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NATIONAL HEALTH MISSION
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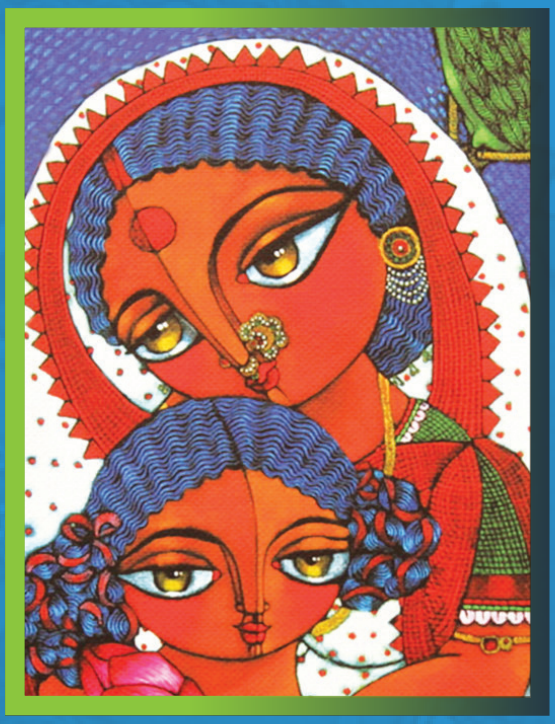
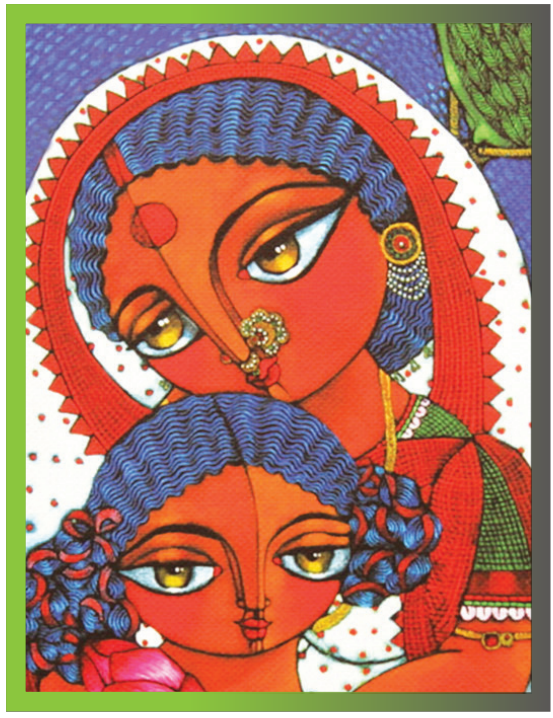


DISTRICT INTENSIFICATION PLAN

IMPROVING MATERNAL AND CHILD HEALTH OUTCOMES IN INDIA

MINISTRY OF HEALTH & FAMILY WELFARE, GOVERNMENT OF INDIA

SEPTEMBER 2017



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IMPROVING MATERNAL AND CHILD HEALTH OUTCOMES IN INDIA

ABOUT
THE DOCUMENT

This document has been prepared in light of the recent data made available in NFHS 4 (2015-16), which reiterates the fact that the burden of maternal, newborn and child mortality continues to be inequitable across states and districts. In 2013, the RMNCH+A Strategic Approach Document and Guidance note for implementation of RMNCH+A interventions were provided to address the inequitable access to health care and services. These documents guided the activities under NHM in 184 High Priority Districts (HPDs) that had been identified as low performing based on the data available at that time (DLHS III, AHS Round II).

As per the information available from NFHS 4, the performance of the districts on maternal, newborn and child health indicators has been reviewed in 2017. A total of 209 districts have designated as HPDs based on a composite index using NFHS 4 data. Of these, 148 districts are the same as those in the list of HPDs shared in 2013. 102 high priority districts are in nine states (Assam +EAG states) and these nine states currently account for 86% total maternal and 70% of total child deaths in the country each year and therefore mandate special attention.

This document describes a District Intensification plan for the HPDs to meet the overall goal of improving maternal and child survival in India. The plan describes some of the innovative approaches to MNCH service delivery for further intensifying the ongoing RMNCH+A activities in these HPDs. The continuous cycle of gap identification, finding local solutions, monitoring, and technical assistance shall remain the same as described in earlier documents on RMNCH+A. Detailed Operational Guidelines for each of the approaches proposed here are either already available under NHM or are in the process of being developed and should be referred to for planning and implementation purposes.

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EXECUTIVE SUMMARY

Maternal, Newborn and Child Survival has been accorded high priority in the National Health Policy 2017 to achieve Sustainable Development Goals. During the MDG period (1990-2015) a faster and higher decline in both child and maternal mortality was witnessed as compared to global average. However inequities exist across states and districts resulting in higher burden of maternal and child mortality in these sites. Nine states (Assam+EAG states) account for 86% maternal and 70% of child deaths each year. Further 102 districts in these 9 states have been designated as high priority districts based on weak MCH indicators where focused action is required to accelerate decline in mortality rates. This document presents an intensification plan for 102 districts in nine states based on analysis of key MNCH service delivery indicators from NFHS 4 (2015-16).

Intensification plan proposes three supplementary approaches for these districts in addition to strengthening ongoing RMNCH+A activities. The approaches are (1) introduction of dedicated midwifery services for family planning, maternal, newborn and child health; (2) augmenting quality of facility based MNCH services (*Labour room Quality Improvement Initiative [LaQshya], labour room strengthening, emergency care for children and family participatory care for newborns*); and (3) implementation of extended community based care (*home based extended infant care, follow up of sick and small newborns in infancy*). The plan includes provision for integrated training package for maternal, newborn and child health for providers and demand generation activities such as intensified campaigns and BCC activities at all levels of the health system. Results based monitoring in 102 districts is integral to the plan and it will be carried out through creation of district specific score card.

