Community Health Learning Programme 2010

CHLP-2010.5 | PR54 (121)

Source: Community Health Cell

A Report on the Community Health Learning Experience

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CHLP-2010.5/FR54

Community Health Learning Programme

January to February 2010

REPORT

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ACKNOWLEDGEMENT

Firstly, I would like to thank Community Health Cell for providing me with a platform to complete my internship and conduct my research in the public health sector.

I owe the successful completion of this project to my internship guides Dr.Rakhal and Mr. Ameer Khan for lending their support and guidance whenever I needed it.

I would like to thank my respondents Dr. Satya, Dr. Sukanya, Dr. Subha, Dr.Rajasekar and Mrs.Renuka for giving me the technical exposure and resources required to complete my research.

I express my gratitude to the members and health activists of Rural Women's Social Education Centre (RUWSEC) and Tribal health Initiative (THI) for giving me an orientation about their projects and providing me with an opportunity to participate in discussions and learn about the public health sector in Tamil Nadu. I would also like to thank them for giving me a memorable time during our interaction.

CHAPTER I

INTRODUCTION

Safe motherhood and institutional deliveries have been talked about as an integral part of public health in Tamil Nadu. I wanted to gain an insight in the area of public health especially in the field of institutional deliveries in Tamil Nadu. The basis for which have been explained to be the following:

Previously I have had one of my internships with an organization named Mobility India in Bangalore city, Karnataka. Its services are targeted towards people with disabilities especially the projects are focused on the people residing in the slums of Bangalore. The director of the organization told me that majority of the people who are disabled are from the slums. The creamy layer of the population gets access to all the services, not affordable by the others. That is why the organization goes to slums & seek them, providing services instead of them seeking for help. So I spent a lot of time in the households of those slums interviewing the mothers who had children with disabilities. My findings at the end of the internship were as follows: There was usually one community doctor and the women don't go for check-ups .They get 50 rupees per day to feed the whole family. Poverty dominated most of the households there. At least twice they attempt suicide while pregnant. Many mothers weren't empowered enough to take decisions regarding children and to go out to seek treatment. Also some mothers who had children with disabilities had delivered at home with out any skilled assistance.

I went for a visit to a non governmental organization (NGO) named Tribal Health Initiative at Sittilingi, near Dharmapuri, Tamil Nadu. The tribal inhabitants of the village that is women as old as 17 and 19 are trained by the NGO members and the tribal hospital senior staff, for managing deliveries, complications and assisting in surgeries. The hospital was very friendly and the infra structure was built resembling the houses of the tribal inhabitants of the village. The hospital is given a very homely atmosphere with many traditional equipments. I was also allowed to witness a delivery. It was a very life altering experience for me also. The hospital was well equipped; the staffs were efficient and friendly. Some beneficiaries mentioned that it was not only safe to deliver a baby there but also it would be a very enriching and satisfying experience.

I also attended a community focused group meeting at an NGO RUWSEC. What is safe motherhood all about and the necessities required for a safe motherhood were being discussed. If safe motherhood can be achieved at homes also. And the quality of public health institutions and their services were evaluated.

CHAPTER II

REVIEW OF LITERATURE AND RESPONDENTS

Gupta, Hemangini (2008, May 17), 'The Return Of The Midwife', Tehelka Magazine, Volume 5, Issue 19.

This article cites some incidents where there were inappropriate birthing practices in hospitals. A mother had an instance where tablets were shoved in, Pitocin used to accelerate labor, water bag ruptured, epidural injected, nurses held her legs and screamed at her, and finally she was given a cut and fundal pressure exerted.
The article also talks about a term called "birth rape' involving Inserting objects into a woman's vagina without her consent and being rude and abusive to women in labor violating women's and children's rights as quoted by a health activist.
Some hospitals use caesarean sections, to speed up the birth process since a normal labor takes up to 12 hours.
A mother quotes that for most mothers caesareans had been induced, had their membranes ruptured, undergone cervical stripping, a routine episiotomy and a regional anesthesia thrown in, all under the guise of a 'normal delivery'.
A midwife mentions that mothers do not have their voices to complain against the system since doctors are paternalistic.
The mothers in these articles after having traumatic experiences in hospitals about the birthing process have opted for home birthing centers. And also describe the process as a very satisfying one.
A neo-natalogist quotes that traditional midwives can handle deliveries but are not equipped for complications. For those times they can be equipped for referring on time and working with obstetricians.

