Improving Maternal and Child Survival in Tamil Nadu

Summary:

A remarkable feat of the Health Department in Tamil Nadu in the late 1990s brought a new lease of life to maternal and child care. A new innovative strategy called a ‘maternal death Audit’ which converted most Primary Health Centres to 24/7 Care Units interlinked to a series of partnerships for Central Emergency Obstetric and New Born Care revitalized the whole health care system in the State. It is a delight to see the reincarnation of the erstwhile sloppy health units charged with an enthusiasm unmatched in service delivery and performance through a strong impact upon not just the primary health care functionaries but specially appointed all field health functionaries which are the capillaries of implementing such a policy.

To address the issues of high maternal mortality rate and female infanticide, Health Department in Tamil Nadu initiated a series of initiatives to arrest the mortality rates that rendered the PHCs as non-performing centers.

The Problem and the Strategy:

During the early 1990s rural areas in the southern State of Tamil Nadu faced high rate of maternal mortality and female foeticide. The irony of it is that this double tragedy happened despite Tamil Nadu having 1415 Primary health centers. During this period, the Primary Health Centers (PHCs) were reduced to non-performing.

With the implementation of series of initiatives, Tamil Nadu witnessed a drastic reduction in maternal death and improvement in child health. The maternal mortality ratio from around 380 per 100,000 live births in 1993 was reduced to 90 in 2007. The focused approach also resulted in reduction in female infanticide death from around 3000 per year in the 1990s to 70 in 2007. The various initiatives undertaken by the Health Department in a phased manner, involving different stakeholders brought a change in the health care facility in rural Tamil Nadu. In this endeavor the Health Department received funding support from World Bank and Danish International Development Agency (DANIDA).

Step 1: A reporting system was developed, whereby every maternal death occurring in the State would be reported to the Project Director, Reproductive and Child Health Project / Commissioner for Maternal, Child Health and Welfare within twenty-four hours. A lapse in the reporting and monitoring of maternal and infant deaths in the State was noted whereby a small number of around 640 maternal deaths were reported for the year 1994, as against 3500 for the year 1994. The first step was to develop a protocol for reporting maternal deaths problem a protocol for reporting and investigation of maternal deaths.

Each maternal death would be investigated, and a report sent to the Commissioner for Maternal, Child Health and Welfare within fifteen days. This was known as Maternal Death Audit, a system to analyze the causes of maternal death and to take appropriate remedial actions. Furthermore to sensitize this issue, various workshops and seminars were conducted for health employees and local body leaders at State and District level citing...
case studies to explain causes of death and how they could be prevented. This system was based on guidelines of WHO (World Health Organization) and the district collector was entrusted the responsibility of conducting monthly meetings to carry out verbal autopsy of any maternal deaths. The main objective was to identify the various delays-in seeking cares, in referral, in transit, and in provision of care after arrival in any health facility, with a view to minimizing/preventing such delays and enhancing the chances of survival of pregnant women.

**Step 2:** The next step was to develop 24 Hour Primary Health Centres (PHCs) around the concept of round the clock services. A staffing pattern of three staff nurses working in shifts to ensure 24/7 availability of normal delivery care, besides two medical officers being available during the day. It was initially tried out in Tamil Nadu in 90 PHCs, and later extended to 180 PHCs.

**Step 3:** Monitoring the PHCs : To monitor the performance of the 1,412 PHCs and develop a feedback mechanism, a health monitoring information system (HMIS) was developed. HMIS enabled to record the performance of the PHCs to ensure an effective feedback mechanism to the field officials. Thus, the daily average number of outpatients per PHC, which was 47 in 1994-95 increased to 140 in the period 2006-07. Similarly, the average number of inpatients per PHC per day increased from 0.1 in 1994-95 to 32.8 in the period 2006-07.

