

Speech by Shri Dinesh Trivedi, Minister of State for Health and
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High – Level Meeting on Maternal Health MDG 5
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Excellencies Madam Thoraya Ahmed Obaid, Mr Bert Koenders, Fellow Parliamentarians, distinguished guests, ladies and gentlemen, I am very pleased to be here with you all in this High–Level Meeting on the crucial issue of Maternal Health - Millennium Development Goal 5. It is an excellent forum to share our experiences and to generate an action oriented vision to speed up the attainment of Millennium Development Goal 5.

Sexual and reproductive health problems account for 18% of the total global burden of disease and 32% of the burden among women of reproductive age 15-44 worldwide. Every minute a woman dies of pregnancy-related complications, including unsafe abortions, almost all of them in our developing countries. The issue is of great concern to us in India where around 25 million women go through childbirth each year. The maternal mortality has been unacceptably high; with huge disparities across states and regions, as well as within states across different socio economic groups. While maternal mortality has been greatly reduced in some states of India such as Kerala, Tamil Nadu, West Bengal and Maharashtra, it remains quite high in states such as Assam and the northern belt states (Uttar Pradesh, Bihar, MP and Rajasthan).

It is well known that obstetric complications are the leading cause of death for women of reproductive age in developing countries. One third of all pregnant women receive no health care during pregnancy; 60 per cent of deliveries take place outside of health facilities; only half of all deliveries are assisted by skilled birth attendants. This issue can however, not be seen in isolation. Evidence shows that the reproductive health strategies will succeed in improving women's health and enabling them to make socially viable fertility decisions if they are set in the context of an overall supportive health and development agenda. Situations, where general

health and social development are poorly funded or given low priority, reproductive rights and health are unlikely to get the funding or attention they deserve.

With this in mind, the **National Rural Health Mission** (NRHM) was launched in India in 2005 with a view to bring about a significant improvement in the health system and the health status of the people, especially the marginalized groups. The mission seeks to provide universal access to equitable, affordable and quality health care which is responsive to the needs of the people. The main focus is on reduction of the maternal and child mortality and overall population development while maintaining gender and demographic balance. The NRHM facilitates increased access and utilization of quality health services by all; through a partnership between central, state and local governments and active community involvement in the management and development of primary health care services. It provides a framework for promoting inter-sectoral convergence with other sectoral programmes like drinking water, education, sanitation, environment, local self government to ensure a holistic approach towards preventive and promotive healthcare and flexibility to promote local initiatives.

My Government has shown great political will to reform the health sector. The budgetary support for NRHM in the 11th plan (2007-12) at Rs. 90558 crores (approximately 18 billion US dollars) is more than a 3 fold increase over the corresponding allocation for the 10th plan. The main focus of the 5 year plan itself, is on faster and inclusive growth. It provides opportunities to restructure policies to reduce poverty and bridge the various divides that fragment the society to achieve a more broad based and inclusive growth so as to benefit especially those who have thus far remained deprived.

Four years of NRHM have shown considerable progress in terms of service delivery, improved infrastructure and other resources. The primary health care infrastructure is being upgraded according to Indian Public Health standards; 7421 Primary Health Centres are functioning on a 24x7 basis and 2500 Community Health Centers are functioning as First Referral Units. The major

focus is on states with poor indicators in maternal health. They are given additional resources based on their own plans. A special emphasis is being laid on accreditation of the health care facilities by the National Board of Accreditation of Hospitals (NABH) to provide high quality evidence based services to the people.

In addition to up gradation of health care infrastructure, the mission has a strong focus on capacity building; more than 26,000 ANMs have been trained as Skilled Birth Attendants. To make up for the shortage of obstetricians in the remote areas more than 1000 medical officers have been trained in basic and advanced emergency obstetric care skills. The access to health care services has been further enhanced through contractual appointment of 60,000 trained nurses and ANMs and over 14,000 doctors and specialists.

Over 7.3 lakh trained Accredited Social Health Activists (ASHAs) have been operationalised in the states to connect the communities to the health system. They carry appropriate drug kits, educate pregnant women and link them to services for ante-natal checkup and childbirth. To ensure continued motivation, it is proposed to provide career pathways selectively to those of the ASHAs who have appropriate educational background and who demonstrate excellence in their work.

The ASHAs work in tandem with the ANMs and ICDS workers to ensure women have access to reproductive health services, including nutrition in their village. This is ensured through the mechanism of Health and Nutrition Day, held every month in each village. Over 12 lakh such days have been organized during the current year itself. In a number of states, where needed, the pregnant women are provided referral support to facilities with obstetricians.

