hospital settings. They often get into conflict with ASHAs who have been recently appointed under NRHM as there is conflict of interest. However, the ANMs valued the experience and role of Dai in home based delivery.

Case Studies from Urban Slums

Case 1: Name: Suchita
Area: New Seemapuri
Age: 32 years
Suchita had a normal delivery in hospital. Right from registration to delivery she was hassled by the hospital staff. She was not registered in GTB on the ground that the locality she belongs to, is not under their jurisdiction. The nurse asked her to go to the dispensary of New Seemapuri. With the help of Action India Community Health workers, Suchita got registered in the dispensary which has 10 beds, but no electricity or water supply. She got continuous support from the health group on nutrition and getting access to antenatal care from the dispensary. But at the time of delivery she had had the worst experience.....which she recalls ***"mujhe bahut tej dard ho raha tha mai chilla rahi thi , kai bar awaj lagaya nurse ko aur dai ko lekin har bar unhone mujhe dat diya, jab dard bahut jyada hone laga to mai baith gayee aur pata nahi kab bachha ho gaya... itne me nurse ne dekh liya aur gusse me mere kamar par laat se mara....mai chillayee phir dusri nurse ne bhi mujhe mara...mujhe pata nahi meri kya galti thi.. baad me pata chala ki mujhe bachha ho gaya hai".*** This was not the end of her problem, after the birth she was told that her child is too weak and blood is required. After a long hunt she got someone from the locality to donate blood for which she had to pay Rs. 200. However the blood was not used and she was said that the child is ok now. She was released and within two days the child was in sinking condition, again she went to the hospital but the doctors refused to admit the child. Suchita had to run from one hospital to another to save her child's life...and finally she got her child admitted to a private nursing home and spent Rs. 2000. As she recalled the whole situation she was outraged and said that birthing is a very natural process

and we should seek "safe birthing" wherever it may be, get registered, take nutritious diet but deliver wherever we get proper care and attention. Institutional birthing should not be mandatory. She said that she had to spend around 2500 /- for medicine and tip to the nurse, "dai" and she got 600/- under JSY.

Case 2:
Age: 21 years
Village: Sultanpur
Month of Pregnancy: 5
The respondent belonged to Muslim community and had conceived for the second time. She shared her experience of her first pregnancy and delivery. As she said she had faith in the experience of the traditional “Dai”. She said, that Dais is easily available anytime and they not only perform delivery but they also help in household chores if needed. She recalled that during her labor pain there was no one at home; her mother in law had gone to the weekly market and would only return by evening. Women in the neighborhood called the Dai who attended her and arranged whatever was required. Within an hour she delivered a male child. According to this respondent if there is no complication there is no reason for going to hospital as the ‘Dai’ is available in the community. Home based delivery is more convenient and involves less cost.

Case 3:
Age: 28 years
Village: Sudna
Month of Pregnancy: 5
Order of pregnancy: 3rd

Respondent was registered with sub center and had also received two TT injections. But her last experience of delivering children in hospital had not been good. Behavior of nurses in the hospital was not good, she said that when she was in acute pain the nurse shouted at her and asked her to keep lying on the bed and none of the family members were allowed to enter into the room. The respondent said that she did not had any complication, but as she had undergone regular antenatal check ups she went for institutional birthing. When her labor pain started, ASHA and her mother in law accompanied her to the hospital. Everything was ok, however the nurse and doctor behaved harshly and they turned her away saying that she had come too early. It would appear that it was anticipated that if it was to be a normal labor the doctor did not think their services was necessary.

Her pains grew stronger and the fluid leakage started, by that time the doctor had left. She had to pay some amount to the staff nurse only then did she attend to her, and she delivered the baby within half an hour. She spent around Rs. 2000 for a normal delivery which included transportation, medicine, and miscellaneous payments to frontline workers. However during her first delivery she was at her natal place and as she gave birth to a male child her mother had to spend Rs. 500 inclusive of a set of cloths that she had to give to the Dai.

