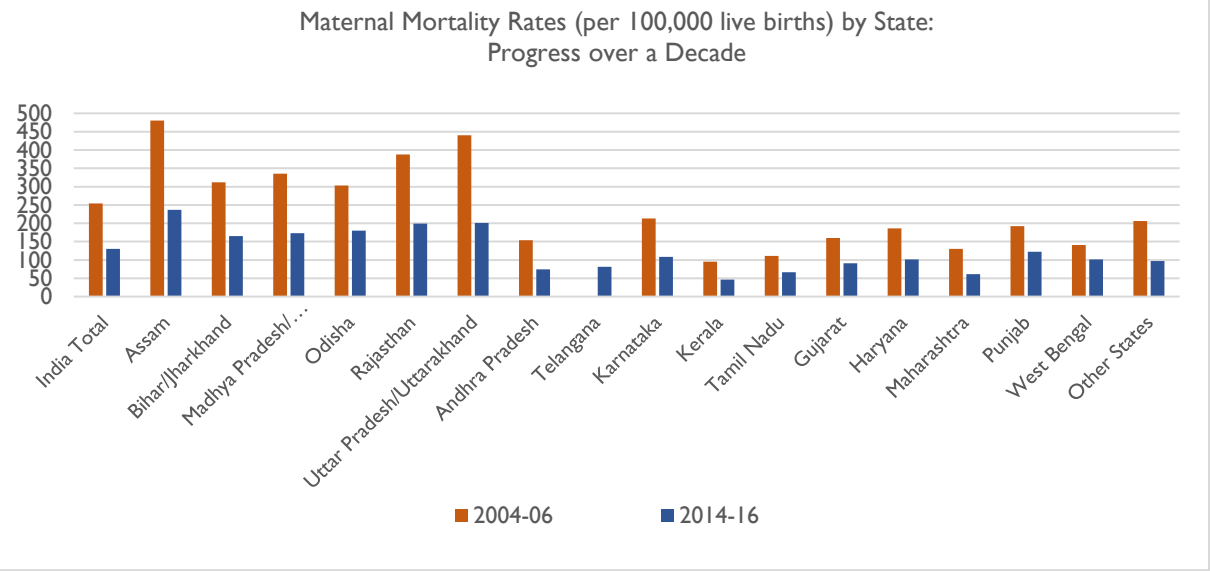
Examining Ethics & Equity Dimensions in Efforts to Reduce Maternal Mortality

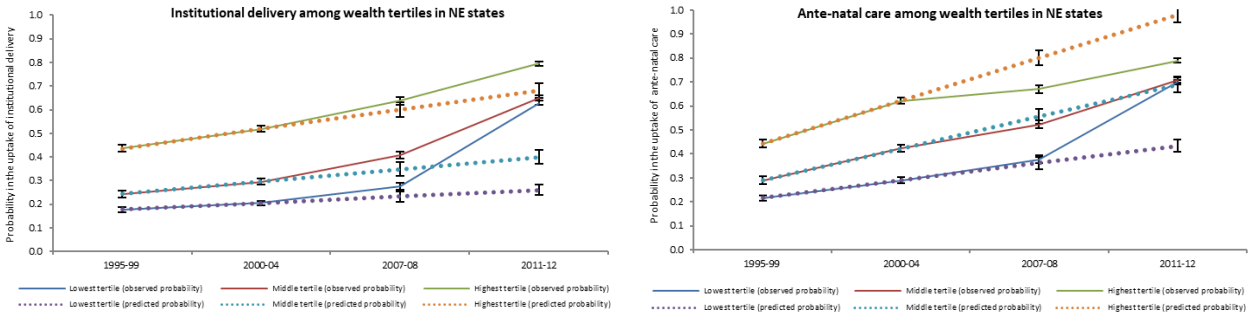
Despite significant progress over the last ten years to reduce maternal mortality rates, with significant public investments to increase antenatal care visits and attended births, maternal mortality rates in a number of Indian States remain some of the highest in the world.



