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RMNCH+A Highlight Series

Strengthening Essential Newborn Care: Facility Readiness and Supportive Supervision in Haryana

Photo by MCHIP

"Every child has the right to survive. In Haryana when a health facility can be reached in 15 minutes, then why should any child die in Haryana?"

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India accounts for one-fifth, or approximately 26 million, of the world's annual births. Since 1990, India's infant mortality rate (IMR) has declined steadily, but the neonatal mortality rate (NMR) has stagnated. One third of all infant deaths worldwide continue to occur in India each year. India currently accounts for 29% of all first day deaths globally, approximately 300,000 per year. Most of the 940,000 newborn deaths in India are from preventable causes (Lancet, 2011). To further reduce infant and child mortality, it is crucial for India to focus on significantly reducing newborn death.

Background

The Government of India co-convened the global Call to Action for Child Survival in 2012 with USAID, the Government of Ethiopia and UNICEF, and then hosted its own National Summit to accelerate progress toward Millennium Development Goals 4 and 5 and the health goals of the 12th Five Year Plan. A new, comprehensive Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy launched at the National Summit is currently being rolled out in all 29 states and 184 high priority districts (HPDs). MCHIP provides technical support to the MOHFW and six state governments for RMNCH+A roll out.

In India, institutional deliveries increased from 67% in 2009 to 84% in 2013. This represents an impressive 15% increase every year since the launch of the National Rural Health Mission in 2005. Haryana State realized that despite the addition of new staff nurses and auxiliary nurse midwives (ANMs), its health facilities were not ready to handle the increased delivery load.

In Haryana, the under-five and infant mortality rates fell from 76 and 59 per 1000 live births in 2003, to 48/1000 and 42/1000 in 2012, respectively. However, as in India overall, neonatal mortality was generally stagnant (31/1000 in 2003, to 28/1000 live births in 2012) and the early neonatal mortality rate had increased. The Government of Haryana reviewed the data and concluded that staff nurses and Auxiliary Nurse Midwives lacked the capacity to manage two major causes of neonatal death--birth asphyxia and respiratory distress. Government of Haryana then took the initiative to reduce newborn deaths using the MCHIP Facility

Readiness Tool and supportive supervision, an approach that can be used to analyze the delivery of services, understand the performance of the providers, and then systematically work with them, on-site, to improve their knowledge and skills in essential newborn care and resuscitation (ENCR), with the goal of saving newborn lives and preventing disability.

Adapting RAPID for Newborn Care

MCHIP introduced the Government of Haryana to the Regular Appraisal of Program Implementation in Districts (RAPID) approach for strengthening immunization services. The approach, which includes quarterly distict and health facility visits, and on-site training and mentoring, has been adapted in Haryana and used for Essential Newborn Care and Resusciation and well as immunization.

State Consultation

When approached to provide technical support for newborn services, MCHIP shared its experience establishing ENCR skill development centers and model demonstration sites in Jharkhand with the Haryana State Officials. A state level consultation was organized in January 2013, that included orientation on the use of the facility readiness tool developed by MCHIP to assess health facility preparedness in providing ENCR, evaluate practices of skilled birth attendants during intra-partum care, and improve the knowledge and practices of ENCR in facilities by providing on-site training and regular follow-up. The consultation included Child Health Officers and Chief Medical Officers from districts in the state, as well as State Program Officers and Deputy Directors. Key decisions taken at the end of the consultation were to hire a team of dedicated child health consultants and to prepare an action plan for assessment of facility readiness and orientation of health service providers. MCHIP supported the development of the action plan and preparation of the scope of work for the child health consultants.

Learning Visit to Jharkhand

As a first step, the newly appointed child health consultants, led by Dr. Suresh Kumar Dalpath, Deputy Director, Child Health, Nutrition and Immunization, Government of Haryana, visited the MCHIP focus districts of Deoghar and Jamtara in Jharkhand state. A one-day orientation on ENCR was conducted to familiarize the team with the training and other technical support provided to health staff to ensure essential newborn care for every newborn and resuscitation support for newborns that are unable to breathe at birth. This was followed by a visit to a Community Health Centre - First Referral Unit, Madhupur in Deoghar district. This facility has a delivery load of nearly 125 births a month, a two-fold increase since MCHIP developed the site as a model newborn care (NBC) demonstration center.

Technical support provided to improve ENCR skills and facility readiness focused on:

- Care prior to delivery
- Delivery area to be dust free
- Temperature > 25 degrees Celsius
- Washing of hands with soap and clean water
- Use of double gloves just before delivery and use of newborn care corner
- Immediate newborn care in the first “golden” minute: drying, establish breathing, skin to skin contact, wrapping
- Between 1-60 minutes: delayed cord clamping, support for and establishment of breastfeeding

At the demonstration site, the visiting team assessed the ENCR practices at the skill station and received orientation on the peer group-facilitated supportive supervision process established at the center. In addition, other home-based newborn care interventions were shared with the Haryana colleagues including recording and reporting practices which had been strengthened through the introduction of an integrated Delivery and Newborn Register.

The team was impressed by the well-managed delivery room, the providers’ demonstration of ENCR on a baby mannequin, and the delivery register that captures data related to delivery and the early postnatal period, including ENCR practice and referral information.

