

**Social Exclusion and Inequalities in  
Maternal Health**

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## Social hierarchies and Health

The health status of men and women in any society is the result of a complex interplay of many socioeconomic and political factors affecting their lives and not merely the presence or absence of any health care system. According to Commission on Social Determinants of Health (WHO 2008)<sup>1</sup>, inequities in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resources. Marmot also used the same logic two years back to explain the inequities in health, as he said that the disease and suffering of disadvantaged people in all countries are a result of the way we organize our societies, (Lancet, 2006)<sup>2</sup>. To explain his point he also quoted a study done by World Bank in 2000 - 2001, in which World Bank interviewed 60,000 people in 47 countries about what relief from poverty meant to them. The answers were opportunity, empowerment, security and dignity. According to him in both poor and rich countries poverty is more than lack of money or lack of resources; and it is social hierarchy which plays a major role in determining people's access to health and health services. These social hierarchies are not limited by the wealth index that populations fall in but also the historical identities that they carry with themselves. Though class also plays an important role as far access to health care and facilities is concerned, there are many more dynamics of our identity that come to play when we try to analyze access or quality of health care in any given society or social set up.

According to Whitehead et.al (2007)<sup>3</sup> the long term rise in average life expectancy in many countries gives the impression of almost continuous progress in health. But there are serious differences in health achievement of different groups within countries. The progress has been slower for some sections as compared to others and it has actually stagnated or deteriorated for others. He terms these systematic differences in health within societies - inequities, because they are avoidable and unfair. These social differences arise due to social hierarchies inbuilt in social system, which are either strengthened by the political forces or weakened by creating more opportunities for the communities living at the lower rung of the social strata. It is not automatic that provisioning of services will make sure it reaches to everyone. Studies done in developing countries also show that racial and ethnic discrimination effects people's health and their life expectancy in spite of having good health infrastructure and services. According to David Satcher (2006)<sup>4</sup> "the significant gender and racial gaps for African American men because of death rates associated with the prevalence of cardiovascular disease, diabetes, hypertension, cancer, HIV/AIDS, and homicide among this group. African American men are more likely to die

from these diseases, or their associated problems, and from homicide than their white counterparts”.

While social hierarchies are a social phenomenon present in every society, the degree of social differences that exists within a society varies from country to country and region to region. In India caste identities is a unique phenomenon which touches each aspect of people's lives and has deep rooted linkages with access to health and health status of communities at large. S.N.M. Kopparty (1995)<sup>5</sup>, showed the differences in utilization of health resources by various caste groups and its impact on their lives. Various caste groups in India face extreme forms of social exclusion including untouchability, apathy towards their problems and taboos related to their caste and religious identities. Social stigmas and identities have great bearing not only on their socio-economic status but on the health status as well. Menon and Contractor (2002), point out that Dalits (Schedule Castes) are not only socially discriminated and oppressed but also face ample inequalities in health sector as well. According to them earlier the form of oppression was clear and visible, which today has become more sophisticated thus difficult to pin point but it exists in subtle ways in almost all walks of life.

Tribal communities (Schedule Tribe) have been seen and categorized for a long time as socially and ethnically marginal and have the poorest socio-economic indicators. They constitute roughly 8 percent of the nation's total population, nearly 84 million people according to the 2001 census. Most of the tribal communities live in areas which are inaccessible by roads and lack most of the modern facilities like phone, train connections, industries etc. The tribal are at the lowest level of economic progress till date and have the largest number of poorest of the poor among them (Census 2001). Despite the efforts, tribal community remains aloof from mainstream progress not because they do not want, because the system fails to cater in a culturally sensitive manner. Government policies on forest reserves have affected tribal peoples profoundly. Wherever the state has chosen to exploit forests, it has seriously undermined the tribes' way of life. Government efforts to reserve forests have precipitated armed (if futile) resistance on the part of the tribal peoples involved.( James Heitzman and Robert L. Worden, 1995)<sup>6</sup> Being away from mainstream progress also makes them vulnerable to immense exploitation and oppression especially due to lack of employment opportunities and high rate of migration for livelihoods. (Shiraz Bulsara and Priyadarshini Sreenivasa 2003)<sup>7</sup> Thus tribal community in India is one of most vulnerable communities with lowest socio-economic development indicators.

