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Are development and cultural preservation compatible objectives? An inquiry into the public health care in India

Subir K Kole*

*Scientific Writer and Statistician, Futures Group International, New Delhi, India

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[ABSTRACT]

Postdevelopment theorists have argued that development is an inherently violent form of Western domination over the marginalized, impoverished Other that presumes a superior, Euro-American way of being and existing as "normal". They argue that development abolishes local, indigenous knowledge, cultural traditions, and practices, since the entire development project is premised on its subjects "developing into something else" – and that something else is the West. Hence development must be discarded by all means to preserve the indigenous local cultures, and traditions. This paper aims to provide a critical insight into what happens when this theory is applied to public health care in India. Based on the critiques of post-development theory, and theories of cultural preservation, I aim to unfold the dichotomy between these two contending paradigms. I conclude that there exists a total disjunction between the theory and practice of the postdevelopment scholars and the concern for cultural preservation is rather informed by an aesthetic concern for the sensual pleasure of the elites. Drawing evidences from health care practices among various communities in India, I conclude that both development and cultural preservation are compatible objectives as they tend to reinforce on each other. Culture is both a means and ends of development.

Keywords: Post-Development; cultural preservation; India; healthcare

Introduction

Sundarban – literally meaning, the “beautiful forest,” the land of mangrove forests, poisonous snakes, reptiles, and of course, the Royal Bengal Tigers as they will tell you, stands in the mouth of the Gangetic delta occupying world’s largest mangrove ecosystem. The land is extremely dissected by numerous fast flowing channels, small streams and rivulets creating a maze of small and big islands. I had an opportunity to visit an Oxfam funded forestry program in one such island (Gosaba) in 2002, where Tagore Society for Rural Development was its local partner. What I experienced is described in the following few paragraphs.

At around 11 o’clock at night, I heard someone frantically knocking on my door. On opening, I found a man whom I have known for barely two days during...
my visit who has come to take me to his house. He took me about a kilometer away in a small, dingy hut. I saw a group of women who have gathered around, panicking, and running everywhere in order to save two lives struggling to get a new lease of life. One is an adolescent pregnant mother (may be around 16 years), who is about to deliver a baby. But since her reproductive organs were immature, the baby was “stuck” at the pelvic region. Generally, men (unless doctor) are not allowed to witness a childbirth, but in this case, it was an emergency, and they thought being an “educated” man from a city, I could suggest and do something. She has been apparently laboring for over two days, wherein a local midwife (dai) was reported to be helping her. But when nothing happened, she ran away panicking, leaving her hope that anything could be done.

All the windows, including small holes on the walls were closed; so I suggested opening all the windows to let the fresh air in. While the woman was writhing, screaming and moaning in pain, one gunee (traditional woman healer or magic-woman) was called in. The gunee first closed all the windows and holes again saying it will cause fever; then put some magical oil extracted from lizard (water-monitor) on the woman’s head and rubbed a while. On the other side, she had set a fire-pit with cow-dung cake; had put some “magical things” in the fire that produced a thick suffocating smoke, and ordered the woman to inhale it. The smoke was asphyxiating! Apparently, this did not help. The gunee then took out some plant roots, animal bones (which is called Ayurvedic medicine) prepared a mixture in a stone bowl-grinder, and then told the woman to drink it with a glass of water and honey. When nothing helped, she declared “bonbibi [local spirit] is angry with her conduct.” I helplessly kept watching as an outsider!

One dai was called in from another island who tried to estimate how far the baby has descended and then suggested to cut the belly open. But who will do it? There is no equipment, no surgeon, no doctor, and the nearest health facility is about 15 Kilometers away, which would take switching between boats and cycle-rickshaws to cross and commute over the islands. And at this hour of night, no services are available! The gathering lost hope, everyone started getting back to their own bed as the midwife continued her “traditional” way of dealing with pregnancy and childbirth using warm water, bamboo blades, banana leaves, honey, ashes of cow-dung, mustard oil, lizard oil, snake skin, and such. In the morning I heard the news: both the mother and the newborn had died!

Did I get the “problem statement” correct? I am not here to defend the practices that result in the death of innocent lives in the name of “cultural preservation” (that way, one can go on defending sati, the custom of burning brides alive with their husbands’ funeral pyre as a measure of preserving “culture”). At the pragmatic level, I am here to evaluate if modern development program has any contribution in raising people’s health status by way of enhancing their choices to adopt modern health practices and medicines replacing the traditional ones? Assessing what should be the right balance
between the two places me in a difficult position as there are complex relationships between these two contending paradigms in the way they interact with each other. This complexity has been multiplied by an all-pervasive process of economic and cultural globalization that has linked the "local" and the "global" in a complex web of relationships. Explicating this complexity is not an easy task. However if I understood the "problem" correctly, and if I am asked to take only "one" side of the debate, then I would say "yes": cultural preservation and development are compatible objectives as they tend to reinforce on each other. Culture is both a means and ends of development!

"Traditions" ruining health

My example of pregnancy and childbirth cited above was only "one" among several thousand "traditional" health practices that continue to wreck India and its people's health every day. People in rural areas, which constitute 70 percent of India's total population, continue believe in black magic (jhar-phook); local spirits (bhoot-pret); using plants and herbs (jaribooti) for treating disease and illness, the knowledge of which often develops from rumors or a perceived understanding that "this works." And exploiting their situation and ignorance, a class of traditional healers (vaids and guneens), and quacks (hatures) continue to flourish, often by killing the patient and shifting the blame to a local spirit. There is a group of scholars (Nandy 1992, 1998; Rahnema 1992; Sachs 2002; Escobar 1995; Munck & O'Hearn 1999; Kothari & Minogue 2002) who would possibly argue "yes," these practices need to be preserved, as modern scientific rationality can not adequately explain the epistemological foundation of such practices using its universal, hegemonic, "scientific" criteria. The number of such scholars is growing as globalization tends to engulf small cultural practices and replace them with its dominant cultural frame. These scholars are extremely critical of modern science and technology (and development). They argue that introducing modern systems would run havoc among traditional communities, and hence they need to be left "as is" since "we don't understand them." Part of my answer then, is philosophical, as I grapple with understanding a rationality that justifies institutionalized human killing and depravation. But before I proceed, I would like to explicate what is indicated by the term "cultural preservation".