http://www.tehelka.com/story_main39.asp?filename=cr170508the_return.asp

Dr. Sudhakaram V, (2009, March 9), 'Institutional Deliveries in India - A Socio Economic and Cultural View', Women's health articles. Retrieved from www.articlebase.com*

The article quotes that social and cultural aspects on institutional deliveries is important as India has the largest no. of births in the world (27 million) and with high maternal mortality of 300-500 per one lakh births. It describes the various causal factors for low utilization of delivery services being distance from health services, costs that includes user fees, the cost of transport, quality of care, drugs availability and supplies, attitudes of the health personnel, multiple demands on women's time, women's lack of autonomy in decision making.

Poverty plays a major role and India has a lot of BPL families and is related to other causes like literacy, availability of health services. Norms and traditional beliefs about child birth coupled with misconceptions fears of medical institutions, have led to low utilization maternal health services. Shame in the first birth and newly pregnant girls are expected to exhibit modest behavior by remaining calm in their vital condition and not talk at all about the pregnancy, the social pressure may create a major barrier to seeking antenatal care or delivering in hospital. Overcoming some old norms and beliefs and knowing herself about the physiology of pregnancy is important. Woman's education is a major factor affecting utilization of maternal health services in both north and south India as quoted by an earlier research. Transport availability, availability of care givers, distance from health care facility, the cost including the user fees, the quality of health care in India with shortage in human resource in health sector and the attitude

of health personnel towards the patient and their higher absenteeism to the duties questioning the improvement of utilization of maternity health services are important causes too.

The inability of women to make decisions in relation to choice of medical care severely affects their choice of delivery care. A conflict between biomedical and traditionally perceived causes of health conditions also limits women's access to delivery care. Scheduled caste and scheduled tribes mothers living in urban areas are more utilizing the maternal health services.

Demographic factors like increase in the Maternal age has a strong positive effect in utilizing delivery services. Increase in the birth order has a negative in the maternal service utilization Also Unmarried pregnant girls are less likely to utilize the maternity health services.
http://www.articlesbase.com/womens-health-articles/institutional-deliveries-in-india-a-socio-economic-and-cultural-view--808672.html

Mint (2008, May 6), 'India's health system neglects midwives', article .Retrieved from Oneworld.net*

The article quotes incident of a traditional birth attendant (TBA) along with 100 midwives from 11 states and their civil society organizations were in the capital to make a representation to the government for having a more defined and concrete role in public health programmes, specifically the National Rural Health Mission (NRHM) to re-examine their de- legitimization and to bring them back into the mainstream public health domain. After having been part of the public health system for generations, these TBA-dais find themselves on the periphery, marginalized and ignored as castaways.

The director for Health and Social Justice quotes that points out that for the last three decades, dais have been put through training modules, funded by governments and international agencies, and now suddenly they have been declared redundant. However, there is a Dai association in Gujarat running successfully.

More than 60% deliveries in rural India continue to be at home since a dai recounts that the mothers are ill treated at the maternal health services and not many PHCs function. The article claims that since dais represent marginalized sections of society and are illiterate, their candidature is weak. The dais argument is that if they cannot be recruited as ASHAs, they should still be retained in the system so that they can help the women who may otherwise be denied safe delivery and post-partum care.
http://us.oneworld.net/article/india's-health-system-neglects-midwives

Menon, Meena (2008, July 6), 'Delivery on roadside, peon gives injections' (Electronic version), The Hindu. Retrieved from www.thehindu.com*

This article quotes about an adivasi dominated area near Mumbai, India where women are delivered of babies on the road, peons give injections in the primary health centre and the doctor collects donations in a neat little metal box kept on his consulting table. Later a public hearing was conducted as part of community monitoring to register complaints.

The article quotes an incident where a mother was refused at various hospitals and her family members were victims of corruption.

Also it is quoted that adivasis were treated badly at PHCs where often women in the family had to clean up after a delivery and dispose of the placenta and the umbilical cord as the PHCs do not have disposal facilities.
The article quotes that in one PHC, peon Pandu gave injections to people and charged them Rs. 20 under doctors' instructions. Also a doctor was charged against forcing people to drop money

in a donation box. Also there are institutional gaps were there is juts one contractual staff receiving pay every four months catering to a crowd of 1,000 people a month, out-patients Department remains closed for 10 or even 15 days at a time, no sanitation, misuse of funds, and forcing people to buy medical equipments.
http://www.thehindu.com/2008/07/06/stories/2008070659721000.htm

Meiselas, Susan (2009, October 7), 'India: Too Many Women Dying in Childbirth', Human rights Watch. Retrieved from www.hrw.org.

