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





Image credit: Mubeen Siddiqui/MCSP, Tukhipoda, Odisha, India

Moderated by



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Presenters from the National Health Mission





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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

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)

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



Neonatal mortality trends & major causes

Neonatal Mortality Rate

Causes of Neonatal Mortality,2018



COVID impact on progress – yet to be measured



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

NMR, UP (SRS)

Current AARC of Rajasthan (-4.5%)

AARC needed to achieve SDG goal (-8.4%)

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%)



IMR per 1,000 live birth AARC: 72.7 -1.4% AARC: 63.5 -4.6% 57.0 50.4 40.7 35.2 AARC: -3.4% AARC: -2.9% NFHS-3 (2005) NFHS-4 (2015) NFHS-5 (2020) -India — UP

FATE OF 1000 live births -UP

| Mortality rates | Deaths | Cumulative & indicator | |
|------------------------------|---------|------------------------|-------------------------------|
| First 1 week (within 7 days) | 24 | 24 | Early Neonatal Mortality Rate |
| 1-4 weeks | Add 8 | 32 | Neonatal Mortality Rate |
| 1–12 months (next 48 weeks) | 11 more | 43 | *Infant Mortality Rate |
| 1-5 years (next 48 months) | Add 4 | 47 | Under-5 Mortality Rate |

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 medium ARoR
Low rate and high ARoR
Low rate and high ARoR



| Indicators | High mortality states (9) | | | Low mortality states (11) | | |
|---|---------------------------|--------|--------------------|---------------------------|--------|-----------------|
| | NFHS-4 | NFHS-5 | Change (points) | NFHS-4 | NFHS-5 | Change (points) |
| Neonatal mortality | | | | | | |
| NMR (Per 1000 live births) | 34.7 | 29.1 | -5.6 | 19.5 | 16.9 | -2.5 |
| Contextual | | | | | | |
| Per-capita income | 57738 | 72247 | 14510 | 1,09,589 | 140819 | 31,231 |
| Female education* (%) | 65.0 | 68.7 | 3.7 | 74.2 | 76.0 | 1.8 |
| Teenage pregnancy (%) | 7.8 | 6.4 | -1.4 | 7.5 | 6.6 | -0.9 |
| RMNCH and nutrition coverage | | | | | | |
| ■ mCPR (%) | 42.4 | 53.3 | 10.9 | 56.5 | 61.5 | 5.0 |
| ■ 4+ ANC (%) | 38.2 | 52.2 | 14.0 | 72.2 | 71.8 | -0.4 |
| Institutional delivery (%) | 72.6 | 85.1 | 12.6 | 88.8 | 95.3 | 6.5 |
| PNC newborn (%) | 22.5 | 76.4 | 53.9 | 30.1 | 88.2 | 58.1 |
| Early initiation of breastfeeding (%) | 40.4 | 38.8 | -1.6 | 47.4 | 50.5 | 3.1 |

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

Key issues - across RMNCH+A in UP

| | | Adolescent/pro | Pregnancy | Birth | Newborn/ Postnatal | Childhood | | |
|-------------------|--------------------|---|--|---|--|---|--|--|
| KEY ISSUES | | High unmet need for contraception | Quality of ANC Anemia in pregnancy | Quality of Care around Birth Many districts without single FRU | Early initiation of Breast feeding Home visit in first 2 days of life | Complimentary feeding High malnutrition and Anemia | | |
| INTIONS | Community level | Ensuring availability & capacity building of FLWs | Birth Prep plan/ VHND | Skilled birth attendance for home deliveries | Quality Home visits by ASHA | Low birth weight tracking beyond post natal period | | |
| INTERVE | Facility level | Skill upgradation | Iron sucrose administration | FRU Activation, Quality MCH Care/ Mentoring | NBCC/NBSU/SN CU/ FPC | Facility based Paediatric care/ETAT | | |
| | | Social Behavior Change and Communication (SBCC) | | | | | | |

Current gap of sub-district level of Facility Based Newborn Care



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

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

Community – Facility – Community linkage for continuum of care

Strategies and programs-UP

RMNCH+A STRATEGY



Strategic Interventions under Maternal Child Health Programme



SAANS-' Social Awareness and Action to Neutralise Pneumonia Successfully'

