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Inequities in Maternal Mortality Rate and its Implications in the State of Odisha: An Analysis

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Abstract:
Maternal morbidity and mortality along with infant mortality rate is universally considered as human development indicators in a country and determines the health status of the people. In spite of various plans and programmes, the reduction in MMR and IMR is much below the target rate. Odisha is one of the poorest states in India having MMR 358 per 1,00,000 live births as per SRS-2003 which is much higher than the national average and significantly contributing high MMR of the country. The poor health infrastructure and lack of skilled personnel/health professionals affect the effective delivery of maternal health care services leading to high maternal mortality and imbalanced growth in the society.

Keywords*: Maternal mortality, Maternal morbidity, human development, IMR, Odisha*

1. Introduction

Every minute, one woman somewhere in the world dies of pregnancy related causes. In India, every five minutes, a maternal death occurs. The death of a mother affects not just the immediate family but is a loss in economic as well as social terms to the nation. India's Maternal Mortality Rate(MMR) is as high as 407 maternal deaths per 100,000 live births, which is about four times higher than the National Population Policy(NPP) 2010 goal. Regional disparities in maternal mortality are wide. For example, maternal mortality is considerably lower in states like Kerala and Punjab. On the other hand, in some northern states MMRs exceed 400 per 100, 000 live births.

2. MMR in Odisha

In India, over a 100, 000 women die every year due to pregnancy or child birth related complications i.e one woman dies every five minutes.

The latest report on maternal mortality in India released by the Registrar General, India, shows that the MMR (maternal death per 100,000 live births) is 301 for India and 358 for Odisha. The improvement shown in the decline of MMR from 1998(SRS Survey) is 407 for India and 367 for Odisha, which suggests that it has reduced by 106 points at the national level and by 9 percents in the state. The declining trend of Odisha over the last decade is less than negligible. If the trend continues, then we may reduce it by another 10 points by 2015 (MDGs'Goal) making it 348.

The situation in Odisha is nothing short of alarming. The high incidence of maternal deaths is leading us to a situation where the development of the state is highly affected. The challenges thrown up by the high MMR in Odisha are varied.

In the above context, this paper attempts to examine the diverse and multiple factors responsible for high MMR in the state and its inequities in terms of their access to health care.

3. Methodology

It is an analytical study based on data drawn from NFHS – III and other governmental and non-governmental reports and surveys.

4. Factors Responsible for High Maternal Deaths in Odisha

The underlying causes of maternal mortality are poor health and nutrition, gender discrimination, lack of physical access to health care (including transportation & finances), medical causes, health determinants and socio-cultural factors that obstruct and underplay the importance of health care for women. The important factors are:

- Lack of access to and inadequate utilization of health care facilities, especially essential or basic emergency obstetric care(BEOC) services, is an important cause of maternal deaths.
- Absence of Skilled Birth Attendants at delivery is another factor contributing to maternal deaths and complications. Skilled personnel attend to only above 40% of deliveries in Odisha. In some districts, the figure drops to 5 – 10 %.
- 60% of all maternal deaths occur at domiciliary set up, yet, less than 20% of women in Odisha receive any post-partum care.
- Unsafe abortions contribute to nearly 10% of all maternal deaths.

- Lack of blood transfusion facilities at Health Centres increases maternal deaths. In Odisha, 38% die due to excessive bleeding.
- Lack of support from men and other members of the family leads to poor utilization of pre-natal, natal and post-natal services by pregnant women. Only 52% of women are involved in decision making on their own health care. Participation of males is almost negligible in the reproductive life of a woman.
- Socio-economic factors like early marriage (about 50% of women in Odisha are married below the age of 18 years) results in early pregnancy, which greatly increases the risk of maternal death. A disproportionately high number of maternal deaths - around 24% - occur among young mothers aged between 19 – 25 years, where use of contraceptives also lessens during this age groups.
- Short birth intervals results in complications that cause maternal deaths.
- Inaccessibility to health care services in tribal areas, where 23% of the population of Odisha lives.
- Odisha being a disaster prone state declines the health status during the improvement process preventing the socio-economic status to develop.