1. Culture and Preservation

Culture remains one of the most contested concepts among the anthropologists, and there is no single definition of it. Theorists offer some common attributes of culture involving systems of knowledge, values, beliefs, practices, material possession, that are shared by a group of people. Culture is learned, socially constructed and determines the way people relate to the material world consisting of patterned behavior. Culture is, thus, dynamic, constantly in flux and evolves over time. Edward Said (1994) offers two important dimensions of
culture: First, it means all those practices, like the arts of description, communication and representation, that have relative autonomy from economic, social and political realms, one of whose principal aims is pleasure (I would come to this point later); and second, culture is a concept that includes a "refining and elevating element, each society's reservoir of the best that has been known and thought" (Said, 1994: p. xii). Thus culture comes to be associated, often aggressively, with the nation state which differentiates "us" from "them," with some degree of xenophobia. Culture in this sense is a source of identity, which we see in recent years, is manifested in the effort of "returns" to culture and tradition. "These 'returns' accompany rigorous codes of intellectual and moral behaviours that are opposed to the permissiveness associated with such relatively liberal philosophies as multiculturalism and hybridity. In the formerly colonized world, these 'returns' have produced varieties of religious and nationalist fundamentalism (ibid., p. xiii).

Said (1994), therefore, observed culture as a sort of "theater where various political and ideological causes engage one another" (ibid., p. xiii). This idea of culture entails not only idolizing one's own culture but also thinking of it as somehow divorced from the everyday world. They also see the idea of culture as "order" emphasizing on the idea of 'power' which stands as Hobbsian Leviathan against the persistent threat of chaos and anarchy. Gupta and Ferguson (1997) observed that "whether understood as functionalist glue that make social cohesion possible (the Durkheimian concept); the abstract code enabling societal communication possible (structuralist one); or the domain of shared, intersubjective meaning that alone make symbolic social action possible (Weberian/ Geertzian interpretation), concept of culture has consistently emphasized the shared, the agreed upon, and the orderly." (p. 4). Marxist and feminist revisions in the 1960s and 1970s only partly displaced the earlier versions by centering questions of domination: how the cultural "rules of the game" got made, by whom, and for whom. Yet the idea of culture as orderly, remained intact. In the era of cultural globalization and transnational cultural flows, dominant cultural forms are picked up by various localities and significantly transformed in the midst of a power relation that links localities to the wider world. In that process, the sense of culture as "space of order" and "agreed upon meanings" undergoes significant transformation. Rather than being a domain of sharing and commonality, culture becomes a site of difference and contestation.

*Cultural preservation*, thus recognizes, that all such strands of culture as language, folklores, songs, dance, practical skills; arts and crafts; materials, artifacts; buildings, monuments, architectures, sacred sites; relationships to the land; and forms of subsistence must be maintained intact and preserved. It is because they retain ‘memories’ of the old pattern of resource use and tell us how people interact with a specific ecosystem. This “memory” component in the idea of preservation makes one romantic: to go back in time, be nostalgic, sad, and finally exasperated about something that we lost. By preserving then, we get tremendous artistic pleasure, which is at the same time psychological, aesthetic
and sensual. This aesthetic concern of preservation has almost always remained a domain of the rich, of elites, of powerful, for whom preserving culture gives tremendous sensual pleasure. As Said (1994) has rightly pointed out, culture is something whose principal purpose is pleasure.

However, there is a nuance here. Cultural objects may be classified into two categories— as UNESCO does; that of tangible and intangible ones. Tangible cultural objects are by definition consists of material things. UNESCO in its Convention for the Safeguarding of the Intangible Cultural Heritage (2003) defines that intangible cultural heritage as “practices, representations, expressions, knowledge, skills— as well as the instruments, objects, artifacts and cultural spaces associated therewith— that communities, groups and, in some cases, individuals recognize as part of their cultural heritage.” It consists of oral traditions and expressions, language; performing arts; social practices, rituals and festive events; knowledge and practices concerning nature and the universe; and traditional craftsmanship. UNESCO notes that this intangible cultural heritage is transmitted from one generation to the other, is constantly recreated by communities and groups in response to their environment, and provides them with a sense of identity and continuity. However, UNESCO is quick to point out that such preservation must be compatible with existing international human rights instruments and the requirement for sustainable development.

“Culture” of health

Based on my understanding of the traditional health practices (one example that I cited above), I would think that most of them are ‘intangible’ ones. Health practices such as when you have jaundice, drink extract of lentil leaves mixed with equal proportion of limestone (sodium bi-carbonate); if you want an abortion, insert large amount of tobacco or opium in the reproductive tract; consuming large amount of chalk, earth or ashes to supplement the calcium deficiency during pregnancy; using bamboo blades for circumcision and after cutting the foreskin covering the glans with large amount of clay or cow-dung ashes; are all intangible ones.

Thus, if I am asked to take a side, I would argue cultural properties that include materials, things, and tangible objects (involving monuments, architectures, sacred sites, buildings and “things” as such), need to be preserved, because they do not interfere with what we understand as “human rights,” or one’s chances of survival, neither they bring any bodily harm or injury to people. Preserving tangible or intangible cultural heritage that deeply interferes with human rights and limits one’s capacity or freedom to survive, amounts to some degree of tyranny and brutality. As such it can not be argued that it is all right

to burn the wife alive with her husband's funeral pyre and maintain the cultural heritage of sati.

