Maternal Health in Villages of Northern Uttar Pradesh Assessing Options, Practices and Outcomes in Bahraich District

Elizabeth Curtis

SIT Graduate Institute - Study Abroad, efc2@williams.edu

Follow this and additional works at: http://digitalcollections.sit.edu/inh

Part of the Family, Life Course, and Society Commons, Inequality and Stratification Commons, Politics and Social Change Commons, Public Health Commons, and the Women's Studies Commons

Recommended Citation
http://digitalcollections.sit.edu/inh/2

This Article is brought to you for free and open access by the ISP Collection by Program at SIT Digital Collections. It has been accepted for inclusion in India: Public Health, Policy Advocacy, and Community by an authorized administrator of SIT Digital Collections. For more information, please contact digitalcollections@sit.edu.
MATERNAL HEALTH IN VILLAGES OF NORTHERN UTTAR PRADESH

Assessing Options, Practices and Outcomes in Bahraich District

Elizabeth Curtis
Academic Director: Azim Khan
ISP Advisor: Dr. Jitendra Chaturvedi, Director of DEHAT
SIT Study Abroad
India: Public Health, Policy Advocacy, and Community
Fall 2015
# TABLE OF CONTENTS

ABSTRACT.................................................................................................................................iii

ACKNOWLEDGEMENTS................................................................................................................iv

ACRONYMS....................................................................................................................................vi

INTRODUCTION..............................................................................................................................1

- Objectives..................................................................................................................................2

BACKGROUND....................................................................................................................................4

- Bahraich District..........................................................................................................................4
- National Rural Health Mission.....................................................................................................5
- Study Population..........................................................................................................................6
- Global School of Learning.............................................................................................................6
- Experiencing Otherness..................................................................................................................7

MATERNAL HEALTH IN CHITTAURA BLOCK........................................................................8

- Before Pregnancy.......................................................................................................................8
- During Pregnancy.........................................................................................................................9
- During Delivery.............................................................................................................................10
- After Delivery...............................................................................................................................11
- Maternal Deaths..........................................................................................................................12

HEALTH SYSTEMS......................................................................................................................14

- Reality of Health Infrastructure.................................................................................................14
- “Safe” Institutional Deliveries.....................................................................................................15
- Medical Officers..........................................................................................................................17
- ANM/ASHA/AWW.......................................................................................................................18
- TBAs...........................................................................................................................................19

POINTING BLAME......................................................................................................................20

- “They should come here!”...........................................................................................................20
Maternal mortality distinctly highlights a health burden women face, particularly in developing countries. For that reason, poor maternal outcomes in rural India are a field in which Public Health workers and researchers continue to question and study. This project aims to understand the reasons behind poor maternal health outcomes for village women in Bahraich District of Uttar Pradesh. The focus of this topic is the accessibility of available health services and the attitudes of various players who distribute or consume services of the health system. Through fieldwork with doctors, medical institutions, auxiliary health workers, traditional health workers, and village women, this study examines the importance of how different communities work together and against each other, how they perceive each other, and how the biggest health risk for women in villages is the lack of understanding between health workers and the women. It shows the realistic options for pregnant women and new mothers regarding their healthcare, and how a community health worker model could help health systems better work together to improve the health, safety, and overall well-being of traditionally disadvantaged women in rural communities.
ACKNOWLEDGEMENTS

Bhavnaji, each time I asked you to hide in my suitcase and live with me in Bahraich, you reminded me that ISP stands for independent study project. However, joking aside, this project would never have been possible alone.

First and foremost, I would like to extend my immense gratitude to the wonderful faculty and staff at the INH program in Delhi. Azimji and Abidji, your expertise and guidance made me feel more prepared to embark on a study of health in rural India than I ever imagined possible, and our frequent emails, phone calls, and one visit during the ISP period are the entire reason I am not turning in a blank stack of papers. Archanaji, Bhavnaji, and Goutamji, my Indian moms and dad, I cannot thank you enough for your unending hugs, love, support, and pump-up texts. I never once felt completely lost or alone in my experience here, and that is all thanks to you. And the Hindi came in pretty handy, too! All of the SIT program’s staff go above and beyond their duties, and I only wish that all students get the chance to experience the kind of commitment and enthusiasm from their teachers as I did here.

Dr. Anjali Capila, your hours spent sitting and helping me in Delhi to prepare my project’s focus and interview questions not only got me excited to go out on this study, but to continue immersing myself in women’s health research for the rest of my life. You are an incredible mentor, and your selfless dedication to your students is one of a kind. I count myself as exceptionally lucky to know you.

Dr. Jitendra Chaturvedi, you are my project’s savior. Without your expert knowledge of the area and your counseling, I would have had nowhere to turn. Your pointed questions and your readiness to pour over my work with me made you an phenomenal advisor, and getting to know you and your family has made for an empowering personal experience on my future path to public service.

To all the health workers in the area, the medical officers, Nurses, ANMs, ASHAs, Anganwadi workers, and dais, thank you for your time, energy, and patience given to me as I struggled to learn the basics of the Indian rural health system and the focused scope of maternal health simultaneously. Without your aid, I would be lost in the intricacies of both.

To all of the women who let me into their homes and hearts to answer personal questions about their lives and and the status of women’s health in the area, I am in awe of your wisdom, strength, and generosity. Thank you for being the backbone of my work and my understanding of your community.

