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Efforts of NGO – Preventing Maternal Mortality in India

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In recent years there has been a growth of Non-Government Organisations (NGOs) in India. NGOs have been successful in reaching the poor and reducing mortality and fertility. As innovators and experimenters, NGOs have the potential to help operationalize the reproductive and child health (RCH) Programme. The paper discusses strategies for reducing maternal mortality drawn from NGO experiences. Issues related to the safe motherhood programme are raised. Attention is also drawn to the problem of stagnating maternal mortality. The paper appeals the government to form new partnerships with NGOs. NGOs should also develop new coalitions and allies to address emerging challenges.

The non-government sector in India

A growing interest among government and donors in health and development initiatives of the non-government sector reflect to a considerable degree, a growing disenchantment with the public system. A vigorous non-government sector, as is present in India, is indicative of the acknowledgement on the part of government that some social functions are outside its legitimate control. In the field of health, there has been a significant growth of NGOs in the country over the past two decades. The 1970s witnessed the emergence of a new breed of NGOs -- several of whom took on the challenge of translating the concepts of equity, social justice, community participation, and integrated development, embodied within the primary health care concept. Through community-based, people-oriented programmes targeted to the poor, NGOs were able to demonstrate the feasibility and effectiveness of alternative health care models that were successful in reaching the unreached and serving the unserved.

The 1980s were characterized by three significant changes in the NGO sector: First, since it had become abundantly clear that fundamental changes in attitudes, values, social structures -- and perhaps political thinking itself were necessary to address questions of social change, empowerment, conscientization, and participation became important NGO strategies. Second, a growing constituency of women's NGOs began to incorporate the gender factor along with class, caste and economic concerns in their grassroots initiatives by combining twin strategies of struggle and development to address the problems of poor women. And third, professionalization of the NGO sector in this period resulted in the development of intermediary organizations that began to undertake several support functions including training, advocacy, research, publication and documentation. There has since been a growing professionalization of voluntarism.

Through these processes, the NGO sector built up a body of knowledge and practice on how to identify the poorest in the community and how to involve them in the process of development. Through innovative training and communication strategies, NGOs demonstrated that illiteracy need not hinder the successful involvement of people in

solving their own problems and that women are not only important clients for health and Family Planning programmes, but are also an important resource for development.

The successful experience of NGOs in reducing mortality and fertility resulted in their, developing credibility with government, and NGO leaders began to increasingly interact with policy-makers. NG0s began to assume a higher profile in policy advocacy. In recent years, and particularly since the Seventh Five-Year Plan period, the government has increasingly consulted NGOs in policy formulation. But while NGOs demonstrate several strengths, they also suffer from many weaknesses. NGOs have high motivation and social commitment, sensitivity to the poor, flexibility, and innovativeness -- attributes that have enabled them to develop programmes that are more responsive to the needs of the communities they serve and are, therefore, better accepted and more effective. But their impact is limited and scattered because of the scale of their operations and they have problems of weak management, inadequate technical inputs, isolation, limited professional interaction and financial insecurity.

As the government moves forward to operationalize the Reproductive and Child Health Programme in India, the need to work in partnership with NGOs will enhance. New modalities for working as allies must, therefore, are developed by government, NGOs, and donors. NGOs have the responsibility, as innovators and experimenters, to field-test new strategies -- an urgent need for operationalizing reproductive health services. Maternal and child health services form an integral part of reproductive health programmes. In the past, several NGOs have focussed their efforts on designing services targetted to women and children.

The essence of the NGO approach has been to mobilize, empower, and conscientize people. Through their community-based programmes, NGOs have important lessons to offer, particularly about how to identify the poorest in the community and how to involve their participation in the process of development. The following are some characteristics of successful NGO initiatives:

- NG0s are flexible and responsive to the needs of the communities they serve, particularly needs as perceived by the people.
- An explicit effort is made to listen to and learn from the people, especially women whose voices are otherwise not heard.
- Grassroot workers from the community are used as change agents and are trained to provide services to the unserved.
- A strong thrust of NGO programmes is on empowering women both as users and providers of health services.
- There is a special focus on generating a demand for services, improving service quality and designing services to address user's needs.

