

**Summer Training at
National Health Mission, Himachal Pradesh
(April 1– June15, 2014)**

**Staff Experience of providing Maternal and Child Healthcare Services in
Rural Shimla - A focus on Drugs, Equipments and other major issues**

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**Under the guidance of
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**MBA- Hospital & Health Management (MBA-HM)
2013-2015**



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CERTIFICATE

This is to certify that **Dr. Akanksha Sood**, a student of Post Graduate Programme in Health Management, Institute of Health Management Research, Jaipur, batch 2013 – 15 has successfully completed her summer training for the period of **April 1st to June 15th, 2014 under National Health Mission, Himachal Pradesh** under my guidance. During this period she has completed a study titled **“Staff Experience of providing Maternal and Child Healthcare Services in Rural Shimla – A focus on Drugs, Equipments and other major issues.”** as a part of partial fulfillment of the course requirements, recommended for the Post Graduate Diploma in Health and Hospital with specialization in Health Management. Her approach towards the study has been sincere, scientific and analytical.

I wish her all the best for future endeavours.



Col. (Dr.) Ashok Kaushik

Dean (Academic & Students Affairs)

IIHMR, Jaipur



Nirmal Kumar Gurbani

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CERTIFICATE

This is to certify that Dr. Akanksha Sood, student of Institute of Health Management Research, Jaipur has successfully completed her Summer Training at National Health Mission, Himachal Pradesh, Kasumpti, Shimla with effect from 01/04/2014 to 15/06/2014.

During her training she has worked on a project titled **'STAFF EXPERIENCE OF PROVIDING MATERNAL AND CHILD HEALTHCARE SERVICES IN RURAL SHIMLA'**. I appreciate the efforts made by her for the completion of above project and submission of the project report.

I extend my best wishes for her bright future and success.

(Amit Kashyap), IAS
Mission Director
National Health Mission
Himachal Pradesh

Dated: 16-06-2014

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LIST OF ABBREVIATIONS

ANC	Ante Natal Care
BEmOC	Basic Emergency Delivery Obstetric Care
BMO	Block Medical Officer
CEmOC	Comprehensive Emergency Obstetric Care
CHC	Community Health Centre
EDL	Essential Drug List
EmOC	Emergency Obstetric Care
FRU	First Referral Unit
Hb	Haemoglobin
IFA	Iron and Folic Acid
IUCD	Intra Uterine Contraceptive Device
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LSAS	Life Saving Anaesthesia Skills
MCH	Maternal and Child Health
MTP	Medical Termination of Pregnancy
NHM	National Health Mission
NBCC	New born Care Corner
NSSK	Navjat Shishu Suraksha Karyakram
PHC	Primary Health Centre
PIH	Pregnancy Induced Hypertension
PPIUCD	Post-partum Intra Uterine Contraceptive Device

SECTION- A

INTRODUCTION TO THE ORGANIZATION

About National Health Mission, Himachal Pradesh

For the effective implementation of National Health Mission in the State a separate Mission Directorate (NHM) has been created within the Directorate of Health headed by Mission Director. It has a Programme Management Unit (PMU) headed by a Deputy Director cum State Programme Officer and a Financial Management Unit (FMU) headed by Joint Controller Finance. The Mission Directorate functions in close co-ordination with Directorate of Health and reports to the Principal Secretary (Health). The plans and budget of the vertical programmes have been integrated in the State NHM.

In Himachal Pradesh the Mission is operating through the existing structures of Health Department up to Sub centre level. There is a State Health Mission at the State level chaired by Hon'ble Chief Minister. A District Health Mission has been constituted at District Level with Chief Medical Officer as Member Secretary and Deputy Commissioner as convener. The Govt. has decided to constitute Rogi Kalyan Samities upto PHC level with increased public and Panchayati Raj partnership. The community is also involved in the functioning of health institutions through Village Health Committees at village level, Panchayat Sub-Committees on Health Education and Sanitation at Panchayat level and Rogi Kalyan Samities in all the Hospitals from PHC upwards.

The public health services in the rural areas at village level are delivered through Anganwadi Workers as Link Workers. The Anganwadi Workers are already involved in ante- natal registration of pregnant women, nutrition and immunization of children and providing of DOTs etc. Keeping in view the vast presence of Anganwadi Workers in the State (more than 18,000 Anganwadi's for 17,495 villages). The Department of Health and Family Welfare intends to utilize the strength of Anganwadi Workers for health delivery system at village level in place of ASHAs. There are 2065 Health Sub-Centres, 475 PHCs, 78 CHCs and 53 Sub-Divisional and Higher Hospitals in the State. The Sub-Centres are manned by a male and female health worker, a Medical Officer heads the PHC. There are 69 Block Medical Officers functioning in the State. The Chief Medical Officers control the implementation of all the programmes in their districts through Programme Officers and BMOs. At the Directorate level, the Director Health Services looks after general establishment, budget, planning and other programmes through additional / joint / Deputy Directors and other Programme Officers.