The article quotes about high number of maternal deaths despite various government programs .The article also quotes a report called "No Tally of the Anguish: Accountability in Maternal Health Care in India" documenting gaps in health care provisions and steps to address them in Uttar Pradesh. The report cites numerous examples of cases in which breakdowns in the system ended tragically.

Quoted by a health activist, accountability of maternal deaths is very less and no actions taken will be successful unless accountability is high.

The human rights watch research has showed a lot system gaps despite the NHRM launch that is very low quality maternal death audits and also the absence of accessible grievance and redress mechanisms, including emergency response systems. The research also pointed out lack of facilities, corruptions among the staff and untrained staff in PHCs

The article claims that this happens because many women are unaware of their health rights. The complaints of these women and the ASHAs are not being addressed.
http://www.hrw.org/en/news/2009/10/07/india-too-many-women-dying-childbirth

Meiselas, Susan (2009, November 4), 'India: Reveal Truth about Childbirth Deaths', Human rights Watch. Retrieved from www.hrw.org.

The article cites that India is unable to meet international commitments to improve obstetric care because of various health system gaps. Human Rights Watch research shows that women with pregnancy complications are able to get appropriate care during childbirth despite government programs guaranteeing free service to rural women. AS quoted by a health activist, women are dying preventable deaths whose causes have not been pinned down.

The article quotes the gaps in the Government lacking appropriate monitoring logistics and services for maternal and infant death audits and also maternal morbidity in the immediate post partum period.

The health information system has some of these dates but is the data collection consistent and effectively used for maternal health programs is a doubt. Cases have been documented in which women died after childbirth even though they gave birth in health facilities. In these same districts, government health records showed "zero" deaths.

The Indian Government treats huge amount of institutional deliveries as progress but failed to measure the quality of these health services to as to say that safe motherhood can't be directly attributed to institutional deliveries. Poorly equipped health facilities coupled with poor referral systems are serious barriers to timely care for pregnant women. Cases of pregnant women seeking emergency obstetric care being sent from one clinic to another desperately seeking care has been cited.

As quoted by a health activist , unless there is certification for health staff and proper monitoring of public and private health facilities , safe motherhood can not be guaranteed.

http://www.hrw.org/en/news/2009/11/04/india-reveal-truth-about-childbirth-deaths''

'Rural TN rises against corruption' (2008, December 9), article show, the Times of India. Retrieved from www.timesofindia.indiatimes.com

The article cited talks about a laborer at Coimbatore who was forced give bribe the administrative officer to process her petition regarding Dr.Muthulakshmi Maternity assistance scheme but she reported the issue to the anti corruption office to get her issue resolved. A village administrative officer was caught for receiving a bribe of Rs 6,000 for issuing a birth certificate.

http://timesofindia.indiatimes.com/articleshow/msid-3810595,prtpage-1.cms

Rajalakshmi,T.K.,(2009,November7),'Maternal Trajedies',Frontline,Volume 26, Issue 23 *

The article cites that there area high number of maternal deaths happening in the country and the policies should consider welfare of women and children regardless of caste or income. A report titled "No Tally of the Anguish" focused on Uttar Pradesh, published by Human Rights Watch, has been quoted. A study by WHO says that, India alone contributes to a little under a fourth of the world's maternal mortality, with 450 maternal deaths for every 100,000 births.

The report by Human Rights Watch basically criticizes the Government, in maintaining the maternal death records. Poor maternal health care continues to be pervasive among the poorer sections, in particular the marginalized Dalit communities, the MMR in Uttar Pradesh is three times higher than that of Tamil Nadu. There is a lack in facilities for basic and also emergency obstetric care, there is very less care for the immediate post-natal period of 48 hours of delivery. Even after institutional deliveries, there is no follow-up effort to record whether the mother survived the post-natal period without injuries, disabilities or infections. The women who use the government health facilities do not complain against health providers for fear of reprisals from doctors and health workers. The report also criticizes the Janani suraksha yojana schemes not being open to pregnant girls under 19 and women who already have two children. There is no information about the type of care that women get. Uttar Pradesh, the report says, has the worst civil registration systems in the country. The report quotes the direct causes of maternal deaths being hemorrhage, sepsis and unsafe abortions and indirect causes being tuberculosis, viral hepatitis, anemia and malaria. The report claims that setting a statistical target to reduce maternal deaths is meaningless without proper health systems and nutrition.

