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at

NHSRC, New Delhi
(01 Feb - 30 April 2019)

Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme

By
Dr S Kirti
PG/17/049

Under the guidance of
Dr Pradeep Panda

Post-Graduate Diploma in Health &Hospital Management
Batch 2017-19

International Institute of Health Management Research,
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Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme (01 Feb - 30 April 2019)

Internship and Dissertation Report Submitted in Partial

Fulfillment of the Requirements for the Award of

Post-Graduate Diploma in Health and HospitalManagement

Batch 2017-19

By

Dr S Kirti
PG/17/049

Under the guidance of

Internal Mentor

Dr Pradeep Panda
Associate Professor
Dean(Academics)
IIHMR, Delhi

External Mentor

Dr JN Srivastava
Advisor,
Quality Improvement
NHSRC,New Delhi

International Institute of Health Management Research, New Delhi

2019

Abstract

Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme

Aim of the study was to To determine the Quality of Care of facilities assessed in Labour rooms under ''LaQshya'' Programme in the financial Year 2018-2019

Objectives of this study was to to Identify High and Low performing standards inLabour room in the LaQshya implemented states and to measure the quality of care according to eight specific thematic areas

In **Methodology,** Data of the external assessments of the, District Hospitals (DHs), Sub-District Hospitals (SDHs) and under "LaQshya" across the states in the financial year 2018-2019 was analyzed. Also, the Hospital Score card and Report of the states under the "LaQshya" initiative was studied to analyze their over all score and standard wise score to Identify the high and low performing standards and an overall pattern of quality certification of labour rooms under "LaQshya" implementation in the states .Collection of secondary data of total assessed Facilities under LaQshaya was carried out.

The **Expected Outcome** was identification of good and weak performing standards in Labour room under ''LaQshya'' Programme, Knowledge of the trend in quality certification of labour rooms in LaQshya implementation states

Major **findings/results at** Organisational level- NHSRC there is a requirement of Training of assessor regarding facility assessment, Regular workshop with assessors and Regular monitoring of assessed facilities. At National Level requirement of Periodic visit to the states and to a sample of the health facilities, Orientation and training, Development of IEC & resource material and Monitoring & evaluation. At State Level there is need for Visit to the facilities and 'on site' support for under performing facilities, Training and mentoring of the coaching teams and Tracking and reporting of indicators. At the Facility level there is a requirement of Monitoring Adherence to protocol & Clinical guidelines and Prioritisation and action planning for closure of gaps as per 'Maternal and Newborn Health Toolkit' and 'Guidelines for standardisation of Labour Rooms at Delivery Points

Key Words: LaQshya, Labour Room, Maternal OT, Quality, Standards,

(Completion of Dissertation from Respective Organization)

The certificate is awarded to

Dr S Kirti

In recognition of having successfully completed her

Internship in the department of

NHSRC, New Delhi

And has successfully completed her Project on

Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme

From 01 Feb – 30 Apr 2019

NHSRC, New Delhi

She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

We wish her all the best for future endeavors

Dr JN Srivastava
Advisor,
Quality Improvement
NHSRC, New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr S Kirti, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at NHSRC,New Delhi from 01 Feb to 30 Apr 2019.

The student has successfully carried out the study **"Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme "** which was assigned to her during her internship training and her approach to the study has been sincere,scientificand analytical.

The internship is in fulfillment of the course requirements.

We wish her all success and very best in all her future endeavours.

Dr Pradeep Panda
Associate Professor
Dean(Student Affairs and Academics)
IIHMR, Delhi

CERTIFICATE OF APPROVAL

The following dissertation titled **"Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Heath and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve and statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for Evaluation of the Dissertation.

Name	Signature
Name	Signature
Name	Signature

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Dr S Kirti**, a graduate student of the **Post Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision.

She is submitting this dissertation titled**"Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme**" in partial fulfillment of the requirements for the award of the Post Graduate Diploma in Health and Hospital Management.This dissertation has the requisite standard and to the best of our knowledge no part of it has been produced from any other dissertation, monograph, report or book.

Dr Pradeep Panda
Internal Mentor
Associate Professor
Dean(Academics)
IIHMR, Delhi

DrJN Srivastava
External Mentor
Advisor,
Quality Improvement
NHSRC, New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr S Kirti**, student of Post Graduate Diploma in Health and Hospital Management (PGDHM) from International Institute of Health Management Research, New Delhi has successfully completed training at NHSRC, New Delhi from 01 Feb to 30 Apr 2019.

During her tenure with the organization she has successfully completed her project on the topic **"Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme".**

During the tenure of her association with the organization, I found her sincere, hardworking and focused in the tasks and assignments allotted to her. Throughout the training she was found to be a keen learner and her performance was found to be excellent.

I wish her all success and the very best in all her future endeavors.

Dr JN Srivastava
External Mentor
Advisor,
Quality Improvement
NHSRC, New Delhi

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme"** and submitted by Dr S Kirti,Enrollment No. **PG/17/049** under the supervision of **Dr Pradeep Panda**, Associate Professor,Dean (Academics), Internal Mentor, IIHMR, Delhi for the award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **01 February to 30 April 2019** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

(Dr S Kirti)
PG/17/049

FEEDBACK FORM

Name of the Student : Dr S Kirti

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Suggestions for Improvement : Health Informatics and Digital Technology

Suggestions for Institute : Nil

(Signature)

Dr JN Srivastava
External Mentor
Advisor,
Quality Improvement
NHSRC, New Delhi

CONTENTS

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Dr S Kirti
PG/17/049
IIHMR
Delhi

ACRONYMS / ABBREVIATIONS

1. **NHSRC** - National Health System Resource Centre
2. **NRHM** - National Rural Health Mission
3. **MoHFW** - Ministry of Health & Family Welfare
4. **EMS** - Emergency Medical Services
5. **NHM** - National Health Mission
6. **IFT**– Interfacility Transfer
7. **GIS** - Geographic Information System
8. **EMT** - Emergency Medical Technician
9. **SPSS** - Statistical Package for the Social Sciences
10. **SRT** - Site Response Time
11. **DRR**- Disaster Risk Reduction
12. **WHO-** World Health Organisation
13. **HIS** - Hospital Safety Index
14. **DH** – District Hospital
15. **CHC** – Community Health Centre
16. **DM**- Disaster Management
17. **HRVCA** -Hazard, Risk and Vulnerability and Capacity Analysis
18. **SDRN** - State Disaster Resource Network

SECTION 1: OVERVIEW

INTERNSHIP REPORT

SECTION 1: OVERVIEW

INTERNSHIP REPORT

(01 Feb - 30 Apr 2019)

Organization Profile

1. National Health Systems Resource Centre (NHSRC) has been set up under the National Rural Health Mission (NRHM) of Government of India to serve as an apex body for technical assistance.

2. Established in 2006, the National Health Systems Resource Centre's mandate is to assist in policy and strategy development in the provision and mobilization of technical assistance to the states and in capacity building for the Ministry of Health and Family Welfare (MoHFW) at the Centre and in the states. The goal of this institution is to improve health outcomes by facilitating governance reform, health systems innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models.

3. It has a 23 member Governing Board, chaired by the Secretary, MoHFW, Government of India with the Mission Director, NRHM as the Vice Chairperson of the board and the Chairperson of its Executive Committee. Of the 23 members, 14 are ex-officio senior health administrators, four from the states. Nine are public health experts, from academics and Management Experts. The Executive Director, NHSRC is the Member Secretary of both the board and the Executive Committee. NHSRC's annual governing board meet sanctions its work agenda and its budget.

4. The NHSRC currently consists of seven divisions – Community Processes, Public Health Planning, Human Resources for Health, Quality Improvement in Healthcare, Healthcare Financing, Healthcare Technology and Public Health Administration.

5. The NHSRC has a regional office in the north-east region of India. The North East Regional Resource Centre (NE RRC) has functional autonomy and implements a similar range of activities.

Vision

6. They are committed to facilitate the attainment of universal access to equitable, affordable and quality healthcare, which is accountable and responsive to the needs of the people of India.

Mission

7. To provide Technical support and capacity building for strengthening public health systems in India.

Policy Statement

8. NHSRC is committed to lead as professionally managed technical support organization to strengthen public health system and facilitate creative and innovative solutions to address the challenges that this task faces.

9. In the above process, they intend to build extensive partnerships and network with all those organizations and individuals who share the common values of health equity, decentralization and quality of care to achieve its goals.

10. NHSRC is set to provide the knowledge-centre technical support by continually improving its processes, people and management practices.

Governing Board

11. Chairperson- Ms Preeti Sudan, Secretary, Department of Health & Family Welfare.

12. Vice Chairperson - Shri Manoj Jhalani, Additional Secretary & Mission Director (NHM), D/H & FW,Ministry of Health & Family Welfare.

