

VRIDDHI PROJECT

Improving Maternal, Newborn,
and Child Health in India

MARCH 2018



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Introduction

The Scaling Up Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) Interventions project, also known as “Vridhhi,” is a United States Agency for International Development (USAID)-supported, four-year initiative (2014-2018) led by IPE Global (IPEG), with JSI, Jhpiego, and Save the Children as consortium partners. The project’s mandate is to support the scale-up of high impact RMNCH+A interventions through innovative programming and by working closely with the Ministry of Health and Family Welfare, the National Health Mission (NHM), and state governments. While the focus of the project is on the six priority states allocated to USAID by the Government of India – Jharkhand, Uttarakhand, Punjab, Haryana, Himachal Pradesh, and Delhi – USAID’s expectation is that the project’s models of successful scale-up and innovations will influence national policies and programs. As such, this unique project is in a pivotal position to assist the Government of India in convening states and partners to accelerate the RMNCH+A agenda aimed at Ending Preventable Child and Maternal Deaths (EPCMD).

Vridhhi has an unprecedented opportunity to assist the Government of India in taking its RMNCH+A programming to scale. IPEG made a strong beginning towards these efforts by placing district-level staff in all High Priority Districts (HPDs) in the six USAID-led states, as well as at the state and national levels. In the initial project phase, IPEG was to provide overall leadership and management of the project, and technical programming was assigned to partners, including child health (assigned to JSI), newborn health, and maternal health and family planning. This aligned well with the USAID Forward Policy, which calls for leadership among national organizations with

The program accomplished these objectives through three program components: demonstration models for Kangaroo Mother Care (KMC), demonstration models for community management of neonatal sepsis and home-based newborn care (HBNC), and strengthening private sector engagement.



additional partners providing cutting edge technical expertise according to technical strengths and country needs. It also provided continuity with the former Maternal and Child Health Integrated Program (MCHIP) consortium, which was led by JSI and staffed by JSI, Save the Children, and Jhpiego. Unfortunately, due to unforeseeable circumstances, some partners were unable to provide technical support in maternal and newborn health and family planning, leaving an urgent need to strengthen the project's technical leadership in these areas to achieve the project's objectives. After several rounds of discussion between IPEG and JSI, and with USAID's encouragement, IPEG formally asked JSI to play an expanded technical leadership role in maternal, newborn, and child health (MNCH). In consensus with IPEG and USAID, JSI focused its efforts on demonstrating high-impact newborn health interventions in two districts and to develop a strategic roadmap to engage the private health sector to improve RMNCH+A services.

The program accomplished these objectives through three program components: 1) demonstration models for Kangaroo

Mother Care (KMC), 2) demonstration models for community management of neonatal sepsis and home-based newborn care (HBNC), and 3) strengthening private sector engagement. By working with local actors at the district and block levels to develop demonstration models, and collaborating with key stakeholders across the public and private sectors to identify opportunities for private sector engagement, Vriddhi generated evidence for what was needed to take these approaches to scale. Lessons learned from these activities were then shared with key actors at the state and national levels, leading to strategy development, scale up, and ultimately improved RMNCH+A service delivery.

Throughout this process, JSI works continuously with government counterparts at national and state levels to advocate for the inclusion of high-impact RMNCH+A interventions in policies and budgets and to strengthen local and national health systems, ensuring the integration and sustainability of these approaches in government policies and systems for years to come.

USAID priority states in which Vriddhi works

Punjab

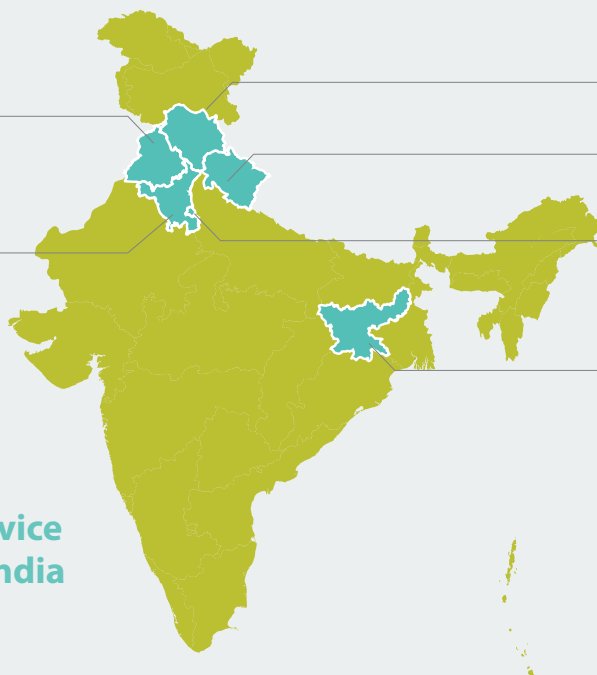
Haryana

Himachal Pradesh

Uttarakhand

Delhi

Jharkhand



Though Vriddhi, JSI strengthens RMNCH+A service delivery and outcomes in India through three initiatives:

1) creating sustainable, effective demonstration models for successful implementation of newborn care interventions to inform nationwide strategies for scale up;

2) facilitating and strengthening public and private sector coordination and engagement for efficient delivery of high-impact RMNCH+A interventions; and

3) advocating for high-impact RMNCH+A interventions at the national and state levels.

Program Component: Kangaroo Mother Care (KMC) Demonstration Model

RATIONALE

Half of the 80 newborns that die every hour in India are born either premature or with low birth weight (LBW).¹ KMC is a proven intervention to reduce early neonatal mortality among preterm and LBW newborns through skin-to-skin contact with caregivers, leading to reduced incidence of hypothermia and infections and improved breastfeeding. The Government of India released KMC guidelines in 2014. While sporadic efforts were made to initiate KMC in large hospitals in some states, there was no plan for nationwide roll out of KMC services, and implementation was limited in most north Indian states. Under Vriddhi, JSI provided technical assistance for KMC introduction and scale up in government district hospitals in HPDs.

APPROACH

Key stakeholders selected two facilities in two HPDs, one in Uttarakhand and one in Jharkhand, to serve as KMC demonstration sites. While these facilities led KMC introduction and implementation, JSI supported these facilities to embed a KMC policy, identify needed infrastructure and supplies, train relevant staff on KMC and counselling techniques, and

KMC is a proven intervention to reduce early neonatal mortality among preterm and LBW newborns through skin-to-skin contact with caregivers, leading to reduced incidence of hypothermia and infections and improved breastfeeding.

¹ Fadel, S.A., Rasaily, R., Awasthi, S., Begum, R., Black, R.E., Gelband, H., Jha, P. (2017). Changes in cause-specific neonatal and 1–59-month child mortality in India from 2000 to 2015: a nationally representative survey. *The Lancet*, 390(10106), 1972–1980.



establish a patient flow for KMC. Through this process, KMC was institutionalized in the facilities and JSI identified key recommendations to overcome barriers to scale.

These findings were discussed at a national dissemination meeting with public and private sector stakeholders from across the country. With findings from the dissemination workshop and pilot implementation, JSI developed a strategy to scale up this KMC model and conducted trainings to scale up the approach.

RESULTS, OUTCOMES, AND IMPACT

- 1. Lifesaving KMC care provided to 300 babies to date, with coverage steadily increasing.** Both health providers and families see the benefit of KMC, and KMC coverage is steadily increasing as it becomes part of routine care in the demonstration sites. An internal assessment indicates that mothers were happy to continue KMC at home after discharge from facilities and provided KMC at home for 4 hours a day. These infants were more likely to have better weight gain, better bonding with mothers, and less frequent illness than other sick or small newborns not receiving KMC.
- 2. Scale up initiated in Jharkhand and Uttarakhand.** With sustained advocacy from Vriddhi, the state governments of Uttarakhand and Jharkhand have endorsed scale-up of KMC at all district hospitals state-wide under the technical guidance of Vriddhi.
- 3. Evidence-based national policy and planning initiated.** Vriddhi partners have been nominated by the Government of India to serve on the National Technical Advisory Group for KMC, creating a policy platform for the project to support and inform the roll out of KMC country-wide.
- 4. Monitoring system for KMC established.** The government developed a coverage indicator for KMC, but use in facilities was limited. JSI developed systems to record KMC service provision in a written register and in computerized records, and worked with the HPDs and Government of India to roll out this monitoring system in the pilot facilities. With lessons learned from using these forms at the demonstration sites, these improved systems can now be used in facilities across India to track KMC coverage and duration and continuously improve newborn care.

Scale up has the potential to reach nearly 550,000 small babies annually with KMC. The intervention will be initiated in 10 existing Sick Newborn Care Units (SNCUs) as well as 13 new SNCUs in these states, and will be further scaled up to include more than 30 Newborn Stabilization Units and Post Natal Care wards. Institutionalizing KMC in these units will lead to improved weight gain and reduced infections among small and sick newborns, thereby substantially reducing costs incurred by the facility and family to provide care for these newborns and ultimately helping India achieve targets for Sustainable Development Goal 3.

