Tackling social factors to save lives in India

Health inequalities persist amid a booming economy. Patralekha Chatterjee reports.

Inside the primary health centre at Gharuan village in the north Indian state of Punjab, a family is excited about its newest member. Ram Kaur looks fondly at her grandson, barely hours old, lying beside his mother. Although she herself had given birth at home, she encouraged her daughter-in-law Karamjeet to give birth at a health centre. "Many women die in childbirth because they do not make it to a hospital or a health centre in time. I did not want that to happen in my family," she says.

Karamjeet is fortunate. In India, only 41% of births take place in a health facility and only one in seven babies born at home is delivered by a skilled birth attendant, according to the most recent figures. Still, thousands of women die every year in childbirth or just afterwards across this vast country of 1.2 billion because they live too far from a health facility to get antenatal care and because they can't afford the transport and other costs linked to hospitalization. Also – unlike Ram – family elders often have more faith in traditional birth attendants, who are not always able to handle obstetric emergencies.

A community health worker convinced Karamjeet's family of the benefits of institutional delivery. Such workers are vital for improving health in communities with little education. "In the beginning, I was scared," says Karamjeet. "But after a few visits to the health centre for check-ups the fear disappeared." She smiles after receiving her US$ 15 (700 Indian rupees) cheque under the *Janani Suraksha Yojana* (Motherhood Protection Scheme), a federal government cash assistance programme which requires recipients to undergo at least three antenatal check-ups and give birth in a health facility.

The health worker who persuaded Karamjeet's family is one of a national cadre of village-based workers (accredited social health activists). These workers also advise villagers on sanitation, hygienic practices (including hand washing), contraception, immunization and other health issues. They form the backbone of a flagship government programme launched in 2005 known as the National Rural Health Mission.

The Planning Commission, the government agency responsible for the federal budget, has pledged to spend more on health in the next Five-Year Plan, which begins next year. And, as funds for health are set to increase, public health advocates are calling for more to be spent tackling the social factors that determine health.

"While some initiatives have been taken to address the social factors that impact health ... the government has not adequately invested in employment," says Mirai Chatterjee, the director of social security for the Self-Employed Women's Association. "Since 1990 we have seen mostly 'jobless growth'. This has led to increasing inequalities," she says.

For Nata Menabde, the World Health Organization (WHO) Representative to India, despite the fact that the health system is there to serve everyone who needs it, the rich often have better and easier access to services than poor and vulnerable populations. "This is, among other reasons, because the poor have reduced access to information and take more time to find their way to needed services within the system. Therefore, having services available to all is not enough. Extra efforts are needed to ensure that all people can benefit from them in an equitable manner."

"A significant body of evidence shows that living conditions and poverty in a broader sense are important determinants of health. Can WHO improve health without addressing poverty and living conditions? Although poverty has many dimensions – not all of which fall within the scope of WHO's mandate – WHO can contribute to concerted actions towards poverty reduction by bringing evidence to the attention of policy-makers and making them aware of the links between those determinants and health outcomes," Menabde says.

"There are promising signs of change," says Chatterjee, who was a member of the Commission on Social Determinants of Health, a group of policy-makers, researchers and activists set up by WHO in 2005. She is now a member of the High-Level Expert Group appointed by India's Planning Commission in October 2010 to develop plans for universal health coverage.

"The High-Level Expert Group has noted that universal health coverage will only be possible if there is accompanying action on the social determinants of health," says Devaki Nambiar, a member of the Group's secretariat. These, she says, include "food and nutrition security, social security, water and sanitation, work

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Karamjeet Kaur with her newborn baby holds a cheque for 700 rupees. Mother-in-law Ram Kaur, a recent convert to institutional delivery, sits on the bed next to her

and income security as well as ... gender, caste and religion". Nambiar says that such action is needed "within a broader macroeconomic policy context that prioritizes equity".

It remains unclear what form such initiatives would take. Meanwhile, the merits of some current attempts to tackle social factors affecting health remain in doubt. Nambiar questions whether cash incentive schemes really go to the heart of the matter.

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> *Mirai Chatterjee*

"Equity advocates feel that cash incentives take away from a rights or entitlements-based approach by incentivizing certain behaviours," she says. And it has yet to be seen whether *Janani Suraksha Yojana,* launched in 2005, will reinforce recent improvements in maternal health.

The number of rural women giving birth in hospitals across India has increased from 34% in 1998–99 to 41% in 2005–06, according to official government figures. This trend is evident in Punjab. "Institutional births are going up," says Ashok Nayyar, director of Health Services Family Welfare there. He adds that the maternal mortality ratio in the state has fallen from 192 deaths per 100 000 live births in 2004–06 to 172 in 2007–09.

Punjab tops up the federal government 700-rupee cash incentive with its own scheme offering an additional 1000 rupees to mothers – like Karamjeet – who give birth in a health facility. It also offers them free transport to these facilities.

Chatterjee points to other attempts to tackle the social factors that affect health. For example, the national union, to which she belongs, represents over 1.3 million poor, self-employed women mostly in the informal sector and offers its members social security schemes and health insurance according to their ability to pay.

She says that more girls are going to school since India's flagship programme for universal education and the Right to Education Act (2009) came into force. Literate women are more receptive to community health workers' messages.

Chatterjee also cites the Right to Information Act (2005), under which citizens have the right to request and receive government information in a timely manner. "People have started asking questions citing the Right to Information Act, asking why basic health services are not reaching them," says Chatterjee.

Maternal mortality has been declining across the country, from 254 deaths per 100 000 live births in 2004–06 to 212 in 2007–09. To further reduce these deaths, the Ministry of Health and Family Welfare launched the Maternal Death Review in 2010 to track key factors underlying such deaths. A key component is a verbal autopsy, consisting of a questionnaire that queries relatives or others who were caring for the deceased at the time of her death on the non-medical circumstances surrounding the death. This can help to identify the factors leading to death to allow the health system to take corrective measures. Punjab is one of several Indian states implementing the Maternal Death Review.

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Another initiative is the *Delhi Sehri Swastya Yojna* (Delhi Healthy Urban Project), a recently launched partnership between Sulabh International Academy of Environmental Sanitation and Public Health, a nongovernmental organization, and local authorities. It takes a holistic approach to improving health.

The increase in noncommunicable diseases in recent years in India also strengthens the case for greater emphasis on the social and cultural factors that determine health. "One good example of how various departments can come together is the fight against tobacco. There is a national level Inter-Ministerial Task Force on Tobacco Control, which has the finance ministry and the health ministry on board. If we want to really control noncommunicable diseases, we have to tackle their social roots," says Jarnail Singh Thakur, a noncommunicable diseases expert at the WHO Country Office in India. "The school should be the starting point for health promotion," Thakur says. WHO, he notes, is working in partnership with other United Nations agencies as well as academia, nongovernmental organizations and the public health community to advocate on this issue.

These may be steps in the right direction. But the recent turmoil across India also shows that there is a groundswell of rising aspirations, with people calling on politicians to tackle corruption. Karamjeet, the young mother from Punjab, one of India's affluent states, shows what can be achieved. The challenge is to make such cases the norm. ■

WHO/Patralekha Chatterjee

Community health worker on a home visit talks to a mother in Punjab state