Improving quality of care through capacity building and data-informed decisions in Uttar Pradesh, India

20 January, 2022

Hosted by the Quality of Care subgroup
Moderated by

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Newborn and Child Health
Uttar Pradesh Technical Support Unit

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Institute for Global Public Health
University of Manitoba
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Uttar Pradesh National Health Mission

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Quality
Uttar Pradesh National Health Mission
Newborn Health – Uttar Pradesh

Quality of Care Subgroup – Webinar
Child Health Task Force
January 20th, 2022

Dr Ved Prakash
GM, Child health,
National Health Mission, UP
**Goal for Uttar Pradesh**

**Ambitious goals of National Health Policy:**
Under 5 Mortality Rate of 23 per 1000 livebirths and Neonatal Mortality Rate of 16 per 1000 livebirths by 2025

**Committed to Sustainable Development Goals (SDGs)**

<table>
<thead>
<tr>
<th>SURVIVE</th>
<th>THRIVE</th>
<th>TRANSFORM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>End preventable deaths</strong></td>
<td><strong>Ensure health and well-being</strong></td>
<td><strong>Expand enabling environments</strong></td>
</tr>
<tr>
<td>▪ <strong>SGD 3.2:</strong> End preventable deaths aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births &amp; under-5 mortality to at least as low as 25 per 1,000 live births</td>
<td>▪ Comprehensive implementation plan on maternal, infant and young child nutrition: reduce low birth weight by 30%</td>
<td>▪ SDG 3.8: Achieve universal health coverage</td>
</tr>
<tr>
<td></td>
<td>▪ SDG 4.2: Ensure all girls and boys have access to quality early childhood development care and pre-primary education</td>
<td></td>
</tr>
</tbody>
</table>

Committed to Sustainable Development Goals (SDGs):
Mortality trends
Neonatal mortality trends & major causes

**Neonatal Mortality Rate**

- UP’s NMR will be **25** by **2025** with the current AARC **(-3.3%)**
- The required rate of change is **more than twice (AARC:-8.3%)** to achieve SDG goals of 12 neonatal deaths per 1000 live births

**Causes of Neonatal Mortality, 2018**

- Birth Asphyxia: 42%
- Prematurity: 33%
- Pneumonia: 15%
- Meningitis/Sepsis: 6%
- Congenital Malformation: 4%

**LBW remains a challenge – Prevalence of LBW (<2.5kg): 20.7%**

COVID impact on progress – yet to be measured

Source: 2018: xMLE Presentation
Neonatal and Infant Mortality

- Substantial reduction in mortality indicators from NFHS-4 to 5 in UP:
  - **NMR: 9.4 points** with AARC of -4.7% (India: 4.6 points with AARC of -3.4%)
  - **IMR: 13.1 points** with AARC of -4.6% (India: 5.5 points with AARC of -2.9%)
## FATE OF 1000 live births -UP

<table>
<thead>
<tr>
<th>Mortality rates</th>
<th>Deaths</th>
<th>Cumulative &amp; indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 1 week (within 7 days)</td>
<td>24</td>
<td>24 Early Neonatal Mortality Rate</td>
</tr>
<tr>
<td>1- 4 weeks</td>
<td>Add 8</td>
<td>32 Neonatal Mortality Rate</td>
</tr>
<tr>
<td>1–12 months (next 48 weeks)</td>
<td>11 more</td>
<td>43 *Infant Mortality Rate</td>
</tr>
<tr>
<td>1-5 years (next 48 months)</td>
<td>Add 4</td>
<td>47 Under-5 Mortality Rate</td>
</tr>
</tbody>
</table>

NMR is 65% of U5MR

*IMR is 41 as per SRS 2019

Based on SRS 2018
Inter-District variations in child mortality (2017) against ARoR (2010-17)

High, medium, and low groups based on tertiles of rate in 2017 and the annual rate of reduction (ARoR) from 2010 to 2017 among the districts within the state.

- High rate and low ARoR
- High rate and medium ARoR
- High rate and high ARoR
- Medium rate and low ARoR
- Medium rate and medium ARoR
- Medium rate and high ARoR
- Low rate and low ARoR
- Low rate and medium ARoR
- Low rate and high ARoR
Comparative changes in RMNCHN coverage in high and low mortality states

<table>
<thead>
<tr>
<th>Indicators</th>
<th>High mortality states (9)</th>
<th>Low mortality states (11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NFHS-4</td>
<td>NFHS-5</td>
</tr>
<tr>
<td>Neonatal mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMR (Per 1000 live births)</td>
<td>34.7</td>
<td>29.1</td>
</tr>
<tr>
<td>Contextual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per-capita income</td>
<td>57738</td>
<td>72247</td>
</tr>
<tr>
<td>Female education* (%)</td>
<td>65.0</td>
<td>68.7</td>
</tr>
<tr>
<td>Teenage pregnancy (%)</td>
<td>7.8</td>
<td>6.4</td>
</tr>
<tr>
<td>RMNCH and nutrition coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mCPR (%)</td>
<td>42.4</td>
<td>53.3</td>
</tr>
<tr>
<td>4+ ANC (%)</td>
<td>38.2</td>
<td>52.2</td>
</tr>
<tr>
<td>Institutional delivery (%)</td>
<td>72.6</td>
<td>85.1</td>
</tr>
<tr>
<td>PNC newborn (%)</td>
<td>22.5</td>
<td>76.4</td>
</tr>
<tr>
<td>Early initiation of breastfeeding (%)</td>
<td>40.4</td>
<td>38.8</td>
</tr>
</tbody>
</table>

- **High mortality** states recorded **higher changes** in NMR and also observed higher changes in RMNCHN indicators.