13. **Members**

(a) Dr. S Venkatesh, DGHS, Ministry of Health and Family Welfare.
(b) Dr. R K Vats, Additional Secretary & Financial Advisor, D/H&FW.
(c) Prof. Balram Bhargava,Secretary,Department of Health Research.
(d) Dr. Manohar Agnani,Joint Secretary (Policy),MoHFW.
(e) Ms. PreetiPant,Joint Secretary, Urban Health, MoH&FW.
(f) Ms. Vandana Gurnani**,**Joint Secretary (RCH), D/H & FW.
(g) Prof. J.K. Das,Designation: Director, NIHFW.

(h) Mrs.Gauri Singh, Principal Secretary (Health),Gov.of Madhya Pradesh.

(i) Shri Samir Kumar Sinha,Principal Secretary (Health),Govt. of Assam.

(j) Shri Prabodh Saxena**,**Principal Secretary (Health),Govt. of Himachal Pradesh.

(k) Smt. Poonam Malakondaiah**,** Principal Secretary (H& FW),Govt. of AP.

(l) Dr. DevadasanN,Director,Institute of Public health Bangalore.

(m) T. Sundararajan,Dean,School of Health Systems Studies.

(n) Professor Gautam Sen,Chairman and Founder Healthspring, Mumbai.

(o) IndraniGupta**,** Professor, Institute of Economic Growth, University Enclave, University of Delhi (North Campus).

(p) Prof.SunilMaheshwari**,**Chairperson(AHRD), IIM Ahmedabad

(q) Dr.SundarRavindran**,**Professor,Achutha Menon Center for HS Studies,

(r) Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum.

(s) Prof.LipikaNanda,Director,Indian Institute of Public Health Bhubaneswar.

14. Member Secretary-Dr Rajani R. Ved,Executive Director, National Health Systems Resource Centre.

15. **Divisions**

(a) Community Processes.

(b) Public Health Planning.

(c) Human Resources for Health.

(d) Quality Improvement in Healthcare.

(e) Healthcare Financing.

(f) Healthcare Technology.

(g) Health Informatics.

(h) Public Health Administration.

Quality Improvement

16. Universal access to care under NRHM, implies universal access to quality care. The Quality Improvement at the Public Health facilities looks into organisation of the work processes critical to health care delivery, which helps in ensuring that investments made in term of money, material and human resources are optimally used to realise expected outcomes. It helps in delivering quality services those are safe and satisfying to users leading better utilization of facilities.

17. NHSRC's mandate is to make quality improvement an inherent part of service delivery at public health facilities. The NHSRC has implemented pilot programmes that build an approach for ensuring that every public health facility would have a quality assurance program in place. In such an approach every facility is assessed and scored against explicit quality standards and after achieving a certain benchmark gets certified by an external agency. Given the nation's diversity in both health systems development and subjective readiness for assuring quality of care, , the quality approach needs to ensure essential norms for facility management, regulatory compliances, clinical protocols & guidelines but at the same time be flexible enough to accommodate variable (essential &desirable) standards of quality certification objectively.

18. During the Internship period I was attached in the Quality Division with the NHSRC, New Delhi. I undertook a study on "Assessment of Quality of Care of Facilities Assessed in Labour rooms under ''LaQshya'' Programme in the financial Year 2018-2019" between 01 Feb to 30 Apr 2019. Respondents in terms of assessment of the Data of the external assessments of the, District Hospitals (DHs), Sub- District Hospitals (SDHs) and under "LaQshya" across the states in the financial year 2018-2019 was analyzed. Also, the Hospital Score card and Report of the states under the "LaQshya" initiative was studied to analyze their over all score and standard wise score to Identify the high and low performing standards and an overall pattern of quality certification of labour rooms under "LaQshya" implementation in the states . Collection of secondary data of total assessed Facilities under LaQshaya was carried out during this study.

Recommendations

19. The recommendations will go a long way in improving the "LaQshya" implementation in the states. At Organisational level- NHSRC, there is a requirement of Training of assessor regarding facility assessment, Regular workshop with assessors and Regular monitoring of assessed facilities. At National Level requirement of Periodic visit to the states and to a sample of the health facilities, Orientation and training, Development of IEC & resource material and Monitoring & evaluation. At State Level there is need for Visit to the facilities and 'on site' support for under performing facilities, Training and mentoring of the coaching teams and Tracking and reporting of indicators. At the Facility level there is a requirement of Monitoring Adherence to protocol & Clinical guidelines and Prioritisation and action planning for closure of gaps as per 'Maternal and Newborn Health Toolkit' and 'Guidelines for standardisation of Labour Rooms at Delivery Points.

SECTION 2: DISSERTATION

"ASSESSMENT OF QUALITY OF CARE OF FACILITIES ASSESSED IN LABOUR ROOMS UNDER ''LAQSHYA'' PROGRAMME"

CHAPTER 1: INTRODUCTION

Background

20. After launch of the National Health Mission (NHM), there has been substantial increase in the number of institutional deliveries. However, this increase in the numbers has not resulted into commensurate improvements in the key maternal and new-born health indicators. It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery.

21. A transformational change in the processes related to the care during the delivery, which essentially relates to intrapartum and immediate postpartum care, is required to achieve tangible results within short period of time. Prerequisite of such approach would also hinge upon the health system's preparedness for prompt identification and management of maternal and newborn complications. Delivery of such transformed care would not only need availability of adequate infrastructure, functional & calibrated equipment, drugs & supplies & HR, but also meticulous adherence to clinical protocols by the service providers at the health facilities. Pregnant women are often meted out rude and uncourteous treatment at the health facilities. Respectful maternity care not only contributes in ensuring positive outcomes for the mothers and newborns, but also supports cognitive development of the babies later in the life.

22. Determinants impacting health and well-being of mothers &newborns during the intra partum & immediate post-partum period and 'Do's and Don'ts in the labour rooms as per the guidelines are expected to support improved outcome for the maternal and newborn health. For improving the quality of care at Public Health Facilities, Quality Assurance Standards for District Hospitals, Community Health Centres, Primary Health Centre and Urban-Primary Health Centres have been drafted, and their implementation has been operationalised through the National Quality Assurance Programme.

23. While states are in the process of implementing Quality Management System using National Quality Assurance Standards (NQAS) to obtain certification of the health facilities, the process takes substantial time and effort. While the states should continue to work towards achieving full NQAS certification of the health facilities, LaQshya Guidelines are intended for achieving improvements in the intra-partum and immediate post-partum care, which are take place in the labour room and maternity operation theatre.

24. Implementation of these guidelines is expected to result into delivery of respectful and zero defect care to all pregnant women and newborns, and such improvement is incentivised. The states are also expected to accelerate efforts for upgradation of conventional labour rooms as per norms given in 'Guidelines for Standardisation of Labour Rooms at Delivery Points', and establish HDUs as per norms given in the 'Guidelines for Obstetric HDUs and ICUs'.

25. Medical College Hospitals handle substantial maternal and newborn caseloads, besides imparting teaching and training the doctors, specialists, nurses and para-medical staff. This initiative will also be implemented in all Government Medical Colleges (MCs) besides District Hospitals (DHs), and high delivery load CHCs and SDHs. These guidelines are meant to help the States' NHM Directors, Medical Education Departments, Heads of Department of Obstetric s& Gynaecology in Medical Colleges, District Health Officials, Medical Superintendents, In-charge of Gynaecology departments and teams engaged in the maternity care. Reduce preventable maternal and new born mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.

26. **Objectives of "LaQshya"**

(a) To reduce maternal and newborn mortality & morbidity due to APH, PPH, retained placenta, preterm, preeclampsia & eclampsia, obstructed labour, puerperal sepsis, newborn asphyxia, and sepsis, etc.

(b) To improve Quality of care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system.

(c) To enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility.

(d) Reorganizing/aligning Labour room& Maternity Operation Theatre layout and workflow as per 'Labour Room Standardization Guidelines' and 'Maternal &Newborn Health Toolkit' issued by the Ministry of Health & Family Welfare, Government of India.

(e) Ensuring that at least all government medical college hospitals and high case-load district hospitals have dedicated obstetric HDUs as per GoI MOHFW Guidelines, for managing complicated pregnancies that require life-saving critical care.

(f) Ensuring strict adherence to clinical protocols for management and stabilization of the complications before referral to higher centres. Under the National Health Mission, the States have been supported in creating Institutional framework for the Quality Assurance – State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC), and Quality Team at the facility level. These committees will also support implementation of LaQshya interventions.

27. **National Level National Mentoring Group** would include members of the Programme Divisions,IEC Division, NHSRC, NIHFW, AIIMS, and Medical Colleges, Nursing collages, Schools of Public Health, Professional Associations, Hospital Planners, IT professionals, Development Partners, Empanelled external assessors & eminent professional persons.

28. **State Level** State NHM, Departments of Health and Medical Education would jointly create institutional arrangement for seamless flow of support and removal of the bottle-necks, if any for implementation of this initiative.

