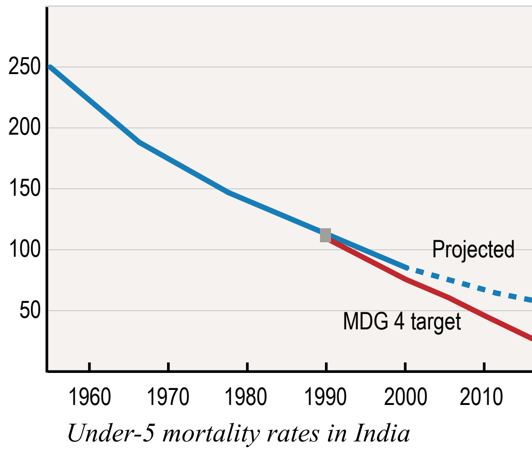
Maternal and Child Health in India
and
Norway India Partnership Initiative (NIPI)

1. The proportion of global child and maternal deaths that occurs in India.



Under-5 mortality rates in India

According to UNICEF (2008), about 9.7 million children died before the age of five years in 2006 globally. Of these, 2.1 million died in India. That means that every fifth child that dies is an Indian child. Half of them die as newborns during the first month of life. However, progress is being made.

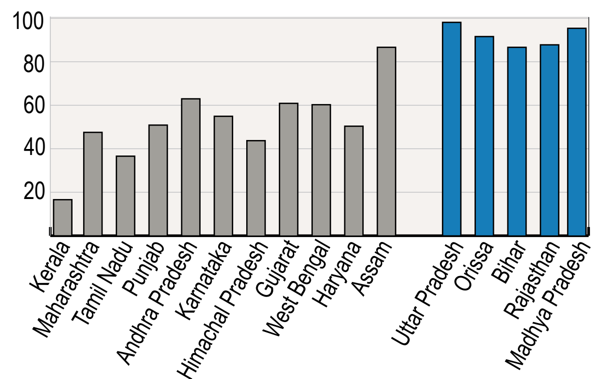
In India the under-5 year death rate was 115 per thousand in 1990, which fell to 76 per thousand in 2006. Yet India needs to make faster progress in order to reach the Millennium Development Goal 4, meaning a 2/3 reduction of child mortality by 2015, in real terms down to 38 per thousand.

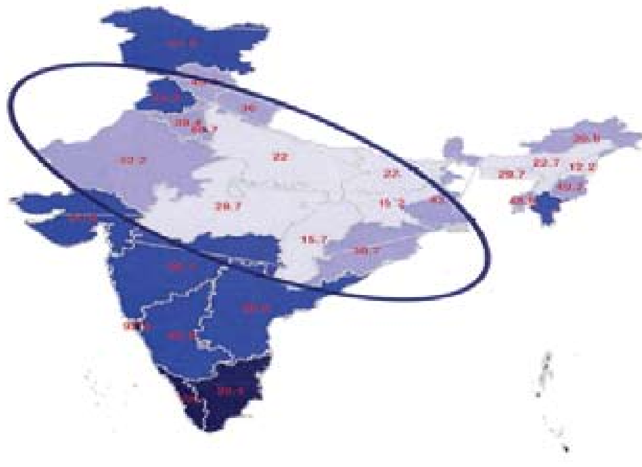
Of the half a million women that die every year from maternal causes, approximately 100 000 are Indian. Progress has been slow globally, including in India, towards reaching the Millennium Development Goal 5 that calls for a 3/4 reduction in maternal mortality by 2015.

2. Where in India?

There are big variations between the states of India with regards to child and maternal deaths. The highest rates for both are found in five northern states: **Bihar, Madhaya Pradesh, Orissa, Rajastan** and **Uttar Pradesh**. Combined they account for about 55 percent of child mortality and 65 percent of maternal deaths in India.

Under-5 death rate by state



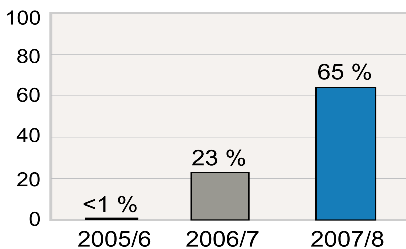


On the figure to the left the states with low percentage of deliveries in facilities are encircled. Those states correspond to the same states with the highest maternal mortality in the figure to the right.

3. What is India doing about it?

The Government of India launched a major program in 2005 called the National Rural Health Mission (NRHM). The goal of the mission is to improve the availability of, and access to, quality health care personnel, especially for those residing in rural areas, the poor, women and children. For that purpose, 22 billion dollars have been committed for the first 5 years.

Under the NRHM a new maternal health scheme, called Janani Suraksha Yojana (JSY), has been introduced. The scheme provides economic compensation, including transport costs, to poor and vulnerable women, as well as the village health workers who bring these women to health facilities to deliver their babies. The compensation for expectant mothers range from USD 25 (1000 rupees) to USD 35 (1400 Rs) depending on where they live, and for the village worker, USD 5 - 15 (200 - 600 Rs).



Coverage of institutional deliveries among poor women in Rajasthan.

The increase in facility based deliveries has been dramatic among eligible women. For example in Rajasthan, facility based deliveries among those women has increased from less than 3 000 in 2005/06 to 340 000 for the second half of 2007/08, and now covers around 65 percent of all eligible women.

Projections by the Government of India as stated by the Honorable Minister Dr. Anbumani Ramdoss, indicate that the JSY coverage will reach 5.5 out of 8 million eligible women in 2008.

