There is an urgent need to put in place adequate infrastructure, human resources (especially specialists) and especially emergency obstetric care services especially blood banks and referral services. With 89% of women giving birth in institutions, the system must be able to gear up to prevent complications that occur after delivery. The Janani Suraksha Yojana provides women with a financial incentive of Rs.1400 for delivery by an SBA in an institution and Rs.500 for a delivery attended by an SBA at home. NFHS data shows that only 65% of women who delivered in an institutional JSY benefit while the AHS 2012-13 shows that as many as 86.6% of women received the benefit. Dotydelaries, it appears, have been left out of JSY benefits. This is evident from the INRE data (2015-16) which shows that only 4% of women delivering at home received the financial assistance. The lack of data in this subsequent survey makes it difficult to understand the quality of both intra and postnatal care, but it is clear that there is a need to strengthen postnatal care provision.

Contraception and Family Planning

Securing maternal health of women requires working beyond the provision of care in pregnancy and childbirth, and also includes ensuring access to contraception and safe abortion services. The link between fertility and MMR is well established, with studies consistently showing that a drop in fertility can result in a reduction in MMR and improved maternal health. In the state of Madhya Pradesh, TFR dropped from 3.1 to 2.3 between NHMS 3 and 4. Data shows that the burden of family planning still lies on the woman until it is centered on limiting methods rather than spacing methods, with female sterilization being the most widely used method. As per the NFHS-4, female sterilization- 42.2%, Male sterilization- 0.5%, IUD/PPIHC- 3.5%, PU- 2.6%, Copper- 4.9%.

The ratio of female to male sterilization is roughly 1:87 for urban areas and 1:330 for rural areas (NHMS-4, 2015-16). Moreover, the quality of family planning services continues to be a matter of concern and this has been reported in news articles in NF for instance. In November 2014, 124 women in Chhatarpur district were sterilized in 5 hours in the camp held at a CHC. The surgeries were conducted well at night, even past midnight. The government is desperately planning programmes on sterilization of married women. The health focus oblastsobeans remain a blind spot. Number of male sterilization methods are not seeing uptake as AllIndia face barriercs.

Overall, the data suggests that greater abortion needs to be given to temporary spacing methods, engaging men in taking on contraceptive responsibility and reducing the burden on women. The quality of contraceptive services is also a matter of concern which must be addressed.

Access to Safe Abortion

 Unsafe abortion is a significant cause of maternal deaths worldwide. Provision of safe abortion services, therefore, is an important measure to reduce maternal mortality. Although abortion is legal in India, access to legal, safe abortion services continues to be a challenge and women end up resorting to unskilled providers. In the case of Madhya Pradesh, AHS (2013-15) shows that 42% of abortions in Madhya Pradesh are not performed by a skilled provider.

• 42% abortions - not performed by a skilled provider.
• 64% abortions in urban areas - performed by skilled health personnel.
• 56.2% in rural areas - performed by skilled health personnel.

It suggests that greater availability and accessibility to abortion services in urban areas as compared to rural Provision of safe and easily accessible abortion services emerges as an important area of improvement in order to reduce complications and deaths due to abortion.

Way Forward

Over the past decade, proportion of women seeking legal abortion has increased. However, quality and adequacy of care throughout the continuum of antenatal care, delivery (especially emergency obstetric care) and postnatal care emerges as a critical concern which must be addressed urgently. There are also important blind spots, such as the lack of provision of skilled birth attendance to home deliveries which require attention. Beyond services provided during pregnancy and childbirth, what also warrants attention is the provision of good quality accessible and voluntary services for contraception and abortion, male contraception and routine services instead of camp approach which would go a long way in ensuring maternal health in a more comprehensive manner.

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What Does the Evidence Say?}

Madhya Pradesh
Maternal and Reproductive Health Status Report- 2016

MMR below national average
MMR between national and state average
MMR above state average

Source: Annual Health Survey (2012-13)

For Private Circulation only

What Does the Evidence Say?

Delhi/Madhya Pradesh
Introduction

Over the past decade, the state of Madhya Pradesh, the second largest state in India, has made significant progress in improving maternal and child health outcomes and specifically in reducing maternal mortality. Although its Maternal Mortality Ratio (MMR) was 221 in 2005-06, it is similar to what it was in the year 2000-01 at 209 (RGI, 2006). Significant efforts to improve maternal health in this high-MMR state include:

- National schemes like Janani Shishu Suraksha Yojana (JSS) and Janani Shishu Suraksha Karyakram (JSS-K)
- State initiatives at village level such as the Gram Arogya Kendra
- National schemes like Janani Suraksha Yojana (JSY)
- State initiatives at village level such as the Gram Arogya Kendra
- National schemes like Janani Suraksha Yojana (JSY)

As shown in the following graph, although the total number of women registered for ANC per NHIS 6 (2014-15) is well over 90%, only 11.4% of women received all the components of ANC, which is not much higher than the 8.0% that it was in DSUS 2007-2008.