* Females 6 years and above ever attended school
### Key issues - across RMNCH+A in UP

<table>
<thead>
<tr>
<th>KEY ISSUES</th>
<th>Adolescent/pre pregnancy</th>
<th>Pregnancy</th>
<th>Birth</th>
<th>Newborn/ Postnatal</th>
<th>Childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>High unmet need for contraception</td>
<td>Quality of ANC</td>
<td>Quality of Care</td>
<td>Early initiation of Breast feeding</td>
<td>Complimentary feeding</td>
<td></td>
</tr>
<tr>
<td>Quality of ANC Anemia in pregnancy</td>
<td>around Birth</td>
<td>Many districts without single FRU</td>
<td>Home visit in first 2 days of life</td>
<td>High malnutrition and Anemia</td>
<td></td>
</tr>
<tr>
<td>Many districts without single FRU</td>
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<tr>
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<td>Complimentary feeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTERVENTIONS

<table>
<thead>
<tr>
<th>KEY ISSUES</th>
<th>Adolescent/pre pregnancy</th>
<th>Pregnancy</th>
<th>Birth</th>
<th>Newborn/ Postnatal</th>
<th>Childhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community level</td>
<td>Ensuring availability &amp; capacity building of FLWs</td>
<td>Birth Prep plan/ VHND</td>
<td>Skilled birth attendance for home deliveries</td>
<td>Quality Home visits by ASHA</td>
<td>Low birth weight tracking beyond post natal period</td>
</tr>
<tr>
<td>Facility level</td>
<td>Skill upgradation</td>
<td>Iron sucrose administration</td>
<td>FRU Activation, Quality MCH Care/ Mentoring</td>
<td>NBCC/NBSU/SN CU/ FPC</td>
<td>Facility based Paediatric care/ETAT</td>
</tr>
</tbody>
</table>

Social Behavior Change and Communication (SBCC)
Estimated 3-5% will require tertiary care (at NICU) (L3)

- Estimated 2 lakh newborns shall require SNCU care (Advanced L2) = 2700 beds/day approx.
- Currently 60% of beds available across the State

5.6 lakh require care at NBSUs (L2) = 3100 beds/day approx.
Only one third of the beds are currently available

Newborn Care Corner (NBCC) (L1) (47 Lakh)
70% of public health delivery points need to be saturated with NBCC

Assumptions:
85% of the total births require L1 care (i.e. approx. 47 lakh) & remaining
15% (i.e. 8 lakh) require facility based care (L2 & L3)
Facility based newborn care is mostly at public health facilities

Community – Facility – Community linkage for continuum of care
Strategies and programs-UP
Life Cycle Approach

- Strengthening Facility based newborn care including essential newborn care and neonatal vaccines
- Home visits up to 6 weeks by Community health workers i.e. ASHA and follow-up from 3m up to 15m of age
- Child screening and early intervention services
- Empowering ANM for detecting and management of preterm labour, sepsis in young infants and birth asphyxia

Continuum of Care

- Capacity building of the service providers at all levels

Strategic actions

- Prioritization of Aspirational districts
- System Strengthening under NHM
- Entitlements to Eliminate OOP expenses and incentives
- Convergence with other stakeholders

RMNCH+A STRATEGY
Strategic Interventions under Maternal Child Health Programme

Maternal Health
- JSY, JSSK
- PM Surakshit Matritva Abhiyaan
- LaQSHYA
- Strengthening of MCH Wings and FRU
- SUMAN, Midwifery

Child Health
- Facility Based Newborn care (SNCU/MNCU)
- Home based Newborn and Young child care
- Defeat Diarrhoea & Pneumonia Management- SAANS
- Immunization
- Rashtriya Bal Swasthya Karyakram

Nutrition + POSHAN
- Nutrition Rehab centres
- IYCF promotion (MAA Program)
- Anaemia Mukt Bharat (AMB)
- Vitamin A supplementation
- Deworming

Adolescent Health
- Adolescent friendly health clinic
- Peer Educators
- School Health
- Menstrual Hygiene

Family Planning
- Spacing & limiting methods
- Mission Parivar Vikas
- Expanding contraceptive choices
- Improving accessibility

SAANS-‘ Social Awareness and Action to Neutralise Pneumonia Successfully’

Child Death Review
First Special Newborn Care Unit in UP was established in the year 2007-8 with UNICEF support.

In 2011, GOI released operational guidelines for Facility Based Newborn Care (FBNC).

National Health Mission supported budgets for FBNC under State Annual Plans.

Till date there are 89 SNCUs for 75 Districts across the State admitting over 0.1 million sick newborns with an average mortality rate of 8 percent.

Newborn Care units at Medical Colleges are also supported

Training and mentoring of providers is done as per FBNC training package

State resource centres developed at Medical colleges to lead capacity building
Focused efforts to strengthen newborn care at sub-district level

- Proposal in State Annual Budgets for new units
- Appointment of dedicated pediatricians at the proposed units
- First state to complete planned 3 State ToTs as per plan for New Born Stabilization Units (NBSUs)
- Plan for additional structured “Hands on” training for service providers at NBSU (Innovation)
- Regular mentoring mechanism
- Reviews at state level happening

1st batch of State ToT

Hon'ble HFM & stakeholders together

NBSU REVIEW in progress
Newborn Care Corners

- **Delivery Points (DP)** at all levels in Public Health System, including OT, to have a “Functional NBCC” to provide immediate care to neonates including resuscitation, warmth and initial care to sick newborns.

- Training and mentoring packages for skill upgradation of providers for essential newborn care.

- Registers for recording and regular reviews using data.
Actions at all levels for Newborn Care

- **Quality of care**: Emphasis on quality care with close monitoring of the SNCU data.
- **Utilization**: Activation & strengthening of NBSUs with 24*7 trained HR, logistics, and commodities.
- **Saturation**: Ongoing skill upgradation and capacity building of personnel & saturation of all delivery points with NBCCs.
- **Deriving Impact**: Deriving impact by improving quality of home visits through increasing supportive supervision, digitisation, and referral linkages.
Way forward

1. Budget proposals in annual plan for human resourcing & capacity building mechanisms specially to care for sick and small babies
2. Digital technologies for better HR & logistics management (Manav Sampada, UPMSCL etc)
3. Improve data collection (UPHMIS, SNCU online & civil registration) including stillbirth
4. Family Participatory care, MCP card etc to harness power of parents & communities in driving change for MNH
5. Coordination across sectors like Nutrition & WASH
6. Ongoing research on newborn health, social and behavioural change education etc (KGMU

Fully committed state leadership & policies in place to deliver universally, people centric, quality of care to achieve the SDG Goals
Quest for improving Child Survival.
Dr. Archana Verma

National Health Mission Uttar Pradesh
Why ‘Quality of Care’ is Important

- High-quality health systems could save over 86 Lakhs lives each year in LMICs*

- Over 24 lakh deaths in India from treatable conditions

- In India, 15.99 lakh deaths per year on account of poor quality of care**

- Expected deaths per year on account of poor quality of care in Uttar Pradesh could be approx. 2.6 lakh deaths per year

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* The Lancet Global Health Commission on High Quality Health Systems in the SDG era

Trends of Infant Mortality Rate (IMR)- India vs U.P.