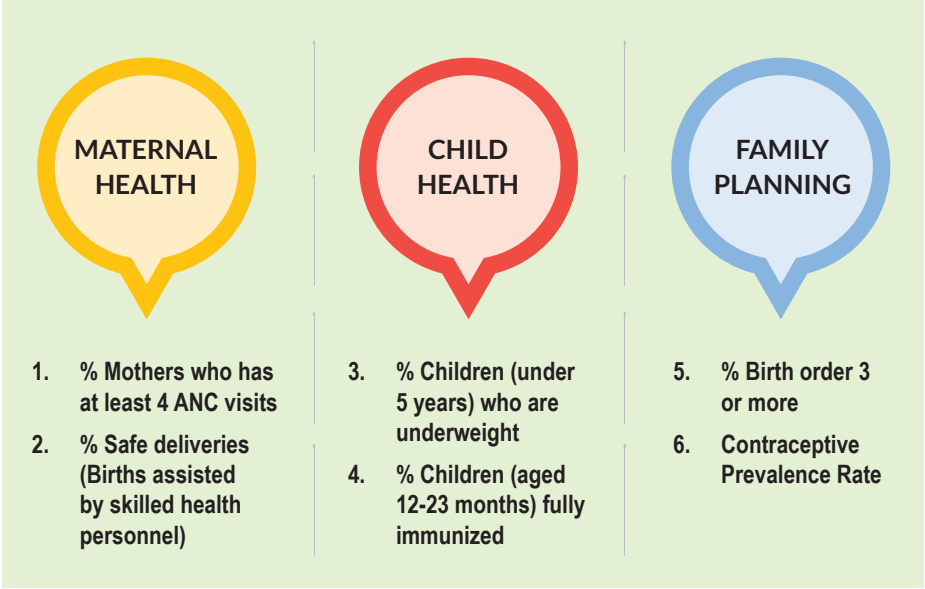
In order to implement this plan, additional funds and technical support by development partners shall provide the required impetus to this plan for next few years.

I.

BACKGROUND

RMNCH+A strategic approach was launched in 2013 to address the major causes of maternal and child mortality as well as the delays in accessing and utilizing health care and services. The RMNCH+A strategic approach focused on providing 'continuum of care' across the life stages and reaching out to most vulnerable and disadvantaged population groups in the country. Under this strategy, 184 High priority Districts were identified for implementation of focused health care interventions under National Health Mission. These districts were identified based on District Level Household Survey (III) and Annual Health Survey (Round II).

Recently, National Family Health Survey 4 was conducted in 2015-16 which provides comprehensive information of progress made at national, state and district level on various indicators of population, health & nutrition. Based on the information available from NFHS 4, a composite index, as a means of identifying progress of districts on RCH indicators has been prepared comprising of following indicators:



Based on this composite index, a total of 161 districts are placed in < 25% quintile (bottom 25%).

Another 48 districts have been identified from the previous list of HPDs (identified in 2013, based on AHS data) which are placed in 25-50% quintile.

Thus a total of 209 districts are now designated as HPDs in 2017. Of these 209 districts, 148 are those that were also included in the list of HPDs in 2013.

The details of 102 HPDs in EAG states +Assam and 209 districts (across the country) is placed in Annexure.

In order to intensify efforts for improving MCH outcomes, it has been proposed to augment interventions in 8 EAG + Assam which account for 102 out of 209 districts. The detailed intensification plan is described in subsequent pages. This plan is in continuation of the Guidance note for implementation of RMNCH+A shared in 2013. The revised list of high priority districts along with supplementary approaches for service delivery has been provided in this document. The goal & targets of the intensification plan shall be achieved by implementation of supplementary approaches in addition to ongoing RMNCH+A activities.

II.

INTRODUCTION

The National Health Policy (NHP) 2017 accords highest priority to improving maternal and child survival and nutrition. This policy is a step in direction of meeting the Sustainable Development Goals (SDG) commitments (Table-1). Accelerating progress towards SDGs necessitates intensification of efforts for maternal and child survival in specific geographic areas.

India witnessed a higher decline in maternal and child mortality compared to global averages since the inception of National Health Mission (NHM). Adoption of the RMNCH+A strategy provided further impetus by establishing a strong platform for implementing a continuum of care approach. With the NHP 2017 in place, there is an unprecedented opportunity to build upon the gains made in the last ten years.

Table 1: Maternal & Child mortality: Decadal change and future targets

Ratio	2005	2015	NHP targets	SDG target
MMR	280 *	167**	100 (by 2020)	70
U5MR	75 *	43***	23 (by 2025)	25

*United Nations. MDGs Indicators Database ** SRS 2011-13, ***SRS 2015

While significant progress has been made, inequities in health outcomes continue to persist across states and districts. The challenge is to address the high burden of maternal mortality (44,400 deaths; 2011-2013) and child mortality (1.08 million deaths; 2015) every year. A key strategy to accelerate progress on maternal and child survival is the differential focus on underperforming districts identified under NHM.

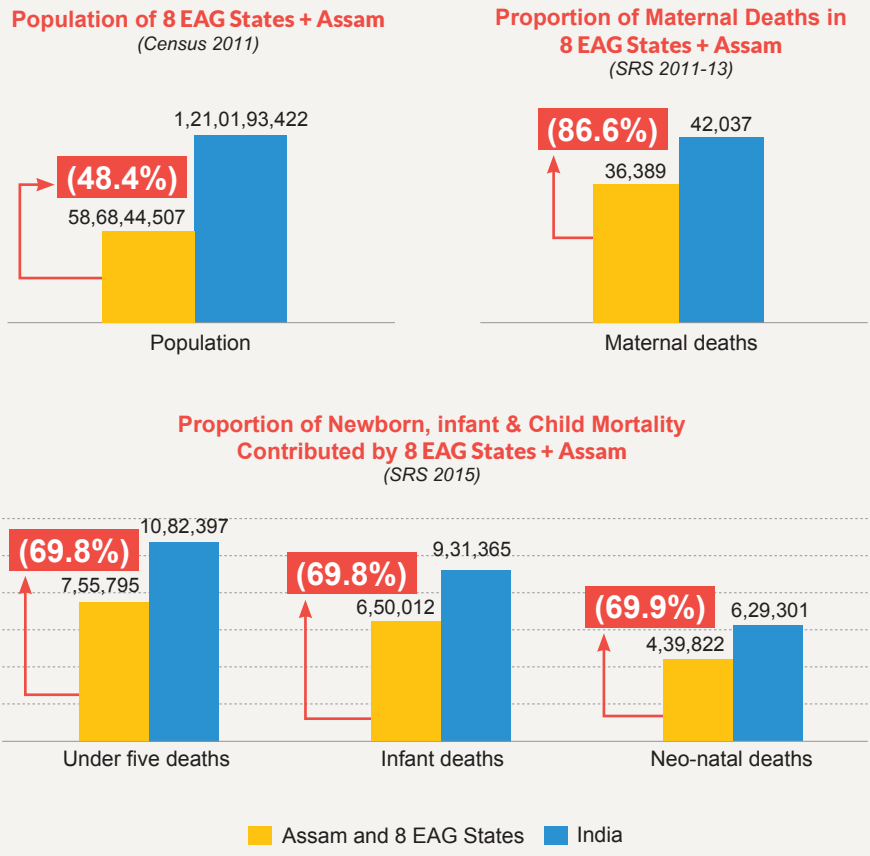
This document describes the plan for further intensifying maternal and child survival efforts in 102 high priority districts in order to achieve the NHP 2017 and SDGs & targets.

III.

SITUATION ANALYSIS

As per the recent reports (SRS), 9 states (EAG States and Assam) currently account for 36,390 maternal deaths (86%) and 756,000 (70%) of under five deaths each year (Annexure-1).

