Dangerous Motherhood
Exploring Maternal Deaths in Assam

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Despite recent improvements in the maternal health scenario in rural Assam, it remains the state with the highest number of maternal deaths in the country. Institutional delivery, antenatal care, and postnatal care have been actively promoted by the state to deal with the situation. However, state policies are still incongruously geared towards addressing the issue without taking sufficient note of the various sociocultural impediments in the way of institutional care.

This article is based on the author's doctoral work submitted to the Centre for Political Studies, Jawaharlal Nehru University, New Delhi. The fieldwork was carried in Goalpara in 2011 and 2012. The article only discusses a part of the study. All the names of the respondents have been altered keeping in mind privacy issues.

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Within the current debates around reproductive health, maternal health comprises an important component. Maternal deaths constitute a serious impediment to achieving better reproductive healthcare for women. India therefore focused specially on reducing the maternal mortality rate (MMR). Though there has been considerable improvement, reaching the set goal of the decline rate still remains a challenge. Various factors have been held responsible for these deaths ranging from poor living conditions, nutritional deficiencies, age at pregnancy (Radkar and Parasuraman 2007), inadequate healthcare system and lack of information (Sundari 1992) to pathological reasons like sepsis, toxaemia and haemorrhage (Anandalakshmy and Buckshee 1997).

Against the vast terrain of reproductive health discourse, this article looks at the lapses of the maternal healthcare system in Assam and probes into the question of why despite repeated attempts the maternal health situation still remains so challenging. It is based on the findings of an ethnographic work consisting of 15 in-depth interviews with women in the reproductive age group in Goalpara district of Assam. These women were participants at the village health and nutrition day (VHND).[1] They were chosen keeping in mind certain demographic similarities in terms of their socio-economic conditions.

The National Rural Health Mission (NRHM) emphasises the problems of maternal healthcare in rural areas. Owing to its reputation of being the state with the highest number of maternal deaths, Assam has been a major focus area. Institutional delivery, antenatal care (ANC) and postnatal care (PNC) have been actively promoted by the state to curb the problem. But state policies are often incongruously geared towards addressing the issue without taking account of various sociocultural impediments in the way of institutional care. There is a need to question the issue of reproductive health from the perspective of gender as well as the social situation.

Healthcare Scenario

Despite the recent improvement in the maternal health scenario in rural Assam, the state still has the highest number of maternal deaths in the country.[2] On assessing the health scenario, 61% to 70% of women in Assam are found to be anaemic (Arnold et al 2004), of the total 51.5% women with gynaecological symptoms only 26.7% sought treatment (Rani and Bonu 2003). The dismal picture of maternal health in the state is further validated by studies pointing to the inequalities in the healthcare and nutritional status across the states (Roy et al 2004), the inefficient healthcare

system and outcomes (Sankar and Kathuria 2004).

According to the National Family Health Survey (NFHS) 3 (2005-06) in Assam, about 36.3% of women have at least three ANC visits in their last birth, which saw a rise from 24.9% in NFHS 1 (1992-93) to 30.9% in NHFS 2 (1998-99). Again about 31.2% women gave birth assisted either by a doctor/ nurse, lady health visitor (LHV), auxiliary nurse midwife (ANM) or other health personnel. Likewise, institutional births stood at 22.9%, which is a rise from 11.7% of NHFS 1 and 17.6% of NFHS 2. Again, the proportion of mothers who received PNC within two days of delivery is 13.8%.[3]

As per the District Level Household and Facility Survey (DLHS) 3 (2007-08) survey, institutional delivery stood at 35.3% as against 63.6% home deliveries. Again 32.8% mothers received PNC within two weeks of delivery and 25.2% mothers received financial assistance under the Janani Suraksha Yojana (JSY) scheme.[4] Table 1 shows a steady improvement in the overall maternal healthcare scenario in the state.