Between 1997 and 2018

- **India IMR Decline**: 55%
- **Uttar Pradesh IMR Decline**: 51.6%

Data Source: SRS India bulletin
Key Initiatives under National Quality Assurance Program

SUMAN: NQAS certification of SUMAN Services

MusQan: Quality Certification of Pediatrics Services

Kayakalp: Swachh Bharat Swasth Bharat

LaQshya: Ensuring Quality of care during delivery & immediate post-partum

National Quality Assurance Standards: For DH, CHC, PHC and UPHC

AEFI Surveillance: Ensuring Quality in AEFI Surveillance

Mera-Aspataal: Platform to capture voice of Patients for improving Quality Services
International & National Standards

- IRDAI recognize NQAS as benchmark for empanelment hospitals
- NHA is considering to include NQAS certification for Gold Category
## National Quality Assurance Standards

<table>
<thead>
<tr>
<th>Level of Facility</th>
<th>Total Functional (RHS 2019-20)</th>
<th>National Certified</th>
<th>State Certified</th>
</tr>
</thead>
<tbody>
<tr>
<td>DH</td>
<td>149</td>
<td>29</td>
<td>78</td>
</tr>
<tr>
<td>CHC</td>
<td>723</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td>PHC</td>
<td>3407</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>UPHC</td>
<td>592</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labour Room</th>
<th>Maternity Operation Theatre</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>21</td>
</tr>
</tbody>
</table>

LaQshya
Key Action Points

1. Ensuring Base-line Assessment
   1. Internal assessment according to NQAS checklist
   2. ‘Gap-Analysis’ done
   3. Identification for ‘better’ performing facilities and leaders

2. Prioritization of facilities for the certification
   1. Preparing action
   2. Prioritizing Gap closer activities

3. Allocate Targets
   1. For all stake holders

4. Supportive Supervision
   1. Compliance on mandatory requirements

Quality Certification
LaQshya – QI initiative for LR & M-OT

Focus

• On reducing maternal & newborn morbidity & mortality

Criteria

• NQAS Certification of Labour Room and Maternity OT
• Attainment of at least of 75% facility level targets
• 80% of the beneficiaries satisfaction

Achievements

• Labour Room Certified – 24
• M- OT Certified - 21
Respectful Maternal & Newborn Care

- Right to safe and appropriate treatment
- Right to birth companion
- Privacy and Confidentiality
- Informed consent

- Right to equality
- Highest attainable level of health
- Treated with dignity and respect
1. Labor room Monitoring
   **Frequency** – Daily
   **Eight critical practices** – Delivery type, birth weight, resuscitation, Breastfeeding practices, KMC, Vit-K1, Delayed cord clamping, Birth companion
   **Who** - HQM

2. BFHI monitoring
   **Frequency** – Monthly/three rounds in a year
   **Area** – focusing on facility based breastfeeding practices (ten steps of BFHI practices)
   **Who** – HQM, Div./District Quality Manager and external monitors

**Quality Assurance** – Monitoring of critical practices using mobile based technology

**Strategy**

**Report cards**

- **Daily LR monitoring**
  - **Period** – Oct-Dec 2021

**Webinar on Basics of breastfeeding promotion in health facilities**

- **15 October 2020**

**Online sensitization on Breastfeeding**

- **15 October 2020**

  Experts from BPNI
  300+ participants across the districts sensitized
MusQan: Ensuring Child Friendly Services In Public Healthcare Facilities
### Key Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; parent/attendant friendly ambience infrastructure</td>
</tr>
<tr>
<td>Strengthen referral and follow-up services</td>
</tr>
<tr>
<td>Provision of respectful &amp; dignified care</td>
</tr>
<tr>
<td>Strengthen Clinical Protocols &amp; Management Processes</td>
</tr>
<tr>
<td>Quality Certification, Improved Indicators and Satisfied Families</td>
</tr>
</tbody>
</table>
QA-NHM, NQOCN and UNICEF conducted a state level workshop for gynecologists, pediatricians, quality team from 75 districts.

Capacity of more than 120 participants enhanced on QI tools for improving Maternal and newborn health in the state.

Facility mentoring visits were done to Labor rooms and SNCUs of three Aspirational Districts.
QI - Aspirational Districts in Collaboration with NQOCN
Orientations Workshop for District Magistrates on Quality Assurance Program 27.08.2021
Certification Process

Issue of Certificate & Incentives

Submission of Assessment Report

Recommendation for Certification

Assessment by external Assessor

Processing of Application and appointment of assessors

Application to Director, NHM, MoHFW, GoI

Internal Assessment and Quality Improvement

Recommendation for Certification

State Level Assessment & Certification
Certification Criteria

a) NQAS Certification of SNCU/NBSU, Paediatric Ward, OPD and NRC. Facility needs to take 70%, or more in external assessment

b) Attainment of at least of 75% or more of facility-level targets

c) 80% of the parent-attendant group are either satisfied or highly satisfied (or Equivalent score >4 on the Likert scale).
Uttar Pradesh on way of progress

- 29 District hospitals certified on NQAS
- 15 SNCUs certified
- 5 Nutrition Rehabilitation Centers certified
- 24 Labour rooms & 21 Maternity OTs certified on LaQshya
### Target setting (3yrs)