Child Death Review

Special Newborn Care Units at District Hospital

- 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









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



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



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

**Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet. 2018 Sep 5.

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



Data Source: SRS India bulletin

Key Initiatives under National Quality Assurance Program



International & National Standards

| International Society for Quality in Health Care External Evaluation Association |
|--|
| National Health Systems Resource Centre (NHSRC) |
| National Quality Assurance Standards (NQAS) |
| Awarded by IEEA following an independent assessment against the Guidelines and Principles for the Development of Health and Social Care Standards, 4th Edition |
| The period of Accreditation for these Standards is from August 2020 until August 2024 |
| akaly Archlen |
| Curine O'Connor Head of Operators |

ISQUA Accredited Standards

| ISQua® | Ref: IRDAUHLT/GDL/CIR/114/07/2018 |
|--|--|
| International Society for Quality in Health Care | To |
| National Health Systems | All insurance Companies and Third Party A |
| | Re: Modified Guidelines on Standard provider network |
| Resource Centre | On examining the extent of compliance to |
| (NHSRC) | supercession of Clause (a) and Clause (b) o in Health Insurance issued vide Circular Ref |
| (, | July, 2016, the following modified Clause (a |
| | a) All the existing Network Providers notification of these modified guideling |
| Awarded by ISQua following an | i. Register with Registr |
| independent assessment against the | (ROHINI) maintained [https://rohini.iib.gov.in |
| ISQua Surveyor Training Programme Standards | ii. Obtain either Pre-entry |
| | issued by National Acc Providers (NABH) or |
| | certificate) under Nati |
| The period of Accreditation of this | For the new entrante from |
| Programme is from | Guidelines, only those hospit |
| July 2018 until July 2022 | specified at Clause (a) (i) at These network providers sha |
| | Clause (a) (ii) above within on Provider and this shall be |
| ale a Nickley Comoio | Agreement. |
| Head of the International Accreditation | |
| Programme and Strategic Partnerships | |
| | -X-1 (101) |

Surveyor Training Program (NQAS External Assessors' Training)

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA 27th July, 2018 dministrators and Benchmarks for hospitals in the the standards and benchmarks specified in of Chapter IV of Guidelines on Standardization IRDA/HLT/REG/CIR/146/07/2016 dated 29th a) and Clause (b) are issued. shall, within twelve months from the date of es, comply with the following: of Hospitals in the Network of Insurers by Insurance Information Bureau (IIB). level Certificate (or higher level of certificate) reditation Board for Hospitals and Healthcare State Level Certificate (or higher level of onal Quality Assurance Standards (NQAS). alth Systems Resources Centre (NHSRC). the date of notification of these modified als that are compliant with the requirements ove shall be enlisted as network providers. Il comply with the requirements stipulated at e year from the date of enlisting as a Network one of the conditions of Health Services Page 1 of 2

भारतीय बीमा विनियामक और विकास प्राधिकरण

Survey No. 115/1, Financial District, Nanakramguda, Hyderabad-500 032, In

 IRDAI recognize NQAS as benchmark for empanelment hospitals

 NHA is considering to include NQAS certification for Gold Category

Implementation Status in Uttar Pradesh



National Quality Assurance Standards

| Level of Facility | Total Functional (RHS 2019-20) | National Cer | rtified State Cer | tified |
|-------------------|-----------------------------------|--------------|----------------------------|--------|
| DH | 149 | 29 | 78 | |
| CHC | 723 | 3 | 41 | 41 |
| PHC | 3407 | 16 | 28 | |
| UPHC | 592 | 1 | 2 | |
| | | Labour Room | Maternity Opera Theatre | ation |
| | LaQshya | 24 | 21 | |
| I | AUSHYA लक्ष्य | | | |

Key Action Points



- 2. 'Gap-Analysis' done
- 3. Identification for 'better' performing facilities and leaders

for the certification

2. Prioritizing Gap closer activities

1. Preparing action

1. For all stake holders

Supportive Supervision

1. Compliance on mandatory requirements



Respectful Maternal & Newborn Care



Quality Assurance – Monitoring of critical practices using mobile based technology

Report cards

Daily LR monitoring Period – Oct-Dec 2021

Strategy



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



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

Children & parent/attendant friendly ambience infrastructure

Strengthen referral and follow-up services

Provision of respectful & dignified care

Strengthen Clinical Protocols & Management Processes

Quality Certification, Improved Indicators and Satisfied Families

QI workshop for MNH care delivery in UP

- 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



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





Road-Ahead









Presenters from the Technical Support Unit



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Indian Administrative Service Executive Director Uttar Pradesh Technical Support Unit University of Manitoba



