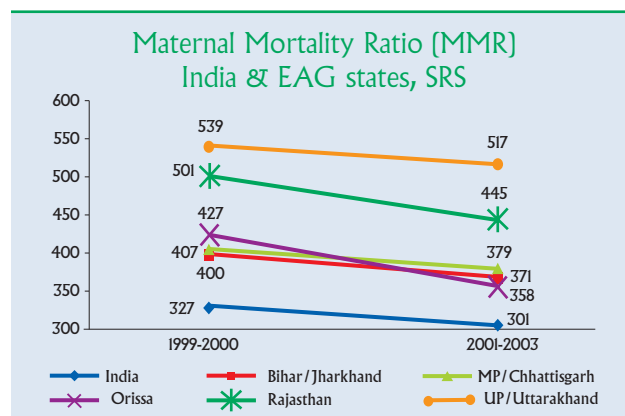


# Maternal Health in India

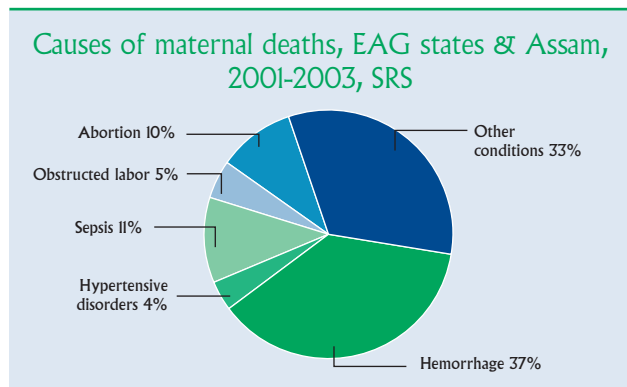
Preventing deaths to mothers associated with pregnancy and childbirth is one of the greatest challenges before the nation in the 21st century. Despite substantial improvements in life expectancy at birth for the Indian population from 41 years in 1961 to 63 years in 2003, the maternal mortality ratio continues to be unacceptably high at 301 per 100,000 live births\*. The Millennium Development Goals for 2012 call for the reduction of maternal mortality to 30/100,000 live births, one-tenth the current rate.

## Did you know?

- India has the highest number of maternal deaths in the world with 117,000 women dying due to complications of pregnancy and childbirth each year‡. That is one woman dying every 7 minutes‡.
- The life-time risk of a woman in India dying during pregnancy, delivery and through the first six weeks after delivery is 1 in 70. The risk to women in India is 2 times greater than that faced by women in the Asia region, 60 times that of women in developed countries, and over 600 times greater than for women living in Sweden‡.
- Maternal death ratios are highest in the eight Empowered Action Group States of Rajasthan, Jharkhand, Uttar Pradesh, Bihar, Uttarakhand, Chhattisgarh, Madhya Pradesh and Orissa\*.
- The decline in Maternal Mortality Ratios in the States with most need has been slow.

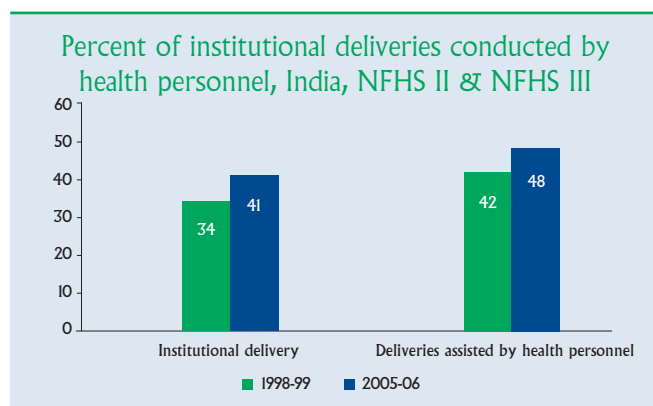


- The major causes of maternal deaths are hemorrhage, puerperal sepsis (infections after delivery), complications of abortion, obstructed labor, and hypertensive disorders associated with pregnancy\*.



- Most maternal deaths occur between the last three months of pregnancy and the first week following delivery. The highest number of deaths occur on the first day after delivery.
- Maternal care practises continues to be a cause for concern in India. Lack of required services, poor quality of services and reluctance to use services are major barriers to use of maternity care service.
- Maternal deaths occur due to a number of delays: delays in seeking care; delays in reaching appropriate care, usually requiring a series of referrals to reach a facility capable of managing emergencies; and delays in receiving emergency obstetric care at the facility due to non-availability of skilled health personnel, equipment and supplies required for managing emergencies.
- Many women reach health facilities too late and in such serious condition that medical interventions are not effective.
- Fewer than half of deliveries (41%) are conducted in a health facility†.
- Skilled assistance by medical personnel during

delivery remains low at 48%. These rates are startlingly low when compared to the Asia region as a whole and developed countries where 95% and 98% of deliveries are by skilled attendants. Progress in use of skilled attendance between 1999 and 2005 has been slow<sup>†</sup>.



- The institutional deliveries among mothers belonging to lowest quintile of wealth index remain dismally low at 14% and of scheduled tribes (STs) at 20% compared to 85% of mothers of wealthiest households<sup>†</sup>.
- Only 36% of mothers reported receiving post natal care from health personnel within 2 days of delivery of their last birth. This was as low as 13% for the lowest quintile and 22% for ST women in the country<sup>†</sup>.

### What we know that works

- Well informed and prepared women and family decision-makers that seek obstetric care services without delay at the nearest health facility with obstetric emergency care.
- Attendance at delivery through the first 48 hours by skilled health personnel backed by 24-hour availability of comprehensive emergency obstetric care, along with antenatal care.
- Maternal health services made affordable and accessible to the most vulnerable and marginalized groups using targeted strategies for the poor such as eliminating user fees and or hidden costs, increased government investment, and providing government subsidized insurance schemes that include maternal health services.

- High quality maternal health services that treat the most vulnerable with humanity and respect.
- Sustained strong political and technical leadership championing change and increases in resource allocation for improved maternal health.

### What more is needed

- A better understanding of the subtle and indirect societal, social, psychological, geographic and biological factors that influence maternal health outcomes that go beyond poverty to address why some poor groups have worse outcomes than others.
- Good information and strong management systems within facilities to avert deaths, to process lessons learned, and to document causes of maternal deaths and the chain of events leading to maternal death.
- Effective ways to routinely track progress in maternal outcome within facilities and at the community, district, and state levels.
- Maternal health interventions targeted at the most vulnerable populations with maternal health outcomes monitored to ensure equity.
- More evidence on the effectiveness, sustainability and impact of innovations such as conditional cash transfers and vouchers.
- Evidence on what works in scaling up proven maternal health services.

### References

\**Maternal Mortality in India: 1997 – 2003, Trends, Causes and Risk Factors, Sample Registration System, Registrar General of India in Collaboration with Centre for Global Health Research, University of Toronto, Canada, October 2006*

\**The White Ribbon Alliance for Safe Motherhood, <http://www.whiteribbonalliance-india.org/>*

\**Maternal Mortality in 2005: Estimates developed by WHO, UNICEF and UNFPA and the World Bank, WHO, Geneva, 2007*

<sup>†</sup>*National Family Health Survey (NFHS 3), 2005 – 06, India: Volume I, International Institute for Population Sciences, Mumbai, September 2007*

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