Mission and Vision

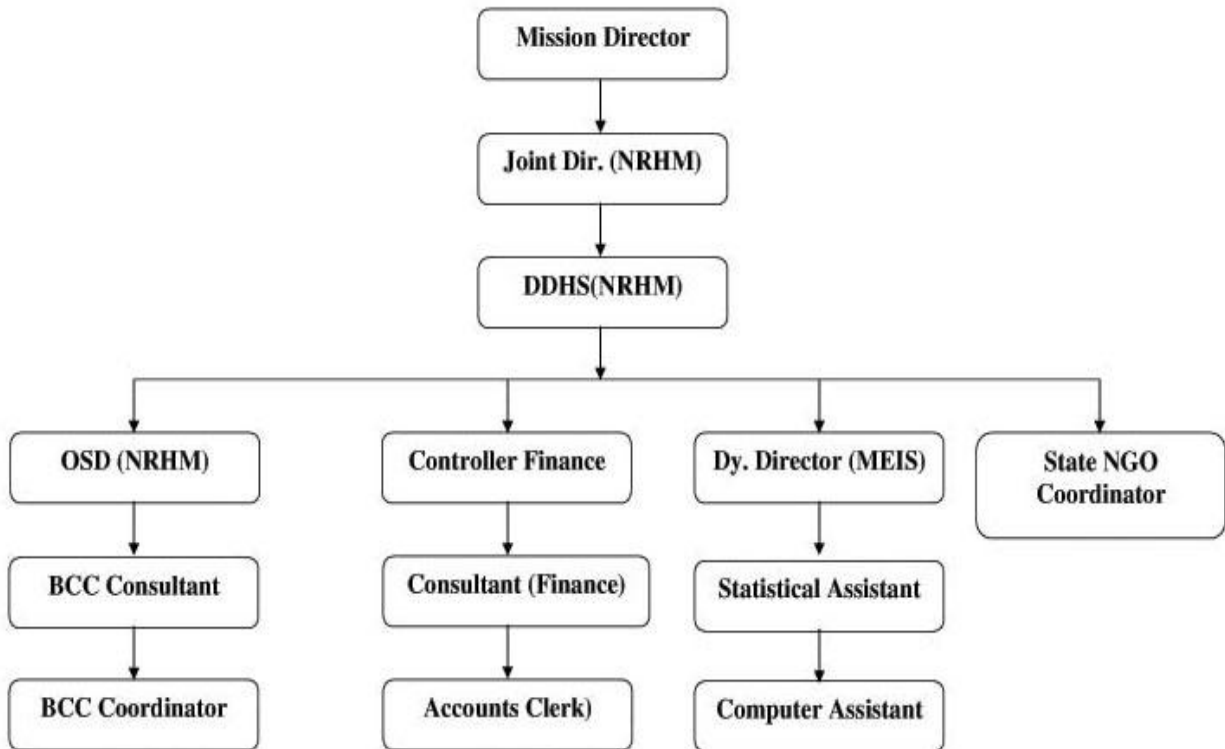
The vision is to provide accessible, affordable and quality universal health care, both preventive and curative, which would be accountable and at the same time responding to the needs of the people.

Objectives:

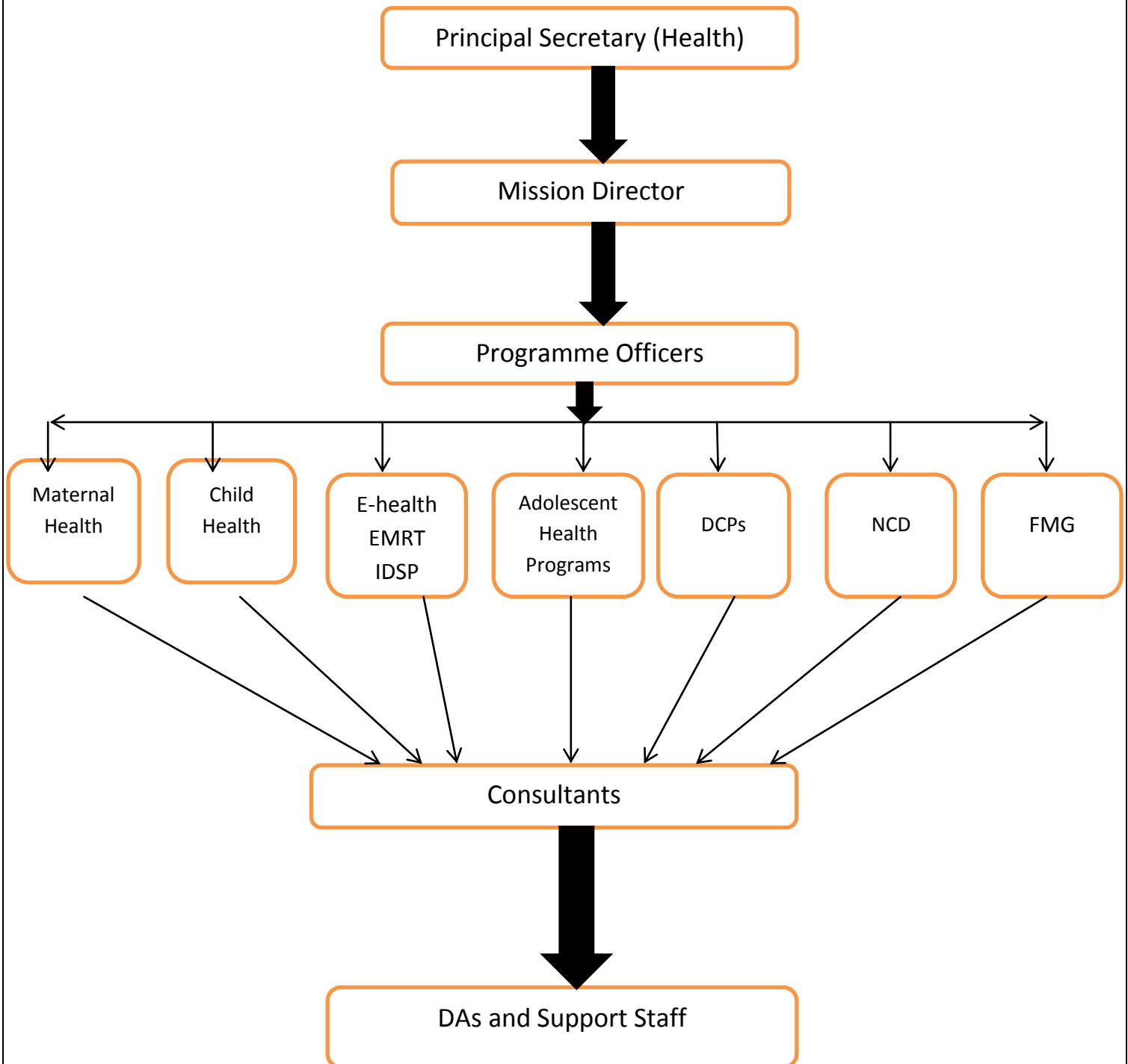
- Reduction of infant mortality and maternal mortality.
- Universal access to public health services such as women's health, child health, drinking water, sanitation and hygiene, nutrition and universal immunization.
- Prevention and control of communicable and non-communicable diseases.
- Population stabilization, gender & demographic balance.
- Access to integrated comprehensive primary health care.
- Promotion of healthy lifestyles.

ORGANOGRAM

Organogram of Mission Directorate at State Level of Himachal Pradesh



ORGANISATION CHART



SECTION- B

SPECIFIC PROJECT FINDING

Providing Maternal and Child Healthcare Services in Rural Shimla

A focus on equipment, drug supply and major issues

Background

Improving maternal and child health is a global priority. In 2011, an estimated 7.6 million children under the age of five died. Almost 358,000 women – most of them in low income countries – died from complications of pregnancy and childbirth. According to the UN Commission on Life-Saving Commodities for Women and Children, many of these deaths are due to conditions such as infections, haemorrhage, pneumonia, and malaria that can be prevented or treated by affordable medicines.