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UTTAR PRADESH TECHNICAL SUPPORT UNIT

CHTF QoC Group Meeting

January, 2022











| 1 | Nurse mentoring program |
|---|-----------------------------------|
| 2 | FRU strengthening - RRTC |
| 3 | Mentoring related program outcome |





Nurse Mentoring Program







Uttar Pradesh Overview





Growth in Nursing Institutions





University ⊴Manitoba *INC Annual Report 2019

Uttar Pradesh Nursing Pre-service – Public vs Pvt







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

| | Public | | Private | | All Faculty | |
|----------------------------|---------|---------|---------|---------|-------------|----------|
| Skills Station | GNM (2) | CoN (7) | GNM (4) | CoN (8) | GNM (6) | CoN (15) |
| Mgt. of 2nd stage of labor | 0% | 14% | 0% | 0% | 0% | 7% |
| AMTSL | 50% | 14% | 0% | 38% | 17% | 27% |
| ENBC | 0% | 14% | 0% | 13% | 0% | 13% |
| NBR | 0% | 14% | 25% | 25% | 17% | 20% |
| Infection Prevention | 0% | 71% | 25% | 50% | 17% | 60% |
| Partograph Plotting | 0% | 14% | 0% | 0% | 0% | 7% |
| Overall | 0% | 14% | 0% | 0% | 0% | 7% |





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







Strategy









Nurse Mentor - Scale up and Transition





Key Interventions









Network of Skills lab - progress

UP-TSU



Topics of on site clinical mentoring of LR / NBSU staff



| | LR Staff | NBSU Staff |
|---------|--|--|
| Cycle 1 | Partograph, | Emergency Triage of New Born |
| | Documentation | Use of Glucometer |
| | Case sheet | Measuring Temperature of a Stable New Born Using Digital |
| | Referral slip and registers | Thermometer, Management Of Severe Hypothermia |
| Cycle 2 | Pregnancy Detection Test , EDD, Weight and BP Measurement | Use of Radiant Warmer |
| | Abdominal Examination | Newborn Resuscitation (NBR), NBSU |
| | PV Examination | Measuring Oxygen Saturation Using Pulse Oximeter |
| | HB Estimation ,Urine Test | Oxygen Therapy In New Born |
| | Drills :RMC | |
| Cycle 3 | AMTSL,ENBC ,4th Stage Monitoring | Management of A New Born with Emergency Signs |
| | Breastfeeding | Umbilical Vein Catheterisation |
| | FP counselling | Use Of Phototherapy Unit |
| | Drills :NVD, AMTSL, ENBC | |
| Cycle 4 | Insertion of IV Line ,CAB Approach | Orientation On Breastfeeding |
| | PPH ,Eclampsia | Management of Neonatal Seizures |
| | ANCS | Sepsis In New Born |
| | Drills :PPH , Eclampsia | |
| Cycle 5 | Use of Radiant Warmer, NBR | Kangaroo Mother Care (KMC) |
| | • KMC | Technique for EBM and Katori-Spoon/Paladai Feeding |
| | Drills :Preterm Labour , BA | Feeding with Oro-Gastric Tube |
| Cycle 6 | PPE ,Handwashing | How to Clean Self Inflating Bag |
| | • Preparation of 0.5% Chlorine Solution .Processing of Instruments | • PPE ,Handwashing |
| | • BMW | • Preparation of 0.5% Chlorine Solution .Processing of Instruments |
| | | • BMW |
| mona | | |



Strengthening of Maternal / Newborn Referral Services through Improved communication

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







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:

center

- 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



Figure 1: Existing RRTC Landscape: 8 Medical Colleges in 25 HPDs



Overview of RRTC Program

Objective: Upskilling of Doctors Through Training and Mentoring Visits

| e | Induction workshop for faculty Master Trainers |
|-----------------------|---|
| Resourc | Regional Training of FRU doctors |
| ent of RRTC ackage | 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 |
| /elopm Pa | Continuous Medical Education –Participants in the CME includes doctors who scored <70% and newly recruited doctors posted at FRUs |
| RTC: Dev | Creation of district pool of trainers for strengthening of CHC-FRUs |
| R | Support in CEmONC/LSAS Accreditation and trainings(National/State) |





