# The Status of Maternal Health

## in

## Madhya Pradesh

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**Madhya Pradesh, India**

# The Status of Maternal Health in Madhya Pradesh

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# Executive Summary

The Status of Maternal Health in Madhya Pradsh is an analytical report. Through this report we try to understand all situations and conditions that effected maternal health. MP government has committed to improving maternal health but hasen't reach satisfactory position. The report brings out the analysis of various indicators on maternal health, which are at different levels of human development and varied performances of state policies in guaranteeing women health.

The state of maternal health in MP is a cause for concern as compared with other states of India. Maternal Mortality Rate in MP is one of the highest in the country, 379 per 100,000 live births.

In the past decades there has been a reduction in the number of maternal deaths but in spite of this the number of maternal deaths is 7700 per year in the state. Nearly one maternal death every hour. The average number of maternal deaths in Madhya Pradesh ten years ago was 498 per lakh, which has come down to just 379 per thousand at present. (Madhya Pradesh Economic Survey-2006-07). As per the National Family Health Survey (NFHS-3) released recently by the Union Government, Madhya Pradesh has stands 3rd highest maternal mortality ratio in the country. According to the National Family Health Survey-3 the number of women who underwent the three necessary examinations prior to delivery during heir last pregnancy is 42.2%, the number of women who deliver under the care of some doctor, nurse, A.N.M, L.H.W. or some trained health worker is 37.1 %, the number of institutional births is 29.7% and the number of pregnant women suffering from anaemia (15-49years) is 57.9%.

State's expenditure on Health has declined sharply as a proportion to total expenditure from 5.1 in 200/01 to 3.4 in 2004/05 Though the state has introduced many schemes to help combat the same, but due to bureaucratic hassles and corruption the schemes are not yielding the desired results for women. Schemes initiated by the State of Madhya Pradesh for reducing maternal deaths are not being implemented properly.

The situation is made clear by the report of Comptroller Auditor General of India that says that the schemes do not reach 52-62 percent children and 46 to 59 percent pregnant and lactating mothers. The Government is of the view that though the share of salaries in non-plan health expenditure is 86.7%, however, the government is not getting fair returns on its investment in health care and there is widespread dissatisfaction with the access and quality of health care in the government health care institutions. The problem is compounded as government does not have an effective monitoring, surveillance or control function with regard to private health care.

The link between poverty and ill-health are also ignored in the actual implementation plan laid out as part of the NRHM. So, attainment of the goals envisaged by NRHM by 2012 remains wishful thinking. The privatization of primary health services will create new challages for the poor and the excluded in the state.

MP government's effort to achieve all the indicators of Maternal Health seems to be far from its actual achievements. The role of all stakeholders like civil societies, media, people's organisation and NGOs in the process of achieving Maternal Health set by the State Government is very important for providing alternative to the government's programme implementation and monitoring system as well as complement government's efforts.

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# Scenario of maternal health

If you really want to experience at the deepest levels of your soul what it means to be a part of the neglected section of society with no access to basic health services, you should visit Balwadi health centre in tribal dominated Sendhwa development block in Badwani district of Madhya Pradesh. This health centre `caters' to around 30 villages inhabited by about 21,000 people. Since there is no doctor here, a compounder looks after the center since last three years and there is no availability of medicines and equipments for 9 months in a year. It is only natural that in this circle, 13 children died due to malnutrition related diseases[1] and 34 women died over the last one year during childbirth obviously due to lack of adequate socio-psychological-medical services. This scene is not confined only to this Balwadi, but it plagues entire Madhya Pradesh, where several people have to compromise on their lives due to severe violations of basic health rights.

If Sendhwa shocks you, you would certainly not like to visit Reethi. When the policy makers in State were in throes of hot debate over the change in the political leadership, a sad incident was unfolding in Reethi development block of Katni district during the month of October. At least 20 out of 32 infants (born during month) died in the solitary hospital providing health services to 56 panchayats in this block[2]. There is no gynecologist, no surgery department, equipments, emergency services or medicines available in the block hospital. Only one differently abled lady doctor continues her struggle all alone waiting for a miracle (Sandip Naik, 2005). It is difficult to provide maternal health care, when a single gynecologist has to cover a population of 1.20 Lakhs.

It is a bitter truth that Governments are still not constitutionally bound to provide health services to the society, as the right to health is a matter of directive principles and the state is not bound to follow directions. In this context, most marginalized sections of the society, specifically women, suffer most and pay with their lives highlighting negligence and insensitivity of the government. While governments put some basic efforts, there is no political will or power to sustain these efforts or make them successful.

In fact, people not only face diseases, but also are caught in the net of attractive Government schemes mostly confined to paperwork. According to available figures 7700 women die due to maternal related causes and most of the deaths can be prevented, if taken seriously. This puts Madhya Pradesh as one of the top three states with highest number of maternal deaths in country. Although, this data has been challenged by different studies, even the Madhya Pradesh Family Welfare Program Evaluation Survey (MPFWPES) 2003 carried out by State Government, covering 25 percent of the rural population of the state, does not paint too rosy a picture. This survey provides the estimates of maternal mortality ratio for rural areas of Madhya Pradesh, minus Chattisgarh. According to the MPFWPES-2003, the risk of death due to complications of pregnancy and childbirth in the rural areas of the state was 763 maternal deaths for every 100,000 live births. The estimates provided by the Rapid

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[1] A study done by the Sendhwa based Adiwasi Mukti Sanghthan, a people's organization fighting for the tribal rights, 2005.

[2] Case study documented during the group discussion with the local social developmental organizations.

House Hold Survey suggest a maternal mortality ratio of 597 maternal deaths for every 100,000 live births for the year 1999.

**Table 1 - Maternal Health**

| Sr. No | Indicator[3] | Situation in the Year 1998-99 | Situation in the Year 2006-07 |
|---|---|---|---|
| 1 | Institutional birth | 22.0% | 29.7%. |
| 2 | Ever married women age 15-49Yrs., who are anemic | 49.3% | 57.6% |
| 3 | Mothers who received postnatal care within two days of delivery | na | 27.9% |
| 4 | Pregnant women age 15-49 Yrs, who are anemic. | 49.9% | 57.9% |
| 5 | Mothers who had at least 3 antenatal care visits for their last birth | 27.1% | 40.2 % |
| 6 | Births assisted by a doctor/nurse/LHV/ANM/other health personnel | 28.9% | 37.1% |
| 7 | Women whose body mass index is below normal | 35.2% | 40.1% |
| 8 | Ever married women who have ever experienced spousal violence | na | 45.8% |
| 9 | Ever married women age 15-49 Yrs, who have heard of AIDS | 23.7% | 45.3% |
| 10 | State's expenditure on Health has declined sharply as a proportion to total expenditure from 5.1 in 2000/01 to 3.4 in 2004/05.<br>Health budget of the State – Rs. 856.27 Crore, 2.5% of total state budget[4].<br>State spends Rupees 150 per person per year, 86.7 % is salaries, Rs 2/person/month is provided .<br>67 % of deliveries in rich families were assisted by doctors/trained health care personnel compared to 17 % in poor families.<br>70.3 % of ST women suffered from anemia compared to 54.3 % in total MP.<br>Total number of beds available in the rural hospitals – 9300 ( 1 bed on 5.6 villages).<br>Cost of hospitalization in Madhya Pradesh is Rs 2191 for rural areas and Rs 2774 for urban areas.<br>5893 doctors are in Government services out of which 5000 do private practice.<br>70 % of qualified doctors are in urban areas (for 27 % population).<br>Lowest per capita expenditure per month on food — Rs 128.60 {US $ 2.85 (1 US $ =Rs 45.00)}. | | |

[3] i- Sr. No 1-6 Ministry of Family Welfare, Government of India, National Family Health Survey III (2005-06)

ii- Sr. No.7 Report No. 512 Perceived adequacy of Food Consumption in Indian Households 2004-05, NSS – 61st Round, report released in February 2007.

[4] Year 2006-07

Unfortunately, all these figures present a bleak picture that the women of Madhya Pradesh carry both a substantially high risk of death due to complications of pregnancy, delivery and in post partum period and a substantially high life time risk of death due to reproduction associated consequences[5].

The per capita public expenditure on rural areas amount to less than a third of that spent per capita in urban areas. More than 86% of deliveries in rural areas were at home as compared to 50% in urban areas. 61% of the deliveries in urban areas were assisted by doctors or trained personnel as compared to 21% in rural areas. There are about 5000 qualified doctors (including 1500 ISM&H practitioners) in government service compared to 20,000 in the private sector. The DoHFW's 16,900 MPW (male) and ANMs could be contrasted with RMPs and Dais (50,000 each) offering health services at the household level, particularly in rural areas[6].