CHALLENGES AND LESSONS LEARNED

KMC services can be initiated relatively rapidly using available resources at a district hospital, with minimal external support. The main elements needed to implement KMC in a facility are policy and finances (a facility KMC policy and funding to support renovation and recurrent costs), infrastructure (private spaces near the SNCU with reclining chairs or adjustable beds), and capacity strengthening (training, monitoring tools, and supportive supervision). While JSI and the Government of India provided significant support for capacity strengthening, each hospital facility was largely independent in ensuring the necessary infrastructure, policies, and finances to implement KMC. This approach tested the model in routine hospital conditions using available resources, thus ensuring the sustainability and replicability of the model for scale-up.

IMPLEMENTATION AT DEMONSTRATION SITES

CAPACITY BUILDING



300 field workers



50 doctors and nurses

SUPPORTIVE SUPERVISION



4 visits per month by experts

LOGISTICS AND SUPPLY CHAIN MANAGEMENT



2 hospitals with appropriate materials for KMC services

DATA FOR DECISION MAKING



Recording and reporting forms developed



300 BABIES PROVIDED KMC IN A YEAR



SCALE UP WILL BENEFIT **550,000** SMALL BABIES PER YEAR



COMMUNITY SUPPORT IS CRUCIAL FOR CONTINUING KMC

In a small village in Uttarakhand, Asha Devi, an Accredited Social Health Activist (ASHA), calls for an ambulance for her neighbor, Seema, who has gone into labor and needs to reach Chain Rai Womens' Hospital. Within an hour, Seema and Asha arrive at the facility, 19 miles away from home. Being an ASHA – ray of hope – is in Asha's name. Over the last three years, she has linked several pregnant women in her village of Jwalapur to the local Auxiliary Nurse Midwife (ANM) and hospital, ensuring that these women are able to seek and access maternity and newborn care.

While the delivery goes well, Seema's baby has a low birth weight, weighing only 1800 grams. The baby is admitted to the SNCU, where Seema receives counselling from the hospital's KMC counsellor and nurses and initiates KMC. She remembers the advice of the counsellor and nurses – *Aisa karne se wazan badega, bacha swasthya rahega* (KMC will ensure adequate weight gain and keep the baby healthy) – and continues to provide KMC for her newborn. After two days in the postnatal ward and three days in the KMC unit, Seema is confident that she will be able to continue KMC at home.

For the next three weeks, Seema keeps her baby in a KMC position for five to six hours daily. While many mothers have found it difficult to continue KMC at home while caring for older children, Seema's will, the counselling she received in the facility, and Asha's regular follow-ups motivate her to continue practicing KMC. She sees rapid improvements in her baby's weight and development, and, at her second hospital follow-up visit, the baby is happy and healthy, weighing over 2200 grams.

Creating champions for KMC among facility leadership and staff is crucial for successful implementation. Initially, hospital authorities knew little about KMC and were hesitant to provide space and funds. Vridhhi generated awareness through workshops and supported facility authorities to create a KMC policy, which ensured facility ownership of KMC services. Because these facilities did not have a dedicated budget for KMC, creative and committed facility staff presented proposals to the District Health Society to secure funds for renovations, and facility leadership dedicated existing beds and chairs for KMC. To encourage facility-wide engagement in KMC, both pilot facilities adopted policies to make hospital staff accountable for ensuring all eligible newborns receive KMC and are followed-up until target outcomes are achieved.

Task shifting is an effective approach to overcome staff shortages and avoid burdening overworked staff. Staff shortages can be a barrier to implementation, as overburdened staff may not have time to prioritize KMC counselling or support. Thus, efficient use of available staff and staff motivation is crucial. In pilot facilities with few pediatricians, trained and experienced SNCU nurses were authorized to screen and shift newborns from the SNCU to the KMC area. In addition, family planning counsellors were trained and authorized as KMC counsellors, and their job descriptions were modified to include KMC counselling services. Vridhhi also streamlined record-keeping processes to save health workers' time.

Creating a supportive environment for mothers and caregivers, with significant follow-up, is crucial for sustained KMC practice. More family support is needed for mothers practicing KMC. Families must often remain with mothers for the duration of their hospital admission, posing a large financial and opportunity cost and forcing many mothers and babies to leave the facility early. Pilot facilities provided beds to mothers to practice KMC for a longer period of time in a safe and hygienic space, and families received counselling at facilities on the importance of KMC. Community support and follow-up is also crucial, including training field nurses and Accredited Social Health

Activists (ASHAs) to increase awareness of KMC in communities, complete postnatal visits, and support mothers and families to continue KMC at home.

