Going ‘Beyond the Numbers’: Maternal Death Reviews in India

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ABSTRACT
This essay discusses the Indian government’s implementation of maternal death reviews (MDR) across the country in response to a global WHO strategy called ‘Beyond the Numbers.’ India’s MDR process attempts to better count and assess maternal deaths across the country, yet considerable challenges remain. Existing studies of the MDR process in India still reveal systemic failures including poor quality of obstetric care, as well as omissions or delays of care that are covered up or denied. An ethnographic case study suggests ways that ethnographic sensibilities or techniques could be used to harness community stakeholders or lay perspectives by privileging ambiguity, multiplicity, and conflicting views in order to reveal these systemic omissions or failures of accountability. It concludes by suggesting how ethnographic ways of knowing might elicit lay concerns or critiques that threaten the very medical privileges that the MDR process inadvertently shores up.

KEYWORDS
India; maternal mortality; reproductive health; verbal autopsy; WHO

Overarching statistics about the level of maternal mortality do not help policymakers, service commissioners, and providers or health professionals identify what can be done to prevent or avoid such unnecessary deaths. (Lewis 2008:449)

After two decades of research into the causes of and solutions to maternal mortality, the World Health Organization (WHO) initiated the ‘Beyond the Numbers’ strategy in 2004, aiming to reduce maternal deaths across both the developing and developed world. The WHO strategy promoted a process of maternal death reviews (MDR) intended to illuminate why so many women were still dying from largely preventable or treatable complications. It proposed reviewing every individual maternal death, regardless of where it had occurred, to understand whether a patient had sought or received care and whether that care had been delayed, inappropriate, or of poor quality (WHO 2004; Lewis 2008, 2003). The WHO recognized that while many women may die from a single clinical cause such as hemorrhage, that cause alone tells us little about how or if obstetric care was delivered or delayed. In other words, attention to the uptake and quality of care is as critical as attention to the supply of obstetric care. Although the Indian government implemented MDR across the nation in 2011, they have not been as effective as hoped given the rampant apathy toward poor quality of care that plagues the Indian health care system. This essay aims to show the existing challenges that MDR face in India, and offer some preliminary thoughts on how the MDR process in India might be improved.

The WHO strategy of promoting MDR is built on the realization that individual narratives of a maternal death, like Grand Rounds, can provide ‘teachable moments’ by encouraging medical staff (as well as community members) to examine their own practices in order to reduce medical errors, delays, or omissions of care. With a motto of ‘no name, no blame,’ the MDR process seeks to use the tragedy of maternal death to develop improved clinical protocols and better community
awareness around quality of or access to care (Lewis 2008, 2010; WHO 2004; Graham 2009). In developing countries such as India with high maternal mortality ratios (MMR) and where most deaths occur outside facilities, the WHO recommends two types of MDR: community-based reviews and facility-based reviews. Both methods involve detailed interviews with health care providers and community members who witnessed the events leading up to the death. Community-based MDR (also known as verbal autopsies) require interviews with family members and/or bystanders present before, during, and after the death, while facility-based MDR concentrate on the health care providers who attended the patient or referred her onwards, and community members if possible (WHO 2004; Lewis 2008).

Critically, community-based and facility-based MDR in the developing world rely on honest inputs from medical staff that may have precipitated the death being reviewed, unlike MDR in the developed world that tend to use obstetricians who tend to be uninvolved in the case being reviewed and blind to the identities of patient or provider. The WHO guidelines (2004:15) recognize that MDR “require committed and skilled individuals at the facility.” They stress a ‘natural’ propensity to help others, in assuming that the review process “builds on the natural altruism of individuals or teams of health care professionals who are prepared to freely give their time and effort in order to learn lessons to help save women’s lives” (WHO 2004:8). It may be hard to generate this altruism in India today among a health care staff that is chronically underpaid, overworked, and resentful of systemic problems in health care such as lack of accountability, poor quality of care, and corruption (Jeffery and Jeffery 2010, 2008; Subha, Sarojini, and Khanna 2012; Iyer, Sen, and Srivasti 2013). Let us briefly examine how India came to use verbal autopsies and later MDR to better count and assess maternal deaths.

**Maternal death reviews (MDR) in India**

India produces nine million deaths from all causes every year—or roughly one sixth of all deaths worldwide. More importantly, nearly 70% of India’s deaths take place at home in the absence of medical supervision (Jha et al. 2006). Although maternal deaths represent only 1 percent of all deaths in India, they represent 11% of all deaths of women aged 15–49 years and are a leading cause of death for this age group (Montgomery et al. 2014). India has three major ways of counting deaths: (1) civil registration—yet less than a third of all deaths are registered and only one third of deaths registered have cause-of-death data; (2) medically certified cause of death, which covers less than 5% of all deaths and is largely confined to urban or hospital settings; and (3) India’s Sample Registration System (SRS), which covers only 0.5% of India’s deaths, but is the most reliable source for estimating all-cause mortality in India (Registrar General of India 2012; Jha et al. 2006; Aleksandrowicz et al. 2014). Having begun in 1970, the SRS divides India’s population into one million small areas of 1000 people and randomly selects less than 8000 of these million areas where it conducts interviews known as a Verbal Autopsies (VA). VA are used in India and across the developing world to assign causes of death when civil registration systems are incomplete or deaths are undercounted (Baiden et al. 2007; Fottrell and Byass 2010; Byass 2014). For the SRS, local, part-time enumerators conduct VA interviews to assess all births and deaths in 1.3 million households across India every month, while their supervisors recheck the sample area every six months, revisiting households as needed if the enumerators’ and supervisors’ reports do not match. The VA reports are sent to two trained physicians who assign cause of death; if the physician reports do not agree, a third physician adjudicates and assigns the final cause of death.