There has been serious debate over whether social categories or class categories affect the health seeking behavior of populations. However many researchers also looked at the cross sections of society which reflected a complex interplay of caste and class together. A study done to understand health seeking behavior of people in Karnataka (Aditi Iyer et al 2007)<sup>8</sup> for long term ailments which lasted for more than two years on an average, it was found that gender and economic class made a difference in treatment seeking but no significant differences due to caste were reported. On the other hand K.R. Nayar (2007)<sup>9</sup> in his article on Social Exclusion caste and health, a review based on social determinants of health stressed that economic capability (poverty)/ gender/ age/ caste and religion etc. are important variables,

which indicate exclusion from socio-economical opportunities. Though he also gives a caveat that caste identities and economic conditions are interlinked in Indian context and they work as proxy to each other.

In addition to SCs and STs, the Muslim community is another social group which shows remarkably low indicators almost in all spheres of development viz economic progress/literacy or employment opportunities (Sachar report 2005)<sup>10</sup>. Being a religious minority they also face social discrimination. Thus Muslims can be easily categorized as socially excluded community in context of India and vulnerable to differences in access to health services. Though according to Sachar report the health indicators like IMR (Infant Mortality Rate) and Under 5 Mortality rate is better for Muslim community as compared to general population. These health indicators in spite of having low socio economic profile of majority of Muslims in the country raise questions and calls for an enquiry into the causes.

## **Maternal Health and Socio Economic Status**

International Conference on Population and Development (ICPD) held in Cairo in 1994 brought to limelight an issue which was considered important by most of the countries but lacked efforts and will to actually tackle it. The Cairo conference gave a vision for reproductive health especially for maternal health which also helped India adopt its reproductive and child health programme at national level. Later Millennium Development Goal (MDGs) also talked of the maternal deaths and reducing it substantially up to 2015. All this activated the sleeping system of India to some extent to take cognizance of the problem and react to the situation, however limited it might be. However all the governmental programmes have straight jacketed approach which fails to recognize socioeconomic differences playing major roles in deciding health seeking behaviour of women in majority of cases.

Socioeconomic variations which are mainly represented by caste in Indian context plays a significant role when it comes to measuring reproductive health of women amongst various caste groups. Papiya and Aditya Raj in their study on "Caste Variations in reproductive Health Status of Women", based on NFHS I found that 64.4 percent high caste women had High Reproductive Health Index (RHI) whereas among schedule caste only 36.5 percent women had high RHI. According to them caste status of individuals influences their socioeconomic variables that includes educational status, work status and standard of living, which in turn have impact on knowledge and utilization of contraceptive and reproductive health services. Thus access and utilization of health services by communities and women in particular determines reproductive health of women. As we go down the line, the reproductive status of women continues to deteriorate according to their position in social structure.

Women bear triple burden of discrimination, on the basis of gender and caste, in addition to poverty. In a society where women's concerns are not seen as important concerns and their status is linked to the utility to the , there are numerous indicators which show a

pathetic state of affairs as far as women's status in general and health status in particular is concerned.

## **Maternal health care in socially excluded communities**

Maternal health care has been seen at three level by most of the researchers i.e. ante natal care, care during delivery and post natal care. There are numerous studies which have specifically looked at various stages in the care system of pregnant women and have given different opinions about the interventions at various stages to improve maternal health, more importantly to reduce maternal deaths.

### **Ante Natal Care**

Ante natal care has long been considered one of the four important pillars of safe motherhood along with family planning, safe delivery and essential obstetric care (WHO1996)<sup>11</sup>. Radkar and Parusraman (2007)<sup>12</sup> observed that though place of delivery/abortion has no significant role in case of maternal death, ante natal checkups would definitely identify the problem on time and suggest referrals if required. For research purposes as well programmatic interventions ante natal care generally includes blood pressure check ups, three abdomen checkups administration of tetanus injections, availability of Iron and folic acid tablets and nutritional supplements.