**Set target for different level of HCFs for 3yrs**

<table>
<thead>
<tr>
<th>Level</th>
<th>National Certified (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>DH</td>
<td>30</td>
</tr>
<tr>
<td>CHC/SDH</td>
<td>10</td>
</tr>
<tr>
<td>PHC/UPHC</td>
<td>10</td>
</tr>
<tr>
<td>HWC</td>
<td>5</td>
</tr>
</tbody>
</table>

**Road-Ahead**

- **Identify**: Quality champions
- **Mentoring**: Capacity building and hand holding
- **Monitor**: Progress Review - Monthly

- **Target setting**: Monthly Review for different levels of Health Care Facility (HCFs) for 3 years.
Thank You
Presenters from the Technical Support Unit

Dr. Vasanthakumar Namasivayam  
Indian Administrative Service  
Executive Director  
Uttar Pradesh Technical Support Unit  
University of Manitoba

Dr. Ravi Prakash  
Deputy Director  
Monitoring and Evaluation  
Uttar Pradesh Technical Support Unit  
University of Manitoba
 Uttarakhand Technical Support Unit

CHTF QoC Group Meeting

January, 2022
<table>
<thead>
<tr>
<th></th>
<th>Agenda</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Nurse mentoring program</td>
</tr>
<tr>
<td>2</td>
<td>FRU strengthening - RRTC</td>
</tr>
<tr>
<td>3</td>
<td>Mentoring related program outcome</td>
</tr>
</tbody>
</table>
Nurse Mentoring Program
Uttar Pradesh Overview

75 Districts
820 Blocks
100K+ Villages

235 Million population
17% of Indian Population
78% Rural Population

5.5m Live Births
20% of India’s total

11K+ Maternal Deaths/year
37% of India’s Total
5.5% of Global Total
MMR: 197 vs. 113 (India)

180K+ Newborn Deaths/Year
30% of India’s Total
6.3% of Global Total
NMR: 32 vs. 23 (India)

230K+ Infant Deaths/Year
IMR: 43 vs. 32 (India)

57.2 Female Literacy Rate
vs. 65.5% in India

26% 4 ANC visits (vs. 51% in India)
68% Institutional Delivery (vs. 79% in India)
54% PNC Visit in 48 hours (vs. 62% in India)
Growth in Nursing Institutions

**India**

<table>
<thead>
<tr>
<th>Year</th>
<th>ANM</th>
<th>GNM</th>
<th>BSc</th>
<th>MSc</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>298285</td>
<td>360</td>
<td>377</td>
<td>59</td>
</tr>
<tr>
<td>2005</td>
<td>360</td>
<td>377</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>676</td>
<td>1326</td>
<td>315</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>1921</td>
<td>1690</td>
<td>577</td>
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</tr>
<tr>
<td>2019</td>
<td>3212</td>
<td>1904</td>
<td>1968</td>
<td></td>
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</table>

**Uttar Pradesh**

<table>
<thead>
<tr>
<th>Year</th>
<th>ANM</th>
<th>GNM</th>
<th>BSc</th>
<th>MSc</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>29</td>
<td>8</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2005</td>
<td>29</td>
<td>35</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>26</td>
<td>28</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>58</td>
<td>9</td>
<td></td>
<td></td>
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<tr>
<td>2020</td>
<td>203</td>
<td>37</td>
<td></td>
<td></td>
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</tbody>
</table>

*INC Annual Report 2019*
Uttar Pradesh Nursing Pre-service – Public vs Pvt

Eligibility
- ANM – 10+2 any subject
- GNM – 10+2 any subject
- BSc – 10+2 in science
- MSc – BSc/Post-basic BSc
- NPM – GNM/BSc with 2 yrs in MH

Annual Production Capacity
- ANM – 14851
- GNM – 14656
- BSc – 7830
- MSc – 809

Total registered with INC (2017)
- ANM – 60258
- Nurse and Midwife - 74777
### Pre-service training quality

Table 9: Percentage distribution of competent GNM and CoN faculty in public and private sector institutions

<table>
<thead>
<tr>
<th>Skills Station</th>
<th>Public</th>
<th>Private</th>
<th>All Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mgt. of 2nd stage of labor</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>AMTSL</td>
<td>50%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>ENBC</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>NBR</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>0%</td>
<td>71%</td>
<td>0%</td>
</tr>
<tr>
<td>Partograph Plotting</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td>Overall</td>
<td>0%</td>
<td>14%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Jhpiego Baseline*
Goals and objectives

Objective-
- Sustain and optimize quality MNH services in district and sub district block facilities
- Improve clinical competencies of service providers and system strengthening in 10 core areas

Core Areas

1. Initial assessment
2. Labour monitoring
3. Active management of third stage of labour
4. Essential new born care
5. Management of 4th stage of labour and Post natal care
6. Infection Control and BMW
7. Availability & Use of drugs and supplies
8. Referral strengthening
9. Documentation
10. Service integration with community
Quality improvement initiative
LaQshya roll out

Self Assessment by QC members
Facility action plan
Gap closure

Provider:
Knowledge; Skills; Practice

Strengthening quality of RMNCH care

On site mentoring at MSL, LR, OT, PNW and NBSU
Mentoring of SNs, ANMs and EMTs
Objective structured clinical examination

Facility System:
Infection prevention and BMW; Documentation Referral Program Monitoring

Referral strengthening

Client:
Respectful maternal and newborn care; Grievance redressal through SUMAN

Improved documentation
Pre-referral management
Vertical Integration
**Nurse Mentor - Scale up and Transition**

Nurse mentors status in 820 Blocks across state

Legend
- Nurse Mentor (In Place)
- Nurse Mentor (Vacant)

**Mechanism for rapid nomination of NMs**

Create pool of State and District master trainers

Digital tracking of NM performance

Mentees performance – OSCE and practice

Network of functional Skills lab at State, Districts and Blocks
Key Interventions

1. HRP Identification & management
2. Capacity building of outreach ANM's on ANC skill

1. Triage
2. Labour monitoring
3. AMTSL
4. ENBC

1. Immediate post partum care
2. Maternal and newborn complication identification and Management
3. PPFP

1. Activation and strengthening of NBCC and NBSU
2. Care of sick and small newborn

1. Quality improvement in LR and OT
2. Infection prevention and BMW
3. Documentation and reporting
Network of Skills lab - progress

