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Extending quality maternal care into the community: What is needed?

Dr. Sulochana Abraham

As we stand at the threshold of the new reproductive health approach, there is growing recognition that a woman's health and that of her unborn foetus has a profound impact on the overall health status of the community. While the constitution of India pronounces an equal status and opportunity for all citizens, there exists major disparity; be it female foeticide, malnutrition and anaemia in the girl child; adolescent sexuality, unwed pregnancies and its associated risks; the increasing threat of RTIS, STD, HIV/AIDS; deaths due to back alley2 abortions and neglected child births or the aftermath of an unclean delivery; these are but a few of the telling indicators of the neglect of women. To remedy these disproportionate effects on the health of women which spills over to their off-spring as well, the wide mandate of reproductive health attempts to focus on the 'life span approach' and on the quality of life of the woman. It needs not only a constellation of methods and services but also the unstinted support, down from the policy makers to those at the grassroots, who are the actual implementors.

Despite numerous public health interventions and varied approaches, the availability and accessibility of services for women continue to be poor. Any 'trickle down' effect from the centre finally down to the community has largely bypassed the women at the grassroots. The extremes in maternal morality (370 per 100,000 births in India in contrast with the national averages of 2 to 8 per 100,000)l births in the Scandinavian countries, is of great concern. While the statistical coverage is no way near complete, it throws light on the alarming realities. While the mortality figures are gloomy, they tell us only part of the picture.

According to a study done in rural Rajasthan, for every maternal death, an estimated sixteen others develop various illnesses during the puerperium'. Little is known about the morbidity pattern in pregnancy, nor about the gynaecological problems that women endure. The magnitude of the problem among poor women is depicted in a study' done in a rural tribal area of Maharashtra which highlights the contribution of reproductive tract infections to the burden of reproductive morbidity. The problems of reproductive tract infections and sexually transmitted infections cannot be seen in isolation. There is also compelling evidence that extramarital sexual activity is on the increase.

Adolescents, a hitherto neglected group, are particularly vulnerable and are in need of urgent attention.

An interplay of social, cultural and biological factors are plausible explanations for this dismal scenario and the poor reproductive health of women. Needless to say,-a more holistic approach and multifaceted solutions are needed to tide over this crisis. Today, when both national and international efforts are being made to move primary health services out of the hospital to almost the doorstep of the people, health can not just be handed out at clinics to 'passive' patients waiting in queues. The movement for change which is emerging everywhere, seeks equality in every aspect, where women are better informed and educated, with better opportunities for income generation, better family health and, above all, good quality of maternal and child care.

The Indian Government recognised this and through its ROME programme (Reorientation of Medical Education) called upon the medical colleges to respond to this challenge. The CHAD (Community Health and Development) programme of the Christian Medical College is just one of the examples where its commitment to community health and maternal and child health care in particular is more than just a tradition. The CHAD hospital (Community Health and Development) at Bagayam serves as the first referral unit (FRU) for a population of 100,000 in Kaniyambadi block, situated at the Southern part of North Arcot District in Tamil Nadu. The focus of CHAD's activities however is what happens in its villages. The village based members of the CHAD team, selected by the community (the part time community health workers and the health aides) are responsible for the day-to-day implementation of the programme within the villages, monitoring the programme and liaising with the professional staff and resources at the FRU. The 80-bedded hospital at Bagayam, acts as the base from which the mobile health team goes to each of its villages once a month. CHAD's mother and child health clinics, the labour room, the outpatient section, the operating theatre and its wards, treat patients who are referred from the village clinics, or those who come simply because they want to be cared for. The hospital2s laboratory and pharmacy provide support for its other services.

In all its programmes, CHAD works primarily with women and children and rightly so, since the-T comprise 70 per cent of the population. Recognising that women are the key to strong healthy families and to tap these under-used resources of the country, CHAD's earliest ventures were to encourage young girls to continue schooling and improve their image in society. Further, school drop cuts were organised to set up traditional handicrafts and embroidery units as well as non-conventional welding and masonary units. While their younger siblings were looked after in local creches, they were able to develop skills and

generate an income for their families. As a consequence, these rural women then set up 'Mahila Mandals2 and were much more aware of the factors that govern their daily lives. One of the most evident outcomes of these efforts was an increase in the age at marriage, as young girls were now increasingly valued as assets to their families and to the society at large.

Monthly meetings of young and newly married couples, identified by CHAD's team, are an opportunity for social interaction. These meetings are also venues for educating are couples about healthy family life, stressing on reproductive health.

Much emphasis is placed on identifying pregnant women as early as possible and the grassroot level workers who are part of the community are responsible for this. Between 60 per cent to 70 per cent of antenatal women have registered by 16 weeks. Antenatal and postnatal women are examined monthly at the mobile clinic or at the FRU. The schedule for the mobile clinic and its venue are carefully planned to enable access to almost all pregnant women. Over 90 per cent of all pregnant women and 98 per cent of the underfives are adequately immunised and receive appropriate care. High risk antenatals presenting at the village clinics with obstetric problems are referred to a clinic held weekly at the FRU where a specialist sees them. About 300 high risk antenatals are seen annually and the perinatal mortality is much lower than that of women who do not attend the clinic. The referral system is an important aspect of the whole programme. A home based antenatal card serves as a useful tool. With renewed efforts and education, most of the women carry the cards with them to hospital and even preserve them till a subsequent pregnancy. Supervision and follow-up services are as essential a component as any other and the monitoring system is designed particularly to help with these.

Monthly meetings with all the staff, serve to sort out all the clarifications as Well as problems that the health staff encounter. The decisions made at these forums are then fed back to the community. A low-cost nursery, with simple inexpensive aids has contributed substantially to an appreciable fall in perinatal mortality. Here, dedicated nurses teach mothers tirelessly on how to feed the baby and give the attention that the baby needs. An ordinary Perspex device with a 60-watt bulb serves as the warmer for hypothermic babies and a simple locally made light source with 8-10 fluorescent bulbs provides ultraviolet therapy for new-boms with hyperbilirubinemia.

The acceptance of family planning has also shown marked improvement. Regular visits by the health staff facilitate rapport between the staff and the women. The assurance of a better chance of survival for their offspring also contributes to this change in the attitude. As a result, women do not have to be

coerced to accept tubal ligation. The success of the programme can be judged by the fact that less than 20 per cent of couples who had delivered recently have more than two children.

The programme is monitored monthly by reviewing the data. A close check on the services is maintained by medical and social audits, not only of deaths but also of any untoward event. The number of referrals to a tertiary care institution, the number of instrumental deliveries and caesarean sections, instances of wound infection, are all reviewed with a view to improve the quality of the health delivery system.

The CHAD experience has brought to light the need for an innovative approach as well as appropriate technology with community involvement. The health of the community has shown marked improvement. As a result of education, accessibility and availability of good quality services, the people have a positive attitude to the health services, which may not be typical of the nation as a whole. It has also brought about awareness among the people that good maternal and child health care can be a legacy passed on from one generation to another.

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