Lastly, and most importantly, an impossibly huge thank you to all the faculty, staff and students of the Global School of Learning. You so generously provided me with not only all of your transportation and informational resources, but a community, and this project would have been impossible without you all. Sushmaji, bahut, BAHUT dhanywaad for your SUPERSTAR translation skills and your hours away from your class spent talking to random people. Absolutely NONE of this would have been possible without your help. Special thank you to
Principal Mam, who always supported me and gave me her snacks, and Subela (Puuci), who was the loveliest mom I could ask for. But the biggest thank you goes to my *pariwaar* in Bahraich—you welcomed me into your home not as a guest, but as a sister. Nausheen and Zainab—our hours spent rolling over laughing, asking each other silly questions about our homes, meeting your students, and making chai and *chapati* will live in my mind as the highlights of my project here. I love you immensely, and can’t wait until we meet again, whether it be in Bahraich or New York!
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>AWW</td>
<td><em>Anganwadi</em> Worker</td>
</tr>
<tr>
<td>BPL</td>
<td>Below Poverty Line</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>CRHP</td>
<td>Comprehensive Rural Health Project</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IPHS</td>
<td>Indian Public Health Standards</td>
</tr>
<tr>
<td>JSSK</td>
<td><em>Janani Shishu Suraksha Karyakaram</em></td>
</tr>
<tr>
<td>JSY</td>
<td><em>Janani Suraksha Yojana</em></td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NMBS</td>
<td>National Maternity Benefit Scheme</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Center</td>
</tr>
<tr>
<td>PPC</td>
<td>Postpartum Care</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UP</td>
<td>Uttar Pradesh</td>
</tr>
<tr>
<td>VHND</td>
<td>Village Health and Nutrition Day</td>
</tr>
<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
INTRODUCTION

Maternal health, along with child health and disease prevention, is one of the three indicators for the quality and effectiveness of a health system. The World Health Organization (WHO) defines health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity."\(^1\) The obligation of health institutions and public health efforts is not merely to treat disease and provide health services, but to address and remedy the social determinants of health that lead to an inequitable health system. The UN and the WHO have identified this human rights dialogue as fundamental in strategies to address maternal health, aiming to “increase access to timely and appropriate health care, to address underlying determinants of health, to address gender and equity and to achieve community participation in programme planning and in improving services.”\(^2\)

In 1994, the International Conference on Population and Development (ICPD) in Cairo shifted development policy and programs away from a focus on numbers to a focus on human lives, and turned the conversation away from the idea of “Maternal and Child Health” (MCH) towards the idea of “Reproductive and Child Health” (RCH), emphasizing the importance of promoting voluntary and safe choice for individuals and couples. It is through this lens that maternal health and maternal mortality must be analyzed, as they are not only issues of health, but also of gender inequality; to improve maternal health outcomes, there must be a targeted understanding of the attitudes towards women, their reproductive lives, and their roles in particular societies, “not merely counseling and care related to reproduction and sexually transmitted diseases.”\(^3\) In this way, reproductive health has become a public health focus as “the means to bring about social transformation.”\(^4\)

Maternal mortality distinctly highlights a health burden women face, particularly in developing countries. A maternal death is the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, not from accidental or incidental causes.\(^5\) Maternal mortality reflects several interlinked causes: complications directly associated with pregnancy or childbirth (haemorrhage, sepsis, eclampsia, obstructed labor, etc); other medical conditions (anemia, heart disease, etc); and socio-economic determinants of health (education

---

1 Constitution of the World Health Organization.


level, caste, religion, income level, etc). India, itself a paradox between its status as a rising world power and its status as a developing country, contributes nearly 20% to the global maternal deaths. The highest maternal death burden in India comes from rural areas, especially among vulnerable populations.

In 2000, India adopted the U.N. Millennium Development Goals (MDG), which aimed to reduce the maternal mortality ratio (MMR) of 437 in 1990-91 to an MMR of 109 by 2015. MMR is defined as the number of maternal deaths compared to 100,000 live births. India has been unsuccessful in reaching that goal. Many argue that there was still significant progress, which can’t be discounted: the United Nations Population Division Maternal Mortality Estimation Inter-Agency Group reported that India dropped from an MMR of 560 in 1990 to an MMR of 190 in 2013. However, there is also criticism that this is merely a secular change, not a sustainable step towards progress; India’s health budget as a percentage of GDP was low compared to other countries and WHO recommendations, so the drop observed in MMR was simply the result of more funds being allocated to health, not any radical shifts in attitudes or behaviors. There is an interplay between biological and social determinants of maternal health that remains unaddressed.

Objectives

There is a gender perspective that is conspicuously absent in specific policies and programs that have “hitherto not shown the links between women’s education, social and economic status on the one side and their nutritional and health status associated with their morbidity and mortality on the other.”

In a statement about using a human rights approach to address problems in women’s health, the WHO said:

Public health, medicine and human rights share a common goal: to improve the health, life and well-being of individuals, communities and populations. Moreover, they are deeply complementary. The right to the highest attainable standard of health cannot be

6 Jeffrey, Patricia and Jeffrey, Roger. “Only when the boat has started sinking: A maternal death in rural north India.” Nov 2010.


realized without the expertise of health professionals. Equally, the long-established objectives of public health and clinical care can benefit from the dynamic discipline of human rights.\textsuperscript{11}

Childbearing in \textit{dehat}, the local word for “villages,” highlights the convergence of inequalities of gender, caste and class, and the ways social hierarchies are maintained through the management of reproduction and sexuality.\textsuperscript{12} In her book \textit{Where There is No Midwife}, Sarah Pinto described the contradictory nature of village women’s role in public health efforts: “In ‘villages’ (as iconic as ‘the rural’ yet bounded rather than expansive) women live at once under the scrutiny of state and transnational forces of intervention and at a remove from the certainties of life captured in the term ‘infrastructure’ or the fantasy of ‘health care.’”\textsuperscript{13} It is for this reason that simply examining health conditions alone will not improve the health of women. Instead, as the WHO suggests, we must reexamine reproduction within its social and cultural context, examining the hierarchical and patriarchal nature of the society, from a clinical, public health, and human rights focus.

This study aimed to understand why maternal outcomes in rural India are so poor, with the following as its guiding questions:

\begin{itemize}
  \item What are the realistic options for pregnant women regarding their healthcare (particularly antenatal care, skilled attendance at labor and delivery, and postpartum care)?
  \item How to various medical systems work together or work against each other in improving maternal health?
  \item What do the women in these areas want to see change?
  \item How could a successful program be implemented to facilitate this change?
\end{itemize}

The participants interviewed in this study were categorized into three groups: institutional medical professionals (medical officers, staff nurses, ANMs, etc); women with a different set of women’s health skills or training (TBAs or “dais,” ASHAs, and AWWs); and village women who had given birth in the area. The purpose of this focus is to triangulate the answers from different sources to get a more complete picture of why health indicators are still low and how the health system and government can work to address them.


