



**Mata Jai Kaur**  
MATERNAL AND CHILD HEALTH CENTRE

*A PROMINENT HOMES CHARITY*



**OUR WORK  
OUR VISION  
2017**

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#### COVER PHOTO

A young resident of village 35BB holding her newborn cousin delivered by the Mata Jai Kaur Maternal and Child Health Centre.



BY SHARING OUR LESSONS,  
CONTINUALLY LEARNING  
FROM OTHERS,  
AND COLLABORATING WITH  
LIKE-MINDED INDIVIDUALS  
AND ORGANIZATIONS,  
WE HOPE TO CONTRIBUTE  
TO THE BROADER MOVEMENT  
FOR GLOBAL HEALTH EQUITY  
AND THE HUMAN RIGHT  
TO HEALTH.

# PRESIDENT'S MESSAGE



OUR MISSION REMAINS TO IMPROVE THE HEALTH OF MOTHERS AND CHILDREN IN THIS CORNER OF THE WORLD, AND OUR RESULTS SHOW WE ARE SUCCEEDING. IN A REGION WHERE INFANT AND MATERNAL MORTALITY RATES ARE AMONG THE HIGHEST IN THE WORLD, WE ARE BRINGING CARE TO THOSE WHO WOULD NOT OTHERWISE RECEIVE IT, INCLUDING MANY WHO ARE AT HIGH RISK OF MAJOR COMPLICATIONS AND PREGNANCY-RELATED DEATH.

In this Report, we present the joint efforts of the Prominent Homes Charitable Organization, based in Calgary, Canada, and the Mata Jai Kaur Maternal and Child Health Centre, located in Rajasthan, India, to build healthy communities through investments in health and education.

I am thrilled to see the smiling faces of women, children and families in the various photos of this Report. What is harder to see is the despair and stress that these women, children and families might have been under. People in this part of the world are thankful for whatever assistance is availed to them. Despite their circumstances they are always generous with what they have. Their hospitality is something that our volunteers from Canada, the US, India and elsewhere experienced these past several years while collecting much needed survey and interview data that is presented in the following pages.

This data was needed to evaluate whether we have remained true to our vision and mission, as expressed when we first started, or to reflect and fine tune those statements. We have found that our vision and mission can remain largely intact with one small adjustment: **explicitly acknowledging structural violence against women** as another obstacle to improving maternal and child health outcomes.

#### STRUCTURAL VIOLENCE

The ways in which poverty and inequality become embodied as illness and experienced as violence.

**We have indeed, as per our vision, empowered woman we have come into contact with. The challenge still remains to reach out to more of the vulnerable population within**

**our catchment area.** Challenges exist in making sure that these women have the knowledge and guidance to provide a healthy life for themselves and their children. We need to make sure that they have hope for something better for their sons and daughters compared to the life they themselves had. This is an ongoing endeavor that at times seems attainable and at times seems a bar set too high. The real fact here is that if we don't try, we will not succeed. If we try we might fail, but we will rise up to try it again in a different way and finally we will not only succeed but we will have planted seeds for others to do the same.

**Our mission remains to improve the health of mothers and children in this corner of the world, and the current results show we are moving in the right direction.** In a region where infant and maternal mortality rates are among the highest in the world, we are bringing care to those who would not otherwise have received it, including many who were at high risk of major complications and pregnancy-related death. There is still work to do. Difficult pregnancies don't come to us until it is too late. But for those women that are in our care from the beginning of their pregnancy to delivery and postnatal care, our success rate is something we are proud of.

Much work still remains, as this is just the beginning of what needs to be done to accomplish our goals. It is not enough to bring healthy children into this world; we also need to make sure that their mothers are there to guide them through life, and that these mothers are there to enjoy their children growing up and succeeding.

To this end we will need to provide a greater variety of services to make sure that other illnesses don't take these mothers from their children and

families. **Women's health and child health are not, despite the claims of many governments and international organizations, the highest priority for our global society - if it were, why would we let so many women and children die needlessly?** The latest estimates show that over **300,000 women die every year** from causes related to childbirth, and **2.7 million babies die every year within the first 4 weeks of life.** The vast majority of these deaths are preventable with access to the most rudimentary care.

Our role is to make sure quality health care, early detection, and treatment of illnesses related to pregnancy and delivery are available. We need to continue educating women about healthy behaviours before, during and after pregnancy. But more importantly, we need to demonstrate and convince others that **providing health care to the most vulnerable is not only possible; it is necessary. Demonstrating what's possible, sharing our lessons, and engaging people in this work is part of the struggle to overturn structural violence.** We are proud to share what we have accomplished over the last 4 years. With the love and support of my wife, Pinky, and the commitment of our team, our dreams for this work are becoming a reality. I invite you to join our cause.

#### DEEP SHERGILL

President

**Prominent Homes Charitable Organization**

Calgary, Canada



*Deep with his grandmother, Mata Jai Kaur May, 1960*

## OUR VISION

**WE ENVISION A HEALTHY SOCIETY WHERE WOMEN ARE EMPOWERED AS AGENTS OF CHANGE AND CHILDREN ARE FREE TO ACHIEVE THEIR HIGHEST POTENTIAL IN LIFE. SUCH A SOCIETY IS FREE OF UNNECESSARY AND PREVENTABLE DEATHS OF WOMEN AND CHILDREN DUE TO A LACK OF QUALITY REPRODUCTIVE AND CHILD HEALTH SERVICES.**

## OUR MISSION

**OUR MISSION IS TO IMPROVE THE HEALTH OF MOTHERS AND CHILDREN IN THE DISTRICT OF SRI GANGANAGAR, RAJASTHAN THROUGH THE PROVISION OF HIGH QUALITY REPRODUCTIVE AND CHILD HEALTH SERVICES IN A SAFE, HYGIENIC, AND WOMEN-CENTERED ENVIRONMENT. WE STRIVE FOR THE HIGHEST ATTAINABLE LEVEL OF CARE THAT REFLECTS LOCAL NEEDS AND IS INFORMED BY EVIDENCE AND EMPATHY. WE WORK IN SOLIDARITY WITH THE MOST VULNERABLE WOMEN OF SRI GANGANAGAR TO UNCOVER AND ALLEVIATE STRUCTURAL VIOLENCE.**

# COO'S MESSAGE



**GIVING BIRTH SHOULD NEVER BE A MAJOR CAUSE OF DEATH, NOR SHOULD IT CAUSE FINANCIAL CATASTROPHE. THESE ARE THINGS MANY CANADIANS CAN TAKE FOR GRANTED. BY PROVIDING FREE, QUALITY CARE, OUR PATIENTS BENEFIT BY NOT HAVING TO WORRY ABOUT GETTING THE CARE THEY NEED.**

## LISTENING AND LEARNING: OUR JOURNEY OF UNDERSTANDING

I write this entering my 6th year as the Chief Operating Officer of the Mata Jai Kaur Maternal and Child Health Centre (MJK). It's been an incredible personal and professional journey. I left Calgary to live fulltime in village 35BB in August 2011 — a transition that pushed the boundaries of my cultural comprehension, language ability, and my physical and mental fortitude. But the journey from Canada to rural India was much more profound than a mere physical relocation. Reflecting on the past 6 years, I see that I, along with the teams at MJK and the Prominent Homes Charitable Organization (PHCO) have been on an incredible journey of understanding.

As a small health care organization dedicated to serving the most vulnerable in rural Sri Ganganagar, Rajasthan, we knew early on that we needed to do two things. First, we had to ensure that we were targeting the right interventions to the appropriate population. Second, in order to understand how we might do this, we had to seek out marginalized women in our district and learn from them how best to deliver health care. These efforts were born out of a conviction that **those affected the most by poverty and inequality can teach us the most about the challenges they face.** Much of what's presented in this report, which covers the years 2012-2016, is the result of us listening to women living in these conditions and translating their lessons into better programs.

We have a long way to go. Many women in Sri Ganganagar continue to face enormous obstacles to care. But we are nonetheless proud of our progress. We've safely delivered **almost 800** babies since 2010 in a district that continues to have among the worst

maternal and child health outcomes in the world. Our average of about **125** deliveries a year may not sound like a lot relative to any major district or city hospital, but we know, based on socioeconomic surveys and interviews, that the vast majority of our patients are vulnerable women who would not otherwise receive care. Many of our deliveries are complicated, requiring surgery or other specialized interventions that are only available at private facilities where the cost of service is often several times a household's monthly income. Although India has public hospitals, these are rarely capable of dealing with complex pregnancies. Poor patients are often forced to choose between dangerously incomplete care or financial ruin.

**Giving birth should never be a major cause of death, nor should it cause financial catastrophe. These are things many Canadians can take for granted. By providing free, quality care, our patients benefit by not having to worry about getting the care they need.**

In terms of antenatal care, which is vitally important to ensuring the health and life chances of mothers and children, our village-based clinic has had over **6,500 antenatal outpatient visits** since 2012 in a region where only **13.1%** of low-income women receive adequate care. Besides antenatal patients, we have served over **9,500 women for non-pregnancy related illnesses**, for a total of over **16,000** clinic visits over the last 4 years. We do not deny care to non-pregnant women since they often come to MJK both for treatment and to support their pregnant family-member or sibling.

Additionally, since 2013 **we have provided pediatric care to 147 children** at our annual child health camps.

These were instituted in response to our 2012-2013 Mother's Survey, which indicated that 81% of children did not receive any health check-ups despite high rates of disease, including diarrhea and acute respiratory infection, which remain among the biggest and most easily treated causes of death among children.

## OUR WORK IN THE MIDST OF PROGRESS AND DEEPENING VULNERABILITY

We know we are helping families and saving lives, but what hasn't always been clear is whether we are achieving the broader impact we desire. Are we adding value to the health care system? Are we doing anything to help mitigate the structural forces that condemned our patients to vulnerability in the first place?

Complicating these questions is the fact that we are providing our services in the midst of some major progress in maternal health both locally and globally. **The maternal mortality ratio (MMR) in Sri Ganganagar improved by 44% between 2006 and 2011**, an improvement that mirrors global trends. Additionally, when we started MJK in 2010, it was estimated that less than half of rural women in Rajasthan received a safe delivery. **Now our studies show that over 90% of low-income women deliver in a hospital.** Though we have undoubtedly contributed to this improvement, it is more a result of welcome changes in government policies that have encouraged change in health-seeking behaviour (refer to page 31).

But these trends don't reveal the whole story. Infant and child mortality rates remain largely unchanged and abhorrently high — almost every poor family we encounter in Sri Ganganagar is touched by it. And despite

this progress, **India still accounts for 15% of all maternal deaths globally** – the second highest of any country – with poor states like Rajasthan experiencing the highest burden. More fundamentally, the current MMR estimate (191/100,000) is still simply unacceptable since major causes of death are preventable with access to even the most rudimentary care.

The signs of progress also did not correspond with our experience on the ground. **We continue to serve a steady stream of vulnerable patients and desperate families**, which is unsurprising. Progress has led to a widening gap in health outcomes between the most vulnerable and the rest of society. Part of what prevents our target population from benefiting from this progress is the complex and often hidden nature of their vulnerability. **Geographic isolation and poverty are commonly recognized barriers to care in rural areas, but equally important are social barriers that constrain a women’s agency – i.e. her ability to act and decide in her own best interest both within the household and in society.**

We have logged thousands of miles interviewing and surveying hundreds of women in every corner of our district to better understand the nature of their vulnerability.

**You will find in this report the personal stories of several women from the community.** All of these convey the various ways structural forces become embodied as death or illness during and after pregnancy. We also present two new avenues of care that we will be integrating into our existing programs – **maternal mental health and family planning** – that will help uncover and overturn the structural forces many of our patients face.

#### OUR SEVA; OUR CALL TO ACTION

For us, the end result of our journey is a renewed sense of commitment and purpose. **Our cause remains the same: To identify the most vulnerable, understand their challenges, and find ways to get them the care they need.** By committing ourselves to listening, critical self-reflection, and uncovering structural violence, we will help bridge the widening care gap and achieve health equity. This is how we will continue to empower women to become agents of change in Sri Ganganagar. By sharing our lessons, continually learning from others, and collaborating with like-minded individuals and organizations, we hope to contribute to the broader movement for global health equity and the human right to health.

We have embraced the word “seva”, meaning selfless service, as the core of our commitment to this goal. Part of this commitment is to embrace the challenges that are inevitably part of a project in social transformation. In reflecting over the past several years, I am heartened that our commitment to our dream, which some might call impractical, hasn’t wavered despite some serious practical challenges. The vast majority of our funding comes from the Prominent Homes Charitable Organization (PHCO), which has doubled down on their support of our joint venture despite the economic downturn in Alberta. PHCO’s seva extends not only to Sri Ganganagar, but also to Calgary through the **Kirpal Kaur Dhindsa Scholarship**, the results of which are presented on page 50 of this report.

I am in awe of the hard work and dedication of the PHCO and MJK teams, which have remained relentlessly committed to our vision and mission, and am humbled by the many people

from around the world who have contributed to our cause and volunteered their time. You will see their faces in these pages too. This investment in time, energy, and resources has constituted an initial investment, not only in the rural community we serve in Sri Ganganagar, but in the creation of a mechanism for collaboration, solidarity, and empathy in the service of our mission and vision. We look forward over the coming years to building and strengthening these bonds and to having others join the movement.

Six years in, and I feel this journey is only beginning.

