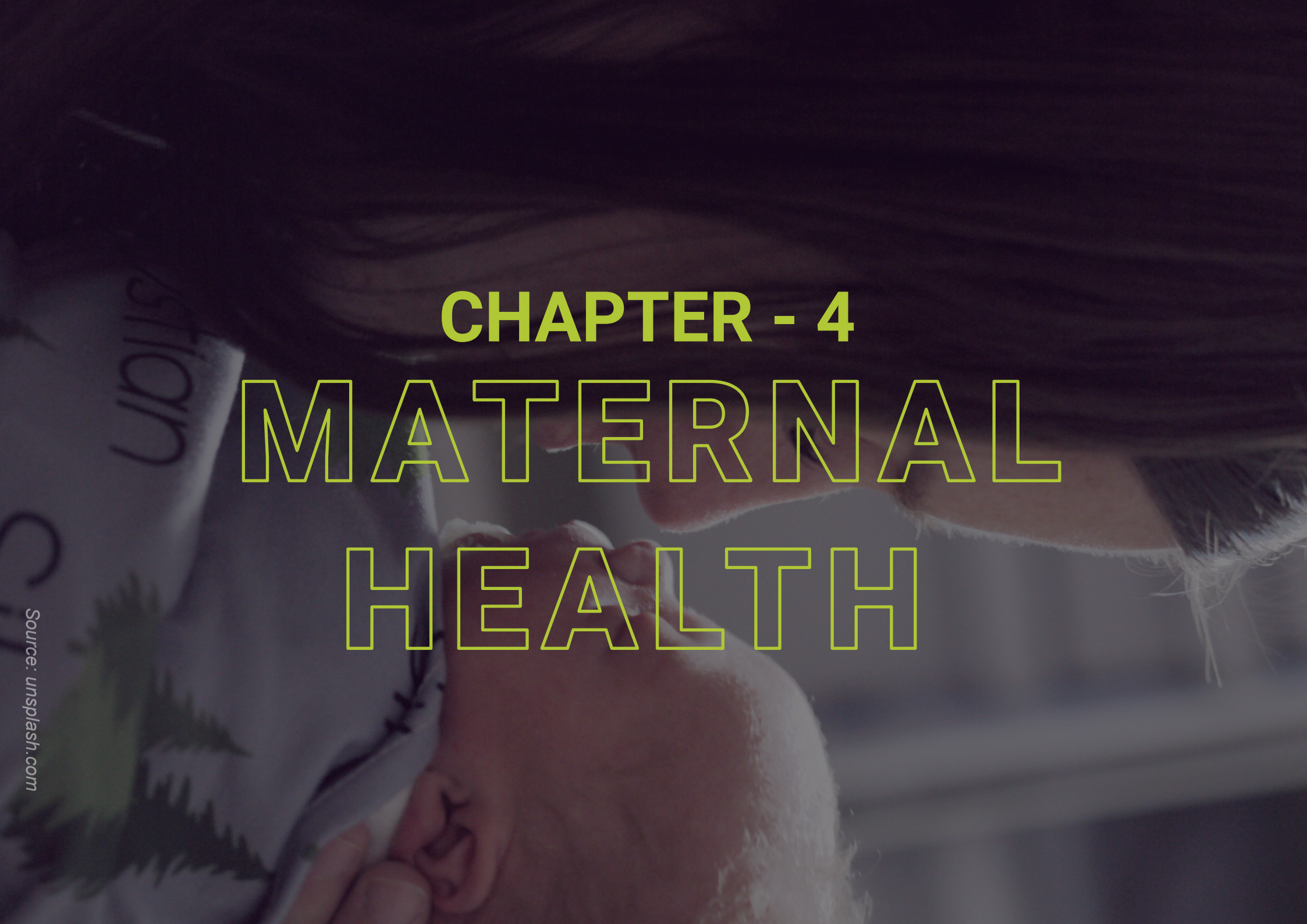

CHAPTER - 4

MATERNAL HEALTH

Source: unsplash.com

4.1. Literature Review

By definition, maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period (Desk n.d.)[51]. One of the significant health inequalities between the developed and the developing countries is the gap in the risk of maternal deaths. Of the 140 million births that take place every year, the World Health Organization (WHO) estimates that ~810 women die every day globally from preventable causes related to pregnancy and childbirth (Desk n.d.)[51]. Of this, India contributes to about 27 million births per year and accounts for 20% of global maternal deaths. While India has made remarkable progress with declining maternal mortality rate in the last decade from 212 deaths in 2007-09 to 130 in 2014-16, significant socio-economic differences and inaccess to quality maternal healthcare continue to persist in India with unsafe abortion being the third leading cause of death. Lack of accountability as a part of governance in health service delivery (e.g., lack of grievance or redressal mechanisms, provider's negligence during delivery, irrational referral) could lead to poor health outcomes in terms of delays or even avoidable deaths (Mukesh Hamal 2018)[52].

It is quite ironic that an agrarian country like India witnesses appallingly high rates of anaemia. Despite government efforts to combat under-nutrition and anaemia, and that the country is self-independent to grow its own seasonal fresh fruits and vegetables, the problem of anaemia continues to persist and seep into every nook and corner of the country (MD 2020)[53]. According to NFHS-4 in 2015-16, over 67% of adult women in rural Jharkhand suffered from anaemia. The predominant symptoms of anaemia include fatigue, feeling cold, dizziness, irritability, and shortness of breath. A diet that lacks sufficient iron, folic acid, or vitamin B12 is a common cause of anaemia. Other plausible conditions that may lead to anaemia include pregnancy, heavy menstrual cycles, blood related ailments or cancer, hereditary disorders, and infectious diseases. The two common types of anaemia in India are iron-deficiency and vitamin B12-deficiency anaemia. Iron deficiency is more predominant among women than men owing to menstrual iron losses and the high iron demands of a growing foetus during pregnancies (Dhillon 2021)[54].

