



MATERNAL HEALTH IN TRIBAL COMMUNITIES:
A Qualitative Enquiry into Local Practices and
Interactions with the Health System in
Rayagada District, Odisha



National Alliance for Maternal Health and Human Rights (NAMHHR), India

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Dr. Sana Contractor

Research Assistance: Bijayalaxmi Rautaray

Contributors:

Dr. Abhijit Das

Jashodhara Dasgupta

Copy Editor:

Dr. Y.K.Sandhya

Cover Design and Layout:

Anju Kumari

Cover Photo:

Trinath Khadanga, District Correspondent SAMBAD

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ACRONYMS

AHS	Annual Health Survey
ANC	Antenatal Care
ANM	Auxillary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy - alternate systems of medicine
BP	Blood Pressure
BRGF	Backward Regions Grant Fund
CHC	Community Health Center
DH	District Hospital
DLHS	District Level Health Survey
EAG	Empowerment Action Group
GP	Gram Panchayat
Hb	Haemoglobin
ID	Institutional Delivery
IFA	Iron Folic Acid
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MAPEDIR	Maternal and Perinatal Death Inquiry and Response
MMR	Maternal Mortality Ratio
MO	Medical Officer
NFHS	National Family Health Survey
PDS	Public Distribution System
PHC	Primary Health Center
PNC	Post Natal Care
PVTG	Particularly Vulnerable Tribal Group
SC	Scheduled Castes
ST	Scheduled Tribes
VHND	Village Health and Nutrition Day

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Sana Contractor, CHSJ
Bijayalaxmi Rautaray

PREFACE

India is an amazingly diverse country. While this diversity is a unique strength, there is also an increasing realisation that the various efforts at development that are underway in the country do not reach and benefit all citizens equally. The call for inclusive development stems from the fundamental understanding that as a country all efforts need to be made to reach out and include all citizens within the ambit of our ambitious development goals. Tribal communities or Scheduled Tribes as they are described in India are a unique and still diverse community. While on the one hand many are characterised as relatively primitive forest dwelling communities, on the other many are considered as the 'original' inhabitants of a country that has been the fertile mixing ground of different races and cultures across the millennia.

However tribal communities have probably benefited least from development interventions in recent times. Many argue that development efforts have adversely affected tribal communities. Improvement in maternal health, especially in those areas where the maternal outcomes have been poor, has been among the most important thrust areas for the Indian government in the last ten years. Large amounts of money and materials have been invested in improving maternal health related service delivery. While surveys and other large scale investigations have shown improvements in maternal health outcomes, a steady stream of reports from different areas of the country have also indicated that the situation is not so good in pockets where tribal communities reside.

The National Alliance for Maternal Health and Human Rights (NAMHHR) as its name implies is an alliance of NGOs and health activists from around the country who are deeply concerned about the improvement of maternal health in the country. Many among the NAMHHR members are involved in working with tribal and other disadvantaged communities, while others are working closely with Government bodies at the state and national levels in devising, implementing and reviewing Government initiatives around maternal health. NAMHHR members have earlier also been involved in bringing to light and investigating the poor state of maternal health among tribal communities.

This report is the result of a collective desire of NAMHHR to understand how tribal communities negotiated their own maternal health both in the case of normal and complicated pregnancies; and how they perceived and interacted with the public health system. We believe that this understanding of the lived reality of tribal communities is fundamental to designing and implementing effective interventions. This study was conducted in one district of Orissa and indicates that there are some specific tribal beliefs and practices around maternal health which the health system has failed to either understand or incorporate into its well meaning interventions. We would like to highlight that these findings should not be interpreted as a representation of a 'general' tribal reality. Similar small studies or assessments need to be conducted in different areas to understand the unique situations and then programmes devised respecting these realities. Interventions which respectfully incorporate the reality of tribal communities, while maintaining the life-saving potential of modern medicine and advantages of modern science and technology, will be a true measure of 'inclusive development' as well as a celebration of the diversity that is India.

Dr Abhijit Das
NAMHHR

I. INTRODUCTION



Health Status of Tribals in India

Scheduled tribes (STs) constitute 8.6% of the total population of India (Census 2011). They are spread across the country and are extremely diverse in their language, customs, physical features, social stratification, level of development, source of livelihood and extent of acculturation. (Xaxa Committee report, 2014) The majority of the ST population is concentrated in the state of Madhya Pradesh, Chhattisgarh, Jharkhand, Maharashtra, Gujarat, Rajasthan, Odisha, West Bengal and Andhra Pradesh. Tribal communities in India are among the most marginalized in Indian society. Although they form a minority of the Indian population, they are over represented among the economically impoverished and have poor indicators on many counts including health.

Although several protections for tribal peoples are in place in the Constitution of India, and efforts have been made to provide greater allocation of resources to the community, the overall indicators continue to be poor. The impoverishment of tribal communities can, in part, be attributed to the dominant 'development' paradigm which the State has been pursuing since Independence, and more so in the last two decades. This push to 'bring development' to tribal areas especially in the mineral rich areas, in connivance with corporate interests, has led to involuntary displacement and disempowerment of the tribal people, pushing them into a precarious position of existence. It is no surprise then that these conditions have made it possible for left wing extremism to proliferate in these regions¹.

1. Nine states in India have been demarcated as 'seriously affected by left wing extremism' and six of these are ones with a significant ST populations

Moreover, the steadily worsening living conditions, increasing poverty and displacement, loss of access to/ destruction of forests which are a source of nutrition, medicine and livelihood for the tribal peoples, has had a significant impact on their health. As per the National Family Health Survey 3 (NFHS 3, 2006), the Infant mortality for STs was 27% higher than the general population and Under-5 mortality was 61% higher. Data from the District Level Household Survey 2008 (DLHS 3) shows that tribal women were less likely to receive full antenatal check-up, and also less likely to deliver in institutions. Similarly, tribal new borns were less likely to receive a check-up within 24 hours of birth than non-tribal ones and immunization of children aged 12-23 months was lesser among ST children than non-ST children.

The very comprehensive Xaxa committee report (2014), drawing on data collected by the Indian Council for Medical Research (ICMR), found that the 'diseases of underdevelopment' which includes malnutrition (including low birth weight, undernutrition of children, lower body size of adults, anaemia and other nutritional deficiencies), communicable diseases (especially malaria, filarial, tuberculosis, diarrhea, hepatitis, viral fevers, cholera, typhoid) and maternal and child health problems, abound in tribal communities.

The lack of adequate food security, destruction of forests and general dispossession are an obvious cause of the high prevalence of malnutrition. Similarly, the high prevalence of communicable diseases can be directly related to living conditions and lack of access to clean drinking water and sanitation. The Census 2011 shows that only 11 percent of tribal households have access to tap water as compared to 29 percent of non-tribal households. In Odisha, only 2 percent of tribal households have access to tap water. Similarly only 17 percent of tribal households had access to improved sanitary facilities as compared to 44 percent of non-tribal households, and only 6 percent of tribal households had closed drainage as compared to 19 percent of non tribal households.

The poor health status of tribal communities, is well established in literature today. Most recently, the Xaxa committee report (2014) has addressed various dimensions of tribal health, highlighting the high prevalence of 'diseases of underdevelopment'. This 'lack of development' of tribal populations can be viewed from two perspectives, which also the Xaxa committee report references in the following excerpt:

“With respect to tribal development, there were two prominent colonial discourses which have continued into the postcolonial period. In one of the discourses, the overall condition of tribal people, including their poverty, is attributed to their social and geographical isolation. Correspondingly, the whole thrust of the approach to tribal development in independent India was to be centred on the integration of tribes into the larger Indian society. In fact, their integration was seen as the solution to tribal 'backwardness'. There was, however, also a dramatically contrasting explanation for their poverty. The main architect of this view was Verrier Elwin who attributed their deplorable and impoverished condition to their contact with the outside world, which had led to indebtedness and loss of control over their land and forests. The nationalist leadership recognized both of these dimensions and addressed them. The provisions enshrined for Scheduled Tribes in the Indian Constitution are a testimony to this dual approach. It provides for development as well as for safeguarding and protection of their interests. However, it was development (of a particular kind) that became the primary thrust of the State's agenda, with minimal regard for protections and safeguards. What the State is actually pursuing in tribal areas - apart from Northeast India - is assimilation rather than integration, contrary to what is claimed. A policy of integration would provide space for protections and safeguards for their distinct identity, as enshrined

in the Constitution. However, these provisions are precisely what are under threat of erosion through the process of cultural domination and more importantly, the prevailing development paradigm. (pg 29-30) ”

As far as the health system is concerned, the predominant view is that the poor health status of tribal communities is due to their 'isolation' and due to inadequate reach of health programs. The effort therefore, has always been to allocate greater resources and aggressively push existing health programs in tribal communities. While the efforts to ensure that government schemes reach the most isolated is to be appreciated, it is also true that the social divide between tribal communities and the mainstream health system has been viewed from the perspective of the 'primitiveness' of tribal communities and their 'resistance to change'. The effort therefore has been to mould and persuade tribal communities to leave behind their 'backwardness' and adopt modern medicine. With respect to maternal health, this has been done largely through introducing incentives to drive women to the health facilities.

The Context of Maternal Health in India

Over the past 15 years significant resources and efforts have been put in by the Government of India, to achieve the MDG 5 goal of "Improving maternal health". Large health programmes have been implemented by the central government, and have received significant amount of funds. The focus of these programs has, essentially, been to offer women cash incentives to attend institutions/ hospitals for childbirth through the Janani Suraksha Yojna (JSY). In 2011, taking into account persisting high out-of-pocket expenses incurred by pregnant women and their families, which was seen to serve as a barrier to accessing institutional care, the cashless scheme of Janani Shishu Suraksha Karyakram (JSSK) was launched. Although this is a move forward from the earlier Conditional Cash Transfer scheme, the focus is still on institutionalization of deliveries.

However, there is little evidence to show that the singular approach of institutionalizing deliveries has been able to reduce maternal mortality and improve maternal health.² Health institutions in the country are not equipped to detect or manage life-threatening complications in a timely manner, and have poor back up in the form of emergency obstetric care.³ A study based on Annual Health Survey (AHS) data demonstrated that while there is a good overall 'simple coverage' of institutional delivery (ID) services, the coverage of 'effective institutional delivery' (meaning ID with access to Emergency Obstetric Care) is actually very poor. Further, the study found that the association between reduced Maternal Mortality Ratio and effective ID coverage was stronger than with simple ID coverage, suggesting that it is effective coverage and not just simple coverage which is required to make a dent in the MMR⁴. As a result, even though there has been an increase in institutional deliveries, this has not translated into a reduction in MMR. Moreover, the large number of home deliveries that continue to take place, remain out of the purview of the health system.