#### ANEEL BRAR

Chief Operating Officer  
**Mata Jai Kaur Maternal and Child Health Centre**  
Village 35BB, Sri Ganganagar  
Rajasthan, India

**“I COULD HAVE DIED.  
IF I HADN’T COME TO 35BB [MATA JAI KAUR],  
I WOULDN’T HAVE RECEIVED ANY TREATMENT.  
EVEN MY BABY COULD HAVE DIED  
WITHOUT THE CARE I WAS GIVEN HERE.  
MY OWN MOTHER DIED;  
THERE IS NOTHING WITHOUT A MOTHER.  
ALL OF MY BROTHERS’ WIVES  
HAVE LOST THEIR MOTHERS TOO.”**

**KULWINDER**

# KULWINDER'S STORY



When Kulwinder<sup>2</sup> first came to MJK, we realized she had hypertensive disorder, one of the leading causes of maternal death in developing countries. Without proper care and careful monitoring, Kulwinder and her unborn child had a very high chance of dying. To make matters worse, her family was impoverished but not destitute enough to qualify for government benefits. While they had some assets, these weren't enough to cover the cost of a medical emergency. In addition, Kulwinder's husband was addicted to drugs and alcohol and he, along with his family, had been physically and emotionally abusive to Kulwinder for many years. Much of this abuse could be attributed to Kulwinder's

past infertility: in Rajasthan, a woman's worth is often tied to her ability to bear children.

For the mothers of rural Sri Ganganagar, it is difficult to independently navigate the obstacles associated with getting care, such as travelling to city hospitals, getting the attention of hospital intake staff, and haggling at pharmacies. Realizing that Kulwinder lacked the support required to overcome these challenges, MJK led an intervention with her husband so that he would assist Kulwinder in getting the care she needed for a safe pregnancy. With the help of MJK's obstetrician/gynecologist and her own profound courage and willpower, Kulwinder de-

livered a healthy daughter and avoided the life-threatening consequences that could have resulted from her condition. Kulwinder's case reveals a level of vulnerability that goes beyond poverty to include an absence of support that would make it difficult for anyone to overcome a life-threatening health condition.

2. Kulwinder and her family have agreed to have us share her story.

# WHERE WE ARE

## GLOBALLY

### 308,000 MATERNAL DEATHS OCCURED IN 2015<sup>3</sup>

- Death related to pregnancy and childbirth
- Equivalent to 830 deaths/day
- 99% of these deaths occur in developing countries

### 2.7 MILLION NEONATAL DEATHS<sup>4</sup>

- Deaths within the first 28 days

### MAJOR CAUSES OF MATERNAL AND CHILD DEATHS ARE PREVENTABLE WITH ACCESS TO QUALITY MEDICAL CARE

## SRI GANGANAGAR, RAJASTHAN

### 15% OF ALL MATERNAL DEATHS OCCUR IN INDIA<sup>3</sup>

- The second highest behind Nigeria
- Sri Ganganagar has among the worst maternal and child mortality outcomes in the world

### 191 MATERNAL DEATHS PER 100,000 LIVE BIRTHS<sup>5</sup>

- India: 174 maternal deaths per 100,000 live births
- Canada: 7 maternal deaths per 100,000 live births

### 34 NEONATAL DEATHS 1000 LIVE BIRTHS<sup>5</sup>

- India: 28/1,000
- Canada: 3/1,000

### ONLY 13.1% OF LOW-INCOME WOMEN IN SRI GANGANAGAR RECEIVE COMPLETE ANTENATAL CARE

- Defined as a minimum 3 medical check-ups during pregnancy, tetanus vaccination, and at least 100 days of iron folic acid supplementation



3. MMEIG. Trends in maternal mortality: 1990 to 2015. Geneva, World Health Organization, 2015.  
 4. UN IGME. Levels and trends in child mortality report 2015. New York, 2015.  
 5. Office of the Registrar General & Census Commissioner. Annual health survey: 2012-13 fact sheet. New Delhi, 2013.



# WHAT WE DO

## MJK CATCHMENT AREA:<sup>6</sup>

- 558 VILLAGES
- 5 RURAL TOWNS
- POPULATION: 359,746 (170,823 FEMALES; 188,932 MALES)
- TOTAL FEMALES OF CHILDBEARING AGE (15-49): 80,134

## OUR INTERVENTION

The **Mata Jai Kaur Maternal and Child Health Centre (MJK)** is located in **village 35BB, district Sri Ganganagar, Rajasthan.**

Our core health care delivery model is based on **reducing geographic, social, and economic barriers** to quality antenatal care and safe delivery services for low-income and vulnerable women. We provide antenatal care services every Sunday at our **Mata Kartar Kaur Prenatal Clinic (MKK)**, during which our medical team travels from Ganganagar city to 35BB, an approximately 50km journey.

After enrolling in our maternal health program, we see mothers through to the end of their pregnancy, providing essential diagnostics, medicines, and health education programs.

We deliver their children at our partner facility, **Sihag Hospital**, located in Ganganagar city, providing a transportation subsidy when required.

We also provide neonatal care and health monitoring for several days after delivery, as necessary.

## REDUCING GEOGRAPHIC, SOCIAL, AND ECONOMIC BARRIERS

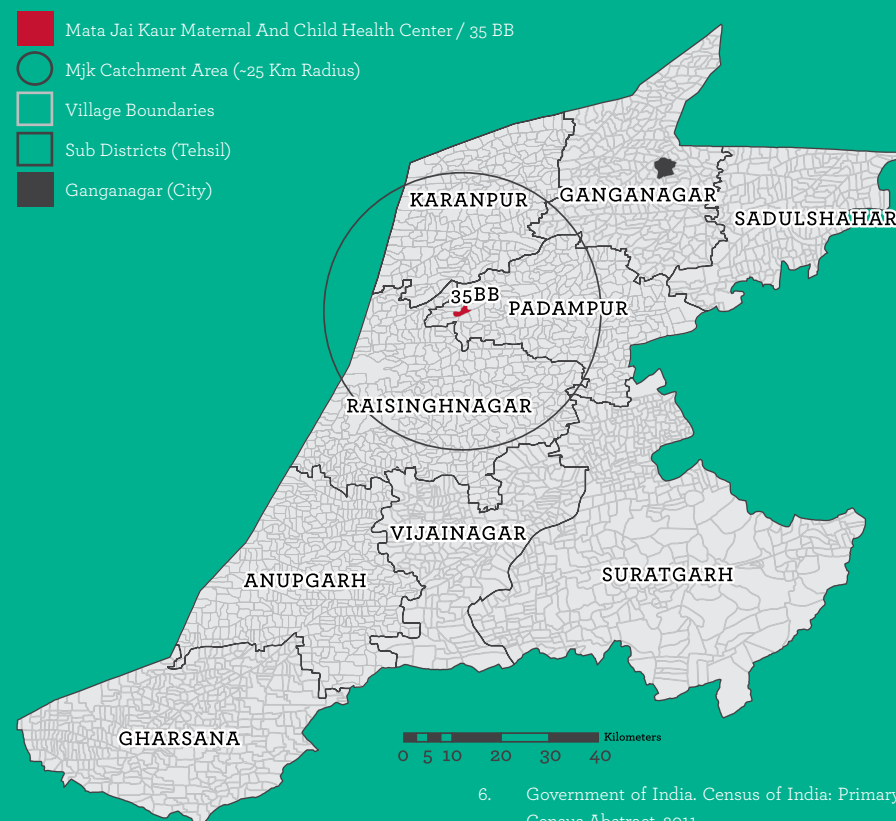
By existing in a rural village setting we are accessible to remote, isolated villages along the India-Pakistan border, and to communities connected only by unpaved or unmaintained roads. Our village setting is also comfortable and familiar enough for rural women that they can travel for care independently.

In addition to our core intervention, we conduct:

- Village outreach and education programs
- Pediatric health camps
- Global health research

**Our catchment area includes all villages located within a 25km radius of 35BB.** We have added villages outside of this circle, particularly along the northern and southwestern border areas, and to certain other communities that are in need of our services. Often, pregnant women travel to our clinic with a support group of women from their communities. We have found that not providing care for these other women negatively impacts accessibility for pregnant women, and so we gladly provide this service to ensure pregnant women continue to access the care they require.

## SUB-DISTRICTS (TEHSILS) AND VILLAGE BOUNDARIES OF SRI GANGANAGAR



**WE PROVIDE ALL OUR SERVICES TO LOW-INCOME AND VULNERABLE WOMEN FREE OF COST. THIS ELIMINATES THE OFTEN CATASTROPHIC FINANCIAL BURDEN FOR WOMEN WITH COMPLICATED PREGNANCIES.**

**WE DO NOT DENY SERVICES TO ANY WOMEN IN NEED, EVEN IF THEY COME TO US FROM OUTSIDE OUR CATCHMENT AREA. WE ALSO PROVIDE CARE FOR NON-PREGNANCY RELATED CASES FOR FREE.**

# WHAT WE HAVE DONE

## WE HAVE SAFELY DELIVERED 772 BABIES SINCE 2010

- Many of our patients have complicated pregnancies and have previously had poor outcomes
- We provide all necessary care required for a safe pregnancy, including C-sections, free of cost

## WE HAVE AN EVEN SEX-RATIO (GIRLS:BOYS)

- Sri Ganganagar has a skewed sex-ratio at birth of 895 girls to 1000 boys due to boy-preference and sex-selective abortion<sup>3</sup>
- Our sex-ratio at birth as of 2016 is 1059 girls to 1000 boys

## 12% OF OUR BABIES ARE UNDERWEIGHT VS. 20% IN SRI GANGANAGAR OVERALL<sup>3</sup>

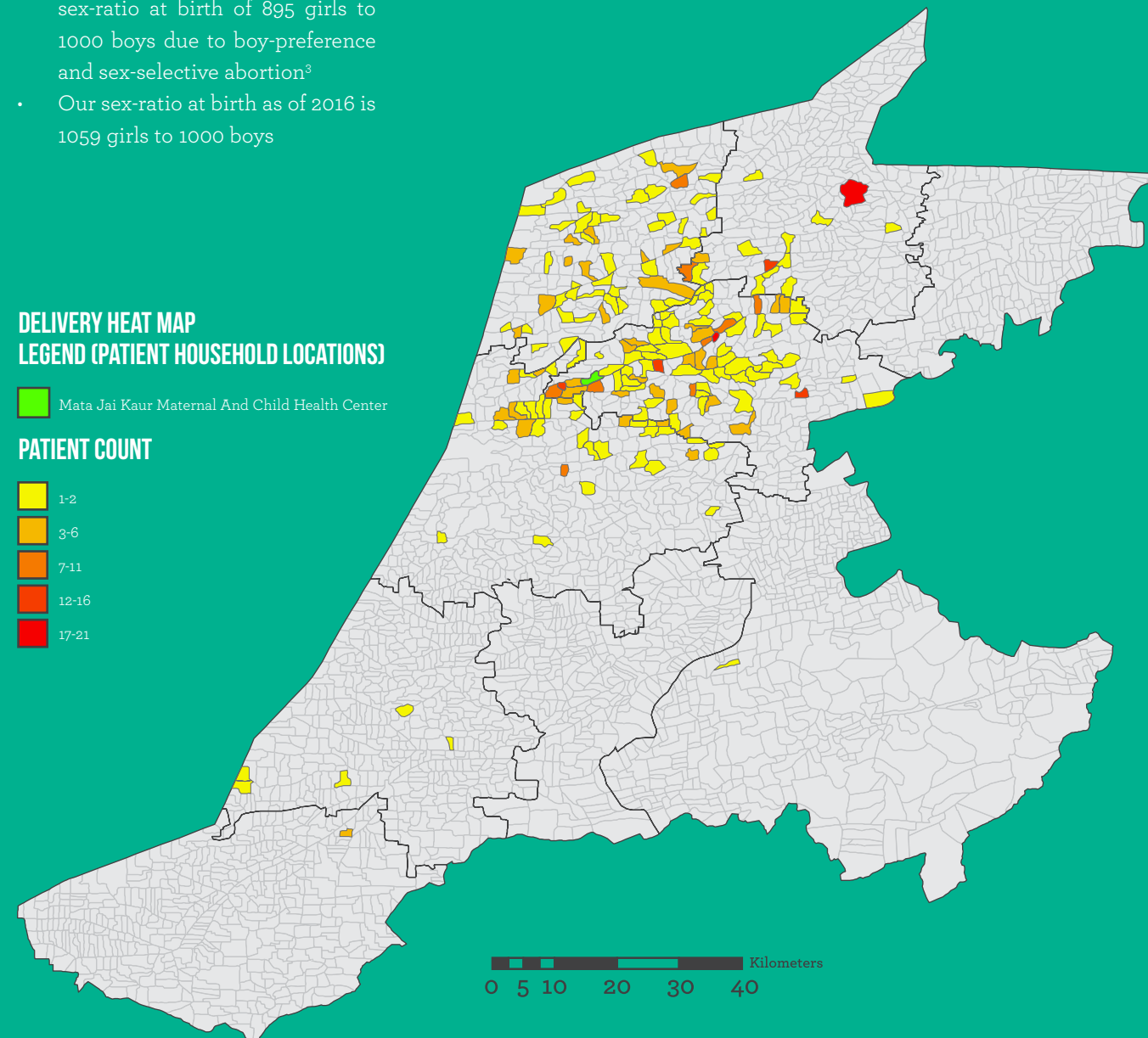
- Defined as less than 2.5kg at birth
- Proper antenatal care can help increase birth weight
- India and Rajasthan have high prevalences of low birth weight and poor nutrition among women and girls

### DELIVERY HEAT MAP LEGEND (PATIENT HOUSEHOLD LOCATIONS)

 Mata Jai Kaur Maternal And Child Health Center

#### PATIENT COUNT

-  1-2
-  3-6
-  7-11
-  12-16
-  17-21



## WE HAVE PROVIDED QUALITY ANTENATAL CARE TO 1,326 WOMEN SINCE 2012

- Amounts to over 6,500 antenatal outpatient visits to our weekly clinic (~5 visits per woman during pregnancy, however not all out antenatal patients delivery through us)
- Includes regular check-ups, lab testing and ultrasound, vaccinations, and all other necessary clinical care