Table 1: Maternal Healthcare Status in Assam[5]

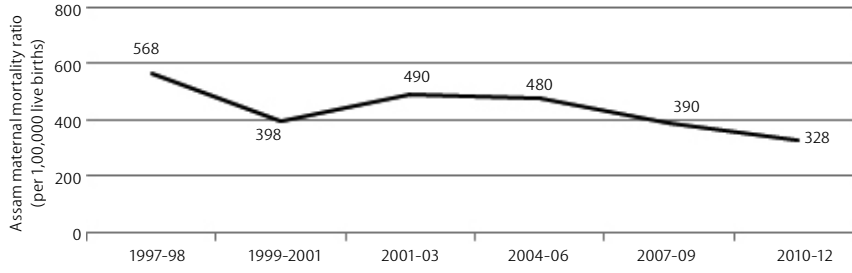
	2008-09	2009-10	2010-11	2011-12	2012-13*
Tetanus immunisation for expectant mothers (%)	73.3	73.5	75.3	80.4	83.2
Prophylaxis against nutritional anaemia (IFA full course completed) (%)	66.8	79.2	83.5	88.4	80.5
Pregnant women who received three ANC check-ups (%)	Not available	55.96	64.05	66.54	71.33
Total ANC registration reported	7,36,696	7,34,711	7,72,510	8,03,938	8,03,370*
% of institutional delivery	71.1	77.6	77.6	80.2	83.0
Number of women receiving post-partum check-up within 48 hours after delivery (%)	Not available	45.71	56.16	58.94	68.88

* Figures are provisional.

Figure 1 shows a corresponding decline in maternal deaths over the years. Interestingly however, the period from 1999-2001 shows a steep decline from the preceding year and was also lower than the period in which the NRHM was introduced. The reasons for such a decline might be attributed to causes like proliferation of various non-governmental organisations (NGOs) in the healthcare sector of the state[6] and active promotion of the Reproductive and Child Health (RCH) programme.

Despite the concerted efforts at reducing the MMR, tangible results are yet to be seen. The state's arm of the NRHM introduced the maternal death review (MDR) as one of the strategies to improve the quality of obstetric care and to identify the factors leading to maternal death at the community level. It has made rigorous attempts at keeping track of the maternal deaths on a daily basis through the integrated MIS-GIS system (a software tool). However, 99 deaths were reported between 21 December 2013 and 20 January 2014.[7] An analysis of 484 maternal deaths revealed that 23.14% deaths were directly due to anaemia and 27.07% were related to pregnancy-induced hypertension (PIH), stroke or eclampsia.[8]

Figure 1: Decline in Maternal Deaths over the Years



Between State and Community

Over the past few years the state government has introduced various schemes and measures to tackle the problems of reproductive health, like the Mamoni (nutritional food for pregnant women) scheme introduced in 2008, the Majoni scheme (promotion of the girl child's well-being), the Mamta scheme (ensuring reduction in infant mortality rate-(IMR) and MMR), apart from the regular NRHM facilities. Despite these efforts, maternal health still seems to be threatened and leads to questions about the efficacy and viability of all such state-sponsored schemes and programmes.

The lower rate of institutional delivery and lack of skilled and trained birth attendants has been linked to the rise in maternal deaths and therefore promoting institutional care has received special focus. However, this approach has dealt a blow to the semi-skilled, local birth attendants (*dais*). However it is also true that attempts have been made to induct these dais into the formal system. They mainly act as motivators for institutional care and more specially for promoting institutional deliveries and contraceptive facilities.

With their presence in the village healthcare system, the accredited social health activists (ASHAs) who act as intermediaries are expected to bridge the gap between the people and the healthcare delivery system. These workers are selected from the local community itself and the state hopes to cater to the population in a language they feel comfortable in and through a person they can relate to. This is also a way of acknowledging the need for a bottom-up, participatory health programme. Many of the ASHAs pointed to the urgent need to raise the level of awareness about institutional delivery and care. Institutional delivery, they felt, is necessary because it provides proper care, delivery by skilled personnel, proper monitoring and better survival of both the mother and the newborn. They also pointed out that their interaction with people shows that community norms are often detrimental to women, preventing them from availing the healthcare services provided by the state and also bar them from the monetary benefits and incentives under these schemes. The ASHAs end up constantly nagging and pursuing people to accept contraceptive measures and hospital delivery. The state, in turn, has discreetly instituted a form of surveillance on the population through these workers and attempted to deal with these community norms.

