MCHIP Country Brief: India

Selected Health and Demographic Data for India	
Maternal mortality ratio (deaths/100,000 live births)	200
Neonatal mortality rate (deaths/1,000 live births)	32
Under-5 mortality rate (deaths/1,000 live births)	74
Infant mortality rate (deaths/1,000 live births)	57
Contraceptive prevalence rate	54.8%
Total fertility rate	2.7
Skilled birth attendant coverage	53%
Antenatal care,4+ visits	51%
Sources: *World Bank; **WHO India statistics summary 2002–2012; ***UNICEF 2013.	

Health Areas

- Maternal Health
- Newborn Health
- Child Health
- Family Planning
- Immunization

Program Dates	October 1, 2009–August 30, 2014			
Total Mission Funding	Redacted			
Geographic Coverage	**No. (%) of States**	**24%**	**No. of districts**	**92**
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INTRODUCTION

Between 1990 and 2012, India's mortality rate in children less than five years of age declined by more than half (from 126 to 56/1,000 live births). The infant mortality rate also fell steadily (from 88 to 44 deaths per 1,000 live births).[1] The country's maternal mortality ratio also decreased by two-thirds during the last decade (from 370 to 190 per 100,000 live births), and the total fertility rate fell from 3 to 2.4 children per woman. Despite these improvements, at the current rate of decline in maternal mortality and under-five mortality, India will fall short of Millennium Development Goals 4 and 5. With a neonatal mortality rate (NMR) of 31 per 1,000 live births, newborn deaths account for about 55 percent of all child mortality, which is estimated at 56 per 1,000 live births.[1] Given the significant contribution of NMR to the under-five mortality rate, India must reduce newborn deaths if it is to achieve its Millennium Development Goal 4 target of 41 deaths per 1,000 live births. In addition, the major causes of maternal mortality in the country are preventable, and most of the births are inadequately spaced and happen too early in the life of the mother. To improve maternal and neonatal survival, there is an urgent need to focus efforts on healthy timing and spacing of pregnancy through family planning, as well as on the major causes of maternal and neonatal death.

In 2005, the Government of India (GOI) established the National Rural Health Mission (NRHM) with the goal of improving the quality of health centers and health providers and addressing barriers to the delivery of maternal, newborn, and child health (MNCH) services. By channeling funding to state and district health offices for priority programs (Janani Suraksha Yojana [JSY] or conditional cash transfers to encourage institutional births and uptake of, accredited social health activists [ASHAs], and others), NRHM has contributed to increasing institutional deliveries, expanding mechanisms for providing skilled attendance at births, increasing access to postpartum family planning (PPFP) services, strengthening routine immunization standards and services, and scaling up provider knowledge and best practices in newborn care and resuscitation, among others. Despite significant progress since the introduction of the NRHM and the strengthening of national programs (Universal Immunization Program, reproductive health, child health, other), there is still much that needs to be done along the continuum of care.

The goal of USAID's Maternal and Child Health Integrated Program (MCHIP) is to assist in scaling up evidence-based, high-impact MNCH interventions to contribute to significant reductions in maternal and child mortality. MCHIP has worked in India since 2009, with national, state, and district-level health departments and national programs as well as development partners to strengthen reproductive, maternal, and child health. The program built on lessons learned from four earlier USAID global technical assistance programs—IMMUNIZATIONbasics, ACCESS, ACCESS/FP, and Save the Children's Saving Newborn Lives. During its first three years, MCHIP India worked with a number of national programs to: (1) revitalize family planning, with an emphasis on PPFP and increasing contraceptive choice by expanding access to postpartum intrauterine contraceptive device (PPIUCD) insertion; (2) reform and strengthen pre-service education for nurses and midwives working through the India Nursing Council; (3) strengthen routine immunization services and support national disease control efforts and the introduction of new vaccines by working with the Universal Immunization Program, and (4) strengthen the national Navjaat Shishu Suraksha Karyakram (National Newborn Care and Resuscitation Initiative, or NSSK) program and develop a package of interventions to improve care for newborns in government health facilities. Programmatic successes include dramatic improvements in access to PPFP in three USAID-supported states and in all districts of the six high-focus states where funding has been leveraged to expand PPFP and revitalize family planning; the establishment of a more robust nursing

[1] World Health Organization. Child Mortality Levels. http://apps.who.int/gho/data/node.main.ChildMort-2?lang=en (accessed May 8, 2014).

and midwifery education network, including the establishment of national and state nodal centers for nursing education; the development, demonstration, and rollout of national standards, capacity-building packages, job aids, and tools (best practices) to improve the coverage and quality of routine immunization and the introduction of new vaccines; and the establishment of demonstration sites for training in newborn care and resuscitation and cross-training in "best" immunization practices.