## WE HAVE RECEIVED OVER 16,000 TOTAL OUTPATIENT VISITS SINCE 2012

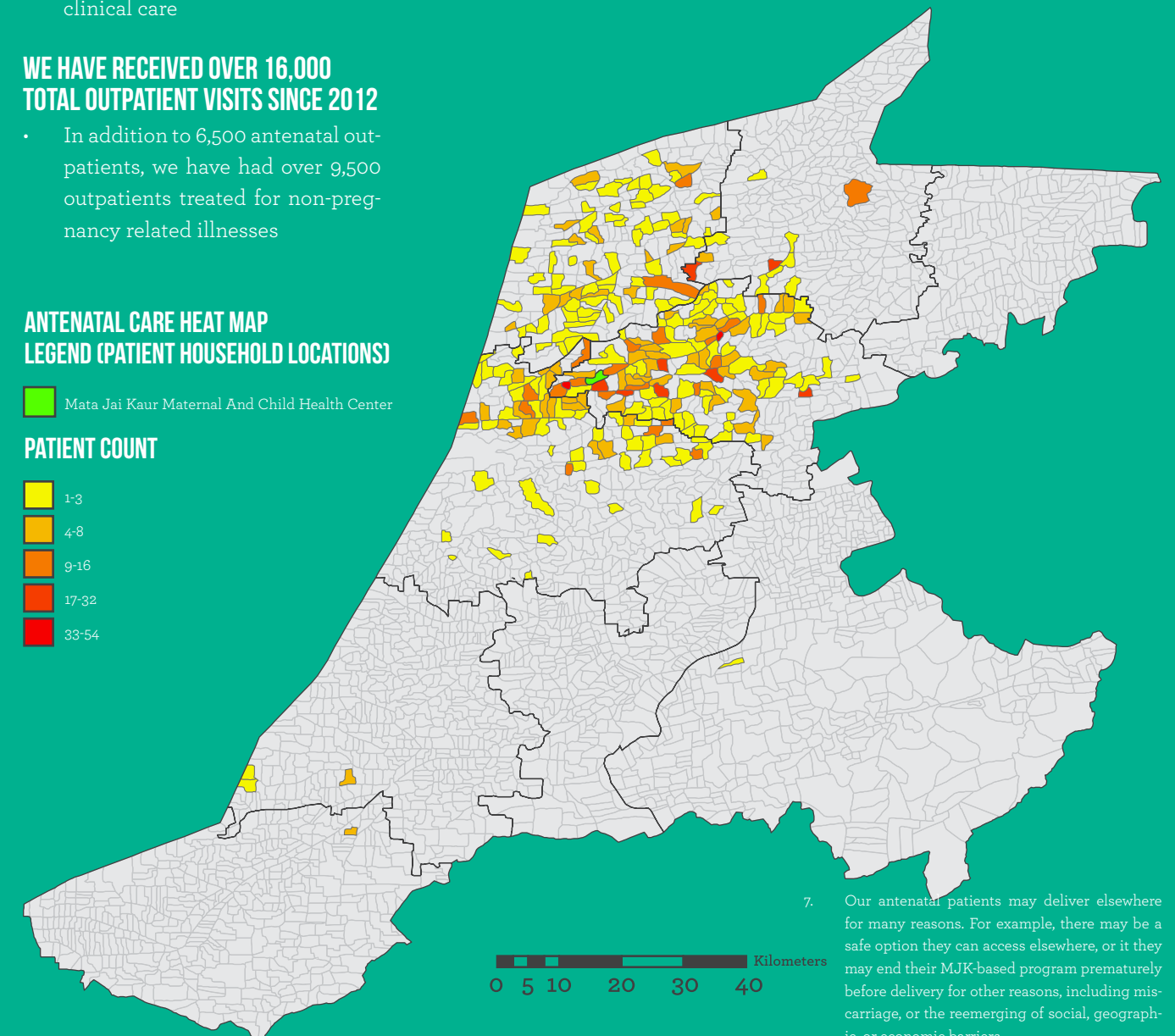
- In addition to 6,500 antenatal outpatients, we have had over 9,500 outpatients treated for non-pregnancy related illnesses

### ANTENATAL CARE HEAT MAP LEGEND (PATIENT HOUSEHOLD LOCATIONS)

 Mata Jai Kaur Maternal And Child Health Center

#### PATIENT COUNT

-  1-3
-  4-8
-  9-16
-  17-32
-  33-54



## TARGETING OUR INTERVENTION: OVER 96% OF OUR PATIENTS ARE OF LOW OR VERY-LOW SOCIOECONOMIC STATUS

- In 2014, we implemented a socioeconomic questionnaire to ensure that our intervention is targeted to the most vulnerable women. We record information that provides an indication of the women's socioeconomic status in relation to a number of social

determinants of health, including caste, distance to maternal village, education level, income, arable land ownership, and assets.

- Wealth isn't the only measure of vulnerability, and we use the socioeconomic questionnaire in conjunction with a personal interview with each family to determine their level of vulnerability.

7. Our antenatal patients may deliver elsewhere for many reasons. For example, there may be a safe option they can access elsewhere, or it may end their MJK-based program prematurely before delivery for other reasons, including miscarriage, or the reemerging of social, geographic, or economic barriers.

# OUR MOTIVATION OUR AGENTS OF CHANGE

**THE MOTIVATING FORCE BEHIND OUR PROJECT COMES FROM TWO WOMEN—MATA KARTAR KAUR AND MATA JAI KAUR (“MATA” IS A RESPECTFUL TERM MEANING “MOTHER”). THEIR STORY EPITOMIZES THE STRUGGLE THAT MANY WOMEN IN GANGANAGAR STILL ENDURE. THEIR TRIUMPH THROUGH TRAGEDY HAS TRAVERSED OCEANS AND CONTINENTS AND HAS NOW RETURNED TO WHERE THEIR STORY BEGAN. IN OUR FAMILY’S HISTORY, THESE TWO WOMEN STAND OUT AS OUR AGENTS OF CHANGE.**



**MATA KARTAR KAUR**

Mata Kartar Kaur, after whom our prenatal clinic is named, gave birth to nine of her ten children in a small, mud-walled hut on the very spot that our clinic now stands. Due to unhygienic conditions and unsafe delivery techniques she contracted puerperal fever, still one of the biggest killers of women in developing countries, and died soon after giving birth to her last child, Baldev (Deep) Shergill, founder and President of Prominent Homes Ltd. and the Prominent Homes Charitable Organization (PHCO).

Although Kartar Kaur died young, her influence on her children’s future was tremendous. At a time when literacy and education were not highly valued, especially for girls, Kartar Kaur ensured that all of her children – and her husband – could read and write. The value for education she instilled in her family paved the way for brighter futures in Canada and United States. Through her strength and independence of spirit, Kartar Kaur also resisted significant social pressures for

sex-selection. In a society that greatly valued boys over girls, Kartar Kaur ensured that all five of her daughters survived childhood to become loving and supportive mothers themselves.

Kartar Kaur died at the age of 35 in 1956 from a preventable condition. Indeed, many of the risks that Kartar Kaur faced while giving birth to her ten children continue to threaten the wellbeing of mothers in Sri Ganganagar and across the developing world. The major causes of maternal death are hemorrhage, infections, unsafe abortions, hypertensive disorders (eclampsia) and other complicating issues like anemia and malaria, both of which are common in Rajasthan.

All of these risks are avoidable and any deaths they cause are unnecessary.

**Our work is a reflection of Kartar Kaur’s love and sacrifice and is dedicated to the health and wellbeing of the women of Ganganagar.**

## **MATA JAI KAUR**

After Kartar Kaur’s death the responsibility for caring for her newborn child passed to her mother-in-law – Deep’s grandmother – Mata Jai Kaur. Jai Kaur was 85 years-old at the time and dutifully continued working in the cotton and wheat fields, preparing food, and managing other household

chores while caring for her infant grandchild.

In many ways, Mata Jai Kaur’s life reflects the struggles that women continue to face in many parts of India and the developing world. She was forced to marry young, denied opportunities for education and lived a life of servitude. Her responsibilities as a young woman included hauling drinking water over long distances through Rajasthan’s scorching summers and freezing winters. Like Kartar Kaur, Jai Kaur faced the many health risks associated with early pregnancy in an environment that lacked reproductive healthcare services. Many poor families in Sri Ganganagar still marry their children young, which increases the likelihood of early pregnancy and its associated health risks.

Fortunately, Jai Kaur survived to live a long time. She passed away in 1976 at the age of 105 and in the process had a direct and profound influence on three generations of her family. For her children, grandchildren, and the great-grandchildren Jai Kaur remains an everlasting source of inspiration and love that makes the Mata Jai Kaur Maternal and Child Health Centre possible.

**In development discourse it is well established that women can play a central role in lifting their families out of poverty. Together, Mata Kartar Kaur and Mata Jai Kaur were agents of change. They planted a seed that bloomed around the world and that has come back to Ganganagar through MJK.**



# EXPLAINING OUR VISION & MISSION

## OUR VISION

**WE ENVISION A HEALTHY SOCIETY WHERE WOMEN ARE EMPOWERED AS AGENTS OF CHANGE AND CHILDREN ARE FREE TO ACHIEVE THEIR HIGHEST POTENTIAL IN LIFE. SUCH A SOCIETY IS FREE OF UNNECESSARY AND PREVENTABLE DEATHS OF WOMEN AND CHILDREN DUE TO A LACK OF QUALITY REPRODUCTIVE AND CHILD HEALTH SERVICES.**

Our vision statement encapsulates the core of our philosophy which is based on two main ideas:

**1. EMPOWERING WOMEN AS AGENTS OF CHANGE**

Human and economic development are intricately linked with the empowerment of women.

Evidence shows that healthy, educated women lead to healthy, educated children. Such children can more readily achieve their fullest potential and contribute to creating a healthy, more productive society. Women, in other words, are vitally important agents of change. We aim to empower our

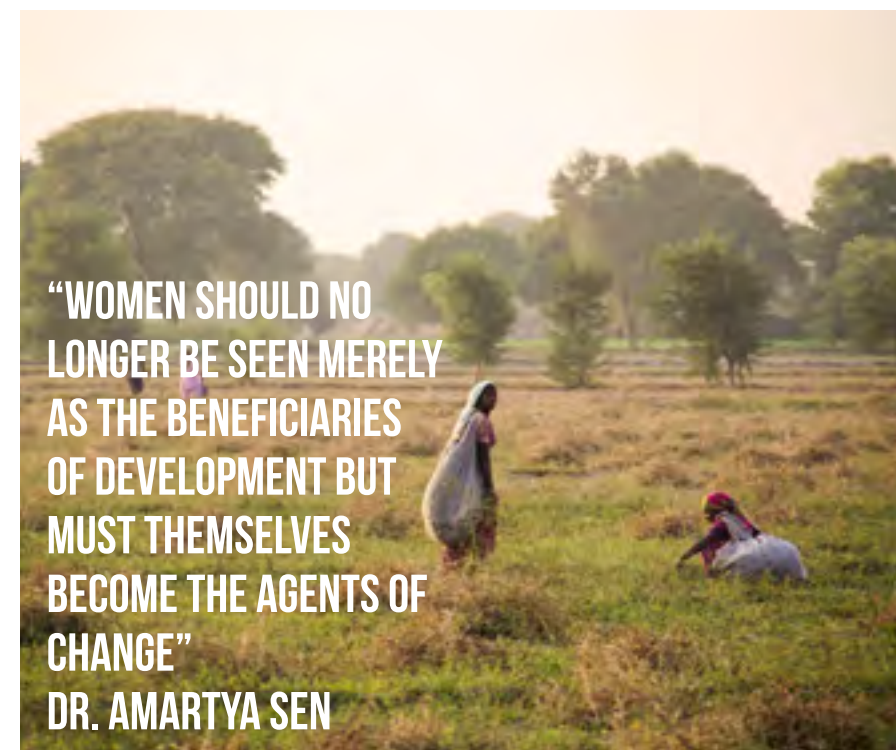
women not only by providing them with quality, accessible medical care, but also with education, information, and the freedom of choice.

**2. PREVENTING UNNECESSARY DEATHS**

The second idea underpinning our vision is the recognition that the majority of maternal and child deaths are unnecessary.

Harvard-based anthropologist and physician Dr. Paul Farmer, calls these “stupid deaths” — deaths that could easily be prevented with safe, effective, and affordable treatments readily available in developed countries.

We consider it ethically wrong that such deaths persist and a moral obligation to do all we can to prevent them. We also consider preventing unnecessary death of women important in its on right, not only as a means for improving child health or stoking societal change.



## OUR MISSION

**OUR MISSION IS TO IMPROVE THE HEALTH OF MOTHERS AND CHILDREN IN THE DISTRICT OF SRI GANGANAGAR, RAJASTHAN THROUGH THE PROVISION OF HIGH-QUALITY REPRODUCTIVE AND CHILD HEALTH SERVICES IN A SAFE, HYGIENIC AND WOMEN-CENTERED ENVIRONMENT. WE STRIVE FOR THE HIGHEST ATTAINABLE LEVEL OF CARE THAT REFLECTS LOCAL NEEDS AND IS INFORMED BY EVIDENCE AND EMPATHY. WE WORK IN SOLIDARITY WITH THE MOST VULNERABLE WOMEN OF SRI GANGANAGAR TO UNCOVER AND ALLEVIATE STRUCTURAL VIOLENCE.**

Our mission conveys how we will achieve our objective of improving the health of women and children in Sri Ganganagar.

Our approach is based on five interrelated pillars:

**1. PROVIDING QUALITY MEDICAL SERVICES**

Our primary aim is to provide the best quality medical services possible. This includes building well-designed facilities that are hygienic and are equipped with

all the necessary equipment, staff and resources essential to achieving high quality care.

