Report of the Short course on "Making Pregnancy Safer" Trivandrum, 13-17 July 2010

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1. About the Course

Goal

To build commitment, knowledge and leadership skills at various levels of the public health delivery system for action to improve pregnancy related health care**.**

Objectives

By the end of the course, participants will

- Understand the dimensions of maternal mortality and morbidity including unsafe abortion; and their underlying social, economic and political determinants.
- Have conceptual clarity on a rights-based and gender-sensitive approach to policies and programmes for making pregnancy safer.
- Acquire skills for understanding and using data for evidence-based decision-making
- Have in-depth understanding of varied policy approaches and health system factors affecting maternal mortality and morbidity and unsafe abortions
- Develop plans for effecting change to improve access to maternal health and safe abortion services within their own settings

Facilitators

There were seven members in the facilitators' team: Aditi Iyer, Mala Ramanathan, Manju Nair, Renu Khanna, Subha Sri, Suchitra Dalvie and Sundari Ravindran. In addition, Indu PS provided support to group work on the last day and Geetha Rana made contributions to developing the curriculum. All were persons with several years of experience and considerable expertise in the field. Administrative support was provided by Suresh Kumar.

Participants

Sixty-two applications had been received for only twenty places available. Twenty-one participants were selected, of which 20 finally attended (Annex 1 contains list of participants). All except one were from government health services. There were four

participants each from Chattisgarh, Jharkhand and Orissa, three each from Assam and Karnataka, and one each Kerala and Maharashtra.

2. Duration of the course and topics covered

The course was of five days' duration, Tuesday through Saturday. Most participants arrived on the Monday. The days were long and intensive. Sessions were held every day from 8.30 am to 5.30 pm, with a lunch break of an hour and a quarter and two tea breaks of 15 minutes each. The course timetable is attached in Annex 2.

Day 1

The first day of the course started with an introductory session addressed by Dr Radhakrishnan, director of the institute, and Professor Ramankutty of Achutha Menon Centre for Health Science Studies. They spoke about the need for a course on Making Pregnancy Safer, given the poor status of maternal health in the country, and said that the institute was happy to host such a course. After this, participants introduced themselves.

Next was a fun game in which each participant had to tell his/her name and also the names of those who had introduced themselves before him/her. So the second person would say her own name and that of the first, the third person would say the names of the two persons before him as well as his own, and so on with the last person having to remember the names of everyone in the room.

Participants were then requested to think about their expectations from the course, prioritise three of these and write these on a card. All cards were put up on a bulletin board, and summarised by the facilitator. Most expectations related to learning more about strategies to reduce maternal mortality and morbidity, to learn about policies and international experiences, and learning from each other the experiences of other states. Following this, the objectives of the course and course structure were presented to them, making the links between their expectations and course contents.

Session one presented an overview of the maternal health situation globally and in India. Participants first shared their experiences with encountering maternal deaths, bringing faces on to the figures of maternal mortality and morbidity. There was then an interactive presentation on the dimensions of maternal mortality and morbidity in the world and in India, and in Indian states. The need to locate maternal health within the framework of sexual and reproductive health was highlighted through reproductive histories of women, showing that good maternal health could not be ensured by merely providing good pregnancy-related care. The presentation made a call for action on the part of health professionals in the government system to become change agents to prevent avoidable deaths and disability related to pregnancy.

The second session of the day introduced concept s of gender and gender analysis. Starting with participants' own understanding of the differences between biologically determined "sex" and socially constructed "gender", the facilitator illustrated how socially constructed beliefs about how girls/women and boys/men should be and behave and about their roles leads to norms related to masculinity and femininity, to sexual division of labour and roles and responsibilities, resulting in unequal access to and control over resources and decision-making power. Gender norms privilege boys and men over girls and women and establish unequal power relationships between them. As an application exercise of the concepts introduced, participants then worked in groups to analyse four case studies of maternal deaths to identify the role of gender in these.

Day two

Day two began with the concept of rights: the values underlying human rights and the obligations of the state to respect, protect and fulfil rights, major international covenants and conventions, and constitutions and legislations of countries as codifiers of human rights; right to health and health care; and sexual and reproductive rights.

Participants had been given as homework readings the Universal Declaration of Human Rights and a WHO paper on what was meant by a rights-based approach to health. After the presentation introducing rights concepts, participants were divided into two groups. Each group was given a case study of a woman experiencing pregnancy-related morbidity or mortality. Each of the two groups again further divided their task, with one subgroup enacting the case study while the other sub-group analysed the case study to identify which human rights were violated, and which aspects of the Right to Health were being violated. Enactment of the skits based on the case study helped participants to visualise or (for the actors) live through the experiences of women. The analysis of violations was an eye-opener. What was usually a routine scenario in many health facility settings were now being viewed from a rights lens and acknowledged as violations of the rights of the women.

