Quality, Equity, Dignity
A Network for Improving Quality of Care for Maternal, Newborn and Child Health

India

A. Background[1–6]

Core demographic data

Population[1]	1,339,180,000
Total fertility rate (children per woman)[1]	2.3
Maternal mortality ratio (MMR) (per 100,000 live births)[2]	130
Neonatal mortality rate (NMR) (per 1,000 live births)[3]	24
Infant mortality rate (IMR) (per 1,000 live births)	34
Child mortality rate (per 1,000 live births)[3]	39
Stillbirth rate (per 1,000 live births) [4]	4
Current health expenditure (% of GDP)[5]	4
Current health expenditure per capita (in US$)[5]	63
Health insurance coverage (% women aged 15-49 years) [4]	20.4

National coverage of key interventions

	%
Antenatal care (4 or more visits) [4]	51
Skilled attendance during delivery[4]	81
Institutional deliveries[4]	79
Cesarean section rate[4]	17
Children under age 3 years breastfed within one hour of birth[4]	42
Exclusive breastfeeding rate (of infants under age 6 months) [4]	55
Postnatal visit for baby (within 2 days of birth) [4]	24
Postnatal care for mother (within 2 days of birth) [4]	62

B. Implementation milestones

completed · in progress · not started or incomplete · no data

National leadership for quality of care (QoC)	
Supportive governance policy and structures developed or established	completed
QoC for maternal and newborn health (MNH) roadmap developed and being implemented	completed
Learning districts and facilities selected and agreed upon	completed
QoC implementation package developed	completed
Adaptation of MNH QoC standards	completed
Action: Learning sites identified and prepared	
Orientation of learning districts and facilities	completed
District learning network established and functional (reports of visits)	completed
QoC coaching manuals developed	completed
Quality improvement (QI) coaches trained	completed
On-site coaching visits occurring in learning districts	in progress
Learning and accountability: QoC MNH measurement	
QoC for MNH baseline assessment completed	completed
Common set of MNH QoC indicators agreed upon for reporting from the learning districts	completed
Baseline data for MNH QoC common indicators collected	completed
Common indicator data collected, used in district learning meetings, and reported upwards	completed
Identification and agreement with an academic or research Institution to facilitate documentation of lessons learned in the implementation of QoC activities	in progress
Accountability and community engagement	
Mechanism for community participation integrated into QoC planning in learning districts	in progress

C. Progress at the national level (2017–2018)

National overview of QoC for MNH

National quality policy or strategy

- India's National Quality Assurance Program (NQAP) ensures quality across health systems in India focusses on maternal, new-born and child health as priority areas. NQAP along with its subdomains: Kayakalp, LaQshya, Swachh Swasth sarvatra, Mera Aspataal aims to ensure quality in Health Systems.

National aims

- National Health Mission mandate is to provide accessible, affordable and quality healthcare services to all. National Quality Assurance Program was launched in alignment to it in 2013 by Ministry of Health, India

National targets

National Health Policy targets :
- MMR from current levels to 100 by 2020
- Under Five Mortality to 23 by 2025
- Reduce infant mortality rate to 28 by 2019.
- Reduce neo-natal mortality to 16 and still birth rate to "single digit" by 2025

QoC technical working group (TWG)

- TWG consists of Maternal Child Health Division of Ministry, Quality Team, IEC Division, Medical Colleges, Nursing collages, Schools of Public Health, Professional Associations, Hospital Planners, IT professionals, Development Partners, Empanelled external assessors & eminent professionals.

Joint products and activities by the QoC TWG

- Meetings are held at regular interval to take the mandate of QoC forward efficiently.
- Provided technical support in developing standard guidelines for Quality of care.
- Provided trainings on quality of care.
- Framing of action plan for implementation of Quality Improvement Initiatives.
- Prepared package of Quality Improvement Cycles.
- Technically assisted in identification of Quality indicators.
- Imparted hands on training on various key quality skill components.
- Technically supported in gap assessment of health facilities.

Learning districts and facilities

- Active planning, Implementation and monitoring by Central Quality Supervisory committee at National Level and Quality Assurance Committees and units at 36 states and their districts.
- For labour room and maternity OT quality Improvement -2188 government health faculties (CHC, FRU, Sub divisional Hospitals) including 179 government medical colleges are currently LaQshya faculties.