**Step 4:** This is a capacity building initiative to address the issue of lack of trained anesthetists and obstetricians in public health facilities which has developed into a partnership initiative of private anesthetists and obstetricians to work on an honorarium bases as per the requirement. Currently, about 15% of emergency caesarian sections in government hospitals are performed using this option. A new team of female field health functionaries were introduced to enhance understanding and awareness about this problem. Steps were taken to enhance women empowerment through imparting mobility and communication skills. Under the DANIDA project, five-day residential camps were organized for village, sector and community health nurses. In these camps, women were provided hands-on training in the use of mopeds, and they learnt both driving and the rudiments of vehicle maintenance. They were also trained in communication skills and this contributed both to their empowerment and to their ability to interact better with the communities they served.

**Step 5:** Improvement of PHCs and Health Sub Centres (HSCs) in conducting deliveries: Community participation and village health nurse (VHN) involvement in HSC construction from the design stage itself was introduced. Thus by 2006-07, the share of institutional deliveries to total in the state had become 96.6% and the share of PHCs and HSCs was a healthy 14.6%. During 2006-07, the percentage of institutional deliveries in government institutions at 55.4% exceeded the percentage of deliveries in private nursing homes at 41.2%.

**Step 6:** Setting up of Central Emergency Obstetric and New Born Care (CEmONC) at least 3 in every district with trained staff nurses, anaesthtists, gynaecologists and general surgeons.

**Step 7:** Introducing a ‘Birth Companion Program (BCP)’ to allow a female relative / known neighbor / friend inside the labor room to provide psychological support to the delivering mother. Furthermore it helped in eliminating prevailing corrupt practices inside the labor room. This had tremendous support for the deliveries of poor or abandoned women who were subjected to negligent techniques resulting in many medical problems which incapacitated them for their lives.
The Innovation in the practice:

The initiative of Department of Health, Tamil Nadu has brought a drastic reduction in maternal mortality and improved child health. Three characteristics make it a really best practice;

1. Interlinking health department related government agencies and where they could not be linked some new innovative bridges of administration were generated. These new set of functionaries such as those being part of the BCP or FFHF or village nurse of CEmONC strengthened the feedback mechanism and brought affected woman at the core of the policy implementation. While on one hand it improved coordination, it also increased a team spirit for a pro-poor service delivery system.

2. Two erstwhile segregated problems were brought under a single monitoring agency of the District Magistrate. These were maternal mortality and female foeticide. Earlier the former was a health department problem and the latter was a social welfare department problem left to NGOs. This brought greater integration and administrative coordination in district administration. It also enhanced accountability in the system.

3. To ensure a constant flow of funds the initiative was not simply dependent upon government funds but developed a partnership with local, national as well as international donors for the programme. This partnership ensured sustainability of this initiative.

4. This initiative can be and should be replicated in other rural areas especially Bihar, UP, Rajasthan and MP. Different stakeholders and State agencies have been able to collaborate in developing an effective feedback mechanism and awareness among people to build an effective rural health care system.

Lessons learnt:

- People and administrators do not care if the problem is ‘not in my backyard’(NIMBY). To bring it to the backyard of each administrator is to first generate awareness about the seriousness of the problem and the sloppyness of district administration efforts in understanding even the contours of its devastating impact upon society. Introduction of partnership systems in Government health services to work with NGO and international health care organizations have broadened up the horizon of administrators.

- Partnerships through new bridges made out of ordinary village women who could discuss issues of health and obstetric care in complete confidentiality made the system more pro-women rather than pro-administration or pro-NGO.

- More than the equipment or concrete infrastructure it is the human infrastructure which is required to generate a success story out of an initiative.

However a few constraints were discussed by the project participants. It was found that the initiative was primarily individual driven and not yet institutionalized hence a framework for sustainability of the initiative needs to be developed. Another drawback of the low rate of literacy that plagues the programme from below. A committed deadline based programme for complete literacy need to be developed in the area so that many more programmes which are backfiring may get a lease of life.

- The reduction of maternal morality and child health depends upon public awareness and community participation. To achieve maximum results requires an increase in literacy rate among the poor.

- The key to efficient public service lies in the hands of committed health sector employees.