പതിമൂന്നാം കേരള നിയമസഭ

ഒമ്പതാം സമ്മേളനം

നക്ഷത്ര ചിഹ്നമിട്ട നിയമസഭാ ചോദ്യം നമ്പർ: 15 — 10/06/2013-ൽ മറുപടിക്ക്

അട്ടപ്പാടിയിലെ ശിശുമരണം

ചോദ്യം		മറുപടി	
ശ്രീമതി ജമീലാ പ്രകാശം ശ്രീ. മാത്യു. റ്റി. തോമസ് ,, ജോസ് തെറ്റയിൽ ,, സി.കെ.നാണു		കുമാരി. പി.കെ. ജയലക്ഷ്മി (പട്ടികവർഗ്ഗ ക്ഷേമവും, യുവജനകാര്യവും, കാഴ്ചബംഗ്ളാവുകളും മൃഗശാലകളും വകുപ്പ് മന്ത്രി)	
എ	അട്ടപ്പാടിയിലെ ശിശുമരണത്തെ സംബന്ധിച്ച് അന്വേഷണം നടത്തി സർക്കാരിന് റിപ്പോർട്ട് സമർപ്പിച്ചിട്ടുണ്ടോ;	എ	ആരോഗ്യ വകുപ്പിന്റെ വിദഗ്ധ സംഘം അന്വേഷണം നടത്തി റിപ്പോർട്ട് സമർപ്പിച്ചിട്ടുണ്ട്.
ബി	എങ്കിൽ റിപ്പോർട്ടിന്റെ പകർപ്പ് ലഭ്യമാക്കാമോ;	ബി	റിപ്പോർട്ടിന്റെ പകർപ്പ് ഉള്ളടക്കം ചെയ്യുന്നു.
സി	ശിശുമരണത്തിന് ഉത്തരവാദികളായവർക്കെതിരെ നടപടികൾ സ്വീകരിച്ചിട്ടുണ്ടോ; എങ്കിൽ ഇതിന്റെ വിശദാംശങ്ങൾ വ്യക്തമാക്കാമോ?	സി	അട്ടപ്പാടിയിലെ പട്ടികവർഗ്ഗത്തിൽപ്പെട്ട ശിശുക്കളുടെ മരണം സാമൂഹ്യവും സാമ്പത്തികവുമായ കാരണങ്ങൾക്കു പുറമെ ജീവിത ശൈലിയിൽ ഉണ്ടായ വ്യതിയാനം മൂലവും സംഭവിച്ചതാണെന്ന് മനസിലാക്കുന്നു. ആരെയും കുറ്റക്കാരായി കണ്ടെത്താൻ കഴിയില്ല.

സെക്ഷൻ ഓഫീസർ

Report on the visit to Attappadi on 24TH and 25TH of May by Dr.N.Sreedhar, Addl.DHS, Dr.G.Sunil kumar,Dy.DHS and Dr.V.Rajeevan, Asst.DHS.

A team of doctors consisting of Dr.G.Sunil Kumar, DD(FW), Dr. Rajeevan, Asst.DHS and State Nodal Officer for Tribal Health, headed by Dr.N.Sreedhar, Addl.DHS(FW) visited Attappadi on 24th and 25th of May, 2013. The team visited CHC Agali, Tribal Specialty Hospital Kottathara and some hamlets. Later, the team had interaction with the ADM, Palakkad and DMO, Palakkad and with officers of the Social Welfare Department and Tribal Department. Based on the visit the following report is submitted.

The team went to CHC Agali at 11am on 24th May. A meeting was convened there. Doctors of CHC Agali, Dr.Sreehari, DPM of Palakkad, Dr.Prabhudas who is well versed with the hamlets and their traditions and the supervisory staff for the whole area of the CHC were present. Agali CHC is the site proposed for starting a Nutritional Rehabilitation Centre(NRC). There is sufficient room to accommodate the NRC at the building behind the office block. But it requires repair works that will take a few months to finish. The repair work has to start urgently. In the meantime, there is another space that can be used as NRC during this time gap until the proposed building is ready for use. The space that is now used as conference hall has sufficient room that can accommodate about twenty children with family, has play space for the kids and room for the kitchen. Only minor works will be needed for this and can be finished in less than two weeks.

