



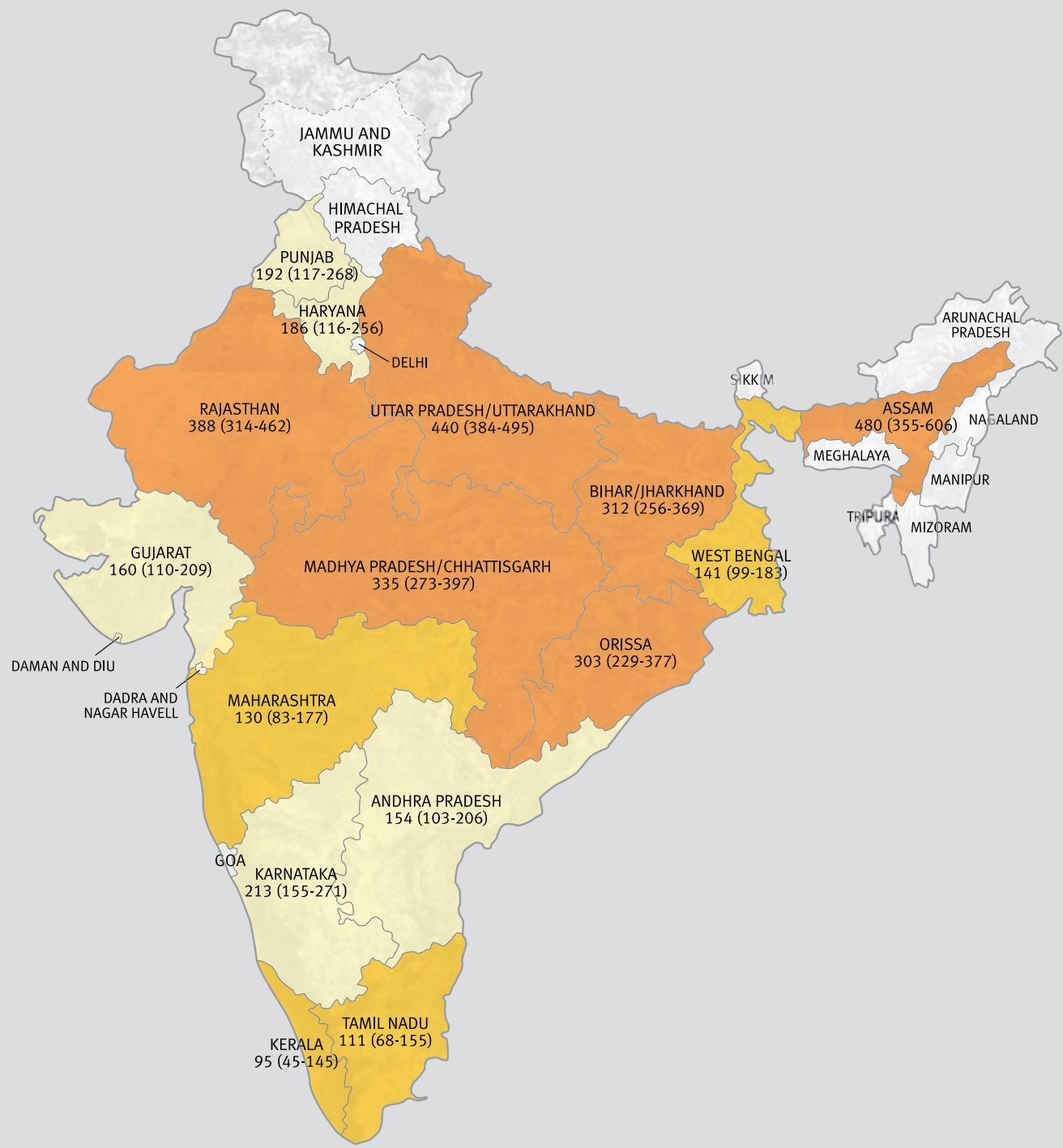
SUMMARY AND KEY RECOMMENDATIONS

No Tally of the Anguish

Accountability in Maternal Health Care in India

HUMAN
RIGHTS
WATCH

MATERNAL MORTALITY IN INDIA (2004-2006)



LEGEND
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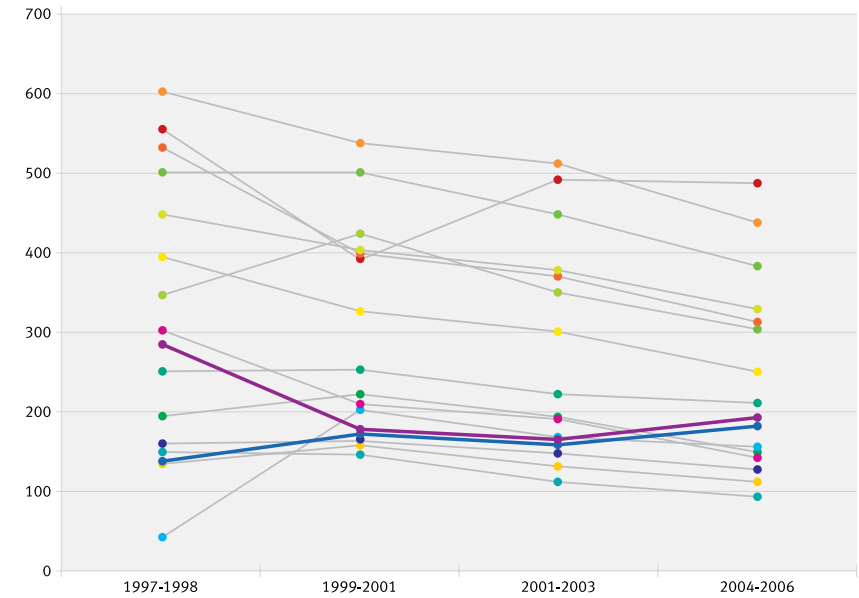
Maternal mortality ratio (MMR) = Number of maternal deaths per 100,000 live births
Source: Based on data from Registrar General of India, Special Bulletin on Maternal Mortality in India, 2004-2006, 2009.

