

A Recent Trend of Increasing Number of Deliveries in Primary Health Centers in Tamilnadu: A Systematic Analysis

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Abstract:

*Tamilnadu has recently showing increased number of deliveries at the Primary health care centers. This paper aimed at analyzing various policies of the state and central governments for finding the reasons behind this trend. **Methods:** Google scholar was used to identify the published materials on various policies related to mother and child health. **Results:** Infrastructure and other Innovative methods like 24X7 PHC services for deliveries and Birth Companion as well as the women friendly clinics were the major reasons for this particular trend.*

Conclusion: However, not only mere infrastructures do not guarantee its use. Provision of user friendly services and innovative marketing of services has helped to create a demand in the community.

Introduction:

Tamil Nadu, a state located in south India fairs well in terms of maternal health indicators compared to other states and its maternal mortality ratio (MMR) now stands at 90.^[1] Promotion of institutional deliveries has been its key strategy to reduce MMR. Today the state has a high percentage of

institutional deliveries bringing its domiciliary deliveries to near zero.^[2] The public health facilities in Tamil Nadu provides birthing care through the primary health centers (PHCs) and health sub centers (HSC) at primary level, district and sub district hospitals at secondary level, and teaching institutions and its attached hospitals at the tertiary level. Women have direct access to all levels of care and services are provided free of cost.

Private facilities provide birthing care through small nursing homes to corporate hospitals, nongovernmental organization (NG-O) run hospitals and private medical college hospitals.

Prior to 2006, around 43% of the deliveries were conducted in the private institutions, 42% in the secondary and tertiary level public hospitals, 6-7% each in the PHCs and HSCs and 4% were domiciliary deliveries. An analysis of institutional deliveries by sectors from 2006 onwards showed a changing scenario. HSC and domiciliary deliveries declined to less than 1%, a four-fold increase was observed in PHCs, marginal decline in secondary and

tertiary hospitals, and surprisingly deliveries in the private sector declined by 10 points. [3-5]

At the root of any successful interventions in maternal health, a fundamental shift in norms and behavior are required in many fronts: Government policies, investments,

Methodology:

The Google Scholar was used to identify the existing policies in terms of mother and child health at the primary health care level of Tamilnadu. In addition to that Financial Incentive provided by both state government of Tamilnadu and Central government for promoting Institutional deliveries were also reviewed.

Results:

Physical infrastructure, essential equipments, and lab Services

In 2006 there were 1,417 PHCs, another 200 new PHCs werestarted over the last 6 years in a phased manner and 92% of themfunction in the government buildings. One PHC in each blockhas been upgraded as 30 bedded PHC, providing basic emergencyobstetric and newborn care (BEmONC) and upgraded PHCs has increased from 106-309 in the last six years. Upgraded PHCshave operation theatre (OT), modern diagnostic equipments likeultrasonogram (USG), electrocardiogram (ECG), and semi autoanalyzer. [3-5,7,8]

Around 1,000 PHCs have been equipped with semi auto analyzers and USG and another 122 PHCs have blood storage units.[3]

Screening for gestational diabetes and USG examination has been made mandatory.[4]Under the National Rural Health Mission (NRHM), 24 × 7 PHCs are

initiatives, community support, and changes in the health seeking behavior. [6]

This study analyzes the various state policies and supply side initiatives and innovations which have led to the increased utilization of PHCs for deliveries.

provided with an annual maintenance grant of 1 lakh rupees and untied grant of Rs. 25,000/-. These grants are being used for minor repairs, keeping the premises clean and purchasing consumables. The Patient Welfare Society of the PHCs have agreements with private bodies to provide infrastructure support, ancillary services, adopt wards, and is empowered to mobilize funds from donors, industries, and professional organizations. [9]

Human resources

24 × 7 PHCs: 'Three nurses' model'

Prior to 2005, PHCs were grossly underutilized contributing to less than 5% of the institutional deliveries. People were reluctant to seek services in the PHCs due to non availability of doctors and ANMs beyond the normal working hours and would go to the referral hospitals even for normal delivery. [10]

Policies

Government policy on rural posting for non specialist doctors and nurses entering into government service and compulsory stay for at least 2 years has ensured availability of adequate manpower.

GoTN's order to permit a birth companion in all public hospitals is a boon to delivering women especially those delivering their first baby.