\textsuperscript{12}\textsuperscript{Pinto, Sarah. \textit{Where There is no Midwife: Birth and Loss in Rural North India}. New Delhi: Berghahn Books, 2008: 21.}

\textsuperscript{13}\textsuperscript{Pinto, Sarah. \textit{Where There is no Midwife: Birth and Loss in Rural North India}. New Delhi: Berghahn Books, 2008.}
BACKGROUND

Bahraich District

*Health cannot be divorced from culture, or a way of life as a whole.*

Bahraich District is one of the Northern districts in the Indian state Uttar Pradesh (UP). Several of UP’s health indicators are among the worst in India, and within UP, Bahraich is considered a “high focus district,” its health indicators for maternal and neonatal health some of the worst in Bahraich.

Many of the men in the villages of Bahraich are laborers (farmers in season), or travel to bigger cities for work. Nearly 80 per cent of UP’s population lives in rural areas, and 90 per cent of the population in Bahraich lives in rural areas, yet government facilities show a strong urban bias. Even rural facilities are generally located only in larger villages. These rural facilities often lack basic equipment and sufficient human resources.

UP has the largest population of socially excluded communities (scheduled castes, scheduled tribes and other so-called "backward castes"). The proportion of scheduled caste population in Bahraich (14%) is lower than that of UP’s figure (21%), but still high on a national level. Thirty five per cent of the population in Bahraich is Muslim.

While the Right to Education Act has been rolled out in the state, giving all children access to a place in school, the quality of education is low. The state has the highest number of children who leave school to work, and education is much less valued for girl children than boy children. The sex ratio (females per 1000 males) in the district is 891, showing a strong bias towards male children, and a manifestation of gender inequality in the area. One major indicator that adversely affects health conditions in the district is the low average age at marriage of girls.

———


15 Village Women, Personal Interview, 26 November 2015.

16 Jeffrey, Patricia and Jeffrey, Roger. “*Only when the boat has started sinking: A maternal death in rural north India.*” *Social Science & Medicine* 71 (Nov 2010): 1711-1718.


The fieldwork for this study was based in villages from one Sub-Center in the Chittaura Block of Bahraich District. For the sake of confidentiality, the name of the villages have been omitted from this report. All names of people interviewed have been changed to protect their privacy.

**National Rural Health Mission**

Despite its poor health indicators, India’s legislative commitment to a “right to health” has been very strong—particularly reproductive health. In 1951, India became the first nation to launch a family planning program. After their commitment to health at the ICPD Conference, India began their RCH Program Phase 1 (RCH I) in 1997. The “National Maternity Benefit Scheme” (NMBS) was a highlight of RCH I, giving women below the poverty line (BPL) who delivered in a medical institution a 500 Rs incentive—for the first two children. This aimed to address economic barriers for access to services.

India signed onto the MDGs in 2000. A significant step India’s Ministry of Health and Family Welfare made towards the MDGs was the establishment of the National Rural Health Mission (NRHM, later the National Health Mission) in 2005, which stated as its goal to “provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups.” Reducing maternal mortality was a key goal of reproductive health programs under NRHM, as it established the RCH Phase 2 (RCH II). RCH II’s main three actions were: infrastructure development, bringing in the ASHA program, and the “communitization of health.”

Infrastructure development included the Indian Public Health Standards (IPHS), which established guidelines for, from most periphery preventive health services to most advanced health services, Health Sub-Centers, Primary Health Centers (PHCs), Community Health Centers (CHCs), and Sub-District and District Hospitals for building, medical staff, and supply requirements.

Another key component of the NRHM was to provide every village in the country (or every 1,000 people) with a trained female community health activist, an “Accredited Social Health Activist” (ASHA). The ASHA is supposed to be supported by institutions, but be the front-line health-worker in rural communities, providing information, counseling, and support to village members—especially as it related to reproductive and child health (RCH). Each village also got an *Anganwadi* Worker (AWW) who focused more on the health and nutrition of children under the age of 5 years old and pregnant women.

---


Janani Suraksha Yojana (JSY) was an NHRM initiative launched to improve upon the previous NMBS. It also offered a cash incentive for pregnant women delivering in medical institutions, offering a monetary incentive of up to 1,400 Rs for all women, not just those BPL. Janani Shishu Suraksha Karyakaram (JSSK) was then launched in 2011 to assure free medical services by Indian government to all pregnant women, for all pregnancies.

An important program in which each rural health center takes pride is their free ambulance service. This is intended to reduce any barriers to accessing medical facilities.

**Study Population**

While this study included interviews with many people across the health system, many people across all religion and castes, and people who gave birth in many different locations, my primary focus for this study became low-caste village women who delivered at home.

In my first round of village interviews, while shadowing an AWW going door-to-door for the polio vaccination campaign, I could see the gradient from disadvantaged to advantaged women from the beginning of our rounds to the end. In my first interviews, when asking women about their healthcare, some knew about the ASHA and ANM visiting each month for Village Health and Nutrition Days (VHND) but never went, some didn’t know about VHND, some said the ANM did come to register their pregnancy, some said she didn’t. They said that they were more comfortable giving birth at home, and they could not afford to go to the government hospital because people ask them for money. The only two women who gave birth at the hospital went because in the end of their pregnancies they were having serious complications and their husbands and mother-in-laws made them go. The women I spoke to a little later down the road were different—they all bragged about being vaccinated, said they all go to VHND because they learn a lot, and some said they went to the government hospital for delivery. The last group was a little more isolated from the rest of the village, in bigger homes, and the women that came to answer the doors here said that childbirth isn’t safe anymore, that everyone delivers in private hospitals and gets the proper care so no one dies during delivery anymore.

It was clear that the last two groups were taking advantage of the services being provided, and I realized the real goal of the NRHM and public health efforts now must be focused on that first group of women—how can they be reached?