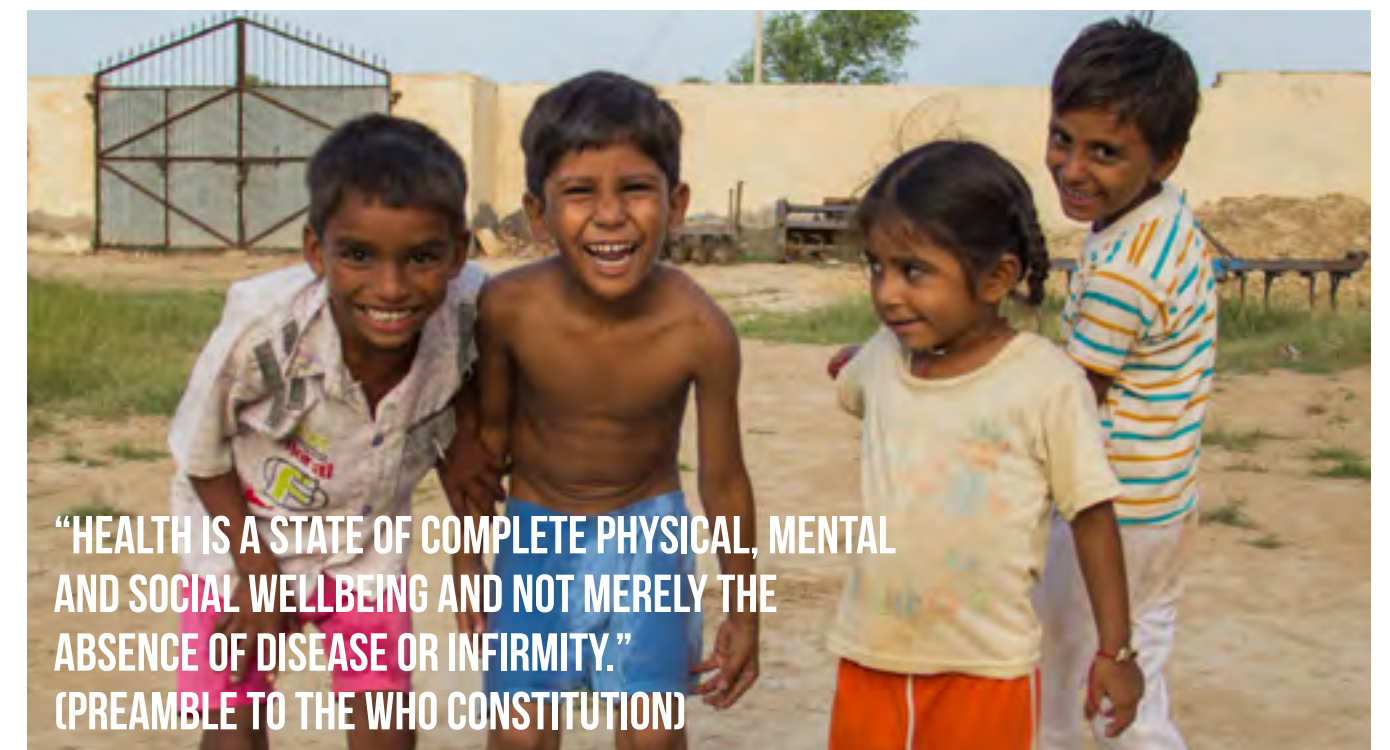
**2. CREATING A WOMEN-CENTERED ENVIRONMENT**

Often, women are not informed of their options and prevented from making important decisions regarding their health. MJK will strive to maintain our patient’s comfort, privacy, and agency in the care they receive. Beyond providing medical and clinical services, this means we will ap-

proach health holistically. We see health not just as the absence of disease, but as a state of complete physical, mental, and spiritual wellbeing.

**3. A HUMAN RIGHTS-BASED APPROACH TO HEALTH**

We operate under the assumption that access to the highest attainable standard of health is a fundamental right of every human being without distinction of race, religion, political belief, or economic condition. At MJK, this



means ensuring that low-caste, low-income and otherwise vulnerable families have equal access to quality health services. Adopting a rights-based approach is an acknowledgment that social conditions are important determinants of health, and that equality and social justice are fundamental imperatives.

#### 4. EVIDENCE

Our organization is guided by evidence and research. This means providing medical interventions that are based on the best available scientific evidence. It also means continuously learning, monitoring ourselves, and critically reflecting on our impact. Part of our evidence-based approach includes uncovering structural violence, highlighting the voices and concerns of the most vulnerable, and contributing to global health knowledge. To help us achieve these aims

we will seek to collaborate with other organizations — such as non-governmental organizations and universities, — with health experts both within India and internationally, and with the communities and vulnerable families we serve.

#### 5. EMPATHY

Our aim is to inform all of our efforts with empathy, understanding, and solidarity.

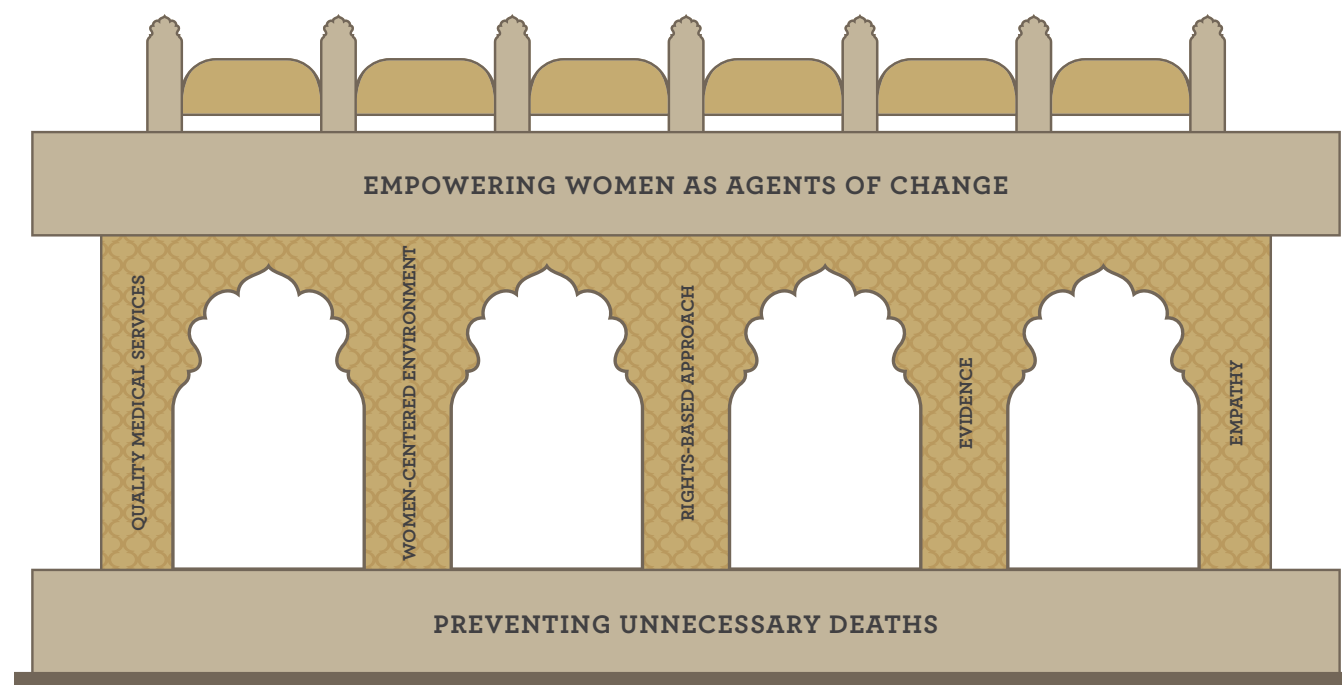
Too often, externally-funded projects impose solutions to local problems without consulting the local community, usually to detrimental long-term effect. We will inform our programs and decision making with local voices to ensure that what we are providing is needed and desired by the people of Sri Ganganagar. This principle is reflected in our efforts to put the operation of the MJK primarily in local hands. At the

individual patient level we will operationalize this principle with a simple motto: **we consider our patients as our sisters, mothers and children.**

## THE HAVELI METAPHOR

The ideas and principles that constitute our vision and mission work together to achieve our intended outcome: **empowering women as agents of change.**

Our organization can be metaphorically represented as a Haveli, a traditional Rajasthani house, where the ‘prevention of unnecessary deaths’ is the foundation, and our five ‘pillars’ the support-beams of a complete structure that empowers women. A well-built Haveli can stand for centuries. We hope that the influence that our healthy mothers have on their children and families will ripple through society for much longer.



**“MY MOTHER WAS WITH ME THEN BUT I GREW MORE ANXIOUS WITH EACH PASSING DAY AS MY DUE DATE CAME CLOSER. I WORRIED ABOUT WHAT WOULD HAPPEN THIS TIME. MY IN-LAWS ADVISED ME TO STAY WITH THEM SO I COULD GIVE BIRTH IN A HOSPITAL. MY PREVIOUS DELIVERIES AT MY PARENTS’ HOME HAD NOT BEEN SUCCESSFUL; I THOUGHT I SHOULD TRY A HOSPITAL THIS TIME.”**

**SUNITA**

# SUNITA'S STORY



Over the last several years, it has become increasingly common for the women of Sri Ganganagar to deliver their children in medical facilities. Nevertheless, some mothers still choose to give birth at home, typically in their parents' village, or *mayka*.

Sunita's<sup>8</sup> first delivery took place on a bed in her parents' house - it was a stillbirth. When she became pregnant for the second time, Sunita's husband made sure she received antenatal care from a private hospital in the town of Raisinghnagar. But again Sunita travelled to her *mayka* to deliver and again her pregnancy ended in a still-birth. She was heartbroken.

After two tragic births, Sunita and her family decided to use a maternal health facility going forward; eventually, she gave birth to a daughter at a private clinic. Still, she and her husband wanted to have a son, despite Sunita's advancing age. Although MJK was ultimately able to help Sunita deliver a healthy boy, her final pregnancy was risky and developed life-threatening complications.

Sunita's case demonstrates how the cultural mores surrounding maternity in Rajasthan can be adverse to women's wellbeing. Traditional birthing in a mother's *mayka* often results in unsafe deliveries and male-sex preference leads many mothers to continue

having children late into their child-bearing years.

Sunita and her family courageously rejected these norms, but not until after tragedy had befallen them. For many younger and lower-income mothers, however, these societal pressures continue to constitute major risk during pregnancy.

8. Sunita and her family have agreed to have us share her story.

# MJK CHILD HEALTH CAMPS



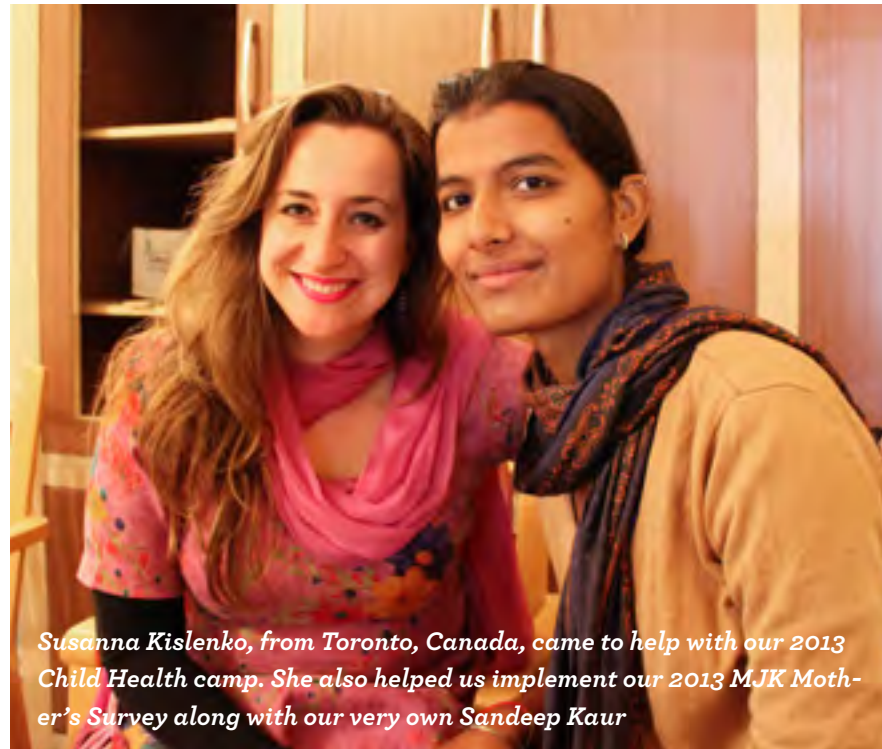
**MJK'S CORE INTERVENTION IS TO PROVIDE ANTENATAL CARE AND SAFE DELIVERY SERVICES, BOTH OF WHICH ARE VITAL FOR PREVENTING MATERNAL AND CHILD DEATH. MEDICAL CARE DURING PREGNANCY AND DELIVERY, HOWEVER, IS ONLY HALF THE BATTLE. POSTNATAL CARE FOR THE MOTHER AND CHILD, FROM THE FIRST FEW DAYS UP TO 42 WEEKS AFTER DELIVERY, IS EQUALLY IMPORTANT. THIS IS THE PERIOD WHERE THE MAJORITY OF MATERNAL AND INFANT DEATHS OCCUR, AND YET WE'VE FOUND THAT MOST MOTHERS AND INFANTS RECEIVE NO QUALITY CARE DURING THIS TIME.**

From our patient follow-up surveys, we found that **81% of children did not receive any care in the six months after birth** other than the immediate post-partum care we provide up to four days after delivery.

Similarly, **84% of our mothers did not receive postnatal care within six months of delivery.** This was the case despite some very high rates of illness experienced by both mothers and their children.

- 89% of mothers who experienced post-delivery complications including fever, vaginal bleeding, convulsions and signs of infection did not seek medical care
- 38% of our children experienced diarrhea up to three years after birth
- 81% of children did not receive any care in the six months after birth<sup>9</sup>

Another important indicator of the urgent need for child health care is child undernutrition.



Susanna Kislenko, from Toronto, Canada, came to help with our 2013 Child Health camp. She also helped us implement our 2013 MJK Mother's Survey along with our very own Sandeep Kaur

43% of children under 5 in India are undernourished, measured by weight for age, compared to 20% in Sub-Saharan Africa.<sup>10</sup>

9. 2012-2013 MJK Mother's survey.  
10. Drèze J, Sen A. An Uncertain Glory: India and its Contradictions. Princeton, NJ, Princeton University Press, 2013.

