Case Report

A grand multipara woman in the modern era: A case of public health dilemma from an urban slum

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ABSTRACT

With the advancement in family planning practices and shifting norms from "hum do hamare do" to "one child," there still exist mothers who are delivering their 10th children. Such an example is a woman residing in an urban slum in the Khordha district of Odisha, India. She has never used any modern methods of contraception. Neither the health workers in that area could fulfill her unmet need for family planning. The helpless mother missed all the antenatal checkups as she did not have anyone to accompany her to the hospital. Three of her children were delivered at home and none of them were immunized to date. She has become a victim of domestic violence by her husband, who is addicted to alcohol. She has done two medical terminations of pregnancy due to non-usage of any contraception. Neither she is able to provide herself nor her children sufficient food every day, as she is not able to go to work in her post-partum period. Her alcoholic husband is not able to earn regularly and there is no other family member to support her. There is no Accredited Social Health Activist appointed for that area whom she can rely on. We need to look at what is the cause of such a scenario – Is it poverty, lack of awareness, lack of education, or our health system has failed to achieve universal health coverage.

Key words: Extended health clinic, Family planning, High-risk pregnancy, Immunization, Maternal mortality

About 49% of the Indian urban population and more than one-fifth of Odisha's urban people live in slums [1,2]. The people living in these slums pose a challenge to sound health as there are a lot of problems related to overcrowding, migration, and lack of basic needs in slum areas [3]. According to the 2018–2020 sample registration system report, Odisha's maternal mortality ratio is 119 [4]. Home delivery rate in India during 2019–2021 is still 11.4%. If we look at the scenario of Odisha, the percentage of home deliveries is 7.8%. Only 1.9% of home births in India are conducted by skilled health personnel [5]. Home delivery is an indirect indicator of poor service utilization. Poor service utilization means a high chance of worsening maternal and child health indicators, particularly an increased risk of perinatal and neonatal mortality and morbidity. Not only the delivery but the antenatal care (ANC) is also compromised in different areas. Still, 5% of births in Odisha who have not received Td immunization are happening. Children aged 12–23 months fully vaccinated are only 76.4% [5]. Various schemes such as Janani Suraksha Yojana (JSY) and Janani Sishu Suraksha Yojana (JSSK) have been implemented to decrease the "Three Delays" of maternal mortality and catastrophic health expenditure. Still, some people could not utilize the health-care system efficiently. With the mission "Parivar Vikash" India has reached a total fertility rate of 2.0 using modern family planning methods, there is still an unmet need for family planning among 9.4% of women and 4% for spacing [5].

This case report is about a 10th gravida female who came for immunization in an outreach session in an urban slum of Bhubaneswar, Odisha, to take Td second dose at the 9th month of pregnancy on November 24, 2022. The case was unique because she had no mother and child protection card card for the current pregnancy, nor was the pregnancy registered. She has seven children, immediate three deliveries happened at home, and she has never opted for sterilization. Now the question arises who has failed? Is it due to a lack of knowledge or health care-seeking behavior of the family, or our health system has failed?

CASE REPORT

During the monthly extended health clinic, we were surprised to see a mother continuing her 10th gestation in the third trimester without any registration and investigation. She is a 32-year-old

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mother residing at the Sabar Sahi Basti, ward no 28, Nayapalli, with her seven children. She was identified as the sister-in-law of the Anganwadi helper of that area. The extended family of that female consists of her six children, husband, and mother-in-law residing in a kaccha house with one room and one kitchen without any washroom. The problem family consists of nine members [6]. The head of the family is a gardener by occupation, earning Rs. 6,000/month. She was working as a house-help in two houses and earning 2,000/month. The total monthly family income was 8,000/month. However, recently, one of the house owners dismissed her from the workhouse help. The head of the family and his wife are both illiterate. As per the modified Kuppuswamy scale, the family comes under the upper-lower socioeconomic strata. The head of the family is addicted to alcohol and often misses his work.

