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Making pregnancy safe for women in Rajasthan: Targeting the most vulnerable

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Making Pregnancy Safe for Women in Rajasthan: Targeting the most vulnerable

As recently as in 2005–2006, almost two in three (65%) women in Rajasthan were married before age 18 (of those aged 20–24, IIPS and Macro International 2008). Moreover, half (51%) of currently married girls aged 15–19 years in the state had already begun childbearing. The dangers of childbearing among adolescent girls, whose bodies have not physically matured, are widely acknowledged, as are the links between poverty and unsafe pregnancy. Yet, less is known about whether morbidity and mortality experiences vary within the subgroup of adolescent girls, whether such experiences differ between adolescent and adult women of similar parity, and whether treatment seeking behaviours and the delays experienced in seeking treatment differ between adolescent and adult mothers. Little is known, moreover, about the extent of the disadvantage faced by women from different social classes.

This policy brief documents the magnitude of self-reported pregnancy-related morbidity among low-parity adolescent and adult women, and the constraints that they faced in seeking appropriate and timely care in Rajasthan. It also sheds light on the extent to which morbidity and the constraints experienced in seeking care differ across social classes.

The study

Data are drawn from a cross-sectional study, comprising a survey and in-depth interviews, conducted in 100 villages of four blocks, Bansur, Kishangarh, Rajgarh and Tijara, in Alwar district. Respondents for the survey included: (a) young women who had experienced a recent delivery, that is, during the two-and-a-half years preceding the survey, and were aged below 20 years or between 25–29 years at the time of the index delivery; and (b) family members of young women who had died during delivery or within six weeks following delivery due to maternal complications in the two-and-a-half years preceding the survey and were aged below 20 years or between 25–29 years at the time of death. The study was conducted during May-October 2007. A total of 1,935 women or family members of women who died of maternal complications were successfully interviewed. In addition, a total 104 women or a family member in case of maternal death were interviewed in-depth.

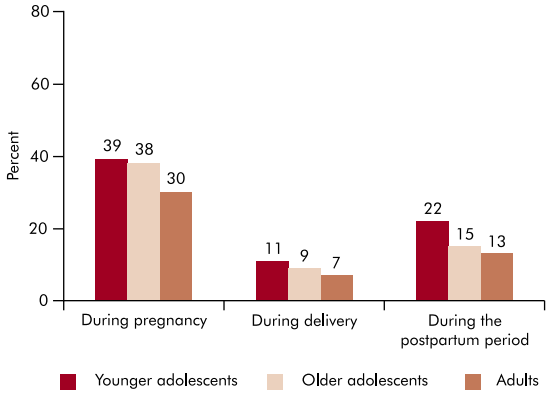
Pregnancy-related complications were common among women

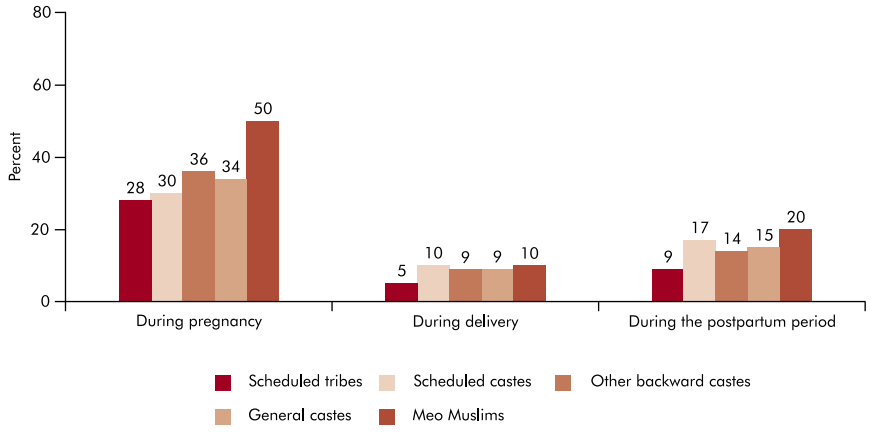
Findings indicate that pregnancy-related complications were common; indeed, almost three-quarters of women had experienced at least one pregnancy-related complication. Specifically, less than 1 percent of women had experienced death due to pregnancy-related complications; half had experienced one or more severe complications; and almost three-fifths had experienced one or more non-severe complications.

