DEAD WOMEN TALKING II
Learning from Women's Experiences

Report of a Workshop, February 26, 27 and 28, 2014

CommonHealth with CEHAT, SAMA, SOCHARA, SAHAJ,

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Sarvodaya, St. Pius Campus, Goregaon, Mumbai

I. BACKGROUND AND INTRODUCTION:

Many organizations and networks across India have been working in the area of maternal and neonatal health. As a group they came together 18 months ago to develop a framework wherein they could advocate for the cause and influence policy changes. The group came together as Dead Women Talking in a Workshop in Chennai in June 2012. What emerged was an understanding of the gaps in the GOI MDR Guidelines and tool. Social determinants like caste, gender, etc were missing in the tool. A small group of individuals attending the DWT meeting came together to develop a Social Autopsy tool for Maternal Deaths. Post the DWT Meeting, CommonHealth, with the help of several individuals and organizations, has been engaged in training several grassroots organizations across the country in use of the tool and documentation of maternal deaths. Several states that have been covered by these trainings - UP, Bihar, Orissa, Jharkhand, Maharashtra, Gujarat, Chhattisgarh, and a few states of the North East.

After the training, participants from these organizations have been documenting maternal deaths. It was now felt that this would be a good time for members across the country to get together to review the process of this maternal death documentation and also to explore what is emerging from these varied contexts in terms of determinants of maternal deaths. Towards this, CommonHealth, in partnership with CEHAT, SAMA, SOCHARA, SAHAJ, organized a three day workshop in February 2014 (Feb 26th, 27th, 28th) in Mumbai. 30 participants from 18 organizations attended the meeting. A few participants joined on the second day – amongst them were Dr. Prakasamma, Smita Baajpai, and Dr. Sharad Iyengar and Dr. Aditi Iyer joined on the third day. The schedule of the Meeting is in Annexure 1. List of participants is in Annexure 2.

The objectives of the two day workshop were

a) To review the tool that emerged out of the Dead Women Talking and that has been used across several states, experiences and challenges with using it.

b) To analyze factors behind the documented maternal deaths and bring out what could possibly be a civil society shadow report on maternal deaths.

As preparation participants had been asked to send in the stories on all maternal deaths they had documented as well as to share their experiences of documenting maternal deaths on a prescribed format. See Annexure 3.

II. HIGHLIGHTS OF SESSIONS

DAY 1, 26TH February 2014

a) Experiences of conducting social autopsies: (Session 1, 10:00 am to 11:30 pm)

The first session was on people's experiences of conducting social autopsies, the process involved, challenges, and also any comments they had on the tool. Participants shared the following.

1) Value Addition: There was an agreement that the tool was exhaustive and addressed several issues related to social aspects of maternal deaths that were not considered before.

2) Lengthy: The tool is long and it is difficult to remember the questions in so much detail, especially for the field workers.

3) Need for observation, not just interviews: A lot of information cannot be sought the way it is asked in the tool – it has to be inferred from the living conditions and through the fieldworker's own observations. For instance, information on how far the water source is from the home. Some participants stated that transect walks through the village helped them to observe some community factors – like well, type of house, school and so on.

4) Differing information gathered from various sources: Participants mentioned that often, the information gathered was from different sources. For instance, the natal family and marital family may have differing perceptions about how the woman's relations were with the rest of the family. However, in order to get a holistic picture, it is important to gather information from varied sources – the doctors' version is also important though it was very difficult to get this.

5) Challenges in getting information about social aspects: Participants felt that often, one cannot be sure of the validity of information received from the family. For instance, they may say that her food intake was excellent, she had no problems, did not do household work before the pregnancy. However, it is natural that the family also has an instinct to protect itself and would not want to say if the woman was ill treated. Families also feel like the interviewer is targeting them and trying to pin the blame of the woman's death on them.

6) It was also noted that families tend to talk about what happened on the day of the death, or the incidents surrounding the death. In the process of analyzing the deaths, some background social determinants get neglected like house type, occupation, NREGA holder, SHG member, etc.

7) There was a consensus all around that more than just one or two visits are required to get all the information. One reason being the long format, but other than that, it is also critical to establish good rapport with the family in order to gain information.

8) A Team approach is required to conduct the interviews – often people at varying levels would visit the family as part of the team and ask different questions to the ASHA, ANM, Dai, etc. The quality of questioning and information obtained varies according to who is asking the questions. Field workers doing social autopsies are not optimal.

9) Reluctance to speak to interviewers: Participants noted that usually anganwadi workers and ASHAs were very reluctant to talk about the death. Some participants also noted that families themselves were reluctant, especially when the system itself had done a death review. They found it pointless to talk about the issue again, and were also suspicious of the interviewers. Participants also noted that neighbors were reluctant to give any information at all.

10) The need for getting a health system perspective was expressed – as of now, generally, only the family's version was being gathered, view of the doctor, service provider, etc was missing which is also very important. It has been difficult to get the health system perspective through interviews with providers. Families often had little or no information about the technical details. Any documents that families might have are burned when the woman is cremated. Further, when the case was presented at a *Jan Sunwai* or to the authorities, it was challenged stating that there is no information of what the hospital did, thereby questioning validity of the claim that the system had been unable to save the woman. Moreover, adding a health system perspective would also help to understand better why a woman was not provided services, thereby providing more insight into possible solutions.

11) Lack of medical system records – one of the biggest issues mentioned by participants was that families hardly ever had any documentation of the treatment provided to the woman, or even reasons for why she had been referred from one place to another. Very often, the death had not been recorded by the health system at all (for e.g., a woman may come to the CHC, is not registered there, directly told to go to the DH, dies on the way – no one is aware of her death). There are instances wherein there is no documentation of the deaths, in spite of its occurrence in medical colleges of cities. When it had been recorded, there was no transparency in providing records. It was discussed that this must be taken up as an important advocacy issue.

12) Challenges in tracking deaths: participants spoke about how difficult it is to get information about deaths, even if they have been working in the area for a long time. Maternal deaths do not get reported because there is no clarity about what constitutes a Maternal Death. Different organizations shared their strategies for how reporting could be increased. For instance, Amhi Amcha Arogya Sathi used a snowball method to get information about deaths in the area. JSS has used a combination of RTI, news papers, holding meetings with VHSCs and Gram Panchayats to get access to information about deaths. ANANDI in Gujarat has been sending text messages to the CDHO when they hear of a death that has not been recorded by the system, thereby putting pressure to ensure that all deaths are recorded**.** PHC level, CHC level it is still possible to get information as there is rapport, the problem lies at the District level. They generally don't have any documents.

13) Response of system when issues are presented to them: Some of the organizations had conducted Jan Sunwais to raise concerns about the maternal deaths. Their experience was that

the officials try to discredit the statement of the victim's family saying that there are no hospital papers to prove the accusation as also try to discredit the organization by saying that they were not competent to arrive at a cause of death. When they accepted there was a death, they would either victimize the family, saying that they did not feed the woman well, she was anaemic, etc. or try and shift the focus to social causes and then ask about what the NGOs were doing**.**

14) Lastly, the question of expectations of the family was discussed. Even though at the beginning of the visit, the NGO teams clarify that the purpose of their enquiry and that they would not be able to ensure any compensation, etc. families' expectations do get raised. Participants felt that having a concrete outcome such as a *Jan Sunwai* was useful as families were able to see that their problems were at least being heard by the officials, and not being merely noted down by an interviewer.

Emerging issues and suggestions

1) There is certainly a value addition that social autopsies bring to the MDR process.

2) Lack of transparency in the health system, and the unavailability of medical records is a big hurdle that must be addressed a pertinent advocacy issue. The fact that both the medical systems as well as the community were reluctant to acknowledge and talk about the maternal death is emerging very strongly. This is a challenge in conducting MDRs.

