MATERNAL MORTALITY IN INDIA: GEOGRAPHY (HUMAN)

NEWS: Fostering a commitment to stop maternal deaths

WHAT'S IN THE NEWS?

India's Maternal Mortality Ratio (MMR) has improved nationally but remains critically high in EAG states due to regional disparities, weak emergency care systems, and delays in accessing maternal health services. Major causes include postpartum haemorrhage, sepsis, and systemic gaps like lack of specialists and poor facility readiness.

Maternal Mortality in India: Persistent Challenges Despite Progress

1. Recent Progress but Continued Challenges

- India's **Maternal Mortality Ratio (MMR)** has declined to **93 per 1,00,000 live births** during 2019–21 (Sample Registration System).
- However, the national figure masks **stark inter-state disparities** and **avoidable maternal deaths**, especially in **Empowered Action Group (EAG) states** like Madhya Pradesh, Bihar, and Uttar Pradesh.

2. Stark Regional Disparities in MMR

- **Kerala** leads with the **lowest MMR at 20**, reflecting robust maternal health infrastructure and proactive interventions.
- **Madhya Pradesh (175)** and **Assam (167)** reflect **alarmingly high maternal deaths**, highlighting systemic gaps.
- **Southern and western states** show better outcomes due to earlier and sustained investments in **health system strengthening**, ANC coverage, and institutional deliveries.

3. Weak Functioning of First Referral Units (FRUs)

- National guidelines recommend **4 FRUs per district** for emergency obstetric and newborn care.
- Out of **5,491 Community Health Centres (CHCs)**, about **66% lack key specialists** such as gynaecologists, anaesthetists, or surgeons.
- Many FRUs also lack **24×7 operational blood banks** and **functional operation theatres**, limiting the ability to address birth complications.

4. Need for a Cluster-Based Strategy

- A **differentiated approach** is essential, given the heterogeneous performance across states:
    - **EAG states** must prioritize **early antenatal registration, birth preparedness, JSY-based institutional deliveries**, and **basic infrastructure expansion**.
    - **Southern and western states** should focus on **improving emergency obstetric care**, postnatal follow-ups, and **refinement of quality assurance systems**.

Three Delays Model in Maternal Deaths

5. Delay 1: Decision-Making at Household Level

- Many families **delay seeking medical care** due to:
    - Low awareness of danger signs during pregnancy
    - Cultural beliefs, gender norms, and reliance on home births
    - Financial barriers despite JSY incentives
- Programs like **JSY (Janani Suraksha Yojana)** and **ASHA–ANM networks** have improved decision-making but gaps remain in **awareness and trust-building**.

6. Delay 2: Reaching a Health Facility

- **Geographical isolation**, lack of roads, and **poor public transport** contribute to delays in reaching facilities.
- **108 Ambulance Service** under NHM has improved accessibility but is limited in coverage in **tribal, hilly, and flood-prone areas**.
- Transport cost, vehicle unavailability, and **last-mile connectivity issues** exacerbate delays.

7. Delay 3: Receiving Timely and Adequate Care at Facilities

- Even after reaching a hospital, **delays in receiving care** persist due to:
    - Unavailability of trained obstetricians or anaesthetists
    - Non-functional operation theatres
    - Lack of blood transfusion services and essential drugs
- This is the **most preventable delay**, highlighting the need for **health systems reform, accountability, and monitoring**.

Clinical Causes and Gaps in Treatment

8. Leading Medical Causes of Maternal Deaths in India

- **Postpartum haemorrhage (PPH)** – leading and most preventable cause
- **Obstructed labour and ruptured uterus** due to late referral
- **Hypertensive disorders of pregnancy** such as preeclampsia and eclampsia
- **Sepsis** due to poor hygiene and lack of aseptic delivery conditions
- **Unsafe abortions** remain a major threat in areas lacking MTP services
- Underlying conditions like **untreated anaemia and poor antenatal care** worsen outcomes

9. Kerala's Model of High-Quality Obstetric Care

- Uses **low-cost clinical innovations** like uterine artery clamps, suction cannulas, and oxytocin protocols to control bleeding
- Proactive interventions in rare conditions like **amniotic fluid embolism**
- Ensures **team-based emergency response** with round-the-clock OT and blood availability
- Demonstrates **how public sector facilities can deliver near-tertiary level care** with right investments and governance

Systemic and Mental Health Reforms

10. Strengthening Surveillance and Maternal Death Reviews

- **Maternal Death Surveillance and Response (MDSR)** under NHM mandates audits at district and facility levels
- **Kerala and Tamil Nadu** conduct **confidential reviews** to pinpoint preventable factors and improve system-level responses
- Maternal death reviews also guide **local training, resource allocation, and accountability**

11. Integrating Maternal Mental Health into Public Health

- Kerala integrates **screening for antenatal and postpartum depression** through PHCs
- Addresses issues like **postpartum psychosis, anxiety disorders, and emotional neglect**
- Reflects a **holistic maternal health approach**, going beyond physical health to include psychological well-being

Way Forward: Key Policy Recommendations

- **Expand specialist availability** in CHCs through bonded service, telemedicine, and incentives
- **Operationalise FRUs fully** with blood storage units and 24×7 OTs
- Promote **maternal health equity** by focusing more on EAG states
- Integrate **maternal health with climate resilience planning**, especially in flood- and heat-prone regions
- Enhance **community engagement, male involvement, and real-time digital tracking of high-risk pregnancies**

Source: **https://www.thehindu.com/opinion/lead/fostering-a-commitment-to-stop-maternal-deaths/article69784339.ece**