Session three was on indicators for evaluating outcomes of policies related to making pregnancies safer. After a lecture-presentation by the facilitator on indicators and their many types and uses, and on how indicators can be made gender-sensitive, participants were given an application exercise. Participants were given the 9 guiding principles for organising maternal and new born care as spelt out by the National Rural Health Mission (NRHM) (Annex 3). Two groups were given the HMIS reporting formats for *Janani Suraksha Yojana* for selected states, and two groups were given HMIS format for reporting on family planning programmes. In both instances, in addition to the reporting formats, participants were also provided with data submitted for the first quarter of 2009 using these formats. Participants were required to develop at least two indicators they would use for monitoring the progress over time using HMIS data, keeping in mind the 9 principles of organising maternal and newborn care. They were also required to assess whether these indicators

would capture gender and rights dimensions of the services, and if not, to develop new indicators that would do so.

One important observation by participants when working on this assignment was that the HMIS reporting formats did not include any reporting for reversible methods of contraception. Also, the reporting format for JSY only included information on women registering for JSY. Data was available on proportion of women registered for JSY who attended ANC, and had an institutional or home delivery. Women who did not register for JSY remained invisible and were nowhere counted. The data did not provide scope for capturing gender or rights dimensions of delivery care and family planning services.

The next two sessions were on policies for making pregnancies safer. The first of these followed a similar format to the indicators session, of a lecture-presentation followed by an application exercise in groups. The presentation introduced participants to concepts of gender-unequal, gender-blind, gender-neutral, gender-specific and gender-transformative policies and gave examples of sexual and reproductive health policies that fell into each of these categories. Participants were then given a handout with strategies for maternal and newborn health listed by NRHM (Annex 4). They worked in five groups, and each group was assigned one strategy. They had to identify what the approach to gender was in that strategy, and then had to rework and transform it to become a gender-transformative policy.

Later that evening was a talk by Dr Rajasekharan, Deputy Director Health Services from Tamil Nadu, on the innovations he had implemented in Vellore Health District to promote institutional deliveries in primary health centres. He had successfully motivated health care providers; mobilised financial resources from the NRHM and other sources; garnered political support from the district collector and from elected representatives and political leaders; consulted PRI leaders and the community and made health services responsive to women's needs. Dr Rajasekaran's leadership and dynamism was a source of inspiration to all present and of hope that change was indeed possible.

Day three

Day three started with a revisit of the session on indicators, on request from many of the participants. This was followed by the second session on policy. The facilitator presented a detailed overview of major global landmarks on policy related to safe motherhood, starting from the Safe Motherhood Conference in Nairobi in 1987 through to the MDG assessment being undertaken in 2010. This was followed by a description of global policy approaches to reducing maternal mortality and morbidity and lessons learned from high-income as well as middle and low-income countries. Some major lessons were that maternal mortality reduction was made possible by a multi-sectoral strategy which addressed some important social determinants of poor maternal health such as poor nutrition and high illiteracy among

women; skilled-birth attendance for all women through a midwife-based approach; and a functioning health system that could deliver quality emergency obstetric care.

The next module was on health systems. The module started with a presentation on health systems challenges at the macro-level. It outlined the low levels of public financing for health care in India and in different states, and the heavy reliance on out-of-pocket expenditure by households. Many low-income households were impoverished due to catastrophic health expenditures. There was also a human resources crisis –not because we were not producing enough doctors, but because few of these doctors were willing to serve in the government health system in rural areas. Another dimension of the human resources crisis was the very low nurse to doctor ratio, the absence of a specialised midwifery cadre and the limited midwifery skills of the auxiliary nurse midwives and other nurses. There was a short supply of anaesthetists seriously affecting the country's capability to ensure emergency obstetric care (EmOC) to women who developed complications in labour. Drugs and supplies were not in short supply but systems failures often caused lack of these in secondary and primary health facilities. Another major force affecting the country's health system was privatisation in health. The expansion of the private sector diverted human and financial resources away from the public health sector, creating a crisis of confidence in the public sector in health, further corroding the morale of those working in the public sector in health. Many policies were not in line with intended objectives, and often the means became the end. For example, while reduction of maternal mortality and morbidity was the intended objective, and institutional deliveries was one of the means to achieve this end, the policy thrust of JSY had resulted in a preoccupation with institutional deliveries without due attention to whether these had succeeded in reducing deaths and disability.