Even after years of using VA, India—which produces more births, maternal deaths, and neonatal deaths than any other country in the world—continues to undercount maternal deaths. A recent study from Rajasthan (Iyengar et al. 2009:302) found that 45% of all maternal deaths
were not registered by the government. Although the Indian government rolled out MDR across the country in 2011, let us consider a case study that illustrates the poor quality of care still found in India today.

An ethnographic review of a maternal death

Tendzin’s case took place in Ladakh, a remote Himalayan region comprised of two districts, Leh and Kargil, that each contain a single public hospital providing the only comprehensive emergency obstetric care (CEmOC) in the region. Unlike most of India’s 640 plus districts, there are no private maternity hospitals in either of these districts, a testimony to the quality of care at the two government hospitals and the remoteness of the region. Although the rate of institutional delivery in Leh district is nearly double that of the neighboring Kargil district, where our case study occurred, both districts share a steady increase in institutional delivery and contraceptive prevalence in the past three decades (Gutschow and Dolma 2012; Gutschow 2011). Leh and Kargil districts reported the first and second highest contraceptive prevalence rate (CPR) across all India in 2011, while Leh district was tied with Chennai for having the lowest total fertility rate (TFR) in India in 2001 (Rajan 2005). According to a recent survey (Indian Council of Social Science Research 2008), the average villager in Leh district needs to travel 33–42 km, often on foot, to reach a health clinic in a region whose average altitude is 3000 meters above sea level. Although a third of the population lives below the poverty line, most households own land or a business and nearly all of the medical staff in the region are locals who share the language & culture of their patients. Roughly 90% of Ladakh’s residents claim Scheduled Tribe (ST) status—which confers affirmative action privileges—yet caste is rarely foregrounded in routine social interactions. Ladakhi society is not divided by deep caste divisions or violence, as 90% of the Buddhist population are considered commoners (mi dmangs) who now eat with but often still refuse intermarriage with the backward castes but not the aristocrats (sku drags) who make up the remainder of Ladakh’s Buddhists (Gutschow 2004; Aengst 2014). Ladakh’s high degree of female autonomy, low fertility, prevalence of land ownership, and widespread ST status but absence of caste violence are less common elsewhere in North India. However, our case study illustrates a poor quality of care that is hardly unique to Ladakh.

Tendzin was eight months pregnant with her first child and bleeding heavily when she arrived at the Padum Community Health Center (CHC), the only clinic in the Zangskar subdistrict of Ladakh to provide basic emergency obstetric care (BEmOC). Stanba, the senior medical officer (MO), gave Tendzin a speculum exam and diagnosed placenta previa after “seeing a little bit of the placenta” (sha ma tsha pigs gtong song) covering the cervix, but since she was not losing much blood, he told her “not to worry” (tsher ka ma byos). He ordered the senior nurse-midwives at the CHC, Lhamo and Deskyid, to administer glucose, iron, and haemecel to balance her blood volume and put her on bed rest for a week. After four days in the CHC her bleeding stopped. When Tendzin began to bleed again because she walked to the courtyard toilet—the toilet off the ward was too soiled to use—she was put on another week of bed rest. Stanba told Tendzin’s father and father-in-law that he wanted to induce her, but they refused as she was not yet full term. Instead they called her husband, a soldier stationed in Leh, to have him take her to Leh hospital but he was not granted leave. Stanba then discharged Tendzin with firm instructions to stay on bed rest in her father’s apartment behind the hospital. Yet Tendzin ignored this advice and followed her mother home to her natal village of Tetsa, where she started to bleed in the middle of the night three days later after performing household chores.