Phase-III-Proposed Network of 16 Medical Colleges







RRTC Program Methodology







Topics to be covered for MO & Specialist during Training & Mentoring



Maternal Components for Medical Officer

- 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

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

Maternal Component (OBGY)

- Anaemia
- Haemorrhage (APH& PPH)
- Hypertensive disorder(HDP)
- Use of Partograph
- 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







Improvement in competency of staff (2019-20)





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





University Source: xMLE evaluation







JP-TSU)





Thank You



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UTTAR PRADESH TECHNICAL SUPPORT UNIT

Uttar Pradesh's Data systems and Data Use Mechanism

NEW BORN AND CHILD HEALTH

20/1/2022









| 1 | Background |
|---|--|
| 1 | Uttar Pradesh's Key Health Data Systems: New-born Child Health |
| 2 | Data Use Mechanism for Decision Making |
| 3 | Key insights from |







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







System

Human resource Drugs Equipment's Infrastructure Finance & Incentives

Community

Facility

ANM/ Staff nurse/ Doctor

- Behaviour and service provision
 - FLW visits

Villages

ASHAs

University ≝Manitoba

- 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

- 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

Human resource

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







Facility



System

Human resource Drugs Equipment's Infrastructure Finance & Incentives

Community

• TSU/GoUP surveys

University Manitoba Community Behaviour Tracking Surveys(CBTS): captures various community level behaviours regarding child Rapid Assessment Survey (RAS): Captures immunization in the community

- **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

- 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

- 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









- 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)



Rountine **Monitoring System** (HMIS/UPHMIS)







Drugs and Logistics (DVDMS Warehouse & Facility)



Facility Features





Multilayered analysis to identify the gaps and help decision-making

STATE LEVEL



Poor performing districts notified

University Manitoba



Less than 70% for availability of HR, equipment and drug

Less than 80% for process (Session plan, held)

DISTRICT LEVEL

BLOCK LEVEL



Action plan prepared



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





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









Case Study: Increase in Home based new born care (HBNC) visits in Farrukhabad district (2/2)



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

Action Plan /कार्य योजना (Based on District and Block Ranking/जिलास्तरीय एवं ब्लॉक स्तरीय रंकिंग के आधार पर) Date of Meeting/ मीटिंग की दिनाक:09/07/2020 roposed Action Plan Key identified gap Area-Block/SC (dd/mmm/yyyy) Respon Name with current rogress/ No 6 of NB Shamshabad(4%) BPM's were unaware DCPM DCPM will share the Rajepur(34%) eceived about the new guidelines new guidelines to **IBNC** visit Kayamganj of HBNC visit Blocks and Asha and (39%) ANM's will be orientated 6 of NB Baraun 30% ASHA does not have & 01/07/2020 Procurement of HBNC DCPM HBNC drug kit eceived Nawabgani drug kit from district to CMSD **IBNC** visit Rajepur required block 6 of NB Kavamgan HBNC visit form All vouchers must be BCPM submitted are very low eceived Rajepur collected during the IBNC visit Shamshabad compared to Live birth time period 6 of NB All Blocks · ASHA payment done for Only those vouchers BCPM 21/07/2020 eceived HBNC is more than forms are to be paid which is IBNC visit submitted verified by ANM hief Medical Officer

E. Result

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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





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.

| Aumission prome | | | | | | |
|-----------------------------|-------|--|--|--|--|--|
| Indicator | N | | | | | |
| Total Admission | 4837 | | | | | |
| Inborn | 92.5% | | | | | |
| Outborn | 7.5% | | | | | |
| Outborn Facility Referred | 25.9% | | | | | |
| Community Referred | 8.0% | | | | | |
| Male | 57.0% | | | | | |
| Female | 43.0% | | | | | |
| Gestation (<34 Weeks) | 6.0% | | | | | |
| Low Birth Weight (<2500 gm) | 48.0% | | | | | |