Case 4:
Name: Lalita (changed name)
Area: Sundernagri
Age: 27 years
Experience of Delivery at GTB Hospital and exchange of baby
Triveni was pregnant for the third time and had no difficulty during her pregnancy. She was in the pregnant mothers group of Action India and said that the community health workers were of great help to her. They not only guided her to get registered at the govt. hospital, they also taught her about the nutritious diet at home, regular exercises and check up and importance of IFA. Finally when she was in pain, she was taken to GTB. The nurse on duty said that this is a case for cesarean delivery, but the doctor was not on duty. So she insisted on going to some other hospital. As the private nursing homes charge a lot Triveni's husband got worried as he had to arrange at least Rupees 10,000/- immediately. But Triveni was confident that she will have a normal delivery and she refused to move to another hospital. Within an hour she had a normal delivery on the verandah of the GTB hospital. The nurse on duty got angry and did not give the child to her until the doctor came. The child was under weight, the doctors taking advantage of the situation negotiated to exchange the child with a healthy one for Rs. 1500. The doctor would benefit from both sides, but Triveni was happy to keep her own baby.

Case 5:
Name: Rabiya
Age: 23 years
Area: New Seemapuri
"When I had my first pregnancy, Basanti didi from Action India included me in the Pregnant Women's Group and guided me throughout pregnancy and she was with me even at the time of delivery". Rabiya has two healthy children now and she reaffirms that the community support group can play a supportive role in antenatal and postnatal care. She expressed her gratitude to the Action India community health workers for guiding her throughout, as she was too young at the time of her first pregnancy and her mother in law did not help her initially. But after attending two three rounds of pregnant mothers' group meeting even her mother in law was quite supportive. Rabiya had normal deliveries, one at home and other in hospital. Her first delivery had been in the presence of Action India Health Worker while in the hospital her delivery was not very smooth. She was in acute pain but no one from the hospital staff came to attend to her delivery. The Dai at the dispensary refused to touch her, and kept on asking for money. Finally Rabiya delivered child with the help of elderly women from her family.

Case Studies from Hapur

ASHA sometimes face very difficult situation when doctors do not support and the patients are harassed. According to one of them “As we have been appointed to promote institutional birth, we try our level best to prepare women for institutional delivery, but in some cases we lose our image and become the defaulter”. Women are

needlessly suffering serious harm during pregnancy, childbirth, and the postnatal period until the government creates reliable and affordable services. Also effort to ensure that the ASHA program benefits the pregnant mother and child and should not be hijacked by unscrupulous people.

Case Study: 6
Name: Anjum
Age: 20 yrs
Village:
Case detail: Infant Death
This was the case of sheer negligence. Anjum had her first pregnancy. Despite the resistance from family Anjum decided to deliver in hospital and got registered at the sub center. She received TT Shots, underwent all antenatal check ups and took regular IFA. Fifteen days before the due date Anjum went to CHC for checkup, the gynecologist said that the heartbeat of the child was ok but the delivery will be only after 15 days. However within 3 or 4 days, Anjum had pain and she was rushed to hospital at around 2:00 pm, but neither doctor nor staff nurse were available. Ultimately ASHA went and called staff nurse from home and Anjum had normal delivery but the child was gasping. In the absence of doctor the nurse was unable to do anything, so she suggested to take the child to some other hospital. Anjum's family members kept on rushing from one place to another, finally they could catch hold of a doctor in a private nursing home, that too only when they had paid Rs 300 for fees, and by the time the paper formalities were done the child was declared dead. Anjum and her family members could not understand the reason of death. Anjum strongly feels that her child died just because of negligence and delay at each step, right from the beginning of delivery to reaching the doctor with the child seeking medical care. The ASHAs repeatedly said that in remote areas children are born by God's grace, we are here to facilitate institutional birthing, but due to the lack of proper transportation and infrastructure women still prefer home based delivery". The govt. facilities in no way meet the needs of the common women.

Case : 7
Case detail: a case of improper demand for payment as a condition for delivery of health care services.
Name: Wakila
Age: 25 yrs
Wakila had her 2nd pregnancy and everything had gone well except that she could not afford money to pay the doctor. When Wakila went to the hospital the doctor returned her saying that there is 2 to 3 days time. Also the nurse asked Wakila that if she wants delivery in hospital she should pay Rs. 700 in advance. As Wakila was not prepared to pay she came back and next morning she delivered the baby at home with the help of the Dai. Though Wakila was registered and had undergone all antenatal check ups and TT shots, she did not get the amount under JSY and neither did the ASHA. The ASHA said" We genuinely give our time and energy to convincing the pregnant mother for 9 months but the attitude of doctors make our efforts futile."