**Global School of Learning**

The Global School of Learning (GSL) was my home-base during my ISP. Instead of being supported by an NGO, I was provided with all housing, food, transportation, and translation by GSL, and for that I am forever grateful.

Not being partnered with an NGO did pose a challenge during my research, because it was more difficult to establish rapport with villagers who couldn’t understand why I was there and wanted to ask them these questions. It also meant there was less research prepared on the area and the
population’s needs, which meant I had to learn the basics of this health system and ask my pointed questions all at the same time.

But in the end, the faculty and staff at GSL became my family, and they gave me an insider’s perspective to the community and a better grasp on village life. I try to cite their influences in this paper to make it clear from where my ideas were coming.

**Experiencing Otherness**

Every field worker’s dream is to be able to enter a community and observe it in its natural state. But the presence of someone recording your moves will make you change your attitudes to begin with. Because of my blonde hair and inability to speak Hindi, there was no way I could blend in.

In some ways, this worked to my advantage. Often I would enter a village and start interviews, and more women would come over, curious, and start adding in their opinion, too. My status as an “American” also made me seem relatively important in the medical institutions (each time I went to visit the staff at the CHC, a different reporter would come to take my pictures). Putting aside the possibly problematic colonialist attitudes behind these, it got me many more voices in my study.

In other ways, my otherness prevented me from connecting with individuals and learning their truth. Some women seemed very suspicious of me when I walked into their house with whoever was escorting me that day, but seemed to feel obligated to speak with me. And often, my whiteness and otherness may have implied to people that I was looking for what I wanted to hear. Women might tell me that all women want to deliver in hospitals and should go to the hospital, but then when I asked where their daughter-in-law would be delivering, they would say home is better. Some people would give me certain answers one day, and then opposite answers the next.

In the end, I had to be aware of my whiteness and otherness while out in the field and while writing this paper, as it played a huge role in my data collection.
MATERNAL HEALTH IN CHITTAURA BLOCK

This section will recount the most common health problems lower caste women villages would see across different points in their reproductive health.

**Before Pregnancy**

*There are too many kids, do you have medicine to make them stop?*

- Village woman as I was standing up to leave her home after an interview\(^\text{24}\)

The first step in reproductive health is everything that happens before a person reproduces. This includes school education, education about health, age of marriage, and family planning.

In the villages, girls’ education is valued less than boys’. When walking around the villages with my translator Sushma-ji, we would meet some parents of students at GSL. On two different occasions, we found out that the family’s son went to GSL, whereas the daughter went to a cheaper private school nearby. This is often because parents don't believe girls are worth the investment, or the girls are pulled out of school to help around the house.\(^\text{25}\)

Education about health seemed similarly discounted for many girls and women. Most girls follow their mothers’, then mother-in-laws’, health instructions. Without the autonomy that comes with health education, young women cannot make informed choices about her daily actions, such as food and exercise, let alone the family-inclusive act of delivering a baby, and she will not feel empowered to question her elders’ instructions.\(^\text{26}\) Furthermore, Bahraich’s low average age of marriage for girls leads to an even smaller chance that the woman will have a voice in her new home.

Age of marriage is another risk factor for women’s reproductive health. Apurva, a low caste woman and dai in one of the villages, explained her experiences with childbirth as a young mother:

> I was married when I was 6, and I moved to my husband’s home when I was 8 because my mother-in-law was blind and needed help. I became pregnant when I was 12. *Bahut halu* [too young]! When I gave birth my body was not grown up properly, so I could not make milk and I had to give my daughter buffalo milk, and suddenly she died.\(^\text{27}\)

Pregnancy and childbirth are particularly dangerous for young girls whose bodies aren’t developed, but they can also be dangerous for any woman without proper nutrition or health.

\(^{24}\) Village Women, Personal Interview, 26 November 2015.  
\(^{25}\) Field Visit to VHND, 18 November 2015.  
\(^{26}\) Village Women, Personal Interview, 28 December 2015.  
\(^{27}\) Apurva, Personal Interview, 28 November 2015.
That is why family planning is crucial for women who do not want, or are too weak to have, children.

When counting for differences between Total Fertility Rate (2.68) and the Wanted Fertility Rate (1.9), resulted in women having 41% more children than they desired. Bahraich has a high fertility rate and unmet need for family planning; 48.9% of the population don’t use any kind of family planning. While family planning has been going up around the rest of India, female sterilization consumption of oral pills has decreased in Chittaura Block in comparison with previous years. Some say that the area’s large Muslim population is the reason behind this: Muslim religious leaders in India have generally claimed that Islam forbids contraception (or at least sterilisation), and the Population Research Center in Delhi wrote that, “the minority dominated community [in Bahraich] has been directly linked with low performance in adoption of family planning measures.” Even though the theological basis of this claim is contested, it is a widespread view among North Indian families.

During Pregnancy

Only mother in law tells you what to eat, what not to eat, what to do, what not to do.

Antenatal care is crucial for widespread improvement in maternal health. However, women from poorer wealth quintiles and scheduled castes and tribes have poorer health indicators including in receiving antenatal care. The women who are most likely to not receive care are scheduled tribe women, women with no education, and women in households with a low wealth index.

In antenatal care with the ANM, complications can be detected, women can get the proper vaccines and nutritional information, and women can be counseled throughout her pregnancy. The low-caste women who do not see the ASHA, AWW or ANM on VHND often don’t understand or trust the services that the health workers provide, so they don’t think it is worth taking a day off of work to travel and see them. Some women don’t think any ASHA comes at all.

Me: Does the ASHA come?


31 Village Women, Personal Interview, 28 November 2015.

First Village Woman: Yes, when she comes we go and take her advice.

Second Village Woman: No, when does the ASHA come? sometimes the ANM comes, but the ASHA does not come.

First Village Woman: Two women come every month!