Graph 1:
Proportion of total mortality contributed by EAG states & Assam



The analysis of trends in decline in mortality shows that a higher average annual rate of reduction (AaRR) of 6.2% of MMR and the current rate of reduction of 6.1% for U5MR must be sustained nationally in order to reach the NHP 2017 goals.

However 9 states (EAG States & Assam) will need to accelerate significantly over the current rates for achieving the national goals as shown in the table 2 below.

Table 2: Current and desired annual rates of reduction for achieving NHP 2017 targets

States	MMR		U5MR	
	Current AaRR (SRS 2007-09 to 2011-13)	Required AaRR (100 by 2020; NHP 2017)	Current AaRR (SRS 2010-2015)	Required AaRR (23 by 2025; NHP 2017)
India	**5.8%**	**6.2%**	**6.1%**	**6.1%**
Assam	6.3%	12.8%	5.7%	9.4%
Bihar	5.5%	8.7%	5.6%	7.1%
Chhattisgarh	4.8%	9.4%	4.7%	7.1%
Jharkhand	5.5%	8.7%	7.9%	5.2%*
Madhya Pradesh	4.8%	9.4%	5.4%	9.4%
Odisha	3.7%	9.5%	6.4%	8.5%
Rajasthan	6.4%	10.6%	6.2%	7.5%
Uttar Pradesh	5.6%	12.3%	8.4%	7.7%*
Uttarakhand	5.6%	12.3%	na	4.9%

** These two states are currently experiencing higher decline as they started from high mortality rates; subsequently it will be challenging to sustain the projected AaRR when starting at lower levels of mortality.*

Based on six critical MCH indicators, 209 districts (Annexure-2) at the lowest quintile of composite health index have been identified across the country. In order to intensify efforts for improving MCH outcomes, it is proposed to focus on 102 high priority districts (HPD) of 8 EAG states and Assam as these account for higher mortality burden (Annexure-3).

A comparative analysis of 102 HPDs based on NFHS 4 (2015-16) provides an insight into the implementation status of key MNCH services (Table 3). It shows that coverage of many essential interventions remains much below the national average and is variable across districts.

Table 3: Variation in coverage of key MNCH interventions across 102 high priority districts (NFHS 4)			
Sr. No	**Indicators**	**National Average (including 102 HPDs)**	**Number of HPDs performing below national average (out of total 102)**
1	Current use of IUD/PPIUD (in currently married women age 15–49 years) (%)	1.5	77
2	Unmet need for spacing (%)	5.7	73
3	Mothers who had at least 4 antenatal care visits (%)	51.2	91
4	Mothers who had full antenatal care (%)	21.0	96
5	Registered pregnancies for which the mother received Mother and Child Protection (MCP) (%)	89.3	61
6	Institutional births (%)	78.9	88
7	Births in a public health facility delivered by caesarean section (%)	11.9	98
8	Children under age 3 years breastfed within one hour of birth (%)	41.6	72
9	Children under age 6 months exclusively breastfed (%)	54.9	40
10	#Children age 6-8 months receiving solid or semi-solid food and breast milk (%)	42.7	38 (out of 46)
11	Children under 5 years who are severely wasted (weight-for-height) (%)	7.5	53
12	Children under 5 years who are underweight (weight-for-age) (%)	35.7	86
13	Children age 6-59 months who are anaemic (<11.0 g/dl) (%)	58.4	67
14	Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)	62.0	78
15	Children with diarrhoea in the last 2 weeks who received oral rehydration salts (ORS) (%)	50.6	48
16	Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility (%)	73.2	71

Source: National Family Health Survey-4, 2015-16

#Data available for 46 districts only

High Priority Districts (HPDs) have higher prevalence of underweight & anaemia and lower rates of full immunization, ORS use and access for ARI treatment. This calls for innovative approach to community based interventions including interpersonal communication to bring about change in child caring practices and demand generation for related services.

An overwhelming number of HPDs had antenatal care coverage below national average and institutional deliveries remained low. There were gaps in access to contraceptive services, with HPDs having a lower current use rate for IUCD and higher unmet need for contraceptives. Amongst those who reached the health facilities, there are missed opportunities for PPIUCD. Accessible midwifery services can improve provision of antenatal & postnatal care and increase acceptance of spacing methods.

Almost all high priority districts have inadequate provision for comprehensive emergency obstetric services (low rates of caesarean section). Improving quality of care by strengthening identified health facilities in the HPDs is required so as to ensure access to timely and appropriate care for women, newborns and children who are likely to face a higher prevalence of disease and adverse outcomes of common childhood illnesses as well as closely spaced pregnancies.

Health providers currently positioned in HPDs could benefit from strategic skill building through focused and customized training, especially focusing on the time period during and around birth.

IV.

APPROACH FOR IMPLEMENTATION

Goal

To improve maternal and child health outcomes in 102 high priority districts through intensification of maternal, newborn and child health interventions by introducing innovative service delivery approaches and provision for requisite technical support with focus on coverage and quality.

Targets

- 90% antenatal care coverage for pregnant women
- 90% skilled attendance at birth
- At least 10% contraceptive use rate
- 80% infants 0-6 months are exclusively breastfed
- 80% all low birth weight infants receive extended home based care
- More than 90% newborns are fully immunized by one year of age
- 60% families practice hand washing and provide appropriate feeding and care for development for children 0-23 months of age
- 90% children with acute diarrhoea are treated with ORT (including ORS where indicated) and continued feeding
- At least 70% cases of suspected pneumonia (in children under five years) are treated with antibiotics recommended under the national program.

The goal & targets of the intensification plan shall be achieved by implementation of following supplementary approaches in addition to ongoing RMNCH+A activities.

Supplementary approaches
A. Provision of midwifery services
B. Augmented facility based MNCH services
C. Extended community based approach

District specific need assessment shall be carried out. Actions in these districts will be tailored according to the major causes of maternal and child mortality as well as the major gaps in health systems and service delivery.

Disparities between sub populations shall be progressively minimized through interventions designed to reach all marginalized groups. Special focus on the girl child will be ensured in all interventions.

Following guiding principles of National Health Policy 2017 shall be adopted for the implementation of this plan:

- **Equitable & universal access**
- **Reducing 'out of pocket' expenses**
- **Empowerment of family**
- **Quality of Care**
- **Innovation**
- **Partnerships**

A. Provision of midwifery services

Introduction of Public Health Midwife (PHM) is an approach to enhance access and delivery of quality maternal and newborn services in remote and inaccessible areas. Situation analysis (NFHS 4) shows that in HPDs full coverage of antenatal care and tracking of high risk pregnancies is a cause of concern. Number of women delivering at health institutions is much lower in HPDs and there is a lack of quality of care at and around the time of birth.

