Review of literature

The following literature is used as a reference to this thesis:

Dileep Mavalankar (2004) “State of Maternal Health in India”. This report focuses on the maternal mortality rate and the coverage of major policies and program goals for maternal mortality keeping FRUs and CEmOC focus. In comparison to the other Asian countries, MMR in India is quite high. A comparison of the FRUs and primary health centres among different states is shown by the author. North eastern states have shown poor performance in terms of improvements in health standards. States which had high literacy rates had good health facilities and showed good figures for IMR and MMR.

K S Vora (2009) “Maternal Health Situation in India: A Case Study”
The author signifies that Maternal Health Services are one of the basic health services to be provided by any government health system as pregnant women are one of the most vulnerable victims of dysfunctional health system, India, in spite of rapid economic progress is still far away from the goal of lowering maternal mortality to less than 100 per 100,000 live births. It still accounts for 25.7% maternal deaths. The maternal mortality in India varies across the states. Geographical vastness and socio-cultural diversity make implementation of health sector reforms a difficult task. The chapter analyses the trends in maternal mortality and various maternal health programs implemented over the years including the maternal health care delivery system at various levels including the recent innovative strategies. It also identifies the reasons for limited success in maternal health and suggests measures to improve the current maternal health situation. It recommends improvement in maternal death reporting, evidence based, focused, long term strategy along with effective monitoring of implementation for improving Maternal Health situation. It also stress the need for regulation of private sector and proper Public Private Partnership (PPP) policy together with a strong political will for improving Maternal Health

Since the beginning of the Safe Motherhood Initiative, India has accounted for at least a quarter of maternal deaths reported globally. India’s goal is to lower maternal mortality to less than 100 per 100,000 live births but that is still far away despite its programmatic efforts and rapid economic progress over the past two decades. Geographical vastness and socio-cultural diversity mean that maternal mortality varies across the states, and uniform implementation of health-sector reforms is not possible. The case study analyzes the trends in maternal mortality nationally, the maternal healthcare-delivery system at different levels, and the implementation of national maternal health
programmes, including recent innovative strategies. It identifies the causes for limited success in improving maternal health and suggests measures to rectify them. It recommends better reporting of maternal deaths and implementation of evidence-based, focused strategies along with effective monitoring for rapid progress. It also stresses the need for regulation of the private sector and encourages further public-private partnerships and policies, along with a strong political will and improved management capacity for improving maternal health.

Lynn M. Sibley & Theresa Ann Sipe (Dec.2006) “Transition to Skilled Birth Attendance: Is There a Future Role for Trained Traditional Birth Attendants”. This report gives a brief history of training of traditional birth attendants (TBAs), summary of evidence for effectiveness of TBA training, and consideration of the future role of trained TBAs in an environment that emphasizes transition to skilled birth attendance are provided. Evidence of the effectiveness of TBA training, based on 60 studies and standard meta-analytic procedures, includes moderate-to-large improvements in behaviors of TBAs relating to selected intra-partum and postnatal care practices, small significant increases in women's use of antenatal care and emergency obstetric care, and small significant decreases in prenatal mortality and neonatal mortality due to birth asphyxia and pneumonia. Such findings are consistent with the historical focus of TBA training on extending the reach of primary healthcare and a few programmes that have included home-based management of complications of births and the newborns, such as birth asphyxia and pneumonia. Evidence suggests that, in settings characterized by high mortality and weak health systems, trained TBAs can contribute to the Millennium Development Goal 4—a two-thirds reduction in the rate of mortality of children aged less than 14 years by 2015—through participation in key evidence-based interventions

Mridha MK, Anwar I & Koblinsky M.(2009) “Public-sector Maternal Health Programmes and Services for Rural Bangladesh”: This paper is focused on maternal healthcare delivery by public subsector. Maternal healthcare services in the public sector of Bangladesh have been guided by global policies (e.g. Health for All by the Year 2000), national policies (e.g. population and health policy), and plans (e.g. five- or three-yearly). The Ministry of Health and Family Welfare (MoHFW), through its two wings-Health Services and Family Planning-sets policies, develops implementation plans, and provides rural public-health services. Since 1971, the health infrastructure has developed though not in a uniform pattern and despite policy shifts over time. Under the Family Planning wing of the MoHFW, the number of Maternal and Child Welfare
Centres has not increased but new services, such as caesarean-section surgery, have been integrated. The Health Services wing of the MoHFW has ensured that all district-level public-health facilities, e.g. district hospitals and medical colleges, can provide comprehensive essential obstetric care (EOC) and have targeted to upgrade 132 of 407 rural Upazila Health Complexes to also provide such services. In 2001, they initiated a programme to train the Government's community workers (Family Welfare Assistants and Female Health Assistants) to provide skilled birthing care in the home. However, these plans have been too meagre, and their implementation is too weak to fulfill expectations in terms of the MDG 5 indicator-increased use of skilled birth attendants, especially for poor rural women. The use of skilled birth attendants, institutional deliveries, and use of caesarean section remain low and are increasing only slowly. All these indicators are substantially lower for those in the lower three socioeconomic quintiles. A wide variation exists in the availability of comprehensive EOC facilities in the public sector among the six divisions of the country. Rajshahi division has more facilities than the WHO 1996 standard (1 comprehensive EOC for 500,000 people) whereas Chittagong and Sylhet divisions have only 64% of their need for comprehensive EOC facilities. The WHO 2005 recommendation (1 comprehensive EOC for 3,500 births) suggests that there is a need for nearly five times the existing national number of comprehensive EOC facilities. Based on the WHO standard 2005, it is estimated that 9% of existing doctors and 40% of nurses/midwives were needed just for maternal healthcare in both comprehensive EOC and basic EOC facilities in 2007. While the inability to train and retain skilled professionals in rural areas is the major problem in implementation, the bifurcation of the MoHFW (Health Services and Family Planning wings) has led to duplication in management and staff for service-delivery, inefficiencies as a result of these duplications, and difficulties of coordination at all levels. The Government of Bangladesh needs to functionally integrate the Health Services and Family Planning wings, move towards a facility-based approach to delivery, ensure access to key maternal health services for women in the lower socioeconomic quintiles, consider infrastructure development based on the estimation of facilities using the WHO 1996 recommendation, and undertake a human resource-development plan based on the WHO 2005 recommendation.