The demand side for the safe institutional deliveries is addressed by conditional cash transfers of up to Rs 1400 (US\$ 28) to the poor pregnant woman and Rs 600 (US\$ 12) to the ASHA worker for facilitating the institutional delivery under the Janani Suraksha Yojna Scheme (JSY). JSY

has been hugely successful in mobilizing poor women to institutions for safe delivery services; More than 8.5 million poor women benefitted under the scheme in the last year. In addition to the government facilities, more than 3154 private facilities across the country have been accredited to provide antenatal care and delivery services under JSY. Efforts are currently being made to improve the quality of deliveries at health care facilities through NABH accreditation of such facilities. All these efforts have resulted in an increase in the institutional delivery rate to 54% during 2008-09.

In keeping with the Cairo Programme of Action, the **Family Welfare Programme** in India is working on a target free voluntary approach; by addressing the unmet needs in limiting and spacing, so that the couples have children by choice and not chance. The programme focuses on increased male participation through promotion of NSV and promotion of spacing methods (IUD 380 A) through a network of quality family planning services and an increased basket of choice. Though slow, the progress is steady; Total Fertility Rate (TFR) has declined from 3.0 in 2003 to 2.7 in 2007. Fourteen states in the country have already achieved replacement levels of fertility.

India was one of the first countries to have progressive legislation for abortions way back in 1972. It is legal to have termination of pregnancy up to 20 weeks for specified indications. Efforts are being made to increase access to early and safe abortions through a network of health care delivery institutions.

All the above activities are carried out in an environment which encourages innovations towards improving access and quality of services in the states. As an example, in the state of Gujarat 862 qualified private obstetricians are available to supplement services from the government hospitals; as a result the poor pregnant women are able to use private hospitals for delivery at no extra cost, since the government is compensating these hospitals per delivery. Amongst themselves these private obstetricians have provided safe delivery facilities to more than 384,000 poor women. Rajasthan has a dearth of providers in remote desert areas, so a Telephone Helpline Scheme has

been set up there to enable local birth attendants to seek urgent advice. A number of the states have started an emergency ambulance service with a “108” number, which is used most for transferring pregnant women to referral health facilities. Tamil Nadu has been giving very poor women a compensation of Rs 1000 for six months before and after delivery (Rs 6000 in all; US \$120) to ensure her nutrition and well-being. Some states have instituted Maternal Death Audit and reviews to exactly identify why women are losing their lives and plan corrective interventions accordingly.

All these interventions are effectively monitored on a regular basis through an online health management information system. This is supplemented by regular reviews in partnership with civil society experts through Common Review Missions. In addition regular evaluation is carried out through national surveys, and independent studies. There is a provision for citizen participation and oversight through health committees at every level such as Patient Welfare Committees. These committees are provided Un-tied Funds for improving institutions. In addition over 4.27 lakh Village level Health & Sanitation Committees have been operationalised for community oversight over primary health care. All information relating to plans, budgets, reviews, accomplishments and publications is displayed on the NRHM website to ensure transparency and wider community awareness, participation as well as oversight.

These policies have not been designed in isolation; they are integrated into the framework of social and economic development strategies and overall process of good governance. The over arching goal is to promote, support and sustain human development to realise the highest potential and well being of all by eliminating poverty and other forms of exclusion. The emphasis is on ensuring full participation, rule of law and consensus orientation in a transparent environment to ensure equity and effectiveness. The strategies for human development aim at generating economic growth, productive employment, social integration and environmental regeneration through extensive public participation and empowerment of the vulnerable groups.

Decentralized planning and programme implementation has been made one of the strategic themes of the National Population Policy to achieve the national socio economic goals. The most exciting development in our country from the vantage point of deepening of democratic traditions is the institutionalization of local self governance through the mechanism of Panchayati Raj. This means a significant change in India's federalism; in addition to the widening of the democratic base of India's polity, it has led to an amazing development - the emergence of grassroots level Women Leaders.

We are the only country to ensure that out of the 3 million elected office bearers that we have, more than one million are women. Their participation at the three levels - district, sub-district and village level, has not only led to their personal growth but has also enabled them to respond to the needs of the more vulnerable sections of the village community. There are no doubt, many instances of women *Panchayat* Members encountering resistance and exclusion, but there are now hundreds of thousands of women who are shouldering, with grace and dignity, enormous administrative responsibilities. They have brought to their offices - immense courage, enthusiasm and creativity. This has also enabled the involvement of the local bodies in health care, family welfare and education.

Leadership in *Panchayats* has transformed the women and their communities. They seem to have enjoyed their role and there is no greater proof of this, than the fact, that instead of the constitutionally reserved one third, women members and officer bearers in *Panchayats* today account for approximately forty two per cent of the elected representatives. If there is one exhilarating aspect of the Constitutional Provisions relating to *Panchayats* - it is this empowerment - with its elements of a high level of self confidence and self esteem combined with political awareness and a spirit of service.