With about 26% of Indian population constituting women of reproductive age (15-49 years), it is estimated that six in 10 women in India face the risk of anaemia; about half of all global maternal deaths are due to anaemia and India contributes to about 80% of the maternal death due to anaemia in South Asia. According to the National Family Health Survey (NFHS) 2019-20, Indian women and children are overwhelmingly anaemic, with colder places witnessing much worse. In the union territory of Ladakh, a whopping 92.5% children, 92.8% women and around

76% men are anaemic in the given age groups, as per the NFHS-5 survey (Welfare 2020)[119]. Along with other South Asian countries, India is off track to meet the World Health Assembly target of a 50% reduction in anaemia among women of reproductive age between 2012 and 2025. The speculation of health representatives imply that the high prevalence of anaemia in the colder regions is due to lack of fresh green vegetation during the long winter each year owing to harsh weathers and restricted connectivity.

Another dimension to the maternal health issues are the deaths due to sepsis and obstructed labour that may be attributed to the high proportion of deliveries at home (University n.d.)[55]. Despite a liberal law on abortion in India, abortion-related complications cause an estimated 8% of all maternal deaths (Manning 2018)[56]. Owing to social stigma or misinformation that abortions are illegal even though India has a law allowing medical termination of pregnancies, they are often misclassified as suicides or murders, especially where the death is due to abortion by an unmarried pregnant woman.

The recent stigma and paranoia around the pandemic has also had a huge impact on pregnant mothers and infants; approximately 9,00,000 pregnant women (15% of the six million women giving birth) who needed critical care had to face enormous hurdles to obtain treatment at an appropriate hospital (Dasgupta 2020)[57]. Added to this were the women who have had miscarriages or sought abortions: that would be another 45,000 women every day. A 20-year-old in Telangana with anaemia and high blood pressure died after being turned away by six hospitals. Similarly, a 25-year-old woman in labour coming from a COVID-19 containment area in Delhi was turned away by at least six hospitals and clinics (Dasgupta 2020)[57].

4.2. Common Myths and Misconceptions

MYTH: 01 | **Consumption of saffron results in fairer skin of the child.**

FACT: While saffron has its own valuable medicinal benefits, high intake of saffron may increase the risk of miscarriage due to its uterotonic properties. At higher doses, saffron has also been shown to cause embryonic malformation in animal's models and is therefore suggested to be avoided by pregnant women (Norain Ahmad 2019)[58].