Of note is that young adolescent mothers (those aged below 17 years at the time of the recent delivery) were at higher risk than older mothers (those aged 25–29 years): 39 percent of young adolescent mothers compared to 30 percent of adult mothers experienced one or more severe complications during pregnancy; 11 percent compared to 7 percent experienced severe complications during delivery; and 22 percent compared to 13 percent experienced severe complications during the postpartum period.

Also notable are differences by social class[1]; findings suggest that women belonging to scheduled tribes (predominantly Meena) were least likely and Meo Muslim women were most likely to have experienced pregnancy-related complications, particularly during pregnancy and the postpartum period. For example, while 28 percent of scheduled tribe women reported at least one severe complication during pregnancy, many more—50 percent—of Meo Muslim women so reported.

Self-reported pregnancy-related morbidity: percentage of women who reported at least one severe complication during pregnancy, delivery and the postpartum period, according to age at delivery and social class





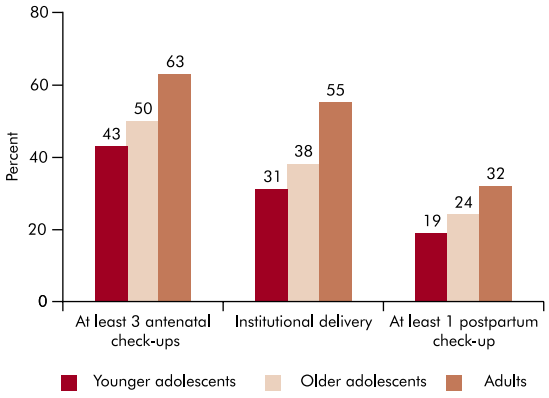
[1] Note: The percentages are standardised for age differences

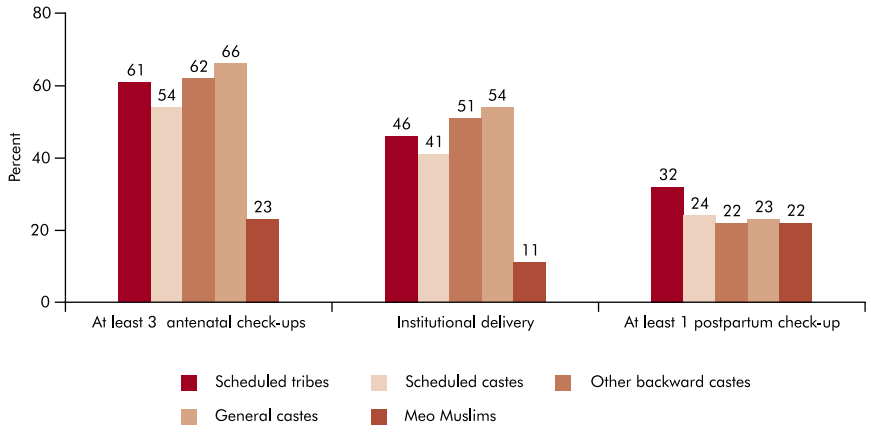
Pregnancy-related care was limited

The study findings also underscore that maternal health care seeking was limited among women in the study setting. Just half of women had received three or more antenatal check-ups for the most recent birth, only about two-fifths (38%) had their most recent delivery in a health facility and about one-quarter (24%) had received a postpartum check-up. Findings, moreover, indicate that outreach services tended to be weak, for example, as in the case of postpartum services.

Young adolescent mothers were more constrained than adult mothers with regard to maternal health care seeking. They were less likely than adult mothers to have had the recommended number of antenatal check-ups (43% versus 63%), experienced institutional delivery (31% versus 55%) or received a postpartum check-up (19% versus 32%). Findings show that institutional deliveries did indeed increase following the introduction of the Janani Suraksha Yojana scheme; however, young adolescent mothers were much

Maternal care seeking: percentage of women who had received at least 3 antenatal check-ups, had institutional delivery and had received at least 1 postpartum check-up, according to age at delivery and social class





less likely to have benefited from the JSY scheme than other women (12 percentage point increase in institutional delivery following JSY introduction among young adolescent mothers compared to 19–26 percentage points increase among old adolescent and adult mothers).