State Skills Lab (4/4)
ToTs and hub for other labs

District Skills lab (56/75)
Mentoring DWH SNs and Refresher trainings

Block Skills lab (300/820)
Onsite mentoring and SBA training for ANMs
<table>
<thead>
<tr>
<th>Cycle 1</th>
<th>LR Staff</th>
<th>NBSU Staff</th>
</tr>
</thead>
</table>
|         | • Partograph,  
|         | • Documentation  
|         | • Case sheet  
|         | • Referral slip and registers | • Emergency Triage of New Born  
|         | • Use of Glucometer  
|         | • Measuring Temperature of a Stable New Born Using Digital Thermometer, Management Of Severe Hypothermia |

<table>
<thead>
<tr>
<th>Cycle 2</th>
<th>LR Staff</th>
<th>NBSU Staff</th>
</tr>
</thead>
</table>
|         | • Pregnancy Detection Test , EDD, Weight and BP Measurement  
|         | • Abdominal Examination  
|         | • PV Examination  
|         | • HB Estimation ,Urine Test | • Use of Radiant Warmer  
|         | • Use of Radiant Warmer  
|         | • Newborn Resuscitation (NBR), NBSU  
|         | • Measuring Oxygen Saturation Using Pulse Oximeter  
|         | • Oxygen Therapy In New Born |
|         | Drills :RMC | |

<table>
<thead>
<tr>
<th>Cycle 3</th>
<th>LR Staff</th>
<th>NBSU Staff</th>
</tr>
</thead>
</table>
|         | • AMTSL,ENBC ,4th Stage Monitoring  
|         | • Breastfeeding  
|         | • FP counselling | • Management of A New Born with Emergency Signs  
|         | • HB Estimation ,Urine Test | • Umbilical Vein Catheterisation  
|         | • Use Of Phototherapy Unit |
|         | Drills :RMC | |

<table>
<thead>
<tr>
<th>Cycle 4</th>
<th>LR Staff</th>
<th>NBSU Staff</th>
</tr>
</thead>
</table>
|         | • Insertion of IV Line ,CAB Approach  
|         | • PPH ,Eclampsia  
|         | • ANCS | • Orientation On Breastfeeding  
|         | • PPH , Eclampsia | • Management of Neonatal Seizures  
|         | | • Sepsis In New Born |
|         | Drills :PPH , Eclampsia | |

<table>
<thead>
<tr>
<th>Cycle 5</th>
<th>LR Staff</th>
<th>NBSU Staff</th>
</tr>
</thead>
</table>
|         | • Use of Radiant Warmer, NBR  
|         | • KMC | • Kangaroo Mother Care (KMC)  
|         | | • Technique for EBM and Katori-Spoon/Paladai Feeding  
|         | | • Feeding with Oro-Gastric Tube |
|         | Drills :Preterm Labour , BA | |

<table>
<thead>
<tr>
<th>Cycle 6</th>
<th>LR Staff</th>
<th>NBSU Staff</th>
</tr>
</thead>
</table>
|         | • PPE ,Handwashing  
|         | • Preparation of 0.5% Chlorine Solution .Processing of Instruments  
|         | • BMW | • How to Clean Self Inflating Bag  
|         | | • PPE ,Handwashing  
|         | | • Preparation of 0.5% Chlorine Solution .Processing of Instruments  
|         | | • BMW |
**Vertical Integration (VI) Meetings**

- Forum to discuss referral-in and referral-out cases under the chair of CMO and CMS along with facility leads.
- Objective is to discuss referral linkages between BEmONC and CEmONC facility and identify delays in care seeking of mother and newborn.
- Cases with good practices, near miss cases were discussed and Action plan prepared against major area of improvement with timeline.
- It should enable the district to identify gaps in the referral linkages and fill them month on month basis.
- Standout feature is the involvement of the EMTs of 102/108 services in the meeting.

**Communication Channel**

- Identify complications → Pre-referral management
- Referral slip and complication case sheet
- Inform the higher facility/BB/ambulance in advance along with a picture of referral slip
- Sharing of Information
- Communication to the lower facility regarding status of the case
- WhatsApp
FRU strengthening- RRTC network
Complications management competencies enhancement – RRTC model

Network of medical college faculties mentoring care providers at FRUs

- Faculty network of 8 government medical colleges conduct training and clinical mentoring of government doctors posted in FRU Health facilities on managing complications of pregnancy

- TSU roles:
  - Standardization of curriculum and mentoring methodology
  - Facilitation of visit with FRU specific inputs
  - Care providers competencies analysis based on OSCE
  - Skills lab in Medical Colleges

This innovative initiative led by KGMU, Lucknow as apex training center
Overview of RRTC Program
Objective: Upskilling of Doctors Through Training and Mentoring Visits

- Induction workshop for faculty Master Trainers
- Regional Training of FRU doctors
- Mentoring:
  A) Pre- Mentoring- facility readiness by RRTC team
  B) Mentoring by faculty- facility round, one to one OSCE of doctors, Feedback sharing with CMS/MOIC
  C) Post Mentoring- Compliance by facility inchage of faculty suggestion - done by RRTC team
- Continuous Medical Education – Participants in the CME includes doctors who scored <70% and newly recruited doctors posted at FRUs
- Creation of district pool of trainers for strengthening of CHC-FRUs
- Support in CEmONC/LSAS Accreditation and trainings (National/State)
Phase-III-Proposed Network of 16 Medical Colleges
RRTC Program Methodology

Presentation

Case Study (Brainstorming)

