MATERNAL HEALTH IN BOKARO
A cause for concern

A Report by Jan Chetna Manch, Bokaro

Presented at

'Saving Mothers' Lives: What Works'

Bokaro
29th March, 2009

Supported by IWHC and CMNHSA

Maternal Health in Rural Bokaro: A Report by Jan Chetna Manch

Why maternal health?

Over one lakh women die due to pregnancy related causes in India every year. It is estimated that 20 times more women suffer lifetime health problems due to childbirth. In spite of much progress in other spheres of development, maternal health continues to be a matter of shame. It is estimated that in India around 300 women out of 100,000 deliveries will die, whilst in Jharkhand it is higher – 371. Some estimates of maternal mortality are higher, since there are no accurate figures of maternal deaths – an indication itself of the low priority society gives to women in general.

Most of the women who die are poor. Indeed death certificates – like birth certificates – are rarely made in rural Jharkhand. The press hardly reports maternal deaths, unlike road accidents and murders which find their way into print every day. These women die in the far flung villages, unnoticed by the media, the big doctors, the politicians and the bureaucrats.

Why do women die?

The 'medical' causes that women die from are well known:

- Haemorrhage (34%),
- Sepsis (8%)
- Obstructed labour (5%)
- Unsafe abortion (8%)
- Hypertensive disorders (5%)
- Other conditions (34%)

(Source: Sample Registration System, Maternal Mortality in India: 1997 – 2003 Trends, Causes and Risk Factors. Registrar General India, New Delhi)

The tragedy of maternal deaths is that almost all of them are avoidable. Most deaths could have been averted if women had access to essential health care services.

The underlying or 'real' causes of maternal morality would include:

- Poverty
- Gender inequality
- Non availability of emergency obstetric care
- Lack of political will

Reaching the right care, at the right time

"Globally evidence suggests that most maternal deaths can be averted, but for the 'three delays' –
(i) delay in decision to seek professional care,
(ii) delay in reaching the appropriate health facility, and
(iii) delay in receiving care after arriving at a hospital.
Tackling and averting these delays will help …India to reduce the burden of maternal mortality."
(Source: 'Maternal and Perinatal Death Inquiry and Response', UNICEF, India)

What contributes to these delays?

1. The delay in decision making
    - Lack of knowledge of complications
    - Lack of resources (money & transport) to reach an appropriate facility
    - Low status of women
    - Lack of appropriate facilities nearby
    - Cost of appropriate facilities

2. The delay in reaching appropriate health facility
    - Distance
    - Transportation
    - Condition of roads

3. The delay in receiving care after arriving at a hospital
    - Non availability of personnel (especially doctors)
    - Non availability of medicines and emergency equipment
    - Quality of care

The Millennium Goal No 5

The fifth Millennium Development Goal to which the Government of India is committed is to reduce the maternal mortality ratio (MMR) by three-quarters by 2015. The Government aims to reduce the maternal mortality ratio to less than 100 per 100,000 live births by 2010, from a high 540 in 1998-99. It seeks to "accelerate the decline of maternal mortality" by ensuring that "all women have access to high-quality delivery care…. namely, a skilled attendant at delivery, access to emergency obstetric care in case of a complication and a referral system to ensure that those women who experience complications can reach life-saving emergency obstetric care in time" (Source: MOHFW, 2005: 103)

Evidence from Jharkhand, though sparse, suggests that rural women do not receive quality care during pregnancy or childbirth. Most are not attended by a 'skilled attendant'; they do not have access to emergency obstetric care, or a referral system to ensure timely live saving care. In Bokaro only 20% of rural women deliver in an institution. The recent jump in 'institutional deliveries' is largely due to the introduction of financial incentives to women from the government, and not due to significant changes in community awareness, or in the improvement in levels of care in these institutions.

Access to emergency obstetric care in Bokaro

Emergency obstetric care includes:

1. Functioning operation theatre for cesarean sections
2. A blood bank
3. 24/7 medical staff (including an obstetrician and anaesthetist)
4. Life saving medicines

Unfortunately Bokaro district does not have any of these in the state government sector. The families of poor women facing problems during childbirth have the following 'choices':

1. Mobilize large sums of money to access private health facilities (often taking loans or mortgaging/selling their land – their only asset in order to do so)
2. Go to the government district hospital in Purulia (where they are most unwelcome, since they are from Jharkhand, and the hospital is already overcrowded)
3. Call village medical practitioners (RMPs or 'dais') in the hope that they can manage
4. Or lastly – Risk the life of the woman, call the faith healer ('ojha') and pray to God.

