FROM OTHER JOURNALS

Aarogyasri: strengthening the private healthcare sector

The Rajiv Aarogyasri scheme was launched by Andhra Pradesh (AP) in 2008. It was designed to extend healthcare coverage to all people living below the poverty line (BPL). Its need was especially felt because the growing private healthcare sector left the poor outside the ambit of medical care. AP had already become the state with the highest out-of-pocket medical expenditure in the country. This tailor-made insurance scheme required a premium of Rs 250 per family unit and offered a total reimbursement of Rs 1.5 lakh per person or family.

However, it was soon seen that instead of strengthening government hospitals in the urban and rural networks, the scheme enabled a number of private and corporate hospitals to be empanelled. In official documents the scheme was touted as a unique public-private partnership, but the distribution of cases between the two sectors was skewed. Private health workers functioning within the system were expected to facilitate referral of BPL patients from rural to urban hospitals, but usually diverted cases from government to private hospitals. Reports indicated that corporate hospitals preferred attending to only high-cost cases that did not require lengthy post-operative care, and less 'risky' surgeries; all others were referred to government hospitals, making the latter a "dumping ground" for critical cases.

In the light of the widespread prevalence of such unethical practices, the authors point out, the Aarogyasri scheme has actually fed into the private healthcare sector, even as primary and secondary healthcare are put on the backburner. Aarogyasri has become a populist scheme promoting the interests of the corporate health industry, which in turn has aggravated the medicalisation of society in complex ways.

Prasad NP, Raghavendra P. Healthcare models in the era of medical neo-liberalism: a study of Aarogyasri in Andhra Pradesh. *Econ Pol Wkly.* 2012 Oct 27: 47(43): 118-26

Training for reduced maternal mortality

Maternal mortality ratios in less developed countries like India and Bangladesh are high. Following the adoption of the Millennium Development Goals-5 by several nations, many steps have been taken to tackle this issue in these countries. Taking off from the premise that post-partum haemorrhage (PPH) is one of the leading causes of maternal deaths, and that in developing countries traditional birth attendants (TBAs) attend to most of the deliveries, this study was designed to train TBAs to better manage PPH. Conducted across six rural districts in Bangladesh, TBAs were taught to use misoprostol, a uterotonic used to control PPH. One advantage of misoprostol is that it can be kept at normal room temperature, making storage much easier in settings like rural Bangladesh. The other component is 'Quaiyum's mat' or the absorbent delivery mat used to measure the amount of blood a woman loses during childbirth and decide if she runs the risk of PPH. The study employed a pre- and a post-training questionnaire to test the TBAs' knowledge and their retention of the training. The results were found to be satisfactory. The results also indicated that after training, many more TBAs were using misoprostol and preventing PPH. The authors add that the training also warned the TBAs against using the drug casually and equipped them to evaluate the dosage and timing effectively. The authors make a case for what the WHO describes as "task shifting"– a process of delegation wherein tasks are shifted to less specialised personnel depending on the situation and necessity – and integrating TBAs into the existing healthcare system. At the same time, they note that drugs like misoprostol have often been misused for inducing or hastening labour. While it is important to arrest PPH in homebirths, there are concerns about making labour-inducing drugs widely available and part of normative practice.

Prata N, Quaiyum Md Abdul, Passano P, Bell SS, Bohl DD, Hossain S, Azmi AJ, Begum M. Training traditional birth attendants to use misoprostol and an absorbent delivery mat in home births. *Soc Sc Med.* 2012. (75): 2021-7.

Qualitatively examining the "maternal migration effect"

This article looks at what it identifies as the "maternal migration effect": when women from low socio-economic countries migrate to countries that offer universal healthcare access, what happens to their maternal care and maternal health. The authors discuss this in terms of sub-Saharan African women entering the UK and coming within the ambit of the National Health Service (NHS).

The study uses the "three delay" model: (i) delays in the decision to seek care, because of perceived or actual barriers to acting; (ii) delays from inadequacies in infrastructure needed to reach a medical facility, such as ambulances and road systems; (iii) delays in care at the facility, because of the lack of skilled birth attendants, technological equipment and medical supplies. The women routinely faced such barriers in the African setting. The authors looked at the barriers when accessing the NHS.

In the NHS, the barriers were at times culturally and psychologically constructed. The authors identify three levels of trust – mistrust, distrust and feigned trust. The practice of explaining procedures prior to taking consent was sometimes seen as reflecting the provider's indecisiveness, and led to a decline in trust in the doctor's abilities. Some white doctors were found to exhibit racial bias. The use of different languages often caused a gap in trust, even when interpreters were available. Language problems led to a host of other difficulties. Explaining the need for prenatal screening for foetal abnormalities was often understood as a confirmation of an abnormality; this in turn created stress for the woman. For women migrating mid-way in their pregnancy, delay in stage-1 in their own setting adversely affected their care-seeking behaviour in the subsequent stages.

The authors suggest that the "maternal migration effect" creates a scenario where women make their choices based on their prior experience –limited or even non-existent -- with facility-based care. As migrants, they are likely to adjust slowly to the new culture. This study is important in the Indian context with growing rural-urban migration. Poor migrant women often remain outside government health services.