While examining the achievements of government and NGOs in reducing maternal and child mortality, it was identified that lack of access to health care by poor women and children as a key factor.

It has been widely observed that in contrast to government programmes, NGOs have implemented health delivery strategies that specifically aim to reach the poor and to stimulate a demand for services. Personnel who deliver these services have played an

important role. NGOs have recruited field workers from within the community and have made special efforts to involve women. Training of workers has been geared to problem solving. They have been well supported and supervised and have been accountable to the programme as well as to the community. NGOs have also instituted effective community-based monitoring and surveillance systems to estimate workloads, enable planning of realistic schedules for workers, facilitate monitoring of programme coverage and utilization, and provide outcome indicators to reflect programme impact. Village workers provide first level of care, generally by women who can best deal with health problems of women and children. Second level care is usually provided through mobile health teams that visit villages at fixed schedules. At the third level, in most cases, there is a base hospital where critical problems encountered at the first and second levels are referred and attended to. This strategy lends itself to continuing education, supervision and monitoring and ensures equitable access to health care.

Health status of women

Poverty underlies the poor health status of most of the Indian population, and women represent a disproportionate share of the poor. Women's relatively low status (particularly in the north) and the risk associated with reproduction exacerbate what is already an unfavourable overall health situation. Since the turn of the century, India's sex ratio has become increasingly favourable to males. This is in contrast to the situation in most countries, where the survival chances of females have improved with increasing economic growth and declining overall mortality. In India, excess female mortality persists up to the age of 30-a symptom of a bias against females. But there are wide disparities in fertility and mortality among states and within states, between rural and urban areas.

Maternal mortality in India, estimated at 437 maternal deaths per 100,000 live births, results primarily from infection, haemorrhage, eclampsia, obstructed labour, abortion, anaemia, toxemia and others. Lack of appropriate care during pregnancy and childbirth and especially the inadequacy of services for detecting and managing complications, explains most of the maternal deaths. Reliable data on mortality and morbidity in pregnancy are scarce, and for female morbidity in general, they are almost non-existent. The limited studies available report high morbidity and malnutrition among girls and women. Emerging evidence indicates that the prevalence of reproductive tract infections is considerably higher than previous figures suggested and that the spread of HIV/AIDS is a concern. Iron-deficiency anaemia is widespread among Indian girls and women and affects 50 to 90 percent of pregnant women.

Female mortality and morbidity rates are linked to overall fertility levels--in India, 3.4 children per woman. Childbirth closely follows marriage, which tends to occur at young ages: 30 percent of Indian females between 15 and 19 are married. Childbearing during adolescence poses significantly greater health risks than it does during the peak reproductive years and contributes to high rates of population growth. Indian women also tend to have closely spaced pregnancies. Some 37 percent of births occur within two years of the previous birth, endangering both the health of the mother and the survival of the infant and older siblings.

Maternal mortality continues to be uniformly high since interventions for saying women's lives when threatened by problems during pregnancy and delivery have yet to be seriously

implemented. Strategies to address the heavy load of reproductive morbidity among women have, so far, received little or no attention. Gender disparities resulting in low status of women have manifested in adverse sex ratios and have seriously impacted on morbidity and mortality; women continue to bear a heavy burden of ill health in India.

Programmes to reduce maternal mortality

Although Maternal and Child Health (MCH) services form an integral part of the government's Family Welfare Programme, so far efforts have focussed primarily on improving child survival. Maternal health has suffered from relative neglect in this programme. There is, therefore, an urgent need to strengthen maternity care services. The government's relatively recent initiative, the Child Survival Safe Motherhood (CSSM) Programme, an effort to redress this neglect, should receive strong emphasis.

The principal objective of the safe motherhood programme is to prevent maternal deaths. Maternal mortality, a neglected tragedy, affects women who are doubly disadvantaged by both poverty and gender. The causes of maternal mortality are deeply rooted in the adverse social, cultural, political and economic environment of society and especially the environment that society creates for women. Poor health is a reflection of the disadvantage and discrimination that women suffer from birth through childhood, adolescent and adult life. Therefore, these deep-rooted causes must be addressed through broad-based policies that aim to improve women's health and improve women's status.