Findings also indicate that maternal health care seeking was far more limited among Meo Muslim women than others. For example, just 11 percent of Meo Muslim women compared to 41–54% of others reported an institutional delivery. As with young adolescent mothers, Meo Muslim mothers were far less likely to have benefitted from the JSY scheme than others (9 percentage point increase in institutional delivery following JSY introduction among Meo Muslim mothers compared to a 19–35 percentage point increase among others).

Most women sought care for pregnancy-related complications, but experienced delays in seeking treatment

Treatment was commonly sought for pregnancy-related complications; over 70 percent of women who had experienced complications had sought treatment. Nonetheless, considerable proportions experienced delays in seeking treatment.

Need for seeking treatment was rarely recognized promptly

Indeed, few women were aware of the danger signs during pregnancy (27%), delivery (41%) and the postpartum period (21%). Closely related to women's limited awareness of danger signs was their delayed recognition of complications; just 33 percent of women who had experienced one or more complications had recognised the need to seek treatment promptly, that is, within six hours of experiencing the complication.

Age differences in recognising a complication were narrow; even so, older adolescents were more likely than others to recognise the need for seeking treatment promptly. The differences by social class were, however, wide. Women belonging to scheduled tribes were most likely to have recognized the need for seeking treatment promptly (almost half of women who experienced a complication) and Meo Muslim women were least likely to have done so (just one-fifth).

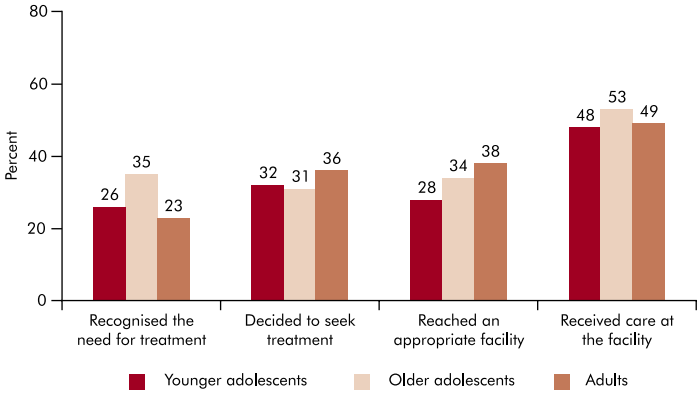
Decision to seek treatment from an appropriate health facility was typically delayed

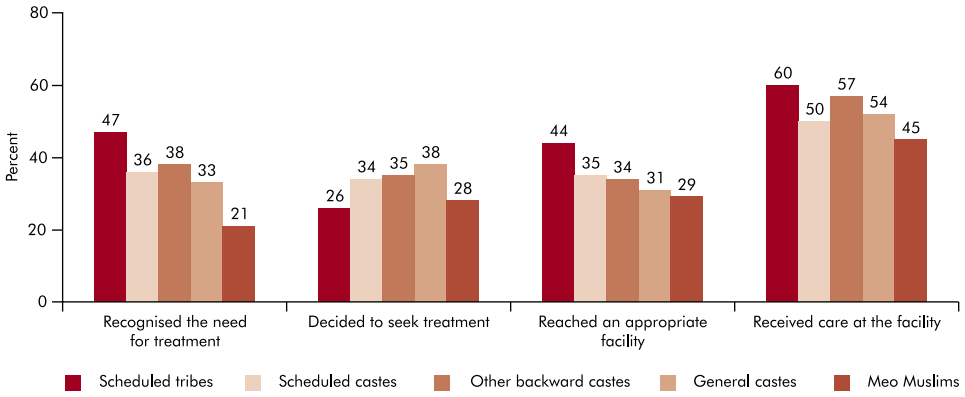
Large proportions of women also experienced the second delay—deciding to seek treatment from a health facility that could provide appropriate care. Just one-third of women who experienced complications reported that the decision to seek treatment was made promptly, that is, less than six hours after recognising the need for treatment. Adolescent mothers were somewhat less likely than adult mothers to have done so (31–32% versus 36%). Differences by social class were mild; even so, scheduled tribe and Meo Muslim women were less likely than others to report that the decision to seek treatment was taken promptly (26–28% versus 34–38%).