http://www.hinduonnet.com/fline/fl2623/stories/20091120262309600.htm

Respondents

I met Dr. Satya who is a pediatrician at Chengalpet Government hospital. I met the deputy director of health services of Kanchipuram district, Dr. Rajasekhar. I also met the Maternal and child health officer of the same district, Mrs. Renuka. I also had some views from Mr.Ameer Khan, a health activist of the NGO Community Health Cell. I interviewed Dr. Subha, a health activist heading a federation called Rural Women's Social Education Centre (RUWSEC). She had wanted to define safe motherhood (technical, social) and bring about indicators of safe motherhood. So she had some focus group meetings with health workers and beneficiaries of nearby villages who are a part of RUWSEC. And I had the opportunity to participate in the meetings for exposure and interaction.

CHAPTER III

ANALYSIS AND INTERPRETATION

Maternal Mortality Rate (MMR)

Dr. Subha mentioned that at first infant mortality was a huge issue till a document named 'Where is the M in MCH ?' (Rosenfield, A.; Maine, D.), was published in 1985. The article questioned as to why so little importance was given to the mother in maternal and child health (MCH) programs. After that, maternal mortality became an urgent issue to be attended world wide. Many schemes were adopted by the government of India too. Under Janani Suraksha yojana (JSY) scheme, comprehensive emergency services were formed and deliveries were pushed to PHCs. The supply of these services was lesser than the demand. There was a slow raise in institutional deliveries from 25% to 80% from 1970s onwards. But the scheme was a failure due to fewer supplies. But in Tamil Nadu, the scenario was different where supplies were higher than the demand so it was an immediate success right from the 1980s.

Traditional Birth Attendants (TBAs)

Dr. Subha mentioned that first home deliveries were present in the villages. They were conducted by traditional birth attendants (TBA). The Indian government to stop maternal mortality started various interventions .One of them was to train midwives in villages who conducted home deliveries. The project was abandoned entirely deeming the training as a failure. The training module for the dais where not evaluated. There were no steps taken by the government to check the flaws in the training. Instead, the dais were blamed for their lack of knowledge for the failure of the training.

Mrs. Renuka mentioned that midwives no longer conduct or assist in deliveries. They have all been debased and stripped off their jobs. But a few are now retained in the Public health centers(PHCs) as sanitary workers .They are allowed to do only menial jobs and earn around Rs.500 per month. They are not recognized by the government as authorized experts for conducting the deliveries.

Government's Attitude toward Home Births

Home births are considered as something very unhygienic and barbarous by government staff and public health officials alike .According to them, safe motherhood can happen only at PHCs with technical provisions and schemes. People at homes do not know how to handle deliveries. There is no electricity; no space to have equipments and equipments can't be brought to homes. Especially in the poor people's houses, mothers lie on the floor for delivery. And some mothers work till the day before the delivery. In case of an emergency or a sudden labor, bringing these mothers to the PHC will be difficult, as it's difficult to locate them in interior villages.

But the scenario would be different if the mother arrives at the PHC a day before the delivery and stays there for three days. While she is there she can be properly monitored. Complications can be easily referred to specialized hospitals. Audits and accountability of emergencies and deaths can be recorded as the centers are located at accessible areas for the health staff. All these services cannot be done on a door to door basis by sending the nurses and the public health staff to interior villages to households who have pregnant women.

Dr. Rajasekar complains that mothers in the villages give sugar water to babies and the babies die. Dr. Satya points out that some traditional birth attendants (TBAs) cause infant deaths. They give oil bath for the babies and blow into their mouths and noses to remove dirt .The babies die of infections and pneumonia.

For safe motherhood, the women need to take care of birth spacing, nutrition, ante- natal check ups and also need to have iron / folic acid abundantly. She says the mothers ought to be counseled by social workers about negligence at home, breastfeeding, cleanliness, medication awareness, consanguineous marriage and nutrition .The mothers are illiterate and ignorant about such things. They do not go to higher specialists when their babies are referred, in case of complications. They think it's a very big complication and worried about expenditure .Instead they rely on faith based treatments.