On the other hand, in any kind of Indian context this matter requires a significant consciousness, especially in terms of socio-psychological support to the women from its early adolescent age, which prepares them to face pregnancy related complications psychologically. Women are between two and three times more likely to experience depression and anxiety than men. Pregnant women or those caring for infants and young children are more vulnerable. Depression in women during pregnancy and during first year following birth has been reported in all the cultures, though the rates vary considerably, but the average in industrialized countries is about 10-15%. Contrary to earlier perception, higher rates are reported from developing countries. Many factors contribute to maternal depression during pregnancy and post-natal period, including lack of practical and emotional support, or criticism from relations, particularly in-laws. Apart from other risk factors, the infants and children of mothers suffering from depression, especially those experiencing social disadvantage, have significantly lower birth weight, are more than twice as likely to be underweight at the age of six months, are three times more likely to be short for age at six months, have significantly poorer long-term cognitive development, have higher rates of anti-social behavior, hyperactivity and attention difficulties and, more frequently emotional problems[7]. It simply means that maternal health concerns require urgent social action on priority.

The state Government is providing many health facilities through Anganwadis. In M.P. although 69,238 'Anganwadi' centers have been sanctioned against the total need of 0.146 million Anganwadis, at present only 49806 are functional. The Supreme Court of India[8] has ordered that the sanctioned centers should be opened by July 2007. The State government has promised to start and make functional only 10,000 centers out of the 20,000 sanctioned, but non functional centers by June 2007.(June 2007 has already gone by). 1.46 lakh 'Anganwadi' centers are needed[9].

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[5] Obstetric Care in Central India, Ed. - Alok Ranjan & R William Stones, Pg-25 to 60.

[6] The Health Sector in MP, Situation analysis, June 2002, HLSP Consulting Ltd., MSG.

[7] The World Health Report 2005: Make every mother and child count, Pg- 65. Published by the World Health Organization, Geneva.

[8] Supreme Court of India is hearing public interest litigation since 2001 on Right to Food to make sure that all the food, employment and social security schemes are implemented properly.

[9] Analysis of the Commissioners to the Supreme Court in PUCL vs Union of India and others -196/2001

# Health and Gender - A tragic truth for women

A few months ago, in Bhopal (the capital of Madhya Pradesh), the state Health Department had mentioned that it is a major challenge for the government to prevent all the deaths of women due to pregnancy related complications. At the same time, the department had announced that poverty would not be allowed to become the reason of death for women and the government would play the role of natural protector of women.

The policymakers are of opinion that the increased institutionalized deliveries can bring the shocking figure of 21 maternal deaths per day to minimum level. For this purpose the health department has provisioned an amount of Rs 700 for the pregnant women living below the poverty line to go for institutionalized childbirth, monetary encouragement of Rs. 600 to the anganwadi worker or health worker who encourage the women to go for such childbirth and provide the facilities of transport to the pregnant woman to the hospital for safe motherhood. The objectives are clear with ambitious schemes. Though the state government recently celebrated the success in their efforts of safe motherhood, the lives of the Saharia primitive tribal continue to be steeped into deep darkness.

As the issue of unsafe motherhood has now come out very much on the soici-political agenda after serious efforts of Civil Society Organizations, the pressure on the government to make serious efforts could be felt clearly. During the last one year the government made hasty announcements of five policy-level schemes including the `transport for childbirth scheme', Vijayaraje Scindia Antyodaya Insurance Scheme and Janani Suraksha Yojana, but the actual effort to implement these schemes with accountability and transparency have been nil.

The maximum effort is at fulfilling the targets of institutionalized delivery, but none of the schemes can make the doctors and nurses sensitive at the ground level. The ground level situation of safe motherhood schemes makes it clear that corruption and misbehavior by the health staff is still big challenges.

The analysis of the policy level decisions makes it clear that the government has failed to make any solid work plan for deprived areas like Sheopur and the backward and poor tribes like Saharia. Even today, the implementation of the mobile dispensary and the Dhanwantari schemes are restricted to only one development block of Sheopur district. It is very important that the government makes wider schemes for preventing maternal deaths and not schemes restricted to 50 blocks or five districts. Also review is necessary regarding the eligibility criteria for beneficiaries of such schemes. Till today names of many families that are actually poor do not figure in the BPL lists which mean that they are neither getting free treatment nor medicines. To get protection, the pregnant women have to break through the complications of five schemes. The villagers have never even seen the basic treatment facilities, which are supposed to be present in every village.

Normally it is believed that the rural people go to quacks or registered health workers for treatment, but the people of Ranipura and Gothra are so poor that even quacks do not want to set up establishments there as they would not get enough patients to sustain themselves. Under the transport for childbirth scheme, a vehicle is on contract for every village and the government pays up the vehicle owners, but the Saharia tribal

do not have knowledge of any such facility and spend between Rs 500 to Rs 1500 to take their pregnant women to hospital.

**Not a fairytale**

In the Saharia dominated villages of Sheopur district of the state, the objective and schemes of safe motherhood are looking totally off-colour. When Bhabhuti, the wife of Shivlal of Ranipura village, 60 kms from the district headquarters got pregnant she had no idea that she would have to bear the deep pain of inhuman treatment from the government machinery along with the pain of childbirth. Bhabhuti had seen six women succumbing to the pregnancy related complications right before her eyes, so she was sure that she would bleed so much after the childbirth that she might not remain alive to bear the unbearable pain. But the local health worker, Shivlal told that Bhabhuti would give birth to her child at the Karahal Government hospital where she would get the right to live along with the right to safe motherhood.

When the time for childbirth neared, the villagers made arrangements for a vehicle and took Bhabhuti to the Karahal hospital, even as she was bleeding profusely. However upon reaching there, Shivlal could not get hold of a doctor for four hours, even as Bhabhuti was writhing in pain and when the doctor did appear, he referred Bhabhuti to the district hospital without looking at her even once. This put Shivlal in dire straits as he had used up his entire savings to bring Bhabhuti to the Karahal hospital. Still he immediately pawned his land to a local person for Rs 700. The uppermost thought in his mind was that Bhabhuti should not succumb somewhere away from home, because he had no money to take the dead body. When he reached the district hospital, he was asked for the Deendayal Antyodaya Health Card, which was never issued to him. It is one of those 7 health related schemes run by the State government and each require different eligelibility criteria to be fulfilled by the poor people. Even for "so-called educated" it is very difficult to remember the details and processes of these schemes, and this net leads these schemes to an Un-Productive end.

Along with the birth of his child, Shivlal got liability of a loan of Rs 2500 that is almost impossible for him to repay. Mamta of Gothra Kapura village near Ranipura saw another face of the government scheme. The Janani Suraksha Yojana provisions Rs 700 for the woman immediately after childbirth so that she could get nutritious food along with safe motherhood and so that the woman does not have to undergo heavy manual labour immediately after childbirth for the sake of livelihood. However Mamta was greeted with abusive language by the nurse at the hospital and had to pay Rs 300 each to the nurse and doctor and Rs 150 to the cleanliness worker to get the childbirth process done properly, importantly on time. She had already spent Rs 500 at her own for transport till the hospital (but government is running a scheme for transport and treatment facility for safe motherhood) and her husband had to spend another Rs 330 for purchasing medicines from outside as free medicines from hospital were refused to her. When Mamta asked from the nurse about the financial assistant from government she was told very roughly that "Han, Tum bacche peda karto jao aur sarkar baad me paise deti jayge" (Government would keep paying money as they would keep giving birth to children and that the money would be paid later".

Mamta had narrated this incidence before the enquiry committee, set up by the Commissioners appointed by the Supreme Court in the writ petition 196/2001 on Right to Food, looking into the malnutrition deaths in Sheopur and upon hearing the incident, the Chief Medical Officer of Sheopur A K Dixit intervened by saying that "Tumne apni marji se hi to paise baaten honge, kisi ne cheene to nahi the" (You might be distributed the money out of joy of birth of your child and no one might have taken the money away forcefully from you). It seems that the field level officials and employees have took up a very inhuman definition of the schemes like Janani Suraksha Yojana – the definition being that the government assistance received by the women should be used for paying bribes to them for availing minimum health and care facilities. The Anganbadi worker from Gothra Kapura, Bilasi said that "the objective is still not pure. She adds that the scheme is meant for the BPL women and at least 14 families in the village facing regular starvation yet they are not considered poor. The women of these families would neither get the benefit of the Janani Suraksha Yojana nor that of Deendayal Antyodaya scheme. While the Saharia tribal are naturally considered very poor, many of the families still don't have the government approval of being poor".