In Program Year 5, after co-hosting the Global Call to Action for Child Survival with USAID, UNICEF, and the Government of Ethiopia, the Government of India held its own National Summit on the Call to Action for Child Survival and launched a new National Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCH+A) initiative. At USAID's request, MCHIP served as the secretariat for the Call to Action Summit and then worked with the Ministry of Health and Family Welfare (MOHFW)/NRHM to develop and roll out a nationwide RMNCH+A initiative. In the following paragraphs, key achievements are summarized in relation to the RMNCH+A roll out and in each of the project's programmatic priorities.

KEY ACHIEVEMENTS

Call to Action/RMNCH+A: Following the Global Call to Action co-convened by the United States, Ethiopia, and India in April 2012 in Washington, DC, MCHIP supported India's National Summit on the Child Survival Call to Action in February 2013. The three-day meeting was attended by global experts, GOI officials, and representatives from state governments, the private sector, and nongovernmental and civil society organizations (NGOs and CSOs). The major conclusion of the conference was that, if the rate of decline in maternal and child mortality is to be accelerated, India must take action across all life stages and should ensure continuum of care. The GOI launched *A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health* (the RMNCH+A initiative) at the National Call to Action Summit. Following that event, the *National Consultation on Intensification of Efforts in High Priority Districts for Improved Maternal and Child Health* was held in April 2013. The meeting was attended by representatives of the MOHFW and various development partners, including USAID, and discussions were held on (1) the roadmap for follow-up to the Global Call to Action, (2) the need for intensification of efforts in high-priority districts (those with a high burden of maternal and child mortality and morbidity), and (3) modalities and mechanisms for harmonizing partner technical assistance for integrated programming and monitoring.

Development partners, including USAID, UNICEF, and UNFPA, realized that they could play a significant role at the national, state, and district levels as the country accelerated the pace of implementation of interventions to reduce maternal, neonatal, infant, and under-five mortality. The partners recognized the need to establish a mechanism for harmonized support to national and state government efforts as they worked toward the Millennium Development and 12th Five-Year Plan Goals. They agreed to shift priorities so that they could commit to the RMNCH+A rollout. This was a paradigm shift toward direct coordination with Government of India and an emphasis on making an impact on policy based on evolving global evidence rather than small-scale, decentralized efforts.

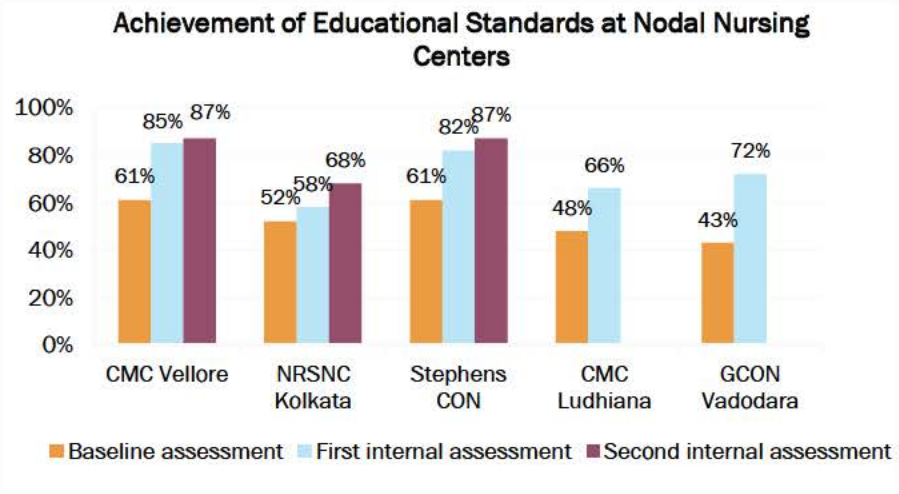
The MOHFW identified 184 high-priority districts (HPDs) across 29 states for the rollout of the RMNCH+A initiative. Lead development agencies working in those states (USAID, the Bill and Melinda Gates Foundation, DFID, UNICEF, UNFPA, and NIPI) agreed to harmonize their efforts in the HPDs and provide technical assistance to state governments. USAID was mandated to support 33 HPDs in six states (Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand) in the rollout of the strategy. Mechanisms at the national and state levels were put into place, with MCHIP support, including a national RMNCH+A unit and state RMNCH+A units, as well as state unified teams (SUTs).