29. **State Mentoring Group** State Mission Director would constitute the State mentoring group, consisting of programme officers, suitable faculty of AIIMS and other eminent National Institutions and medical education department, State Nodal Officers for Quality, IEC, procurement, infrastructure, State Level Development Partners and eminent professionals.

30. **District Level** Coaching Team- An external multidisciplinary team, responsible for mentoring one or more labour rooms, would comprise of District family welfare officer/RCHO (equivalent),district/divisional quality consultants, nursing instructors /mentors from the functional skill, faculty of nearest medical colleges and representatives of professional associations and development partners. The coaching team in districts with medical college could include one or more retired faculty members as a coach for medical college labour rooms and operation theatre. In the early phases, one coaching team could mentor four or five districts since training every district coaching team in a short span of time may not be possible.

31. **Quality Circle** Quality circles are informal groups of the staff in each department that works closely to improve the QOC therefore example, Quality circle in a labour room would involve of Gynaecologist, Paediatrician, Matrons and Nursing Staff &Support Staff. In the Operational theatre, anaesthetist would also be a member of the Quality circle. The Quality Circles will work in coordination with facility level quality team headed by the Medical Superintendent or facility incharge.

32. **Targets**

(a) **Immediate (0-4 Months)**

(i) 80% of the selected Labour rooms &Maternity OTs assess their quality and staff competence using defined NQAS checklists and OSCE.

(ii) 80% of Labour rooms & Maternity OTs have setup functional quality circles and facility level quality teams.

(b) **Short Term (up to 8 Months)**

(i) 80% of Labour Room and OT Quality Circles are oriented to latest labour room protocols, quality improvement processes and respectful maternity care (RMC).

(ii) 50% of deliveries take place in presence of the Birth Companions.

(iii) 60% of deliveries conducted using safe birth checklist and Safe Surgery Checklist in Labour Room &Maternity OT respectively.

(iv) 60% of the deliveries are conducted using real-time parto graph.

(v) 30% increase in Breast Feeding within one hour of delivery

(vi) 80% labour rooms and Maternity OT stake microbiological samples from defined areas every month.

(vii) 30% reduction in surgical site infection rate in the Maternity OT.

(c) **Intermediate Term(Up to 12 Months)**

(i) 30% increase in antenatal corticosteroid administration in case of preterm labour.

(ii) 30% reduction in pre-eclampsia, eclampsia & PIH related mortality.

(iii) 30% reduction in APH/PPH related mortality.

(iv) 20% reduction in new-born asphyxia related admissions in SNCUs for inborndeliveries.

(v) 20% reduction in newborn sepsis rate in SNCUs for inborn deliveries.

(vi) 20% reduction in Stillbirth rate.

(vii) 80% of all beneficiaries are either satisfied or highly satisfied.

(viii) 60% of the labour rooms are reorganized as per 'Guidelines for Standardisation of Labour Rooms at Delivery Points'.

(ix) 80% of labour rooms have staffing asper defined norms.

(x) 100% compliance to administration of Oxytocin, immediately after birth.

(xi) 30% improvement in OSCE scores of labour room staff.

(xii) 100% Maternal death, Neonatal Death audit and clinical discussionon near miss/maternal and neonatal complications.

(d) **Long Term (up to 18 Months)**

(i) 60% of labour rooms achieve quality certification against the NQAS.

(ii) 50% of labour rooms are linked to Obstetrics HDU/ICU.

(iii) 15% improvement in short term &Intermediate targets.

32. Key approach under this initiative is break through improvement using business process re-engineering concepts. This would require substantial reorganization of labour room structure (Infrastructure, HR, and Drugs& Equipment) and processes.

33. **Structural** improvement will include :

(a) Upgrading the infrastructure as per norm& realistic case-load.

(b) Human Resource augmentation and skill upgradation.

(c) Ensuring availability of adequate functional& calibrated equipment, as per need.

(d) Strengthening the supply chain system of drugs & consumables for ensuring their availability in the labour room and OT as per need

34. **Process** improvement will include:

(a) Assessment and Triage

(b) Management of Labour including Active Management of Third stage of labour.

(c) Management of complications and High-Risk Pregnancies.

(d) Management of referral services.

(e) Peri operative processes for C-Section.

(f) Newborn care and resuscitation.

(g) Management of required support services for the Labour room, Maternity OT.

(h) Sensitisation of the Staff on RMC and its monitoring.

CHAPTER 2 : REVIEW OF LITERATURE

35. While India's maternal mortality rate declined substantially during 2004-2006 to 2014-2016, at an annual rate of 5%, the reduction is still short of what is required to achieve the National Health Policy target. Strategy to sustain and accelerate the decline by greater access to quality and respectful healthcare for women; funding for infrastructure, medicines, and interventions in the labour room; and training of personnel is the call of the day.

36. As per the Sample Registration System (SRS) data, India has achieved the Millennium Development Goal (MDG) 5A, which stated that all countries should reduce Maternal Mortality Rate MMR by 75% of their respective 1990 figures by 2015[i]. However, other sources seem to put the MMR at a higher figure[ii]. Regardless, we have seen a pan-India decline in (MMR), at an annual rate of 5% during 2004-2006 to 2014-2016. In March 2017, with the aim of achieving the Sustainable Development Goals (SDGs)[iii], Government of India proposed the National Health Policy (NHP), which set an MMR target of 100 to be achieved by 2020. This means that India would have to reduce its MMR at an annual rate of 5.75% in the coming years, which is more than its annual average reduction during 2004-2006 to 2014-2016.

37. However, achieving this target would be an uphill task, as any further reductions in the MMR at the national level would require ending preventable maternal mortality. Moreover, considerable amount of resources need to be instituted for per unit of count reduction in order to sustain and accelerate India's successes. This would require continuous reductions in both mortality and morbidity, with complementary improvements along the continuum of care for women (World Health Organization (WHO), 2015).

38. Within this context, strengthening of health systems and continuous learning; enabling and mobilizing individuals and communities; and advancing quality, respectful care have been identified as critical to making progress towards this goal (United States Agency for International Development (USAID), 2014).

39. Secondly, access to healthcare in terms of maternal health should be given to all women. This encompasses a broad spectrum of interventions ranging from educating and empowering women with regard to maternal health; family planning initiatives; addressing inequities in access to and quality of sexual, reproductive, and maternal healthcare; and enhanced mobilization of individual and communities. A good starting point would be to learn from past experiences through a thorough review of existing demand-side interventions[7].

40. This will aid in identifying major gaps in the provision and access of basic maternal healthcare that impede reduction in maternal mortality, and guide stakeholders in adopting practices that have been proven to work. For example, assessments of the Janani Suraksha Yojana (JSY)[iv] show that it had an impressive effect on rates of institutional delivery, but no effect on maternal mortality. Certain studies show that targeted delivery of messages through media campaigns was found to be more effective than peer education, and women receiving health education were less likely to experience pregnancy and labour-related issues. Moreover, such interventions can be effectively complemented by community-led interventions to hold the government and providers accountable, in case the quality of existing services falls. For example, how following local protests against a high number of maternal deaths in 2015 in Barwani district in Madhya Pradesh, a maternal death review was conducted by civil society to investigate the 27 maternal deaths reported in the district Furthermore, in order to save mothers lives, there is a urgent requirement to provide them with skilled obstetric care, which can be accessed in facilities.

41. But what happens it has been ensured that mothers opt for institutional deliveries and these facilities turn out to be ill-equipped. Muldoon et al. (2011) finds that almost one-third of rural health sub-centers lack regular water and electrical supply, elevating the risk of infection (Neil et al. 2017). Additionally, Hulton et al. (2007), Ghodki and Sardesai (2014), Jadon and Bagai (2014) show that one-third of PHCs lacked labour rooms, and some hospitals lacked essential drugs, performed surgical procedures such as Caesarean sections with no onsite blood banks or reliable anesthetics and sometimes without health professional, further increasing the risk of unmanaged pregnancy complications. In such cases, the process would not be effective unless funding is set aside by each state for improving infrastructure and training staff to tackle major causes of maternal deaths across all delivery points[v].

42. Finally, none of the above processes would work efficiently without continuously updating personnel knowledge related to the management of labour and delivery and also in terms of improving the quality of "respectful care". Das et al. (2015, 2012) find that less than one-third of providers in India adhere to clinical guidelines and fewer than half of clinical interactions result in correct diagnoses and treatment (Neil et al. 2017). Hence, a direct complement to review, access, and funding is a homogenized emergency obstetric care (EMOC) training programme, which should be initiated at the state level.

43. It should be directed at two levels of caregivers, that is, at the facility level for obstetricians, nurses and nursing attendants/cleaners[vi], and at the frontline worker level for accredited social health activists (ASHA) and auxiliary nurse midwives (ANM). Ideally this training programme should cover evidence-based clinical guidelines and techniques to ensure that caregivers are updated with the latest information and best practices. Anecdotal evidence has shown that training and feedback reduces unnecessary and potentially harmful practices, improves access to skilled maternal and neonatal care in rural areas, and helps in managing maternal complications with and without the need for referral. Training clinicians and programme managers also improve in adherence to evidence-based practices (Iyengar et al.2014).