2. Recent studies point to the fact that there is no significant relationship between the rise in institutional deliveries and reduction in MMR. See, for instance, Bharat Randive et al (2013).
3. Studies in various parts of the country have highlighted this gap in maternal health care services. In UP for instance, one study found that only 17% of PHCs and 17% of CHCs were equipped to provide basic and comprehensive emergency obstetric care respectively. (Varma D et al 2010). Lack of access to blood transfusion facilities has been reported to be a challenge as well. In the states of Maharashtra and Chhattisgarh, all the district hospitals included in the survey had blood banks. Jharkhand fared the worst, with only 2 of the 6 District Hospitals surveyed having blood banks. (IIPS, 2010)
4. DeCosta A et.al (2013) Effective coverage of institutional deliveries under the JSY programme in high maternal mortality provinces of India: analysis of data from an annual health survey, Lancet 2013.

Exclusion of tribals from Maternal Health Schemes and Services

Among tribal communities, maternal health indicators are significantly lower. According to UNICEF (MAPEDIR, 2009⁵), 24 percent of reported maternal deaths were from schedule tribes which form only 8 percent of the population. In terms of maternal health services received by women, the NFHS-3 shows that, while nearly 48 percent women from 'other caste' category delivered with the help of a skilled birth attendant, the percentage was as low as 25 percent for schedule tribe women. Schedule tribe women also have the least likelihood of post natal check-up amongst all social groups. In states such as Orissa, Madhya Pradesh, Chhattisgarh and Jharkhand, which have a high proportion of tribal populations, there is a significant difference in these indicators between tribals and other groups⁶. It is worthwhile to note that despite the gross inequities evident in these large surveys, recent surveys such as the Annual Health Survey, carried out precisely to monitor progress on important indicators do not disaggregate data by caste and tribe. This makes it difficult to understand how the ambitious schemes of the Government of India to address maternal health have fared vis a vis bridging inequities.

However, some evidence of inequities is apparent from small, localized studies. Evidence shows that the availability of maternal health services in districts with concentrated tribal populations is poor. For instance, an investigation of maternal deaths in Barwani, Madhya Pradesh,⁷ which has 67% tribal population, found an absence of antenatal care (despite high prevalence of anaemia), lack of skilled birth attendants and poor emergency obstetric care. Primary and Community Health Centres, were not even capable of managing uncomplicated deliveries. Even at the level of the district hospital, there were no skilled birth attendants available for deliveries, let alone management of complications. The investigation also found that a high proportion of maternal deaths were among tribal women.

The implementation of JSY too has not been uniform. Studies from various states have shown women from Scheduled Tribes tend to be neglected. Even in the well-developed state of Karnataka, it was found that the JSY did increase numbers of women who were accessing antenatal care and delivering in hospitals. However, large disparities were found in uptake of these services among different castes. Mothers belonging to general castes were almost twice as likely to have an institutional birth as compared to those belonging to scheduled castes and tribes⁸. Another study assessing impact of JSY in Uttar Pradesh⁹ found that a larger proportion of women who had not received any ANC check-ups or had received less than three ANC check-ups often were from scheduled castes/tribes, minority religious groups, non-literate, residing in remote villages or hamlets of large villages and had not been contacted by an ASHA. Studies have also documented

5. UNICEF, MAPEDIR Fact Sheet, Maternal and Perinatal Death Inquiry and Response 2009, at: www.unicef.org/media/files/India_Mapedir_fact_sheet.doc

6. In Orissa, for instance, only 20.8 percent of women delivery in institutions as compared to 44 percent in the state. Similarly in Madhya Pradesh, only 28 percent of women deliver in institutions as compared to 47 percent for the state. In Chhattisgarh, only 10 percent of tribal women delivery in institutions as compared to 47 percent of women from 'other castes'. Because the tribal population of the state is very high, the average proportion of institutional deliveries is as low as 18 percent.

7. Subha Sri B et al. An Investigation of maternal deaths in a tribal district in Madhya Pradesh. *Reproductive Health Matters* 2012; 20(39):11-20.

8. Balasubramaniam and Santhi (2011) How does NRHM help tribal women? A study of Financial incentives for maternal health services in Heggadadevanakote taluk, Mysore district, Karnataka. *Rapid Assessment Studies of Health Programmes Implementation in India*.

9. M. E. Khan, Avishek Hazra, Isha Bhatnagar (2010) Impact of JananiSurakshaYojana on selected family health behaviours in rural Uttar Pradesh. *Journal of Family Welfare*, Vol. 56, Special Issue - 2010.

that awareness about financial entitlements under JSY is low among tribal women. Even when aware, the lack of documents establishing eligibility is a barrier in accessing financial entitlements¹⁰.

Cultural Appropriateness of Maternal Health Services

One of the reasons for the failure of maternal health schemes in reaching tribal populations is that, although ambitious, they have been influenced by various international agencies and do not necessarily emerge from a local contextual understanding. For one, the services are physically inaccessible and women have to travel long distances to reach them. There is also the question of cost of treatment that deter impoverished tribals, as well as other associated costs like transport and loss of wages.

The perception fostered by the JSY scheme is that women who do not come to institutions for delivery are ill-informed, uneducated and therefore unwilling to seek medical services. However, the fact that maternal health services provided by the government do not make efforts to integrate contextual realities or cultural practices of these communities has not been taken into account. The maternal health services that are being provided by the government are heavily focused on modern medical practices, administered by health personnel, in clinics or other sites designated by the government. These practices and services, likely, are not in tune with the health beliefs and practices of tribal communities and are alien to their way of life.

A recent study among tribals in Jharkhand, found a range of problems that adivasis faced in accessing maternal health services. The study finds that traditionally, pregnancy and child birth are not considered events that require significant medical intervention in the community. Yet, contrary to popular perception, tribal women are not 'resistant' to seeking health care from the formal system. They do follow their own customs, but have also made an effort to utilize some of the maternal health services and schemes. Yet, the poor quality of care in health institutions, the attitude of health care providers, and informal payments deter them from accessing services. The findings of the study make a compelling case for addressing the specific concerns of tribal populations, including instilling a respect for local customs into the formal health system.¹¹

Different cultures assign different meanings to health, illness, childbirth, healing practices and providers of healing services. The perception of emergency and management of complications is also varied. This understanding must inform health programs, which is not the case today. There is little value, therefore, in trying to merely push women to seek maternal health services from institutions. Instead, it would be useful to try and understand what their specific health beliefs and practices related to childbirth are, and tailor health programs so that they are integrated into the existing systems in these communities. Specific anxieties of women from tribal communities, vis-à-vis the existing health system, must also be acknowledged and addressed while designing maternal health programs.

10. Balasubramaniam and Santhi (2011) How does NRHM help tribal women? A study of Financial incentives for maternal health services in Heggadadevanakote taluk, Mysore district, Karnataka. Rapid Assessment Studies of Health Programmes Implementation in India.
11. Priya John (2013) Accessibility to maternal health care in a Paharia and Santhal village in Sundarpahari, Godda district, Jharkhand. Maternal health task force, international institute of education, Indian institute of health management research. Unpublished.

II. RATIONALE FOR THIS STUDY

In the year 2014, NAMHHR conducted a Fact-Finding in Godda District of Jharkhand, as there was high reporting of maternal deaths in the tribal dominated blocks of the district. The Fact-Finding found significant gaps in the health system response to maternal health, especially the lack of services to handle complications. It also found that a large proportion of women do not go to health institutions at all, and choose instead to deliver at home. One of the recommendations of the Fact-Finding report about Godda¹² was to undertake a systematic investigation of how home deliveries are managed and the range of traditional practices that are employed. Therefore it was decided to undertake a study that explores the practices that tribal communities undertake in the pre, post and intra natal period, traditional sources of nutrition, the role of traditional health providers, the ways of detecting and managing complications, the manner in which tribal communities interact with the formal health system and where there is a mismatch with the design of the formal government system. The study was situated in Odisha which has a significant tribal population (22 percent of the population of Odisha belongs to Scheduled Tribes and close to 10% of STs in India reside in Odisha). Odisha is also one of the Empowered Action Group (EAG) states and is a High Focus state for improving Maternal Health. The state has poor maternal health indicators. Its Maternal Mortality Ratio (MMR) is 230 deaths per 100,000 births as compared to India's 178 deaths. The MMR is higher at 245 in the Southern Division which has the maximum tribal dominated districts. According to UNICEF (MAPEDIR 2009), 67 percent of maternal deaths across 8 districts of Odisha (Koraput, Rayagada, Malkangiri, Nawarangpur, Kalahandi, Nuapada, Bolangir, Sonepur) were of tribal women.⁵ Analysis of data on maternal health from large surveys shows that tribal women in Odisha are significantly disadvantaged as compared to other groups. One such analysis found that tribal women are 2.5 times more likely to bear a child by age 19 years, and 2.7 times more likely to have more than four children. Tribal mothers were reported to be 1.3 times more likely to be underweight and anemic and were 4 times more likely to never/occasionally consume milk/curd or pulse/beans. Tribal children of Odisha were 2.6 times less to receive any vaccination, 1.4 times more anemic, 1.6 times more underweight and had 1.3 and 1.8 times higher risk of infant and under five mortality compared to non-tribal children.¹³

Objectives:

Given this background, the current study sought to understand maternal health practices of a tribal community in Odisha. Specific objectives of the study were to understand:

1. Perceptions of what constitutes pregnancy care in prenatal, post natal periods and childbirth; Perceptions of complications in pregnancy.
2. Normative practices during pregnancy, delivery, post-partum period and for new born care both in non- emergency and emergency situations.
3. Perceptions about and experiences with the public health systems and formal medical systems.

The objective of such an exploration was to provide recommendations for formulating policy related to maternal health of tribal communities.

12. NAMHHR and Torang Trust (2014) Maternal Health and Nutrition in Tribal Areas Report of the Fact-Finding Mission to Godda, Jharkhand

13. Agarwal S (2013) Disadvantageous situation of tribal women and children of Orissa, india: a special reference to their health and nutritional status. Journal of Community Nutrition & Health, Vol.2, Issue 1, 2013, 3-14.