PS Raman, Bharti Sharma Dileep Mavlankar & Mudita Upadhyaya (2009) “Assessing the Regional and District Capacity for Operationalizing Emergency Obstetric Care through First Referral Units in Gujarat” This study is a part of the project for strengthening midwifery and Emergency Obstetric Care in India. The study apart from giving an in-depth insight into the
functioning of various health facilities highlights the results from the basic to the more comprehensive level of EmOC services. It gives recommendation on various measures to rectify shortcomings noticed and make EmOC a more effective at different levels in the State of Gujarat. The study uses both primary and secondary data collection. The study was conducted in six regions of Gujarat - one district from each of these regions was selected. Out of these districts 27 health facilities were examined, which consists of seven district hospitals, eight designated as first referral units (FRU), four community health centers (CHC) and eight 24/7 primary health centers (PHC). Detailed field notes for individual facilities were prepared and analyzed subsequently for all facilities together. A common feature among all health centres were issues related to general infrastructure. Many times infrastructure planning (location, layout and maintenance) is left to engineers, who have limited knowledge about proper EmOC services. Poor infrastructure leads to poor quality of health services and wastage of resources. Through National Rural Health Mission (NRHM) and Rogi Kalyan Samiti funds major and minor repair/renovations are taking place to improve hospital buildings. In some health facilities from poor resource setting with high demand from patients were still able to deliver services. Human resources analysis suggests that there is shortage of specialists at FRUs, and committed nursing staff in labor room. As result of the Chiranjeevi initiative, the Below Poverty Line (BPL) population who earlier used to public health facilities are now accessing private facilities for delivery, and this has affected and decreased the workload of the public health facilities. Furthermore, there is lack of managerial skills at senior level hospital staff. Registers like birth, drug, Medical Termination of Pregnancy are maintained but not in standard format. Since complicated cases are not registered properly, maternal deaths are not reported. Even though the system of monitoring is well established at the state and district level, they are not properly followed. The funds for operationalization of First Referral Units come from department of family welfare. However, the administrative control is in the hands of department of medical services. Due to this factor monitoring system has become weak. The weak link between these two departments is the Regional Deputy Director who has only one administrative staff to take care of the issues in their region. The problem of monitoring the Primary Health Centres has become smooth with the appointment of new District Project Coordinators. Some facilities especially in district hospital reported that internal meetings and monitoring are happening because of the special interest of facility managers and newly appointed assistant hospitals administrators. In lower facilities this type of internal monitoring exists in a weak form. Underutilization of government facilities is a result of poor quality of services provided. In spite of reasonably developed health system, several problems of infrastructure,
staffing, accountability and management capacity contribute to the poor functioning of facilities to act as an EmOC service delivery center. Some of the major bottlenecks in improving EmOC services are limited management capacity, lack of availability of blood in rural areas and poor registration of births and deaths and no monitoring of EmOC. District hospitals, FRUs, CHCs and Sub district hospitals come under the administrative control of the department of medical services. The clinical monitoring of these facilities lies with the department of health and family welfare. At the district level monitoring of these facilities are not properly done, therefore it effects directly the operationalization of the facilities. In the absence of adequate management capacity, the operationalization of EmOC is not well planned, executed or monitored, which results in delays in implementation and poor quality of care.

Ray Sandip Kumar, Mallik Sarmila, Kumar Satish & Biswas Biswajit (2005) “An evaluation of first referral units in border districts of West Bengal”, page 52-56. This report assess the facilities and manpower available in the first referral units (FRUs) for mothers and childcare, and the functioning of the existing manpower in seven FRUs of three districts of West Bengal bordering Bihar and Orissa. Data was collected by interviewing the district officials, analysing information available in the districts, direct observation of the FRUs and review of maternal morbidities.