Her mother immediately called the pharmacist and the auxiliary nurse-midwife (ANM) from Tetsa. The pharmacist wanted to take Tenzin to Padum, but he and the ANM delayed calling the ambulance driver (who was stationed in Tetsa along with his vehicle) until the next morning. The next day, the ambulance leisurely picked up half a dozen health care staff that needed a ride to the CHC’s annual archery festival, before reaching the Padum bazaar. Only a hundred yards short of the
When Tendzin and her mother reached her husband’s house in Uberag, her mother-in-law invited them both in for a cup of tea. Tendzin’s mother soon departed, claiming she had to tend to her livestock and catch the last bus home from Padum. Tendzin went to lie down in the room off the kitchen—perhaps fearing that her copious bleeding might offend the hearth gods (thab lha) and water spirits (klu) who ‘reside’ in the kitchen and govern household prosperity and fertility (Gutschow 2011). By the middle of the night, Tendzin’s father-in-law heard her moaning and saw that she was bleeding heavily. He ran next door to call his oldest son, Tashi, who soon arrived to see blood seeping from under Tendzin’s robe. After discussing the emergency with his parents, Tashi ran down to the Padum CHC. He went directly to see Lhamo, the senior nurse-midwife, who apologized profusely saying she could not assist as she was due in property court that day. Lhamo was understandably confused because she had seen Tendzin’s mother in Padum the night before and had been told that Tendzin was fine and staying in Uberag. Tendzin’s mother made no mention of Tendzin’s second bout of bleeding in Testa nor the ride to Padum in the ambulance. Lhamo then took Tendzin’s brother-in-law to see Stanba, the MO, who refused to help, as he was too drunk from the day’s archery festival. Tashi was sent onwards to find Skalzang, a nearby midwife who only agreed to go if accompanied by a junior MO and a pharmacist.

Skalzang, the junior MO, the pharmacist, and Tendzin’s brother-in-law hiked up to Uberag, where they found Tendzin drifting in and out of consciousness in a pool of blood at 6 a.m. Skalzang noted that Tendzin had little pallor in her eyelids or lips, a sign of heavy blood loss. When Skalzang did a quick cervical check, she found the baby’s head descended, the cervix not fully dilated, but no sign of placenta previa. She got an IV into Tendzin’s vein, administered glucose and epidocin (a muscle relaxant) to open the cervix, and two shots of syntocinon (synthetic oxytocin) to stimulate uterine contractions. Soon afterwards, Tendzin delivered a stillborn infant. The MO attempted to revive the baby boy with CPR for a few minutes to no avail. Skalzang got increasingly worried when the placenta did not emerge after nearly a half an hour as she had exhausted her supplies of oxytocin and glucose. Her kit still contained methergen (a combination of oxytocin and ergometrine), but she did not use it because it causes contraction of the uterus and can prevent expulsion of the placenta. The MO, who had little knowledge of obstetric complications, began to panic and insisted on tying an unconscious Tendzin onto Tashi’s back with a shawl. The medical team rushed out of the house they had only entered a few hours earlier, just as Tendzin’s father arrived from Padum. They had not gone more than 500 yards when Tendzin seized up. When they opened the shawl, Tendzin had no pulse. After the medical team returned to the house and knocked on the door, the pharmacist reported “your daughter is gone” (khyed rang gi bu mo tsar song) and both men began to weep. The medical team wanted to take the body to the CHC for an autopsy, but the fathers refused. Tendzin’s body was cremated four days later and her infant’s body was buried in the innermost winter room (yog khang) as is customary (Gutschow 2004).

There was no maternal death review (MDR) for Tendzin’s death as it occurred in 2006, long before the government implemented MDR. However, I undertook an extended MDR between 2006 and 2009 involving lengthy interviews with 12 people (eight health care staff and four relatives) who attended Tendzin in the final hours and days of her life. I tried to replicate the MDR process by reviewing the facts of the case with the medical staff who attended Tendzin and the chief obstetrician at Leh hospital in order to clarify clinical confusion, omissions, and errors. While I do not propose
that the MDR process should involve months interviewing individuals, I do believe that a few additional interviews might help triangulate conflicting information between narratives. The MDR process should return to or seek out specific informants who have conflicting views in an effort to present a more complex and sophisticated view of what aided and obstructed the case. Most important, MDR interviews could stress ambiguity by enabling informants to express regret, failure, or alter their initial cover-ups while also providing a view ‘from below’ or outside the realm of medical authority. My interviews necessarily involved a strategic combination of ‘not-knowing’ and ‘knowing,’ in which I allowed each informant to offer their own narratives before asking them to clarify when their stories conflicted with other accounts, while preserving the anonymity of those who confided in me.

While Stanba, the senior MO, first offered a mistaken diagnosis of placenta previa, at a second interview he changed the diagnosis to placental abruption—which can either worsen or resolve with minimal intervention, supporting his decision to place Tendzin on bedrest. It was only during a third interview that he admitted that his initial diagnosis had been incorrect. Even then, he did not appreciate that both complications—placenta previa or placental abruption—may become life-threatening to mother or baby and would then require an emergency cesarean and/or blood transfusion, both unavailable at the Padum CHC. Both Stanba and the senior nurse Deskjyid refused to admit guilt for not treating Tendzin the night she died. Instead they continued to blame Tendzin for not staying on bed rest and not returning to the Padum CHC. By contrast, Lhamo regretted her decision not to attend to Tendzin the night she died and added that it had been a ‘sin’ (dig pa) because her own mother had died from a postpartum hemorrhage decades earlier. While Deskjyid and Lhamo, both senior nurses at the Padum CHC, had wanted to refer Tendzin to Kargil, they were unable to over-ride Stanba’s decision to put her on bed rest nor did they urge Tendzin’s family to take her to Kargil. The numerous inconsistencies about who called the ambulance, when it arrived, and who rode to Padum seemed attempts to cover up the egregious delay in getting Tendzin to Padum, especially if one considers that the medium time from onset to death for untreated severe hemorrhages is only six hours, something none of my informants seemed to know. Tendzin’s family did not blame the staff for not referring her to Kargil but were angry that they had not been apprised of the urgency of her case. Yet they did appreciate the chance to talk about what had happened and expressed a wish that their stories would help prevent similar deaths in the future. Both Skalzang and the junior MO did not feel skilled enough to perform a manual compression of the uterus or a manual removal of the placenta, nor did they realize that the amount of oxytocin administered was only one-fourth the amount required to stanch the hemorrhage.