III. METHODOLOGY



The study was exploratory in nature and employed qualitative methods. An Ethnographic approach was used to understand the culture, practices and perspectives around maternal health in the community. The field area comprised primarily of 9 villages in Korpa GP in Kalyanasinghpur Block of Rayagada district in Odisha. Fieldwork was conducted between the months of December 2014 to April 2015.

A researcher was stationed in the field for a total of one month and used various methods of data collection. The study was carried out in collaboration with PRADAN (Professional Assistance for Development Action), a non-profit organisation that works with SHGs in the area, on developing locally suitable economic activities, mobilizing finances and introducing systems to improve livelihoods. It was only with PRADAN's assistance and existing rapport in the field that the field work was made possible. In-depth interviews were carried out with recently delivered women - home deliveries (10) and institutional deliveries (5) - and currently pregnant women - (7). These included two cases of maternal deaths from neighbouring panchayats (Sikarpai and Budaguda). The ages of the women varied from 16 to 30 years of age. In addition to this, informal discussions were carried out with women in the villages along with others such as the Dishari and Guru. Key informant interviews were conducted with formal Service providers - 2 ASHA, 2 AWW, 2 ANM, one Maa Ghar co-ordinator - and two former Dais.

The researcher also spent time conducting participant observations, including observation of VNHDs, and observation of deliveries in the CHC and District Hospital. A total of two VHNDs were observed. 12 deliveries of ST women were observed and documented in detail (10 in the CHC and 2 in the District Hospital). The deliveries observed at the health facilities were of tribal women from all over Kalyansinghpur block; only one of them was from Korpa Gram Panchayat (although not from our study villages).

IV. DESCRIPTION OF THE AREA

This study was situated in Kalyansinghpur block of Rayagada district in Odisha. Rayagada district is a mineral rich district in the southern part of Odisha. It was carved out of Koraput district in 1992. It shares a border with Andhra Pradesh and used to be a part of the Vijayanagram empire which forms modern day Andhra Pradesh. The district is highly forested. It consists of 63% forest cover, 16% of which are reserved forests.¹⁴ STs account for as much as 56% of the population of Rayagada. There are mainly two tribes who live in this area - the Kondhas and the Sauras. The Kondhs are of two types - the ones who live in the hills (Dongaria Kondh, a PVTG tribe) and the plain Kondhs who reside in the low land. (Our study is situated among the latter)¹⁵

In terms of development indicators, Rayagada district is one of the most deprived districts in Odisha. It is one of the 19 districts receiving funds from the BRGF program. Less than half of the population is literate. In terms of maternal health indicators, Rayagada fares worse than the rest of Odisha. It belongs to the southern division of the state which has an MMR of 245 (greater than 230 for all of Odisha). The proportion of women receiving full ANC in Rayagada is lower than that for Odisha, and the proportion of home deliveries is also higher in the district. (*Table 1*)

Our study is situated in Kalyansinghpur, in the northern region of Rayagada district, bordering Kalahandi. The block has a population of about 59,334 of which 71% is tribal, belonging to the Kondha tribe. The block has a literacy rate of merely 24 percent, and is one of the poorest blocks in the district. Much like the rest of Rayagada, the area is rich in bauxite. The famous Niyamgiri hill, which the local Dongaria Kondh tribal community (a PVTG tribe) has fiercely protested against acquisition by Vedanta, is located in this block. The hill has spiritual value for the people and they depend on it for livelihood, produce and herbs.¹⁴

For the purpose of convenience, we concentrated the study on the gram panchayat of Korpa (population 4663). This GP was selected as a field site because it had both accessible and inaccessible areas. That is, there were some villages that were well connected by roads, and others that were completely cut off. This provided us an opportunity to explore the differences in birthing customs and utilization of formal maternal health services, based on relative isolation of the village.

We concentrated our fieldwork on nine villages belonging to Korpa Gram Panchayat (marked with red circles in the map in Annexure 1). The decision to choose these villages was based on the fact that they were predominantly tribal and had had deliveries in the past one year. The sample was based on convenience. Of the nine villages, four were easily accessible, connected by all weather roads. Five (Lelingpadar, Ranipadar, Sadalas, Dimripadar and Muktukuni) were isolated. Lelingpadar, Ranipadar and Sadalas were located in the hills and did not have any all weather roads. Dumripadar was not in the hills but the route had a small stream and no all weather road. Muktukuni did, but people had to walk at least 5 kms to be able to get a vehicle.

The isolated villages were more deprived than the accessible ones, in terms of amenities. While

14. Soumik Banerjee (2013) Field Visit Report on villages visited at Kalyansinghpur block, Rayagada District-Odisha, PRADAN.

15. Although not inhabited by Dongaria Kondh, some of the villages in our field area are isolated and located high up in the hills.

villages with more accessibility had hand pumps for water, the isolated ones depended on river streams. However, no matter how isolated, PDS would reach all villages. In villages like Ranipadar and Lelingpadar, people walked close to 7 kms and 15 kms respectively, crossing hills and streams and carried PDS from the Gram Panchayat.

Table 1: Key Maternal Health Indicators, Odisha and District Rayagada

Maternal Health Services		
ANC	ODISHA	RAYGADA
Mothers who received any ANC	98	98.2
Mothers who received ANC in 1st trimester	71.4	51.9*
At least 1 TT	97.6	97.8
Mothers who consumes IFA for 100 days or more	31.2	39.9
BP checked	85.7	86.5
Blood taken for Hb	70.4	71.5
3or more ANC	81.9	75.7
Full ANC	27.8	33.6
Delivery	ODISHA	RAYGADA
Institutional delivery	80.8	62.3
Delivery at govt institution	70.8	53.7
Delivery at home	18.7	37.7**
Home delivery by health personnel	24.5	12.5
Safe delivery	83.7	64.8
PNC	ODISHA	RAYGADA
Received PNC within 48hrs of delivery	82.8	69.1
Within 1 week of delivery	86.5	79.3
No PNC	12.1	15.5
Other indicator		
MMR	230	245***
Women aged 15-19 yrs who were already mothers or pregnant at the time of survey	43.4	34.9
Early marriage(girls)	4.4	8.4
Early marriage(boys)	6.1	12.4

Source: AHS 2012-13

*lowest among all districts in Odisha

**Fourth highest among the districts

***MMR of Southern division of which Raygada is a part

V. PROFILE OF WOMEN IN THE STUDY



Age and Parity

The ages of women in the study ranged from 16-30 years. Early child bearing appears to be a common trend in the community. Women who were delivering for the first time were between the ages of 16-20 years. It is worthwhile to note that women did not accurately recall their own ages but instead mentioned approximate ages. One of the primis who said she was 18 actually looked no more than 15. It also appears that most women end up having 4-5 children. The oldest woman in our sample, one who was 30 years of age, had 8 children. Another who was 28 had 5 children. Both - the low age at first pregnancy - and multiparity, indicate the vulnerability of the women *vis a vis* maternal health.

Occupation

Farming is the main occupation of people in this region, which mostly consists of reserved forests. Most families are landless despite provisions of the Forest Rights Act.¹⁶ They practice shifting

16. Villagers in Lelingpadar mentioned that the government had done surveys of the land but they had still not received their 'patta'. As per another report from this area, some households have reported taking loans to bribe the Revenue Inspector for land titles but to no avail.

cultivation or work as agricultural labourers or wage labourers. The grains grown include finger millet, pigeon pea, black gram, etc. also maize and mustard. The mustard is taken down to the plains and converted into mustard oil which the villagers sell. Apart from this non-timber forest produce especially *Siali* leaves¹⁷ are a source of income.

Family Structure and Status of Women

Kondha society is patrilineal and patrilocal, and women are usually married from a different village. Formal marriage is not a prerequisite for staying together, although most of the women in our study had been through a marriage ceremony. Polygamy is very common with men having upto 3 or 4 wives and several children. Each wife however has her own home. Nuclear families are the norm, but in-laws (husband's parents) stay close by and are a source of support especially during delivery and child care. In cases where there is discord between the couple and the in-laws, support during delivery and child care is provided by an aunt or by someone from the natal family of the woman.

Women in the community participate actively in labour both in the household as well as outside the home. Tending to fields, rearing animals, selling produce is all carried out by women in addition to housekeeping, fetching water and firewood, cooking, child care and so on. This is often strenuous work and involves walking and climbing for long hours at a stretch, which women continue to do even in pregnancy.

Yet, despite women's contribution to paid and unpaid work, the status of women in the community remains low, which was reflected in various ways. Decision making regarding major issues like seeking health care and large expenditures rests with men. During fieldwork we also noticed that women do not generally sit on an elevated structure in the presence of men, (especially married women who have come from another village). Right to custody of the child also was the prerogative of the man; in case the husband and wife separated, the custody of children remained with the man and not with the woman.

Apart from this, other mainstream taboos around menstruation were strongly entrenched. Every month during the menstrual period, women stayed outside the house or in a secluded space and were not allowed to touch anything, nor were they allowed to take part in household chores. Usually, tribal culture is said to be less patriarchal than mainstream Hindu culture, but in this case it is unclear whether these practices were traditional Kondh practices or imbibed in the process of 'mainstreaming' with Hindu culture. All the same, awareness of this background is relevant in the context of maternal health, to understand women's relative status and access to resources.

17. Leaves of the *Shorea robusta* plant which are stitched together and made into plates. The sale of these plates is a major source of income for tribals.

VI. HEALTH FACILITIES IN THE FIELD AREA



Eighteen sub-centers, three PHCs and one CHC comprise of the health infrastructure available in Kalyanasinghpur block. Our field area, Korpa Gram Panchayat, is serviced by one sub-center (in Tikra) and one PHC (Badatarada). The sub-center is absolutely inactive and infact shut. The ANM who should be residing at the sub-center are not stationed there but instead roam around the 15 villages in the catchment area for VHND and other services. The PHC is staffed by an ANM and a pharmacist. The PHC provides treatment for small medical problems such as fever, malaria, flu, small trauma etc. However it is not accessed by many people. Most people depend on unqualified informal local practitioners and other traditional practitioners for routine health problems.

