INDIA

Program Years 2006 to 2009

Increased Skilled Birth Attendance in Underserved Rural Communities in Jharkhand State

INTRODUCTION

With a high maternal mortality ratio and a population of more than one billion people, India leads the world in the number of women dying in pregnancy and childbirth every year. When ACCESS began working in India in 2006, only 29.1% of births were attended by skilled providers in Jharkhand state;[49] the majority of women also give birth at home. This lack of skilled birth attendants (SBAs) meant no life-saving emergency obstetric services for the many women who experience life-threatening complications, putting them and their newborns at great risk.

In 2005, the Government of India (GoI) addressed the need for SBAs by expanding the range of skills for auxiliary nurse-midwives (ANMs) and lady health visitors (LHVs) to enable them to provide life-saving skilled care at birth. With USAID support, ACCESS worked with the Government of Jharkhand, CEDPA and implementing partners[50] to operationalize these guidelines and improve health outcomes for mothers and newborns.

ACCESS designed a pilot project and evaluation to demonstrate that increasing the availability of skilled delivery care offered by ANMs—combined with community mobilization activities—improves access to and use of key MNC services, ultimately contributing to improved health outcomes and reducing maternal and newborn morbidity and mortality. ACCESS implemented this project in Jharkhand, where skilled attendance at birth, ANC attendance and the contraceptive prevalence rate are among the lowest in the country (see text box above right). Dumka District was

KEY INDICATORS FOR JHARKHAND

Total fertility rate: 3.3

Contraceptive prevalence: 31.1% (modern methods)

Births with skilled attendant: 29.1%

Antenatal attendance (3+ visits): 36.1%

Source: National Family Health Survey-3, 2005–06
WHO Statistical Information System

Women's group, India

[49] National Family Health Survey-3, 2005–2006.

[50] GoI, Government of Jharkhand, Government of Dumka, Mohulpahari Christian Hospital, Sadar Hospital Dumka and ANM Training Center, Chetna Vikas, CEDPA, Jhpiego (ACCESS), Save the Children (ACCESS), Social and Rural Research Institute/IMRB International.

selected due to its challenging MNH situation, and the project was implemented in three of Dumka's ten blocks: Jarmundi, Shikaripara and Saraiyahat.

PROGRAM STRATEGIES AND INTERVENTIONS

The project's formative assessment in June 2006 found that the majority of women and their families in Jharkhand seek care from traditional birth attendants (TBAs) and that basic emergency obstetric and newborn care (EmONC) remained out of reach for most women. Within the formal health care system, ANMs are intended to provide midwifery care, but they infrequently attended deliveries.

To make skilled care by ANMs available in communities in Jharkhand, ACCESS focused on three areas: 1. creating demand in the communities for skilled care; 2. training ANMs to ensure that they are competent SBAs; and 3. supporting ANMs to provide care in the communities, either at home or from peripheral health care centers (sub-centers and primary health care centers). ACCESS and its partners worked at the national, state and district levels to achieve the program objectives.

ACCESS conducted a number of key, coordinated activities that were essential to the project's success, including:

- Trained ANMs as community-based midwives for 12 weeks using competency-based training materials in Hindi.
- Strengthened clinical training sites and built/strengthened capacity of faculty, clinical providers and supervisors.
- Deployed and supervised ANMs in communities and developed ongoing support systems within the government health care system.
- Introduced community mobilization activities and materials to increase awareness of birth preparedness/complications readiness (BP/CR).
- Established/strengthened *mahila mandals* in communities to generate support for BP/CR and ANMs placed in communities.

ACCESS monitored and evaluated its model to inform the ongoing national discussion of strategies to increase skilled birth attendance. The project conducted a pre/post quasi-experimental evaluation that included a household survey of pregnant women and recently delivered mothers, and interviews with ANMs in intervention and comparison areas. ACCESS also strengthened systems for collecting service statistics from ANMs and project-supported CHWs. In early 2009, ACCESS shared findings with stakeholders at the state and national levels and then continued to work with national policymakers—such as the Indian Nursing Council (INC)—to integrate key findings with ongoing programs.

RESULTS

Increased ANM Training Capacity

- Strengthened the ANM training centers (including a teaching skills laboratory) and training skills for ANM tutors and improved the teaching quality. These sites offer in-service and pre-service ANM education.
- Strengthened two hospitals and three primary health centers, improving evidence-based practices consistent with GoI guidelines. The hospitals were used as clinical practice sites for ANMs during training.
- Developed and tested a 12-week competency-based training course on GoI guidelines.
- Trained 58 ANMs to competency as SBAs in evidence-based care in ANC, normal delivery, postnatal/postpartum care and management of complications.

