Dissertation
At
State Institute of Health and Family Welfare,
National Health Mission
Gujarat

"A Study to assess the impact of Skilled Birth Attendant training on the knowledge of SN/ANM at Ahmedabad District, Gujarat"

By

Sujata Singh

PG/14/062

Under the Guidance of

Ms. Kirti Udayai

Assistant Dean- IIHMR Delhi

Post Graduate Diploma in Health Management

2014-16

International Institute of Health Management Research, New Delhi

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CERTIFICATE OF DISSERTATION

The Certificate is awarded to **Sujata Singh**, in recognition of having successfully completed her Internship at **State Institute of Health and Family Welfare, National Health Mission, Gandhinagar, Gujarat**. She has successfully completed her Project on "**A study to assess the impact of Skilled Birth Attendant Training (SN/ANM) at Ahmedabad District, Gujarat.**"

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

We wish her all the best for future endeavors.

એસોસીએટ/પ્રોફેસર
રાજ્ય આરોગ્ય અને પરીવાર કલ્યાણ સંસ્થાન,

Dr. Bina Vadalia
Associate Professor
State Institute of Health and Family Welfare
Gandhinagar
Gujarat

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Sujata Singh,** 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 **State Institute of Health and Family Welfare, National Health Mission, Gujarat** from **15th February 2016** to **16th May 2016.**

The candidate has successfully carried out the study designated to her during Internship and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all the success in all her future endeavors.

for KirtiUdayai

Dr. A.K. Aggarwal
Dean
IIHMR, New Delhi

Ms. KirtiUdayai
Assistant Dean
IIHMR, New Delhi

CERTIFICATE OF APPROVAL

The following dissertation titled "**A Study to assess the impact of Skilled Birth Attendant Training on knowledge of SN/ANM at Ahmedabad District, Gujarat**" at "**State Institute of Health and Family Welfare, National Health Mission, Gujarat**" is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of Post Graduate Diploma in Health and Hospital Management for which it has been submitted.

It is understood that by this approval the undersigned do not necessarily endorse or approve any 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 dissertation.

Name Signature

Dr. SB. Arora.

Dr. B.S. Singh

Dr. Preetha Rd

B S Singh

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Ms. Sujata Singh**, a graduate student of **Post-Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting the dissertation titled "**A Study to assess the impact of Skilled Birth Attendant training (SN/ANM) at Ahmedabad District, Gujarat.**" At "**State Institute of Health and Family Welfare, National Health Mission, Gujarat**" 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 reproduced from any other dissertation, monograph, report or book.

for Kirti Udayai

Ms. Kirti Udayai
Asst. Dean
IIHMR-NewDelhi

12/5/16

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ગાંધીનગર.

Dr. Bina Vadalia
Associate Professor
SIHFW,Gujarat

INTERNATIONAL INSTTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**A study to assess the impact of Skilled Birth Attendant training on the knowledge of SN/ANM at Ahmedabad District, Gujarat**" and submitted by **Sujata Singh,** Enrollment No. **PG/14/062** under the supervision of **Ms. KirtiUdayai, Asst. Dean, IIHMR-New Delhi** for award of Post-Graduate Diploma in Hospital and Health Management of the Institute carried out during the period from **15th February 2016** to **16th March** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this way or any other Institute or other similar institution of higher learning.

Sujata Singh.

Signature

FEEDBACK FORM

Name of the Student: Sujata Singh.

Dissertation Organization: State Institute of Health & Family Welfare, Gujarat (NHM, Gujarat)

Area of Dissertation: SIHFW, Gujarat

Attendance: 100%

Objectives achieved: She has successfully completed tasks given to her.

Deliverables: Assessment of SBA training in Ahmedabad.

Strengths: committed, sincere, have strong drive & zeal for learning.

Suggestions for Improvement: Keep doing the good work.

13/6/16

એસોસીએટ પ્રોફેસર
રાજ્ય આરોગ્ય અને પરીવાર કલ્યાણ સંસ્થાન,
ગાંધીનગર.

Signature of the Officer-in-Charge

Date:
Place:

Acknowledgement

At the completion of my dissertation, I would like to show my sincere gratitude to the **State Institute of Health and Family Welfare**, **Gujarat,** especially to the **Dr. Nilam J. Patel, Director, SIHFW-Gujarat** for providing me such opportunity. Without his constant support and guidance it would never be a success.

I wish to express my deep sense of gratitude to my Organizational Mentor **Dr. Bina Vadalia, Associate Professor, SIHFW, Gujarat** for her constant help and cooperation, able guidance and Valuable suggestion and inspiration. She was kind enough to give her valuable time from her extremely busy schedule. Words are inadequate to offer my thanks to all the respected staff at **SIHFW, Gujarat** for their able guidance and support throughout the dissertation period.

I am glad to acknowledge my guide **Ms. Kirti Udayai, Assistant Dean, IIHMR-New Delhi** for incorporating right attitude in me towards learning and for helping and supporting whenever required.

I am grateful to **International Institute of Health Management Research, New Delhi** for giving me an opportunity to learn administrative tricks and styles.

I genuinely thank my parents, family and friends for their blessings and support.

Sujata Singh
PG/14/062

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
AD(PH)	Additional Director (Public Health)
AD(FW)	Additional Director (Family Welfare)
AD(MS)	Additional Director (Medical Services)
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AFHS	Adolescent Friendly Health Services
AMTSL	Active Management of Third Stage of Labour
BEmOC	Basic Emergency Obstetrics Care
CEmOC	Comprehensive Emergency Obstetrics Care
CTI	Collaborating Training Institute
CDMO	Chief District Medical Officer
CDHO	Chief District Health Officer
DTC	District Training Center
DTT	District Training Team
DPMR	Disability Prevention and Medical Rehabilitation
DPHN	District Public Health Nurse
DNEA	Diploma in Nursing Education and Administration
ENBC	Early New Born Care
EmNBC	Emergency Newborn Care
EmOC	Emergency Obstetrics Care
FBNC	Facility Based New Born Care
FHS	Female Health Supervisor
FHW	Female Health Worker
FHSTS	Female Health Supervisor Training School
FHWTS	Female Health Worker Training School
FIMNCI	Facility Based Integrated Management of Neonatal and Childhood Illnesses
FPTC	Family Planning Training Center
GNM	General Nursing and Midwifery
GOI	Government Of India
GOG	Government Of Gujarat
GNC	Gujarat National Council
HFWTC	Health and Family Welfare Training Center
IMR	Infant Mortality Rate
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IUD	Intra-Uterine Device
ICDS	Integrated Child Development Scheme
IYCF	Infant and Young Child Feeding
INC	Indian National Council
LSAS	Life Saving Anesthetic Skills

MMR	Maternal Mortality Ratio
MDR	Maternal Death Review
MDG	Millennium Development Goals
MO	Medical Officer
MPHW	Multi Purpose Health Worker
MPHS	Multi Purpose Health Supervisor
MTP	Medical Termination of Pregnancy
NSV	Non Scalpel Vasectomy
NSSK	Navjat Shishu Suraksha Karyakram
NHM	National Health Mission
NVBDCP	National Vector Borne Disease Control Programme
NIPI	National Iron Plus Initiative
NPPCD	National Programme for Prevention and Control of Deafness
NCD	Non Communicable Diseases
OJT	On Job Training
ORS	Oral Rehydration Solution
PIP	Program Implementation Plan
PHN	Public Health Nurse
PPIUCD	Post Partum Intra Uterine Device
QMO	Quality Management Officer
RPHN	Regional Public Health Nurse
RPHTI	Regional Public Health (Nurse) Training Institute
RTI	Reproductive Tract Infection
RFPTC	Regional Family Planning Training Center
RCH	Reproductive Child Health
RMNCH+A	Reproductive Maternal Neonatal and Child Health plus Adolescent Health
RBSK	Rashtriya Bal Swasthya Karyakram
RKSK	Rashtriya Kishor Swasthya Karyakram
RNTCP	Revised National TB Control Programme
STI	Sexually Transmitted Infection
SAM	Severe Acute Malnourishment
SBA	Skilled Birth Attendant
SIHFW	State Institute of Health and Family Welfare
SFI	Self Financed Institute
TFR	Total Fertility Rate
TOT	Training of Trainers
WIFS	Weekly Iron Folic Acid Supplementation

CONTENTS

ABSTRACT

This Descriptive Study was conducted in Ahmadabad District, Gujarat. The study was conducted to assess the impact of SBA training in knowledge; attitude and work efficiency of SBA trained SN/ANM in Ahmadabad District, Gujarat. A total of 49 Government Healthcare Facilities including PHCs, CHCs, SDH and DH were visited to carry out the study. 50 SBAs (20-SNs/30-ANMs) were selected through convenient random sampling. The data was collected through pre-designed and pre-tested interview schedule cum monitoring checklist. The data was analyzed through Microsoft Excel 2013.

Result: In this study it was found that around 50% of SBAs (SNs/ANMs) were given training 4-5years ago. And also they are lacking knowledge about key areas viz. active management of third stage of labour, MagSulph dose and route, Identification & management of complications related to pregnancy etc.

Conclusion: It was found that 20% SBAs did not received practical hands on training and majority of them did not stay in the campus during the whole training period. Around 50% has received training years ago. Therefore, it is recommended to conduct strict monitoring during ongoing training. A refresher training for SBAs may also be conducted for better results.

INTRODUCTION

Majority of births in India take place at home and a large proportion are assisted by unskilled persons. In such situations, women who experience life threatening complications seldom receive the required lifesaving emergency services because of several factors including lack of skilled birth attendant at the time of delivery. The major causes of maternal deaths have been identified as haemorrhage, sepsis, obsrtucted labour, toxaemia, and unsafe abortion. Anemia as an indirect cause, contributes to one fifth of maternal deaths. It is estimated that for each woman who dies, as many as 30 other women develop chronic debilitating conditions which seriously affect their quality of life. Most of these causes cannot be reliably predicted; early detection and timely management can save many of these women's lives.