Who asks what happened afterwards? ... If a person dies, she dies. If someone hangs himself then it becomes a police case. But if someone dies in a hospital then no one cares.
— Suresh S., neighbor of deceased pregnant woman, Uttar Pradesh, March 2, 2009.

NOT “FATED” TO DIE

For an emerging global economic power famous for its medical prowess, India continues to have unacceptably high maternal mortality levels. In 2005, the last year for which international data is available, India’s maternal mortality ratio was 16 times that of Russia, 10 times that of China, and 4 times higher than in Brazil.*1 Of every 70 Indian girls who reach reproductive age, one will eventually die because of pregnancy, childbirth, or unsafe abortion, compared to one in 7,300 in the developed world. More will suffer preventable injuries, infections, and disabilities, often serious and lasting a lifetime, due to failures in maternal care.
“Destiny” or “fate” brought this upon them, say many of the families that experience maternal deaths, unaware that as many as three in four might be prevented if all women and girls had access to appropriate health care.

MMR IN INDIAN STATES

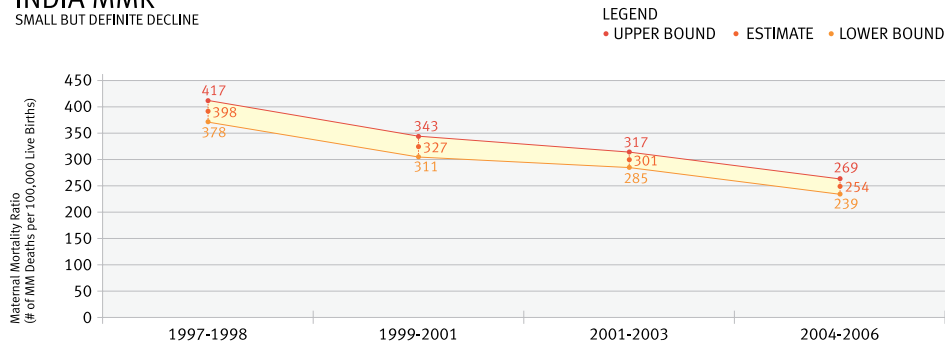


*1: Maternal mortality ratio is defined as the number of maternal deaths per 100,000 live births.

LEGEND
ASSAM INDIA ANDHRA PRADESH HARYANA
BIHAR/JHARKHAND MADHYA PRADESH KARNATAKA MAHARASHTRA
UTTAR PRADESH /CHHATTISGARH KERALA PUNJAB
ORISSA GUJARAT WEST BENGAL
TAMIL NADU RAJASTHAN

INDIA MMR

SMALL BUT DEFINITE DECLINE

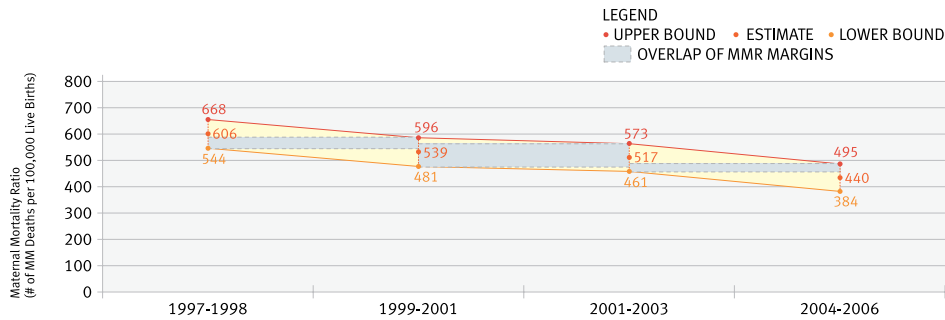


After more than a decade of programming for reproductive and child health with few results, the Indian government acknowledged the problem and in 2005 took steps under its flagship National Rural Health Mission (NRHM) to improve public health systems and reduce maternal mortality in particular. Recent data suggest it is having some success: all-India figures show a decline in maternal deaths between 2003 and 2006.

This decline, however, is small in relation to the scope of the problem, and camouflages disparities. Some states like Haryana and Punjab actually showed an increase in maternal mortality . And significant disparities based on income, caste, place of residence, and other arbitrary factors persist even within every state, including those that appear to be improving access to care for pregnant women and mothers. Poor maternal health is far too prevalent in many communities, particularly marginalized Dalit (so-called “untouchable”), other lower caste, and tribal communities.

UTTAR PRADESH MMR

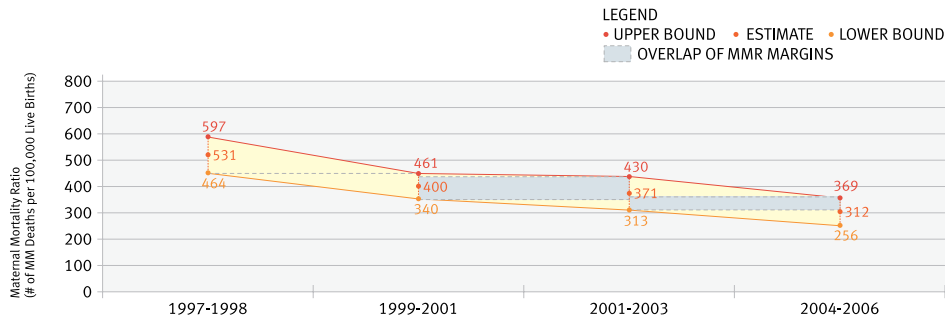
IS THERE A REAL DECLINE?