### ANNUAL MJK CHILD HEALTH CAMPS

In response to this urgent need, we instituted an annual Child Health Camp. With the help of Dr. Sunil Agarwal, a pediatrician, neonatologist, and the founder of Rainbow Hospital in Ganganagar city, we have instituted these camps to provide free specialist check-ups and medicine for the children of families in our catchment area. We have held three camps, each coinciding with either the anniversary of MJK's first delivery, which happened in mid-December, 2009, or Lohri, a traditional Northern Indian festival usually celebrated in mid-January. The event has become somewhat of a celebration, as we host visitors and reflect on the work we have done over the past year. Not only do we provide health care to mothers and children on these days, we also offer food and drink to all our guests and patients.

In addition to Dr. Agarwal's team, we have had the pleasure of hosting a number of volunteers in 35BB who have generously given their time to



Bharat Arora is a regular volunteer at our children's health camp. Seen here with our very own Rajesh Kumar.



Dr. Sunil Agarwal, paediatrician and neonatologist

our cause. These volunteers have come from as far away as Canada and the United States, and as close as 35BB itself. We are thankful for their assistance and proud to have them contribute to our work in the community.

reverse this in the coming years, as the need is very great. We also plan on moving beyond periodic interventions by making our child health programming at 35BB more permanent and ongoing. It is clear that the need is great, and if our antenatal care and safe delivery work is to translate into bigger societal change, then child health is something that cannot be ignored.



### CAMP DATES AND NUMBERS OF CHILDREN CHECKED

- January 17, 2016 – 18 children checked
- January 18, 2015 – 32 children checked
- December 22, 2013 – 97 children checked

In total we have served 147 children from across the district of Sri Ganganagar, ranging in age from a few weeks to 11 years old.

### MOVING FORWARD: CHILD HEALTH AT MJK

Although our camps were very welcome, it is clear that more needs to be done. Because of resource constraints we could not devote as much to outreach, and have therefore had decreasing attendance over time. We hope to



Dr. Nikhil (Sunny) Patel, currently a psychiatry resident at Cambridge Health Alliance/Harvard Medical School provided assistance to Dr. Agarwal during our 2016 Camp.

# 2013 VILLAGE VISITS & WOMEN'S MEETINGS



IN THE SPRING OF 2013, THE MJK TEAM EMBARKED ON A TOUR OF 23 VILLAGES WITHIN OUR CATCHMENT AREA TO CONDUCT A HEALTH EDUCATION AND OUTREACH PROGRAM AND TO GATHER INFORMATION THAT WOULD HELP US EVALUATE AND IMPROVE OUR SERVICES. WE GATHERED AT VILLAGE TEMPLES, LOCAL SCHOOLS, GOVERNMENT BUILDINGS, OR WHATEVER SPACE COULD ACCOMMODATE US FOR HOUR-LONG CONVERSATIONS WITH AS MANY VILLAGE WOMEN AS WE COULD INVITE IN EACH COMMUNITY.

## VILLAGE HEALTH EDUCATION

Our objective with the education and outreach program was to provide information on maternal and child health to low-income women. We wanted women in our area to know exactly what the risks associated with pregnancy are in Sri Ganganagar and what they can do to mitigate that risk. These kinds of programs are fundamental to our mission of “empowering women with knowledge” — i.e. to increase their agency in the decisions that affect their chances of surviving childbirth.

The education plan was simple. We engaged in four main topics related to maternal and child health:

1. The burden of maternal and child mortality in Sri Ganganagar versus other places
2. Why and where to seek antenatal care and safe delivery services
3. Nutrition during pregnancy
4. Sex-selective abortion and early marriage

The first two topics were mostly about consciousness raising. Maternal and child death has almost become a normal part of life in Sri Ganganagar. Almost every group of women we talked to had been touched by the death of a family member or friend due to childbirth. Most had experienced or known someone who'd lost a child.

We wanted to contextualize this experience by letting the women know that local maternal and child mortality estimates compared unfavourably to the rest of Rajasthan, neighbouring Punjab, to India as a country, and to places that experience almost zero maternal deaths, such as Canada. To everyone's consternation, Sri Ganganagar performed even worse than Pakistan and Bangladesh.



*Our team for the visits included Arshdeep, Sandhya, and Sandeep, our student nurse and clinic volunteer, and MJK's President, Balwant Kaler.*

We asked a simple question: **If it's possible to achieve such low maternal mortality rates in other places, why not in Sri Ganganagar, especially when simple, cost-effective and proven solutions exist?**

We wanted to let women know why they should seek antenatal care and have a safe delivery and that there was a high-quality option at MJK in village 35BB. But more importantly, we wanted to activate and motivate an awareness that could spur community mobilization for change.

By the time we got to the particularly thorny issues around sex-preference, cultural practices around nutrition, and early marriage, the

conversations were often led by the women themselves. Since abortion and sex-determination with ultrasound are illegal in India, the entire practice is pushed underground and is enormously risky for the mother.

Young age at marriage, often before 15 years in our area, is another huge risk since younger brides tend to have underdeveloped pelvises that are not yet able to handle childbirth.

Through these conversations, we learned about the structural violence women in Sri Ganganagar encounter, and how often various social forces circumscribe their choices around sex-selective abortion, nutrition, and early marriage. We learned much





Sandhya

who might potentially work with us to improve the health of their communities. We also met with village leaders to encourage them to take a more proactive role in the health of their communities.

In the end, we were able to sign-up almost 80 women – including teachers,

local leaders, students, and community health workers – to work with us moving forward.

We hope to involve these women in our future community health programming related to mental health and family planning.

more than we could have possibly taught them.

**OUTREACH**

The second main objective of the program was to encourage community buy-in for our intervention. We used the village visits to identify women



Christie James (aka Santro Bhanji), came all the way from Canada to volunteer her time with us.



Sandeep

**MJK WOMEN'S MEETING - MAY 5, 2013**

Our village tours culminated with the first MJK Women's meeting, a focus group discussion intended to help us understand the needs of our clientele. We invited all participants in the village meetings to join us at 35BB and the response was tremendous. Over 60 women arrived for the meeting, which was facilitated by Dr. Hillary Lawson, a Canadian doctor and longtime friend of MJK. Dr. Lawson has worked on several maternal health-related projects throughout Africa, India (including on our MJK mother's survey in 2012), in addition to her usual practice in rural Ontario, Canada. Christie James and another guest, Stefanie Foerster from Germany, also helped facilitate the meeting and took notes.

We had two very simple objectives for the meeting: 1. To get a better sense of the various social and geographic obstacles women face getting to care; and 2. to understand how MJK can best serve their needs.



We were honoured to be joined by (L to R), Christie James, Stefanie Forester, and Hillary Lawson (joined by a local girl) for our MJK Women's Meeting



Hillary and Christie James addressing the women

**KEY LESSONS**

Although the turnout was larger and the meeting more hectic than expected, we gained valuable lessons and insight from the meeting that we hadn't received on our village tour:

1. Frustration at the lack of transparency and agency regarding health care

Many women told us about how little information they are given when they seek medical care through government or private providers. We heard many stories of how women were not given explanations for poor outcomes such as late miscarriages or



tance needed to travel to get to care, but that it also lowered other social barriers to care. We were told by many women that they felt comfortable and secure coming to village 35BB for care because of the rural setting. As one woman stated, “we can come here without our husbands; we cannot go by ourselves to the hospitals in the city or town.” The very fact that we are located in a remote village, in other words, made the medical care more accessible. The consistent criticism we received from the women was that we should offer more services in the village of 35BB, where our rural antenatal care clinic is located. We are taking these lessons to heart and slowly centralizing as much care provision as is feasible to 35BB.

emergency C-sections, how they were never told why they were prescribed certain medicines, and how they were rarely given any choices regarding treatment options. **Health care, in other words, was in many cases a disempowering and frustrating experience. We at MJK will continue to provide transparent, women-centered care.**

nurses, doctors, and community health workers.

3. The value of MJK

We also learned of the value MJK offers our patients. **We were told that our village-based health center not only reduces the dis-**

*Support for the 2013 Village Visits and Women’s Meeting kindly provided by Metanceia, based in Paris, France.*

2. The costs of care

We also learned of how much care during pregnancy actually costs. The cost of treatment itself was burdensome, especially at private hospitals, but costs associated with transportation, the mental and emotional toll of receiving poor clinical care, and unexpected emergencies or complications were all much greater. We were told how medical conditions, even when ostensibly treated for free at government clinics, often left families indebted to lenders, usually for transportation costs, medical fees, and kickbacks to



# 2015-16 MAJOR STUDY

## UNDERSTANDING THE MATERNAL HEALTH EXPERIENCE OF VULNERABLE WOMEN IN SRI GANGANAGAR

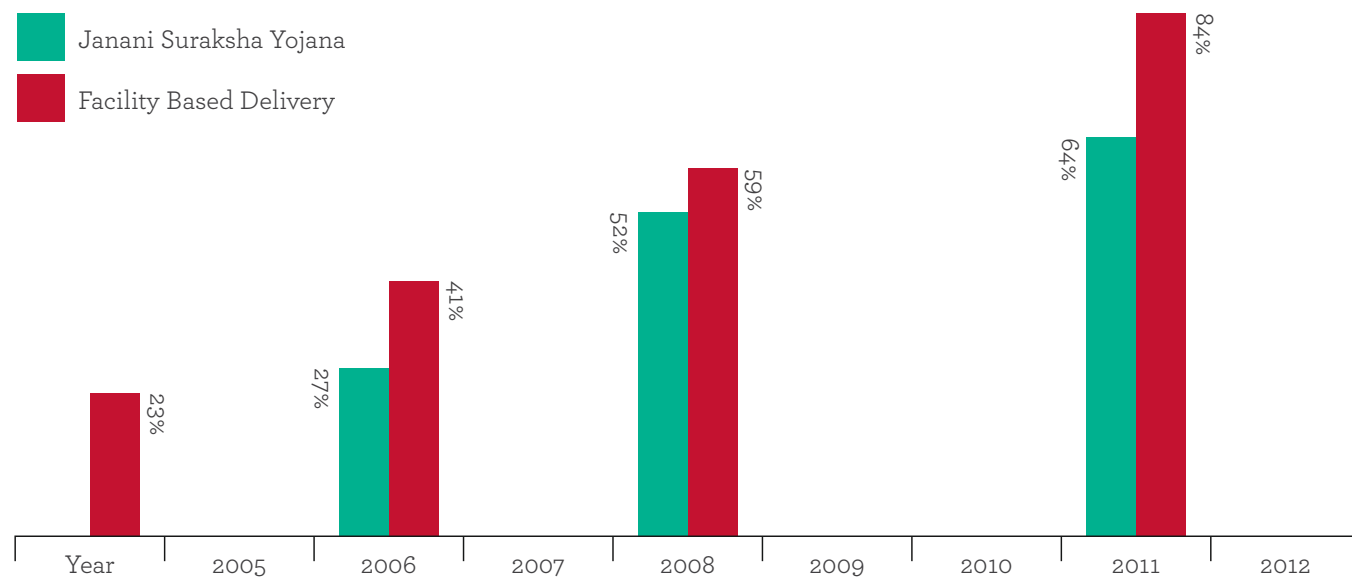
### PROGRESS IN FACILITY - BASED DELIVERY AND MATERNAL MORTALITY

From September 2015 to January 2016, MJK embarked on a major study to better understand the needs of the vulnerable women we aim to serve. When MJK began providing maternal health services in 2010 we were responding to two very dire statistics related to maternal health care access. First, it was estimated that less than 50% of rural women in Sri Ganganagar had a “safe delivery” — defined as deliveries that occur in the presence of a trained medical provider, usually in a hospital. Second, we knew that only 2.5% of Rajasthani women in the lowest income bracket



received “full” antenatal care, which is defined as receiving at least 3 antenatal check-ups, a tetanus vaccine, and at least 100 days of iron folic acid supplementation.

The combination of delivering safely in a properly equipped healthcare facility and receiving full antenatal care is very important for reducing the risk of pregnancy-related death and for improving the life chances of mothers and their children. It was not surprising, given the low proportion of women who delivered in a safe setting and received antenatal care, that Sri Ganganagar’s maternal mortality ratio (MMR) was 343 deaths per 100,000 live births — among the worst in India and the world.



**Figure 1: The proportion of women in Sri Ganganagar who had a facility based delivery (FBD) and received a conditional cash transfer (Janani Suraksha Yojna (JSY)).**

By 2013, official MMR estimates improved by 44% to 191/100,000.<sup>11</sup>

Undoubtedly, the improvements in MMR were at least partially due to two government programs:

**The National Health Mission (NHM)** is a program that aimed to extend access to primary care, including antenatal care, out to rural communities through a network of health centers and community-based care providers. The second program is a conditional cash-transfer program called **Janani Suraksha Yojna (JSY or “safe motherhood scheme”)** which provided cash incentives to women, regardless of socioeconomic status, to deliver at government hospitals or private birthing centers (the incentives are 1,400 rupees (\$28) if the baby is a boy, and 2,100 (\$42) if it is a girl).

Government estimates showed remarkable upward trends in the proportion of women who delivered in

a hospital and who received the JSY incentive. By 2011, an estimated 84% of women delivered in a hospital and 64% of women received the JSY benefit, compared to 23% and 27%, respectively, 5 years earlier (see figure 1).

These were tremendous signs of change related to care-seeking be-

haviour and significant improvement in health care coverage over a relatively short period of time.

