

Understanding Maternal Health from a Gender and Rights Perspective:

A Training Module for Advocates and Practitioners

Compiled by Renu Khanna on behalf of CommonHealth, SAHAJ and RUWSEC



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CommonHealth: Coalition for Maternal-Neonatal & Safe Abortion

SAHAJ: Society for Health Alternatives

RUWSEC – Rural Women’s Social Education Centre



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Training Module for Maternal Health from a Gender and Rights Perspective

Introduction and Rationale

Several CommonHealth members have been conducting workshops on Making Pregnancy Safe since 2005. The contents of these workshops have been refined over the years and participants - a mix of doctors, programme managers, researchers, women's health advocates, have responded positively. The guiding principles have been as follows:

- The intention is not to give clinical inputs, but a public health perspective on maternal mortality and morbidity
- This means gaining an understanding of how big and complex the problem is and what may be done to address it
- Among the many approaches one could take to this issue, this course adopts a 'gender and rights' perspective.
- Gender as a determinant of maternal mortality and morbidity
- Maternal mortality and morbidity as a rights issue – a violation of women's right to life because most of the suffering is avoidable and preventable

Based on the positive feedback received on the Course, CommonHealth members decided to develop a Training Manual that could be used more widely.

Who can use it and how

- Middle level managers of Maternal Health programmes to orient programme staff to Maternal Health with a Gender and Rights perspective

Design

This is a four day module comprising of six class room session each day and a total of around 24 hours. The Training Module consists of Session Outlines detailing the objectives, methodology and contents of each session. Reference material for each session, exercises, case studies, and PowerPoint presentations are provided for each topic.

Expected outcomes

At the end of the course, participants will:

- Have conceptual clarity on a rights-based and gender-sensitive approach to policies and programmes for Maternal Health.
- Understand the dimensions of maternal mortality and morbidity including unsafe abortion; and their underlying social, economic and political determinants.
- Have in-depth understanding of varied policy approaches and health system factors affecting maternal mortality and morbidity and unsafe abortions

Topics included

1. An overview of the Maternal Health situation globally and in India
2. What is Maternal Health, definition of Maternal Health, Determinants of Maternal Health
3. Gender issues in Maternal Health
4. Maternal Health as a Human Rights Issue
5. Maternal Deaths – What is a Maternal Death? Pregnancy related deaths, Causes of Maternal Death, 3 Delays, Measurements of Maternal Deaths – MMR etc.,
6. Emergency Obstetric Care – Comprehensive and Basic
7. Safe abortion services
8. Maternal morbidities
9. Maternal Health Policy in India: – What it can do and what it cannot
10. Addressing maternal health from a gender and rights perspective

Topic	Learning Objectives	Methodology	Time
Session 1. Overview of Maternal Health situation globally and in India	Participants will be able to <ul style="list-style-type: none"> • State why Maternal Health is a key issue globally and in India 	<ul style="list-style-type: none"> • Participants share stories of maternal deaths from their experience • Presentation on Maternal Health Situation, globally and in India 	90 minutes
Session 2. Concept of Maternal Health	Participants will be able to: <ul style="list-style-type: none"> • Define maternal health • Recognise the role of Social determinants 	<ul style="list-style-type: none"> • Debate around three statements • PowerPoint presentation to summarise and highlight issues 	90 minutes
Session 3. Gender issues in Maternal Health	Participants will be able to <ul style="list-style-type: none"> • Differentiate between Sex and Gender • Apply a gender analysis framework to maternal health case stories 	<ul style="list-style-type: none"> • Discussion • Quiz • Presentations • Group work – analysis of case stories 	3 hours
Session 4. Maternal Health as a Human Rights issue	Participants will be able to <ul style="list-style-type: none"> • Differentiate between concepts of Human Rights, Right to Health and Health Care, Reproductive Rights, Sexual Rights, Obligations of Duty Bearers. • Be able to analyse Maternal Health case studies using the above mentioned concepts • Be able to distinguish between needs based, rights based, victim blaming approaches to Maternal Health 	<ul style="list-style-type: none"> • Presentation • Group work/role plays around case studies • Discussion 	3 hours

Session 5 Maternal Deaths and measurements	<p>Participants will be able to</p> <ul style="list-style-type: none"> • Differentiate between Maternal Deaths and Pregnancy related deaths, • Define perinatal death, and recognise its importance as an indicator of quality of delivery care • State different indicators of maternal deaths • State reasons underlying difficulties to measure maternal death rates 	<ul style="list-style-type: none"> • PowerPoint presentation • Quiz 	90 minutes
Session 6 Prevention of Maternal Deaths -1	<p>Participants will be able to</p> <ul style="list-style-type: none"> • Enumerate the causes of maternal deaths • Describe three delays • State the strategies necessary to prevent maternal deaths • Describe the difference between Skilled Birth Attendant and Skilled Birth Attendance • Contextualise the role of the traditional birth attendant 	<ul style="list-style-type: none"> • Reflection on case studies • PowerPoint presentation • Small group discussions • Reading and debate 	2 hours
Session 7 Prevention of Maternal Deaths - 2: Emergency Obstetric Care	<p>Participants will be able to</p> <ul style="list-style-type: none"> • State the components of Emergency Obstetric Care • Differentiate between Basic and Comprehensive emergency Obstetric Care 	<ul style="list-style-type: none"> • Presentation • Quiz 	90 minutes
Session 8 Prevention of Maternal Deaths – 3 -Importance of ANC and PNC	<p>Participants will be able to</p> <ul style="list-style-type: none"> • Relate the importance of components of ANC and PNC with causes of Maternal Deaths • Incorporate women’s perceptions of quality in monitoring of ANC, Deliveries and PNC. 	<ul style="list-style-type: none"> • Interactive lecture using a PowerPoint presentation and questions for discussion 	60 minutes
Session 9 Maternal Morbidities	<p>Participants will be able to</p> <ul style="list-style-type: none"> • Define maternal morbidities • Identify maternal morbidities • Analyse how morbidities are related to maternal health 	<ul style="list-style-type: none"> • Case studies • Presentation 	90 minutes
Session 10 Abortion as a Maternal Health issue	<p>Participants will be able to</p> <ul style="list-style-type: none"> • State why Abortion is a Maternal Health issue • Identify gender and rights issues related to abortion 	<ul style="list-style-type: none"> • Presentation • Case studies 	90 minutes
Session 11 Maternal Health policy in India	<p>Participants will be able to</p> <ul style="list-style-type: none"> • Describe the milestones in India’s Maternal Health Policy • Analyse the strengths and weaknesses of India’s MH Policy. 	<ul style="list-style-type: none"> • Homework reading • Group work • Presentation 	2 hours
Session 12 Addressing Maternal Deaths from a gender and rights perspective	<p>Participants will be able to</p> <ul style="list-style-type: none"> • Suggest strategies to address Maternal Health from a gender and rights perspective 	<ul style="list-style-type: none"> • Group work exercises • PowerPoint presentations 	3.5 hours

Session 1: Overview of Maternal Health, Globally and in India

Session Outline

Learning Objectives

Participants will be able to

- State why Maternal Health is a key issue globally and in India
- Locate maternal health within the framework of sexual and reproductive health

Methodology

- Sharing of stories of Maternal Deaths by participants
- Interactive presentation

Materials Required

- PPT 1.1 Maternal mortality and morbidity– An overview of major issues

Time

90 minutes

Activities

1. Facilitator asks participants to share stories of maternal deaths that they have encountered. Between 10 to 15 minutes are spent on this activity.
2. Facilitator makes the presentation – interspersing it with questions for discussion and allowing for discussion

Key Issues of Emphasis

- Facilitator emphasises that the state of Maternal Health in a society reflects how seriously that society considers its women, the importance given for their wellbeing.
- Facilitator also calls for participants' commitment to strive for improvement in maternal health wherever they are located.

Note for the Facilitator

You may need to update the data on Maternal Health depending on when you are doing the training. Point out that Health is a state subject and that states take different levels of initiative - study the DLHS Fact Sheets on the states where the participants are coming from and be prepared with the state differences. Ask the participants from different states to comment on their state Maternal Health schemes and programmes.

Readings and References

1. *Trends in Maternal Mortality: 1990-2010, WHO, UNICEF, UNFPA and World Bank Estimates.2012*
2. *Special Bulletin on Maternal Mortality in India 2007-09, Sample Registration System. June 2011*
3. *Annual Report to the People on Health, Government of India, Ministry of Health and Family Welfare. September 2010*
4. *District Level Household Services, Fact Sheets for the states where the participants are coming from.*
5. *WHO, UNICEF, UNFPA: Maternal Mortality Estimates in 2000.2004*

Session 2: The Concept of Maternal Health

Session Outline

Learning Objectives

Participants will be able to

- State what is meant by Maternal Health
- Describe the role of Social determinants

Methodology

- Prior reading to get an idea of the concept of Maternal Health
- Debate on statements
 - ✓ Maternal Health is only concerned with high Maternal Mortality Ratios.
 - ✓ A good Maternal Health package consists of prenatal care, intranatal care and post natal care.
 - ✓ Technical quality of maternal health care services is the most important factor in bringing down the Maternal Mortality Ratio.
- Power Point presentation

Materials Required

- Readings distributed as homework
- PPT 2.1 Concept of Maternal Health

Time

90 minutes

Activities

1. Debates of the 3 statements

Divide participants into two teams – give them innovative names, like and

- In Round 1 – debate on *Maternal Health is only concerned with high Maternal Mortality Ratios* - team A argues FOR the motion and Team B argues AGAINST the motion. Let the debate continue for 15 minutes.
- Round 2 will be on *a good Maternal Health package consists of prenatal care, intranatal care and post natal care*. This time team A will argue AGAINST the motion and team B will argue FOR the motion. This round will also be for 15 minutes.
- For Round 3 on *Technical quality of maternal health care services is the most important factor in bringing down the Maternal Mortality Ratio* let the teams decide who will be FOR and AGAINST. Let this round also go on for 15 minutes.

2. Facilitator summarises the main points very briefly and then goes into the PowerPoint presentation.
3. Facilitator leads a discussion on listing the determinants of Maternal Health using some of the stories from session 1.

Key Issues of Emphasis

- Maternal Health is equated with Maternal Mortality. All the emphasis in our programmes is on Maternal Mortality. While this is very important because most maternal deaths are preventable, it is important also to focus on what will contribute to Maternal Health. Quality contraceptive services and safe abortion services are an important part of Maternal Health. Maternal morbidities that result from poor quality of maternity care also need to be recognised and prevented – they cause lifelong hardship for women.
- In addition to direct causes of maternal deaths, there are also indirect causes – like anaemia, malaria, TB and other health conditions – as well as other determinants like poverty, social class, age, education levels, gender factors that contribute to maternal Mortality.
- Respectful care at birth is very important. Labour room abuse has been ‘normalised’ and this is not acceptable.

Readings and References

1. WHO (2008), *Fact sheet on Maternal Mortality*, WHO/MPS/08.12
http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_maternal_mortality.pdf (Accessed Nov. 26, 2010)
2. WHO (2008), *Fact sheet on Millennium Development Goal 5*, WHO/MPS/08.15
3. DFID (2007), *Fact sheet on Maternal Health*. November 2007
4. DFID (2005), *How to note, How to reduce maternal deaths: rights and responsibility*. February 2005
http://www2.ohchr.org/english/issues/development/docs/rights_maternal_health.pdf
(Accessed Nov. 26, 2010)
5. Berer, Marge (2010), *A response to UN Secretary-General Ban Ki-moon, Investing in our common future: Joint Action Plan for Women's and Children's Health, Draft for Consultation*, WHO
http://www.who.int/pmnch/activities/jointactionplan/201006_jointactionplan_a4en_lowres.pdf
6. Bowser, Diana, Kathleen Hill, (2010), *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*, USAID-TRAction Project, Harvard School of Public Health. University Research Co., LLC. September 20, 2010

Session 3: Gender Issues in Maternal Health

Session Outline

Learning Objectives

Participants will be able to

- State the differences between Sex and Gender.
- Describe the elements of a gender analysis framework and how gender operates at various levels and in diverse institutions
- Apply the framework to analyse gender issues in Maternal Health

Methodology

- Presentations
- Small Group work on Case studies

Materials Required

- PPT 3.1 Gender as a System
- Case studies
- PPT 3.2 on Gender issues in Maternal Health

Time

3 hours

Activities

1. Discussion on differences between Sex and Gender (45 minutes)
 - Facilitator initiates a discussion on difference between Sex and Gender and covers the points listed in Handout 3.a.
 - Facilitator follows up this discussion with the Quiz contained in Handout 3.b.
2. Presentation on a Gender Analysis Framework (45 minutes)
 - Facilitator does an interactive presentation on Gender as a System
3. Group work on case studies (45 minutes)
 - All participants are given copies of the 4 case studies.
 - Participants are divided into four small groups.
 - Each group is assigned one case study and asked to use the Gender Analysis Framework and identify the Gender issues contained in the story
4. Plenary discussion summarising the discussions and main issues
 - Each group presents their analysis in 10 minutes
 - Facilitator summarises through the Power point presentation.

Notes for the Facilitator

- In addition to how gender issues impact women in the case studies, point out the effect of gender on men e.g. gender norms for men (Savita's husband could be drinking and behaving irresponsibly and society would not look askance, or the brothers as protectors.)
- Also discuss how intersectionalities makes women even more vulnerable – caste, class, age factors in each case study.

Readings and References

1. UNDP. *Human Development Report 2005*. New York and Oxford, Oxford University Press. 2005
2. Royston E and Armstrong S (Eds). *Preventing maternal deaths*. Geneva, World Health Organization. 1989
3. Gopalan S and Shiva M (Eds) *National profile on women health and development: Country-profile – India*. VHA and WHO-SEARO, 2000, New Delhi
4. WHO-SEARO. *Women of South-East Asia: A health profile*. World Health Organization Regional Office for South East Asia, New Delhi. 2000
5. Ravindran TKS, Savitri R and Bhavani A. *Women's experience of utero-vaginal prolapse: A qualitative study from Tamil Nadu, India*. In Ravindran TKS and Berer M (Eds). *Safe motherhood initiatives: Critical issues*. London, Reproductive Health Matters. 1999
6. International Institute of Population Sciences (IIPS) and ORC Macro. *National family health survey (NFHS-2) 1998-99: India*. Mumbai, IIPS. 2000
7. Ramachandran, P. *Women's Vulnerability to AIDS: A Symposium in the Transmission, Prevention and Management of the Pandemic*, Seminar 396, August 1992, pp. 21-25
8. Patel V, Rodrigues M and DeSouza N. *Gender, poverty and postnatal depression: a study of mothers in Goa, India*. *American Journal of Psychiatry*, 2002; 159(1): 43-47
9. Moktan RP. *Barriers underlying delays among women seeking emergency obstetric care in a referral hospital in Sikkim*. Trivandrum, Achutha Menon Centre for Health Science Studies, Unpublished MPH dissertation. 2004
10. Khosla AH, Dua D, Devi L and Sud SS. *Domestic violence in pregnancy in North Indian women*. *Indian Journal of Medical Sciences*, 2005; 59(5):195-199
11. Purwar MB, Jayaseelan L, Varhadpande U et al. *Survey of physical abuse during pregnancy GMCH, Nagpur, India*. *Journal of Obstetric and Gynecological Research*, 1999; 25(3):165-171
12. Peedicayil A, Sadowski LS, Jayaseelan L et al. *Spousal violence against women during pregnancy*. *British Journal of Obstetrics and Gynecology*, 2004; 111(7): 682-687
13. Jejeebhoy SJ. *Associations between wife-beating and fetal and infant death: impressions from a survey in rural India*. *Studies in Family Planning*. 1998; 29(3):300-308
14. Parasuraman S. *Domestic violence and pregnancy outcomes with special reference to abortion: A study in Madhya Pradesh*. *IIPS Newsletter January 2004*: 11-20
15. Campbell JC. *Abuse during pregnancy: a quintessential threat to maternal and child health- so when do we start to act?* *Canadian Medical Association Journal* 2001; 164(11): 1578-1579
16. Ganatra BR, Coyaji KJ, Rao VN. *Community cum hospital based case-control study on maternal mortality: a final report*. Pune, India, KEM Hospital Research Centre. 1996

Handout 3.a Gender Concepts, Tools and Gender Analysis¹

Introduction

Health is a state of physical, mental and social well-being, not merely the absence of disease or infirmity (WHO). Women's and men's well-being is determined by social, political and economic factors that shape their lives, as well as by their biological condition. Biological differences between women and men – that is differences related to their sex – affect their vulnerability to illness or disease. Differences in the roles, resources and status of women compared to men interact with biology to increase or decrease this vulnerability. These gender differences also affect access to health knowledge, self-perceptions of health needs and the ability to access services. Gender inequalities in the preconditions for health and in health information and services produce inequalities in health outcomes.

In order to understand and address the health needs and priorities of women and men gender analysis must be integrated into health research and the design, implementation and monitoring of health services.

This handout introduces gender analysis and related concepts.

Gender analysis

Gender analysis is a social analysis that distinguishes the resources, activities, potentials and constraints of women relative to men in a specific socio-economic group and context. Gender analysis does not focus only on women but on the differences in the condition and position of women and men, and to the socially constituted relations between them.

Social relations of gender

Gender relations are determined by society, not biology, and are therefore specific to particular contexts and times. Gender relations are not necessarily harmonious. In the past many development

Sex refers to the biological characteristics that define humans as female or male

Gender is the social meaning given to being male or female in a particular place and time. Gender is an acquired identity that is shaped through social norms, changes over time, and varies widely within and across cultures. Gender describes the array of *different* roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that a particular society assigns to men or women.

Masculinity and **Femininity** refers to the attributes that men and women are expected to possess. Let us take a few minutes to reflect on how our own culture and context defines masculinity and femininity. [Pause for reflection]. What did you come up with? In most contexts we find that while men are expected to be strong, brave, adventurous, rational, articulate, and decisive, women are expected to be delicate, timid, emotional, wavering and so on. Society also has its ways of punishing men and women who do not subscribe to the social norms laid down for them.

Patriarchy refers to historical power imbalances and cultural practices and systems that accord men on aggregate more power in society and offer men material benefits, such as higher incomes and informal benefits, including care and domestic service from women and girls in the family (United Nations Division for the Advancement of Women, 2003).

¹) "Glossary" by the United Nations International Research and Training Institute for the Advancement of Women (INSTRAW) (<http://www.un-instraw.org>)

initiatives assumed that women's and men's different roles were complementary, that relations between them were primarily cooperative, and that therefore initiatives which benefitted men would also benefit women. The failure of development to improve the situation of women challenged this belief and led to more focus on the unequal power balance between women and men, and the recognition that social relations of gender are often conflictual. Recognising differences in power, and identifying the norms and practices which maintain unequal relations of gender, is a critical aspect of gender analysis.

Key points to remember about gender and gender relations:

- Women and men are given different values based on their socially assigned gender. Women in many parts of the world are generally less valued than men and enjoy fewer human rights than men (For examples see resources listed below: UN Human Development Report (1995), UNICEF (2007) and The Global Gender Gaps Report (2008)
- Although the different characteristics, roles and status of men and women may appear 'natural' or unchangeable, they can and do change. They are not given by nature or a divine plan; they are created by society and can be changed by society. The mutability of gender roles and relations is easily seen by looking at changes in women's and men's roles and opportunities over the last few generations or considering differences between contexts.
- Gender is **not** about men and women being the same nor or that they should be doing the same things. What is the same are the rights that they are entitled to.