In the last few decades various Government of India (GoI) programs focused on women and children have addresses the issue of maternal morbidity and mortality. The focus has shifted from providing mere essential obstetric care and training of TBAs to include emergency obstetric care and skilled attendance at birth.

Skilled birth attendance is central to the continuum of care in public health systems, serving as a critical link between the mother-baby units, community, and health system. Skilled birth attendants are recognized as health professionals trained (and accredited) in skills to manage normal pregnancies, deliveries, and postnatal care, and to identify, manage, or refer presenting complications in pregnant or postpartum women and newborns (WHO 2005).

Up to 40% of pregnancies can require some form of special care, and about 15% of all pregnant women develop complications during the intra-partum and immediate post-partum period and need access to emergency obstetric care (Fauveau 2004). Twenty-five percent of obstetric complications and maternal deaths occur during childbirth, while 60% occur immediately thereafter (WHO, ICM, FIGO 2004; UNFPA 2005). Skilled attendance during this period can help prevent, detect, and manage major complications, reducing maternal deaths by 16-33% (Graham *et al.* 2001).

State Profile:

The state of Gujarat has an area of 196,024 sq. km. and a population of 60.38 million. There are 25 districts, 170 blocks and 18539 villages. The State has population density of 258 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 22.66% (against 21.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

The Total Fertility Rate of the State is 2.3. The Infant Mortality Rate is 41 and Maternal Mortality Ratio is 122 (SRS 2010 - 2012) which are lower than the National average. The Sex Ratio in the State is 918 (as compared to 940 for the country). Comparative figures of major health and demographic indicators are as follows:

Demographic, Socio-economic and Health profile of Gujarat State as compared to India figures

Indicator	Gujarat	India
Total population (In crore) (Census 2011)	6.03	121.01
Decadal Growth (%) (Census 2011)	19.17	17.64
Infant Mortality Rate (SRS 2013)	36	40
Maternal Mortality Rate (SRS 2010-12)	122	178
Total Fertility Rate (SRS 2012)	2.3	2.4
Crude Birth Rate (SRS 2013)	20.8	21.4
Crude Death Rate (SRS 2013)	6.5	7
Natural Growth Rate (SRS 2013)	14.3	14.4
Sex Ratio (Census 2011)	918	940
Child Sex Ratio (Census 2011)	886	914
Schedule Caste population (in crore) (Census 2001)	0.35	16.6
Schedule Tribe population (in crore) (Census 2001)	0.74	8.4
Total Literacy Rate (%) (Census 2011)	79.31	74.04
Male Literacy Rate (%) (Census 2011)	87.23	82.14
Female Literacy Rate (%) (Census 2011)	70.73	65.46

Health Infrastructure of Gujarat

Particulars	Required	In position	Shortfall
Sub-centre	9156	7274	1882
Primary Health Centre	1433	1158	275
Community Health Centre	358	318	40
Health worker (Female)/ANM at Sub Centres & PHCs	8432	6431	2001
Health Worker (Male) at Sub Centers	7274	4874	2400
Health Assistant (Female)/LHV at PHCs	1158	875	283
Health Assistant (Male) at PHCs	1158	758	400
Doctor at PHCs	1158	778	380
Obstetricians & Gynecologists at CHCs	318	9	309
Pediatricians at CHCs	318	3	315
Total specialists at CHCs	1272	76	1196
Radiographers at CHCs	318	168	150
Pharmacist at PHCs & CHCs	1476	1428	48
Laboratory Technicians at PHCs & CHCs	1476	1365	111
Nursing Staff at PHCs & CHCs	3384	2705	679

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

PROBLEM STATEMENT

In 2000, UN Millennium Development Goals were adopted by United Nations which were hinged on 8 critical aspects covering large ambit of life which were focal for developing countries. Of the eight goals of the MDG Goal 4 is to reduce child mortality, Goal 5 is to improve maternal health while Goal 3 is about promoting gender equality and woman empowerment. Thus three out of eight goals are associated closely with mother and child health.

The fourth and fifth goals closely associated with motherhood thus pregnancy related complications are considered as focal points. According to Two-thirds rule most of the child deaths occur within 24 hours of birth and other side there is still high maternal mortality rate in developing countries which underscores importance of the MDGs and vis-à-vis professional care during pregnancy and specifically during delivery.

Provision of universal health coverage is one of the welfare mandates which feature itself in 12th Five year plan that necessitates special focus on vulnerable population groups. In a country like India which is primarily a rural country where most of the population resides in rural India combined with low literacy level. Also almost in all parts of country age of marriage for girls is still considerably low where they bear their first child at a very low age. The data shows that even today many deliveries are taking place at homes by traditional birth attendants which is coupled with public services' having limited outreach capabilities. As a result India is having high MMR (Maternal mortality rate) and IMR (Infant mortality rate). Thus maternal mortality has always been considered a sensitive indicator for development and equity.

As per estimates around 4 million new-born die in first week of their life along with more than 0.5 million mothers die due to pregnancy-related complications. In early stages of pregnancy very few high-risk pregnancies are identified thus subsequently maternal mortality rises. So, SBAs can be the apt service delivery channels to provide accessible care to women during their pregnancies and delivery as well. It has been proven that around 20-30% neo-natal deliveries could be avoided by provision of Skilled Birth Attendants.

Similarly, according to DLHS-3 in India 52.3% deliveries take place at homes and of these 52.3% the percentage of births are attended by the skilled person is just 5.7%. Gujarat with IMR of 36 per 1000 live births and MMR of 112 per lakh live births has a long way to go to achieve MDGs. This fact highlights the high percentage of deliveries attended by unskilled person. Therefore, the presence of an

SBA at every delivery, along with the availability of an effective referral system, can help reduce maternal morbidity and mortality to a considerable extent.

REVIEW OF LITERATURE

With about 77,000 women dying every year during pregnancy and post-partum period, maternal mortality in India continues to remain unacceptably high. To effectively reduce Maternal Mortality provision has to be made for providing basic and emergency obstetric care to every pregnant woman.

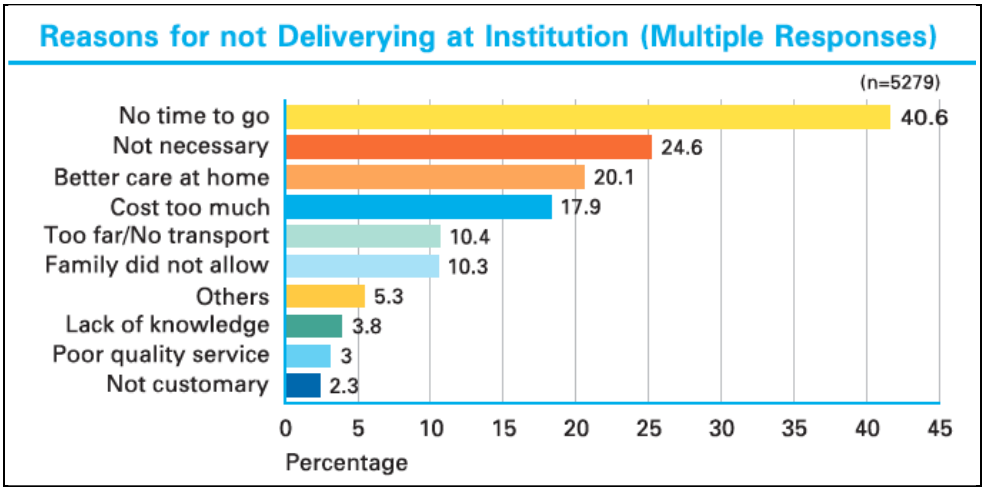
Reducing Maternal Mortality and providing Skilled Attendance at every Birth has been envisioned in Reproductive and Child Health Programme, under the umbrella of National Rural Health Mission (NRHM), which has been launched by the Government of India in April 2005, in order to improve the availability and access to quality reproductive health care services throughout the country.

Skilled birth attendance is central to the continuum of care in public health systems, serving as a critical link between the mother-baby units, community, and health system. Skilled birth attendants are recognized as health professionals trained (and accredited) in skills to manage normal pregnancies, deliveries, and postnatal care, and to identify, manage, or refer presenting complications in pregnant or postpartum women and newborns (WHO 2005).

Up to 40% of pregnancies can require some form of special care, and about 15% of all pregnant women develop complications during the intra-partum and immediate post-partum period and need access to emergency obstetric care (Fauveau 2004). Twenty-five percent of obstetric complications and maternal deaths occur during childbirth, while 60% occur immediately thereafter (WHO, ICM, FIGO 2004; UNFPA 2005). Skilled attendance during this period can help prevent, detect, and manage major complications, reducing maternal deaths by 16-33% (Graham *et al.* 2001).

In India, the continuum of skilled attendance has a number of providers—in the absence of a formal midwifery cadre—including auxiliary nurse midwives (ANM), lady health visitors (LHV), staff nurses, and doctors. The National Rural Health Mission (NRHM) envisions that safe delivery services should be available at the community level—which is not widely available to date—and at primary and referral facilities. India's safe delivery rates have been increasing, with a reported 71.8% of rural deliveries having a skilled birth attendant available, either as an institutional delivery or at home with a skilled attendant (CES 2009). Sixty-eight percent of rural deliveries occurred in institutions, and of these, 70% in public facilities; Figure 1 explores reported survey responses for not delivering in an institution (CES 2009).