#### PROGRESS FOR WHOM?

Despite the significant progress in MMR and facility-based delivery coverage, however, there were still signs



*Mira Vale (second from right), a PhD student at the University of Michigan, provided valuable research help for this study.*

11. Office of the Registrar General & Census Commissioner. Annual health survey: 2012-13 fact sheet. New Delhi, 2013.



*We only surveyed mud brick houses to ensure we talked only to low-income women, and we focused only on women who delivered in the previous two years.*



*In order to locate women who delivered in the last two years, we consulted village birth registries with the help of Ashas or community health workers. Ashas, who knew their communities well, would then help us locate the households.*

that we had a long way to go. Full antenatal care coverage was still estimated to be only 15.2% in 2012 for all women regardless of income level, and rates of child sickness and death remained unacceptably high. Additionally, our clinic kept receiving a steady stream of vulnerable mothers and families desperately seeking care. The signs of progress did not correspond with our experience on the ground.

**We had questions we wanted to investigate: Were the statistical trends showing improvement repre-**

**sentative of the lived-experience of our target population? If not, then who was being left behind?**

Our study objective was to assess **NHM** and **JSY** in terms of facility-based delivery and antenatal care coverage in our catchment area, but focusing only on low-income households. We also wanted to understand the lived experience of these women in order to better understand the nature of their vulnerability, including their social, economic, and physical barriers to care.

The study would not only help us deliver health care to vulnerable women in Sri Ganganagar, it would also help the Government of Rajasthan under-

stand where NHM and JSY are successful and where it could improve.

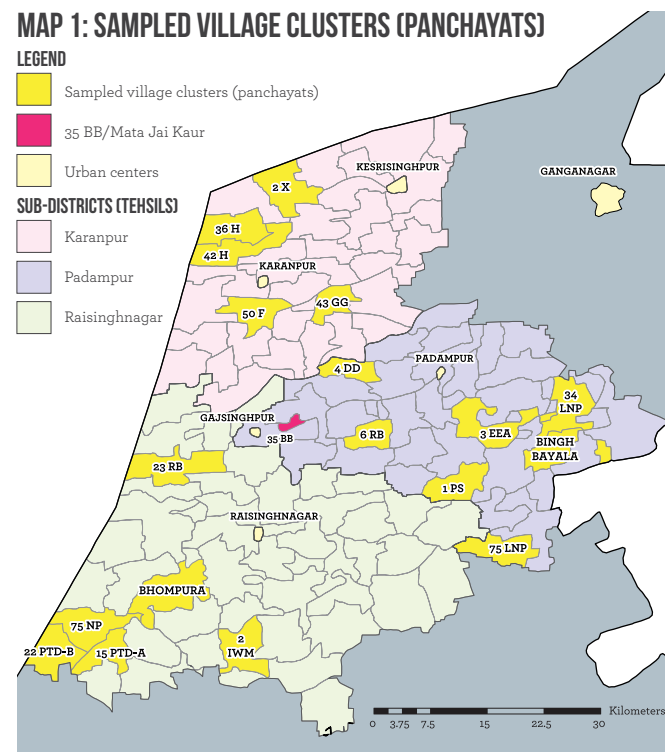
#### OUR STUDY

To answer these questions, we designed a survey to assess the proportion of low-income women who received full antenatal care and/or delivered in a hospital for their most recent pregnancy. We surveyed and interviewed 313 low-income women living in 18 different clusters of 5-11 villages (also known as panchayats). In total we covered 151 of the area's 893 villages (see map 1, page 34).

We also interviewed providers at various levels of the healthcare system.



*Our research team travelled thousands of kilometers to the furthest corners of the three sub-districts - Karanpur, Padampur, and Raisinghnagar - that constitute the major part of our catchment area.*



**MAP 1:** The sampled village clusters (in yellow). The red area is village 35BB, the location of MJK. Village clusters are generally named according to number-letter designations, just like 35BB.



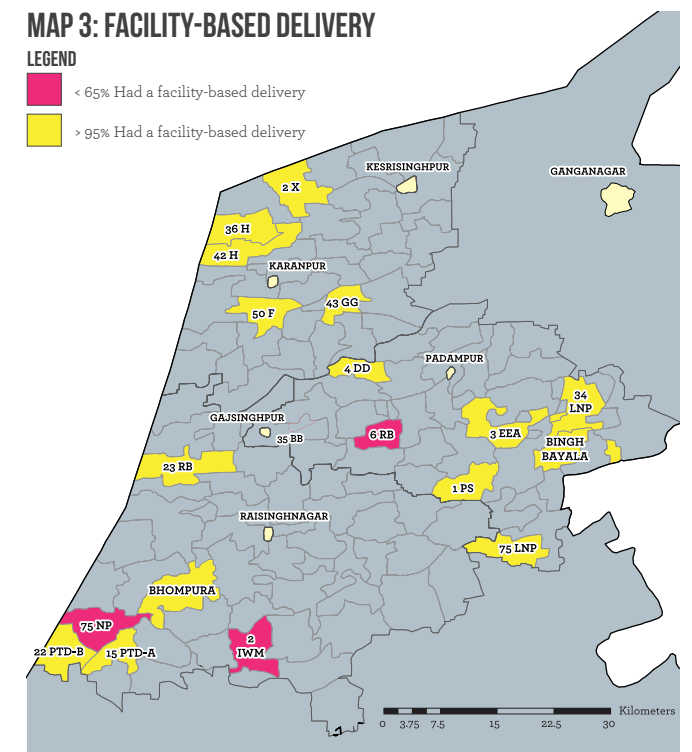
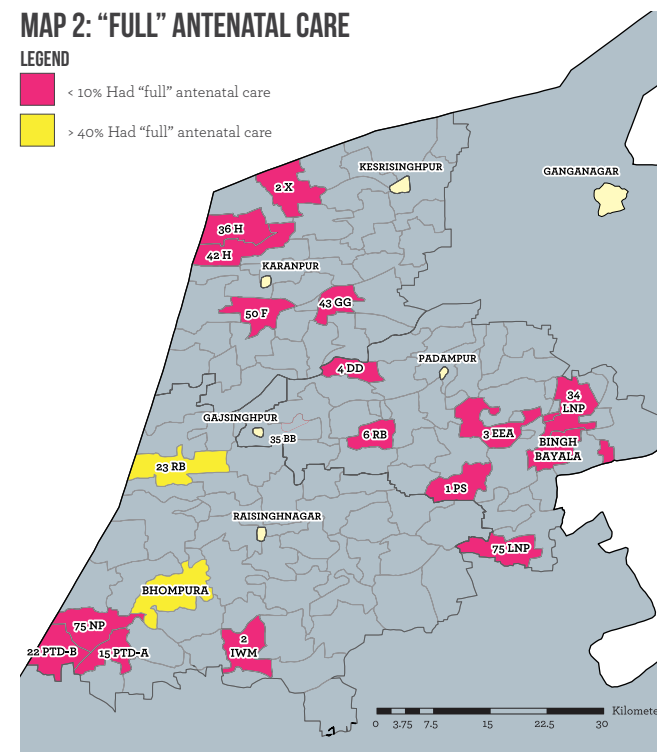
**BOX 1:**  
**NUMBER OF WOMEN SURVEYED AND INTERVIEWED**

**SURVEYED:**

- 313 women
- 18/118 clusters (Panchayats)
- 151/893 villages

**INTERVIEWED:**

- Interviewed 313 women, with 9 in-depth follow-up interviews
- Interviewed 5 providers : Asha (community health worker); Auxiliary nurse midwife; Government health official; 2 private doctors



**RESULTS: ANTENATAL CARE AND FACILITY-BASED DELIVERY COVERAGE AMONG VULNERABLE WOMEN IN SRI GANGANAGAR\***

*\*For more details please see the full study at [www.matajaikaur.com](http://www.matajaikaur.com)*

**ANTENATAL CARE**

**MAP 2:** In only 2 clusters, coloured yellow in map 2, did 40% or more low-income women receive full antenatal care. In the other 16 clusters, less than 10% of low-income women received full antenatal (i.e. receiving 3 or more checkups, a tetanus vaccine, and 100 days of iron folic acid supplementation).

**Overall, we estimate that only 13.1% of low-income women on our study area received full antenatal care, with Raisinghnagar performing worse than the other sub-districts. This is lower than the most recent government estimate of 15.2%, suggesting that much more can still be done to improve antenatal care access for the poor.**

**FACILITY-BASED DELIVERY**

**MAP 3:** In comparison to antenatal care, we saw tremendous improvements in the proportion of low-income women that received a facility-based delivery. In map 3, only 3 districts (coloured red) did not have at least 95% of women deliver in a hospital.



For our study area overall, we estimate that 90.8% of low-income women who delivered a baby in the last two years delivered in a hospital, with slight variations across sub-districts. Our results are encouraging and confirm the overall trend of increasing facility-based deliveries. We also found that 84.4% of low-income women received the JSY cash incentive.

### IN-DEPTH INTERVIEWS: UNCOVERING STRUCTURAL VIOLENCE

Statistical trends alone provide an incomplete picture of whether a health program is fulfilling its intended purpose. We found that women who received proper antenatal care and had a facility-based delivery — i.e. those who contributed to the positive statistical trend — were still affected by social, political, and economic forces that caused undue risk during pregnancy and delivery.

The process by which these forces become embodied as sickness and death



is called “structural violence,” which is often difficult to recognize and measure.

By interviewing women and examining their lived experience, we gained tremendous insight into the nature and complexity of how structural violence works in our catchment area.

#### 1. A lack of agency

*“I wanted to get care, but there was no one in my family except my husband [to help me]. But he goes to work all day, and comes back in the evening”* (Mother from Raisinghnagar, age 23).

We found that virtually all women we interviewed suffered from a fundamental lack of decision-making power over their health care during pregnancy. Whether they received antenatal care and a safe delivery or not often depended on whether others, such as their husbands, in-laws, or parents, allowed them to get it.

#### 2. Unsafe delivery journeys

*Interviewer: “Was it not troublesome to go in the hospital by tempoo (auto-rickshaw)?”*

*Respondent: “Of course it was problematic. But how we could arrange a big vehicle? Our pocket [i.e. budget] didn’t allow for that”* (Mother from Karanpur, age 27).



*Our amazing research assistants, Sandeep, Jaspreet, Navi, and Kiran.*

By asking women about their delivery day, we received many stories that showed how precarious the journey from a rural household to a hospital for delivery could be, regardless of distance. Auto rickshaws, motorcycles, buses, and even bicycles were some of the unreliable means of travel to the hospital during labour. The potential to get stuck on a rural road, especially at night or during Rajasthan’s frigid winter, makes any delivery risky.

Many women who experienced obstetric emergencies described major delays in getting from rural clinics to better-equipped city hospitals in order to deal with an obstetric emergency. In one case, a mother experiencing obstructed labour requiring an immediate C-section had to endure a several hour-long ambulance ride because the road leading to Ganganagar city was so badly potholed.

#### 3. Bad referrals and denial of care

Other delays in getting necessary care, however, had nothing to do with transportation, but rather clinical de-

lays and convoluted referral pathways. “Lakshmi” (real name withheld), a 26-year-old mother from Karanpur, had been diligent about her antenatal care, which was facilitated by the tremendous support she received throughout her pregnancy from her family. On her delivery day she had arrived at the local birthing center

well ahead of time, but after several hours she was told she needed to travel to another hospital for emergency obstetric care. Her baby was stuck - she was having an obstructed labour. Transportation to a better-equipped private hospital took only ten minutes, but delays in decision-making at both the local center and private hospital constituted the real mishap. It took 4 to 5 hours before Lakshmi received an emergency C-section, but by that time her daughter suffered permanent brain damage due to a lack of oxygen.

The emergency C-section and the subsequent intensive neonatal care for her infant were devastating medical expenses for the family. While Lakshmi was registered as a “success” in terms of antenatal care and facility-based delivery, her actual experience with pregnancy was far from successful.

#### 4. Sex preference

*Interviewer: “Would you also like to have more children?”*

*Respondent: “Of course it a necessity*



*because I want a son. I already have four daughters but no son. It is not possible to lead life without a son. ...I think about these things because of our misfortune of having only girl children.”* (Mother from Karanpur, age 27).

Another factor that causes undue risk to mothers are the strong normative pressures for women to produce sons. Son-preference not only causes many mothers to undergo additional pregnancies they might not otherwise want or be able to physically cope with, but it can also lead to unsafe abortions, which is one of the top killers of women in developing countries. Norms of son preference not only has negative consequences for many mothers but also for daughters, who often suffer neglect, and for society at large which suffers from what Nobel Prize-winning economist Amartya Sen calls the “missing girls” phenomena.

**CONCLUSION: DEALING WITH PROGRESS AND ENTRENCHED VULNERABILITY**

Our study reveals the complex nature

of health care accessibility and the nature of vulnerability among low-income women in Sri Ganganagar.

On the one hand, we confirmed that deliveries in hospitals among these women have dramatically increased, which is very important in the fight to improve maternal mortality. Government programs, especially the conditional cash transfer program (JSY), seemed to dramatically change health-care seeking behaviour over the last ten years.

Nevertheless, the lack of antenatal care is a major problem, as are the continued risks women face even if they intend on delivering at a hospital. For MJK, our work has gained a renewed sense of urgency.

Other recent studies have shown that as we achieve progress in maternal and reproductive health, the burden of death and sickness due to childbirth with fall disproportionately on populations that are the most vulnerable. The real challenge will be identifying and providing care for this segment of

society. Progress should not engender complacency, but increased attention and vigilance. This is the only way we will achieve health equity and eliminate unnecessary deaths due to childbirth. The insights we gained in this study will help us identify women who continue to be at risk and to design health programs that address their specific vulnerabilities. Two examples of such programs we have included in this report are our Family Planning and Maternal Mental Health programs.