Purpose of gender analysis

Gender analysis can help to reveal the gendered realities of day-to-day life and highlight how these realities affect health status, health decisions and access to health care.

Gender analysis is essential to understanding underlying causes of illness or disease and a critical step in planning interventions to prevent or treat disease and promote wellbeing. Gender analysis reveals how biological and social differences between women and men interact to produce differential health outcomes. For example more women than men are affected by anaemia. Women may be biologically predisposed to anaemia because they lose blood through menstruation but the susceptibility of women to anemia may be worsened by social customs that favour men in terms of access to iron rich foods. Gender analysis also shows how social beliefs about gender have a direct affect on health. For example, beliefs that men should be strong, take risks and be sexually aggressive put men at higher risk for particular injuries and increase their exposure to sexually transmitted diseases. In the case of STD's, men's exposure may lead to increased incidence of STDs in women because they are biologically more vulnerable but more importantly because they often lack power to negotiate safe sex practices. Gender-blind HIV/AIDS interventions have failed to address these realities and therefore failed to prevent the spread of the infection, particularly among women.

Gender analysis should also take cognizance of the different ways gender is constructed across cultures, classes and ages. For example in Sub-Saharan Africa women are more vulnerable to HIV/AIDS (women contribute 60% of HIV/AIDS infections in SSA – UNAIDS/WHO, 2009) but poor women may be even more vulnerable than other women. In Sri Lanka, a gender-sensitive study observed a greater demand for health services by widows than among women with partners, raising the question of whether this was due to relatively more autonomy in decision making, greater health needs or social isolation (Oxaal and Cook, 1998). Identifying the need and raising these issues enables better targeting of health services; in this case it also highlights the need to investigate the constraints that may affect married women's access to health care.

Sometimes health initiatives are called on to address gender in order to strengthen women's role in promoting the health of children and men (see for example...). While this may be efficient, it values women only in certain socially determined roles and therefore does not challenge the status quo. Gender analysis can also contribute to effectiveness by increasing the likelihood that the health problem has been accurately understood and that the intervention will work in practice. However, to promote wellbeing and contribute to human rights, gender analysis in health needs to go beyond efficiency and effectiveness to promote social justice and empowerment for women. Gender blind interventions can reinforce or worsen inequalities and poor health status for poor women. On the other hand, greater equality and empowerment are recognized as contributing to optimal health.

How to do a gender analysis

At its simplest gender analysis involves answering a few key questions:

- Who does what?
- Who has what?
- Who decides?
- Who needs what?
- Who wins? Who loses?

Answering these questions requires collecting sex-disaggregated data and analysing this information using the concepts discussed below. Sex-disaggregated data can come from surveys, health system statistics, etc (although many surveys still collect data at the household level and not all statistics are disaggregated by sex or other characteristics). Research or documentation on gendered aspects of health, or specifically on women's health, is often available through universities and women's organizations. Most importantly, however, is to gather information directly from women and men in order to understand gender relations in the specific context. Local women's organizations are an invaluable resource for this purpose.

Gender analysis should be conducted

- As part of any situation analysis
- As part of planning processes (at local or national level)
- When designing a project or policy and making plans for implementation and monitoring
- In the evaluation of a project or policy

In summary, gender analysis is essential because:

- It helps us to understand a particular development problem in a more comprehensive and precise way. A better problem analysis supports the formulation of more effective projects that are more likely to contribute to better health outcomes for women and to prevent any possible negative effects of an intervention by taking into account the differences between women and men, boys and girls.
- In the case of health, gender analysis helps us to identify the health needs of men and women and to understand factors that give rise to illness and diseases in different groups of people.
- It helps us to expose barriers to accessing health for different categories of people. For example, social and economic factors that favour men in the distribution of resources may negatively impact on women's ability to access health services even where they are formally available.
- Gender analysis (through recognition of other intra-group differences, such as class) may help us understand which kinds of health care services are used by different groups (e.g. Traditional Birth Attendants compared to hospital midwives) and to design appropriate strategies to improve utilization and access.
- Gender analysis can suggest how activities can be implemented and organizations / services structured to facilitate equitable participation and benefit at all levels by both women and men.
- Women's gender roles are often invisible during development and health planning such that their gendered needs and interests are not taken into account.

The next section introduces some of the analytical concepts that are part of a gender analysis and that help to answer the five key questions.

WHO DOES WHAT?

Gendered Division of Labour

Women and men, girls and boys all take on tasks to contribute to the survival and well-being of the household and the community. There are three overall types of labour:

- *Productive work*: tasks and activities that involve the production of goods and services that usually can be exchanged for cash or kind. This could be farming, informal work (such as selling produce or small items by the road or doing piece work at home) or waged employment.
- *Reproductive work*: tasks and activities carried out to reproduce and care for people and households. This includes child birth, child rearing and family planning, but also food preparation, water and fuel collection, shopping, housekeeping and family health care.
- *Community work*: Community work is different from reproductive work. Where reproductive work is mostly regarded as women's work, both men and women participate in community work. However, the type of community work that men and women engage in may be different depending on their socially ascribed roles. For instance, the work that women

undertake at community levels is usually an extension of their reproductive roles. This type of work supports collective consumption and maintenance of community resources (e.g., water, healthcare, and education, etc). It relies on women's voluntary labour, and 'free time'. Women are not paid for activities that they do under this role. On the other hand men may predominate in community work activities that may involve community level organizing at the formal political level. Men more than women may receive both direct and/or indirect compensation for their efforts. For example, they may be paid a wage or may get compensation through indirect means such as increased status and power within their communities.

The concept of a gendered division of labour recognizes that the roles, responsibilities and activities assigned to men and women differ according to what society considers appropriate. For example:

- Both men and women engage in productive work, but women's productive work is often invisible, and the work that is recognized is usually less valued than men's work. Women's productive roles are usually less diverse than men's due to socio-cultural constraints. Gender differences in productive work affect the illnesses to which women and men are exposed. For example, in much of the developing world, women comprise the majority of agricultural workers – often working as unpaid family laborers – and also tend to work in the informal sector (ILO) as lowly paid unskilled workers. Women's work in agriculture may expose them to diseases like malaria and bilharzia. Chronic back pain and leg problems may be more prevalent in women farmers than men because of the division of agricultural tasks which relegates women to subsistence agricultural and activities like weeding, transplanting, threshing etc. Men may have more responsibility for cash crops, operating equipment and overseeing the work of women or children as well as paid labourers. Many poor women and men work in the informal labour force although in different roles. Informal work conditions do not easily lend themselves to government regulation hence women may work in sweat shops and export processing zones with unsanitary conditions that may further expose them to risk of disease and ill-health.
- Reproductive work is unpaid, manual work done mostly by women and girls. For example, in Pakistan women spent twice as much time as men on these activities (Government of Pakistan, 2009). Women's dominate responsibility for reproductive labour can affect their health, access to health and health seeking behaviours. For instance, indoor pollution disproportionately affects women and girls. Women in households that use biomass fuels for cooking are up to four times more likely to suffer from chronic obstructive pulmonary disease, such as chronic bronchitis. Diseases like lung cancer, cataracts, asthma, TB have also been linked to indoor pollution (<http://news.bbc.co.uk/2/hi/science/nature/3244214.stm>). Due to the unpaid nature of women's reproductive roles they may also lack time, money and resources to seek health care. Social norms that value women only for their reproductive roles can lead to other health risks. For instance, early marriage for women may expose them to the risk of Vesico Vagino Fistula.

- Although both men and women engage in community work, the community work that women engage in is usually unpaid work; regarded as an extension of their reproductive roles and there is usually a huge expectation for women to volunteer their time., Usually men are paid for their contribution or receive indirect payments such as an improvement of their status within the community whilst women community work is usually not paid for and is regarded as of low value and is often invisible. Women's community roles often increase when states cut down budgetary support for the provision of services in general and health services in particular. For example, the socio-economic and political problems in Zimbabwe have led the state to cut spending on health facilities. The health sector has deteriorated drastically with dilapidated health infrastructure, shortage of medical personnel and lack of drugs being the norm. Yet, the health system remains seriously underfunded with the current budgetary allocation spending approximately USD 7 per head per year far below the USD 34 minimum allocation per capita recommended by WHO. In such a scenario women have become providers of health care within the communities looking after the ill through their unpaid participation in the numerous home based care activities that have mushroomed in many communities. This is usually in addition to their already existing roles within productive and reproductive work.

Women's and girl's tasks are generally less valued than men's and boy's tasks. As a consequence, there may be less value given to maintaining their health, they often have fewer resources and they may be expected to take on unrealistic workloads (since much of their work is so unvalued as to be invisible).

How does this concept relate to understanding and addressing health issues?

- Women's work and men's work may expose them to different health hazards.
- The Gender Division of Labour leads to specific needs for women and men (see Gender Needs below) and constraints for women. These need to be identified and taken into account in order for women benefit from health programmes.
- The activities of men and women influence their health seeking behaviours.
- Women's predominance in unpaid reproductive roles and unpaid or poorly paid productive work may mean they lack resources to access health care services or to purchase food, medicine or other items needed to improve their health. On the other hand, women's reproductive roles make them key resources for the health of family members.
- Women's reproductive health may not always be valued as highly as maintaining the health of men who are seen as the productive workers.

WHO HAS WHAT?

Access and Control of Resources and Benefits

- *Access* is the opportunity to use something. *Control* is being able to define and impose its use.
- *Resources* are what people need to perform their roles and address their needs. For many poor people health and well-being are critical resources since they earn a living through

physical labour. Other productive resources are money or credit, land or materials as well as information, educational opportunities, bargaining power, mobility, social networks and access to collective organisation. Internal resources such as self-esteem and confidence are also critical.

- *Benefits* are the result of the use of a resource and can include income, asset ownership, knowledge and status. For example, education, health, mobility and social networks are all resources that can help to secure paid employment; income, skills and social status are benefits gained through employment.

To understand ‘who has what’ it is important to distinguish between access and control, and also between resources and benefits.

- Because of women’s and men’s different roles and, more importantly, differences in their position, they have different access to resources (for example, women generally have less access to credit) and the benefits derived from that resource (for example, the income earned by using credit to buy materials for production or to start a small business).
- In other circumstances women or men may have access to a resource but not have any control over that resource. For example, women may have access to land to grow food crops, but if the land is owned by someone else then they can lose that access at any point. Girls and boys may have equal access to education, but if women or girls have no say in where schools are built or how they are equipped or operated, then girls may not be able to reach the school or may drop-out due to harassment.
- Similarly women may have access to certain benefits, but not control over their use. In some contexts women may be expected to turn over their income over to the male head of household, who will then decide the uses to which that income can be put.
- Finally, access (and even control over) a resource does not guarantee access or control over the benefit. For example, even if girls and boys receive equal quality of education, labour market discrimination may prevent women from accessing the same employment or to being paid the same as men with the same training and experience.

How does this concept relate to understanding and addressing health issues?

- Women and men have different opportunities and constraints related to accessing health resources. A health programme may be intended to provide resources for both women and men, but the differential positioning of women and men means they will access these resources differently. Measures need to be taken to ensure both women and men actually access programme resources, for example, giving both women and men a say in decisions over allocation of resources.
- Direct costs (such as user fees) and indirect costs (such as transportation to health services) will have different impacts on men and women from different groups (depending for example on age, class and membership in other social groups).
- Just because both women and men are accessing a resource it does not automatically follow that both will benefit equally from the opportunity. For example both women and men may have access to contraceptives, but women may not be able to negotiate their use and therefore will not benefit. Studies in Kenya have shown that although sex workers know

about condoms and can sometimes get them freely from different organizations they are not empowered to negotiate their use. Their clients may offer to pay more money for sex without a condom which the sex workers may not refuse because of their economically disadvantaged position. Measures need to be taken to ensure both women and men actually benefit the same from accessing project resources (this is called equality of outcome).

- Health information may not reach the targeted groups depending both on access (for example, written material will reach fewer women in countries where fewer women are literate) and control over resources (for example, health campaigns on television or radio may not reach women if they do not have a say in when and how the radio / television is used).
- Research findings in Ghana link access to and control of resources with health behaviours of women suffering from Malaria. Women who lacked short- or long-term economic support from relatives, or who disagreed with their husbands or family elders, faced difficulties in accessing appropriate treatment for malaria (Malaria Knowledge Program, www.liv.ac.uk/lstm/majorprogs/malaria/outputs.htm)

WHO DECIDES WHAT? HOW ARE DECISIONS MADE?

The question of ‘who decides’ is partially addressed in analysing who has control over resources and benefits (see above). Having control means have the power to make decisions over the use of that resource or benefit; those who have access but not control may not be able to use the resource or benefit in practice.

The other critical concept is that of gendered power relations. Social relations of power determine who is included and who is excluded in claiming and realising their rights and in determining their own development. Gender relations are a unique form of power relations, because they are created and reinforced in both the private sphere of households, kinship systems and communities and in the public sphere including through economic and political institutions at the national and international level.

Understanding ‘who decides what’ therefore requires consideration of decision-making processes and power within the household and family, as well as in the community and in specific organizations that affect who can access and benefit from development. At the level of development interventions, ‘who decides’ is shaped by who is consulted; how the input of different groups is weighed and considered, who is directly involved in decision-making, etc.

WHO NEEDS WHAT?

Health is affected by the specific conditions of people’s lives – their biology but also their nutrition, housing, etc – and by their social status. A gender analysis looks at the practical gender needs of women and men, needs arising from their material condition, and at their strategic gender interests, which arise from their social status.

- *Practical Gender Needs* (PGNs) arise from the gendered division of labour and women's and men's access to resources. These are the physical things that women or men need in order to carry out their tasks and meet the daily requirements of life. Women/girls and men/boys share some basic needs, such as the need for food, water and shelter. However their different roles and resources also lead to different practical needs. For example, in Pakistan, women/girls are responsible for preparing all food and maintaining the household and one result is that women/girls spent twice as much time collecting fuel and water for the household as men (Government of Pakistan, 2009). Better water systems, introducing different fuels for cooking and heating, and other labour saving devices, would therefore address practical gender needs of women. Worldwide, women predominate in reproductive roles. Planning clinic opening hours around women's responsibilities and combining maternal and child health services recognizes women's practical gender needs, whereas (for example) if maternal and child health services are provided on different days women may not have the time or other resources to return to the clinic to address their own health needs. Addressing women's (and men's) practical gender needs improves their material situation but generally does not change the balance of power between women and men.
- *Strategic Gender Interests* (SGIs) are related to women's/girls' and men's/boys relative positions in society. Women's strategic gender interests result from women's subordinate position and men's privilege. Addressing SGIs for women improves relative position of women to men. For example, a SGI for women is freedom of movement or women being able to take decisions for themselves. An HIV/AIDS intervention program that recognizes and addresses power imbalances in the sexual relationship between men and women addresses women's strategic gender interests. Strategies aimed at empowering women are also trying to address women's strategic interests. Addressing strategic gender interests can improve the position of women, reduce inequality and transform gender relations.

Of course in reality PGNs and SGIs are not always distinct, and addressing one can lead to improvements in the other. For example, combating domestic violence may address women's practical gender needs by temporarily removing her from a violent situation, but also a SGI, if the intervention is about changing community tolerance for violence against women and supporting women to demand their right to live free of violence. Another example is that of education. If education concerns training girls to be better housewives, it is working at the level of PGN. If, on the other hand, it concerns empowering girls and educating boys to be more gender aware, then it is addressing SGIs.

WHO GAINS WHAT?

Gender analysis looks at what has changed (or not) in the condition of women and men, and in women's position relative to men.

- Condition refers to people's material state and immediate environment. This usually includes the extent to which basic needs are met and refers to daily routine. Most development policies and programmes attempt to address women's and/or men's condition. If these initiatives are sensitive to gendered realities, they may improve both

women's and men's condition, however if these initiatives are gender-blind they may even worsen women's condition, increasing inequalities.

- Position, on the other hand, refers to women's economic, social and political standing relative to men. Many fewer development programmes attempt to improve women's position and therefore reduce gender inequality.

Equality of opportunity or equality of outcome?

Asking 'who gains' means looking beyond the question of whether women and men have had equal opportunities. Even if women and men are given the same opportunity to access a resource (such as applying for a job or accessing health care), they face different constraints to taking advantage of that opportunity. For example, in many countries, women are significantly less educated than men, have less access to resources and have a lower status than men, all of which may be barriers to utilizing available health resources. Focusing only on increasing equity of access to health facilities may actually further marginalize women from health institutions by failing to address the barriers that prevent women from using (or benefiting from) these resources.

Understanding who gains means looking at the actual outcomes of an intervention. Equality of outcome means women and men enjoying the same benefits. Focusing on the results of projects, not just the provision of inputs, calls attention to the measures that will be needed to ensure that women and men can both take advantage of the opportunities provided and both receive the intended benefits.

IMPLEMENTING A GENDER ANALYSIS – FINDING THE INFORMATION

Gender analysis requires collecting information about the situation of women and men and then analysing this data using the gender concepts outlined above.

Key sources of information:

Sex-disaggregated data

Sex disaggregated data is collected and recorded on the basis of women/girls and men/boys. It also refers to collecting data on issues that allow monitoring and evaluation of gender issues relevant to the project. Depending on the level of analysis sex disaggregated data can be gathered at every level, from the household, to community level, for particular services or interventions and at the national level. For example, sex disaggregated data can be collected at the household level to understand who controls what at household level and who has what power to make which decisions; as these considerations affect the ability of women to make health decisions independently. Sex disaggregated data on public expenditure may also expose gender inequities in public health spending and policies. Sex disaggregated data will assist practitioners to understand who gains and who loses from certain health policies and project interventions.

Sex-disaggregated data (including both quantitative and qualitative data) can help practitioners to examine:

WHO gets ill (different ages, sex, ethnic groups, socio-economic groups)

WHAT types of illness do men and women get

WHEN do they get sick

WHERE do they get sick the most (place of work, or specific regions)

WHY do different groups of women and men suffer from ill-health

HOW are women and men's responses to illness influenced by gender? (KIT Fact Sheet, Sector Review tools for SWAps)

Consult directly with women and men

Giving women the opportunity to voice their own needs and interests, and to identify their constraints, is a step toward giving women more control over decisions that affect their lives. It is also provides critical input for interpreting quantitative data, understanding more about context-specific gender relations and identifying priorities. When collecting primary data ensure that data collection methods take women's opportunities and constraints into account, for example

- considering when and where women can attend meetings,
- considering who to include in order for women to be able to speak freely,
- use methods according to literacy and education levels, etc.
- working with women's organizations can enable women to meet separately from men and therefore to express their own perspectives more freely, and also increase your access to the women intended to benefit

Search out local or national gender-sensitive reports and research

There are often many reports and research on the situation and needs of women produced by local or national women's organizations, social justice groups, research institutes and women's studies departments of universities. These can be a rich source of insight and data.

Handout 3.b Quiz on Sex or Gender

Q. Women give births to babies, men do not.

A. **Sex.** Reproductive conditions related to hormonal changes such as pregnancy and menopause and sex-specific organs such as cervix, uterus, and penis and scrotum are based on biology.