Many women of the Beltola Pathar and other *char* (riverine areas) adjoining areas under the Mornoi block primary

health centre (PHC) of the Goalpara district were found to be cynical and apprehensive of the state healthcare facilities. The reasons given for not availing of the hospital delivery facilities were: unwillingness of the family especially the elderly members, lack of transport facilities, and fear of an operation or stitches and needles. However, according to the health workers, there is a provision for free of cost referral transport to the health centre for delivery and other emergencies. Nevertheless, the poor condition of the roads or even the non-existence of roads in many cases is an impediment. According to the Rural Health Statistics of 2012,[9] Assam has 4,604 functioning sub-centres, of these 46.7% are without regular water supply, 90.5% without electric supply and 15% without all-weather motorable roads. At the PHC level, of the total 975 functioning ones, 26.2% are without electric supply, 27.4% without water supply and 6.9% without all-weather motorable roads. Further, many people also complained that while the government provides for transportation to the health centre for delivery, the return journey has to be arranged by the healthcare seekers themselves.[10]

The Assam government is also promoting the Mamoni scheme for registration of pregnancy and the ANCs for pregnant women, along with providing monetary benefits in instalments for proper nutritional care. Under the JSY scheme, in order to avail all the benefits under the scheme the mother and baby are required to stay in the hospital for 48 hours after delivery for observation and care. However, for many people this poses a problem for two reasons. First, a person must accompany the woman during her hospital stay, and second, there is a widespread belief amongst the people that hospital delivery means compulsory adoption of various family planning measures. Though health officials say this is a misconception there are references to post-partum family planning measures in the official documents.[11]

While community perception undoubtedly influences the reproductive decisions of women, the state healthcare facilities are also fraught with gender biases. For many women in the rural setting, being examined by a male doctor is embarrassing. Recent health infrastructure statistics again show that of the 975 PHCs in Assam only 37.2% have female doctors while there are none without a doctor unlike the situation in many other parts of the country.[12] Many of the women interviewed during the study said they were more comfortable when a female nurse accompanied the male doctor during examination but would always want a senior doctor available in the PHC for prescribing medicines and tests.

More importantly, in order to address the shortfall of doctors in the rural areas the state also trains batches of rural health practitioners (RHPs) through the three-year Diploma in Medicine and Rural Health Care (DMRCH) at the Jorhat Medical College. According to the State Implementation Plan 2011-12[13] from October 2010 to December 2010 a total of 1,97,097 patients were examined by the RHPs in out-patients departments (OPDs) and 153 deliveries were conducted. Though these RHPs have addressed the shortfall in healthcare personnel, their scope of practice is only limited to rural areas and they can treat diseases only specified in the rules. They cannot carry out any surgical interventions. However, in interviews it was revealed that the RHPs in rural areas actively conducted and assisted women during institutional deliveries.

According to many respondents, feeling dizzy, weak or unwell are perennial problems faced by women and they often have little time to pay attention to their own health in face of a heavy domestic workload. It is only at the critical stage that they realise their deteriorating health condition. Anaemia has been pointed out as one of the major causes of maternal deaths in Assam and the government has initiated a special drive to address this condition during the pregnancy period by providing an iron and folic acid (IFA) course. There are schemes to address the problem of anaemia in adolescent girls too. However, problems of anaemia and malnourishment are not just clinical in nature but deeply rooted in gender differentials existing in our society. Ironically, the state seems to be addressing this problem only for the reproductive age groups whilst ignoring the systemic problem of female malnourishment.

Discussion

The maternal health scenario in Assam has undoubtedly improved in the past few years owing to the introduction of the NRHM with a 152-point drop in maternal deaths during this period. However, there is a need to address several other impediments in the way of realising women's well-being and better health.