Under the Janani Suraksha Yojana being run with the support of union government, there is provision of paying Rs 700 to pregnant woman, Rs 1000 to a woman if she survives childbirth and Rs 50000 as insurance amount to family if she succumbs (not for her). However the budget provision of the state government is so little that only 50 to 100 women per development block can benefit from the scheme. This budget has already been used up in first six months of the financial year. Isn't it possible that the government comes out with a comprehensive policy and safe motherhood scheme that would free the poor people from immense paper work and would make it possible for them to take care of themselves and their newborn?

As for the Reproductive and Child Health (RCH) programme, entire attention of government is on the purchase of implements, which gives a huge scope of corruption. The basic thing is that to ensure the basic right to health, not only hospital buildings are important but also sensitive doctors, other health staff, necessary medicines, diagnostic facilities and good atmosphere for the common people (patients as well as attendants). But the tragedy in state is that neither the health infrastructure improves nor is any display of sensitiveness and humane behavior among the health workers is evident.

Other side, capitalist globalization has enhanced the gap between the rich and the poor our society, which was already segregated on the basis of caste, has further excluded the most marginalized from the mainstream, thereby increasing their vulnerabilities manifold. Free market forces are responsible for urbanization and the disintegration of Bedia and Banchda communities, and questions of dowry, bride price, desertion and violence against women are seen to be enhancing by the day, Industrialization, desirability of easy life promoted by consumerism, and extortion of economical resources from the women and children (prevalent in this society beforehand) are viewed as marketable commodities. The status of women and children in relation to property rights, institutionalization of exploitative practices, and lack of awareness about legal protection and rights, and discriminatory laws are some of the legal factors which contribute towards the acceleration of human trafficking.

With the increasing marketisation and the feminization of migration, violence against women is exacerbated manifolds. The last three decades have seen an unexpected increase in both dowry (bedia) and bride price (bachchdas). In 1985, the bride price was approximately Rs 20-25,000 payable in installments. Today, the lowest is around Rs 1, 20,000 with the increasing amounts based on families and the looks of the girl. A factor never considered before.

Similarly, amongst the Bedias, the dowry has escalated from rs 1 lakh in late 80's to above 5 lakhs as of now. Many families, who cannot afford to give the dowry, are coerced into trafficking their daughters as the both the pull and push factors for marketisation and commodification operate at all levels.

Rape, beating, thrashing and sexual exploitation of women are some of the other most commonly used tools for forcing them into submission. Due to the increased mobility and change in location, women and girls are subjected to perverted acts and violence as street walkers, bar dancers and hitch hikers in trucks. There is an increased violence at home, as they are treated as tools to obtain money and goods and at the same time, as they leave their homes and enter an unknown area; they are left at the mercy of the traffickers and customers.

With the structural adjustments programmes being pushed, the role of the state has shrunk tremendously. Access to public services like health is decreasing and thrust on issues like HIV and AIDS have further stigmatized the women! *The Jabali Yojana, which envisaged eliminating the practice, has not been put into practice with the zest and precision it required.* The scheme is different from others as it was formulated as a result of a court order (Gwalior High Court Bench) in 1990. Fifteen years later, even the first phase of the scheme, does not seem to have been implemented (the original scheme had six phase to be implemented within three years of its formulation in 1990 with a budget of Rs 1600 crores!). At the district and block level, micro experiences show that there is complete indifference towards the community and the scheme.

State mechanisms like the Commission of Women, Department of Women and Child Development and others also have not taken a very strong stand as desired to abolish the practice or provide people with choices. Efforts, though rare, have also been biased in maligning the reputation of the community. A study conducted by NHRC actually claimed that more than half the population of these castes is affected by AIDS and HIV! State interventions have also been in the mode of forcing people to get these tests done and these, many a times, have also been made public. Nirmal Abhiyan, done at a large scale in Mandsaur, was a campaign in which girls where forcibly married off. This also affirmed the belief that marriage seemingly is the only option to change the system. At present, experiences have shown that the Abhiyan actually put more women into this practice as many times, the husbands were traffickers who sold off the women and absconded with the money that was given during the wedding.

In both rich and poor countries, gender discrimination persists, and its consequences are difficult to ignore. Nowhere is this more apparent than in some developing countries, where traditional beliefs and practices put a high premium on boys' education, while girls are excluded. Even when girls start school, they are more likely to drop out for these reasons. Without at least a complete primary education, women face limited employment options, discrimination, lower pay, and less control over their health.

Due to lack of education girl children have to face many problems in the all aspects of their lives. They become prey to psychological, physiological and sexual violence from a very young age. They are not made able to fight against such violence. Lack of education seems to be the one of the root causes of health problems arising from the marriage of young girls or even other health problems, which may occur due to other reasons.

Health related problems of adolescent girls, health problems of pregnant women, their freedom of choice of whether they want to become mothers or not, their participation/ involvement in making decisions in the family or society, their being treated on a basis of equality in the family and society etc are some of the issues which are directly related to education of the girl child.

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# Curbing Maternal Mortality – Still a big challenge

On April 3, 2007, a common incident occurred at MY Hospital in Indore. A 30-year-old woman succumbed after giving birth to her child. If this news had not reached the people who are making efforts for safe motherhood and to curb the maternal mortality rate (MMR), it would have indeed remained a very common incident. But the news reached them. When the matter was investigated, it was revealed as to why the maternal mortality rate was not being reduced despite several efforts.

The woman from Gambhirpura village in Burhanpur district was referred to Indore by the Nehru Hospital, Burhanpur on March 31. The formality of admitting her was completed after her primary check-up, when the doctors found that the patient was HIV positive and decided to send her away. Despite several requests, the hospital authorities refused to admit her and before her relatives could think of alternative, the woman gave birth to a girl child near the hospital water tank. Her condition started deteriorating and she was taken into the hospital on April 2, but it was already too late and the woman breathed her last at 11.30 pm on April 3. The doctors had not even given the required dose of Nevadrin to the patient.

This isn't an isolated case in Madhya Pradesh, but one among several where the patients are neglected by the hospitals by some excuse or other. They cannot afford to get treatment in private hospitals. In such situation, how MMR could be curbed despite several government schemes. Everyone knows the situation of the primary health centers in rural areas in government health set-up. Whether safe childbirth is possible in these centers always remains doubtful. Unavailability of medicines, dilapidated buildings and paucity of doctors are common problems.

The maternal mortality is still very high in the country. As per the 2001 census, the MMR at national level was 407 per lakh while it was 498 per lakh in MP. Recently the statistics of Maternal Mortality in India: Trends, Causes and Risk Factors - 1997-2003 report released by Census of India, Government of India were released, which revealed that the MMR had reduced but not as much as it was needed. As per the latest figures, the national level MMR is 301 per lakh and 379 per lakh in MP, which is very high when compared to national average.

The NFHS survey also reveals that in the age group of 15 to 49 years, 56.2 percent of women in country and almost same percent in MP suffer from anaemia. As per the survey, the percent of institutionalized childbirth in state is just 29.7 percent and body mass index (BMI) of 40.1 percent women in lower than normal.

In such situation, the issue of safe motherhood is not only connected to institutional childbirth and only government schemes cannot provide safe health services to the women for 42 days from pregnancy to childbirth period, when she requires maximum care. Apart from social and economic reasons, medical reasons are also responsible for high maternal mortality. If MMR is to be curbed then the registration of women, three check-ups, provision of Iron and Folic Acid tablets, ensuring nutritious food, identifying medical complexities and immediate decision on treatment are necessary steps. To ensure all these steps, sensitive attitude towards pregnant women is necessary. Especially, it should be expected from doctors that they provide good medical care without disparity and make the life of mothers safe.