Case 8:

Case Detail: Infant Death

This was another case of negligence. Bhuri had opted for delivery in hospital and she did deliver in hospital but not in the presence of a doctor or nurse. She had a normal delivery and her mother- in - law was there with her. She delivered the child in a standing position, but as no one was there the child fell on the ground and had brain injury and became unconscious. As it was a male child the family members were also active, they immediately took the child to a private nursing home where the doctor referred him to Delhi. But even after spending around Rs. 7000 / 8000 the child did not survive. The family members became furious. As they were powerless and could not their grievance officially against the hospital they directed their anger on to the ASHA. The ASHA says, after such cases people ask questions like “What’s the point of going to hospital? If the doctor cannot deal with the case here, then why should we go to the doctor? Just for Rs.1400, are we going all the way to kill ourselves or our children?”. As of now the face value of ASHAs is on stake, as she is the one who is in contact with the women directly.

In Conclusion:

India stands at 132 among 179 countries ranked in the Human Development Index based on a list of indicators about health, wealth and social outlook in the study conducted by the UN Development Program (UNDP). [8] The stagnation in India’s rank in the U.N.’s HD Report between 2000 and 2007-08 is attributable to a sustained reluctance on the part of the government to move away from lateral interventions, to the selective “indicators” of the MDGs.

Failure to provide available, accessible, acceptable and quality health care for women during pregnancy and childbirth is a violation of women's rights to life, health, equality and non-discrimination. Respect and protection of women's rights to information and decision-making in reproductive health, to freedom from gender-based discrimination and violence, and to participation in planning and implementing health policies are critical for making pregnancy and delivery safer for women.

After more than a decade of programming for reproductive and child health, Indian Government acknowledged the problem and introduced "NRHM" to improve public health system and reduce MMR. Though NRHM has increased demand for deliveries in health facilities, however it could not ensure safe deliveries and continuum of care through antenatal and postnatal stages. Also it has not done much to ensure the reasons for the poor implementation of healthcare programs as they lack information about gaps in the health system.

Securing Reproductive Rights:

It is therefore essential to recognize a woman's reproductive autonomy and health as critical to her human rights and stimulate advance reproductive rights initiatives, advocacy and policy. The combination of advocacy, policy work, and other strategies may ensure that government implement effective and equitable policies and programs to reduce maternal mortality.

Gender Sensitivity:

It is essential to foster attitudinal and behavioral changes among service providers at all levels and their orientation towards reproductive rights. Both the medical fraternity and frontline health workers must be gender sensitive and accountable for their ill behavior towards economically and socially disadvantaged, marginalized women. Strengthening and improving the reproductive health services may include provision of information to illiterates and poor communities, making staff available (reduce absenteeism), monitoring the availability of medicines and basic equipments and up grade the knowledge, skill and behavior of medical staff at public health systems.

Enhance Inclusion and Need to locate the vulnerable.
Redefining the actual beneficiaries is the emergent need of the day, more essentially those who are less informed and do not get sufficient care. The antenatal coverage should stretch out to the socio economically disadvantaged groups and address their basic rights to health and dignity.

In the light of adolescent marriage and early child bearing it is now essential to include adolescents in the reproductive health systems, provide counseling and knowledge and increase interaction with health workers or the community trained women's group.

Recognizing Dais:
The emphasis on institutional deliveries have ostracized the traditional roles of dais as the midwives of their villages, also the new policy paradigm has totally ignored the role of dais in any form of health care provisions. This abrupt shift does not recognize the thousand of birth attendants who were trained under various programs even beyond the launch of NRHM, including those being supported by government agencies.

Traditional birth attendants have immense potential in the communities for providing basic health care and must be brought under the ambit of NRHM. This may give them recognition and help them work in coordination with ASHA, ANM and Aanganwadi and avoid potential conflicts. The skilled and experienced dais is fast disappearing and the transfer of knowledge from the older to younger dai seems to have lost momentum. However, continued attendance by TBAs at home deliveries suggests potential to influence maternal and neonatal outcomes. Efforts to institutionalize the role of Traditional Birth Attendants (TBAs) in maternal and neonatal health programs have had limited success. Thus to motivate the new entrants it is essential to recognize their skill, set minimum standards for accreditation and organize formal training. The reorientation of 'Dai' may increase their efficiency to perform safe delivery and timely recognition of pregnancy related complications.