The next session was on health system challenges at the micro-level. Participants were divided into state-wise groups. Each group was given data on the maternal health situation in their respective state, and also assigned one strategy for maternal and newborn health. The task in each group was to

- Analyse the situation using data given
- Identify gaps in the specific service
- Select one issue that they would address to achieve the goals of the strategy
- List health system-related actions that they would take to address the issue identified

Day four

The health systems module continued in the first session on day four, which was on health systems challenges related to ensuring emergency obstetric care (EmOC). The session

started with a brief presentation on components of EmOC and indicators required to monitor progress in availability and quality of EmOC. Participants were then given an exercise that required them to analyse in depth the various failures that could occur in health systems causing avoidable maternal death and disability, and to come up with action that they would take to prevent such failures. In this exercise, known as the "but why" exercise, participants worked in groups and analysed the causes and causes behind the causes of one case of maternal death from PPH and one case of a stillbirth, both of which occurred in a health facility. The health system failures identified in the exercise are presented in Annex 5. Participants also identified gender –related barriers that led to late arrival at facilities or poor prognosis because of poor health status of the woman. The discussion that followed the exercise identified concrete solutions that participants could themselves implement in order to prevent the failures identified. Thus, participants not only identified where the problems lay but also came up with creative solutions to these problems.

The next module was called "Contemporary challenges in making pregnancy safer". This module was designed as a series of debates on four topics:

- Should second trimester abortions be curtailed in order to prevent sex-selection against the female foetus?
- Will the availability of medical abortion in the public health system lead to "misuse" of the method?
- Should doctors insist on husbands' signature for performing medical terminations of pregnancies?
- Should screening for domestic violence become a part of routine antenatal care in health facilities?

Each of the four groups debating a topic was given a set of readings as homework for the previous evening and were required to base their arguments on these. For each topic, the remaining participants and facilitators present voted to determine the winning side. After the debate on a particular topic and voting on the winning side, facilitators led a discussion on the topic, highlighting the evidence available.

The final module of the course was "Making Change Happen". In the opening session of this module, participants shared their experiences of being change agents within their settings. After this was a presentation on understanding resistance to change and strategising to bring about change after analysing the sources of support and opposition. This was followed by a role play. There were three players: the superintendent of a medical college hospital, a prominent member of the District Health Committee and the District Project Manager (DPM). The DPM was trying to win the support of the superintendent to strengthen EmOC

within the hospital because of past instances of poor outcomes due to delay. The role play illustrated that different stakeholders had different agendas and that working together required tact and team-playing, and working at win-win solutions.

After this, participants were assigned to work in state-specific groups to plan for a specific intervention that would promote maternal health or contribute to reducing maternal death and disability.

Day five

Work in state-specific groups to prepare action plans continued on the morning of Day five, the last day of the course. After the morning tea break, each of the action plans was presented to the larger group and discussed in detail. Suggestions were made by facilitators as well as colleagues from other states for improving on or adding to the interventions.

The Assam team planned an intervention to increase institutional delivery from 33.5% to 45% by 2010-11 in Udalguri District; and to operationalise seven PHCs into 24 x7 services to provide BEmOC services.

The team from Chattisgarh developed a plan to increase skilled birth attendance in Bastar district to 60 %, which was the state average, by the end of 2012. The actions they would take to achieve this included orientation of all health professional through public health resource network, and of Mitanin/ ASHA; to hold VHSC sammelans at block and village level ; to ensure SBA training, and to include gender and rights issues in the refresher training of SBAs; to provide nutritional supplements to pregnant women and to strengthen the referral mechanisms for pregnancy-related complications.

The Jharkhand team elaborated on an action plan for referral transportation. The goal was to provide transport facility to deal with the emergency complications during pregnancy , delivery and post partum to reduce maternal mortality and morbidity. This was an intervention already planned in the state PIP and was elaborated in some detail as part of this exercise.

Reduction of unsafe abortions in eight districts was the goal of Karnataka team's interventions. Specific activities that they would initiate in order to achieve this included: providing medical abortion facilities at S/C, PHC and above; providing safe surgical abortion services at PHC and above; strengthening adoption of temporary and permanent contraceptives; conducting Adolescent Reproductive and Sexual Health clinics on regular basis at PHC and above; strengthening of BCC activities and setting up helpline for abortion services at state level.

