Risks of Maternal Health Article: India

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The state of maternal health in India is dire. Globally, India contributes more than any country to the maternal death rate. In fact, one quarter of global maternal deaths occur in India. (Ramararo & Caleb, 2001, p. 256) . Estimates of India's national mortality rate ranges from 301 /100 000 (WHO, 2006, p. 5) to 407 /100 000. (Ramararo & Caleb, 2001, p. 256) It 's estimated that 68 000 women die annually due to poor maternal health in India. (Chatterjee & Paily, 2011, p. 256) Within the country, India's highest reported mortality ratio is in Uttar Pradesh- the country's most populated state. (Ramararo & Caleb, 2001, p. 256)

The principle medical causes of maternal death are attributed to the following factors: hemorrhage 37%, sepsis 11%, complications of abortion 8%, hypertensive disorders 5% and obstructed labour 5%. (Chatterjee, 2011,p.50). Further, certain health conditions put women at risk for maternal mortality such as heart and kidney diseases, tuberculosis and malaria (Ramaro, 2001, p.257). However, it is important to note that the medical causes of maternal mortality are primarily preventable. The WHO states: "Forty seven percent of maternal deaths in rural India are attributed to anemia and hemorrhage, causes that are very much avoidable." (2006,p.5)

Social –economic risk determinants are the reason why so many Indian women die of " very much avoidable causes". According to the WHO "Of the total pregnant women, only 34 percent had institutional deliveries and 42 percent received professional medical care." (World Health Organization, 2006, p.5). Lack of access to quality

antenatal care and emergency obstetric care are barriers to good maternal health (Ramararo et al, 2010)

In India the onus is on the patient to pay for health care. Government expenditure for health care is at 20.3 % while the patient pays for 77.4 % of health expenditures. Contrastingly, in Western Europe public health care expenditure is over 80%. (Chatterjee, 2011,p.51) Chatterjee further illustrates how economic in access to health care ultimately proliferates maternal mortality, "Contrary to popular belief, the contribution from international funding agencies like WHO and UNICEF on health was a meager 2.3%. 15 To make matters worse, there is very little insurance cover- age available for maternity services in India." (2006,p.51)

Many Indian women cannot afford to have a delivery in the hospital. Consequentially, most women have home deliveries. Delivery without a skilled birth attendants place women even more at risk for mortality (Chatterjee, 2011, p. 51).

Further even if women are in fact able to access health care centers other factors such as the quality of these center put women at risk for maternal mortality. For example, a lack of resources is available at these hospitals to perform basic prenatal tests. Moreover, there is a lack of skilled staff. On a national and state level poor management of maternal health had created poor quality services for maternal health. Chatterjee states, " India has only three technical officers for maternal health at the national level, and there are no maternal health directors in most states." (2011,p.51)

Illiteracy is another social –economic determinant of maternal health. The literacy rate of women in the reproductive age group (15–49 years) in India is just 55%. This has profound effects on maternal heath because illiteracy deters women's ability to seek help

during maternal and neonatal emergencies. However, educated women are more likely to take a full course of IFA, receive teta- nus toxoid and have delivery in a health care institution. Disempowerment of Indian women is a fatal risk for maternal health. Illiteracy and poor social status give women little control over their health care during pregnancy.

Inadequate access, ability to pay, lack of public and private funding, and low levels of education as socio-economic determinants of maternal health are especially dire in rural areas where infrastructure and service access is limited. Difficulties implementing 1997's Reproductive and Child Health Programme, for example, outlined well the challenges unique to health care in rural Uttar Pradesh. Ramarao et al. (2001, p. 261) note that, "reducing maternal mortality in settings where health care utilization is low and where the capacity to provide services is inadequate is doubly challenging", underscoring the importance of both local knowledge and practice, as well as the uneven geographic distribution of resources to maternal health outcomes. On the one hand, utilization of local health care facilities is low in rural Uttar Pradesh, where the vast majority of births occur in homes with minimal antenatal care (ibid, p. 258). Women and families are thus unable to prepare for what could be foreseeable health complications, and lack the knowledge to adequately address such complications when they arise (USAID 2009). Even if knowledge were perfectly symmetrical, even if rural women knew of the services available to them, physical access (especially during an emergency) and insufficient funding continue to plague rural areas of Uttar Pradesh to the detriment of maternal health outcomes (Mehrotra, p 6).

Broader gender issues also impact maternal health in lasting and important ways. Though males are traditionally less involved in reproductive health issues, they have more say in the host of choices surrounding reproductive health than women, including the allocation of household resources, poor knowledge, and restrictions on mobility (Chattopadhya 2012, p. 130). It is this pervasive unequal power dynamic that continues to exacerbate poor maternal health outcomes, in which men frequently display ignorance, ambivalence and a lack of concern for women's health. Couples in Uttar Pradesh show a strong correlation between the husband's knowledge of maternal and pregnancy health and the wife's health outcomes (ibid, p. 148). In India, 41 % of women didn't receive antenatal care because their husbands " did not think it was important or did not allow them to access care." (Chatterjeee, 2011,p. 51). In what is a commonly male dominated society, moving towards gender equality and engaging men in the pregnancy process can hold positive outcomes for maternal health in rural Uttar Pradesh (Chattopadhya, p. 129). "Encouraging men to be more involved in, and supportive of, women's needs, choices and rights in reproductive health…and addressing male's reproductive and sexual health needs and behaviour" (ibid, p. 130) are steps to empower men and women to pursue positive changes in maternal health.

The socioeconomic determinants of maternal health in rural Uttar Pradesh are wide-ranging and the products of various institutions, norms, and geographies. Such diverse impediments to maternal health underscore the need for village health care workers as knowledgeable, engaged, and helpful members of their communities, able to help address maternal health complications as well the broader socioeconomic and gender determinants at their root.

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