Recommendations

DEAD WOMEN TALKING- IV
Learning from Women's Experiences
Report of a Workshop
January 5th and 6th, 2015
CommonHealth
with
Oxfam India, SAHAJ and RUWSEC
www.commonhealth.in

Addressing Anemia

Anaemia is proven to be a major cause of maternal mortality and morbidity and it also tends to be grossly under-reported

- Concerted efforts need to be made to address anaemia. While it is not enough to address anaemia in pregnancy alone, systems need to be put in to diagnose and treat anaemia during antenatal care. Front line health providers need to be trained and provided with field level equipment to diagnose anaemia. Treatment of women found to be anaemic must be ensured with adequate follow up and cross referrals between facilities and the community.
- The life cycle approach to addressing anaemia needs to be strengthened with identification and treatment of adolescent girls who are anaemic as an important component.
- Anaemia interventions need to go beyond the health sector to involve addressing nutrition, food security, education and gender issues from a rights perspective.
- There is a need to understand the causes of anaemia in pregnancy all of which is not owing to iron deficiency. Short studies should be done to assess the causes and inform a multi-pronged solution which moves beyond provision of iron tablets.
- Ensure sickle-cell anaemia diagnosis and treatment in adivasi areas.

Maternal Death Reviews

- Make Maternal Death Reviews transparent and accountable. MDRs should be a fact-finding exercise rather than finding fault.
- Strengthen reporting systems for maternal deaths by including reporting from persons outside the health system like AWWs, teachers, PRI members and self help group members.
- Broaden district and state MDR committees to include civil society representatives, PRIs and independent technical experts
- Include private sector deaths in MDR
- Consolidated reports of MDRs should be made public with details of action recommended and taken
- Verbal Autopsy Tool of the GoI should be modified to include better evidence for technical details and also social determinants

Referral systems

- Referral systems need to be made accountable.
- Referral protocols must be developed and health staff at all levels be trained in them. These must include
  - stabilizing the woman before referring her,
  - referral to the most appropriate facility that can manage that particular complication (and not the nearest understaffed/under resourced facility),
  - written referral slip with all relevant clinical details,
  - phone calls to facilities where the woman is being referred to give advance notice of her impending arrival,
  - accompanied transfers where an appropriate health care provider accompanies the woman during referral and ensures continuing care en route
  - Removing barriers to inter-state and inter-district referrals
- Referral audits should be done regularly with a view to decrease unnecessary referrals and to improve the quality of referrals.

Transport

- Free of cost emergency transport systems for obstetric complications must be ensured.
- These must be in adequate numbers and distributed equitably such that they are able to arrive within the stipulated period of 30 minutes on receiving a call.
- Barriers to inter-state and inter-district transport should be removed
- Staff of these emergency transport systems must be trained to recognize and transport women with complications to an appropriate facility that can manage them adequately. Staff should be able to report to the referred facility regarding care provided to the woman.
- Creative solutions must be evolved for transport in remote areas and contextually appropriate modes of transport – for example, boat ambulances in Assam – must be put in place.
  - In remote areas where mobile connectivity is poor special provision for vehicles should be ensured e.g. Dedicated vehicles for hard to reach areas with poor connectivity
- Overarching framework of rights and security of women and health service providers should be put in place

Blood

Availability is as important as safety and equitable access. Failure to provide blood is a violation which has been brought out by the data on shortfall of blood availability and responsibility needs to be fixed for this rights violation

- Immediate action must be taken – functional blood banks in every district and blood storage facility in every FRU should be ensured
- Blood bank requirements should be revised and modified - for instance ease area and equipment for blood banks requirement, shorter span of training of medical officers with better prepared module and online support.
- Encourage voluntary donation by various methods including organizing regular camps based on the local blood requirement and ensure compliance through monthly report to state drug controller

- Replacement of blood by a relative should not be mandatory to get blood from a blood bank of blood storage centre.
- Ensure blood storage centres are established and functional for every 1 lakh population
- As an aid to improve the availability of blood in all blood storage centres, in areas where there is a lack of blood, licensed UDBTs with adequate checks and balances should be permitted as an interim measure till blood availability is ensured through blood banks

Human resources: Professional Midwives and Dais

The world over professional midwives have played a pivotal role in reducing maternal mortality/morbidity. Moreover, pregnancy is a normal physiological process. Low risk mothers form 85% of a pregnant population and they should be cared for by midwives. Obstetricians are required for high risk and complicated pregnancies. Despite varied contexts, midwives play a crucial role in improving maternal health.

Proposed Midwifery Cadre

- Currently available ANMs with skills of midwifery to be designated as Public Health Midwives with 6 months additional training (approved by GoI – syllabus designed by INC)
- *Professional midwife:* Staff nurses who have completed the one year diploma in midwifery to be designated as professional midwives on an equivalent scale to the clinical nurse, nursing sister and clinical instructor or tutor
- *Specialist midwife*: On completion of ten years of service in maternity units, and undertaking further training in one of the areas of maternal health, they will be eligible for promotion as specialist midwives equivalent to the clinical nurse specialist

Dais

Currently, the Dai plays a unique role in maternal health care in many parts of India. One meta-analysis showed that perinatal and neonatal deaths were significantly reduced with interventions incorporating training and support of dais. By dai we mean an experienced person who has been supporting women during pregnancy, childbirth and post partum care within the community

- Dai to be explicitly acknowledged, accepted and linked to the health system - she should be formally recognised as a part of the maternal health care team at the primary level
- Investment should be made in research, training, equipment and back-up health system support related to the dai – this would help in mapping her role and contribution in maternal health in different contexts
- Dais unique knowledge and practices proven to be beneficial to the mother and newborn need to be incorporated into the formal training of all maternal health care providers

Thank you