The Action Plan of the Orissa team was aimed at achieving a reduction in case fatality rate of deliveries in institutions; increase in coverage of delivery by SBA and increase in proportion of complicated cases referred to CEmOC facilities and in lives saved as a consequence.

In the closing session of the course participants filled up of an evaluation form and certificates were distributed to participants. The course ended with a round of thanks to everyone who had contributed to the course.

3. Participants' feedback on the course

Expectations from the course and whether these were met

Expectations from the course mentioned by participants in their evaluation centred around learning more about dimensions of maternal mortality and morbidity globally and in India; gaining a gender and rights perspective on maternal health issues; learning strategies to promote institutional deliveries; learning about policy approaches from around the world and in India that have succeeded; and cross-learning from colleagues working in other states on innovations; and to gain knowledge and skills that will be useful in their work in states especially to train ASHAs and Village Health and Sanitation Committees.

All but one of the participants said that their expectations had been met.

"*Really effective; gave time to think about many issues that we tend to forget or not give importance*

Good and adequate

Mega management skills we learnt with human and women's right perspective

All aspects of maternal health services touched upon. Materials given are "solid"

Especially appreciated and admired the use of small group exercises and case studies which provoked thoughts in myself. It made me also understand and analyse complexity.

The different techniques used for different topics are worth commenting

On the first day I felt a little upset but gradually the sessions increased my gender and rights perspective. Then it also enhanced my managerial skills to act at the district level. The sequencing of topics (was good,."

The one person who said that his/her expectations were partly met said later in the evaluation that some of the contents were not relevant for someone from a tertiary institution.

Methodology

The mix of methods was appreciated by 18 of 20 participants.

"Good flow of topics with a good balance starting with gender and rights to policies and indicators and contemporary issues"

Of the two who said there could be improvement, one did not give any specific suggestions. The other person's comment was more related to the content and not method; s/he said that more time needed to be allocated for discussion on promoting access to emergency obstetric care.

Readings

While 18 of 20 participants appreciated the comprehensiveness of reading materials given to them, almost all said also that they were able to read only a few of these, but that the readings would be very useful for their work.

"*Very rich resources, can be used at all times.*

Readings – hard and soft copies – are very informative and need to be shared with all my medical officer s and managerial staff

One participant felt that some of the readings were not quite relevant, another opined that they were "*too much".*

Length of the course

Fifteen of 20 participants said that the length of the course was "perfect", "just right" and so on. Five wanted the course to be longer, by 1-2 days.

Topics to be included

There were many interesting suggestions for topics to be included or topics for which more time may be allocated.

- *Community needs assessment for maternal health care from a gender perspective*
- *Some administrative themes*
- *BEmONC and CEmONC to be dealt with in more detail; referral indicators of BEmONC and sub-centres would have been useful in the indicators session*
- *Adolescent maternal health issues; also child survival*
- *Mental health issues related to maternal health to be included*
- *More time for safe abortion issues*
- *Expectations of WHO regarding Maternal health and how GOI measures up;*
- *Coordination between NRHM and main DHS, because of confrontation*
- *-More time should be given for the planning exercise*

Feedback on specific sessions

Almost all sessions were mentioned as most valuableby one participant or another. The most frequently mentioned sessions were Gender, rights and "But why".

There were suggestions to make the indicators session easier and more directly relevant to maternal health issues, with more data application exercises. One person said that concepts related to indicators should be introduced "*in small capsules, data often confuses people".*

All participants said that all the topics were relevant and none could be left out.

Impact of the course

The course had obviously made a significant impact on many.

"*Participatory course*

Made an impact at personal and professional level

Helped in visualizing the problem and in analysis

Motivation to make the 3500 pregnancies of my district safer

We got great advantages here which can really change our views and ideas

Looking at things differently

Gender and rights and global policies made an impact

Yes, the way I look at the whole aspect of maternal and neonatal health; to look at numbers as faces which we should not have lost at all

Yes, to a great extent, learned so much; also understood where the country is moving in maternal health

Provides lots of ideas for implementation of activities at the district level in gender and rights perspective; it shaped my managerial skills and upgraded my knowledge on health management"

Logistics

Not many people commented on the logistics, but a small number said that the service in the hotel they stayed in was not up to the mark. One person said that although the quality of stay could be improved it was okay because the place of accommodation had to be changed in the last minute.

General comments on the course

Many suggestions for improvement were made in this section of the evaluation.

More video presentations needed
Could be more oriented also to non-medical persons
Reading materials were good but voluminous. Somehow as adults we need more time and assimilate the contents.