Second Village Woman: When does she come?33

They mostly get their prenatal advice from no one but their mothers or mother-in-laws.34 In some situations, traditional wisdom passed down is good. However, some beliefs and practices are very dangerous to both mother and child. For example, some women believe that if a baby gets too big, they will not be able to deliver normally, so they restrict their food during pregnancy. This is dangerous, as it can lead to malnourishment and anaemia, which can bring complications later in pregnancy or delivery.

Most women were vaccinated, and that did not seem to be a problem in the area.

Many women cited the most frequent complication during pregnancy as “weakness.”35 When I questioned them what that weakness was from, some said it was from not getting proper nutrition, and some said it was from anemia.

I asked what they eat during pregnancy, and women kept saying “daily diet,” so I assumed they thought they should eat the same amount. I pushed and asked if they believed it was better to eat less, the same, or more, the women then replied that most women cannot afford to eat more than usual.

During Delivery

If baby’s normal, it is pointless to travel, it is expensive, and there might be more harm at the hospital. Why would I go the hospital when I could be at home?36

If the nurse doesn’t know the woman who comes to deliver, the nurses beat and hit them, shout at them, and the women are scared, so most people want to give birth at home.37

33 Village Women, Personal Interview, 28 November 2015.
34 Apurva, Personal Interview, 28 November 2015.
35 Village Women, Personal Interview, 28 November 2015.
36 Village Women, Personal Interview, 26 November 2015.
37 Apurva, Personal Interview, 28 November 2015.
No one feels afraid in the village, but women are afraid to go to the hospital, because it’s sitting in our mind that they will beat us.  

The overwhelming majority of women I spoke with delivered at home. Some women called a dai, but most women just had their female family members around them. A few women went to the hospital because of unexpected complications, such as “too much pain” or “not feeling any pain.” But the women were split on where they thought it was best to give birth. Some said home was always the best. Some said the hospital was best, but they couldn’t afford it. Some said the home was best, unless there were any complications. The women made it clear, however, that if a family has money, the woman definitely goes to a private hospital. This debate of hospital delivery versus home delivery is only there when a family does not have enough money to afford a private hospital.

When women complained about the costs of deliveries in government hospitals, I knew that shouldn’t be the case, because the Indian government has Maternity Benefit Schemes in place that are not only supposed to make all services free of cost to every pregnant and delivering woman, but are supposed to give the woman 1,400 Rs after giving birth. However, women said that the ambulance drivers and nurses always ask for money.

Me: How much does it cost to go to the government hospital?

First Village Woman: 1,000 to 1,500 Rs... The driver usually charges 100 Rs. Well, no, he doesn’t charge a set amount, he says, “Give according to your willingness.”

Me: What happens if you don’t give money?

First Village Woman: If we are not giving money, nothing happens, they take us anyway.

Second Village Woman: No, if you give money, they take care. Otherwise, they don’t take care. When I brought my daughter in law to the hospital for delivery, the hospital asked for money, but I told them I didn’t have money. Then they didn’t look after the child, and the child died.

After Delivery

First Village Woman: For two days we give goat milk, then our milk on the third day.

Second Village Woman: For two days we give market milk, then our milk on the third day.

38 Village Women, Personal Interview, 28 November 2015.

39 Village Women, Personal Interview, 28 November 2015.
Third Village Woman: No! My daughter in law starts giving milk after one hour after giving birth! \(^{40}\)

Considering that 60% of deaths occur after delivery, only 1 in 6 women receives postpartum care (PPC). \(^{41}\) After the baby is born, health systems switch towards promoting infant health, such as breast feeding practices and vaccinating newborns. These are vital, yet women’s health can then fall by the wayside at a time when her nutrition and practices are crucial to her and her child’s health.

An interesting part of PPC in India is that there is indeed routine postpartum care: after most pregnancies, a woman comes to “rub the oil.” This is considered good for the pains. The women who do this are in the naau caste, a caste that’s considered very “backwards” in this village. This shows there’s an element of pollution and untouchability associated with the woman’s body after birth. However, she does not do anything for the woman postpartum besides rubbing the oil. When I asked her if she gave any postnatal advice, such as about breastfeeding, she responds, “I don’t know. The women here are healthy. I think they start breastfeeding within three days.” \(^{42}\)

An important part of PPC that is often ignored but is perhaps most important is assuring the health, nutrition, and financial stability for the woman and the family after this child, and the cycling back to the beginning of the “before pregnancy,” particularly focusing on family planning.

**Maternal Deaths**

Maternal mortality is the big statistic that public health organizations regard as a marker for progress. The MDG’s specific goal for improving maternal health was to lower the MMR. Interestingly, I could not find a uniform answer from village women, health workers, or medical institutions about the actual pattern.

**First village:**

*Village Woman 1: “If 10 women women are pregnant, maybe one or two will die.”*

*Village Woman 2: “About one in ten women dies during delivery. But our health is improving, and I think it will soon be lower.”*

*Village Woman 3: “I don’t know how many women exactly have died, but a lot.”*

**Second Village:**

---

\(^{40}\) Village Women, Personal Interview, 28 November 2015.


\(^{42}\) Sana, Personal Interview, 28 November 2015.
Apurva: “Lots of women die during childbirth!” (Later in our interview) “In the past 10 years, only one woman in our village has died.”

Village Woman 2: “Only one woman in the past 15 years has died.”

Village Woman 3: “I think there are two women who have died in the past 10 years.”

Medical Workers

Dr. Nadim, MO: “Barely any women die anymore! Maybe one in one thousand.”

Sunita, ANM: “Very few women die. One in one hundred.”

AWW: “Many women here die during childbirth.”

The data accessible online is not very helpful either. Numbers are so exaggerated in monthly HMIS reports that it is clear false reporting occurs. For this reason, I have stopped regarding public MMR data as an accurate measure of maternal health, instead focusing more on level of anemia, nutrition, number of children, and antenatal checkups.
REALITY OF HEALTH INFRASTRUCTURE

There’s no question. The Indian Government is very committed to maternal and child health, which we’ve seen with NRHM. There has been lots of good change since NRHM.⁴³

The Indian Government has said time and again that they are committed to improving rural health, particularly that of women and children and vulnerable communities. The Public Service Commission places government doctors in rural hospitals to ensure health personnel is in those hard to reach locations. IPHS sets standards for every government institution to assure highest quality. They strive not only to make ALL costs associated with maternal health and child health free, but to give each new mother a cash incentive that she can use however she wants.