According to Shariff and Singh (NCAER 2002)<sup>13</sup>, there are large variations in ANC usage across castes and religious groups, even after controlling for income and education. The report clearly sites that Muslim women and those from the schedule caste and tribes use/receive significantly less prenatal and postnatal care than upper caste Hindu women. Similar findings were revealed by Sandhya Rani et al (2007)<sup>14</sup> that ante natal care seeking among adolescent girls in Jharkhand was much lower as compared to national average. While majority of young women in Jharkhand (59 percent) received some antenatal services, the proportion of women who received full ante natal services was much lower that is 12 percent.

Raj and Raj (2004)<sup>15</sup> in their study revealed that there is large differences in access to ANC by women of different regions. They found out that, only 40.8 percent women in Bihar received ANC care as compared to 79.8 percent in West Bengal. Within these states also it was further seen that proportion of lower caste women receiving ANC was much Lower (35.5 percent) compared with their upper caste counterparts (68.1percent). Similar caste variations were noticed in Orissa also. More than 80 percent women from upper caste had access to ANC as compared to less than 70 percent from Lower caste (Ager and Pepper 2005)<sup>16</sup>. At the national level in the year 2003, WHO reported 48 percent, women had received ante natal care. The ANC coverage was found to be lowest in UP and highest in Maharashtra (WHO report 2003)<sup>17</sup>

As per NFHS 3 (2005-6)<sup>18</sup>, there are variations by religion in the likelihood of women receiving antenatal care. Amongst Muslims, the antenatal care was received by 73%

women compared to 78% Hindu women. The data also shows that likelihood of receiving any antenatal care was lowest for schedule tribe women and highest for women who did not belong to schedule tribe, schedule caste or Other Backward Castes.

### **Help During Delivery**

In addition to range of ante and post natal care health services, access to skilled care during childbirth is of vital importance to reduce maternal mortality towards maternal mortality reduction. Proportion of births assisted by skilled birth attendants is one of the ICPD +5 indicators and also one of the Millennium Development indicators. Although this is a process indicator, it is a vital indicator due to its strong links with maternal outcome Apart from ANC services a birth attended by a skilled health professional/birth attendant assures safe delivery and reduces risk to the life of the mother and the child (Raj and Raj 2004). Data from the NFHS-2 (1998-99)<sup>19</sup> shows that among all castes and groups, the highest percentage of anemic who delivered at home without skilled birth attendants were from ST community. They were also ranked lowest among women who had tetanus immunization and iron folic acid supplements during their pregnancy.

### **Access to Skilled Birth Attendant-National Averages for various social categories**

<b>Social Categories</b>	<b>NFHS-2</b>	<b>NFHS-3</b>
Other caste (Hindu)	41.6	47.5
Muslims	39.2	38.8
Schedule Tribe	23.0	25.4
Schedule caste	36.8	40.6

The gap in provisioning of a skilled birth attended widens with the social religious identities. This is one concrete indicator which shows that maternal health facilities are not available and accessed by every one equally, in spite of being crucial in checking maternal deaths. As shown in the table, according to NFHS-3, nearly 48 percent women from 'other caste' category delivered with the help of a skilled birth attendant, the percentage was as low as 25 percent for schedule tribe women. Access to skilled birth attended is also reasonably low for Muslim women at 39 percent and it has not changed from NFHS-2 to NFHS -3. If we go by the data from RCH 2 (2002-04)<sup>20</sup>, less than 50 percent deliveries in India can be called 'safe' that is attended by skilled personnel. Again according to RCH 2 also, schedule tribe (28%) and Muslim (44%) women are the one with minimum possibility of having a safe delivery amongst all social categories.

According to an ICMR task force study in UP (2006)<sup>21</sup>, over 75 percent of the 212 cases that died during intra-natal or post natal period had delivery/abortion at home. In comparison the proportion of home deliveries among the survivors' group, was higher (90%) than that reported in maternal mortality group. Similarly higher proportion of women in survivors' group (90%) had their delivery conducted by Dai or other untrained

person. In Bihar, skilled professionals attended only 23.4 percent deliveries and the situation was grimmer for the lower castes. Less than 20 percent births were attended by skilled health professional against 53.4 percent among higher caste women's deliveries. The differences were highest in West Bengal amongst high and caste communities seeking help from trained health professionals. 60 percent of the births among the high caste were assisted by skilled professional, in contrast to 26 percent among the lowest caste. (Raj and Raj 2004).