She presented with weakness and head-reeling at 9 months of pregnancy for the second dose of Td in the immunization session. She was G10, P7, A3, and L6 on the first visit. She was married at 15 years of age and completed 16 years of married life. Her first pregnancy was at 16 years of age. Her eldest son is 15 years old and attending high school. The other two sons are also in the adolescent age group – 13 years and 11 years, respectively. The youngest son is only 9 years old and going to primary school. The first three male children were born at Capital Hospital. However, the youngest male child was born at home. He and the two girl children, aged six and four, were also born at home. They are going to the Anganwadi center (AWC). She had three abortions. One abortion at 1 month of pregnancy, one at 2 months after taking a medical termination of pregnancy kit from the medicine store without any consultation from any doctor. Except for the first three, none of her pregnancies were registered. Even the current pregnancy was not registered with the health system. Only the birth dose of the first three children was done at Capital Hospital, none of the children were immunized, and neither did they visit the AWC. As she works, all the children only got exclusive breastfeeding for 2 months. She had one stillbirth after the youngest 4-year-old child. She took abortion pills, but the product of conception did not come out. Without consulting any doctor, she continued the pregnancy, leading to stillbirth. She was using contraceptives for the first 2 years of her pregnancy because she could not remember taking pills every day. She never used any other form of contraceptive ever, although she was counseled many times by frontline health workers. She has not done ANC checkups in any hospital or health-care facility during pregnancy. Her last menstrual period was March 06, 2022. She has not done any urinary pregnancy test to confirm the pregnancy. She has not done any ultrasound scans for the current pregnancy. After mobilizing her during the extended health clinic session in that area, first dose of Td was given at 8 months. The auxiliary nurse midwife (ANM) gave her iron folic acid (IFA), but it was not taken regularly.

When identified, she was unaware of her life-threatening health condition and only complained about weakness. She had no history of chronic diseases such as diabetes or tuberculosis, and hypertension. She never had any bleeding per vaginally or excessive vomiting or blurring of vision, burning micturition, fever with rash in any trimester, or any medication used for any condition during pregnancy except IFA. Dietary history was taken using the 24-h recall method, where she was found to be grossly deficient in calorie and protein intake.

The vitals of the lady were stable. Pallor was present. There was no cyanosis, icterus, or edema. On general examination, weight was 46 kg, and height was 144 cm. On abdominal examination, fundal height was 36 s, and linea nigra and striae gravidarum were present. The presentation was cephalic; fetal heart sound was present. Per vaginal examination was not done in the home setting.

On the first visit, the mother was counseled regarding the birth preparedness. Health education on contraception and diet was advised. As the patient had a history of domestic violence, the Edinburgh Postnatal Depression Scale was administered to the patient, which was found positive. She was brought to the nearest urban health center for hemoglobin and other blood investigations.

After 1 week, she went to the capital hospital due to the sudden onset of labor pain with the Anganwadi helper and delivered a female child by normal vaginal delivery. The birth weight of the baby was 2.6 kg. There was no complication between the mother and the child. The Bacillus Calmette–Guérin, hepatitis B, and oral polio vaccine birth dose were administered within 24 h. She was discharged from the hospital.

The female is residing in an owned kaccha house. There is an absence of a recommended setback area around the house. There is only one room in the house, one kitchen outside the room but attached to the house. The size of the living room was inadequate and overcrowding was present. The lighting and ventilation of the house was inadequate. Although the kitchen was separate, there was no elevated platform for cooking, no outlet for smoke, and cooked foods were also not stored properly. There was no toilet in the house, even there were no nearby community toilets. Sometimes she is using community toilets, sometimes practicing open field defecation. Water was also borrowed from other's houses. There is no continuous supply of water. Household purification of water is also not done. No proper dry and wet waste segregation. Infrequent waste disposal from the house. The unhygienic environment around the house. Breeding site of mosquitoes around the house is present. There are several potential hazards to their home environment. (a) The physical construction of the house was not proper. The walls were not weather-resistant and there was inadequate ventilation and lighting. The roof material was not strong. (b) Chemical – there was no use of smokeless chula, earthen chula was used. (c) Biological – Breeding site of mosquitoes around the house present due to artificial collection of water. No insect control measures are being adopted by the family. There was a history of multiple times dog bites in the children present.

DISCUSSION

The incidence of multiparity in India is 9.8%. Among them, 95% are having anemia. The chance of complications such as abruption

of the placenta, gestational hypertension, gestational diabetes, malpresentation, postpartum hemorrhage, and ruptured uterus is high in multiparous women (Fig. 1) [7]. It also may cause an adverse impact on the newborn child such as low-birth weight babies, preterm children, and low Apgar scores [8].