Government's Programs to address MMR

One of the reasons the NRHM scheme was presented in India was to reduce MMR. Dr.Rajasekar explained about the public health infrastructure before and after the introduction of National rural health mission (NRHM).

Upgraded 30 bedded PHC (deliveries happens all the time; x rays, operation Theatre available)

Block PHC (operation Theatre; 2 staff nurses available all the time)

PHC – caters to 30, 000 population (ANMs do a few deliveries)

Village Health Sub Centers (VHSCs) - 5 or 6 available (all ANMs do delivery)

He says, there was an acute lack of quality and equipments did not function much at VHSC s so deliveries happened at block level PHCs only. Accessing public health was a major issue for mothers till 2005 .With the introduction of NRHM – 12 services were brought .They were: all PHCs working around the clock , establishment of basic emergency obstetric services , RTI and STI clinics , mobile medical units , indigenous ISM medicines, hiring of specialists , using good amount of funds for caesarean operations and family planning services, patient welfare societies, village health and sanitation committees, scan centers and audits , '108' ambulance services.

He said that he has done many innovations in health services while being posted at Vellore and kanchipuram as a deputy director for public health. The government has evaluated those and instructed PHCs of other districts to follow the same .It has regularly sent a team of directors from other districts to observe these innovations to incorporate the same in other districts.

The early neonatal mortality rate is high (Safer Pregnancy in Tamil Nadu: From Vision to Reality; WHO Monograph) .A sensitive issue in a developing country, Dr.Rajasekar mentioned that a project is being executed to approach the causes. The reasons have been located to be pneumonia, diarrhea, congenital problems, and asphyxia.

Government policies to reduce MMR

Dr.Rajasekar explained about the Kalaigner's Insurance scheme benefitting families whose annual income is less than Rs.72, 000 per year. It is not a scheme exclusively made to reduce MMR but nonetheless it's a health scheme. People who are members of various welfare boards can avail that scheme. There are 22 welfare boards E.g.: welfare boards of construction workers.

Also smart cards are given to these people that can be used by private and government hospitals. Through this scheme families can avail around 52 types of treatment.

The Janani Suraksha Yojana (JSY) scheme was brought for BPL families to reduce MMR all over India .It provides mothers with Rs.1400 for their nutrition, antenatal care, perinatal and post partum care .An improvisation of it is the Muthulakshmi Reddy Scheme (MRS) in Tamilnadu which provides Rs.6000 instead.

Some flaws of the JSY scheme was pointed out by health activists, beneficiaries and government officials alike. The scheme is not for mothers who

1, are below 19 years of age

2 have more than two children

3 live at husband's house during pregnancy.

Some flaws mentioned about MRS are as follows:

Dr. Subha points out that the scheme has been manipulated by various governments that held office through various time periods. Since then the amount has been raised from Rs. 450 to Rs.6000 consecutively, to target mothers for getting more votes and sustaining the parties.

Also she says the amount is of no actual benefit as the families use it for getting ambulances and other bribes.

A health activist Mr.Ameer pointed out that the mothers don't receive the money in installments before delivery but receive the money only after it once they register with the government. So no money is received for nutritional purposes during antenatal period, which defies the entire purpose of the scheme. He also pointed out that the nutrition scheme can be integrated with middy meals scheme (MMS) in villages by providing meals to mothers everyday instead of giving them the amount, but the government is reluctant to adopt such an idea.

Dr. Rajasekar agreed that the amount is not used for nutrition but for other multi purposes. According to papers for MRS Rs. 1000 has to be distributed to mothers starting from the 7th month, but that is practically impossible due to accountability issues. So mothers get the amount at one installment after registration. He says the scheme is beneficial for other aspects because getting a lump some amount of Rs. 6000 by BPL people by government is amazing. People also get Rs. 500 from JSY scheme though they have home deliveries. He said that the idea of integrating the nutrition scheme along with MMS, was articulated and government dismissed it. He said that government has administrative and financial issues, so its not allowing funds properly for nutrition pilot projects but compensates for that gap by providing MRS.