The closest delivery point is a CHC with nine beds. It is staffed by one Medical Officer (on deputation), an AYUSH doctor, ANM, LHV, Pharmacist, three laboratory technicians (Malaria, RNTCP, Pathology), and two attendants. There is no supply of blood and no specialist, so only normal deliveries are managed here. Between April 2014 to March 2015, 1081 deliveries were conducted by the CHC. Although the CHC has sufficient staff, deliveries are routinely carried out by the ANM and LHV only.

In terms of physical condition, there is much lacking in the CHC. There is a dearth of water in the bathrooms and women have reported staying for 3-4 days at a stretch avoiding use of the bathroom. Electricity at the CHC is also erratic and in the warmer months, women often move from the beds to the verandah outside to escape the heat. The condition of the labour room and ward is evident from the fieldnotes below:

“ Yesterday night when I reached the hospital and visited the labour room, the condition was just awful. The table was not cleaned and blood was spread all over where the woman was lying. In the ward, the patients were lying on dirty beds without bedsheet. The ASHA asked me to look at the condition of the labour room. Because of the foul smell of dry blood, and other fluids in the labour room, the ASHA roamed around carrying an empty perfume bottle in her hand! (Researcher's field notes)

”

In the ten days that we observed cases at the CHC, out of 23 cases of delivery, three were referred to the District Hospital (DH) for complications and one was referred because of 'staff shortage'.¹⁸ Cases referred were those who were severely anaemic, had other obstructed labour or eclampsia. If cases cannot be handled by the District Hospital, they are referred to Bissam-Cuttack hospital. These referrals are by the government ambulance. The district hospital is reported to be perennially crowded. Because of this, women do not stay for very long after delivery. In two cases that we observed, who were referred to the DH because they had very low haemoglobin, they were discharged on the very next day following delivery. Moreover, no ambulance service was available to take the women back to their homes. The district hospital has an attached blood bank run by the Red Cross, which is sufficient for its need. One pint of blood costs Rs. 300 but this cost is covered by JSSK. Only if plasma is required, the woman has to be referred to another blood bank in the medical college. The one investigation that all women are referred outside for is sonography. Although a sonography machine was available, there was no technician to manage it so it was lying unused and women had to get the investigation done from outside.

'Informal' and 'Traditional' Service Providers

Throughout the fieldwork, it was evident that a range of traditional healers and informal providers were consulted by the community, for various health issues and also during pregnancy. For routine illnesses, two local informal providers in the area were consulted. They administered allopathic medicines. As regards pregnancy and childbirth, we were told that the informal providers do not provide any services at all. This is surprising considering the fact that the community does access their services for other illnesses. However, they insisted that they do not deal with pregnant women. This information, however, needs to be interpreted in light of the fact that, the former collector had passed a circular forbidding informal providers from providing any services to pregnant women, perhaps with the purpose of averting harm to the women. However, there was a case (discussed in detail later) of a woman who died who did receive some treatment from the informal provider, suggesting that in times of need women do contact them. There seems to be a great deal of silence around the role of the informal provider, however, and this could be attributed to the circular from the collector. In terms of traditional healers, there is the '*guru*' and the '*dishari*' who are known to be both 'healers' as well as 'sorcerers'. In pregnancy and childbirth, however, their role is limited; the dishari's only role

18. When we enquired with the LHV we were told that this woman was uncooperative and did not want to lie down. The staff did not have time to deal with her so she was sent off to the DH. She was an SC woman.

is to name the child, while the guru is sometimes consulted in case of an illness during pregnancy and may dispense herbs to cure it.

The more important player in childbirth is the 'Bejini' or the sorcerer of the village and the *Dai* (midwife, whose role is discussed in detail in Section IX). The *Bejini* is usually a single woman, sometimes a widow living in the village. She is considered to have 'black magic' powers. The *Bejini* is consulted in the antenatal period to predict the '*doomba*' (ghost) of the baby and such a prediction is said to be indicative of whether a complication is likely to occur. The *Bejini* is consulted routinely in the village for health problems. She usually accepts an animal sacrifice (usually a hen) and conducts a puja to heal or avert a disease. The frontline providers considered the *Bejini* and *Guru* to be negative influencers of women's health. We heard stories recounted by the AWW and ANM about situations where, villagers had refused to take services on the advice of a traditional provider:



“Yesterday a child came for immunization at Korpa but his father did not let me give him the vaccine. He said the child is very weak. His waist is not strong enough and so he cannot stand. I tried to explain to him that the child is too small to stand. He told me that the *Gunia* had told him it is because of *dumba* the child becomes weak, so I should stop his immunization for next month. He took the child to the *Gunia* to cure him. (Interview with ANM).”

These narratives depict that the power of the *Bejini* and other traditional providers in the village is great and their word can influence people's decision to seek care from the formal health system. Yet, by and large, women do access a combination of services - traditional as well as formal - and they see no contradictions in this. In fact, one *Dai* reported that she herself had asked a pregnant woman who had a complicated pregnancy to go to the hospital. In that sense, traditional providers do not necessarily serve as a barrier to seeking formal services.

Relationship between outreach Workers and Community

In the project area, there was one ASHA who was responsible for taking care of 3-4 villages. The ASHA only monitored women in those villages that were accessible. Because the hamlets were located far from each other, she could not reach all the villages that she was in charge of herself. Moreover, the ASHAs received no remuneration for expenses incurred during travel (like food or vehicle expenses). The ASHAs had to accompany women to the health facility many times in some cases and there was no benefit for them in this. Thus, they restricted their activity to hamlets in which they lived and others that were close by. The villages where the ASHA did not go, were completely

out of the purview of all outreach services. Three villages out of the nine villages in the study area were of this nature, where no health services reached at all, but women from these villages did travel to VHND being organized in nearby villages when possible.

An additional complication was the caste of the ASHA. While the communities are tribal, the ASHAs in all the villages belonged to scheduled castes. This may have to do with the fact that they are better educated and are fluent in Odia (the tribals speak a language called Kui). However, the Tribals consider SCs to be untouchables; while tribal women are allowed to go to SC households, SCs are not allowed into tribal households. This creates a further barrier for the ASHA to reach out to the community. Outreach workers on their part also harboured biases towards tribal people. They considered them dirty and illiterate. One of the Anganwadi workers mentioned how women don't bathe regularly or cut their nails.

On the part of the outreach workers like ASHA and ANM, reaching out to every single woman was a priority. Maternal deaths are a big concern in the health system and no ANM wants a death in her area. In order to get women to come to the VHND, ANMs and AWWs at the local level have instituted their own 'conditionalities'. As one AWW said *"We tell them that if they do not come, they will not get their take home ration, or they will not get the MAMATA installment. We know this is not true, but they believe us. What can we do, we will be in trouble if they don't come"*. Moreover, the ANM informed us and the BPO confirmed that an additional conditionality had been imposed on the ASHAs to ensure that they identify the women in time - if women were not registered for ANC in the first five months, the ASHA would not get her incentive.

VII. BIRTHING IN THE STUDY AREA

In our study area, there were 70 deliveries recorded in one year preceding the study and 26 of those (close to 40%) occurred in the home (source: ANM records). This figure however is probably an underestimate of the actual proportion of home deliveries. We noted during field work, that not all deliveries that were recorded as 'institutional delivery' were necessarily conducted in the institution. Several women who actually delivered at home were later taken to the institution and recorded as institutional deliveries. Others delivered on the way because the ambulance took too long to arrive. In both cases, the ASHA reported that this was done so that the woman could avail of the incentive. Significantly, none of the deliveries at home were attended by a skilled birth attendant because the ANM was serving 15 villages and could not possibly be available for each delivery. In some villages, the ASHA was present but did not attend to home deliveries at all. Her only job was to call the ambulance, and take the woman to the institution.

It was interesting to note that home deliveries took place, both in villages that were well connected by roads, as well as those that were far flung and had no connectivity. In more isolated villages such as Lelingpadar and Dumripadar, all deliveries took place in the home.¹⁹ In the more well connected villages like Iripur, most deliveries occurred in the institution, but some still occurred at home, despite the ease of geographical access. This suggests that it is not just geographical isolation that prevents women from utilizing the formal health system for delivery care.

The outreach workers acknowledged that it was difficult to get women to come for institutional deliveries. They genuinely believed that they were working for the benefit of the woman by making her go to the institution, but women were resistant. The following case study narrated by an Anganwadi worker illustrates this impression of the health workers. It is also an example of how women who deliver at home eventually end up being recorded as institutional deliveries:

“She was not interested in going to medical for delivery. We are Adivasi people, we don't want to go outside and other male member shouldn't touch us. I told her we are all present for your benefit why shouldn't you listen to us? Both mother and baby will be safe in medical. When she was not convinced I also convinced to her husband. If anything happens the family will suffer. I convinced them and was feeling very happy. But unnecessarily she delivered at home. From morning her labor pain started but without informing anybody she went to field for work. Only after she came back home she called me and asked me to contact the ASHA for the vehicle. In the meantime she delivered the baby before the vehicle reached the village. Thankfully her family agreed to visit the hospital and the cord was cut there. She received the Rs.1400/- for institutional delivery. Many times if before vehicle reached after they delivered, they refuse to visit the hospital. What's wrong with it, they can get treatment, child immunization and the cash benefit. (Interview with AWW) ”

Through interviews with women who had delivered at home, as well as observations, we were able to understand the traditional practices that women followed during various stages of pregnancy. In this section, we describe in detail the practices in the antenatal period, during delivery and the post natal period.

19. While we were not able to get exact figures for number of deliveries in each village, this data is based on group discussions with women in these villages.

VIII. PRACTICES IN THE ANTENATAL PERIOD



Traditional Practices

It is significant to note that women do not necessarily do anything special in the antenatal period. Our questions enquiring about practices during the antenatal period were met with querulous responses such as '*why should she do anything special?*' Discussions with women revealed that pregnancy was treated as a natural process, something that women had been doing for generations. It did not require any special treatment. As one woman who had delivered five children at home remarked "*A woman must continue living her life normally when she is pregnant. Women who work and remain fit always have an easy delivery.*"

The one ritual that was reported during the antenatal period, was related to ascertaining the '*doomba*' or ghost of the fetus. It is believed that the *doomba* of a forefather is reborn and inhabits the fetus. In order to find out whose *doomba* inhabits the womb, women go to a *Bejini* who is able to ascertain this. If the *doomba* is that of someone who the woman or her family had a conflict with, it could lead to a difficult pregnancy and delivery. In order to avert this possibility, and save the woman and fetus from harm, the *Bejini* conducts a ceremony (by giving her a hen as sacrifice) which propitiates the *doomba*. By doing this, it is believed that the pregnancy and delivery will be easy. Similarly, if a pregnant woman or her new born child falls ill, it is believed that the *doomba* is angry and the *Bejini* is called upon to propitiate the *doomba*.