### **Post Natal Care**

Post delivery care is equally crucial to improve maternal health as assistance during delivery as majority of maternal deaths take place during these two stages. In fact the maternal deaths are highest due to post partum complications i.e 60 percent of all maternal deaths occur after delivery (WHO 2000). Thus maternal deaths and illness due to pregnancy, both are linked to the conditions during and after delivery. According to WHO report (2003), up to 80 percent of maternal deaths are due to direct obstetric causes like hemorrhage, eclampsia, infection etc. In the context of India seeking post partum care is not very common unless there are serious complications. Thus the proportion of people seeking post natal care or services reduces drastically as compared to those seeking or receiving ante natal and intra natal care and services. Unfortunately there is no segregated data available for various caste groups according to access or availability of post delivery services. But looking at the trends of less access to all kinds of care, one can easily draw inference that in case of post delivery care also women from lower caste and tribal groups do not get their share of care and facilities.

According to NFHS 3, births to Jain (74%) women is most likely to be followed by a post natal checkups and births to Muslim women (36%) are least likely to be followed by a post natal check-up. Again in this case also schedule tribe women (33%) have the least likelihood of post natal checkup amongst all social groups.

### **Maternal Mortality**

According WHO report (2005)<sup>22</sup>, nearly 5,36,000 women die each year world wide from complications of pregnancy and child birth. Over 99 percent of these maternal deaths take place in developing countries, out of which nearly 1,88,000 maternal deaths take place in South Asia region that is India, Bangladesh and Pakistan. There are more maternal deaths in India in one day than there are in all the developed countries in one month. According to WHO, UNICEF, UNFPA and World bank combined report, India has the largest number of women, 117,000 dying from maternal causes each year followed by Nigeria, where the number is 59,000. The adult life time risk of maternal deaths (the probability that a 15 year old female will die eventually from a maternal cause) is 1 in 70 in India. This means that out of every 70 adolescent girls there is probability that one will eventually die due to reproductive responsibilities (WHO, UNICEF UNFPA, World Bank 2005)

Based on various evidences that are available from national and state level studies, maternal mortality is a problem of serious proportions in India, but still there is no consensus among researchers, activists and policy makers on the extent of problem. Thus the estimates around Maternal Mortality Ratio (MMR) are also an area of contestation amongst various health researchers and activists. As per P.N. Mari Bhat (2003)<sup>23</sup>, in spite of the growing concern about reproductive health, information on levels, trends and differentials in maternal mortality remains fragmented in India. According to him the widely used data for maternal mortality is based on NFHS -1 and NFHS- 2 is also limited in its estimations and not able to give regional variations. As the maternal mortality was reported at 437 by first round of NFHS and it second round of NFHS reported a much higher mortality rate i.e 520 per 100,000 women, but failed to confirm statistically the possible rise in the level of maternal mortality. Registrar General of India, also chipped in to fill the data gap and gave estimated of 407 maternal deaths per -100,000 women but state level patterns indicated by it raised some critical questions.

There seems to be a contradiction about the MMR in India and particularly in various states. Not just the maternal death count is difficult to reach it is more difficult to know the real causes of deaths and thus there is always an uncertainty about the extent of problem though there is a general consensus amongst most groups that the problem is greater than what it is reported. Many researchers agree that in the context of high levels of maternal mortality in India there is very little information that is available about the deceased women (Radkar and Parasuraman, 2007).

In case of segregating maternal mortality data on socio economic conditions, there is very little that is available through research and empirical studies. As mentioned earlier, most of studies which looked at the impact of socio economic conditions on health looked at the poverty as overriding and single most important characteristic leading to differing health status and health behaviours. However a recent study done by UNICEF (MAPEDIR, 2008)<sup>24</sup> has traced the causes and extent of maternal mortality according to caste categories in rural India. The report clearly established that certain communities like schedule caste and schedule tribe are more disadvantaged than other communities. Whereas some researchers also argued that though it is the poverty which impacts people's health, control over resources is part and parcel of the caste system in India and thus lower caste communities are also the poorest communities (Menon and Contractor 2004) Thus caste and class play together for these marginalized communities and more so if the cause is related to women that is maternal health. Feminists have argued that women wear the triple burden of caste and class gender oppression and face more discrimination than their counterparts within their caste groups.