RECOMMENDATIONS

Scaling up KMC will require the following:

- Despite the simplicity of the KMC method, health workers need at least one day of dedicated training to understand all aspects of KMC, including the correct method, duration, breastfeeding practices, and importance of counselling and follow-up support.
- Facilities should “demystify” KMC by presenting mothers and nurses with simple, doable actions that are easy to understand. In addition, the concept of KMC should be introduced to mothers before childbirth (for example, in antenatal care visits) to promote understanding of KMC.
- Counselling is a critical factor for KMC initiation, continuation, and quality. Trained counsellors can be effective in offering this service in settings where doctors and nurses have high workloads.
- To increase community engagement for KMC, KMC programs must be adapted to the local context and norms; community health workers must be oriented and trained on KMC; and community support for KMC must be generated through information, education, and communication (IEC) efforts.
- Future programming should stress the importance of follow-up health facility visits to ensure sustained practice and infant growth monitoring.
- Without demand generation, supply side-driven interventions are difficult to take to scale. Mass campaigns, as well as better use of one-to-one counselling opportunities during the antenatal and postnatal periods, are necessary to promote KMC.

Program Component: Community Management of Neonatal Sepsis & Strengthening Home-Based Newborn Care (HBNC) Demonstration Model

Through Vriddhi, JSI supported the state governments of Jharkhand and Uttarakhand to establish demonstration sites for community management of neonatal sepsis, which generated evidence for a strategy to scale up this intervention.

RATIONALE

A large proportion of neonatal deaths in India are caused by sepsis² (infection), which is often curable if detected and treated early and appropriately. A confirmed diagnosis requires laboratory tests, which are often inaccessible and time consuming, so experts have developed a set of “signs of sickness” to indicate Possible Serious Bacterial Infection (PSBI), also known as “sepsis,” in newborns. In 2014, the Government of India recommended that Auxiliary Nurse Midwives (ANM) administer antibiotics to infants with signs of sepsis to avoid treatment delays. However, the government did not yet have a strategy to roll out the intervention, and the six USAID priority states had not initiated the intervention prior to the Vriddhi project. Through Vriddhi, JSI supported the state governments of Jharkhand and Uttarakhand to establish demonstration sites for community management of neonatal sepsis, which generated evidence for a strategy to scale up this intervention. Through the same strategy, Vriddhi contributes to strengthening ASHAs in their roles for HBNC.

APPROACH

Key stakeholders selected two blocks in two HPDs, one in Uttarakhand and one in Jharkhand, to serve as demonstration sites. Through this intervention, ANMs provide the first dose of antibiotics, injectable Gentamicin and oral Amoxicillin, upon recognizing signs of sepsis, and immediately refer the infant to a hospital. In special situations, when family members refuse to take the newborn to the hospital, ANMs are permitted to complete the entire course of treatment after explaining risks to the family.

² Liu, L., Johnson, H.L., Cousens, S., Perin, J., Scott, S., Lawn, J.E., Black, R.E. (2010). Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *The Lancet*, 379(9832), 2151-2161.



Working with health system staff, JSI institutionalized a process for community management of neonatal sepsis in these blocks. To strengthen the health system to support this intervention, JSI developed a cascade training model for field workers and provided referral cards and job aids for drug dosage and treatment. JSI also supported logistics and supply chain management to ensure drug availability, and ensured the inclusion of these drugs in annual plans. Finally, JSI provided supportive supervision, developed checklists for supervisory visits, and oriented staff on using data for decision-making and program improvement. Findings from routine monitoring, assessments, and field observations are shared regularly with key officials in the national and state governments to advocate for the scale up of guidelines on PSBI treatment state-wide.

RESULTS, OUTCOMES, AND IMPACT

1. Timely identification and management of 145 babies with signs of PSBI.

Since January 2017, health workers visited nearly 3,500 newborns during HBNC home visits, identified 496 infants with signs of sickness, and referred these infants to ANMs. After further examination, ANMs suspected PSBI in 145 infants, of whom 91.7 percent accepted treatment from the ANM. The most common signs of sickness were presence of 10 or more pustules, hypo- or hyperthermia, and decreased movement. ANMs gave pre-referral Injection Gentamicin and Amoxicillin doses to these 133 infants before referring them to a public health facility. Fifty-nine percent of these families accepted referral and proceeded to public health facilities to complete treatment; 39 percent continued treatment with ANMs; and 2 percent refused treatment or went to the private sector for further treatment. Almost all babies completed the seven-day course of antibiotics and were cured (seven babies did not).