India contributes to 20 per cent of global maternal deaths. In India, Post partum haemorrhage, sepsis, obstructed labour, Pregnancy induced hypertension and unsafe abortions remain the biggest direct preventable medical causes for maternal deaths. Excessive bleeding after childbirth and high blood pressure during pregnancy, two of the leading causes of maternal deaths, can be prevented and significantly reduced with expanded availability of maternal health medicines. Data from country surveys show that access to essential medicines, particularly for children, is generally poor. Availability of medicines like Zinc tablets can prevent child mortality from one of the leading causes of child mortality in India i.e. Diarrhoea. Essential medicines are imperative to be made available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality. The provision of quality emergency obstetric care has been advocated as a cost-effective intervention for reducing maternal deaths. The concept of emergency obstetric care (EmOC) is based on the assumption that maternal complications are unpredictable and that obstetric complications can occur in around 15% of deliveries. When such complications occur, maternal mortality could be prevented in a setting where skilled health attendants, drugs and medical supplies, equipment needed for EmOC are available

The poor maintenance of equipment and inadequate supplies of drugs and other items contribute to the low quality of maternal and child healthcare services often found in rural settings in low- and middle-income countries, and raise the risk of adverse patient outcomes through delaying care provision. Lack of drugs and medical supplies at the facilities means delays in early interventions in obstetric emergencies, which contributes to maternal deaths at health facility level. This implies that the mere use of facilities by mothers for deliveries would not reduce maternal mortality automatically; rather, mortality is affected by the quality of services offered, which are determined by, amongst other things, the adequate availability of medical supplies and drugs. A recent study in India indicated that increased access to facility deliveries did not result in the reduction of maternal deaths because it was connected to a weak supply system that led facilities to provide poor quality obstetric care. Other studies in Tanzania have also reported the provision of poor obstetric care due to lack of drugs and medical supplies at health facilities. Furthermore, an inadequate supply of drugs and medical supplies results in a difficult working environment and causes a worsening of staff morale.



Shimla (Rural) being one of the 12 tehsils in district Shimla with a population of 84,240

(Source: hpshimla.nic.in)

Rationale for Study

The success of RMNCH programme depends upon the quality of services being provided at each level of the facility. The quality of services provided can be measured based on tangible parameters like adherence to clinical protocols/standards of service delivery, ensuring infection prevention measures, appropriate infrastructure, equipment, drugs and supplies.

The quality of maternity services is variable and often poor in Low Middle Income Countries. Reasons for this include management issue, insufficient and inadequately skilled staff, high staff turnover and absenteeism and poorly maintained equipment and stocks of drugs and other items. The latter is itself an important direct contributor to the delay in women receiving timely and appropriate maternity care upon reaching a facility (known as the Phase 3 delay), which increases the risk of maternal and newborn mortality through delayed treatment of obstetric complications.

Inadequately stocked and equipped facilities can compromise the health system's ability to reduce maternal and neonatal mortality and morbidity by affecting staff personally and professionally, which hinders the provision of timely and appropriate interventions. Improving stock control and maintaining equipment could benefit mothers and babies, not only through removing restrictions to the availability of care, but also through harnessing the capabilities of the staff. Health systems can only provide good quality maternal and child care if facilities have sufficient and skilled staff that has access to functioning equipment, and sufficient drugs and supplies.

The present study focuses on identifying the gaps in context of drug supply and equipments. We also intend to identify other major issues affecting maternal and child healthcare services through interaction with staff and use the findings to make suggestions for better service delivery. The findings can be utilized for strengthening the Maternal and Child healthcare services in the district and state.

Objective

To examine the experiences of professional staff providing maternal care in public rural health facilities in Shimla (Rural), focusing on issues arising in the context of equipment and essential drugs. We also aim to quantify the availability of functioning equipment and medical supplies.

Research Design

A **cross sectional descriptive study** was conducted over a period of one month in public rural health facilities in Shimla (Rural) Tehsil, District Shimla, Himachal Pradesh. In-depth interviews were conducted with different staff cadres from all facility levels in order to explore experiences and views of providing maternal and child healthcare particularly in the context of equipment and drug supplies. A facility survey quantified the availability of relevant items.

Study area

The study was conducted in Tehsil Shimla (Rural), District Shimla, Himachal Pradesh. Tourism and Agriculture/Horticulture is the major source of income in the area. The area consists of a hilly terrain.

Study design

We conducted a mixed method study comprising a cross-sectional survey of health facilities (Primary Health Centres / Community Health Centres) in the study area to quantify the availability of drugs and equipments, and qualitative in-depth interviews (IDIs) with professionals and workers in order to understand the structure and function of health services in relation to maternal and child care and identify major issues and bottlenecks.