The conflicting accounts between medical staff revealed complicity around mistakes in care that indicate ignorance, denial, and possible duplicity. There was no official analysis of Tendzin’s death, and it was not recorded by the Padum medical staff nor by the health data office in Kargil that year. The senior MO was later transferred out of Padum and there was no indication in the next years that the medical staff in Padum changed their protocols after this tragedy. Without MDR, similar deaths occur and are unrecorded daily across India and provide little opportunity for improving obstetric care.

**The challenges of MDR in India**

To appreciate how MDRs are intended to but often fail to improve the quality of obstetric care in India, let us examine the empirical evidence of how they affected obstetric care or outcomes as well as consider the government guidelines that shaped their implementation across India. Using the WHO’s (2004) MDR recommendations as a guide, the Government of India (2010) published an MDR guidebook that lays out a set of standard questions and processes within the community, block, district, and state levels. According to India’s MDR guidebook, community-based MDR begin when (mostly female and often undertrained) community health workers report the death of a woman of reproductive age (15–49 years) to the Block Medical Officer (BMO) in exchange for a
nominal payment of 50 Rupees ($1). After the BMO determines whether the death is a maternal death, an investigative committee is formed that is made up of medical officers, nurses, or Auxiliary Nurse Midwife (ANM)—the latter of whom are paid 100 Rupees as incentive. Facility-based MDR begin with a report by the medical officer who attended or was in charge of the facility where the death occurred. However, even after implementation of MDR, ANMs and Accredited Social Health Activists in Uttar Pradesh ‘overlooked’ more than a third of the maternal deaths they were supposed to report during a single year (Raj et al. 2013). India’s MDR guidebook assumes that medical staff will report maternal deaths honestly, and that higher-ranked medical staff would not blame lower-ranked medical staff like ANMs for clinical errors. Yet studies from Karnataka and Madhya Pradesh both before and after the implementation of MDR indicated that medical staff routinely blamed ANMs or traditional birth attendants for errors they did not cause and referred women with life-threatening complications to other facilities in order to avoid being blamed for maternal deaths at their own centers (George 2007; Subha et al. 2012; Iyer et al. 2013). This pervasive culture of blame and denial within India’s health care system is recognized by the MDR guidebook:

Many of the questions seek sensitive information that may appear to reflect badly on care provided to women by their families and sometimes by the health system. All these conditions can lead to temptations to falsify data in order to quickly complete the interview and not record painful facts. (Government of India 2010:39, my emphasis)

By assuming that MDR will reveal poor care provided by families but only ‘sometimes’ by medical staff, the MDR guidebook subtly perpetuates an implicit bias against laypeople. More critically, there are few suggestions for how medical staff might be trained not to cover up their own errors. If the medical staff who conduct MDR are susceptible to falsification of data, the entire MDR process is fundamentally compromised. In short, how can the MDR process fix a dysfunctional health care system rife with such a lack of accountability? Several studies document the provider apathy and poor quality of care that the MDR process has failed to fix:

Lack of accountability was demonstrated by the poor quality of care and apathy among the health professionals in the institutions and the frequent flouting of ethical principles in the provision of care. … There are serious issues in the culture of the district health system—corruption, individual personal gain, dereliction of duty—that need to be changed. (Subha et al. 2012:15)

While it may be idealistic to expect the MDR process to change underlying problems of corruption or dereliction of duty, it is possible that systemic reviews will begin to raise awareness or outrage among laypeople or community organizations about these failures of health care. Notably, facility-based care is implicated in a majority of the maternal deaths in India, contrary to the assumption that most maternal deaths lack skilled attendance or take place at home. Iyengar and colleagues (2009) found that two-thirds of all maternal deaths included women who had sought care in facilities and George’s (2007) study reported that three-fourths of all maternal deaths resulted from poor quality obstetric care including inappropriate diagnoses, treatments, or referrals. Barnett and colleagues (2008) found that 28% of all maternal deaths took place in facilities, and a further 11% of all deaths occurred in transit to/from a facility where treatment may have been denied or ineffective. Furthermore, it was unclear how many of the women who died at home had sought care at a facility. Before the implementation of MDR, there was ample evidence that medical staff in India covered up inappropriate or delayed obstetric care that caused maternal deaths (Human Rights Watch 2009; George 2007). Yet even after the implementation of the MDR, studies indicate that medical staff may try to cover up their own failures. Iyer and colleagues (2013) documented a case in which medical staff caused a hemorrhage by excessive abdominal pushing and vaginal sweeping, although the official verbal autopsy named the woman’s family rather than medical staff as the cause of death. Subha and associates (2012:15) documented an MDR case in which medical staff threaten relatives of the deceased with imprisonment when they complain about lack of obstetric care. The most marginalized women are most likely to be the targets of intimidation and discrimination:
Women patients also reported instances of verbal and physical abuse by staff during delivery, and tribal women felt they were discriminated against by health care providers (Subha et al. 2012:15).

