



Ensuring Equitable Access for Safe Institutional Child Birth

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What is the Briefing Paper Series?

*These Briefing Papers document a collection of initiatives, funded through UNICEF and implemented jointly with the Union and State Governments of India and other partners over the past five years. They cover a range of pilots and more advanced interventions that have variously generated lessons, demonstrated potential or achieved verifiable results in the delivery of maternal health, child survival, education, environment, protection and gender equality. Each paper provides an overview of a practice: its context, purpose, strategy and key elements of implementation as well as, to varying extents, the results and costs involved. The papers go on to consider lessons and wider application of the initiative. The series aims to generate greater knowledge and support effective replication and scale up. **This paper describes the results of efforts by UNICEF and the Government of Madhya Pradesh (GoMP) to ensure rural women from marginalised groups have equitable access to safe institutional child birth services. Through the provision of efficient referral transport services and bringing service delivery closer to the community by strengthening lower level public healthcare facilities in remote areas, the State has managed to increase access and demand for 24x7 safe delivery services. This has given a further boost to the gains made under the Government's conditional cash transfer scheme, increasing institutional delivery rates and reducing maternal mortality.***

Summary

MDG-5 aims to improve maternal health and reduce the maternal mortality rate by three quarters between 1990 - 2015. To address the fact that India had one of the highest maternal mortality rates in the world and expedite progress towards MDG-5, in 2005 the Government of India (GoI) launched the largest conditional cash transfer scheme in the world, Janani Suraksha Yojna (JSY), to incentivise women to give birth in medical institutions. JSY significantly increased the numbers of institutional deliveries, but it also raised challenges for institutions to keep pace with an increasing delivery load. In addition, remotely located villages, often with predominantly marginalised populations and bad road connectivity were also poorly served by health centres, making it difficult to ensure timely access for safe institutional deliveries for women residing in these localities. These barriers resulted in pockets of low institutional delivery and geographical exclusion, diluting the gains of JSY. On the service delivery side the capacity of health workers and increasing load of normal deliveries coming to first referral units (FRUs) were affecting quality of care.

To address the low rates of institutional delivery and high maternal mortality in Madhya Pradesh¹, UNICEF worked in partnership with the District Health Society (DHS) and the GoMP to pilot a three pronged initiative to (i) strengthen the free referral transport system linked to reliable and closely monitored 24x7 decentralised call centres, (ii) operationalise 24x7 delivery services at sub centres in remote areas and (iii) improve the level and quality of care at

¹ At 335 per 100,000, Madhya Pradesh had the fourth highest Maternal Mortality Rate (MMR) in India, Sample Registration Survey of India 2004-06.

peripheral health facilities by training and deploying staff and providing infrastructure and equipment at under-equipped health facilities. The initiatives were first piloted in Guna district and subsequently replicated in Shivpuri district in 2008.

Based on the success of these innovations the GoMP decided to roll out the initiatives state-wide, with required provisions under the National Rural Health Mission (NRHM) starting in 2009². Budgetary and human resource allocations by the state coupled with handholding support from UNICEF have led to 46 operational call centres reaching 50,000 pregnant women every month, as of August 2011. This accounts for nearly 44% of the women delivering in government hospitals³, with half the beneficiaries from Schedule Castes and Schedule Tribes; the most disadvantaged groups in the state⁴. In addition 125 sub centres have been operationalised in the state with trained staff for 24x7 safe delivery services.

These initiatives have helped to optimise and ensure greater equity in the gains envisioned under JSY, contributing to the achievement of two significant results:

- (i) Increase in institutional deliveries in Guna from 29%⁵ to 50.4%⁶ and to 94% in 2009-10⁷. Overall, institutional delivery increased from 47% to 81% in Madhya Pradesh in two years, which is nearly 10% above the national average⁸.
- (ii) Lowest MMR in Gwalior Division, which at 262 is 48 points below the State average of 310. The pilot districts of Guna and Shivpuri account for 60% of the population of this division⁹.

Situation Analysis and Context

With a population of over 72.5 Million and health indicators below the national average Madhya Pradesh is a 'high focus state' under NRHM. The MMR of the state stood at 335 in 2004-06, which was significantly higher than the national average of 254. Between 2002 to 2006, the neonatal mortality rate remained stagnant at 51; diluting the gains in infant mortality reduction, which had showed an 11 point fall from 74, over the same period¹⁰.

² The Government of India launched the National Rural Health Mission (NHRM) in 2005 to improve health care for the rural population throughout the country with specific focus on 18 States which have weak public health indicators. NRHM seeks to improve the access for rural people, especially poor women and children, to equitable, affordable, accountable and effective primary health care. Maternal health care, promotion of institutional deliveries, home-based newborn care, integrated management of childhood illnesses (IMNCI) and routine immunisations are the key interventions under NRHM.

³ Management Information System (MIS), Madhya Pradesh, second quarter 2011.

⁴ Call Centre data from Guna and Shivpuri, Jan 08 – July 11.

⁵ DLHS 2 2002-04

⁶ DLHS 3, 2007-08

⁷ District data

⁸ The Coverage Evaluation Survey 2009 (CES-2009) was a nationwide survey covering all States and Union Territories of India. It was conducted during November 2009 to January 2010. The survey was commissioned by United Nations Children's Fund (UNICEF) with the funding from IKEA Social Initiative. ORG – Centre for Social Research was entrusted to carry out the survey.

⁹ MMR data for the State as per Annual Health survey 2010.

¹⁰ Sample Registration Survey of India, 2003-06

One of the key contributors to high infant and maternal mortality rates was the large proportion of deliveries undertaken at home by untrained personnel in unhygienic conditions. The proportion of institutional deliveries was an alarmingly low 28%¹¹ in 2004, and while this increased to 47% in 2007¹² there remained large sections of the population, especially from Scheduled Caste and Tribes, that continued to face barriers in access to quality health facilities for institutional deliveries.