Binder P, Johnsdotter Sara, Essén Birgitta. Conceptualising the prevention of adverse obstetric outcomes among immigrants using the 'three delays' framework in a high-income context. *Soc Sc Med***. 2012. (75): 2028-36.**

State health schemes abused

There have been reports of scams in Chhattisgarh and Bihar in which health insurance provided by the Rashtriya Swasthya Bima Yojana for BPL people is used by private practitioners to conduct unnecessary hysterectomies. "Beneficiaries" – several in their twenties – have reportedly said that public facilities turned them away, but private providers convinced them to have a hysterectomy, most of which were not indicated. This points to a host of problems: from the apathy of the state to unethical medical practice, to the extremely low premium placed on the health of women, especially the poor and uneducated. The fact that this happened under a state health insurance scheme also underscores the fact that mere implementation of schemes will never work without strict regulatory protocols for providers, and awareness amongst users. The editorial also urges medical associations to take note of these gross violations and take steps towards addressing them.

Editorial. A "twisted" scheme: state health insurance schemes are being abused to profit private care providers. ***Econ Pol Wkly.*** **2012 Sep 22. 47(38): 8.**

Islamic institutional fatwas and their views on medical and research confidentiality

This article investigates what fatwas issued by Islamic institutions say about the ethics of confidentiality in medical practice and research. The authors studied fatwas issued by 14 Islamic juristic councils at the international, regional and national levels, like Dar al-Ifta al-Massriyyah in Egypt, Islamic Fiqh Academy in India, Fatwa Committee of the National Council for Islamic Affairs in Malaysia and Islamic Religious Council of Singapore, etc. They found only one fatwa specifically on medical confidentiality, which was issued by the International Islamic Fiqh Academy. The most comprehensive guideline relating various aspects of Islam and medicine came in 2005 when the document 'International ethical guidelines for biomedical research involving human subjects – Islamic view' was published by Islamic Organization for Medical Sciences (IOMS) and the Islamic Medical Association of North- America (IMANA), based on the IIFA fatwa.

The Fiqh council's fatwa focuses on two areas within the principle of confidentiality: the obligation to maintain confidentiality and the circumstances in which it is appropriate to breach it. While the first aspect is mentioned without much detail, the second point is elaborated on, with examples of specific situations where an infringement of confidentiality may be made. These are based on three Islamic principles: prohibition against backbiting; the duty to protect secrets, and protection of information by way of demonstrating loyalty.

The authors conclude that there is insufficient guidance from these councils on confidentiality. Most fatwas only mention it briefly but they lack the specificity needed to address this complex subject. They suggest that this may be due to the relative newness of the area of medical ethics and research confidentiality, particularly in Islamic countries. Moreover, the descriptions of cases permitting a breach of confidentiality seem to be based only on the logic of "public interest overrides individual interests". The authors argue that the issue of medical confidentiality should be thoroughly explored from the Islamic point of view so that it is able to guide Muslim practitioners, should an ethical dilemma arise.

Alahmad G, Dierickx K. What do Islamic institutional fatwas say about medical and research confidentiality and breach of confidentiality? ***Dev World Bioeth,*** **2012. 12(2):104-12.**

Achieving patient safety in India

This editorial traces the history of discussion on inadequate patient safety in India and suggests a five pronged strategy which can be used to tackle this continue problem.

Hospitals in India were brought under the purview of the Consumer Protection Act, 1986. However, many cases continue to be reported. The writer suggests that there is a trend of 'defensive' medication by doctors and increased litigation, with a consequent increased cost in health care. Naming and blaming an individual makes it more difficult to fix systemic problems, which are exacerbated by the general '*laissez faire*' attitude pervasive in Indian society. The editorial suggests addressing the issue of patient safety by formulating standard operating protocols for medical treatment and procedures. It suggests a long-term strategy, based on learning from the West

but modified for the Indian context. This is important with the introduction, in the 12th Five Year Plan, of universal healthcare, which will result in massive growth of the system, and more chances of harm if measures to ensure patient safety are not implemented. Against this background, the five-pronged strategy discussed by the editorial is:

1. Advocating for and helping in creating systems for recording, learning and reporting on service quality and adverse incidents;
2. Speeding up the implementation of proven interventions for patient safety, like the hand hygiene and surgical checklist;
3. Empowering patients and working with groups like the Patient Safety Alliance;
4. Capacity building and training among youth at undergraduate level using the WHO curriculum on patient safety though distance education mode, and
5. Undertaking further research on the issue.

Editorial. Patient safety in India: time to speed up our efforts to reduce avoidable harm. *Natl Med J India,* 2012.25(3):129-31.

The cultural and social dimensions of suicide in a Mumbai slum

Suicide has a peculiar position in India. The victim is the perpetrator and if s/he survives, s/he faces both social stigma and criminal prosecution. This study employed a cultural epidemiology framework to understand the social determinants of suicide in an urban slum in Mumbai. Using both qualitative and quantitative methods, researchers interviewed the closest relative and a distantly related person of the deceased. A total of 50 pairs of interviews found that tension, sadness, various behavioral problems, marital conflict and financial problems were the most frequently reported causes of suicide. However, as the article reports, relatives often did not agree on the 'cause' of suicide. When mental illness was a possible factor, differences of opinion were greater. The explanations were also influenced by relationship of respondents to the victim. Further the responses were also shaped by what is considered socially acceptable.

The study highlighted the consistencies and discrepancies within explanations of suicide within a community. The authors emphasize the need to look at the complexity of social and cultural determinants to complement a purely psychological approach to understanding suicide. Despite the limitations of the study, more such studies are needed. Suicide should be treated as a problem that requires both demystification and ethical and sensitive interventions.

Parkar RS, Nagarsekar BB, Weiss MG. Explaining suicide: identifying common themes and diverse perspectives in an urban Mumbai slum. *Soc Sc Med* 2012. (75): 2037-46

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