Additional staff for running the NRC is under posting and training and can be put in position in one week's time. Four Medical Officers are staying there in the quarters. There is a labour room. A few deliveries are happening now. If more deliveries are conducted here, it can reduce load on the Tribal Specialty Hospital, Kottathara. Doctors lack orientation on HMIS and MCTS. Their HMIS and MCTS training shall be urgently done. MCP card has been distributed to the field level workers and issuing them to antenatal women has just begun. Once registration of antenatal cases using this card is done, it is an effective tool to monitor the health status of both the mother and the child. Here, strong need to train JPHNs to identify nutritional deficiencies especially marasmus and kwashiorkor is felt. This will enable better risk identification. Anganwadi workers and ASHA also should be trained on identification of children and women with nutritional deficiencies. JPHN, ASHA and AWW should have contact numbers of one another and should be encouraged to communicate between themselves.

In the afternoon, another meeting was conducted with all the field staff covering the area, Medical Officers of the three Mobile Medical Units and the supervisors. It was generally observed that communicable disease surveillance was sluggish. The Health Supervisor did not know the fever status. There were 65 fever cases in the 20th week and 121 cases in the 21st

week, but this was not identified by the field staff or supervisors and no data analysis had taken place. On enquiring, the MOs told that they are not briefed on the communicable disease status of the field level by their field staff or supervisors.

The team visited the hamlet at Nellippathi. There is an Anganwadi in the hamlet. There is good rapport between the Anganwadi worker and the inhabitants. Generally the women of the hamlet are short statured. Immunization of the children is usually done from the CHC Agali. Food habit of the hamlet is mainly based on cereals alone in majority. They take Kanji in the morning and afternoon with a little curry based on leaves or pulses. But the quantity of curry consumed is very little only. In the night, they take "puttu" consisting of rice and ragi with a little amount of curry that too based on leaves or pulses. The quantity of pulses they use is very little. Generally they do not consume milk. Very occasionally they use eggs. They are otherwise vegetarians.

The women of that hamlet go to the Government facility as well as to a private facility – Bethany Hospital – for antenatal care. But majority go to Bethany Hospital because there is facility for doing Caesarean there, according to a woman, Chitra of the hamlet. They have educated men and women in the hamlet and are aware that advancements like Caesarean facility are required for better delivery care.

The Anganwadi can be put to use for a few more activities. The centre can be the hub for health information dissemination in local dialect. A translator from among the educated youngsters of the hamlet will bring better acceptance of the messages. Non formal education can also be routed through Anganwadi. There is an Anganwadi in almost all the hamlets. This place is an ideal place for supplying cooked food to the women and children. Take Home Ration also may be distributed through the Anganwadi. Supply of "nutrimix" or "SAT mix" can be done to these Anganwadis. This can be cooked in local recipe for better acceptance. But there is severe shortage of drinking water in all these areas. This will hinder supply of cooked food at the Anganwadis. Availability of potable drinking water should be the first priority in all the hamlets for getting rid of the problem of nutritional deficiency in the tribal population. In the Nellipathi hamlet, they have taps that do not give them water. They dug a bore well and are now getting water every alternate day only that too during odd hours. They are paying for the electricity that they consume for pumping water from that well and they gain this money by contributions from the families inhabiting the hamlet.

TSH Kottathara

The team visited TSH Kottathara in the evening. This is an institution that can be equipped to provide good quality service to tribal people. There is sufficient space available. Now there are two gynaecologists. Number of deliveries taking place there was one or two before. Now the number has begun to increase due to presence of gynaecologists. But the

provision for Caesarean section should improve to bring about a sustainable change. This institution may be brought under KASH programme at the next possible opportunity. There is an operation theatre there. But there is no plumbing provision. Sterilization room has not been established even though there is a large sterilizer available. Electricity connection to the OT has not been established. Instruction has been given to the Asst.Biomedical Engineer, Junior Consultant (Engg) and Quality Assurance Officer to make proposals with budget estimate for providing the lacking facilities and to follow them up. There is no lift here to serve the patients especially antenatal. The labour room is upstairs and this is causing a lot of difficulties. There is room to provide lift. This may be considered as a priority. If sufficient facility with surety for doing Caesarean in needy cases can be provided, tribal women will approach this institution confidently for services.