Postpartum Family Planning: MCHIP India helped to revitalize PPFP, emphasizing intrauterine contraceptive devices for use in the immediate postpartum period (within 48 hours of delivery), and advocated for PPFP as a maternal and child health intervention through extensive work in training and advocacy. After experiencing the limitations of off-site training, the training process was improved using an innovative approach of training service providers onsite at their own facilities to rapidly saturate the facility with trained providers and hence institutionalize service delivery. Activities were implemented in 117 facilities across three states: Uttar Pradesh, Uttarakhand, and Jharkhand. Through this work, 645,000 women were counseled in PPFP, with 43,000 women accepting the PPIUCD as a method for spacing or limiting subsequent births. Strengthening the PPFP program with the introduction of the PPIUCD was a shift in the GOI's approach to promoting birth spacing, and the approach is being scaled up throughout the country, with more than 300,000 women provided PPIUCDs since its introduction. Following the encouraging results of this intervention in the three MCHIP states, the Ministry of Health and Family Welfare decided to scale up the PPFP/PPIUCD services to all districts in the six high-focus states of India. The majority of the funds for this scale-up are being derived through the GOI National Health Mission program implementation plans of these states. Technical assistance to support implementation in 247 districts of the six states (with a total population of 500 million) is being provided by multiple donors, including the Bill & Melinda Gates Foundation, the David & Lucile Packard Foundation, and the Norway-India Partnership Initiative (NIPI).

Status of PPIUCD Services in MCHIP States, 2010–2014

* Data till Feb-14

Nursing and Midwifery Pre-Service Education: As one step in strengthening pre-service education (PSE) for nurses and midwives, MCHIP India helped establish a robust and technically focused system, network, and approach for nursing and midwifery education strengthening, marked by the launch of the national nodal center (NNC) for nursing education in Kolkata, and provided technical assistance to four other new NNCs co-located at the country's premier nursing institutions. Each NNC was designed as a key demonstration and training site for the nursing faculty from the region. MCHIP has trained the faculty of 121 schools for auxiliary nurse-midwives and general nurse-midwives (ANMs and GNMs) at the NNC at Kolkata. At the request of the state governments, MCHIP facilitated the development of state nodal centers (SNCs) in Uttarakhand and Jharkhand; these SNCs were created to train the nursing faculty and provide mentorship to ANM/GNM schools within the states. This

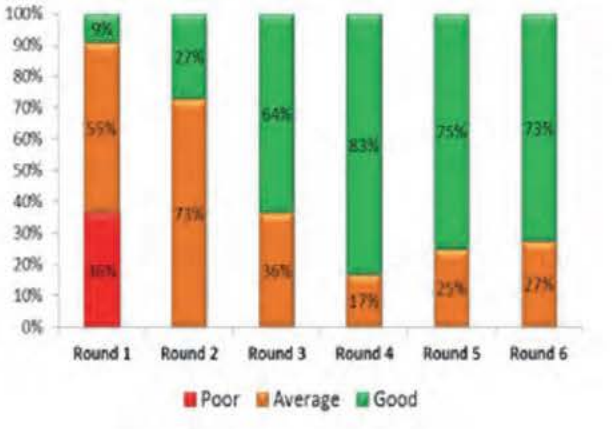


approach was first taken up by the Government of Bihar, through support from NIPI, to strengthen PSE for the nursing and midwifery cadre in the state. Later, the MOHFW, the GOI, and the Indian Nursing Council (INC) decided to scale up this program model to all high-focus states and have earmarked funds through the respective state program implementation plans (PIPs). NIPI and DFID are supporting this initiative in their respective focus states, which are a part of the 10 high-focus states. Replicating the approach used by MCHIP for establishing the SNC at Dehradun, Uttarakhand, Patna has established a similar SNC at the Indira Gandhi Institute of Medical Science, and 15 participants from ANM/GNM schools have been trained in the first six weeks of training at the SNC.

The approach pioneered by MCHIP was adopted by the MOHFW and INC to develop the "Operational Guidelines for Strengthening PSE for Nursing and Midwifery Cadre in India." These guidelines provide a comprehensive roadmap that will help program managers, state nursing cells, faculty of the midwifery institutions, and other stakeholders strengthen pre-service nursing and midwifery education throughout the country, particularly in the high-focus states.