Several studies have reported systemic failures or delays of obstetric care that stem from discrimination against poor, tribal, or lower caste women (Human Rights Watch 2009; Iyer et al. 2013; Jeffery and Jeffery 2008, 2010). Subha and colleagues (2012:11) indicated that 60% of all maternal deaths in India occur among women with Scheduled Tribe (ST) or Scheduled Caste (SC) status, while 77% of all maternal deaths at one district hospital were ST women. Iyengar and associates (2009:295) reported that three-fourths of all maternal deaths in their study were women of ST or SC status, although these groups only comprised only 37% of the study population. George (2007) argued compellingly that many maternal deaths are the result of systemic gender and caste biases, as poor women’s urgent medical needs are ranked below routine, nonemergency care. Despite this data, the Indian government’s MDR guidebook is largely silent on how caste, class, and gender hierarchies can influence the MDR process or inappropriate obstetric care:

What is most striking about the maternal deaths we documented in Koppal is not the lack of access to care, but the irrational or inappropriate care provided to women during delivery (George 2007:98).

While India’s MDR guidebook insists that the process will be kept confidential, it specifies that the name, residence, and husband’s name of the deceased woman be listed on the first page of the MDR report that is sent up the chain of command.12 The Chief Medical Officer within the district is instructed to ‘select’ a few maternal death cases and ‘ensure’ that at least two relatives of one woman who died attend an official hearing with the District Magistrate (Government of India 2010:18). The innocuous use of the term “ensure” implies the possible coercion of relatives and directly contradicts the anonymity so central to the MDR ethos. It also ignores the obvious fact that laypeople may be loath to critique a health system unless they are protected from retaliation by those they are evaluating.

The Indian MDR guidebook states that a district-level MDR Committee will meet monthly to review all maternal deaths and develop specific ‘corrective measures’ at three levels—the community, the facility, and the state—but it fails to describe what these corrective measures might entail (Government of India 2010:19). Instead of setting forth clinical standards, it is assumed that medical staff will correctly identify clinical errors and implement evidence-based clinical protocols. However, an MDR implementation study found: “No standard management protocols such as the use of partographs were followed, infection measures were found to be inadequate, and the level of cleanliness was unsatisfactory” (Subha et al. 2012:15).

Neither the WHO’s MDR guidebook nor the Indian government’s MDR guidebook recommends specific clinical protocols, perhaps because it is assumed they would already be present in a given healthcare system (WHO 2004; Graham 2009). Yet the new MDR handbook issued by the International Federation of Gynecologists and Obstetricians explicitly addresses the importance of using clinical standards (De Brouwere, Zinnen, and Delvaux 2013; De Brouwere et al. 2014):

Clinical standards define the minimum acceptable level of quality of care. ... If there are no explicit standards, the risk is that it may be difficult to reach a consensus on the appropriateness of the care provided, especially if professionals have different ways of practicing due to different training backgrounds. (De Brouwere et al. 2013:22–23)

While this is a welcome addition, the new MDR handbook also fails to address the differences between various providers that may help illuminate fissures in power between providers or between clinic and community. Given these pervasive obstacles to quality and accountability in Indian obstetric care, how might MDR staff be trained to better implement the MDR process?
Ethnographic ways of knowing and MDR

A rich phenomenon with inherent ambiguities calls for a characterization that preserves those shady edges, rather than being drowned in the pretense that there is a formulaic and sharp delineation waiting to be unearthed that will exactly separate out all the sheep from the goats. (Sen 2005:xiv)

Amartya Sen’s foreword to Paul Farmer’s (2005) manifesto on the anthropology of structural violence offers a hint at how the MDR process might begin to privilege ambiguity, multiplicity, and dissent in productive ways. The Government of India’s (2010:42) MDR guidebook categorically states, “more than one person answering the same question can lead to confusion and greatly lengthen the interview.” As such, the guidebook effectively silences the very inconsistencies and multiplicities that might help illuminate gaps of care that providers may be trying to deny and patients trying to expose. Iyer and colleagues’ study (2013) is one of the few to explicitly focus on the ‘Rashomon effect’ of multiple perspectives around maternal mortality, in order to develop an improved analytic model of why access to care was delayed or denied (Thaddeus and Maine 1994). Other MDR studies have tried to avoid the “dominance of biomedicine” as well as the “reductionist biomedical paradigm” (D’Ambruoso, Byass, Qomariyah, and Ouedraogo 2010:1736), but failed to avoid a situation in which MDR interviewers “represent the structures of ‘medical authority’” while informants tended to exhibit “feelings of powerlessness to question the medical staff and systems associated with authority” (D’Ambruoso, Byass, and Qomariyah 2010:233, 229). I argue that MDR will be most successful when they privilege the following ethnographic insights and sensibilities: (1) a self-awareness of how the surrounding context and status of people involved in the interview influences the power imbalance or betrayal inherent in MDR interviews; (2) a strategic awareness of how the contested, contingent, and partial nature of knowledge shapes the MDR process; (3) an ethical engagement and commitment to dialogical exchanges that allows both informants and interviewers to affect the outcome of the interview and the MDR process. Let me take each of these points in turn.