Budgetary provisions should be made within the overall family planning and RCH program, to give them financial support and motivate new entrants. TBAs also disseminate nutritional and dietary advice. Thus training on basic principles of nutrition may reduce undernourishment and non compliance to the iron foliate tablets in many communities.

Emergency Obstetric care Services:
Although EmOC was one of the prime strategies, it was not implemented due to lack of focus and limited management capacity. Even today there is no systematic government monitoring of how many EmOC facilities are fully functional and what facilities are actually available against the required need. During the study in 15 villages of Hapur the stark reality of inadequacy of even the basic equipment at sub center level surfaced. Not a single sub center has had equipments to check blood pressure. Just training peripheral health workers to attend normal deliveries, or appointing ASHA under NRHM with no feasible medical backup (functioning sub centers and regularity of doctors) may not likely make much difference in current high rates of maternal death.
A cumulative approach should be made towards access to EmOC, focused antenatal and postnatal care, birth preparedness and complication readiness. Improving access to emergency obstetric care does not necessarily need building new hospitals or training new cadres of workers. Community awareness on signs of obstetric risks among women, TBAs and other frontline workers may also minimize maternal mortality risks. Much can be achieved by improving the functioning and utilization of existing facilities and personnel. To a significant extent, this is a problem of policies, priorities, and management, not of resources.

Rationalized resource allocation:
Owing to the inadequate and unequal distribution of services in the villages and the existing socio economic gaps in society, the accessibility to the services has also been partial for those who reside in remote areas. There has been proliferation of private hospitals and nursing homes which has raised the cost of healthcare. At the same time public healthcare services, which were never adequate, are now shrinking. The public health system needs to focus and operate more efficiently, reach out to the poor and target resources to them.

A campaign should be launched to activate govt. policies to build a comprehensive reproductive healthcare movement, addressing all sides of the issue – delivery, providers, policies, government obligations and accessibility.

Regulating Clinics: Making Abortion Safe
India legalized abortion in 1971 through its MTP Act. This allows clinical abortion if pregnancy carries the risk of grave physical harm to a woman or endangers her mental health or is likely to lead to physically or mentally abnormal child. However the implementation of such restrictive laws is still under question mark.

Despite the existing restrictive, laws like PCPNDT and MTP, sex selective abortions are common both in urban resettlement colonies and rural areas. Owing to exorbitant charges for safe abortion, cheap backdoor alternatives are opted which is highly unsafe and cause mortality due to abortion. It is therefore essential for Govt. to make available “safe abortion” services in the remote areas, regulate clinics and penalize providers of unsafe abortions.

In order to substantially minimize abortion related mortality, family counseling should be done to make men more responsible and prevent unwanted pregnancies due to contraceptive failure. This may avoid repeated abortions and ensure the well being of women and children and post abortion care. Also it may reduce the demand for sex selective test and abortion. The overall mission to improve the social status and value of girls and women's empowerment are also needed to promote women's decision making power within families. RCH programs have to be gender based and develop a strategy of informed choice.

Awareness Generation:

The survival of mothers is an issue of extreme health importance and improving survival is a great challenge, particularly in rural areas where almost no health system exists. However, during the study we realized that motivation is very strong in the village but need to be supplemented with awareness generation and community mobilization to address complex, long-term issues involved in assuring quality health. That is building a method for "Social Audit" through access and demand.

Consistent observations and experiences have proved the importance of organizing women's group on issues of gender and reproductive health, create demand for better health services and develop strategies for policy advocacy. To this end the recommendation is to bring together and consolidate the experience of rural and urban women to articulate their needs and rights as equal citizens in India.

Active Panchayati Raj Institutions:

Awareness of PRIs on rights and participation in women's health issues may strengthen the women's groups further to take local action and generate demand for health services, improve the utilization and quality of services and save women's lives and their new born. The National Population Policy already proposes to form the sub-committee to monitor health RCH programs, which in villages do not exist or are ineffective. Formation and Capacity building of such committees may lead to establish linkage between community, public health and hospital systems in a standing relationship to decrease the high maternal mortality. Ultimately community awareness will address the poor implementation of ongoing Govt. programs i.e the issue related to facilities for transportation , improving road conditions, the cost of seeking care, avoid multiple referrals to different health facilities through educating the community and making them self reliant.