At any point in time, the interaction between human beings and the environment, both animate and inanimate, constitutes the state of human ecology. This interaction lays the foundation for the state of health and illness among the people. The culture of the people, that is, their capacity to learn, store, and transmit knowledge to others enables them to respond to health problems that might result from unfavorable ecological conditions (Banerjee 2004). Culture affects the perception and meaning of the health problems people encounter, and it is instrumental in devising mechanisms for coping with them, which in turn, determine people's health behavior. Thus one may argue that where topography is unfavorable and ecosystem is hostile (as in my opening example), people's action would depend on what available choices they have. So it is basically a "choice" argument. But most of India is like that anyway! Large parts of Madhya Pradesh, Bastar, Telengana, western Orissa, and Rajasthan, Uttaranchal, West Bengal and Bihar represents what a real India look like – deep forest, desert, hills and plateaus, no roads, no electricity, no health service, no doctor, virtually a collapsed public health system. There is a system of Primary Health Center (PHC in rural areas) that was established for every 10,000 people and a higher level Health Center for every 100,000 people. But the doctors and nurse do not come in the rural PHC as they manage their private business in the nearest urban areas. Only once a month they turn up to collect their pay check. And in this background, quacks, vaidas, guineens and Bengali Dawakhana flourish. The question is: should we not enhance people's choice or should they not have an option to choose from both modern and traditional heath facilities, since the argument goes, introduction of any such initiatives will destroy traditional practices? I would think this idea is deeply flawed which I will discuss after I treat the second concept in this paper.

2. Development

Now let me explain the second concept. Like culture, development is another contested terrain, whose definition is not very clear among those who practice it. However, there is an agreed framework on which the practitioners act (Sachs 1992). To define it in a single sentence, development is a process of achieving economic growth and positive social change in which the later must accompany the former. In this instrumental view of development, economic growth only has the “potential” of enhancing well being of a nation, but it does not "ensure" how, in what ways, the benefits of growth will be distributed among people. Then what is the goal of achieving economic growth if it does not enhance social well-being of people, ensure their freedom and increase their security? From this perspective, development can also be conceptualized as a process that enhances people's choices and freedom, which is variously termed by Amartya Sen as human development. In a broader sense, the notion of human development incorporates all aspects of individuals' well-being, from their health status to
their economic social and political freedom. Thus since achievement of development is dependent on the free agency of people, and progress is measured by how much freedom people enjoy, “freedom” constitute both the means and the ends of development (Sen 1999).

Now the question, where does development end? There is not shortcut answer for this. What is understood is that, during the process of achieving economic growth over the last few centuries, world’s resources have been used indiscriminately that has put tremendous pressure on earth and raised questions of sustainability. Is the current level of growth sustainable? Thus a new concept of “sustainable development” was introduced in the development literature. According to the classical definition given by the United Nations World Commission on Environment and Development (UN WCED) in 1987, a development is sustainable if it “meets the needs of the present without compromising the ability of future generations to meet their own needs.” It is usually understood that this “intergenerational” equity would be impossible to achieve if the present day social inequality is not removed; or if the economic activities of some groups continue to jeopardize the well being of people belonging to other groups living in other parts of the world.\(^2\)

This view of development has been seriously critiqued by those who call themselves ‘post-development’ theorists, but the epistemological platform they share consists of a deep hatred for development, or what might be called “anti-development.” Gustavo Esteva puts it more succinctly that: “You must be either very dumb or very rich if you fail to notice that development stinks” (Cited in Crush 1995, p. 45). Indeed, the late 1980s saw a flourishing of ‘post-development’ approaches (Sachs 1992; Munck and O’Hearn 1999; Rahnema and Bawtree 1997) not only in the academic, but also in the activist arena, who have genuinely disrupted development projects by rallying, protesting and debunking delivery mechanism in such a way, that it is not the projects, but the people who has suffered in their ideological battle. I provide below main tenets of the post-development discourse before I take up the final part, whether development and cultural preservation are compatible.

2.1. Post-Development

"Development is the process whereby other peoples are dominated and their destinies are shaped according to an essentially Western way of conceiving and perceiving of the world. The development discourse is part of an imperial whereby other peoples are appropriated and turned into objects. It is an essential

\(^2\) Take for example, the emission of greenhouse gases produced by highly industrialized nations that result in global warming and flooding of low-lying islands resulting in displacement and impoverishment of entire island nations. Or to take another example when the pharmaceutical companies patent their drugs to earn higher profits whereas millions of people in the developing world can not afford medications to treat life threatening diseases. Both these examples are concerned with the question of "values" that I take up in the later part of my essay.
part of the process whereby the developed countries manage, control and even create the Third World economically, politically, sociologically and culturally... The real nature of this process is disguised by a discourse that portrays development as a necessary and desirable process, as human destiny itself.3

In the above paragraph, Vincent Tucker was describing that since development has no ends, the concept itself is a myth. As O’Hearn (1999) argues that in contemporary times, development has been “repackaged” as globalization and the neoliberal regime has forced the developing states believe that market is the most rational way to do things correctly. As a set of practices and beliefs, both globalization and development are part of the same Western political and cultural imagination, and presented as universal, natural and inevitable.4 Both these concepts presume a universal and superior way of ordering society, and that all societies are to advance towards the same goal. Local and indigenous cultures, economies, self-concepts, diversity and ways of existing have largely no value in this discourse, for the entire development project is premised on its subjects “developing into something else” and that something else is the West.5 Development discourse thus, by its very nature, is Eurocentric6 that presumes a superior Euro-American way of being and existing as normal and universal thereby providing moral and legal justification for substantial intervention in the affair of those who are ‘underdeveloped.’ Though it is portrayed as a natural, universal, desirable process, and an inherent condition of human existence, it is essentially planed, directed and controlled by specific international and national institutions, donor agencies and international aid-NGOs. James Ferguson’s classic (1990) Anti-politics Machine argues that development institutions generate their own form of discourses, and this discourse then constructs the communities as an object of knowledge and also creates a structure of knowledge around that