44. Kerala's example of efforts put in should pave the way for more states to adopt a viable strategy to improve MMR. Their experience also points out where the strategy could fail especially if the administration becomes lax in its implementation. This will be a potential logistical problem that the states might face while implementing the Review component of the strategy in the beginning. Therefore, the central government should support the states, firstly in their efforts to adopt a viable strategy to improve MMR, by institutionalising it and making it mandatory for all public hospitals to report maternal deaths with complete documentation to a CRMD committee at the state level[vii]. This can be further extended to private hospitals over a period of time. In addition, special attention should also be given to improving documentation practices among physicians and their interns[viii]. Within this capacity, a central mandate conveying such responsibilities to relevant obstetrician and gynecologist unions[ix] in each state would be a way to go. In this process, the states could work with these unions to set up a CRMD committee. Such unions could decide on the methodology for the review committees to follow, given the situation in a particular state, that is, review of case sheet, death report or autopsy reports. Secondly, the Centre should also extend funds to each state for the purchase of necessary equipment, improving infrastructure, and for training labour-related personnel. Presently, **LaQshya** and **Dakshata programmes** under the aegis of the National Health Mission are steps in that direction. Thirdly, an expert panel should be set up at the national level to review the present course structure of the EMoC (Emergency Obstetric Care) initiative [x] which all the states could follow, thereby ensuring homogeneity in training content across the country.

45. Fourthly, a separate cadre of obstetric nurses should also be formed. This would ensure that such trainings do not suffer from administrative bottlenecks like staff rotation. This would help in retaining staff trained in such methods within the delivery unit. Therefore, if the administration is able to adopt the core principles and provide necessary support to states for its implementation, it can be expected that India will be able to achieve its MMR target set by the SDGs.

46. Ministry of Health and Family Welfare has launched the program 'LaQshya', aimed at improving quality of care in labour room and maternity Operation Theatre (OT).The Program will improve quality of care for pregnant women in labour room, maternity Operation Theatre and Obstetrics Intensive Care Units (ICUs) and High Dependency Units (HDUs).The LaQshya program is being implemented at all Medical College Hospitals, District Hospitals and First Referral Unit (FRU), and Community Health Center (CHCs) and will benefit every pregnant woman and new-born delivering in public health institutions.

47. Essential Details of LaQshyaProgramme

(a) 'LaQshya' will reduce maternal and newborn morbidity and mortality, improve quality of care during delivery and immediate post-partum period and enhance satisfaction of beneficiaries and provide Respectful Maternity Care (RMC) to all pregnant women attending public health facilities.

(b) The Program aims at implementing 'fast-track' interventions for achieving tangible results within 18 months. Under the initiative, a multi-pronged strategy has been adopted such as improving infrastructure up-gradation, ensuring availability of essential equipment, providing adequate human resources, capacity building of health care workers and improving quality processes in the labour room.

(c) To strengthen critical care in Obstetrics, dedicated Obstetric ICUs at Medical College Hospital level and Obstetric HDUs at District Hospital are operationalized under LaQshya program.

(d) The Quality Improvement in labour room and maternity OT will be assessed through NQAS (National Quality Assurance Standards). Every facility achieving 70% score on NQAS will be certified as LaQshya certified facility. Furthermore, branding of LaQshya certified facilities will be done as per the NQAS score.

(e) Facilities scoring more than 90%, 80% and 70% will be given Platinum, Gold and Silver badge accordingly.

(f) Facilities achieving NQAS certification, defined quality indicators and 80% satisfied beneficiaries will be provided incentive of Rs 6 lakh, Rs 3 lakh and Rs 2 lakh for Medical College Hospital, District Hospital and FRUs respectively.

48. India has come a long way in improving maternal survival as Maternal Mortality Ratio (MMR) has reduced from 167 maternal deaths in 2011-13 to 130 in year 2015-16, an impressive decline of 22% in this period. India is further committed to ensuring safe motherhood to every pregnant woman in the country.

49. A transformational improvement in the quality of care around child-birth- relating to intrapartum and immediate postpartum care shall dramatically improve maternal and new-born outcomes.

50. The LaQshya programme aims at implementing 'fast-track' interventions for achieving tangible results within 18 months. Under the initiative, a multipronged strategy has been adopted, including improving infrastructure upgradation, ensuring availability of essential equipment, providing adequate human resources, capacity building of healthcare workers and improving quality processes in the labour room.

51. Therefore there is a need to review the LaQshya programme with reference to assessing the Quality of Care of facilities in Labour rooms under ''LaQshya''Programme and find out if the targets and deliverables as envisaged are being met or not by the government health care facilities.

CHAPTER 3: AIM AND OBJECTIVES

Aim

52. Assessment of the Quality of Care of facilities assessed in Labour rooms under ‘’LaQshya’’Programme in the financial Year 2018-2019.

Objectives of Study

53. The objectives of this study is to analyze the following from the perspective of a health administrator:

(a) To identify high and low performing standards in Labour room in the LaQshya implemented states.

(b) To measure the quality of care according to eight specific thematic areas.

54. **Expected Outcome of the Study**

(a) Identification of good and weak performing standards in Labour room under ‘’LaQshya’’ Programme.

(b) Knowledge of the weak areas in labour rooms in LaQshya implementation states.

CHAPTER 4: METHODOLOGY

55. **Methodology**

(a) **Gen**. Data of the external assessments of the, District Hospitals (DHs), Sub- District Hospitals (SDHs) and under "LaQshya" across the states in the financial year 2018-2019 was analyzed. Also, the Hospital Score card and Report of the states under the "LaQshya" initiative was studied to analyze their over all score and standard wise score to Identify the high and low performing standards and an overall pattern of quality certification of labour rooms under "LaQshya" implementation in the states .Collection of secondary data of total assessed Facilities under LaQshaya.

(b) **Study Area**. The study was carried-out at NHSRC, New Delhi and data of the external assessments of the public health facilities to include District Hospitals (DHs), Sub-District Hospitals (SDHs) who had undergone external assessment under "LaQshya" across the states in the financial year 2018-2019 was analyzed.

(c) **Study Design**. Descriptive study design involving quantitative analysis to assess the Quality of Care of facilities assessed in Labour rooms under ''LaQshya'' Programme in the financial Year 2018-2019,

(d) **Study Period**. 01 Feb to 30 Apr 2019 in three phases. In first phase Organization protocols, framework, work culture was understood and study approval was taken. In second phase tools were decided. In third phase data analysis was done. Data collection was done simultaneously during a period of three months.

(e) **Study Population**. The study involves all the district hospitals and sub district hospitals assessed under LaQshya Programme in the financial year 2018-2019. It includes 43 facilities from different states which are certified, certified with conditionality and declined as per the certification criteria mentioned for Labour Room under LaQshya programme. (Annexure1).

(f) **Sampling Technique and Size**. Purposive sampling technique was used. The facilities which were assessed according to Labour room checklist were taken out of which the data of District Hospitals and Sub District Hospitals were collected. 43public health facilities out of total of 60 have been analyzed during the study.

(g) **Study Tool**. For data collection, reports filed by assessors of NHSRC was studied and relevant data extracted for comparison. Secondry data has been used for the entire study purpose.

S.No	Objective	Variable	Study Population	Tools & Technique
(a)	To Identify high and Low performing standards in Labour room in the LaQshya implemented states	External assessment score of certified, certified with conditionality and differed/declined District & Sub District Hospitals assessed in Labour room department under LaQshya programme	43 facilities assessed in labour room department under LaQshya programme	Record review (summary reports of each faciltiies, Labour room checklist)
(b)	To measure the quality of care according to eight specific thematic area	External Assessment score of the all 43 facilities under LaQshya Programme	43 facilities assessed in labour room department under LaQshya programme	Record Review