There were also appreciation for the overall conduct of the course and requests for running such courses at the regional level:

"Good opportunity to learn in an inter-state environment; please send us more materials, reports, journal articles; please conduct courses at the state-level so that other health managers may benefit.
Conduct such courses regularly so as to train more persons

Wish to meet all of you on other health related topics. Our expressions (?) can't be measured

Please ensure that the members who came for this course are given chance in future for any other courses organized in the centre, big or small

I am very impressed with your professionalism, clarity, timing, culture, behavior etc. Your team work is highly appreciable. I congratulate each one of you for your kindness and hospitality. Everything is good; but seating arrangement of participants could have been improved. I am happy to be a trainee in your institute; Kerala is a role model in all aspects. "

Annex 1

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Annex 2

Timetable

Day and time	Session	Topic	Responsibility
Monday, 12th July		Participants arrival	
DAY 1: Tuesday 13 July, 2010			
08.30 – 09.00		Registration	
09.00 –10.30	Session 0	Opening Welcome Address by director SCTIMST Address by Prof. Ramankutty, AMCHSS Participants' self-introduction Expectations from the course; Course objectives Briefing on logistics etc.	
10.30 – 10.45		Coffee break	
10.45 – 12.15	Session 1	Maternal mortality and morbidity: No room for complacence	TK Sundari Ravindran
12.15 - 13.30		Lunch	
13.30-15.15	Session 2	MODULE 1: VIEWING MATERNAL HEALTH FROM A GENDER&RIGHTS PERSPECTIVE Gender-analysis framework and application to making pregnancy safer	Renu Khanna & Aditi Iyer
15.15 –15.30		Coffee Break	
15.30-17.30	Session 2 Contd.	Gender-analysis framework and application to making pregnancy safer –continued	Renu Khanna & Aditi Iyer
Evening		HOMEWORK- Readings on Rights	

DAY 2: Wednesday, 14 July 2010			
8.30-10.15	Session 3	Rights-based approach to making pregnancy safer	Renu Khanna & Aditi Iyer
10.15–10.30		Coffee Break	
10.30-12.15	Session 3 contd.	Rights-based approach to making pregnancy safer –contd.	Renu Khanna & Aditi Iyer
12.15 -13.30		Lunch	
13.30-15.15	Session 4	MODULE 2: EVIDENCE AND POLICY Indicators for Evaluating Outcomes of Policies for Making Pregnancies Safer	Mala Ramanathan and B. Subhasri
15.15-17.30	Session 5	Policy approaches to making pregnancy safer: I	Mala Ramanathan and B. Subhasri,
19.00-20.00	Special Lecture	Innovating for Making pregnancies safer: The case of Tamil Nadu: Lecture and discussion	Dr.S, Rajasekaran, Deputy Director Health Services, Govt. of Tamil Nadu
20.00-21.30		Dinner for participants, course faculty and support team and faculty members of AMCHSS	

Day 3 Thursday, 15 July 2010			
8.30 – 10.30	Session 7	Policy approaches to making pregnancy safer: II	Renu Khanna,
10.30– 10.45		Coffee break	
10.45-12.15	Session 8	MODULE 3: HEALTH SYSTEMS Health-system challenges at the macro-level	TK Sundari Ravindran
12.15 -13.30		Lunch	
13.30-15.15	Session 8	Planning for and addressing Health-system challenges at the micro-level	B. Subhasri

	contd.		
15.15 –15.30		Coffee	
15.30 onwards		EARLY CLOSING AND FREE TIME	
Day 4 Friday 16 July 2010			
8.30-10.30	Session 9	Meeting health systems challenges related to Emergency Obsteric Care	B. Subhasri
10.30-10.45		Coffee	
10.45-12.15	Session 10	Contemporary challenges in maternal health-I	Manju Nair and Suchitra Dalvie
12.15-13.30		Lunch	
13.30-15.15	Session 10 contd	Contemporary challenges in maternal health-II	Manju Nair and Suchitra Dalvie
15.30-17.30	Session 11	MODULE 4: MAKING CHANGE HAPPEN Planning for making change happen within our own settings	TK Sundari Ravindran
Homework		Group work in state-level groups to develop a plan of action	
Day 5 Saturday 17 July 2010			
8.30-10.30	Session 12	Group work continues: Planning for change in our own settings	All faculty members present
10.30-10.45		Coffee	
10.45-12.15	Session 13	Group presentations	All faculty members present
12.15 - 13.30		Lunch	
13.30-15.15	Session 13	Group presentations-continued	All faculty members

	contd.		present
15.15 – 15.30		Coffee	
15.30-17.00	Session 14	Closing session Participants' feedback and evaluation; certificate distribution; leave taking	All faculty members present

Annex 3

Principles of Organising Care for Maternal and Newborn Health

1. Every woman must be enabled to have her childbirth with a Skilled Birth Attendant (SBA) competent to provide essential newborn care, in a setting of maximal dignity, comfort, and care.