4 See for example, the claim that globalization is a natural, inevitable and irreversible process that must be embraced whether we like it or not! in Steger, Manfred (2004), Globalism: The New Market Ideology, Lanham, Rawman and Littlefield, p. 54-61; and Gordon, Ruth E. and Jon H. Sylvester (2004), Deconstructing Development, School of Law Working Paper Series No. 4, Villanova University School of Law.
object. Interventions are then organized on the basis of that structured knowledge. In effect, they not only fail but also create entrenchment of bureaucratic power. At a glance they depoliticize everything they touch, but while performing their own political operation they tend to expand state bureaucratic power into the lives of people.

While part of the critique is valid and emanates from genuine concern about how development is practiced, but to say that the concept itself is unnecessary has little epistemological grounding. Whereas the discourse is detached from reality, it is also ideologically inconsistent to suggest that since practitioners of development do not practice it ethically, it should be discarded by all means. In fact, post-development theorists as Escobar (1995), Esteva and Prakash (1998), (and Asish Nandy in India) exactly suggests that we need to abandon and discard the idea of development altogether. I don't think the formulation is so simple. As Ray Kiely (1998) suggests that dismissing development as Euro-centrism is 'too simplistic, for it homogenizes both the West and the Third World and reduces the later to passive recipients of the ideas of the former. It then becomes difficult to imagine how the people of the Third World could behave in any way other than being simple puppets of the West.7 Kiely observes that development as a process of continuous negotiation, responses, reactions and resistance to dominant power structure evolves over time and the development discourse, its language, strategy and practice constantly adjusts itself in response to the resistance and shifts in power relations.

The introduction of participatory methods in development planning has provided much needed space for indigenous people to negotiate and modify the power-balance through dialogue. Though quality of “participation” and who wins in such negotiation may remain a concern (Rahnema 1992) the fact that people now have a choice to negotiate, sends a powerful symbol to think how development can be conceived. As James Scott (1998) in his Seeing like a State notes that bureaucratic planning does not bring about success in development projects; it is the local, practical knowledge possessed by the person-on-the-spot is important; that the locus of decision-making must remain with those who have the craft to understand the situation. For any system to function we must create and maintain a space for local people with practical knowledge even though the hierarchy of the system does not permit this flexibility.

3. Culture and Development

Explicating the relationship Amartya Sen (1999) writes- cultural matters are an integral part of our lives. If development is seen as enhancement of our living standards, then efforts geared to development can hardly ignore the world of culture. If development is seen as enhancing people’s freedom then cultural

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freedom must be viewed as an indicator on which to assess development. Culture is intricately related as a means of development. In a recent work, Culture and Public Action, Vijayendra Rao and Michael Walton (2004) brilliantly explicate how culture affects development and public policy making. They argue that culture is necessary to confront the questions of what is valued in terms of well-being, who does the valuing, and why economic and social factors interact with culture to unequally allocate access to a good life. They cite two examples of famine-aid work in Sudan that miserably failed because of the lack of understanding of local culture; and HIV/AIDS prevention work among sex workers in Sonagcahi red light district in Calcutta, that succeeded as an international model of prevention work due to cultural sensitivity. They opine that a culturally aware approach to public action pays attention to factors that may be common sense to the intended beneficiaries but are often exotic, irrelevant, or irrational from the perspective of the policy maker. Ignorance of this contextualized notion of common sense, which James Scott (1998) calls metis, has been endemic among policy makers in government and in development institutions. A culturally informed approach is not a prescription, but a way of seeing, in which it is understood that individuals are driven by a set of culturally influenced motives, incentives, beliefs that interact with economic incentives to produce outcomes.

As I have noted earlier, that the relationship between culture and development has been influenced by two polar opposite, often extreme views: First, a hyper-modernist perspective that is exemplified in the works of Barber (1996) and Huntington (2000). They argue that "culture matters" because societies embedded in traditional cultures are unsuited for market-oriented development and are thus hampered in their pursuit of growth. In Huntington’s Clash of Civilizations, culture is viewed as an enemy that prohibits societies from functioning in the modern world. Second, there is another post-development paradigm reflected in the ideas of Escobar, Sachs and Esteva who says that there is a “culture of development” associated with dominant western worldviews that has adverse effects on world’s poorer countries. I have already said that such discourses allow little room to think constructively about how to integrate both cultural parameters and economic change to design more effective development projects. Of course “culture matters” because if cultural parameters are ignored, development projects tend to produce disastrous results.

With respect to HIV/AIDS prevention in India, there are examples where AIDS awareness programs did not consider local culture and ran into problems by disseminating sexually explicit messages. Often they have created a backlash and more nationalistic “anti-HIV-prevention” rhetoric. These are quite damaging not only for the NGOs who face difficulties in implementing projects, but also for the people, who die because they don’t have access to information or any other basic health services.
4. Are they compatible?