First, an ethnographic sensibility that privileges subjectivity ‘from below’ could lead MDR interviewers to attend more fully to conflicting views over “what really matters” and what types of social suffering maternal deaths represent (Kleinman 2007; Farmer 2005; Biehl, Good, and Kleinman 2007; Kleinman, Das, and Lock 1998; Wendland 2010). The MDR staff—usually medical staff—could be trained to better attend to the voices of the individuals most disposed or marginalized by social and medical hierarchies including women, the poor, backward castes, or staff at the bottom of the medical hierarchy. This training could include explicit discussion of an ethics that privileges subaltern or oppositional voices while recognizing that any interview is riddled with an asymmetry of power, even when researchers come from the same community as their informants (Skeggs 2011; Stacey 1988; Freidenberg 1998; Narayan 1993; Visweswaran 1994; Behar 1996). This will help dispel the assumption found in MDR studies that informant and interviewer have “equal claims to power” merely because the interviewer is a local field researcher “who speaks the same dialect, relates to local customs, and is able to decode items and local symbols” (Iyer et al. 2013:399, 394). As studies from India indicate, the perspectives of nurses, orderlies, and family members are all too often silenced, elided, or dismissed. The MDR process could attend to the feminist insight that interviews may involve betrayal by explicitly ensuring the anonymity and job security of less powerful informants (i.e., nurses who describe mistakes made by superiors), rather than merely paying lip service to the slogan ‘no name, no blame.’

Ideally, the MDR process will need to displace the medical models of authority in which doctors trumps orderly or nurse, the clinical trumps the cultural, and rational consensus trumps discursive ambiguity or conflict. In our case study, that could mean trying to understand and harness the Buddhist beliefs about purity and pollution that caused Tendzin’s mother to take her daughter to her in-laws’ house rather than to the clinic. MDR training might openly discuss the shift in birthing rituals in Leh district, where many women who deliver at Leh hospital now hold
ritual practices to appease guardian deities in nearby rented rooms before they drive home from the hospital (Gutschow 2011). They could build on this knowledge that families can promote institutional delivery and preserve their Buddhist ritual practices of purification in ways that are healthy for mother and baby. Last but not least, the inversion of hierarchies between doctor and midwife might allow the MDR process to attend to state agendas that alienate or disempower local midwives or birth attendants that have been documented in India and elsewhere (Aengst 2014; Adams et al. 2005; Berry 2006, 2008, 2010; Allen 2004; Davis-Floyd and Sargent 1997; Hay 1999; Obermeyer 2000; Pinto 2008; Wendland 2010).

Second, MDR interviews can provide a more complex and comprehensive view of obstetric care when they strategically use conflicting statements between informants to better understand the sequence of action and inaction, awareness, and misunderstanding that may cause deaths but also be fertile junctures of practice or power. Put another way, both facility-based and community-based MDR should attend to multiplicity and conflict between informants, not just points of agreement. For instance in our case study, all agreed that Tendzin died from a hemorrhage. Yet the disagreement about why Tendzin was not referred to Kargil or Padum and why she went to Uberak provided useful insights into the complexity of the case. While the MO never admitted his mistake in not referring Tendzin to Kargil given the danger of placenta previa or placental abruption, one of the nurses argued that similar cases of antepartum hemorrhage had been managed successfully at the Padum clinic during the winter months. Indeed, the Padum clinic manages these cases by necessity in the winter when referrals usually involve unreliable emergency helicopters that can be delayed for days or weeks. When Tendzin first arrived at the Padum CHC in late May, the MO could have called for helicopter to transport Tendzin to Kargil. Yet he also knew that the military might not send the helicopter if there was any suspicion that the road was open and the snow had melted. Given the uncertainty about whether a helicopter would be sent and his knowledge that road transport might be risky while Tendzin was bleeding, his decision to treat her in Padum makes more sense.

Third, MDR interviewers could be taught dialogic methods of interviewing that allow informants to co-construct the process and outcome of the interview and the MDR. Insights from the reflexive, activist, and postmodern turns in ethnography all yield the important recognition that the ‘facts’ that emerge from any interview are relational, contingent, and constituted by the variable and fluid nature of the interview itself (Holstein and Gubrium 1995; Kvale 1996; Heyl 2011, among others). MDR interviewers could learn to attend more closely to what the informant chooses to say or not say as well as how it is said and understood in relation to the interview dynamic itself (Heyl 2011; Denzin 2009; Holstein and Gubrium 1995; Kvale 1996). While the Indian government might well question the additional utility of training MDR interviewers in reflexive techniques, these techniques could be phased in if pilot studies show their utility. Because both community-based and facility-based MDR already involve laypeople, the efforts at making MDR interviews more dialogical could harness lay insights that lie outside, are occluded, or ignored by the medical realm. If MDR trainings improved the interviewers’ capacities in active listening, they might better elicit lay critiques that threaten the very medical privileges or biases that are contributing to poor quality of care.