District aims towards national strategy

- To provide quality care and work towards national strategy at district level, District Coaching Team is in place which is an external multidisciplinary team, responsible for mentoring one or more labour rooms, would comprise of District family welfare officer/RCHO (equivalent), district/divisional quality consultants, nursing instructors/mentors from the functional skill labs, faculty of nearest medical colleges and representatives of professional associations and development partners.
- The coaching team in districts with medical college could include one or more retired faculty members as a coach for medical college labour rooms and operation theatre. In the early phases, one coaching team could mentor four or five districts since training every district coaching team in a short span of time may not be possible.
- All coaching teams must be trained in skills lab/Dakshata, so that they are proficient mentors.

Clinical improvement aims

- Based on baseline assessment health facilty selects Improvement cycles. Aim is to
- To reduce maternal and newborn mortality & morbidity due to APH, PPH, retained placenta, preterm, preeclampsia & eclampsia, obstructed labour, puerperal sepsis, newborn asphyxia, and sepsis, etc.
- To improve Quality of care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system.
- To enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility.

Quality interventions included in the national MNCH QoC package*

Interventions to build a supportive environment

- Hands on skill training and implementation Respectful maternity care at health facilities

Interventions to support change at facilities

- Standard operating procedures, Documentation practices, Digitalization of data, Regular audits like Cesarean section audits, Near miss audits, Maternal Death review, Provision of infrastructure and equipments.

Interventions involving people, families and communities

- Birth companion during delivery, patient satisfaction survey and feedback

*Interventions have started since the last update.

D. MNH QoC baseline data for learning facilities

Baseline common indicators

Challenges

- Inconsistent documentation practices in various non standardized formats.

Opportunities and progress made

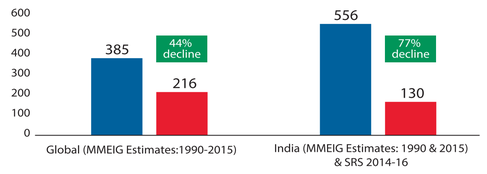
- Standard Indicators developed for facilities to report and trainings given on how to report on these Indicators.

Planned activities

- To work upon how to use data effectively by providers and beneficiaries both

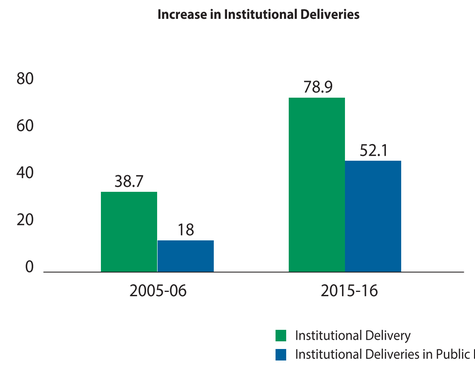
Significant progress has been achieved

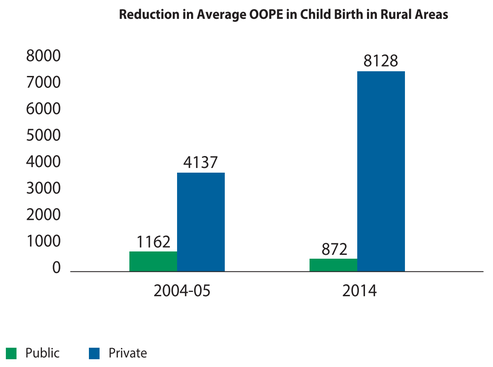
MMR in India has declined much faster than the global MMR



India's Progress on MDG 5 – Maternal Mortality Ratio

Institutional Deliveries & OOPE on Childbirth





E. Implementation progress in learning districts

On-site support for clinical skills and QI

Support for clinical skills

Who provides on-site support for clinical skills	• National and State coaching teams and mentors who have experience. • Master trainers created take this cascade of training to state level, district level finally facility level.
Challenges solved implementing on-site support for clinical skills	• Hands on skill training to health care providers was given. • In house trainers for each facility
Unresolved challenges implementing on-site support for clinical skills	• Transfer of trained health care provider to other department of Health.

