NEONATAL

Elective experience in Christian Medical College, Vellore, Tamil Nadu, India

written by Man Wai Vivian Leung (Final Year Medical Student, Bart's and the London SMD)

I chose to do my elective in India because it has the highest maternal mortality rate worldwide: They account for nearly 20% of maternal mortality globally. I wanted to understand what accounts for such a huge difference between the UK and India.

Being British, we all take pride in our National Health Service(NHS). This system provides free healthcare to everyone, regardless of their class or colour. Primary care is easily accessible for everyone in the country, a GP is always round the corner and we not only have road ambulances, we also have air ambulances providing emergency medical care and transport. We have guidelines and logarithms, nationally and locally. We have multidisciplinary teams, including doctors, nurses, pharmacists, physiotherapists, occupational therapists, and all the other healthcare professionals in one single hospital. In India, all of these are rarity.

I came to Christian Medical College in Tamil Nadu because I know it is different from the rest of India. They try to provide primary care, not only by having a community healthcare and development unit base (CHAD), but also organises doctors- or nurses- run outreach mobile clinics nearly every day. This is a legend in India, where primary care is next to non-existent. I took the privilege of joining a mobile clinic. It consists of 7 people, including me. The driver, without whom none of these can happen; two community nurses, who are responsible for taking blood pressure and giving out prescriptions; 1 sister, who assists with antenatal care; and 2 doctors, who are responsible for consulting the patients and writing prescriptions. We visited 4 villages that day, where doctors do antenatal checkups as well as general consultation, mainly chronic disease follow up including diabetes, hypertension and epilepsy. These mobile clinics increases the patients' compliance to their medication and provide regular antenatal checkups, which in turn improve their general health.

I had the opportunity to do a home visit with a doctor. We visited a family with strong family history of schizophrenia. Three siblings live in one small hut, without any sanitary facility, without any cooking appliance. Nothing, other than a roof. Under this roof they constantly experience auditory and visual hallucinations, telling them to hurt themselves and kill themselves, telling them never to leave the hut, never go to the hospital or seek any help or else they will be hunted down. They believe their hut has been bewitched by black magic. I could not help but wonder, what if I were born in this family? What will I become?

Their problem is just the same of many schizophrenic in the UK and the rest of the world --- compliance. In the UK it would have been easy, just give them monthly injections instead of daily tablets can easily solve the problem. But in India, where patients have to pay for their own prescriptions, where healthcare is difficult to access, where patients are more worried about their next meal than their chronic illnesses, this problem is very hard to tackle.

I also visited the labour room in CHAD. Being trained in London it was very hard for us to observe normal vaginal delivery; many of the planned normal vaginal delivery would become assisted or Caesarean section

as soon as the mother or the foetus express any sign of distress. But while we were there, we observed three normal vaginal delivery within 3 hours. The difference between being delivered in the UK and India is huge. Witnessing normal delivery in India is a crucial reality check for me. There was no air conditioning, ventilation is not great, no anaesthesia, no continuous CTG. Being in CHAD we have nurses and doctors, but in most part of rural India you will be on your own. These women are suffering from the pain of labour in 40 degrees without any kind of anaesthesia. They do not even have good light source to suture up perineal tear postpartum; while in the UK, they would be looked after 1:1 by a midwife, in a private air conditioned room, usually with their husband or family, sometimes even with aromatherapy and music, and of course, with pain relief of your choice. Witnessing what happens here reminds me what kind of luxurious kind of care we are providing in the UK, reminds me that actually, a normal delivery can happen without anything other than a mom willing to push.

After that I visited the labour ward in CMC hospital. Again, another big shock. This is actually very similar to what we have in the UK. 1:1 CTG monitoring, ultrasound readily available, patients' record by their bedside, digitalized radiography and laboratory results, plus a multidisciplinary team working alongside. I was so impressed by how similar this is to where I came from. This is probably partly why Tamil Nadu has the lowest maternal mortality amongst India.

I also take this opportunity to look into why maternal mortality is so high in India, compared to the rest of the world. There are

Firstly, difficult access to healthcare. If it weren't for the mobile clinics running to different villages around CMC monthly, that population is unlikely to seek any health advice until later stages when their symptoms start affecting their daily activities. Late presentation often results in poor prognosis. Not being able to access healthcare facilities also means that many of them do not have antenatal checkups(ANC). It has been shown that a third of the cases of maternal mortality did not have previous ANC. Without ANC there is no baseline and thus impossible to assess foetal wellbeing accurately and poses danger to both the foetus and the mother. This is also regarding as a high risk in the UK.
Secondly, low socio-economical status. Many women in rural India are illiterate or have very low level of education. These women may be unable to recognise the symptoms of complications of pregnancy and the seriousness of the situation, resulting in devastating outcome.
Thirdly, adolescent pregnancy. In India, it is their tradition to get married and pregnant young. Getting pregnant as young as 16 is common and these women have an increased risk of pregnancy-induced hypertension, which in turn increases the risks of pre-eclampsia and eclampsia.
There are many other associated challenges and difficulties regarding maternal mortality in India, like lack of national guidelines, lack of national quality assurance, causing discrepancy between what should be done and what is available between hospitals and areas. India is a big country with 1.2billion people, where it is their tradition to start a family early without any family planning policy. Although maternal mortality has been reduced significantly in the past years, more changes are yet to be made for India to become a safe country for women to deliver their babies.