Further the impact of JSY on maternal mortality is being currently evaluated by the UN and other agencies. Preliminary analyses suggest that the impact has been dramatic and has halved the maternal mortality in the targeted poorer group.

4. The Norwegian - Indian collaboration.

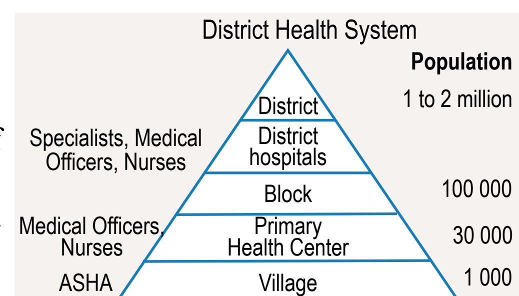
When Prime Minister Stoltenberg met with Prime Minister Singh in December 2005, they agreed to a partnership of collaboration focusing on child health – Millennium Development Goal 4. The Norwegian - Indian Partnership Initiative (NIPI) was launched in September 2006.

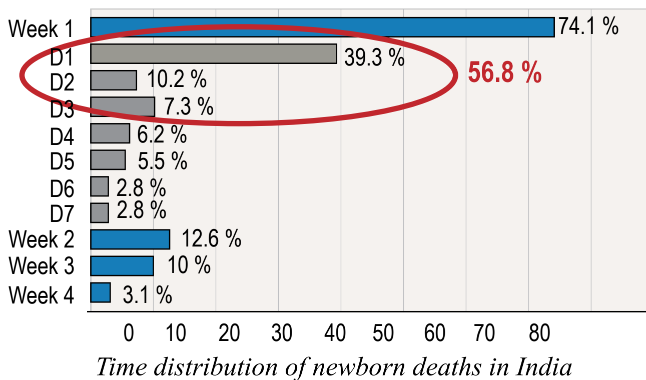
Norway has committed to provide 500 million Norwegian kroner, approximately USD 90 million, over five years to NIPI. It was agreed that it would facilitate the work of the NRHM, by providing flexible support to strengthen child health and related maternal health care services as required by the local situation in the five most challenged states referred to above.

This partnership would operate through a secretariat that would work closely with WHO and UNICEF and the government health system (at central and state levels). In 2007, the NIPI secretariat was established both at National and State level. The secretariat in collaboration with the federal ministry and state authorities has been working on State specific action plans. Based on these plans, agreements with four of the five states have been signed. Funds have been transferred at the beginning of 2008 to the states.

5) Bharatpur: An illustration of how NIPI will work.

Bharatpur is one out of 32 districts in Rajasthan with a population of 2.1 million. A district is subdivided into Blocks of about 100 000 people, and villages of about 1 000 inhabitants with a hierarchy of hospitals, health centres and health workers of various categories. The village health worker is called ASHA (Accredited Social Health Activist).



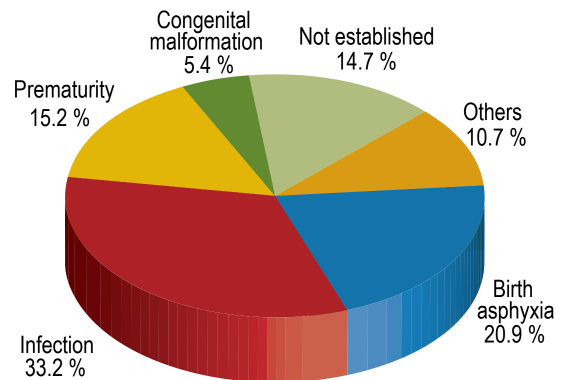


Time distribution of newborn deaths in India

In Bharatpur, the maternal benefits scheme JSY has lead to a very rapid increase of facility deliveries, increasing from less than one percent in 2005 to over 95 percent in 2007. This has provided a great opportunity for providing skilled support to the mother and the newborn in order to reduce newborn deaths, because over 70 percent of neonatal deaths take place during the first week of life. (See figure.)

NIPI will build on this opportunity in line with its basic principles by supporting village health workers living close to the health centres, to provide assistance to mothers and their newborn babies during their stay in the facility to prevent common causes of deaths. They will also counsel mothers on the basic principles of warmth, hygiene, exclusive breast feeding and other aspects of infant care.

NIPI will also provide financial support to Women Self Help Groups in villages and ASHAs to ensure that basic needs of newborns are met, and transport provided to sick children that require institutional care.



Causes of neonatal deaths in India.

At District and Block levels, NIPI will also provide flexible support to solve unforeseen problems, and strengthen the management and care for children in the different health institutions (hospitals and health centres) of the district.

Vaccination coverage is lagging behind in India. DPT 3 coverage show wide variations between states from 40 percent to 90 percent, with an average of 68.4 percent according to UNICEF in India. Rajasthan is reported to have 56.4 percent. NIPI is providing support partly through UNICEF and WHO to reach more children with life-saving vaccines in villages. Child survival strategies is also being implemented trough UNICEF and WHO and these are reflected in the State Health Plans. These plans will also address undernutrition which is common in India.

The Norwegian support is intended to be time-limited for one to two years until they can be incorporated onto NRHM budgets. Allocations to maternal and child care is increasing. Therefore, Norwegian support can be freed up to address other problems as they arise.

GAVI has supported India for safe injection materials and the introduction of Hepatitis B vaccine in the routine immunization system, which is being scaled up in a stepwise fashion. From 2008 onwards all vaccines will be given safe injection syringes.

NIPI is part of a global effort to accelerate progress to MDG 4 & 5. See “The Global Campaign for the Health Millennium Goals,” available to download from **www.norad.no/motherchildhealth**