Figure 1



Source: CES 2009 (MoHFW,UNICEF)

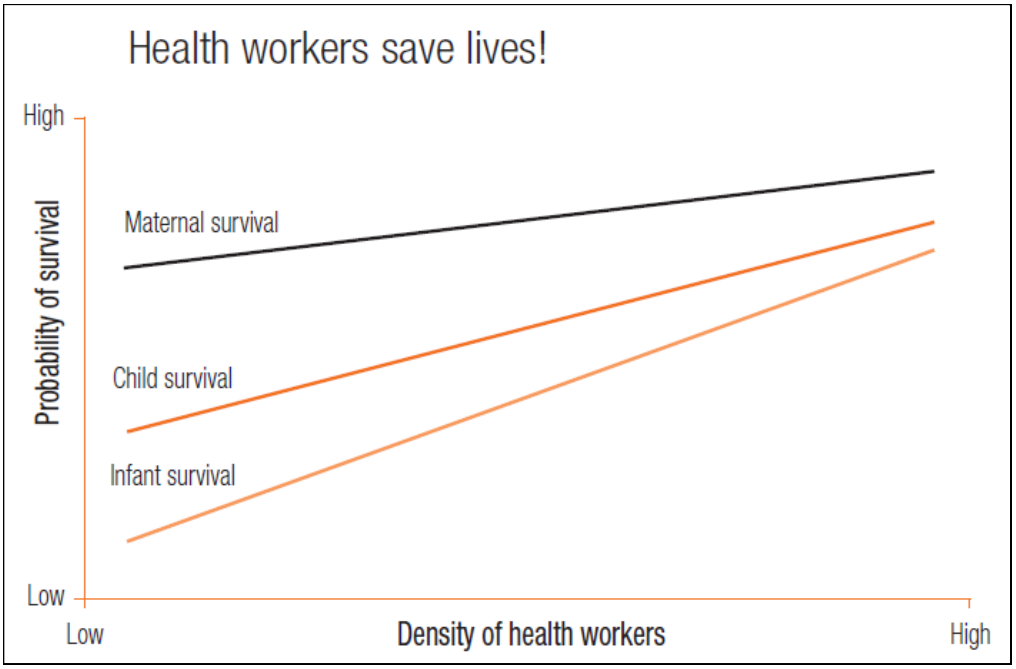
With the increase in institutional deliveries during NRHM and the uptake of Janani Suraksha Yojana (JSY), referral facilities are often overwhelmed with the load of normal deliveries, which complicates the capacity for postnatal monitoring and providing emergency obstetric care (EmOC) or handling other complicated cases. Up to 75% of women reported to have stayed in facilities for post-delivery monitoring between 24 hours and four or more days; a quarter of women leave within 24 hours of delivering. Additionally, antenatal care uptake varies widely across the country; 22.8% of women reporting to have received full ANC1 (CES 2009). Community-based postnatal care in the country requires strengthening (Paul *et al*. 2011); CES 2009 reports that 60.7% of newborns received at least one visit within ten days after birth, but only 24.8% received three or more visits. Continued strategies to strengthen primary-level skilled birth attendance is thereby essential to achieve equitable service delivery (e.g. reducing opportunity costs for families that are poor and/or living in difficult-to-reach areas) and effective care systems (e.g. birth planning, referral transport, quality assurance and supervision, referral systems).

As per estimates around 4 million new-born die in first week of their life along with more than 0.5 million mothers die due to pregnancy-related complications. In early stages of pregnancy very few high-risk pregnancies are identified thus subsequently maternal mortality rises. So, SBAs can be the apt service delivery channels to provide accessible care to women during their pregnancies and delivery as well. It has been proven that around 20-30% neo-natal deliveries could be avoided by provision of Skilled Birth Attendants**. (**K Hill, C AbouZhar, T Wardlaw. Estimates of maternal mortality for 1995. *Bull World Health Organ* 2001; 79: 182-93.)

Similarly, according to DLHS-3 in India 52.3% deliveries take place at homes and of these 52.3% the percentage of births are attended by the skilled person is just 5.7%. This fact highlights the high percentage of deliveries attended by unskilled person which explains high maternal mortality rate in India.

Evidences suggests that if the health workforce is qualified and motivated towards their duty and is associated with adequate number of the workforce then it results in increased immunization coverage, low maternal mortality, low infant mortality, improved primary health care delivery which is evident in following figure 2 (WHR 2006).

Figure 2

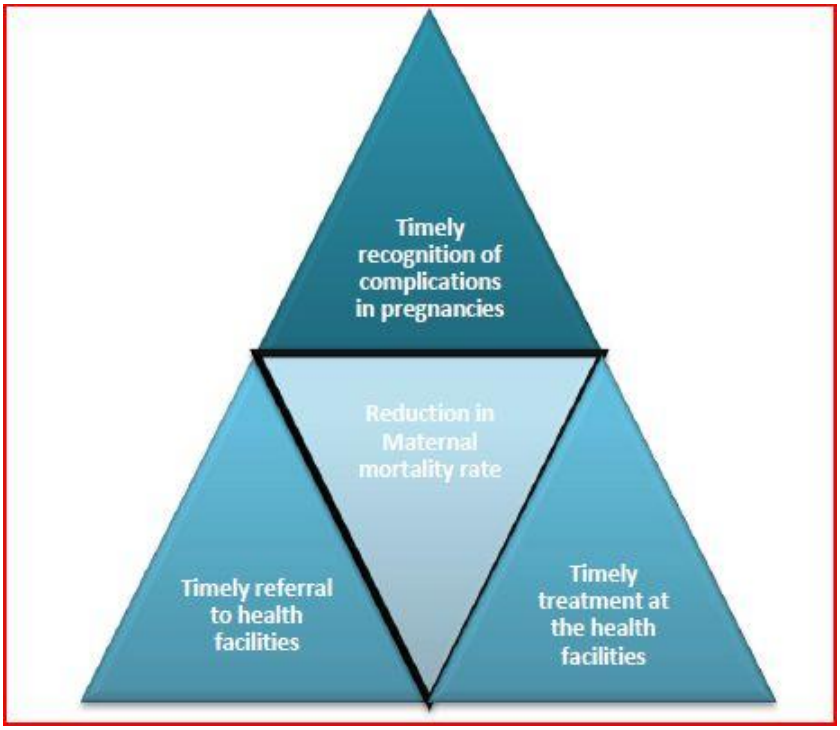


Source: WHR 2006 (page xvi)

Goldie et al also goes in same line when it argues in favour of skilled attendance to decrease the high maternal mortality rate and infant mortality rate considering skilled attendance as an effective public health intervention**.**

Thus a three-pronged strategy is needed to see reduction in maternal deaths which is as follows:

Figure 3



Source: SBA Evaluation Report MP

So, here SBAs role comes who are formally trained in these aspects. Along with attending normal deliveries they can identify complicated pregnancies, manage the complicated pregnancies and when such situation emerges when complications are beyond his/her competence then she works as linkage between health system and the community.

PURPOSE OF THE STUDY

This study aims at finding out the impact of training on skilled birth attendance and recommending the steps to enhance the proficiency of training.

OBJECTIVES OF THE STUDY

General Objective

- To study the effectiveness of SBA training, in terms of knowledge among Skilled Birth Attendants (SN/ANM).

Specific Objective

- To study the knowledge of SBAs in Ahmadabad, Gujarat.
- To find out reasons of discrepancy (if any) and suggest recommendations.

RESEARCH METHODOLOGY

This chapter will give a description of how the study area and sample for the study were selected. It also gives details of how the data was collected from the sample population with respect to objectives, how the data was managed and analyzed.

STUDY DESIGN

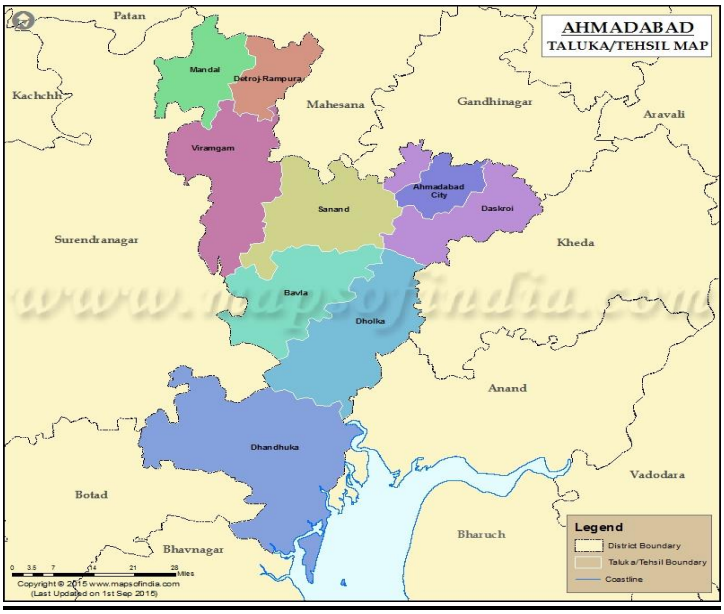
Type of Study

Quantitative approach is used in this study.

Design of Study

A Cross-sectional descriptive research design are used to obtain the optimum level of understanding of skilled birth attendants (SN/ANMs) about the level of knowledge and utilization in Health facilities of Ahmedabad district.

Study area



Health Infrastructure:

Total Taluka	10
District Hospital	1
Sub-District Hospital	1
Community Health Center	10
Primary Health Center	37

NHM, Gujarat Statistics -2014

Reason for selecting Study Area

No previous studies were conducted to assess the training proficiency of SBAs in Ahmedabad, Gujarat. The study area is easily accessible from SIHFW headquarter at Gandhinagar.

SAMPLE SIZE

- 50 SNs/ANMs who have taken SBA training

Inclusion Criteria

- SNs and ANMs who had taken SBA training earlier.

Exclusion Criteria

- SNs and ANMs without SBA training.