2. Appropriate management of 346 babies with local infections. Of the 496 babies identified to have signs of sickness, 346 (69.7 percent) were classified by ANMs to have signs of local infection and were given oral Amoxicillin to consume at home.

3. Adequate drugs and logistics facilitated and distributed to field workers.

The capacity of district drugs managers was built to correctly estimate the required number of doses of antibiotics and syringes needed to treat suspected PSBI cases. Further, districts were supported to access local funds to procure 3,500 doses of Injection Gentamicin and syringes for the year.

4. Scale up initiated in Jharkhand and Uttarakhand. The state governments of Uttarakhand and Jharkhand have endorsed scale-up of community management of neonatal sepsis in all 13 districts of Uttarakhand and in 24 districts of Jharkhand, under technical guidance from the Vridhhi project. Vridhhi also supported these states to include required budgets in their Annual Plan for the year 2017-18.

Continued scale up has the potential to reach more than 1,972,000 babies born in these two states per year, directly benefitting approximately 148,000 newborns with PSBI. Reaching these newborns early with treatment and referral will reduce the risk of complications and neonatal death. In addition, for families with limited access to health services, community management of sepsis in special situations provides a lifesaving alternative for newborns that would otherwise be unable to receive treatment.

CHALLENGES AND LESSONS LEARNED

Community care-seeking behavior for newborn care is closely linked to community trust in public health services. This trust needs to be developed to improve case detection and referral. An assessment of the program indicated that the area with poorer case detection and poorer uptake of referral had limited public health infrastructure and human resources, larger ANM catchment areas, and poor transport services. In addition, private sector health services thrived in

IMPLEMENTATION AT DEMONSTRATION SITES

CAPACITY BUILDING



300 field workers **10** supervisors

SUPPORTIVE SUPERVISION



2 visits per month by experts

LOGISTICS AND SUPPLY CHAIN MANAGEMENT



More than 3000 Gentamicin doses facilitated and distributed to ANM

DATA FOR DECISION MAKING



Recording and reporting forms developed



200 BABIES GIVEN ANTIBIOTICS BY COMMUNITY HEALTH WORKERS IN A YEAR



SCALE UP HAS THE POTENTIAL TO BENEFIT

1,972,000 BABIES BORN IN THESE STATES PER YEAR

this area. In effect, the community relied heavily upon traditional healers and private practitioners for newborn care, rather than seeking care from public health workers who may be better trained and are able to provide services free of charge at the doorstep. Conversely, the area with better detection and uptake of referral had a functional Community Health Center within reach, twenty-four hour access to a doctor and nurses, and better acceptance to field health workers. Social and behavior change efforts are needed in the community to increase trust in the health system, coupled with improved quality of services and infrastructure. Additionally, in areas with a stronger private sector presence, the public sector will need to coordinate more closely with private sector providers to agree upon and ensure compliance with standard treatment guidelines.

Continuous motivation and support for ANMs after training is crucial to ensure they feel comfortable administering antibiotics. While ANMs are eager to support the program and showed improved knowledge scores post-training, formal and informal support systems are critically important to meet ANMs' support and guidance needs. Lady Health Visitors and Primary Health Center Medical Officers are ANMs' first and second line supervisors, respectively. However, their time is often limited to support the high number of ANMs to which they are assigned. In addition, ANMs are often less comfortable seeking guidance from Medical Officers. Informal peer support groups emerged in pilot districts among ANMs, with less experienced ANMs calling ANMs with more experience for guidance and support. In addition, experienced ANMs now share their experiences in monthly meetings, increasing peer networks and creating an environment to address concerns. Both formal supervision, and formal and informal peer support, has been crucial to ensure ANMs are confident and motivated.

It is crucial to maintain availability and functionality of necessary equipment for screening newborns. In several places, it was found that ASHAs did not possess functional thermometers or timers. These items are crucial when identifying hyper/hypothermia and increased respiratory rate respectively, which are two critical signs of PSBI. In a few areas, ANMs were persuaded to use sub-center flexi-funds to procure and create a pool of five or six thermometers for local ASHAs to borrow and use. To compensate for the absence of timers, ASHA were encouraged to use watches or mobile phone timers to count the respiratory rates of newborns.

