

Integrating maternal and newborn health care in India

India's progress is critical to improving maternal and newborn health on a regional and global scale. According to the latest international estimates, India's maternal mortality ratio stood at 450 per 100,000 live births in 2005, while the neonatal mortality rate was 39 per 1,000 live births in 2004. Both figures represent reductions of rates in previous years. Yet even as its economy grows rapidly – with real gross domestic product expanding at an average annual rate in excess of 9 per cent in 2007–2008 – widening disparities are prevalent in health outcomes between income groups and between social and caste groups. Growing inequities, combined with shortages in the provision of primary health care and the rising cost of care, are complicating the country's efforts to meet the health-related Millennium Development Goals.

With a total population of roughly 1.1 billion, broad environmental and sociocultural diversity and an intricate political system comprising 28 states and 7 union territories, India's efforts to manage its citizens' health care have been largely decentralized. The Government of India has emphasized expanding primary health care, which is, by constitution, under the purview of the states. Beginning in 2000, it began a greater push to provide care to women and children in rural areas and in poor-performing states such as Bihar, Orissa and Rajasthan. It has also encouraged private health care, which few can yet afford, while spending on public health care has fallen to just 2 per cent of gross domestic product.

To address the widening disparities, the Government of India has issued a commitment to 'inclusive growth'. One such initiative is Janani Suraksha Yojana, a government-sponsored project under the National Rural Health Mission that provides cash incentives for antenatal care during pregnancy, assisted institutional delivery, and post-partum care by field-level workers. The benefits extend to all pregnant women aged 19 and older living below the poverty line in 10 states, for up to two pregnancies. Women who are not enrolled in the programme but who experience complications such as obstructed labour, eclampsia and sepsis are also eligible for benefits. The programme also includes a mechanism for accrediting and compensating participating private practitioners.

According to one follow-up study undertaken in select districts in Rajasthan in 2007–2008, Janani Suraksha Yojana has increased access to antenatal and post-natal care. The review also revealed that 76 out of 200 participants in the study, or nearly 40 per cent, were girls under 18, the legal age of marriage in India. The programme is successfully expanding access to care while allowing the Government to monitor more closely the situation of girls and women.

Some states have also taken the initiative to inaugurate health partnerships with the private sector. In Gujarat state, one of India's most developed provinces, the shortage of skilled health-care providers has prompted the state government to join with private hospitals to provide free obstetric care for pregnant women living below the poverty line, especially those of scheduled castes and scheduled tribes. Chiranjeevi Yojana – meaning 'a programme for long life' – was launched in 2005 and operates through a memorandum of understanding between the Government of Gujarat and private obstetricians. For every delivery, the Government pays Rs 1,795 (US\$ 40), which also includes Rs 200 towards transportation costs for each patient and Rs 50 for the person accompanying the beneficiary, to compensate for the loss of earnings.

In 2006, a United Nations Population Fund study of Chiranjeevi Yojana reported that the programme had successfully raised the number of births delivered in health facilities, and that private practitioners were mostly enthusiastic about their participation in the initiative. It also noted the reluctance of patients to utilize facilities for births, and that their spouses and in-laws had great influence on decision-making, which limited their ability to actively seek healthcare. The study made several recommendations, including the establishment of an independent body to ensure quality control and equitable implementation.

The Gujarat Government's initiative is a departure from previous practice in that it took sole responsibility for the reimbursement of private health-care providers, rather than relying on intermediary parties such as insurers. The state government is working with professional agencies such as associations of obstetricians and academic organizations to plan and implement the new arrangements.

Showing remarkable successes, the programme has been expanded from five to all 25 districts of Gujarat. Between January 2006 and March 2008, 180 doctors were enlisted. Nearly 100,000 deliveries were performed, with each doctor performing an average of 540. While a promising experience, ongoing monitoring and evaluation are required to ensure improvements are made and the desired impact is achieved.

See References, page 112.