Q. According to United Nations statistics, women do 67 percent of the world's work, yet their earnings for it amount to only 10 per cent of the world's income.

A. **Gender.** Most of women's work is invisible and undervalued.

Q. In one case, when a child bought up as a girl learned that he was actually a boy, his school marks improved dramatically.

A. **Gender.** He was treated differently by teachers, many who believe that boys are smarter. He also believed himself that boys are smarter and performed better.

Q. Women suffer from pre-menstrual tension, men do not.

A. **Sex.** Reproductive and/or conditions related to hormonal changes such as pregnancy and menopause are sex-specific and based on biology.

Q. Sex is not as important for women as it is for men.

A. **Gender.** This perception is based on societal norms and values that seek to control women's sexuality.

Q. In ancient Egypt, men stayed at home and did weaving. Women handled family business. Women inherited property and men did not.

A. **Gender.** Gender roles are contextual and they change over time

Q. Men's voices break at puberty, women's don't.

A. **Sex.** Reproductive and/or conditions related to hormonal changes such as these are based on biology

Q. In a study of 224 cultures, there were 5 in which men did all the cooking and 36 in which women did all the house building.

A. **Gender.** Norms of gender division of labour vary from culture to culture and are contextual and historically specific

Q. Men are naturally prone to violent behavior.

A. **Gender.** It is believed that because of the male hormone testosterone, men are naturally violent. However we know that not all men are violent. Their violence in fact is related to the socialization of men where characteristics such as aggressions are rewarded in men. This is similar to the belief that just because women have a uterus and breasts they are naturally nurturing and caring.

Q. Women are more vulnerable to STDs than men.

A. **Both.** Sex - Women are vulnerable to STD because of their biology Women have a much larger surface area of the vagina and cervix where infection can occur. Gender – Unequal power relations curtail women's sexual autonomy which makes them unable to say no to sex or to negotiate safer sexual practices even where they suspect their partner of being unfaithful or infected.

Handout 3.c Gender in Obstetrics

Why gender matters in obstetrics

TK Sundari Ravindran

The term 'gender' was first used in the 1970s to describe those characteristics of men and women that are socially determined, as against 'sex', which describes biologically determined characteristics. The lower status of women as compared to men in almost all societies has less to do with the fact that they are biologically different and that women alone can bear children. It has more to do with 'gender' factors such as social and cultural norms about what women and men should and should not do. These in turn are derived from a belief that men are inherently superior to women and it is the natural order of things for men rather than women to be 'in charge' within and outside the home, as heads of families, communities and countries.

Gender factors play a critical role in promoting and protecting, or adversely affecting women's health. The influence of gender on female health starts right from childhood, and continues through the reproductive years to old age. It is important for doctors to understand the many ways in which gender factors influence a clinical problem seen in a pregnant woman or new mother, as well as treatment seeking behaviour and compliance with treatment and advice given by the doctor. Such an understanding will help the doctor in making better diagnosis, providing better care and advise to his or her patient, and improve the outcome of treatment.

Objectives

At the end of this chapter, the reader should be able to:

- Define gender
- List ways in which gender factors influence maternal health in terms of
 - risks and vulnerability to ill health
 - health seeking behaviour
 - utilisation of health services and ability to successfully access and complete treatment
- List the health consequences of gender-based violence during pregnancy, childbirth and puerperium
- Apply the above knowledge to history-taking, clinical examination and to diagnosis, treatment and advice given to patients

What is gender?

The term 'gender' is used to describe those characteristics of women and men, which are the result of socialisation. In contrast, 'sex' refers to characteristics of women and men, which are biologically determined.

Gender roles are learnt. From very early in life, parents, family members and the community treat boys and girls differently. Boys and girls are systematically taught to be different from each other, for example in terms of

- The way they dress, walk and talk
- The activities and pastimes they are allowed to pursue
- The tasks they perform and responsibilities they shoulder
- The emotions they show
- The way they are supposed to behave within the home and especially, in public spaces

Gender-based discrimination

Although society prescribes specific roles for girls and boys, women and men, it does not treat these different roles and responsibilities as equally valuable. In almost all societies girls and women are valued less than boys and men. Studies from many parts of the world show that there is usually less investment on girls than boys in terms of care given, nutrition and education. This is reflected in the gap between women and men in educational attainment. Women work longer hours than men practically everywhere in the world. They are responsible for all domestic work and childcare in most societies, and this continues even when women are engaged in income-earning activities. Work that is considered 'women's work' commands lower wages. Many laws and policies - for example marriage and divorce laws and laws related to inheritance systematically allow women less rights as compared to men. Even in the early 2000s, nowhere in the world did the proportion of women members of parliament exceed 20 percent (1).

The unequal value placed on women's roles and responsibilities is the source of discrimination of women and accounts for the inferior status given to women in society. Women have less access to money and other resources as compared to men, and also have less decision-making power both within the house and in society.

Gender discrimination is perpetuated by a belief system, which holds men as superior to women, and vests greater power in men. Women as well as men may play a role in perpetuating this belief system.

The influence of gender factors on maternal health

When a woman dies in childbirth, what we usually note is the immediate cause of death, which may be eclampsia or haemorrhage. We tend to think of the woman's death as a misfortune, a chance event which is unavoidable in a risky process such as child birth (2).

This is a false impression. The outcome of pregnancy, and associated morbidity and mortality is profoundly influenced by the circumstances of a woman's life. Wherever maternal mortality and morbidity rates are high, women's status is low mainly as a result of gender discrimination. Yet, this connection is rarely perceived and usually ignored.

Gender-based inequalities and discrimination affect maternal health in many ways. For example, they contribute to enhancing risks and vulnerabilities to maternal health problems; influence health

seeking behaviour; ability to utilise health services, or comply with treatment and advice given by the health provider.

Risks and vulnerabilities

A large proportion of women who become pregnant are poorly nourished. It is also well known that a vast majority of pregnant women are also anaemic. To some extent, this is a result of poverty and scarcity of nutritious food. However, many studies point to the fact that from infancy and childhood onwards, girls and women receive less food, and less nutritious food than their male counterparts (3, 4).

If girls do not have adequate supplies of protein, calcium and Vitamin D in their growing years, their bones do not grow strong. There is a likelihood that their pelvic bones will be contracted, increasing risk of obstructed labour.

Gender-based disparity in access to food within households continues into adulthood. More Indian women (41%) than men (34%) suffer from chronic energy deficiency, with a body mass index of 18.5 or less (3). Not receiving the additional calories required during pregnancy and especially during breastfeeding contributes further to under-nourishment.

Women's heavy burden of work, the result of gender-based division of labour, is another major factor contributing to poor nutrition. In addition to the constant demands of pregnancy, motherhood and childcare, women are almost exclusively responsible for all the domestic work. In conditions of poor housing and basic amenities, women spend several hours fetching water, fuel and fodder. In addition, they have also to work for wages outside the home, just to make ends meet.

Poor nutritional status compromises immunity to infections and healing capacity, making childbirth much more risky than for well-nourished women. Severe anaemia is being reported as cause of maternal death in recent Indian studies (4). Even when they do not directly cause death; anaemia makes women poor anaesthetic risks. It also increases risk of death from haemorrhage, because anaemic women may not be able to tolerate loss of blood of even as little as 150 ml (2).

Chronic under-nutrition may also contribute to poor muscle tone of the uterus even in women of low parity, increasing the chances of prolonged labour and postpartum haemorrhage. Also, when combined with women's heavy work burden immediately after childbirth, it may result in utero-vaginal prolapse even in younger women, as a 1999 report from Tamil Nadu suggests.

Early childbearing is known to be associated with increased risk of maternal mortality and morbidity. In 1998-99, 16 per cent of Indian girls below 19 years have already borne one or more children (7). Despite legislations on the legal minimum age at marriage, many parents prefer to get their daughters married at an early age. Gender norms underlie this practice. An unmarried daughter is considered a burden. Also, it is feared that the later the marriage, the greater the likelihood of a steeper dowry-demand.

Gender norms – values that dictate appropriate behaviour for girls (as different from boys) also underlie girls' lack of information about their bodies, and about reproduction. This may have many adverse consequences, ranging from vulnerability to sexual abuse, pregnancy out of wedlock, and early childbearing. Girls often enter marriage not knowing about how to prevent pregnancies. Even

the few who know about contraception may not discuss the issue with their spouses for fear that this would be considered inappropriate. There is also pressure on the newly married woman to bear a child within the first year of marriage, and to establish her fertility.

Women's unequal position within marriage is often an important factor that contributes to non-use of contraception, and frequent pregnancies, which are either carried to term or end in abortions. For example, a woman who has recently delivered may not want an immediate pregnancy, but her husband may not be in favour of her using a spacing method of contraception. Only 5% of men use any contraceptive method (NFHS-2), and this exposes women to unwanted pregnancy unless periodic abstinence is practised (6). Once again, women may not be able to enforce periodic abstinence because men usually control sexual relationships within marriage.

Unequal gender relations also expose married women to risk of sexually transmitted infections, which can seriously affect pregnancy outcome and maternal morbidity. Social norms which accept extra-marital and pre-marital sexual relationships in men as 'normal', and women's inability to negotiate safe sex practices with their partners, are factors that make it difficult for women to protect themselves from sexually transmitted infections. A 1992 study from Mumbai found that while not a single man visiting an STD (sexually transmitted diseases) clinic was infected by his wife but by casual sexual partners and commercial sex workers, a significant proportion of monogamous married women had been infected by their husband (7).

Son-preference is another gender factor that has many negative maternal health consequences. It is very common to see women who go through several pregnancies till they give birth to a male child. More recently, with the desire for smaller families, women have been going through sex-selective abortions of the female foetus, till a male child is born.

A study from Goa indicates that son-preference may also affect mental health in the postpartum period. Women living in poverty, experiencing gender-based violence (see next section) and those who gave birth to a female child when they already had one or more female children but no male child, were at a considerably elevated risk of postpartum depression(8).

Health-seeking behaviour

Women's low educational status limits their access to information about health. They also have less exposure to the media, and fewer opportunities to interact with sources or providers of information as compared to men. In addition, the gendered socialisation of girls discourages them from learning about their bodies and about sexuality and reproduction. All these together place women at a disadvantage in recognising symptoms of health problems, and therefore, delaying health-care seeking. For example, some community-based studies show that many women with ante partum bleeding did not realise that they needed to seek medical advice, and that symptom of pre-eclampsia went unrecognised.

Case example: *Primigravida aged 17 years went to the PHC for treatment for a severe cough. The doctor found her blood pressure to be very high and diagnosed her as a probable case of pre-eclampsia and referred her to the district hospital. Until she was told that she had a major health problem, she did not realise that anything was wrong with her (9).*

Another problem relates to women's embarrassment in discussing matters related to their reproductive organs even with other women, and especially with their husbands. It is well known that women with white discharge, uterine prolapse and urinary incontinence rarely disclose it to health providers, especially male doctors, unless the condition becomes unbearable. .

Women's health-seeking behaviour is influenced by their socialisation in yet other ways. Being brought up to put her own-self last, a woman does not perceive herself as entitled to invest in her well-being. She feels guilty about taking rest or spending money on herself. This causes women to consider any symptoms they notice as not warranting medical help. As a result, they may decide to treat their problems with home remedies. This may be especially the case in higher order pregnancies, after the male heir to the family has been produced.

Utilisation of health care services and ability to comply with treatment

Women's access to health services is impeded by many factors, many of them a combination of gender and poverty.

To begin with, women do not have the power to make decisions about health care, and need the permission of their husbands and other significant elders in the family. According to NFHS -2, 9 percent of Indian women reported that they were not involved in any decision-making within the household, and about half the women (48.4%) did not have any role in decisions made about their health care (6). The nature of antenatal and delivery care that women are able to get is thus not within their control, but is based on the decisions made by family elders. This in turn is influenced by how they value the woman's health and the pregnancy. First pregnancies may be valued more than subsequent pregnancies, and women who have borne many female children may be relegated to poorer quality of care. Family members' traditional beliefs, and their lack of information about danger-signs during pregnancy, delivery and postpartum are other formidable barriers.

Restrictions on women's physical mobility, common in many parts of India, often makes it necessary for women to be accompanied to a health facility by a male family member. This again may cause delay in treatment.

Women also have very little time to seek health care. A day taken off to go to the health centre or to a referral hospital usually means arranging for someone else to do the cooking, cleaning and fetching water, getting someone to mind the children and the elderly, in addition to losing the day's income. When the health facility is far away and involves long travel time, and when there are long queues in the health facility, they feel increasingly reluctant to go see a doctor. There are instances when women are not able to go to the hospital for delivery even when they have been advised to do so, because they cannot be away from home for even a few days. Many continue working in the farms or in other remunerated jobs till the very last minute before their delivery.

Case example: A third gravida who delivered a stillborn baby, had gone to the referral hospital 12 days after she was told to go, by the PHC doctor. Her husband was out of station and she had to wait for him to come back. After he came, the children were left with relatives, someone was found to take care of the house, a loan was raised and then they came to the referral hospital.

Cost of seeking health care often discourages many women from going to a doctor or a health facility. Even when there is no formal fee for services as in many government health facilities, the cost of transportation, costs of drugs and supplies prescribed and the loss of income together can make health care unaffordable for women who have to get the cash or approval for spending from their male family members. Women's lack of control over finances becomes a major factor in delaying access to emergency obstetric care. Anecdotal evidence suggests that wives of migrant workers are unable to get a loan from community members for meeting the cost of emergency care, because no one would lend without their absent husbands' express permission.

Women's unequal access to resources and decision-making power within the household is also the reason why many women are unable to complete a course of treatment or adhere to advice given by the doctor. Repeated visits, long course of drugs, special diets and rest, and timely medical attention are all luxuries that many women cannot easily have.

Domestic violence against women and maternal health

We tend to think of all pregnancies as happy events and all pregnant women as enjoying the support of their families and especially their husbands. Unfortunately, this is not true for many women who regularly experience violence from their husbands or other members of their families, within the confines of their homes.

In many instances, domestic violence is not a chance event but a regular pattern. The violence may be physical, such as regular hitting, slapping, kicking and throwing things. It may be sexual, where the wife is forced into sexual intercourse without her consent and/or engaged in sexual acts that she does not want to be a part of. Less recognised as violence is a wide range of behaviour on the part of the husband, which causes psychological and emotional distress. These may include angry outbursts and threats to instill fear in the wife, having extra-marital affairs or frequenting sex workers, controlling the wife's movements and social interactions, not providing her with money or resources, and regularly humiliating her and undermining her self-worth.

According to NFHS-2, 19 percent of women in the reproductive age group have experienced physical violence by their husbands at some time during their married lives, and 11 percent had been beaten during the 12 months preceding the survey (6). Micro-studies from various parts of India show that between 22 and 28 per cent of pregnant women experienced psychological, sexual or physical violence during the index pregnancy. In another study done in six Indian urban centres, about 13 percent experienced physical abuse (10, 11, and 12). About one in five of the women in one study reported being hit in the abdomen.

A study based in government medical college, Nagpur, in 1998 showed that women experiencing violence during pregnancy were twice as likely to seek antenatal care after 32 weeks of pregnancy as compared to women who did not face violence (11). They have a higher likelihood of experiencing miscarriages, stillbirths and infant deaths. Studies from other countries have also shown a significant association between experience of violence in pregnancy and giving birth to a low birth-weight infant. (13, 14, 15).

Adverse consequences to the pregnant woman include higher likelihood of depression during pregnancy and in the postpartum period, injuries, and in the worst case, even death. In a study from Maharashtra during 1993-95, about 16 per cent of maternal deaths could be attributed to gender-based violence (16).

Case example: A 22 year old primigravida is admitted with ante partum bleeding. She has suffered trauma to the abdomen, which she says was the result of a fall. When taking history it is learnt that she has not had any antenatal care till the third trimester. She has not gained adequate weight, and appears distressed. On probing, it is learnt that she has been regularly subjected to physical and psychological violence by her husband and in-laws because her family had defaulted on the promised dowry.

How to address gender in patient management

One may wonder what the physician can do about gender discrimination, which is a larger social problem. It is true that many of the problems cannot be solved by the physician. However, just being aware of the many ways in which gender discrimination affects maternal health can make a huge difference to obstetric practice and to health outcomes.

Some principles for addressing gender in obstetric practice include:

- a) A focus on the woman's life circumstances and the role of gender
- b) Prioritising health education, information and counselling
- c) Respect for the decisions and choices she makes
- d) Upholding the woman's dignity and her safety
- e) Recognising the role and responsibility of husbands

The following are some illustrative examples of how these principles may be put into practise:

The first contact

- Remember that the woman may have come to the health facility/provider against great odds. If turned back and asked to come another day, she may never be able to. For example, women seeking abortion services when asked to return on another day may turn to an unqualified provider, with adverse health consequences. Again, it may be preferable to admit a high-risk woman with 'false' labour pains if her date of delivery is not far away, rather than risk her not returning to the health facility for delivery.
- Try as far as possible, to deal with her health problem within the same visit, and cut down the number of return visits needed to the essential minimum.
- Do not blame the woman for delaying her first visit to the provider or for missing a follow-up visit. Treat the woman with understanding and respect. She is interested in resolving her health problem, that is why she has come to the health facility. Find out what the reasons were and help find ways to address these in future.
- If for some reason the service a woman seeks cannot be provided to her, make sure that the problem she has is addressed in some other way. For example, a woman seeking sterilisation may be turned down because she is a poor surgical risk. But if she is not provided with

another method of contraception, she will probably become pregnant again, further compromising her health.

- If referring the woman to another facility, find out whether the woman will be able to go to the referral facility. If she cannot, other ways of addressing her problem needs to be found.

When taking history

- Ask about the woman's family circumstances: whether she is part of a joint family; what her work-load is; whether she is able to get enough food. These are useful pointers towards her chances of having a healthy pregnancy and delivery.
- Ask about whether her husband is a migrant worker, and is away a lot from home. This will help assess several risks. The woman may have less decision-making power if she is in a joint-family and her husband is away. Decisions about her health care may be delayed, and this is especially crucial when it comes to obstetric emergencies. The woman may also be at risk for STIs and HIV infection.
- If she has had an induced abortion before, find out the circumstances that made her opt for it. This may provide useful insights for contraceptive counselling following the present delivery. It may also indicate whether or not the present pregnancy is a 'wanted' pregnancy. Women with unwanted pregnancies tend to neglect their health and not comply with medical advice.
- Ask about the sex of her previous children. A woman with two or more daughters may have had sex-selective induced abortions, which she may not disclose. She may be highly stressed about the outcome of the present pregnancy, and at risk of prenatal as well as postpartum depression.
- Gently probe for the likelihood of domestic violence. The importance of prenatal screening of women for domestic violence is now widely acknowledged. It is recommended that the examining physician ask the woman about the presence of violence (See Box 1 for examples of screening questions and Box 2 for a sample guideline).

