Making the impossible, possible – highlights from the scale up of the emergency obstetric care program in India

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Presenter Disclosures

Dr. Himanshu Bhushan

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- Avni Health Foundation
  - Mr. Ajey Bhardwaj, Dr. Dhawal Naik, Support Staff
- JHPIEGO
- 34 Medical Colleges
  - Chief Coordinators, Technical Consultants, Trainers, Support Staff
- 340 District Hospital Trainers
- 22 State Governments of India
India

- World’s Largest Democracy
- 1 Billion + population
- 28 States, 7 Union Territories, 660 Districts
- GDP Growth Forecast 3.8% in 2013 (Higher than World growth of 2.9%)
- 22+ Languages, 700 Television Channels (80 beaming only news 24x7), 70,000 newspapers, 900 mio Mobile Subscribers, 100 mio Internet Users
- 25% people between ages of 18-25 (approx)
Health Facilities - India

- Health Sub Centers 1,48,124
- Primary Heath Centers 23,887
- Community Health Centers 4,809
- Sub District, District & Medical College Hospitals 12,760

Total Medical Colleges in India: 362 (Govt.168, Private: 194). Producing 45,000 doctors per year, average of 124 doctors per medical college per year

Number of Doctors – 0.867 mio (as per IMR)
Doctor Population Ratio – 1:1739 (current) Target ratio– 1:1200 by 2025
Additional Doctors required – 0.4 mio by 2022
27 million women deliver per year

15 % develop complications, resulting in 56,000 maternal deaths/ year

MMR is 212/1,00,000 LB (SRS 2007-09)

MMR Reduction Goals - MDG 5 - 150 by 2015 and 12th plan - 100 by 2017
Causes of Maternal Mortality

- Haemorrhage, 38%
- Sepsis, 11%
- Abortion, 8%
- Other Conditions, 34%
- Obstructed Labour, 5%
- Hypertensive disorders, 5%

SRS 2001-03
Almost all of these complications cannot be predicted – BUT the vast majority can be effectively prevented or managed – with skilled care and

Ensuring EmOC

80% of maternal deaths are due to a few direct obstetric complications – sepsis, haemorrhage, eclampsia, obstructed labour and abortion
Issues contributing to high MMR

- Inadequate skilled HR, Irregular distribution, Irrational Deployment
- Inadequate Service Provision
- Possible way out

- New Hiring
- Rational deployment
- Task shifting
Program Objective

- To develop capacity of doctors (General Practitioners & non specialist Medical Officers) in India to provide high quality Emergency Obstetric Care (EMOC) services in areas where specialists obstetricians are not available
Forging a Public/Private Partnership

FOGSI partnered with JHPIEGO to setup 5 pilot EmOC centers in 2003-5

Based on success of pilot, FOGSI – GOI forged the countries FIRST BIG public/private partnership for scale-up

FOGSI is the world’s largest society of OBGYNs. 29000 members with private practice/nursing homes

Having an OBGYN association on our side makes a great difference to the smooth program implementation

FOGSI contribution - technical skills, program management (through AVNI)
Target

Program stakeholders and their roles

MBBS doctors trained for EmOC

FOGSI/AVNI
Implementing Steps for EmOC training

GOI
Facilitate Mobilization of STATE Health Dept. / DME/ Release of Funds

DIRECTORATE MEDICAL EDUCATION
Supporting Medical College identification/ Release of Master trainers/ Permit training

STATE HEALTH & FW DEPT.
Identification & Release of MO,DH/ Up-gradation of DH,FRU/ Release of Funds for every batch/ Transfer of MO,DH/ Stay of MO for 16 weeks at Medical College & DH/ Nodal Officer appointment/ Steering committee formation
Program Strategy

✧ 1 Tertiary center (4 Master trainers)

✧ Each Tertiary center to have 8 District Hospital trainers

✧ Each Training batch to comprise of 8 MOs from First Referral Units.

✧ Annually the Center to conduct 3 batches of 16 weeks each

✧ Provision for creating Backup of Master & District Trainers
Course Structure

6 weeks at Tertiary Training center

2 weeks classroom classes: lectures, role plays, demonstrations and practice on models