One step the Indian government has already taken is to increase women’s demand for deliveries in health facilities, on the assumption that doing so will promote safe deliveries. National and state officials are also taking steps to upgrade public health facilities to improve the standard of care. They are also making efforts to improve monitoring of health parameters through a new Health Management Information System, and are launching an annual health survey in some key states to boost the levels of health-related information.

BIHAR STATE MMR

IS THERE A REAL DECLINE?

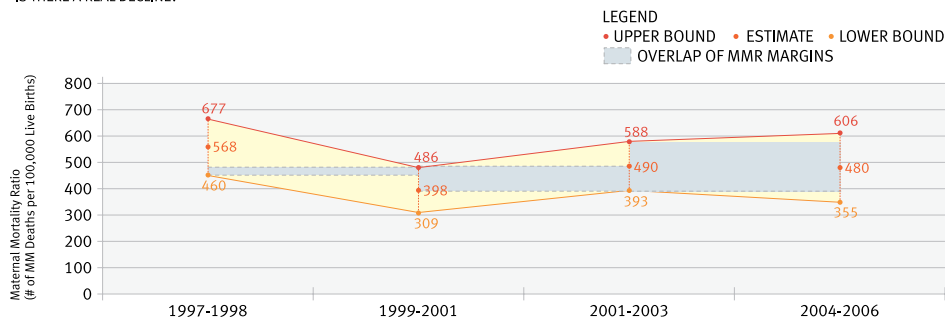


These steps are important and, indeed, suggest India has the potential to be a leader among developing countries in attacking maternal mortality and meeting the international commitments spelled out in the “Millennium Development Goal” on maternal mortality. This will be possible, however, only if officials do more to diagnose and steadily improve healthcare systems, programs, and practices by addressing barriers to care and filling health system gaps. And it will be possible only if officials do more to ensure that policies make a difference in the lives of all women and girls, regardless of their background, income level, caste, religion, number of children, place of residence, and other arbitrary factors.

Human Rights Watch believes that a critical issue, one that has received inadequate attention to date, is healthcare system accountability. Accountability, a central human rights principle, is integral to the progressive realization of women’s right to sexual and reproductive health and to the realization of the Millennium Development Goal on maternal mortality reduction.

ASSAM STATE MMR

IS THERE A REAL DECLINE?