When examining the woman

- Explain to the woman what you are doing, and why.
- Many women are especially fearful of examination per-vaginum, because they have been brought up never to expose themselves. It would help if they are told what to expect. Treat their fears with respect, and reassure them.
- Treat the patient with dignity. For example, ensure a private, enclosed space for disrobing, even if it only a corner with a screen. Do not keep the woman waiting with her legs up in the stirrups. When performing per-vaginum examination, ensure visual privacy even from distance: no open windows exposing the women's genitalia to passers-by, undermining women's dignity. They may fear ever coming for a gynaecological examination otherwise. Avoid staff members coming in and out of the room.
- Make sure that there are no staff members present who are not strictly essential. Avoid conversations with the colleague/staff member present, on unrelated topics.

- Explain the reasons and ask for the patient's consent if there will be students or others present during her physical examination.
- If there are any signs of physical injury, record these and gently question the woman about the causes of the injury to determine if domestic violence could be a cause
- Adherence to universal precautions for infection prevention is not only sound medical practice. The consequences of a physician's non-adherence to universal precautions are likely to affect women far more than it affects men. This is because they may not be able to afford the time and money for further treatment when infections or other complications develop. They may not even be able to return to the same health facility with the complications.

Box 1. Introducing the screening questions

A. Asking directly

- Before we discuss contraceptive choices, it might be good to know a little bit more about your relationship with your partner
- Because violence is common in women's lives, we have begun asking all clients about abuse
- I don't know if this is a problem for you, but many of the women I see as clients are dealing with tensions at home. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.

B. Asking indirectly

- Your symptoms may be related to stress. Do you and your partner tend to fight a lot?
- Does your husband have any problems with alcohol, drugs, or gambling? How does it affect his behaviour with you and the children?

Source: Heise L, Ellsberg M, Gottemoeller M. *Ending violence against women*. Population Reports, Volume XXVI, No. 4, December 1999.

Box 2. Sample guidelines for screening for domestic violence

- *Meet the patient alone.* Husband, in-laws, women friends or even staff members from the health facility not trained to maintain confidentiality, may not be present
- *Ask about violence.* You may ask directly or indirectly, using your judgement to identify women who you consider may be 'at risk'.
- *If patient says no, but you suspect violence:* Thank the patient. Tell her that she can get in touch with you at any time that she needs to. Give her your contact details.
- *If patient says yes:* Tell her it is not her fault. Explain to her that many women experience domestic violence. Make her understand that you take her seriously.
- *Document in case sheet:* If you find any symptoms of probable violence, and especially physical injury, document these clearly in the patient's case sheet. This will help in a future visit, to identify whether she has been subjected to violence.
- *If patient's health is seriously under threat:* Discuss with the woman ways in which she can be away from the source of violence through pregnancy and delivery.
- *If needed:* Give the patient information about organisations that offer services for women experiencing violence. Many directories are now available with the Social Welfare Department.

Source: *Perinatal domestic violence identification services (PDVIS): A guide to culturally relevant care in health clinics.* Washington State Department of Health, April 2004.

Education and counselling

- Make time to give at least basic information to the pregnant women on danger signals during pregnancy for which she needs immediate medical attention.
- Try to identify relevant health education materials available in the local language and make these available to the patients. Even if the patient herself cannot read, she may find someone to read it for her.
- Counselling is an important component of health care provision for women, especially those in very difficult circumstances. For such women, counselling should be considered an essential component of the treatment. Without it, the treatment and advice given may not be adhered to or may be ineffective. For example, many such women may not be able to have an institutional delivery. It is important then that they are counselled to find a trained attendant at birth and also on how to recognise and prepare for obstetric emergencies.
- Whenever possible, speak to the woman's husband and seek his participation and co-operation in the care provided to the pregnant woman. It is important that he knows of danger signals during pregnancy, and of preparation for emergency obstetric care. Most importantly, counsel the men about using a method of contraception, so that the entire burden of birth control does not fall on the woman.
- An exception to male involvement is when there is a history of domestic violence. If you know that the husband is being violent to his wife, then it is important not to involve him or disclose to him what his wife may have said in confidence to you.

Treatment and advice

- Many women find the process of giving birth in a hospital humiliating. They feel this way when their pain is treated as trivial, the staff members shout at them, and they receive no

information on how the labour is progressing and what is being done to them. Women deserve to be treated with honour and dignity through the process of labour and delivery. Kind words and reassurance, and keeping them informed of what is happening, will go a long way in making them feel better.

- Be sensitive to the fact that a woman may not have the resources for expensive or long-drawn treatment. Whenever possible, try to prescribe drugs and tests that are less expensive. Minimise the interventions to the absolute essential ones.
- Discuss with the woman potential difficulties in her compliance with treatment or advice, and jointly arrive at alternatives.
- When referring a woman for an obstetric emergency, provide clear guidance on where they may go, taking into account their financial situation. Always give a referral slip with a summary of case history so that delay in the referral centre is minimised.
- Be aware of the potential danger of violence to a woman when specific conditions are diagnosed. For example, many hospitals routinely screen antenatal women for HIV status. Disclosure to the husband or family when the woman is detected HIV positive may have dire consequences for the woman.

Key points:

- a) It is important to address gender issues in obstetric practice.
- b) Biological risks associated with pregnancy and childbirth interact with gender-based discrimination to affect women's maternal health.
- c) Gender factors contribute to increasing health risks, influencing health seeking behaviour and health outcomes of women during their pregnancy, delivery and postpartum.
- d) Domestic violence on women seriously affects pregnancy outcomes and compromises women's maternal health.
- e) Gender-aware practice of obstetrics can go a long way in reducing avoidable morbidity and mortality and promoting maternal health.

Handout 3.d Case Studies

Case Study 3.c.i - Savita

Savita continued with this 5th pregnancy against her will. She wanted an abortion even though her son had died 10 years ago and her 3 living children (aged 11, 9 and 7) were all daughters. She felt burdened with the responsibilities she was already shouldering and feared that the child from the current pregnancy would be another daughter. Her natal family wanted her to get sterilised after the last child, but her husband and his family would not agree. They were keen on another son.

Fifteen years had passed since her marriage. The relationship between husband and wife was tension-filled. They argued constantly over his excessive drinking, which usually resulted in his passing out on the road and Savita helping him back home. He also contributed almost nothing to the household, although he earned more casual wages than Savita did for similar kind of work (picking and cleaning cotton, plucking groundnut). Savita rationed the meagre resources she had at hand by providing first for her children and husband, and only then for herself. No wonder then, she was weak to begin with, and got progressively so as her pregnancy wore on.

During the 4th month, she went to a private provider for an abortion. The doctor gave her tablets and an injection, when she needed a clinical procedure. When the tablets did not have the desired effect, she then went several times to an informal provider who rendered equally ineffective treatment. In desperation, she went back to the private provider in her 5th month, who told her that it was too late for her to have an abortion.

Once it was obvious that she had to continue with the current pregnancy, Savita went every month to the PHC for an antenatal check-up. The entire responsibility of obtaining care was hers alone. She was not identified as risk, although she was visibly weak and thin. Although she made periodic contact with health providers, there did not seem to be any systematic follow up of her HB status. She did not take any of the IFA tablets that were given, but there was nobody to ask why.

15 days before her death, while she was 8½ months, she went to another private doctor in a nearby market town, as she felt very weak. The doctor gave her an injection and prescribed a tonic (though she was in need of blood). He told her what she already knew (that she was very weak), asked her to come back to the clinic for a check-up and to have an institutional delivery. Savita did not go back to the doctor. Nor did she buy the prescribed tonic, as she felt she could not afford it.

4 days before her death: Savita's stomach started feeling hard. She complained about it to some neighbours but not to anybody in the family.

1 day before death: Savita stopped going for wage work. She decided to have a home delivery, as she had done during all previous deliveries.

On the day of her death (around 7 AM): Savita asked her daughter to bring the untrained midwife, who told her that she was in the early stages of labour after checking her abdomen. She promised to return after finishing up some work at home.

(Around 9:30 AM): The midwife returned after Savita's daughter came back for her. She noticed that the tightening of Savita's stomach had reduced, and sent the girl to fetch the ASHA, who was in the Pulse Polio booth.

(Around 10:00 AM): The ASHA arrived, asked Savita to go to a hospital, and phoned 2 CHCs before one of them agreed to accept her. As it was Pulse Polio day, there was no doctor in attendance. The ASHA called the 108 ambulance and the family got ready to leave without her, as she was also on duty at the Pulse Polio booth.

(Around 12:00 Noon): Savita reached the CHC. The doctor was not in, only a staff nurse, who did not give Savita attention immediately upon arrival, as she was busy with another woman had just delivered. After the labour room had been cleaned and the woman shifted to another room, the nurse checked Savita's abdomen and did a vaginal examination. She felt that her cervix was dilating and decided to keep Savita under observation. She told the family that she would deliver by 4 pm. However, Savita's pain neither increased nor decreased. The nurse felt that she looked a "little anaemic" and asked the family to take her to the district hospital. But the family requested the nurse to treat her and the nurse agreed, as she assumed that delivery would happen quickly.

(2:00 to 4:30 PM): Savita's water broke, her pains increased, she was fully dilated. Injections and tablets were prescribed and bought. But she still did not deliver. The nurse came to see her with a male colleague (who was neither a doctor nor a paramedic). She checked the passage and found that the baby was fixing its head. She asked Savita to push, at which time, the baby's head could be seen. But being weak, she could not push enough. The nurse gave her injections every half hour and a sub-lingual tablet, while her male colleague pushed the abdomen.

(4:30 to 5:30 PM): When all of her efforts failed, the nurse referred Savita to the District Hospital. The ASHA, who arrived an hour earlier, asked Savita's husband to arrange for a private vehicle, as the CHC's vehicle was deployed for Pulse Polio. Half to one hour later, the husband returned, drunk and without having secured one. In the meantime, the Medical Officer came with the government ambulance carrying vaccine carriers that had to be emptied. He checked Savita and shouted at the nurse for detaining her for so long, especially when there were no doctors. He told the family to travel to the District Hospital immediately and gave them the ambulance.

(5:30 to 6:20 PM): Too weak to walk, Savita had to be helped to the ambulance. She was bleeding – one saree was changed. The nurse gave them Rs.300, which the ambulance driver demanded.

(Around 6:20 PM, at the District Hospital): Savita was carried to a trolley by people other than the hospital's staff and then wheeled inside. She was gasping for breath, had no pulse or BP.

Question:

Did gender play a role in this maternal death? If so, which of the aspects described in the Gender Analysis Framework (Gender as a System) did you see in this case study? If not, why do you think gender did not play a role?

Case Study 3.c.ii - Kusuma

Kusuma died in a private nursing home one day after being brought in an unconscious state. She was 18 years and this was her 1st pregnancy.

She had been married for 2 years. Her marriage was arranged 3 years after she attained menarche and had been pulled out of school. Her mother-in-law liked her, as she was mature and capable of hard work in their joint family that included 22 adults and 4 children. She worked at home each day with 3 sisters-in-law. She also went out for wage work when there was nothing to be done on the 12 acres that the family cultivated as sharecroppers. They were a dalit family, not abjectly poor but not well off either. Still, there was poverty within the household, as the resources at hand were not distributed fairly among its members.

Kusuma's pregnancy was identified at the end of the 3rd month of pregnancy by a retired government doctor who had treated her when she did not conceive for more than a year after marriage. She was also seen by the ANM who gave her an ANC card, some 'red' tablets (IFA) and a TT injection. Nobody made sure that she took the iron tablets or asked her whether they were causing any problems. Nor were her HB, BP or urine tested.

During her 6th month of pregnancy, she went to her natal home consisting of 11 members. Although she had a sister-in-law and two younger sisters with whom she could share the housework, she ended up taking responsibility for most of it, as she had done since age 8, after her mother died. She did not work for wages outside the home, but was always busy about the house.

15 days later, she developed swelling of her legs, which was more pronounced in the morning but reduced as the day wore out. She was taken back to the retired doctor, who also ran a private clinic every Sunday near her natal village. According to the doctor, he diagnosed her with severe anaemia and hypertension. According to the family, he gave her medicines and injections and asked her to take less salt in her food. He also told the family that her swelling was not likely to go until after childbirth. There is no evidence of his having done any of the appropriate tests (i.e., BP on consecutive days, urine albumin, HB). For her part, Kusuma reduced her intake of salt and took her medicines. But as the doctor did not tell her to lie down each day, she never stopped to rest. In time, her swelling worsened.

In her 9th month, Kusuma ended the day after preparing rotis for the entire household, including some cousins who reside in the same village. A few hours later, she vomited twice and had severe pain (pricking) in the stomach. When her brother and cousin were about to call the doctor, she reportedly held them back, saying there was no need. The cousin then called an RMP, who attempted to treat her for more than an hour before asking the family to take her to a hospital. The family then called the 108 ambulance.

Although the ambulance is supposed to arrive within 20 minutes, it did not come for more than an hour. Three hours had passed since the start of her emergency before she was taken to the hospital. She had fits in the ambulance but was not stabilised. Soon after, she lost consciousness. Despite this, the driver insisted on taking them to the PHC. He agreed to turn back and go to the sub-district headquarter only after Kusuma's brother and cousin (who are Taluk President and General Secretary of the Dalit federation) threatened him with dire consequences.

At the sub-district headquarter, Kusuma's family took her to a private hospital with which they were familiar. A member of the hospital's staff called the (lady) doctor, who came immediately and examined Kusuma. Her BP was 210/190, her HB was 8. There was no foetal heartbeat. The doctor

told the family that she was in a critical condition and that the baby had died. She referred them to another hospital, but after Kusuma's brother and cousin pleaded with her, she agreed to treat her. She obtained their signatures on a note that absolved the hospital of all responsibility and asked them to pay Rs. 5000.

Kusuma was put on oxygen and given injections to control her fits, which according to the doctor, occurred continuously. A caesarean was conducted to extract a stillborn (male) child. A bottle of blood was transfused and medicines were administered via the IV drip. The doctor did not give the family any updates about her health condition until the following morning when she took Kusuma's brother aside and told him that she was not likely to survive. Three and a half hours later, Kusuma was dead.

Question:

Did gender play a role in Kusuma's death? If so, which of the aspects described in the Gender Analysis Framework (Gender as a System) did you see in this case study? If not, why do you think that gender did not play a role?

Case Study 3.c.iii - Renuka

Renuka lived with her in-laws until the 8th month of pregnancy. She had no problems, other than white discharge, for which she was taken by her elder brother-in-law to a private doctor in a nearby town. She received routine antenatal check-ups first at the Anganwadi Kendra and later at the Panchayat Office whenever the ANM ran a clinic. Her weight was checked (and found to be 40 kgs). TT and IFA tablets were given, but her BP, HB and urine were not tested. Renuka went to these check-ups unaccompanied, as they were 2-3 doors away from home, but was otherwise always accompanied and rarely at leisure to interact with people on her own terms. On the other hand, she came from a non-poor household where there was enough food to be had at all times.

Three days before death, her brother noticed that Renuka seemed dull and tired, while they sat talking to neighbours. His mother and neighbours assured him that it was normal for women who are nearing childbirth to be so. **Two days before death**, Renuka experienced loss of foetal movement but did not tell anyone in the family about it. However, her brother (who was still concerned about her tiredness) took her to a private doctor in the next village on market day. The doctor checked her and asked her to get a scan done. But Renuka could not be taken for one, as her mother was unwell and there was nobody else at home to do the housework. **One day before death**, Renuka cleaned the house, cooked, carried 2 containers of flour from the flourmill, and served dinner. While chatting with neighbours after dinner, she told her friend that her lower abdomen was paining. No action was taken for the pain at that time, as they thought it was a natural consequence of impending childbirth.

On the day of her death:

(Around 3.30 AM) Renuka woke up and asked her mother to accompany her to the open “toilet”. She told her mother she was feeling strange. However, after squatting, she could not get up on her own. As it was difficult for her to manage, her mother called her son, who came promptly, carried Renuka to the house and deposited her on the bed.

(Between 3.30-4 AM) Renuka was sweating profusely and complained of weakness below the waist. Her brother decided to take her to the hospital. He borrowed the neighbour’s Cruiser and borrowed additional money from another neighbour.

(Around 4 AM) Renuka was helped into the vehicle and the family set out for a private nursing home at the District Headquarters. She said nothing during the entire journey, but vomited what looked like plain water.

(Between 4.30 and 5.45 AM) The family reached the District Headquarters but failed to secure care for her. They were turned away from the private maternity “hospital” to which they first went, as the doctor was not in. Next, the surgeon of the District Hospital, who had operated on one of Renuka’s brothers and treated her sister-in-law during pregnancy, refused to open the door or come out of the house although he knew the family. He told them to wait for him until 10 am at the Government Hospital. As the family did not want to wait for so long, they took Renuka to another private hospital. They got no help there either, as the doctor was away on business connected with the elections.

(Between 5.45 and 7.35 AM) The family went to the last Maternity Hospital in town. The doctor was not there when they reached, but the Lab Technician took her in and called the doctor. The doctor

came 15 minutes later, and asked them to take her elsewhere. She agreed to take her in only after one of her regular patients, who knew Renuka's family well, used her influence. The doctor then asked the family to deposit Rs. 2000 before examining her.

- A blood test was done, which revealed an HB level of 4.2. The Laboratory Technician said her blood was like serum.
- A scan was done which established that the baby was well formed but dead. However, the placenta was full of blood clots. Renuka admitted to the doctor that she had stopped feeling foetal movements 2 days earlier.
- The doctor told Renuka's brother that she would have to be operated and needed blood urgently, which her brother set out to arrange.
- The doctor then administered glucose. Even as the first bottle was getting over, Renuka told her mother and neighbour that she wanted to use the toilet, but had in the meantime passed stools in the bed. Her mother and neighbour changed her saree and noticed a spot of blood on her clothes. They asked a member of the hospital's staff to inform the doctor that she was likely to deliver.
- The doctor got Renuka shifted to the labour room and examined her, while the family waited outside.
- She came out shortly and, without further ado, asked the family to take her to a hospital in the next district.

(Around 7.30 AM) Without waiting for the family to respond, the doctor arranged for a private ambulance. Within minutes, the hospital staff deposited Renuka into the ambulance and sent her away. In the ambulance, Renuka was beyond speech and movement. Soon after, her face changed colour and she became still.

(Around 8.30 AM) The ambulance reached the hospital. Renuka was taken in, examined and pronounced dead. She was 23 years.

Question:

Did gender play a role in Renuka's death? If so, which of the aspects described in the Gender Analysis Framework (Gender as a System) did you see in this case study? If not, why do you think gender did not play a role?

Case Study 3.c.iv - Jyoti

This was Jyoti's 8th pregnancy. Although 35 years, weak and over-burdened with the responsibility of looking after 5 living children (4 girls, 1 boy) and earning an income, she very much wanted another son. She feared that if her only son became like her (alcoholic) husband, she would have no one to take care of her. She also feared the tubectomy her husband wanted her to have after the previous child and the abortion he now wanted to have. Both husband and wife had never been to school, were poor, middle caste BPL cardholders.

During the current pregnancy, the ANM saw her at home, routinely gave her IFA tablets and asked her to go to the PHC for regular antenatal checkups. Jyoti did not take the tablets given to her and there was nobody to ask why. She did, however, go to the PHC for a check-up at the end of the 3rd month. The doctor, who examined her, recommended an institutional delivery, as she seemed anaemic and was multigravida. But he did not get her HB tested and did not know how severely anaemic she was. Nor did he put her on a course of treatment to raise her HB level, let alone follow up.