Women's Health in Bokaro

The situation is compounded by women's poor health status; 73 percent of rural women in the state are anaemic and 43 percent are chronically energy deficient, i.e., they have a Body Mass Index (BMI) of less than 18.5 kg/m^2. (Source: National Family Health Survey-2) 'Jan Chetna Manch' found, in one assessment of the BMI of women accessing health care from the Chas and Chandankiari blocks, that it was even worse. 30 out of 75 women were found to be suffering from severe chronic energy deficiency (BMI < 16 kg/m^2), whilst 16 women were < 17 kg/m^2, 20 women 17 – 18.5 kg/m^2, and only 9 out of 75 women had a normal BMI of more than 18.5 kg/m^2

According to informal assessments although an increasing number of women are accessing antenatal care, the health of most of these women is poor in terms of both weight-gain during pregnancy and body mass index. A random sample of 100 women who had accessed antenatal care at the Women's Health Centre from the fifth to the ninth month of pregnancy showed that 83 weighed less than 45 kg during the fifth month of pregnancy (42 were less than 40 kg) and 47 weighed less than 45 kg during the ninth month of pregnancy (14 were less than 40 kg). Anaemia, as is well known, is rampant in our villages, compromising the mothers' health further, and putting them at even greater risk of dying due to haemorrhage at the time of birth.

It is in this poor status of health that the women of Bokaro's villages continue to risk their lives to produce another.

Maternal health in Bokaro: Studies from Jan Chetna Manch

'Jan Chetna Manch' has undertaken several studies in the past, and has gathered much experience in the course of working with rural women in the Bokaro district. We feel that some of these findings should be shared with the wider community, especially with the medical profession.

1. ***Quality of Care of Reproductive Health Services in Jharkhand: Case study of Chandankiari Block, Bokaro District*** *(2004)*

This was a small study based upon interviews with women in 2 villages of Chandankiari with regard to four reproductive health issues: childbirth, contraception, abortion and RTIs/STIs. The study also involved the interviews of health care providers: 'dais', unqualified medical practitioners (RMPs / village 'doctors'), MBBS-qualified doctors (private and government) and ANMs.

It sought to understand where women were going for these different services, and the reasons for their choice. The study aimed to identify the constraints poor women face in accessing good quality services – as defined by them.

The study attempted to answer the following questions:

- Where poor rural women go for these selected reproductive health needs, and why?
- What are the perceptions of 'quality of care' of rural women and the different health care providers?
- What are the barriers in accessing quality reproductive health services?

The following summarises the conclusions:

- Few poor village women are accessing any service from the government health system. Good quality care, according to the perceptions of all (village women, doctors, health officials) is not being provided. However there does not seem to be any expectation that the government ought to provide quality health care.
- The government health personnel were found to be extremely demoralised and frustrated. They themselves cannot convince the public to access their services, since they do not feel they are providing a good service.
- There is a strong preference for home-based delivery care amongst village women. The push for 'institutional care' in this situation might not prove to be successful. The provision of infrastructure alone will not lead women to the institutions.
- There is a strong reluctance of tribals in particular to access any institutional care, leaving them vulnerable to exploitative and unscrupulous health care providers – both qualified and unqualified.
- There are many misconceptions regarding the risks of contraception, though not of abortion. Abortion is not provided in government hospitals in the district, even though this is an important RH service.
- The identification of lack of transportation as a major constraint was identified by most women in remote villages. This problem also prevents ANMs from visiting their health centres.

2. ***Abortion Options for Rural Women: Case studies from the villages of Bokaro District, Jharkhand****, (Abortion Assessment Project – India, Centre for Enquiry into Health and Allied Themes (2003))*

This study was based on interviews with 25 rural women who had experienced an abortion in the previous 2 years. The study noted:

- *Women compromise their own health.*
  Women often juggled what is perceived to be 'safe' with what is affordable. Their own health often suffers from the compromises that they are forced to make.
- *Frequent complications.*
  15 out of the 25 women had accessed treatment from more than one health care provider, such as RMP and then MBBS doctor; herbal practitioner, MBBS doctor and then lastly obs/gyn doctor. This indicates that the provider could/did not deal with the complications which arose. Only in one case did the same doctor – an obs/gyn manage the complication which arose. Only 3 women had a 'safe' abortion from a single, qualified, service provider.
- *No abortion service available in government hospitals in whole district.*
  This is supposed to be available under RCH programme.
- *No counseling for contraception from private doctors.*
  None of the women who had an abortion from a private practitioner was given contraceptive counseling.

