Chapter VI

ANNOTATED BIBLIOGRAPHY

1. Assaf, A.F., (MD, CQA) 2001.Health Care Quality: An International Perspective WHO, Regional Publication, SEARO No.35.

This book, a WHO publication, is very comprehensive text on quality in health care setting. It gives very clear definitions of quality of care as is applied to the health. It is divided into fifteen chapters. Various issues on quality are discussed ranging from standard setting, monitoring and evaluation of quality. This book is targeted for wide variety of audiences in the health and even for those who are basically concerned with quality issues. It can be used as reference for managers in quality management. It quotes references and websites. This gives clear view of what quality mean and is understandable by any lay person.

2. Enkin,Murry., Kreise,Marc,JNC., Nealson,James., Crowther, Caroline at.el. 3rd Ed.2000. A guide to effective Care in Pregnancy and Childbirth. Oxford University Press. ISBN 019263173 X.

This book gives the reasons for doing any interventions based on the evidences in the literatures and authentic results of control trails. It urges people to based decisions on hard evidences. It gives insights into what an effective care and varied perspectives. This is an interesting book, which encompasses quite an area in the pregnancy care like it gives various methods of evaluating care, talks about antenatal education, lifestyles affecting pregnancy, and other related care in pregnancy. Another section gives care during childbirth and associated problem. At the end it give synopsis of all the interventions which are proven to be beneficial, which has equivocal benefit and which are harmful. It gives good insight into management of pregnancy.

3. EngenderHealth & Mailman School of Public Health: Columbia University. 2000 Emergency Obstetric Care: Tool book & leadership manual for Improving the quality of Services/www.engenderHealth.org.

This is a manual, which have two parts, one give general information about how to use the manual and the role of the leader in training the team in the continuous quality improvement by using a participatory approach or team approach. It talks about the role of the group dynamic and conflict resolution in working with the group specially when designing for such work. The second part gives details of the tools and tells about the ways to use and to analyze them specially while assessing the emergency obstetric care. It gives ways to set the continuous quality control in motion.

4. Haaland,Ane., Vlassof, Carol., 2001. Introducing Health workers for change: from transformation theory to health system in developing countries. Health policy & Planning. 16 (suppl. 1) 1-6.

The author begins with familiarization of the founder of the concept of learning for action, Paulo Frier, who transformed the didactic learning to dynamic learning. The paper gives the details of the concept of an intervention tool known as *health workers for change*, and the role of interactive, participatory learning approach in promoting social change. It says how health workers for change can make the work place more conducive and bring fostered client and provider relationship. Being the subject of their own learning brings about very positive changes in the attitudes and the behaviors of health workers themselves. But need for the consistency in the support from the supervisors in such a process is stressed. Health worker for change is being tried in many countries and proven to be successful.

5. The Kasongo Project Team.1984. Antenatal screening for fetopelvic dystocia. A cost effectiveness approach to the choice simple indicators for use by auxillary personal . Journal of Tropical Medicine and Hygiene, 87. 173-183

This journal article gives the report of screening study in Kasongo in the Eastern Zaire in Africa, on 4772 pregnant women during antenatal visit to screen for life threatening fetopelvic dystocia and for abnormally prolong labor by using simple markers as used by the auxillary nurses. This study shows how simple screening

method by using age, parity, and height and per abdominal examination and proper history taking can screen highrisk pregnancy even when they have just two visits per pregnancy. The sensitivity and the predictability from this study can be used to determine the criteria for referral of the high-risk patients to higher level. It gives reasons of limitation of such screening test as the sensitivity and the specificity in are low.

6. McDonagh, Marilyn. 1996. Is antenatal care effective in reducing maternal morbidity and mortality ? Health Policy and Planning 11(1) 1- 15.

This is a critical review of literatures regarding the effectiveness of the antenatal care in reducing maternal morbidity and mortality. The article looks at the antenatal procedures as screening tools, which are used to predict the adverse outcome of a pregnancy. Antenatal care a procedure for screening for 'at risk' is discussed in detail with special emphasis on the routine measurements like blood pressure measurement, abdominal examination and provision of nutritional interventions. It takes one through various pros and cons of individual procedures and gives evidences regarding the usefulness of antenatal care procedures. The article emphasizes the role of antenatal to influence the women to select a trained birth attendant, so that it will help reduce death from delayed referrals, sepsis, obstructed labor and poor obstetric techniques. ANC as opportunity to reach women and to provide a service more appropriate to women's need.

7. Hall, Marion H., Chng,PK., MacGillivery I., 1980. Is routine antenatal care worthwhile? The Lancet. July12. 1980.

The journal article though is published in 1980 is widely quoted in various article reviews. It points out the reasons for reduction of the visits for those who are asymptomatic pregnant women. The routine visits can be reduced and seen at specific gestational ages where chances for occurrence and detection are high, like detection of pre eclampsia, detection of mal presentation and intrauterine growth retardation, which are three most common asymptomatic complications. So the authors suggest that instead of visits scheduling for early registration, and visit monthly until 30 weeks, then fortnightly visit until 36 weeks and then weekly until delivery. They suggest that for normal multigravida, visit should start with full examination around 12 weeks of gestation, then 22 weeks to detect multiple pregnancy, 30th week of gestation for clinical diagnosis of intrauterine growth retardation, and 36 weeks for mal – presentations and other examinations at full term. And for the primigravida a special visits additionally to assess for preeclampsia. The authors stress on specifying the objectives of each visit to assess whether the objectives are met or not.

8. Villar Jose., Bergsjo,Per., 1197. Scientific Basis for the contents of routine antenatal care. Acta obstetricia et gynecologica Scandivica.

This paper discusses the usefulness of the routine antenatal care in decreasing or removing the adverse pregnancy outcome. The first part describes all the variations in the contents, frequency, and initiation of visit and number of visits both in the

developed and developing world. Since most of the contents have low predictability the need for more randomized control trials have been stressed.

The second section describes the possibilities of either eliminating or alleviating the adverse outcome of pregnancy through selected components of routine antenatal care. Routine antenatal care activities should be goal oriented for specific maternal and fetal or newborn health problems, which are proven to be effective in control trails. The authors describe in detail the role of antenatal in preventing adverse outcomes like bleeding during pregnancy, maternal anemia, preeclampsia, sepsis and genitourinary infections, and obstructed labor. In newborn adverse outcome like intrauterine infection, intrauterine growth retardation and pre-term birth . The role of antenatal has to be based on evidences is further emphasized.

9. Srinivasa,DK., Danabalan M., et.al. 1982. Method to assess quality of services in antenatal clinics of primary health center. Indian Journal Medical Research 76. September 1982, pp 458-466.

This article describes the study on quality of antenatal care in the primary health centers in South India. It gives the details of the quality indicators and to group them based on the essentials of the good antenatal care. Then to assign scoring so that the items can be analyzed depending upon the performance of the care giver. The article gives the results and discusses the problems for such studies like score for tetanus immunization, but the authors suggests that it can be used by others in similar assessment as it easy.

10. WHO, Antenatal Care, Report of a Technical Working Group 1994. (WHO/FRH/MSM.96.8)

This is recommendation of the Technical Working Group on the antenatal care. It recommends the care of the normal pregnancy with minimum of four visits with specified objectives per visit beginning from 16th week onwards. It provides the methods to carry out the care. There is separate section for the identification and treatment of the high-risk pregnancy. It gives stepwise approach to management of the high risk. At end it discusses all the policy issues and other approaches to make antenatal care more effective in lowering adverse maternal outcome.