Nutrition and Rest during Pregnancy

No special foods or restrictions are exercised by women during pregnancy. Although women know that they should not be carrying heavy loads during pregnancy, a lot of the work involves strenuous labour which cannot be avoided, as the family's livelihood depends on it. Women work till the last hour, until they go into labour. A lot of women who had delivered in the home, reported this to be one of the most important considerations in choosing to deliver at home. Going to the institution, they said, required them to take out time for travel and stay at the health facility after delivery. Not just the woman, but her family members too had to take this time out of work for the delivery. This was not affordable for everyone. Moreover, as mentioned before, continuing to work during pregnancy was considered important and said to make the delivery easier. It was also considered to be better for the baby. As one mother-in-law of a woman remarked *"If the woman doesn't keep working, the baby will become still. The child that is born will also be dull."*

In terms of nutrition, women ate two meals a day consisting of rice, *sattu* or watery *ragi kheer*. Women were also aware that they should be eating greens (not just in pregnancy but also otherwise), but they had no access to vegetables at all. In the more remote areas such as Lelingpadar, the women still consumed forest produce as that was the only thing available to them, however in the other areas, vegetables and especially greens were difficult to come by. The traditional diet consisted of millets but now, most women only have *sattu* and rice which is provided by the ICDS and PDS. This new diet is far lesser in nutritive value than millets. Some families still did grow millets, but not in a very large quantity and hence they could only afford to have watery *ragi kheer*. The lack of rest and continued strenuous labour like carrying heavy loads and pounding grains coupled with poor nutrition in pregnancy is bound to have an adverse effect on women's health during pregnancy and delivery.

Sickness During Pregnancy

Common illnesses in pregnancy were reported to be malaria, cough and cold. Women seek medicines in the form of herbs from the local guru or medicines from the informal practitioner and they also go to the *Bejini* for '*puchuna*' (a ceremony which involves sacrificing a hen or goat). Illness during pregnancy is considered a sign of "revenge of the soul which is in mother's womb for the wrong done by the pregnant lady". A few women also go to the PHC for medicines although this is not common. Taking herbs during pregnancy is not common practice. It is believed that taking herbs in this period can cause harm to the fetus. Women also reported other problems like swelling of feet during pregnancy. However, these were not perceived to be of much importance and no special attention was paid to them.

Outreach by the Formal Health System for Antenatal Care

Maternal Health entitlements through the formal health system include three antenatal check ups which includes a range of services, to prepare the woman for childbirth, identify complications and monitor her health. In the villages, these were provided at a village health and nutrition day (VHND) which was held at four locations in the study area. One of the important things that we noted was that women used a combination of formal and traditional health systems during pregnancy. Despite the fact that a large number of deliveries took place at home, it was interesting to note that many of the women who had delivered at home had also sought antenatal care from the formal medical system.

All ANC services are provided by the ANM at the VHND. In the villages that had a VHND close by, most women had gone for at least one antenatal check up. Women from L, D and S, had not received ANC check-ups and did not have MCP cards either. These villages are isolated ones which have no ASHA, Anganwadi center or any other government services. Almost all other women had an MCP card, some reported having paid 25 rupees to get a Xeroxed MCP card because the original ones were not available. ASHAs were expected to motivate women to come for the VHND. However they themselves were not aware of all the entitlements and incentives that women should receive.



Almost all women reported receiving IFA tablets, having an abdominal check up, haemoglobin test and BP test. Observations at the VHND validated this information. The counseling component however, was weak. None of the women really understood what was being done in the ANC. Several times, they would not follow advice that was given in the VHND. For instance, although IFA tablets were being provided and almost every woman reported receiving them, none of the women had taken a full course. Part of the reason for this was that traditionally, no herbs were supposed to be taken during pregnancy, and so women did not consider it necessary. One woman reported that she had experienced vomiting after taking the IFA tablet and so she discontinued it. Women considered it a waste of time to go to the VHND and it was something that they did because the ASHA instructed them to. The monetary incentive through the MAMATA scheme, was also a big factor influencing women to seek ANC services.

Women also did not give much importance to birth planning and preparedness and neither was this reinforced in the ANC. Many women were not aware of when they should inform the ASHA. They were not told what to carry with them when they went to the hospital. There was no concept of an 'expected date of delivery'. Many women laughed when we asked them when they were due. They said '*how can we predict when the baby will be born? It will be born when it is time*'. There was also a belief that complications and death, if they have to occur, will occur anyway and nothing can really be done to stop them apart from allaying the *doomba*. Therefore, the need for identification of 'high risk' women or birth planning was not something that women were able to appreciate and the interaction with outreach workers also did not address this. Thus, although the inputs of ANC is good, there seems to be a gap between the intended purpose of ANC, and how the women understand it, which could be overcome if the counseling component of ANC is strengthened.

IX. DURING DELIVERY



Traditional Practices during Delivery

The entire process of delivery, as perceived by women is natural, requiring no intervention at all. The delivery is attended to by a close family member, usually the mother in law or another elderly woman in the household. We were told that Dais did exist but they have not been practicing for a very long time. Some of the villages do have a dai but she is very old and there are no younger dais anymore. We spoke to only two such women who had been Dais but were no longer assisting deliveries.

The process of delivery is said to be 'impure' and so delivery takes place outside the home, in the open. It takes place in a squatting position but women are allowed to walk around. Generally, no herbs are given during this time. However one dai reported that the root of the apamaranga plant may be used to reduce the pain during delivery. After delivery, the placenta is buried in a pit. Some sticks are kept over the pit and then the woman bathes over the pit to wash away all the impurity. Then the pit is filled up. This is done by a close family member or the woman herself. The purpose of this ritual, as reported by women, is to protect the baby. If the placenta is left out in the open it is likely that it would be eaten by animals and this could bring harm to the fetus. In order to avoid this, the placenta is buried.

Perception of complication: The delivery is perceived to be complicated if the labour goes on for more than 12 hours, or if there is a lot of bleeding following the delivery. In this situation, the woman is taken to the CHC. The ambulance is called by contacting the ASHA, but sometimes a private vehicle may also be taken. In case of prolonged labour, a jadibooti (herb) is tied into her hair or given orally (only one Dai reported giving something orally for this purpose). The same is done for retained

placenta. In case of retained placenta, the woman is asked to bite on a stick and blow as this is said to aid delivery of the placenta. These were some of the traditional methods of dealing with complications, that the women recounted.

Women's experience of Institutional Delivery

In order to understand women's experiences with ID, we observed twelve women who had come to the health facility and interviewed five others in the study area. Below we describe the barriers faced by women and their perceptions of formal health facilities.

Barrier of Distance and Poor Transport Services

One of the major problems faced by women who went for institutional deliveries was the isolation of many villages, which were accessible only by foot. So, women had to be brought quite a distance till a motorable road, in order to reach the ambulance.

“*Lelingpadar is an isolated village in Korpa GP with no government services at all. There is no ASHA or AWW situated in the village, nor do they visit. All deliveries in Lelingpadar occur at home. The reason for this is quite obvious, considering the long and difficult journey that a woman would have to undertake to get from the village to the CHC. A woman from Lelingpadar would first have to climb down for about 6 kms in a very hilly terrain crossing four streams, to a village called Sadalas. From here she would need to walk downhill about 5 kms to Ranipadar and then another 1.5-2 km to Ajaygarh, after crossing two streams. For this entire journey there is no road. From Ajaygarh to Iripur there is a kacha road of about 2.5-3 km. Only once the woman reaches Iripur does she have access to an all weather motorable road where an ambulance can be reached to get to the CHC which is located about 12 km away. The entire journey takes around 6 hours. (Researcher's fieldnotes)*”

Although a free and dedicated ambulance service has been provided by the government, availability of a vehicle for transport to the health facility was reported as a major problem. by almost everyone - respondents, families and services providers. To begin with, most villages had very poor cell phone connectivity. When they were able to get connectivity, the 102 emergency helpline for ambulances was perpetually busy. At night especially, we were informed that the ambulances could never be reached. Even when ambulance was contacted, it could take as long as 3-4 hours for it to reach the village. In case of isolated villages, ambulances refused outright. Of the 12 women who we observed at the CHC, 4 of those who had come from far off distances had not been able to come by ambulance. The ASHA stated that in the past, the Janani Express was quite efficient and did come on time. But since 102 (a dedicated ambulance service for pregnant women) has been implemented, it is quite erratic and not easily reachable. In one case, out of desperation, a woman's family called another ambulance 108 (which is not meant for pregnant women) and said that she has malaria and needs to urgently get to the hospital, in order to get access to an ambulance.

If a government ambulance could not be reached, women would proceed to deliver at home or 'on the way' and later go to the institution to 'register' as an institutional delivery and avail the incentive, or if there was an emergency and they could collect some money, they would hire a private vehicle at a very high cost. One family reported spending almost 5000 rupees in all for transport (to the CHC,

for referrals, and back home). Despite there being a free government services and JSSK, it is appalling that women should still have to bear such high costs for transport.

The lack of timely transport services is also likely to jeopardize the woman's chances of survival. A month or so after we concluded fieldwork in the community, a case of a woman was reported in many newspapers where the delay in getting an ambulance had resulted in the woman's death and caused a great furore in the area.

“Hikaka Alma, a tribal woman belonging to the Dangaria Kondh community, residing in Tentulipadar village which is located some 8-9 km from Parseli in Parseli GP had labour pains. Parseli gram panchayat is in the hilly areas and no AWW/ASHA goes there and so the woman had received no ANC. When Hikaka had labour pains, she was brought on shoulders to Naringitala village from where the family tried to call the 102 ambulance. However the ambulance was busy and could not be sent. So the family carried her on a make shift cloth carrier to the CHC some 17 k, from Naringitala. A lot of time was lost in this transit. When the doctor saw Hikaka at the CHC he referred her to the District Hospital because she was anaemic. However once again the 102 ambulance was not available, nor was 108. The family was very agitated and so the doctor called the CDMO who ensured that an ambulance was sent from the DH to pick up the woman. On the way to the DH, the woman died. (Source: Newspaper article from Sambad)”

This case was reported widely in the media. It highlights the specific disadvantage that women situated in far-off areas have. Apart from the fact that the tremendous delay in reaching a facility was likely a contributing factor for the woman's death, there is also the question of lack of proper antenatal services in isolated areas where neither ANMs nor ASHAs go regularly.