Demo By Faculty

Video

Post Mentoring Evaluation

Training Cascade on ANC, INC* and PNC ( *C- Section Services- Pre operative, Intraoperative and Post operative care )
<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
</table>
| **New Born Component for Medical Officer** | - Essential New-born Care  
- New-born Resuscitation  
- Post partum care of new-born  
- Pre-term and LBW baby |
| **New Born Component for Specialists (Paediatricians)** | - Essential New-born Care  
- New-born Resuscitation  
- Post partum care of new-born  
- Pre-term and LBW baby |
| **Specialist Topic** | - Anaemia  
- Haemorrhage (APH & PPH)  
- Hypertensive disorder (HDP)  
- Use of Partograph  
- Shock  
- Blood Transfusion  
- Post Natal Care - Care of Mother till 48 hrs after delivery, post natal complications of mother, post partum counselling |
| **Maternal Component (OBGY)** | - Anaemia  
- Haemorrhage (APH & PPH)  
- Hypertensive disorder (HDP)  
- Use of Partograph  
- Shock  
- Blood Transfusion  
- Post Natal Care - Care of Mother till 48 hrs after delivery, post natal complications of mother, post partum counselling |
| | - Breech & Shoulder dystocia  
- Cord prolapse & foetal distress  
- Twin  
- PROM & Pre term  
- Prolonged/Obstructed Labour/Induction of Lab  
- Assisted Vaginal Delivery (forceps & ventouse)  
- Shock  
- Caesarean Delivery  
- Post Natal Care - Care of Mother till 48 hrs after delivery, post natal complications of mother, post partum counselling  
- Blood Transfusion |
Mentoring related Program outcome
The OSCE data on few key newborn care skills between 2019-20, shows substantial improvement in the skills of the staff nurses.
Key Improvements in select BEmONC practices in public facilities

**Initial assessment**
- Any initial Assessment was done: 28.3% in 2014, 51.8% in 2016, 83.9% in 2019
- Initial Assessment - Temp., B.P., Pulse, Respiratory

**AMTSL**
- Oxytocin administered as per protocol: 49.2% in 2014, 75.9% in 2016, 95% in 2019
- AMTSL, all three steps done: 31.6% in 2014, 56.6% in 2016, 79.6% in 2019

**Essential newborn care including EIBF**
- Abdominal delivery: 46% in 2014, 66.4% in 2016, 91.5% in 2019
- Clamp the cord: 53.4% in 2014, 87% in 2016, 95.6% in 2019
- Breastfeeding initiated: 46% in 2014, 78% in 2016, 88.4% in 2019
- Newborn weighed as per protocol: 42% in 2014, 94.6% in 2016, 97.2% in 2019

Source: xMLE evaluation
Knowledge/skill and clinical practices: Shift from RFS-3 to RFS-4, 25 HPDs

Composite index is calculated based on 8 knowledge/skill and 9 practice indicators
UTTAR PRADESH
TECHNICAL SUPPORT UNIT

Uttar Pradesh’s Data systems and Data Use Mechanism
NEW BORN AND CHILD HEALTH

20/1/2022
<table>
<thead>
<tr>
<th></th>
<th>Agenda</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Background</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Uttar Pradesh’s Key Health Data Systems: New-born Child Health</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Data Use Mechanism for Decision Making</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Key insights from</td>
<td></td>
</tr>
</tbody>
</table>
The goal is to enhance the **use of data for decision making**

- **Strengthen the availability, accessibility and quality** of government data system
- **Increase the use of data to promote data driven review of health system** for problem solving by gap analysis and prioritization
Key Platforms and Interventions for improving newborn and child health

**Community**
- **Behaviour and service provision**
  - FLW visits
  - Home based new born care
  - Identification and referral for newborn complications and childhood diseases
  - Tracking of LBW baby
  - Immunization
  - Identification and referral of severe malnourishment
  - Counselling for appropriate behaviour

**Facility**
- **Skill, practice and quality**
  - Essential new born care
  - Identification of new-born complications
  - Management of New born complications
  - Treatment at NBSU/ SNCU
  - Immunization
  - Management of severe acute malnourishment through NRC
  - Treatment for ARI and Diarrhoea
  - Treatment for PSBI/other infections

**System**
- **Human resource**
- **Training**
- **Infrastructure**
- **Drugs and equipment**
Data System is aligned to track and monitor newborn and child health

### Community

- **TSU/GoUP surveys**
  
  *Community Behaviour Tracking Surveys (CBTS)*: captures various community level behaviours regarding child

- **GOI survey (NFHS)**: Provides district level estimates for key coverage indicators

- **Sample Registration System**: Neonatal mortality and infant mortality at the state level

- **Program monitoring data**: HBNC and VHND monitoring

### Facility

- **Health Management Information System (HMIS)**: Services provided to children such as immunization, HBNC, essential new born care, treatment of ARI and Diarrhoea. It also captures outcomes like low birth weight, still births, childhood diseases, neonatal and infant death

- **UP-HMIS**: UPHMIS captures additional data on new born complication identification and management

- **Sick New-born Care Unit (SNCU) portal**: SNCU tracks admission and outcomes of new-born admitted for management of complications

- **Rolling facility survey (RFS)**: Knowledge, skill and practise of health care service provider

### System

- **Manav Sampada**: Human resource management portal of UP government

- **DVDMS**: Captures supply chain of drugs and vaccines

- **BCPM-MIS**: Tracks incentive payments to ASHAs across the state.

- **HMIS-infrastructure report**: This is a section of HMIS which captures the available infrastructure at the health facilities in the state
Monitoring systems to help decision making
Key principals

- Integrated data system

- Multi-layered analysis to identify the gaps and appropriate decision-making

- Looking beyond the routine monitoring data for more evidence
  - Community Surveys
  - Facility quality assessments

- Data triangulation and synthesis
Integrated Data system: Opportunities to link service uptake with service provisioning

HR details
(Manav Sampada)

Facility Details
(Location, services, population coverage)

Routinely Monitoring System
(HMIS/UPHMIS)

Drugs and Logistics
(DVDM5 Warehouse & Facility)

UP K Swasthya Kendra
(Facility Layer Application)

GIS

Facility Features
Multilayered analysis to identify the gaps and help decision-making

**STATE LEVEL**

Identification of Poor performing districts by indicator

**DISTRICT LEVEL**

Identification of Poor performing block by indicator

Factors identified for poor performance and action plan prepared

**BLOCK LEVEL**

Identification of poor performing SC/Facility

Factors identified by SC area for poor performance in discussion with FLWs

MoIC/BPM discuss factors (both quantitative and qualitative) contributing to poor performance in ANM review meetings