A dedicated Public Health Midwifery-led model of care around birth is envisaged for bringing about improvement in quality of maternal and newborn services in high priority districts that have many remote and inaccessible areas. The midwife is visualised as the cornerstone of providing professional care and advice for women, thus enhancing the efficiency and effectiveness of maternal and newborn care service delivery in the health system.

The role of midwives would be to provide antenatal services including quality counselling during antenatal period, track each pregnant women and develop micro birth plan for each delivery, conduct normal and assisted deliveries in her geographic area, consult with and make appropriate referrals to obstetricians when required and provide essential newborn care. They would be provided with mobility facility such as a moped for easy commutation for tracking and follow up of pregnant women and high risk newborns.

The Midwives shall be equipped with relevant skills through dedicated training. The model for deployment of Midwives and their work allocation will be based

on the principle of provision of round-the-clock intra-partum services and daily fixed time ANC and newborn care services. Full Antenatal care and post-partum follow up services including daily fixed time O.P.D services and field visits would be provided by Midwife. Delivery points where midwife is positioned shall offer care for normal and assisted deliveries and for healthy newborns.

With the introduction of midwives who have greater mobility in their designated area, some of the interventions that have so far lagged in terms of implementation will find the much necessary impetus. This includes the use of antenatal corticosteroids in cases of preterm labour, use of antibiotic (amoxicillin & gentamycin) in infants (0-2 months) with suspected sepsis and advanced distribution of misoprostol tablets to prevent PPH in home deliveries.

To provide support to the State health Departments to undertake training, recruitment and accreditation of Midwives, a Nursing Coordination Unit under National Health Mission is recommended for each state. The plan for roll out of midwifery cadre will be technically supported under the intensification plan for HPDs.

B. Augmented facility based MNCH services

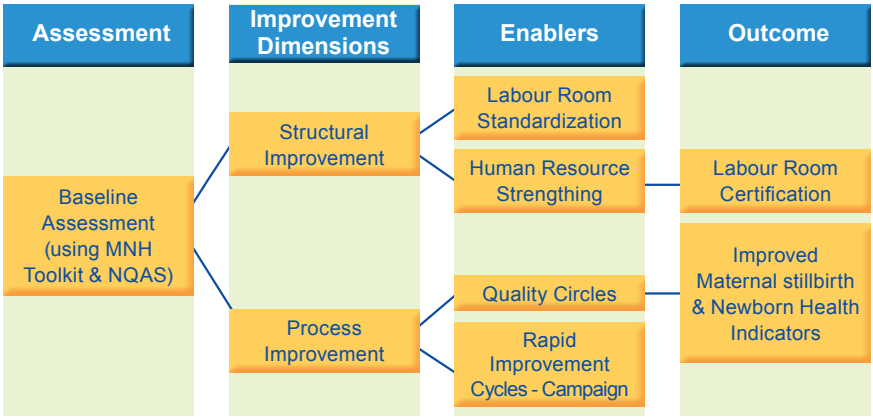
B1. Labour room quality improvement initiative (LaQshya)

The number of institutional deliveries have increased substantially without commensurate improvements in the preventable maternal and newborn morbidity and mortality. The first day of birth continues to pose the greatest risk for still births, maternal and new-born deaths. This underlines the need for a transformational change in the processes related to quality of care on the day of delivery, including intrapartum and immediate postpartum period care. LaQshya is envisaged as the initiative to bring about intensified focus on all processes related to intrapartum and immediate post-partum care. This will include the re-organisation of labour room to facilitate natural birthing process, enable adherence to quality standards and clinical protocols; thus reducing preventable maternal and newborn mortality and morbidity, stillbirths associated with care around delivery- in labour room and Maternity OT, and ensure respectful maternity care.

Structural improvement in the Labour Room will be achieved through upgrading the infrastructure and equipment as per Government of India guidelines and bridging the Human Resource gaps with financial support under the NHM & from State budget.

Meticulous adherence to clinical protocols for delivery of ‘zero-defect’ clinical

Components of LaQshya: QoC in Labour Room



care shall be one of the key aspects. Competent and committed professional teams at National, state and district level shall provide supportive supervision and mentoring to all identified facilities. Dedicated teams at labour room (quality circle) and coaching team (external multidisciplinary team, responsible for mentoring labour rooms) would work together on solving problems and taking all possible actions for the gap-closure in 'campaign mode'. Continuous measurement of target linked quality indicators would be undertaken along with systematic audit of all cases of maternal/ infant deaths, stillbirth, and maternal near miss etc., by various mentoring teams.

In the first phase, labour room improvement initiative will be undertaken in (1) All government medical college hospitals; (2) All District Hospitals & equivalent & (3) All designated FRUs and high case load CHCs and particularly with high rates of mortality. Based on Gap analysis, states shall be able to request for allocation of funds in relevant financial heads through NHM PIPs including proposals for strengthening LR in medical colleges.

One important aim of LaQshya will be to ensure that all labour rooms meet the National Quality Assurance Standards (NQAS). It is envisaged that within 6 months all labour rooms taken in for this initiative will achieve at least 70% score on labour room checklist and apply for external assessment (valid for 3 years & subject to annual verification). National Health System Resource Centre (NHSRC) would coordinate all relevant quality certification activities. Labour rooms will be provided badges based on the quality score they achieved in state level assessment thus branding of the labour rooms. Besides certification, teams of Labour rooms and related OTs could be given incentives on achievement of National Quality Certification.

Detailed description of the approach, implementation plan and target linked quality indicators are provided in a separate document.

B2. Strengthening labour room practices

While the proportion of women delivering at health facilities has increased significantly, the decline in maternal and newborn mortality has not been commensurate. Considering that 80% of pregnant women are under institutional care (nationally as per NFHS 4) at the time of childbirth, there is an opportunity to provide standard evidence-based care to mothers and children. Majority of causes of both maternal and newborn mortality are preventable through appropriate care of mothers during labour and birth, and appropriate care of newborn immediately after birth. An innovative package termed 'Dakshta has been developed for strengthening quality of care during the intra and immediate postpartum period.

Dakshta leads to strengthened Quality of Care during childbirth through competent and confident providers at high caseload facilities for improved adherence to highest impact practices for intrapartum and early post-partum care.

The key pillars of Dakshta initiative are:

1. Strategic skill building through focused and customized training- Strengthening competency of service providers in labour rooms through training and onsite mentorship for translation of skills into practice;
2. Ensuring Resource Availability- ensuring availability of resource necessary for essential practices;
3. Improved adherence to evidence- based practices through use of compliance tools;
4. Improved accountability through better data recording, reporting and utilization of data.

The initiative will require additional expenditure to be incurred for hiring of dedicated human resources and logistics of post-training follow-up and support, procurement of training materials, and conducting training of health workers. Additional funds will be provided for these activities under the NHM funds. Funds for ensuring adequate resources, including human resources, will need to be budgeted as routine activities as per the need of districts and facilities in respective Program Implementation Plans (PIPs).