This report unearths the gross violation of women's maternal health rights in Madhya Pradesh (A centrally located state of India), one of the most populas states in India and together with Bihar, Orissa, Rajasthan and Utter Pradesh accounting for half of the India's projected population of 1.0 Billion by the year 2012 (10th Five Year Plan, Planning Commission, Government of India). This reveals that the Government of Madhya Pradesh spends only Rs. 9 per women per annum to provide maternal health care and unfortunately the society never registered its reaction towards state's gross negligence. Problems do not end here. The state has highest rate malnutrition, particularly amongst among children. Fifty five percent of children below 3 years are under weight, 51% are stunted, 20% are wasted and 75% of them are anemic. Maternal Mortality rate in MP is one of the highest in the country, 498 per 100,000 live births, IMR is high too 76/1000 live births[10]. Latest report released by the Government of India titled - *Maternal Mortality in India: Trends, Causes and Risk Factors - 1997-2003 report released by Census of India, Government of India*, says that MMR in Madhya Pradesh has decreased to 379 per one lac live births but the Madhya Pradesh Family Welfare Program Evaluation Survey (MPFWPES) 2003 conducted by the Government of Madhya Pradesh reveals that the risk of death due to complications of pregnancy and childbirth in the rural areas of the state was 763 maternal deaths for every 100,000 live births. The reach of health and nutrition services is far from satisfactory, with only 22% of the children having received all vaccinations before 12 months and only one fourth of the children 6-35 Months having received one dose of Vitamin-A. The present paper discusses the reality of health services, social negligence.

**About Maternal Mortality!**

Many times we encounter the data of Maternal Mortality or Maternal Deaths. It is really tough to make sensitive efforts to define these terms in a socio-political manner rather than in medical terminology. The causes of deaths during or after the pregnancy period or at the delivery time has traditionally been classified in two sections - Direct and Indirect. In *Direct causes* pregnancy causes death and in *Indirect causes* where an underlying disease is aggravated by pregnancy (Ref.-1). It is worth mentioning fact that in the past a number of indirect causes of maternal mortality were excluded from the estimation processes before the release of 9th revision of the International Classification of Diseases, Disability and Causes of Death (ICD) prepared by the World Health Organization. After certain debates and studies, the ninth revision of ICD includes the direct and Indirect causes of death during pregnancy or within 42 days of the termination of pregnancy in defining pregnancy related deaths (Ref.-2).

But Tenth revision of the ICD includes two new categories defined as causes of maternal mortality. The first category is of "Late Maternal Deaths" that occur between 42 days and one year while the second category, on the other hand, includes a "Time of Death" definition among the pregnancy related deaths. This category includes any death in pregnancy or within the 42 days of termination of pregnancy irrespective causes (Ref.-3).

Ref.-1-Birth Counts: Statistics of Pregnancy and Child Birth – A. Macfarlane and M. Mugford, 1984.
Ref.-2-World Health Organization, 1977, International Classification of Diseases. Manual of the Internal Statistical Classification of Diseases, Injuries and Causes of Death, Ninth Revision, Geneva.
Ref.-3-WHO, ICD- 1983: 1986

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[10] SRS Data released by the Government of India in October 2006.

# Mothers and Children: Survival questioned

Sangram Singh of Khatia-Narangi village in Baiga-tribal dominated Mandal district is not able to open his eyes despite many efforts. His eyelids collapse instantly and his eyes close. His skin is getting contracted. There are several questions about the chances of his survival. The weight of this 50-day child is just 2.2 kg. If such young children are capable of thinking, then Sangram Singh must be surely thinking about the unjust character of the Society. He is still in critical situation and Government of Madhya Pradesh has ordered an enquiry in the Shivkali's, his mother, death case. The term of reference of this enquiry does not contain any point to investigate the violation of child rights. They will only do a formality of investigation of death, not the violation of rights.

Sangram Singh is not just any child but a character of the story that is common for the 7700 children who are born every year in Madhya Pradesh. These are those children who do not have the good luck of receiving mother's milk and the warmth and sensitivity of her lap. The tragic aspect is that the negligence of government and society becomes the biggest reason for the maternal deaths during childbirth.

If a woman dies within 42 days of childbirth, then the death is considered as maternal mortality. Shivkali died within 11 days of childbirth, yet the state Health depaetment did not consider it as maternal mortality. As per the Health Department, Mandla district did not record a single maternal death during April 2007, which means that along with life of Shivkali, the government is also denying her death. After the death of his mother, the life of Sangram is also in dire straits. At birth, his weight was 2.4 kg, which means he was under waint during birth. In such circumstances, the local health workers have refused to treat the child. Finally with the help of local social workers, Sangram was taken to a doctor Mukesh Rutela in Nainpur on May 22. Here it was diagnosed that Sangram was already entered in grade IV malnutrition category and is also suffering from various infections. At the time of birth he was not severely malnourished and if his treatment is not carried out very intensively, the chances of his survival are poor. The family is full of anger and sadness, but they are now not ready to go to government hospital.

Baiga tribal woman Shivkali had given birth to Sangram Singh on April 4 in her hutment. Local traditional midwife Jethibai assisted the childbirth. There is a primary health centre in this village. Interestingly, the village is not away from the mainstream of system. It is located just by the main gate of Kanha National Park. Ironically the objective of the Primary Healht Centre located at the Khatiya village has been to take care of the national and international level tourists rather than the villagers. The PHC has now got a beautiful building, but only three to four villagers reach the PHC every day. When we reached the centre, out of the 15 member staff including four nurses, doctor, ANM and sanitary workers, only one nurse was present. Son Sai of Khatia village says that whenever one approached the centre, the message is that majority of staff have gone to block or district headquarters for some meeting. In such circumstances people are forced to go to Bicchia or Mandla. It is incomprehensible as to why the government is denying that the Baiga tribal (whom former Prime Minister Indira Gandhi had described as national people) live in a traditional setting. Because forest rights were taken away from them, they have also lost access to traditional medicines owing to which women and children are dying, but the modern medicine system is far out of their reach. If the future of the children is to be safeguarded then the government would have to bring the Baigas close to

modern treatment facilities in a sincere and sensitive manner. The maternal and child mortality cannot be contained only by writing slogans on the walls or presenting unbelievable statistics. Isn't it a serious fact that around 10 million children die every year before celebrating first birthday in Madhya Pradesh?

The effort for protection of life is also the responsibility of anganbadis, but it could only be called misfortune that the name of Shivkali was not registered in the list of pregnant women in the local anganbadi. Naturally this pregnant woman from a poor family could not get enough nutrition to sustain herself and her foetus. However, after her death, the local anganbadi worker Shashikanta Thakur took possession of her mother-child card and filled up all details regarding completion of immunization doses. Similarly the district hospital took possession of all medical documents related to Shivkali and Sangram Singh. The amount of efforts taken to destroy evidence if taken previously could have saved lives of Shivkali and Sangram. Shashikanta waves off her responsibility saying that the tribal people do not want to get immunized or treated. ``Khushiyal Singh (Shivkali's husband) should have

**Newa Bai Excluded**

**19th November 2006 –** Newa Bai, a seven month pregnant poor tribal women of Nidanpur (To add district and kilometers from the district HQ etc.) died at the government hospital. She could not benefit from any of the health schemes and services of the state health department as claimed officially. Newa bai and child in her womb are no more today. Insensitive attitude of the hospital staff added to her misery and death. In recent times State Government of Madhya Pradesh is strongly advocating institutional deliveries as the mantra to combat high rates of maternal deaths in the state. Unfortunately in the state the campaign exists in the advertisement hoardings, newspaper advertisements and in media, thanks to efforts of public relation department of the state. Very little effort is being put to strengthen quality of services and hardly any on improving human – human interaction of the health delivery staff. Newa Bai is just one such example. Her husband Kpoora adiwasi took her to the nearest Chanderi government hospital. After a primary check-up, doctor in charge (a male doctor, the position of Gynecologist is lying vacant and there is no timeline till when she would be recruited). She was put on a blood infusion. It was about 1.00 pm which is lunch time for the staff and they left the hospital for extended lunch break, which normally lasts few hours. Only Nurse returned that too after 5 hours. In meanwhile condition of Newa Bai had detoriated and became critical. People accompanying her told that there was even reverse blood flow after the transfusion was over. Sainath, a civil society organization working in the area took up the issue and a concern was raised by them with the district administration. They urged the district to undertake a maternal enquiry.

**27th December 2006** – The moment concern was raised, accountabilities were questioned. The same was not liked by many in the state administration. Interestingly every time a political leader or a bureaucrat publicly makes a statement, they encourage civil society to bring the issues to forefront. The moment that happens efforts are undertaken to curb the same. Similar thing happened here. The moment the issue was raised, district hospital stopped providing any treatment to villagers of Nidanpura. Even if one dares to go to hospital from the village the staff yells at them and even uses bad words. On 27 December one more pregnant woman Phool Kunwar (Uday's wife) from the same village in labour pains was taken to Chanderi Hospital. She delivered a girl child on the way. By the time she reached hospital her position got serious. Medical doctor in-charge, which knowing that she is from Nidanpur village, denied any treatment to her. Uday took her to the district hospital and then Guna hospital. But she could not be saved and the new born baby also died on 30th December.