Alienating Environment in the Hospital

When women delivered in institutions, they found the environment there to be very unfamiliar and uncomfortable. There were, of course, significant differences between a home birth and an institutional birth, but several factors made the environment of the health facility hostile for women. Some of these are discussed below.

The language barrier between health care providers at the facilities and the women posed the first barrier in any interaction between them. Because most of the women did not speak Odia, all communication with the health care providers was through the ASHA. The family was asked to wait

outside, and only the ASHA was allowed to wait with the woman. Most times, after a few hours, the ASHA too would go away and the woman would be left absolutely alone. Women found this very unnerving.

“*S, a 16 year old Primi Gravida, was sent to the District Hospital in Rayagada for delivery. S was very young, weak and severely anaemic, hence the ANM had recommended that she be taken to the institution before she went into labour. On reaching Singhpur CHC, she was referred to the District Hospital as a complicated case. S had to stay in the District hospital for 10 days before she delivered her child. For this entire time, her family stayed with her, outside the hospital. They cooked for themselves. The ASHA who had accompanied her could not stay for this entire period and so she and her family were left to themselves. She expressed her discomfort and absolute isolation during this time, as she was required to stay alone and did not understand the language that was being spoken. Although she and baby are healthy, S says that she will never go back to the institution for delivery. She did not even stay for the mandatory 2 days after the delivery, and returned home immediately. (Interview with recently delivered woman)*”

The difficulty in communication between women and health care providers at the CHC and DH both, was amply evident during observations and was also reported by women in interviews. Almost all the communication between women and providers was mediated by the ASHA, and if the ASHA was not around (which was often, considering that the ASHA could not possibly stay with the family for the entire time), the family and woman usually had no information about what was happening. The health care providers had also become accustomed to this situation and did not even attempt to communicate with the women. In one instance, the prescription for the woman carried the ASHA's name rather than the woman's! In another instance, a woman had travelled a long distance to the CHC because she had fever during pregnancy, but was asked to go back and 'return with the ASHA'.

Apart from language, there were other things about the health facility that did not agree with women, such as the food. Women were provided food that was insufficient as well as unfamiliar for them - sooji in the morning, one slice of bread, a glass of milk and an egg in the afternoon and one slice of bread and milk at night. Moreover, the food was not in keeping with their dietary habits - tribal communities do not consume milk and so it was either discarded or returned. As a result, most women ended up being provided food by the accompanying persons who would either cook while they waited for her or would buy food from outside.

Moreover, the surroundings and birth practices were not at all familiar to the woman. Delivery took place in the lying position as opposed to the sitting position that women were accustomed to. As one woman remarked in a group discussion:

“*“[at the hospital]... all women lay in bed. In my case I didn't want to sleep in bed. They consoled me not to worry. If they allowed me to sit it would have been better. But they don't allow that. I know their problem. If we sit how could they check? And it is not possible for the nurse to sit with every woman when the time comes for delivery.” (Recently delivered woman, in a group discussion in village Muktukuni)*”

The experiences of women described in this section emphasize how birthing in institutions is so different from women's experiences of delivery at home. It is not difficult for the health system to be mindful of these concerns of the community and make adjustments accordingly. However, no effort whatsoever has been made to do so.

Our interviews with the Dais also illustrated how their role has been made completely irrelevant in the existing set up. One dai narrated that she had been practicing for 12 years and performed many deliveries in hard to reach areas like Sulipadar and Dimripadar. For the past 4-5 years, however, she has stopped going for deliveries, once the ASHA stepped in. Her mother too was a Dai and she had learnt the skill from her. She did not get paid in cash but got rice and clothes in return for her services. Her role was to be present during child birth, support the woman, stand behind her while she gave birth, massage her abdomen and help her bear the pain. Sometimes she would give the woman a mixture of herbs and roots to quicken the delivery of the placenta. The Dai narrated that back when she used to help women to birth, she also called on the ANM's help in some cases, especially when twins were expected or when the position of the baby was incorrect. She said that these were cases she could not handle, and so she would call upon the ANM from Tikra who would assist her or ask her to send the woman to the hospital. However now, she doesn't manage any births. This suggests, that even when Dai's were assisting births, there was a system by which they identified complications and sought help from skilled providers. There was no hesitation as such, in sending women to the hospital. However this collaborative way of functioning does not exist anymore. As of today, there is no Dai to help women during birth, nor does the ANM have time to go to every home to assist home births. As a result, women are left with no support.

Adverse Experiences with Birthing in Institutions

A significant factor that affected women's decision whether to choose institutional care was that of other's or their own adverse experiences. A few months before we began fieldwork, two maternal deaths had taken place in neighbouring gram panchayats and when we asked women about institutional deliveries in the area, they invariably cited these examples. In one informal interaction with women in a village which was well connected by roads, when we probed as to why women were delivering at home, one of the older women remarked "*why should they deliver in hospital? To die? If you have to die it should with near and dear ones, where the person can have some food or water.*" Another woman remarked that she would go to the hospital only if the labour was prolonged. The old lady mentioned that in the last month there had been a death of a woman from a neighbouring GP. It was clear her death had some impact on the community.

“ S, a woman in her third pregnancy, belonged to the Jani (priestly) family. Her last child had been born in the CHC and she was planning to deliver once again at the same place. S was expecting twins. She had an uneventful pregnancy and in fact she continued to work till a few days before the delivery. When she began to get labour pains, she called the ASHA who called the ambulance and took her to the CHC. Her husband and some family members went along with her. The next day, S delivered twin girls and the family members were very happy. The doctor was not present in the CHC and the delivery was carried out by the ANM. However in a few hours, something happened to her and the LHV ran to call the doctor but he was not available. The family members do not know what happened, because they were asked to wait outside. But they were told later by the ASHA (who learnt from the ANM), that S had had a heart attack. According to the ASHA it was because the woman was shocked to have delivered two girls! The family members, naturally, did not believe this. When the doctor returned, he declared S dead, told the family that the hospital was not at fault, and that they should take the body away. The family put her body into the ambulance but a short distance from the CHC, it stopped working. By this time a lot of people from the woman's village had gathered at the CHC, and they carried the woman's body back to the village on a Charpoi. The case

was reported in the local media. Thereafter, the MOIC and collector requested the family to tell the media that the hospital had provided proper treatment. According to the ASHA, they promised to get the family the JSY benefits and the doctor who was in charge offered to pay the family 20,000 rupees for raising the children. The family accepted his offer. They faced the wrath of the media for having taken a bribe from the doctor. However after a few months, the doctor disappeared (for higher studies, apparently), and was not heard from again. S's husband feels cheated. He said "Why should we go to hospitals when they do not care for us? If Salema delivered at home she may have died but she would at least have received some food or water to drink. At the hospital she got nothing. If she had died at home, we would regret it, but at least she would be around us and we could have done something. We would not have to spend money to take her dead body to village? What is the profit for us in taking woman to hospital for delivery?" (Interview with husband and ASHA) ”

Perhaps because the woman belonged to the Jani family, S's story spread to other villages. No explanation was offered for her death by the system and in fact, the disappearance of the doctor deepened the sense of mistrust that people have in the system. In the other case which belonged to Sikarpai GP, the woman had run away from the hospital despite being in a lot of pain and refused to return in the post-partum period when she was extremely ill.

“ B, a 24 year old pregnant woman with two previous institutional deliveries, was taken to the PHC at around 8 months because she developed blurred vision and severe headaches. The doctor told her husband that she had malaria and referred her to the CHC. B had gone for all three antenatal check ups and no risk factors had been identified. When B reached the CHC, the family was told that her case was 'serious' and so she was shifted to the District Hospital. For three days B stayed in the district hospital and got no relief. Her husband says they gave her three injections for which he paid 600 rupees each. The family was not aware of what was wrong with her and they were receiving no information from the doctor. B's husband was not allowed to stay by her side. Because B did not know the language, she could not communicate with any of the hospital staff. After three days of being ill, B and her husband left the hospital without informing anyone as she was not getting any better. She felt that if she was going to die, she would prefer to die at home, in the presence of her family and children. They took a private vehicle and came back to B's mother's house where she delivered. The child did not survive. After the delivery, B was very weak. She continued to have blurred vision. Her husband tried to convince her to go back to hospital, but she refused. Two days after the delivery, she died. A maternal death investigation was conducted which concluded that B had died because she had not adhered to medical treatment and left the hospital against medical advice. No effort was made to explore why B had left the hospital. Her husband feels that it was her fate and could not have been averted, even though she had gone to the hospital. However, he feels that the hospital did not diagnose her case properly - how could she have malaria and not have fever? (Interview with woman's husband) ”

Such experiences of women with the institution easily spread to the entire community and they played a role in how women made decisions about whether to go to the facility or not. For instance, in one case, a woman who delivered at the CHC but had a 'weak child' was asked to take the child to the district hospital, but she refused. The doctor merely informed her that if she doesn't take the child

to the hospital, the child's wellbeing will not be his responsibility. On speaking with the woman and her husband, the researcher realized that the reason for his refusal stemmed from the fact that his neighbour's child had been referred to Rayagada, they spent 20,000 rupees and eventually the baby died. Thus the family had no faith in the district hospital and felt that it would only lead to a loss of money and no relief.

Moreover, there were women who had themselves faced bad experiences at the health facility and did not want to go back. One of the respondents had had a previous delivery in the CHC but her second delivery occurred at home. When we initially met her, she said that she meant to go to the institution but the ambulance did not arrive in time so she delivered at home. However later in the interview she revealed that she had delayed informing the ASHA about her labour pains because she did not want to go to the institution. Her first delivery had occurred in the institution and she had lost her child thereafter. She did not want to take a risk a second time and found a way to deliver at home. This time the delivery was normal and the child was well.

It appears therefore, that women's experiences with institutional delivery and their perceptions based on other women's experiences play an important role in deciding where women will deliver. It is telling that even with the incentive, there are women who consciously choose not to go to the health facilities because of lack of faith in the facilities.