During the 7th month, her leg began to swell. However, she did not seek care as this symptom occurred with each pregnancy and would resolve after delivery.

During the 9th month, she started having abdominal pain. Her stomach felt hard, the baby stopped moving, and she had vaginal bleeding. The husband called the dai and an RMP who gave her 2 injections. When her bleeding did not reduce, they took her to the PHC. Jyoti was very weak and could not walk on her own to the vehicle they had managed to arrange. It was nearly 3 hours since she first started having abdominal pain and she had already soaked two sarees.

On reaching the PHC, the doctor referred her immediately to the District Hospital. At the District Hospital, a vaginal examination was done, BP was checked (and found to be high) and a bag of fluid was started. But no attempt was made to rupture the membranes to hasten delivery. Instead, the doctors referred her to a tertiary hospital outside the district because they felt she needed blood before labour. They arranged for her to travel in the hospital's ambulance with another pregnant labouring woman. Several kilometres later, Jyoti delivered a stillborn girl and the placenta soon after. But her bleeding continued to be heavy.

On reaching the tertiary hospital, Jyoti was admitted quickly and placed in a separate room. She was identified as a candidate for blood transfusion (5 bottles of which were obtained by the family) and prescribed medicines (which were purchased). The blood was transfused as per plan. But not all of the medicines were given to her: the relative, who accompanied her, alleges that the nurses kept aside what they did not use for other patients. Due to water shortage in the hospital, she was not cleaned properly after delivery. Her sari was changed only once a day despite continued bleeding for 3 days to the point where the bed was getting soaked. The nurses avoided her room because of the stench. She was only seen by a doctor once a day in the morning. While the last bottle of blood was being transfused, the IV line got stuck and blood extravasated into her forearm. No medical personnel came to help. As a result, Jyoti's arm became infected (cellulitis), leading to swelling and redness.

Frustrated with the "care" she was receiving, Jyoti and her family decided to leave against medical advice, despite the doctor's urging them to stay for longer antibiotic treatment. They left without any discharge instructions or antibiotic medications. The journey back by bus stretched on for nearly 4-5 hours.

Three days later, Jyoti was taken to the PHC. The doctor noticed that the swelling of her forearm was red with accompanying fever. He yelled at them for leaving the tertiary hospital against medical advice, without asking why they had done so. Nor did he discuss other referral options with them. As he did not have the aggressive antibiotics that were needed, he treated her with whatever antibiotics he had in stock and prescribed other antibiotics.

Four days later, Jyoti had an episode of fits and was in a state of shock. She was not responsive, not talking. Her husband put her on his motorbike and wheeled her to the PHC with the Anganwadi worker's help. The doctor checked her pulse (which was in the 120's), BP (which had dropped to 80/50) and noticed she had high-grade fever and blebs on her palm. He attempted to clean off some pus, but referred her soon after to the district hospital.

At the district hospital, the doctors removed more pus, administered fluids and antibiotics and referred her to the same tertiary hospital that had treated her so badly. The family resisted, but the doctors got an MLA to convince the family, who then had to collect funds for travel to the hospital.

The hospital's ambulance was not made available this time. The family took Jyoti by rickshaw to the bus stop and by bus thereafter. At the bus stop, she got unconscious, passing urine, her skin cold and clammy. She started having illusions of seeing her children. On the bus, she had another episode of fits.

More than 3 hours later, the family reached the tertiary hospital, where she was placed immediately in the ICU. However, Jyoti never recovered. Six hours later, she was dead.

Question:

Did gender play a role in Jyoti's death? If so, which of the aspects described in the Gender Analysis Framework (Gender as a System) did you see in this case study? If not, why do you think gender did not play a role?

Session 4: Maternal Health as a Human Rights Issue

Session Outline

Learning Objectives

Participants will be able to

- Differentiate between concepts of Human Rights, Right to Health and Health Care, Reproductive Rights, Sexual Rights, Obligations of Duty Bearers
- Be able to analyse Maternal Health case studies using the above mentioned concepts
- Be able to distinguish between needs based, rights based, victim blaming approaches to Maternal Health

Methodology

- Presentation on Rights
- Group exercise to analyse case studies on maternal health and consolidation in plenary

Materials Required

- PPT 4.1 Rights based approach to health
- Case studies from the previous session on Gender issues in Maternal Health

Time

3 hours

Activities

1. Interactive presentation on Rights (45 minutes)
2. Group discussion on Case Studies (90 minutes)
 - Ask participants to get into 4 groups and discuss the following questions based on the case study allotted to them. And to prepare their group reports to be presented in the plenary.
 - Identify the 'affected group'. What social inequities do you see in this case study?
 - What (a) Human Rights, (b) Reproductive Rights, (c) Sexual Rights are being violated in this case study?
 - What rights related to the highest attainable standard of health are being violated?
 - What obligation of the state is not being fulfilled?
 - Bring participants back in the plenary. Have each group present the answers to each question. The facilitator should note on separate sections of the whiteboard/or separate flipcharts the answers to each question. (45 minutes)
 - Summarise based on group outputs, the concepts of – social inequities, human rights, sexual rights, the right to highest attainable standard of health care, obligations of the state.

NOTE: The facilitator could also have the groups do role plays based on the case studies. Divide participants into 2 groups and further subdivide them. Group A is

asked to prepare a role play on Case Study 1, while Group B analyses Case Study 1. Group C prepares a role play on Case Study 2, while Group D analyses Case Study 2. In the plenary first the Role Play is presented and then its analysis. The facilitator should also debrief around feelings and experiences of those who are the characters in the role plays. This method helps participants to visualise or live through the experiences of women. The analysis of violations can be an eye-opener. What is usually a routine scenario in many health facility settings is now viewed from a rights lens and acknowledged as violations of the rights of the women.

3. Discussion on what a rights based maternal health service would look like (30 minutes)

Generate a discussion among the participants. Ask them to focus on the case studies that they have just discussed – what would be the characteristics of a rights and gender sensitive maternal health care service? What would come under each obligation of the state?

4. Concluding the session (15 minutes)

Key Issues of Emphasis

- Social justice is based on the idea that *all* members of society have an equal access to the various features, benefits and opportunities of that society regardless of their position or station in life¹. However, in reality we know that people face ‘discrimination.’ *Discrimination* refers to the process by which members of a socially defined group are treated differently (especially unfairly) because of their membership of that group. This unfair treatment arises from socially derived beliefs each group holds about the other and patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege.
- Women’s human rights is a political term used to underscore that women’s rights are HUMAN RIGHTS, rights to which women are entitled simply for being human. This approach adds both a focus on women in the human rights movement and an emphasis on HUMAN RIGHTS PRINCIPLES in the women’s rights movement.
- The right to health must be understood in indirect terms as a right to the enjoyment of a variety of facilities and conditions necessary for the realisation of the highest attainable standard of health. The effective realization of the right to health is strongly related to and dependent on the realization of other economic, social and cultural rights. *E.g. Rights to food, housing, safe working conditions, and education.* The notion of "the highest attainable standard of health" refers to both the individual's biological and social preconditions and a State's available resources. According to General Comment 14 of ICESCR, the components of the highest attainable standard of health are: Availability, Accessibility, Acceptability and Quality.

- Reproductive and Sexual Rights are intrinsically related to the concept of gender. Unequal gender relations compromise women's reproductive rights. And as stated earlier discrimination based on one's subjective experience of gender and sexuality is a violation of an individual's sexual rights as well as human rights. The concept of sexual rights, like that of human rights, provides a framework to ensure non-discrimination, and therefore cannot be used to privilege one individual or group over another. Sexual rights affirms entitlements, such as the right to bodily integrity, as well as rights that protect against violations, such as the right not to be coerced into sexual activity.
- Gender equality is a social justice issue. Gender-based inequalities interact with inequities by social class, race, caste or ethnicity, so that women may face additional disadvantages compared to men from the same social stratum or group. Further, the construction of gender varies across race, class, caste, and ethnicity and so on. Gender inequality and discrimination based on one's sex, is a violation of our fundamental human right to equality.

Readings and References

1. World Health Organization. *A Human Rights –based approach to health*. Geneva, World Health Organization, Department of Ethics, Equity, Trade and Human Rights (ETH), Information Evidence and Research (IER), www.who.int/hhr (undated)
2. *Fundamental Rights and Directive Principles of State Policy, Constitution of India*. <http://indiacode.nic.in/coiweb/coifiles/P03.hm>
3. *Universal Declaration of Human Rights*. 1948-1998, Adopted and proclaimed by general Assembly resolution 217A (111) of 10 December 1948
4. Hunt P. *Report of the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of health: Mission to India*. United Nations General Assembly, Human Rights Council. 15 April 2010
5. George A, Chopra M, Seejmour D, Marchi P. *Making rights more relevant for health professionals*. *The Lancet*, www.thelancet.com Vol.375, May 22, 2010, p.1764-1765

Session 5: Maternal Deaths and their Measurements

Session Outline

Learning Objectives

Participants will be able to

- Differentiate between Maternal Deaths and Pregnancy related deaths
- Define perinatal death, and recognise its importance as an indicator of quality of delivery care
- State different indicators of maternal deaths
- State reasons underlying difficulties to measure maternal death rates

Methodology

- PowerPoint presentation
- Quiz

Materials Required

- PPT 5.1 Maternal Deaths and their Measurements
- Quiz sheet
- Flip chart or Whiteboard for score keeping

Time

90 minutes

Activities

1. Interactive presentation on definitions and measurements
2. Quiz
 - Divide participants into 4 teams and give them innovative names.
 - Run the Quiz between the teams with the Co facilitator being the Scorekeeper

Key Issues of Emphasis

- Many Maternal Deaths go unreported. There are many reasons for this – the health care providers think that they will be victimised by their superiors if they report Maternal Deaths. Community representatives think that dying in childbirth is not really a big deal. It is part of a woman's life.
- At the policy level now it is being emphasised that Maternal Deaths must be reviewed. There are National Guidelines that the Government of India has asked the states to follow. For Maternal Deaths to be reviewed they first have to be reported. In order to report these maternal deaths we need to know the definition of Maternal Death.

- Abortion related Maternal Deaths many times get missed out – families may not know that there was a pregnancy in the first place, or if they know there may be secrecy around the abortion. So it is suggested that Deaths of All Women in the Reproductive Age Group be enquired into so as to not miss the abortion related maternal deaths.
- Perinatal deaths should also be recognised as an indicator of quality of delivery care and should be enquired into.
- It is important that we are familiar with the different indicators that are used in relation to Maternal Mortality and the contexts in which each can be used.

Readings and References

1. *MDR Handbook*
2. *Presentations (a) Indicators, (b) Introduction to MDR*

Handout 5.a Quiz on Maternal Deaths and their Causes

Q. What is a maternal death?

A. A maternal death is the death of a woman

- while pregnant or within 42 days of termination of pregnancy,
- irrespective of the duration and the site of the pregnancy,
- from any cause related to or aggravated by the pregnancy or its management,
- but not from accidental or incidental causes.

Q. State whether each of the following is a Maternal Death or a Pregnancy Related Death

- a. A pregnant woman dies in a train accident (PRD)
- b. A woman dies three weeks after her delivery (MD)
- c. A pregnant woman who had TB dies in the last trimester (MD)
- d. A woman who delivered a baby four weeks earlier commits suicide (PRD)

Q. What is a perinatal death?

A. A stillbirth or death of a newborn in the first one week of life.

Q. A woman dies in the third month of pregnancy because of a ruptured ectopic pregnancy. This is

- a. A maternal death
- b. A pregnancy related death
- c. None of the above

A. Maternal death – the definition states “irrespective of site of pregnancy”.

Q. A woman died 2 weeks after delivery of sepsis. This is a

- a. A maternal death
- b. A pregnancy related death
- c. None of the above

A. Maternal death – the definition states “while pregnant or within 42 days of termination of pregnancy”

Q. What is a pregnancy related death?

A. The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.

Q. A woman dies in the 7th month of her pregnancy because of a road accident. Is this

- a. A maternal death
- b. A pregnancy related death
- c. None of the above

A. Pregnancy related death. A maternal death is defined as “from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.”

Q. Name the 5 most important direct causes of maternal mortality in India.

- A.**
- i. Haemorrhage
 - ii. Sepsis
 - iii. Unsafe abortion
 - iv. Hypertensive disorders including eclampsia
 - v. Obstructed labour

Q. What is the most common direct cause of maternal mortality in India?

A. Haemorrhage

Q. State whether True or False.

- A.**
- Perinatal death is a stillbirth.
 - Maternal Mortality Rate is number of women who die in a village every year (False)
 - Perinatal deaths are all still births and death a newborn within the first week of birth.
 - Maternal Mortality Ratio is number of women who die due to pregnancy related causes per 100,000 live births in the same period
 - Maternal Mortality Rate and Maternal mortality Ratio is the same and can be used interchangeably.
 - Perinatal death is a baby who is born dead.
 - Maternal Mortality Ratio is number of maternal deaths during a given time period per 100 000 live births during the same time-period.

Session 6: Prevention of Maternal Deaths - 1

Session Outline

Learning Objectives

Participants will be able to

- Enumerate the causes of maternal deaths
- Describe three delays
- State the strategies necessary to prevent maternal deaths
- Describe the difference between Skilled Birth Attendant and Skilled Birth Attendance
- Contextualise the role of the traditional birth attendant

Methodology

- PowerPoint presentation

Materials Required

- PPT 6.1 Causes of Maternal Deaths, PPT 6.2 Skilled Birth Attendant and Skilled Birth Attendance
- Group discussion on Strategies for Prevention of Maternal Deaths

Time

2 hours

Activities

1. Interactive presentation on Causes of Maternal Deaths
 - Ask participants to recall the case studies that were analysed in the Gender and the Human Rights sessions and state the causes of death of those women
 - Ask them what the delays were in each woman's seeking care. Note down clearly and in an organised way on the Whiteboard/Flipchart
 - Do the presentation, linking what you have written on the Whiteboard with the contents of the presentation
2. Small group discussion on Strategies for Prevention of Maternal Deaths (20 minutes)
 - Divide participants into 4 small groups and ask them to discuss what can be done to prevent Maternal Deaths now that they know what the causes are. Record on Flipcharts for presentation in the plenary.
 - Presentation in plenary and Facilitator's summary. (25 minutes). Facilitator should have done the preparatory reading to comment intelligently while summarising the group report. Look at the reference material (PPT on Strategies, Costello reading, Marge Berer Comment)
3. Presentation on Skilled Birth Attendant and Skilled Birth Attendance (15 minutes)
4. Debate on Role of TBAs

- Facilitator to have assigned readings on TBAs - Costello, Bergstrom and Goodburn, Sibley and Sipe – to participants as homework.
- Divide participants into two teams. Let them debate the issue for 20 minutes.

Key Issues of Emphasis

Strategies for Prevention of Maternal Deaths

- Reducing the first delay by Birth Preparedness, high quality antenatal care to address existing illnesses if any, and to pick up signs of danger
- Discussions with family members and community leaders around making transport available, possibility of need for blood, keeping aside money for the delivery
- Role of the TBA - depending on the context (read the Costello, Bergstrom and Goodburn and Sibley and Sipe references).
- Health systems improvements (emphasise points from the NRHM Guidelines Handout)

Readings and References

1. *J Health Popul Nutr.* 2006 December; 24(4): 472–478. PMID: PMC3001151

Transition to Skilled Birth Attendance: Is There a Future Role for Trained Traditional Birth Attendants? [Lynn M. Sibley](#)¹ and [Theresa Ann Sipe](#)²

2. Berer, Marge. (2010). *Response to UN Secretary General Ban Ki-moon -Investing in our common future: Joint Action Plan for Women's and Children's Health. Reproductive Health Matters.*

Session 7: Prevention of Maternal Deaths - 2: Emergency Obstetric Care

Session Outline

Learning Objectives

Participants will be able to

- State the components of Emergency Obstetric Care
- Differentiate between Basic and Comprehensive Emergency Obstetric Care
- State what is required to improve Quality of Emergency Obstetric Care and the Process indicators

Methodology

- PowerPoint presentation
- Quiz

Materials Required

- PPT 7.1 Meeting Health Systems Challenges Related To Emergency Obstetric Care
- Quiz sheet
- Flip chart or Whiteboard for score keeping
- Handout 7.a Health Systems Quality Checklist

Time

60 minutes

Activities

1. Interactive presentation on Emergency Obstetric Care
2. Quiz

Divide participants into 4 teams and give them innovative names.

Run the Quiz between the teams with the Co facilitator being the Scorekeeper

Key Issues of Emphasis

- It is important to know which facilities are equipped for BEmOC and which can provide CEmOC, because then appropriate referrals can be made to avoid wastage of time.
- Appropriate treatment for each potential cause of death should also be known so that facilities and care provided can be monitored.
- There are some process indicators for EmOC set by UN agencies – we should be aware of what these are.
- All this information will strengthen our advocacy efforts.

Readings and References

1. Paxton*, D. Maine, L. Freedman, D. Fry, S. Lobis, *The evidence for emergency obstetric care*, Received 15 December 2003; accepted 27 November 2004, *Averting Maternal Death and Disability (AMDD) Program*, Mailman School of Public Health, Columbia University
2. *Questions and Answer on what can we do to prevent maternal deaths.*
3. *Emergency obstetric care checklist for planners* UNFPA
<http://www.unfpa.org/publications>
4. *Presentations: Quality improvement in EmOC Facility by Padmaja Samant , Constraints & Challenges to Routine and Emergency Obstetric Care at Tertiary Level Hospitals by Asha Oumachigui*

Handout 7.a Quiz on Emergency Obstetric Care

- Q.** A woman, during the 8th month of her first pregnancy, develops convulsions. Her BP is found to be very high. What is the name of the condition she has?
- A.** Eclampsia
- Q.** A woman who delivered 4 days ago develops high fever with foul smelling vaginal discharge. What is the name of the condition she has?
- A.** Postpartum or puerperal sepsis or infection
- Q.** What is Phase 1 delay in the 3 delays model?
- A.** Delay in decision to seek care
- Q.** Name any 3 common causes of Phase 1 delay.
- A.** Economic status • Educational status • Women's status • Illness characteristics
- Q.** What is Phase 2 delay in the 3 delays model?
- A.** Delay in reaching the medical facility
- Q.** Name any 3 common causes of Phase 2 delay.
- A.** Distance, roads, transport, costs
- Q.** What is Phase 3 delay in the 3 delays model?
- A.** Delay in receiving adequate treatment
- Q.** Name any 3 common causes of Phase 3 delay.
- A.** Availability of • Skilled staff • Drugs • Sterile equipment • Surgical facilities
• Blood for transfusion
- Q.** Name any 3 social determinants of maternal health.
- A.** • Place of residence • Caste • Class – Poverty • Education • Women's status • Nutrition – Anaemia
- Q.** According to accepted definitions worldwide, a TBA is a skilled birth attendant. True or False
- A.** False
- Q.** A delivery in a PHC conducted by an ANM is considered a delivery by a skilled birth attendant. True/False
- A.** True
- Q.** A delivery in a private hospital conducted by a gynaecologist is considered a delivery by a skilled birth attendant. True/False
- A.** True

Q. Name any 3 components of Basic EmOC.

- A.**
- 1) Administer parenteral antibiotics
 - 2) Administer parenteral oxytocic drugs
 - 3) Administer parenteral anticonvulsants for preeclampsia and eclampsia
 - 4) Perform manual removal of placenta
 - 5) Perform manual removal of retained products (e.g., manual vacuum aspiration)
 - 6) Perform assisted vaginal delivery

Q. What are the two critical components of Comprehensive EmOC?

- A.** Perform surgery (e.g. caesarean section), Perform blood transfusion

Q. A 24 hour PHC is supposed to offer what level of care?

1. Skilled birth attendance alone,
2. BEmOC,
3. CEmOC

- A.** BEmOC

Q. An FRU is supposed to offer what level of care?

1. Skilled birth attendance alone,
2. BEmOC,
3. CEmOC,

- A.** CEmOC

Q. Most maternal deaths take place

- a) During the first 7 months of pregnancy
- b) During the last month of pregnancy
- c) During delivery
- d) During the first 48 hours after delivery

- A.** During the first 48 hours after delivery

Q. Unsafe abortions contribute to ---- % of maternal deaths in India.

- A.** 8%

Q. What are the characteristics of Quality EmOC?

- A.** Readiness, Response and Rights

Q. What are the critical steps in EmOC?

- A.**
1. Arrival,
 2. Evaluation and Alert,
 3. Initial treatment,
 4. Definitive treatment,
 5. Monitoring and recovery,
 6. Information, counselling and discharge

Q. What are the process indicators for EmOC?

- A.**
- 1) Number of EmOC facilities - For every 5,00,000 population , At least 4 Basic EmOC facilities, At least 1 Comprehensive EmOC facility
 - 2) Geographic distribution - Minimum level is met in sub national areas
 - 3) Percentage of births in EmOC facilities - At least 15% of all births in the population take place in EmOC facilities
 - 4) Met need for EmOC - All women with obstetric complications are treated in EmOC facilities, No. of women with obstetric complications treated in EmOC facilities (the standard is 15% of estimated live births in catchment area, Based on assumption that 15% of live births are associated with a major obstetric complication)
 - 5) Caesarean section rate - Not less than 5% and not more than 15% of all births in the population are by caesarean section.
 - 6) Case fatality rate - Not more than 1% of women with obstetric complications admitted to comprehensive EmOC facilities die.