**7th January 2007 -** Sarpach of Nidanpur when contacted by us said where we will go, it seems now entire state is against our village. Have we done anything wrong by asking women rights for safe motherhood?

Hello.....Government.....are you listening!!

been more responsible. We cannot go home to home checking upon people," she says. Thus the victim has been made the accused by the system. It is very unfortunate that the woman who could not even express her health problems or pains has been made responsible for her own death.

Ten percent of the populace in MP is that of tribal communities including three primitive tribal groups – Baiga, Bharia and Saharia. But the state government does not have any work plan to change the innate behavioral patterns or gaining confidence of these communities. Not only this, but the 51000 odd traditional midwives (dais) who could have brought these people closer to modern medicine system have been banned in way from offering their services. On one hand the government is not able to provide proper health services and on other hand it is scrapping the traditional and alternative systems under the market pressure.

The situation in Khatia is very unusual. Shivkali never received even a single health check up during her pregnancy period and did not get a single immunization dose. During last 2.5 years, the state government started as many as seven schemes to prevent maternal and child morbidity and mortality, of which the Vijayaraje Janani Bima Kalyan Yojana was closed down on May 11, 2007. The logic given was that the women were getting enough benefits under the other schemes and thus this was not necessary. The truth is that during last year, 56 women and 807 kids perished in Mandla. For both Shivkali and Sangram, the face of the constitutional state was not at all humane. Government touts that institutional childbirth is the best way to safe motherhood and that the responsibility to encourage community for this falls on health administration.

The sub-health centers and the primary health centers have to ensure that every pregnant woman should be registered within 12 weeks of pregnancy so that the regular health check up, immunization, nutritional needs and emergency treatment facilities could be ensured for her. The basic thing is that government would have to take care that health services and health workers should reach the needy people like Shivkali and Sangram. It should not be expected that women and children bearing pain and burdened by exploitation would reach the health centers and demand services.

As per the guidelines of the Government of India, all the primary health centers should have refrigerator and deep freezer to store the medicines, but at the Khatia PHC, the medicines and equipments were lying openly at temperature of 43 degrees. There are no standard arrangements of storing medicines in the 7300 sub-health centers in MP, owing to which the treatment of patients becomes risky in itself.

The issue of health demands sensitive behaviour and attitude, which means that it should be ensured that the people suffering from pains could be provided humane touch. It is a well-proven fact that total cure of any pain is not possible only through medicines. For Shivkali and Sangram, this belief could not prove to be positive.

Sangram was born into tattered unclean rags at home, but after this the health of Shivkali started deteriorating. Then Shivkali's father Mangal Singh started looking for the ANM and the health worker. As it was evening time, Jagat Singh Pande and Subhadra Pande did not pay attention to the issue and asked that Shivkali be taken to Mandla, which is 65 kms from Khatia. Under one scheme of the government, financial assistance is provided to pregnant women facing problems for reaching the health

services, but Shivkali did not receive any such assistance. Mangal Singh rented a private vehicle for Rs 1200 and took her to district hospital, Mandla. They had the Deendayal Antyodaya Treatment Card, but the doctors did not pay attention to it. The lady doctor in the hospital asked for Rs 3000 from Mangal Singh for the treatment. Since it was matter of life and death for his daughter and grandson, Mangal Singh requested the doctor to start the treatment, although he had only Rs 30 left with him after paying the rent of the vehicle. Even this Rs 30 was tkane away by the doctor. Mangal is also the chief of the Baiga Adiwasi Sangathan of Mandla and thus he lodged a complaint with the district collector regarding this exploitation. Inquiry was conducted and pressure was created on the hospital administration.

But the inhumane face of the doctors came to the fore. As soon as the district administration official left the hospital, the hospital authorities refused to treat Shivkali and referred her to Jabalpur. Doctor said to Mangal Singh that you are a leader and only your leadership can save your daughter. Thus Shivkali had to pay for her poverty as well as for demanding her rights, although indirectly. Left with no option, Mangal Singh decided to take Shivkali back to village, but she succumbed even before reaching the village.

Now Mangal Singh is facing a debt of Rs 5500, which he would have to repay at the interest rate of 10 per cent per month. Leave aside treatment and medicine; the family did not even receive any consolation. It is natural that no sacrifice is expected from the health workers, but could not they be expected to at least fulfill the responsibilities allotted to them.ultipurpose health worker Jagat Singh says that it is compulsory to attend meetings every month. Since targets are fixed, thus information has to be provided regularly, even if it means that there is no time left for fulfilling the targets. The health workers also have their limits; Jagat Singh says adding that what would have happened if Shivkali had died while the nurse was trying to treat her. If there are no doctors available permanently, how women like Shivkali could be saved.

**Sensitivity matters**

Bhopal, A newborn child in a government hospital in Madhya Pradesh allegedly died because his parents didn't have Rs.50 to pay the nurse who refused to tie the umbilical cord.
Ram Milan, the father of the baby boy who died Tuesday, said he had taken his wife to the government hospital in Satna for a safe delivery. But fate had other things in store for him.
'The nurse on duty demanded Rs.50 for tying the umbilical cord. When I expressed helplessness, she left the child unattended and he died due to excessive bleeding from the cord,' Milan told a television channel.
'It would have been better if I had taken my wife to a midwife. My child wouldn't have died then,' he rued.
Reacting to the news, the hospital's civil surgeon Usha Soni told journalists over the phone: 'We have come across the complaint of the deceased's father and an inquiry will be instituted to look into the matter.'
(Source - http://safemotherhood.blogspot.com)

It may be mentioned that every year about 17 lakh child births are carried out in state and of them 53 per cent are in BPL, tribal and dalit families. In such situation, 99 out of 137 posts of obstetricians and gynecologists are vacant. About 648 out of 4607 posts of doctors are vacant and of the rest 3133 medical officers are posted in urban and semi-urban areas. The situation of their presence in villages is very worrisome. Shivkali needed blood, but although getting blood is easy for people of higher economic classes, she could not get blood. There was hospital, medicine, anganbadi as well as motorable road, yet Shivkali had to die and the little Sangram is struggling for survival. Can anyone tell why this happened? In Madhya Pradesh out of the 1000

children born, 76 perish before their first birthday. According to this rate, in year 2006-07 as many as 1.19 lakh infants could not be saved. This proved that still at the societal, political and governmental level, the right to honorable life is a much neglected issue.

Despite efforts by the government, as many as 8.56 lakh childbirth in MP in 2006-07 occurred at homes. There are certainly efforts to rid the society of evil of maternal death through institutional childbirth. But the situation of the health centers and the inhumane behaviour meted out there is still a big challenge. In Indore, a nurse physically assaulted a pregnant woman while in Mandsaur a woman had to undergo childbirth on road as she could not pay bribe to health workers. In Ashok Nagar, Nevabai became a victim to negligence of doctors and when the community

**Three delays and one life**

Every pregnant woman is under risk of death and when we keep an eye on the causes of maternal deaths, we see that there are three delays become common cause of death. These delays are-

**Delay-1**: *Delay in decision making to seek care*. It is an important factor because decisions of getting maternal health care are always taken by the family members, who do not aware about the fact that excessive labor pain (more than 12 hours) is a big cause of women's death. There different factors responsible for this delay are- Poverty, Distance, Availability of roads and transport facilities.

**Delay-2**: *Delay in reaching to the health care facilities* due to distance and unavailability of roads and transport facilities.

**Delay-3**: *Delay in receiving adequate qualitative treatment*. Usually it is found that the issues of sensitive human behavior, sanitation, availability of medicines-doctors are not taken seriously.

demanded inquiry of the incident, the health administration boycotted Nevabai's village Nidanpur. Due to this boycott, Phoolkunwar died on the road. Now the bigger reasons for maternal and infant deaths are selfishness and ego of the expert medical practitioners.