Source: niti.gov.in

Beyond the unequal burden of maternal deaths by State, many subgroups of the population have inequitable access to high quality health interventions that could avert preventable maternal deaths. Inequities have been documented in the utilization of antenatal care and institutional delivery – and in the risk factors associated with maternal mortality, such as anaemia – by poverty status, maternal education, caste, ethnicity/religion, and geographic location. Progress has been made to reduce differences in uptake of services like institutional delivery and antenatal care across different socioeconomic divides, in part attributed to interventions like cash transfers under JSY and JSSK and the ASHA programme. Yet, inequities in access, quality, and financial burden (out-of-pocket payments) of maternal care, not to mention maternal mortality rates, continue. Many poor women remain unaware of the cash transfer programmes and choose not to seek appropriate antenatal care because they feel they cannot afford to miss work.

Improvements in Institutional Delivery and ANC Uptake, by Income Status, 1995-2012



Source: Vellakkal et al, 2016

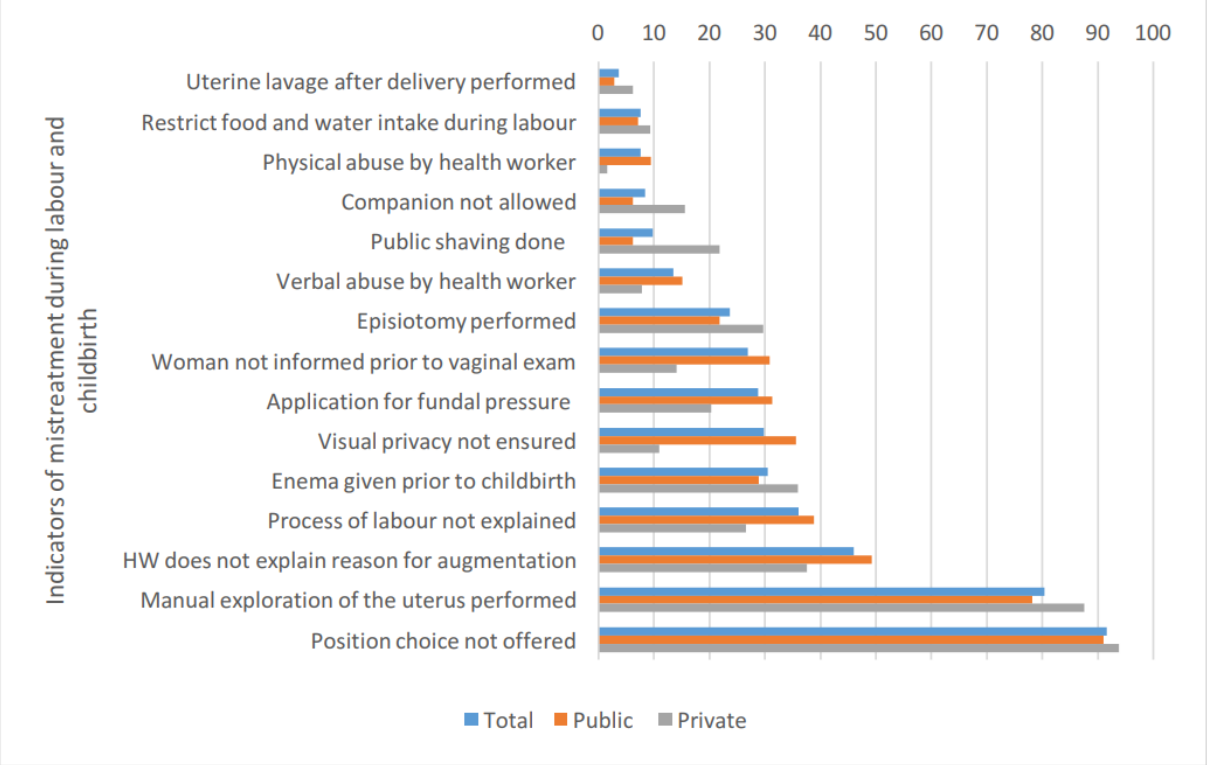
There are a range of complex factors contributing to suboptimal maternal care and high rates of maternal death. These tend to fall under 3 categories: (1) inadequate access to and uptake of evidence-based, beneficial interventions in the antenatal, intrapartum, and post-partum periods; (2) overuse of non-evidence-based interventions that, in some cases, may be harmful; (3) Issues related to dignity and respect in the context of childbirth as well as quality of care provided. Some select issues are highlighted below:

