

# FIELD VISIT NOTE: AADHAAR USE IN MIGRATORY WOMEN SEEKING MATERNITY CARE

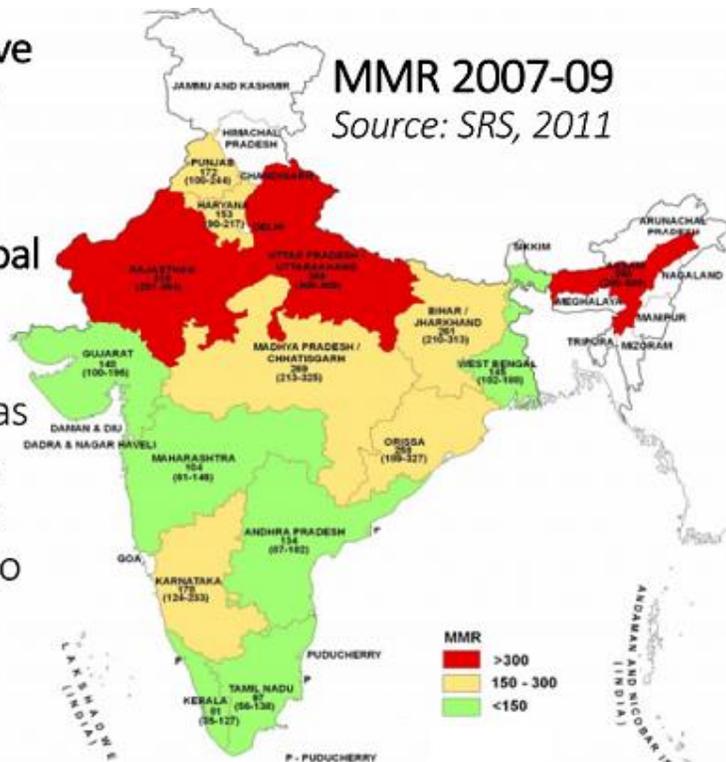
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## INTRODUCTION

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Maternal care provisions in the country continue to be a pressing problem: The Maternal Mortality Ratio defined by the number of maternal deaths that occur within 42 days of the termination of a pregnancy stands at 130 per 100,000 live births for the period of 2014-16. Only three states have achieved MMRs of less than 70 per 100,000 live births as per the target of the Sustainable Development Goals. (PTI, 2018) As per the District Level Household and Facility Survey of 2007-08, an estimated 52.3 percent of deliveries occurred at home with only 5.7 percent being attended to by a Skilled Birth (Charlette, Kankaria, Rai, Krishnan, & Kant, 2017; Tyagi, Pattabi, & Kaur, 2016) Attendant (SBA). (Ministry of Health and Family Welfare, 2010). Although institutional births have risen considerably since 2005-06, adequate antenatal care (ANC) provision remains low, below 10 percent of women in several states of the country.

Only 3 states have achieved MMRs less than the Sustainable Development Goal The Maternal Mortality Rate (MMR) defined as maternal deaths per 100,000 live births dropped to 130 in 2014-16, down 22% from 2013.



Multiple studies have shown that receiving ANC is correlated with mothers seeking institutional delivery and with infants receiving timely vaccinations, which makes ANC a critical component of maternal care and sets the pace for downstream services. The government has institutionalized guidelines for maternal care and more recently instituted the Janani Suraksha Yojana which includes four visits by trained providers, injections and supplements, emergency transport, delivery, PNC etc. (Charlette et al., 2017; Tyagi et al., 2016). The maternal care process flow in India is shown below.



A research partner who runs affordable maternity hospitals in Hyderabad has cited fragmentation of care as an ongoing problem. This includes women who choose to transfer between providers/doctors especially when they move from their marital to their maternal homes for delivery. A similar problem is found for healthcare among populations that migrate for labor and this is better studied than the former: studies show that migrants are less likely to receive ANC and that differences in care exist between women who are resident to an area and those who recently move. (Mohan, 2017) (Gawde, Sivakami, & Babu, 2016).

To determine the suitability of Aadhaar for application in this area, literature on technology applications were also covered such as UNICEF’s Maternal Death Review, ANMOL and Khushi Baby. The latter, for example, consists of mothers provided with a unique, wearable record of their digitized health data with offline access which transmits to a consolidated dashboard, providing accountability and real-time information. The program has so far covered 10,000 registrations and 50,000 immunizations for infants by training 87 ANMs in 365 villages. (Singh, 2016; UNESCO, 2015).

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## DISCUSSION WITH STAKEHOLDERS

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Discussions were held with doctors, ANMs and other healthcare workers in both the government system (in villages on the outskirts of Hyderabad) and in the private healthcare system with Lifespring Maternity Homes. Preliminary interviews with 15+ women who sought maternal care at Lifespring Hospitals, which would form a basis for a survey were held. Along with the above, field visit to understand how the tablet-based application for maternal care that has been rolled out in Telangana works was undertaken.

From preliminary discussions, it appeared that fragmentation of care was a problem for only certain pockets of the population. A nuanced research problem that emerged was that of difficulties with Aadhaar based registration of informal sector women in urban areas – either residents who don’t have an address proof in the city or seasonal laborers – who are denied healthcare or monetary benefits of healthcare schemes because their Aadhaar cards don’t reflect their residency status.