Thus when we talk about the maternal mortality amongst Schedule caste and Schedule tribe women, the figures are much higher, though there are no real estimates or consensus about the extent of problem amongst marginalized groups. According to MAPEDIR, 2008 61 percent of the reported maternal deaths were from lower castes. 37 percent of them were from schedule caste which, form only 16 percent of the total population at the national level and 24 percent were from schedule tribe which form only 8 percent of the

total population at national level. Another estimate based on RCH-2 revealed that among those who died 84 fetched water from outside the house and 72 percent of them had no toilets. Only 20 percent lived in pucca house. The differentials in maternal deaths were observed by caste and standard of living of women along with place of residence, indicating that lower socio-economic groups experienced maternal mortality more (Radkar and Parsuraman, 2007).

Another estimate based on the sisterhood data collection method, the maternal mortality ratios were found quite high among Schedule castes and tribes. It was 652 for schedule tribe and 584 among schedule caste per 100,000 women as against 516 among higher castes (Levels and Differentials in Maternal Mortality in Rural India: New Evidence from Sisterhood Data, P.N.Mari Bhat 2002). If we look at the regional variations, states with low socioeconomic performance and with higher percentage of schedule tribe and schedule caste populations are faring poorly in maternal health also. As per ICMR study (1989), data from 7 districts of Uttar Pradesh showed a range of 533-745 deaths per 100,000 live births except in Ghaziabad. Like wise maternal mortality is very high in states like Orissa, Jharkhand, Bihar and Chhatigarh. But there is need to substantiate this knowledge with facts and figures. There is also a larger need to segregate data based on caste profile to actually estimate, how social hierarchies are impacting women's access to reproductive health, a known reality not backed by data.

Number of studies in addition to NFHS has suggested that Muslim women have less access to maternal health care as compared to Hindu women in general. But maternal mortality among Muslim women is lower than Hindu women in all. This is one paradox which has not got the attention of researchers and there are no explanations available for this phenomenon. In addition to Sachar Committee, this has been reported by sisterhood data collection method also. The MMR among Muslims is 384, as compared to MMR of women from other religion which is 428. If we compare the same with only Hindu women the difference is much larger at 573 MMR (P.N. Mari Bhat 2002). Due to lack of research in this area there are no logical reasons to explain it unless the whole gamut of things including cultural practices are studied and understood. . Till now we have no answer to the question as to why maternal mortality is lower among amongst Muslim women despite having low indicators of Ante Natal and Post natal care as well as availability of skilled birth attendant during child birth.

The background characters which have been known to impact the maternal health are literacy level, economic status and access to ANC and PNC services. Muslim women have minimal figures for almost all the indicators, ensuring better maternal care including very low likelihood of having skilled birth attendants for delivery. Yet the maternal mortality among Muslim women is not so high as among schedule caste and schedule tribe women. In fact it is better than majority of Hindu women who have better access to most of maternal care facilities than Muslim women. The literacy levels of Muslim women are also known to be poor along with wide spread poverty among majority of Muslim population. Thus none of the indicators suggest any clue as to why maternal mortality is not so high among Muslim women. This is one area which needs careful study and understanding of

the reasons what helps or deters maternal health when it comes to specific communities or social identities from equity perspective.

## **Discussion**

Inequities in health have been the centre stage since early 90s and there have been numerous researches and arguments which established that the unequal health status does not only exist between countries and regions but also within countries and within societies as well. Studies done in America and Britain also tried to argue that within developed countries, disparity lies among various classes and more specifically among races like whites and blacks. Like wise large differences in health status within countries and amongst various communities has been studied and put forward for policy makers and health activists.