3. ***Women's Experience of Childbirth in Rural Jharkhand,*** *Lindsay Barnes, Economic and Political Weekly, December 1 – 7, 2007*

This is an article based on research into childbirth experiences of rural women in the Bokaro district. 32 recently delivered women were interviewed, of whom 30 had home births. It showed that, in the home births, 29 were attended by elderly women in the village, all by 'dais' (though 17 came after the birth only) and 26 by RMPs (20 were called prior to birth to give oxytocin injections, and 6 were called after the birth to give TT injections to mother and baby).

9 out of these 32 women reported that they experienced serious (potentially life-threatening) complications (heavy bleeding, retained placenta, prolonged labour, baby born with severe birth asphyxia), 13 experienced some problem (though not life threatening), whilst 10 women reported no problem at all. Although this is too small a sample to draw conclusions about the magnitude of women experiencing complications, what women and their families did when such complications arose was the subject of the study. Significantly none of them availed higher level of care when such complications arose.

What emerged was a whole host of beliefs, perceptions and systemic obstacles which prevent women from accessing the right sort of care at the right time. Some community based health care providers – dais and RMPs – were found to have misconceptions about heavy bleeding after childbirth, for example. Some stated that heavy bleeding was needed to cleanse the uterus of 'dirty' blood. However they also stated that too much bleeding was potentially fatal, and would refer the woman to a hospital if needed. What was clear, however, that they did not really know where to refer such women. Indeed blood banks are not available in any government hospital in the district, and are only available in nursing homes which are beyond the reach of the poor.

Village health care providers were reluctant to refer women facing complications during childbirth, not only due to their perceptions of risk. Quality emergency obstetric care is effectively absent in the district. Women themselves stated that the perceived quality of care in the health care institutions was a strong deterrent. Fear of cost, surgery, abusive behavior during labour, corruption (repeated demands for money). Dais and elderly women also reported being abused by the nurses and hospital staff in nursing homes and hospitals.

4. ***Documentation of the Implementation of the Mukhya Mantri Janani Shishu Swasthya Abhiyan,*** *UNICEF (Ranchi) 2007*

This study was undertaken in 6 districts of Jharkhand, including Bokaro. The problems with MMJSSA can be summarised as follows:

1. Money was not given at the right time. Huge delays in payment were found.
2. Incomplete knowledge of rules at all levels of health care providers (many doctors/ANMs thought that JSY is for $1^{st}/2^{nd}$ delivery or BPL only)
3. Corruption (money for signing coupons demanded by AWS, ANMs, MOs)
4. 'Sahaya' was found to be not effectively in place
5. Non functioning of the government health system in may places (from ICDS to PHC to Referral Hospital)
6. Repeated visits by family members needed for registration and payments.
7. The role of the accredited health institutions is marginal. They cannot make payments at time of delivery since they have not been given any advance.
8. There is no involvement of the 'dai' at all. Whatever payments are made is for the 'sahaya', who normally does not assist women during childbirth, even though the coupon clearly states that any 'link worker' can be given this payment.

Quality of care issues

1. Poor quality ANC, if at all. BP, abdomen check up, weight, Hb, etc not done
2. Noted an increase in institutional deliveries, but many women were extremely critical of the poor quality of care they received. Complaints were received regarding repeated demands for money by hospital staff – including doctors; dirty surroundings; absence of staff; lack of infrastructure etc.

Suggestions made in the report

1. Improve quality of care of health institutions – women and their families should want to go there, and be treated with respect.
2. Timely payments
3. Simplify the registration and payment procedures
4. Disseminate changes in rules of MMJSSA to all levels of government health personnel
5. The 'link worker' should be paid at time of delivery. This may be the 'dai', any other health worker or helper, who has brought the women to the institution for delivery.