3) Problem in tracking maternal deaths seems to be a common challenge faced by several organizations and this too needs to be discussed at length. There has been some sharing of ideas as to how this problem can be overcome and these must be followed up. One necessary step is getting reports of all women who die in the reproductive age group. And then investigating each of these to establish that it is indeed a maternal death.

4) Deaths due to unsafe abortions, deaths during home deliveries and late maternal deaths are likely to get missed out in reporting of maternal deaths. There were areas where people did not even know the definition of maternal deaths, definition of abortions**.** Unless proved otherwise, the death of a woman in the reproductive age group should be considered a maternal death as it is likely to have been caused by factors related to maternal and reproductive health.

5) Training of fieldworkers who report maternal deaths, and conduct social autopsies is critical and some detailed guideline for this also is required.

6) There are a lot of insights into the process that needs to be followed while conducting MDRs, which is emerging –the composition of the team conducting interviews, training of the team, rapport building, number of visits required, need for observation etc.

7) It was suggested that guidelines be prepared for conducting such autopsies, incorporating instructions on all of the above mentioned aspects, which would supplement the format.

b) *Feedback on the tool:* (Session 2: 12:00 – 1:00pm)

Since only four participants had shared their feedback on the prescribed format, the participants were divided into groups and asked to discuss certain questions with regards to the tool.

General feedback on the tool

1) It is lengthy and needs to be shortened. It also needs to be more systematic and some questions which are repetitive must be removed.
2) Needs a lot of formatting, a lot of information can be put into table format so that it is systematic and also shorter.
3) Needs to be clubbed into sections with corresponding guidelines for each section in an accompanying document.
4) The tool should be used as a checklist rather than as an interview guide.
5) Having different forms for antenatal death, intranatal death, and post natal death could be considered.
6) There is need for capacity building on actual use of tool.
7) Multiple sources of information should be taken into account while recording maternal deaths.
8) Prevalence of superstitions surrounding maternal deaths should be recorded.

Time taken to collect information

It takes at least 3 visits, one hour per visit on an average in order to do a verbal autopsy. In some cases, a lot of travel also may be required (for instance if she is a migrant and has moved to another village) so the time required increases tremendously.

Problems with specific sections

1) Participants found it tedious to fill out the section on referrals and felt that having a horizontal flow would be easier. This is there in the ARTH format and can be adopted.
2) The section on 'rights' is difficult to get information on – family may not give the correct information as family members themselves may be involved in violating the woman's rights. Subhasri mentioned that gender issues and rights' violations have to be inferred – they cannot be asked about directly.
3) The section on analysis was difficult to fill out. Participants felt that some guidance is required in filling out this section. Some examples can be provided, specifically to identify gaps.
4) The sections on violence, suicide, pressure to have a male child, alcohol addiction, distribution of food in the family are difficult to ask. There needs to be some guidance on it.
5) Family is also not able to give information about reproductive history very well.
6) Questions around alcohol, smoking and gutka are cultural and contextual – maybe these should be left out? Or noted based on observations about the community and family?
7) ANC section – the family says ANC was done and the ANC cards also record everything as good – difficult to infer anything from these sort of reports and sources.

Following sections can be added

1) Questions around deaths during home deliveries need to be sharpened.
2) Case records – whether available or not, if available they should be listed and attached
3) Information about health facility and what happened at the health facility. If medical records are available, they should be attached.

4) Information about whether the death was reported in the system, whether or not an MDR was done by the system.
5) Ask questions about who is looking after the baby if the outcome was a live birth.
6) A separate mention of private provider should be made if the woman sought services from one. Also, traditional providers such as tantriks, vaids, *jhaad phoonk* needs to be included.
7) A section on traditional beliefs is required. Several families and even ANMs express in the interviews that *'aurat pe bhoot chadh gaya tha'*. There should be space within the format to record such beliefs.
8) More questions on nutrition can be added – again, there needs to be guidance on this as families will not always give accurate information. What the daily diet of the family is can be recorded, including seasonal variations. There is no column for APL – they are also supposed to get rations.
9) Information on migration needs to be included – where is the family from, since when they are staying in a given place, whether they are seasonal migrants.
10) Information on the birth of the child, some details such as at what month of gestation did the delivery occur, sex of the child and weight at birth should be added.
11) Section on abortion can include which month of gestation the abortion took place to find out if it was an unsafe procedure which caused the death
12) A section on impressions of the interviewer is required. In this, the interviewer should make observations about how easy it was to build rapport, whether there was any reluctance from the family, who all were interviewed, what was the approach to the home like, difficulties in travel etc.

Some questions that participants felt may be irrelevant were

1) Joint Family details – what are we going to do with details of all the family members?
2) Access to toilets, how far the water source is from the house? It was discussed that not every question needs to be asked, some information can just be gathered by observation.

Session 3: Afternoon session, Group activity on Review of Tool

The session after lunch focused on studying the tool from the point of view of specific domains such as Gender, Caste/Ethnicity, Poverty, Health System, Rights and Entitlements

Participants were asked to volunteer for each domain. Four groups were formed as the domain on caste and ethnicity did not receive any volunteers. It was decided that the issues of caste and ethnicity would be taken up in the discussion session. The groups were given time to brainstorm and address the following four questions: Is this domain captured adequately by the tool? Any context-specific variations need to be addressed? Anything that can be left out? Anything needs to be added?

A summary of the Group presentations

1. **Health systems:** There was discussion over the ability of the team to determine the medical causes of death. It was felt that the health system perspective had been adequately covered in the tool, and no question could be left out. However certain improvisations or additions could be made, such as:
    - Use of tabular form for ANC, check the ANC card also.
    - Adding information on facilities, etc in sub centers when deliveries occur there
    - Information on birth spacing methods
    - As part of ANC: Detailed medical history, in which month of pregnancy did the woman register herself, how many times did she go for an ANC check up, where? Who provided the ANC? Weight taken?
    - There should be a subheading of Birth Preparedness.
    - Pg 1 Qs 14 – add 42 days.

- What all she was advised – this should be recorded in the ANC card, medical records.
- Triangulation through - ASHAs' incentive record, meeting with ANM/ASHA.

2. **Poverty:** Under this domain, certain points for addition can be:

   - Distinction between working adults/ earning adults and details about the earning members of the family.

   - NREGA work done in last **one** year. Have you used RSBY in the last one year? Get details if YES.

   - The question "Did anyone sleep hungry" needs to be changed as no one will give an honest answer due to the stigma attached to it. Members had alternative formulations

   - Nutrition: How many meals a day? What was included in them?

   - Main occupation of family head

   - Anyone in the family health treatment? From where? How much was spent?

   - How much expenditure on this delivery? From where did you raise the money – debt? Pawning land/jewelry?

3. **Rights:** Add questions on

   - Was this the first pregnancy/ childbirth? A question on birth spacing- access to and choice of contraception

   - Question about beliefs in the family about nutrition for pregnant women- Need to infer food intake, distribution of food in the family

   - Question for natal family – what circumstances le to her marriage? Instead of Was this a forced marriage?

   - Probe around decision about treatment seeking

   - A question on whether the woman had a bank account in her name

   - Whether the woman received JSSK/JSY facilities

4. **Gender:** This domain was adequately addressed in the tool.

- **Context-specific variations**

  - Male migration in certain villages (e.g. in Rajasthan): There are entire villages where there are only women as the men migrate to urban areas for work. This may cause concerns such as added burden of work for the women who are left behind. It may also create logistical problems in accessing health care, eg. The women may find it difficult to reach the facility in absence of support from their male counterparts.

  - Consumption of alcohol: Alcohol consumption is acceptable in some cultures and may go unremarked in the questions on food intake, etc. However, it may have adverse effects on women's health during pregnancy and information needs to be sought on this.