4 weeks supervised acquisition of clinical skills

9 weeks at District Hospital

Self directed clinical practicum at district hospital

On site mentoring and supervision

1 week at Tertiary Training center

1 week theory, practical & OSCE examination
EmOC Course Protocol Guide

Tertiary Center

- Instructional 20%
- Assist 50%
- Perform 30%

Dist. Hospital

- Assist 40%
- Perform under Supervision 60%

Perform at Work Place

Tier 1 Exam During 6 weeks

Tier 2 Exam

Tier 3 Exam 1 week after completion of DH training

6 + 1 week

9 weeks
Basic Content of EmOC Course

‧ Normal child birth and newborn care
‧ Early recognition of obstetric emergency
‧ Administration of oxytoxic drugs and parenteral anticonvulsants
‧ Prevention of infection
‧ Intravenous therapy including fluid replacement and blood transfusion
‧ Emergency medical treatment (sepsis, PE/Eclampsia, severe anemia)
‧ Emergency surgical procedures including Caesarean section
‧ Safe abortion, resuscitation of new born, contraception, PNDT and MTP act
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Minimum Competency Practical Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caesarean section</td>
<td>15</td>
</tr>
<tr>
<td>Vacuum extraction</td>
<td>7</td>
</tr>
<tr>
<td>Forceps delivery</td>
<td>5</td>
</tr>
<tr>
<td>Assisted breech delivery</td>
<td>2</td>
</tr>
<tr>
<td>Delivery of multiple preg.</td>
<td>1</td>
</tr>
<tr>
<td>Manual removal of placenta</td>
<td>2</td>
</tr>
<tr>
<td>Caesarean hysterectomy</td>
<td>?1</td>
</tr>
<tr>
<td>Normal deliveries supervised</td>
<td>120</td>
</tr>
<tr>
<td>Episiotomy / perineal tear repair</td>
<td>50</td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>?1</td>
</tr>
<tr>
<td>Destructive operations</td>
<td>?1</td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>?1</td>
</tr>
<tr>
<td>Breech extraction</td>
<td>?1</td>
</tr>
<tr>
<td>Induction/augmentation of labor</td>
<td>10/15</td>
</tr>
<tr>
<td>Premature deliveries</td>
<td>10</td>
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### Current Position
Creating the EmOC human resource

<table>
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<tr>
<th>2006 – Aug 2013</th>
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<tr>
<td><strong>Nodal Centres (Trains Master trainers)</strong></td>
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<tr>
<td><strong>Tertiary Training Centers (Trains MBBS medical officer for 6 weeks + 1 week exam)</strong></td>
</tr>
<tr>
<td><strong>District Hospital training sites (Practicum site for skills practice for 9 weeks)</strong></td>
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<tr>
<td><strong>Master Trainers in Medical Colleges</strong></td>
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<tr>
<td><strong>District hospital Practical Trainers</strong></td>
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<tr>
<td><strong>MBBS Doctors Trained in EmOC 16 week course</strong></td>
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</table>
EMOC TERTIARY CENTERS

Total 34 centers across India
Other programs and trainings have also contributed
Training Impact*

Data of 178 trained MBBS doctors (MOs) was analyzed.

Data of 1 year before the training and 1 year after the training was compared.

Data of cases managed by MOs from 12 States.

* Other programs and trainings have also contributed.
Training Impact *

* Other programs and trainings have also contributed

N= all Public Sector Facilities
Training Impact

* Other programs and trainings have also contributed

N= all Public Sector Facilities
### Challenges/Learning’s – Solutions that Worked

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<tr>
<th>Challenges/Learning’s</th>
<th>Solutions that worked</th>
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<tbody>
<tr>
<td>Convincing Policy makers for EmOC</td>
<td>Pilot and Showcase results</td>
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<tr>
<td>Development of National Nodal and Tertiary training centers</td>
<td>Orientation meetings with the centers</td>
</tr>
<tr>
<td>Preparing Motivated trainers</td>
<td>Empowerment as assessors, examiners</td>
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<tr>
<td>Govt. cannot do it all alone</td>
<td>Build partnerships. Assign tasks with accountability. Review progress.</td>
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<tr>
<td>Motivation levels ?</td>
<td>Monetary/ Non monetary recognition</td>
</tr>
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<td>Delay in release of program funds</td>
<td>Assign accountability at State Level</td>
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<tr>
<td>Trainer burnout/Transfer of Trainers</td>
<td>Create additional trainers</td>
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### Challenges/Learning’s – Solutions that Worked

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<td>Less than batch size number of MO’s come for training</td>
<td>Hold counseling sessions with MOs</td>
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<tr>
<td>Quality of training</td>
<td>Uniform training to the master trainers. Regular monitoring</td>
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<td>Prepare easy to understand program strategy and implementation plan</td>
<td>Each individual connected with the program need to be oriented. A central management unit controls the entire operation</td>
</tr>
<tr>
<td>Delay in placement of trained MO</td>
<td>Performance level monitoring at the highest level. Posting of MOs at DH where they continue practice.</td>
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<tr>
<td>Skill Decay</td>
<td>MOs retrained through refresher course</td>
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<tr>
<td>Periodic program implementation/financial assessment</td>
<td>External and internal assessments carried out</td>
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Design protocols, tools, operational plan, implementation plan, curriculum, videos

- All details can be accessed from our website

www.emocfogsi.in
Thank you

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