Mrs. Renuka said that the people who are not in the BPL category also gain money and plan for it .They don't use it for nutrition purposes. The money also goes to some deserving hands, which are totally downtrodden and do not even earn an annual income of Rs.6000 per month. The schemes are eye wash but can not be terminated totally. It can destroy livelihoods if done .She says that integrating nutrition for mothers along with midday meals scheme will consume a lot of time, energy and money, something that government can't afford. The quantity can be reached but the quality cant be assured .For the food and screening for a month the 7th , 8th and 9th month mothers have to come. For a day around 80 to 120 mothers turn up. To organize food for them is a tough job for PHC staff. Sometimes mothers, who still are due during 9th month, turn up and some mothers who are in the 6th month also turn up. It's not feasible to provide them food everyday .If government can consider this and allot a separate department to executive this project, the goal can be achieved.

Maternal Morbidity is still an issue:

Dr.Subha says that, though Tamil Nadu government has successfully reduced maternal mortality rates (MMR), the question of maternal morbidity has not been addressed anywhere, be it short term or long term.

For this, Dr. Rajasekar's take is that, for maternal morbidity issues there is screening during 7th, 8th 9th month for mother s to anticipate complications and treat them. E.g.: heart diseases, hyper tension, eclampsia, gestational diabetes, infant morbidity and anemia.

But Dr. Subha complains about maternal and infant morbidity after delivery. Mainly mothers after discharge are not followed up. E.g.: Anemia. She says she hasn't seen public health institutions keeping track on post partum complications, statistics and also the quality of care received for it.

Some of the health workers quoted some incidences about system gaps especially in auditing deaths or morbidity. Maternal or infant morbidity during delivery or within the post partum period has to go through government auditing. The families have to be taken by the health workers to the collector to report. In this procedure, the government hospital staff is negligent and provides less quality services once cases are referred to them .The government staff don't know how to tackle complications. They disrespect health workers in the villages, saying they don't have enough knowledge. The get evasive and blame the health workers if there is health system failure, to save themselves from higher authorities.

The cultural, gender and social discrimination in giving services

Abortion, contraception pills or family planning concepts have all become cultural and religious issues. Dr. Subha has reported that the mothers face discrimination and have issues regarding privacy and abortion procedures. The abortion procedures are very tedious and harmful. Women contraceptives are not available widely in the market and if available are inaccessible by the general population due to unreasonable costs. Married mothers do not have a problem as government wants to promote family planning. But unmarried mothers are treated the worst, by government health staff. The government sees premarital sex and motherhood as a blasphemy.

She has also reported that government is selective about the messages it spreads. Women controlled options are not considered especially in the cases of safe abortions. They only talk about condoms (male controlled) but not women controlled techniques to prevent pregnancy. No emergency contraceptive pills are available. And for family planning, the painful manual procedures are to be experienced by the mothers. She also prompted that there can be issues of social discrimination when it to comes to accessibility to services that are not being discussed anywhere. E.g. People affected with HIV, SCs, and STs. Though for family planning SCs and STs have cash incentives .For safe motherhood in general if are there any options, is still a question.

When enquired about the gender bias to Dr. Rajasekar, he mentions that the public health administration is trying to popularize male sterilization and nose scalpel vasectomy, a china procedure. The program is currently on and government is funding for it. The staff is trying to negotiate with government to increase Oral Contraceptive Pills (OCP). Dr. Rajasekar also countered that in Vellore 70% of PHC users are people belonging to schedule and most

backward (Vannier) caste .So there isn't any special allotment for SC and STs and its equal treatment for all people.

CHAPTER V

Reality gaps in theory and practice

Hygiene Issues:

Dr. Satya said the most listed complaints which were that the patients and the caretakers slept on the floor due to insufficient beds. There is also no hygiene as there is one sanitary worker for an entire building.

According to some of the beneficiaries and health workers from villages, the toilet facilities are unsupportive as reported by beneficiaries and health activists. Some NGOs provide toilet facilities with fees .The health facilities are late or unsafe sometimes, are not proportionate for the number of patients. There are less quality of deliveries and vaccines.

Inadequate Staff in government Hospitals:

According to Dr. Satya, the ideal staff ratio in a government hospital ought to be

1 severe complication baby = 1 nurse

8 babies needing medication = 1 nurse

40 babies = 6/7 pediatricians

One social worker.

But in reality she points out that there is just one sanitary worker for the entire building consisting of different departments. One pediatrician is catering to fifty babies and totally 3 nurses .There is no social worker. Staffs are really less in secondary and tertiary hospitals. No amount of petitions and complaints has brought out radical actions on the behalf of the government.

