Enabling Community Action to Promote Accountability for Maternal Health – Gujarat.

Renu Khanna, Sunanda Ganju, Mahima Taparia
SAHAJ and CommonHealth
Presented at
CommonHealth Meeting
March 23, 2013

Principles

- Duty bearers have an obligation to respect, protect and fulfill women's health rights
- They are answerable to rights holders
- Women have a right to participate in designing policies and programmes that affect them

Context

- Distillation from several initiatives that we are involved in – CommonHealth, Dead Women Talking, Community Monitoring of NRHM, COPASAH
- Based on a critique of Maternal Health Policy and Programmes in India
  - 'Institutional deliveries' rather than 'safe deliveries'
  - Inadequate monitoring of quality of MH services
  - Mandated MDRs are largely clinical/medical, only done by Health Department officers.
- Project situated in Gujarat, an economically developed state, 2 backward tribal districts Panchmahals and Dahod, 1 advanced district Anand, the birth place of the White Revolution and Operation Flood.

Two pathways for community engagement

First, monitoring of quality of 'Safe Deliveries' instead of state promoted 'institutional deliveries'.

Second, 'Social Autopsies' by community actors to identify gender and social issues, as well as their understanding of health system factors, that contribute to maternal deaths - complementing official Maternal Death Reviews.

1. Quality of Maternal Health Services Purpose and Process

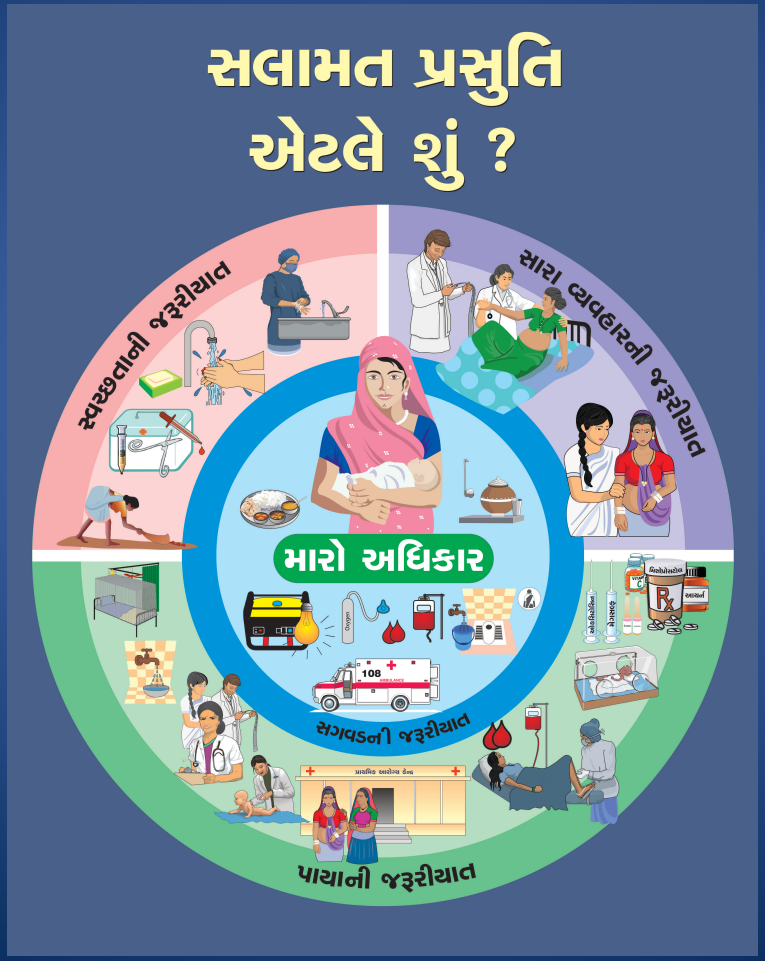
- Monitor quality from women's perspective
- Group discussions in villages on 'What do you consider as a Safe Delivery?'
- Ranking exercises on aspects of Safe Delivery
- Development of a poster on Safe Delivery – for wider dissemination of idea
- Development of a tool to assess quality