In TSH Kottathara, the most felt need is of water. About 50,000 litres of water is required every day. But there is no sufficient provision for this. There is a project to construct a filtration tank at the nearby river "Siruvani" to supply this hospital, but the work needs to be expedited on a war footing.

There is a blood storage unit awaiting license from the Drugs Controller here. The license is not issued because a visit by the Asst. Drug Controller of the district is due. Since gynaecologists are posted and deliveries are increasing in number, this facility should be functional at the earliest. This also may be given top priority.

Bethany Hospital is a private hospital situated at Anakkatty. They are providing free services including delivery and Caesarean services free of cost to tribal women on condition that they should get all the antenatal care from them only. Otherwise they have to pay. Immunization of the baby can be given at the place that the parents choose. 217 tribal deliveries have been conducted in that hospital in the last month free of cost. This institution does not provide JSY now. That hospital may be accredited by the District Medical Officer and JSY benefit may be extended to this hospital also. Since this hospital is located in the land of Tamil Nadu, this will require special sanction subject to condition that it will be provided only to the tribal women from Kerala.

There is still a segment of women especially in the deep forests who do not prefer to come to hospital for delivery. This will increase chances of maternal and infant mortality. In order to reduce such incidents in those hamlets, educated girls can be selected from among them with the help of Tribal Department. They can be given training on identifying risks during pregnancy and to conduct labour. They can advise the women of the risks and persuade them better to seek hospital support with better acceptance. If they are still reluctant, these trained girls can assist delivery in the hamlet. Delivery kits may also be provided to them for this purpose. This proposal may be considered favourably to implement.

In Kottathara, quarters for doctors are under construction. This work may be expedited. A few more staff nurses post may be created there to support the wards, ICU and OT properly. Now there are paediatrician, gynaecologist, physician and ophthalmologist. The present ophthalmologist is not doing surgeries now. An ophthalmic surgeon who can perform surgeries may be posted here.

The team visited the Gounchiyoor hamlet of Sholayur PHC area on 25th May. JPHN Smt. Sheeja and JHI Sri. Rafeeq were present. JPHN has good records of activities. But the JHI who entered service ten months back had no idea about work or keeping registers. HI or the HS have not supervised his work or examined his registers at least once during this period. The JHI may be given in-service training urgently. Disciplinary action is warranted against the supervisors who bitterly failed to guide him. A few children and their house hold were interviewed. Dr.Prasad, Medical Officer for the Mobile Medical Unit-3 also was with the team. Then the team went to the sub-centre for that area. A few cases of children belonging to that area were analysed. One case that represents the majority is detailed below.

Remya, girl–child, 10months, d/o Jyothimani and Murukan. Her DoB is 07/07/2012. Birth weight was 1.8Kgs. Her mother was of 20years of age when she became pregnant. She is the first child of her mother. Her LMP was 04/11/11 and EDC 11/8/2012. Jyothimani has received five antenatal checkups. She received 120 IFA tabs and had ~9gms of Hb consistently. Her weight record showed the following pattern – 46kgs on 29/3/12, 48kgs on 9/5/12, 48kgs on 22/5/12, 49kgs on 5/6/12 and 49.5kgs on 5/7/12. She had a weight gain of only 3.5 kgs in about four months. She had premature delivery, short by one month from EDC. Baby weight was only 1.8kg. We saw the child. She now weighs 6kgs, underweight though normal for the birth weight. Her growth chart was examined from the Anganwadi register. She had good weight gain and reached the green zone and steeply dipped into the red zone in May, dip commencing in January 2013. On taking history, this period corresponds to introduction of "Horlicks" and Kanji into her diet. She is breast fed but is not relishing mother's milk after beginning supplementary feeding. She has Kanji in the morning and afternoon, and traditional tribal "puttu" in the night. Her hair is brownish. There is no pedal oedema. She looks otherwise healthy externally. But obviously the child has Kwashiorkor.