To tackle the problem currently, the government official says that the work load is shifted to PHCs that at tertiary level the doctors can just take care of complications. And government is giving certificates for diabetology and anesthesia by training MBBS holders in PHCs. He says government is benevolent enough to have done that much.

But Dr. Satya contradicts the above claim reasoning that government is building new government hospitals all over the state and spends money for them. Since government does not get profit from old government hospitals, it has abandoned them totally.

Government Officials' negligence:

Mrs. Renuka complains that sometimes when referrals are given from the PHC, the staff of government hospitals doesn't receive that immediately .And she recently gave complaints to the joint directors of government hospitals to fix that up.

Dr. Rajasekar claimed that there are only a few government directors who work sincerely. Coordinating with other directors is tough for him, as there are only a few motivated directors .Also there is always a clash between one director or another of different districts. He feels a strain from his higher officials too. He says government sometimes is benevolent, but otherwise it discards many ideas that are suggested due to monetary inadequacy, system gaps and staff deprivation.

Immunization services have been moved to PHCs

A health worker complained that for polio vaccines the VHNs are supposed come to village households for health advocacy, antenatal checkups and polio vaccination .But now even the immunization has been moved to PHCs. She said that the mothers find it real hard to travel to PHCs for just an injection.

Dr. Rajasekar quoted an incident that had triggered the government to move the services to PHCs .Two years back in Thiruvallur district of Tamil Nadu there had been four infant deaths. Some VHNs went to village and gave immunizations for normal babies without testing them for other issues like pneumonia or chest congestions which had caused the deaths. So, immunization was moved to PHC where Medical officer (MO) checks for all that before administering vaccines.

People had protested a lot but their voices were unheard. Since the government can not take further blames. At PHCs, MOs screen, test and then administer the vaccines .Through NRHM; they sometimes send mobile medical units (MMU), for inspections only if an MO is present.

Inefficiency of ANMs

I accompanied Mrs. Renuka for an inspection at two upgraded block PHCs. One in Parandhur and the other one at Thuruppukuzhi of Kanchipuram districts. These were previously block PHCs which had been upgraded as 30 bedded ones. They were conducting a food mela at Parandhur, for all the pregnant women, giving them nutritious lunch and screening them for complications. A pilot project innovation executed by Dr. Rajasekar in all the PHCs of Kanchipuram district.

There were labor rooms in two upgraded 30 bedded PHCs. Mothers in all different stages of labor were put in the same room. The women who had been aborted where also put in the same room. And also the delivery room is not actually a separate room. It's a small seclusion in the same room as the labor ward. There was another delivery cabin adjacent to the current one, which was not in use, which was badly kept. It is not put to use unless the staff had two simultaneous deliveries. The staffs were not in their uniforms at that time and were warned by Mrs. Renuka about it.

Dr. Rajasekar had an enquiry with an ANM in Vallam PHC, kanchipuram district during his interview with me. The ANM had read the partograph of two labor cases the earlier day. Both cases were in the stage of complication since 6 to 8 hours had passed and the labors had not progressed. Despite knowing that the mothers ought to be transferred to the government hospital as emergency, she had retained both cases at the PHC for 11 hours. She had failed to act even after reading the partograph and so was sacked by the deputy director.

Mrs. Renuka says that unlike in private hospitals where there will be many to assist, the ANMs have to work on deliveries single handedly by leading and taking responsibility. The ANMs need to know the signs whenever a case gets complicated and should do referrals on time without delay. They also need to screen the mothers earlier during 7th, 8th and 9th month. They should anticipate appropriately if a case should be normal or caesarean.

She complained that some ANMs are new and practically inefficient to handle deliveries on their own. They coming from private institutions may be good in theory, but practically they are not well informed. The current situation in PHCs is that ANMs are ill equipped to handle deliveries so these ANMs are given training before being posted at various PHCs. The only eligibility is a certificate authorizing them as government health workers. They are over burdened with responsibilities and are paid Rs. 7500 per month.