STUDY DURATION

The study would be conducted in Three months (February-May 2016)

SAMPLING TECHNIQUE

- Purposive Sampling

STUDY TOOL

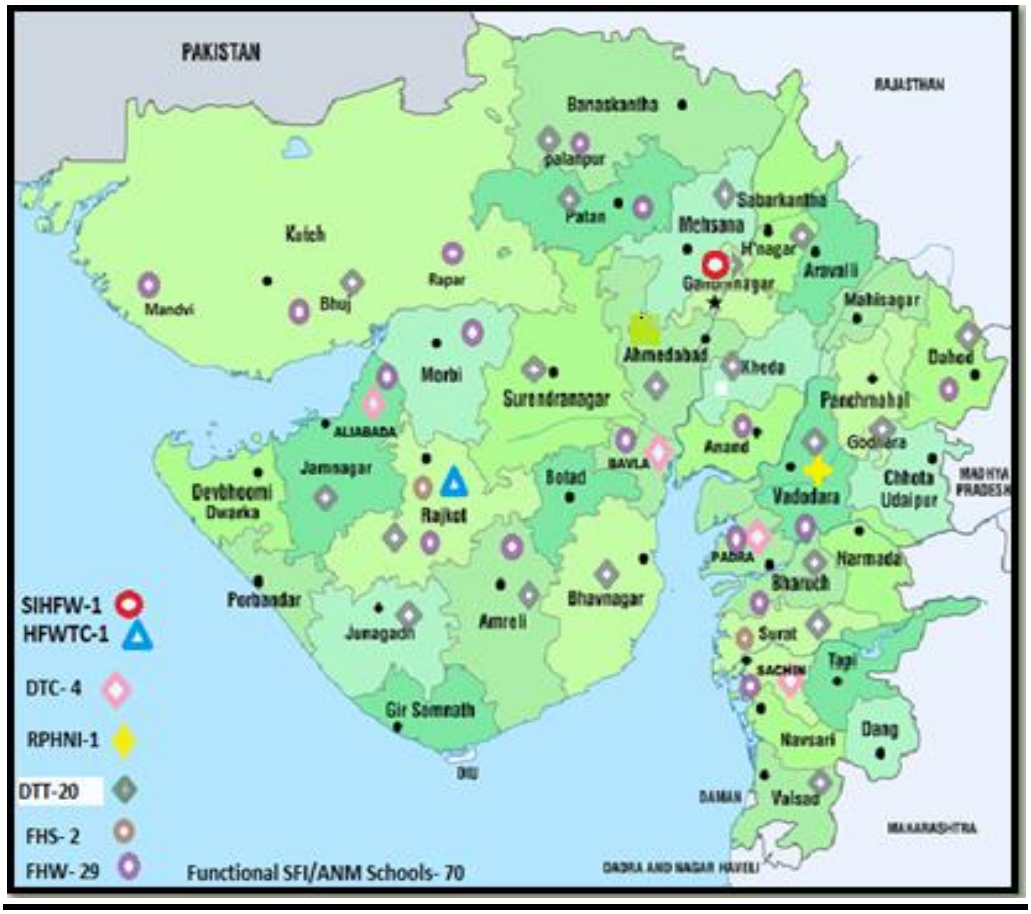
- Pre-Designed and Pre-Tested Interview Schedule cum monitoring checklist.

SOURCES OF DATA

- SBA training statistics available at SIHFW.
- Interview schedule planned and conducted at health care facilities.

AN ASSESSMENT OF SKILLED BIRTH ATTENDANT TRAINING (SN/ANM) IN AHMEDABAD DISTRICT, GUJARAT

INTRODUCTION



State Institute of Health and Family Welfare, Gujarat is an apex training Institute of the Department of Health and Family Welfare, Gujarat. Since its inception in year 1958 as Regional Family Planning Training Center, through a multi-disciplinary approach, the Institute has been addressing a wide-range of issues related to public health, family welfare and health management. In-service training of health personnel of various categories, undertaking multi-disciplinary research studies/projects; especially, operational research, and establishment of institutional mechanisms for coordination with health planners, health care providers and managerial experts; have been the major thrust areas of the Institute.

As per its vision statement *the institution is committed to constant striving for Health promotion & disease prevention by capacity building. This is epitomized in the logo with the slogan "No Laziness in studies".*

The mission of SIHFW is *"To sensitize the health functionaries about the healthy community and to build up a healthy nation through healthy self".*

The objectives of SIHFW, Gujarat are as follows:

- ✓ To train the trainers, so that effective translation of health messages is carried forward.
- ✓ To sensitize the trainees so that they practice the health messages for self and make others practice.
- ✓ To provide advocacy to health managers & Policy makers in the thrust areas of Health care sector.
- ✓ To provide practical skill based hands on training for effective application in the community.
- ✓ To prepare Training components on the basis of the gap analysis in the skills of health functionaries so that the community is to provide need based Health care.
- ✓ To plan and provide high quality Training in the best conducive training Environment.

ORGANIZATION PROFILE

The State Institute of Health and Family Welfare, Gujarat provide- Trainings of Trainers (ToT), teaching-learning material, curricula and modules, provides basic foundation and promotional courses and induction training to fresh medical officers, Professional Development Course for District Health Managers, workout guidelines etc. As an apex institute, SIHFW looks after the planning, implementation and monitoring of all types of training programmes. SIHFW has been recognized as one of the Nodal & Collaborating Training Institute (CTI) for planning & implementation of RCH training programmes.

The institute provides an umbrella support to,

HFWTC - 1,

Divisional Training Centers - 4,

District Training Teams - 20,

Regional Public Health (Nurse) Training Institute - 1,

Female Health Supervisor Training Schools - 2

Female Health Worker Training Schools (Govt.) - 29.

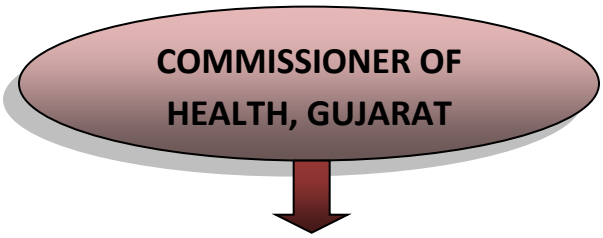
It also works as a link between NIHFW, New Delhi and the State and in turn to HFWTC, DTCs DTTs, RPHTI, FHSTSs and FHWTSs for organizing training programmes.

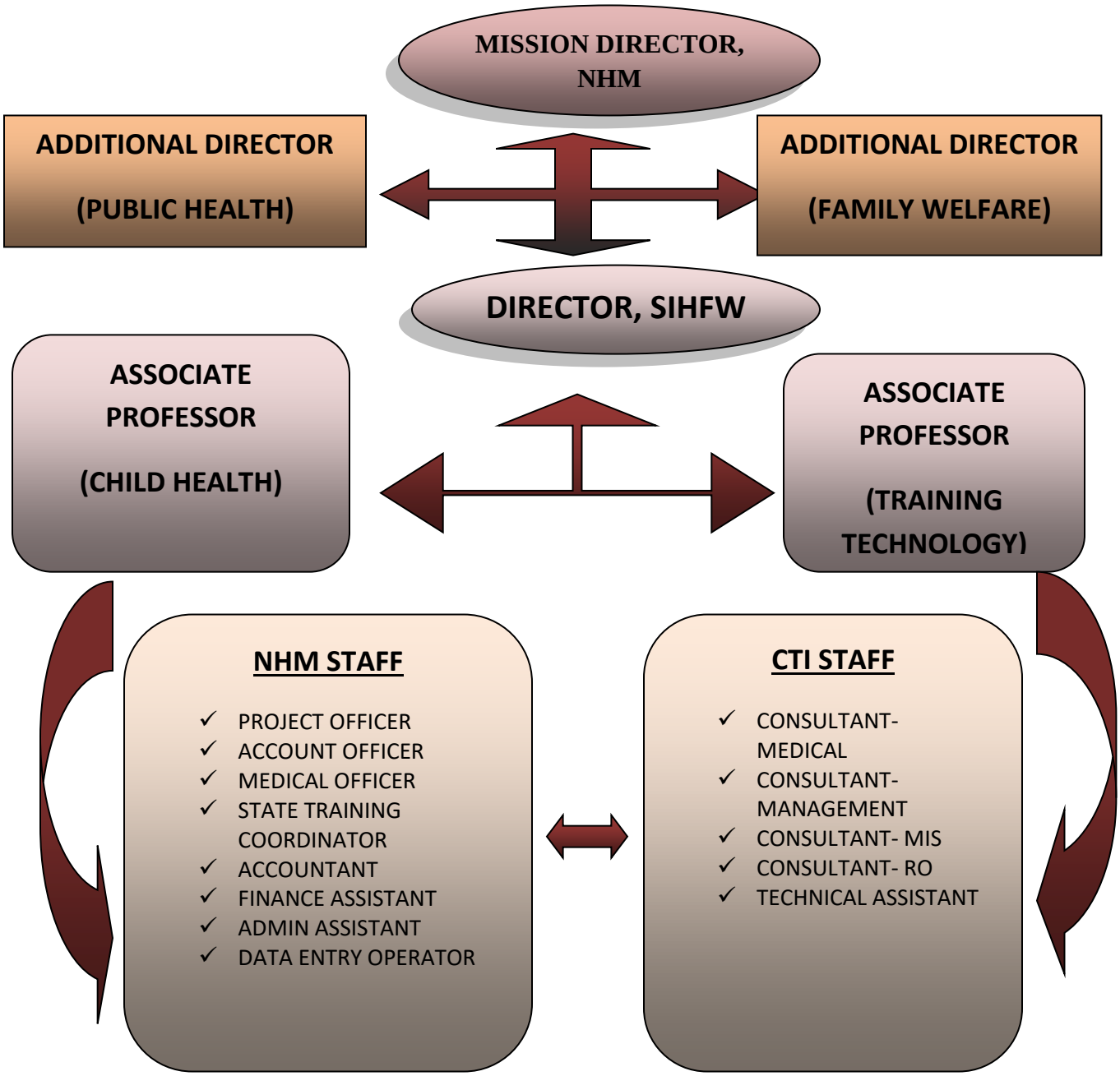
The main function of SIHFW is to conduct State level TOT:

1. Monitoring the quality of training at all levels.
2. Co- ordinate with the admission committee of ANM, GNM schools

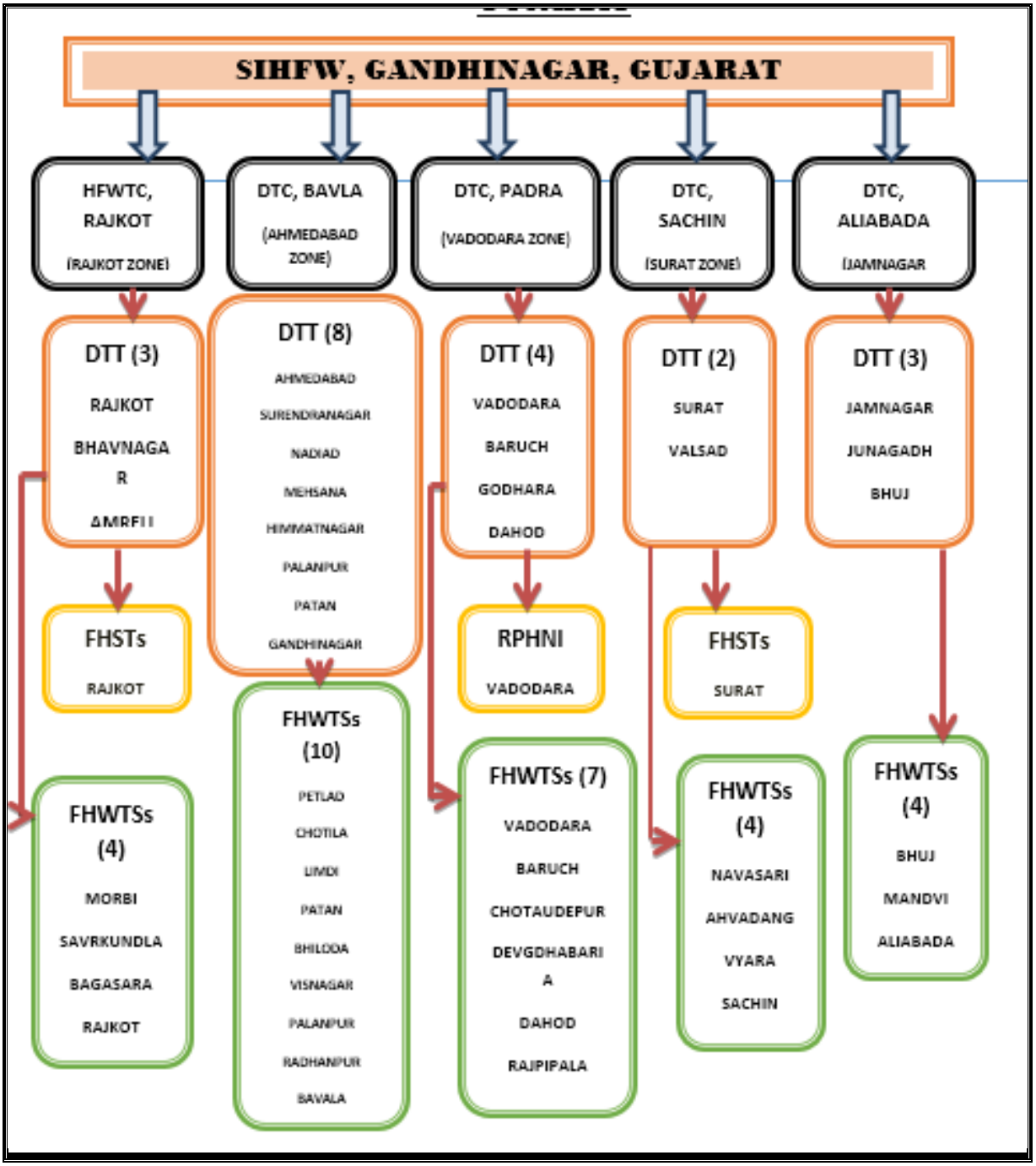
3. To prepare the training calendar and Annual PIP under NHM.
4. Contribute major role in selecting SFI for ANM schools as per the guidelines up to essentiality certificate.
5. Revised and updating the curriculum every year.
6. Co-ordinates administratively, technically and financially for various training with all the DTT, DTC, FHW/ANM, FHS and PHN institutes in the state.
7. SIHFW planned implement and co-ordinate all the activities related to ANM, MPHW (M) basic course.

ORGANOGRAM OF SIHFW




MISSION DIRECTOR, NHM
ADDITIONAL DIRECTOR (PUBLIC HEALTH)
ADDITIONAL DIRECTOR (FAMILY WELFARE)
DIRECTOR, SIHFW
ASSOCIATE PROFESSOR (CHILD HEALTH)
ASSOCIATE PROFESSOR (TRAINING TECHNOLOGY)
NHM STAFF
✓ PROJECT OFFICER
✓ ACCOUNT OFFICER
✓ MEDICAL OFFICER
✓ STATE TRAINING COORDINATOR
✓ ACCOUNTANT
✓ FINANCE ASSISTANT
✓ ADMIN ASSISTANT
✓ DATA ENTRY OPERATOR
CTI STAFF
✓ CONSULTANT- MEDICAL
✓ CONSULTANT- MANAGEMENT
✓ CONSULTANT- MIS
✓ CONSULTANT- RO
✓ TECHNICAL ASSISTANT

ORGANOGRAM OF HEALTH TRAINING INSITITUTES OF GUJARAT



DEPARTMENTS VISITED/WORKED

During the Internship period apart from working at the State Institute of Health and Family Welfare, Gandhinagar, following departments were also visited:

- Commissionerate of Health, Gandhinagar (For meetings and coordination with CoH)
- State Program Management Unit, NHM, Gandhinagar (For coordination of NHM programs with SIHFW)
- State Nutrition Cell, Gandhinagar (For coordination regarding trainings under Child Health Programme)
- DTT Mehsana (Monitoring Visit)
- Narol, Ahmedabad (Old Location of SIHFW)

KEY LEARNINGS AT THE ORGANIZATION

- How to conduct trainings.
- Functioning of District Training teams and Centers.
- How to coordinate with different departments to carry out a training.
- To give better outputs in limited resources.
- Detailed knowledge about training modules and techniques.

PROBLEMS AND ISSUES IN THE ORGANIZATION

Problems faced in the organization:

- Improper funding pattern hinders the training process.
- Lack of human resource at training centers makes it difficult to carry out the training process as planned.
- Insufficient HR leads to poor maintenance of training records.
- Insufficient supply of logistics is a major issue for SIHFW staff.
- Coordination with different stakeholders sometimes delays the decision making process.

SKILLED BIRTH ATTENDANCE

A **Skilled Birth Attendant** (SBA) is defined as "an accredited health professional-such as midwife, doctor or nurse-who has been educated and trained to achieve proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and immediate postnatal period and in the identification, management and referral of complications in women and newborns."

GoI also has taken policy initiatives to empower the SNs/LHVs/ANM to make them competent for undertaking certain life saving measures. These measures are as follows:

- Permission to use Uterotonic drugs for prevention of PPH.
- Permission to use drugs in emergency situations prior to referral for stabilizing the patient.
- Permission to perform basic procedures at community level in emergency situations.

In view of this SBA training has been launched for SNs/LHVs/ANMs at District level, where intensive hands on training in mid-wifery skills will be provided to these health personnel. States are in process of gearing up their facilities for this training but there is a need to scale up this training to achieve our commitment of skilled attendance and by thus preventing women's dying due to the lack of the same.

The Government of India started an initiative to train SN/ANMs for skilled birth attendance in 2005. Gujarat is one of the initial states to start the training at selected centers based on the Government of India's SBA guidelines; trained ANMs are provided with equipment and supplies. This 21-day competency-based hands-on training also uses models and techniques for adult learning.

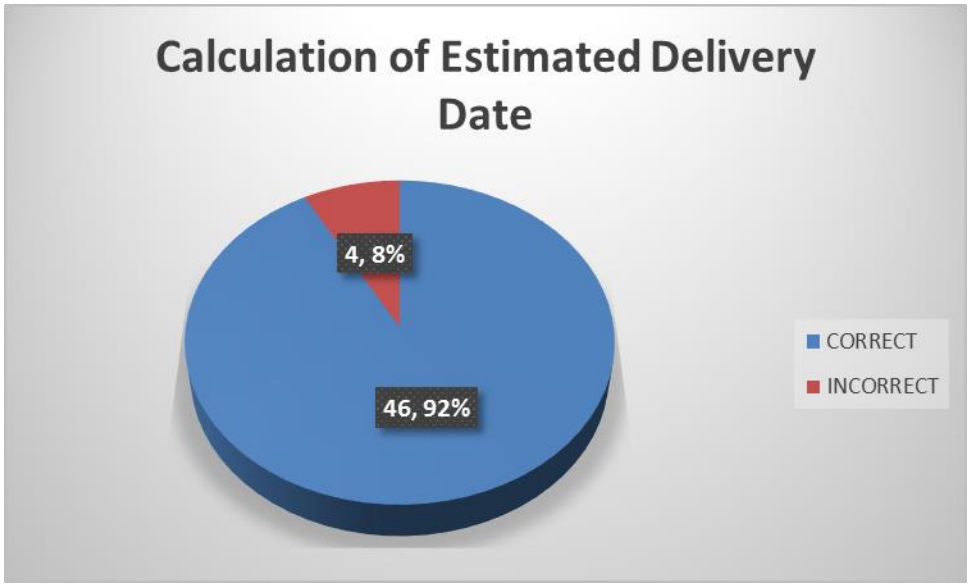
DATA ANALYSIS and RESULTS

Overall assessment of SBA trained SN and ANM was done on the basis of Pre-designed and Pre-tested Interview Schedule cum monitoring checklist. The interview schedule included major criteria of assessment viz.