In context of India there is an overall understanding that health status and access to health services is not equal among different groups divided by various socioeconomic and demographic characteristics. Most of this understanding is based on the economic profile of the populations and researchers have established it beyond doubts that wealth index has major role to play when it comes to the health status or health accessing behavior.

However a society characterized by its unique hierarchical caste system, can not be understood entirely on the basis of economic conditions. The caste system in India not only decides the social status but also defines which communities will enjoy most of the rights and privileges and which will be marginalized in almost all spheres of life. Thus such communities like Schedule Castes and Schedule Tribes are known to be marginalized or socially excluded groups. Though constitution of India assures equal rights and equality to its all citizens, in reality equality is still a dream. Another kind of marginalization has been prominently visible is of Muslim community due to various reasons. A holistic review by Sachar Committee threw a light on the fact that Muslims are not only religiously marginalized but have very poor socioeconomic conditions as well.

Some of the researchers thus also tried to look at the influence of caste and religious categories on health status of communities. However these researchers cautioned that because caste and class operate hand in hand in Indian society it is difficult to just make one of these as the deciding criteria for commenting on health status. Most of the researches that we find around factors influencing health have economic condition as the major criteria and caste as sub criteria influencing within economic status.

From an equity point of view, it is important for us to understand the influence of caste as it not only decides economic status for most of people but also has larger and deeper impact on the perceptions and attitudes of the communities (health seekers) and health providers.

Women in general and poor low caste women in particular are most vulnerable to morbidity and mortality due to gender discrimination and their over rated reproductive roles in Indian society. Maternal death is an accepted reality and morbidity is of no consequence as long as reproductive duties are performed by women according to the demands of the family and society. In such a scenario it becomes all the more difficult to really understand the differences based on caste as even the general morbidity and mortality data is beyond acceptable limits. May be that is the reason why there is not much information available on segregated data for different castes, and whatever little is available; there is no consensus among researchers about one figure which can tell the exact extent of morbidity or mortality amongst various caste groups.

Nevertheless, we have substantial data to show that the dalit (schedule caste) and schedule tribe women are at the lowest rung of the maternal health status with least access to ante and post natal care and highest mortality rates. The rate of home deliveries is highest among tribal women, and chances that their deliveries will be attended by a skilled professional are lowest. The data of maternal mortality may vary from state to state but maternal mortality is high among marginalized communities that Dalits and tribes as compared to non SC and non ST communities across the states. However the differences are more in poor performing states like UP, Bihar, Chhattisgarh or Jharkhand. Unfortunately these are also the states with substantial population of SC, ST and Muslims. According to SRS 2006<sup>25</sup> among the total number of deaths thirds of the deaths are from empowered action group states namely-Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan, Uttar Pradesh, Uttarakhand, Orissa and Assam.

For unexplained reasons the mortality and morbidity ratios are very low among Muslim communities. While Muslims are comparable to SCs (just above STs) in terms of educational status and economic conditions, the reproductive health of Muslim women is much better than their counterparts in Hindu community or other religions if taken together. This means that they have mortality which is much less as compared to SCs and STs, whereas their access to health services or capacity to spend on health services is as low as of any marginalized community. It is already established beyond the realms of doubt that poverty has direct linkages with health indicators. What makes Muslim community better on health indicators in spite of having socioeconomic indicators lower than schedule castes have to be understood?

One of the logics given to explain this situation is urban nature of habitation amongst most of Muslims and according to Sachar committee because most of Muslim population lives in urban centers compared to other population which lives in rural areas having poor health infrastructure and facilities. Thus if Muslim community is compared to Urban population, the health indicators are more or less similar. Another factor which can help in explaining the situation could be historical reason. But all these need a more careful study before they can be used authoritatively to explain this phenomenon.

The data around maternal morbidity or maternal mortality is just the tip of the iceberg to show the disparity among various groups and their relationship with caste. There are

numerous other ways in which these communities face discrimination and it has not been documented yet for the simple reason as most of the health researchers have seen the differences in access to health service from poverty point of view and not from caste angle. Even when caste dimensions have been studied, they were qualified for the poverty dimension as well. While there is no denial of the fact that poverty has a major role to play on health seeking behaviour and access to health care, caste also plays out in unique ways known to Indian communities from time immemorial. For example many studies (not published) have reported that when lower caste women go for abdominal check up doctors or Nurses who mostly belong to upper caste don't like to touch them. Like wise there are more ways in which certain communities are discriminated due to their social identities.

