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Perceptions and Constraints of Pregnancy Related Referrals in Rural Rajasthan

Dr. Jaimala Hitesh

Background

The number of maternal deaths that take place every day in India exceeds the total number of such deaths that occurs in all developed countries in a month [1]. Anaemia, hemorrhage, eclampsia, infections, abortions and the complications of obstructed labor account for most of the maternal deaths in India. A striking feature that shows up when the circumstances in which most of these deaths occur are examined, is that a considerable majority of the women come from rural areas. The two other notable features about the women who die while receiving obstetric care are that they come from long distances, and they come late. Additionally, they share a general background of illiteracy, poverty, malnutrition, socio-cultural problems related to low status and adverse traditional attitudes and practices [2] [3] [4].

While it is true that, poverty and deprivation contribute considerably to high maternal mortality, inadequate availability of preventive health services, such as prenatal care, examination of the immediate cause of death, and the circumstances in which, it occurs vividly point to the grave problem of access to life-saving procedures in emergencies during childbirth [5]. All though this problem is far from being the sole cause of the high maternal mortality rates in rural areas, it is one of the most important, and has not received the attention it deserves.

In November 1995, the WHO convened an Interregional Meeting on Prevention of Maternal Mortality where information from many parts of the third world was presented on the extent, causes and circumstances surrounding maternal mortality and morbidity. The Working Group recommendations endorsed and encouraged efforts to train traditional birth attendants (TBAs) to provide effective prenatal care within the primary health care framed work, and also addressed the "First Referral Unit", the point at which many maternal deaths occur.

This paper is based on a research study carried out as a part of an action research project titled "Maternal and Child Health Action Research Project" by the Indian Institute of Health Management Research (IIHMR), Jaipur, in district Dausa of Rajasthan at the instance of the Indian Council of Medical Research, New Delhi. The project aimed at evolving and demonstrating strategies for an integrated approach to find out if qualitative and quantitative improvements in MCH care and family planning services could be brought about within the existing infrastructure at the district level by adopting a high risk approach.

The IIHMR research team made several interventions to achieve this objective. Improving the referral system in the district was one of the major interventions. Paramedical staff and TBAs were trained mainly to screen and refer high-risk cases promptly to the next appropriate level of referral for treatment of the complication. A special "red card" was designed for referring such risk cases so that anybody holding the card could be easily spotted and given priority. The project also developed a Health Plan for the district [6].

The findings presented in this study are based on the follow up of the women referred during the implementation phase of the project. A total of 206 women were followed up from 12 sub-centers of the district. The women were picked up from the sub-center registers and traced back to find our more about their experiences regarding the referral services. The youngest woman in the sample was a 17 year-old Primiparous woman and the oldest was a 42 year-old multipara who had five living children and had had one abortion (reported to be spontaneous) and a still birth. The average age of the women was 27 years 70 per cent of them had had three or more deliveries prior to their recent pregnancy. Further, a fifth of them (20.8 percent) had attained education up to the primary level and the remaining (79.2 percent) were illiterate.

In-depth personal interviews of the women were conducted by trained social researchers to determine the perceptions of the women regarding the signs of a high risk pregnancy, and their subsequent referrals. They were asked to describe their obstetric history and the type of care they had received during each pregnancy. This helped in obtaining their spontaneous responses regarding their previous experiences. Their perceptions regarding the "risk signs" of the pregnancy and the treatment were recorded. Finally, they were asked whether they had availed of the referral service or not and, if not, the reason(s) for not having taken the service. The data were collected between March and December 1993.

Results and discussion

It was observed that although the women were promptly referred for high level care, their response was very apathetic as can be seen from Table 1. Of the 206 women who had been referred, 185 who had been referred for various reasons did not make any attempt at all to go to the next level of referral.

Table 1: Number of women referred who chose not to avail of the service

Number of women referred	Medical reason	No. of women who did not comply
32	Ante-partum hemorrhage	20 (62.5)
29	Obstructed labor	27 (93.1)
23	Excessive nausea/giddiness	23 (100.0)
47	Oedema	47 (100.0)
31	Bad obstetric history	30 (96.7)
21	Persistent stomach-ache	21 (100.0)
23	Post-partum hemorrhage	17 (73.9)

Figures in brackets denote percentages of women referred.