Factors Contributing to Suboptimal Maternal Care and Adverse Maternal Outcomes

- Anaemia (low iron in the blood) is very common among pregnant women (affects 65% to 80%). Anaemia is associated with adverse outcomes for both pregnant women and their babies (including post-partum hemorrhage and heart failure). Higher rates of anemia have been associated with lower levels of maternal education and belonging to a scheduled caste/ scheduled tribe. Many women among the poorest and most marginalized groups of society may have less or delayed access to early antenatal care visits, reducing opportunities to address anaemia with diet and/or iron supplements early and well ahead of labour and delivery. Given that anaemia in early pregnancy can result in low-birth weight, iron supplementation may need to reach women in the pre-pregnancy period to realize full benefits for women and their babies.
- The blood supply to provide transfusions to women suffering from post-partum haemorrhage varies by facility and geographic location, which can mean the difference between life and death
- Overuse and early administration of drugs to induce labour and speed up delivery (e.g., early administration of oxytocin). Evidence does not support use of these types of drugs prior to the 3rd stage of labour or without specific indication that labour is delayed. Early use and overuse can also pose harms to women and their babies, leading to poorer maternal and neonatal outcomes (including dangerous changes in fetal heart rate and increased risk of post-partum haemorrhage). Yet, in 2011, 79% of women in India were given oxytocin during their first and second stage of labour in order to speed up delivery (Despite MoHFW and WHO recommendations)
- High rates of routine episiotomy (~70% overall and even higher among first-time mothers). Routine episiotomy is not recommended by WHO and other advisory bodies due to lack of evidence supporting the practice and potential for harm. Episiotomies are frequently done without appropriate anaesthesia nor adequate consent. Episiotomy has been characterized by many as a form of obstetric violence.
- Women in labour routinely receive ineffective and potentially harmful interventions, such as perineal shaving, enemas, amniotomy, intravenous fluids, antispasmodics, and antibiotics for uncomplicated vaginal births
- Qualitative interviews with women, their partners, and caregivers in Northeast India identified a range of disrespectful and abusive treatment faced by women and partners in the context of facility-based childbirth. Frequent reports of reprimand, including being yelled at for cries of pain during labour, neglect, as well as verbal and/or physical abuse. Interviewees typically had low levels of education, were poor and rural, often indigenous (tribal), and felt disempowered. Older women remembered previous deliveries with traditional birth attendants and female kin when they felt respect and compassion. [See sample prevalence of mistreatment during childbirth in Uttar Pradesh below]
- In addition to mistreatment of women during labour and delivery being bad in its own right, many studies on trust and negative experiences during childbirth have shown that these types of bad experiences can reduce women's future uptake of facility-based childbirth and other health care – with

implications for slowing progress on maternal mortality and contributing to broader gender inequities in health

Prevalence of mistreatment during childbirth in public and private facilities in UP



Source: Sharma, 2017

After reviewing the material above, each group should spend ~15 minutes discussing the following 3 questions. Please make sure to assign one person to keep notes and one person to present back to the large group.

Discussion questions:

1. What aspects presented in this case (or in your own State contexts) are ethically problematic, specifically as they relate to ***one*** the following:

    - Equity ***[Groups 1 & 2]***
        - In: outcomes, access, quality, financial protection from health-related costs
        - By: age, income, education, caste, religion, geographic location, etc.

    - Efficient Spending on Value-for-Money Investments to Realise Health Gains ***[Groups 3 & 4]***
        - Failure to provide high value-for-money interventions to improve maternal care
        - Investment in low-value for money interventions

    - Avoiding/Minimizing Harms and Easing Suffering ***[Groups 5 & 6]***

    - Respect and Dignity of Patients ***[Groups 7 & 8]***
        - Respecting the autonomous choices of individuals in care settings
        - Eliminating forms of disrespectful treatment and discrimination based on group membership (including ethnicity/race, religion, and gender)
        - Reducing forms of stigma
        - Preserving human dignity
        - Privacy

2. Based on the problems identified above, what changes should be considered with regard to what is included in the benefits package for reproductive and sexual health, such as antenatal care, labour and delivery, and post-partum care and how care is provided and financed? These may include:

    - Changes to what is in or out of the package
    - Changes to the guidelines for who should receive certain types of interventions
    - Changes in payment mechanisms (reimbursements, incentives, etc) to make sure practice follows established guidelines

3. Think about the ways you routinely collect evidence on maternal care and the indicators captured in your health information systems. Discuss how your current information systems enable you to capture important and relevant data on the issues you identified above. What additional types of data would you need to collect to measure and track progress on the issues you identified above?