Let us analyse the situation from a statistical point of view giving incidences of high MMR in different pockets of Odisha and their factors.

As per NFHS – III, institutional delivery in the state is 39% and data from CNNAA for the year 2005 – 2006 shows institutional delivery at 43.05%.

5. Maternal Health

Average age at first birth for women aged 25-49	Percentage of mothers who had 3 or more ante-natal care visits	Percentage of pregnant women aged 15-49 with anaemia	Percentage of women with below normal Body Mass Index	Percentage of births attended by skilled health personnel	Percentage of institutional births	Percentage of mothers given post-natal care within 2 days of birth
20	60.9	68.1	40.5	46.4	39	38.3

Table 1: Maternal well-being, 2005 – 2006
Source : NFHS-3(2005-2006), Odisha

	Urban	Rural	Total
NFHS – 1	47	34	36
NFHS – 2	54	46	47
NFHS - 3	59	49	51

Table 2:Trends in Contraceptive Use in Odisha (%) (Currently Married Women 15 – 49)
Source: NFHS-3(2005-2006), Odisha

States	Sample Female Population	Live Births	Maternal Deaths	MMR	Maternal Mortality Rate	Lifetime Risk
India	5039583	459631	1383	301	27.4	1.0%
Odisha	254176	20914	75	358	29.5	1.0%

Table 3: Live Births, Maternal Deaths, and Maternal Mortality Ratio in India by state from 2005 – 2007 Special Survey of Deaths shows
Source :SRS-2005-2007

6. Strategy Taken

Taking community need assessment approach as a base, all the services were unified by the Govt. of India in October 1997 and Reproductive and Child Health Programme was started, so that reproductive health, including the period of pregnancy, child birth and post-natal period and child health, could be made available to the people. Services to be made available under this programme with an objective to decrease birth rate, death rate, infant mortality rate, child mortality rate and maternal rate and full care of pregnant women and to increase the safe delivery rate are:

- Care of pregnant women – pre-natal, natal and post-natal services.
- Immunization against 6 vaccine preventable diseases i.e TB, Diptheria, Tetanus, Polio and Measles and 5 doses of Vit- A to children.
- Distribution of IFA tablets for Anaemia against pregnant women.
- Treatment of Diarrhoea and Pneumonia in children.
- Spacing methods-permanent and temporary.
- Positive male involvement.
- Provision of contraceptives and knowledge of use.
- Emergency Obstetric Care Services.

- Nutritional counselling and distribution of supplementary foods.
- Environmental sanitation.
- Use of safe drinking water.

Management of Reproductive Tract Infections and STDs like AIDS.

The RCH Programme was taken over under NRHM on 17th April 2005 and its objectives were broadened and strategies made more target oriented. Reducing maternal mortality is one of the key objectives of the National Rural Health Mission. The Mission pledges commitment to a series of health system reforms and community outreach processes upgrading peripheral health centres in accordance with quality public health standards, decentralizing technical functions to the ANMs and motivating women and families at the community level through a combination of awareness raising measures and incentives to access services through and after pregnancy.

7. The Key Components of NRHM Are

- Creation of a cadre of voluntary, female ASHAs in Odisha. ASHAs will help and guide women to access health facilities for antenatal care, institutional delivery, postnatal care and counselling on nutrition and family planning services.
- Creation of a village health team and preparation of a village health and sanitation plan in all districts.
- Upgrading of CHCs to meet the Indian Public Health Standards in all Districts.
- Establishing blood storage centres at First Referral Units (FRUs).
- Integrating health and family welfare programmes under the NRHM at national, state, and districts level in all states.
- Assistance to states to operationalize 50 percent of the PHCs as 24 – hour functional units in a phased manner. These PHCs will be responsible for providing round the clock delivery services, including the management of common obstetric complications, emergency care of sick children and referrals.
- Strengthening programme management capacities under NRHM at State, and District levels.
- Institutionalizing district level health management system in the state.
- Supply of generic drugs to Sub Centre, Primary Health Centres and community Health Centres.
- Janani Surakshya Yojana (JSY) under the umbrella of NRHM, has been introduced with the vision of reducing MMR and IMR and increasing institutional deliveries.
- Mamata Yojana has been introduced as part of Safe Motherhood Programme and for enhancing institutional deliveries.
- The Government has recently issued guideline for ANMs/LHV/Staff Nurses to use certain drugs for specific situations as interventions.
- Doctors at FRUs are to be trained in providing emergency obstetric care which includes caesarean section and training in anesthesia.