Handout 7.b Definitions of Emergency Obstetric and Neonatal Care and Quality of Care

<i>Signal functions used to identify Basic and Comprehensive Emergency Obstetric and Neonatal Care</i>	
<u>Basic EmONC Services</u>	<u>Comprehensive EmONC Services</u>
1. Parenteral Antibiotics (Injection)	(1-7) All of those included in Basic EmOC
2. Parenteral Oxytocics (Injectables)	8. Perform C-sections
3. Anticonvulsants (Injectables)	9. Perform blood transfusion
4. Manual removal of placenta	
5. Removal Of retained products	
6. Assisted or instrumental vaginal delivery	
7. Neonatal resuscitation	

Figure 3 Process of Care for an Emergency Obstetric Care Client

Step	Possible Location	Actions/Standards	Staff Involved <i>Unless specified, this refers to nurses, midwives, doctors, paramedics</i>
1. Arrival	Gate	<ul style="list-style-type: none"> Client and family greeted Client and family directed to area for initial evaluation <p>If emergency situation recognized:</p> <ul style="list-style-type: none"> Client placed on trolley/wheelchair Client transported to appropriate place Alert designated emergency response person to initiate Step 2 	Gate keeper who is sensitive to urgency of relatives, capable of recognizing obvious emergency (coma, blood everywhere), transporting, alerting
2. Evaluation and Alert Emergency Response Team (ERT)	<ul style="list-style-type: none"> Emergency room** Obstetric evaluation area Labor and delivery (L&D) <p>(area with 24-hour personnel)</p>	<ul style="list-style-type: none"> Take quick history, do physical exam Make provisional diagnosis <p>If emergency situation determined:</p> <ul style="list-style-type: none"> Alert ERT Prepare for transport to L&D if needed (trolley/wheelchair, personnel acquired) IF CLIENT IS UNSTABLE, PROCEED IMMEDIATELY TO STEP 3 Evaluate labs, monitor fetus and mother, date pregnancy, determine fetal position 	Health care person who is capable of diagnosing obstetric emergency
3. Stabilize and Prepare for Definitive Treatment	<ul style="list-style-type: none"> Emergency room** Obstetric evaluation area Labor and delivery (L&D) 	<p>While awaiting definitive treatment:</p> <ul style="list-style-type: none"> Stabilize vital signs: (<i>IV fluids, anti-convulsant, oxytocics, pressure on lacerations, trendelenberg, oxygen, CPR</i>) Transfer to L&D Prepare client, staff, facility for definitive treatment Repeat Steps 2 and 3 until definitive treatment initiated 	Health care persons who are capable of providing stabilizing treatment, preparing for definitive treatment
4. Definitive Treatment	<ul style="list-style-type: none"> Delivery room equipped for procedures Operating room 	<ul style="list-style-type: none"> Reconfirm diagnosis and definitive treatment decision Administer definitive treatment "Definitive treatment" is defined as life-saving procedures, including: <ul style="list-style-type: none"> -Provision of IV fluids -Non-routine provision of antibiotics or oxytocin or ergometrine -Blood transfusion -Manual placenta removal -Uterine evacuation -Vacuum/forcep delivery 	Health care person who is capable of performing all duties described above And reconfirming diagnosis, and administering definitive treatment (**Midwife or doctor usually perform definitive treatment. The entire ERT performs a

Session 8: Prevention of Maternal Deaths–3: Importance of ANC and PNC

Session Outline

Learning Objectives

Participants will be able to

- Relate the importance of components of ANC and PNC with causes of Maternal Deaths
- State how complications can be managed
- Examine the parameters of quality of maternal health care through women's eyes

Methodology

- Interactive lecture

Materials Required

- PPT 8.1 Maternal Health-Some technical aspects ANC, Delivery Care and PNC

Time

60 minutes

Activities

- Facilitator generates a discussion amongst participants around the following questions
 - What are the main causes of Maternal Deaths?
 - Is Ante Natal Care at all relevant? Why? Or why not? How do you relate Ante Natal Care to causes of maternal deaths?
 - What are all the components of ANC?
 - What are causes of maternal deaths during deliveries?
 - What are the components of good delivery care? What do women want as safe deliveries?
 - What are the characteristics of good referrals?
 - Why is post partum care important? What should be the focus of PNC?
 - How do the major causes of maternal deaths/ complications need to be addressed?
- Facilitator uses the Power point presentation to substantiate and structure the discussions around the above questions.

Key Issues of Emphasis

- Quality of ANC, delivery care and PNC is extremely important to prevent maternal deaths.
- Several key determinants of maternal health can only be picked up during ANC checkups – e.g. Anaemia, malaria, TB, high BP. If these are addressed, maternal deaths could be prevented.
- Quality standards and indicators should include those expressed by women – freedom from labour room abuse, respectful care, affordability etc.
- It is important to remember that even the best ANC cannot predict or prevent pregnancy complications, but ANC is important for women to come into and maintain contact with the health system

Session 9: Maternal Morbidities as a Maternal Health Issue

Session Outline

Learning Objectives

Participants will be able to

- Define concepts related to maternal morbidities
- Describe how maternal morbidities are related to maternal health

Methodology

- Group discussions
- Presentation

Materials Required

- Case studies

Time

75 minutes

Activities

1. Divide participants into groups and ask them to discuss the case studies for 30 minutes.
2. Each group will present in 7 minutes what they discussed and relate their discussion with the objectives of the session.
3. Facilitator ends with a presentation that he/she prepares after reading the suggested references.

Key Issues of Emphasis

- Maternal mortality is a rare event with a clear definition and can be measured. Maternal morbidities on the other hand are complex, with multiple causes, diagnoses and treatments and can be acute, chronic or severe.
- Maternal morbidities are under reported because of definitional issues and lack of data on incidence and prevalence.
- Behind each woman who dies of pregnancy related causes, there are between 20 and 30 women with acute or chronic morbidities.
- Maternal morbidities affect the quality of women's lives and their relationships. Morbidities reduce women's work productivity thereby affecting also their communities and societies.
- Some of the commonest maternal morbidities are anaemia, maternal health issues following childbirth, uterine and genital prolapse, infertility, fistula.
- Maternal morbidities can be reduced by better data on incidence and prevalence, linking mortality and morbidity outcomes and programming, increased access to facility and community based maternal health and reproductive health care, addressing the antecedents to poor maternal health through a life cycle approach.

Note for the Facilitator

Use the skeletal PPT given to prepare a comprehensive Power point Presentation with the following contents:

- Definition of Maternal Morbidity, categories – acute, chronic, severe.
- Why are maternal morbidities invisible.
- Consequences of maternal morbidities.
- Common maternal morbidities.
- Recommendations for action.

Readings and References

1. Hardee, Karen, Gray Jill, Blanc Ann K., *Maternal morbidity: Neglected dimension of safe motherhood in the developing world*. *Global Public Health*, July 2012
2. G. Rama Padma, *Maternal Morbidity in Rural Andhra Pradesh*. CENTRE FOR ECONOMIC AND SOCIAL STUDIES Begumpet, Hyderabad-500016, Working Paper No. 63 November, 2004
3. Bang, Rani A., Abhay Bang, et.al., *Maternal morbidity during labour and the puerperium in rural homes and the need for medical attention: A prospective observational study in Gadchiroli, India*, *BJOG: an International Journal of Obstetrics and Gynaecology*, March 2004, Vol. 111, pp. 231–238

Handout 9.a Case Studies

Story 1

I had my first child when I was less than 12. I did not know anything. During my third pregnancy, I went to a doctor and took some tablets for abortion. For three days I suffered badly, after that I aborted. I have had two daughters after that. When I became pregnant again, I went on my own and had an abortion and the operation. Nobody helped me after the operation. After that, I have to urinate every five minutes, and urine keeps leaking. I have been having white discharge for many days now. As long as I take medicines it becomes all right, after that it starts again. They now say that my condition (urine leaking) is because of the operation, but that is not true, I don't think that's the reason. (Dalit woman 28 years old, no schooling, former wage worker, now unable to do farm work)

1. What problems does this woman have?
2. What do you think are the causes of her problems?
3. What are the connections with Maternal Health?

Story 2

I come from a big joint family. Had to do all the work by myself and grind Ragi and paddy manually soon after delivery. One day, after lifting up a pot of water to my head (within two weeks of delivery) I felt something give way. Since then I have had the uterus slip down when I squat.

My husband gets angry because I find sex uncomfortable and am reluctant. These days I am not even able to go for work regularly. I often get (urinary) infection and white discharge, can't do much about it in my situation.

1. What problems does this woman have?
2. What do you think are the causes of her problems?
3. What are the connections with Maternal Health?

Session 10: Abortion as a Maternal Health Issue

Session Outline

Learning Objectives

Participants will be able to

- State why abortion is a maternal health issue
- Identify gender and rights issues related to access to safe abortion services

Methodology

- Presentation
- Group work with case studies

Materials Required

- Case studies and PPT 10.1 Abortion as a Maternal Health Issue
- Chart papers for presentation

Time

90 minutes

Activities

1. Facilitator gives a brief overview presentation on introduction to why abortion is a maternal death issue, MTP Act, Safe-Unsafe and Legal and Illegal Abortions.
2. Group discussions on case stories to identify linkages with Maternal Health, Gender and Rights issues

Key Issues of Emphasis

- Unsafe abortions are a significant cause of maternal deaths.
- Access to abortion is a major maternal health issue that is not recognised as such by programme managers and policy makers.
- There are several gender issues and rights violations in each abortion story.

Readings and References

1. *Abortion needs of women in India: A case study of rural Maharashtra.* Manisha Gupte, Sunita Bandewar, Hemlata Pisal
2. *“Yes” to Abortion but “No” to Sexual Rights: The Paradoxical Reality of Married Women in Rural Tamil Nadu, India.* TK Sundari Ravindran, a P Balasubramanian
3. *Availability and Access to Abortion Services in India: Myth and Realities* Dr. Sandhya Barge
4. *Understanding induced abortion: Findings from a programme of research in Rajasthan, India.* New Delhi, Population Council, September 2004.
5. *Fact sheet - CommonHealth*

Handout 10.a Case Studies

Case Study 10.a.i - Bindu

She came for abortion care accompanied by her husband's friend, who was responsible for the pregnancy. Bindu had a three-year-old child. Her husband was impotent, and he had given his consent for her to have this one child by somebody else. A neighbour was her sexual partner for the first pregnancy; she did not know this neighbour's whereabouts now. For the pregnancy that brought her to the clinic, her sexual partner was the friend of her husband, who knew that the husband was impotent. Bindu said she and this person had sexual relations for a long time, but her husband was unaware of this. There was no delay in suspecting pregnancy and Bindu consulted the local hospital for confirmation. She told her partner. He took her for an abortion to a friend who worked in the medical college. The friend wanted her to consult a particular doctor who was on leave. When that doctor returned they consulted him but he was busy. He referred them to the family welfare clinic. By then Bindu was 14 weeks pregnant and it was recommended that she get admitted to the hospital. She refused because she had to reach home before her husband returned from work. Neither her husband nor his family members knew about this pregnancy. Bindu was also not able to take any support from any of her family members, because all of them knew that her husband was impotent. She was discharged on the day of the abortion because she was very anxious. She said that in her marriage she had the power to make decisions and had control over the resources. She said she wanted to get sterilised to avoid the possibility of another pregnancy. She did not want another child. Her sexual partner took care of all the expenditure for the abortion. She said she did not know much about this man, not even if he was married.

Case Study 10.a.ii - Anita

She came with her 36-year-old mother to the clinic to terminate her pregnancy. The mother had been working in a faraway place for the last two years. The girl was staying with her father and younger brother. The mother would come home once in two months, but she used to talk on the telephone every week with her daughter. The girl attained menarche at the age of 12, and since then had irregular cycles. She reported frequent (at least twice a week) sexual contact with her father over the past one year. Initially, the father would beat her for refusing to have sex with him. Later, seeing no way out, she continued the relationship. She had no idea that this could lead to pregnancy. "Only now I have started learning about reproduction in school. We have a chapter about this," she said.

The girl missed her periods but never thought of pregnancy. The amenorrhoea was regarded as part of her irregular cycles. She never talked about the amenorrhoea with anyone. She said she was afraid to tell her mother because she was afraid that her mother would scold her. She did not tell her father or any other family members or close friends. "How could I say bad things about my father to others?" she asked. When her mother came home from her contract work, the girl was taken to a nearby hospital because of pain in the leg. The pregnancy was not diagnosed and she was put on some medication for pain. She was then moved to a hostel for further studies. When she began to feel uneasy, she told the warden about the amenorrhoea. The warden informed the mother. Since then the father has been absconding. There were no further delays in the health system and the girl did not develop any morbidity.

The hospital authorities wanted to register a case against the father, but the mother did not agree. The mother blamed her daughter, saying that the girl should have informed her early about the entire situation. About the abortion, the girl said, "It is good to terminate for my future."

Case Study 10.a.iii - Anjana

Anjana came to the clinic with her 78-yearold grandmother, who was not able to provide any support other than waiting outside the clinic. She would wait outside the clinic till her granddaughter got things cleared at different stages in the health care system. The young woman was working as a housemaid for the past year at a place far from her house. She had been recruited through a broker. She said, “I lost my father 10 years ago. Mother, grandmother and my younger brother were at home. I have an elder sister who is married and lives away from home. My mother was not able to go for work for the last few years because she suffers from weakness of hands and limbs. My brother rarely gets some work. Since I have to support the family I opted for the job.”

Three months after starting work as a housemaid, the unmarried boy in the house, who was 28, (he and his mother stayed in the house), asked Anjana to have sex. She refused. He approached her again with reassurances. She consented and they had regular sexual contact for nine months. He used condoms for about two weeks initially but then discontinued, saying using them was painful. He bought three packets of oral contraceptive pills and asked Anjana to use them. She refused because she did not know how to use the pills. She also thought that the pills might harm her uterus. She knew about pills, condoms, as well as IUDs and injectables from the radio, television and books. Anjana developed itching and vaginal discharge after a month of sexual contact. She was not able to approach any health care provider and took no treatment. She suspected pregnancy at about six weeks of amenorrhoea and told her sexual partner. He said he would not marry her because nobody would agree to such a match. He gave her Rs. 800 and asked her to go home and go to a hospital.

Anjana informed her mother and grandmother but not her brother. Her mother advised her to go to a local hospital. The pregnancy was confirmed and the local hospital referred her to the tertiary care centre. Because her mother was sick, Anjana came to the clinic with her old grandmother. She came late to the hospital and could not get registered that day. She went back and could return only after three weeks because of financial problems. She had a vaginal infection that was treated symptomatically. Her pregnancy was terminated without any immediate morbidity. Anjana said that abortion was bad in general and it was specifically bad for the uterus because there was a chance that in future she may not be able to have another child.

Sowmini CV, ‘Delay in seeking care and health outcomes for young abortion seekers’, Small Grants Programme on Gender and Social Issues in Reproductive Health Research

Case Study 10.a.iv - Sulochana Devi

Sulochana Devi was a poor woman of the barber caste (SC) in a big village of around 5,000 people. Her husband worked as daily labourer. She was the mother of 3 children and she became pregnant for the 4th time. She did not want the baby, and asked her husband to take her to a hospital for an abortion. But her husband said no, let it be. He said have the baby then go for 'operation' (sterilization) next year. Her in-laws also agreed with the husband, and said let it be. When the whole family opposed her, she became angry with everyone, and refused to speak to anyone in the family. She knew that the dai gave medicines for abortion, so she went to her and told her of her wish to abort the baby. She said, "I am 4 months pregnant, can you give me medicines to cause the baby to fall from my womb?" The dai said, yes I can cause the opening of the menstruation, and the baby will come out. So the woman said to give her the medicines. Dai gave her 7 days of herbal medicines, to eat morning and evening on empty stomach. The dai takes Rs.150 for this medicine. Many women of the village go to her secretly. Some women don't have any trouble, and some women die too. So she took the medicines secretly, and didn't tell the family. After 15-20 days her stomach began to swell up then the whole body began to swell too. When her whole body was swollen then they took her to an RMP doctor who lives by the main road. This 'doctor' examined her, and said she has no blood, send her to a big hospital in the city. They took her to the city the next day. She had become yellow by then. They got her admitted, the doctor did a D&C, and blood was given. She was there for 6-7 days. Then she died.

This story was told by a meeting of village women. In the meeting they blamed the woman for this death. She should not have gone and taken this medicine secretly. Her husband has since remarried.

Case Study 10.a.v - Muneja Bibi

Muneja Bibi was a muslim woman, living in a large extended family with 9 brothers and their families. They are not poor, and have many small scale business ventures. They have a two-storied 'pukka' house in an otherwise poor village. 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. She did not return to the doctor after 8 days for the check up. However the bleeding didn't stop. 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.

This story was told by an old woman of the village. The family of the woman gave a different story. They say that she was bleeding before the abortion was done (missed abortion), and went for a D & C. They do not mention anything about the ultrasound. Her husband, however, remarried after 6 months.