RECOMMENDATIONS

Scaling up community management of neonatal sepsis will require the following:

- Improved health infrastructure, functional health facilities, availability of doctors and nursing staff, easier access to health facilities, and rational distribution of field area among health workers will promote trust and faith of communities in the public health system and lead to improved case detection and treatment rates.
- A healthy partnership is needed between the existing private and public health systems to promote use of standard treatment guidelines and protocols within the private sector.
- Resources such as newborn weighing scales, thermometers, and timers are critical for case detection. If these are not being supplied in the ASHA kit or are not functional, ANMs should be encouraged to use flexi-funds (available to ANMs under the NHM) to procure this equipment when unavailable through routine logistics.
- Improve community awareness about existing government schemes for transportation of newborns to health facilities. Under the Government of India's *Janani Shishu Suraksha Yojana* (JSSK) program, transport facilities should be provided free of cost to infants up to one year of age. This scheme is not well known or adequately utilized in most places due to lack of knowledge about provisions under the scheme.
- Promote peer-to-peer learning through various platforms. Supervisory systems have traditionally been weak in the public health system. However, field workers amass a wealth of knowledge during their long career and are happy to share with their peers given the right platform and recognition. Such platforms should be systematically developed and encouraged. Information communications technology (ICT)-based platforms can also be useful.



PEER SUPPORT NETWORKS BOOST HEALTH WORKERS' CONFIDENCE TO TREAT NEONATAL SEPSIS

The first time Beena, an ANM, encountered a 14-day-old newborn who needed injectable antibiotics, she understood the meaning of facing one's fears. "I had been trained on correctly identifying babies needing injectable Gentamicin and had the protocol and the medicines with me," said Beena. "But when I saw this small baby and realized he needed injectables, I froze." Beena then turned to her mentor at the Vriddhi project. She received the guidance and assurance she needed to do the right thing—administer the injectable antibiotic before the baby's condition worsened or the family decided to consult an untrained informal health care provider.

Both informal and formal peer support structures have developed to allow ANMs to share experiences and advice. Beena reports that five of her colleagues have called her in the last few months expressing the same hesitations she initially faced when administering injectable Gentamicin. "They are generally seeking reassurance but once in a while there are questions like, '[The] baby's weight is 1.5 kgs; should injectable Gentamicin be given?' or 'What is the cut-off temperature for hypothermia?'" she said. In these instances, Beena reminds her peers about what they learned in their training, and encourages them to refer to the training materials provided by Vriddhi. In addition, ANMs like Beena, who have been successful in identifying eligible cases and administering the lifesaving injection, share their stories during monthly ANM meetings. This creates a space where other ANMs feel comfortable discussing the challenges they face and reaching out to experienced ANMs when they need support.

To mitigate gaps in support, Vriddhi informally encouraged peer support through experienced ANMs like Beena, and also worked with formal supervisors to proactively address the needs of ANMs and empower them to deliver lifesaving care in the communities they serve.

Program Component: Private Sector Engagement

RATIONALE

Private medical practitioners are preferred health service providers across the socio-economic spectrum in India, and nearly 90 percent of private health care spending is out-of-pocket.^{3,4} The Government of India has created a number of programs to involve private sector providers in RMNCH+A service delivery for low-income workers and their families, but involvement of private practitioners in these programs has been sub-optimal. As private sector practitioners are preferred providers for many Indians, increasing private sector engagement is crucial to increase access to high-quality RMNCH+A service delivery and improve RMNCH+A outcomes.

APPROACH

JSI adopted a consultative and evidence-based approach to facilitate private sector engagement through increased national and state stewardship, increased interface between the sectors, and increased awareness of public-private partnership (PPP) options among private practitioners. JSI led an independent landscaping assessment in the six US-

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3 International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.

4 Raban M.Z., Dandona R., & Dandona L. (2013). Variations in catastrophic health expenditure estimates from household surveys in India. Bulletin of the World Health Organization, 91(10), 726–735.



AID priority states to better understand current RMNCH+A service delivery practices and to identify key issues with existing partnership schemes, readiness for future collaboration, and lessons learned from earlier PPP approaches. Using a mixed-methods approach, information was gathered from over 300 respondents, including facility-based private providers, clinics, professional associations, and government and social enterprises. The results of the assessment were discussed in a national consultation involving a diverse range of participants from national and state governments, professional associations, social entrepreneurs, development partners, and donor agencies.