MAJOR PROJECT RESULTS

- Demonstrated that the 12-week ANM training course produced competent and skilled SBAs in the intervention group who practiced the life-saving skills they were taught, such as partograph use, AMTSL practice and newborn resuscitation.
- Significantly improved the practice of BP/CR for pregnant women and recent mothers and the practice of essential newborn care among recent mothers—including clean cord care, drying and wrapping, and delayed bathing.
- Significantly increased the proportion of births attended by ANMs in the intervention group of recent mothers—from 5% to 13%.
- With the INC, developed a national strategic plan to scale up project findings aimed at supporting improved capacity of ANM training centers (ANMTCs) at the district level.

Increased Access to Skilled Maternal and Newborn Care

- Supported two groups of ANMs (37 total) for a year of training as they worked in communities to provide MNC at home and/or in facilities. Local project staff provided regular monitoring, supervision and data collection.
- Introduced and supported the trained ANMs as skilled providers to communities and linked community workers, communities and trained ANMs to create awareness and accountability.

Increased Knowledge and Action on Maternal and Newborn Care—Community Mobilization and Outreach

- Mobilized 223 communities in 180 locations of three blocks.
- Trained more than 2,600 community members, including 434 safe motherhood volunteers, 231 safe motherhood advocates and over 1,400 *mahila mandal* members.
- Mobilized more than 220 villages to take action to increase access to skilled care, resulting in 100% of villages having a functional emergency transport system.
- Significantly increased knowledge of postpartum/postnatal care, including essential newborn care, among pregnant women and recent mothers in the intervention group.

Increased Use of Maternal and Newborn Care Services and Home-based Practices

- Significantly increased (from 5% to 13%) the proportion of births attended by an ANM among recent mothers in the intervention group.
- Increased the average number of deliveries per ANM based on service statistics they reported, conducting a mean of 4.6 deliveries per month over the last eight months of the project. At baseline, most ANMs in the study area did not conduct any deliveries.
- Increased numbers of institutional deliveries by encouraging ACCESS-trained ANMs to conduct deliveries at health subcenters so mothers could access *Mukhya Mantri Janani Sishu Swasthya Aviyan*[51] benefits.
- Significantly improved the practice of BP/CR during pregnancy, and the practice of essential newborn care among pregnant women and recent mothers:
    - Fewer pregnant women decided to deliver at home (94% to 76% at endline) and significantly more had set aside funds for delivery (17% to 32% at endline) among the intervention group. No significant changes were seen in the comparison group for BP/CR practices.

[51] This is a state-sponsored National Rural Health Mission maternity incentive scheme similar to the national *Janani Suraksha Yojana* that pays women who deliver in facilities.

- Statistically significant difference in the practice of clean cord care (such as using a new razor blade or blade in the delivery kit, and not applying anything to the stump) among the intervention (69%) and comparison (31%) groups of recent mothers surveyed. (See Figure 18.)
- Statistically significant difference in the proportion of the recent mothers in the intervention group (77%) who reported that the newborn was dried and wrapped but not bathed compared with the comparison group (50%). (See Figure 19.) From project monitoring data, 99% of newborns delivered by ANMs in the experimental group received the three key newborn care components (i.e., immediate drying and wrapping, clean cord care, breastfeeding within one hour).

Figure 18: Births with Clean Cord Care

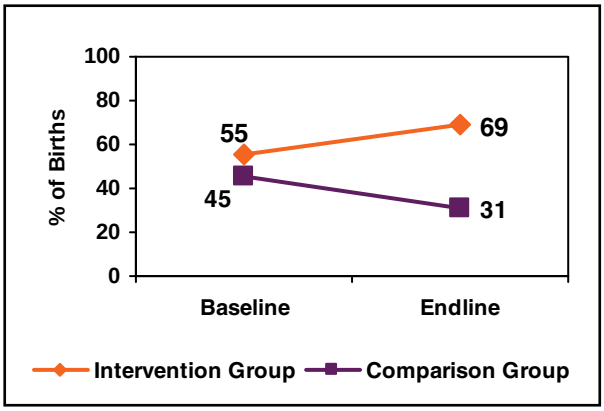
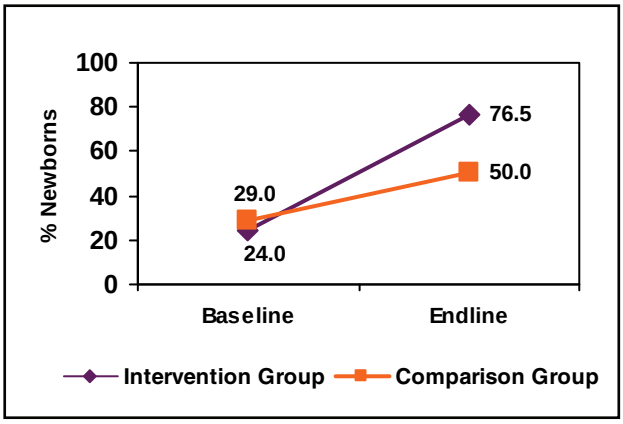