Reducing IMR:

There is no coherent child health policy in India, except for a few programs such as ICDS, immunization, Vitamin-A supplementation, etc. The intention of ICDS was good and well-planned. But the whole package of ICDS interventions has never been implemented besides a few convenient fragments of the scheme. The Aanganwadi worker has limited their role to collect as many as children, give them few food items and fill up the registers. Thus it has become incomplete and inadequate to meet the needs of child health nutrition program aimed to ensure child survival in the 0-6 years.

In order to reduce infant mortality, increase in number of visits to newborn babies, imparting child health education to mothers, making safe deliveries, helping mothers in taking care of low-birth-weight babies is required. A decentralized healthcare model of self-help health, aimed at reducing maternal and infant mortality may empower community to seek services on time. The village level health worker / TBAs must be trained to gain skills of diagnosing and basic equipment and medicines must also be made available at sub-center level.

Establishing Community Based maternity centers:
Another important key recommendation and choice of women was a community based maternity rooms or a community hub with facilities required for safe delivery, wherein the normal deliveries could take place safely. Also delivery related health risks could be minimized especially for women who cannot access the health services or those who are at risk of minor delivery complications, which are usually handled by the TBAs. “Safe Delivery” should be considered as the core of reducing maternal mortality rather than pitching institutional delivery against home based delivery.

Indigenous Health Systems and Medicines:
Women in urban resettlement colonies or in rural areas still believe in traditional systems like Ayurveda/ Unani etc. to promote maternal and child health. However, over decades, there has been a conscious neglect of traditional practices and an erosion of local health heritage knowledge as well as medicinal plants. In order to mainstream these systems it is essential to assess and validate them and promote them at the PHC level through dispensing traditional medicines for preserving health. This may be achieved through community participation and capacity building of community based groups and health workers on the local availability and promotion of traditional medicine and preventing misuse of antibiotics and injections.

Improving Social status of women:
Under aegis of the Ministry of Women and Child Development a gender based program in collaboration with NGOs working with a focus on Women's Health with a Right Based Approach should be developed to address underlying factors of maternal mortality health holistically. Improving women’s secondary status, identifying and analyzing the causes of inequality and discrimination suffered by women from birth to death is an obligation the State must fulfill to keep its commitment to CEDAW.

Rights based approach to enhance the ability of girls and women to negotiate all the entitlements that promote safe motherhood such as accessing nutrition, being supported in making choices regarding marriage, negotiating safe sex, increasing citizen voice to demand accessible high quality services and finally, increased influence over political processes that decide policy and resource priorities.

This in turn require the improvement of delivery of a comprehensive package of maternal and child health and nutrition interventions, including the promotion of water

supply, sanitation and hygiene services, to urban and rural poor communities, an integrated approach through strategic collaboration with other departments is recommended.

Recommendations

Reduction of mortality of women and children has been an area of concern across the globe. Being signatory to several international treaties, India is committed to a human rights approach and to set appropriate mechanism to prevent maternal mortality and morbidity. However, the recurrent gaps in policies and practice suggest strengthening accountability and gaining the required momentum for inclusive reproductive health interventions. Based on the voices raised from the ground and we have collected evidences through primary and secondary sources which we put forward as recommendations to concerned persons and agencies.

- We believe that poor nutrition and low body weight both are compounded by early child bearing has to be addressed as the major root cause embedded in poverty and all forms of gender based violence socio economic factors will have to be addressed by a **paradigm change in inclusive growth in order to achieve the goals set for reducing MMR and IMR**. Therefore we will have to enhance inclusion and locate the vulnerable by stretching out to the socioeconomic disadvantaged groups and address their basic rights to health and dignity.
- **Safe delivery and Informed Choice should be considered** as the core of reducing maternal mortality rather than pitching institutional delivery against home based delivery. A community based maternity room or a community hub with basic equipments and facilities required for safe delivery is suggested, along with community based trained workers and support group.
- Efforts should be made to **institutionalize the role of traditional birth attendants** (TBAs) in maternal and neonatal health programs by bringing them under the ambit of NRHM. A cumulative approach should be made towards access to EmOC, continuum of antenatal and postnatal care, birth preparedness and complication readiness.
- Ensure delivery of **comprehensive package of maternal and child health** and nutrition interventions, including the promotion of water supply, sanitation and hygiene services, to urban and rural poor communities, an integrated approach through strategic collaboration with other departments is recommended.
- Foster **attitudinal and behavioral changes among service providers** at all levels and their orientation towards reproductive rights. The aanganwadi could become the space for pregnant women to come together weekly and share their joys and sorrows. Aanganwadi workers and helpers would need to be oriented towards gender equality; family planning and women's control of their body; contraception and informed choice. They would in the process recognize the outcome of son preference and misuse of ultrasound for sex determination and break the vicious circle of repeated abortions of female fetus.
- To bring together and consolidate the experience of rural and urban women to articulate their needs and rights as equal citizens in India. **Organizing women's group** on issues of gender and reproductive health, create demand for better health services

and develop strategies for policy advocacy.