Case Study	Maternal Health Issue	Human Rights Violations	Sexual Rights	Reproductive Rights	Gender Issues

Session 11: Maternal Health Policy in India

Session Outline

Learning Objectives

Participants will be able to

- Describe the milestones in India's Maternal Health Policy
- Analyse the strengths and weaknesses of India's MH Policy

Methodology

- Readings for homework
- Group presentations on each reading
- Presentation by facilitator

Materials Required

- Sufficient copies of the 4 readings
- Instruction sheet
- Facilitator's Presentation

Time

2 hours

Activities

1. The facilitator gives advance notice to participants (2-3 days) to read the reference material for homework. Participants are divided into four groups – each group is assigned a reading and given the instruction sheet. This directs them to summarise it in a brief PowerPoint – a brief summary of major points in the article, the group's analysis of the strengths and weaknesses of the MH Policy in India. Each group has to make a presentation of not more than 12 minutes.
2. The session begins by facilitator checking whether each group is ready with their presentation. They may need half an hour in the group to polish it up. Group work is allowed for half hour.
3. Each group comes and presents their reading and analysis.
4. Facilitator summarises and highlights the main issues through a PPT prepared earlier.

Key Issues of Emphasis

- Policy emphasis in India is on institutional deliveries, which may not necessarily be “safe deliveries” given the fact that our public health institutions have several weaknesses mainly staff, supplies etc.
- JSY - a conditional cash transfer and incentive - has replaced the National Maternity Benefit Scheme which was an entitlement for all pregnant women.
- Conditionalities in schemes – above 19 years, only for two living children etc.- adversely affect the most vulnerable, namely, young mothers below the age of 19. These are discriminatory and therefore violate rights of women.
- Public Private Partnerships as a strategy to provide Maternal Health Care is not yet proven. There are cost and quality issues in PPPs.
- 108 and other transport services have increased women’s access to maternal health services.
- Equity considerations need to be addressed – there are sharp differences in maternal health indicators across social groups, rural-urban women.
- Health is a state subject. Each state may have their own Maternal Health schemes. It is good to review the state specific schemes and prepare advocacy plans.

Notes for the Facilitator

- A lot of reading material has been provided for this session. Ensure that you read each reference that you are assigning to the participants and make your own summary notes on each.
- Go through the Power Points provided in the reference section. Based on these PPTs and your own notes, prepare a 15 minute presentation highlighting the main aspects of India’s MH Policy as well as some strengths and areas of weakness.

Instruction Sheet for Homework and Group Assignment

1. You are being given 2 days to prepare this assignment.
2. Read through the article assigned to your group. Make notes as you read on
 - a. What does this article reflect as the Maternal Health Policy of India?
 - b. What are the positive aspects of the MH policy as reflected in this reading?
 - c. What are the weaknesses/gaps?
 - d. What would be your recommendations based on what you have read about the MH Policy for India?
3. Sit with your group members and exchange your views and opinions.
4. Synthesise your group's analysis into a 12 minutes PowerPoint presentation covering the 4 points given above.

Readings and References

1. Nair, Harish, Rajmohan Panda. *Quality of maternal healthcare in India: Has the National Rural Health Mission made a difference?* *Journal of global health* June, 2011, Vol. 1 No. 1
2. Ravindran, TK Sundari. *Public-Private Partnerships in Maternal Health Services*. *Economic & Political Weekly* 26 November 2011; vol xlvii no 48
3. Kumar Satish, Chief UNICEF Officer, Chennai, India. *Reducing maternal mortality in India: Policy, equity and quality issues*. 2010; 54 (2): 57-64
4. *Maternal Health Policy In India – From Institutional Deliveries to Safe Deliveries*
B Subha Sri and Renu Khanna. *CommonHealth*. August 2012

Session 12: Addressing Maternal Health from a Gender and Rights Perspective

Session Outline

Learning Objectives

Participants will be able to

- Suggest strategies to address Maternal Health from a gender and rights perspective

Methodology

- Group work around Case studies
- Group work around Making Change Happen

Materials Required

- Case studies
- Handout 12.a Making Change Happen
- PPT 12.1 Components of a health care delivery system, PPT 12.2 Making Change Happen

Time

3.5 hours

Activities

1. Group work on case studies from earlier session. Group task is ‘what would a gender and rights sensitive maternal health service look like while addressing this woman?’ After 30 minutes, groups present their suggestions in the plenary. The issues that will emerge will be as follows: *availability of contraceptives and related information, safe abortion services that are easily available, nutrition for pregnant women – ideally hot cooked meals, good quality ANC with information given in ways that women understand and follow-up, information provided on danger signs, Maternity Benefits so that women don’t have to go out on wage labour during pregnancy, trained SBAs close to home, continuum of care from ASHA to FRU to higher referrals with the required skilled staff available at each level, prompt ambulance service with competent staff and appropriate referrals (not nearest referrals) prompt and respectful care, regulated, monitored private sector that respects patients rights.*
2. Facilitator links the above points with a PPT on Micro level Health Systems issues.
3. Second group work using Handout 12.a Making Change Happen – 1 hour, presentations 15 minutes each.
4. Facilitator summarises and concludes with PPT on Making Change Happen

Key Issues of Emphasis

- Proper implementation of what is in our policy documents – with monitoring from within the system as well as community monitoring – should go a long way in respecting the rights and gender issues within health systems.
- Attitudes of service providers are very important – they need orientation, training and continuous monitoring to respect rights of patients.
- As leaders to make change happen, we have to be convinced and passionate about our vision for just and equitable health systems.

Handout 12.a Health systems challenges at the micro level

Instructions for group work

Examine Handout on “Strategies for maternal and newborn health” from the policy session. Identify the steps that would be put in for implementing the strategy allotted to your group at your district/block level. While discussing the steps in implementation, answer the following questions.

1. What steps need to be taken in sequence to implement this strategy?
2. What are the problems envisaged in this implementation?
3. What could be possible solutions for these problems?
4. Does your strategy incorporate a gender and rights framework?

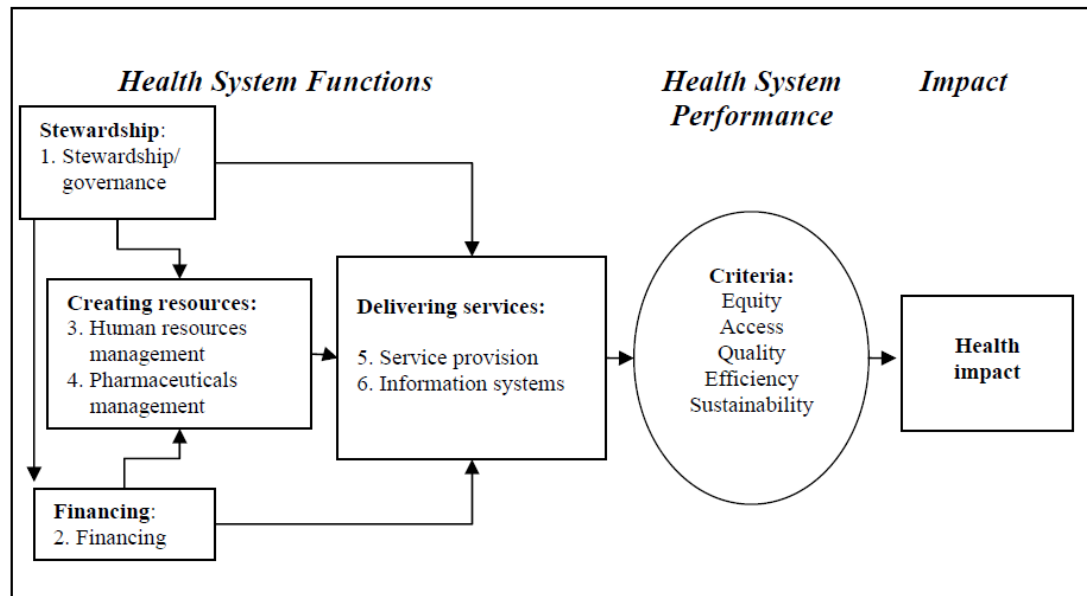
Do keep in mind the following steps while planning the steps of implementation.

- Capacity building of individuals and institutions to ensure implementation of the strategy.
- Human resource management
- Management of supplies
- Quality of services
- Mechanisms for continuous monitoring and organic improvements
- Links to other reproductive health services - contraception, abortion, STI, HIV/AIDS
- Data collection/analysis, mortality/morbidity reviews
- Grievance redressal

Handout 12.b - Health systems challenges at the macro level

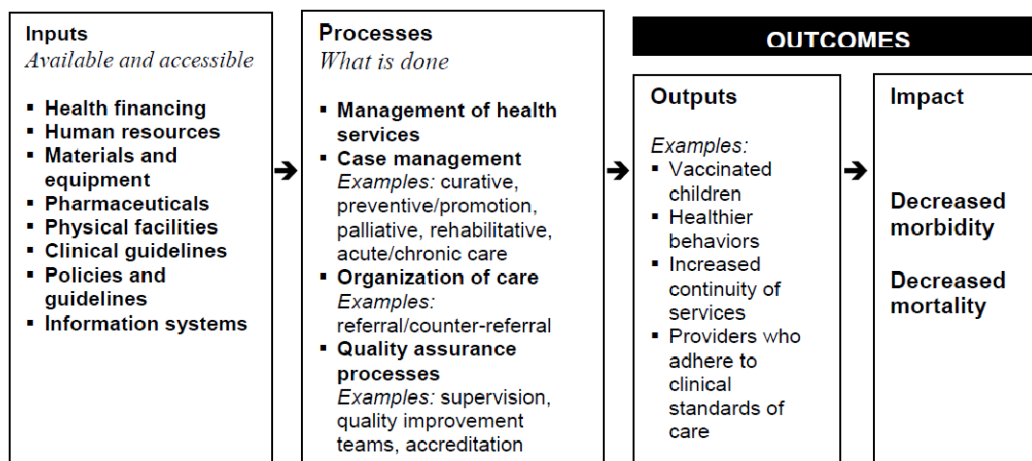
Conceptual framework for understanding health systems

Health system functions, performance and impact



Source: USAID. Health systems assessment approach: A How-to manual. Washington DC, USAID, 2007.

Functioning of the health service delivery sub-system of the health system



Source: Adapted from Massoud and others (2001).

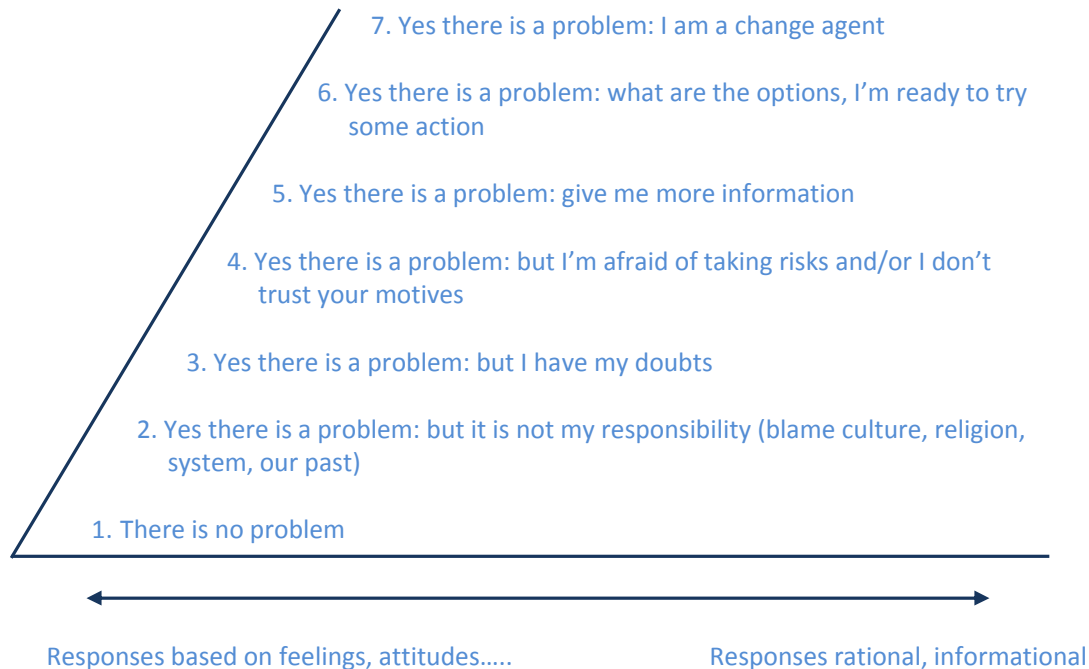
Requirements for reducing maternal deaths (Source: Berer, 2010)

- ☐ A functioning health care system with maternity services at primary, secondary and tertiary level, ensuring that rural areas also have essential services and functioning referral systems.
- ☐ The building of health system management capacity at local and district levels, including for maternity care.
- ☐ An essential maternity services package of antenatal, normal delivery with skilled attendants, comprehensive emergency obstetric care, post-partum care for women and post-natal care for newborns.
- ☐ Decent pay and working conditions, skills development and career paths for health care providers, to encourage them to stay in government service.
- ☐ In maternity services, skilled midwives with the five decision-making skills and 214 competencies as outlined by the International Confederation of Midwives and WHO; including skilled providers of caesarean sections and anaesthetists to work with them.
- ☐ Essential drugs and equipment and training in their correct use, for example: magnesium sulphate for prevention of eclampsia/pre-eclampsia, oxytocin and/or misoprostol for prevention and treatment of post-partum haemorrhage, mifepristone + misoprostol for medical abortion, manual vacuum aspiration equipment for first trimester abortion and/or post-abortion care to deal with incomplete abortion. A full list of essential medicines and equipment is available from WHO.
- ☐ Safe blood for transfusion and anaesthesia supplies.
- ☐ At primary level, nurse-midwives who can provide counselling for women on the importance of recognising and treating complications, and timely referral systems in which nurse-midwives are able to arrange transport, accompany women, facilitate timely hospital admission and support inpatient care.
- ☐ Financing for 24-hour transport from rural areas and from primary facilities to higher level care as required. Community emergency funds to pay for such transport.
- ☐ Dialogue on quality of care between providers and women to break down the barriers that make providers treat women badly and make women avoid using health services until it is too late. Information for women and their families and communities on the importance of maternity care.
- ☐ Links with and cross-referral to STI, HIV and AIDS testing, counselling, prevention and treatment services, including for prevention of mother-to-child transmission of HIV.

- ❑ Community-based and primary level family planning services, including post-partum and post-abortion.
- ❑ Safe abortion services and post-abortion care. Abortion services should be provided at the lowest appropriate level of the health care system. Vacuum aspiration up to 12 completed weeks of pregnancy and medical abortion up to 9 completed weeks of pregnancy can be provided at primary care level. Both surgical and medical abortion can be carried out/managed by trained GPs, clinical officers, nurses and midwives without compromising safety (WHO Safe Abortion: Guidance for Health Systems).
- ❑ Specialist tertiary-level care such as fistula repair after obstructed and prolonged labour.
- ❑ Maternal death and near-miss case reviews that seek to understand why a death happened and what is needed to prevent it happening for those reasons in future.
- ❑ Good data collection and analysis, including examination of data analysis at the point of care and routine self-evaluation as a core skill, so that health workers themselves can see what the data indicate.
- ❑ Financing of these services so as to make them available and accessible most urgently for the poorest women, and preferably free at the point of care so that the need to find money in cases of emergency does not stop women from delivering in a clinic or seeking care in an emergency.

Handout 12.c Making Change Happen

Resistance to Change Continuum



Instructions for group work

You need to plan an intervention to reduce morbidity and mortality related to pregnancy and child birth, or to improve accessibility, availability, affordability and quality of health services related to making pregnancy safer. The intervention has to address gender and rights concerns. You may choose to carry out one limited activity or an intervention consisting of several components.

1. Think of an area in your work where you think it will be possible for you (members of the group) to implement an intervention that fulfils the objectives stated above.
2. Define your goal. What exactly do you want to achieve/change?

For example, the goal may be to ensure that all women who develop complications arrive at an appropriate level of health facility; or to minimise and eventually eliminate all delay within the hospital setting for an Emergency Obstetric Care patient; or a much larger goal, of preventing teenage pregnancies.

3. List a range of interventions that could help achieve the goal, and choose one or two of these that you think are feasible.

For example, for the first goal a wide range of interventions are possible, such as

- Improving health system readiness to provide emergency obstetric care
- Public awareness campaign on danger signals in pregnancy, delivery and postpartum to eliminate delays in recognition of problems.
- Intervention research to address barriers to reaching the hospital once danger signals have been recognised
- Work with women's groups in the community to enable them with information and awareness to feel entitled to seek health care for complications in pregnancy, delivery and postpartum

4. Mention the major steps of the intervention(s) chosen to achieve the above goal. The time line for this intervention can be kept at one year, to begin with.

Just mention the major steps, it is not necessary to get into too many details.

5. Write down for each step what will be done by whom, with whom, over what period of time.
6. Analyse the situation within your institution. Who or what will support your cause? Develop a plan to involve these supporters in your intervention, at some level.

For example, if you know of a colleague from another department who may be supportive, make it a point to consult with this person and keep him/her informed of developments. You could think of constituting an advisory group, if making this formal would help. Include these steps in your intervention.

Think also of allies outside your institution. What will you do to gather this support?

Who will oppose it, or what factors will act as barriers? You may want to go back and modify the intervention accordingly.

For example, if you know that some colleagues will oppose it, you may want to think through how this opposition can be neutralised.

7. To summarise, your final plan should contain the following:

- AREA
- GOAL
- INTERVENTION PLANNED

STEP (WHAT)	BY WHOM	WITH WHOM	OVER WHAT PERIOD OF TIME

- WHERE DO YOU EXPECT OPPOSITION FROM, WHAT WILL YOU DO ABOUT IT?
- WHERE CAN YOU EXPECT SUPPORT FROM –BOTH WITHIN YOUR INSTITUTION AND FROM ELSEWHERE? HOW WILL YOU HARNESS SUPPORT?

Handout 12.d Case Studies

Case Study 12.a.i - Savita

Savita continued with this 5th pregnancy against her will. She wanted an abortion even though her son had died 10 years ago and her 3 living children (aged 11, 9 and 7) were all daughters. She felt burdened with the responsibilities she was already shouldering and feared that the child from the current pregnancy would be another daughter. Her natal family wanted her to get sterilised after the last child, but her husband and his family would not agree. They were keen on another son.

Fifteen years had passed since her marriage. The relationship between husband and wife was tension-filled. They argued constantly over his excessive drinking, which usually resulted in his passing out on the road and Savita helping him back home. He also contributed almost nothing to the household, although he earned more casual wages than Savita did for similar kind of work (picking and cleaning cotton, plucking groundnut). From time to time, her father-in-law would send some of the cereals and pulses that were grown on the familial land, but these were not enough to feed the family. Savita rationed the meagre resources she had at hand by providing first for her children and husband, and only then for herself. She rarely bought vegetables as they were costly. Although she bought curd, milk and buttermilk, she rarely ate any of it. No wonder then, she was weak to begin with, and got progressively so as her pregnancy wore on.

During the 4th month, she went to a private provider for an abortion. The doctor gave her tablets and an injection, when she needed a clinical procedure. When the tablets did not have the desired effect, she then went several times to an informal provider who rendered equally ineffective treatment. In desperation, she went back to the private provider in her 5th month, who told her that it was too late for her to have an abortion.