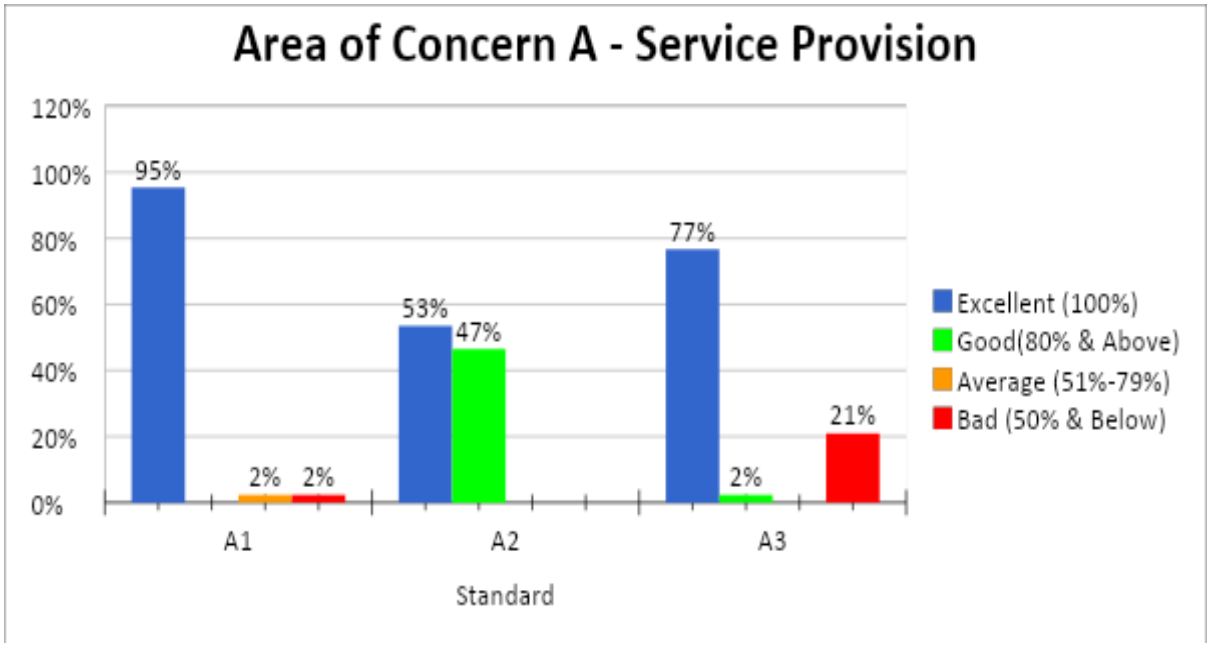
State	Count of Certified	Count of Conditionality	Count of Deferred / Declined	Total
Andhra Pradesh		1	2	3
Assam	1	2		3
Bihar	2		1	3
Chhattisgarh	2	2	1	5
Dadra & Nagar Havelli	2			2
Gujarat	1	3	4	8
Haryana	2	2		4
Jharkhand		1	1	2
Madhya Pradesh	4	1		5
Rajasthan		1	1	2
Tamil Nadu	1	1		2
Telangana	2			2
Uttar Pradesh	1			1
Uttarakhand	1			1
Grand Total	**19**	**14**	**10**	43

CHAPTER 5: OBSERVATIONS AND ANALYSIS

56. All the external assessment scores were checked, coded and entered in excel sheet . After entering the scores criteria of analysis were made. The date was further divided into four categories that are as follows:

S.No	Criteria	Scoring Pattern
(a)	Excellent Standards	Facilities which have scored 100% score in the respective standard showing full compliance.
(b)	Good Standards	Facilities which have scored 80% & above in the respective standard
(c)	Averag e Standards	Facilities which have scored between 51% to 79% in the respective standard
(d)	Poor Standards	Facilities which have scored 50% & below in the respective standard

Ananlysis of Area of concern A

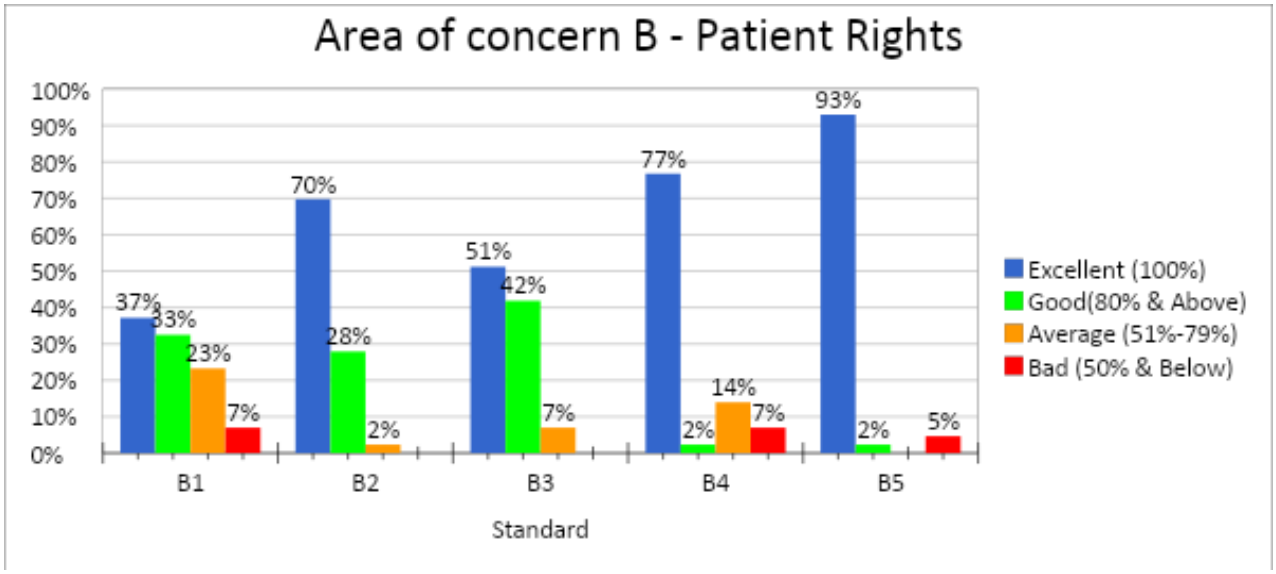


57. **Major Strength**

- 41 facilities provides curative services
- Almost 43 facilities were able to provide RMNCHA services
- 34 facilities have 24X7 availability of diagnostic services

58, **Gap Observed** –

- 21%facilities were not able 24 /7 availability of diagnostic services

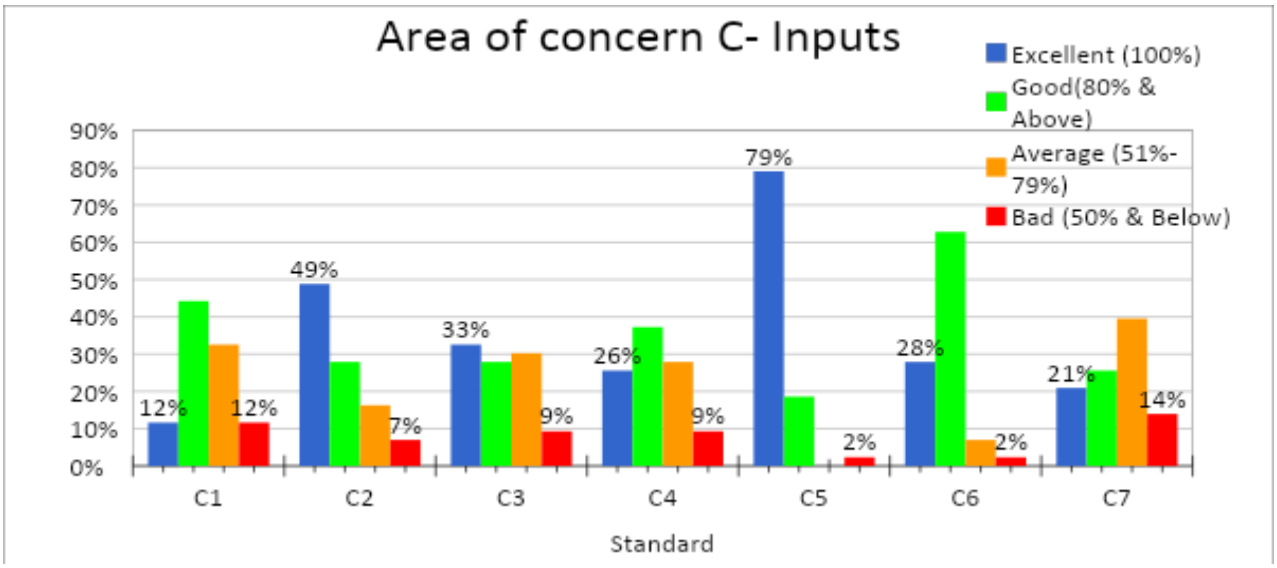


59. **Strengths/ Good Practices**

- 93% of the facilities ensures that there is no financial barrier to access hospital services

60. **Gaps observed**

- 7% facilities lack in providing information to care seekers, attendants & community regarding availability of services
- 7% Facilities lack in informing patients about the medical condition& involving them in treatment planning