Data collection

Quantitative

A checklist was developed with contributions from other publicly available tools such as the Maternal and Newborn Healthcare Toolkit and the Ministry of Health and Family Welfare Checklist for PHC's and non FRU CHC's, CHC's with certain modifications specific to the project. Checklist allowed for a combination of staff-reported and interviewer-observed information. Data were collected on aspects of care provision including availability of drugs and supplies (restricted to presence or absence and recent stock outs), and availability and functioning state of equipment.

Data were collected in May 2014. Interviewer visited each of the facilities in the study area without prior notice. If facilities were closed, revisits were not undertaken. Completed forms were reviewed in the evening after data collection.

Qualitative

In-depth Interview (IDI) guides were designed to collect staff views on aspects of maternal and child care, focusing on maintenance of facility equipment and supplies of drugs and other items. IDIs were conducted with different staff cadres from all facility levels in order to explore experiences and views of providing maternity care. List of the facilities visited have been annexed (Annexure I). Health workers were selected purposively; those who provided maternal, newborn and child health services were invited to participate. Where more staff than required met the inclusion criterion facilities self-selected staff members to attend. Discussions were conducted until no new information was found.

Data were collected in Hindi and English. Notes were made for all the IDIs. Field notes were written up to expanded notes just after the interview, which were the main data analyzed. All the transcripts were reviewed daily and the data used to inform the next IDI.

Data processing and analysis

Quantitative

Microsoft excel was used to develop data entry template. Logical checks took place at data entry. Data records in checklists were not edited after leaving each facility. We only included public health facilities as private and Mission facilities face different problems in relation to their specific procurement and staff support systems. The equipment and drugs were checked against the required items for each facility level.

Qualitative

Expanded notes were explored through multiple readings to ensure familiarity with the data.

Approvals and permission

Prior written consent to approach the facilities to participate in the survey was obtained from Mission Director, NHM, Himachal Pradesh.

Oral Informed consent to participate, which assured anonymity and confidentiality, was obtained from IDI participants.

Results

12 facilities in the study area were visited. Data could not be obtained from two owing to unavailability of staff. Findings from the 12 government facilities (10 Primary Health Centre and 2 Community health centre) providing maternal and child healthcare services are shown here.

The majority of facilities had basic equipment for providing patient care, such as Functional BP instrument and stethoscope, Functional weighing machine, Needle cutter, and Emergency Tray with emergency injections. Over half of facilities had a fridge kept at 2–8°C on the day of survey. The availability of equipment such as Radiant warmer, autoclave and ILR was generally lower; less than half of the facilities had these equipments in functional condition (Table 1). The availability of every item of equipment was highest in facilities located near district headquarters and lower in areas located at a greater distance. The Laboratory equipment was available in less than half of the facilities with functional microscope present in only 3 facilities and semi auto analyzer available in 2 facilities. Basic equipment like Haemoglobinometer was available in only half of the facilities visited.

The availability of supplies and drugs was high; however, several essential items for maternal and neonatal care were not found in some of facilities such as Magnesium Sulphate (n=4). There were instances of items being available in lower facilities that were not being used at that level. It was found out that IUD insertion procedure was carried out only in 4 of the facilities visited.

Stock outs of essential drugs and supplies for maternal and newborn care were not found to be common. In case of stock out the drugs and supplies were procured using Rogi Kalyan Samiti funds. Items that were most commonly out of stock were IFA Syrup with dispenser, Zinc tablets, Misoprostol Tablets, Mifepristone tablets, Emergency contraceptive pills. Essential supplies such as Pregnancy testing kits, Oral contraceptive pills, Sanitary napkins were available in majority of the facilities.

Table 1: Availability of equipment, drugs and supplies

Total number of Facilities visited (N= 12)

Section I: Equipment

Equipment	No of facilities where item present (and functioning for equipment)
Functional BP Instrument and Stethoscope	9
Sterilised delivery sets	6
Functional neonatal, Paediatric and Adult Resuscitation Kit	2
Functional Weighing Machine	8
Functional Needle Cutter	9
Functional Radiant Warmer	2
Functional Suction Apparatus	6
Functional Facility for Oxygen Administration	6
Functional Autoclave	4
Functional ILR	5
Functional Deep Freezer	7
Emergency tray with Emergency injections	10
Laboratory Equipment	
Functional Microscope	3
Functional Haemoglobinometer	5
Function Centrifuge	4
Functional Semi auto analyzer	2
Reagents and Testing kits	4

Section II: Essential Drugs and Supplies (N=12)