2. Since life threatening complications may arise in any delivery, every effort must be made for all women to deliver in an institution where most complications can be promptly and effectively managed, and with the means to transport a patient safely and quickly to an institution where complications that require surgical care and blood transfusion can also be managed.

3. Where a delivery is known to have much higher risk of complications even before the onset of labour,e.g. a previous Cesarean, every effort must be made so that the delivery takes place in an institution where surgical care and blood transfusion for managing emergencies is available.

4. Every mother must be provided with postnatal care that ensures support to her in this period, identifies complications and arranges for referral when required. This care is preferably institutional in the first 48 hours, with home based follow-up for a 42 day period thereafter.

5. Every newborn must be provided with appropriate care and support from the moment of birth. This includes initiation of breastfeeding, keeping the baby warm, identifying illnesses or risk including low birth weight, resuscitation where indicated, access to referral care at an institution, and close follow-up at home for 28 days after birth.

6. The public health system must hold itself accountable to provide skilled human resources, infrastructure and equipment, institutional linkages and supervision needed to ensure that these services guarantees for safe maternal and newborn health are realised.

7. A grievance redressal mechanism must be in place which should receive reports of any failure to deliver the services that are certified as available in a particular facility and take appropriate action, and provide feedback to the complainant and public.

8. Every maternal or newborn death must be accounted for and investigated so as to detect system gaps and to increase accountability.

9. The provision of maternal and newborn care should be based on a 'continuum of care' approach that covers the entire period of pregnancy, delivery and postnatal period, and the needs of the newborn, through a seamless transition from home and community to the facility, referral institutional care where needed, and back again to the home.

Reference: NRHM, 2010: Operational Guidelines on Maternal and New Born Care, NRHM, New Delhi. Pp 14

Annex 4

Strategies for Maternal and Newborn Health

Strategies for maternal and newborn health

(Highlighted strategies were the ones assigned to groups for gender analysis in the policy module and for developing action plans in the health systems module)

1. **Provision for quality antenatal care**
   All women must have access to a package of antenatal services provided in the community or at the facility by a provider who is skilled and who has the necessary equipment and supplies.

2. **Ensure access to a skilled birth attendant**
   A Skilled Birth Attendant (SBA) is a professionally qualified individual who can handle normal pregnancies and deliveries, equipped with skills to provide essential newborn care, identify obstetric and neonatal emergencies, manage complications as per their defined competencies, and undertake timely referral to a higher centre where comprehensive obstetric care can be provided.

3. **Functional facilities to provide institutional delivery**
   Care for pregnancy, childbirth and newborn can be provided at any of the three facility levels shown in the box:

   Definitions

   Level 3 Institutional Delivery (Comprehensive Level-FRU): All complications managed including C-Section and blood transfusion, i.e. comprehensive Emergency Obstetric and Newborn Care **(CEmONC)** provided at equipped public and private hospitals. The public and private hospitals would also be equipped with Neonatal Stabilisation Unit and Sick Newborn Care Unit (SNCU).

   Level 2 Institutional Delivery (Basic Level): Delivery conducted by a skilled birth attendant in a 24x7 PHC level (PHC or CHC with Basic Emergency Obstetric and Newborn Care **(BEmONC)** or in a private nursing home with equivalent facilities) having Newborn Corner and Stabilisation Unit.

   Level1 Skilled Birth Attendance: This refers to a delivery conducted by skilled birth attendant in all Sub-Centres and in some Primary Health Centres (PHCs) which have not yet reached the next level of “24 x 7 PHC”. Newborn Corner in all facilities. Home

deliveries assisted by a skilled birth attendant would also be included under safe deliveries at this level.

The point is simple – any delivery that happens within the four walls of a health institution is not to be called institutional. It must provide a level of care as specified. Private sector care should also be grouped along these categories.