In recent years, a growing constituency of NGOs and women activists in India has begun to draw attention to the importance of women's empowerment and reproductive rights for improving reproductive health. They believe that women's voices must be heard by policy planners and that women's views, which have so far been missing in policy debate, must be incorporated within policies and programmes that are designed for them. They demand that women's confidence and ability to make reproductive health decisions should be enhanced and that women's health and reproductive needs should shape the health and Family planning services that they receive.

Safe Motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. More than 60 percent of maternal deaths take place in the period immediately following delivery, with more than half occurring within a day of delivery. Preventing and managing these problems requires a well-functioning health system that provides accessible, high-quality care--from the household to the hospital level. In addition, a range of social, economic, and cultural factors also contribute to women’s poor health before, during, and after pregnancy.

A number of barriers limit women’s access to care, including:

- **distance and lack of transport:** Nearly 80 percent of rural women live more than five kilometres from the nearest hospital, and many have no way to get to health facilities except by walking – even when they are in labour.
- **cost:** Millions of women cannot afford to use services, even when fees are low or services are delivered for free. This is due to additional, often hidden, costs patients must cover – transport, drugs, medical supplies, and even food and lodging for themselves and their families.

- **interactions with providers:** Too often health care providers are rude, unsympathetic, and uncaring. They often do not respect women's cultural preferences, e.g., for privacy, birth position, or treatment by women providers.
- **socio-cultural factors:** Women in many areas of the world lack the power to make choices about their health and lives, with negative consequences for maternal health. Tradition, family mores, and even laws limit women's decision-making and rights with regard to childbearing, contraception, initiation of sexual relations, and if and when to seek medical care. In some settings, a husband's permission is required for women to receive health services, including life-saving care; in others, mothers-in-law decide whether women can use available services.

The safe motherhood programme has a three-fold focus

- To strengthen community-based maternal health care;
- To organize referral facilities for the treatment of complicated deliveries; and
- To institute an alarm and transport system to promptly transfer women who need emergency care to a referral facility for effective treatment.

A major thrust of the programme is to strengthen first level referral facilities to handle obstetric emergencies. The assumption is that the care women receive during labour and delivery often determines whether they live or die. By some estimates, better care during labour and delivery could prevent 50 to 80 percent of maternal deaths. Since facilities to handle obstetric emergencies are not accessible to the rural poor, an important first step is to identify institutions within reach and to strengthen them so that they can effectively provide essential obstetric functions.

The safe motherhood programme is based on the premise that emergency medical care must be the centrepiece of any plan to ensure that women can give birth safely. The assumption is that primary health care alone is not the solution for preventing maternal mortality in the developing world. Without widespread access to emergency medical care to treat the most common life-threatening obstetric complications, no amount of primary health care will substantially improve a woman's chance of safely giving birth. Although the majority of the women give birth without any serious problems, as many as 10 percent of women whose pregnancies appear normal, develop serious complications during labour and delivery . These women need to be moved quickly to health care facilities that are equipped to manage these complications.

If specialized health services are to become a major plank for promoting safe motherhood, it is important to examine past experience with the health care system in India. During the past 40 years, even though the government has successfully established a countrywide network of health services, the vast majority of deliveries in India are still conducted at home by Traditional Birth Attendants (TBAs). As recently as in 1992-93, no more than 16 percent of all rural births were conducted in institutions and as many as two-thirds were delivered by TBAs.

Therefore, there are serious questions regarding the feasibility and desirability of providing institutional care for all deliveries: First, birth is considered a normal event that does not require institutional care in most cases; many women prefer to give birth at home in familiar surroundings. Second, normal deliveries can be safely conducted at home by TBAs provided that they are trained. And finally, in the foreseeable future at least, India is

not likely to be in a position to afford institutional care for all births even if this was considered a desirable goal. It can, therefore be assumed that in the years to come, traditional systems will continue to dominate the rural scene in India.