Evidence shows that ensuring deliveries at quality healthcare facilities can bring about significant improvements in maternal and child health indicators. Though various interventions were launched and proved successful in increasing institutional deliveries, a number of underlying factors blocked further progress in ensuring universal access and reducing mortality rates associated with child birth.

Under equipped health facilities with inequitable distribution

The GoI launched the Janani Suraksha Yojana (JSY) in 2005. JSY is a conditional cash transfer scheme, part of which provides financial incentives to pregnant women who opt for institutional deliveries. While JSY proved to be effective in enhancing demand levels, it did not focus on addressing supply-side constraints. Most peripheral health facilities in Madhya Pradesh, especially Primary Health Centres (PHCs) were ill-equipped to cater to additional demand due to lack of trained staff, equipment and infrastructure, while the Sub Centres did not have the mandate to conduct delivery services. Demand for services therefore had to be met by higher facilities such as District Hospitals which were already struggling with existing requirements. In addition distribution of 24x7 health centres was inequitable with most health centres being located along major roads, resulting in significant numbers of rural, marginalised women facing lengthy and often challenging travel, made worse during rainy seasons, if they were to get to a centre for delivery.

Absence of reliable referral transport system

The cost of arranging private transportation often exceeded the reimbursement provision made under JSY. The GoMP launched a referral transport scheme, the Janani Express Yojana (JEY) to help address these issues by providing free transportation services to pregnant women. The GoMP used its own ambulances as well as contracting private agencies to increase the fleet size. These ambulances were basic vehicles with minimal equipment and consumables and are stationed at health facilities. Contact numbers of ambulance drivers were shared with community health workers and other community members.

However, JEY faced weaknesses in monitoring and accountability. The absence of a nodal point for controlling operations led to a system which did not guarantee a high degree of responsiveness. There was a large dependence on the commitment levels and attitude of individual drivers and no mechanism for monitoring their response to calls. This especially affected disadvantaged groups who were unable to afford transport services.

As a result, UNICEF along with the GoMP initiated pilots in the districts of Guna and Shivpuri to

¹¹ As per District Level Household and Facility Survey (DLHS) 2 in 2002-04

¹² As per DLHS 3, 2007

improve access to institutional delivery and enhance the quality of services at peripheral health facilities¹³.

Strategy and Implementation

UNICEF and the GoMP adopted a three-pronged approach, leveraging existing schemes such as JSY and JEY and ensuring complementarity with the government system:

- (i) Strengthening free referral transport system linked to reliable and closely monitored 24x7 decentralised call centres
- (ii) Operationalising 24x7 delivery services at sub centre in remote areas
- (iii) Improving the level and quality of care at peripheral health facilities by training and deploying staff and providing infrastructure and equipment at under-equipped health facilities.

The intervention planned to achieve the following:

- (i) Improved institutional delivery rates of marginalised communities
- (ii) Reduced travel time and delay in reaching safe delivery centres
- (iii) Reduced congestion at the district hospital and First Referral Units.

(i) Strengthening the free referral transport system linked to reliable and closely monitored 24x7 decentralised call centres

Round the clock call centres were established to help control and monitor the functioning of the district JEY transport fleet. The call centre was responsible for dispatching and routing vehicles based on calls. It also helped in monitoring the effectiveness of the system by recording critical information.

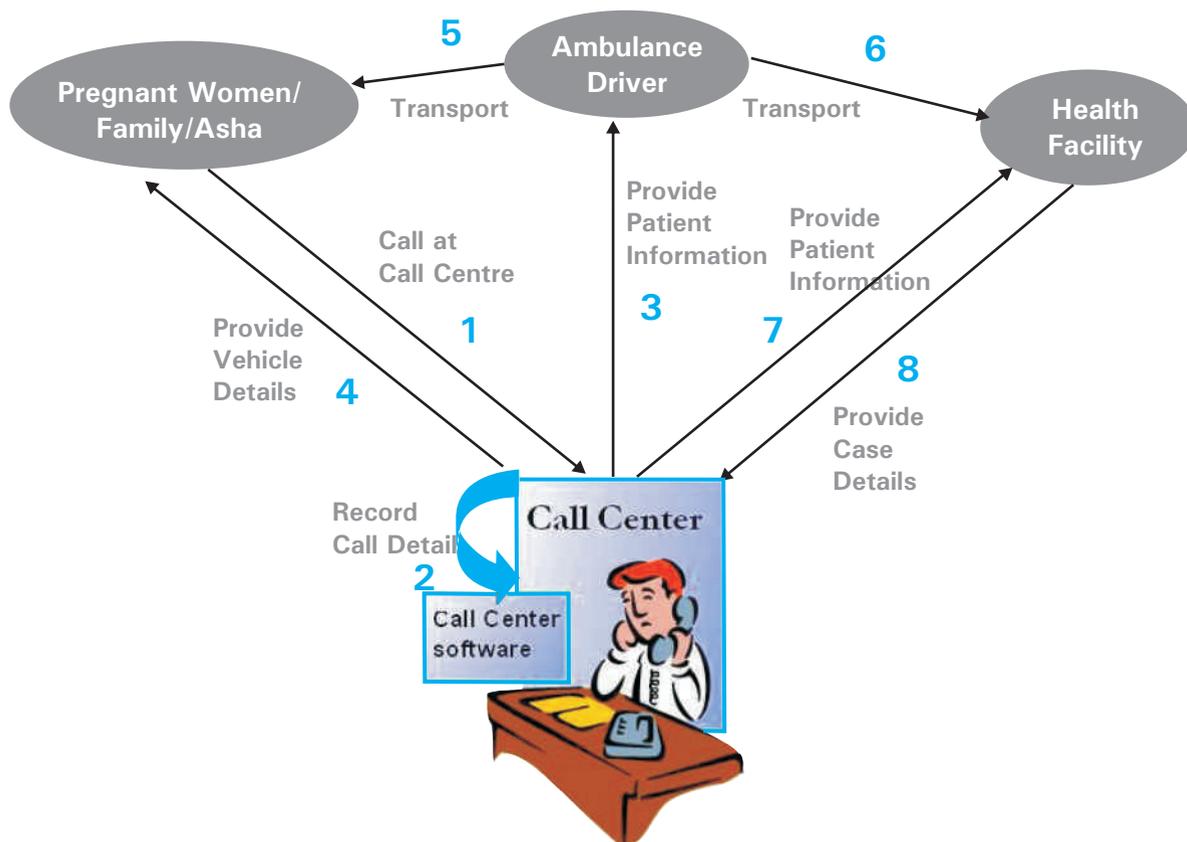
The call centre was established in 2007 at the Guna District Hospital. The key steps taken were:

- **Provision of infrastructure:** a room was provided in the District Hospital, along with furniture and equipment, including computers. A toll free number 102 was established along with another easy to recall number and three phone lines.
- **Software Design:** Software was developed by UNICEF to record and analyse critical information at the call centre, including: name of beneficiary; caste; informer details; time of call; address; ambulance arrival time; place of delivery; referral details; ambulance details; driver's mobile numbers. This robust database allowed for extensive analysis and monitoring of call centre and fleet operations. The software is able to generate reports on various parameters like beneficiaries by caste, response time, distance travelled, call conversion rate and type of caller. These reports help in decision making for corrective action.

¹³ Guna and Shivpuri are focal districts for UNICEF under the 'Integrated District Approach'. The Integrated District Approach (IDA) is implemented in 17 districts in 14 states in India. Districts were chosen on the basis of high infant mortality rates (IMR); those with large concentrations of Scheduled Caste and Scheduled Tribe communities; and those with a population of over one million. IDA promotes the sectoral integration of programmes at the village, block and district levels, applies a cross-sectoral approach to behaviour and social change, and aims to improve service delivery through national flagship programmes by linking community mobilisation processes with decentralised district planning processes.

- **Staffing:** The call centre was staffed by four operators who worked in eight hour shifts. An effort was made to hire operators who understood local dialects. Training was given on how to handle calls and deal with patients and drivers.

How a call centre works



24x7 Call centre

© UNICEF/India/Gagan Gupta



Janani Express Vehicle

© UNICEF/India/Gagan Gupta

(ii) Operationalising 24x7 delivery services at Sub Centres in remote areas

The other critical bottleneck was the absence of a network of quality lower level/peripheral facilities equipped to handle delivery cases. These facilities are closest to the community and easiest for them to access. However many were not operational and did not have adequately trained staff and equipment.

To ensure equitable distribution of delivery centres, UNICEF conducted a mapping of the district and identified 12 new centres that needed to be upgraded to 24x7 delivery centres. The aim was to provide a safe delivery centre at every 20-25 kilometres. The delivery centres were typically Sub Centre and Primary Health Centres (PHCs) which were closest to the community and easily reached.

Mapping of Delivery Centres in Guna



Blue Dots: Delivery Centres till 2006, Red Stars: Delivery Centres started in 2007 – 08

Source: UNICEF / District records

(iii) Improving the level and quality of care at peripheral health facilities by training and deploying staff and providing infrastructure and equipment at under-equipped health facilities.

The activities undertaken to upgrade centres included:

- Provision of infrastructure and facilities: Delivery centres were provided running water supply, solar power backup, new born corners and essential equipment. An emergency transport vehicle - the Janani Express was stationed at each of the health facility.
- Staff deployment and training: Emphasis was placed on ensuring that appropriate staff (such as Auxiliary Nurse Midwives, lady health volunteers and staff nurses) were identified

and deployed at the centres. Staff were trained at the District Hospital. Out of 245 staff posted at peripheral delivery centres in the district of Guna and Shivpuri more than 90% have been trained in skilled birth attendance, Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and routine immunisation while nearly 80% have been trained in newborn care and resuscitation¹⁴.

- On-the-job mentoring with on site correction: UNICEF has put in place a process for regular on-the-job mentoring with onsite correction of practices wherein a gynecologist, a paediatrician and a staff nurse from higher level facilities visit the peripheral centres for a day per month and work alongside the facility staff.



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Then: Chharch Sub Centre, Shivpuri - 2009



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Now: 24x7 Chharch Sub Centre – 2011



© UNICEF/India/Gagan Gupta

Upgraded Sub Centre for 24x7 deliveries



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Delivery Room at a Sub Centre: Shivpuri

The twin approach of establishing call centres and developing delivery centres were undertaken in parallel and were first completed in Guna and then taken up in Shivpuri in 2008. GoMP then decided to scale up the operations to all 50 districts in the State, with monitoring

¹⁴ District records

and technical support from UNICEF. Several call centres and upgraded sub centres were operational by 2009, with full scale up completed by 2010. Necessary budgetary and human resource provisions were made in the NRHM plan for the following three years to 2012.

Resources and Costs

The establishment and initial running costs for the first three call centres were paid by UNICEF. Following this all subsequent call centres were established using NRHM funds while the ongoing running costs for all call centres beyond the first few months and the fleet of vehicles were funded under NRHM. Similarly the cost of upgrading the first few sub centres was supported by UNICEF along with gap filling supplies of equipment but subsequent scale up was done with NRHM funds.