There is lack of data to capture those differences in details in mainstream literature especially what is available through print etc. While the data is sufficient to establish that a difference exists, there is a need to look at these differences more closely. At the same time it is also important to study the nature of differences because just some mortality figures do not tell the whole story. To understand the problem in its entire complexity we need to undergo a more extensive and detailed search of ground reality as far as maternal health and social exclusion is concerned.

## References

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<sup>1</sup> Closing the Gap in a Generation; Commission on Social Determinants of Health, World Health Organization (2008)

<sup>2</sup> Marmot M. (2006), Health in an unequal world, *The Lancet*, 368, Pp 2081-94

<sup>3</sup> Margret Whitehead, Goran Dahlgren & Di Mc Intyre (2007); Putting Equity Centre Stage: Challenging evidence free reforms, *International Journal of Health Services*, Vol 37, Number 2

<sup>4</sup> David Satcher (2006), Ethnic Disparities in Health: The Public's Role in Working for Equality, *PLoS Med.* 2006 October; 3(10): e405. Published online 2006 October 24. doi: 10.1371/journal.pmed.0030405

<sup>5</sup> S.N.M Kopparty (1995), *Social Inequality And Health Care*,

<sup>6</sup> James Heitzman and Robert L. Worden, editors. *India: A Country Study*. Washington: GPO for the Library of Congress, 1995. <http://countrystudies.us/india/70.htm> dated 23/02/09.

<sup>7</sup> Shiraz Bulsara and Priyadarshini Sreenivasa (2003) Driven to bondage and starvation *Combat Law*, Volume 2, Issue 5, December-January 2003/4 <http://www.indiatogether.org/combatlaw/vol2/issue5/bondage.htm> dates 23/02/09

- 
- <sup>8</sup> Aditi Iyer, Gita Sen & Asha George (2007); The dynamics of gender and class in access to health care: Evidence from Rural Karnataka India, *International Journal of Health Services*, Vol 37 number 3
- <sup>9</sup> K.R.Nayar (2007); Social Exclusion caste and health: A review based on the social determinants framework, *Indian Journal of Medical Research*, Vol 126, Number 4, October.
- <sup>10</sup> Sachar Report (2006), *Social Economic and Educational Status of Muslim Community of India*, Report of the Prime Minister's High level Committee headed by Justice Rajinder Sachar.
- <sup>11</sup> World Health Organisation (1996); *Regional health report, 1996*, New Delhi: WHO Regional office for South East Asia.
- <sup>12</sup> Anjali Radkar, Sulabha Parasuraman, *Maternal (2007)*, Deaths In India: An Exploration; *Economic and Political Weekly*, August 4, Pp 3259-3264
- <sup>13</sup> Abusaleh Shariff and Gita Singh, (2002) *Determinants of Maternal Health Care Utilisation in India: Evidence From a Recent Household survey* ; Working Paper Series No 85, National Council of Applied Economic Research.
- <sup>14</sup> Sandhya Rani, Saswata Ghosh and Mona Sharan, (2007) *Maternal Healthcare seeking among Tribal Adolescent Girls in Jharkhand*, *Economic and Political Weekly*, December 1, Pp 56-62
- <sup>15</sup> Papiya Raj and Aditya Raj (2004) *Caste Variations in Reproductive Health Status of Women: A Study of Three Eastern States*;, *Sociological Bulletin*, 53(3), September-December 2004, Pp 326-346.
- <sup>16</sup> Alastair Ager and Katy Pepper (2005) *Patterns of health service utilization and perceptions of needs and services in rural Orissa*;, *The Author 2005*, doi: 10.1093, Pp 176-184
- <sup>17</sup> WHO (2000), *Maternal Mortality in 2000: estimates developed by WHO, UNICEF and UNFPA*, [http://www.who.int/reproductive-health/publications/maternal\\_mortality\\_2000/mme.pdf](http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf), accessed on 16 Dec 2008
- <sup>18</sup> NFHS (2005-06), *National Family Health Survey -3*, International Institute for Population sciences (IIPS), Mumbai, India
- <sup>19</sup> NFHS (1998-99), *National Family Health Survey -2*, International Institute for Population sciences (IIPS), Mumbai, India
- <sup>20</sup> RCH (2002-04), *Reproductive and Child Health, District level Household Survey-2*, International Institute for Population sciences and Government of India, Ministry of Health and Family Welfare.
- <sup>21</sup> N. Gupta, S. Kumar, N.C. Saxena, Deoki Nandan and B.N.Saxena (2006) *Maternal Mortality in Seven Districts of Uttar Pradesh-An ICMR Task Force Study*; *Indian Journal Of Public Health*, Vol. XXXXX No. 3, July-September, 2006, Pp 173-178.

