Maternal Mortality – Indian Scenario

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“Whose faces are behind the numbers? What were their stories? What were their dreams? They left behind children and families. They also left behind clues as to why their lives ended so early”

Every minute a woman dies as a result of pregnancy or childbirth. The loss per annum of 500,000 women [1] is mind boggling. A maternal death is the outcome of a chain of events and disadvantages throughout a woman's life. Every time a woman in the third world becomes pregnant, her risk of dying is 200 times higher than the risk run by a woman in the developed world. The world has come a long way from the times when a woman surviving childbirth was considered to be blessed with a 'second life' to the present when, as the WHO theme for the year 2005 states, “every mother counts”! Maternal mortality figures have plummeted from thousands till a century ago to single digit values in some parts of the modern world. Unfortunately there is a big divide between the developed and developing world on this score of maternal mortality.

Maternal deaths: The Global Scenario

Maternal deaths, too often solitary and hidden events, go uncounted. This is not because of a lack of clarity in defining a maternal death, but because of an inherent weakness in the health information and recording systems. Estimates based on the systematic reviews of available information indicate a problem of considerable magnitude.

A majority of maternal deaths occur in Asia (253,000) and Africa (251,000). Thirteen countries account for 67% of all maternal deaths. India has the dubious distinction of having the highest estimated number of maternal deaths in any country (136,000). Developed countries in contrast have a maternal mortality ratio of around 20 per 100,000 live births [1]. Because of the rarity of maternal death in developed countries, “near misses” are incorporated in their audit systems. Near misses are defined as women who nearly died but, with good luck and care, survived. Incorporation of near

misses strengthens maternal mortality audits[2].

The Sri Lankan Experience

When Sri Lanka gained independence in 1948, its maternal mortality ratio at 630 was comparable to that of India. The MMR in Sri Lanka has shown a marked decline and as per estimates for the year 2000 is pegged at 57[3]. Other indicators of maternal health are equally impressive, 96% of deliveries are attended by trained personnel and 92% of all live births take place in government hospitals. These gains have been achieved through improving both geographic and economic access to institutional health services, availability of emergency obstetric care and non health strategies like female education and women empowerment.

The Indian Scenario

The National Health Policy(1982) aimed at reducing the maternal mortality in India from the over 400 per 100,000 live births to less than 200 per 100,000 live births by the end of year 2000. We, even in 2005, are far from this target [4]. According to RGI estimates for the year 2000, maternal mortality rate for India was 407 per 100,000 live births. The trend has not changed significantly in the last 5 years. This means more than 100,000 women die each year in India due to pregnancy related causes [5]. In the Armed Forces the scenario is very encouraging. In the year 2004, there were 10 maternal deaths amongst 27,215 deliveries, making a MMR of 36 per 100,000 live births. This reflects the importance of comprehensive health care and institutionalized deliveries. However, we should strive to further reduce this number to a single digit.

In India, hemorrhage (25.6 percent) ranks first as the cause of maternal death, followed by sepsis (13 percent), toxemia of pregnancy (11.9 percent), abortions (8 percent) and obstructed labor (6.2 percent) while other causes together total 35.3 percent.

Where are we wrong

Maintaining health care standards which are being

provided to our population at the grass root level in the rural areas requires interdisciplinary collaboration among doctors, midwives, auxiliary nurses and other paramedical staff. The provision of health care at the terminal end of our health provisioning system in the rural areas urgently requires a wilful political drive to improve the present scenario. The high MMR is due to large number of deliveries conducted at home by untrained persons. In addition, lack of adequate referral facilities to provide emergency obstetric care for complicated cases also contribute to high maternal mortality rate. The prominent gray areas in our society are the age at marriage and child bearing, child spacing, family size and fertility patterns, literacy, socio-economic status and also not to forget the customs and beliefs.

Strategies for change

Improving women's health requires a strong and sustained government commitment, a favourable policy environment, and well-targeted resources. The government's strategy should include balancing the roles of the public and private sectors to maximize resources and to extend care to women whom government programs do not reach. The challenge for the government is to help direct and improve privately provided services through appropriate regulatory arrangements and by encouraging an expansion of their scope to include promotion and prevention, in addition to curative care[6].

The unacceptably high maternal mortality rate in India can be reduced by making concerted efforts along the following lines: -

- Initiative from the government would be of paramount importance in this effort. This would include allocation of sufficient funds to all the health institutions including Primary Health Centers. Even more important is to ensure that the funds actually reach the users.
- Construction of better roads and transport facilities especially in the rural areas.
- Local dais and female health workers should be imparted periodic training and be incorporated as an integral part of health care system.
- Early registration of antenatal cases.
- Health education of couples to make them understand the importance of antenatal check ups,

hospital deliveries and small family norms.

- Wide spread availability of Iron – Folic acid tablets and fortified food to the remotest of remote area.
- Prevention and early treatment of infection, antepartum and postpartum haemorrhage.
- Treatment of concomitant illnesses like diabetes, tuberculosis and malaria.
- Emphasising the importance of observing proper aseptic measures while conducting deliveries.
- Providing facilities for hospital deliveries for high risk cases like severe anaemia, diabetes and heart disease.
- Accountability in case of the unfortunate event of any maternal death. Taking appropriate remedial measures for preventing lapses noted in the management of these cases will be of immense value in reducing the maternal mortality.

Conclusion

The existing health system does not adequately meet the needs of pregnant women, particularly for complications of pregnancy and obstetrical emergencies. Three major problems need to be addressed: an absence of links between communities, subcenters, and referral facilities; shortages of equipment and trained staff at referral facilities; and a lack of emergency transport. National government, donors, and nongovernmental organizations must commit to addressing policy barriers to reducing maternal mortality, including efforts to increase resources for health care systems.

References

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