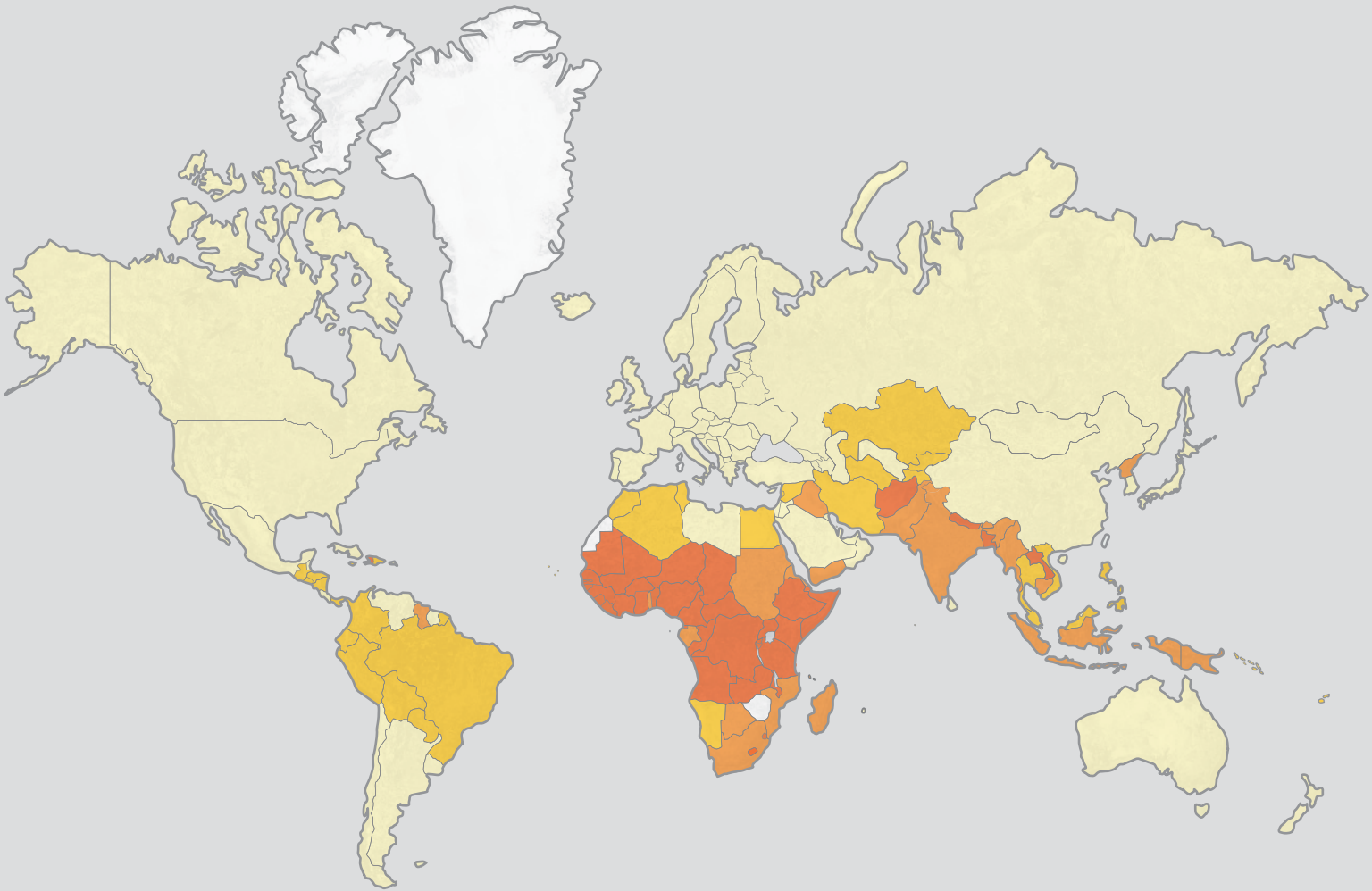


We conducted research in India between November 2008 and August 2009. The work included field investigations with victims and families in Uttar Pradesh and consultations with experts and activists there and in other parts of India. We chose Uttar Pradesh as the locus for field investigation because it has one of the highest maternal mortality ratios and because it is among those states that have introduced an executive order requiring all maternal deaths to be investigated.

Targeted Interventions

Generally speaking, maternal mortality is high where women’s overall status is low and public health systems are poor. India is no exception and efforts to bolster women’s rights and strengthen the healthcare system as a whole must be an important part of efforts to curb maternal mortality. Even so, targeted interventions—better access to skilled birth attendance, emergency obstetric care, and improved referral systems, with particular attention to underserved communities—have been proven to make a significant contribution to reducing maternal deaths, disease, and injury.

MATERNAL MORTALITY IN THE WORLD (2005)



LEGEND

- LOW MMR (< 100)
- MODERATE MMR (100-299)
- HIGH MMR (300-549)
- VERY HIGH MMR (> 550)
- DATA NOT AVAILABLE

Maternal mortality ratio (MMR) = Number of maternal deaths per 100,000 live births

Source: Based on data from World Health Organization (WHO) et al., Maternal Mortality in 2005, Estimates developed by WHO, UNICEF, UNFPA and the World Bank, 2007.

*2: World Health Organization (WHO) et al., “Maternal Mortality in 2005, Estimates developed by WHO, UNICEF, UNFPA and the World Bank,” 2007, www.who.int/reproductive-health/publications/maternal_mortality_2005/mme_2005.pdf (accessed November 22, 2008. Please refer to “Note on Estimates,” in the section below titled “Methodology” for further details about adjustment of country-level data.

Our research identified four important reasons for the continuing high maternal mortality rate in Uttar Pradesh: barriers to emergency care, poor referral practices, gaps in continuity of care, and improper demands for payment as a condition for delivery of healthcare services.

We also found serious shortcomings in the tools used by authorities to monitor healthcare system performance, identify flaws, and intervene in time to make a difference. While accountability measures may seem dry or abstract, they literally can be a matter of life and death.

As detailed below, we believe that failures in two key areas of accountability are an important reason that many women and girls in states like Uttar Pradesh are needlessly dying or suffering serious harm during pregnancy, childbirth, and the postnatal period:

- Failures to gather the necessary information at the district level on where, when, and why deaths and injuries are occurring so that appropriate remedies can be devised; and
- Failures of grievance and redress mechanisms, including emergency response systems.

DISPARITIES: FROM GLOBAL TO LOCAL

Globally, more than half a million women and girls die every year because of pregnancy, childbirth, and unsafe abortions (maternal deaths). Nearly 80 percent of these deaths are directly linked to obstetric complications such as hemorrhage, obstructed labor, or eclampsia (pregnancy-related seizures). Many women die during pregnancy or after childbirth due to indirect causes such as tuberculosis, hepatitis, and malaria. Thousands more—about 20-30 times the numbers who die—are still left with infections, or suffer injuries or disabilities such as obstetric fistula due to pregnancy-related complications. Many others suffer pregnancies ridden with health problems such as anemia and night blindness.

OVERVIEW OF MATERNAL HEALTH IN INDIA BY REGION, WOMEN'S INCOME, EDUCATION, AND CASTE

HEALTH INDICATORS	OVERALL	REGION		WEALTH QUINTILE		EDUCATION		CASTE			
		RURAL	URBAN	HIGHEST	LOWEST	10 YEARS OR MORE	ILLITERATE	SC	ST	OBC	OTHERS
INSTITUTIONAL DELIVERIES	40.7	31.1	69.4	75.4	13.3	80.6	19.8	35	19.6	39.6	53.2
ANTENATAL CARE COVERAGE (Three or more Antenatal Care Visits)	50.7	42.8	73.8	86.3	26.2	85.3	29.8	44.3	40.2	48.5	61.4
POSTNATAL CARE COVERAGE	36.4	28.1	60.7	85	13.8	73.3	17.6	31	22	35.2	46.8

Source: National Family and Health Survey, 2005-2006

SC = SCHEDULED CASTE, ST = SCHEDULED TRIBE, OBC = OTHER BACKWARD CLASS

The direct medical cause of any particular death explains just part of the story. Typically, a maternal death marks the tragic ending of an already complex story with different elements—socio-economic, cultural, and medical—operating at different levels— individual, household, community, and so on. Factors contributing to maternal death include early marriage, women’s poor control over access to and use of contraceptives, husbands or mothers-in-law dictating women’s care-seeking behavior, overall poor health including poor nutrition, poverty, lack of health education and awareness, domestic violence, and poor access to quality healthcare, including obstetric services.