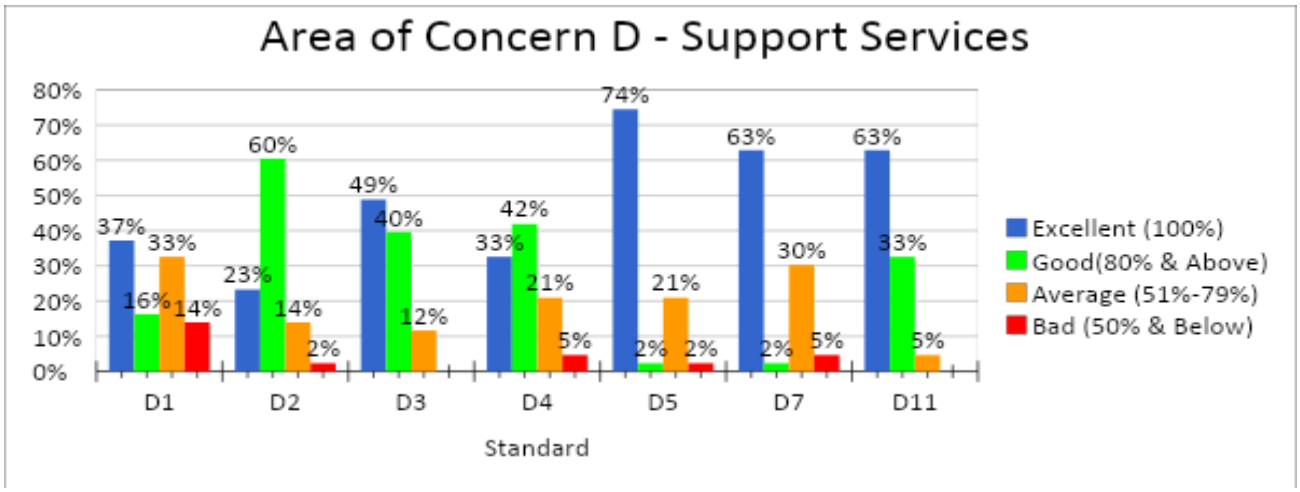


61. **Strengths/ Good Practices**

- 79% of the facilities achieved full compliance in providing drugs and consumables required for assured services

62. **Gaps observed**

- 14% of the facilities lack in providing defined and established procedure for effective utilization, evaluation and augmentation of competence & performance of staff
- 12% of the facilities does not have adequate space as per delivery load& lack of patient amenities such as drinking water, toilet & changing area
- 9% of the facilties does not have established programme for fire safety and other disaster
- 9% of the facilties lack adequate qualified and trained staff as per service provision and work load

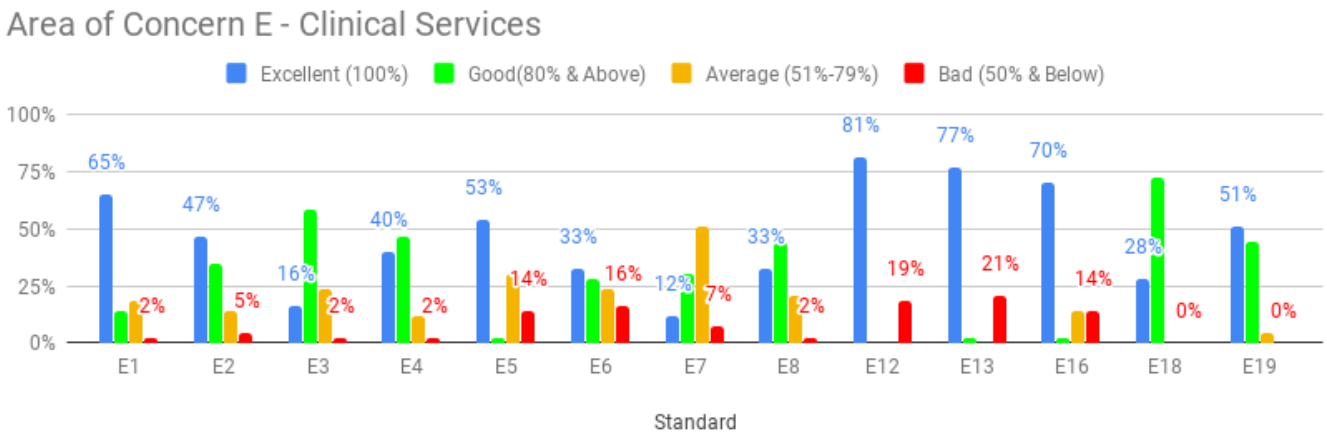


63. **Strengths/ Good Practices**

- 74% of the facilities have achieved full compliance in ensuring 24X7 water & power backup as per requirement of service of delivery
- 63% facilities were able ensure clean line to the patients
- 63% facilities has established procedure for duty roster and deputation to different department

65. Gaps observed

- 14% of the facilities lack in providing established programme for inspection, testing, maintenance & calibration of Equipment

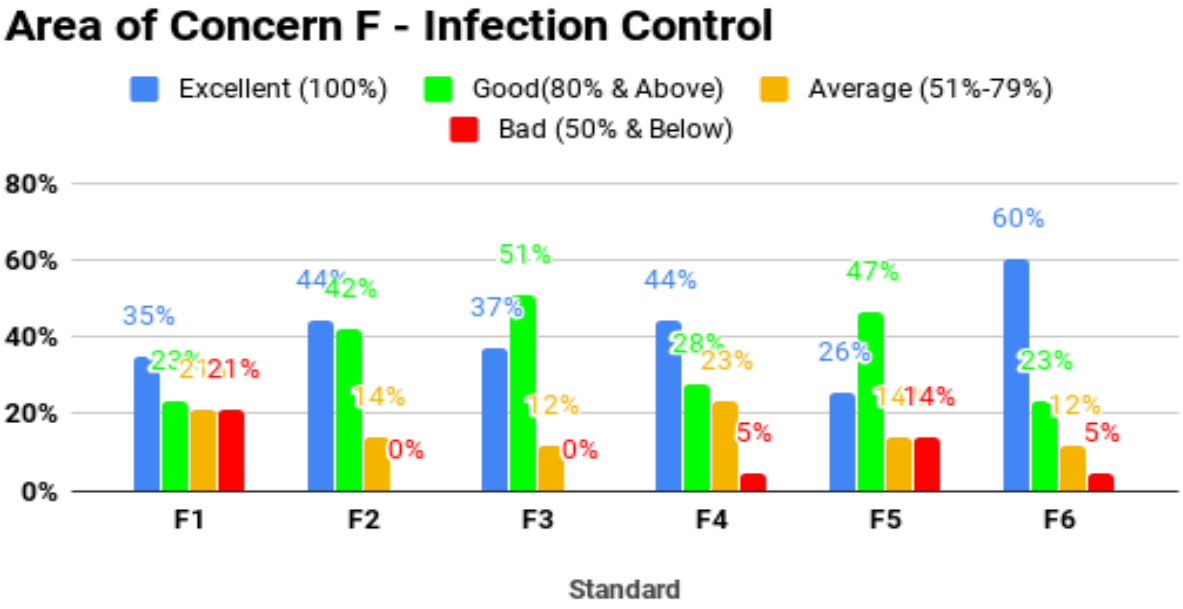


66. **Strengths/ Good Practices**

- 81% of the facilities has established procedure of diagnostic services
- 77% of the facilities has established procedure for Blood Bank/ Storage Management & Transfusion
- **Note-** Although maximum no. of facilities are performing well under these standards but there are high percentage of facilities which are performing poorly under the same standards

67. **Gaps observed**

- 16% of the facilities lack in following standard treatment guidelines defined by state/ Central Govt for prescribing the generic drug & their rationale use
- 14% of the facilities lack in identifying high risk and vulnerable patients
- 14% of the facilities lack in having a standard procedure for handing the death in the hospitals

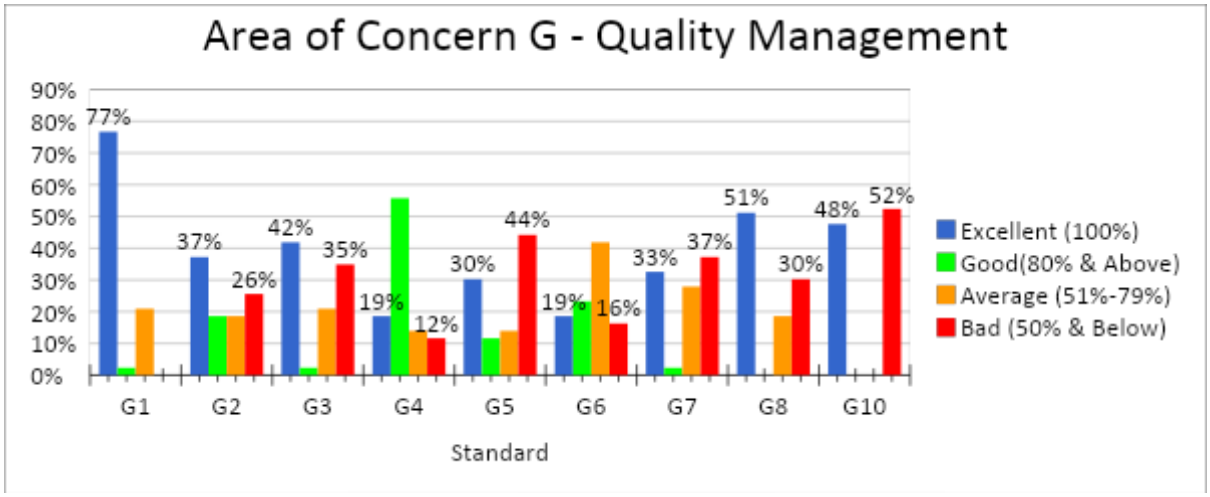


68. <u>Strengths/ Good Practices</u>

- 60% of the facilities has defined procedure for segregation, collection, treatment and disposal of Bio Medical & hazardous waste