The majority did not reach an appropriate health facility promptly

Women also reported experiencing the third delay; that is, in reaching an appropriate health facility for the treatment of complications within an hour of making the decision to seek treatment. Indeed, just one-third of women reported reaching an appropriate health facility promptly. Delays in reaching a facility were considerably more likely to be cited by young adolescent mothers than

Promptness in seeking treatment for pregnancy-related complications: percentage of women who reported that they recognized the need for treatment, decided to seek treatment, reached an appropriate health facility and obtained treatment at the facility promptly, according to age at delivery and social class





adult mothers (28% versus 38%). As with recognizing the need for seeking treatment, findings suggest that women belonging to scheduled tribes were most likely to have reached an appropriate facility promptly (44%) and Meo Muslim women were least likely to have done so (29%). Delays were experienced for several reasons; for example, many women had initially sought treatment from a facility that was not equipped to handle the complication experienced, several families had not made arrangements in advance for transportation in case an emergency occurred, and many had faced problems in obtaining transportation.

Fewer reported delays in obtaining appropriate care after reaching the facility

Compared to the three delays discussed earlier, fewer women reported experiencing a delay in obtaining appropriate care, that is, within an hour of reaching an appropriate health facility. Over half of women who experienced complications reported that they had obtained appropriate care promptly once they reached the facility.

Age differences in obtaining appropriate care were narrow. However, differences by social class were wide, with Meo Muslim women, followed by scheduled caste women least likely to have received care promptly.

Quality of services received at the health facility varied

Findings indicate that the quality of maternal health services received varied. The majority of women who had sought treatment for pregnancy-related complications reported that the health care provider had treated them well. Even so, some women noted that the provider had just dispensed the service and had not provided any information or advice about the complications experienced. Some women also noted poor treatment by the provider, irrespective of whether the provider was a physician or a nurse, or the kind of facility in which the provider worked. Women also articulated concerns about the quality of routine maternal health services received. A sizeable number of mothers who reported contact with health care providers noted that they were rarely given advice regarding care during pregnancy, delivery and the postpartum period. Additionally, many cited poor quality of services as a reason for preferring not to deliver in a hospital.

Recommendations

Findings reiterate the need for programmatic attention to improve pregnancy-related care seeking among all women. At the same time, special attention needs to be paid to young adolescent mothers and mothers belonging to socially disadvantaged classes, Meo Muslim women for example. Findings of the study suggest several priority areas for action, some of which fall within the realm of the department of health and family welfare and others within the realm of such departments as women and child development and panchayati raj institutions.

Support newly-weds to postpone the first pregnancy

Findings that young adolescent mothers were particularly at risk of pregnancy-related complications underscore the need for supporting newly-wed young people to postpone the first pregnancy. This requires a multi-sectoral approach:

- Train and support existing youth groups to hold regular participatory learning sessions to build members' awareness of the adverse effects of early pregnancy and contraceptive options as well as to make it acceptable for young couples to adopt contraception prior to the first birth.
- Train and support adult women's self-help groups to hold participatory group discussions with mothers-in-law to change community and family attitudes to favour the postponement of the first pregnancy.
- Conduct training workshops to orient health care providers, especially front-line health workers, including ANMs and ASHAs, about the need to reach out to newly-married young couples and sensitise them about the constraints young people face in postponing the first pregnancy. These training workshops must also enhance health care providers' counseling skills in dealing with young people as well as skills in addressing the concerns of influential adults in young people's lives.
- Ensure that ASHAs and ANMs make home visits to newlyweds, engaging newlywed girls as well as their husbands and in-laws about the benefits of postponing the first

pregnancy, providing contraceptive counselling and supplies to young couples and following them up for difficulties in method use.