One of the key features of the intervention is the fact that it has leveraged existing resources to a large extent and managed to maintain low costs. Details of the major costs associated with the intervention are provided as follows:

Detailed Costs

CALL CENTRES		
Capital Costs per call centre	INR	USD*
Setting up of Call centre within District Hospital (civil works, furniture etc.)	125,000	2,717
Procurement of equipment including phone, computers, air conditioner	75,000	1,630
Total Capital Cost	200,000	4,347
Operating Costs per annum		
Salaries for computer operators (4 / call centre - monthly salary @ INR 5000)	240,000	5,217
Phone	60,000	1,304
Maintenance and contingency	60,000	1,304
Total Operating Costs (per annum)	360,000	7,826
FLEET OF VEHICLES**		
Operating cost per vehicle	20,000 /mth (first 1500 km free, additional at INR 5/km.	
DELIVERY CENTRES		
Capital Costs per delivery centre		
Existing building upgraded	200,000 – 400,000	4,347 – 8,695
Operating Costs per annum		
Sub Centre Grant untied fund and maintenance grant being used	20,000 excludes staff salary and medicines	434

Source: NRHM PIP 2011 and JEY Guidelines, GoMP April 2010

* USD 1 = INR 46

**Fleet of Vehicles

The JEY fleet of vehicles are hired from private operators through an open tender process at the district level. According to the guidelines laid down by the GoMP, an upper limit of INR 20,000 is set per vehicle per month for covering a distance of up to 1500 km. On exceeding 1500 km, INR 5 per km is paid to the contractor. These costs were borne from the transportation cost inbuilt in JSY of INR 250 per rural beneficiary.

Human Resources and Training

The costs of training in pilot districts were borne by UNICEF while in the scale up districts this was taken over by NRHM. Key operating staff requirements for the initiative are as follows:

Staff	Numbers	Comments
Call Centre Operators	4 per call centre	<ul style="list-style-type: none"> Graduate with diploma in computers Usually local people are chosen due to familiarity with local language and area Contractually employed under NRHM Trained in responding to calls and dealing with drivers
Drivers	2 per ambulance	<ul style="list-style-type: none"> Government drivers/engaged by contractor Provided first aid training
Auxillary Nurse Midwife (ANM)	2 per Sub Centre	<ul style="list-style-type: none"> Trained in SBA, NBC, IMNCI, immunisation
Lady Health Volunteer (LHV)	1 per Sub Centre	
Staff Nurse	1 only at Primary Heath Centre	

Progress and key outputs

Referral Transport and 24x7 Call centres

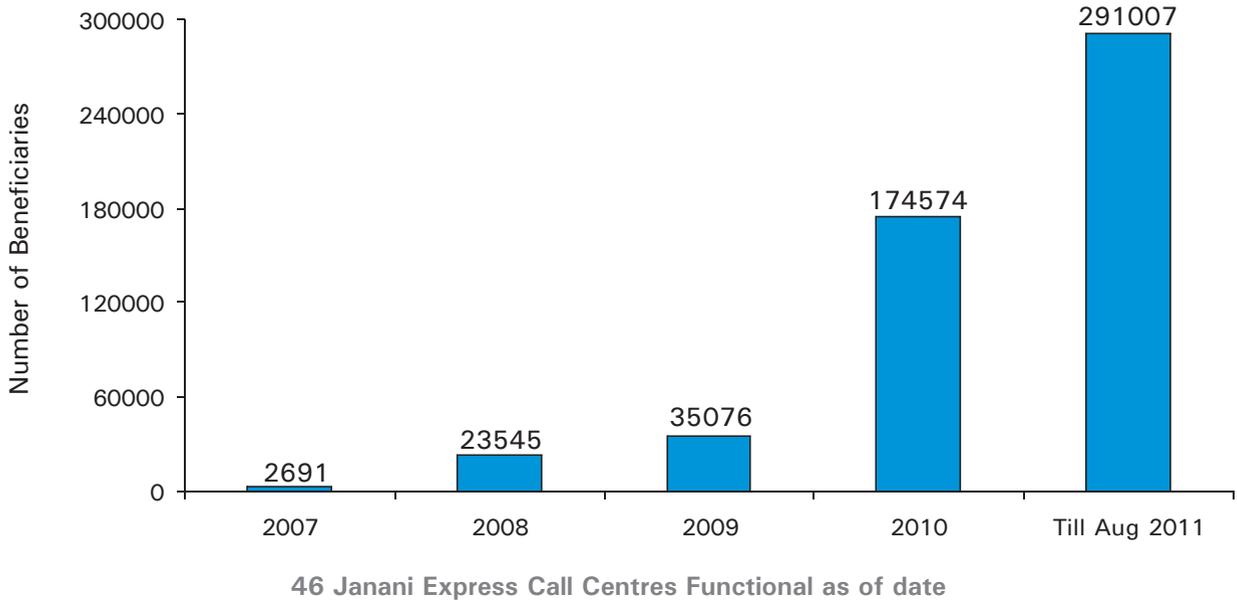
- Scaled up in 46 out of 50 districts with nearly US\$ 4.2 Million spent from NRHM from 2009-2011 for referral transport. More than 650 vehicles and 170 operators working 24x7 to ensure timely transport.
- 526,000 pregnant women transported free of charge across the state through call centres from September 2007 to July 2011.¹⁵
- Currently around 44% of pregnant women delivering in hospital are using free transport facility through call centres.¹⁶
- Nearly 90% of women transported within two hours of receiving call to health facility
- More than 90% of the beneficiaries belonged to Scheduled Caste or Scheduled Tribe and 'Other Backward Classes' which is higher than the population distribution of these categories.¹⁷