True Stories of Mothers from the villages of Chandankiari and Chas

1. Obola Devi: A Home Birth Above All

Obola Devi was pregnant for the first time, after 10 years of marriage. She had seen many practitioners, by the time she came to the Women's Health Centre. However she got pregnant. She came each month for antenatal check ups. Her village is around 15 kms away from the WHC. When she started having pains, the 'dai' was called. The young woman said she wanted to go the WHC. She said, 'I've been checked up there every month, I want to go there. Don't call a village 'doctor'.' But no one in her family agreed. They told her, 'It is far, it is night, where will we get a vehicle? It is difficult to go.' They called a village 'doctor' (RMP). He gave several injections, over 4-5 hours, but the delivery did not take place. The 'doctor' called yet another 'doctor' from another village. Together they gave 9 injections. Then the baby was born. The placenta did not come out. After one hour he inserted his hand and pulled out the placenta. The 'dai' cleaned up the mother and cut the cord, and took the clothes to the pond to wash. When she returned she saw that a lot of blood had been lost, but the 'doctor' had gone, after taking the money. The 'dai' shouted at the mother, but she did not answer. The mother-in-law had thought that she was sleeping, since she had not slept all night. The 'dai' told her that she was cold already. The family called the 'doctor' who said that she was dead.

2. Anita Devi: Antenatal Care - A cause for surgery

Anita Devi had a difficult pregnancy. After 10 years of marriage, having given up on medical practitioners, she had become pregnant. She came regularly to the WHC for antenatal care. With each ante natal visit she brought along another health problem – urinary tract infection, hypertension, dysentery…. A problematic delivery was expected. During early labour she came with hypertension, and she was referred immediately to a higher centre for care. She underwent a cesarean section within an hour of her arrival at the nursing home. Both mother and baby were well.

The doctor at the nursing home told Anita that she should have gone to her for antenatal care, then she could have avoided the CS. Bad antenatal care, she was told, had led to her surgery. Anita's father was called to pay the bill, cursing the antenatal care that we provided to his daughter.

Anita never came back for post natal care or immunization, convinced that her prenatal care had cost her dearly. She quickly became pregnant again within a year. She could not afford the antenatal care of the doctor in the city, so she took TT injections from the village 'doctor' instead. She stayed at home for the childbirth, and called the RMP for administering the injections of oxytocin. Fortunately both mother and baby survived, blissfully ignorant of the risks.

3. Nomita Devi: Referred for a dead baby

Nomita Devi was brought in the early hours of the morning with strong contractions with the 'dai' of her village. She already had a CS from the previous pregnancy. We immediately sent her to a big government hospital. She was admitted, and the nurse in charge told the family that another CS was needed and her papers were made. The 'dai' was told to get out of the ward. Since the 'dai' had no other work there, she came back from the hospital saying that the operation would have been done.

But the operation was not done. After the nurse in charge went off duty, another nurse took over. Since the family was unhappy with the plan for another cesarean, when the next nurse said that she would try for a normal delivery, they were happy. The baby was not born easily. Oxytocin injections were given and abdominal pressure applied. A severely birth asphyxiated baby was born, but was not admitted into the NICU. The baby lay on the bed in the ward with IV fluids and oxygen for 5 days. After 5 days the doctors pulled out the IV line and told them to go to Bankura Medical College. They brought the baby home to die one day later.

4. Gayatri Devi: Saved by the 'dai' or the doctor?

Gayatri was pregnant for the 5th time. Her previous baby was born by CS, since the baby was transverse. The 'dai' of her village brought her regularly for ANC. During the last month of this pregnancy the baby was also transverse. Gayatri was told to get ready for another CS. When the contractions started her husband called another old woman and an RMP – trying to avoid the hospital and another operation for his wife.

Gayatri, however, made him call the 'dai'. When she arrived the RMP was just about to load his syringe with oxytocin. The 'dai' told Gayatri's husband that if the 'doctor' gave the injection she would leave. Fortunately for Gayatri the RMP was asked to leave. The 'dai' did an internal examination and found, as she anticipated – transverse lie. Gayatri was having strong contractions, but hardly any dilation.

The 'dai' sent the husband to bring the ambulance, and they went to the big, government hospital. The nurse there also did a PV examination and said: she has much time to go, maybe by morning she will deliver. The nurse did not see the scar on her belly, nor find a transverse lie. The 'dai' went in search of a doctor. Not an easy task in the middle of the night, even in a hospital. Somehow she managed, and persuaded him to come and see Gayatri. The doctor saw immediately the problem, and an emergency CS was done within the hour. When the 'dai' tried to see the baby the nurse kicked her out. When she protested, saying that she knew a bit about childbirth the nurse gave her a few choice 'gaalis' – if you know about delivery why did you bring her!