References:

1. NITI Aayog. Maternal Mortality Ratio: India, EAG & Assam, Southern States and Other States (per 100000 live births). Accessed 15 Feb 2019. Available from: http://niti.gov.in/content/maternal-mortality-ratio-mmr-100000-live-births
2. Vellakkal S, Gupta A, Khan Z, Stuckler D, Reeves A, Ebrahim S, Bowling A, Doyle P. Has India's national rural health mission reduced inequities in maternal health services? A pre-post repeated cross-sectional study. Health policy and planning. 2017 Feb 1;32(1):79-90.
3. Singh KJ, S Kadian, Kaur A, Saini K, Kuchhal P, Kashyap D, Yadav D, Nambiar A. (2017). Spatial Pattern of Maternal Health in Northeastern States, India-evidence from national family health survey 4 (2015-16). Asian Pacific Journal of Health Sciences. 4. 147-156. 10.21276/apjhs.2017.4.2.25.
4. John AE, Binu VS, Unnikrishnan B. Determinants of antenatal care utilization in India: a spatial evaluation of evidence for public health reforms. Public health. 2019 Jan 1;166:57-64.
5. Randive B, San Sebastian M, De Costa A, Lindholm L . 2014. Inequalities in institutional delivery uptake and maternal mortality reduction in the context of cash incentive program, Janani Suraksha Yojana: results from nine states in India. Social Science & Medicine 1–6
6. Barua K, Baruah R, Ojah J, Saikia AM. Factors influencing the utilization of free delivery care under Janani Shishu Suraksha Karyakram in Kamrup district, Assam, India. International Journal of Community Medicine and Public Health. 2017 Jan 5;3(6):1665-71.
7. Budden A, Chen LJ, Henry A. High-dose versus low-dose oxytocin infusion regimens for induction of labour at term. Cochrane database of systematic reviews. 2014(10).
8. WHO & MCSP. Recommendations for Augmentation of Labour. April 2015 Available from: https://apps.who.int/iris/bitstream/handle/10665/174001/WHO_RHR_15.05_eng.pdf?sequence=1
9. Stanton CK, Deepak NN, Mallapur AA, Katageri GM, Mullany LC, Koski A, Mirzabagi E. Direct observation of uterotonic drug use at public health facility-based deliveries in four districts in India. International Journal of Gynecology & Obstetrics. 2014 Oct 1;127(1):25-30.
10. Sreeparna Chattopadhyay (2018) The shifting axes of marginalities: the politics of identities shaping women's experiences during childbirth in Northeast India, Reproductive Health Matters, 26:53, 62-69, DOI: 10.1080/09688080.2018.1502022
11. Chattopadhyay S, Mishra A, Jacob S. 'Safe', yet violent? Women's experiences with obstetric violence during hospital births in rural Northeast India. Culture, health & sexuality. 2018 Jul 3;20(7):815-29.
12. Baru R, Acharya A, Acharya S, Kumar AS, Nagaraj K. Inequities in access to health services in India: caste, class and region. Economic and political Weekly. 2010 Sep 18:49-58.
13. Warren CE, Ndwiga C, Sripad P, Medich M, Njeru A, Maranga A, Odhiambo G, Abuya T. Sowing the seeds of transformative practice to actualize women's rights to respectful maternity care: reflections from Kenya using the consolidated framework for implementation research. BMC women's health. 2017 Dec;17(1):69.
14. Sharma, G (2017) An Investigation into Quality of Care at the Time of Birth at Public and Private Sector Maternity Facilities in Uttar Pradesh, India. PhD thesis, London School of Hygiene & Tropical Medicine. DOI: https://doi.org/10.17037/PUBS.04646087