Action plan prepared
Results: District Program Officials have taken 177 data based decisions 2.5 Years

Domain wise decisions, April-2019-Dec-2021 (n=1025)

- Delivery Care: 25%
- New-born and child care: 17%
- ANC care: 19%
- Family Planning: 15%
- Data quality: 4%
- Communicable diseases: 2%
- ASHA Incentive: 4%
- Others: 14%

UPHMIS based Decision tracker has been established to track the decisions

1/5th of the total decisions were related child health care

Decisions related to new-born & child care includes HBNC, immunization, facility based new-born care
Case Study: Increase in Home based new born care (HBNC) visits in Farrukhabad district (1/2)

A. Identification of low performing Indicator and geography

% of NBs received HBNC visit was lowest in Farrukhabad in Kanpur Division and significantly lower than Uttar Pradesh’s value during Apr-Jun 2020

B. Gap Analysis to identify the reason of poor performance

- 3 blocks out of 7 were performing lower than the district average
- 30% ASHA did not have complete HBNC drug kit for HBNC visit while only one-third are using HBNC checklist during visit
- Variation among Payout to ASHA for HBNC and HBNCs reported

<table>
<thead>
<tr>
<th>Block</th>
<th>Average Annual NB load per ASHA</th>
<th>% of ASHAs having complete HBNC drug kit</th>
<th>% of HBNC visit form submitted against live birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kayamganj</td>
<td>27</td>
<td>92</td>
<td>49</td>
</tr>
<tr>
<td>Rajepur</td>
<td>30</td>
<td>64</td>
<td>66</td>
</tr>
<tr>
<td>Shamshabad</td>
<td>38</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>District</td>
<td>31</td>
<td>70%</td>
<td>34</td>
</tr>
</tbody>
</table>

Source: HMIS/UPHMIS
C. Action Planned

- CMO has released the action plan with clear responsibility and timeline to concern officials
  - CMSD Store was instructed to supply HBNC Kit to ASHAs without having functional kit
  - BCPM will take only ANM signed Vouchers and will release the payment to ASHA without any delay

D. Action Taken (Implementation)

- CMSD Store supplied HBNC kits to the lagging blocks
- Weekly status of HBNC form submitted was shared with DCPM and only those vouchers which signed by ANM were processed

E. Result

Percentage of live births received complete HBNC visits increased from 35% in Apr-Jun quarter, 2020-21 to 82% in Jan-March quarter, 2020-21

Source: UPHMIS Decision Tracker
New Born Stabilization Units (NBSU) – Admission profile

- **NBSU** is a ‘newborn care unit within close proximity of the maternity ward where sick & small new-born can be cared for a period of short duration’.
- There are **310 NBSUs in the state. Out of these 184 NBSUs are functional.**

## Admission profile

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admission</td>
<td>4837</td>
</tr>
<tr>
<td>Inborn</td>
<td>92.5%</td>
</tr>
<tr>
<td>Outborn</td>
<td>7.5%</td>
</tr>
<tr>
<td>Outborn Facility Referred</td>
<td>25.9%</td>
</tr>
<tr>
<td>Community Referred</td>
<td>8.0%</td>
</tr>
<tr>
<td>Male</td>
<td>57.0%</td>
</tr>
<tr>
<td>Female</td>
<td>43.0%</td>
</tr>
<tr>
<td>Gestation (&lt;34 Weeks)</td>
<td>6.0%</td>
</tr>
<tr>
<td>Low Birth Weight (&lt;2500 gm)</td>
<td>48.0%</td>
</tr>
</tbody>
</table>

**% distribution of admissions by cause**

- HIE/Birth Asphyxia: 35.7%
- Others: 14.4%
- Prematurity: 10.5%
- Respiratory distress syndrome: 8.8%
- Hypothermia: 8.5%
- Meconium Aspiration syndrome: 6.4%
- Jaundice: 3.7%
- Other causes: Respiratory Distress: 2.2%
- Sepsis/Pneumonia/Meningitis: 1.9%
- Major Congenital malformation: 1.6%
- Hypoglycemia: 0.2%

*Note: Data Source: UPHMIS (6 months data)  
*115 cases are missing for outcome status*
NBSU performance

**DURATION OF STAY**

<table>
<thead>
<tr>
<th>Total</th>
<th>&lt;1 Day</th>
<th>1-3 Days</th>
<th>4-6 Days</th>
<th>&gt;2 Days</th>
<th>Average Length of Stay (Days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4569</td>
<td>2800 (61.5)</td>
<td>1549 (33.9)</td>
<td>104 (2.3)</td>
<td>10 (0.2)</td>
<td>2.0</td>
</tr>
</tbody>
</table>

**BED STATUS**

<table>
<thead>
<tr>
<th>Bed Status</th>
<th>Facilities Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Beds</td>
<td>153</td>
</tr>
<tr>
<td>Average Beds</td>
<td>2.3</td>
</tr>
<tr>
<td>Bed Occupancy Rate (Mean)</td>
<td>26.7</td>
</tr>
</tbody>
</table>

**HIGH BED OCCUPANCY RATE**

- Sadatheader (MATH): 94.8
- Phani (HARF): 99.9
- Sani (MATH): 94.5
- Monongga (KAUS): 54.3
- Khatua (MULPA): 49.5

**LOW BED OCCUPANCY RATE**

- Shivrampur (CIT): 8.1
- Shalani (SHA): 8.5
- Tundla (PRC): 5.5
- Manikpur (CIT): 4.8
- DVA (FAH): 8.3

**MANAGEMENT**

<table>
<thead>
<tr>
<th>Phototherapy Usage (%)</th>
<th>Antibiotics Usage (%)</th>
<th>Oxygen Usage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>227 (12.9%)</td>
<td>190 (41.5%)</td>
<td>224 (97%)</td>
</tr>
</tbody>
</table>

**Top 5 Facility: Discharged**

- Jhara (PRK): 95.1
- Bindi (FAI): 94.2
- Shali (SHA): 92.9
- Chhawal (AYO): 90.2
- Sorgon (PRK): 88.9