The urban-rural disparity in this regard is also very high where in urban areas almost double the number of women who receive full ANC as compared to rural areas. The disparity in ANC coverage is also seen across the socio-economic groups. The report shows that women in the highest socio-economic group have 54% Scheduled Tribe and 38% Scheduled Caste women attending ANC checkups, while women in the lowest socio-economic group have only 3% Scheduled Tribe and 24% ‘other caste’ women. Similarly, 58% of women from the lowest quintile received no ANC, as compared to 30% of the entire state. Since the subsequent NHIS surveys do not provide such disaggregation of data, it is not possible to assess whether any improvements are being seen in services to the most marginalized. With regard to the components of ANC, NHIS 6 data shows that while the provision of tetanus injections is reasonably high, the most neglected component of ANC is to be iron & folic acid tablets. The consumption of IM tablets is as low as 21.3%, and it is lower in rural areas than urban areas. This is especially a cause for concern given the high prevalence of anaemia among pregnant women in the state. According to NHIS 6, more than half of pregnant women in Madhya Pradesh are anaemic, and although this is slightly lower than in NHIS 5-05, the proportion is still exceptionally high. This is significant because anaemia is one of the leading causes of maternal deaths in the state, with 20% of women dying due to bleeding (60 CEM Report, 2012).

Overall, the picture of antenatal care services suggests that much greater attention needs to be paid to ensuring optimal quality and adequate provision of antenatal services. In the absence of this, a mere increase in registration of women for ANC is not a substantive improvement.

Attention to Home Deliveries

As expected, there has been a rise in the institutional deliveries over the last decade in both rural and urban areas, due in part to the immense focus on increased antenatal check-ups in the following graph, showing that there is a shortfall of both institutional and home deliveries in the state. In terms of the NHIS and PMJS, the shortfall increased from 2008 to 2012 but remained almost constant 2012-15. The number of nurses has been rapidly increasing and even the number of doctors at PHCs showed growth from 2008 to 2012, which shows that the issue was not recently addressed. But the number of medical graduates who have joined the medical workforce have increased, the infrastructure and health personnel have been able to catch up. The overall attention is the fact that the deficit in infrastructure,

Quality and Adequacy of Antenatal Care (ANC)

Ensuring safe childbirth requires that a continuum of care be provided to women beginning with the antenatal period. Through check-ups and extending into the postpartum period which provided at the right time and in the appropriate manner allows timely identification and management of obstetric complications and infections. As per the NHIS-6 (2014-15), the registration of women for ANC in Madhya Pradesh was seen to be high with 82.3% of pregnant women being registered for ANC. However, of these, only 53% of women had their first antenatal check-up in the first trimester and only 36% received 4 or more check-ups. This is certainly better than DSUS 2007-08 where only 61% of women received any ANC and only 30% received it in the first trimester. However, the quality and sources of complication services remain critically poor.

As per the NHIS-2012-13, in districts the Divisions of Dhar, Chhindwara, and Young 50% to women continue to deliver at home. In absolute terms, this amounts to a significant number of deliveries. As per the NHIS (2015-16), over one lakh deliveries were delivered at home in the state of Madhya Pradesh, and this is most likely to result in suboptimal quality outcomes.

Preparedness of Institutions

Despite the dramatic increase in institutional delivery, one finds that the health institutions have not been able to keep pace and are ill-prepared to deal with increased caseloads. A look at the NHIS-6 reports for the first trimester of delivery in the following graph, shows that there is a shortfall of both bed spaces and blood storage units. For instance, only 42 of the 152 designated CEmONC facilities have a blood bank and 75 others have no blood bank at all. Of the remaining 35, 91 as CEmONC facilities. Of the 152 facilities that were designated as CEmONC facilities, only 95 are functional due to lack of services. For instance, only 42 of these facilities have a blood bank and 75 others have a blood storage unit. The remaining 50 have no blood availability and they cannot provide comprehensive obstetric care services. The report also notes that facilities below the district hospital lack infrastructure and trained human resources in all or a few key-saving obstetric care services.

Conclusion

The report also notes that facilities below the district hospital lack infrastructure and trained human resources in all or a few key-saving obstetric care services.

IHS functional delivery points, less than half of the 152 are functional as the RGI states. 35 of the 152 designated CEmONC facilities have no blood bank, 95 are functional due to lack of various services. For instance, only 42 of these facilities have a blood bank and 75 others have a blood storage unit. The remaining 50 have no blood availability and they cannot provide comprehensive obstetric care services. The report also notes that facilities below the district hospital lack infrastructure and trained human resources in all or a few key-saving obstetric care services.