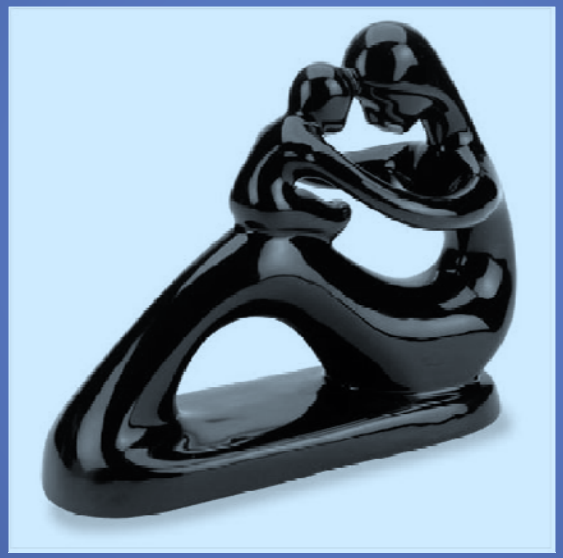
MATERNAL AND CHILD HEALTH

VENTURE CENTER, PUNE

14 SEPTEMBER 2013



INSIGHTS AND FIELD OBSERVATIONS MCH

Rama Sivaram,
HEAL CONSULTANCY, PUNE

FACTORS INFLUENCING OPTIMAL HEALTH OUTCOMES

Social

Economic

Health Care Delivery

Health Care Team/NGOs

Access to Need or Condition related Intervention

Therapy related Interventions

Patient-related interventions

Increased KAPB

PROGRAM EVALUATION: All about ratios

Multiple Resources Inputs (human, financial and product)