4. **Facility based new born care**

This should be given at the time of birth as appropriate to each of the three levels – Sick Neonatal Care Unit at district hospitals, Newborn Stabilisation Units at all institutional delivery facilities, whether comprehensive or basic, and Newborn Care Corner at other facilities

5. **Home based newborn care and post natal care**

This should be provided through a series of visits. (First two days of care should be given at the facility where institutional delivery took place.) At home, care should be provided within 24 hours of delivery for the newborn by a trained community health volunteer who may be an Accredited Social Health Activist (ASHA) or an Anganwadi Worker (AWW) or other health worker as appropriate to that context and who is a resident of that habitation.

6. **Referral linkage and transport**

This is for access to emergency services. The ideal situation is where every mother delivers in an institution with access to a referral centre within one hour in case of complications, requiring surgery and blood transfusion. District health plans must conform to a roadmap to reach this ideal, respecting and supporting the wishes of families at every stage

7. **Behavior change communication (BCC)**

This is carried out by ASHA and other health workers to ensure care in pregnancy and for the newborn, recognition of complications and their danger signs, birth planning, and choosing a safe site for delivery.

8. **Involvement of women's groups and community mobilization**

This is required to promote key messages for delaying age at marriage, spacing, delaying age at first birth, ensuring gap of at least 3 years between pregnancies and management of unwanted pregnancies.

To ensure delivery of these services, the programme should define a) the package of services to be delivered at each level, b) the quality of standards and protocols for these services, c) the minimum skills the service providers would have to be certified for, d) the process of certification of both facility and of service provider, and e) the institutional linkages and community mobilisation that is needed.

Reference: NRHM, 2010: Operational Guidelines on Maternal and New Born Care, NRHM, New Delhi. Pp 15-16.