Therefore, the strategy should be to effectively integrate traditional and modern health care systems so that maternal mortality can be prevented. Integrating systems with vastly different ideologies and cultures is clearly a difficult task. Effective integration requires that health care providers from both systems learn to work together as partners and colleagues. The role of NGOs is crucial in this endeavour. Most government TBA training programmes have had limited success. These programmes have attempted to improve the level of knowledge and skills of the TBA but have done little to bridge the wide socio-cultural gap between traditional and modern practitioners. On the other hand, several micro-level projects, especially in the NGO sector, have shown that when this gulf between the TBA and the formal health system is bridged, TBA training programmes can be much more effective.

The role of Family Planning and Safe Abortion Services to promote Safe Motherhood

Expanding family planning services is an important strategy for decreasing pregnancy-related mortality and morbidity. The maternal mortality rate could be reduced significantly by decreasing the number of pregnancies, by spacing births and by delaying the age at first pregnancy. Estimates show that if all women who state that they want no more children were able to avoid future pregnancies, there would be a substantial decline in maternal mortality.

However, even with vigorous Family Planning programmes, there will always be some unwanted pregnancies, and therefore, a demand for abortion. High levels of maternal mortality associated with clandestine, unsafe abortions can be prevented by enhancing women's access to safe abortion services. The conceptual link between Family Planning and abortion is fundamental. Effective contraception is an important means of preventing unwanted pregnancy and so preempting the need for abortion but in the absence of safe contraceptive backup women will continue to be forced to employ unsafe means for terminating unwanted pregnancies with attendant high maternal mortality and morbidity.

Although unsafe induced abortion is the greatest single cause of mortality for women it is also the most preventable. Of all the major causes of maternal death, those that lead to abortion deaths are the best understood. Women need not die or suffer medical consequences from abortions because abortions do not kill women; it is, rather, unsafely performed abortions, which kill.

While abortion was legalized in India twenty years ago, it has remained a neglected problem by both government and NGOs. Access to safe abortion services for poor, women, especially in rural areas, remains problematic. NGOs, and especially women's groups, should strengthen and stimulate policy advocacy work to bring this neglected area on the public policy agenda.

Maternal malnutrition is an important determinant of pregnancy outcome. Anemia, a major cause of maternal and perinatal mortality, antedates pregnancy, gets aggravated during pregnancy, and the repeated succession of rapid pregnancies and lactation perpetuate the

problem. Studies show that women continually bear an enormous burden of anemia. In a WHO study for instance, the mean hemoglobin level reported for all ages and parity groups in India was 7.5 gms/dl or less . While, the anemia prophylaxis programme in India has targetted women only during pregnancy, waiting to treat anemia until pregnancy, when haemoglobin drops physiologically, ensures that more women will have more severe anemia. Anemia continues to be widely prevalent because nothing is done to improve the nutrition of the young girl, the growing adolescent, the married woman before her first pregnancy, between pregnancies and after pregnancy . To prevent anaemia, programmes for nutrition education and micronutrient supplements such as iron and folic acid, should be targeted to all women in the reproductive age group and also to adolescent girls.

Programmes to reduce the impact of HIV/AIDS and STDs in women

Since AIDS and STDs can seriously affect the health of the mother and the newborn child, their diagnosis and management during pregnancy is particularly important. Sexually transmitted infections can result in infertility, chronic pelvic inflammatory disease and ectopic pregnancy and can adversely affect child survival by causing pre-term delivery of low birth weight, immature infants. The special risk of HIV in women, particularly during pregnancy, the increasing number of HIV infections resulting from mother to child transmission, the rising numbers of AIDS affected children, and the fact that the AIDS virus can be transmitted through breast milk, are problems that have serious implications for maternal health and child survival.