· **Grievance Mechanisms**

And finally having recognized the need for systemic change we recommend a grievance cells in every district, block and taluka to enable health care users to feedback their experience needs and demands to the health functionaries. Systemic change requires regular monitoring and review by the concerned authorities and implementing agencies on a sustained basis to ensure the needs of poorest of the poor women are met and our ultimate goal of eliminating maternal mortality is successfully achieved.

Abbreviations

NRHM	National Rural Health Mission
RCH	Reproductive Child Health
ICDS	Integrated Child Development Scheme
PHC	Primary Health Center
EoCS	Emergency Obstetric Care Services
TBA	Trained Birth Attendants
ASHA	Accredited Social Health Activists
NPP	National Population Policy
UPPP	Uttar Pradesh Population Policy
CEDAW	Convention on the Elimination of Discrimination Against Women
MDG	Millennium Development Goal
JSY	Janani Suraksha Yojna, Motherhood Protection Scheme
ICESCR	International Covenant on Economic, Social and Cultural Rights
CHC	Community Health Centers
ANM	Auxiliary Nurse Midwife
FGD	Focus Group Discussion
NFHS	National family Health Survey
UNHDR	United Nations Human Development Report

Glossary

1	Accredited Social Health Activist	A female health worker appointed under the National Rural Health Mission
2	Anganwadi	Government-run early childhood care and education center.
3		

	Anganwadi workers'	duties include providing nutritional supplements to pregnant and lactating mother
4	Antenatal care	Care during pregnancy (termed "prenatal care" in AmericanEnglish)
5	Auxiliary Nurse-Midwife	A field based health worker usually posted in health sub-centers and primary health centers
6	Block	Administrative division of a district
7	Community Health Center	Thirty-bed government health facilities in rural India providing secondary health care
8	Emergency obstetric care	Obstetric care that includes the ability to provide life-saving interventions through surgery (cesarean sections) and blood transfusions
9	Janani Suraksha Yojana	Motherhood Protection Scheme, an NRHM scheme that promotes facility-based deliveries through cash incentives for pregnant women and community-based female health volunteers
10	Maternal death	Death during pregnancy or within 42 days of childbirth or abortion, caused directly or indirectly by pregnancy
11	Maternal mortality ratio	Number of maternal deaths per 100,000 live births
12	Millennium Development Goals	Eight goals that 189 countries have pledged to achieve by 2015, including a 75 percent maternal mortality reduction compared to its 1990 levels (MDG 5).
13	National Family and Health Survey	A periodic all-India sample survey funded by the Indian government and international agencies
14	National Rural Health Mission	The Indian government's flagship program on rural health care for the period 2005-2012
15		

	Postnatal period	42 days from termination of pregnancy
16	Postnatal care	Health care for women after termination of pregnancy up to 42 days from date of termination of pregnancy
17	Primary Health Center	Basic health facility in rural areas catering to a population of 30,000

[1] Claiming Dignity Reproductive Rights & The Law/Anubha Rastogi/HRLN

[2] "UPPP Ignores the ground realities", Rashme Sehgal, Infochange India

[3] Maternal mortality in 2005: estimates developed by WHO, UNICEF and UNFPA and The World Bank. *Department of Reproductive Health and Research, World Health Organization, Geneva* 2007.

[4] Claiming Dignity Reproductive Rights & The Law/Anubha Rastogi/HRLN

[5] para 11 of ICESCR committee Some of the underlying determinants health identified by the Committee are as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

[6] http://reproductive rights.org/en/press-room

[7] UN Committee on Economic, Social and Cultural Rights (CESCR), "Substantive Issues Arising in the Implementation of the
International Covenant on Economic, Social and Cultural Rights," General Comment No. 14,

[8] http://hdr.undp.org/en/statistics/