Vridhhi then implemented the recommendations of this consultation in the six states. These efforts included supporting the organization of PPP cells, or bodies that include both public and private sector representatives and support and facilitate the creation and coordination of PPPs. Vridhhi also identified lead coordinators from professional associations in each of the six states to: 1) facilitate private practitioner trainings on government-endorsed RMNCH+A guidelines and protocols, 2) liaise with the leadership of professional bodies to raise issues from private sector providers, and 3) promote use of the RMNCH Practitioners Forum (rmncha.in/practitioners-forum) web portal to establish it as a reference point for informed dialogue on challenges faced by private practitioners in PPPs.

RESULTS, OUTCOMES, AND IMPACT

- 1. New evidence generated on private sector RMNCH+A services.** Vridhhi's landscape assessment maps private medical practitioners across six states, including their current RMNCH+A practices as well as barriers and facilitators to PPP. This evidence can be used to strengthen PPP efforts and engagement to improve RMNCH+A outcomes. A brief capturing the findings of the landscape assessment and recommendations is available on the RMNCHA.in website and has been shared widely.
- 2. Strategy for private sector engagement supported by public and private sector leaders.** The highest administrative leadership of the Ministry of Health and Family Welfare has endorsed JSI's approach and state-specific strategy for increasing private sector engagement in RMNCH+A services. Rollout of the private sector engagement strategy has been initiated in three of the six states in partnership with state governments and professional associations. In addition, JSI secured support from the leadership of the Indian Academy of Pediatrics (IAP)/National Neonatology Forum (NNF) and the Federation of Obstetrics and Gynaecological Societies of India (FOGSI), thereby increasing its reach to a network of over 8,000 health specialists in the six states. Champions from the two professional associations are using advocacy forums and social media platforms to move the agenda forward.
- 3. Policy movement towards PPP cells initiated.** Five states have begun discussing plans for the creation of PPP cells. In addition, Delhi, Himachal Pradesh, and Uttarakhand government representatives have actively participated in Vridhhi's PPP trainings and endorsed the need for PPP cells. Further, a PPP nodal officer has been designated in Delhi, Jharkhand, and Uttarakhand.
- 4. Over 150 private medical practitioners trained in government-endorsed RMNCH+A guidelines.** Since July 2017, six state-level trainings for over 150 medical practitioners were organized in Delhi, Jharkhand, and Uttarakhand.
- 5. Attitudes toward PPP engagement shifted through peer engagement approaches.** Working through the professional association network, JSI used a peer-to-peer influencer model to increase private sector engagement. Post-trainings, private sector providers' willingness to engage in government programs has significantly increased.

LANDSCAPE ASSESSMENT OF PRIVATE SECTOR RMNCH+A SERVICES

RESPONDENTS



300 respondents from private providers, professional associations, and government

APPROACH



Mixed methods approach

LOCATION



6 states | 7 districts

RECOMMENDATIONS



4 key priority areas for PPP strategy

SCALE-UP ACROSS SIX VRIDDHI STATES



PPP coordination cells established, and private providers trained in government-endorsed RMNCH+A guidelines



PPP CELLS HAVE THE POTENTIAL TO REACH

7,000

PRIVATE PROVIDERS IN SIX STATES



CHAMPIONS FOR QUALITY OF CARE WITHIN PROFESSIONAL ASSOCIATIONS STRENGTHEN PRIVATE SECTOR ENGAGEMENT

Professional associations are a vital support system for medical practitioners and nurses to maintain standards of quality of care and safeguard professional ethics. JSI collaborates with professional associations FOGSI, IAP, and NNF to support capacity enhancement of private practitioners and advocacy with national and state governments for institutionalizing private sector engagement in improving the reach of RMNCH+A services.

Through Vridhhi, JSI has found that champions for quality of care within professional associations are crucial to strengthen private sector engagement. The strength of JSI's collaboration with professional associations lies in champions – association members who have remained committed to the cause of quality of care. At the national level, ex-presidents of FOGSI and NNF, Dr. Suchitra Pandit and Dr. Ajay Gambhir (shown above) respectively, have lent their voices for increasing private sector engagement in RMNCH+A services and improving ethical practice. They are lead trainers and advocates for JSI's current work and mobilize other members to facilitate state-level activities.

By mid-2018, through these national and state level champions, JSI will be able to establish PPP cells across six states of interest and embed these activities in the government implementation plan to strengthen the engagement of private practitioners in RMNCH+A service delivery.

Sustained investment in JSI's approach has the potential to reach nearly 7,000 private practitioners with the establishment of PPP cells in six states. These efforts will create a platform for crucial discussions between public and private sector stakeholders, spearheading efforts to improve PPPs and private sector engagement and ultimately increasing RMNCH+A service quality and access through private sector providers.