An analysis of this case reveals following facts. The mother was registered and has received five antenatal visits. She had acceptable weight to begin with. She received 120 IFA tablets, but had anaemia. But weight gain during pregnancy was less than required. She went into premature delivery and gave birth to a low birth weight baby. The baby survived and gained weight to come to normal weight with breast Feeding. On introduction of supplementary food after six months of age, the child began refusing milk and started losing weight. At 10 months the child has Kwashiorkor. This shows that majority of the women are already short statured with lower levels of normal weight. Their Hb levels do not significantly rise in spite of

regular IFA administration. Their weight gain during pregnancy is low. This is related not to anaemia alone, but to low intake of protein as seen in their low protein diet to a great extent. Anaemia is the major reason for premature delivery. But baby does not develop good weight resultant mainly to low protein intake by the woman. Report of the State Mission Director, NRHM also testifies to very low birth weight of babies even as low as 0.5kg. This deficit seems out of proportion to the anaemic status and more due to protein malnutrition. Children gaining weight during breast feeding and suddenly dipping after introduction of supplementary diet and landing up in Kwashiorkor also shows the significance of protein malnourishment. In toto, **protein malnourishment during pregnancy and infancy is the major contributing factor.** Anaemia also contributes to it but to a lesser extent. So protein supplementation should be given priority over iron supplementation. Interventions require to be remodeled in this direction.

Recommendations.

Immediate intervention

- NRC may be established now at a temporary space identified with the staff being trained at the SAT Hospital, Thiruvananthapuram. It may be shifted to the proposed building after its repair work is finished.
- JPHNs, AWWs and ASHA may be trained to detect both protein and energy malnourishment. They should communicate to one another on any such finds.
- MCP cards shall be filled for all the antenatal women. This must be monitored by the LHIs and the Medical Officers to ensure adequacy of service. If a case needing admission is identified, that shall be immediately informed to the Tribal Extension Officer.
- Tribal Department may be given the responsibility of mobilizing the case to the nearest Govt health facility as advised by the doctor or the health worker. If such cases are referred from a public facility or require transport back from such facility, the ambulance of the facility or a hired vehicle shall be engaged for the purpose by the Supt. Funds for this may be met from the Tribal Department.

Long term intervention

- Anganwadis are there in almost all hamlets. They may be established where there is none. Workers from the same hamlet may be engaged on priority as workers to these AWs. If this is not possible, an educated girl from the same locality shall be made translator at the AW. Health messages and non formal education in local dialect may be given through these AWs. Protein rich food like "nutrimix" or "SAT mix" may be made available in sufficient quantity by the Social Welfare Dept.

- Making potable water available to the AWs and hamlets may be entrusted to the Water Authority and the Local Administration shall monitor that there is regular supply. Water quality shall be ensured by the Health Services dept. and the Water Authority.
- Food made as per local recipe shall be cooked at the AW including the high protein supplement in it. It shall be given to all the beneficiaries ensuring that antenatal mothers are not skipped out. Take Home Ration also shall be given along with. A study on the impact of the intervention may be done with the help of the Community Medicine wing of the Medical College, Kozhikkod in a few selected hamlets.
- TSH Kottathara may be equipped to conduct normal delivery and Caesarean when required. Water supply to this institution may be accomplished on a war footing.
- If feasible, JSY may be provided to those tribal women from Kerala who deliver at the Bethany Hospital.
- A few studies may be done among tribal population by the Community Medicine wing from Medical Colleges to understand their health requirements better. The suggested topics are
  - Average weight of adult tribal women
  - Average birth weight of children
  - Prevalence of Congenital organic diseases in the tribal population
  - Blood protein analysis among tribal women
  - Prevalence of anaemia in tribal population
  - Average dietary intake of protein