RMNCH+A Highlight Series

Capacity Building to Reduce Neonatal Mortality: On-site Training in Uttarakhand

Photo by MCHIP

"With on-site training, I could immediately put to practice what I learned in the class room; if I made any mistake, I was taught to rectify it right then and there. I will never forget what I learned."

Mrs. Vijaya Laxmi, Auxiliary Nurse Midwife, Haridwar, Uttarakhand

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India accounts for nearly 21 percent of the global burden of infant deaths and two-thirds of infant deaths occur among neonates. To address this disproportionately high mortality rate, the Government of India has developed major initiatives to support training in essential newborn care (ENC) and promote ENC by trained staff in all delivery rooms. However, traditional training methods have disadvantages that limit the effectiveness of the training. The Government of Uttarakhand, with support from the Maternal and Child Health Integrated Program (MCHIP), has introduced on-site training as an innovative and effective approach for building the capacity of health staff to manage the most common causes of newborn death.

Background

The Government of India co-convened the global Call to Action for Child Survival in 2012 with USAID, the Government of Ethiopia and UNICEF, and then hosted its own National Summit to accelerate progress toward Millennium Development Goals 4 and 5 and the health goals of the 12th Five Year Plan. A new, comprehensive Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy launched at the National Summit is currently being rolled out in all 29 states and 184 high priority districts (HPDs). MCHIP provides technical support to the MOHFW and six state governments for RMNCH+A roll out.

Regulatory infrastructure for neonatal care

The national Janani-Shishu Suraksha Karyakram (JSSK) initiative provides free, cashless services to pregnant women, including normal deliveries and caesarean sections, and to newborns up to 30 days after birth, in government health institutions. Navjaat Shishu Suraksha Karyakram (NSSK), a 2009 initiative of the Ministry of Health and Family Welfare (MOHFW), provides training on essential newborn care (ENC) including resuscitation of newborns. NSSK's goal is to ensure that providers trained in newborn care and resuscitation are available at every birth. In addition to resuscitation, NSSK mandates training in evidence-based approaches for critical neonatal care, including prevention

of hypothermia and infection and initiation of breastfeeding, and for a wide range of critical health care providers–medical officers, auxiliary nurse midwives, and staff nurses at district hospitals, community health centers, and primary health centers.

The GoI's RMNCH+A strategy promotes newborn health as part of the effort to provide comprehensive care to women and children from pregnancy through the transition to adulthood. Key RMNCH+A approaches are to train providers in basic newborn care, through NSSK, and to establish functional newborn care corners at all delivery points. The overall aim is to promote immediate routine newborn care, including drying, skin-to-skin contact, and initiation of breastfeeding within one hour of life. These approaches---saturating all delivery points with skilled birth attendants and NSSK-trained personnel, and establishing functional newborn care corners---are a high priority within RMNCH+A. The strategy also calls for the creation of linkages with Special Newborn Care Units at health facilities for newborns requiring advanced care.

Need for Capacity Building on NSSK

Staff in health facilities receive training in delivery and newborn care. However, health staff posted at delivery points often lack knowledge of essential newborn care and resuscitation. Assessments identified many challenges including insufficient numbers of Medical Officers to serve as master trainers; provider inability to travel from the workplace for training (most often due to staff shortages at the home facility); prior commitments; cultural restrictions and norms (especially regarding women's travel); and inadequate transport. Additional training challenges included the classroom method itself - *without immediate* application of new knowledge gained in training, many providers either forgot the information or were not able to put it in practice. And although pre- and post-training assessments often showed an increase in knowledge level immediately after training, there was no way to measure training effectiveness or whether participants used their new skills while conducting deliveries.

Uttarakhand State has a strong track record in maternal and child health. The Annual Health Survey 2013 rates Uttarakhand as the safest state in India for child to be born because of its relatively low infant mortality rate (IMR). However, not all districts are equal. Three of Uttarakhand's districts – Haridwar, Pauri and Tehri – have significantly higher mortality rates than the rest of the state. Their IMRs are 67, 41, and 58, and their U5MRs are 84, 48, and 70 respectively as compared to Uttarakhand's overall IMR of 34 (SRS, 2013) and U5MR of 50 (AHS, 2012). Under RMNCH+A, the MoHFW prioritized these districts for intensified efforts to improve health indicators across the state.