However, these schemes are not all working perfectly.

Spending of designated health funds has progressed very slowly, so the health care system cannot respond adequately to the NRHM demands. As one of the eight Empowered Action Group (or ‘low-performing’) states, UP was allocated additional NRHM funding, but the program has been 30-40% under-spent in all its first three years.⁴⁴

There is still a severe shortage of human resources, one of the most critical factors underlying the poor performance of health systems in resource-constrained settings.⁴⁵ Not enough doctors want to live in these isolated areas, so MOs who do practice in the rural health centers are seeing over 200 patients a day. It is also harder to convince a woman to move out to a rural area on her own, so there is a shortage of women doctors (Lady Medical Officers) at the CHC near the studied villages in Chittaura Block.⁴⁶ While the male doctors are indeed trained to attend deliveries, this area is much more “orthodox,” and women don’t consent to men being in the delivery room. This poses a problem for complicated deliveries at the CHC, as they have to be referred to the District Hospital right away.

Besides human resources, the actual medical institutions around Chittaura Block do not meet the standards set for them by IPHS. The current Bahraich District Hospital started as a CHC, then

⁴³ Dr. Nadim, Personal Interview, 18 November 2015.


⁴⁶ Dr. Juned, Personal Interview, 18 November 2015.
was upgraded to a District Hospital when needed. It currently serves two neighboring Districts as well, whose Hospitals are “under construction,” as they have been for many years. The CHC near the villages in Chittaura Block was a Sub-Center, turned PHC, until it finally was needed as CHC. And the Sub-Center which supposedly serves the villages I was studying was a Sub-Center only on paper only; it had none of the facilities required even for a basic Type A Sub-Center, such as a boundary wall or fencing, a residence for the ANM, signage designating it as Sub-Centre, visible schedule of ANMs, suggestion/complaints box, furniture, or equipment.

Then there is the problem with “free” health services and the Maternity Benefit Schemes. As mentioned before, these services are not in fact free to the women in the community, and the cost remains too high for a woman to consider going to a government facility as a feasible choice for delivery. Furthermore, there are problems with receiving the JSY 1,400 Rs incentive. The poorest and uneducated women do not have the highest odds of being JSY recipients, and instead the benefits are more likely to go to middle class women. HMIS records show that, in Bahraich, over 200% of JSY benefits were paid against reported deliveries—higher than anywhere else in UP. The false reporting undergone here shows serious corruption on the side of the health system. While interviewing women in the villages, it was almost a toss-up whether a woman ever received her JSY benefit. While government and medical employees must be getting a cut of JSY, it is unlikely that the women whom this scheme is intended to support are actually benefitting.

“Safe” Institutional Deliveries

Me: Where is the best place for a woman to give birth?

Dr. Juned: *laughs* What do you think? Hospitals.

The equating of institutional deliveries with safe deliveries is the biggest flaw in India’s Maternal Health policy.

India was the first country to have a national government supported family planning program, beginning in the 50s. As a commitment towards the ICPD PoA, the Government of India changed the national population and family welfare program to remove method specific targets. It formed the National Population Policy based on the principles of the ICPD and introduced the RCH program, dedicated to improving of reproductive and sexual health—milestones!

47 Dr. Nadim, Personal Interview, 24 November 2015.


However, in 2005, RCH II was launched with the purpose of achieving MDG 5. MDG 5 went back on ICPD’s comprehensive reproductive and sexual health approach with the narrow focus only of reducing MMR.

By putting money to incentivize institutional delivery, there was a rise in institutional deliveries, but without an actual change in culture—it was purely a secular change. Such a rapid increase in institutional deliveries without adequate efforts to strengthen the health-system itself contributed to further compromises in quality of care, including “poor availability of appropriately trained health professionals, equipment and supplies at different levels of care; lack of effective referral systems; poor technical quality of care, and most importantly, a pervasive disregard for the rights of clients and an endemic lack of accountability for avoidable maternal death and injury.”52 As discussed before, in the hospitals these women are mistreated. They are forced to pay out of pocket for many services. Encouraging institutional deliveries without first remedying these social injustices is a seriously flawed approach to reducing maternal morality.53

The Report on Progress and Performance of the National Rural Health Mission and Suggestions for the Twelfth Five Year Plan (2012-2017) in a section on Gender Concerns in the Health Sector highlights that little progress has been made in areas like adolescent girls' health, empowerment of women to make informed contraceptive choices, and safe and quality abortion services. With money towards JSY and encouraging institutional deliveries, family planning and vaccine campus, less money is available to be spent on broader, more impactful services.

For example, the quality of ANC remains a serious issue. Complete ANC is hardly provided, and that is a health effort that could create long-term shifts in attitude and accessing services.54 And what do we do with the 72% of women who did not deliver their last birth in a health facility and who said they did not feel it necessary to deliver in a health facility? What do we do with the 11% of women who said a health facility is located too far away or that transport was not available to reach the facility? There is a denial by many health administrators that traditional birth attendants could be positive change agents in these difficult to reach areas, and they continue to push the strategy of institutional deliveries above any other strategies.55 If those health administrators are not willing to try possibly the most effective approach to promoting strong maternal health, then they are indeed encouraging unsafe deliveries.

A focus on skilled birth attendance and emergency obstetric care may be suitable for preventing direct obstetric deaths, but to prevent indirect obstetric deaths and reduce the burden of maternal morbidity requires long-term investment in reducing malnutrition and the burden of diseases in


the community, in women in particular.\textsuperscript{56} To say that non-skilled attendance at birth is the problem for mortality is the equivalent of cutting the head off the messenger. It is the health, nutrition, and education that happen before that lead to many deaths. So now we must examine the health practitioners in this system, and how they work to either promote or do away with the push for universal institutional deliveries as the most important target.