**THIS WORK WAS CONDUCTED WITH SUPPORT FROM THE MASTER OF MEDICAL SCIENCES IN GLOBAL HEALTH DELIVERY PROGRAM OF HARVARD MEDICAL SCHOOL'S DEPARTMENT OF GLOBAL HEALTH AND SOCIAL MEDICINE. WE RECEIVED FINANCIAL AND MATERIAL SUPPORT FROM HARVARD UNIVERSITY, THE ABUNDANCE FOUNDATION, BERKELEY, CA, AND PROMINENT HOMES CHARITABLE ORGANIZATION, CALGARY, AB. THE CONTENT IS SOLELY THE RESPONSIBILITY OF THE AUTHORS AND DOES NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF HARVARD UNIVERSITY AND ITS AFFILIATED ACADEMIC HEALTH CARE CENTERS.**



*Our incredible research team!*



**“GIRLS WILL LEAD THE MODERN WORLD: WE PUT OUR FULL TRUST IN GIRLS TO DO GREAT THINGS IN THE FUTURE.”**

**PUSHPA**

# PUSHPA'S STORY



Pushpa<sup>12</sup> delivered her youngest daughter with MJK in the summer of 2013; it was her eighth pregnancy. Three had ended in miscarriage and three others had resulted in neonatal deaths. We asked Pushpa about these pregnancies and she recounted one in particular. She and her family had wanted to deliver in a medical facility but they were poor and decided to go to a government hospital, where maternity services are supposed to be free. When they arrived at the hospital, Pushpa's delivery was obstructed. Her unborn child, a son, was too large to be delivered without emergency obstetric care, and he died from complications 20 minutes after his eventual birth. The experience made

Pushpa vow never to return to a government hospital. She believed that, had the facilities been better and had the doctors been capable of performing a C-section delivery, her son could have been saved. Less than 15 months later, Pushpa became pregnant with her first daughter. This time, she was give birth at a private clinic in what proved to be yet another complicated delivery. Although Pushpa safely gave birth to a healthy daughter, the cost of care was great. She and her family spent many difficult months repaying the money they had borrowed for the clinic's private services. Years later, MJK was able to provide antenatal care and a safe delivery for Pushpa's second daughter, all without the threat

of financial ruin. It was nothing short of a miracle that a family as poor as Pushpa's was able to manage the cost of private care. But many families are not as lucky. The passing of Pushpa's son attests to the tragedy of neonatal death that is all too common for the poor and rural mothers of Sri Ganganagar. Low quality of care impedes the government health system and disproportionately affects India's most vulnerable women. What's more, the rapid succession of Pushpa's pregnancies, typical of mothers in Rajasthan, jeopardized the health of both herself and her children.

12. Pushpa and her family have agreed to have us share her story.



**WOMEN'S HEALTH AND CHILD HEALTH ARE NOT, DESPITE THE CLAIMS OF MANY GOVERNMENTS AND INTERNATIONAL ORGANIZATIONS, THE HIGHEST PRIORITY FOR OUR GLOBAL SOCIETY - IF IT WERE, WHY WOULD WE LET SO MANY WOMEN AND CHILDREN DIE NEEDLESSLY?**

# MJK LOOKING FORWARD MATERNAL MENTAL HEALTH

Over the last five years, Mata Jai Kaur has invested a considerable amount of time into understanding the context within which we deliver reproductive and child health services. This has, in large part, involved the identification of vulnerable populations of women and children in our catchment area—populations who are underserved and, more critically, invisible to Rajasthan’s local health system. We already know that poor and rural mothers in Sri Ganganagar have some of the worst rates of death and disease anywhere in the world. But what contributes to this vulnerability and how can we work towards addressing it?

One of the most crucial determinants of vulnerability is mental health. In low- and middle-income countries such as India, **it is estimated that 19%-25% of mothers will suffer from depression before birth and 20% will suffer from depression postpartum.<sup>1</sup> One in five of these mothers will either have thoughts of suicide or inflict self-harm before, during, or after pregnancy.<sup>2</sup>** This is aggravated by the fact that women with mental illness are less likely to seek life-saving preventative care over this same period, resulting in more maternal death and disease.

**But maternal mental health doesn’t affect mothers alone. Maternal mental illness is also linked to negative infant and child health outcomes.** Impaired fetal development is associated with maternal depression before

birth, and infants whose mothers were depressed during pregnancy have a lower birth weight, lower gestational age at delivery, and experience lower postnatal growth. Additionally, children of mothers with postpartum depression have elevated rates of disease, including diarrhea and fever, and also demonstrate stunted development after delivery.<sup>1</sup>

Mental health — and maternal mental health in particular — remains one of the **most ignored areas of global health policy and research.<sup>3</sup>** This is especially concerning, given that women are more likely to suffer from depression during pregnancy than at any other time during their child-bearing years.<sup>4</sup> It is thus essential that mental health interventions find a place in maternal healthcare.

## INTEGRATING MATERNAL MENTAL HEALTH WITH ANTENATAL CARE

At Mata Jai Kaur, we are in a unique position to integrate such interventions within our antenatal and child health service delivery model. That is why, in the years ahead, we will begin the development and implementation of a maternal mental health intervention for the women of Sri Ganganagar.

An intervention of this kind is especially pressing for regions such as Rajasthan, where both poverty and structural violence against women are especially prevalent. Women’s im-

poverishment, socioeconomic dependence, low educational attainment, and lack of social, familial, and institutional support at the time of pregnancy are all serious risk factors for the development of adverse mental health outcomes over the course of maternity. Further findings suggest that gender preference — widespread in Sri Ganganagar — is a major source of stress and concomitant depression in mothers who give birth to daughters.<sup>5</sup> Rajasthan’s low average age at marriage is also a risk factor for the development of maternal mental illness, given that suicide is more common in younger versus older women, as are stressors such as unwanted pregnancy.<sup>2</sup> It is for these reasons that maternal mental health is urgently needed in Sri Ganganagar and why Mata Jai Kaur is committed to filling this serious gap in treatment in the coming years.

1. Gelaye B, Rondon MB, Araya R, Williams MA. Epidemiology of maternal depression, risk factors, and child outcomes in low-income and middle-income countries. *The Lancet Psychiatry* 2016; 3: 973-82.
2. Rahman A, Surkan PJ, Cayetano CE, Rwagatare P, Dickson KE. Grand Challenges: Integrating Maternal Mental Health into Maternal and Child Health Programmes. *PLoS Med* 2013; 10. doi:10.1371/journal.pmed.1001442.
3. Miranda JJ, Patel V. Achieving the millennium development goals: Does mental health play a role? *PLoS Med* 2005; 2: 0962-5.
4. Vesga-Lopez O, Blanco C, Keyes K, Olfson M, Grant B, Hasin D. Psychiatric disorders in pregnant and postpartum women in the United States. *Arch Gen Psychiatry* 2008; 65: 805-15.
5. Patel V, Rodrigues M, DeSouza N. Gender, Poverty, and Postnatal Depression: A Study of Mothers in Goa, India. *Am J Psychiatry* 2002; 159: 43-7.

# MJK LOOKING FORWARD FAMILY PLANNING



**FAMILY PLANNING REPRESENTS MORE THAN MERE ACCESS TO CONTRACEPTIVES - IT IS FUNDAMENTAL TO A WOMAN’S AGENCY OVER HER BODY. IT IS ABOUT EMPOWERING WOMEN WITH CHOICE AND IS, WE BELIEVE, A HUMAN RIGHT.**



While MJK's focus on antenatal care and safe delivery are vitally important to ensuring good maternal and child health outcomes for the most vulnerable, there is another component of care that is equally important: family planning. Family planning is about allowing individuals and couples to anticipate and attain their desired number of children, and to achieve the healthy spacing and timing of their births.<sup>1</sup> This is done primarily through the use of modern contraceptives, which not only limit the total number of pregnancies that occur, but also results in pregnancies that are safer for both mothers and their children. But for us, **family planning represents more than mere access to contraceptives - it is fundamental to a woman's agency over her body. It is about empowering women with choice and is, we believe, a human right.**

#### **HOW FAMILY PLANNING SAVES THE LIVES OF WOMEN AND CHILDREN**

There is no doubt that family planning saves lives. Over the last 20 years, a **40% decrease** in the number of maternal deaths in developing countries can be directly attributed to increases in the uptake of contraception.<sup>2</sup>

**Family planning saves the lives of women and children in three ways: childbirth spacing, preventing teenage pregnancy, and preventing unintended pregnancies.**

#### **CHILDBIRTH SPACING**

Having too many children too close together is deadly. Children born less than two years after an older sibling are at a **60% greater risk of infant death** when compared to those born

after an interval of three years or more.<sup>2</sup>

Having children too close together also leads to higher rates of sickness. Children conceived within 6 months of a previous birth are at considerably greater risk for preterm birth, low birth weight, and low size for gestational age, and higher rates of infant death and sickness compared with those born 18-23 months after a previous birth.<sup>3</sup>

#### **PREVENTING TEENAGE PREGNANCY**

In rural Rajasthan, marriage and pregnancy among low-income women is common and a major risk factor for maternal and infant death. Women who are under the age of 18 are more likely than those under the age of 34 to experience maternal death or sick-

**41% OF WOMEN WHO MARRY IN INDIA DO SO BEFORE THEIR 18<sup>TH</sup> BIRTHDAY.**

**UNSAFE ABORTION IS THE 4<sup>TH</sup> MOST COMMON CAUSE OF PREGNANCY-RELATED DEATH IN SOUTH ASIA.**





Amanda Jones, a PhD candidate in Public Health at the University of Waterloo in Canada joined us on this survey.

ness, because their bodies are not ready to bear children.<sup>1</sup>

**41% of women who marry in India do so before their 18<sup>th</sup> birthday.**<sup>4</sup> Babies born to mothers who are under the age of 18 have a 40% greater chance of dying compared to children of mothers 18 years of age or older.<sup>2</sup> Likewise, these same children have a greater chance of being stunted and anaemic.<sup>2</sup>

#### PREVENTING UNINTENDED PREGNANCIES

Among our population unintended pregnancies can lead to higher mortality in several ways. **Women that have four or more children are at**

**an increased risk of maternal death, and this is especially so for mothers over 40.**<sup>5</sup>

Unintended pregnancies can have adverse economic impacts on poor families, especially if the pregnancy becomes complicated. Further, **preventing unintended pregnancies reduces the rate of unsafe abortion. With unsafe abortion accounting for 13% of all maternal deaths** in developing countries, contraception crucially assists these vulnerable groups of women in avoiding pregnancies that endanger their wellbeing. **Unsafe abortion is the 4<sup>th</sup> most common cause of pregnancy-related death in South Asia.**<sup>6</sup>

#### MJK FAMILY PLANNING SURVEY – THE UNMET NEED

Despite the enormous potential benefits of family planning, there was a massive unmet need for contraceptives globally. An estimated **225 million** women in developing countries would like to delay or stop childbearing but do not have the access to contraceptives or decision-making authority within their family or intimate partnerships or to do so.

At MJK, we are eager to include comprehensive family planning into our health care programs, and we have started this process by gathering data to better understand this issue in our setting. **In 2013-14, we conducted a**



**survey of our patients to get a sense of their knowledge of family planning and their unmet need.**

We found that over **35% of our surveyed patients were not using contraception within 16 months of their previous birth**, despite the return of their menstrual cycles. This is in keeping with a 2012 Government of India population survey, which found that a mere 37.9% of women in rural Sri Ganganagar had children within a safe birth interval.<sup>7</sup>

In fact, **only 10% of those surveyed had ever used an intrauterine contraceptive device (IUD)**, one of the safest and most discreet forms of modern contraception, and 23% had never heard of an IUD before. By comparison, condoms were the most common contraceptive used at 46% of women surveyed, followed immediately by the rhythm and withdrawal methods, respectively. What's most troubling is that amongst those surveyed, **36% of our patients interviewed did not know where they could go to obtain contraception.**

Going forward, we would like to do more to help women plan their families. Given the low uptake rates of IUDs and the high uptake rates of condoms, our programming could involve education and free provision of IUDs after delivery, and free distribution of condoms at our antenatal clinic. We have begun providing IUDs to our patients that request it, and we are in the process of evaluating these outcomes.

We will also work towards developing family planning education interventions that will inform mothers about the importance of maternal age, inter-birth intervals, and effective contraception.

**Underlying all of this is our goal of empowering the women of Sri Ganganagar. By assisting women in independently accessing contraception, and by helping them to remain informed about their reproductive health, Mata Jai Kaur aims to help our patients become the agents of change that Rajasthan needs.**

1. Rawe K. Every woman's right: How family planning saves children's lives. London, 2012.
2. Cleland J, Conde-Agudelo A, Peterson H, Ross J, Tsui A. Contraception and health. Lancet. 2012; 380: 149-56.
3. Kesterton AJ, Cleland J, Sloggett A, Ronsmans C. Institutional delivery in rural India: the relative importance of accessibility and economic status. BMC Pregnancy Childbirth 2010; 10: 30.
4. National Health Mission Government of India. NHM Components: Family planning: background. 2013. <http://nrhm.gov.in/nrhm-components/rmnch-a/family-planning/background.html>.
5. WHO. Family planning/Contraception. Fact Sheet N°351. 2015. <http://www.who.int/mediacentre/factsheets/fs351/en/> (accessed 13 Oct 2016).
6. Say L, Chou D, Gemmill A, et al. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Heal 2014; 2: e323-33.
7. Office of the Registrar General & Census Commissioner. Annual health survey: 2012-13 fact sheet. New Delhi, 2013.



**“WE WENT TO THE GOVERNMENT HOSPITAL FIRST BUT THEY REFUSED TO HANDLE MY CASE. THEY SAID THAT MY PREGNANCY HAD COMPLICATIONS AND THAT I WAS TOO FAR ALONG FOR THEM TO HELP ME. THEY TOLD ME I WOULD HAVE TO GO TO A PRIVATE CLINIC INSTEAD.”**

**PARAMJEET**

## PARAMJEET'S STORY



One of the regular questions we ask our patients is why they chose to receive antenatal care from and to deliver through MJK instead of using a government or private facility where they can avail themselves of government sponsored safe delivery subsidies. Paramjeet<sup>13</sup> and her family decided to use our services because her current pregnancy required a C-section delivery. She explained that government hospitals would reject her and that her family couldn't afford the prohibitive cost of a private facility. We asked Paramjeet how she knew that the government hospital would deny her treatment. She described how she had gone to one such facility in Ganganagar city to deliver her

first child but had been turned away and forced to use an expensive private provider. Her first pregnancy, just like her most recent one, required a complicated C-section delivery, which the hospital's government doctors refused to perform. Paramjeet's family had to borrow 20,000 rupees (around \$400), from friends and generous employers to pay for the delivery at a private clinic. This amount was equal to 4 or 5 times the family's monthly income. The family struggled to survive as they slowly but successfully repaid their debts.