Support for QI

Who provides on-site QI coaching	• National and State QI mentors
Challenges solved implementing QI coaching	• Availability of trained pool of coaching team and use of webinars for follow up
Unresolved challenges implementing QI coaching	• Implementation and documentation of Quality Improvement initiatives

Learning for QI

Tools for capturing learning from facilities	• Learnings and experience sharing shared by health facilities through various platforms like review meetings, webinars, documentation of quality improvement intervention by the facility.
Tools for sharing learning between facilities	• Set standard quality indicators are available for various health facilities. Standard protocol developed for QI intervention implementation and mentoring.
Challenges solved implementing a learning system	• Gap identification for quality Improvement of facilities through baseline assessment
Unresolved challenges implementing a learning system	• Incompleteness of data

Measurement system for QI

Patient-level common indicator data	• Common Indicators recorded at facility level- • Percentage of deliveries are attended by a birth companion • Percentage breastfeeding within 1 hour • Neonatal asphyxia rate in Inborn Babies • Neonatal sepsis rate in-born babies • Antenatal corticosteroid administration rate in case in preterm labour • Pre-eclampsia, eclampsia & PIH related mortality • APH/PPH related mortality • Percentage of Womenadministered Oxytocinimmediately after birth.
Programme-functioning data	• Standard Quality Improvement Indicators developed on which facilities do reporting to assess progress in quality.
Availability of data system for measuring QoC	• Data being made available on Quality Portal which is integrated portal for all maternal and newborn related data. HMIS data also being utilised.
Challenges solved implementing a measurement system	• Measurement through key performance Indicators which shall be useful to create benchmark across Health system
Unresolved challenges implementing a measurement system	• Data not being captured and Health providers not looking at data to draw inferences from them for further learning.

Community and stakeholder engagement

Approaches for community/ stakeholder engagement	• Birth companion, respectful maternity care, patient satisfaction survey
Roles of community stakeholders or patient representatives	• To ensure informed choices to beneficiaries. Provider and beneficiary should be on same platform of information.
Challenges solved engaging communities and stakeholders	• Patient satisfaction survey and feedback system
Unresolved challenges engaging communities and stakeholders	• Asymmetry of information between health care provider and patient, Implementation of respectful maternity care

Programme management

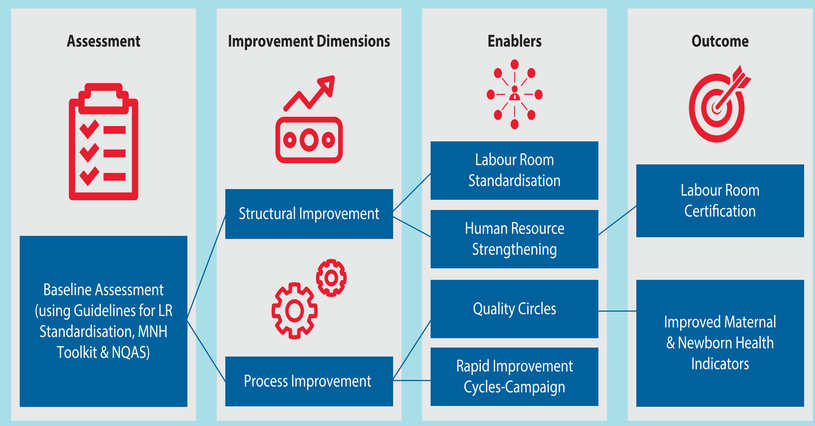
Programmatic responsibility	• **National Level Responsibilities** i. Periodic visit to the states, and to a sample of the health facilities. ii. Orientation and training. iii. Standardization of skill based training programs. iv. Development of IEC & resource material. v. Monitoring & evaluation. vi. Recommend mid-course correction. vii. Video conference with the QC teams and review of the MDSR/Maternal Near Miss review and NMR/Stillbirth review programmes. • **State level Responsibilities** i. Visit to the facilities and 'on-site' support for underperforming facilities. ii. Training & mentoring of the coaching teams. iii. Customization and approval of SOPs & Work-instructions. iv. Performance monitoring. v. Mobilization of State level support including providing inputs for the State PIP. vi. Presentation of Status report to the SQAC. vii. Identification of innovations and promoting their replication. viii. Undertake MDSR & CDR. ix. Assessment and modification of the referral directories prepared by the districts. x. Tracking & reporting of Indicators. • **District Level Responsibilities** i. Mentoring of the Quality circles, Support for the campaign and its monitoring. ii. Periodic Internal review Monthly visits of coaching/support teams for hand holding, problem solving, and verifying reported quality indicators. iii. To provide 'hands-on' training on clinical protocols. iv. Hand-hold the quality improvement process. v. Monitoring of availability of point of care diagnostic services and blood transfusion services. vi. OSCE based assessment of the staff. vii. Development of referral directory. viii. Sample verification of the indicators. • **Facility level Responsibilities** i. Ensuring Adherence to Protocols & Clinical guidelines. ii. Assessment of Labour room & operation theatre using the NQAS Departmental Check-lists. iii. Prioritization and Action planning for closure of gaps as per 'Maternal and Newborn Health Toolkit' and 'Guidelines for Standardization of Labour Rooms at Delivery Points'. iv. Management of 'Campaign'/'Rapid Improvement Cycle'. v. Collation of data elements, required for monitoring Indicators.
Challenges solved implementing program management	• Streamline implementation of Quality efforts in terms of training creating pool of master trainers, facilitating gap analysis and development of action plan for achieving targets
Unresolved challenges implementing program management	• Adequate allocation of Health care service provider based on number of patients and severity of condition addressed.