In September 2006, some of the India’s leading newspapers carried a story.\(^8\) A man (X) in Kendrapara district in Orissa with AIDS was ostracized by the villagers. He remained confined in a solitary dark room for several months. The villagers would not allow him to come out as they feared that mosquitoes will spread the “germs.” Several attempts were made to lynch the person, which were averted due to the interference of an NGO working a few miles away. Mr. X committed suicide. No one came to do the last rites. After two days, local Panchayat arranged some heavily masked people to pack Mr X in a large polythene wrap. At the cremation place (burning ghat), the dom refused to burn him saying, the smoke will spread the “germs.” People residing nearby also protested. Police were called in to settle the turmoil, at which the dom fled away . . .!

Is this the kind of a society we are looking at? Personally, I would not take side with the idea of “preserving culture” if it means curtailing other’s survival chances, freedom, dignity and human rights. Development must be based on values and ethics (Sen 1999). What “value” is it to stone an HIV positive woman to death excusing “she is a witch?” Do we want to protect this witch-hunt as a “cultural practice”? I would argue this is a “culture” of ignorance, where it is no bliss. And yet, if some scholars argue that indigenous communities should be left “as is.” I would think they are somehow misguided.

To ask another related question: preservation in whose interest? And what is at stake? Explicating this question, I find it is mostly in the aesthetic concern of the elites. To suggest that the indigenous need to be left “as they are” amounts to saying we need to create a “living museum” with human subjects in which indigenous people would depict their traditional health practices in the same idea of a cultural theme park. All the primitive people will give real demonstration on how to conduct a traditional delivery; how to stone a woman to death; how to conduct a circumcision as such. I am certain there will be enough performers willing to take part in the demonstration in a poverty-stricken, labour surplus society. The elites will go to such museums once a year on vacation: take a break for a few days from busy postmodern urban life; enjoy rural landscape while dancing around a fire with the indigenous; show their children how the “Other” look like; and then return to their urban solace until the next vacation comes! There is a total disjuncture between one’s own material condition of life and what is proposed for others. There is no moral superiority in prescribing development is bad for others when post-development theorists cannot even escape it from their own material condition of life!

Edward Said (1995) in his introduction to Orientalism quoted an epigraph from Benjamin Disraeli’s Tancred -- “East is a career.” Said’s main concern in Orientalism was to examine the “enormously systematic discipline by which European culture was able to manage, and even produce, the Orient.” In

\(^8\) “Orissa boycotts HIV+, govt. cell has no idea”, Times of India. September 7, 2006.
introducing this idea, Said's main conception was that numerous travelers who traveled to the orient have exoticized it through discourses, which has been consumed by a European audience. This created enormous interest in the Orient. People who went, thus made a career out of Orientalism. Colonial civil servants wanted to go "there" in furtherance of their career.

There is a remarkable parallel of this colonial enterprise that still continues. The East is indeed “a career” – the orient, the mystic, the exotic, the undifferentiated ‘Other’ need to be protected “out there” in the aesthetic concern for the elites. You can write a book about it, you can establish an NGO for it, you can rally and jeopardize the state’s initiative and become famous. And while you are surviving on bottled mineral water produced by the multi-national corporations, and protesting against construction of large dams, it is the people whose throat had burst open for a single drop of water! "The East is reborn and greatly expanded now as a Third World, seems to have become, yet again, a career – even for the Oriental this time, and within the Occident too.”

References


Improvement in the quality of antenatal, intrapartum and postnatal services after a quality improvement intervention in selected facilities in 27 high priority districts in India

Enisha Sarin, Subir K. Kole

Abstract

Despite rapid increase in institutional delivery, quality of obstetric and neonatal care practices continues to be poor in India, contributing to the high rate of maternal and neonatal mortality. A quality improvement (QI) project was implemented in 125 public health facilities across 6 states to improve routine practices in antenatal, intrapartum and immediate postpartum period. QI teams, formed in each facility, developed change ideas to address identified systemic issues and achieve improvement in selected clinical practices. Data on practices were entered and aggregated every month. $X^2$ analysis for trend was conducted, and it was found that routine practices such as hemoglobin measurement during ANC, oxytocin injection after birth, essential newborn care and postpartum vitals monitoring increased systematically over the 21 months of intervention. Results clearly demonstrate the effectiveness of QI approaches in improving coverage of routine practices warranting their wider replication in the Indian public health system.

Introduction

India has witnessed a rapid increase in institutional deliveries since the launch of the conditional cash transfer programme- Janani Suraksha Yojana (JSY)- Health Management Information System (HMIS) data indicates a rise from 56.7% in 2006 to an estimated 78.5% in 2011. Yet maternal mortality at 167 and neonatal mortality at 28 per 1000 has not decreased commensurately. An analysis of annual health survey data from 9 states did not find any association between institutional birth proportion and maternal mortality rate. In explaining the results, the authors suggested that women delivering in institutions could be compromised by poor quality of services. In fact, the reason for promoting institutional births was that skilled birth attendance (SBA) would reduce complications and deaths. However a study in JSY facilities in Madhya Pradesh found low competence among staff to manage obstetric complications while
another study reported an association between maternal deaths and lack of skilled birth attendance, failure to carry out emergency obstetric care and referrals that did not result in treatment\textsuperscript{6} Furthermore, there is evidence of limited adherence to the delivery of routine care that could potentially prevent complications. Observations carried out in labor wards found limited vitals monitoring during and after labor, lack of organized preparation to conduct birth, and staff abuse and neglect of women during delivery\textsuperscript{7}, leading the authors to recommend a strong focus on quality of care.

The same is seen in the case of neonatal deaths. An evaluation of JSY showed that although there was slight reduction in perinatal and neonatal mortality it was not observed in high focus states where mortality is high\textsuperscript{8}. Neonatal deaths account for a large portion (68\%) of under 5 deaths in India.