Adapting On-Site Training to NSSK

MCHIP advocated in Uttarakhand for on-site training as an evidence-based alternative to the traditional classroom training approach. Numerous programs have documented the advantages. For instance, during an immunization program supported by USAID, on-site training led to a significant increase in both service coverage and quality, and subsequently, to improvements in health indicators.

Holistic Approach: Additional elements of child survival that are critical, yet not covered under NSSK, were added to the training. These included an orientation on Active Management of Third Stage of Labor (AMTSL) and use of partographs. With the on-site training approach, the information could be given seamlessly in the delivery room, something that would not have been possible in a classroom setting.

Leadership of the Ministry of Health of Uttarakhand: Presented with evidence supporting on-site training, Mr. D Senthil Pandiyan, the District Magistrate, Haridwar, embraced the concept of on-site training and was instrumental in taking it forward. MCHIP worked with Government of Uttarakhand to develop a plan to pilot the on-site training in two districts, Haridwar and Dehradun.

Implementing the training

Training of Trainers (ToT): A pool of high performing staff nurses and ANMs formed the pilot group for the development of master trainers, who would provide on-site NSSK training to other healthcare providers. The first step was to hold a two-day NSSK training in two districts -. Of

the 18 participants in this training, the 10 highest performers were selected to constitute the district-level master training group (six in Haridwar and four in Dehradun).

Training: The subsequent facility-based trainings took place between December 2013 and March 2014 at all facilities where deliveries are conducted, with support from district-level master trainers and consultants from USAID partner organizations. The training agenda covered NSSK, AMTSL, partograph, and intrauterine contraceptive devices (IUCD). The training was conducted in the delivery room where best practices were demonstrated by trainers and the participants. After training was completed at each site, the master trainers held a debriefing to discuss lessons learned. In total, 43 trainings were conducted in Haridwar and Dehradun, and 98 staff nurses and ANMs were provided on-site training in the package described above.

Feedback from participants: Qualitative feedback indicated that the participants were able to recollect many of the important aspects of the training while they were conducting deliveries right after the training. This they attributed to the hands-on approach. They said that the approach was useful because it enabled immediate feedback on any mistakes they made, which allowed them to learn from their own mistakes -- mistakes that might occur in their work settings.

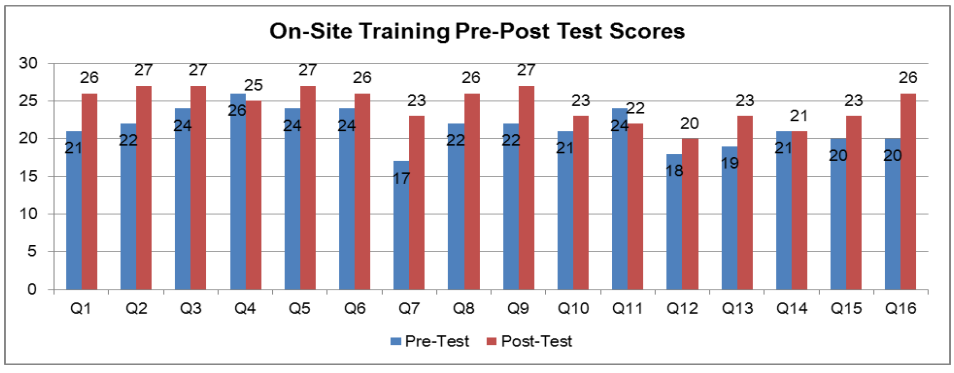
Pre- and post-test scores of participants showed improvement (see box below):

On-site training also enabled participants to raise questions related to their work and to have experienced trainers in real time on-site. This enabled the participants to increase their knowledge and learn more from the trainings, beyond the training curriculum.

Lessons Learned and Promising Practices

Gradual Scale-up: Selecting one district to pilot the training, learning from the experience, and expanding the reach gradually to other districts and health facilities is recommended.

Immediate monitoring and feedback: In situations such as neonatal care, where a gap of just minutes can affect the survival of a child, it is a great advantage to be able to provide immediate feedback and to monitor and mentor trainees on-the-job. The on-site training approach allowed the master trainers to immediately address problems and mistakes that adversely affect the quality of delivery services in other settings.



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