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# Reality of Schemes based approach

***Transport and Treatment Scheme for Safe deliveries*** - The Government is also campaigning intensively for its transport and treatment scheme for delivery in the name of getting women their maternal health rights. This scheme has provision of Rs 150 to 300 to transport a pregnant woman to and from the health centre but the total budget is just Rs 1.03 crores for 5, 97,700 entitled women[11]. Out of this amount, hardly Rs 32.12 lakhs[12] was spent in Madhya Pradesh while the State faces the most serious threat of increasing death rate during and after pregnancy. A study conducted by the *Center for Advocacy* reveals that 53. 7 per cent actual beneficiaries are not aware of any such scheme and among those who know, hardly 0.8 per cent have been benefited from it. They believe that they cannot obtain any benefits from the scheme as no help is extended to them as per procedure. Under this scheme Chief Medical and Health Officer is authorized to sign contracts with the village level private vehicle owners to support pregnant women for taking them to the Hospital, but out of 5.97 lac below the poverty line women only 14 thousand could be given the benefit of this most urgent and emergency service. Our study on five Saheriya primitive tribal community dominated villages of Sheopur district (Ranipura, Ghothra- Kapura, Jaddpura, Karrai and Patalgarh) shows that out of 49 deliveries, 13 took place between their house and the Hospital and 3 died while traveling on non-existent roads.

***National Maternity Benefit Scheme* -** The Commissioners of the Supreme Court in their Sixth report questioned the character of the State regarding implementation of the directive of apex court on the National Maternity Benefit Scheme. The Supreme Court in its order dated November 28, 2001 directed State Governments/Union Territories to implement National Maternity Benefit Scheme (NMBS) by paying all BPL pregnant women Rs 500, 8-12 weeks prior to delivery for each of the first two births. In other words, the most important feature of this Supreme Court of India order was to convert the scheme into a universal entitlement of all BPL pregnant women. The Court order was an important step towards maternal relief as a source for ensuring food security needs of women and her children, during the critical maternity stage, who were hitherto not covered by any form of social security targeted for this stage. This also for the first time ensured maternity relief as a legal entitlement for women in the unorganized sector, who are glaringly, denied the need for special care during this period[13]. But the reality is far from satisfactory. The analysis establishes that the Government of Madhya Pradesh has been highly un-accountable in implementing this scheme. In Madhya Pradesh, the Government provided benefits of this scheme to 22,346 BPL beneficiaries against the annual target of 5,97,700 to cover BPL pregnant women – which means that the State could provide right to care only to a fragment of 3.7 per cent of the total entitled women[14]. Now this scheme has been closed and there is no scheme in existanse to provide nutritional support to pregnant women in India. All the benefits provided only at the time of delivery or mostly after the delivery.

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[11] Data obtained from the Right to Information section of Health department from www.mp.nic.in.
[12] Data obtained from the Right to Information section of Health department from www.mp.nic.in.
[13] Sixth Report of the Commissioners to the Supreme Court, December, 2005, Page No.187,
[14] Data obtained from the Sixth report of the Commissioners to the Supreme Court, December 2005, Page No.189.

***Janani Suraksha Yojana*** – Under Janani Suraksha Yojana (JSY) the government provides a cash incentive for pregnant mothers to have institutional births as well as pre- and ante-natal care. According to the October 2006 JSY guidelines, all women in Low Performing States (LPS), like Madhya Pradesh, receive cash assistance if they have their baby in a government health centre or accredited private institution. In rural areas they receive 1400 Rs and in urban areas 1000 Rs. The money is to be dispersed at the time of delivery in the institution. Importantly, unlike NMBS which provided cash assistance 8-12 weeks before delivery to help with nutrition and other expenses the government states that "the cash assistance to the mother [under JSY] is mainly to meet the cost of delivery."[15]

Under JSY, below poverty line pregnant women older than 19 also receive 500 Rs cash assistance for their first two births if these deliveries are at home. The cash is to be given at birth or around 7 days before for "care during delivery or to meet incidental expenses of delivery."[16]

In the JSY guidelines from October 2006 the government asks under frequently asked questions: "If the focus of the scheme is to promote institutional delivery, why should there be a provision for home delivery?" In reply to its own question the government agrees that it wants to discourage home delivery, but that under the Supreme Court's decision in the right to food case it is mandatory to provide money for home delivery.[17]

This misses the point. NMBS and the Supreme Court orders were not intended to give a benefit for home delivery, but to provide financial support for below poverty line women before the birth of their child, whether that birth was at home or in an institution. The focus in NMBS was on supplying money during pregnancy that mothers could use to supplement their nutrition during these critical months. JSY entirely abandons this goal by giving money only at or near the time of delivery.

Additionally, below poverty line women rarely receive the money for home delivery actually envisioned under JSY. In Sendhwa block in Barwani district there reportedly had been only one applicant by a BPL woman for a home birth for the first two and a half months of 2007.[18] Many Anganwadi workers (AWWs) and nurses reported never hearing about the money available for a home delivery under JSY.[19] Others report they are discouraged to give this money. The AWW in Dargada village, Seoni, says that her supervisor told her to give money out for home delivery only if the delivery was performed by a trained mid-wife and it was an emergency.[20] In turn, most communities reported not receiving this money or even being aware it was available.[21]

The state's own numbers support these field observations concerning the massive under-utilization of the home delivery benefit of JSY. According to the government,

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[15] Oct. 2006 JSY Guidelines, para. 4.7
[16] Oct. 2006 JSY Guidelines, para. 4.13
[17] Oct. 2006 JSY Guidelines, Frequently Asked Question 8.
[18] Interview #24
[19] Interview #20
[20] Interview #7
[21] Interview #30, Interview #36

during 2006-2007 only 1687 women in Madhya Pradesh who had a home delivery received a benefit from JSY. In some districts, such as Barwani and Bhopal, there were no reports of this benefit being given last year. In Seoni district the government claims 56 women who had a home delivery in 2006-2007 benefited from JSY. In Sheopur 23 women reportedly received the benefit.22 When even the state's own optimistic numbers claim only a bit over half of the state's births are in institutions,23 these figures show a massive under-implementation of the home delivery benefit available under JSY. This is especially troubling since women who have a home birth are more likely to be poor and malnourished.

None of these criticisms about JSY are directed against the goals of JSY. Instead, the criticism is that JSY does not have the same goals as NMBS so it cannot possibly replace NMBS. Ante- and post-natal care is vital to the health of the child and mother. Institutional delivery can save lives. However, women also need greater nutritional support before the birth of their child. JSY does not address this need in its current form. NMBS attempted to do so.

***Navigating the Maternity Benefit Programs -*** One of the largest problems facing the implementation of JSY, the pre-birth benefit program, or NMBS is the confusion surrounding what programs exist and what their requirements and benefits are. For example, Janani Express Yojani provides ambulances in 11 blocks for pregnant women. Under Deen Dayal Antoyoday Upchar Yojana a health card is given to a family for one year for medical treatment in a hospital of up to 20,000 Rs. Surakshit Prasav Hetu Pariwahan Evam Upchaar Sahayata Yojana provides transportation costs for above poverty line, scheduled caste or scheduled tribe pregnant women to go to the hospital for delivery24. This Scheme provides support to those women, who are not entitled to receive any benefit from JSY. Dhanvantri Vikaskhand Yojana (implemented in only 50 blocks out of total 313 blocks of Madhay Pradesh) provides a benefit for a BPL pregnant woman to seek ante and post-natal care. Vijaya Raje Janani Bima Kalyan Yojana gives pregnant women 1000 Rs as support for medicine, if they have their birth in an institution. If she dies in the institution her family receives the insurance benefit of Rs. 50,000.

Some of these programs are state-sponsored and some are nationally sponsored. These schemes span two departments – health and women and child development. The websites of neither of these departments are kept up-to-date. There is no booklet explaining all the programs a pregnant woman is entitled to in a clear and simple way. No one interviewed for this report – including many government officials, Anganwadi workers, nurses, and doctors – could correctly identify and explain all the maternity benefit schemes available to a pregnant woman.

A woman should not be expected to have to know each of these programs and then go ask for them. Instead, the government should facilitate their access so that if she has made contact with any government health worker like an Anganwadi worker or

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[22] Reply Submitted on the State of Madhya Pradesh to the Supreme Court on March 1, 2007 in People's Union for Civil Liberties v. Union of India & Others.
[23] Interview #54
[24] http://www.health.mp.gov.in/prasav.pdf

nurse she will be given all the information she needs about each of the programs in an easily understandable manner.

Further, the confusion surrounding these programs makes it more difficult to hold anyone accountable for their non-implementation. It is difficult to fault a nurse or Anganwadi worker for sometimes confusing these numerous programs in good faith.

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# A socio-political approach

Despite a peaceful society, political stability and abundance of natural resources, Madhya Pradesh continues to race ahead in death rate of mothers-to-be and young mothers. At least 379 out of one lakh women die during childbirth. Seventy-seven per cent childbirths take place outside hospitals and untrained persons in Madhya Pradesh manage 53 per cent births.