- Superstitions on sex determination: whether there any such belief prevalent, if so, they could affect the care the woman receives during her pregnancy.

- **Potential points for addition:**

- In the post-partum section: Add question on outcome of delivery- sex of the child and whether the child was able-bodied/disabled. This information is relevant as the woman who has given birth to a girl child or a disabled child may face additional discrimination as well as pressure for another pregnancy.

- Nutrition: Weight during pregnancy

- Access to toilet: If there is no indoor toilet, are there any restrictions on women's use of outdoor toilets/ open spaces with regard to time, frequency of use, etc?

- Superstitions: There are superstitious beliefs about restricting women's mobility, eating, etc during pregnancy if there is an eclipse. This may impact their access to receiving timely health care and nutrition.

- **Caste and gender**

- Access to source of water: Discriminatory practices against lower castes preventing them from using the main source of water in the village add to women's burden of work as they have to walk longer distances to fetch water

- Refusal of service provision to lower caste women: ASHAs refuse to visit parts of the village where lower castes reside

- Restrictions on mobility of upper caste women: Upper caste women may be prohibited from seeking treatment from a male doctor, particularly of a different caste.

- Why was home delivery chosen over institutional delivery?

General discussion after presentations

- Issue of home deliveries vs. Institutionalized deliveries: Most home deliveries happen in the middle group which is not covered by JSY

- There are two kinds of home deliveries: one is due to lack of access to institutionalized health care and the other is due to preference for home birth (could be due to lack of trust in institution, previous bad experience, caste biases, etc)

- Need for balancing the length of tool with the suggestions for additional questions, since the length has been a cause of concern.

- Need to resolve the concerns over Social determinants vs. Biomedical causes

Homework on State Reports of Social Autopsies

The day ended with a homework assigned to participants to prepare a tabular form of the findings of the maternal deaths in each of their respective states which would briefly give details about the following questions:

1. Total number of deaths
2. Who are these women
3. Occupation
4. Reproductive History
5. How many had complication in previous pregnancies
6. ANC during Present pregnancies
7. Detail of Deaths
8. Place of Delivery for Post Natal Deaths
9. Type of Delivery
10. Outcome of Delivery
11. Place of Death
12. Number of facilities visited
13. Cause of Death
14. Emerging issues/ themes

DAY 2, 27TH February 2014

Day Two commenced with a very brief recap of the previous day's discussion on issues faced in conducting social autopsies as well as suggestions for refining the tool. This was followed by a State wise presentation by all the participants that included case narratives from each State, statistical details state wise as per the table given by Subhasri on the previous day as well as the major issues arising from social autopsies from 10 different States.

c) Issues arising from social autopsies from 10 States

- Across States, maternal deaths constituted a lot of women who were primies, illiterate, belonging to the tribal or minority community, like Muslims. ASHAs and Sahiyas have also died in childbirth – if the health system cannot track/look after their own key people, what can we expect about general community women?

- Also it appears that in almost all States, many women had around 3 ANCs but the quality of ANC is questionable. Birth Preparedness seems to be missing. Monitoring of PNC is missing – sepsis story in West Bengal.

- Stories from Maharashtra, Jharkhand, Assam, UP showed that many of the women accessed traditional and local practitioners.

- From the Social Autopsy reports it appears that very few MDRs have been done by the government. Also, most deaths have not even been reported by the health system. Moreover, no action seems to have been taken in response to the deaths, except in Gujarat where a medical officer was reprimanded.

- Majority deaths occur in the post natal period, and there is hardly any post natal monitoring.

- There is an impetus given to the institutional deliveries in policy and program, but the lack of capacity of health facilities to provide care was clearly apparent. The state of health facilities in terms of insufficient medical and paramedical staff and women doctors, availability of adequate drugs and supplies especially blood was universally bad. In most states, any health facility lower than the district hospital was unable to manage complications. There have been instances of women being referred to private facilities even from the Medical College hospital – for instance in Vadodara, Udaipur – citing lack of personnel/services. There were reports of abuse, denial of care, no equipment from Jharkhand and Maharashtra.

- Improper referral mechanisms and lack of transport emerged as important issues in all states. Women were transferred to at least 2 or 3 facilities – both public and private – before death. Deaths often took place in transit, In the majority of cases, 'referrals' merely meant shuttling the woman from one facility to another. No information is provided on referral, neither are there any records. At times the staff do are not present at the CHC and the woman is immediately turned away and sent to a higher centre. This suggests that 'referrals' are more of a refusal to take responsibility or fear to take responsibility, rather than following a protocol.

- Faulty display of information at the facilities or website is another major issue. E.g. a CHC displaying on a poster on deliveries being conducted there in spite of the fact that the CHC was not equipped to handle deliveries.

- Transport is one of the major issues; even public transport is a problem in remote areas.

- There is very poor counselling on danger signs and birth preparedness/ complication readiness.

- Out of pocket expenses are very high- on travel as well as medications, oxygen, diagnostic tests. Informal payments demanded by health systems persons was another recurrent issue. Families having to take loans or sell assets to meet these expenses was also reported.

- Social determinants have a huge role to pay in maternal deaths: Lack of knowledge, gender biases, political issues, behaviour of the professionals, lack of support from the family of the woman in terms of bearing costs of treatment.

- Yet another pertinent issue that emerged during presentations was that of Superstitions. It has been perceived that social determinants such as superstitious beliefs become an excuse for the health system to demonstrate lesser accountability and victimize the family themselves for

their beliefs which perpetuates the causes of maternal deaths. E.g. restrictions on food intake of a pregnant woman, not going for a check up during eclipse and so on

- Deaths due to abortions are rarely recorded by the health system, but their proportion is high. In Jharkhand, over 20% of the deaths that were reviewed were a result of unsafe abortions by informal providers.

d) *Priority Issues and Recommendations (Afternoon Session: 2.00 pm to 6.00 pm)*

After the sharing the analysis of social autopsies from different States, and deliberation over the issues and challenges faced in respective states, an exercise of three priority issues to be taken up for action were generated from each participant. The priorities according to the participants were: Referrals and Transport, Quality of Care, Health Education, Cultural and Social Factors, Accountability and MDRs.

These were subsequently discussed and presented by smaller groups. The themes are elaborated as under:

1. REFERRALS AND TRANSPORT

Issues

Participants of this group listed various issues in this domain that had resulted in maternal deaths. These were:

Multiple referrals, how referral hospitals receive the women, primary care/first aid is not given before referring, delay in the process of referral (3 delay model), accountability - refusal to admit and denial, not giving complete information, quality of care, referral in emergency care, night referrals and remote referrals, rationality in referrals, communication, accessibility and availability of transport, costs.

Recommendations

- **Referral Protocols**- to be prepared and followed by health authorities and need to be displayed and communicated to all; should be followed at all levels of care. It should cover issues such as: No need for following the hierarchy of health institutions – refer where you know services are available, night referral, and remote referral.

- **A Proforma for referral** should be made which include all the details such as: why the woman is being referred, what tests have been done at which level, time of referral and a copy should be given to the patient also. And also the family members should be explained the reason for referral.

- **Inclusion in birth preparedness**: Besides the above, preparation for referral can be made a part of pre birth counseling.

- **Strict guidelines** should be given to each facility, free ambulance/vehicle has to be arranged by the referring facility itself and the referring facility should be responsible or should ensure that the patient reaches the next facility safely.

- A referral should be done after doing the first level emergency treatment.

- The authorities at the initial facility should **communicate** to the next facility (where they are referring the patient) that they are referring X woman due to Y reason and what is the case

about and that they need to be prepared for treatment. And this detail of communications should be noted in the Proforma for referral.