¹⁵ Call Centre Records and State MIS report

¹⁶ State MIS Data for second quarter 2011

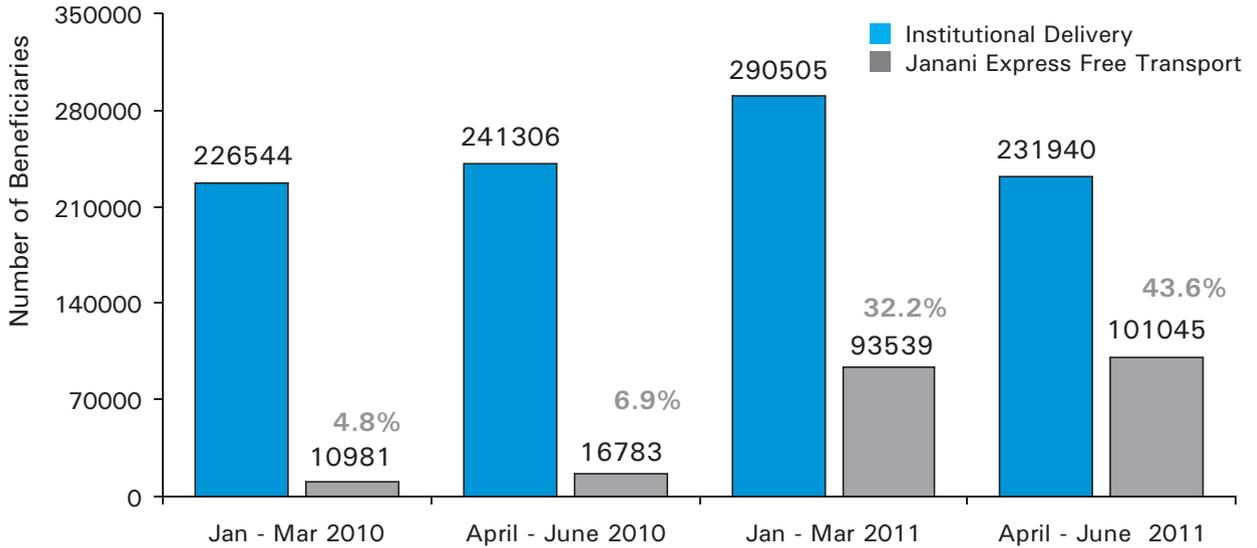
¹⁷ Call Centre Data analysis pilot districts – Guna and Shivpuri

Janani Express Call Centre Annual Beneficiary : 2007 - 2011



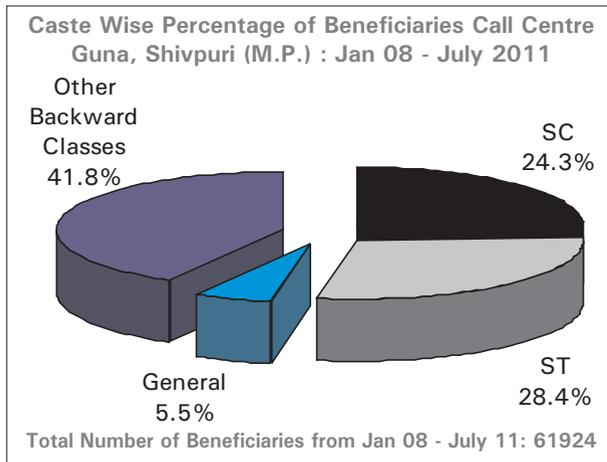
Combined Data: All Call Centres Madhya Pradesh 2007 - 2011

**Institutional Delivery vs Call Centre Free Transport Madhya Pradesh
Quarterly Comparison : 2007 - 2011**

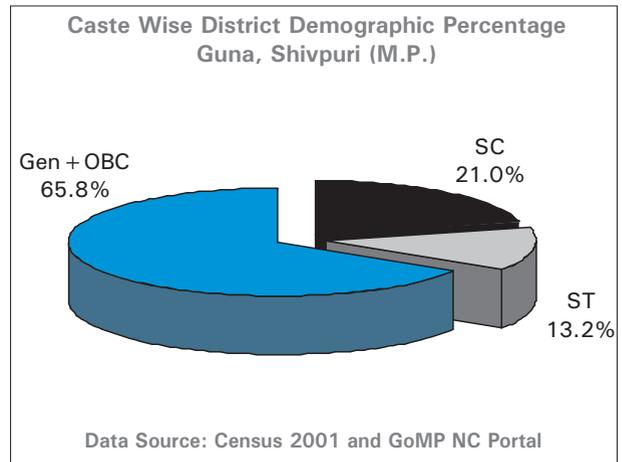


Comparison of Institutional delivery and use of call centre for transportation

Caste wise Call Centre Beneficiaries: Guna & Shivpuri



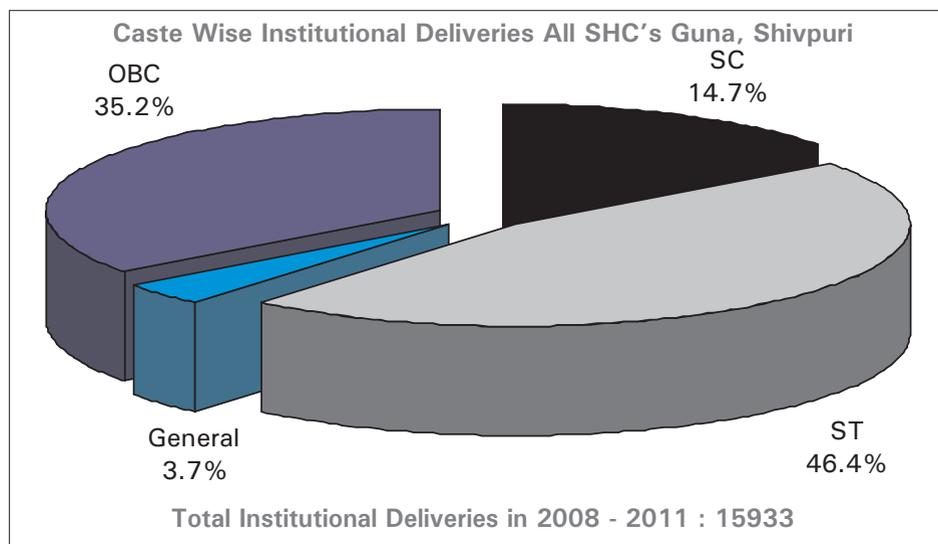
Population Distribution: Guna and Shivpuri



Upgrading peripheral centres

- 16,000 deliveries conducted in pilot districts of Guna and Shivpuri at Sub Centres from 2008 to March 2011.
- 61% beneficiaries from marginalised groups (Schedule Tribe: 46%, Schedule Caste: 15%).
- More than 125 Sub Centres upgraded across the state under NRHM.
- Model adopted by Gol¹⁸.