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<sup>22</sup> WHO (2005), Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank, [http://whqlibdoc.who.int/publications/2007/9789241596213\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf), accessed on 16 Dec 2008

<sup>23</sup>P.N. Mari Bhat (2002) Levels and Differentials in Maternal Mortality in Rural India: New Evidence from Sisterhood Data; Working Paper Series N0. 87, National Council of Applied Economic Research

<sup>24</sup> MAPEDIR (2008), The Maternal and Perinatal Death Inquiry and Response, UNICEF, New Delhi.

<sup>25</sup> SRS (2006); Maternal Mortality in India: 1997-2003, Trends Causes and Risk Factors, Registrar General of India, New Delhi

Summit Menon and Qudsiya Contractor (2004), Dalits and Health; Centre for Health and Allied Technologies, Mumbai, India

I Anwar, M Sami, N Akhtar, U Salma, M Rehman & M Koblinsky (2008) Inequity in maternal health-care services:evidence from home-based skilled-birth-attendant programmes in Bangladesh;, Bulletin of the World Health Organisation, April 2008, 86 (4) Pp252-268.

Krishna Rao and G.N.V Ramana (2004) India: Equity Effects of Quality Improvements on Health Service utilization and Patient Satisfaction in Uttar Pradesh State; David Peters, , Health, Nutrition and Population (HNP) Discussion Paper

Bashir Mamdani (2007); The social hierarchy of health; Indian Journal of Medical Ethics, Vol IV, No. 2, April-June 2007, Pp 87-90.

K Srinivasan and Sanjay Kumar (1999) Economic and Caste Criteria in Definition of Backwardness;, Economic and Political Weekly, October 16-23, 1999, Pp 3052-3058

Jeremy Shiffman, PhD (2007); Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries;, American Journal of Public Health, May 2007, Vol 97, No 5, Pp796-803

Margret E Kruk, Sandro Galea, Marta Prescott, and Lynn P Fredman (2007), Health care financing and utilization of maternal health services in developing countries; The Author, August 2007, 22, Pp 303-310

Roberta A. Downing, PhD, Thomas A. Laveist PhD and Heather E. Bullock (2007) Intersections of Ethnicity and Social Class in Provider Advoce regarding reproductive Health;, PhD, American Journal of Public Health, October 2007, Vol 97, No 10, Pp 1803-1807

Gita Sen, Aditi Iyer and Asha George (2007) Systematic Hierarchies and Systematic Failures;, Economic and Political Weekly, February 24, 2007, Pp 682-690

Safe Motherhood- A Newsletter of Worldwide Activity; World Health Organization (1994), Geneva

---

Bulletin of the World Health Organization, Print ISSN 0042-9686, Bull World Health Organ vol.85 no.10 Geneva Oct. 2007. [http://www.scielosp.org/scielo.php?pid=S0042-96862007001000015&script=sci\\_arttext](http://www.scielosp.org/scielo.php?pid=S0042-96862007001000015&script=sci_arttext). Dated 6.03.09.

Proportion of births attended by a skilled health worker - 2008 updates, WHO Monitoring and Evaluation. [http://www.who.int/reproductive-health/global\\_monitoring/skilled\\_attendant.html](http://www.who.int/reproductive-health/global_monitoring/skilled_attendant.html), dated 6.03.09