B3. Empowering parents of sick & small newborns through Family Participatory Care (FPC)

Sick and low birth weight newborns are highly vulnerable and require careful nurturing in order to survive the neonatal period and first year of life. Increasing number of sick and small babies are being treated in the special newborn care units (SNCU) and are in need of continued care in the post neonatal period.

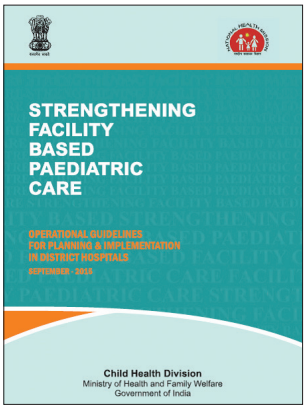
Family Participatory Care (FPC) provides a setting in which family partners with the health providers in care of their newborn. Engaged as a constant caretaker from admission until discharge, parents emerge from the SNCU experience with increased competence and confidence in infant caregiving. This forms the ground for better continuum of care for sick and small babies at home, and their overall growth and development.

Family Participatory Care intervention in newborn care units entails supervised delivery of care to hemodynamically stable, sick & preterm newborns by his / her parents-attendants in addition to the standard care provided by the nurse or doctor in the nursery. FPC has two distinct interventions which include building capacities of parents-attendants in essential newborn care through a structured programme and continuous supervision and support to parents-attendants providing care to their babies in the newborn care unit.

Under the intensification plan, the SNCUs will be made optimally functional and quality of newborn care in these units will be improved to meet the standards. FPC will be initiated and support provided to the doctors and nurses for the training and initiating the information-education programme for parents.

B4. Strengthening facility based paediatric care

Seriously ill infants and children with diarrhoea, pneumonia and fever are often referred to health care facilities. Inadequate emergency services upon patients' arrival to health care facilities contributes to high inpatient mortality rates, particularly early during hospitalization. Facility based emergency and inpatient care can bring down mortality in children who are seriously ill and referred to hospital in time. This however requires high level of preparedness at referral health facilities to receive and manage sick children and ensure quality of care.



Operational Guideline for strengthening facility based Paediatric Care at District Hospitals, 2015 provides the relevant information for planning, operationalization and monitoring of services for children at District Hospitals. It allows for positioning of adequate number of service providers for provision of paediatric care in hospital setting.

All clinical staff (doctors & nurses) should have minimum competencies including recognition of the sick or injured child, basic life support skills, the ability to initiate appropriate treatment in accordance with agreed protocols and effective communication skills.

Facility Based Care of Sick Children, 2017 package includes emergency triage assessment and treatment (ETAT) of children by nurses and doctors as well as the management of common childhood illnesses.

Under the intensification plan, the DHs and FRUs in 102 HPDs will be supported for establishing emergency care facilities and strengthen paediatric care in these hospitals and appropriately skilling the health providers.

B5. Strengthening facility based components of MAA programme

Demand generation activities for infant and young child feeding requires to be complemented with counselling and skilled lactation support and management services. Capacity building of facility level workers is important to ensure that optimal practices are incorporated in the antenatal care of pregnant women, during delivery and postnatal care and sick child contact. All these contacts are opportunities that must be capitalized upon to reinforce key messages on IYCF and support mothers when they face problems in establishing breastfeeding. As part of the approach to strengthen health facilities, providers will be adequately oriented and trained on IYCF. The focus will be on high case load facilities in the HPDs.

C. Extended community based approach

C1. Extended Home Based Infant Care (HBNC+)

Currently new-borns are followed up at home till first 6 weeks of life. There is no provision of reaching families during the critical window period when diarrhoea, malnutrition and ARI strikes in infancy.

One of the innovative approaches to improve infant nutrition, health & development is Home Based Infant Care (HBNC+) through ASHAs in 102 high priority districts. This package comprises of evidence-based interventions through incentivized structured home visits by the community health worker, ASHA at 3, 6, 9 and 12 months. It is based on the premise that Home visits by ASHA during the first 1000 days can result in targeting the key causes of childhood deaths.

ASHA to be paid an incentive per infant for these home visits. ASHA's skills to provide additional care and services to children is built over a three-day period using theory and field practice sessions. A cascade training model is used with training of trainers followed by training of ASHAs. Training packages including audio-visual tools are available for use as HBNC+ has been piloted & tested in four states.

Interventions included in the HBNC+package:

- Ensuring growth monitoring and recording it in MCP card,
- Counselling for exclusive breastfeeding till 6 months of age,
- Counselling for complementary feeding at 6 months & continued breastfeeding for at least 2 years,
- Promoting hand washing,
- Providing IFA supplementation, starting at 6 month of age,
- Providing prophylactic ORS packet to the family,
- Introducing ECD (Early Child Care & Development) through play and communication,
- Ensuring age appropriate immunization.

It is expected that HBNC+ will yield several benefits (1) those linked to behaviour change i.e. improved breastfeeding practices, hygiene practices (hand-washing), care for development (play & communication); (2) initiation of prophylactic measures i.e.; timely administration of ORS in infants with diarrhoea, IFA supplements, and (3) improved uptake of child health services under NHM/ICDS i.e.; regular growth monitoring and immunization services.

C 2. Community follow up of SNCU discharged sick newborns (SNCU+)

Special Newborn Care Units (SNCUs) have been set up countrywide as part of Government of India's Facility Based Newborn Care initiative to reduce neonatal deaths amongst small and sick newborns. Post-discharge, these infants are managed by families with limited support of community health workers (like ASHAs). Available reports point out that 6-10% newborns are dying after discharge within the first year of life.

Special Newborn Care Plus (SNCU+) package extends the continuum of care to small & sick newborns till home, with the aim to reduce mortality and improve survival and development. Three home visits are provided to newborns discharged from SNCU by trained health workers jointly (ANM +ASHA) within the first 42 days of life to ensure;

- Compliance with discharge instructions,
- Continuation of KMC and optimal feeding for LBW newborns,
- Counsel for ECD (Early Child Care & Development) through play and communication by improving sensitivity and responsiveness of mothers,
- Early identification of complications and prompt referral to health facilities.

With the introduction of midwife services in high priority districts, these vulnerable newborns can receive visits by a trained health worker (ANM or midwife) along with ASHA. This will also provide a platform for operationalizing the use of injectable gentamicin in sick new-borns when parents refuse referral. Training packages including audio-visual tools are available for use. SNCU+ is a low cost innovation and its scale up would promote KMC for preterm & LBW babies and improve quality of feeding of low birth weight infants.

V.

CAPACITY BUILDING FOR HEALTH CARE PROVIDERS

Capacity building of these healthcare providers to ensure that they are proficient with regard to both MNCH technical skills and knowledge is a key intervention. It is therefore essential that opportunities for reorientation and reinforcement of knowledge and skills are inbuilt in the health system so that the health professionals are updated regularly.