Not only physical health but also sociocultural factors also influence adverse maternal outcomes. Domestic violence, substance abuse, and non-usage of contraceptives are still major social problems to achieve "health for all." Even social and family support is essential to reach the health-care delivery system. Non-availability of health-care workers is again another challenge to overcome to provide universal health coverage. Another major concern is the poor knowledge of the JSY scheme among health workers. After a discussion with the health workers, it came out that they think that after two pregnancies, mothers cannot be registered and will not get the benefit. Being a low-performing state, mothers can still avail themselves of the JSY and JSSK benefits in Odisha [9]. For that, the Anganwadi worker or ANM is feared to register her pregnancy. In the current scenario, even in the 9th month of pregnancy, it was found to be not registered.

A study by Srivastava *et al*. found that poor socioeconomic status, low education, and poor mass media awareness were important factors in the poor use of modern contraceptive methods [10]. Moreover, in the current case, poor husband support and domestic violence can be one reason for the non-usage of the contraceptive device. Despite being motivated to use contraceptives and for permanent sterilization, the mother never adopted any one of them. A multicounty analysis by Muluneh *et al*. also showed a high correlation between intimate partner violence and non-usage of contraceptives [11]. Due to the fear of out-of-pocket expenditure, the mother had never gone to any hospital during her antenatal period. The same thing happened to her last three pregnancies. Illiteracy is a major reason for her poor health.

Despite the high prevalence of anemia among pregnant women and various programs working on it, a major group of people still lacks awareness regarding anemia. Pradhan Mantri Surakshit Matritva Abhiyan scheme should reach the farthest point of health care. Regular monitoring and tracking of the mothers should be done. Provision and education about male