Measures of maternal deaths and morbidities illustrate the vast disparities in global health and access to healthcare worldwide. Developing countries, including India, bear 99 percent of global maternal mortality. Latest available international figures from 2005 show that India alone contributes to a little under a fourth of the world’s maternal mortality, with a maternal mortality ratio (MMR) of 450 maternal deaths per 100,000 live births (compared with Ireland’s MMR of 1 and Sierra Leone’s 5,400).^{*2}

In-country disparities in maternal mortality are huge, with Uttar Pradesh state in north India having one of the highest MMRs, with nearly three times as much as southern Tamil Nadu state. Even within a state, the access to and utilization of maternal healthcare varies based on region (rural or urban), caste, religion, income, and education. For instance, a 2007 UNICEF study in six northern states in India revealed that 61 percent of the maternal deaths documented in the study occurred in Dalit (so-called “untouchables”) and tribal communities.

RECURRENT HEALTHCARE SYSTEM FAILURES

Indian government policies and programs aim to provide poor rural women with free access to comprehensive emergency obstetric care to save them from life-threatening complications during childbirth. Despite this, thousands of women continue to die because of complications including hemorrhage, obstructed labor, or hypertensive disorders.

The Indian central government’s seven-year flagship rural healthcare program, the National Rural Health Mission (NRHM), has ushered in many changes in rural health care, especially maternal health care. It provides for a range of “concrete service guarantees” for the rural poor, including free care before and during childbirth, in-patient hospital services, comprehensive emergency obstetric care, referral in case of complication, and postnatal care. But, critically, it fails to monitor whether these standards are actually being met on the ground and ensure that women are aware of them. The result is recurring health system or program gaps that are not being effectively addressed in practice.

Our research in Uttar Pradesh shows that while health authorities are upgrading public health facilities, they have a long way to go. Currently, a majority of public health facilities that are supposed to provide basic and comprehensive emergency obstetric care have yet to do so. A health worker trained in midwifery can do very little to save the life of a pregnant woman unless she is supported by a functioning health system including an adequate supply of drugs for obstetric first aid, emergency obstetric care, and referral systems for complications such as hemorrhage, obstructed labor, and hypertensive disorders.

For example, most health staff in community health centers of Uttar Pradesh said that they conducted only “normal deliveries.” Women with complications were referred to another facility, with little or no referral support. Uttar Pradesh has 583 fewer community health centers than Indian public health standards require. Less than a third of existing community health centers have an obstetrician or gynecologist and about 45 percent do not have funds to operate even the one ambulance they have. In practice, roughly 1 in 20 first referral units (comprehensive emergency obstetric care facilities) in Uttar Pradesh offer caesarean sections and only 1 in 100 have a blood storage facility.

Staff at community health centers and district hospitals visited by Human Rights Watch in Uttar Pradesh reported referring women with pregnancy complications to facilities at times more than 100 kilometers (60 miles) away for a blood transfusion or cesarean section.

We do not have a gynecologist now. No blood facility. So if there is any case that needs blood we refer the case to Allahabad hospital—Sadguru Sewa Trust [more than 100 kilometers away] ... Only normal cases are taken here. We do not take critical cases. In my time [more than two years], we have had only one cesar case [caesarean] performed.

— Health staff member at Chitrakoot district hospital, Uttar Pradesh, March 7, 2009. The hospital is supposed to be equipped with comprehensive emergency obstetric care facilities to address all pregnancy-related complications.

Women are often referred from one health facility to another before reaching a clinic or hospital that is equipped to provide the emergency care they need. In the words of Trishna T. from rural Uttar Pradesh, who recalled her neighbor’s frustrating experience of being sent away from a government health facility at the time of delivery: “What’s the point of sending us away? If the doctor cannot deal with the case here, then why should we go to the doctor? For the 1400 rupees [US\$28, the cash incentive given to women who deliver babies in hospitals or clinics]? Are we going all the way to kill ourselves?” Often such referrals are made without any support for emergency transport and information about whether the higher facility actually has the ability to deal with the complication.

From Bachrawan [comprehensive emergency obstetric care facility] they sent the case to the Rae Bareli hospital and from there they were asked to go to Lucknow hospital. They [the family] could not afford to go there [Lucknow] so they came back here [community health center]....But they [family] started falling at the doctor’s [superintendent] feet and holding his hand and leg. So out of mercy he took her and got her admitted. Not into our ward [female ward]. We said no. So he took her into the male ward. She died. He did not want her to die on the road. There is nothing we could have done in that case. We do not have the facilities here.

— Nirmala N., health staff member at a community health center, Uttar Pradesh, February 27, 2009, explaining a failed referral from their center.

We took her [Kavita K.] to the community health center and they said, “We cannot look at this here.” So we took her to [the hospital in] Hydergad. From Hydergad to Balrampur, and from there to Lucknow—all government hospitals. From Wednesday to Sunday—for five days— we took her from one hospital to another. No one wanted to admit her. In Lucknow they admitted her and started treatment. They treated her for about an hour and then she died.

— Suraj S., father of Kavita K., Uttar Pradesh, February 27, 2009, recalling his experience when seeking medical assistance for Kavita after she developed postpartum complications.