69. **<u>Gaps observed</u>**

- 21% of the facilities does not have proper procedure for prevention and measurement of hospital associated infection
- 14% of the facilities lack in ensuring hand hygiene practices and antisepsis

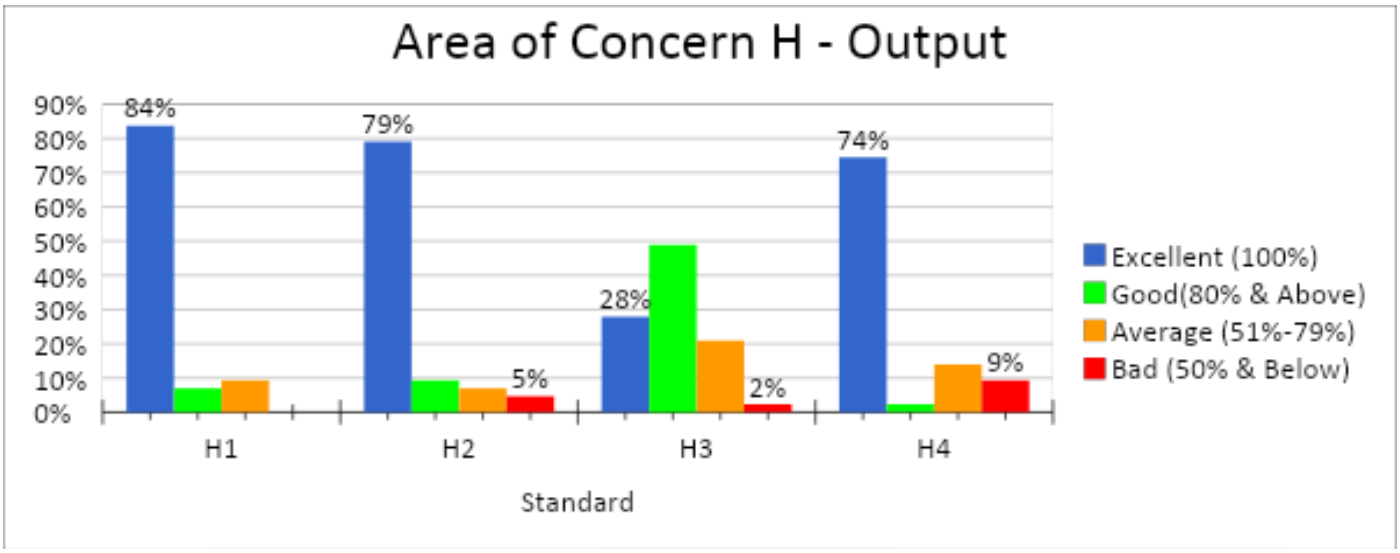


70. **Strengths/ Good Practices**

- 77% of the facilities has established organizational framework for Quality improvement

71. **Gaps observed**

- 52% of the facilities does not have a proper established procedure for assessing, reporting, evaluating and managing risk as per Risk Management Plan
- 44% of the facilities lack in mapping its key processes and seeks to make them more efficient by reducing non value activies and wastages
- 35% of the facilities lack in establishing internal & external quality assurance programme wherever it is critical to quality