8. Initiatives Taken by the State to meet MDGs

- Besides special schemes like Navajayoti, Odisha has played a pioneering role in involving NGOs in Health Sector Mission Services during the last five years after the launching of NRHM. THE State has involved 21 MNGOs and 122 FNGOs in the state covering 30 districts to provide RCH services in the un/underserved sub-centres identified by the state Government.
- Intersectoral convergence with Women and Child Development, Education, Panchayati Raj and Rural Development Departments for effective implementation of schemes.
- Public Private Partnership initiatives are also being taken in inviting NGOs for PHC management.

9. NRHM Progress so Far

- The number of ASHAs has been upgraded to 33516 (97%) to deliver services.
- The number of JSY beneficiaries in the state is 2,36,306 out of which 72,428 are assisted by ASHAs.
- Rogi Kalyan Samitis are being formed at PHC to ensure better management of health services. 371 Samitis are registered by now.
- Provision of Mobile Health Units to provide preventive, promotive and curative health care in inaccessible areas under process.
- To revitalize local health traditions, the Govt. is mainstreaming AYUSH by providing infrastructure, manpower and drugs to strengthen the public health system. So far, 100 AYUSH doctors have been trained at Block PHCs/CHCs and 200 paramedics.
- In the first phase of upgradation of PHCs to IPHS standards, 69 PHC.CHC have been upgraded.
- To make the FRUs functional, multi skilling training of Medical Officers in Anesthesia and obstetric care is going on.
- In order to enable the PHCs to provide round the clock service, staff nurses have been provided in 131 PHCs by now.
- Advocacy and sensitization initiatives have been started for effective implementation of the programmes.
- State and District level technical teams have been formed and operationalized for monitoring and evaluation.
- Training for skilled attendants at birth is under process.

10. Progress in RCH-II

The focus of RCH – II lies in reduction of maternal mortality and morbidity with emphasis on gender, urban health care, adolescent health and public health,, PPP is a supportive focus area. Flexible financing, decentralized planning, improved management capacity are some of the innovations.

11. Under RCH – II the Progress so Far Is

- Renovation and repair of 404 sub centres, 35 PHCs, and construction of 55 sub centres.
- 196 RCH camps in 30 districts.
- 320 no. of Swasthya Melas in 11 tribal districts.
- Workforce management by providing additional support to 17 districts i.e. 1275 ANMs and 60 LTs.
- 21 MNGOs and 122 FNGOs are supported with funds for better mobilization services.

12. Progress by Other Agencies

- Developmental agencies like UNICEF, UNFPA, DFID, CARE and other agencies are working in tandem with the government, policy makers, civil society networks and community towards meeting the target of MDGs 4 & 5.
- Civil society and statutory bodies like White Ribbon Alliance – Odisha Chapter, Nehru Yuva Kendra, State Commission for Women, etc. are engaged in different advocacy programmes for reducing maternal and infant mortality of the state.
- Media sensitization by different agencies is also playing a major role in working as a pressure group on the system and highlighting the policy to implementation gaps for further interventions.

Despite the above efforts, the Maternal Mortality Rate (MMR) continues to be unacceptably high in Odisha and has shown no signs reduction in the past one decade. More than good quality health services, what are required are empowerment of women and a guarantee of their human rights, right to life, liberty and security to have access to appropriate health care and the right to survive child birth irrespective of their location and distance.

13. The Way Forward

- Empowering women in decision making process.
- Increase in women's literacy rate
- Economic independence of women
- Make women know their entitlements and reproductive rights
- Establishing gender equality in the society
- Ensuring positive male participation
- Addressing adolescent health problems
- Reducing nutritional deficiencies and anaemia
- Facilitation of gender equity
- Improve sanitation and hygiene
- Improving accessibility and affordability of services and making them available at the doorstep to prevent maternal deaths
- Upgrading emergency healthcare systems

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