Demographic profile of a beneficiary group

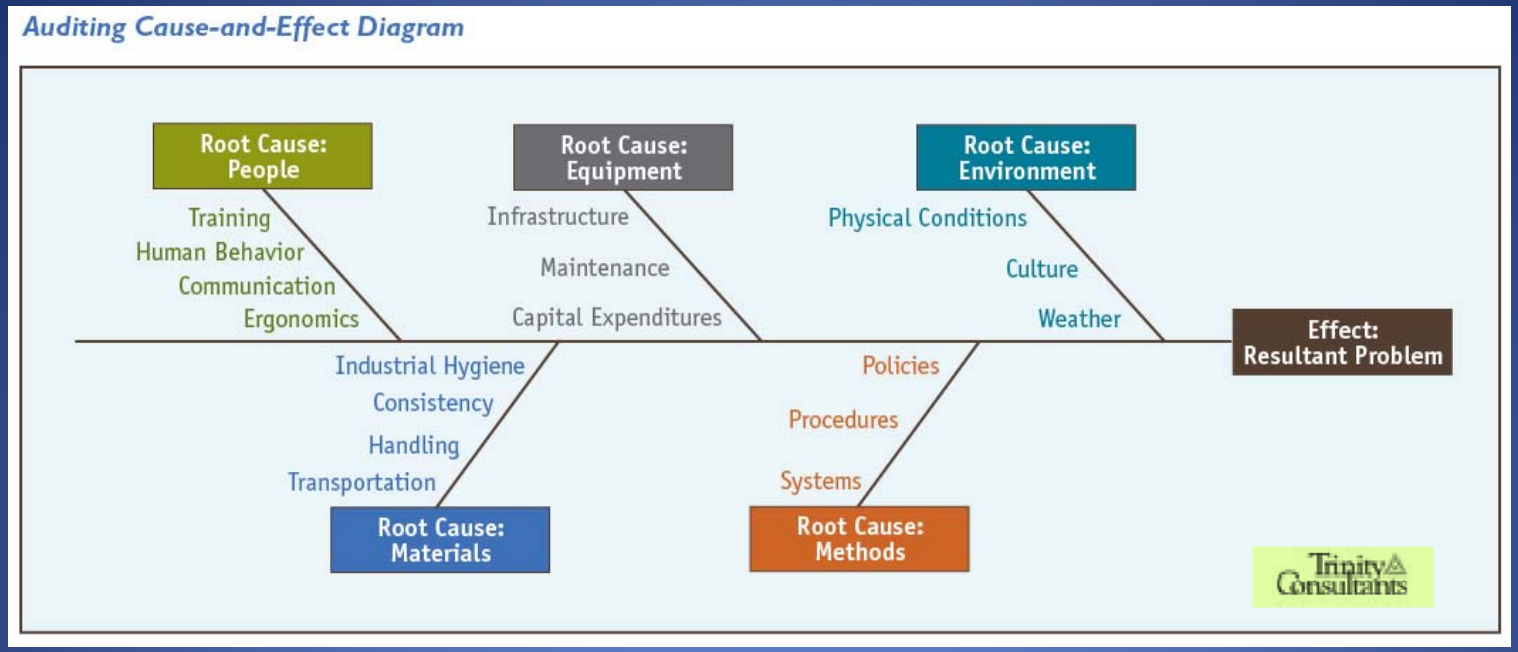
Methods and Processes

Time frame

Output and Outcome Indicators

Replicability Models

AUDITS ! AND MORE AUDITS….



operational social compliance financial, performance

BLAME PEOPLE, PROVIDERS, FACILITATORS AND USERS- WHAT HAPPENED TO OUR ERGONOMICS?

SOMETHING LOOKED AMISS

GROUND REALITIES

Horizontal or Vertical programs

Partial Eclipse of facts

Are We In Tandem?

The Missing Gaps

ERGONOMICS AND HEALTH CARE

Symposium on Human Factors and Ergonomics in Health Care:
BRIDGING THE GAP
March 12–14, 2012
Marriott Baltimore Waterfront Hotel
Baltimore, Maryland, USA

HOW CONNECTED ARE WE

Adherence not Compliance the difference
Active participation not passive reception

We need to go right down to understand community needs

MCH is interlinked with all other aspects habitat and habits.

Delivering awareness , primary health care and essential drugs is a vertical approach with vertical solutions

The preferred route to optimise health care delivery is horizontal when one sees maternal and child morbidity and mortality

Partial Eclipse of Facts

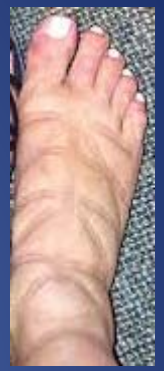
The Girl Child: Iron folate distribution but consumption by girl child?

Reasons: Wasted on paraya dhan
Early menarche
Bony and hard foetal development
Obstructed labour
Son is a better option
Aversion to swallowing pills
Fear of change in bowel movement and colour
Absorption issues
Culturally determined eating habits

Our UNICEF adolescent study showed < 11.5 g/dl not for the girl child alone but boys as well!!

ANTENATAL AND POSTNATAL CARE-MCH

Walk the talk !!!
Poor ASHA ! Rural Infrastructure



ASHAS are part of the System
Professionalism, decision making and breadth of understanding Unaddressed emergencies

Sub optimal care- Lack of easy to read and monitor maternal and fetal status

My rural friends daughter was bumped in the ox driven cart to hasten labour- and died of PPH

My rural friend lives with prolapse uteri

Much of MCH morbidity is due to postpartum infections, bleeding complications, eclampsia , gestational diabetes, poor hygiene and malnutrition

Sub optimal care- Lack of easy to read and monitor maternal and fetal status to forsee emergencies

WHERE ARE THE CHOICES


COVER CLOSE-CONTACT TOXINS

SANITARY PADS
A silent health threat

MANUFACTURERS WITH LOTS OF CHEMICALS

FULL OF BACTERIA

WHAT YOU CAN DO

Toilets, shared pads, reused pads, washing and drying issues

Confinement to interior lack of sunlight

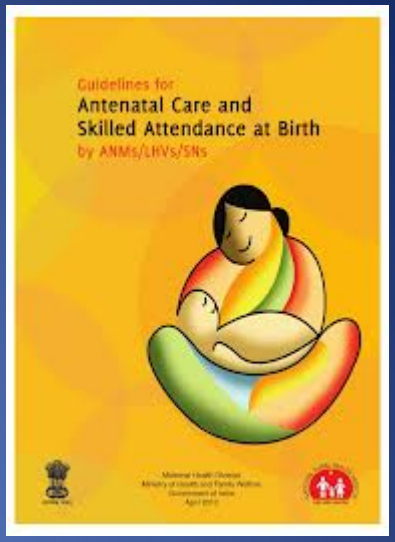
RTI infections – sexual and non sexual transmission

Birth canal infections

Single partner sex with no guarantees

INFANT MORTALITY

Protein energy malnutrition (PEM) Need for proteins with shelf life



Marasmus before 1, Kwashiorkar after 18 months

Infant mortality: respiratory infections leading to pneumonia, umblical infection, passage infections. Unsafe deliveries