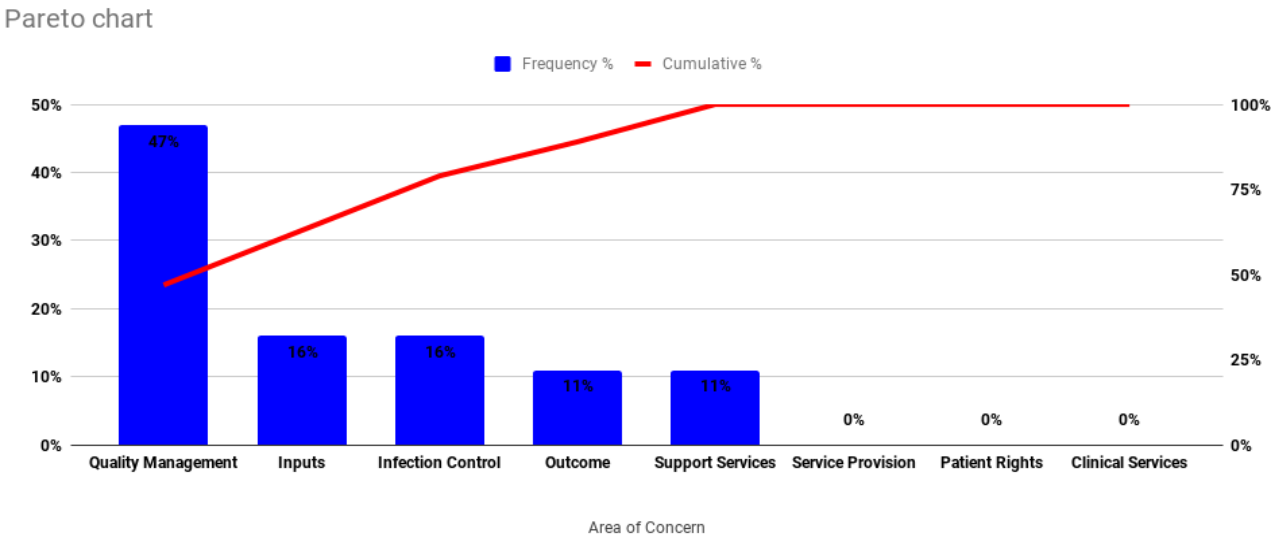


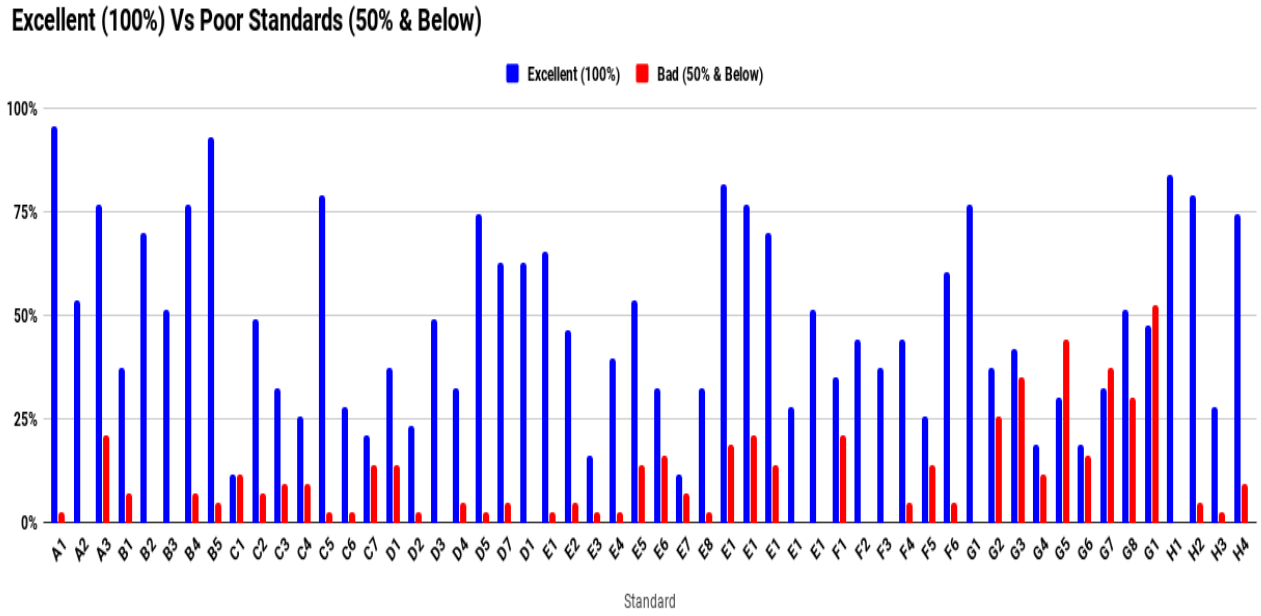
72. **Strengths/ Good Practices**

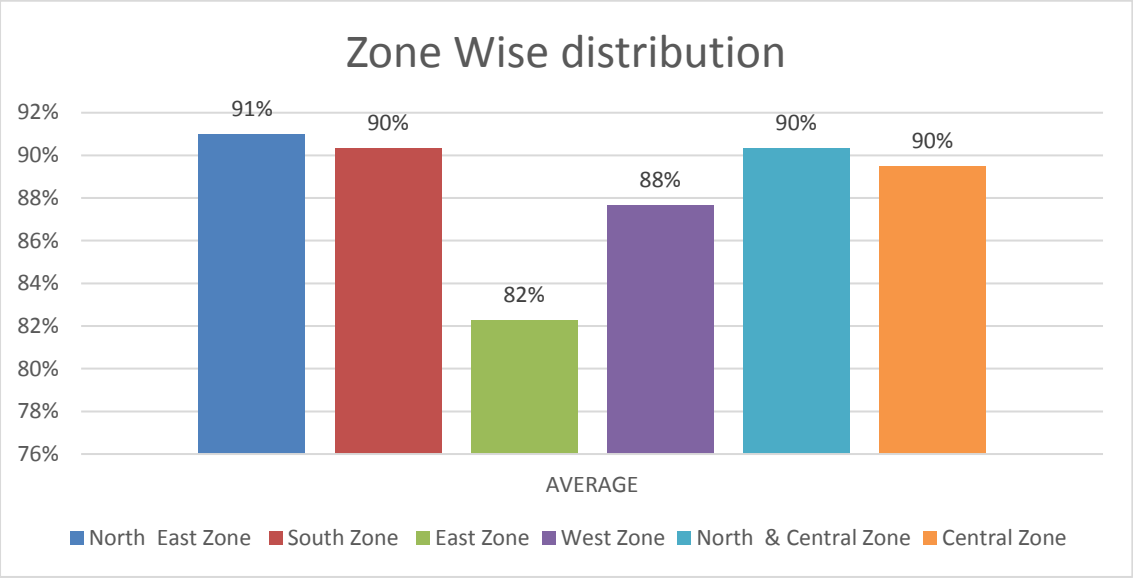
- 84% facilities measures productivity indicators and ensures compliance with state/ National benchmarks

73. **Gaps observed**

- 9% of the facilities measures Service Quality indicators and endeavours to reach state/ National benchmark


Pareto chart
Frequency %
Cumulative %
50%
40%
30%
20%
10%
0%
100%
75%
50%
25%
0%
47%
16%
16%
11%
11%
0%
0%
0%
Quality Management
Inputs
Infection Control
Outcome
Support Services
Service Provision
Patient Rights
Clinical Services
Area of Concern


Excellent (100%) Vs Poor Standards (50% & Below)
Excellent (100%)
Bad (50% & Below)
100%
75%
50%
25%
0%
A1 A2 A3 B1 B2 B3 B4 B5 C1 C2 C3 C4 C5 C6 C7 D1 D2 D3 D4 D5 D7 D1 E1 E2 E3 E4 E5 E6 E7 E8 E1 E1 E1 E1 E1 F1 F2 F3 F4 F5 F6 G1 G2 G3 G4 G5 G6 G7 G8 G1 H1 H2 H3 H4
Standard



Zone	State			AVERAGE
North East Zone	Assam (91%)			91%
South Zone	Telangana (94%)	Tamil Nadu (90%)	Andhra Pradesh (87%)	90%
East Zone	Jharkhand (85%)	Bihar (80%)		82%
West Zone	Dadra & Nagar Havelli (96%)	Gujarat (83%)	Rajasthan (84%)	88%
North & Central Zone	Haryana (93%)	Uttarakhand (81%)	Uttar Pradesh (97%)	90%
Central Zone	Madhya Pradesh (90%)	Chhattisgarh (89%)		90%

Reference No	Standard
Standard A1	The facility provides Curative Services
Standard A2	The facility provides RMNCHA Services
Standard A3	The Facility provides Diagnostic Services.
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities
Standard B2	Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there is no barrier on account of physical, economic, cultural or social reasons.
Standard B3	The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.
Standard B4	The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making
Standard B5	The facility ensures that there is no financial barrier to access, and that there is financial protection given from the cost of hospital services.
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms
Standard C2	The facility ensures the physical safety of the infrastructure.
Standard C3	The facility has established Programme for fire safety and other disaster
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load
Standard C5	The facility provides drugs and consumables required for assured services.
Standard C6	The facility has equipment & instruments required for assured list of services.
Standard C7	Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff
Standard D1	The facility has established Programme for inspection, testing and maintenance and calibration of Equipment
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas
Standard D3	The facility provides safe, secure and comfortable environment to staff, patients and visitors
Standard D4	The facility has established Programme for maintenance and upkeep of the facility
Standard D5	The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms
Standard D7	The facility ensures clean linen to the patients
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures
Standard E1	The facility has defined procedures for registration, consultation and admission of patients.
Standard E2	The facility has defined and established procedures for clinical assessment and reassessment of the patients
Standard E3	The facility has defined and established procedures for continuity of care of patient and referral
Standard E4	The facility has defined and established procedures for nursing care

Standard E5	The facility has a procedure to identify high risk and vulnerable patients.
Standard E6	The facility follows standard treatment guidelines defined by state/Central government for prescribing the generic drugs & their rational use
Standard E7	The facility has defined procedures for safe drug administration
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage
Standard E12	The facility has defined and established procedures of diagnostic services
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion
Standard E16	The facility has defined and established procedures for end of life care and death
Standard E18	The facility has established procedures for Intranatal care as per guidelines
Standard E19	The facility has established procedures for postnatal care as per guidelines
Standard F1	The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection
Standard F2	The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis
Standard F3	The facility ensures availability of material for personal protection
Standard F4	The facility has standard procedures for processing of equipment and instruments
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention
Standard F6	The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.
Standard G1	The facility has established organizational framework for Quality improvement
Standard G2	The facility has established system for patient and employee satisfaction
Standard G3	The facility has established internal and external quality assurance Programmes wherever it is critical to quality
Standard G4	The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.
Standard G5	The facility maps its key processes and seeks to make them more efficient by reducing non-value adding activities and wastages
Standard G6	The facility has established system of periodic review as internal assessment, medical & death audit and prescription audit
Standard G7	The facility has defined mission, values, Quality policy & objectives & prepared a strategic plan to achieve them
Standard G8	The facility seeks continually improvement by practicing Quality method and tools
Standard G10	Facility has established procedures for assessing, reporting, evaluating and managing risk as per Risk Management Plan
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmarks
Standard H2	The facility measures Efficiency Indicators and ensure to reach State/National Benchmark
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark

CHAPTER 6: RECOMMENDATIONS

76. **Organisational level- NHSRC**

- Existing guidelines should focus more on weak performing standards
- Training of assessors regarding facility assessment and certification under LaQshya programme
- Development of IEC and user friendly training material for the facilities and IT enabled tools

77. **District Level**

- Orientation and mentoring of the Quality circles
- Monitoring of availability of point of care diagnostic services and blood transfusion services

78. **Facility level**

- Need to focus on recruitment of optimal and skilled human resources as per case load
- Trainings should be conducted to enhance proficiency of labour room staff for management of the complications through skill lab trainings, simulations and drills
- Sensitization of care providers for delivery of respectful maternity care and close monitoring of language behaviour and conduct of labour room staff
- A comprehensive risk assessment of all clinical processes should be done using pre defined criteria at least one a month
- Process Mapping of critical processes should be done and non value adding activities should be identified.
- Monitoring Adherence to protocol & Clinical guidelines
- Prioritisation and action planning for closure of gaps as per 'Maternal and Newborn Health Toolkit' and 'Guidelines for standardisation of Labour Rooms at Delivery Points

CHAPTER 7: CONCLUSION

80. Under the National Health Mission, the States have been supported in creating Institutional framework for the Quality Assurance - State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC), and Quality Team at the facility level. These committees are required to support implementation of LaQshya interventions. For specific technical activities and program management, special purpose groups have been suggested, and these groups are supposed to work towards achievement of specific targets and program milestones in close coordination with relevant structures within the QA organizational framework.

81. As seen from the above observations and analysis there are few gaps and challenges in the implementation of present standards and checkpoints. Therefore there is a need to review the LaQshya programme with reference to assessing the Quality of Care of facilities in Labour rooms under ‘’LaQshya’’ Programme and review targets and deliverables as envisaged are being met or not by the government health care facilities and amend as per the recommendations of this study..

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[i] As per the SRS, MMR for 2014-2016 is 130. As per the Government of India the target was 140

[ii] The Central Intelligence Agency (CIA) Factbook, World Bank, UNICEF (United Nations Children's Emergency Fund), WHO (World Health Organization) have all calculated the MMR as 176 (2015 estimate).

[iii] So far, Kerala, Maharashtra, and Tamil Nadu have achieved the goal set by the SDGs

[iv] In order to reduce neonatal and maternal deaths, JSY scheme provides a cash incentive for women to deliver at healthcare facilities. It covers about 9·5 million women per year, making it the largest conditional cash transfer programme in the world

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