The state's policies to post one lady MO in all PHCs, providing food for women attending antenatal (AN) clinics and women admitted for delivery in the PHCs, discharge only after 48 h following delivery are policies favoring women.^[5,11] Incentives are provided to village health nurses for providing complete AN checkup and to ANMS and nurses for providing intranatal and postnatal care.^[12]

Muthulakshmi Reddy Maternity Benefit Scheme:

Tamilnadu state Government launched financial assistance scheme for poor women during maternity. The assistance would be extended to poor women over 19 years of age for the birth of the first two children. Muthu Lakshmi Reddy Maternity Benefit Scheme funds is enhanced to Rs.12000/-. The cash assistance will be given in three installments (Rs.4000/-) on conditional release and restricted for first two deliveries only. The pregnant mother should be of age 19 years and above. The pregnant woman should be in the BELOW POVERTY LINE (BPL)GROUP. This cash assistance will be given to every pregnant woman: (a.) who avails all Antenatal services during pregnancy in concerned PHC, (b.) Mother who delivers in the Government institutions (PHC, GH, Govt. Teaching Institutions) and (c.) Completion of immunization for the child up to 3 doses of DPT/PENTAVALENT/HEPATITIS-B/POLIO .^[13]

Janani Suraksha Yojana Scheme:

Janani Suraksha Yojana (JSY) is another maternity benefit scheme, is fully funded by the national government under National Rural Selection of the Health Mission (NRHM). The JSY scheme aims at reducing the maternal and infant mortality by focusing on skilled attendance in delivery. Under the scheme, a sum of between Rs 500/- and Rs 700/- is being granted to women from Below Poverty Line (BPL) households if they deliver in home and an institution respectively. This scheme is only for the first two deliveries. Irrespective of their economic status all the women in the socially marginalized caste group scheduled castes/scheduled tribes (SC/ST women) are eligible to avail the benefit.^[14]

Innovative strategies

Expected date of delivery chart

List of women residing in the catchment area, who are expected to deliver in the subsequent month is prepared and displayed as an EDD chart. This simple tool has helped to track the mothers and counsel them to come to the PHCs for delivery.^[7,11]

Maternity picnics

When women come for the AN checkup, nurses take them as a group to the labor room and wards including toilets and briefed them about the facilities available.

This popularly known as 'maternity picnics' has helped women gain confidence about the services and the clean environment making them opt for PHCs'.^[7,11]

Referral system

The state's emergency transport system: Emergency Management Research Institute (EMRI) now has a fleet of 434 ambulances on road, parked at strategic locations and is accessible within an hour. In 2011, 25% of the cases transported were pregnant women.^[5] In times of emergency private vehicles are hired and paid from untied funds. Intranatal referrals from PHCs are mostly accompanied by nurses. Considering the benefits GoTN has now proposed to give a small incentive to the accompanying nurses.^[5]

Monitoring, review, and supervision

It is only since 2006 that the state directorate started reviewing the number of deliveries in each PHC and districts were ranked based on performance making the DDHS more accountable. Institutional service monitoring report of the PHCs is used for reviewing the performance of the staff during the monthly meetings of the DDHS with the PHC staff.^[3]

Discussion:

Increase in the number of PHCs with good infrastructure, modern diagnostic equipments, and OTs in the PHCs have changed the perception of the people about the public facilities.

Untied funds and grants under the NRHM have given the flexibility to make local purchase based on need. Support from private bodies has also helped to give a face lift to the PHCs. However, it has to be mentioned that support from NRHM is across the country.

Common review mission reports in few states like Rajasthan, Andhra Pradesh, and West Bengal shows that underutilization of PHCs were observed in spite of good infrastructure and more people accessed private sector.^[15,16] Supply side interventions have not resulted in increase in deliveries in additional PHCs unlike TN where 62% of the PHCs conduct more than 10 deliveries per month.^[5] Existence of facilities does not guarantee its use; provision of quality care is essential for effective utilization.^[15]

24 × 7 services with three SNs' model in all PHCs can be singled out as a key determinant for increased utilization of PHCs. This has been acknowledged as a best practice by Policy Reforms Option Database (PROD) and is now adopted by the other states.^[16] Empowering doctors and nurses with adequate skills has made them more competent to handle the cases since most of them are new recruits, thereby reducing unwanted referrals. Nurses posted in TN are posted initially on a contract basis and later absorbed in the regular system.^[10] Other states recruiting contractual staff could also adopt this model for long-term planning to ensure sustainability.^[17,18] A report has shown that 50% of the women did not stay for more than 12 h in PHCs following delivery in some states of India due to both supply and demand side problems.^[15]

The GoTN policies on permitting a birth companion, compulsory stay for 48 hours after delivery, management of anemia and provision of food, basic facilities, and presence of a lady MO have attracted more women towards PHCs.

When users have access to more facilities it is the quality of care perceived by them that decides the choice of the facility.^[19] A key factor for client satisfaction with the public sector is provider behavior which takes a priority over technical competence.^[20] Services provided should meet the accepted standards and equally important is to address the human dimension, otherwise clients will look of other options.^[21] Study on rural health care in West Bengal has recommended that more time has to be spent with patients and a cordial relationship has to be established and premises should be kept clean as services in the public sector lacks attraction and is provided mechanically and not emotionally.^[22]

Conclusion:

This Paper reviewed various reasons for increase in the number of deliveries at the primary health centers in India. However, not only mere infrastructures and human resources do not guarantee its use. Provision of user friendly services and innovative marketing of services has helped to create a demand in the community. Such multipronged effort has led to a trend of increased utilization of primary health centers for deliveries.

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