Annex 5

Analysis of health systems' failures in Emergency Obstetric Care

FIGURE 1

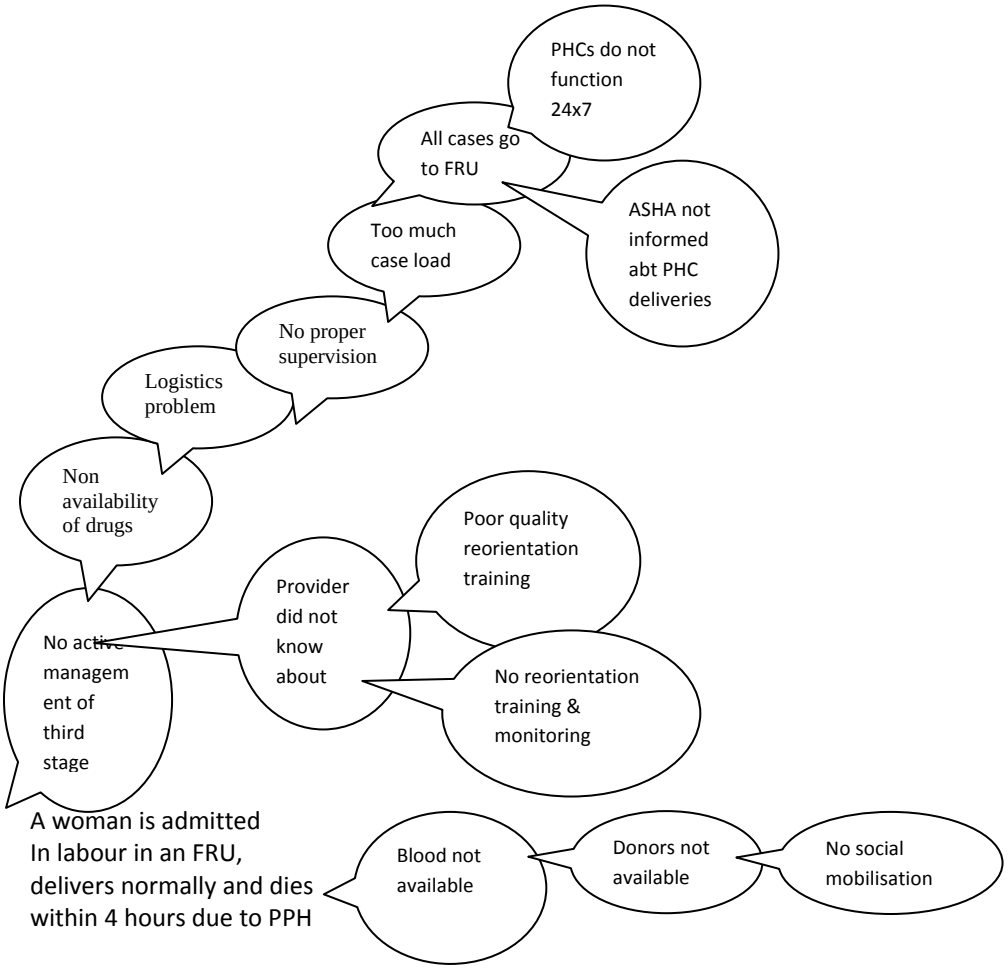

FIGURE 2

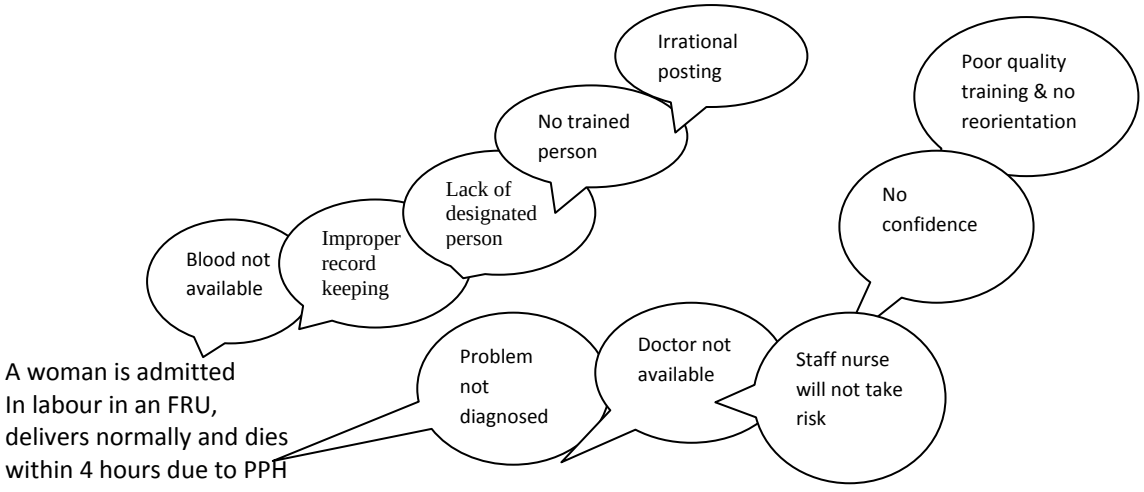

FIGURE 3

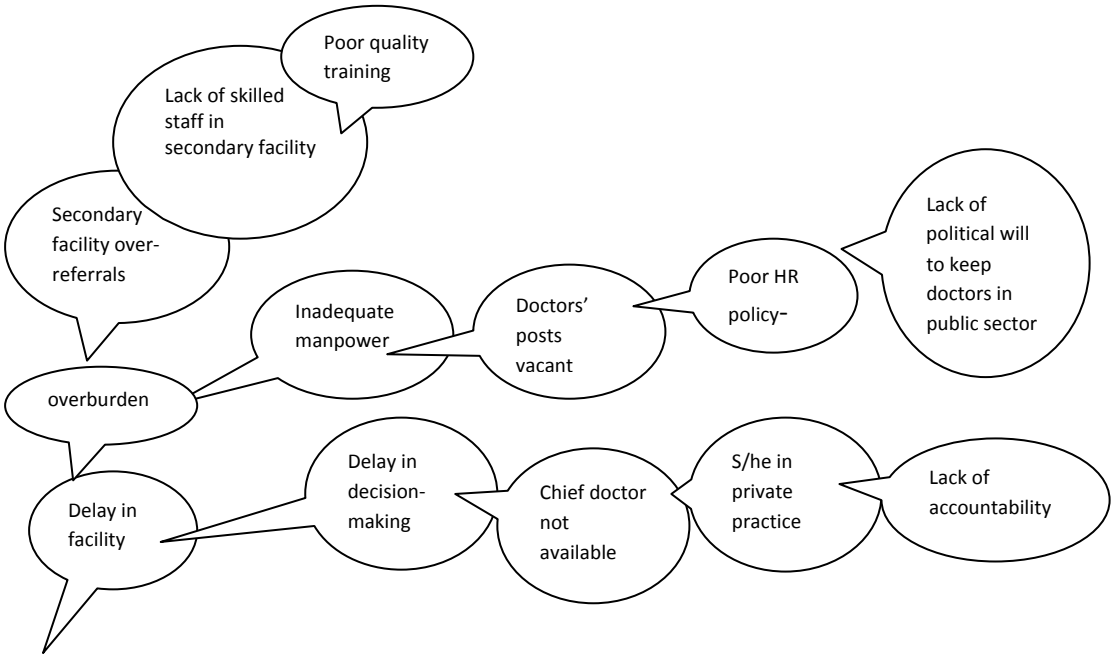

FIGURE 4