**Bottom 5 Facility: Discharged**

- Madhavara (ILA): 90.6
- Gfda (ILA): 14.9
- Phani (HARF): 12.3
- Bilawalpur (AZ): 0.0
- Tundla (PRC): 0.0

*Statuses of Bottom 5 Facility (Transfer, LAMA, Admission)*

- Referral
- LAMA
- Admission

*Notes:
(a) No Outcome records were available for both the facilities (Biharpur & Tundla).
(b) More than 60 cases of LAMA reported by GOLA for Jan ’22 to Jun ’22.*
Facility-based Rolling Facility Survey (RFS)
RFS Plus: Approach (Flow diagram)

Consent obtained

Facility Readiness

Hospital

Registration and consent Service Providers
(Staff Nurse/ ANM/ Medical Officers/
AYUSH/ MBBS/ Specialist)

Screening of women* and new-born

Delivery Observation and Pre-referral management
(including complications)

Delivery
Maternal complication
Newborn < 29 days

Delivery equipment

Labour room

Referral & Discharge

Tracking all eligible arrivals

Telephonic follow-up

Exclusion: Not eligible for the study

Knowledge and Skills

*ANC period - Gestation age ≥24 weeks and in-labour;
PNC period – Post delivery ≤42 days for woman, and ≤29 days for new-born
Essential New-born Care in 25 High Priority Districts

- Clamped the cord as per protocol
- Cut the cord using new blade/sterile scissor
- Provided skin to skin care
- Supported initiation of breastfeeding
- Weighed the newborn
- Recorded the weight correctly
- All components of ENC performed

RFS 2015 (N=502)  RFS 2017 (N=757)  RFS 2019 (N=661)

Source: Rolling Facility Survey, RFS
### Identification & Management of New-born Complication

**Total newborn – 4245**

**Any newborn complication - 1014 (24%)**

**Management initiated – 576 (57%)**

**New-born Died – 32 (3.2%)**

#### Around one fifth newborn identified with complication

<table>
<thead>
<tr>
<th></th>
<th>Total (n=1014)</th>
<th>Birth Asphyxia (n=454)</th>
<th>Preterm (n=102)</th>
<th>*LBW (n=635)</th>
<th>Birth Anomaly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>23.9</td>
<td>10.7</td>
<td>2.4</td>
<td>15.0</td>
<td>0.2</td>
</tr>
</tbody>
</table>

#### Around 3% of newborn with complication died at facility

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=1003)</th>
<th>DH (n=762)</th>
<th>CHC-FRU (n=241)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>67.9</td>
<td>74.1</td>
<td>48.6</td>
</tr>
<tr>
<td>Referred out</td>
<td>18.5</td>
<td>13.3</td>
<td>35.3</td>
</tr>
<tr>
<td>Left the facility- healthy</td>
<td>5.1</td>
<td>6.0</td>
<td>13.3</td>
</tr>
<tr>
<td>Died</td>
<td>6.0</td>
<td>2.6</td>
<td>0.4</td>
</tr>
</tbody>
</table>

#### Complication Table

<table>
<thead>
<tr>
<th>Complication</th>
<th>New-born Death</th>
<th>%</th>
<th>Birth asphyxia</th>
<th>LBW</th>
<th>Pre-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth asphyxia</td>
<td>22</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth asphyxia + birth anomalies</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth asphyxia+preterm</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth asphyxia+LBW</td>
<td>4</td>
<td>11</td>
<td></td>
<td>81%</td>
<td>22%</td>
</tr>
<tr>
<td>Birth asphyxia+LBW+ preterm</td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>LBW+preterm</td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No complication</td>
<td>5</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Birth asphyxia is leading cause of newborn death**

Source: RFS+, 2021
Understanding coverage and quality gaps: Birth Asphyxia Management (n=454)

<table>
<thead>
<tr>
<th>Target population</th>
<th>Service contact coverage</th>
<th>Facility readiness</th>
<th>Crude coverage</th>
<th>Quality adjusted coverage</th>
<th>User adherence adjusted coverage</th>
<th>Outcome adjusted coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn identified / Expected as Birth asphyxia (10.7%)</td>
<td>Newborn who identified as birth asphyxia by provider at facility</td>
<td>#Facility readiness</td>
<td>Newborn received initial steps &amp; bag &amp; mask was initiated among newborn who required</td>
<td>11.3</td>
<td>6.6</td>
<td>6.1</td>
</tr>
</tbody>
</table>

By and large timely provision of B&M/ post ventilation may avert a large number of death (18) and all in DH

Expected Prevalence of birth asphyxia - 10.7% source: https://www.jdrntruhs.org/temp/JNTRUnivHealthSci74245-2443802_064718.pdf; Motepalli et al, 2021-
RFS+ also observed 10.7%; # HR – (Pediatrician/ MO - NSSK/NBR) & NBCC & Bag & Mask (0,1 size)/ **Bag & Mask within one minute who were not cried, PVR who were not breathing well & all initial steps among who were cried and breathing well. also includes shifted to SNCU/NBSU or referred out.
Duration of facility stay after delivery, 25 HPDs, 2018, CBTS

- Overall, the average duration of stay at facility is 15.5 hours (median=7 hours) among normal deliveries

- Live births are considered here
- C-section deliveries are excluded

Source: CBTS-6
Duration of stay by complication cases, RFS+

Maternal

Newborn

Source: RFS+
HBNC visits by place of delivery

HBNC visit by ASHA during neonatal period and place of delivery

- HBNC visit in Month 1
- HBNC visit in Week 1
- HBNC visit in first 24 hours of delivery/return from facility

Place of delivery

- Overall
- Public
- Private
- Home

Source: CBTS, 2018
Note:* Only 25 blocks depicted under home-deliveries wherein at least 30 responses were reported in the current sample.
Thank You

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Subgroup information, recordings and presentations from previous meetings and webinars are available on the subgroup page of the Child Health Task Force website: 
www.childhealthtaskforce.org/subgroups/qoc

*The recording and presentations from this webinar will be available on this page in a couple days


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