Majority of neonatal deaths in India occur within the first week, and about four- fifths of neonatal deaths are due to prematurity or low birth weight, infections, or birth asphyxia\textsuperscript{9} warranting a need for increased focus on intrapartum and immediate post- partum care. Simple interventions like neonatal resuscitation training is found to reduce 30\% intra partum related mortality in facilities\textsuperscript{10}. Besides, training in the World Health Organization (WHO) essential newborn care (ENC) was found to reduce almost 43\% likelihood of death by day 7\textsuperscript{11}. In low resource settings, therefore, alongside care during pregnancy, care at the time of birth as well as post- natal care such as exclusive breastfeeding, hygienic cord care and thermal care contribute to newborn survival\textsuperscript{12}. However it is questionable whether these practices are followed in low resource settings. Available evidence from facilities in India and other South Asian settings point to low rates of asphyxia management\textsuperscript{13}; low coverage of immediate breastfeeding and thermal care\textsuperscript{14}, and low rates of oxytocin administration for active management of third stage of labor\textsuperscript{15}. What this shows is that even while women are being encouraged to deliver in facilities, evidence based routine care is not universally followed.

With the goal to improve maternal and neonatal care in facilities, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) project supported 125 public health facilities across six states in India which deliver approximately 180,000 babies per year. The project aimed to equip and support health care staff on quality improvement (QI) approaches. Routine practices that would have the highest impact on maternal and newborn health were included for improvement. In this paper, we sought to explore whether routine practices improved over time following a QI intervention.

**Methods**

**Intervention sites**

In collaboration with the Ministry of Health and Family welfare, the QI project was implemented in six high focus states - Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand. Within each state, a list of 27 high priority districts were identified by the Ministry based on several health, socio- economic and demographic indicators. A block was selected from each district
according to the following criteria: 1) willingness of state and district leadership to implement a QI project; 2) accessibility, and availability of infrastructure for a QI intervention, and 3) mid-level performance on maternal, child and neonatal health indicators.

QI was implemented in district hospitals (DH) and all community and primary health facilities within the block. Initially, simple to improve indicators were introduced, designated as phase 1 of the intervention, before moving on to more complex indicators such as prevention and management of preeclampsia and eclampsia during phase 2. In this paper, we look at the performance of phase 1 indicators over the intervention period.

Description of QI intervention:

A Quality Improvement (QI) team was formed in each of the 125 facilities involving the facility leader, departmental head, staff nurse, and support staff, whose work was coordinated and mentored by a District Improvement Coach (DIC) posted in each district. An initial two day training on quality improvement was provided to all DICs followed by regular interaction between them and senior programme management. The DICs provided continuous coaching, training and technical support in adhering to clinical standards, data recording, data collection, and sharing of experiences through visits, meetings and bi-monthly learning sessions.

Guided by the DICs, health facilities followed seven steps of quality improvement: 1) identifying a problem to work upon, 2) forming a team, 3) understanding current system, 4) develop a simple measurement system, 5) develop options for possible solutions, 6) test these solutions on a small scale, 7) implement the change. Teams selected antepartum, intrapartum, and immediate postpartum care practices as indicators to improve by identifying barriers along with opportunities for improvement. Simple measurement systems were developed to track progress of these indicators. Teams developed change ideas which were then scaled-up and made a part of new service delivery systems.

Data collection

With the implementation of QI, teams started collecting data on key indicators or practices from existing hospital records. Information on proportion of births in which the said practice was reported to have occurred was captured in a predesigned database in Excel, which was compiled from each facility and reported on a monthly basis. The number of facilities reporting data on these indicators varied as not every facility took them as improvement aims. Additionally, new facilities were added as intervention progressed and occasionally reporting from some facilities stopped as 1) the district coach left the job and QI teams stopped reporting; 2) facilities reached an optimal level in an indicator and stopped reporting; and 3) as new indicators were taken up, data on previous indicators ceased to be reported. The number of facilities reporting on selected indicators ranged from an average of 30 for ANC counseling to an average of 114 for uterotonic administration post-delivery.
The data reported by each QI team from each facility was compiled at the district level, state level, and national level which formed the monthly aggregate data for analysis of performance of QI indicators. Additionally, the DICs and QI teams kept their own field notes, meeting notes, discussions points and records of observations. These data were used primarily to supplement the analysis of the quantitative data and to help the interpretation of trends of indicators.

**Outcome measures**

For tracking the progress of QI intervention, we selected a set of nine indicators spread across four domains of antenatal (ANC), intrapartum, essential newborn care (ENC), and postpartum care as follows:

**ANC:**

1. Proportion of ANCs during which haemoglobin of pregnant woman was checked & documented;
2. Proportion of ANCs during which history was taken (obstetric history, h/o past illnesses & presenting complaints) to rule out high risk pregnancy;
3. Proportion of ANCs during which counseling about nutrition, family planning, breast feeding was provided & documented.

**Intrapartum:**

4. Proportion of vaginal deliveries for which uterotonic was administered within one minute of birth of baby.

**Essential newborn care:**

5. Proportion of newborns made dry and provided warmth immediately after birth;
6. Proportion of newborns provided sterile cutting and clamping of cord;
7. Proportion of newborns breastfed within one hour of birth;
8. Proportion of newborns given injection of vitamin K at birth.

**Postpartum Care:**

9. Average number of times vitals (both BP and pulse) checked and recorded within first 6 hours after delivery.

**Data analysis**

Since most improvement aims were adopted from March or April 2014, with baseline data collected for the preceding months, we explored for trends starting from January 2014 to August 2015 (when the project closed). Data were collected from hospital records and reported each month on excel spreadsheets. The excel sheet was designed to calculate proportions of each indicator reported for every month at every facility. Facility wise data were aggregated and then transferred to Stata version 13.1 for further analysis. Simple percentages were then calculated and plotted on the graph to obtain a trend analysis. X² analysis for trend was conducted for each
indicator to test whether proportions increased systematically over time. Median value of each indicator was plotted on the graphs to examine how far the indicator stood above or below the median value every month.

