AIWC - FTAPCCI Consultation on

Implementation of Sustainable Development Goals (SDGs) in AP and Telangana States from Women's Perspective.

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You may recall history of the Crimean War and plight of British soldiers in the Military Hospital at Scutari, around 1854. Florence Nightingale had been sent to deal with the medical disaster. She successfully improved the hospital and brought down mortality. She had introduced four key reforms. Diet kitchen for patients, Lavatory cleaning and floor scrubbing, Laundry and Linen, and Sanitary engineering works to provide for drainage, disposal of sewage, and plumbing. Her work was widely acclaimed.

In July 2007, I addressed a group of medical & health care professionals in a specialty hospital. At the outset, I took a straw pool of the participants, asking them "Whose Job in a Hospital include the following?"; and listed the four reforms mentioned earlier without linking them to Florence Nightingale's work in the Crimean war. About 50% of the 150 participants voted "Hospital Administration", another 33% voted that these were the functions of the Director. None identified these as functions of Nurses.

This goes to show that Florence Nightingale was a pioneer in the field of hospital administration and management. However, she was acknowledged as a pioneer of the Nursing profession, which of course was a landmark achievement. Given her gender, a pioneer nurse, that extends a woman's traditional role of care giver in home to that in hospital was more palatable. Recognising her as a pioneer hospital administrator was, probably, too revolutionary for the contemporary patriarchy. Even to this day, nurses hardly have any managerial role in our hospitals. So much so, that they need the RMO's (Resident Medical Officer) approval to purchase even linen & mattresses!

The World Wars in 20th century, were an awful time. Men were mobilised into the battlefront. Industry and military production lines in the home front had to be manned! Governments of the day encouraged women to fill in the void.

Women worked in a wide range of jobs that had been the exclusive preserve of men. They were paid a lower "women's" wage. However, production statistics by end of the second world war showed that women had mostly matched and/or exceeded the prewar productivity levels. Man's prejudice about gender differentials in productivity had to yield somewhat to accommodate these experiences!

I am trying to make two simple points. Established patriarchy usually yield's when faced with grave and existential challenges. Women's readiness to grab and hold these opportunities is key to the extent of achieved gender equity.

Maternal mortality, which is one of the indicators of SDG-3, health & well being, is still unacceptably high at about 92 per one lakh live births, as of 2011-13. Increasing resort to Institutional delivery is currently the key strategy to reduce maternal mortality. But poorly organised Institutional deliveries comes with a price of increasing cesarean section rates (CSR). We need to recognize that CSR is an indicator of the quality of maternity and child health (MCH) care in general and quality of obstetric care in particular. Very low CSR indicates non availability of obstetric care. Very high CSR indicates one or more of several maladies in the health system. First would be poor quality and reliability of basic emergency obstetric care for normal deliveries. C-sections can be performed only in medical institutions and hospitals equipped for surgery. Doctors skilled in comprehensive emergency obstetric care ought to be available. When women, their relatives as well as health workers are faced with doubtful competence, poor availability, inadequate resources for normal deliveries, cesarean section with the attendant aura and reassurance of a technological intervention presents itself as an obvious option. On the other hand, doctors are happy, as cesareans help them better schedule their day and hospitals tend to benefit financially as well.

Professional midwife-led maternity services backed by obstetrician support, achieve similar or better results compared with purely obstetrician-led maternity services. Hence, the way obstetric care is organised affects the quality and cost of MCH services. Midwives play a central role in the organization of maternity services in several countries such as Australia, Denmark, France, Sweden, Netherlands, New Zealand and UK, all of which have low maternal mortality at <10 / 100000 live births. In many of these countries perinatal mortality and CSR among women primarily cared for by midwives with back up physician services, have been found to be lower. The National Maternity Hospital in Dublin, Ireland is one of the best known and well-studied examples. There, midwives are responsible for the management of all laboring women, including private patients who are delivered by midwives with their personal

physician in attendance. Midwives are closely involved with the education and training of resident physicians.

Unfortunately, professional midwifery is yet to develop in India for various reasons. Firstly, professional midwifery is confused and mixed up with traditional birth attendants (TBAs). As a result, any talk of professional midwifery gets sidetracked into discussions about raising the skill and competence of TBAs. Secondly, birth of professional midwifery has been stifled by mixing it up with nursing. Thus we have Certificates or Diploma in General Nursing and Midwifery, and Auxiliary Nurse Midwives. One is, at best two thirds nursing and one third midwifery, and the second is an auxiliary midwife and an auxiliary nurse. We have Graduate Nurses and Masters in Nursing, but no graduate level midwives! Countries with a long tradition of midwife-led care have bachelor degree level midwifery courses spreading over 3-4 years of study consisting of 50% theoretical and 50% clinical work. Internships and guided experience of 40 to 60 births is the usual criteria for midwifery license. Licensed midwives usually practice in hospitals with admitting privileges and authority to prescribe relevant medicines.

SDGs 3 & 5 are intricately linked with SDG-17 that seeks to strengthen the means of implementation. Development of professional midwifery will be a win-win for all. Good MCH care meets almost half of the health care needs within close proximity of any community. Professional midwives backed up by doctors, as needed, will be well qualified to render good quality MCH care. We are still struggling with poor availability of MBBS doctors in rural areas. Rendering high quality and reliable maternity care, entirely manned by doctors is unrealistic. Going by the differences in availability of doctors and allied health professionals in remote and rural areas, we can predict that professional midwives will be more available and enhance the quality of MCH care.

The long duration required to develop a cadre of professional midwives is often an alibi to postpone action! Well, we were not deterred by such considerations to develop the cadre of physicians! And yet we have procrastinated for more than 60 years to even recognize the need for professional midwifery? In any case, here are some practical steps to get cracking. Firstly, develop mid-career midwifery courses for registered nurses wanting to branch off into full-time midwifery. Then revise maternity service staffing norms with increased midwives. Eventually, confer admission privileges and prescription authority to midwives and nurse-midwives for maternity & related services only. Gradually, introduce bachelor and masters degree programs in midwifery to sustain human resources for high quality and accessible MCH care. Many of you may have influence over management of private hospitals. Finally, I seek your consideration and influence for development of professional midwifery, in the private health sector, one

hospital at a time. The Fernadez Hospital in Hyderabad is a good example. I would like to see many more such instituions. Incidentally, it makes good business sense, to position your hospital as place of high quality wholistic maternity care.

Thank You All, for Your Attention.

Dr. Prasanta Mahapatra, President & Dean, The Institute of Health Systems.