Admission profile







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





Total

4569

Bed Status

Total Beds

50.0

45.0

40.0

35.0

30.0

25.0 20.0 15.0

10.0

5.0 0.0

Average Beds

Bed Occupancy Rate (Mean)

| DURATION OF STAY | | | | | | MANAGEMENT | | | | | | | |
|--|---|---|----------------------|---|---|--|--|-------------------|-------------------------------|---|---|---|--------------------------------------|
| otal 1569 | <1 Day 2800 (61%) | 1-3 Days 1591 (35%) | 4-6 Days 168 (4%) | >=7 Days 10 (0%) | Average Length of Stay (Days) 2.0 | Photother 227 | rapy Usage (%) 7 (126%) | Anti | ibiotics Usag 1902 (41.8%) | ie (%) | Oxyge 224 | en Usage (%) 46 (87%) | |
| tatus Beds ge Beds ccupancy F ME | BED STATUS Rate (Mean) | Facilities Reported 153 2.3 26.7 Y RATE | Μ | HIGH BE Sadabad (HATH) Pihani (HARD) Sasni (HATH) Sasni (HATH) Iooratganj (KAUS) | 2D OCCUPANCY RATE (146.9) 99.9 94.1 54.3 49.5 | Top 5 F Jsara (PRAY) Bindki (FATE) Shamli (SHAM) Sohawal (AYOD) Sora on (PRAY) 84. | acility: Discharged 92. 92. 90.2 88.9 .0 85.0 88.0 90.0 92.0 94.0 | 95.1 94.4 9 | 1 | Status of Botto 90 90 80 71 70 60 50 40 30 71 14 20 | om 5 Facility (Referra | al, LAMA, Admission | n) 250 200 150 100 50 |
| 32.3 30 | 41.2 2.7 37.9 24.9 8.4 15.2 | 29.1 20.5 24.6 26.7 19.8 | Sh | 0.0 LOW BE nivarampur (CHIT) Shamli (SHAM) Tundla (FIRO) Manikpur (CHIT) | 50.0 100.0 150.0 200.0 D OCCUPANCY RATE 6.1 5.5 5.5 5.5 4.8 | Bottom (Madawara (LALI) Gola (LAKH) Pihani (HARD) Bilariyaganj (AZAM) Tundla (FIRO) | 5 Facility: Discharged 14.9 12.3 0.0 0.0 | 28.6 | | 10 0 (ITVT) exempty Refe | Cola (LAKH) Pihani (HARD) | 0 (ON H) Billanty (AZAM) | 0 |
| Jan'21 Feb | | nay 21 Jun' 21 Total OR-2 | | 0.0 | 3.3 0 2.0 4.0 6.0 8.0 | | 0.0 10.0 20.0 | 30.0 | *(a) 'No Outo (b) More tha | come' records were (in 60 cases of LAM | available for both the fa A reported in GOLA for | cilities (<mark>Biliyarganj</mark> & Jan'21 to Jun'21 | Tundla) |





Facility-based Rolling Facility Survey (RFS)









RFS Plus: Approach (Flow diagram)



Essential New-born Care in 25 High Priority Districts





Source: Rolling Facility Survey, RFS









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Around one fifth newborn identified with complication



Around 3% of newborn with complication died at facility



| Complication | New-born Death | % | Birth asphyxia | LBW | Pre- term |
|----------------------------------|-------------------|----|-------------------|-----|--------------|
| Birth asphyxia | 22 | 59 | _ | | |
| Birth asphyxia + birth anomalies | 1 | 3 | | | |
| Birth asphyxia+preterm | 1 | 3 | | | |
| Birth asphyxia+LBW | 4 | 11 | 81% | 22% | 14% |
| Birth asphyxia+LBW+ preterm | 2 | 5 | | | |
| LBW+preterm | 2 | 5 | | | |
| No complication | 5 | 14 | | | |

Birth asphyxia is leading cause of newborn death

Source: RFS+, 2021









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 University not breathing well & all initial steps among who were cried and breathing well . also includes shifted to SNCU/NBSU or referred out



UP-TSU

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



Average duration of stay (hours) at facility by place of delivery

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

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Duration of stay by complication cases, RFS+









HBNC visits by place of delivery





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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Connect with the us

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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: <u>www.childhealthtaskforce.org/subgroups/qoc</u>

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

Suggest subgroup activities here: http://bit.ly/QoCworkingdoc

Join the Child Health Task Force here: <u>https://bit.ly/joinchtf</u> & follow us on LinkedIn: <u>www.linkedin.com/company/child-health-task-force</u>



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