- Knowledge of Antenatal Care
- Knowledge on Intra-natal Care and New Born Resuscitation
- Knowledge of Post Natal Care
- Management of Normal Pregnancy and Childbirth
- Identification and Management of Complications during Pregnancy & Childbirth

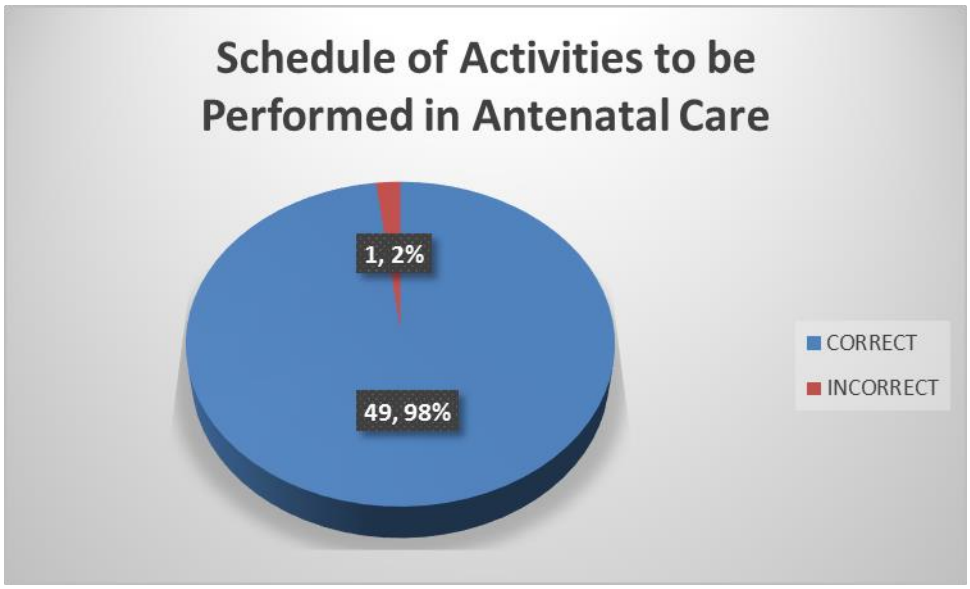
Knowledge of Antenatal Care

1. Knowledge about estimation of Estimated Delivery Date



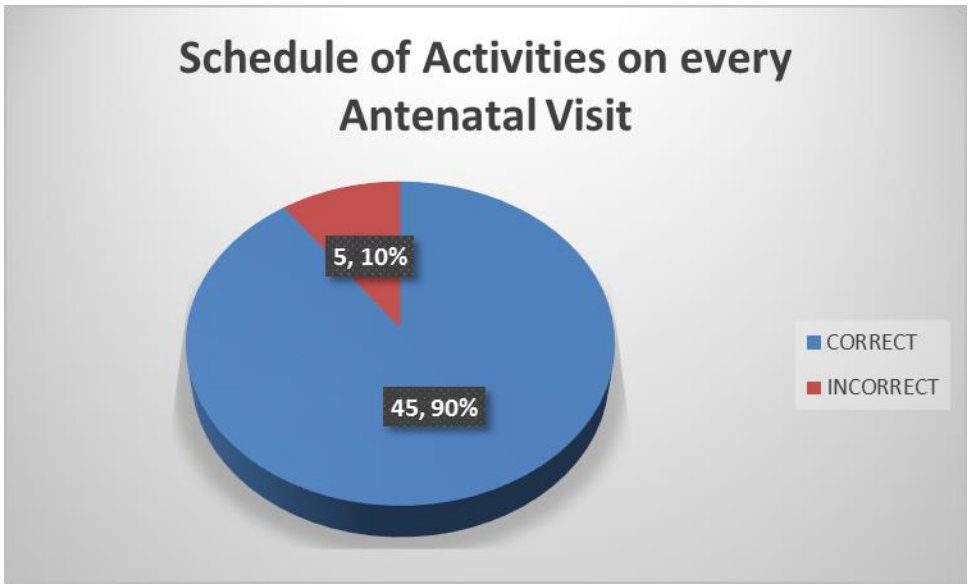
Out of 50 participants (SN/ANM) assessed 92% had correct knowledge of calculation of Estimated Delivery Date. Out of 20, 18 SNs and out of 30, 28 ANMs correctly calculated EDD.

2. Schedule of Activities to be performed in Antenatal Care



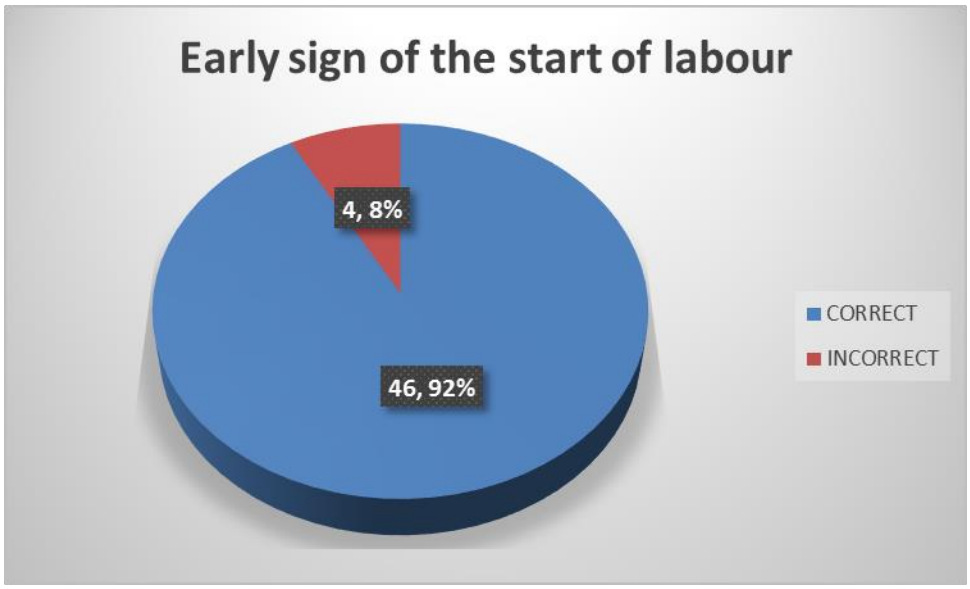
During assessment, 98% SBAs had knowledge of ANC activities as per the guidelines.

3. Schedule of Activities on every Antenatal Visit



90% SBAs were performing ANC activities as per the guidelines.

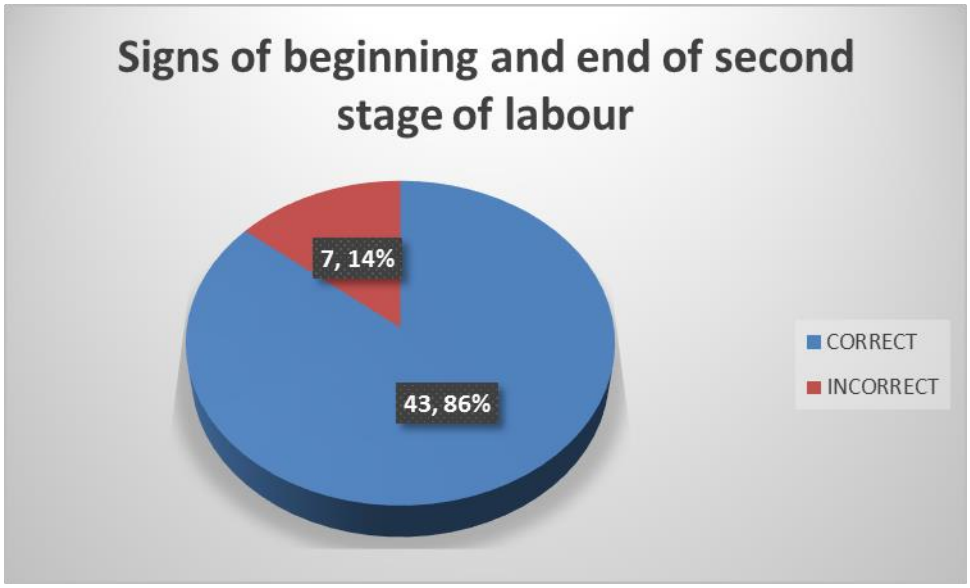
4. Detecting early signs of Labour.



92% SBAs were able to detect early signs of labour.

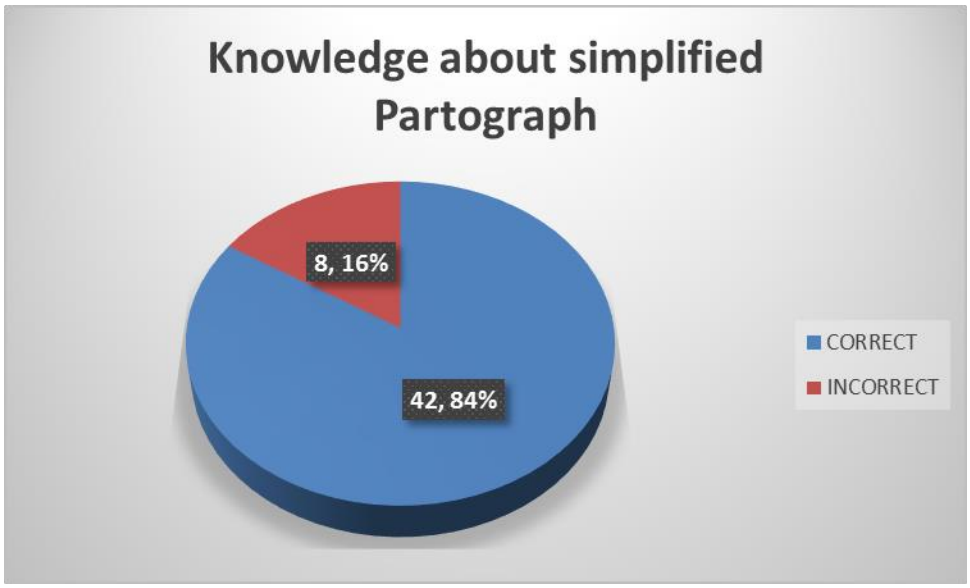
Intra-natal Care and New Born Resuscitation

5. Signs of beginning and end of second stage of labour



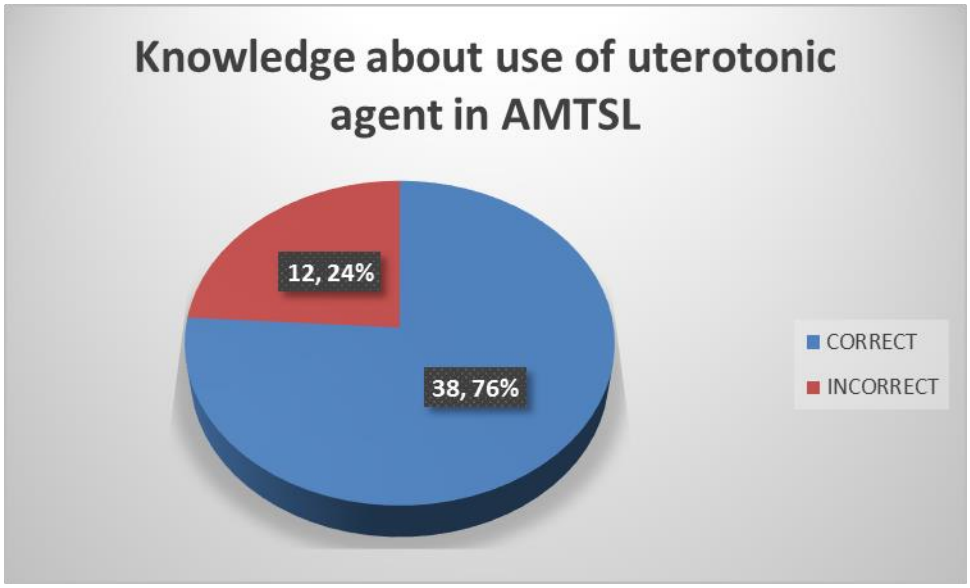
Out of 50 SBAs, 43 (SN-17/ ANM-26) had correct knowledge about signs of beginning and end of second stage of labor.