A recent initiatives is to bring about harmonization of MNCH training packages taking into account the competencies required to deliver the optimal package of services at each level of health delivery system by different cadres of health care providers. Competency Based Learning approach is being emphasized. Institutional mechanisms for health trainings are being reviewed with a view to strengthen the existing mechanisms and to identify newer platforms (such as ICT) for refresher trainings. This MNCH harmonized training packages will be used for up-skilling of health providers in HPDs.

Another initiative of the Government of India's commitment to ensure availability of quality services through public health facilities is the introduction of competency based training and certification programme to be implemented through Daksh skills laboratories. These laboratories provide a platform for augmentation of the skills of health personnel involved in the delivery of RMNCH+A services across public health institutions. The programme covers training requirements of auxiliary nurse midwives, staff nurses, medical officers and obstetricians serving in high case load public health facilities. Skills Labs serve as prototype demonstration and learning facilities for healthcare providers and focus on competency based training. Skills Labs provide the opportunity for repetitive skills practice, simulation of clinical scenarios and training under the supervision of a qualified trainer. HPDs will be prioritise and supported for establishing Skills labs as per the Skills Lab Operational Guidelines.

VI.

DEMAND GENERATION FOR MNCH SERVICES

Given the overwhelming evidence available on the impact of breastfeeding on reduction of neonatal and infant mortality and the less than optimal performance on indicators IYCF, it is imperative that efforts are intensified to improve child feeding practices.

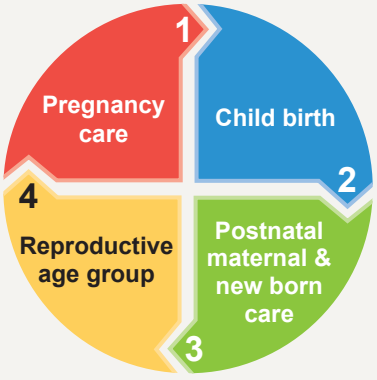
Special campaigns will be organized in the community to address the issue of anaemia malnutrition including anaemia control programme and Mission Parivaar Vikas. An enabling environment for breastfeeding through awareness generation activities, targeting pregnant and lactating mothers, family members and community will be created. ASHA will be supported to reach pregnant and lactating mothers of all under two age children for advocating ideal IYCF practices and iron supplementation in the community.

Ongoing BCC activities will be reviewed and strengthened to incorporate key messages around these issues.

VII.

MONITORING FRAMEWORK FOR INTENSIFICATION PLAN

HMIS data collected during health service delivery is critical for tracking performance and trend analysis.Under the RMNCH+A strategy, a HMIS based 'Score Card' has been developed to assess & improve the service delivery across the continuum of care. Score card assists in comparative assessment of performance of States, Districts and Sub-Districts based on a total of 16 indicators used to calculate a composite index (shown below).



1. Proportion of:

- 1st Trimester registration to total ANC registration
- Pregnant women received 3 ANC to total ANC registration
- Pregnant women given 100 IFA to total ANC registration
- Cases of pregnant women with Obstetric Complications and attended to reported deliveries
- Pregnant women receiving TT2 or Booster to total ANC registration

2. Proportion of:

- SBA attended home deliveries to total reported home deliveries
- Institutional deliveries to total ANC registration
- C-Section to reported deliveries

3. Proportion of:

- Newborns breast fed within 1 hour to total live births
- Women discharged in less than 48 hours of deliveries in public institutions to total number of deliveries In public institutions
- Newborns weighing less than 2.5 Kg to newborn weighed at birth
- Newborns visited within 24hrs. of home delivery to total reported home deliveries
- Infants 0 to 11 months old who received Measles vaccine to reported live births.

4. Proportion of:

- Post-partum sterilization to total female sterilization
- Male sterilization to total sterilization
- IUCD insertions in public plus private accredited institutions to all family planning methods (IUCD plus permanent)

With the introduction of new HMIS formats, there is an opportunity to review the score card (sample shown below) and add new indicators so that the score card covers a larger spectrum of service delivery. In addition, many of the innovative packages for service delivery may entail setting up of additional mechanisms for monitoring if not included in the score card.

Rank	District	Composite Index (2015-16)				
		Overall Index	Pregnancy care	Child Birth	Postnatal maternal & new born care	Pre Pregnancy/ Reproductive age group
1	Godda#	0.6451	0.9335	0.4994	0.6511	0.3004
2	Kodarma	0.555	0.5745	0.8223	0.5704	0.2296
3	Saraikela#	0.5396	0.7372	0.2946	0.6279	0.3082
4	Simdega#	0.5218	0.5232	0.2302	0.4115	0.995
5	Gumla#	0.4965	0.5994	0.3352	0.3771	0.6853
6	Khunti	0.4932	0.4802	0.1738	0.6081	0.6429
7	Sahibganj#	0.4883	0.5379	0.3389	0.6258	0.3257
8	Deoghar	0.4805	0.613	0.4871	0.5681	0.1073
9	Lohardaga#	0.4781	0.3491	0.435	0.4473	0.7875
10	Jamtara	0.4492	0.8072	0.2869	0.3383	0.1999
11	Ranchi	0.448	0.2609	0.4673	0.6406	0.4193
12	Pashchimi Singhbhum#	0.438	0.4428	0.1533	0.4808	0.6431
13	Dumka#	0.4319	0.5911	0.2281	0.5375	0.1946
14	Hazaribagh	0.4153	0.5543	0.4702	0.3566	0.2265
15	Giridih	0.4075	0.5249	0.4097	0.4603	0.1218
16	Chatra	0.4029	0.5387	0.0628	0.5466	0.2773
17	Latehar#	0.3961	0.3749	0.2035	0.5832	0.3122
18	Dhanbad	0.3954	0.3745	0.7625	0.3136	0.1994
19	Pakaur#	0.3839	0.5635	0.1149	0.4429	0.2551
20	Bokaro	0.3759	0.2737	0.3451	0.4544	0.4462
21	Palamu#	0.3745	0.4242	0.5343	0.4192	0.0575
22	Purbi Singhbhum	0.3656	0.1761	0.459	0.4002	0.5304
23	Ramgarh	0.3493	0.2948	0.2536	0.583	0.1463
24	Garhwa	0.2636	0.2635	0.1714	0.4243	0.0879

#: High Priority District

Data analysis and synthesis will be done at various levels of (District to health facility) for the approaches of this plan to enhance evidence based decision making. The results obtained will be summarized into a consistent assessment of the health situation and trends, using core indicators and targets to assess progress and performance and disseminated to key stakeholders (Annexure-4). The focus of analysis will be on comparing the performance at different levels and understanding the reasons for weak performance or slow progress. Service delivery data shall be packaged and displayed at the various health facilities using the HMIS formats already provided.