The best institutional delivery cannot save a pregnant woman or new mother unless she is cared for in the immediate postnatal period (24-72 hours) with follow-up care in case of complications thereafter. Poor continuity of care through the antenatal and postnatal periods has remained a persistent problem in states like Uttar Pradesh. A 2008 government survey reveals that there is a significant drop in care even within the immediate postnatal period of 48 hours of delivery in Uttar Pradesh.

Women and girls also face considerable financial barriers to care. Even though government programs guarantee a host of free services including out-patient obstetric services, drugs, and in-patient obstetric services such as comprehensive emergency obstetric care, in practice, the care is seldom free. The most obvious example is government discrimination among women on the basis of age and number of children while providing benefits under health care programs like the Mother Protection Scheme (Janani Suraksha Yojana or JSY). In many states, pregnant girls under the age of 19 or women and girls with more than two children are not entitled to benefits under the JSY even though young mothers and mothers with multiple pregnancies are especially in need of such medical attention.

Many health workers in hospitals and clinics make unlawful demands for money or payment as a condition for care. Often this is justified as a customary practice around childbirth where families “volunteer” money or gifts to celebrate childbirth. But such practices should be curbed because they impose a severe burden on poor families. In cases where free care is dependent on whether women belong to families holding cards certifying them as below the poverty line, non-issuance of such cards forms a significant barrier to access.

Nothing is free for anyone. What happens when we take a woman for delivery to the hospital is that she will have to pay for her cord to be cut... for medicines, some more money for the cleaning. The staff nurse will also ask for money. They do not ask the family directly ... We have to take it from the family and give it to them [staff nurses] ... And those of us [ASHAs] who don't listen to the staff nurse or if we threaten to complain, they make a note of us. They remember our faces and then the next time we go they don't treat our [delivery] cases well. They will look at us and say “referral” even if it is a normal case.

— Niraja N., female community health worker or ASHA, Uttar Pradesh, February 26, 2009.

One man I know had taken his wife for delivery to the CHC. He had sold 10 kilos of wheat that he had bought to get money to bring his wife for delivery. He had some 200-300 rupees [US\$4-6]. Now in the CHC they asked him for a minimum of 500 rupees [US\$10]. Another 50 [rupees] to cut the cord and 50 [rupees] for the sweeper. So he started begging and saying he did not have more money and that they should help for his wife's delivery. I... asked them why they were demanding money. The nurse started giving us such dirty [verbal] abuses that even I was getting embarrassed and wanted to leave. You imagine how an ordinary person must feel who wants help.

— Activist from a local nongovernmental organization in Uttar Pradesh, March 2, 2009.

An ambulance arrives at the Barabanki District Hospital for a delivery.

A guard at the gate of the maternity ward at the Barabanki District Hospital.

Pratima and her newborn son after her emergency delivery at Barabanki District Hospital.

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Women wait for pre-natal checkups at Barabanki District Hospital.
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IMPROVING ACCOUNTABILITY: THE CRITICAL NEED FOR BETTER MONITORING AND TIMELY INVESTIGATIONS

Existing approaches have not done enough to ensure that district health authorities gather information about why existing health care programs are not being implemented as they should be. They lack critical information about blockages or gaps in the health system. The key issue here is effective monitoring: using maternal death investigations and appropriate monitoring indicators to obtain the data needed for interventions that save lives and reduce harm.

Central and state authorities often point to the number of facility-based deliveries as an important measure of progress. While this can be a useful measure—facility-based deliveries under some circumstances correlate with reduction in maternal mortality—it does not provide the necessary information on whether a mother actually survived the childbirth and postnatal period without injuries, infections, or disabilities.

“Institutional Deliveries” as a Measure of Progress

The Mother Protection Scheme (Janani Suraksha Yojana or JSY) promotes hospital or clinic-based deliveries through cash incentives for pregnant women (1400 rupees, or US\$28, in rural areas) and community-health workers with the objective of promoting safe deliveries through improved access to skilled birth attendance. In theory the JSY seeks to integrate the cash assistance with prenatal and postnatal care. Nearly 20 million Indian women delivered in health facilities between mid-2005 and March 2009, a reflection, authorities say, of the JSY incentives. The Indian central and state governments use the number of such institutional deliveries as a key measure of progress on maternal health.

While the JSY has improved the demand for institutional deliveries, these statistics alone are not an adequate indicator of progress.

While conducting field investigations in Uttar Pradesh, Human Rights Watch found that the number of institutional deliveries at health facilities was counted by keeping track of the number of women who received cash assistance. In several instances, women from rural areas claimed that health workers had approached them saying that they could deliver at home but tell authorities they delivered in the health facility, splitting the cash assistance with the health worker.

More fundamentally, counting the number of institutional deliveries alone is misleading unless one monitors the actual outcome of pregnancies through the postnatal period. Currently missing is information on whether pregnant women who develop life-threatening complications such as hemorrhage, obstructed labor, and eclampsia (pregnancy-related seizures) receive timely and free access to emergency obstetric care as guaranteed under the NRHM. Health officials were able to give Human Rights Watch data on the number of institutional deliveries but not on the type of care received.

Health experts say that for institutional deliveries to be successfully considered a proxy for safe delivery, the following conditions should be met:

A skilled birth attendant should be “trained to proficiency” not only in the skills needed to manage “uncomplicated” cases, but also to identify, manage, and refer complications (WHO, ICM, FIGO Joint statement).

Skilled care itself requires that an “accredited and competent” health care provider has at her disposal the “necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care” (WHO, ICM, FIGO Joint statement).

Too often, these conditions are not being met in Uttar Pradesh and many other parts of India.