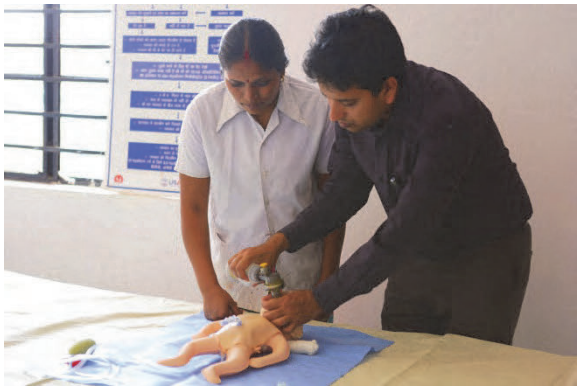
Immunization: MCHIP contributed to national-level immunization initiatives, including the Year of Routine Immunization Acceleration, measles campaigns, maternal and neonatal tetanus (MNT) state-level certifications, and the introduction of new and underutilized vaccines, including Hepatitis B, Measles 2nd dose and Pentavalent vaccine. In addition, MCHIP worked to build the capacity of the national and state governments and leverage GOI and development partner resources for immunization performance improvement through Regular Appraisal of Program Implementation in District (RAPID). To achieve these goals, MCHIP worked in five low-performing districts to improve the coverage and quality of services, establish demonstration sites, and provide supportive supervision. Successful immunization initiatives have been taken to scale and adopted by state governments. Using the RAPID supportive supervision approach and tool at selected district facilities in Jharkhand and Uttar Pradesh, MCHIP India demonstrated progressive improvement in attainment of quality indicators. Sites in Jharkhand district improved from just 9% of quality indicators achieved in the first RAPID round, to 73% achieved by round six of the process. The approach has now been adapted and scaled up by governments in four states (Haryana, Jharkhand, Madhya Pradesh, and Orissa) and UNICEF in India's largest state, Uttar Pradesh. RAPID is used not only as a quality improvement approach for routine

RAPID -- Grading of Health Facilities Based on Composite Scoring for Quality Indicators, Jharkhand



immunization but also for essential newborn care and resuscitation and, in the state of Haryana, to assess the quality of the full RMNCH+A package of care.

Newborn Care and Resuscitation: MCHIP India helped to select and establish 10 newborn care demonstration sites in Jharkhand and Uttar Pradesh for district-level primary care provider training in newborn care (including the establishment of newborn care corners) as well as resuscitation techniques to reduce neonatal asphyxia. These sites are also used to provide innovative cross-learning opportunities for program managers and health providers from other states and non-MCHIP-supported facilities and districts. Through these efforts, MCHIP trained 1,551 NSSK trainers and health facility workers in essential newborn care/newborn resuscitation.



MCHIP staff member demonstrates correct use of resuscitator.

WAY FORWARD

Continued support to the RMNCH+A initiative should include ensuring effective implementation of key performance indicators/quality indicators and performance-based incentives under the RMNCH+A mandate; ensuring accomplishment of targets set by the GOI under RMNCH+A and the 12th Five-Year Plan; ensuring the availability of quality health services in urban areas; and institutionalizing the involvement of the private sector and CSOs to ensure saturation of services to all areas. USAID and other development partners should strongly advocate to take the RMNCH+A agenda forward and provide technical support to the new government to ensure that all components of RMNCH+A are effectively implemented across the HPDs. USAID and other development partners should orient the new government on evidence-based interventions and suggest corrections to the existing service delivery system and issues related to health systems, governance, and accountability.

Continue to scale up PPFP/PPIUCD services, especially to high-delivery load subdistrict-level facilities in states where services have been initiated; increase involvement of ASHA workers in educating clients and their families about PPPF/PPIUCD services during ANC and delivery periods; strengthen supportive supervision for family planning services; and incorporate PPFP services data into routine data reporting and review mechanisms.

To build on progress in strengthening PSE for nurses and midwives, continue to support the NNCs, SNCs, and ANM/GNM schools—including full recruitment of faculty and faculty capacity-building for ANM/GNM schools; national-level review of the progress in upgrading the ANM/GNM schools and establishing SNCs; and initiation of PSE strengthening activities, mentorship and support to ANM/GNM faculty, strengthening the teaching infrastructure, supporting students, improving clinical sites, and improving the regulation of educational quality.

Continued progress in India's immunization program calls for sustaining and expanding use of the RAPID supportive supervision process as a tool for continuous quality improvement of services at the district level; disseminating quality improvement protocols and best practices used at demonstration sites by continuing to present them at public health conferences and events and demonstrating them in the states; advocating for best practices to be scaled up by national and international governments and development partners; supporting establishment of demonstration sites in high-priority districts for continuous training and peer-to-peer

mentoring; and incorporating My Village, My Home data into routine reporting and data analysis to improve the tracking of infant vaccinations against the established schedules. MCHIP also recommends establishing demonstration sites for maternal and newborn care in all districts of the focus states, which can then be used for cross-learning for the remaining district facilities; strengthening linkages between communities and facilities; improving the referral system for stabilizing and managing sick newborns; institutionalizing Kangaroo Mother Care for low birth weight babies in facilities where deliveries are taking place and in all newborn stabilization units and SNCs; ensuring support to mothers to continue skin-to-skin care in the home; and institutionalizing newborn immunization before discharge.

Nurse prepares vaccine for an infant.