As a result, 70.87 per cent women died due to excessive bleeding, infections, insecurity and high blood pressure. A study done by the Bhopal based group, Centre for Advocacy reveals that only 35 percent people know about such schemes and six per cent have availed of its benefits. Pregnancy is in itself the most creative characteristic of nature, but in reality it is the most painful for a common woman. Be it physical pain, mental pain or social taboos, everything is somehow related to pregnancy. The truth is that while only 43 per cent women get their deliveries done under trained `dai's (midwives), 77 per cent women do not feel the need of medical facilities and undergo unsafe deliveries. Not less than 59 out of every 10,000 women die during childbirth. This argument that that woman stays hungry because of poverty is wrong. Had this been true, 80 per cent women would not have fallen prey to anemia. The bitter truth is that be it high, middle or lower class, women are not provided with adequate nutritious food, mainly because of inherent traditions. The Madhya Pradesh Human Development Report reveals that only 20.3 per cent women consume milk or curd daily whereas hardly 43 per cent consume *Pulses* (*Dal).* It also reveals hardly five per cent get to have fruits and only 0.9 per cent women consume eggs and just about half a per cent women consume other non-vegetarian food. In fact the male dominated patriarchal social system today is weakening the women folk physically and mentally with the result that she is not able to contest for political power and challenge male chauvinism.

**Table 4 - pracentage of women getting Food Items [25]**

| Number | Food | Daily | Weekly |
|---|---|---|---|
| 1 | Milk / Curd | 12.1 | 20.3 |
| 2 | Pulses or Beans | 36.9 | 43.0 |
| 3 | Green vegetables | 33.1 | 53 |
| 4 | Fruit | 5.0 | 17.6 |
| 5 | Eggs | 0.9 | 10.8 |
| 6 | Non-Veg. | 0.5 | 10.7 |

Prevalence of anemia reflects impact of an availability of food and gender discrimination in the distribution system within the household and in the larger society as well. It makes clearer that 54.3 % women have anemia in MP and 16.7 % living with severe anemia. 70.3% tribal women population face greater anemia problem due to various causes.

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[25] MPHDR - 3

# Data Politics[26]

Village Sarari Khurd, Sheopur - has a primary health centre but with out any doctor. Since when it does not have doctor, even villagers can't remember the same. The centre is opened by hardly fours days a week by local nurse. It neither has any facility nor any equipments and hardly cleaned ever. This is not the situation of one health centre, 20 kilometers of Sarari Khurd is Karahal. Karahal has community health centre. Though it opens every day but three positions out of the four to be posted there are vacant. Karahal block officially has a facility of mobile health van to reach out to inaccessible areas. But it has just one mobile health van. *If the same works* daily it will reach the same village after a gap of 35 days (please note if it works daily). And there is nothing to take care of a pregnant women and children. Even in case of unavailability of medicines, village level health staff is sailing the various kind of medicines to the Villagers.'

There are 533 villages in the Saheriya primitive tribe dominated Sheopur district with a population of 5.60 lakhs. The total number of bed available at the one district hospital and other hospitals is only 166, of which 148 beds have not been changed during the last 13 years. During the last two years, several big claims have been made about promoting safe motherhood but just like last six years, three out of four posts of doctors in the Karahal block are still vacant. There was no improvement in the medical facilities during this period and even a single gynecologist and obstetrician could not be posted.

Anganbadi worker from Gothra Kapura village of the district, Bilasi Devi speaks from experience and asks as to why should one go to hospital? No one even speaks properly there and everyone right from doctors to nurses to sanitary workers asks for money to take any action. Government claims that anyone going for institutional childbirth would get Rs 1700 worth financial aid, transport fare and free medicines, but Babhuti was taken for childbirth to a hospital and her family had to pawn their land for completing the process.

In such situation, the Government of India has recently released figures related to maternal mortality for the first time since 1998, which claims that the Maternal Mortality Rate (MMR) has gone down from 498 (per lakh childbirth) to 379 during the period. But the report of the GoI (Maternal Mortality in India: Trends, causes and risk factors - 1997-2003) is itself facing some basic technical questions. The biggest question is as to whether the government is trying to veil the ground situation by some statistics under some pressure.One important point is that this study of MMR has been conducted by considering only limited number of cases in specific situation. The survey was conducted over a period of six years and the low MMR is reported in MP and Chhattisgarh (365) although during this period about 103000 cases of maternal mortality were reported in the two states. The second point is that all these cases (365) are those that have been registered in official records while analyses tell that only one out of three maternal deaths gets officially recorded. The problem is that in the district hospitals, community health centers and the lower level of health set up, the deaths during childbirth are recorded as general mortality.

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26 Maternal Mortality in India: Trends, Causes and Risk Factors - 1997-2003 report released by Census of India, Government of India

The next question is that the Madhya Pradesh Government (GoMP) had in 2003 pointed out through the State Family Health Evaluation made it clear that in the rural areas of the state, the MMR is as high as 763, which clearly tells that the situation is far graver than the analysis by the union government. This study by the GoMP was done on 25 percent populace of each district and not only a selected group yet the union government is releasing contradictory figures for the same period.

The controversy should not remain limited to statistics because the health facility condition in state clearly brings forth the ugly face of the situation. The analysis of recent efforts of state government does not bring any good news.

In the state, only one hospital bed is available per two villages. In total, 18 lakh childbirth occur in the state every year and 40 percent of state populace is below poverty line, yet the government provides only Rs 150 per person per year as health budget of which Rs 126 is spend on salary-allowances and other infrastructure costs. Only 137 posts of gynecologists and obstetricians are approved in entire state and of these 38 are vacant since several years. After a long battle, the government started the process of filling up the vacancies last year but no doctors are willing to take up government jobs owing to lack of facilities including diagnostic

**Health centre without doctor for 18 months**

For 18 long months, a primary health centre in Madhya Pradesh has been without a doctor, putting the poor, particularly the pregnant, in great distress.

Munni, nine months into her pregnancy, came to the centre at Kushwai village in Shadol district, only to be told that a compounder was running it. For someone in an advanced stage of pregnancy like Munni, the absence of a doctor may be life threatening.

Groaning in pain, Munni, who traveled six kilometers by bus and walked more than a kilometer over rough roads to reach the centre, starts for another centre eight kilometers away.

'For a woman in labour, in remote Madhya Pradesh, it is common to travel in worn-out buses, bullock carts or even cycles over potholed roads to distant rural health centers in the hope of getting proper health care,' one health official said.

Ironically, this happens at a time when the state government boasts of providing transport, treatment and cash incentives to women delivering child at a government facility.

Still, 10,000 women die every year during pregnancy.

The reasons for these deaths are not far to seek - lack of awareness about government schemes and their tardy implementation. Often pregnant woman like Munni walk to the health centers or at times get carried to distances as far as 20-22 km away.

The government has in the recent past announced several schemes to prevent child and maternity related deaths.

'But the reach and awareness about major health schemes is pathetic, with only a handful of people benefiting from them,' revealed a recent survey conducted by an NGO.

'More than 50 percent people do not know about the major health schemes, as high as 43.9 percent do not have the `yellow card' meant for Below Poverty Line (BPL) people, 61.7 percent people do not have access to a government health facility and 71.6 percent people never received free medicines,' said the survey, conducted in both urban and rural areas of Bhopal, Raisen, Hoshangabad, Katni and Jabalpur districts.

'Let alone reach, even awareness about the schemes is so low that it seems improbable that economically backward residents will be able to seek benefit of most elfare schemes in near future,' said the NGO, which covered 1,000 respondents belonging to economically poor strata to ascertain their awareness, reach and availability of the health schemes.

'Besides, most primary health centres do not function; the MMUs (Mobile Medical Unit) are not in place,' the study found.

It also cited poor infrastructure, lack of labour rooms and medical equipment, large-scale absenteeism and vacancies as well as poorly trained and unmotivated manpower as some of the other reasons for the poor health care services. According to a health official, the scenario reflects the lopsided nature of health care in Madhya Pradesh.

(Source - http://safemotherhood.blogspot.com)

implements, medicines and general sanitary facilities. In such situation, doctors often have to face the wrath of the family members of the patient in case of death.

Government started the process for filling up 78 posts of gynecologists and obstetricians but only 31 applications were received. A total 112 posts of anesthetists were to be filled up but only 12 took up the job. Corruption at all levels is making conditions far more dangerous for the pregnant women. Corruption has begun in the medicine purchase under the new medicine policy, as now in the new medicine policy all the purchase will be done centrally and the Rs 700 of financial support under Janani Suraksha Yojana is all spent in giving bribe to the local health staff.