First, reproductive health even today, contrary to what the official discourse points at, is still strictly seen as a pathological challenge. The State Programme Implementation Plan and the MDR format[14] still takes recourse to compartmentalising the pathological causes of such deaths.

Second, and ironically, much of the debate on the reproductive health of women has historically focused on its relationship to population control, the family planning programme and target achievement which still holds true. Changes in the official lexicon and its significant "paradigm shift" from a target-oriented approach to more acceptable terminology like Expected Level of Achievement (ELA), is essentially nothing but a newer method of monitoring programme targets to ascertain contraceptive use, unmet needs, etc.

Third, the Indian state duly acknowledges the dichotomisation of the public and the private realm and the community implications on the reproductive health outcomes. It skilfully manoeuvres the ASHAs to pervade the domestic sphere of conjugal lives and bring people into the folds of institutional care. Again, the trained birth attendants (TBAs) have been incorporated into the system not as service providers assisting childbirth, but as motivators for family planning and institutional delivery.

Fourth, following as a corollary to the above-mentioned point, despite significant focus on institutional delivery under the NRHM, factors of patriarchy affecting reproductive health decisions have not been rightfully addressed in

the official discourse. While community norms are often found to be detrimental to women, the state is not geared towards questioning the power differentials that often affect women's autonomy and even existence. There is still a need to address the question of gender differential along with issues that put women in a disadvantageous position vis-à-vis community and gender.

Fifth, there are visible incongruences between the knowledge of the people and the services provided by the government machinery. Besides the shortage of skilled health personnel and infrastructural facilities, dissemination of information regarding various schemes still requires to be addressed properly. If the government is prompt to answer the inconsistencies pointed by the people as in the case of the Janani-Shishu Suraksha Karyakram, it still fails to disperse information adequately.

The state has not achieved much success in addressing the reproductive health needs of the people. The state seems to position itself with some normative rationality of institutional and prescriptive care, and ambiguous policies often inimical to women.

NOTES

1 VHND is held in every village on a particular day of the week, where the local ASHA worker speaks to women about various issues of health, sanitation, etc.

2 EPW editorial "A Matter of Life and Death" (18 January 2014, Vol xlix, No 3), pointed out that Assam still leads the MMR in the country with 328 deaths.

3 http://www.rchiips.org/NFHS/pdf/Assam.pdf, accessed on 15 January 2011.

4 http://www.nrhmassam.in/pdf/Assam_Fact_Sheet.pdf, accessed on 15 January 2011.

5 Maternal Health, Health and Family Welfare Statistics in India, 2013, Statistics Division, Ministry of Health and Family Welfare, Government of India, Table C1-C11.

6 The Rural Women Upliftment Association of Assam (RWUAA) is one such NGO that has been acting as a mother NGO since 1999 for the RCH Phases I and II in various parts of Assam.

7 Status on Maternal Death up to 20 January 2014, available at http://nrhmassam.info/Dash Board/md_index2.php, accessed on 22 January 2014.

8 State Programme Implementation Plan, 2012-13, p 67.

9 Table 35 B, Facilities available at Sub Centres, 36 B Facilities at Primary Health Centres, *Rural Health Statistics in India,* 2012, Statistics Division, Ministry of Health and Family Welfare, Government of India.

10 However, the state health officials refer to the Janani Shishu Suraksha Karyakram (JSSK), which also entitles the mother not only transportation to hospital but also drop back at home.

11 Post-partum family planning services and IUCD are promoted as effective and safe method for spacing and limiting birth and the State Programme Implementation Plan 2012-13 has detailed outlay of such services.

12 Table 22, Number of PHCs with Doctors and Without Doctors/Lab Technician/Pharmacist, *Rural Health Statistics in India,* 2012, Statistics Division, Ministry of Health and Family Welfare, Government of India.

13 State Programme Implementation Plan 2011-12, State Health Society, NRHM, Government of Assam.

14 A format of this Maternal Death Review (MDR) was obtained from the State NRHM office during the course of this research.

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