Given the immense burden of her first pregnancy, Paramjeet might have opted for an unsafe home delivery if MJK

had not been an option. Given India's objective of reducing the number of unsafe deliveries, this outcome would have been counterproductive and potentially deadly. The local health care system, including the government's subsidy program, failed Paramjeet, but her local support network in the form of her immediate family, community and—for the second delivery—MJK was what enabled her children to be born safely.

13. Paramjeet and her family have agreed to have us share her story.

# KIRPAL KAUR DHINDSA SCHOLARSHIP



**THE KIRPAL KAUR DHINDSA SCHOLARSHIP IS IN ITS 9<sup>TH</sup> YEAR OF PROVIDING FINANCIAL SUPPORT TO CALGARY HIGH SCHOOL GRADUATES. THE SCHOLARSHIP OFFERS \$1000-\$2000 TO HIGH SCHOOL GRADUATES WHO HAVE DEMONSTRATED A DESIRE TOWARDS EDUCATION, A DRIVE FOR SUCCESS AND WHO HAVE OVERCOME BARRIERS IN ORDER TO GRADUATE FROM HIGH SCHOOL. SINCE THE SCHOLARSHIP'S INCEPTION, 190 STUDENTS HAVE RECEIVED THE KIRPAL KAUR DHINDSA SCHOLARSHIP AND ALL 45 CALGARY AREA HIGH SCHOOLS HAVE HAD A STUDENT RECEIVE THE SCHOLARSHIP. IN TOTAL, THE KIRPAL KAUR DHINDSA SCHOLARSHIP, THROUGH THE PROMINENT HOMES CHARITABLE ORGANIZATION, HAS GIVEN OUT OVER \$309,000 IN FINANCIAL SUPPORT IN ORDER FOR STUDENTS TO ACHIEVE THEIR EDUCATIONAL DREAMS.**

“*Kirpal Kaur Dhindsa is my grandmother. She passed when I was 12 years old. From my earliest memories of her, she was constantly finding ways to instill in us the value of learning. I recall being taught at a young age, that books should never be placed on the ground and that they should always be handled with the utmost respect. Reading and learning were fundamental parts of my childhood, with my grandma reading to us from the newspaper, taking us to the zoo and museums on weekends and ensuring that we always finished our homework.*

*She would always tell us that we had to finish school before we ever got married. I didn't understand until later in my life, what a big part my grandmother's own education played in her and her daughters' lives and why it was important to her that her grandchildren continue to learn and succeed academically.*

*Kirpal Kaur Dhindsa was a woman who believed family and knowledge were two true joys of life. She grew up in rural India and completed a Masters of Science before being married off by her father. Her new husband treated her poorly and continued the maltreatment despite her giving birth to their three children. Soon after her youngest daughter's birth, her husband left her to pursue a life in Canada. Kirpal was devastated and knew the stigma and troubles that she and her daughters would now face. Kirpal fought her way out of the village, using her education to receive a Canadian visa to work in a laboratory.*

*Despite finding herself a single mother living in conservative India, Kirpal recognized that education was the one thing that no one could take from her and that it was her ticket to independence and a better life for herself and her children. Kirpal and her children*

*immigrated to Canada and continued to work hard, setting down roots first in Winnipeg and then Calgary.*

*In Calgary, Kirpal watched her four grandchildren grow, and instilled the same values for education and family in them.*

*It is in her name that this scholarship was created to support students who have struggled on their path to higher education, and have demonstrated a drive to succeed, in spite of their life circumstances.*

*Being Kirpal's granddaughter, I am forever grateful for her tenacity and proud of the lessons her life has taught me and my siblings. She taught us that education was the key to success and would be our ticket to independence. Kirpal Kaur Dhindsa never felt sorry for herself, instead she used the life that she was given and made the best of it, while supporting the people around her to be the best versions of themselves. This is what we look for in recipients of the KKD scholarship.”*

**SHERRI SHERGILL**

# SEVA VOLUNTEERS & VISITOR

OVER THE YEARS, MJK HAS HOSTED A NUMBER OF VISITORS, MANY OF WHOM HAVE CONTRIBUTED MEANINGFULLY TO OUR NUMEROUS PROJECTS. WE ARE PROUD OF THE WORK WE HAVE BEEN ABLE TO ACCOMPLISH WITH OUR VOLUNTEERS, ALL OF WHOM COME TO US IN THE SPIRIT OF "SEVA."

"SEVA" MEANS SELFLESS SERVICE, AND WE CELEBRATE ALL THOSE, FROM NEAR AND FAR, WHO EMBODY THIS IDEAL!



*Amanda Jones  
Ontario, Canada*



*Bharat Arora is a regular volunteer  
at our children's health camp.  
Seen here with our very own Rajesh Kumar.*



*Eric Christenson  
Edmonton, Canada*



*Susanna Kislenko  
Toronto, Canada*



*Nirupama Laroia  
Rochester, New York  
(left to right: Balkeesh, Rajesh, Dr. Renu Makker,  
Nirupama, Aneel)*



*Christie James, Canada;  
Stefanie Foerster, Germany;  
Hillary Lawson, Canada*



*Khushboo Awasthi  
Bangalore, India*



*Brothers for maternal health!  
Inderjeet, Balwant, and Aneel.*



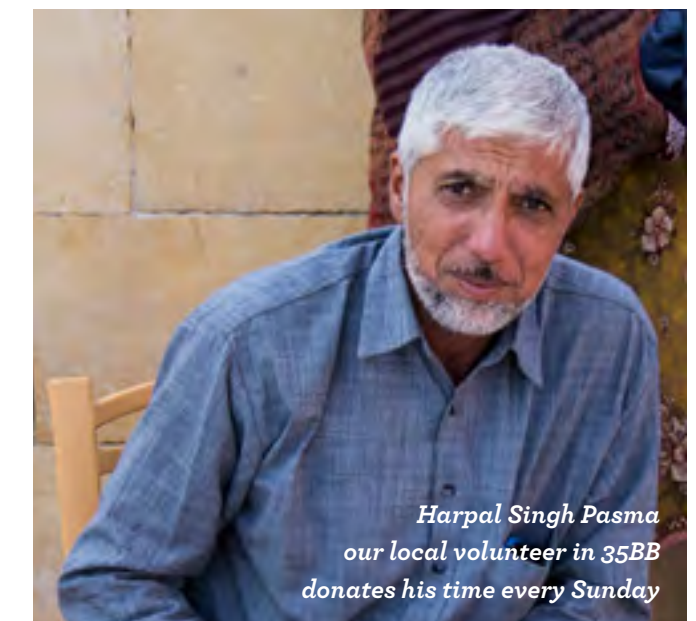
*Nick Allen, USA;  
Santosh More, Bangalore;  
Khushboo Awasthi, Bangalore;  
Mira Vale, USA*



*Sonu and Serve Satveer "Harman"  
local volunteers*



*Aman Dhanoa and Rajesh Kumar*



*Harpal Singh Pasma  
our local volunteer in 35BB  
donates his time every Sunday*



*Amanpreet Sooch*



*Aneel Brar  
Sunny Patel, USA  
Kiran Kumbhar, Pune, India*



*We would also like to thank our major local partner,  
the **Sihag Health Care Foundation** and  
**Dr. S.L. Sihag**, based in Ganganagar city,  
where we conduct all of our patient deliveries.*

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Pediatrician/Neonatologist



*Sandeep Singh Sahota*  
Lab Technician



*Neeraj Chawla*  
Chartered Accountant



*Deepak Kumar Maingi*  
Accountant



*Sukhdev Shergill*  
Community Advisor



*Harpal Singh Pasma*  
Community Advisor/Volunteer

# THE MJK TEAM



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*Phoolan Bai*  
Community Volunteer



*Eric Christenson*  
Research and Development Assistant

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- Nimrat Dhanjal, Chief Operating Officer, Kirpal Dhindsa Memorial Scholarship
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# SUPPORT US

WE ARE EXPANDING OUR REACH INTO THE COMMUNITY AND THE SCOPE OF OUR PROGRAMS.

HELP US DEVELOP OUR PROGRAMS TO INCLUDE:

- POST-DELIVERY HEALTH CARE FOR MOTHER AND CHILD
- FAMILY PLANNING
- MATERNAL MENTAL HEALTH
- EDUCATING AND EMPOWERING WOMEN AND GIRLS

100% OF DONATIONS GO TOWARDS PROGRAMS AND CLINICAL SERVICES.

PROMINENT HOMES COVERS FACILITIES, CONSTRUCTION, AND ADMINISTRATIVE EXPENSES.

- DONATE ONLINE AT: [WWW.MATAJAIKAUR.ORG/DONATE](http://WWW.MATAJAIKAUR.ORG/DONATE)
- CHECKS PAYABLE TO PROMINENT HOMES CHARITABLE ORGANIZATION
- TAX RECEIPTS AVAILABLE TO CANADIAN DONORS

The Mata Jai Kaur Maternal and Child Health Centre (MJK) is registered as a charitable trust (non-profit) in Rajasthan, India

The Prominent Homes Charitable Organization (PHCO) is registered as a charity (non-profit) in Alberta, Canada.

# FINANCIALS

FINANCIAL SUMMARY FOR FISCAL YEARS 2012 THROUGH 2015 Fiscal year ends on March 31<sup>st</sup>

MATA JAI KAUR MATERNAL AND CHILD HEALTH CENTRE CHARITABLE TRUST  
SUMMARY OF REVENUE AND EXPENSES 2012 - 2015

(Converted from INR to CAD (~50INR=1CAD))	2012-2013	2013-2014	2014-2015	2015-2016
Revenue (MJK Centre)*	72,819.52	98,684.64	65,143.92	0.00
Revenue (MJK Trust)	0.00	0.00	59,815.26	104,302.28
<b>Total Revenues</b>	<b>72,819.52</b>	<b>98,684.64</b>	<b>124,959.18</b>	<b>104,302.28</b>
Expenses (MJK Centre)	81,516.88	104,541.76	50,216.48	0.00
Expenses (MJK Trust)	0.00	0.00	61,993.68	108,016.14
<b>Total Expenses</b>	<b>81,516.88</b>	<b>104,541.76</b>	<b>112,210.16</b>	<b>108,016.14</b>
<b>Total</b>	<b>-8,697.36</b>	<b>-5,857.12</b>	<b>12,749.02</b>	<b>-3,713.86</b>

\*"MJK Trust" denotes revenues and expenses after the Mata Jai Kaur Maternal and Child Health Centre was registered as a non-profit in Rajasthan, India on March 28, 2014. "MJK Centre" denotes revenue and expenses prior to this transition.

The Prominent Homes Charitable Organization (PHCO) is the primary funder for the Mata Jai Kaur Maternal and Child Health Centre (MJK), with additional funds coming from individual donors in the community we serve and abroad.

## EXPENSES BREAKDOWN

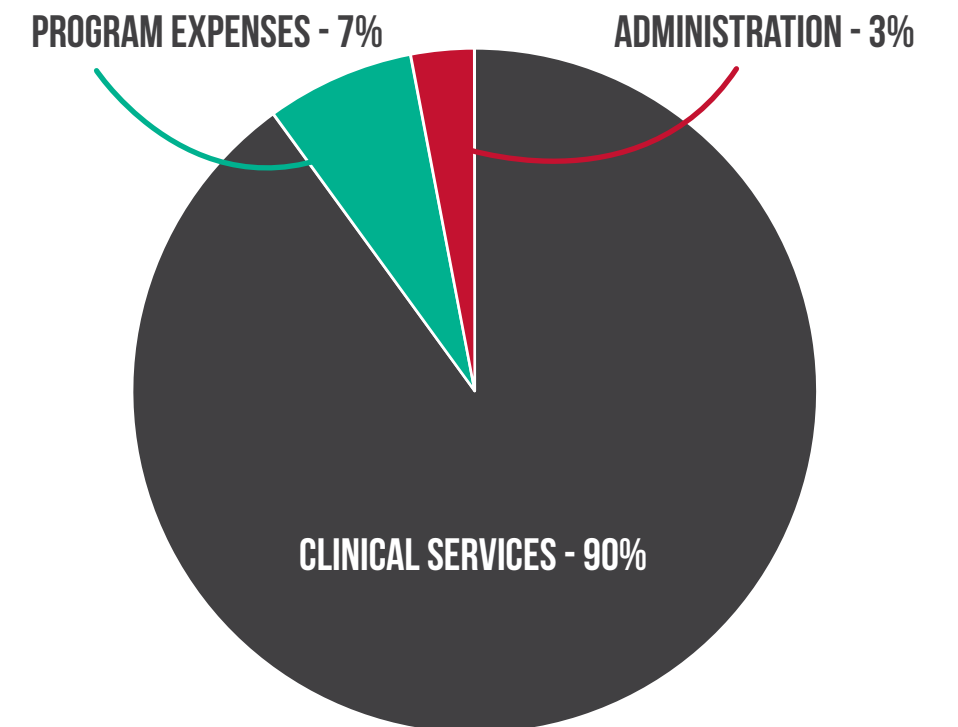
The vast majority of our expenses are for clinical services. We provide care free of cost to vulnerable, low-income women.

### Clinical services include:

- Antenatal medicines, lab testing, ultrasound
- Vaccines
- Delivery services, including necessary surgery

### Program expenses include:

- Patient and medical staff transportation costs
- Community outreach and education
- Surveys and research





CALGARY, CANADA  
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**REPORT AUTHORS**

Aneel Singh Brar  
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Sherri Shergill  
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**PROMINENT HOMES LTD.**

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