Results

Antenatal care practices

Antenatal care practices increased considerably over the intervention period. Within 6 months, hemoglobin check (from 65% to 88%) and obstetric history taking (from 19% to 93%) increased among pregnant women coming for antenatal care, and this increase was sustained across the intervention period (fig 1). Similarly, ANC counseling increased within the first 5 months thereafter fluctuating and then sustaining improvement from month 12 onwards ($X^2$ for trend 3.95, $p <0.001$). All indicators were consistently above the median value after 11 or 12 months of the project.

Figure 1

Caption: Trend in ANC indicators over intervention period (January 2014 - August 2015)

Source: ASSIST monthly data
Intrapartum care

Giving oxytocin injection within one minute of birth significantly increased from 18.8% to 99.0% over the 21 month period ($X^2$ for trend 4.19, $p <0.001$). Within the first 5 months of the intervention, oxytocin injection increased fourfold and thereafter sustained at 98% until the end of the project (fig 3).

Figure 2

Caption: Trend in Essential Newborn Care indicators over intervention period (January 2014- August 2015)
Essential newborn care practices including keeping baby dry and warm, cord care, and vitamin K injection increased over the intervention period. While increase in drying and wrapping and cord care reached 100% at the end of the project period (table 1), it took 6 months to increase vitamin K injection from 53% to 91% after which it was sustained at 98% until the end of the project. On the other hand, early breastfeeding made only a modest improvement and the increase was not significant ($X^2$ for trend 0.07, p 0.95). Although there was an early increase in breastfeeding it dropped subsequently and picked up again to remain at an average of 86% during the last 4 months (fig 2). Sterile cord care saw a sharp increase in the first 3 months thereafter improving progressively. It declined in between for 4 months after which it saw a sustained increase (fig 2).

**Postpartum care**

Postpartum care in terms of checking of mother’s vitals also improved over the intervention. The average number of times that blood pressure and pulse was checked for a woman after delivery increased from 0.8 to 3.5 times ($X^2$ trend 4.27, p <0.001). There was a progressive increase in number of vitals check with it rising above the median consistently after 11 months of intervention (fig 3).

**Figure 3**
Discussion

The quality improvement initiative was effective in improving basic antenatal, intrapartum, and postnatal care practices. Several studies have examined the strategies to improve maternal and child health care in developing countries and have found small to moderate or variable effects on improving quality of MCH services\textsuperscript{16-18}. Strategies have mostly focused on the effect of training to improve care\textsuperscript{19,20}. A systematic review of strategies to improve maternal and child health care observed that while 25 out of 45 studies reported positive effect on outcomes, most of them focused on only one or two aspects of improving quality such as training of staff or making a facility adequate while ignoring issues such as supply distribution or community acceptance\textsuperscript{21}. Another review of quality improvement, highlighting the limitation in having any one approach, and the lack of studies that describe the process of quality improvement, has suggested a need for research to provide evidence of the effectiveness of the identified methods and tools\textsuperscript{22}. Our study attempts to fill this gap by providing a description of the methods and approaches used in the QI intervention in increasing adherence to clinical standards.

Table 1. Trends in ANC, intrapartum and postpartum services in facilities over the intervention period (Month 1 (January 2014) – Month 2 (August 2015)*.

Source: ASSIST monthly data
<table>
<thead>
<tr>
<th>Clinical indicators</th>
<th>Month 1 Jan 2014 (%)</th>
<th>Month 21 Aug 2015 (%)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin check</td>
<td>64.5</td>
<td>88.2</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Obstetric history taken</td>
<td>19.3</td>
<td>95.0</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>ANC counseling</td>
<td>5.7</td>
<td>92.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Oxytocin injected within 1 minute of birth</td>
<td>18.8</td>
<td>99.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Keeping baby dry and warm</td>
<td>60.6</td>
<td>99.8</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sterile cord care</td>
<td>59.8</td>
<td>100.0</td>
<td>&lt;0.000</td>
</tr>
<tr>
<td>Vitamin K injection</td>
<td>52.7</td>
<td>98.4</td>
<td>&lt;0.000</td>
</tr>
<tr>
<td>Breastfeeding within 1 hour of birth</td>
<td>78.1</td>
<td>87.7</td>
<td>0.95</td>
</tr>
<tr>
<td>Average time post-natal vitals checked per woman</td>
<td>0.9</td>
<td>3.5</td>
<td>&lt;0.000</td>
</tr>
</tbody>
</table>

**Antenatal care:**

The results clearly demonstrate that with improvement in redesigning care delivery processes and addressing context specific problems, delivery of antenatal care can increase. With most antenatal interventions being in practice for years, the major part of improvement involved reorganization of work place and processes, coupled with improved recording practices aimed at identification and early management or referral for high risk conditions. For example, in facilities in Himachal Pradesh, ANC triage was improved through redesign of space and task shifting of staff. Previously, crowds of ANC patients would rush into a hall, where depending upon the patient load and number of staff, they may or may not receive the requisite care. After QI implementation, stations and staff were defined for specific activities which led to less crowding and fewer missed opportunities. Simultaneously, recording of clinical care practices improved. While reporting of hemoglobin measurement and obstetric history taking was done diligently as these indicators were considered vital for identification of high risk pregnancy, we do not see the same for ANC counseling, exhibited by fluctuating trends, which is considered a routine and mundane job by most staff. It is only after 12 months that counseling shows a
gradual increase and this occurred due to renewed focus on counseling and introduction of guidelines. Our findings are in alignment with another study in Kenya which demonstrated improved adherence to clinical standards of antenatal care such as measurement of hemoglobin and blood pressure, administration of tetanus toxoid vaccination and counseling following a QI intervention.