Drugs	No of facilities where item present
IFA tablets	10
IFA tablets (blue)	5
IFA syrup with dispenser	0
Vit A syrup	3
ORS packets	10
Zinc tablets	5
Inj Magnesium Sulphate	4
Inj Oxytocin	6
Misoprostol tablets	2
Mifepristone tablets	0
Antibiotics	10
Labelled emergency tray	10
Drugs for hypertension, Diabetes, common ailments e.g. PCM, anti allergic drugs etc.	10
Vaccine Stock available	6
Supplies	
Pregnancy testing kits	10
Urine albumin and Sugar testing kits	5
OCPs	9
EC pills	1
IUCDs	6
Sanitary napkins	8

Staff experiences of providing Maternal and Child Healthcare Services

Respondent characteristics

A total of 18 staff from 11 facilities participated in the IDIs. Participants were mainly female (3 male participants). Participant qualifications included Medical officers (N = 10), Female Health Workers (N=5), Pharmacist (N=3).

Staff experiences of providing care

Staff reported no shortage of supplies. In majority of the facilities essential drugs were available in 6 month stock. But non-functioning, damaged equipment remains a cause of concern.

‘To get the equipment repaired through government channels it takes a lot of time. We sometimes get the basic equipment repaired on our own expenses.’ [Medical Officer]

‘We have a serious problem of not having Vitamin A syrup in government supply regularly. Children up to the age of 5 years should receive Vitamin A regularly at regular interval of 6 months. Vitamin A should be included in the supplies regularly.’ [Medical Officer]

As well as facilities reported receiving infrequent supervision visits.

Majority of facilities had the post of Male Health Worker vacant which is a great inconvenience when it comes to conducting home visits.

‘I have to travel to villages for ANC alone. 5 subcentres come under this PHC and I have to walk through forest area for home visits. One of the villages is 10 kilometer from this place and there is no motor able road. I feel insecure at times.’ [Female Health Worker]

Facility staff reported many ways in which they adapted and improvised in order to continue providing patient care in the absence of functioning equipment or sufficient supplies.

‘I wanted to use a suction machine because the baby had asphyxia, but the suction machine was not functioning and these days it is not allowed to do mouth to mouth resuscitation. I decided to take a syringe to draw the dirty stuff out of the baby’s mouth to help the baby.’ [Medical Officer, CHC]

‘We do not have ILR or deep freezer. On the immunization day the vaccines have to be brought from the nearest PHC using vaccine carriers and unused vaccines have to be returned the same day. Deep freezer is the minimum a PHC should have.’ [Medical Officer]

‘Without basic equipments like an autoclave how do you expect us to conduct deliveries and maintain sterilization? We have oxygen administration equipment but no oxygen. We might risk carrying out a procedure but who takes the responsibility?’ [Medical Officer]

Discussion

Drugs, supplies, and functioning equipment are all crucial for a facility to provide maternal care. In majority of the facilities visited the level of care provided does not match the standards. The benchmark signs for quality MNH services indicate sub standard level of care being provided at these facilities. Of the 10 PHC's visited, all facilities were providing antenatal services but delivery services were being provided only at 2 health facilities. One of the CHC designated as FRU since 1 year in the list of Department of Health was still functioning at the level of a non FRU CHC with the post of anesthetist vacant.

During the study one major issue which emerged as a big concern is of unnecessary referrals to tertiary level of Maternal and Child Health Centre. Facilities expected to provide BEmOC including normal deliveries and assisted vaginal delivery (eg. Vacuum extraction, forceps delivery) refer cases to higher levels of facilities even for basic procedures like IUD insertion; the most common reason sighted being insufficient equipment to carry out such procedures and absence of equipment to maintain sterilization and infection control. But it was observed that even in facilities having all essential equipments and drugs for providing BEmOC the referral rate was as high as 100%. The situation indicates sub-optimal care for patients, unnecessary inconvenience for patients and their family, increased risk because of delay in providing services and high expenditure on transport; all of which can be easily avoided.

This study also found weaknesses in the maternal referral system. Referral linkages are not followed and all the cases are referred to DDU Zonal Hospital, Shimla or Kamla Nehru Hospital, Shimla. In majority of cases the respondents were not even aware of the First Referral Units.

It was also found that the maternal healthcare delivery system relies heavily on the tertiary level hospitals in District Headquarters. A high referral rate to these institutions bears testimony to the fact that presence of two state of art hospitals in the vicinity of Shimla (rural) Tehsil, gives professionals the privilege to refer even all of the uncomplicated cases on the grounds of better facilities available at these tertiary level institutions. Unnecessary referrals must be causing crowding of Level III facilities thereby compromising the quality of care being provided due to increased workload on staff.