- Incorporate such indicators as the number of newly-married young couples contacted and contraceptive services provided to newly-married young couples among the indicators used to monitor front-line health workers' performance.

Promote care during delivery and the postpartum period, as well as during pregnancy

Findings underscore that few women sought maternal health care services, particularly institutional delivery and postpartum check-ups. The study finding that the JSY scheme tends to have a positive effect on promoting institutional delivery is encouraging; however, the implementation of the scheme needs to be strengthened.

- Orient front-line health workers at the village level, including ANMs, ASHAs and *anganwadi* workers, to make special efforts to inform the most vulnerable, for example, young adolescent mothers, first-time mothers and mothers belonging to socially disadvantaged classes about the JSY scheme and to encourage them to avail of it.

- Ensure that front-line workers help pregnant women in the last trimester to develop a birth plan.

- Ensure that front-line workers provide postpartum checkups to newly delivered women within a week of delivery, and include the number of women who received postpartum check-ups within a week of delivery as a criterion for assessing their performance.

Build in-depth awareness of pregnancy-related complications

Although the vast majority of women who experienced complications had sought treatment, findings indicate that they had experienced considerable delay in recognising the need for treatment. Also evident was women's, particularly adolescents', limited awareness of pregnancy-related complications in the study setting.

- Train and support women's self-help groups to hold participatory group discussions with pregnant women and their family members about danger signs during pregnancy, delivery and the postpartum period, as well as about appropriate facilities where treatment can be obtained.

- Develop and distribute ready reference materials for low-literate audiences that provide information about basic maternal health care, danger signs and appropriate facilities where treatment can be sought for pregnancy-related complications.

- Regularize activities for counseling pregnant women and their family members on danger signs as part of antenatal and postpartum check-ups.

Empower the most vulnerable—adolescent and young mothers and the socially disadvantaged—to make informed decisions, and involve influential adults in young women's lives in pregnancy-related care

Findings indicate that for many women, especially the young, husbands and other influential adults in the family play a key role in decisions related to pregnancy care. Moreover, adolescent mothers and their families were more

likely than their adult counterparts, and Meo Muslims were more likely than other women, to have delayed the decision to seek treatment from a health facility. These findings call for actions that enable adolescent and young women and those belonging to socially disadvantaged classes to make informed decisions with regard to pregnancy-related care, and that actively seek the participation of husbands and other influential adults in the family in ensuring that pregnancy is safe.

- Improve outreach services by front-line health workers and ensure that they pay special attention to adolescent and young mothers and the socially disadvantaged.

- Make special efforts to link adolescent and young mothers with existing women's empowerment programmes and make sure that empowerment programmes are functioning in socially disadvantaged areas.

- Work with existing young men's groups and clubs and adult women's self-help groups to ensure the participation of husbands and other influential adults in making pregnancy safe.

Mobilise communities to address delays in reaching health facilities

Findings indicating that women experienced considerable delays in reaching a health facility call for community mobilisation activities to develop mechanisms to ensure that women experiencing severe complications are taken to health facilities promptly.

- Explore the option of entrusting adult women's self-help groups with the task of arranging transport for women facing obstetric emergencies

- Make PRI representatives sensitive about danger signs and responsible for arranging transport for women to deliver in a health facility as well as for those facing obstetric emergencies.

Improve the quality of maternal health care

Although the majority of women reported that health care providers had treated them well, a sizeable proportion of women raised concerns about the quality of services received.

- Conduct training workshops for health care providers that enhance their capacity to render maternal health services in friendly and non-threatening ways.

- Introduce social auditing to assess the quality of maternal health services.

- Initiate community mobilization activities to create among women and their family members a sense of entitlement to health care and other services

Reference:

International Institute for Population Sciences (IIPS) and Macro International. 2008. *National Family Health Survey (NFHS-3), India, 2005-06: Rajasthan.* Mumbai: IIPS.

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