While improving access to basic and comprehensive emergency obstetric care is critical to reducing preventable maternal mortality and morbidity, so far the Indian central government and states like Uttar Pradesh have not monitored the availability and utilization of such services. In 1997 the United Nations Children’s Emergency Fund (UNICEF) adopted a set of indicators that monitor key interventions required to reduce maternal mortality, including whether the need for emergency obstetric care has been met and the number of deaths from complications in facilities equipped with emergency obstetric care. These indicators are not being used widely in India. Recently, the Indian government rolled out the Health Management Information System (HMIS) which records whether there is access to first referral units or facilities equipped with comprehensive emergency obstetric care as an indicator, but this is being poorly implemented in Uttar Pradesh.

Maternal death investigations identifying health system shortcomings are a powerful method of monitoring the implementation and effectiveness of healthcare schemes at the district level. Studies in different parts of India have repeatedly illustrated their utility in identifying and plugging gaps in healthcare schemes, particularly in underserved areas, and the Indian government is taking steps to institutionalize such investigations. But for such a system to be implemented successfully, authorities will have to take measures to ensure that maternal deaths are reported accurately.

Human Rights Watch documented several continuing barriers to reporting maternal deaths in Uttar Pradesh, the principal of which are illustrated briefly below:

- 1) Low priority for the collection and use of data on the frequency and cause of maternal deaths.

This information [maternal deaths] doesn’t come to us because we don’t get this through the pro forma. We don’t have a column for maternal deaths.
— Senior health officials, Directorate of Family Welfare, Uttar Pradesh, March 2009.

When we used to have CSSM forms [Child Survival and Safe Motherhood forms], under “Surveillance” we used to have a maternal deaths column. From last year we have given new forms—called routine immunization now— but most of the data collected in this form is also the same—about deliveries also. But the maternal deaths column in this form is missing—I think it got left out by mistake.
— Officer from Directorate of Family Welfare, Uttar Pradesh, March 2009.

- 2) Lack of clarity among health workers on what a maternal death is.

In this we note down the name of the person who died, date of the death, age, reasons—we note down if it is a child, but adults also sometimes we note down. If it is a pregnant woman who died then we note it down—we have to report it—any death during delivery or after delivery—within 6 or 8 hours after delivery ... If it is after that then we write the reason—there will be other reasons—fever or something else. Those are not maternal deaths. How can those be maternal deaths?
— Ratna R., health worker, Uttar Pradesh, February 26, 2009.

- 3) Poor continuity of care, essentially excluding from the records any deaths that happen during the immediate postnatal period or thereafter.
- 4) Jurisdictional concerns with health workers refusing to provide care or document deaths they do not see as within the purview of their care. Many health workers stated that they were instructed to provide JSY services to only those women who are married and residing in their husband’s homes.

This is Rohini’s *maikai*’s [mother’s house] village. So her death will not be noted here. We do not register women when they are in their *maikai*’s.
— Ratna R., health worker, Uttar Pradesh, February 26, 2009.

I do not have to note down her name because I did not attend her case.... Only *bahus* [daughters-in-law] of our village get registered. We are told in the training that we have to motivate only the *bahus* [for institutional delivery].... We get money if we motivate them for sterilization—150 rupees [US\$3] for every case. It does not matter where the woman is [for sterilization]. I learnt all this from the training.
— Pooja P., health worker, Uttar Pradesh, March 3, 2009.

- 5) Fear of disciplinary actions against health centers and workers that report deaths.

The tracking and monitoring [of maternal deaths] is very poor. How much can you expect one lady [referring to the government-appointed birth attendant, or ANM] to do? There is underreporting of [maternal] deaths. My personal experience has been that some ANMs hide deaths. They are busy—out for 10 days doing polio [administering vaccine]—they do not go to all of the villages. If there is a [maternal] casualty in this period, they do not report it.
— G. S. Bajpai, district surveillance officer, Uttar Pradesh, March 9, 2009.

- 6) Caste-based discrimination by health workers, which excludes many communities from care and therefore reporting.

Even when they [health workers] come they bring someone else who is a Chamar [Dalit community]. He is the one who gives polio [drops]. The nurse is Mishra [so-called upper caste] so she would not touch our children.
— Trishna T., woman who had recently delivered, Uttar Pradesh, March 7, 2009.

- 7) Poor reporting by private facilities that conduct about 20 percent of all deliveries in India.

In our research, we also visited Tamil Nadu, where authorities have taken measures to improve maternal death reporting and investigations. While the Tamil Nadu system has scope for improvement, certain positive features of the Tamil Nadu approach warrant consideration for possible adoption in other parts of India:

- Awareness campaigns around maternal health.
- Encouraging death reporting from multiple sources, including family members and health workers.
- Encouraging reporting of all deaths of pregnant women irrespective of cause of death.
- Targeted training for health workers on maternal death investigations.
- Focusing on all health facilities, public and private.

- Creating a conducive environment for reporting deaths, including by explaining to health workers the purpose of such reporting.
- Assigning a clear purpose to the inquiry—identifying health system gaps that need to be rectified.

A robust civil registration system that records all births and deaths, including cause of death, is essential for effective long-term monitoring of trends in maternal mortality and enforcing laws against early and enforced marriages that directly influence maternal health. India has a civil registration system put in place by Registration of Births and Deaths Act of 1969, that mandates recording of maternal deaths, but the system has not yet been implemented consistently. Uttar Pradesh has the worst civil registration system in the country. The latest report by the Office of the Registrar General on vital statistics for the period 1996-2005 has no information on Uttar Pradesh and indicates that no annual reports have been submitted. Since collection of vital statistics is a shared responsibility of the Indian central and state governments according to the Indian Constitution, the Indian central government has direct responsibility for the state of the civil registration system in Uttar Pradesh. For a country famed worldwide for its prowess in research, information technology, and medical sophistication, this shows not a lack of capacity but a lack of political will.