Intrapartum care:

As a simple intervention that didn’t require any additional technical skills for nurses to implement, initial improvement of oxytocin administration within one minute of birth was quick (19% to 95% in 5 months) as most facilities started implementing this with simple changes like prefilling syringes with oxytocin and disseminating information among staff conducting deliveries. The practice quickly improved as the staff gained knowledge of its importance through peer learning sessions organized as part of QI. Our finding echoes that of another study in Rajasthan where a QI intervention helped increase delivery of oxytocin after birth from 57% to 90%24. Although our intervention increased coverage of this practice to 98% of delivering mothers, a small proportion were not covered owing to special circumstances like complications among the mother and/or newborn, and surgical deliveries explaining why this practice does not reach 100% coverage of all delivering women.

We found swift improvement in processes that are simple to implement i.e. do not require additional technical skills, are delivered as a single step, and are one-sided (do not involve client compliance issues, like vitamin K, cord care and keeping babies dry and warm.) Decline in cord care for a few months in the middle of the intervention can be attributed to stock outs of sterile cord clamps in one state (Jharkhand) perhaps highlighting the fact that despite efforts by QI teams, procurement and supply of essentials runs into hurdles which cannot be overcome at facilities. Keeping babies dry and warm increases to cover almost all babies at project end, which is higher than what the Rajasthan QI intervention achieved, covering 80% of newborns24. It could be that our intervention ran for a longer period of time (21 months) during which new steps in improvement had time to become established practices. Early breastfeeding did not show improvement perhaps due to perception, by health care staff, of its lesser importance in saving newborn lives. Additionally, coverage of breastfeeding was limited due to complications of the mother or the baby and in surgical deliveries. In general, immediate breastfeeding was found to be low in facility delivery in South Asia14, while the Rajasthan study found only modest improvement, emphasizing that this practice needs more attention. However the baseline value of immediate breastfeeding reported from our sites is much higher than reported in other studies14,24. A possible explanation is that reporting was not always accurate and performance was projected to be better than actual due to fear of punishment. Since we aggregated all state data, very high rates reported by some facilities influenced the overall baseline figures. However, as the intervention progressed, inflated reporting decreased and therefore, we do not see any dramatic increase in breastfeeding. With Vitamin K administration, initial 90% was easy
to achieve while remaining 10% coverage took a lot of change ideas and therefore time. Difficulties arose with newborns who were asphyxiated, pre-term, or otherwise sick, making Vitamin K a non-priority. Gradually, QI teams innovated and structured their care processes around each of these special scenarios.

Postpartum care

With the use of the quality improvement methodology, the health facility staff was able to examine, identify and monitor mothers with signs of complications. This was achieved by setting a schedule of monitoring vital parameters in the patient’s records and documenting it for all cases. In some facilities, such as in Delhi, vitals monitoring increased by reorganization of labor ward and ready proximity of equipment. Family members were educated and asked to inform nurses in case of danger signs. This shows that even with shortage of staff which is reported as the main limitation in carrying out monitoring of heart rate and blood pressure improvement can be made. When other states aggregates are combined, we find that although the average number of times for checking vitals has increased, it is still below the recommended guideline. This to some extent is affected by the average duration of stay in the health facility as most of the health facilities lacked amenities to cater women and their attendants. Indeed, most newly delivered women are discharged in less than 24 hours from a facility. Despite this, the aim toward which this clinical practice was undertaken, namely identification of high risk women, also increased. While initially teams overworked and increased frequency of post-partum vitals checking with no obvious difference in outcomes and causing problems like overcrowding in delivery rooms, complaints from staff and clients, teams were coached to retain focus on identifying potential complications for early intervention and innovating on improving frequency of checks without overworking like task shifting to ASHAs, involving family members, and using digital equipment.

Limitations

There are several limitations in our study. The intervention period varies across facilities as interventions began at different times. However, the bulk of the intervention began in the months of March to April 2014, and since most district coaches, responsible for implementing QI, were in place in January 2014, we are reasonably assured that early intervention activities like team formation, orientation and training started from this time. Another limitation is that the number of facilities reporting the data varied over time. However the number of facilities remain more or less constant after the initial months when facilities were in the process of identifying indicators to work on. In the case of ANC indicators, many more facilities reported baseline data compared to a smaller number which actually started working on these indicators. With regard to other indicators, the number does not vary greatly across the intervention period. Another limitation is that the sources of data varied which may give rise to some inaccuracies. While data were generally obtained from hospital registers, some data were based on observations of 20 patients or a sample of records. This, however, occurred in the initial stage of the intervention. As the said indicator became an established practice, data from hospital registers became the
norm. Additionally, a limitation is that we did not examine the data by facility type or by state in this paper. Nevertheless, our results did inform improvement work in facilities, and on the state governments’ decision to scale up to other districts.

Conclusion

The findings from this study suggest that quality improvement methods including setting a goal, forming a team, and working collectively to improve that goal can increase the delivery of facility based routine clinical practices. With rising institutional delivery, it is essential that quality of care improves, and our intervention demonstrates that, without adding resources, we can accomplish high coverage of clinical practices that ultimately impacts maternal and neonatal deaths. Furthermore, our results demonstrate that following a QI methodology allows one to tailor specific interventions leading to improved care. Compilation of these change ideas can be found in the ASSIST website. We could not estimate the effect of external variables, such as the effect of multiple development partners’ intervention on RMNCH+A; the exposure of staff to other programs in addition to ASSIST; and other confounding variables, which pose a limitation to our conclusion. However, assuming that in 21 months period under reporting, no drastic changes to the macro-level factors (policy and program) occurred, our story demonstrates the general effect of QI intervention in improving patient care.

References

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