CHALLENGES AND LESSONS LEARNED

While there are a number of barriers, facilitators for PPP engagement exist and can be utilized to increase private sector engagement. Limited knowledge and limited compliance to standard treatment protocols and government guidelines, underutilization of available infrastructure and human resources, limited interest in accreditation and quality improvement initiatives, and highly variable compliance to legal regulations emerged as major competence and capability challenges in the private sector across six states. However, private practitioners' flexible payment options and a willingness to be empanelled for government schemes, provided there are grievance redressal mechanisms and safeguards against reimbursement failures, emerged as operational facilitators.

The process of knowledge sharing increases transparency and acceptability of challenges on both sides of the partnership. The findings of the landscape assessment were jointly shared in four states – Delhi, Himachal Pradesh, Jharkhand, and Uttarakhand – in meetings with the State Health Mission Directors and representatives of professional associations. This approach, creating open discussions between public and private sector providers to share successes and challenges in PPP engagement, was groundbreaking for India. While it required skilled facilitation, this open dialogue was crucial to identify key barriers and facilitators for private sector engagement. Open

dialogue and interface should be continued to regularly review and strengthen PPP efforts moving forward.

RECOMMENDATIONS

Scaling up the private sector engagement strategy will require the following:

- Both private and public sectors need to be involved in planning and review of PPP schemes and become accountable for their outcomes.
- Regular public and private interface is necessary for overcoming known challenges related to PPPs. This engagement can be facilitated through quarterly meetings with Mission Directors of State Health Missions and representatives of professional associations.
- Professional associations can improve visibility and understanding of PPP schemes among members through their websites as well as by including PPP discussion in agendas for association meetings and conferences.
- Most specialists are located in and around larger cities and towns and sub-district reach of specialists is low. However, these specialists are willing to offer consultancy services through camps and other outreach efforts, and can be engaged through these approaches moving forward.
- A dedicated techno-managerial lead is needed at the state level to customize and manage PPPs within the Health Mission.

Moving Forward

The success of each of these interventions shows strong promise for scale up across states with similar contexts to improve RMNCH+A outcomes. Demonstration states have committed to, and initiated, scale up of the demonstration models, and these interventions are already reaching newborns and saving lives. The private sector engagement strategy is also being rolled out across the USAID priority states and has already resulted in increased engagement and dialogue among private and public sector actors to improve RMNCH+A service delivery.

The program's achievements have resulted from the following keys to success, which should be continued to allow these interventions to successfully reach national scale.

- Existence of government guidelines does not imply that facilities and state and district governments are prioritizing the intervention. Guideline roll out requires strengthening all elements of the health system, including planning for budgets; strengthening policies, logistics, and information systems; human resource development; and the creation of an enabling environment. Under Vridhdhi, JSI works to strengthen all these components.
- For these interventions to be sustainable, they must be government-led and government-funded. Through the Vridhdhi model, JSI played a catalytic role to support local health systems to pilot these government-endorsed interventions within the public health system, but implementation was always led by health system actors using health system funds. This allowed JSI and government counterparts to understand and overcome barriers to implementation in the real world context to ensure sustainability and replicability when taking these approaches to scale.

- When the evidence base for an intervention is robust and from similar settings, models must shift beyond testing efficacy to test operationalization and efficiency of innovations in the local context. While high-impact interventions are well known, identifying and overcoming barriers to scale and scaling interventions through government funds was a unique and much-needed approach to support the implementation of the government's RMNCH+A strategy.
- PPPs will be crucial to ensure access to quality RMNCH+A services, and will require open and honest dialogue between sectors and continued commitment to collaboration. Vridhdhi's efforts to bring government and private sector actors together to discuss weaknesses and challenges was new and challenging, but was a crucial first step to generating open communication and dialogue to overcome barriers to collaboration.
- A consultative process involving all stakeholders takes time, but is needed to create sustained support for scale up. Through each program component, JSI facilitated a consultative process with knowledge sharing and advocacy to ensure integration within policies and support across stakeholders for long-term sustainability.
- Though essential, training alone cannot change health workers' practices and behaviors. JSI demonstrated that supportive supervision is a must until new interventions become routine practice. Peer support is critical for confidence building and should be encouraged by supervisors.
- It is important to ensure that both service providers and managers are oriented and trained. JSI oriented district and sub-district managers to new interventions, which ensured prioritization of these interventions in plans and budgets.



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