MYTH: 02 | **Pregnant women should not undertake any physical activity including exercises/lifting weights. Mothers should not climb stairs or uphill in the first trimester.**

FACT: USA's Centers for Disease Control and Prevention stated that physical activity is good for overall health of pregnant and postpartum women since it also improves mood in the postpartum period. It does not pose any safety risks or cause low birth weight babies, early delivery or miscarriage. In fact, the lack of physical activity would consequentially cause more problems during and post labour.

MYTH: 03 | **Pregnant women should eat for two people.**

FACT: Maternal obesity that may result from this myth are found to be associated with Gestational Diabetes Mellitus (GDM), gestational hypertension, pre-eclampsia, large for gestational age babies and childhood obesity.

MYTH: 04 | **Colostrum, the bright yellowish thick first milk, is impure.**

FACT: Colostrum is rich in proteins and has anti-infective properties.

MYTH: 05 | **Pain during labour is excruciating and completely unbearable.**

FACT: The right preparation done in a prenatal class – physical, emotional, and mental, will help cope with labour, and the breathing techniques will enable one to control pain.

MYTH: 06 | **Pregnant women develop perfect facial glow/facial glow implies a baby girl.**

FACT: Changes/fluctuations in hormonal levels can cause greasy hair, hyper pigmentation, oily skin, etc., and is independent of the baby's sex.

MYTH: 07 | **Pregnant women experiencing heartburns imply better hair growth of the baby.**

FACT: Heartburns occur due to the secretion of gastric juices more frequently by the pressure of a growing uterus over the oesophagus.

MYTH: 08 | **Babies born at night tend to stay awake at night.**

FACT: Birth time has no effect on the sleep/wake habits of the baby.

MYTH: 09 | **Turning on either side while lying down will result in the cord wrapping around the foetus' head and in suffocation.**

FACT: The baby is well protected by the umbilical cord and it does not cause strangulation.

MYTH: 10 | **Ghee intake acts as lubricant to make the delivery easy.**

FACT: While moderate quantities are harmless, excess ghee, which is a saturated fat will only add to unecessary weight

4.3. Case Study- Postnatal Isolation in Bundelkhand, Central India

In an agrarian country like India, over 90% of the tribal population continues to depend on agriculture and allied services. Given the challenging geographical terrain and the absence of the required medical infrastructure, it is no surprise that the needs of the tribal population are often excluded or overlooked. The livelihood and the food security of the marginalised groups, especially the women, continue to be prodded with high maternal and infant mortality rates despite the overall dip in MMR and IMR at the all-India level owing to certain social beliefs and customs. The problem is further compounded by poverty, lack of health facilities, people's ignorance and illiteracy. This combination of disadvantages threatens their very livelihoods. Case in point being, the peculiar belief of the tribal communities of Gonds, Kols and Mawasis residing in the forest regions of Bundelkhand in Central India owing to the lack of health support and education (Manjunatha B L 2017)[59].

> *The tribals believed that their goddess would watch the mother and baby during these three days and that it was against her wishes to attend to the mother and baby. Effectively, mother and child are left to starvation and eventual death. **(Manjunatha B L 2017)*** [59]

The social norms of the tribal populations are tightly knit, and certain practices have been continuing for generations together. In these tribal hamlets, illness or death is often associated with the curse of their goddess. Taking sick patients to the hospital or visiting doctors would imply disrespect to their goddess and is against their belief. Therefore, sickness is accepted as an act of God instead of seeking treatment. In this regard, a strange birth practice was followed by the tribal communities. Child marriages are still prevalent among the tribal populations. Whenever a tribal girl/woman delivers a baby, both the mother and the new-born infant were isolated from the family for at least three days following the delivery. The duo is not touched or attended to by anyone including the husband, family, or the midwife. In fact, even the mother is forbidden to attend to (touch, feed, care) the new-born baby and is made to lie on the floor while the baby is put in a bamboo basket. The tribals believed that the goddess would look after the new-born to the extent that the baby is denied the initial colostrum and even the milk/first feed from the mother. This brutal ordeal, rooted in superstition, would vary anywhere between three and seven days. It was believed that "if the mother and the baby are attended to, the Goddess would get angry and her curse can wipe off the entire family". Effectively, the mother and the child were left to starvation and eventual death owing to this practice. Even if they survived, the babies would inevitably suffer from malnutrition in the later stages of life and were often