Despite unreliable data, statistics say that out of 1.47 lakh maternal deaths in the country every year, 97000 are contributed by the five BIMARU states and the three newly carved states. The World Health Organization also accepts this. The half of the maternal deaths in South Asia are contributed by the states of Rajasthan, MP, Bihar, UP and Orissa in India.

In such situation the statistics need to be manipulated to show lower MMP so that the policies foreign investments and privatization of services could be justified. MMR is directly related to social disparity, exploitation and poverty. The government has limited the scope of poverty around hunger and this has limited the rights of the women for safe motherhood. On one had health services have been hugely privatized and on other government's accountability for rights of community to health has reduced. Due to poverty, more than 40 percent below poverty line families are not able to seek benefit of private health services.

Number of PHC in terms of population and its impact on efficacy and maternal mortality is one more issue which needs to be looked into. At present the norm is that there would be one primary health centre on a population of 30,000. But is this number sufficient and whether it is possible to cater to such large population in sparsely populated tribal dominated districts is point to note. Shahdol and Mandla districts have only there is one PHC at the population of 24992 and 28639 respectively and only 11.7 and 10.7 women had availed the facility for institutional deliveries. Unfortunately the norm of one PHC per 30000 populations is not based on the ground realities and does not take care of the variable population density in the state and country.

Actually this is the time to sincerely implement the efforts for safe motherhood. A political debate has started on the issue but lack of commitment is easily perceptible. The fear is that the rights of women might get entangles into a web of schemes. Government provides cheaper food grains but it is ironic that a women suffering from childbirth pains has to prove that she is poor as per government guidelines to get free medical care and medicines. The government needs to chalk out a comprehensive policy and coordinated effort for child and maternal health and not keep churning out irresponsible and discrepant schemes just to please some political leaders.

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# Response of the State

This aspect is to be considered seriously that now Right to Health Services is no more a Universal duty of the state. Now state government, while responding various demands and complaints, announces schemes for a certain group of people, such as BPL, SC, ST etc. However, some of the really needy people still to be included and get benefits. For example of Saheriyas, they are identified as Primitive Tribal Group in Madhya Pradesh and Rajasthan but they are in SC and ST category (not PTG) in Utter Pradesh. It should be called the State initiated Social Exclusion.

Government of Madhya Pradesh in its policy document admits that in spite of the best of efforts on behalf of the Government institutions, the people of the state are not satisfied and the health status, though improved from yesteryears, is far worse compared to the national scale (as reflected by the health indices). For every 100 rupees spent on health, Rs 75 come from private (out of pocket) sources. In the last Budget of the GoMP the overall per capita on health care is Rs. 150. Although Government Health Expenditure has risen in absolute terms, it has by and large remained static in per capita terms. As far as structural reform to provide better maternal health care is concerned, a lot remains has to be done.

In the rising tide of privatization of the Health services, the Government of MP also believes that only private participation could save women from maternal deaths. The Government is of the view that though the share of salaries in non-plan health expenditure is 86.7%, however, the government is not getting fair returns on its investment in health care and there is widespread dissatisfaction with the access and quality of health care in the government health care institutions. On the other hand, there are serious questions about the economic access and quality of health care in private sector, particularly in the rural areas. The problem is compounded as government does not have an effective monitoring, surveillance or control function with regard to private health care.

**DRAFT State Health Policy -** It is matter of concern that State government could not finalize State Health Policy in last 5 years and the policy is still a Draft Policy. There is thus no point in asking the question as to when the implementation of the following goals would begin-

1- Ensuring geographic and economic access to primary and secondary quality health care family services to the entire population of Madhya Pradesh within a span of five to seven years. Following will be the core characteristics of the health care:

- Health care would be gender sensitive
- Health care to address health promotion, prevention, treatment (curative) and rehabilitation.
- All health care resources including NGOs and private providers would be utilized for health care provision.
- Public fund would be primarily focus on rural and urban poor.
- Focus will be on communicable diseases (diseases of poverty), reproductive health conditions and preventive actions to reduce chronic diseases e.g.

Cardiovascular diseases, cancer, mental disorder, diabetes (secondary prevention), hypertension (secondary prevention) etc.

- Address the increasing incidence of injuries by prevention and treatment.

2- Prevention of disaster, to the extent possible, and preparedness for disaster management as and when necessary.

3- Reducing the MMR to 220 by 2011 from the level of 498 (1997 level).

4- Reducing the IMR to 62 by 2011 from the level of 97 (1997 level).

5- Total Fertility rate to reach replacement level fertility (i. e. TFR of 2.1) by the year 2011.

6- Stabilize the prevalence of HIV/AIDS at low level (present level) and further decrease it.

7 Address problems related to mental health and initiate action to create information base and preventive intervention for improved mental health in the state.

For the service provision, there is a clear rural urban divide – 70% of qualified providers (doctors) are in urban areas and only 30% in the rural areas of the State. Seven out of about eight persons in selected health care staff categories work in the private sector. This does not include the public sector health employees (e.g. doctors, nurses and others) who practice privately after the duty hours[27].

Despite so many deaths of infants, neither the local administration nor the State administration has taken any note. Everyone who should have been concerned were busy welcoming the change in power and leadership and dying mothers could not find space in the priority list of policy makers and political parties.

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[27] Draft State Health Policy, www.mp.nic.in/health

# Conclusion

The State now wants society to shed all its hopes of provision of health services so as to throw open the medical field to the market and multinational companies. Probably this is the reason why the budget allotments in this area have been receding at a fast speed. Under the present conditions, Madhya Pradesh Government spends only Rs 150 per person[28] every year on health facilities but forgets to publicize that out of this amount too, Rs 126 is spent on salary, transport and administrative expenses, so the actual per capita amount spent by the Government is just Rs 24 which means Rs 2.00 per month and seven paise per day.

Under these circumstances, does not the commitment of government become questionable? Is the need not felt that health should be given the status of fundamental right and every act of negligence in this regard be considered punishable by law?

The experiences gained till date can surely give some points to internalize the pain more than a figure. Now the government has also started realizing the need of Cost-effective interventions to reduce MMR range from the presence of skilled attendants at the time of birth, involving a combination of personnel, drugs and back up emergency care, better nutrition, good antenatal care and tetanus toxoid injections during pregnancy. Several non-health interventions can also help to reduce the MMR: age at marriage and enhancement of women's status in society, which may be associated with improved nutrition and education. Unfortunately, changes in these 'cultural characteristics' occur slowly over time, and cost effective interventions to influence these characteristics are not readily identifiable[29]. It is also to be analyzed that whether the structure and character of our state permit us for innovations to change in Cultural characteristics maintaining ownership, commitment and transparency. We can see that women are going to be the biggest sufferer in the debate of increase in population on the religious basis and state is still behaving as a silent viewer. Although this confession make sense that the NHP, 1983 made a strong policy commitment to establish comprehensive health care, based on the active involvement of the community and inter sectoral linkages to health determinants such as nutrition, water, sanitation, etc. Such an approach, if implemented, would have helped aver the premature death of an additional 1.50 million infants and 800,000 maternal deaths[30]. In continuation to this point now we also will have to look and counter the political calls to increase population by the fundamentalist forces.

The government also does not seem ready for achieving better maternal health, even though the government is mobilizing many schemes for achieving this target for maternal health such as the 'Janani Suraksha Yojana (Safe Motherhood scheme), the convenience for pregnant women, institutional delivery scheme, transport and treatment for pregnant women are the chief ones. But the question is whether they getting the benefit of these schemes or not. Not only this, but also the attitude of the hospital management, their poverty, the lack of facilities in the hospitals, the

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[28] Source- http://www.mp.nic.in/health/healthpolicy. HTM

[29] Report of the National Commission on Macroeconomics and Health, Govt. of India, September, 2005 pg- 37

[30] Report of the National Commission on Macroeconomics and Health, Govt. of India, September, 2005 pg- 48

encouragement of privatization and many other reasons which act as obstacles in reduction of maternal deaths[31].

To improve maternal health, more investment in and better management of health systems is needed to improve the quality and coverage of service delivery. Additionally, governments must work with local communities to provide improved prenatal and postnatal care for the poor. Universal access to reproductive health care—including family planning, care during pregnancy and after childbirth, and emergency obstetric care—will save women's lives and the lives of their children.

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[31] Robbinson, Nick, Visiting Madhya Pradesh, a study on Maternal Health Scheme in Madhya Pradesh