5. Maloti Devi: Referral Notes Count for Naught

Maloti was not progressing well during delivery. She had strong contractions for 6 hours, and was fully dilated. But the baby's head was not descending. Even after the membranes ruptured – which were clear – the baby didn't move down. Maloti had no other problem. The baby's heartbeat was regular.

One of the WHC's health workers, asked the family to take her to a nursing home or hospital. She wrote down all the findings of the 6 hours since Maloti had come: her BP, foetal heart rate, noted the time of membranes rupturing and the colour of the liquor. She also remembered to take her antenatal card, which had all the other investigations written on it. The health worker accompanied Maloti to the big hospital.

At the hospital the health worker tried to give this information to the nurse. The nurse told her to get out saying: If you know so much then why did you bring her, this information is of no use to us, all concocted I'm sure. Whatever information I need I'll get from the mother herself, now get out!

6. Sahachori Devi: One for the road

Sahachori had been registered with the ANM for the Mukhya Mantri Janani Swasthya Abhiyan, helped by the 'anganwari sewika'. Told to go to the PHC for delivery, she was taken to there in the night by the 'sewika'. It was a cold winter's night. The PHC was locked, and not a nurse or doctor was around. The driver told them that the Women's Health Centre in Chamrabad is always open, so he brought Sahachori. As soon as she got out of the auto she squatted and delivered on the road. The health workers quickly cut the cord and wrapped up the poor, shivering, now filthy, preterm baby. Cleaned and wrapped and warmed with hot water bottles, the baby survived. When Sahachori went to the PHC later on for payment she was asked – why did you not come here for delivery!

7. Taslimun Bibi: All for a Son

Taslimun Bibi' family was not poor, by village standards. She was pregnant for the 4th time. She had 3 daughters but she desperately wanted a son. She went with her husband to a big doctor in the city, where an ultra sound was done and they told her that the baby was another female. It was the 4th month of the pregnancy. She and husband returned to the doctor (an MBBS & DGO) the next day for an abortion. The abortion was done. The doctor told her to come back for check up after 8 days.

When she returned home her in-laws all came to know what they had done, and she faced much abuse from them. They said whatever be the case, she should not have had an abortion. Although she continued to bleed, she did not return to the doctor after 8 days for the check up. She bled for 18 days. One day she went to the pond for a bath, and she collapsed. The family took her to a private hospital in the city, where the doctor told them that she had no blood left in her body. Before they could give any blood or start the treatment she died.

"Saving Mothers' Lives – What Works": The Experience of 'Jan Chetna Manch'

Goal: To provide the best quality care to the poorest of women during childbirth

Strategies

- Empowering poor women, through self help groups, at community level.
- Health education through meetings, fairs, posters, leaflets, songs and drama.
- Training village women to provide primary health care, link them to a supportive health centre
- Working with dais, upgrading their skills, recognizing positive traditional practices, and treating them with respect.
- Quality ANC (Investigations, treatment, counseling, nutritional support)
- Safe abortion care for unwanted pregnancies
- Contraception counseling and services
- Linking the village to health care in times of need (telephone, ambulance, link worker)
- Safe delivery care (Management of common obstetric emergencies and timely referrals)
- Working with the government in the implementation of Janani Suraksha Yojana

Results

- Regular ANC for around 200 women per month
- No case of eclampsia in past 5 years of women registered for ANC
- Two maternal deaths from the registered women in last 5 years (out of 5000 deliveries) (MMR of 40 per 100,000)
- One abortion related death in villages where women's groups exist in last 5 years (compared to 4 in one year 6 years earlier, when health centre was not registered)

Gaps

- Weak documentation – impact on neonatal outcome, nutritional status, etc needed
- Weak referral system – expensive still for poor people, or poor care in government hospitals

In conclusion

The poor cannot depend upon highly qualified people alone, to reduce maternal mortality and morbidity. In order to save mothers lives we need to build upon the available resources in the community – the women, their families, the traditional birth attendants, mobilizing and organizing women's groups. However highly qualified health care professionals are needed as part of the referral system, to treat the obstetric emergencies. The community can be made aware of the problems of childbirth, the dais can be taught to recognize emergencies, but the question still remains – refer to where? This question still remains, and until it does, women will continue to die and suffer due to childbirth.