susceptible to more diseases. The problem was solved only when the female functionary of Samaj Shilpi Dampatis (SSD) scheme took up the challenge and provided timely help to save the mother and child from starvation and death. The Samaj Shilpis are essentially social workers who lived and worked for the villagers on behalf of the Deendayal Research Institute (DRI), an NGO that has been relentlessly working for the uplift of the poor in the Bundelkhand region. From providing daily tuitions to their children to dismantling social evils, the work of the SSDs cannot be overstated in uplifting the lives of the tribal populations. The idea of such an intervention is to build rapport and trust to change the traditional practices and seek betterment. It is more so in case of reaching out to women and helping them with timely advice and medical treatment by breaking the shackles of the age-old life-threatening practices.

4.4. Experts Speak

DR ANUJA JAYARAMAN

She is the Director, Research at SNEHA, where she leads the research, M&E, and information management functions. She has an established track record of policy-oriented research in the areas of poverty and non-income dimensions of wellbeing, including maternal and child health outcomes in South Asia and Africa. Dr Anuja's scholarship has been published in national and international journals of repute.

PROF. M. SIVAKAMI

She is a Professor at the Centre for Health and Social Science, School of Health Systems Studies (SHSS), Tata Institute of Social Sciences (TISS), Mumbai. Prof. Sivakami broadly works in the areas of demography, gender, and health, and has been published in peer-reviewed national and international journals including the Lancet, BMJ Global Health, BMJ Open, Journal of Global Health, among others. She is also an academic editor at PLOS Global Public Health.

01 What kinds of misinformation (myths and misconceptions) prevail around maternal health in India?

Prof. Sivakami: Maternal and child health can be compartmentalised into the following three groups:

a. People's behaviour
b. Health system behaviour
c. Environmental factors

If you look at it from a people's behaviour perspective, there are many myths and misinformation on food habits, especially for expecting women. You will often hear people talking about these myths with no scientific proof whatsoever. With the health system too, there are rumours that C-sections will be prescribed for all or that pregnant women experience violence during labour. While we acknowledge such practices happen, we must not spread unnecessary rumours. This phenomenon will consequently affect women and restrict the number of such women seeking medical care, which implies they will resort to other means, like quacks. Usually, such misinformation spreads through word of mouth, with widespread consequences. Also, during the initial phase of COVID-19, health facilities denied maternal healthcare to women of the minority, especially Muslims, fearing the spread of COVID-19. However, they cannot deny healthcare, especially delivery care, to women from any background. The environment also adds to the misinformation regarding seeking and providing healthcare, i.e., the government's promises on maternal care. For example, there is a fear of the use/misuse of government schemes, like saying that if you go to the government drive in a clinic, they will perform a sterilisation or provide the wrong and same medicines for all health issues.

Dr Anuja: The challenges are in terms of not revealing their pregnancy in the first three months, which is not only the case in rural areas but is common in urban areas as well. Many are not open about it, so early registration of pregnancy becomes a challenge.

In the COVID-19 situation, many fear going to the hospital because they may be turned away or out of fear of contracting the disease during pregnancy, which can affect the child's health. This is a valid fear but there must be ways of circumventing this.

02 What are some of the biggest challenges in maternal health and how should these challenges be dealt with?

Prof. Sivakami:

a: Maternal Health

One of the existing challenges is to convince women of the significance of institutional deliveries. It also depends on the institutions to provide the proper care and respect for women. To me, not providing universal health coverage, especially to pregnant women, remains a huge challenge. More so now, while we are trying to push more institutional deliveries, we miss out on the demand side to equip the institutions in terms of infrastructure at all levels, resources, funding to deal with the voluminous intake, and provide care to the patients. Therefore, these have consequences on women for generations to access institutional deliveries.

b: Menstrual Health

There are many issues with menstrual health. There are myths and taboos with absolutely no scientific basis like not touching or eating things or participating in activities, to name a few. The measures and behaviours reflect on how society treats women, especially during menstruation. When our systems/governments talk about providing menstrual hygiene products, they only talk about supply, i.e., distribution of pads. But unfortunately, giving low-cost pads does not solve the problem of menstrual hygiene. It is a much larger issue with the following four parameters:

i. Creating knowledge
ii. Providing facilities
iii. Ensuring supplies
iv. Disposal and waste management: imagine the amount of waste generated and we have absolutely no sustainable mechanism for disposal. There are a couple of Policy documents here and there, but we do not have the clear behavioural change that we expect or the necessary structure in place for implementation.