Out-of-pocket Expenses

Another reason for not wanting to go for an institutional delivery, was that of lack of resources. Despite the fact that the JSSK is operational, all women who had gone for an institutional delivery reported having spent money - either at the facility, in transport or for other expenses. The ambulance service, although free, always had to be given a sum of 400-500 rupees. In cases where the ambulance did not come in time, private vehicles were hired which were much more expensive. At the hospital too, on birth of the child, a token amount not less than 500 Rupees had to be paid to the nurse. These informal fees were called '*beta*' and said to be given '*out of happiness*'. If the fees were not provided, sometimes the birth certificate and discharge certificate were reported to be withheld. Talking about why she was reluctant to take women to the Hospital, one ASHA remarked:

“We don't like to take our patient to Rayagada hospital. Not only is it far, but they treat our patient like dogs. They ask for money, otherwise they are not willing to give birth certificate or discharge slip. In the night they demand special tea and snacks. Sometimes ASHA has to bear the cost if patient is unable to pay. (Field notes, discussion with ASHA)”

Some women reported that they had to pay 20 rupees for a bedsheet and bednet at the hospital. Apart from these there were expenses related to food and shelter for the accompanying family members. Every woman that we met came to the CHC with not less than two or three accompanying persons. Loss of at least 3-4 days of wages meant even more economic strain for the family. These expenses do not get reimbursed through any scheme. Some local government functionaries spoke quite candidly about the various expenses that going for an institutional delivery entails. Given the cost and distance that women have to travel, some remarked that women have begun utilizing the formal health services only because of the cash incentive. As one Anganwadi worker remarked "*If they are going to hospital, the only reason is Rs.1, 400/- if it stops in future they will stop going to hospital.*" Indeed, the MAMATA and JSY incentives together make up about 6400 rupees which is a large sum, considering the relative deprivation of this community.

X. POST DELIVERY PRACTICES



Traditional Practices

Following the delivery, the woman stays in a secluded area (in one case, outside the house) for a period varying from 15 to 30 days after delivery. In this time she does not do any work except caring for the new born baby. She is not allowed to touch anyone else in the house, even her older children. This is because she is in a state of 'impurity'. (Women are made to live in a secluded area even while they are menstruating). It is not until the period of impurity is over that the woman comes back into the house. This event is marked by a ritual bath in '*Ambapani*' (water infused with mango bark). Bathing with *Ambapani* is said to remove impurities; anyone who comes in contact with the woman in this post natal period of seclusion is required to bathe with *Ambapani* to purify themselves. Even when the *Dai* conducted delivery, she would be required to bathe in *Ambapani* after conducting the delivery. It is interesting to note that this practice is followed even in case of institutional delivery; once the woman goes home, the same restrictions on food and mobility are placed on her.

Several kinds of food are prohibited in the post-delivery period; because the mother is lactating it is said that foods can cause harm to the baby. The mother eats plain rice only for the entire period. The same restrictions also applied to women who had an institutional birth; all the women in our study who had institutional delivery followed this prohibition on food. Clearly, this diet is deprived of a lot of essential nutrients and is likely to result in poor health of the new mother. Interestingly, we noticed that in the more remote areas, women did not follow any restricted diet. They ate a regular diet and supplemented it with some herbs which were said to counter the harmful effects of the food that was being eaten by the mother.

Much like in the antenatal period, women viewed illness in the post-natal period as something normal and did not accord it much importance. Fever was reported to occur commonly in the post-natal period and is said to be related to bathing with cold water (*paani jaar*). Pain in the abdomen was also reported, which, some women said, is treated with a paste made of the root of sarpagandha. Other than this, problems in lactation and pain in the breast were reported (perhaps breast abscess). Solidified milk of the tigress was considered to be a potent remedy for this.

For the first few months, until the child starts walking, he/she only feeds on breast milk. Interestingly, colostrum is considered impure milk by some of the lowland communities and is discarded. But in the most remote ones on the hills, the colostrum is considered very good for the baby. The baby receives turmeric and water massage everyday as this is said to ward off illness. No other child related illnesses were reported by the women.

Post natal care provided by formal institutions

Post natal care, as is the case elsewhere, was the weakest component of the entire maternal health service delivery, both for women who had home deliveries as well as those who had institutional deliveries. In the project area, we found that most women did not receive a routine post-natal check-up. Post-natal checks were only reported by those women who had some kind of complain or complication. In the low-land areas, the ASHA would pay a visit to every mother who had a complicated birth, but in the high-land areas where it was difficult to reach, this was not done.

Moreover, when the ASHA visited, several times she was not allowed to enter the house (especially if she belonged to SC). This too serves as a barrier to availing of services. However when there was a serious problem, women did call upon the ANM who visited the woman and if required took her to the CHC or district hospital. As discussed before however, fever, pain in the abdomen, problems in lactation etc are not looked upon as problems requiring attention, and so women rarely visited a health facility or even the VHND for a check-up for these issues, but rather resorted to traditional remedies stated above.

XI. POSITIVE INTERVENTIONS BY THE ODISHA GOVERNMENT TO REACH OUT TO TRIBAL COMMUNITIES



There is a recognition in the Government that special efforts are required to reach out to tribal communities and with this intent, the government of Odisha has initiated various programs to reduce barriers for women in accessing health facilities. Two such initiatives are discussed in this section.

Maternity Waiting Home (Maa Ghar)

Following a well-established model of reaching out to women in far flung areas, maternity waiting homes have been set up by the Government of Odisha since 2012. Because women who live in far-off areas may not be able to come to the facility in time for delivery, the waiting home is meant to serve as a temporary home close to the delivery point, where the woman can stay for approximately one month before delivery. Such a home has been set up in Jagannathpur and is run by an NGO by the name of SHED. In our interaction with the ANM, she mentioned that women who are at high risk of complications are referred to the home. Specifically, women who were severely anaemic or had high blood pressure were referred to the Maa Ghar. On receiving information from the ANM, a

coordinator from the Maa Ghar was meant to visit the woman's house and take her along in a vehicle. However, this did not seem to work the way it was intended. ANMs were routinely identifying women who were at high risk of complications, but there were barriers in going to the Maa Ghar. The following story illustrates this:

“Z, a 22 year old woman, pregnant for the first time, was referred to the Maa Ghar by the ANM because she had a haemoglobin of 4 gms. The Maa Ghar coordinator visited her village and asked her to come along, but she was reluctant. However under pressure from the ASHA, she went to the Maa Ghar. However as soon as the ASHA left, Z also came back to her own house. She said she could not afford to stay there as her home and husband needed taking care of.”

This is a common concern and it seems like it has not been taken into account while implementing the Maa Ghar scheme. A visit to the Maa Ghar showed that it was empty. Only one person was admitted and she too had gone home for some chores. The coordinator mentioned that the home is used more by SC women than tribal women. Women from the field area rarely go there as it is quite far from their home and they cannot afford to stay there for long.

Perceptions about the Maa Ghar in the village

Most people are unaware that such a facility exists. For those who are, very little information has been provided regarding the Maa Ghar. The exact purpose of taking women to the Maa Ghar is not clear to villagers. Those who have been asked to go to the Maa Ghar are wary because they think that they will not get food there, and will have to spend more money (this is not an unusual concern, considering their experiences with health facilities at times of delivery). Moreover, if women have to stay at the Maa Ghar for a long time, they prefer to go with their family and that brings in more concerns about extra expenses of food and stay for the family, which they may not be able to incur. In reality however, the Maa Ghar provides all these facilities. In fact, there is even space for families to live with the woman, but villagers are unaware of this. This suggests that there is a need for better understanding about the Maa Ghar in the community, and the need for an effort to address women's concerns about it. This effort has not yet been made, and hence there is reluctance on the part of many women in going there.

Shakti Varta: Participatory Learning Action

In 2013, the Government of Odisha launched the Shakti Varta program which utilizes a Participatory Learning Action (PLA) approach to empowering communities to take decisions regarding their own health. The program has a strong focus on maternal health and through 20 cycles of facilitated learning, it helps community women to identify problems, craft solutions and strategies to the problems, implement those strategies, and evaluate them. The approach requires trained facilitators to facilitate 20 meetings at the community level. However, we did not see any component of this program being actively implemented in Korpa Gram Panchayat, nor did we hear about it from any of the villagers, or the health care providers (maybe because it is not yet being implemented in this area). Therefore it is not possible to comment on its effectiveness or drawbacks.

XII. DISCUSSION



The exploration of traditional practices of women during pregnancy and delivery shows that in this community, pregnancy and childbirth is treated as part of a natural process, not requiring much external intervention. Traditional practices both in the antenatal and post natal period, are primarily geared towards protecting the mother and child, through conducting pujas or through restricting diet. Not much importance is given to 'small problems' like fever in the post natal period or swelling of feet in the antenatal period as these are considered a common part of pregnancy. Women go through childbirth without disturbance to their regular life. The woman can go about her daily activities and work until the time of delivery and this is an important consideration for them. The delivery is conducted in the home with a close family member as an attendant, in a surrounding familiar to the woman. Yet, there is awareness that pregnancy can get complicated, and in case of prolonged labour, retained placenta or unrestrained bleeding, the necessity to take the woman to the health facility is well recognized. This suggests that there is a well established traditional practice of birthing in the community which also recognizes the need for health system interventions in certain cases.

However, there is no recognition or understanding of this traditional health system by the public services. For instance, there is no doubt that traditional health providers are important stakeholders in the village as regards health issues, but the formal health system has not been able to integrate

them, nor has it been able to utilize their influence to women's benefit. Instead, it continues to treat them with distrust. Similarly, with respect to antenatal and postnatal services, no effort is made by the health system to build on the traditional understanding of safety of woman and child, in order to encourage uptake of services. Instead, it continues to rely on incentives and disincentives to motivate women.

Despite the immense difficulties that women face, however, we do see that they are coming for institutional deliveries. However the services at the health facility do not meet their expectations. The data presented above depicts the stark difference between delivering at home and in the institution and the implications that this has for women. Delivering in the home provides women a familiar environment, family support and saves them a great deal of time and money. Birthing is a traditional event and there are a host of practices that women can adhere to while in the home. The perception of risk of birthing at home also is low and women who have had previous births at home tend to believe that their experiences were better than those that women have in institutions.