Figure 19: Newborns Who Were Dried and Wrapped But not Bathed after Birth



Increased Quality of Maternal and Newborn Care Services

- Introduced and increased partograph use by ANMs in the intervention group over three-quarters (in a nine-month period) up to 25%.
- Increased AMTSL practice among ANMs in the intervention group. (See Figure 20.) Service statistics showed that AMTSL was provided by these ANMs for 97% of deliveries they attended in the same nine-month period (July 2007 through March 2008). Prior to training, AMTSL was not practiced by ANMs in the study area.
- Significantly higher reported practice of newborn resuscitation among ANMs in the intervention group as opposed to the comparison group. (See Figure 21.)

Woman and baby, India

Figure 20: AMTSL and Partograph Use among Women who Gave Birth and Were Attended by Trained ANMs

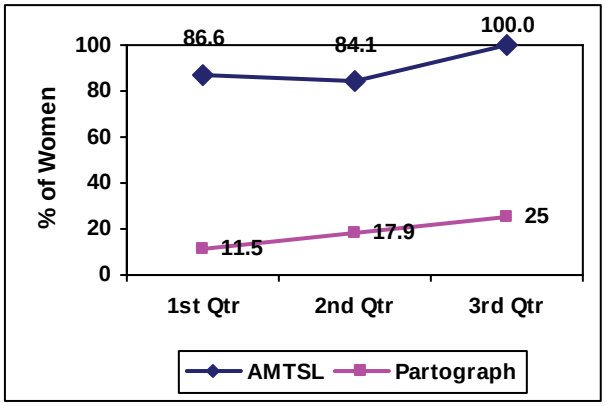
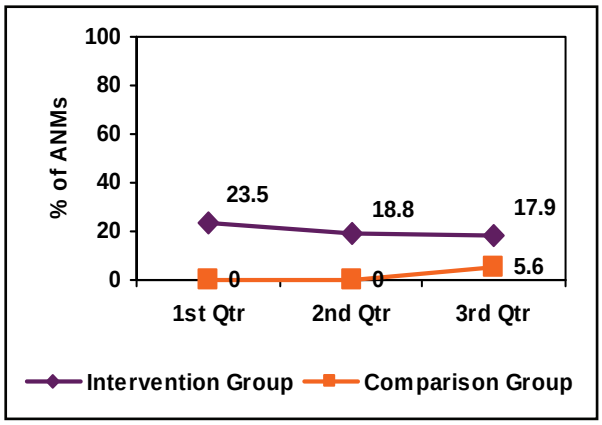


Figure 21: Reported Practice of Newborn Resuscitation



Increased Capacity of the Indian Nursing Council and National Auxiliary Nurse-Midwives Educational System to Produce SBAs

- Expanded perspective on the role of INC and selected nodal centers of education to lead a process of reform of the ANM education system.
- Developed a strategic plan with INC to establish national- and state-level resource centers to support improved capacity of ANM training centers at the district level.
- Supported INC to develop a network of nursing/midwifery education institutions across India.

LESSONS LEARNED AND SUSTAINABILITY

There were important lessons learned that are relevant to national SBA policies and programs:

- Because ANMs are generally not positioned as midwives and are not very skilled in delivery care, they required substantial refresher training to develop all the necessary skills to provide normal MNC—including recognition, management and referral of complications. All project-trained ANMs achieved competency, but the full 12 weeks was required to master all skills.
- The overall health care system needs to be strengthened to ensure that providers have the infrastructure, equipment, supplies and supervision they need to provide high-quality MNC services—particularly referral to comprehensive EmONC services.
- The project demonstrated that ANMs can provide community midwifery care with proper training, support, a well-equipped environment and connections to the communities they serve.
- Informed and mobilized communities seek and use MNC services. Community mobilization activities were essential to help women, families and communities understand the importance of skilled care and know where to seek services. Villages mobilized to organize emergency transport systems, save funds for emergencies through the *mahila mandals*, and sought MNC from trained ANMs and/or facilities. Once communities were aware and wanted MNC services, accessibility to skilled care was important.
- Communities need MNC advocates to connect them to available services. ACCESS supported those who worked closely with the communities, trained ANMs and health facilities. With training, *sahiyaas* and *anganwadi* workers could play this role.

ACCESS, in its work with the INC, planned for long-term sustainability and impact on ANM education through the development of a pre-service education regulatory and quality improvement system. Built on the experiences and lessons learned from Dumka, this system incorporated the resources and the long-term goals of the INC, and has the potential to be catalytic in producing fundamental change in the approach to nursing

and midwifery education across the country. It is anticipated that the resources from USAID—used strategically to guide INC—will leverage INC and other donor funds and create a new pathway for excellence in pre-service education.