The team also visited the Additional Primary Health Centre, Pabia in Jamtara district. The center is run by three auxiliary nurse-midwives (ANMs) who manage a delivery load of 80 per month and offer services 24 hours a day, 7 days a week (24X7). The skill station developed and facilitated initially by an MCHIP Block Facilitator is set up so that providers can regularly practice and hone their new skills; job aids provided by MCHIP also help to refresh what they learn in on-site training and mentoring. The ANMs conduct supportive supervision, observing the delivery practices of their peers using a checklist and then explaining best practices and discussing the gaps they have observed to help each other improve. The visit to the centers provided an opportunity for the team to observe the on-site practices and processes used at the demonstration sites.

Training, Facility Assessment, and Supportive Supervision

Following the visit, a one-day training of Child Health Consultants was held in March 2013 to orient them about the supportive supervision approach to improving the quality of newborn services. Training focused on ENCR technical content and the facility readiness assessment tool including skill building on facility scoring/ranking to generate a picture of the current conditions in each facility. Consultants were also trained on key skills for data collection including observation and interviewing and a district plan for assessment was also prepared. It was emphasized that information from all facilities would be analyzed to understand the status of newborn care services across districts and the state as a whole and that findings would be used to prioritize districts and facilities for corrective actions, supportive supervision, and mentoring.

Immediately after the training, teams of two investigators and one supervisor were formed. Each team visited two facilities each day for a qualitative and quantitative assessment of facility readiness for ENCR. The quality of essential newborn care provided to neonates immediately after birth and understanding existing knowledge, skills, aptitude, and practices of health providers were the focus of the facility visits. Data was collected on eight parameters *[see box]* covering 75 critical program indicators using the facility readiness tool. Assessment of facility readiness for newborn care was conducted at 600 delivery points across all 21 districts of Haryana from March 2013 to December 2013. Information was also gathered through interviews with labor room staff and observation of infrastructure and practices. Based on the findings, the ENCR readiness for each facility was scored. Facilities with an average score of <50% were color coded red indicating problem areas, scores of 50-79% were coded yellow as partial achievers, and facilities that scored above 80% were coded green and were designated as high achiever facilities.

Eight parameters of data collection

1. Infrastructure
2. Availability of newborn services
3. Human resources
4. Essential drugs and supplies
5. Protocols and guidelines for ENCR
6. Registers and client case record reviews
7. Infection prevention knowledge and practice
8. Health provider ENCR knowledge and practice

As part of supportive supervision, staff nurses were also oriented on essential newborn care practices using a “Neo Natalie” newborn simulator and job aids which were provided for display in the labor room. Towards the end of each visit, a de-briefing meeting was organized to share findings and recommendations with the Medical Officer In-Charge and other service providers. Together, an action plan for the facility was prepared. Facility reports of findings, recommendations, and the action plan were formally shared with the signature of the Mission Director. Facility heads were advised to report compliance within 30 days. Compliance reports were submitted when actions on all recommendations were accomplished. De-briefing meetings were also held with the Civil Surgeon, Deputy Civil Surgeon, and other district officials to enhance their support and involvement in improving the status of each facility.

Results and Actions

Analysis of baseline data from all 600 facilities revealed that facilities in 10 districts of Haryana scored less than 50%, the lowest performing included Naruaul (39%), Palwal (41%), and Sonipat (43%). Facilities in the districts of Hisar (61%), Rohtak (61%), and Jhajjar (60%) had

higher ENCR readiness compared to other districts of Haryana.

As a result of the facility readiness assessment, various actions were taken by the facilities themselves and by the Government of Haryana.

The second round of assessment was initiated in January 2014 in five districts which scored less than 50%. Improvement was reported in all five districts and their score increased to at or around 60% in all cases.

"Neo Natalie" newborn simulator

One example of dramatic improvement seen during the second round was Primary Health Centre Barwala, District Panchkula, where: the labor room was clean; staff nurses were using personnel protective equipment and had good knowledge of newborn care and use of bag and mask; baby sheets as well as paper for hand drying were sterilized; essential newborn care IEC materials were properly displayed; the newborn care corner and medicine cabinet were well organized; and all necessary drugs and supplies were available in appropriate quantities in the labor room.

Conclusion and Way Forward

Essential newborn care and resuscitation saves newborn lives. Facility readiness assessments, like those carried out in Haryana, help determine the capacity of health facilities to provide necessary care to mothers and their newborns and they establish a baseline that can be used in developing district and block action plans for improving newborn care. Applying the RAPID strategy and conducting multiple rounds of facility/program assessments empowers facility heads and district and state health officials with information and data to guide corrective actions.

Providing supportive supervision during facility visits improves the knowledge and skills of health providers and generates a greater sense of responsibility to contribute towards improved newborn health and saving lives.

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Moving forward, Haryana, through the state budget, plans to appoint a dedicated Child Health Coordinator for each District, who will be trained in Navjaat Shishu Suraksha Karyakram (NSSK) and ENCR practices. The Coordinator will provide supportive supervision and mentoring support during follow-up visits conducted in three monthly intervals at each facility to ensure that ENCR skills are retained and strengthened and new facility norms are maintained. Also, a change in HR policy has been initiated to ensure non-rotation and retention of trained staff in each facility. ENCR will be integrated with regular facility assessment of maternal health and immunization.

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