- For social autopsies a **framework for analysis** of referral process should be developed.

2. QUALITY OF CARE

Issues

Participants listed the issues in Quality of Care as:

Lack of focus on post natal care, issue of accountability at both public and private hospitals as well as primary care facilities, problems in 24 x 7 health service delivery with quality, quality of ANC and PNC, lack of quality equipment, infrastructure, skilled service provider, management of delay, inefficiency in taking adequate precautionary measures during emergency, regular checkups, counselling for emergency and backup plan are components of quality in outreach services which are not given emphasis.

Recommendations: Quality of Care can be: Community Based – long duration, and Facility based - short duration.

Quality of Community Based Care

- First point of contact of the woman is with the peripheral providers - ANM/AWW/ASHA - hence appropriate education on birth preparedness and complication readiness should be imparted during the ANC period.
- Strengthening the outreach services as they are the foundation of quality care.
- Skills of frontline workers such as ASHA and ANM need to be strengthened.

    a) All women in the given population - young mothers, teen mothers, and migrant women should be tracked and covered through maintenance of register of incoming and outgoing cases.

    b) Aspects on cultural sensitivity, caste, gender, etc should be incorporated as an integral part during training of frontline providers.

    c) Training of providers from the community/ ANMs-for home delivery is a necessary step.

    d) Training of providers to identify cases of high risk pregnancy during ANC and adequate precautionary measures to be taken.

Quality of Care in Facilities

- Updated information of services available in every facility needs to be shared with the community - published/ displayed at the Anganwadi Centre, Sub Centre, during VHND

- Every labour room must be treated as critical care area and equipped with water/electricity/, etc.
- Monitoring of irrational non evidence based practice- use of Misoprostol/Oxytocin; episiotomy, enema, shaving, etc should be avoided.
- To ensure active support during labour - evidence based position, moral support, encouragement, understanding the mother's situation and treatment in a dignified manner are necessary.
- There must be a counselling cell at all health facilities. Labour rooms abuse has to be addressed.
- Post Partum-ward-protocols, hygiene, culturally sensitive diet practices etc must be followed.
- Regular up gradation/accreditation of skilled providers in public and private sector should be monitored and implemented.

Birthing Temples – Dr. Prakasamma

Dr. Prakasamma shared her vision of Birthing Temples. Such models have been developed by her organisation ANSWERS outside Hyderabad. These Birthing Temples project an alternative vision of the Labour Room – not the biomedical, cold, insensitive space, but one where Birth is treated as a social, spiritual, psychological as well as a physiological phenomenon. And the woman is supported in all these dimensions.

Quality of Care in Emergency

- Taking responsibility for follow up post referral in any emergency and management for the same should be ensured through guidelines for the same.
- It is important to ensure definite emergency treatment to stabilize the case when pregnant women reaches facility,
- Equal priority should also be given to services at night - information about on duty staff to be displayed and disseminated.
- Strengthening of Rogi Kalyan Samiti is required for effective monitoring and decision making.

3. HEALTH EDUCATION

The issues in this area were: lack of information about entitlements and programmes amongst communities, traditional cultural beliefs and practices, role of traditional local providers.

There was a long discussion on Traditional Birth Attendants as Skilled Birth Attendants. Dr. Prakasamma told the participants that the international definition of Skilled Birth Attendants that the Government of India was also following precluded any possibility of TBAs ever becoming SBAs – there were a set of qualifications required which would not be possible for many Traditional Dais to fulfil. She emphasised that the Traditional Dais had a complementary role to the SBAs which was no less valuable. During childbirth the woman requires psychological,

spiritual as well as physical support that the Dai is well placed to provide. She clarified that there is another dimension to the SBA debate – Skilled Birth **Attendant** or Skilled Birth **Attendance**? The latter implies going beyond the *person* to include *a set of necessary elements* for Skilled Birth. International opinion on Skilled Birth Attendants was now being reconsidered. Government of India has decided to set up Skill Labs in every state to ensure that Skilled Birth Attendants actually have the skills for child birth. Smita Bajpai informed the group that the GOI was now finally coming around to the idea of accepting that home deliveries do happen. Mapping of contextual factors is required to identify where home deliveries are still happening in large numbers. Participants shared experiences from various States - Odisha government is training Dais to identify danger signs and refer women accordingly. In Rajasthan CHCs the Dai is now appointed as Labour Room Attendant and helping in deliveries. In Tamil Nadu and West Bengal, they are appointed in 24 x 7 PHCs.

Recommendations

- Health education is an important role of health functionaries. Their knowledge and skills must be enhanced so that they can fulfill this role.

- As NGOs, Prakasamma said, we can share many techniques and processes with the government – folk theatre through ASHAs, anaemia song through SHGs, one PHC/CHC visit by pregnant women during the ANC period - *'making friends with the health facility'*. Tamil Nadu's programme of *'goad bharai'* once a month was also shared.

- During the VHND the ANMs/ ASHAs should initiate a discussion amongst pregnant women on 'In an emergency what can we do?' List down the 10 – 15 health facilities in the District for various needs – laboratory, blood, USG, emergency ob care, etc.

- Health education must incorporate a gender perspective and accountability principles – build in health education through community/village institutions – VHNSC, Gram Sabha, Panchayat members, etc. And all health education must increase women's power, access to and control over resources and control over her own body.

4. ACCOUNTABILITY AND MATERNAL DEATH REVIEWS

Issues

Lack of accountability in terms of equipments and staff, lack of records for the MDRs conducted by the government, one sided view in the MDRs which is generally skewed as it's done by doctors or someone from the health system, dearth of details for any MDR meetings conducted, defensiveness among health system people – look for scapegoats and penalise the weakest, conflict of interest in the constitution of the MDR Committee – only health system representatives are in the MDR Committee**.** **'**Can we ask for compensation?' – participants cited that sometimes in the poor communities where they work the grandparents cannot afford to raise the newborn child.

Recommendations

- MDR committee should be functional at district and state level.

- Reporting system for maternal deaths should be strengthened.

- MDR training to doctors should be given.

- MDR should take place at 4 levels- community based, facility level, district and state level as per the guidelines. There needs to be revisions to the guidelines because nothing is mentioned about where the State level report will go, how and where action taken will be reported.

- The guidelines for MDR and the minutes of the MDR committee meeting should be available.

- The committee should comprise of civil society representatives and family members.

- Action taken report should be prepared after MDR. There should be some feedback loop.

- The review should be done by a Committee independent of the health system, to prevent conflict of interest.

- Provision of compensation to the new born for the period of 6 months in case of the death of mother.

Dr. Subhasri shared the Tamil Nadu experience of MDRs. Responsive health administrators and bureaucrats instituted MDRs to improve the system. Reporting of maternal deaths increased because there was no punitive action or penalising of any health care provider.

5. CULTURAL/ SOCIAL FACTORS

Issues

Exploitative nature of superstitions/ culture/ traditional practices, exclusion of informal health practitioners from the health system, not laying enough emphasis on training of traditional birth attendants, negligence by family, anaemia is the most prominent issue across cultures and geographies.

In addition, it was pointed out that cultural and social factors are also an integral part of peoples' lives. This has to be kept in mind while making strategies and recommendations.

The politics of the ASHA's role vis a vis the Traditional Dai's has to be recognised – how come an ASHA who is absolutely unfamiliar with the process of childbirth is being given Misoprostol, while the Dai who knows childbirth is being discounted?

Can negligence by family be reframed as violence against women? Can community and family be held responsible for the cultural practices that bring harm to women?

Anaemia's many dimensions – protein deficiency also, intergenerational issue, intersectoral issue, social dimensions- intrahousehold food distribution, food taboos.

