REPRODUCTIVE HEALTH matters

FEATURE

An investigation of maternal deaths following public protests in a tribal district of Madhya Pradesh, central India

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Abstract: *Since 2005, the Government of India has initiated several interventions to address the issue of maternal mortality, including efforts to improve maternity services and train community health workers, and to give cash incentives to poor women if they deliver in a health facility. Following local protests against a high number of maternal deaths in 2010 in Barwani district in Madhya Pradesh, central India, we undertook a fact-finding visit in January 2011 to investigate the 27 maternal deaths reported in the district from April to November 2010. We found an absence of antenatal care despite high levels of anaemia, absence of skilled birth attendants, failure to carry out emergency obstetric care in obvious cases of need, and referrals that never resulted in treatment. We present two case histories as examples. We took our findings to district and state health officials and called for proven means of preventing maternal deaths to be implemented. We question the policy of giving cash to pregnant women to deliver in poor quality facilities without first ensuring quality of care and strengthening the facilities to cope with the increased patient loads. We documented lack of accountability, discrimination against and negligence of poor women, particularly tribal women, and a close link between poverty and maternal death.*

Keywords: maternal mortality and morbidity, maternity benefits, reproductive health policy and programmes, health systems, accountability, India

Every year, some 80,000 women die due to pregnancy-related complications in India, the largest number of maternal deaths in any one country, with an estimated maternal mortality ratio in 2004–06 of 254 per 100,000 live births.[1,2] An estimated two-thirds of these deaths take place in the states of Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh.[1] According to UNICEF, 61% of maternal deaths occur in women from *dalit** and tribal communities.[2]

Since 2005, the Government of India has initiated several interventions to address maternal mortality. For example, the National Rural Health Mission was launched in 2005 by the Ministry of Health and Family Welfare with the goal of improving "the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children". Investments were made in the provision of community health workers called Accredited Social Health Activists (ASHAs) in every hamlet, development of infrastructure of facilities, capacity building for health workers, and the development of standards for public health facilities. Specifically, the National Rural Health Mission began providing funding for maternal health as one of its key areas, with special attention to the states mentioned above, which have the poorest health and development indicators.

The biggest policy initiative on maternal health, however, has been the push for greater institutionalisation of childbirth, based on the premise that moving women to institutions at the time of delivery would automatically result in better

*The lowest caste in the traditional hierarchy, earlier called "untouchable".

care and reduce maternal deaths. This has been promoted by the *Janani Suraksha Yojana* (Mother Protection Scheme) that gives conditional cash incentives to deliver in a facility. In the named states, women from families designated as below the poverty line are provided Rs.1400 (approximately US$ 31) to deliver in institutions, roughly equal to the total monthly income of a tribal family in those states. Evaluations have shown that these incentives have had a significant effect on increasing use of antenatal care and in-facility births. However, quality of care remains poor,[3,4] and it is not known whether maternal mortality has decreased under this programme. Recently, the Government issued national guidelines that mandate states to carry out maternal death reviews at both community and facility level.

From April to November in 2010, there were reports of 27 maternal deaths from the District Hospital in Barwani, a predominantly tribal district in southwestern Madhya Pradesh, central India. Nine of these deaths were reported in November alone. These deaths were brought to public attention by *Jagrit Adivasi Dalit Sangathan*, a social movement, and SATHI, a non-governmental organisation working in the area. There were two large-scale protests on 28 December 2010 and 12 January 2011 in Barwani, particularly including tribal women, regarding the high number of maternal deaths. In response, a fact-finding team undertook a visit to Barwani in January 2011 to study the factors contributing to these deaths.[5] We present here an analysis of the contributory factors, based on verbal autopsies, a review of case records, and observation and interviews during visits to the facilities.

Methodology

The fact-finding team consisted of the authors, an obstetrician, a health activist and a health systems analyst. Verbal autopsies were conducted by members of the team with the families of six of the deceased women who were living in the area where the local organisations who were our point of access worked. These families agreed to be interviewed and oral consent was given. The team also had access to the District Hospital's case records of all 27 deceased women and to the referral records of other women who had been referred on from the District Hospital.

In addition, the team undertook visits to local public and private health facilities, including the District Hospital, one Community Health Centre and one Primary Health Centre, to study the infrastructure and quality of care provided in them and to interview 12 health care staff at these facilities, including medical officers, obstetricians, nurses and auxiliary nurse-midwives. Several policy and programme documents related to maternal health were also perused, including district programme implementation plans for the National Rural Health Mission, guidelines of various maternal health schemes of the government and state level audit reports.

Findings

Of the 27 reported maternal deaths, 26 were on the government list of maternal deaths and one was reported by the District Hospital as a referral to a higher centre, though it was found during the investigation that the woman actually died in the District Hospital. This may not be a true picture of the situation in the district, however, as there was no maternal death reporting system and there were no data on how many deaths had occurred at home or in transit to or from facilities.

Causes of death investigated

Twenty-one of the 27 women who died belonged to Scheduled Tribes, who are indigenous people outside the traditional caste system, one of the poorest and most vulnerable sections of society, with considerably less access to health care services than non-tribals and other castes. This percentage is disproportionately large even for Barwani, where Scheduled Tribes constitute 67% of the population. Table 1 shows the direct causes of death.

Table 1. Direct causes of maternal deaths, Barwani District, April-November 2010

Cause of death	n=27
Severe anaemia	7
Antepartum haemorrhage	3
Post-partum haemorrhage	2
Eclampsia /Pre-eclampsia	4
Malaria	4
Jaundice	3
Obstructed labour (transverse lie with hand prolapse)	2
Fever with unconsciousness	1
Convulsions with shock	1