Star Rating of health facilities:

A system for quality certification and criteria for rating of health facilities for RMNCH+A services will be developed and linked to incentive/ awards for facilities that are certified. The programme will focus on standardization of labour rooms, SNCUs, operation theatres and post-natal ward & paediatric wards based on IPHS standards. The current system and mechanisms developed under Quality Assurance Programme would be adapted to meet the requirements for quality certification. Client-oriented, provider-efficient (COPE) services and functionality of grievance redressal system will be part of the programme.

Annexure 1: Contribution to MNCH mortality by 9 high burden states in India

States/UTs	Under 5 Deaths		Infant Deaths		Neonatal Deaths		Maternal Deaths	
	Estimated no. (2015)	Contribution to India	Estimated no. (2015)	Contribution to India	Estimated no. (2015)	Contribution to India	Estimated no. (2015)	Contribution to India
Assam	42515	3.9%	32229	3.5%	17143	2.7%	2057	4.9%
Bihar	131043	12.1%	114663	12.3%	76442	12.1%	5679	13.5%
Chhattisgarh	28442	2.6%	24294	2.6%	15998	2.5%	1309	3.1%
Jharkhand	30214	2.8%	24791	2.7%	17818	2.8%	1611	3.8%
Madhya Pradesh	114777	10.6%	92562	9.9%	62942	10.0%	4091	9.7%
Odisha	45102	4.2%	37048	4.0%	28189	4.5%	1788	4.3%
Rajasthan	85090	7.9%	73177	7.9%	51054	8.1%	4152	9.9%
Uttar Pradesh	271770	25.1%	245126	26.3%	165194	26.3%	15187	36.1%
Uttarakhand	6843	0.6%	6123	0.7%	5042	0.8%	513	1.2%
Total of 9 States	755795	69.8%	650012	69.8%	439822	69.9%	36389	86.6%
India	1082397		931365		629301		42037	

Note: *These 9 States also contributes 48% of population in India*
** Estimated number of maternal and child deaths in EAG states and India (SRS 2013; SRS 2015)*

Annexure 2: List of 209 High priority Districts in India (2017)

S. No.	Name of State	Total High Priority Districts	Name of Districts already part of 184 HPDs	Name of newly added districts
1	Andhra Pradesh	6	Kurnool, Visakhapatnam, Y.S.R.(Cuddapah), Vizianagaram	Anantapur, Chittoor
2	Arunachal Pradesh	6	Upper Subansiri, East Kameng, Kurung Kumey, Lower Subansiri, Tawang	Tirap
3	Assam	8	Karimganj, Hailakandi, Dhubri, Nagaon	Chirang, Cachar, Karbi Anglong, Goalpara
4	Bihar	13	Jamui, Saharsa, Sheohar, Kishanganj, Sitamarhi, Katihar, Purba Champaran, Gaya, Araria, Purnia	Madhubani, Madhepura, Darbhanga
5	Chhattisgarh	7	Jashpur, Dakshin Bastar (Dantewada), Bijapur, Surguja	Kabirdham, Bastar, Narayanpur
6	Delhi	2	North West	South
7	Gujarat	9	Valsad, Kachchh, Banaskantha, Panchmahal, Dohad, The Dangs, Narmada, Sabarkantha	Kheda
8	Haryana	5	Panipat, Palwal, Mewat	Faridabad, Gurgaon
9	Himachal Pradesh	4	Chamba, Lahul & Spiti	Bilaspur, Sirmaur
10	Jammu & Kashmir	6	Punch, Kishtwar, Rajouri, Ramban, Doda	Reasi
11	Jharkhand	12	Latehar, Sahibganj, Simdega, Pashchimi Singhbhum, Saraikela Kharsawan, Godda, Gumla, Pakur, Lohardaga, Palamu	Garhwa, Chatra
12	Karnataka	10	Bijapur , Gulbarga, Raichur, Koppal, Yadgir, Bellary, Gadag	Shimoga, Uttara Kannada, Chikmagalur

S. No.	Name of State	Total High Priority Districts	Name of Districts already part of 184 HPDs	Name of newly added districts
13	Kerala	4	Kasaragod, Malappuram	Alappuzha, Wayanad
14	Madhya Pradesh	16	Dindori, Chhatarpur, Shahdol, Tikamgarh, Panna, Singrauli, Barwani, Sidhi, Jhabua, Alirajpur, Mandla, Damoh, Satna	Ashoknagar, Sheopur, Vidisha
15	Maharashtra	11	Nanded, Hingoli, Jalgaon, Dhule, Nandurbar, Aurangabad, Jalna	Yavatmal, Nashik, Thane, Ahmadnagar
16	Manipur	3	Ukhrul, Tamenglong, Chandel	----
17	Meghalaya	3	Jaintia Hills, West Khasi Hills	East Garo Hills
18	Mizoram	4	Mamit, Lawngtlai, Lunglei, Saiha	----
19	Nagaland	4	Kiphire, Mon, Tuensang	Longleng
20	Odisha	10	Kandhamal, Malkangiri, Rayagada, Koraput, Nabarangapur, Gajapati, Baudh, Nuapada	Debagarh, Kendujhar
21	Punjab	5	Sangrur	Fatehgarh Sahib, Firozpur, Sahibzada Ajit Singh Nagar, Ludhiana
22	Rajasthan	10	Dhaulpur, Jalor, Udaipur, Jaisalmer, Barmer, Karauli, Banswara	Chittaurgarh, Sirohi, Bharatpur
23	Sikkim	2	West District	East District
24	Tamil Nadu	11	Tiruvannamalai, Tirunelveli, Virudhunagar, Krishnagiri, Madurai, Tiruchirappalli	Viluppuram, Nagapattinam, Ariyalur, Ramanathapuram, Thoothukkudi
25	Telangana	3	Adilabad, Mahbubnagar	Nizamabad

S. No.	Name of State	Total High Priority Districts	Name of Districts already part of 184 HPDs	Name of newly added districts
26	Tripura	2	Dhalai	North Tripura
27	Uttar Pradesh	23	Sonbhadra, Sitapur, Bara Banki, Hardoi, Shahjahanpur, Kheri, Gonda, Budaun, Kaushambi, Siddharthnagar, Shrawasti, Balrampur, Bahraich, Bareilly, Etah, Faizabad, Sant Kabir Nagar, Kanshiram Nagar	Kannauj, Auraiya, Fatehpur, Banda, Farrukhabad
28	Uttarakhand	3	Tehri Garhwal, Hardwar	Udham Singh Nagar
29	West Bengal	7	Murshidabad, Maldah, Uttar Dinajpur, Koch Bihar, South 24- Pargana	Dakshin Dinajpur, Puruliya
TOTAL		**209**	**148**	**61**