Despite of the fact that majority of Primary health Centres do not provide delivery services and women have to travel large distances to procure maternity services no initiatives have been taken to train the professional staff on Skilled Birth Attendance and operationalize the PHC's as BEmOC centre. A PHC visited during the study located at a distance of 50 kilometer from district headquarters does not have the basic equipment to conduct normal delivery procedures. Patients are referred to Mashobra and have to travel 20 kilometers by kaccha road to reach the higher facility. Delay in transportation to higher level of facility and delay in provision of EmOC can tax the system with the life of a mother or child, even worse both. The study shows that unavailability and poor maintenance of equipment also impacts upon staff morale.

Strengths and limitations

The staff experience of providing maternal and newborn care has been well explored in this study. However, we did not explore the main causes of poor availability of certain essential drugs and maintenance of equipments. Factors arising in this study but not explored in detail included causes of equipment malfunction, reasons behind unnecessary referrals, high absenteeism in staff of public health facilities, issues in maintaining supplies of essential drugs. Frequently finding non functional equipment during the survey suggests poor systems for routine maintenance and repair of equipment, which has been noted as a problem. The survey focused on determining the presence or absence, and recent stock outs, of a number of key items for maternal and neonatal care. However this list was not exhaustive and excluded non-medical items that are essential for the provision of care or maintenance of facilities, e.g. a functioning and fuelled car at the district level. We examined neither the amount of drugs in stock nor the use of stock levels (the quantity of remaining stock that prompts the facility to reorder).

We used both qualitative and quantitative data collection methods. The qualitative data were collected from health facilities using In-depth Interview technique in order to obtain a broad range of views and experiences however the data had to be manually analyzed.

Due to time constraint the study could only be conducted in Shimla (rural) Tehsil, District Shimla. Only public health facilities in the study area were visited so the findings represent public sector facilities in the study area. However, many women deliver in private health facilities. First-line facilities are the main provider of ANC, but it was found that many of these deliveries take place in higher-level facilities in the Shimla (Urban) Tehsil.

Findings from the quantitative data on the availability of drugs, supplies and functioning equipment, and frequency of stock outs matched the situation described by health workers in the IDIs.

Conclusions

The chronic situation of missing or non functional equipment for maternity care despite sufficient drug supplies found in this survey affected patient care and staff morale prompting Medical Officers to refer even uncomplicated delivery cases to higher facilities. Where there was availability of all essential drugs and equipments the staff motivation emerged as a major issue. This prompts the investigator to ask whether the challenge lies in equipping the facilities adequately or training and motivating the staff.

Timely provision of emergency obstetric care and routine essential obstetric and newborn care are the key strategies for reduction of Maternal and Neonatal morbidity and mortality. Avoidance of unnecessary maternal referrals together with implementation of emergency obstetric care functions to every facility providing maternal services is recommended. Ensuring BEmOC Primary Health Centres will help in reducing the workload on staff at Level III facilities, reduce inconvenience to patients, and lay foundations of a strong maternal and child healthcare system.

Training staff in Skilled Birth Attendance, Emergency Obstetric Care (EmOC), Life Saving Anesthesia Skills (LSAS), Use of Intra-uterine Contraceptive Devices (IUCD & PPIUCD) at Primary Health Centres can help in providing quality maternal services at the ground level and reduce great inconvenience to patients and their family. Also the quality of services being provided at tertiary level will not be compromised as the workload on staff will reduce at this level if the unnecessary referrals are curbed. Equitable distribution will only be achieved if the cases deserving CEmOC are referred to Level III facilities. But this requires the Level I and Level II facilities to provide BEmOC with benchmark standards. Only then the MDG of reducing MMR could be achieved.

On the demand side, JSY has led in overcoming many traditional barriers to institutional deliveries. This has led to an unprecedented surge in the proportion of institutional deliveries. But schemes like JSY and JSSK can only prove to be successful if the healthcare system is well equipped to handle this increase in demand and provide efficient and quality service to mother and child at all levels of service delivery.

Making essential drugs, equipment and consumables available to the staff is indispensable. Along with orders for essential drugs, report of non-functioning equipment should be submitted periodically to BMO office and prompt arrangements for fixing equipment should be made. For maintenance and repair of basic equipment periodic funds should be allocated. During Supervisory visits special attention should be given to upkeep and maintenance of equipment. The new computerized inventory management system needs to be installed at each facility to determine if such changes will result in improvements in stocks and maintenance of equipment, without compromising regular supervision sessions that are essential for ensuring quality of care and motivated staff.