Safe delivery discussions

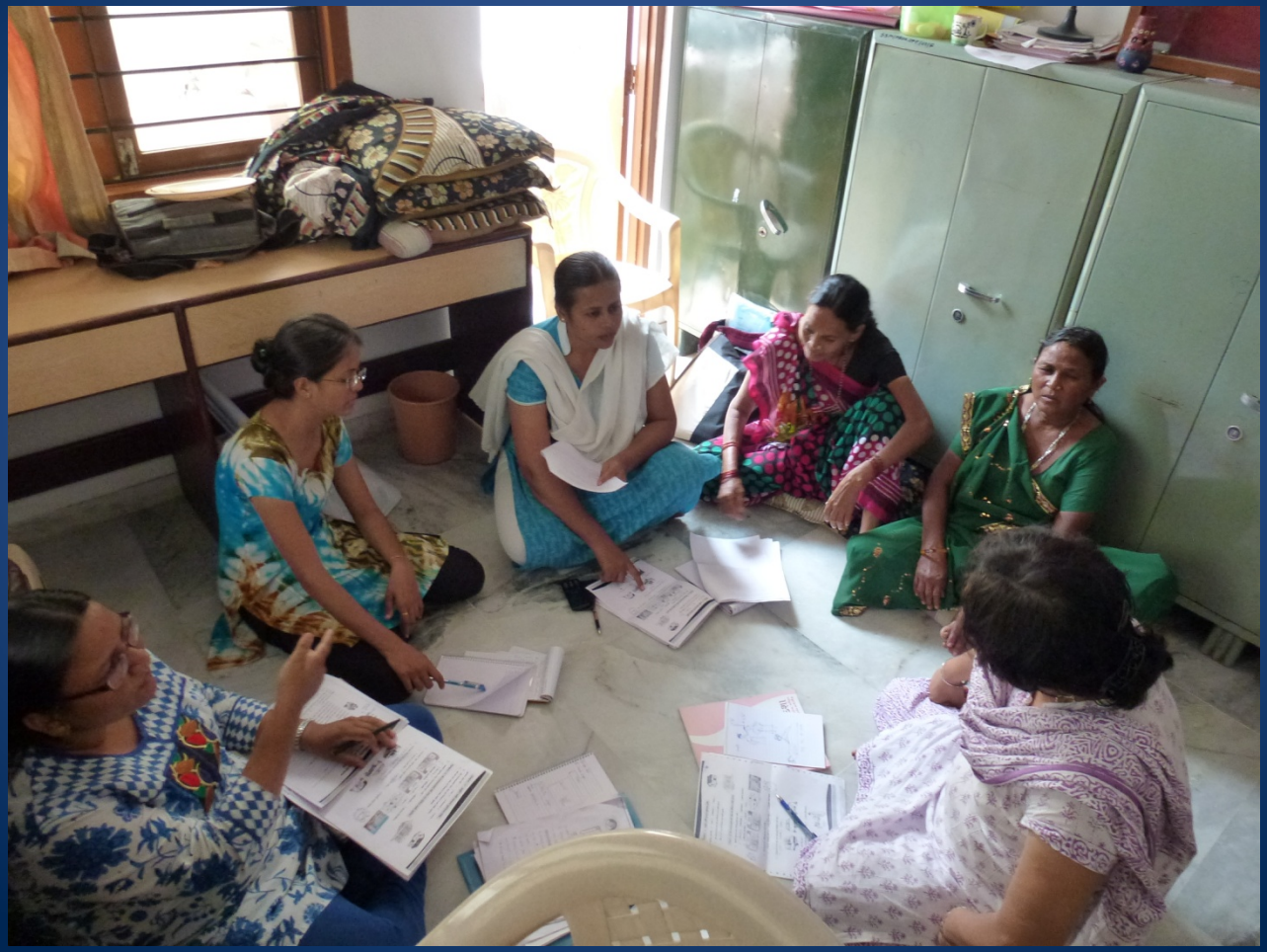
Ranking exercise conducted in tribal district (Dahod and Panchmahals)

Validation Procedure

Poster based on the 'Safe Delivery' exercise



Discussions with traditional birth attendants for finalizing the pictorial tool

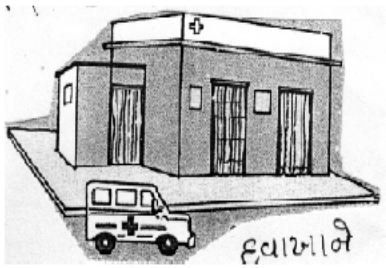


સુવાવડને કેટલા દિવસ થયા : _____ માહિતી લીધેલ તારીખ _____

વિભાગ 3 - પ્રસુતિ પછી માતાને પુછવાના પ્રશ્નો

સુવાવડ ક્યાં થઈ :

ઘરે ☐



દવાખાને ☐

અન્ય _____

૧. જો દવાખાનામાં થઈ હોય તો વિભાગ ૪ના પ્રશ્નો પુછવા

૨. જો ઘરે થઈ હોય તો વિભાગ ૭ના પ્રશ્નો પુછવા

વિભાગ ૪ – જો દવાખાનામાં થઈ હોય તો નીચેના પ્રશ્નો પુછવા

૧. તમારી સુવાવડ કયા દવાખાનામાં થઈ હતી ?

