



HESVIC methodology

The Health System Stewardship and Regulations in Vietnam, India and China (HESVIC) is a multi-country, multi-disciplinary project funded by the European Commission (2009-2012). HESVIC sought to examine the role of regulations and through it of governance to ensure equitable access to quality maternal health care.

In India, we focused the study of regulations and governance in the state of Karnataka, in two districts one each in North and South Districts. We conducted field work in August 2011-January 2012. The methodology of the study involved a) document analysis of policy and regulation documents b) in-depth interviews (n= 94) with users of maternal health services, administrators and implementers in the health system at different levels (including private providers), policy makers at state and national levels c) Focus Group Discussion with health workers and d) analysis of quantitative data.

More details about HESVIC available at www.hesvic@iphindia.org, <http://www.leeds.ac.uk/nuffield/research/HESVIC.htm>

Contributors

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Averting maternal deaths: Ensuring 24*7 emergency obstetric care

Background

The current Maternal Mortality Ratio at 178/100,000 in the state of Karnataka falls far short of the target set by the National Rural Health Mission (NRHM) at <100 by 2012.

Experiences of countries worldwide show that round the clock equitable access to quality emergency obstetric care is critical to save the lives of pregnant women.^{1,2} Provision of EmOC has received sharper focus in the National Rural Health Mission (2005). NRHM has sought to improve access to EmOC services by strengthening Primary Health Centres (PHCs) and First Referral Units (FRUs) through a) infrastructural development (physical up gradation, human resources, blood storage unit, functional operation theatre) b) improve monitoring of services and c) establish minimum standards in health facilities to ensure delivery of quality care including EmOC.

We examined how far current policy efforts under the NRHM have been able to ensure CEmOC (Comprehensive emergency obstetric care) and prevent maternal deaths in Karnataka.

Findings

FRUs: Physical up-gradation but not fully functional

149 FRUs ((from an identified list of 192) have been upgraded in 2005-2010. Only 139 have C-section facilities. In the two districts studied, out of the 14 FRUs, only 8 FRUs have the provision for C-sections, though these may not ensure round the clock service.

“These days our referrals are caesarean sections which we get during the night time”

“We refer women who require blood transfusion due to severe anaemia during pregnancy. If it is one or two bottles we can manage with our blood storage unit but not more”

Shortage of specialists and trained personnel in FRUs

None of the 14 FRUs surveyed in the two study districts had the required number of specialists to provide round the clock EmOC service. Additionally, evidence from our study indicated that specialists' skills were mis-utilized as many of them ended up managing general out-patient cases too.



An upgraded FRU in Karnataka

Providers trained in task shifting (EmOC and Life saving anaesthetic skills) do not perform C-sections in many cases due to inadequate training and team support.

Multiple referrals due to deficit in resources and tendency to avoid risk

Multiple referrals take place either due to non-availability of resources (specialists, availability of blood, non-functioning operation theatre) or often due to a tendency to avoid risk of treating a 'risky' case - a woman having obstetric complications. This is due to the fear of blame, perceived lack of support and lack of enforcement of accountability mechanisms.

Maternal deaths have taken place due to long time lag between the onset of complications and their management either in the hospital or in transit.



108 emergency transport service in referral

Maternal death audit: More blaming than learning

Our study showed that while monitoring mechanism like maternal death audits take place on a regular basis (and hence contributed to better recording of number and causes of deaths), there was hardly any follow up of the lessons learnt during such maternal death audits. Systemic malfunctioning was obscured by blaming the lower level health functionaries.

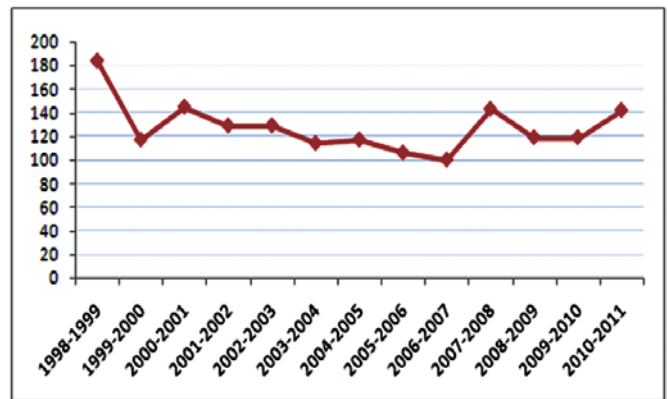
Implications of poor policy implementation

24 *7 EmOC is not ensured and preventable maternal deaths continue.

References

1. UNICEF, World Health Organization, UNFPA. Guidelines for Monitoring the Availability and Use of Obstetric Services. UNICEF: Geneva 1997
2. Paxton A et al. The evidence for emergency obstetric care, Int J Gynaecol Obstet 88 (2): 181-193 2005

Maternal mortality ratio in the study district



Source: District Health Reports

Recommendations

The following actions need to be taken to ensure 24*7 quality emergency obstetric care to save the lives of pregnant women.

- **Strengthen human resources:**
 - Task shifting needs to receive a special and urgent focus
 - Ensure that trained providers in EmOC and LSAS provide services through adequate supervision and close monitoring
 - Recruit more General Duty Medical Officers to relieve specialists of general duties at the level of FRUs
- **Improve auditing of maternal death audits.** These audits should be conducted in a non-threatening environment to be able to identify and solve systemic problems
- **Improve the monitoring of the performance of the facilities and ensure accountability.** Strengthen the quality of existing accountability mechanisms through building into these enforceable sanctions and incentives at all levels (Primary Health Centers - First Referral Unit - District Administration-State level administration).

We do recognise that these actions require the courage and willingness of health providers, administrators and managers to review information, recognise systemic problems, learn lessons and support each other towards creating a responsive health system.