Kanti, a young village woman, married just one and half year ago, was pregnant for the first time. The family was happy and waiting for the arrival of the new born. On the day labour pains started she was taken to the nearby PHC, for delivery. The doctor was absent but two young nurses available at the PHC helped in her delivery, which was somewhat difficult and the baby was stillborn. She was discharged within few hours of the delivery. On the way home she started to bleed. By the time the family reached home, Kanti was bleeding profusely. The family decided to take her to the big hospital in a nearby city. But within minutes, Kanti died. This was indeed, so unfortunate. Kanti lived in a district which has the capital city of a major, economically rapidly growing state. The district hospital was only 1 hours away and major medical college hospital only 2 hours away. It is sad that the progressive state cannot even count how many Kantis die every year of child birth.

Every year, around 75,000 to 150,000 maternal deaths occur in India. This is about 20 percent of global maternal deaths. Therefore, India’s effort to reduce maternal mortality becomes crucial to global achievement of Millennium Development Goal 5 (MDG 5) for maternal health. Post-delivery bleeding alone kills 30,000 women in India. Why does India not bother about its mothers and their health? There is clear lack of political, administrative and managerial focus for maternal health and women’s welfare in India. Our Indicators for women are not much better than Bangladesh or some sub-Saharan countries.

Though, Indian government spend huge amount of money on defense, various subsidies, and non-vital infrastructure, the expenditure on health is just 1 percent of GDP. The lack of political priority to maternal health is reflected through the absence of discussion on maternal health in parliament and state legislatures. Even mass media is not much interested in talking about maternal health. 100,000 women dying each year have never hit the front page of major newspapers or prime time news in TV.

In the 1960s, India started developing trained rural midwives known as “Auxiliary Nurse Midwives” (ANMs) to provide maternal and child health services. However, their designation as “auxiliary” undermined their status and function as midwives. Later on, under advice and pressure from international agencies, the role of ANMs was changed from midwifery to family planning and immunisation. The government also replaced the posts of institution-based midwives which were active in British India with general nurse-midwives after independence. Due to rotation of nurses in all the departments of the hospital, they did not develop or retain expertise in midwifery - the science of child birth. Consequently, India continued lacking in professionally trained and skilled midwives. Over time the training of midwifery and its importance also declined in the nursing and medical community. As a result, today only 12 percent of deliveries are carried out by ANMs in the country.

Fortunately since 1990, government has come up with different programmes such as Child Survival and Safe Motherhood programme (additional budget US$ 300 million) in 1992; and Reproductive and Child Health-I (additional budget US$ 250 million) in 1997. However, these programmes also lacked strategic focus on critical interventions to reduce maternal mortality. The much talked National Rural Health Mission (NRHM), launched in 2005, has focused on producing health volunteers at village level, fancily called, Accredited Social Health Activities (ASHA). The health ministry...
believes that the neglect of the maternal health and non-development of fully qualified well-trained midwives will be compensated by minimally trained village women called ASHA. On the other hand, to improve services for women in delivery, government has been promoting deliveries in hospitals and health centres by paying money to women who deliver in government institutions. The old wine of “incentives” which were used in family planning programme is in the new bottle of Janani Suraksha Yojana. The development partners have invented a new name for these payments - they are now called “demand side financing” or “conditional cash transfers”. Unfortunately, not adequate and effective steps are taken to improve the public health institutions where women are coming for deliveries. Kanti is just one example of how poor quality care cannot help prevent maternal deaths.

Even today the government does not systematically monitor how many PHCs and community Health Centres are providing good quality delivery services and emergency obstetric care (EmOC) on 24 hours 7 days a week. One of the reasons for this lack of monitoring is that our public health departments are ridiculously thin at the top. We have only three technical officers for maternal health at the national level and almost no state in India has a director at state level focusing on maternal health. Such thinly staffed health departments cannot plan, implement and monitor maternal health program in a country of 1 billion with 26 million births per year.

According to National Family Health Survey (2006), only 52 percent of women receive three antenatal contacts and 42 percent receive any postnatal care in India. With more than 60 percent of births as domiciliary deliveries, India needs skilled birth attendance by well trained and accountable midwives at community level to reduce maternal mortality rate. Relying on traditional birth attendants (TBAs), which India has done for years, will not work to save mothers. Sweden started to train midwives 300 years ago and it passed a law not to employ TBAs about 150 years ago. Sri Lanka made policy to ensure deliveries by public health midwives about 50 years go and hence both these countries have very low maternal mortality rate. In India on the other hand we de facto abolished the whole cadre of midwives which existed before independence and till 1960s. That is why we still have an high maternal mortality rate.

Therefore, to reduce maternal mortality rapidly, we need skilled birth attendance by midwives, back up in emergency care by obstetricians and referral services. To convert the goals of maternal health into reality in India, we require a comprehensive maternal health services within efficient public health systems. Maternal health should be seen in the framework of women's health and welfare. The increased political priority, managerial capacity, and resource allocation will determine seriousness of our efforts and future of maternal health in India.