6. Knowledge about simplified Partograph



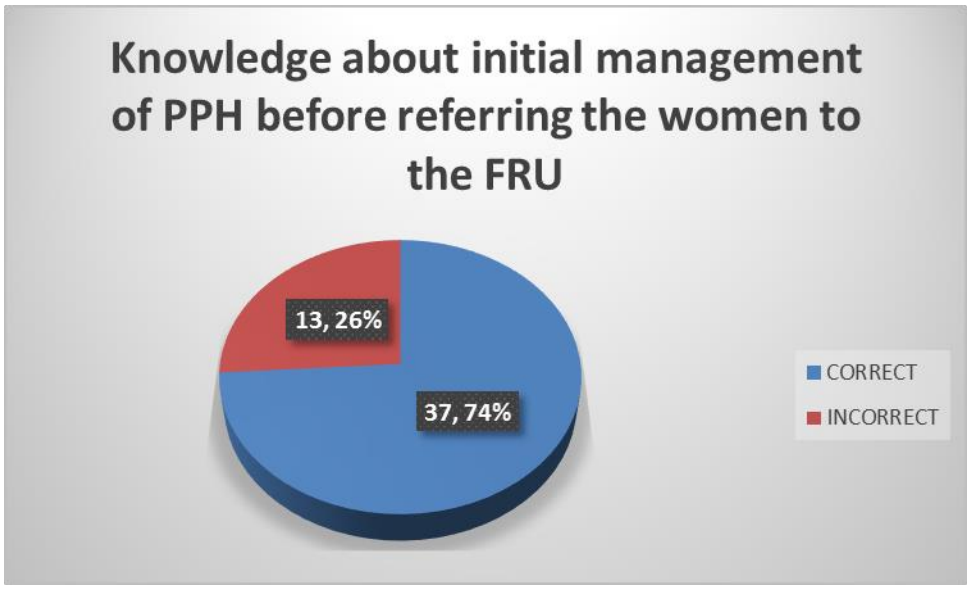
Simplified Partograph helps in will help you in recognizing the need for action at the appropriate time and thus ensure timely referral. Out 50 SBAs, 42 were able to fill the simplified partograph correctly.

7. Knowledge about use of uterotonic agent in active management of the third stage of labor.



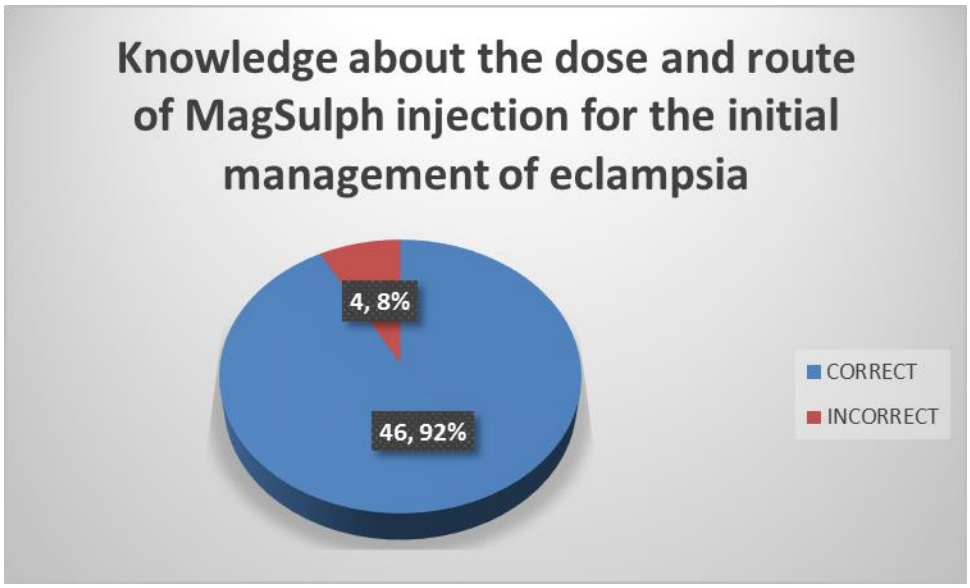
Active management of third stage of labour is a crucial event to avoid post-partum hemorrhage. Only 76% SBAs had the right knowledge regarding steps involved in AMTSL.

8. Knowledge about initial management of PPH before referring the women to the FRU



Before referral to FRU, PPH should be managed to ensure the avoidance of further threat to mother's life during transportation. Out of 50 SBAs, only 37 were knowledgeable about management of PPH before referral.

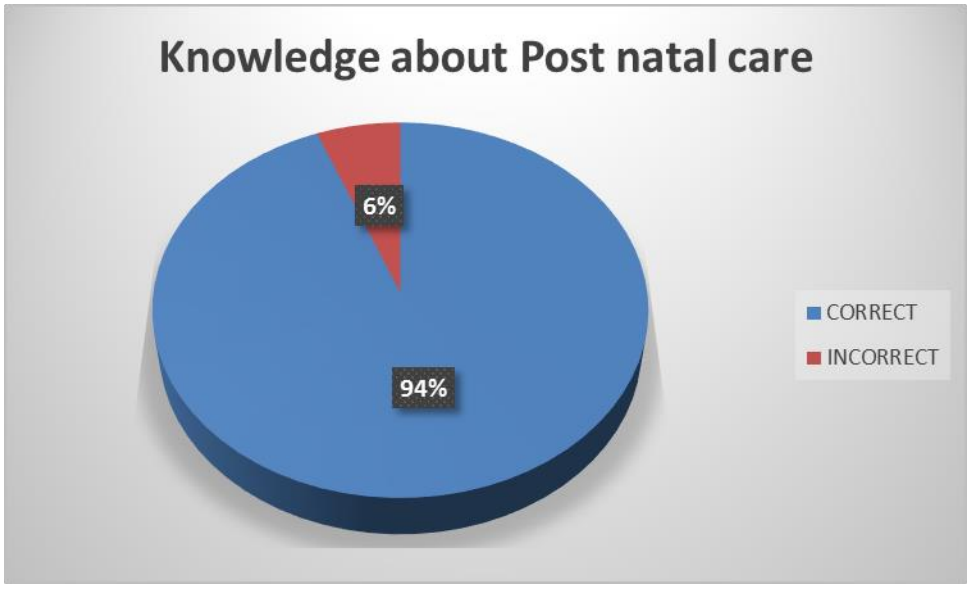
9. Knowledge about the dose and route of Magnesium sulphate injection for the initial management of eclampsia.



MagSulph is administered for the management of Eclampsia in pregnant woman. 92% of respondents were aware about the dose and route of Magnesium Sulphate.

Post Natal Care

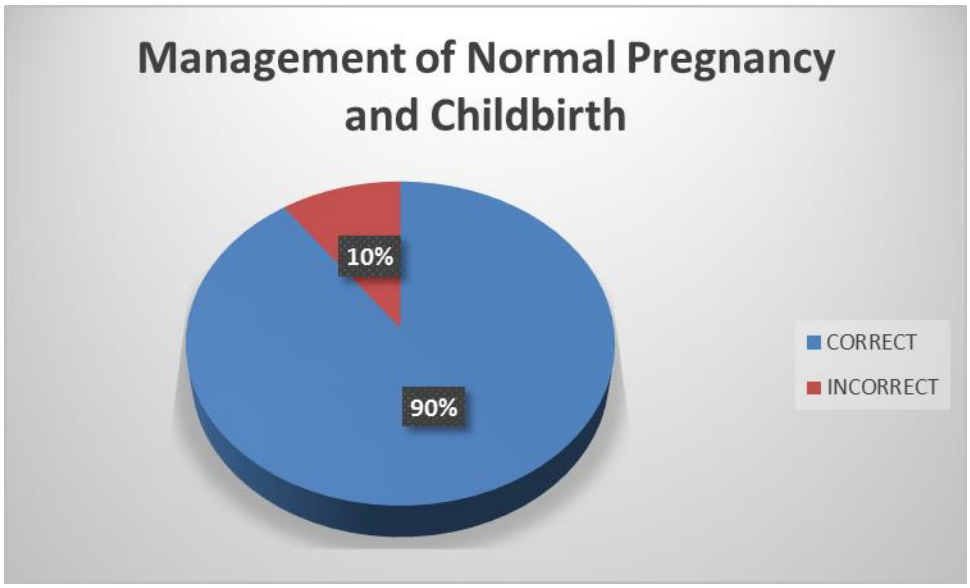
10. Knowledge about things to be taken care during post natal period viz. breast feeding, IFA supplementation, supplementary feed to infant.



94% SBAs were knowledgeable about things to be taken care during Post Natal period and they counsel mothers about the same.