Recommendations

a. Superstitions, Beliefs, Cultural Practices

- Cultural beliefs of the people need to be respected.
- Beliefs/ traditional practices which restrict a woman's mobility or access such as not being allowed certain types of food, not touching the woman during menstruation, not going out during an eclipse, etc need to be altered through collective effort of government as well as civil society groups.
- Superstitions or cultural practices should not be used as a tool for victimizing families or an excuse by the health system for demonstrating inefficiency

- In the context of so many young primis dying in childbirth, age at marriage which is a social factor, has to be addressed.
- Training of frontline workers, ASHA, ANMs, should incorporate aspects on cultural and caste sensitivity and minimize any biases they nurture.

b. Involving informal health practitioners

- The informal health practitioners are people who have been residing within the community for ages, are locally available at given point of time, are familiar with the language and customs, and moreover people trust them. Hence including them in the process which contributes to reduction in maternal deaths is very important. The success of the National Polio Surveillance programme eradication has exemplified this.
- They lack the skills, especially technical knowledge, i.e. where they can be educated as well as prohibited from misusing medicines, etc.
- Capacity building of informal health practitioners should be taken up more vigorously.

c. Training traditional birth attendants

- The promotion of institutional deliveries has been advocated by the Government for very long now long but there are serious practical and operational concerns with regards to feasibility, logistics, quality, transport and so on. With such constraints**,** training the birth attendants is a more sustainable option. Their role needs to be revisited – before and after the institutional delivery.
- Some communities are socially shy of delivering in public clinics, which can be effectively handled by a trained dai.
- These traditional birth attendants need not be necessarily perceived as being outside the health system, but a system can be devised wherein their skills can be sharpened to contribute to reduction in maternal deaths.

d. Negligence by Family

- In a lot of cases families are ignorant about birth preparedness and handling an emergency during pregnancy, so educating the family about the basic care needed during pregnancy is necessary.
- Knowledge on family planning as well as resource management should be imparted.
- The gender perspective should be an integral part of counselling by frontline workers.
- Families and the community at large should be encouraged to maintain basic hygiene.
- Creating a good and harmonious atmosphere while the woman is pregnant is of utmost importance for her and the child's health.

e. Anaemia

- Since anaemia is one of the most critical issues, and an aggravating causal factor in maternal mortality, mass awareness on a community level as well as health education is a necessary step in the right direction.
- Women do not consume the IFA tablets provided to them due to the fear of side effects coupled with other myths, so this can be altered through counselling and explanation of correct dosage.
- Rather than merely providing IFA tablets, inculcating knowledge about locally available iron rich foods, by using innovative ways such as explaining through the colour of vegetables, screening videos in vernacular languages, etc can be an effective way to include such food items habitually.
- Worm infection due to open defecation is also common, so knowledge about public toilets can be increased.
- Make anaemia and malnutrition amongst women and girls into a gram sabha and a panchayat issue.

- Health sector responsibility – detect anaemia, when identified followup on anaemic women, ensure uninterrupted supplies of IFA, iron sucrose, blood

DAY 3, 28th February 2014

III. WAY AHEAD: SUGGESTIONS AND DECISIONS

(11:30 – 1:30 pm– Session on future plans)
Chaired by Subhashri, the last session was an overview of all the aspects that had been discussed over the past two days. There was an emphasis on the challenges faced not just in terms of lack of records, lack of multiple perspectives, gaps in the tool, etc but also the operational issues in terms of time and resources used, and how this process could be made more sustainable for the future.

One of the reflections was that the social autopsies were begun by the civil society groups to supplement the technical ones that were being done by the health system, but as our work progressed, we realized that the system is really not doing any review of its own systems and we have got into looking at both health system causes as well as social causes of these deaths. Moving forward from here, it is critical for us to think and deliberate upon the following key issues:

1) Where are we going to position these MDRs vis a vis the system – how do we see ourselves? What is our aim?

2) What are we going to do with the data that we have collected? – 120-130 cases. If we add ARTH data then we have more than 600 deaths.

3) How will we take this process ahead in the next 2-3 years?

The floor was opened for discussion and the following key points emerged:

1) **Push the government to do MDRs themselves.** Doing the MDRs adds value to the system our approach is holistic, but our final aim should be to highlight the gaps in the system, and advocate for their improvement, not continue doing MDRs indefinitely ourselves. Finally, this is the responsibility of the government.

2) **Value addition** by us is highlighting: social determinants, rights violations, health system gaps.

3) **Actions can be taken in several ways and at various levels:**

    a. We need to take the findings of these MDR back to the health system and ensure that there is some discussion around it in order to influence health systems in our respective areas of work. Some organizations have done *Jan sunwais*, some others have tried to put pressure to make recording better.

    b. Advocacy is also required at the national level. There is a commitment of the government to make MDRs public and this should be doggedly pursued by all National Alliances.

    c. We also need to use the State Level data on maternal deaths and it becomes a good point for State Level advocacy. So preparing a State level report is also a good move.

However, it is equally important to advocate at the centre, because of the power politics.

d. We need to record what is the action taken for each death – it may not be a formal review process, but even informal discussions and meetings within the health facility. Some facilities do have regular facility based maternal death review meetings, and these should be looked at more closely, particularly in terms of what action is being recommended in each case, and whether the perspective of the family is being taken on board.

e. We also need to discuss each such death at the community level so that responsibility for women's health becomes a family and community issue.

4) **The danger of focusing solely on social issues**: Several participants who had conducted Jan Sunwais felt that officials are likely to victimize the families if social causes are highlighted. At the same time, the health system dismisses social issues as those that need to be dealt with by NGOs – passing on the burden off their shoulders. It was discussed that how much emphasis we lay on various causes in public domain is contingent upon the audience. Not all information needs to be presented to everyone. Depending on the action that one would like to see on the part of the official, we should highlight only those issues during any kind of advocacy to change the system. Further, it was stressed that when interacting with the ground level health facilities and officials, we should never leave things at the problem statement – but we should come up with recommendations and give alternatives to the system, so as to look at the gaps very constructively.

5) **Need for reforming the government form** was discussed in some detail. Aditi Iyer, gave a brief account of IIM's study on four maternal deaths, wherein interviews were conducted with the family and then looked at against the government's own reviews. One of the key findings was that the government's forms are inadequate to capture causes of death. When it comes to biomedical causes, in the medical forms there was only one cause of death. But in reality, there are usually multiple biomedical causes in addition to complicating factors that lead to the death. When it comes to social issues, the form focuses on the 3 delays model which does not tell us much about the social causes. So on the basis of this analysis, suggestions were made that the MDR should be independent, should have multiple levels – one at the health facility, but then an independent inquiry at a higher level. The other recommendation was that the form itself needs to be strengthened and the process changed.

6) **Focus on medical cause of death** was also discussed, more specifically use the medical causes to prioritise social determinants. It was discussed that medical causes of death help us to understand what the health system lacunae are, and prioritize which problems need to be tackled by the health system. That is why they must be given due importance if we are to be taken seriously by the system.

7) **Assigning a 'cause of death' and whether we are qualified to do so:** One of the concerns of participants was that of the health officials dismissing 'causes of death' arrived at by the organizations as invalid. Whether or not lay persons can arrive at a cause of death was discussed in great detail. It was shared that there is an algorithm to identify cause of death – this could be done by gyanecologists and centralized in one part of the country. Assigning a final cause of death is not difficult for grassroots workers to do, but proximal causes and complicating factors should be looked at by experts in order to validate what the organizations have concluded. This would make the process more robust. There is another level of analysis where one can look at the actions taken by the health system, the sequence of events and whether the decisions made were correct or not – but these require a different kind of expertise in not just obstetrics but also health systems and social causes. We need to strike a balance between accuracy, and what we would like to achieve with this MDR. One way to do this is to assign 'possible, probable and definite' causes of death. This would ensure that we do not 'over diagnose', but at the same time we should also not 'over mystify' cause of death. The value that this group's process adds to MDRs, is the interplay of the health system issues, clinical issues and the social issues – that is the analysis that we should aim to highlight.