The factors that motivated the family members to take the woman to the next level of referral were few, and were mainly the good economic status of the family, and the possession of (private) transport. A few women also reported that they could not have gone to the district hospital if their relatives had not offered to take care of their homes and children. However, more varied reasons were given for not availing of the referral services; these have been presented in Table 2.

Table 2: Factors influencing non-utilization of referral services by women

Women who did not use service		Reason (multiple responses)
No.	% *	
147	79.4	Non-availability of transport
131	70.8	Un-sympathetic nursing staff
83	44.9	Non-availability to doctors
171	92.4	TBA advised against it
83	44.9	Mother-in-law says "no"
113	61.1	They are "normal signs" of pregnancy
138	74.6	Previous bad experience
89	48.1	Superstitions bad experience
70	37.8	Female doctors not available
185	100.0	Involves a lot of expense
171	92.4	Follow-up is not done

* Denotes percentage of all women referred.

Factors Influencing Non-Utilization of Referral Services

As the information was obtained through in-depth interviews, it was possible to collect voluminous data, which was later critically analyzed. In the following section, each reason for not availing of the referral services is discussed in detail.

Non-Availability of Transport

The baseline survey of the district revealed that 43 per cent of the villages were more than 5 km. away from the nearest health center and had no regular connecting transport service. In case of an emergency, the villagers had to either hire private transport which was too expensive for attending to "routine problems" related to pregnancy, or they had to take any local available form of transport such as a camel cart, bullock cart, or under

the best of the circumstances, a tractor. All this involved a lot of planning as to who would cool and take care of the children while the mother was away and so on, and had financial implications.

Unsympathetic Nursing Staff

A large number of women were of the strong opinion that the paramedical staff, have a general tendency of treating poor rural women with a high degree of indifference. Some went to the extent of saying that because the staff, are very rude and discriminate between rich and poor patients, they avoid going to them even if they have a serious problem. They also differentiated between the "Chhoti Nurse" meaning the Nurse of the Sub-center and the "Badi Nurse", meaning the Nurse at the PHC or the district hospital, and said that the higher the level, the more difficult it is for a rural illiterate woman to get proper attention. Therefore, the best option was to manage without them as far as possible.

Non-availability of Doctors

At least 45 per cent of the women reported that even if they took the trouble of going for the recommended referral service, it proved to be of no use as most of the time the doctor was not available in the dispensary. Moreover, when present he gave preference to patients who visited him at his private clinic too. It was also a common observation of many respondents that their condition usually improved soon after they paid a visit to the doctor's private clinic.

TBA Advised Against It

It was found that many women did not visit the next referral unit because the local dai (TBA) advised them against it. In fact, 27 of the 29 women with obstructed labor did not seek trained medical care only because the dai told them not to. Actually, there are a few dais who are skillful in manoeuvering the birth of the baby in extremely difficult situations; they do not refer cases of obstructed labor, breach or twin deliveries. The local TBAs were also contacted to find out more about why they did not refer high-risk cases. The following issues emerged:

1. The TBAs, prior to being trained, used to deliver all kinds of cases without being aware of the fact that some of them could be "risk cases". The concept of a "high risk case" was introduced to the TBAs at the training course, and they were trained to

identify such cases. However, that factors like low weight, weakness, paleness etc. were dangerous and could cause harm to women and children proved to be beyond their comprehension, and therefore, they did not refer such cases.

2. By referring more cases they would suffer a loss of income.

3. The indifferent attitude of the Sub-center staff towards the trained TBAs was another reason, which deterred TBAs from referring high risk pregnancies. The TBAs claimed that they were not considered as a part of the health system and did not receive serious attention from the paramedical staff. Whenever they asked the ANM for help while conducting a delivery, it was denied, and after several such experiences, they had stopped referring even a genuine case of high-risk pregnancy with an abnormal presentation such as breech or twins.

Mother-in-law Says "No"

The general remark of a mother-in-law to a daughter-in-law's need for any special pregnancy related care was quoted by the respondents, as: "I have borne 11 (or more) children and never ever visited a doctor. What is so special about your deliveries?" And, such a remark would almost always put an end to the matter. About 45 per cent of the respondents complained about their mothers-in-law's attitude in this regard. In any emergency and/or problem, they were asked to consult the local dai or the 'ojha' (village medicine man) for treatment as the mothers-in-law were found to have tremendous faith in traditional healers.