Caste Wise Distribution of Beneficiaries

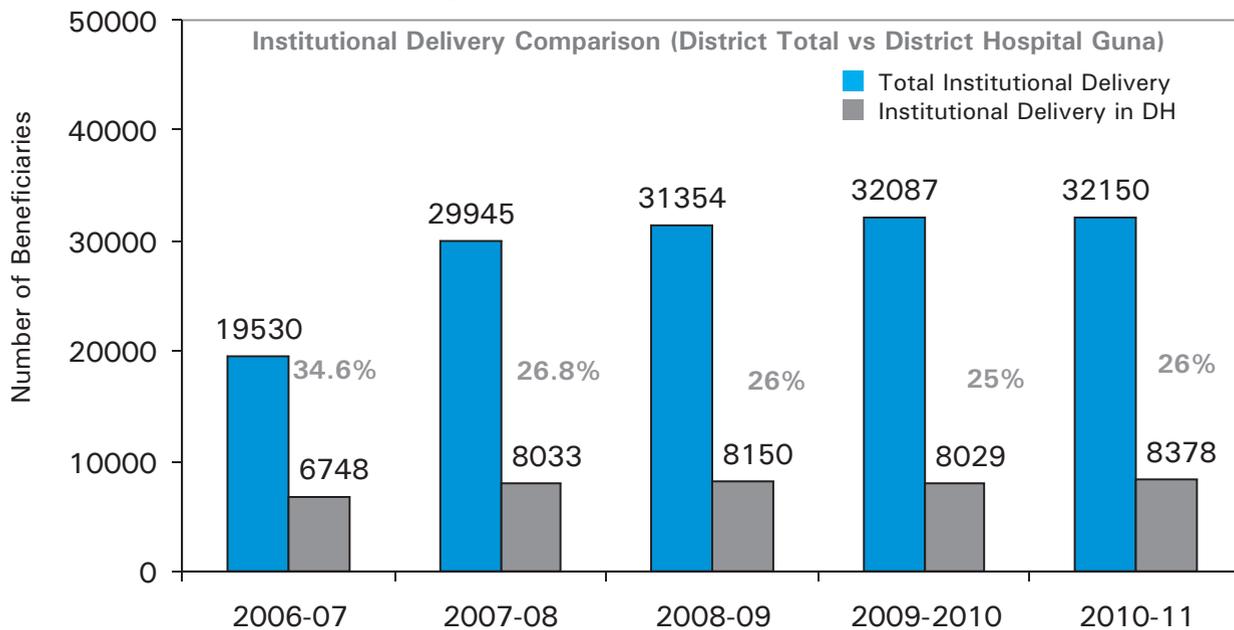


Source: District Data

¹⁸ This model has been adopted by Gol as Level 1 Maternal and Child Health centres

With the improvements in infrastructure and staffing, the peripheral health facilities, namely the Sub Centres and PHCs in Guna and Shivpuri were able to manage a significant number of delivery cases which helped reduce the load of the over-burdened District Hospital.

Decongestion at Guna District Hospital

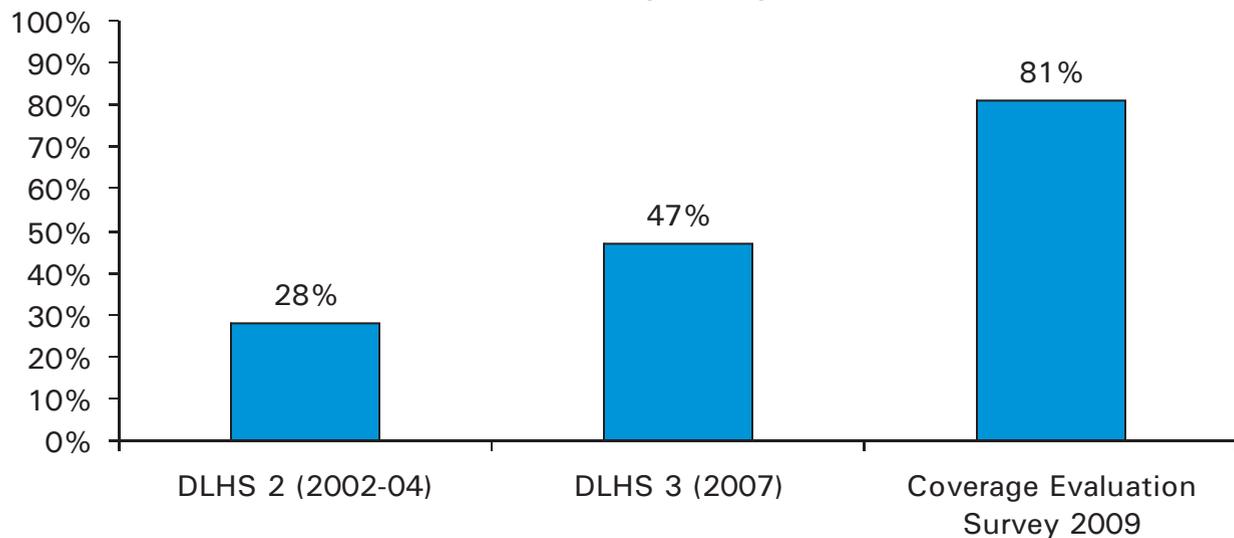


Key Results

These initiatives have contributed significantly to ensuring skilled birth attendance for rural women of Madhya Pradesh and helped in optimizing gains envisioned under JSY contributing to two key results:

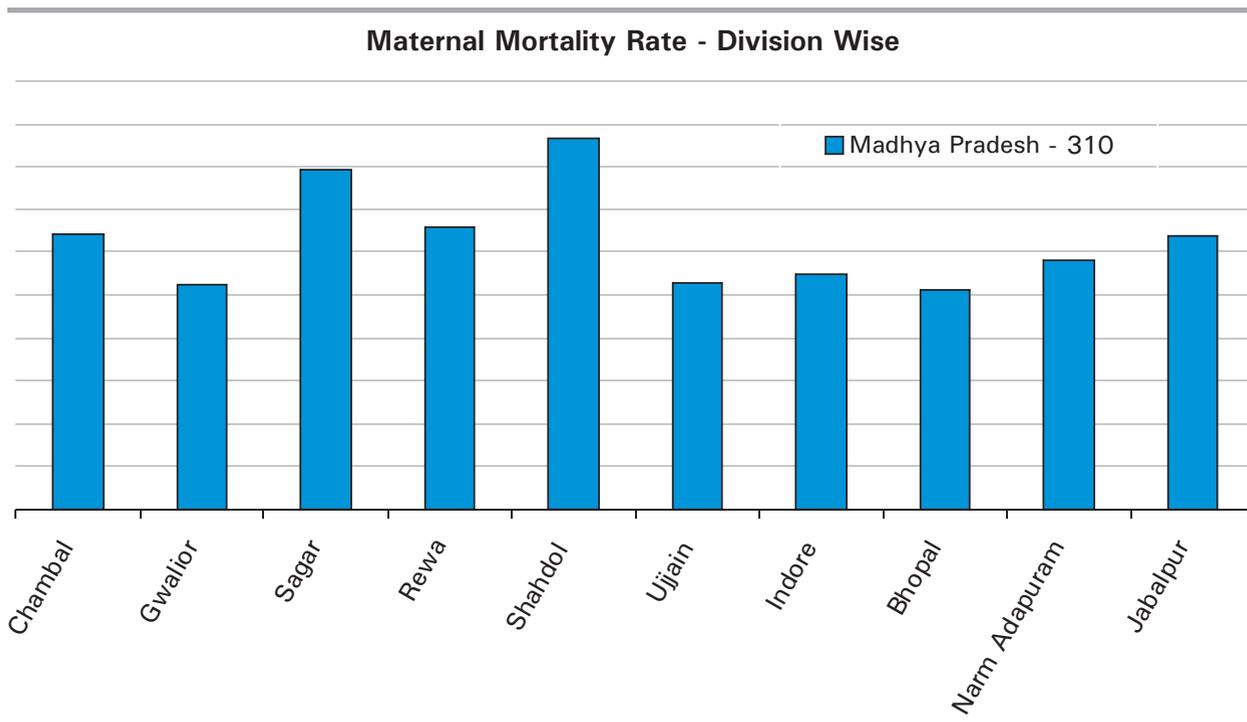
- (i) Increase in institutional deliveries in Guna from 29% in DLHS 2 (2002-04) to 50.4% in DLHS 3 (2007-08) and to 94% in 2009-10 (district data). 10% reduction in District

Institutional Delivery: Madhya Pradesh



hospital share of deliveries in Guna from 35% in 2006-07 to 25% in 2009-10. Overall, institutional delivery increased from 47% to 81% in Madhya Pradesh in two years, which is nearly 10% above the national average.¹⁹

(ii) MMR data for the state as per Annual Health Survey 2010 has shown the lowest MMR in Gwalior Division which at 262 is 48 points below the state average of 310.²⁰



In addition to the above results, the Neonatal Mortality Rate, which was stagnant at 51 from the year 2002 to 2006 had reduced to 44 by 2009²¹. Though initiatives like IMNCI and Special Care Newborn Units have contributed to this the increase in institutional delivery is a critical factor.

Good Practice

There were a number of key elements of good practice in the design and implementation of the intervention which were critical for its success. These are discussed below.

(i) Response from the public and uptake of services: There was a positive response and engagement from communities which can be attributed to the following:

- **Needs-based intervention to provide workable solutions at the ground level:** The intervention addressed the felt need of the community which was built on a sound understanding of where the blockages were in the system and simple, workable solutions to address them. This was evident not only in the uptake of services but also from the fact that in certain areas communities agreed to exchange bigger local government buildings with smaller Sub Centre buildings so that the delivery services

¹⁹ Coverage Evaluation Survey: 2009

²⁰ Gwalior division had some of the worst health indicators in the district. Guna and Shivpuri account for 60% of the population of this division.

²¹ Annual Health Survey, 2010

could be effectively operationalised. In addition Panchayats made decisions to contribute from different government schemes such as National Rural Employment Guarantee Scheme and Backward Region Grant Fund to upgrade infrastructure and local area development funds were utilised by elected leaders to provide ambulances. Members of the public also made individual contributions.

- **Building on the successes of what was already there and ensuring complementarity:** JSY and JEY had already contributed to building demand and enhancing quality. Once supply was made more equitably available and barriers to access were addressed, utilisation of services increased significantly.
- **Reducing travel distance to access services and ensure value for money:** The initiative was clearly successful in bringing service delivery closer to the community, stimulating uptake of services and ensuring value for money. The analysis of Call Centre data for Guna and Shivpuri for nearly 50,000 beneficiaries from 2008 to 2010 showed 80% of the women had to travel less than 20 km to reach the nearest facility.
- **Quality and availability of services 24x7:** A call conversion rate of nearly 90%, response time of less than 2 hours from receiving the call to reaching the facility in 90% of the cases as well as the fact that health centres have been successfully operational around the clock, demonstrate efficiency in the service. In addition, ensuring this efficiency early on contributed significantly to building the faith of the public. A robust monitoring system has also supported performance quality in the system.