From the preceding discussion, ***the following points can be clearly concluded***:

1) Whatever documentation we are doing must be used for action and advocacy – both at the ground level as well as the national level, as a collective.

2) We cannot continue to do MDRs indefinitely and we must discuss a cap on the time frame that we want to work with. Refining the tool at this point is required, so we should continue the process for at least another 6-8 months. Meanwhile, strengthening the MDR process, suggesting changes and advocating for them at different levels is an imperative of this group.

3) With all the limitations of the process that have been discussed, we have concluded that with training, reasonable data can be collected and a cause of death can be arrived at with the help of a technical group. The focus of our analysis should then be on putting the medical, health system and social causes together to paint a coherent picture, and highlight gaps at all levels.

4) A point reinforced from day one was the need for *building capacities* of field investigators as well as team members.

5) Finally, there is a need to look at the deceased woman as a human and not just a 'dead potential mother'. What was striking in Prakasamma and Dhanraj's story of their colleague was its human angle. We must try at all times to highlight the woman's own personality and identity. Otherwise we fall into the trap of seeing her as yet another 'case'.

The discussion then moved on to Definite Actions that we would like to take around three areas – processing the data that has been collected so far and coming out with a shadow report, refining the tool, and articulating a long term strategy for this group.

1) **Shadow Report –**

    a. There was a unanimous consensus that the shadow report must look not just at clinical issues, but in fact its focus should be on system issues and social issues.

    b. In addition to this, it was discussed if we can include an economic analysis – what the death cost the family, not just in terms of expenses incurred but also wages lost or belongings mortgaged/sold.

c. The response of the system to the deaths that have been documented is imperative – Was the death recorded anywhere in the system? Was it acknowledged as a maternal death? Was an analysis done by the system of what went wrong? Who investigated? What did the investigation conclude and what changes did the system make if any? Was there any feedback to the facility and what was the action taken? This need not be a formal review, but even informal discussions/meetings within the system should be documented.

d. The cause of death should be kept as 'possible'/ 'probable' and a technical person should validate it.

e. Systemic causes should include not just failure of the health facility or transport facility, but also lack of information for the family and the woman herself.

f. For analyzing social causes, it would be useful to map them in concentric circles so that the most proximate social determinants and the distal ones are depicted visually. This will make it possible to assign responsibility and suggest actions/changes.

g. Two big themes are emerging – one is the issue of referrals and transport, and the second is that of the role/capacity of tertiary hospitals to deal with complications. These must be analyzed in detail and various facets of it explored from the narratives.

h. The recommendations made must be sharp and strong, and must flow from the analysis that has been discussed above

i. In terms of dissemination of the report, it was reported that the Jan Swasthya Abhiyan is having a meeting in Delhi on 28-29th March in the context of approaching elections, and the issue of maternal deaths will be raised there. The report should be ready before that and if any of the participating organizations can attend, that would be useful too.

j. The deadline for the report is the 20th of March 2014.

2) **Discussion on the MDR Tool –** Specific suggestions for modification of the tool have emerged in the course of the three days. Many of the organizations have also made changes in the tool from their end – JSS and ARTH in particular. A small group was constituted who would take the suggestions forward and incorporate the changes suggested. This could be vetted by the rest of the group. The group would consist of – Sanjeeta (Oxfam), Sharayu (JSS), Vaibhav (Sama), Preeti (Oxfam), Renu (Sahaj), Kalpana (ARTH). The deadline for this too is 20th March.

3) **Long term plan** –Several suggestions for advocacy and action- both at the grassroots as well as the national level had been discussed earlier in open discussion. In addition to this, other ideas were discussed such as:

a. Policy briefs on the four priority issues could be prepared – Health Education, Accountability, Referrals, Social Factors, and Quality of Care. Important

recommendations had emerged from the group work which could be included in these policy briefs.

b. A newsletter/journal focusing on 'how Mrs X could have been saved?' has been tried out in the past, which takes the medical cause and analyses it to highlight what a clinical individual (whether a doctor, nurse or ANM) could have done to prevent it. This serves as learning for PHC staff.

c. Since there are organizations working in different parts of the country, we could consider building a registry for maternal deaths and push the government to do so as well. This would help to monitor the deaths and where the gaps in system were.

d. There are some cases that we need to spend more time on, trying to identify and document – such as unsafe abortion related deaths. We also could include 'near misses' i.e. cases of women who had complications, but are survivors.

e. Six to eight months more of MDRs are planned so that we can refine our own methodology, after which the focus would shift to consolidating them and advocating for changes at various levels. '*We see ourselves working together for the next two years.'*

f. The need for more capacity building has also been expressed and we must pursue this.

The meeting ended on a high note – although our collective agenda is depressing, participants went back with shared learnings and a sense of satisfaction and solidarity. There were hopes that we would meet again as a group and with more stories of success to share.

ANNEXE 1

LIST OF PARTICIPANTS

Sr. No	Name	Organization	Email
1.	Pallavi Saha	Sahaj	pallavisaha2@gmail.com
2.	Mahima Taparia	Sahaj	mahima.taparia@gmail.com
3.	Kalpana Rathore	ARTH	arth.smp@gmail.com
4.	Ranjanben Atodriya	Seva Rural	
5.	Shilki	Oxfam India (Delhi)	shilki@oxfamindia.org
6.	Proshik Das	The Ant	
7.	Rwmwi Rmwmi Basumatary	The Ant	rwmwirwmwi@gmail.com
8.	Sandhya	Shikhar Prashikshan Sansthaan	Sps.chunar@gmail.com
9.	Devika Biswas	Health Watch Forum	devikabiswas@gmail.com
10.	Shalini Gaur	SAHYOG	shalini@sahyogindia.org
11.	Nandaris Marwein	SOCHARA, Bangalore	nandaris.marwein@gmail.com
12.	Chongneithem Lhouvum	SOCHARA, Bangalore	chongneiithem@gmail.com
13.	Pradeep Kumar	NEEDS	pradeep@needsngo.in
14.	Preeti Bohidar	Oxfam (Raipur)	preeti@oxfamindia.org
15.	Manmohan Pradhan	SODA	pradhan67m@gmail.com
16.	Sana Contractor	CEHAT	sanacontractor@gmail.com
17.	Asilata Karandikar	CEHAT	asilata@cehat.org
18.	Archana Khanyal	NAMHHR	archana@sahyogindia.org
19.	Sharayu Shinde	JSS, Chattisgarh	sharayushinde123@gmail.com
20.	Bhavana Jadhav	AAAS, Gadhchiroli	jadhav.bhavana514@gmail.com
21.	Subhasri	Common Health	subhasrib@gmail.com
22.	Govinda M Murari	Oxfam India (Bhubhneshwar)	gmmuraritiss@gmail.com
23.	Sumeet Pokharnikar	CEHAT	drsumeetp@gmail.com
24.	Dhanaraj	ANSWERS	answers.mytri@gmail.com
25.	Dr.M. Prakasama	ANSWERS	answers.mytri@gmail.com
26.	Vaibhao Ambhore	Sama	vaibhao.ambhore@gmail.com
27.	Sanjeeta Gawri	Oxfam (Raipur)	sanjeeta@oxfamindia.org
28.	Renu Khanna	Sahaj	sahajbrc@yahoo.com
29.	Smita Bajpai	CHETNA	chetnarrc@gmail.com
30.	Arpita Suthar	CHETNA	chetnarrc@gmail.com