\textit{Medical Officers}

Dr. Juned and Dr. Nadim have already been mentioned earlier in parts of this paper, as they worked with me to help me understand the medical side of the world of maternal health. These two Medical Officers are important to mention as they represent both the side of aloof doctors, in that they dismiss some of the villagers’ “ignorant” attitudes and practices, and the side of the doctors who really do want to improve the health of their area.

While talking with the MOs, in formal interview and informal settings, these were the only two people in my project who expressed discomfort with being recorded. They said they might not be as comfortable with being candid about true issues in the area if their voices are on record. This shows both a desire to critique, them wanting to bring about big change, and their self-preservation, their discomfort with breaking the status quo.

This divide was seen deeper in Dr. Nadim, the elder of the two. He was very passionate for social change, and we spent time bonding over ideas of Community Health Worker models, particularly that of CRHP in Jamkhed. However, having his own family living in Lucknow, he did not want to live and become part of this community—even though he is provided a house on the campus of the PHC, he commutes from farther away during the week, going home to his family in Lucknow on off days.

What impressed me most about Dr. Nadim was his willingness to drop a sense of superiority that comes to so many professionals with medical degrees; Dr. Nadim explained to me the history of dais’ role in the medical system, how they used to be treated as partners in the medical system, how they have a huge wealth of knowledge, but how policy has changed and he accepts that. While we were visiting a VHND camp, we spoke with one ASHA who looked young and shy. It turns out, she was the ASHA in name only—her mother in law did the real duties. Her mother in law was a dai, very skilled in women’s health, and very invested in the health of the community, but she was illiterate. Since her daughter-in-law passed 8th class, the minimum education for ASHAs, the mother worked in her name. I looked at Dr. Nadim’s reaction, nervous he would be upset that his job was entrusted with an illiterate woman. But he looked pleased. He told me has tremendous respect for dais, and they are crucial allies in promoting health.

This seemed to me a very progressive attitude for a doctor, only curbed by his inability to understand any woman who does not want to give birth in an institution.

ANM, ASHAs, AWWs

Before meeting Sunita, I had a skewed image of ANMs. I often heard them, ASHAs and AWWs blamed as lazy and inactive in their roles, that they were the ones responsible for the lack of a success in government programs. However, Sunita was the opposite of that lazy image I had built in my mind. Much depends on the personality and accessibility of ANMs who are often the only people in residence near state health centers.

Sunita, the ANM for the villages I was covering, is animated and passionate when she speaks about her work. She explained to me that she gives her 100%, and that she wants her villages to be as healthy as possible. No matter what, she’s always available to her people, especially in emergencies. Right after she said that, she got a phone call from one of her ASHAs with a woman who had just gone into labor—and it was an emergency. She spoke for a bit, before hanging up and explaining to me that she instructed the ASHA to bring her to the District Hospital immediately, and she had to remind her ASHA on the phone how to hold the woman’s legs to contain bleeding. She casually mentions how she is training her ASHAs in some safe delivery maneuvers.

Sunita views her biggest jobs as working with pregnant women, and vaccinations. She calls pregnant woman in, asks her month and trimester, gives her all the facilities for good delivery, give nutrition and vaccination, and when the baby gets born, she and her ASHAs and AWWs provide materials to educate the mother. She says that she believes institutional deliveries are the best option, but that if if a woman wants to give birth at home, she will be there too. She always keeps a pair of sterile gloves in her bag ready for delivery.

In all the villages, even if the women I’m speaking to don’t know their ASHA, or if the women say they don’t have an ANM, if I say Sunita’s name everyone knows who I’m talking about. Some refer to her as a doctor. The women who speak with her say that she gives good advice.

While this is good news for Sunita, it reflects a little more unfortunately on the ASHAs and AWWs. Those two roles as community health workers are supposed to be working directly with the people, the people through whom Sunita can pass her knowledge. However, the ASHAs and AWWs explain that they feel like they are not respected enough to make serious change in some places. Sometimes, she is close with the village, like with family, and they don’t respect her as a person holding any superior knowledge to theirs, thus not worth their time. Sometimes, a village doesn’t know her personally at all, and then they don’t respect her because she’s not one of them and doesn’t understand their specific health concerns. Numerous CHW programs have failed in the past because of unrealistic expectations, poor planning, lack of supportive supervision, and underestimation of resources required to make these programs work.57 The ASHA and AWW workers in India face some similar issues. They need a way to secure more village support and respect.

TBAs

I am illiterate, but I have mind.

TBAs in the area were different than I expected. They’re romanticized as these women who are low caste, illiterate but body literate, and having mrs knowledge about birth than we give them credit for. In Bahraich, they appeared to be broken into three groups: one, the old fashioned, romanticized elderly dai who is illiterate but body literate, who has now begun working as a link between formal health service and village women. In this category, I met a few dais who were now involved with the medical birth system and encouraging institutional deliveries, and their daughters are ASHAs. These TBAs appear to be respected by the medical community, not seen as posing a threat; while sitting interviewing an ANM, ASHA, and dai at the CHC, the ANM for the CHC came into the room to grab the dai, tell her a laboring women just arrived, and asking her to assist in the delivery.

The second type is the “trained dai” found in villages. These dais are given training by a hospital or NGO with the “five cleans” and other important basics. These women are required to advertise their training and skills around the village so that women will call on them when they’re giving birth. However, these women don’t appear to be as trusted. As a result, these women are rarely called to births.

The third type of TBAs is a lower caste village woman who is experienced with birth and goes to some deliveries. This is the only TBA who didn’t identify with the label “dai,” although it is probably she whom Westerners idealize as the birth worker, independent from the medical trappings of the institutional birth system. She is also the one whom medical institutions don’t like, the kind of person they are nervous is encouraging more home births and making birth riskier.

