

***My Experience in Gnanadurai Maternity Hospital-India 2008-08-24***  
***By Adele Phillips***

As a newly qualified midwife, I feel passionate and privileged to be a keeper of safe normal birth and an advocate for women's choice. These I feel to be the basic fundamental principles in the care of childbearing women. Throughout my training I have developed a strong interest in international midwifery and am saddened by the inconsistent care given to women worldwide, particularly those in lesser developed countries, which is clearly depicted in maternal and fetal mortality and morbidity rates, which remain unacceptably high, often due to preventable or treatable conditions, and new interventions are required. One woman dies every seven minutes in India due to pregnancy-related complications and these are conservative estimates since more than 30 per cent of maternal mortality cases go unreported, according to estimates (Global sisterhood network 2007). India has one of the worst statistics in the world as far as maternal mortality goes. I was thankful for the support Iolanthe gave me to experience midwifery in South East India for 2 weeks to give me a clearer insight into the care received by women and how this reflects the current morbidity and mortality rates. An opportunity I would have only dreamt about having with my limited resources as a student.

Through an organisation called Projects Abroad, I was placed in a private hospital in Sivakasi, which is in the South Eastern state of Tamil Nadu. Far away from the popular touristy delights of India. The hospital was run by husband and wife doctors, and is the busiest maternity hospital in the region. Dressed in the traditional salma kameez I arrived at Gnanadurai hospital excited and intrigued to absorb different midwifery practices and as encouraged, share knowledge and skills where appropriate.



When I walked into the 'labour room' I was unexpectedly taken aback and shocked to see a room with 6 steel tables whereby women birth their babies.

No sooner had I stepped in the room when a baby was about to be born. The woman in labour was lying supine, had a catheter in situ which was taped to her thigh with no catheter bag, in addition she had a cannula in her right hand with oxytocin running, there was meconium stained liquor draining and no fetal monitoring observed. An episiotomy was performed before the head was on

the perineum, pressure was then put onto the perineum by a student nurse as the 1<sup>st</sup> nurse-midwife inserted fingers from both her hands and began stretching the perineum. Her fingers remained inside the vagina whilst pressure was put on the advancing head with the perineum being guarded. As the woman pushed, another nurse-midwife applied firm fundal pressure. The baby was born in grade 2 meconium and handed to another nurse-midwife upside who performed what looked like vigorous cardiac compression while the cord was clamped and cut. The baby was taken to a table covered in a mesh cloth and given nasal and deep throat suctioning and cried within a minute. The placenta was delivered with no oxytocic drug used and thrown away immediately without checking. Catgut was used for suturing, continuous from the apex to the introitus and interrupted for the muscle and skin. Meanwhile the baby was weighed and bathed and given to a family member in the next door ward which doubled as an antenatal and postnatal ward. After being washed down the women went to meet her baby, a joyous occasion celebrate with many family members. I found this difficult to watch and felt so sad for the woman who had no privacy or consent for anything. At no point received any caring and sensitive communication, support, reassurance, encouragement or congratulations for birthing her baby. This did not seem to part of the culture here.

It took a couple of days for the midwives to get used to my presence but eventually we found ways of tackling the language barrier as only a few of them spoke broken English. I was informed that although private, this hospital was on the lower scale of care that is provided, the patients were very poor and this was reflected in the care they received. I was also told that the doctors determine the protocols. Women are told to come to hospital when they feel pain, some women having a 2-hour bus journey. They remain in the antenatal ward, most with female family members for labour support, some on their own. Morning and evening they are brought into the labour ward and examined by the doctor who palpates and auscultates with a stethoscope and performs VE's assessing the cervix, presenting part and adequacy of the pelvis. Women are then given an enema, are shaved, cannulated before returning to the antenatal ward until their contractions are closer together and regular or they feel the urge to push. They are given various pain relief IM, usually pethidine, diazepam, morphine or tramadol. Oxytocin is used sparingly if labour appears to be slow, an ARM will also be skilfully performed with a needle, second stage almost always involves the use of oxytocin. Many of the women I witnessed had meconium stained liquor. For very thick meconium, 500ml of sodium lactate are inserted into the uterus, the rationale being to dilute the liquor and reduce morbidity. The midwife in charge auscultates randomly throughout the day but this is not consistent. The women in labour although in pain are relatively submissive and quiet, even with the use of oxytocin. Labour pain was dealt with and accepted as part of the whole necessary process.

Many women present in labour unbooked. As a result I witnessed 4 stillbirths, one of these babies was an anacephalic baby, another hydrocephalus. Again, these women were not given any extra

emotional support when they delivered their stillborn babies. One woman came into labour with an antepartum haemorrhage, her baby was born healthy but she continued to bleed. Oxytocin was put up and the bleeding was controlled, however her blood pressure dropped to 90/40. This woman lost her life 4 days later after she fell unconscious. A number of drugs were used including mephentermine, crystalloid fluids, steroids and dopamine. However there were no resources for a blood transfusion.

After a few days I began giving women support during their contractions and encouraged them to sit up or stand up instead of lying flat on their backs. Communicating through sensitive touch warmed me immensely. It really drove home how important women centred care, additionally I saw an improvement in the look of fear many of these women had and I felt happy to be able to offer this valuable support and hope I encouraged the nurse-midwives to continue



Taking a break from the labour ward I had the opportunity of shadowing a 70 year old traditional midwife who baths all the babies up to 1 year old in the village. I observed her swinging newborns by the legs as a form of physiotherapy, and blowing the mucous out of the nose. Additionally, turmeric was put on older babies as an antiseptic and to protect from disease. 3 bindi's are then put on the head and cheeks to protect from evil spirits.

I feel even more passionate about the importance of consent and women centred care. I hope I was able to give the few women I cared for a degree of sensitive support and reassurance, in addition to acknowledgement for the wonderful journey they had gone through to birth their babies. As a qualified midwife I will continue to provide sensitive support to women and keep them involved in all aspects of their care and their labour. I hope to take my skills and work in an under developed country like India to spread this practice like a ripple in a pond.

References: <http://www.global-sisterhood-network.org/content/view/1594/76/>