ANNEXE 2

SCHEDULE FOR MDR WORKSHOP

DEAD WOMEN TALKING- II

Date	Time	Session title	Facilitator
Feb 26th	9.30 am	Registration	
	10 to 10.15 am	Introduction to workshop and objectives	Subha Sri
	10.15 to 10.30 am	Introduction of participants	Subha Sri
	10.30 to 11 am	A mapping of participants' experience of doing social autopsies and engaging with the findings with the health system/community	Renu Khanna
	11 to 11.15 am	Tea break	
	11.15 to 12 noon	Previous session continued	Renu Khanna
	12 noon to 1 pm	Experiences of using the tool	Subha Sri
	1 pm to 2 pm	Lunch	
	2 pm till 3.30 pm	Small group discussion on the different domains of the tool that need validation	Renu/ Subhasri
	3.30 to 3.45 pm	Tea break	
	3.45 pm to 5 pm	Plenary presentation of small group work	
Feb 27th	9.30 am to 12 noon (tea break in between)	Presentations of narratives of maternal deaths	CEHAT
	12 noon to 1 pm	Large group discussion on the major themes that are emerging from the narratives	CEHAT
	1 pm to 2 pm	Lunch	
	2 pm to 3.30 pm	Small group discussion on the emerging themes	SAMA
	3.30 pm to 5 pm	Plenary presentation of the discussion	SAMA
Feb 28th	9.30 am to 11 am	Finalizing shadow report structure and content	Renu Khanna
	11 to 11.15 am	Tea break	
	11.15 am to 12.30 pm	Next steps and future plans	Subha Sri

ANNEXE 3

STATE WISE PRESENTATIONS OF FINDINGS ON MATERNAL DEATHS

GUJARAT STATE, 2012-2013

1. Total number of deaths: 19

- Districts: Dahod, Panchmahals, Umreth, Anand and Jhagadia
- Duration : 2012 – 2013

2. Who are these women?

Age(years)	**N**
19- 24	9
25-30	4
31-35	6
Total	19

Caste	**N**
ST	13
SC	2
OBC	2
No data	2

Religion	**N**
Hindu	10
No data	9

Education	**N**
Illiterate	11
Up to primary	5
Graduate	2
No data	1

BPL status	N
BPL cards	7
APL	4
No data	8

Occupation	**N**
Only house work	6
House work and labour	6
Migrants labour	3
House work and job	1
No data	3

3. Reproductive History

Category	N
Primy	9
Second	4

Third	2
4 or more	4

How many had complication in previous pregnancies

Complications	N
Yes	7
No	12

ANC during Present pregnancies

ANC	N
Yes	17
No	2

4. Details of Deaths

Period of death	N
During pregnancy	4
During delivery	2
Post natal	13
During/ After abortion	-

Place of delivery for PN deaths	N
Home	3
Hospital (Private/ Public)	10

Type of Delivery	N
Normal	9
Caesarean	4
Instrumental	-

Outcome of Delivery	N
Live birth	8
Still birth	5
Newborn death	-

Place of Death	N
Home	2
Hospital	6
On the way	5

Referrals	N
Yes	17
No	2

Cause of Death	N
Anaemia	4
PPH	3
Sickle cell	2
Eclampsia	2
Others (Malaria, Jaundice, Mental Problem, Sepsis, Hypoglacimia)	5
Not clear	3

EMERGIING ISSUES:

1. Majority of maternal deaths occurred in the age group of 19-24.
2. Majority of the women belonged to the tribal community.
3. Most of the women were illiterate.
4. Majority of the women who died were primies.
5. Largely, it can be observed that women went for at least 3 Ante natal checkups.
6. Majority of the deaths occurred during the post natal period.
7. Most of the deliveries were institutional deliveries.

CHATTISGARH, 2013

1. Total number of deaths: 77, Reviewed: 15

- Districts: Bilaspur and Mungeli
- Duration : January to December 2013

2. Who are these women?

Age(years)	N

17-20	3
21-25	7
26-50	4
40	1
Total	15

Caste	**N**
General	1
OBC	4
SC	5
ST	5
Total	15

Education	**N**
Illiterate	3
Primary	5
Secondary	5
B.A.	1
M.A.	1
Total	15

BPL status	N
Yes	10
No	5
Total	15

Occupation	**N**
Cultivator	3
Homemaker + cultivator	2
Homemaker	8
Wage worker	2
Total	15

3. Reproductive History

Category	N
Primy	6
Second	1
Third	4
4 or more	4
Total	15

How many had complication in previous pregnancies

Complications	N
Yes	
No	

ANC during Present pregnancies

ANC	N
Yes	
No	

4. Details of Deaths

Period of death	N
During pregnancy	3
During delivery	1
Post natal	10
During/ After abortion	1
Total	15

Place of delivery for PN deaths	N
Home	3
Private Hospital	2
Medical College	5
Data unavailable	5
Total	15

Type of Delivery	N
Normal	8
Caesarean	2
Data unavailable	5
Total	15

Outcome of Delivery	N
Live birth	8
Still birth	2
N.A.	5

Place of Death	N
Home	1
Private Hospital	3
On the way	4
Medical College	6
CHC	1
Total	15

Referrals	N
Yes	8
No	7
Total	15

Cause of Death	N
Anaemia	2
PPH	6
Sickle cell	-
Eclampsia	3
Others (Malaria, Jaundice, Mental Problem, Sepsis, Hypoglacimia)	3
Unsafe abortion	1
Total	15

UTTAR PRADESH, 2013

1. Total number of deaths: 10

- Districts: Azamgarh, Banda,Mirzapur
- Duration : 2013

2. Who are these women?

Age(years)	N
19- 25	7
26-32	3
Total	10

Caste	N
ST	0
SC	3
OBC	6
General	1

Religion	N
Hindu	10
Others	0

Education	N
Illiterate	5

Up to 10th std	5
Graduate	0

BPL status	N
BPL cards	2
APL	2
Don't have card	6

Occupation	**N**
Only house work	8
House work and labour	2
Migrants labour	0

3. Reproductive History

Pregnancies	N
One to Three	8
4 or more	2

How many had complication in previous pregnancies

Complications	N
Yes	2
No	6
No data	2

ANC during Present pregnancies

ANC	N
Yes	8
No	2

4. Details of Deaths

Period of death	N
During pregnancy	1
During delivery	2
Antenatal	2
Post natal	3
During/ After abortion	2

- For postnatal deaths – Place of delivery-Dist. Hos-5

Place of delivery for	N

PN deaths	
Home	3
District Hospitals	5

Type of Delivery	N
Normal	5
Caesarean	0
Instrumental	0

Outcome of Delivery	N
Live birth	3
Still birth	2
Newborn death	-

Place of Death	N
Home	1
Hospital	7
On the road	1
ANM's home	1

Type of Facility	N
Public	7
Private	1

Referrals- No. Of facilities visited	N
1 to 2	3
3 to 5	5

Cause of Death	N
Anaemia	1
PPH	-
Excessive bleeding	3
Eclampsia	4
Others (Malaria, Jaundice, Mental Problem, Sepsis, Hypoglacimia)	2
Not clear	-

EMERGIING ISSUES: - Multiple referrals, Anaemia, traditional practices (ojha,pandit)

ASSAM, 2013- 2014

1. Total number of deaths recorded: 14

- Districts**:** Chirang, Sonitpur, Dibrugarh, Darang
- Duration : August 2013 to July 2014

2. Who are these women?

Age(years)	**N**
16- 24	14
25-30	-
31-35	-
Total	14

Caste	**N**
ST	5
SC	No data
OBC	8

Religion	**N**
Hindu	2
Muslim	8
No data	4

Education	**N**
Illiterate	
Up to primary	
Graduate	
No data	

BPL status	N
BPL cards	12
APL	2

Occupation	**N**
Only house work	10
House work and labour	-
Migrants labour	-
Daily wage earner	4