For instance, in my village in Tamil Nadu, where there is no proper disposal mechanism, if there is a pad with a blood stain on it, there are rumours that ghosts will haunt the girls in the village; this can have long-term effects on young adolescent girls. While the states have progressed in terms of distributing supplies, the disposal mechanisms are still at the nascent stages.

Dr Anuja:

a: Contraceptive prevalence rates are low and unmet need is high among vulnerable communities residing in urban areas. Emphasis should be on promoting family planning methods for spacing and limiting number of children in a family.

b: Around 50% of women in India are likely to be anaemic, so working on anaemia is another challenge. Anaemia is not a disease like fever where it manifests openly. It results in tiredness and other such symptoms that people don't usually associate with any particular illness.

c: Once pregnant, taking care of themselves including intake of nutritious food, going for antenatal care (ANC) visits, and taking iron and folic tablets also is not consistent.

03

Behavioural change is one of the toughest goals to achieve. How do we address this problem in maternal health, considering that lack of awareness is the first hurdle here?

Prof. Sivakami:

Start early. Start awareness through the school curriculum. Our media has a huge role to play in shaping the mindsets of young boys, especially. Only recently, I have been told that Maharashtra school textbooks show women as police officers and men undertaking household work. Therefore, I am of the strong opinion that if there must be a behavioural change, it has to start early.

04

Given the low female literacy rates, what are the strategies to empower women to take decisions to use reproductive health services?

Dr Anuja:

Messaging and giving information to women regarding reproductive health services is the first step towards empowering women to take health-related decisions. At the same time, one needs to make sure that health services are indeed available when women try to avail them.

05 Considering the problem runs deep, what kind of strategies should the state/local governments adopt to tackle this important challenge?

Prof. Sivakami:

Health is a state subject and therefore, we need to increase the state budgets, equip the health delivery services, and improve infrastructure. All these are possible if all view health as a fundamental right. In states like Kerala and Tamil Nadu, people demand good health services. Similarly, other populations must demand good health services.

Dr Anuja:

Role of government in healthcare is significant. Civil society can only play a supporting role in tackling health issues in India. There is an urgent need to invest in public health systems and facilities. From our experience, one can offer global solutions, but every corporation or every city or every state has its own context, and one has to look at that context and then design the solutions. What works for a rural community need not work in an urban set-up. The government could select poor performing indicators based on national surveys, understand the local context, and design strategies that address the specific constraints faced by the population.

4.5. Conclusion

In case of maternal health, misinformation manifests in more ways than one. Most times, pregnant women lack the adequate knowledge or withhold their reproductive and medical information, owing to family/societal pressures, and to evade private questions. Especially with something as gendered and sensitive as maternal health, there are social issues that combine with the medical issues, leading to a lot of confusion. And this confusion, fear and doubt, in turn become breeding grounds for misinformation, which only complicates things further. Traditional vertical health communication strategies are eroded by horizontal diffusion of conspiracy-like messages. The narratives of health especially maternal misinformation are often dominated by subjective biases including personal anecdotes, word of mouth, opinions on doctors, institutions & treatments, which in turn induce fear, panic, confusion, anxiety and mistrust in institutions. Therefore, one must be careful of the credibility of the agents who spread misinformation either through experience, or knowledge that is passed on from generations. Although traditional knowledge remains valuable, it must be taken with a pinch of salt, and given the access to modern knowledge (factual, scientific, and logical research),

it is essential for women to understand what their bodies are going through physiologically. Given that each pregnancy is unique, it is crucial that expecting mothers discuss their entire obstetric and reproductive health with their doctor so that right and customised guidance can be provided from the first trimester until the labour time.

These layers of stigma and misinformation are not going to disappear anytime soon. In fact, false information has significantly seeped into our households and have become the norm. However, However, specialized frameworks from subjects including Behavioral science, psychology and network science are being utilised to understand the patterns of misinformation and how to combat them. However, at an individual level, we can educate ourselves and talk about these issues more freely, so that with time, we learn to talk about maternal health with data instead of rumours and misinformation.