The schemes of the government hinged largely on incentives, have persuaded people to begin accessing institutions for antenatal services and delivery care, however the health system has not been able to adapt itself to women's needs. In contrast to the traditional tribal perceptions of birthing, formal institutional births are far more medicalised. This medicalisation is presented to women by healthworkers as something that is 'better' and 'safer' for the woman. However women's own experiences are very different. To begin with, geographical isolation is a big barrier in reaching health facilities in time and without spending much money. As described above, some of the villages have no access to an all-weather road and women either need to walk or they need to be carried long distances. The ambulance does not always reach and when it does, informal fees need to be paid to the driver.

There is an obvious lack of faith in the formal health services, stemming from women's adverse experiences with it. Incidents where women or infants have died due to what is perceived by the community as negligence, the abdication of all responsibility for the death by the health system, and so on, contribute to this mistrust. Thus there is a definite case to be made for strengthening the health services and introducing more accountability to the community. Moreover, the environment in the hospital is also alien to women in many ways. Unlike in their homes, women in the hospital are alone during labour, they are expected to lie down and give birth, they are unable to communicate with anyone owing to language barriers. Even when the quality of inputs is good, such as in the VHND or the Maternity Waiting Home, there is no effort made to explain to women the importance of these services, nor is there an effort to address the barriers that prevent women from utilizing these services. Despite all the problems with the health system, however, what we observed was that women were not averse to seeking treatment from the formal health system. In fact, in most cases, women adopted a mix of traditional and formal health system practices. If better services, adapted to their needs were available, women would certainly be more likely to utilize them.

XIII. CONCLUSIONS AND RECOMMENDATIONS



This study throws light on the experiences of women with the formal health system, their lack of faith in the system and persistence of home deliveries despite the various incentives that are in place. Given the levels of impoverishment and destitution in the community, it is no surprise that women are availing of these incentives and we can see the proportion of institutional deliveries increasing (the true magnitude of which this study questions, since we have also observed women having their pregnancies registered as 'institutional' even though they were conducted in the home). However, it is important to reflect on whether a mere increase in utilization of maternal health services is a positive indicator.

These experiences suggest that there is a need for the health system to step back and reconsider its aggressive approach of institutionalizing deliveries. Action is required both in terms of strengthening the health system and addressing the physical and financial barriers to accessing maternal health services, as well as to adapt health facilities themselves to the needs of the community. This would be far more effective in truly impacting maternal well-being, rather than using a carrot-and-stick approach of incentives and disincentives to get the community to utilize the formal health services. At the same time, there is need to make some provision for those women who continue to deliver at home, until such time that women voluntarily choose to go to institutions, and the barriers in accessing institutions are removed.

Recommendations

1) **Ensure home deliveries are safe:** Due to a complicated set of factors, deliveries in tribal communities continue to take place in the home. As described in this study, however, no support is provided to women who deliver at home, to ensure that these deliveries are safe. Urgent attention needs to be paid to this gap in services.

- a. Make provisions for skilled birth attendance in home deliveries by making available trained ANMs as well as training new cadre
- b. Train birth attendants to identify complications and have a strong system of referral in place in case the woman needs to be transported to a health facility
- c. Ensure proper monitoring of women who have had home births. Because almost all women are seeking antenatal care, they must be monitored throughout the period of pregnancy. This is especially true in the post-natal period, as these may be at high risk for post natal complications.

2) **Address health system gaps,** specifically related to

- a. availability of timely and efficient transport facilities,
- b. in-house diagnostic tests and availability of all medicines
- c. presence of a doctor during delivery,
- d. management of complications at the CHC rather than referral to DH,
- e. better infrastructure and sanitation at the CHC
- f. availability of proper food and nutrition at the health facility
- g. availability of a grievance redressal system especially to make complaints regarding informal fees

3) **Need for accountability and trust-building measures** between the formal health system and the community. This can be established through:

- a. community platforms where the community's adverse experiences with the health system can be tabled and addressed by the system.
- b. In cases of death, doing the maternal death review process in the community, and incorporating the concerns of the community into it.
- c. Sensitization of community outreach workers as well as health service providers to understand tribal customs, their unique problems and address the lack of trust between the providers and communities.

4) The health system must find ways to **cater to the specific cultural needs of tribal women** during delivery. Some of the specific ways in which this can be done are as follows:

- a. Allowing women to choose a birthing position. Tribal women are accustomed to birthing while squatting and having this provision will make the experience of a hospital birth both familiar as well as more comfortable.
- b. Providing a diet that adequate and in keeping with the traditional foods of tribal women. Milk, for example, is not consumed by tribal women at all and should not be replaced with something else.
- c. Allowing birth companion during delivery, as this is also in keeping with how women birth traditionally.

- d. Address needs of accompanying family members, such as shelter, food and so on to reduce out of pocket expenses.
- e. Make available personnel who can communicate with women, as language appears to be a great barrier between the woman and the service provider.

5) Conscious efforts need to be made to **preserve traditional practices** especially related to nutrition. The introduction of traditional foods such as millets into PDS (as a replacement to rice and sattu) would be a good way to address this, as millets are higher in nutrient content and also acceptable to women.

6) Behaviour change communication strategies need to **build on the tribal community's own understanding of maternal health, child birth and illness**. This would enable the community to see the services being offered as part of their own belief system. Such an understanding would go a long way in ensuring that the services provided to the women in the community are owned and complied with, rather than accessed because of an incentive.

7) **Integrate traditional and informal providers:** Instead of 'banning' local and traditional practitioners from treating women, it may be more useful to include them in the process. The faith that the community reposes in these practitioners is significant. They could be engaged in the health system in the following ways:

- a. Health education messages related to maternal health can be disseminated through these practitioners and will be better accepted by the community.
- b. Dais and older women in the community can play the role of birth companions.
- c. In case of informal practitioners, it would be useful to define their role in treating pregnant women rather than forbidding them from doing so altogether.

Annexure 1: Maps of Rayagada, Kalyanasinghpur Block and Study Area

Map of India



Map of Odisha



Map of Rayagada

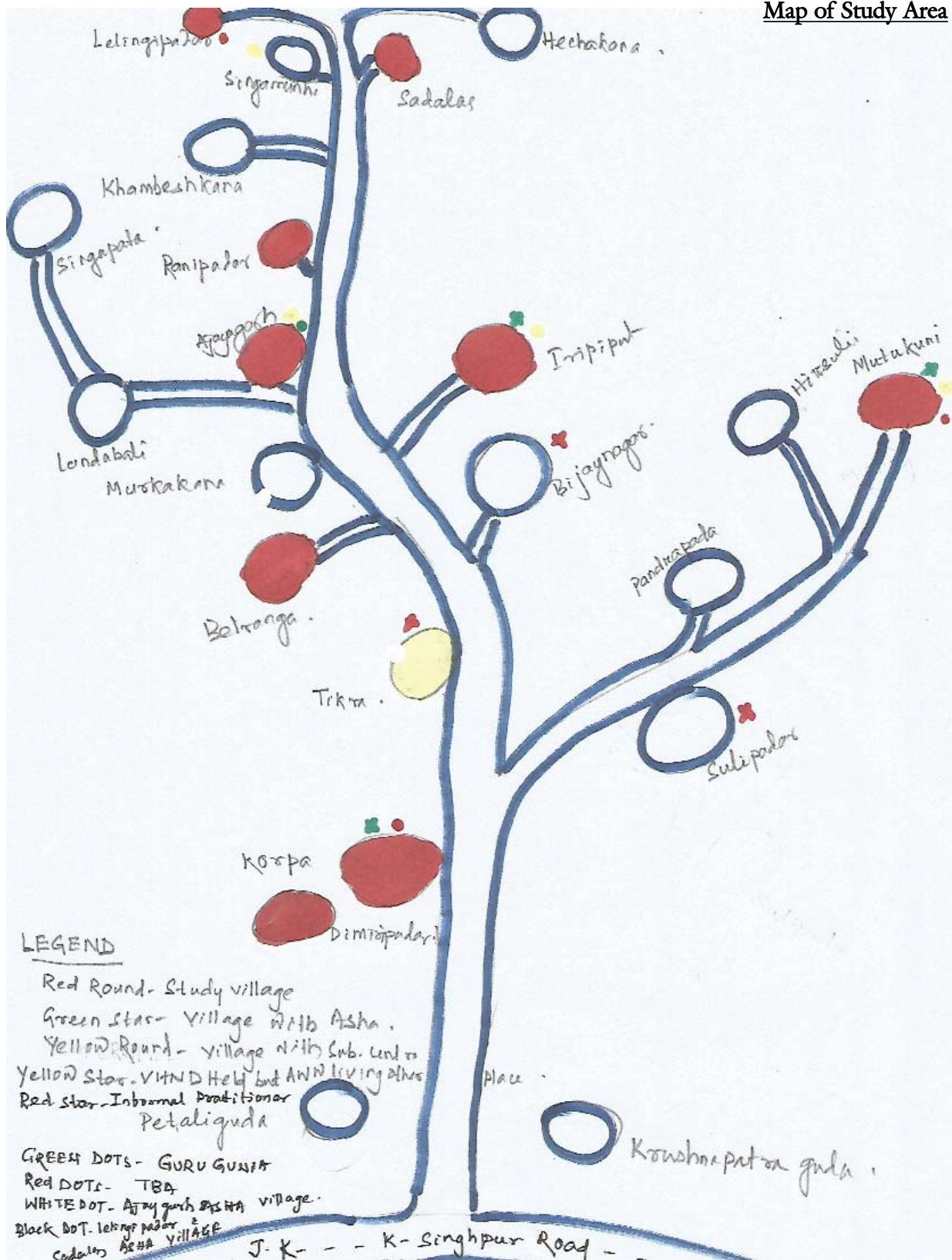


Map of Kalyanasinghpur

Kalyanasinghpur Block Map



Map of Study Area



The National Alliance for Maternal Health and Human Rights (NAMHHR) works with the mission of attaining highest quality of maternal health for the marginalized in India. NAMHHR recognizes that strong rights-based strategies are needed to build greater accountability for thousands of preventable maternal deaths and morbidities among women in India. NAMHHR currently has 37 members from 14 states of India as well as six expert advisors working with law, research and public health issues. The Alliance is being directed by a nine-member Steering Committee and the Secretariat of the Alliance is currently held by SAHAYOG, Delhi

National Alliance for Maternal Health and Human Rights (NAMHHR)

Secretariat:

G-66, Saket, New Delhi - 110017,

Tel: 011-26581101

Blog: <http://namhhr.blogspot.com>