3. Reproductive History

Category	N
Primy	

Second	
Third	
4 or more	

How many had complication in previous pregnancies

Complications	N
Yes	
No	

ANC during Present pregnancies

ANC	N
Yes	
No	

4. Details of Deaths

Period of death	N
During pregnancy	
During delivery	
Post natal	
During/ After abortion	-

Place of delivery for PN deaths	N
Home	6
Medical college hospital	2
State dispensary	2
District civil hospital	2
Private Hospital	2

Type of Delivery	N
Normal	12
Caesarean	1
Abortion	1

Outcome of Delivery	N
Live birth	9
Still birth	3
Newborn death	1
Unsafe abortion	1

Place of Death	N
Home	6
Medical college	1
On the way	1
District civil hospital	4
Private hospital	2

Referrals	N
Yes	17
No	2

Cause of Death	N
Anaemia	4
PPH	4
APH	1
Eclampsia	1
Others (Malaria, Jaundice, Mental Problem, Sepsis, Hypoglacimia)	1
Obstructed labour	1
Not clear	2

EMERGIING ISSUES

Negligence within family, inefficiency of health system in terms of insufficient medical and Para medical staff, referrals, traditional beliefs

RAJASTHAN, 2011-2012

Age(years)	**N**
19- 24	
25-30	
31-35	
Total	

Caste	**N**
ST	
SC	
OBC	
No data	

Religion	**N**
Hindu	
No data	

Education	**N**
Illiterate	
Up to primary	
Graduate	
No data	

1. Total number of deaths: 410 deaths recorded

- Districts**:** 10 districts of Rajasthan
- Duration : December 2011- December 2012

2. Who are these women?

BPL status	N
BPL cards	
APL	
No data	

Occupation	**N**
Only house work	
House work and labour	
Migrants labour	
House work and job	
No data	

3. Reproductive History

Category	N
Primy	
Second	
Third	
4 or more	

How many had complication in previous pregnancies

Complications	N
Yes	
No	

ANC during Present pregnancies

ANC	N
Yes	
No	

4. Details of Deaths

Period of death	Percentage
During pregnancy	19%
During delivery	8%
Post natal	73%
During/ After abortion	-

Place of delivery for PN deaths	Percentage
Home	19%
Hospital (Private/ Public)	78%
Transport	3%

Type of Delivery	N

Normal	
Caesarean	
Instrumental	-

Outcome of Delivery	N
Live birth	
Still birth	
Newborn death	-

Place of Death	Percentage
Home	12%
Hospital	65%
Transport	22%
Other	1%

Referrals	N
Yes	
No	

Cause of Death	Percentage
Anaemia	23%
PPH	31%
Obstructed labour	3%
Eclampsia	12%
Others (Malaria, Jaundice, Mental Problem, Sepsis, Hypoglacimia)	24%
Caesarean complications	7%

EMERGIING ISSUES:

- Majority of women with postpartum MDs delivered in an institution like district hospital or CHC
- It is observed that Hemorrhage & anemia are the biggest contributors to MDs
- Caesarean complications should be seen as a separate cause of death in cause of death analysis – merging them with other causes will prevent attention from unnecessary surgeries and quality of care issues

WEST BENGAL:
Area – District Malda
4 deaths

Profile of Women

- Aged 22 to 38 years
- All four were Muslim
- Varied levels of education – one was illiterate, one was BA
- All four were home-based beedi workers
- 2 of the four were BPL (least educated)

Reproductive History

- One was Primi, one was having her second child
- 2 were in their 5th pregnancy
- Two of these had had home deliveries before
- No complications reported in previous pregnancy in any of the cases

Referral

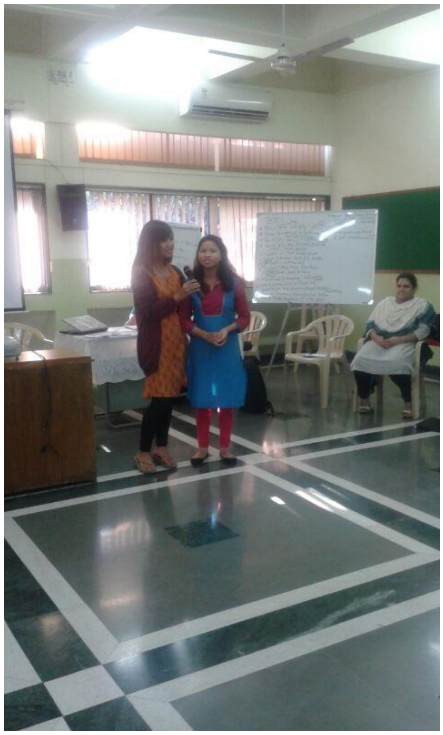
Cause of Death	Place of Delivery/Place of Death	Outcome of delivery	Referrals	Out of Pocket Expenses
Sepsis (8 days PN)	PHC/Medical College	Live birth	3 facilities (BPHC-Home-BPHC-Med College)	All medicines bought in Antenatal period, private car in emergency, diagnostics paid for
PPH (Few hrs)	PHC/Medical College	Live birth	2 facilities (PHC-Med College)	For medicines in Antenatal period, transport from home to PHC.
Post-CS complications (6 Hrs PN)	Pvt Hospital/Pvt Hospital	Still Birth	2 facilities (BsPHC to Pvt Hosp)	Transport, pvt hosp
Obstructed Labour, Eclampsia, primi (Intra-natal)	Private nursing home	---	3 facilities (PHC to Med College to Pvt nursing home)	Had to bear expenses for Oxygen, medicines, diagnostics at medical college.

Issues identified

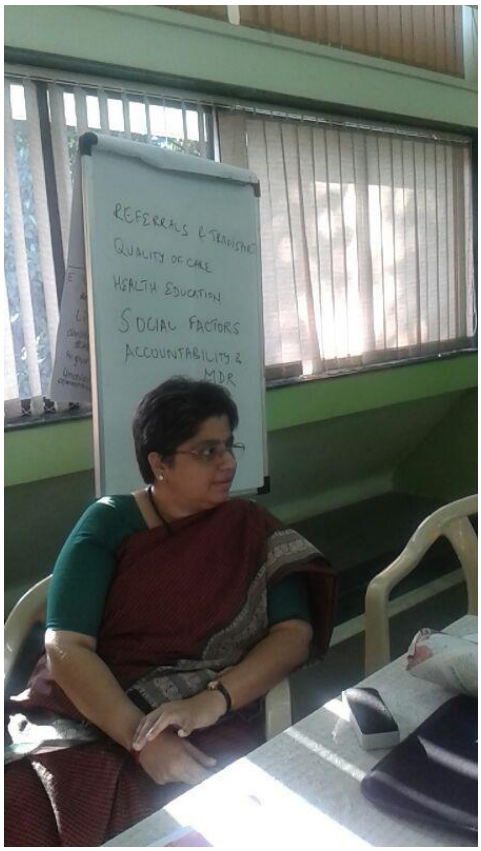
- Poor counselling on danger signs and birth preparedness/complication readiness
- CHCs poorly equipped to deal with any kind of complication, Tertiary institutions far away (avg 50k)
- No information provided on referral

- Quality of clinical care at tertiary facility?
- High out of pocket expenses – on travel as well as medications
- No post natal monitoring

GLIMPSES OF THE WORKSHOP



Song by participants from Shillong, representing SOCHARA, Bangalore



Day two being anchored by Subhasri
REPORT PREPARED BY:

INDIVIDUAL SESSION RAPPORTEURS:

Day 1: Asilata and Sana Contractor

Day 2: Pallavi Saha

Day 3: Sana Contractor and Pallavi Saha