During the past few years, 30 to 50 percent of AIDS cases globally have been women in the reproductive age group AIDS has become one of the leading causes of death in women 15 to 44 years of age in the United States. Recent research in developing countries shows that sexually active women under 20 have higher risks of HIV infection than older women or younger men; one possible reason could be that the reproductive tract of teenage girls is not as developed and leaves them more susceptible to sexually transmitted infections. Their thinner vaginal mucous membranes are a less efficient barrier to HIV. In developing countries, women are infected on an average 5 to 10 years earlier than men because cultural, economic and physical characteristics place teenage girls at greater risk. The initial presenting symptom of many HIV positive women is an RTI such as vaginal candidiasis.

Reported rates of perinatal transmission for HIV range between 15 and 50. Such adverse pregnancy outcome has been attributed to the larger proportion of cases with advanced disease and factors such as inadequate antenatal care, and poor access to treatment. HIV has been isolated from the fluid as well as the cellular histiocytic component of breast milk and recent studies have documented HIV transmission through breast milk These findings have significant public health implications, particularly for MCH programmes.

NGOs have been on the forefront of action to prevent HIV -- trying to address the multiple medical, social, legal, ethical and policy dimensions of the problem NGOs are working with sex workers, their clients, drug abusers, youth, migrant workers, industrial workers and women. In the years ahead, the impact of AIDS will intensify and the ways in which society responds will affect its spread. Large-scale community-based responses will be needed to address a range of sensitive issues such as sexuality, gender roles and family relationships. And since in the foreseeable future, changing sexual behavior is the only

available intervention for its prevention and control, organizations that are close to the people and can work most efficiently with populations that are especially vulnerable, will have an important role to play. As the demands on NGOs and community organizations escalate and these agencies begin to take on a major share of the responsibility for the prevention and control of AIDS and other sexually transmitted diseases (STDs), government and donors will need to develop new partnerships to jointly address the serious social, economic and health consequences of the AIDS crisis.

Conclusion

At present, India is in the midst of an epidemiological and health transition wherein diseases of affluence and new environmental and behavioural threats are being added to the already heavy burden of morbidity due to communicable diseases and malnutrition. Multiple factors are involved in India's health transition, including the aging of the population; urbanization and migration; changing lifestyles; and the impact of health interventions.

To respond to these changing needs, NGOs are emerging as an increasingly visible force in the health scene in India. They are increasing in numbers and are taking on additional activities beyond their traditional areas of involvement. In the years ahead, the frontiers of voluntary action are likely to change with changing health needs, unfolding new dimensions of voluntarism. There will be increasing demands on NGOs to become more sophisticated and professionalized. Therefore, a high priority should be to strengthen their institutional capacities so that they can he more effective in their multiple roles in addressing new challenges. For example, the recent shift in policy toward democratic decentralization in India, with a promise of transfer of power and delegation of authority to districts and panchayats, will provide new opportunities for NGOs to work for the democratization of institutions at the district and village levels. These initiatives require that NGOs develop new allies within the system and form coalitions to broaden the base of political, economic and social participation.

So far, government and NGOs, have for the most part, operated on parallel tracks even while pursuing common goals. Over time, the relationships between the government, donors, and NGOs have been continually evolving and undergoing qualitative changes. While the tensions and conflicts between them are not easily resolved, a growing interdependence of these institutions in their efforts to address the multiplicity of emerging health and development challenges will require much greater interaction and exchange to find solutions to problems of common concern. With the implementation of a reproductive health approach there is an urgent need to identify new institutional mechanisms to facilitate greater collaboration between government, donors, and NGOs -- mechanisms that can allay concerns about co-opting NGOs and undermining their spirit of voluntarism.

Partnerships must be evolved based on trust as well as on a realistic understanding of the strengths and shortcomings of the government and non-government sectors. In the past far-sighted and well-conceptualized policies of government have often been fraught with weak implementation. The government should recognize its limitations and make a concerted effort to forge alliances with a range of institutions including the corporate sector, educational and research institutions, NGOs, panchayats, and most importantly with the people, to achieve its goals. There should be a strong focus to decentralize and devolve

power to the people so that their participation is sought in all efforts to improve their quality to life. The involvement of NGOs as partners to achieve these ambitious goals is inescapable. There is an urgent need for government and NGOs to develop modalities for working harmoniously.

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