I spent a lot of time with one woman who fit into this third category, Apurva, and she amazed me with her knowledge. When I asked her if she would consider herself a dai, she said, “No, there is a dai in a far away village, but she doesn’t come here. If you call her to come for birth, she tells you to go to the hospital. But it’s okay because I know how to deliver the baby. But it is not my profession, I don’t take money, or anything. If anyone is happy they can give money themselves, but it is for my satisfaction.” What impressed me about Apurva was how knowledgeable she was, even though she was illiterate: “When I touch any woman, I understand everything, whether it is convenient to give birth at home or if she should be sent to the hospital.” Apurva learns more about health from TV and from attending VHND, and she says she uses that knowledge to encourage women to start breastfeeding their babies right away, to get their children vaccinated, and she’s a big fan of institutional delivery. Activists like her call into question the education and literacy requirement of ASHAs.
POINTING BLAME

In this health system, each person wants to find her or her own scapegoat. MOs say that ANMs are lazy and not doing their part to improve access and education. ANMs say that village women just won’t listen and don’t care about their or their children’s health. Village women say that the ASHAs and AWWs don’t do their jobs. This last section seeks to highlight some of the missed connections between services, between attitudes, and between understanding.

“They should come here!”

When asked what the biggest problems were in women getting health information:

MOs: The women don’t go to prenatal checkups with ANM and ASHA at the village level.

Apurva: “[ASHAs and AWWs] don’t give real advice when they come. They just come here, sit in place, and go. They don’t say anything about pregnancy. They just sit there and pass the time. (Later) If [ASHAs, ANMs, or AWWs] should come they should give advice and solutions. If they come, it’s better for health.

Sunita: People are not interested in going to the hospital for health problems, so they just want me to come to their house to give vaccines. I can’t go door to door to give the medicine... There are lots of gender restrictions, because they don’t allow the women to go out, so they want the ANM to come to them to give the vaccines, but that is not possible because we don’t have enough people or energy to go to every house in every village.

This whole idea is that the services are there, people just don’t understand and aren’t taking advantage of them. Implementation and monitoring are not there, but the planning is good.

Lack of Understanding

There is a lot of discrimination against village women who don’t come to take advantage of these sources because they are not only hurting themselves, but they are hurting their families. Sunita said:

There are women who don’t care—they make a basket for their children, and they put the baby in there while they do the work. Then the baby starts crying, the woman is out working, and the baby eventually falls asleep. But even though the baby falls asleep, there is still that hunger, and that leads to malnutrition. Then she comes back from work and she THEN gives the milk even though it’s not the time the baby wanted it. If this continues, the baby gets malnutrition. The women don’t care about the baby’s nutrition.

She also believes their reasons for not coming to the hospital are ridiculous. About women saying they’re scared, she said:
They are all faking it. they are giving an excuse for not going to the hospital. they are making up excuses with any reason even though there are good doctors available at the hospital.

In regards to ambulance drivers and nurses asking for money, she said:

The main excuse is given by the women that the ambulances ask for the money, the nurses ask for the money, it is very common for the ambulance people and the nurses to ask for money because it's kind of a gift. Whenever there is a marriage or the baby is born, some people come to the house to ask for money to give blessings to the boy or girl. Similarly, these people are asking to take part in the joy as well. According to them, they’re asking for happiness only, but the women think ‘why? they don’t need money. they’re not part of the family’… there is no harm when you are getting the 1400 and medications and food for free.

However, the village women who are giving these “excuses” are not as capable of making the decision to do what Sunita says as Sunita thinks they are. As a confident, educated, and empowered woman, Sunita has a hard time relating to these women’s struggles. Even ASHAs and AWWs who passed 8th class would have a hard time imagining the struggles of the women who they criticize for not wanting to learn from them.

A barrier in needs and a barrier in understanding is what keeps the people who need these services out of arms reach from the providers of these services. Until that distance is bridged, the health of the community can’t be improved.
CONCLUSIONS

Out of the age of the MDGs, with the adoption of the Sustainable Development Goals (SDG), new steps will hopefully be taken by the Indian government to once again create programs with a comprehensive reproductive and sexual health approach.

The greatest need in the villages right now are more human resources. However, this does not necessarily mean more nurses or more doctors, but the women whose voices we have not traditionally valued with a place in the health system: lower caste, illiterate women. There needs to be a bridge to bring these groups together and promote not only health, but respect, justice, and empowerment. That is the way in which we can use reproductive health as our means for social transformation.

RECOMMENDATIONS FOR FURTHER STUDY

• One key factor that I was not able to address in this work was abortion as part of maternal health and maternal death—it is a huge cause of maternal mortality, and in this area where family planning is not used regularly, it would be interesting to understand abortion’s place in the villages.

• Religious tensions and divisions are alive and strong in Bahraich, but my limited knowledge in both of those theologies was not enough to examine religious attitudes and their effect on health in the area. It would be important to find out the role these religions, and also the way in which discrimination against these religions, impacts health.

• A door-to-door survey would be eye-opening in the breadth of data one could collect. This is necessary in the near future, especially if any major health initiatives are to be set in motion in this area.
BIBLIOGRAPHY

Primary Sources

Anganwadi Worker, Personal Interview, 26 November 2015.

Anganwadi Worker, Personal Interview, 4 December 2015.

ANM/SBA, Personal Interview, 3 December 2015.

ANM at CHC, Personal Interview, 3 December 2015.

ANM at VHND, Personal Interview, 18 November 2015.

Apurva, Personal Interview, 28 November 2015.

ASHA at CHC, Personal Interview, 3 December 2015.

ASHA at VHND, Personal Interview, 18 November 2015.

Dai, Personal Interview, 18 November 2015.

Dai, Personal Interview, 3 December 2015.

Dr. Nadim and Dr. Juned, Personal Interview, 18 November 2015.

Dr. Nadim at nearby CHC, 24 November 2015.

Sana, Village Woman and naau caste, Personal Interview, 28 November 2015.


Sunita, Personal Interview, 4 December 2015.

Village Women, Personal Interview, 26 November 2015.

Village Women, Personal Interview, 28 November 2015.

Secondary Sources

Arole, Mabelle and Arole, Rajanikant, Jamkhed: A Comprehensive Rural Health Project, 
Comprehensive Rural Health Project (2003).