"They are normal signs of pregnancy"

A very large number of women (61 per cent) opined that giddiness, oedema, nausea, anaemia, stomach-ache etc. were normal signs of pregnancy and therefore did not require any medical intervention. They also said that these symptoms vary in terms of frequency and intensity from one woman to another and only indicate that everything is normal. In fact, they believed that the absence of these symptoms were a cause for concern.

Previous Bad Experience

As many as 67 per cent of the women reported that they had tried to avail of the referral service on the advise of either the TBA or the Sub-Center nurse but had been highly frustrated by the treatment they had received. One such woman's experience is narrated here: At the time of performing her delivery, the dai had found that it was going to be a breech birth and immediately asked the family members to take the woman to the hospital. They did not find anybody at the hospital, and after waiting for about half an hour, a nurse examined her and said that there was still time for her to deliver. As there was no bed, she was asked to lie down on a small bench where she spent the entire night without being attended to. She was examined in the morning by the nurse and told that the pains were 'false' and she would not deliver for another 48 hours. Her family took her home and she delivered the same evening. The same local dai conducted the delivery. Many other women had similar experiences to narrate which included rough and inefficient treatment, long waiting hours, highly uncomfortable resting places, no drinking water, and so on.

Superstitions and Beliefs

Low literacy and poverty are the root cause of several social evils. Illiterate people tend to associate most good or bad events with the supernatural such as ghosts, goddesses and gods, and as a remedial measure, seek the help of ojhas and tantriks (persons practicing black magic). Prevention is the most preferred form of avoiding these problems, and hence the pregnant women, is not permitted to go out after sunset, or to travel on a road that passes alongside a cemetery, pond, peepal tree etc. She is also not supposed to contact any woman who is childless or who has been declared to be "possessed", and so on. All these beliefs make it difficult for a pregnant woman with a medical problem to get the appropriate service.

Female Doctors Not Available

As many as 38 per cent of the women said that they would have liked to avail of the referral services if there were lady doctors posted at appropriate levels. The presence of a male doctor had a de-motivating effect. Several reasons were given by women for preferring a female doctor, one of them being that a being a woman herself, a female doctor has a better understanding of women's problems and is empathetic whereas a male doctor usually lacks that empathy. Unlike in the West, where most gynecologists are male, in a closed Indian society it is, considered indecent to discuss gynecological problems with any male; that is one of the reasons why women do not go to them.

Involves A Lot of Expense

This was one aspect that bothered almost everybody and discouraged them from availing of a referral service. When a woman is asked to go to a health service center (which may be 20-30 km. away), the transport itself would cost her family something between Rs. 200-300. After she reaches there, the expenses for performing various laboratory tests and for the medicines are overwhelming. To this is added the expenses incurred on food during the waiting hours. And finally, when after spending about Rs. 1,000 or so, the woman is asked to come again, the family decides not to. Those who cannot afford even one visit, simply stay back.

No Follow-up is Done

When a local dai deals with a case in her village, she goes back to the woman quite often to Enquirer after her health and to ensure that all is well with her and the baby, but when a woman is under the supervision of even the best of doctors or nurses, it is highly unlikely that they would try to contact her. As many as 92 per cent of the women said that they did not avail of the referral service mainly because of the lack of follow up.

Conclusions and Recommendations

Considering the magnitude and the diversity of the problem it can be concluded that the referral of pregnancy related complications, needs special attention. The causes are so varied in nature that a very specialized approach is required to tackle the issue. The important revelation is that this is more of a "family problem", a problem that can be handled if awareness is created and a large number of maternal and infant deaths can be averted by doing this.

A well-designed IEC program implemented under skilled supervision can bring about a change for the better, and the most important target group should be the family members of the pregnant woman. Special attention should be given to make them aware of the seriousness of the problem and its implications in the personal and global contexts. There is also a need to develop an empathetic attitude among the medical and paramedical staff, and to define the role of the traditional birth attendant in the health care delivery system.

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