Management of Normal Pregnancy and Childbirth

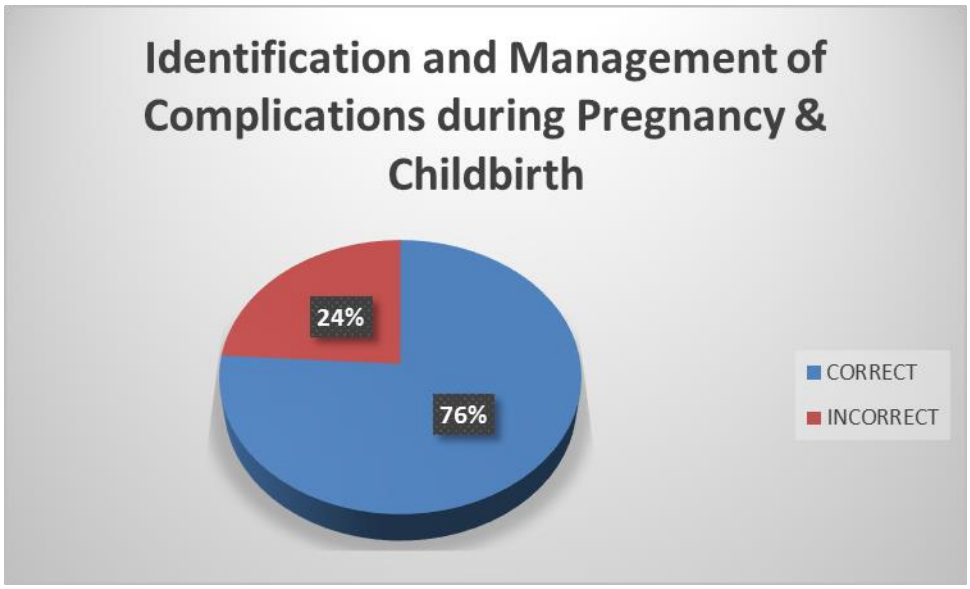
11. Knowledge about events during pregnancy and childbirth, management of complications, activities to avoid complications, new born care etc.



90% SBAs had knowledge about management of Normal pregnancy and Child birth.

Identification and Management of Complications during Pregnancy & Childbirth

12. Knowledge about complications like PPH, threatened abortion, anemia, eclampsia, fetal distress, high BP etc. and its treatment.



76% SBAs gave correct answers to the questions related to identification and management of complications during pregnancy and childbirth.

DISCUSSION

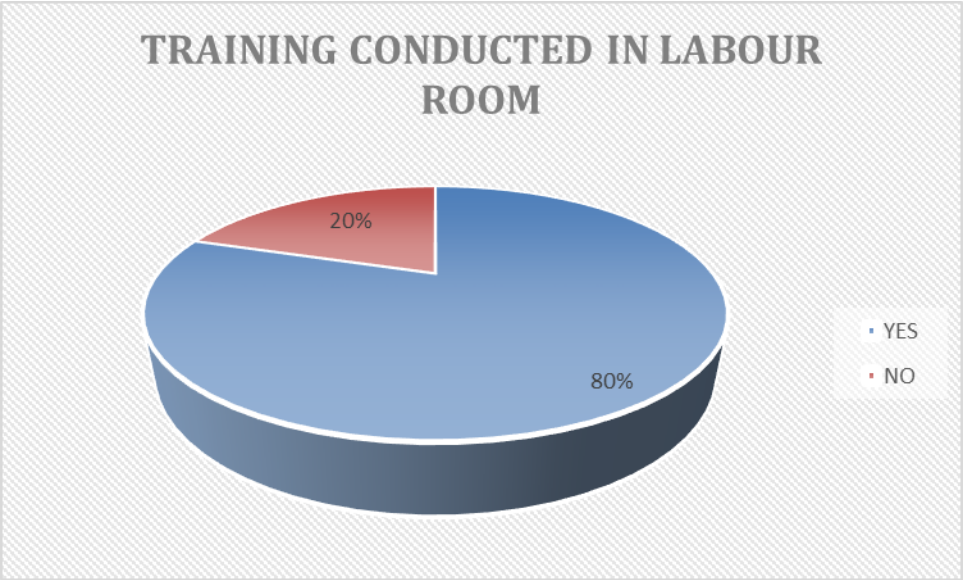
After analyzing the collected data, it was found that there are some major areas where SBAs are lacking knowledge. It partially reflects the training proficiency. It was observed that SBAs lack therapeutic knowledge regarding active management of third stage of labour, Identification and management of complications, management of eclampsia, management of post-partum hemorrhage etc.

After further interrogation, it was discovered that there are certain factors which may have contributed to the discrepancy in knowledge of SBAs.

Time of SBA training taken

It was found around 50% SBAs were trained =>4yrs ago.

It is mandatory to conduct training in labor room to give practical knowledge to the participants. But, it was found that 20% participants were not given practical training.



Further investigations revealed that, SBA participant did not stay at night. SBA is a residential training and participants should stay at night as well to get a hands on training if any case comes up.

LIMITATIONS OF THE STUDY

This study was conducted to assess the knowledge of SBAs in order to determine the proficiency of SBA training. The study conducted was more theoretical than practical. Due to limited time frame and restricted conditions, it was difficult to assess practical skills of SNs and ANMs.

CONCLUSION AND RECOMMENDATIONS:

As evident through the study results, SBAs lack knowledge of major areas viz. active management of third stage of labour, management of eclampsia, identification & management of complications during pregnancy etc.

Possible reasons could be:

- Time since training taken
- No hands on practical exposure

To overcome the fallouts in outcome of SBA training, following is recommended:

- ✓ On the job training of SN/ANM at District Hospital with delivery load more than 100 per month
- ✓ Strict monitoring of ongoing training
- ✓ Evaluation of trainers
- ✓ Training honorarium should be given only to those who stay in campus throughout the training to encourage participants.
- ✓ Evaluation and monitoring of practical training conducted at labour room.

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ANNEXURES

ASSESSMENT OF KNOWLEDGE OF SBA TRAINED SN/ANM

S.NO	QUESTIONS	REMARKS
Antenatal Care		
1.	Calculation of Estimated Delivery Date	
2.	Schedule of Activities to be Performed in Antenatal Care	
3.	Schedule of Activities on every Antenatal Visit	
4.	Early sign of the start of labour	
Intra-natal Care and New Born Resuscitation		
5.	Signs of beginning and end of second stage of labour	
6.	Knowledge about simplified Partograph	
7.	Knowledge about use of uterotonic agent in active management of the third stage of labor	
8.	Knowledge about initial management of PPH before referring the women to the FRU	
9.	Knowledge about the dose and route of Magnesium sulphate injection for the initial management of eclampsia	
Post Natal Care		
10.	Knowledge about the frequency of Breast feeding an infant	
11.	Knowledge about supplementary feed in addition to breast feeding an infant	
12.	Knowledge about duration for prescribing IFA tablets to a woman of childbearing age	
Management of Normal Pregnancy and Childbirth		
13.	A women should gain 9-11 kg during her pregnancy (Y/N)	
14.	If the blood pressure of a pregnant women is more than 140/90mmHg, check again after 4 hours to confirm hypertension (Y/N)	
15.	The normal foetal heart rate is between is 80-120 beats/min (Y/N)	
16.	The fundal height indicates the progress of the pregnancy and foetal growth (Y/N)	
17.	Constipation and passage of dark stools indicate that the IFA tablets should be immediately stopped as they are not suiting the pregnant women (Y/N)	
18.	If a woman has received TT injections during her previous pregnancy, a single dose of TT is sufficient in the present	

	pregnancy if the interval between the two consecutive pregnancies is less than 3 years. (Y/N)	
19.	The left lateral position is the best position for pregnant women when lying down (Y/N)	
20.	Mother's first breast milk, called colostrum, should be discarded as it can harm the baby. (Y/N)	
21.	Immediately after the baby is born, it should be bathed with soap and warm water to keep it clean. (Y/N)	
22.	Normally 6-7 cm dilatation of the cervix is considered full dilatation (Y/N)	
23.	In the active stage of labour, a vaginal examination must be done every hour. (Y/N)	
24.	The JSY cash benefit scheme is for the mother and the ANM. (Y/N)	
25.	An important element of essential care of the newborn is to maintain a clear airway and breathing. (Y/N)	
Identification and Management of Complications during Pregnancy & Childbirth		
26.	In threatened abortion, when a woman complains of light bleeding and lower abdominal pain, the "os" is found to be open on vaginal examination. (Y/N)	
27.	Vaginal examination should not be performed in women who have bleeding during pregnancy beyond 12 weeks.(Y/N)	
28.	In case of secondary PPH, in addition to 20 IU of oxytocin in 500ml of Ringer lactate, the first dose of antibiotics should be given.(Y/N)	
29.	A catheter should be used to empty the urinary bladder to manage a case of PPH.(Y/N)	
30.	If the blood pressure is more than 140/90 mmHg and there are proteins in the women's urine, it is a case of pre-eclampsia.(Y/N)	
31.	A woman with pre-eclampsia should be advised to restrict to her intake of salt and fluid. (Y/N)	
32.	To manage a convulsion during eclampsia, one should administrator a magnasium sulphate injection (5g. Deep intramuscular) in each buttock. (Y/N)	
33.	A pregnant woman with anaemia must be given the therapeutic dosage of IFA in the postpartum period. (Y/N)	
34.	You should suspect urinary tract infection if the pregnant woman complains of fever and/or a burning sensation during micturition.(Y/N)	
35.	Foetal distress is diagnosed if the FHR is less than 120 or more than 160 per minute.(Y/N)	
36.	In premature rupture of membranes and puerperal sepsis,	

	the ANM should give the first dose of antibiotics before referral. (Y/N)	
37.	In case of secondary PPH, in addition to 20 IU of oxytocin in 500ml of ringer lactate, give the first dose of antibiotics. (Y/N)	
38.	If there is bleeding P/V before 20 weeks, one of the most probable diagnoses is threatened abortion. (Y/N)	
39.	A pregnant woman with anaemia should receive only 100 tabs of IFA. (Y/N)	
40.	Pre-term labor is defined as labor prior to 40 weeks of gestation. (Y/N)	
41.	Oxytocin injection is the preferred option for initial management of PPH. (Y/N)	