Moreover, MDR staff should be trained to more actively seek out and engage community stakeholders that can foster better rapport or trust between clinic and community (Denzin 2009; Skeggs 2011). Local stakeholders already have been used in India to create community grievance or monitoring procedures that have been shown to improve quality of obstetric care (Subha et al. 2012). Similarly in the United States, community stakeholders were able to help the Centers for Disease Control (CDC) find the most at-risk and vulnerable groups when it rolled out the largest nationwide HIV survey, the National HIV Behavioral Surveillance system. In the CDC survey, “the support of community stakeholders” in metropolitan project sites was critical in locating key informants and conducting focus groups with high-risk groups including intravenous drug users and prostitutes (Allen et al. 2009:31). In Ladakh, the MDR process should include key informants such as village-based women’s alliance groups, prominent nuns, or community organizers who might direct focus
groups or provide links to those groups most at risk of maternal death such as unwed mothers, adolescents, or migrants from Nepal and elsewhere in India. Furthermore, youth skills in social media could be harnessed to spread awareness about obstetric danger signs or develop hotlines that facilitate the calling of ambulances, taxis, or local midwives.

Conclusions: MDR beyond India

It is expensive and time-consuming for the Indian government to review the 50,000–72,000 maternal deaths that occur every year. Yet if the MDR process is to have any impact, it must begin to change the dynamics of power between patients and providers. Sensitivity is required in getting both patients and providers to reflect honestly on a recent and traumatic death and change their practices accordingly. Even when adopting reflexive ethnographic sensibilities, medical staff may be unwilling to acknowledge substandard care in their own facilities, while families may refuse to admit errors or assist the MDR staff whom they may blame for a death. The WHO guidebook for MDRs emphasizes the notion of “no name, no blame” and anonymity for all involved (WHO 2004). Recent studies from Eastern Europe and Central Asia found that existing maternal death audits had tended to operate in the context of a top-down culture of blame and scapegoating before the WHO intervened (WHO 2010; Stratulat et al. 2010; Drife 2010; Bacci et al. 2007; Bacci 2010). It took considerable training before health care staff could conduct MDRs without fear of being fired or other legal sanctions, and begin to use MDR to promote evidence-based obstetric practices.

This situation of mistrust within obstetric care is still found in the United States despite the introduction of MDR. A notorious propensity to litigation in obstetrics has produced an ‘omertà’ of silence among obstetricians who regularly cover up maternal deaths for which they may be sued (Wagner 2006). Because they fear social ostracism from their peers, doctors may be unwilling to testify in obstetric malpractice cases and may collude to cover up egregious medical errors even after implementation of MDR (Wagner 2006). The lack of maternal mortality review boards across the United States—only 21 states had such boards in 2010—implies that obstetricians and hospitals are not being held accountable for the preventable errors that cause up to half the maternal deaths in the United States (Amnesty International 2010). In the United States as in India, inequality structures the likelihood of maternal death. Black women are nearly four times as likely to die in childbirth than white women, even when they do not have a higher prevalence of maternal complications (Amnesty International 2010; Bingham, Strauss, and Coeytaux 2011). Some hospitals misreport these maternal deaths, especially for women of color, as this data might force them to admit systemic discrimination in care. This lack of oversight may contribute to the undercounting of maternal deaths in the United States.

Both India and the United States have higher rates of maternal mortality and higher rates of undercounting maternal deaths than their economic peers. With an MMR of 28, the United States has an MMR that is 2-14 times higher than any country in Western Europe, for instance (WHO 2014). Yet the CDC consistently undercounts the actual maternal deaths that occur each year (Deneux-Tharaux et al. 2005). The CDC’s estimate of annual pregnancy-related deaths in the United States—is roughly half the WHO’s official estimate of 1200 annual maternal deaths (WHO 2014; CDC 2014). Similarly, the Indian government estimates its MMR to be one-third the official estimate reported by the Global Burden of Disease (GBD) Study (Kassebaum et al. 2014; Registrar General of India 2013). Notably, the WHO and the GBD—who count maternal deaths most systematically across the globe—diverged widely in their estimates of MMR for India and the United States and indicated considerable uncertainty about maternal mortality in both nations. Although the MDR process aims to go ‘beyond the numbers,’ it still requires paying attention to numbers when there is so much uncertainty about total maternal deaths.

If the MDR process is to be successful in India, it will need to address fundamental issues of quality, access, and power within obstetric care (Freedman 2001). Tendzin’s case offers some critical insights into the failures of obstetric care as well as the obstacles that can hamper a review of
omissions or delays of care. If India’s MDR process is to address the lack of accountability and denial of obstetric care that is partly to blame for many of the country’s maternal deaths, it will need to train its staff to ask both hard questions and tackle the pervasive hierarchies of power and access that are producing maternal deaths across India today.