(ii) Scaling up with Pace and Quality: One of the important elements was rapid scaling from the pilot in 2007 to state-wide scale up by 2010. Achieving quality in scale up is notoriously challenging. This was achieved quickly without compromising quality due to ensuring the following factors:

- **Involvement of state from design stage generated knowledge and built ownership:** The State technical team was involved right from the design stage of the pilot in Guna. This along with periodic updates on progress at the ground level and sharing of data generated knowledge and built ownership.
- **Catalytic funding for pilot and technical support by UNICEF during scale up:** Availability of catalytic funding from UNICEF to support the pilot until it was mainstreamed under NRHM was critical for the initial pilot to take off. This enabled the management arrangements and operations of the initiative to be clearly established, a rigorous road map for scale up developed and roles to be clearly defined. A continuation of UNICEF's role in guidance and technical support ensured continuity and efficiency through the scale up process.
- **Good data management systems generated clear evidence and enabled on-site advocacy with key policy makers:** Due to emphasis on a robust data management system and sound monitoring arrangements the initiative not only ensured a good degree of internal accountability for performance but also generated clear evidence of results. With this confidence the project team were able to arrange joint field visits with senior officials and key policy makers from the department. This powerful on-site advocacy, resulted in GoMP quickly agreeing to state-wide scale up with required resource allocations.

- **Rapid mainstreaming under NRHM with necessary resource allocations:** The interventions were mainstreamed under NRHM within six months of the pilot with all the required resource allocations to support scale up, incorporated under the plan. In addition the funds were leveraged from existing provisions of transport under JSY and Sub Centre grants under NRHM which helped the government at to accord necessary approvals. The low cost of the interventions also helped mainstreaming.
- **Standardisation, quality assurance and on-going mentoring:** The designs and lay outs were standardised with uniformity in all key aspects such as design, software, data recording formats, human resource deployment and training packages which ensured scale up with continuity and efficiency. This was well supported by UNICEF staff and field coordinators who worked closely with District and State officials to ensure facilitation from planning to roll out and addressing bottlenecks at all levels. In addition regular visits by coordinators are done to monitor quality, make onsite corrections and provide on-the-job mentoring support to staff.
- **Management Information System ensuring quality performance and corrective action:** The software for Call Centres is able to generate information on various parameters. Reports generated from the system are regularly shared with District and State officials for discussion and necessary corrective action. The Call Centres are graded by performance on select indicators and focussed effort is made to improve performance. The system is utilised as an effective management tool. The system will go online this year to ensure real time monitoring of data by the state.

Application, Replication and Recommendations

Although there has been significant progress in recent years, India continues to be plagued by high maternal and infant mortality. A large proportion of the population is still deprived of quality services due to social and geographical barriers. This is an issue common to many States. The model implemented by UNICEF and GoMP can be easily replicated and has proved good value for money. The interventions implemented in Guna and Shivpuri were simple yet effective, building on sound analysis to understand the blockages in the system and ensuring workable solutions in line with the existing institutional set up and available services. They were well received by the public as evident from the increased uptake in services and contribution of the community in their development.

Following successful pilots in two districts, the GoMP has rolled out the initiatives state-wide with monitoring and technical support provided by UNICEF. In each district between 5-10 Sub Centres were upgraded to 24x7 delivery centres and one Call Centre was established. The funds for the scaling up came from the government's NRHM budget. The pilot centres in Guna and Shivpuri have now been operational for three years without any further financial support from UNICEF which is a clear indication of the sustainability of the intervention. In addition successful scale up across the state with NRHM funds has proved it is possible to replicate rapidly without compromising the quality, if certain factors and guidance are assured, as detailed above.

The model of Sub Centre delivery has been adopted by the GoI for nationwide replication (as Maternal and Child Health Level 1 Centres). While the Call Centre and Janani Express model is being looked at by several states as a viable low-cost transportation model. The Government of

Chhattisgarh has already replicated the intervention in Bilaspur District, named as the Mahtari Express. The States of Haryana and Odisha also are looking closely at this model with teams having conducted site visits.

Efforts to maintain quality and make improvements are continuous. Certain challenges that need to be addressed going forward include:

Dealing with Private Agencies

Since the referral transport system relies on private agencies which provide ambulances and drivers, it is critical to continue monitoring third party operations and ensure that they meet basic service levels. In addition the fluctuations in the petrol price must be factored into the contract of the vehicle provider.

Ensuring Call Centre as the Single Point of Contact

Under the Janani Express model, the driver’s numbers were shared with community workers (such as Accredited Social Health Activists – ASHAs) who would call for the ambulance directly. This practice is continuing in some locations calls directly to drivers instead of the Call Centre. In all cases, the call centre needs to be the single point for effective monitoring, evaluation and accountability.

Ensuring Uninterrupted Mobile Connectivity

Mobile connectivity is a minor issue in some parts of the state and some mobile networks do not work in the interiors. Some networks also do not allow the user to dial the toll free number. This is being addressed by the state with telecom providers and additional numbers have also been provided at the centres alongside the toll free number. It would be worthwhile considering this in any replication and scale up.

Differential Maintenance Grant For 24x7 Sub Centres

The maintenance of services at 24x7 Sub Centres is currently being done through the provision of the maintenance grant and untied funds provided under NRHM. However given the increased costs of operating a sub centre for 24x7 delivery services there is a need to reflect this in higher resource allocations compared to normal Sub Centres.

Further Information

Key Contacts	Key Documents
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