IMPROVING ACCOUNTABILITY: REFORMING GRIEVANCE AND REDRESS MECHANISMS AND CREATING EMERGENCY RESPONSE SYSTEMS

Our research also found that when women suffer preventable harms or have complaints about their treatment, they have no realistic avenue to raise their concerns and have them resolved. Too often, grievance and redress mechanisms, which should be empowering women and helping to identify gaps in maternal care, do not work. Such systems are vital not simply for holding to account those responsible for past violations but also preventing repetition of the same behavior in the future.

Problems with existing mechanisms for grievance and redress:

- 1) Women’s lack of awareness of their entitlements under the different schemes.
- 2) Absence of a clear complaints procedure with a time-bound inquiry period.
- 3) Absence of an early or emergency response mechanism to help families that experience difficulties in seeking appropriate care.
- 4) Poor access to any complaints procedure, especially for poor women with little or no formal education.
- 5) Lack of support to pursue complaints. For example, daily wage workers are unable to make repeated appearances before human rights or other commissions to present evidence.
- 6) Fear of reprisals from doctors and health workers where complaints are pursued.
- 7) Lack of independence at the time of inquiry.

Where obstacles rise in emergencies—such as when a woman requiring urgent care is refused admission to a facility because of discrimination or because she cannot pay—there should be a mechanism for alerting authorities immediately. Bolstering early response systems will allow people who can make a difference to get the necessary information when they need it.

Even where reforms have reduced maternal death and disease, a good grievance and redress mechanism can serve to warn against possible backsliding and address other concerns of women and girls seeking maternal care, including discrimination and mistreatment.

Appropriate mechanisms for individual redress may include compensation or other appropriate action where there is individual responsibility. Individual responsibility should not be limited to frontline health workers and doctors. Any inquiry into a complaint should also examine possible failures in planning and oversight at the district and sub-district levels.

SEVEN CONCRETE RECOMMENDATIONS

The Indian government is already committed to a human rights approach to preventable maternal mortality and morbidity and has shown this commitment in several ways. The Indian central and state governments are poised to play a leadership role among developing countries to strengthen accountability en route to achieving the Millennium Development Goal on maternal mortality reduction. This will go a long way toward recasting India’s reputation as a country with the highest number of maternal deaths in the world.

To this end, the Indian central government and Uttar Pradesh and other state governments should:

- Require that all healthcare providers, public and private, “notify” (formally report) all pregnancy-related deaths.
- Institutionalize under the NRHM a system of maternal deaths investigations. Investigations should identify systemic shortcomings and findings should be integrated into the planning and development of district and state-level plans.
- Revise the JSY monitoring indicators through a participatory and transparent process, ensuring that they track adverse pregnancy outcomes. The indicators should be in accordance with “United Nations Process Indicators” for availability and utilization of obstetric services.
- Appoint a full-time special officer to oversee the implementation of the civil registration system in Uttar Pradesh and create a special plan for implementation, including adequate funding.
- Develop, through a participatory and transparent process, a facility-based or regional system of ombudsmen to receive grievances and pursue timely redress. The mechanism should be easily accessible to women with little or no formal education.
- Develop early response systems, including a telephone hotline for health-related emergencies which women facing obstetric emergencies could use.
- Donor countries and international agencies should provide technical and financial assistance to promote notification and investigation of maternal deaths. They should also provide technical and financial assistance to ensure that all government health interventions, particularly interventions funded by them, are monitored and evaluated in accordance with UN process indicators.

No Tally of the Anguish

Accountability in Maternal Health Care in India

“Let this not happen to anyone else,” wept a mother-in-law who saw her pregnant daughter-in-law dying in a health facility. Another vowed never to go back again to a hospital.

Pregnancy is not a disease. Yet tens of thousands of women needlessly die every year because of pregnancy, childbirth, and unsafe abortions. More disturbingly they die uncounted, without leaving a trace of what happened to them. Most families accept these deaths as destiny or fate, not aware that as many as three in every four maternal deaths can be prevented if everyone has access to appropriate healthcare.

Even though India has joined the elite club of emerging global superpowers, far too many women and girls, particularly those who are poor or come from marginalized Dalit and tribal communities, continue to face severe barriers while trying to access life-saving healthcare. Many of them die in the process, not being able to afford even transport to a health facility.

Based on field investigations in Uttar Pradesh and consultations with experts and activists in other parts of India, *No Tally of the Anguish* examines those barriers and the reasons they persist. A key finding is that while authorities are taking important steps to improve access to maternal care, accountability systems—gathering necessary information on where, when, and why deaths and injuries are occurring; and responding to and addressing grievances in timely fashion—are not working. While accountability measures may seem dry or abstract, they literally can be a matter of life and death.

The report concludes with measures the Indian central government, Uttar Pradesh, and other state governments should take to ensure that their well-intentioned efforts meet the ultimate goal—of realizing women’s and girls’ rights to healthcare, including maternal health care.

The full report is available online at www.hrw.org.



Bidyawati, sister-in-law of Kiran Yadav, holds Kiran’s newborn son, Barabanki district, Uttar Pradesh. Kiran did not have timely access to a blood transfusion and died due to complications of childbirth.
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