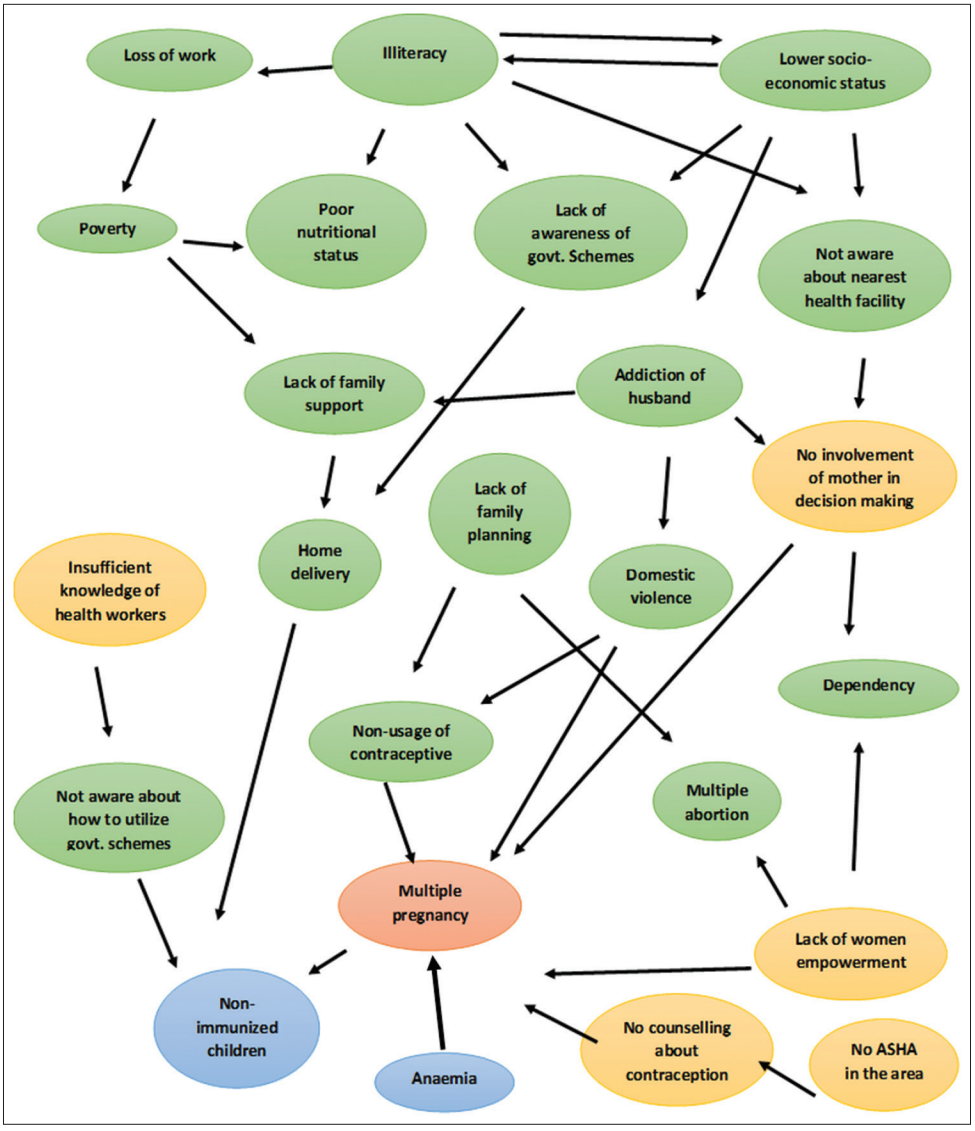

Figure 1: Factors leading to multiple pregnancies

sterilization should be there. Tracking immunization records and enlisting the left out should be done more vigorously. Dangerous complications of multiple pregnancies such as antepartum hemorrhage, post-partum hemorrhage, pre-term labor, premature rupture of membranes, hypertension, and fetal distress - result in increased morbidity and mortality among the mother and children. Lack of knowledge, especially awareness toward family planning services, puts the mother's life at stake.

Moreover, alcohol use results in marital problems, domestic violence, physical abuse, loss of employment, and poverty. Adequate family support and social support are essential to lead a healthy life. The index case is none but a representative of such a helpless woman handling all the responsibility alone.

CONCLUSION

The mother described in the case report is representative of the helpless uneducated mothers who are deprived of the government schemes. The lack of knowledge of them and the unavailability of the health-care worker had led her into a miserable condition. Health education is required to bring them to their desired path.

REFERENCES

1. Population Living in Slums (% of Urban Population) - India-Data. Available from: https://data.worldbank.org/indicator/en.pop.slum.ur.zs?locations=in [Last accessed on 2023 Feb 01].
2. HUDD-Government of Odisha. Available from: http://www.urbanodisha.gov.in/urbanScenario.aspx [Last accessed on 2023 Feb 01].
3. Indicator Metadata Registry Details. Available from: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/2476 [Last accessed on 2023 Feb 01].
4. SRS - Maternal Mortality Bulletin-Government of India. Available from: https://censusindia.gov.in/census.website/data/srsmmb [Last accessed on 2022 Aug 26].
5. Release of NFHS-5 (2019-21) - Compendium of Factsheets-Ministry of Health and Family Welfare-GOI. Available from: https://main.mohfw.gov.in/basicpage-14 [Last accessed on 2022 Aug 23].
6. Publisher A Removed at Request of Original. 10.2 Sociological Perspectives on the Family; 2016. Available from: https://open.lib.umn.edu/socialproblems/chapter/10-2-sociological-perspectives-on-the-family [Last accessed on 2023 Mar 03].
7. Shahida SM, Islam MA, Begum S, Hossain MA, Azam MS. Maternal outcome of grand multipara. Mymensingh Med J 2011;20:381-5.
8. Singh SP, Chawan J, Mangla D. A descriptive study: Maternal and fetal outcome of grand multipara. Int J Reprod Contracept Obstet Gynecol 2015;4:219-23.
9. Janani Suraksha Yojana: National Health Mission. Available from: https://nhm.gov.in/index1.php?lang=1&level=3&lid=309&sublinkid=841 [Last accessed on 2023 Nov 26].
10. Srivastava S, Mohanty P, Muhammad T, Kumar M. Socio-economic inequalities in non-use of modern contraceptives among young and non-young married women in India. BMC Public Health 2023;23:797.
11. Muluneh MD, Francis L, Agho K, Stulz V. The association of intimate partner violence and contraceptive use: A multi-country analysis of demographic and health surveys. Int J Equity Health 2023;22:75.

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