Once it was obvious that she had to continue with the current pregnancy, Savita went every month to the PHC for an antenatal check-up. The entire responsibility of obtaining care was hers alone. She was given a red and white ANC card, which had some information of services received (1 TT, IFA tablets, ICTC test results) but not all (no HB test results although her blood was tested). She was not identified as risk, although she was visibly weak and thin. Although she made periodic contact with health providers, there did not seem to be any systematic follow up of her HB status. She did not take any of the IFA tablets that were given, but there was nobody to ask why.

15 days before her death, while she was 8½ months, she went to another private doctor in a nearby market town, as she felt very weak. The doctor gave her an injection and prescribed a tonic (though she was in need of blood). He told her what she already knew (that she was very weak), asked her to come back to the clinic for a check-up and to have an institutional delivery. Savita did not go back to the doctor. Nor did she buy the prescribed tonic, as she felt she could not afford it.

4 days before her death: Savita's stomach started feeling hard. She complained about it to some neighbours but not to anybody in the family.

1 day before death: Savita stopped going for wage work. She decided to have a home delivery, as she had done during all previous deliveries.

On the day of her death (around 7 AM): Savita asked her daughter to bring the untrained midwife, who told her that she was in the early stages of labour after checking her abdomen. She promised to return after finishing up some work at home.

(Around 9:30 AM): The midwife returned after Savita's daughter came back for her. She noticed that the tightening of Savita's stomach had reduced, and sent the girl to fetch the ASHA, who was in the Pulse Polio booth.

(Around 10.00 AM): The ASHA arrived, asked Savita to go to a hospital, and phoned 2 CHCs before one of them agreed to accept her. As it was Pulse Polio day, there was no doctor in attendance. The ASHA called the 108 ambulance and the family got ready to leave without her, as she was also on duty at the Pulse Polio booth.

(Around 12:00 noon): Savita reached the CHC. The doctor was not in, only a staff nurse, who did not give Savita attention immediately upon arrival, as she was busy with another woman had just delivered. After the labour room had been cleaned and the woman shifted to another room, the nurse checked Savita's abdomen and did a vaginal examination. She felt that her cervix was dilating and decided to keep Savita under observation. She told the family that she would deliver by 4 pm. However, Savita's pain neither increased nor decreased. The nurse felt that she looked a "little anaemic" and asked the family to take her to the district hospital. But the family requested the nurse to treat her and the nurse agreed, as she assumed that delivery would happen quickly.

(2:00 to 4:30 PM): Savita's water broke, her pains increased, she was fully dilated. Injections and tablets were prescribed and bought. But she still did not deliver. The nurse came to see her with a male colleague (who was neither a doctor nor a paramedic). She checked the passage and found that the baby was fixing its head. She asked Savita to push, at which time, the baby's head could be seen. But being weak, she could not push enough. The nurse gave her injections every half hour and a sub-lingual tablet, while her male colleague pushed the abdomen.

(4:30 to 5:30 PM): When all of her efforts failed, the nurse referred Savita to the District Hospital. The ASHA, who arrived an hour earlier, asked Savita's husband to arrange for a private vehicle, as the CHC's vehicle was deployed for Pulse Polio. Half to one hour later, the husband returned, drunk and without having secured one. In the meantime, the Medical Officer came with the government ambulance carrying vaccine carriers that had to be emptied. He checked Savita and shouted at the nurse for detaining her for so long, especially when there were no doctors. He told the family to travel to the District Hospital immediately and gave them the ambulance.

(5:30 to 6:20 PM): Too weak to walk, Savita had to be helped to the ambulance. She was bleeding – one saree was changed. The nurse gave them Rs.300, which the ambulance driver demanded.

(Around 6:20 PM, at the District Hospital): Savita was carried to a trolley by people other than the hospital's staff and then wheeled inside. She was gasping for breath, had no pulse or BP. The Physician on duty tried to resuscitate her but it was no use. The hospital's Obstetrician-Gynaecologist did a vaginal examination, found that she was fully dilated and saw the baby's head at

the opening. There was no obstruction. Treatment was rendered, consisting of dopamine 1 in glucose, Atropine 1 IV, Adrenaline 1 IV. In the end, it was too late to save her. She was 30 years old.

Question:

Refer to your analysis in Session 3. As a representative of the health systems, how would you address the gender and rights issues identified?

Case Study 12.a.ii - Kusuma

Kusuma died in a private nursing home one day after being brought in an unconscious state. She was 18 years and this was her 1st pregnancy.

She had been married for 2 years. Her marriage was arranged 3 years after she attained menarche and had been pulled out of school. Her mother-in-law liked her, as she was mature and capable of hard work in their joint family that included 22 adults and 4 children. She worked at home each day with 3 sisters-in-law. She also went out for wage work when there was nothing to be done on the 12 acres that the family cultivated as sharecroppers. They were a dalit family, not abjectly poor but not well off either. Still, there was poverty within the household, as the resources at hand were not distributed fairly among its members.

Kusuma's pregnancy was identified at the end of the 3rd month of pregnancy by a retired government doctor who had treated her when she did not conceive for more than a year after marriage. She was also seen by the ANM who gave her an ANC card, some 'red' tablets (IFA) and a TT injection. Nobody made sure that she took the iron tablets or asked her whether they were causing any problems. Nor were her HB, BP or urine tested.

During her 6th month of pregnancy, she went to her natal home consisting of 11 members. Although she had a sister-in-law and two younger sisters with whom she could share the housework, she ended up taking responsibility for most of it, as she had done since age 8, after her mother died. She did not work for wages outside the home, but was always busy about the house.

15 days later, she developed swelling of her legs, which was more pronounced in the morning but reduced as the day wore out. She was taken back to the retired doctor, who also ran a private clinic every Sunday near her natal village. According to the doctor, he diagnosed her with severe anaemia and hypertension. According to the family, he gave her medicines and injections and asked her to take less salt in her food. He also told the family that her swelling was not likely to go until after childbirth. There is no evidence of his having done any of the appropriate tests (i.e., BP on consecutive days, urine albumin, HB). For her part, Kusuma reduced her intake of salt and took her medicines. But as the doctor did not tell her to lie down each day, she never stopped to rest. In time, her swelling worsened.

In her 9th month, Kusuma ended the day after preparing rotis for the entire household, including some cousins who reside in the same village. A few hours later, she vomited twice and had severe pain (pricking) in the stomach. When her brother and cousin were about to call the doctor, she reportedly held them back, saying there was no need. The cousin then called an RMP, who attempted to treat her for more than an hour before asking the family to take her to a hospital. The family then called the 108 ambulance.

Although the ambulance is supposed to arrive within 20 minutes, it did not come for more than an hour. Three hours had passed since the start of her emergency before she was taken to the hospital. She had fits in the ambulance but was not stabilised. Soon after, she lost consciousness. Despite this,

the driver insisted on taking them to the PHC. He agreed to turn back and go to the sub-district headquarter only after Kusuma's brother and cousin (who are Taluk President and General Secretary of the Dalit federation) threatened him with dire consequences.

At the sub-district headquarter; Kusuma's family took her to a private hospital with which they were familiar. A member of the hospital's staff called the (lady) doctor, who came immediately and examined Kusuma. Her BP was 210/190, her HB was 8. There was no foetal heartbeat. The doctor told the family that she was in a critical condition and that the baby had died. She referred them to another hospital, but after Kusuma's brother and cousin pleaded with her, she agreed to treat her. She obtained their signatures on a note that absolved the hospital of all responsibility and asked them to pay Rs. 5000.

Kusuma was put on oxygen and given injections to control her fits, which according to the doctor, occurred continuously. A caesarean was conducted to extract a stillborn (male) child. A bottle of blood was transfused and medicines were administered via the IV drip. The doctor did not give the family any updates about her health condition until the following morning when she took Kusuma's brother aside and told him that she was not likely to survive. Three and a half hours later, Kusuma was dead.

Question:

Refer to your analysis in Session 3. As a representative of the health systems, how would you address the gender and rights issues identified?

Case Study 12.a.iii - Renuka

News of Renuka's death spread quickly in the village. Although she was rarely seen walking about or participating in community activities, she still drew a large group of mourners, as her in-laws were one of the more prominent upper caste families of the village and many other families were related to them.

Renuka lived with her in-laws until the 8th month of pregnancy. She had no problems, other than white discharge, for which she was taken by her elder brother-in-law to a private doctor in a nearby town. She received routine antenatal check-ups first at the Anganwadi Kendra and later at the Panchayat Office whenever the ANM ran a clinic. Her weight was checked (and found to be 40 kgs). TT and IFA tablets were given, but her BP, HB and urine were not tested. Renuka went to these check-ups unaccompanied, as they were 2-3 doors away from home, but was otherwise always accompanied and rarely at leisure to interact with people on her own terms. On the other hand, she came from a non-poor household where there was enough food to be had at all times.

Three days before death, her brother noticed that Renuka seemed dull and tired, while they sat talking to neighbours. His mother and neighbours assured him that it was normal for women who are nearing childbirth to be so. **Two days before death**, Renuka experienced loss of foetal movement but did not tell anyone in the family about it. However, her brother (who was still concerned about her tiredness) took her to a private doctor in the next village on market day. The doctor checked her and asked her to get a scan done. But Renuka could not be taken for one, as her mother was unwell and there was nobody else at home to do the housework. **One day before death**, Renuka cleaned the house, cooked, carried 2 containers of flour from the flourmill, and served dinner. While chatting with neighbours after dinner, she told her friend that her lower abdomen was paining. No action was taken for the pain at that time, as they thought it was a natural consequence of impending childbirth.

On the day of her death:

(Around 3.30 AM) Renuka woke up and asked her mother to accompany her to the open "toilet". She told her mother she was feeling strange. However, after squatting, she could not get up on her own. As it was difficult for her to manage, her mother called her son, who came promptly, carried Renuka to the house and deposited her on the bed.

(Between 3.30-4 AM) Renuka was sweating profusely and complained of weakness below the waist. Her brother decided to take her to the hospital. He borrowed the neighbour's Cruiser and borrowed additional money from another neighbour.

(Around 4 AM) Renuka was helped into the vehicle and the family set out for a private nursing home at the District Headquarters. She said nothing during the entire journey, but vomited what looked like plain water.

(Between 4.30 and 5.45 AM) The family reached the District Headquarters but failed to secure care for her. They were turned away from the private maternity "hospital" to which they first went, as the doctor was not in. Next, the surgeon of the District Hospital, who had operated on one of Renuka's brothers and treated her sister-in-law during pregnancy, refused to open the door or come

out of the house although he knew the family. He told them to wait for him until 10 am at the Government Hospital. As the family did not want to wait for so long, they took Renuka to another private hospital. They got no help there either, as the doctor was away on business connected with the elections.

(Between 5.45 and 7.35 AM) The family went to the last Maternity Hospital in town. The doctor was not there when they reached, but the Lab Technician took her in and called the doctor. The doctor came 15 minutes later, and asked them to take her elsewhere. She agreed to take her in only after one of her regular patients, who knew Renuka's family well, used her influence. The doctor then asked the family to deposit Rs. 2000 before examining her.

- A blood test was done, which revealed an HB level of 4.2. The Laboratory Technician said her blood was like serum.
- A scan was done which established that the baby was well formed but dead. However, the placenta was full of blood clots. Renuka admitted to the doctor that she had stopped feeling foetal movements 2 days earlier.
- The doctor told Renuka's brother that she would have to be operated and needed blood urgently, which her brother set out to arrange.
- The doctor then administered glucose. Even as the first bottle was getting over, Renuka told her mother and neighbour that she wanted to use the toilet, but had in the meantime passed stools in the bed. Her mother and neighbour changed her saree and noticed a spot of blood on her clothes. They asked a member of the hospital's staff to inform the doctor that she was likely to deliver.
- The doctor got Renuka shifted to the labour room and examined her, while the family waited outside.
- She came out shortly and, without further ado, asked the family to take her to a hospital in the next district.

(Around 7.30 AM) Without waiting for the family to respond, the doctor arranged for a private ambulance. Within minutes, the hospital staff deposited Renuka into the ambulance and sent her away. In the ambulance, Renuka was beyond speech and movement. Soon after, her face changed colour and she became still.

(Around 8.30 AM) The ambulance reached the hospital. Renuka was taken in, examined and pronounced dead. She was 23 years.

Question:

Refer to your analysis in Session 3. As a representative of the health systems, how would you address the gender and rights issues identified?

Case Study 12.a.iv - Jyoti

This was Jyoti's 8th pregnancy. Although 35 years, weak and over-burdened with the responsibility of looking after 5 living children (4 girls, 1 boy) and earning an income, she very much wanted another son. She feared that if her only son became like her (alcoholic) husband, she would have no one to take care of her. She also feared the tubectomy her husband wanted her to have after the previous child and the abortion he now wanted to have. Both husband and wife had never been to school, were poor, middle caste BPL cardholders.

During the current pregnancy, the ANM saw her at home, routinely gave her IFA tablets and asked her to go to the PHC for regular antenatal checkups. Jyoti did not take the tablets given to her and there was nobody to ask why. She did, however, go to the PHC for a check-up at the end of the 3rd month. The doctor, who examined her, recommended an institutional delivery, as she seemed anaemic and was multigravid. But he did not get her HB tested and did not know how severely anaemic she was. Nor did he put her on a course of treatment to raise her HB level, let alone follow up.

During the 7th month, her leg began to swell. However, she did not seek care as this symptom occurred with each pregnancy and would resolve after delivery.

During the 9th month, she started having abdominal pain. Her stomach felt hard, the baby stopped moving, and she had vaginal bleeding. The husband called the dai and an RMP who gave her 2 injections. When her bleeding did not reduce, they took her to the PHC. Jyoti was very weak and could not walk on her own to the vehicle they had managed to arrange. It was nearly 3 hours since she first started having abdominal pain and she had already soaked two sarees.

On reaching the PHC, the doctor referred her immediately to the District Hospital. At the District Hospital, a vaginal examination was done, BP was checked (and found to be high) and a bag of fluid was started. But no attempt was made to rupture the membranes to hasten delivery. Instead, the doctors referred her to a tertiary hospital outside the district because they felt she needed blood before labour. They arranged for her to travel in the hospital's ambulance with another pregnant labouring woman. Several kilometres later, Jyoti delivered a stillborn girl and the placenta soon after. But her bleeding continued to be heavy.

On reaching the tertiary hospital, Jyoti was admitted quickly and placed in a separate room. She was identified as a candidate for blood transfusion (5 bottles of which were obtained by the family) and prescribed medicines (which were purchased). The blood was transfused as per plan. But not all of the medicines were given to her: the relative, who accompanied her, alleges that the nurses kept aside what they did not use for other patients. Due to water shortage in the hospital, she was not cleaned properly after delivery. Her sari was changed only once a day despite continued bleeding for 3 days to the point where the bed was getting soaked. The nurses avoided her room because of the stench. She was only seen by a doctor once a day in the morning. While the last bottle of blood was being transfused, the IV line got stuck and blood extravasated into her forearm. No medical

personnel came to help. As a result, Jyoti's arm became infected (cellulitis), leading to swelling and redness.

Frustrated with the "care" she was receiving, Jyoti and her family decided to leave against medical advice, despite the doctor's urging them to stay for longer antibiotic treatment. They left without any discharge instructions or antibiotic medications. The journey back by bus stretched on for nearly 4-5 hours.

Three days later, Jyoti was taken to the PHC. The doctor noticed that the swelling of her forearm was red with accompanying fever. He yelled at them for leaving the tertiary hospital against medical advice, without asking why they had done so. Nor did he discuss other referral options with them. As he did not have the aggressive antibiotics that were needed, he treated her with whatever antibiotics he had in stock and prescribed other antibiotics.

Four days later, Jyoti had an episode of fits and was in a state of shock. She was not responsive, not talking. Her husband put her on his motorbike and wheeled her to the PHC with the Anganwadi worker's help. The doctor checked her pulse (which was in the 120's), BP (which had dropped to 80/50) and noticed she had high-grade fever and blebs on her palm. He attempted to clean off some pus, but referred her soon after to the district hospital.

At the district hospital, the doctors removed more pus, administered fluids and antibiotics and referred her to the same tertiary hospital that had treated her so badly. The family resisted, but the doctors got an MLA to convince the family, who then had to collect funds for travel to the hospital.

The hospital's ambulance was not made available this time. The family took Jyoti by rickshaw to the bus stop and by bus thereafter. At the bus stop, she got unconscious, passing urine, her skin cold and clammy. She started having illusions of seeing her children. On the bus, she had another episode of fits.

More than 3 hours later, the family reached the tertiary hospital, where she was placed immediately in the ICU. However, Jyoti never recovered. Six hours later, she was dead.

Question:

Refer to your analysis in Session 3. As a representative of the health systems, how would you address the gender and rights issues identified?

Publications by CommonHealth

Fact Sheets (in English and Hindi)

1. Cost of Abortion
2. Sex Selective Abortion and India's Declining Female Sex Ratio
3. Safe Abortion: Women's Health and Rights Issue
4. Frequently Asked Questions about Safe Abortion
5. Malaria in Pregnancy in India
6. Essential Drugs for Maternal Health - Frequently Asked Questions

Working Papers

1. Policy and programmatic commitment to promoting access to safe abortion services in selected states of India, TK Sundari Ravindran and Bhuvaneshwari Sunil, March 2012
2. Access to safe abortion services in Tamil Nadu: Intentions and achievements - An analysis based on secondary sources, TK Sundari Ravindran and Bhuvaneshwari Sunil, December 2011
3. Many a slip between the cup and the lip: Universal Access to Safe Abortion Services in India, TK Sundari Ravindran and Renu Khanna
4. Maternal Health Policy In India – From Institutional Deliveries to Safe Deliveries, B Subha Sri and Renu Khanna

CommonHealth-Coalition for Maternal-Neonatal Health and Safe Abortion

We are a coalition of concerned individuals and organizations from across India, who have come together to work towards changing the unacceptable situation around issues of maternal-neonatal health and safe abortion.

Vision

A society that ensures maternal-neonatal health care and safe abortion for all women, especially those from marginalised communities in India.

Mission

To raise visibility of the unacceptably high mortality, morbidity among mothers and newborns, and the lack of access to safe abortion services, especially among the disadvantaged.

To mobilise advocates from different constituencies to:

- a. Ensure effective implementation of relevant policies and programmes.
- b. Contribute to the development of new policies and changing of existing ones when needed.
- c. Build a rights based and gender sensitive perspective within communities, health care providers, researchers, administrators, elected representatives and the media, among others.

SAHAJ, Society for Health Alternatives was founded with an idea of providing a supportive and facilitative atmosphere to persons interested in the area of health and development.

SAHAJ's vision is a just, equitable and sustainable society where every child has an opportunity for quality education and every person is healthy. SAHAJ's philosophy is to strive for health of poor communities - health defined broadly to encompass the social, spiritual, economic and political.

Rural Women's Social Education Centre (RUWSEC) is a non-governmental women's organisation started in 1981 by a team of women from the local villages near Chennai, with the aim of promoting women's wellbeing through their empowerment.

RUWSEC's Broad activities include:

- a. Innovative field programmes on Gender, Sexual and Reproductive Health Rights and Social Justice
- b. Research on Gender, Sexual and Reproductive Health Matters
- c. Running a Reproductive Health Clinic and Resource Centre.