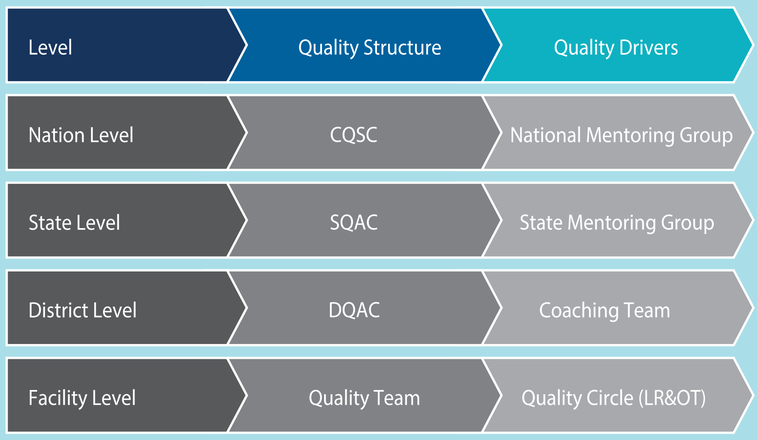
Lessons learned implementing a QoC program

- Ownership, initiative and innovation is key to effective implementation of quality program.
- The design based on evidence and experiences of implementing quality assurance mechanisms that are more acceptable and feasible to implement ownership by the health facilities.
- Standard operating procedures should be in place to ensure standardization of practices
- Continued hand holding and mentorship by people with a range of expertise facilitate streamlined implementation and nurture the potential of the initiative in impacting morbidity and mortality of women during childbirth.
- The approach of ensuring technical quality as well as satisfaction of service users provides the opportunity for greater efficacy and sustainability of the initiative.

F. Example from implementation

Programme Framwork





Design by Inís Communication – www.iniscommunication.com

References

1. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA Population Division), childmortality.org, 2018.
2. UNICEF WHO Interagency SAB Database, data.unicef.org, 2018.
3. United Nations Children's Fund, Division of Data Research and Policy (2018). Global UNICEF Global Databases: Infant and Young Child Feeding, New York, May 2018.
4. United Nations Children's Fund, Division of Data Research and Policy (2018). Maternal and Newborn Health Coverage Database, New York, May 2018.
5. United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, DVD Edition.
6. WHO Global Health Observatory data repository. http://apps.who.int/gho, 2017.

All other data received from the relevant Ministry of Health and WHO Country Offices.

Acronyms

APH	antepartum haemorrhage
CHC	community health centres
DQAC	District Quality Assurance Committee
FRU	first referral units
GDP	gross domestic product
MMR	maternal mortality ratio
MNH	maternal and newborn health
NMR	neonatal mortality rate
NQAS	National Quality Assurance Standards
OT	operating theatre
PPH	postpartum haemorrhage
QA	quality assurance
QI	quality improvement
QoC	quality of care
RMC	respectful maternity care