Notes

1. Freedman and colleagues (2007:1384) noted: "In short, we know what to do, but how to do it varies by context. Understanding context entails an appreciation of the relation between supply and demand within the district level health system. . . ."
2. In contrast, in countries with low MMR, high resources, and where most deaths take place in facilities, the WHO (2004) recommends three other methods of MDR: (1) confidential enquiries into maternal death, (2) reviews of severe morbidity or near-misses, and (3) clinical audits.
3. According to the WHO (2012) the leading causes of death in India are ischemic heart disease, chronic obstructive pulmonary disease, stroke, diarrheal disease, lower respiratory infections, preterm birth complications (often related to intrapartum or neonatal complications), tuberculosis, suicide, falls, or road injury.
4. There are notable disadvantages to VA including (1) they are labor-intensive and require skilled field-based personnel as well as physicians or algorithms to assess cause of death, (2) the list of causes of death assessed using VA is smaller than the list found in the International Statistical Classification of Diseases and Related Health Problems, tenth revision, and (3) the quality of the assessment can be influenced by recall bias, social desirability bias, or error, such as when laypeople systematically underecount early maternal deaths from illegitimate or hidden pregnancies (Garenne and Fauveau 2006).
5. After 2006, the Indian government refined its verbal autopsies using a method known as RHIME (Routine, Reliable, Representative, Resampled Household Investigation of Mortality with Medical Evaluation) for the Million Death Study, the largest prospective study of deaths in the world (Jha et al. 2006).
6. According to the 2011 census, Leh was the second largest in area but one of the least populated of India’s 640 plus districts, while Kargil district has a third of the land mass of Leh district but roughly equal population of 140,000 people making it three times as densely populated as Leh district. Freedman and colleagues (2007) defined CeMOC (Comprehensive Emergency Obstetric Care) and BEmOC (Basic Emergency Obstetric Care) as follows: BEmOC includes 6 functions: IV antibiotics, IV anti-convulsants, IV oxytocins, manual removal of placenta, removal of retained uterine products, assisted vaginal delivery. CEmOC includes these six signal functions plus surgery (i.e., cesarean or hysterectomy), and blood transfusions.
7. An Indian Council of Social Science Research (2008) survey of Leh district found that 90% of all children were delivered institutionally, while the government reported the institutional rate of delivery in Leh and Kargil districts as 74% and 45% respectively in 2007 (Government of India 2007a, 2007b).
9. In 1989, the state government officially declared eight ST groups including both Buddhists and Muslims (Balti, Bot, Purigpa, Drokpa, Changpa, Beda, Gara, Mon) that confer affirmative action including admission quotas to higher education and government jobs. The Beda, Gara, and Mon are considered ‘backward castes’ as they have traditionally been subject to discrimination by commoners who refused to eat food cooked by these groups or intermarry.
10. As described elsewhere (Gutschow 2004, 2011), Buddhists believe that married women are protected by their husband’s guardian deity (pha lha) if they deliver in their husband’s home, but that they offend their former, natal guardian deity—whose protection they abandon after marriage—if they deliver in their natal household. After marriage, a woman’s menstrual blood or bleeding during pregnancy/childbirth is offensive to the guardian deity of her natal household.
11. The Auxiliary Nurse Midwife (ANM) offers a host of preventative services including family planning, immunization, and counseling that prevent her from attending to her already overscheduled midwifery services, the Accredited Social Health Activist receives no salary but cash transfers for a variety of reproductive services or referrals, and the Anganwadi Worker provides nursery care and food to infants and children.
12. The MDR Guidebook perpetuates the assumption that a pregnant women must have a husband by requiring the label w/o (wife/of), while men have no such epithets.
13. The CDC (2014) stated that “roughly 650 women die each year” in the United States as a result of pregnancy-related complications that occur up to a year after delivery. The category of ‘pregnancy-related complication’ is far broader than a ‘maternal death,’ which only includes deaths that occur within 42 days of termination of pregnancy.
14. The WHO estimates the United States’ MMR to be 28 while the GBD places it one third lower at 18.5, and the GBD estimated India’s MMR to be 281 while the WHO estimated it to be 190 (WHO 2014; Kassebaum et al. 2014). Both studies recognize but do not fully explain the wide uncertainty intervals in MMRs for the United States and India.

Acknowledgments

The final version of this article has been benefitted from conversations with audiences at the Seventh European Congress on Tropical Medicine and International Health in Barcelona, Williams College, Goettingen University, and the Fortieth Anniversary Conference of the Society for Medical Anthropology at Yale University. I thank Antonia Foias, Peter Just, Julia Kowalski, Claire Wendland; Patricia Jeffery, Claudia Gras, Cecilia Van Hollen, Arthur Kleinman, and Siobhan Doria for conversations and comments on this essay.

Funding

The research for this essay has been funded by Goettingen University, the Humboldt Foundation, Williams College, and the Harvard Society of Fellows.

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