To accelerate the decline in MMR and CM it is necessary to improve the quality of care being rendered at the public health facility. Strategies and interventions have to be tailored to meet specific needs and situations and implemented as a continuum of care. To remove the blot of high MMR and IMR from the face of our country strengthening of the health system at grass root level is the most relevant solution.

Annexure I

List of Facilities Visited.

INSTITUTION	BLOCK	Tehsil/Sub Tehsil	Constituency	Area
Primary Health Centre, Mashobra	Mashobra	Shimla (R)	Kasumpti	Rural
Primary Health Centre, Gulthani	Mashobra	Shimla (R)	Shimla (R)	Rural
Primary Health Centre, Kufri	Mashobra	Shimla (R)	Kasumpti	Rural
Primary Health Centre, Koti	Mashobra	Shimla (R)	Kasumpti	Rural
Primary Health Centre, Ghanahatti	Mashobra	Shimla (R)	Shimla (R)	Rural
Primary Health Centre, Gumma	Mashobra	Shimla (R)	Shimla (R)	Rural
Primary Health Centre, Jatol	Mashobra	Shimla (R)	Kasumpti	Rural
Primary Health Centre, Sharda	Mashobra	Shimla (R)	Shimla (R)	Rural
Primary Health Centre, Shoghi	Mashobra	Shimla (R)	Shimla (R)	Rural
Primary Health Centre, Tutu	Mashobra	Shimla (R)	Shimla (R)	Rural
Community Health Centre, Dhami	Mashobra	Shimla(R)	Shimla (Rural)	Rural
Community Health Centre, Jalog	Mashobra	Shimla(R)	Shimla (Rural)	Rural

Annexure II

PHC/CHC (NON FRU) level Monitoring Checklist

The same checklist was used for CHC Dhamsi, listed as First Referral Unit but still functional at the level of a Non FRU CHC.

Name of District: _____

Name of Block: _____

Name of PHC/CHC: _____

Catchment Population: _____

Total Villages: _____

Distance from Dist HQ: _____

Date of last supervisory visit: _____

Date of visit: _____

Name & designation of monitor: _____

Names of staff not available on the day of visit and reason for absence: _____

Section I: Equipment

Equipment	Yes	No	Remarks
Functional BP Instrument and Stethoscope	Y	N	
Sterilized delivery sets	Y	N	
Functional neonatal, Paediatric and Adult Resuscitation kit	Y	N	
Functional Weighing Machine (Adult and infant/newborn)	Y	N	
Functional Needle Cutter	Y	N	
Functional Radiant Warmer	Y	N	
Functional Suction apparatus	Y	N	
Functional Facility for Oxygen Administration	Y	N	
Functional Autoclave	Y	N	
Functional ILR	Y	N	
Functional Deep Freezer			
Emergency Tray with emergency injections	Y	N	
MVA/ EVA Equipment	Y	N	
Laboratory Equipment	Yes	No	Remarks
Functional Microscope	Y	N	
Functional Hemoglobinometer	Y	N	
Functional Centrifuge,	Y	N	
Functional Semi autoanalyzer	Y	N	
Reagents and Testing Kits	Y	N	

Section II: Essential Drugs and Supplies

Drugs	Yes	No	Remarks
EDL available and displayed	Y	N	
Computerised inventory management	Y	N	
IFA tablets	Y	N	
IFA tablets (blue)	Y	N	
IFA syrup with dispenser	Y	N	
Vit A syrup	Y	N	
ORS packets	Y	N	
Zinc tablets	Y	N	
Inj Magnesium Sulphate	Y	N	
Inj Oxytocin	Y	N	
Misoprostol tablets	Y	N	
Mifepristone tablets	Y	N	
Antibiotics	Y	N	
Labelled emergency tray	Y	N	
Drugs for hypertension, Diabetes, common ailments e.g PCM, anti-allergic drugs etc.	Y	N	
Vaccine Stock <i>available</i>	Y	N	
Supplies	Yes	No	Remarks
Pregnancy testing kits	Y	N	
Urine albumin and sugar testing kit	Y	N	
OCPs	Y	N	
EC pills	Y	N	
IUCDs	Y	N	
Sanitary napkins	Y	N	
Essential Consumables	Yes	No	Remarks
Gloves, Mckintosh, Pads, bandages, and gauze etc.	Y	N	

Note: For all drugs and consumables, availability of at least 2 month stock to be observed and noted .

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