This positive trend has forcefully been reiterated at the national level. Following in the steps of our former Prime Minister Mrs. Indira Gandhi, our country today has elected Honorable Shrimati Pratibha Devisingh Patil as its

first woman President. While Mrs. Sonia Gandhi leads the ruling party at the national level; the House of the People in our Parliament is presided over by a distinguished lady speaker. The largest employer in the country the Indian Railways is overseen by a distinguished lady Minister. The deputy Leader of Opposition in the Lok Sabha is another distinguished lady. Crossing the national boundaries, the Indian women have made their mark globally as doctors, engineers and scientists. While Sunita William has made her mark in the space as an astronaut; Indira Nooyi, chief of Pepsico straddles the corporate world as one of the most powerful women globally.

Our challenges

While the impact of all these efforts is visible in the further decline in India's **Maternal Mortality Ratio** (MMR) from 301 (2001-03) to 254 (2004-06), we have, as Robert Frost would say, 'miles to go before we sleep'. Maternal mortality remains unacceptably high in states such as Assam and the northern belt states (Uttar Pradesh, Bihar, MP and Rajasthan). We need to provide more skilled birth attendants in these states. The health facilities need to be upgraded with trained professionals; clinical, and diagnostic equipments as well as blood storage facilities. Costs of care for complications is pushing families into debt; thus poor families need considerably more support for referral in terms of accurate information, transportation, accompaniment by paramedics, and free services including medicines.

Our major concern has been malnutrition. Results from the National Family Health Survey (NFHS-3, 2005-06) highlighted that prevalence of anaemia among pregnant women across the country has increased to 58.7% (from 49.7% during NFHS-2 in 1998-99), and that the prevalence of anaemia in breastfeeding mothers was even higher (at 63.2%, NFHS-3). Although, consumption of at least 100 Iron & Folic Acid (IFA) tablets by women during pregnancy has increased from 20.5% to 46.8% since DLHS-2 (2002-04), however, much greater attention is needed during antenatal care to ensure IFA consumption.

Similarly, a large proportion of girls in rural areas of highly populous states of India are married by age 18. This continues to be a significant challenge for the country that results in teenage pregnancies, high infant, neo natal and maternal mortality rates. It represents perhaps the most prevalent form of sexual abuse and exploitation of girls depriving her of opportunities and facilities to develop in a healthy manner, to get educated and to lead a life of freedom and dignity. It also deprives the young girls of capabilities, opportunities and decision-making powers and stands in the way of her social and personal development.

The resulting adolescent pregnancies contribute to nearly 19 percent of total fertility and record the highest maternal mortality rates. Women aged 15-19 have higher maternal death rates compared to those in the age group 20-24. Studies show that children born to mothers in their twenties have a 50 percent lower risk of dying by their first birthday than children born to teenage mothers.

My Government has taken a number of steps to address these issues. The Right to Education Bill has been recently passed by our parliament. This bill is not just about taking children to school, it is about quality education, in terms of the physical infrastructure, teacher-pupil ratio, as well as the qualification of teachers. It will provide "free education to students" and all states will compulsorily have to provide it. Evidence shows that a girl with 10 years of schooling is not likely to have more than 2 children. Therefore, special attention is being paid to ensure that girls complete at least their secondary education. Our efforts have borne fruit; as against an enrolment of 9 million girls in secondary education, 5 years ago, today we have more than 14 million girls in our secondary schools. We are confident this will provide an environment that promotes creativity and self reliance, especially amongst our girls and delay the age of marriage.

Further, in order to raise the age of marriage of girls and space the birth of children, the National Population Stabilisation Fund, has recently launched PRERNA, a Responsible Parenthood strategy in some of the most backward

districts of the country. The strategy retrospectively recognizes and awards couples from below the poverty line who have broken the stereotype of early marriage and early childbirth and helped change mindsets. In order to qualify, the girl should have been married not before 19 years, given birth to the first child after she is 21 years old. The couple should have maintained a 36 month gap between first and second child and followed by one parent getting sterilized after the second child is born. Such girls are publically honoured and felicitated with handsome monetary rewards.

To provide economic support, the National Rural Employment Guarantee scheme has been launched to provide gainful employment in the rural areas. More than 45 million households are enlisted under the scheme. Over and above their regular occupation/employment the enlisted families have been provided 48 days employment during the year under the scheme. Almost a year after its launch, 21 million core households were provided employment (2006-07 over 200 districts). Today, over 33 million households are beneficiaries of this programme that is providing greater social security in rural India. The budget outlay for this programme for the current year is Rs 39,100 crore (6 billion US Dollars). In addition the government has now decided to provide substantial nutrition support to poor expectant mothers in both the anti natal and post natal periods.

We have as I said earlier, miles to go; but that does not deter us. We are committed to provide an increased thrust to evidence based programs to reduce maternal deaths. We will continue to work in partnership with the civil society and the communities to meet their felt needs in a decentralised environment. We will continue to ensure greater inter-sectoral coordination for integrated action by all stakeholders for development on social, economic, political, environment fronts to ensure access to safe delivery facilities for all our women.

I would like to end here today by emphasizing India's wholehearted commitment to ICPD Programme of Action.

Thank You