Annexure 3: List of 102 High priority Districts in EAG States and Assam identified in 2017 for intensification of MNCH activities

S. No.	Name of State	Total No. of Districts	Total High Priority Districts	Name of Worst Performing Districts
1	Assam	27	8	Dhubri
				Cachar
				Chirang
				Goalpara
				Haliakandi
				Karimganj
				Karbi Anglong
				Nagaon
2	Bihar	38	13	Araria
				Darbhanga
				Gaya
				Jamui
				Katihar
				Kishanganj
				Madhepura
				Madhubani
				Purba Champaran
				Purnia
				Saharsa
				Sheohar
				Sitamarhi
3	Chhattisgarh	27	7	Bastar
				Bijapur
				Dakshin Bastar Dantewada
				Jashpur
				Kabirdham
				Narayanpur
				Surguja
4	Jharkhand	24	12	Chatra
				Garhwa
				Godda
				Gumla
				Latehar
				Lohardaga

S. No.	Name of State	Total No. of Districts	Total High Priority Districts	Name of Worst Performing Districts
				Pakur
				Palamu
				Pashchimi Singhbhum
				Sahibganj
				Saraikela Kharsawan
				Simdega
5	Madhya Pradesh	51	16	Alirajpur
				Ashoknagar
				Barwani
				Chhatarpur
				Damoh
				Dindori
				Jhabua
				Mandla
				Panna
				Satna
				Sahdol
				Sidhi
				Singrauli
				Sheopur
				Tikamgarh
				Vidisha
6	Odisha	30	10	Baudh
				Debagarh
				Gajapati
				Kandhamal
				Kendujhar
				Koraput
				Malkangiri
				Nabaranagpur
				Naupada
				Rayagada
7	Rajasthan	33	10	Banswara
				Barmer
				Bharatpur
				Chittaurgarh
				Dhaulpur

S. No.	Name of State	Total No. of Districts	Total High Priority Districts	Name of Worst Performing Districts
				Jaisalmer
				Jalor
				Karauli
				Sirohi
				Udaipur
8	Uttar Pradesh	75	23	Auraiya
				Banda
				Bahraich
				Balrampur
				Barabanki
				Bareilly
				Badaun
				Etah
				Faizabad
				Farrukhabad
				Fatehpur
				Gonda
				Hardoi
				Kannauj
				Kanshiram Nagar
				Kaushambi
				Kheri
				Sant Kabir Nagar
				Shahjahanpur
				Shrawasti
				Siddharth Nagar
				Sitapur
				Sonbhadra
9	Uttrakhand	13	3	Tehri Garhwal
				Haridwar
				Udham Singh Nagar

Annexure 4: Results Framework for Intensification Plan for MNCH Survival in 102 HPDs

TARGET	Outcome Indicators	Process and Output Indicators	MNCH packages that will contribute towards this outcome
Reducing Fertility	1. % contraceptive use rate **T: at least 10%**	• % IUCD insertions in public and private accredited health facilities	* Public Health Midwife, * Daksh Skill Labs,
Reducing maternal, newborn and child mortality	2. % antenatal care coverage T: 90%	• % Pregnant women received full ANC check-ups to total ANC registration • % of identified pregnant women, received iron supplements/therapy as per the guidelines	* Public Health Midwife, * Daksh Skill Labs & Harmonized training packages, * Dakshata quality of care around birth, * LaQshya
	3. % skilled attendance at birth T: 90%	• % Institutional deliveries to total ANC registration • % of the labour rooms reorganized in LDR format as per labour room standardization guidelines • % of labour rooms have staffing as per defined norms • % of deliveries where safe birth checklist is used • % Increase in proportion of women with pre-eclampsia or eclampsia, who were managed successfully in the health facility without referral • % reduction in new-born asphyxia rates attributed to labour room • % increase in Breast Feeding within 1 hour	

TARGET	Outcome Indicators	Process and Output Indicators	MNCH packages that will contribute towards this outcome
	4. % of infants 0-6 months are exclusively breastfed **T: 80%**	• No of health providers oriented on IYCF	* Public Health Midwife, * Family Participatory Care, * Follow up of SNCU discharged babies, LBW babies * Extended home based infant care, * MAA campaign,
	5. % of all infants receive community based essential care **T: 80%**	• Number of district SNCUs where FPC provided • % of newborns discharged from SNCUs received home visits during newborn period • % Eligible newborn received KMC • % of identified children under five received iron supplements/therapy as per the guidelines	
	6. % of all low birth weight infants receive extra care **T: 80%**		
	7. % of the newborn are fully immunized by one year of age **T: More than 90%**	• No of districts covered under mission Indradhanush	* Extended home based infant care * MAA campaign,
	8. % of the families practice hand washing **T: 60%**	• % blocks covered by comprehensive IEC campaign	
	9. Children 6-8 months receiving complementary feeding and breast milk **T: 60%**	• No of health providers oriented on IYCF	

TARGET	Outcome Indicators	Process and Output Indicators	MNCH packages that will contribute towards this outcome
	10. % of children with acute diarrhoea are treated with ORT (including ORS where indicated) and continued feeding **T: 90%**	• % of children received prophylactic ORS packets	
	11. % of cases of suspected pneumonia are treated with antibiotics recommended by the national program **T: At least 70%**	• Number of district health facilities where pediatric emergency care services are available.	* Facility based Paediatric care and ETAT. * Skill Labs & Harmonized training packages

ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infections
ANC	Antenatal Care
ASHA	Accredited Social Health Activist
AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
AaRR	Average annual Rate of Reduction
BCC	Behaviour Change Communication
DH	District Hospital
EAG	Empowered Action Group
ECD	Early Child Development
ENC	Essential Newborn Care
ETAT	Emergency Triage & Treatment
FPC	Family Participatory Care
FRU	First Referral Unit
HBNC	Home based Newborn Care
HMIS	Health Management Information System
HPD	High Priority District
ICDS	Integrated Child Development Services
IEC	Information Education and Communication
IFA	Iron Folic Acid
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IUCD	Intrauterine Contraceptive Devise
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
LWE	Left Wing Extremism

MCH	Maternal and Child Health
MDG	Millennium Development Goal
MAA	Mothers Absolute Affection
MNCH	Maternal, Newborn & Child Health
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
NBSU	Newborn Stabilization Unit
NFHS	National Family Health Survey
NHM	National Health Mission
NHP	National Health Policy
NHSRC	National Health System Resource Centre
NIPI	Norway India Partnership Initiative
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PPIUCD	Post-Partum Intrauterine contraceptive devise
RMNCH+A	Reproductive, Maternal, New born, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SRS	Sample Registration System
SNCU	Special Newborn Care Unit
TT	Tetanus Toxoid
UIP	Universal Immunisation Programme
U5MR	Under-five Mortality Rate
WHO	World Health Organization