Follow ups are not done

There are also issues about follow ups done by the public health institutions. Usually the mother stays in these institutions for three days after which she is discharged and she has to come for regular follow ups. But some beneficiaries complained that doctors are not present for antenatal check ups or consultancies. Mondays and Wednesdays are reserved for consultations in the out patient departments. But the doctors never carry out consultations on Wednesdays. Even for emergencies at 11:00 am, the clinics are closed. Bed patients are alone given consultations Mothers in the out patient departments (OPD), for follow ups don't get consultations. The pregnant mothers in OPDs are forced to buy beds in the PHCs.

Bribe, Violation of Patients' rights and schemes like BCP

Some health workers complained that there are monetary issues for medicines especially before and after delivery .The mothers are forced to buy stuff like covers, soaps, blades. Depending on the money given, the staff takes care of patients. Government hospital doctors take bribe during private practice at clinics, especially when mothers go for antenatal check ups. There is also an increase in the bribe rates by government hospitals.

Dr. Satya also said that earlier people paid Rs.1000 to Rs.1500 for a baby for ambulance and other services but now they get it free of cost according to government rules. But the ambulances are also ill equipped. She says that one of the reasons for infant mortality is that ambulances are available but there are no equipments in the ambulance for emergency. For e.g.: Oxygen tubes are not there. By the time baby arrives to the hospital it dies. The health workers say that Emergency transport, on papers is supposed to be free but people are charged for it.

The most prominent complaints from beneficiaries and village level health workers were that there is a lot of physical abuse and coercion at PHIs. There is no space for complaints. People's basic dignity and rights are being hampered for mothers and also for VHNs alike. Many VHNs feel the pressure from higher authorities. The mothers don't have the rights to even choose their hospitals.

Dr. Subha said that, once her federation RUWSEC organized an awareness talk on the birth companionship programme (BCP). There was a huge response from the beneficiaries and they were outraged that nobody from the government had taken initiative to disseminate such an important scheme to them, since previously they all had faced a lot of abuse in government hospitals when regarding caretaking. And a copy of the government order (GO) was then given to all the women. But a lot of them were still denied access to the mothers at government hospitals, the GOs were rejected.

CHAPTER V

CONCLUSION

Possible ways forward

About safe motherhood, there were focused group discussions with beneficiaries, health activists and health service providers of some districts around Chennai, organized by the NGO RUWSEC.

They brought out a lot gaps that are present in the current public health institutions in Tamil Nadu. And they have raised a lot of demands, to see some changes in the functioning of the system.

According to them:

Abuse of women has to be ceased. Public health systems have to be provided with clean toilets. Bribe and corruption has to be abolished. All services ought to be free, as they are stated on paper. Unsafe abortion has to be checked.

Basic medical provisions ought to be given. For examples: generator, transport, ambulance, blood banks, disposable needles, (delivery) pregnancy table, incubator, operation theatre.

They want qualified, professional medical officers that are practised professionals who can be accessible at any time. For example : Nurses , dais , gynecologists , surgeons , child specialists , pediatricians , consultants / counselors (pre /post delivery) . Follow up should be there after deliveries for the post partum period.

Family support / social support systems need to be good. The family should be sensitized about providing good nutrition and assisting the staff in medical procedures and birthing process and to give appropriate psychological support. And a caretaker has to be allowed to be along with the mother during the birthing process.

The mothers should have the right to choose hospital/ doctors / clinics. One such instance was quoted by health activist Dr. Subha about an incident while having a meeting on safe motherhood with some beneficiaries in a village. The women claimed that even the technical aspects of medical policies are to be discussed with beneficiaries. And that safe motherhood is possible at homes, and even some complications can be treated.

E.g.: A beneficiary stated home deliveries can happen at home. And that syringes can be stored in nearby shops which can control hemorrhage etc. close to homes rather than PHCs so that women can attend to complications at home instead of travelling to PHCs which are very far. And midwives can be trained in the administration of injections and better use of equipments and medication. And safe motherhood can be practiced at homes.

They say safe motherhood can happen anywhere be it public health institutions or home. But in reality, they have to opt for institutions since the equipments can't be had at homes. But they definitely wanted their right to choose whichever hospital they wanted to give birth. Safe motherhood happening at home is an ideal condition for them now, which can be slowly put into practicality later.

The above gives some insight and is representative of evaluation of the quality of services received by the people from Tamil Nadu's public health institutions (PHI). It also gives us a picture of how far is safe motherhood being practiced in PHIs in TamilNadu. And also gives a scope to envisage if birthing processes can be brought to homes, by adding a few complementary services to make them effective instead of institutionalizing them.