Contents of MH Quality Tool

- Guidelines on how and when to fill the tool
- Section 1 – Primary information about the pregnant woman
- Section 2 – Questions to be asked during pregnancy
- Section 3 – Questions to be asked about place of delivery
- Section 4 – Questions related to institutional delivery
- Section 5 – Questions to be asked if referred
- Section 6 – Questions about the health facility
- Section 7 – Questions to be asked if home delivery

Use…

- Being filled for each pregnant woman in 40 villages of a block – twice, 8th month and 10 -15 days after delivery
- Data from all cards to be compiled in a Block level Report Card every six months
- Report Card to be used for dialogue with Block level Health Officers
- Block level Report Cards and Public Dialogue proceedings to be presented to District Health Officer and CEO of District

Compilation - Dahod (in progress)

- **ANC**

- 3/7 not registered
- 4/7 have Mamta cards
- 2/7 weights taken, 3 times
- 2/7 - urine test, blood test, and only one woman had BP check up.
- No Abdomen check up, Height, Breast, Hemoglobin, Blood group, Malaria, Sickle cell, HIV , TB and sonography done
- 4/ 7 TT given
- 5 - IFA tablets, 60 tablets were given to them. No calcium tablets were given them.
- 5 respondents were taking ICDS THR.
- One woman gone to vatslay center 2 times during her pregnancy.
- Women had no information regarding government schemes.
- 4 women had high risk symptoms found during data collection
- In difficulties whom to contact no information was given.
- Majority delivery of place related decision taken by husband
- Only one woman had information on place of delivery which was given by nurse

PNC related information:

- 5/7 had home delivery and 2 in private hospitals.
- All deliveries were normal

- **Hospital Delivery**

- one delivery conducted by doctor and other one was by nurse
- In the hospital injection for pain was given to women, relatives were present with respondents and after delivery immediately injection was given to them. Within 3 to 4 hours discharge them.
- They used private vehicle. In the hospital blood facility was not available, in the labour room one woman said no clean room
- They had paid money for admission, medicines, prize, cleaning and before discharge
-

- **Home Delivery**

- 4 done by trained dai, one by untrained dai.
- Trained daies came with their dai box, clean their hand with soap and water, use plastic sheet, use of gloves but one dai who was untrained come without dai box, clean hand with water only, on use of plastic sheet.
- For removing placenta all pressed abdomin and 4 dais did kalla. For cord cutting they used new blade, to tie the cord cotton thread and cloth was used
- Delivery place was clean and lipan was done,4 women's delivery were on floor , and one on bed. 4 respondents delivery was in separate room.
- After delivery dai visited them and nurse visited 4 respondents
- Result of all respondents was healthy baby. All babies were given bath within one day. Wrapped with clean cloth, immediately given to mother, clean with clean cloth.

2. Social Autopsy

- A response to critique of the official MDRs…
  - Social determinants not recorded
  - Indirect causes not recorded
  - Only health systems personnel involved
- Designed to document
  - System related factors
  - Social factors
  - Science (Technical) factors
  - Rights violations

Tool or Methodology?

- Guidelines vs Checklist?, Open ended vs structured?
- Be guided by the framework - SSSR
- Ethical Guidelines on how to approach family, how to probe, confidentiality…
- Importance of triangulation, multiple perspectives
- Time factor - how many visits? When to go?
- Iterative process
- Team approach

Sections

- Individual woman's history
- Family situation
- Community factors
- Health facility/facilities, health system factors
- Technical quality of care factors
- Rights issues

Some promising outcomes…

- Response of District Health Officers
  - Welcoming dialogue based on systematic data collection
  - NGO representative part of District level MDR committee
- Excitement of partner organisations
- Potential of upscaling through government Village Health and Sanitation Committee training
- Tools and Methodology developed are being requested by several networks

Challenges

- Political challenges
  - Maternal Deaths a political issue … wariness at state level?
  - Resistance among state health department officers to becoming part of State Level Working Group?
- Challenges of inequitious contexts
  - Low literacy levels
  - Dispersed hamlets/settlements

Process intensive work… likelihood of fatigue??

Some lessons learnt…

- Awareness of entitlements and affiliation with a community based organisation is a powerful trigger for demand for accountability
- Need to recognise that resistance of the health system is normal (challenge to existing power relations). Therefore someone in the coalition needs to invest in preparing the health officers – division of roles…
- Dialogue based on systematic data collection is welcomed by health system

Some issues…

- Struggle between identifying health system gaps and pinpointing individual provider's failures/lapses
- How can we prevent punitive action on the weakest, instead enable systemic problem solving?
- Process intensive work – marginalised women as empowered citizens volunteering their time?

Acknowledgements

- For collective work, to all friends, collaborators and partners – ANANDI and Tribhuvandas Foundation
- Women who participate with such enthusiasm and commitment
- Sunanda Ganju and Dr. B Subhasri for feedback on earlier version of this presentation
- MacArthur Foundation for support

Thanks!

Renu Khanna, sahajbrc@yahoo.com, www.sahaj.org.in