Millions of mothers still lack access to maternal services

Bringing quality antenatal care and delivery services within reach of everyone, everywhere. Impossible? With an innovative pay-for-performance model we're on a mission to reduce maternal and newborn mortality rates.

Every morning, as the sun rises, it brings with it excruciatingly high temperatures over the dusty sandscape stretches in rural Rajasthan, India. On a windy dirt road, Anju*, a 28-year-old-mother-to-be is hastily being driven to a hospital in Gangapur, Sawai Madhopur district. Anju is 36 weeks pregnant. She suffers from a severe headache and abdominal cramps, facing preterm labor, which is putting her and her baby at risk.

Nurse Pooja* is the attending physician that night at the small private healthcare facility. Pooja quickly performs the relevant tests and realizes that Anju's vitals are alarming – she has elevated blood pressure and large amounts of protein in her urine. Being trained in eclampsia management (treating pregnant woman who experience convulsions, and suffer from high blood pressure), Pooja was able to understand the early warning signs and immediately informed a doctor immediately. Anju was monitored every half an hour and prescribed antihypertensive drugs. Unfortunately, the high blood pressure medication didn't kick in fast enough, causing Anju to experience convulsions. There was no more turning back, it was clear that Anju would be delivering her baby that night. Pooja who monitored the mother and baby was quickly by her side. While the nurse called for help, she swiftly turned Anju on her side to prevent her from pulmonary aspiration. Seconds later the attending obstetrician-gynecologist (OBGYN) came running to administer magnesium sulfate, and safely deliver the baby. Anju was monitored for two more days before being discharged from the hospital.

Anju's life was saved, and her baby is healthy. Not every mother in rural Rajasthan – and the many other remote areas around the world – are that lucky. Pooja was confident in managing Anju's case because she had received eclampsia management training – many nurses don't.

The fate of pregnant women living in rural Rajasthan

With 1.38 billion people, India has the second largest population after China, and an economy that has enjoyed high growth rates in the past.[1] The developments in the healthcare sector however, are less promising, and, if at all, efforts to improve the quality and consistency of care in hospitals have mainly focused on public providers.

One of the biggest challenges pregnant women in rural Rajasthan face is access to quality mother and child healthcare. With more than 70 percent of the population living in rural areas and low level of health facilities, India has one of the highest newborn mortality rates in the world, currently ranking 184 out of 217 countries. The maternal mortality rate in Rajasthan is 47 percent above the national average – 244 mothers in Rajasthan die per 100,000 live births. And an estimated 80,000 babies die every year in Rajasthan.[2]

Reasons are plentiful: rural Indians often have no access to public healthcare, which is why more than 90 percent of the Indian population turns to local private health facilities as their first choice of care.[3] In fact, 25

[1] Worldometer (2020). India Population. Available at: https://www.worldometers.info/world-population/india-population/. Last consulted: December 15, 2020.

[2] Office of the Registrar General & Census Commissioner, India (2013). SRS Statistical Report. Available at: https://censusindia.gov.in/vital_statistics/SRS_Statistical_Report.html. Last consulted: September 21, 2020.

[3] Gram Vaani (n/a). Rural Health Care: Towards a Healthy Rural India. Available at: https://gramvaani.org/?p=1629. Last consulted: December 15, 2020.

percent of women of all socio-economic backgrounds in Rajasthan choose private facilities for their deliveries.[4]

The problem: Private healthcare is costly, and facilities are often unregulated and the quality of care provided varies widely. Also, there is often lack of resources, skilled manpower or leadership. The fact that many healthcare facilities don't maintain basic records and procedures according to minimum requirements mandated for the sector, doesn't make it any easier, and demonstrates a lack of interest in adhering to evidence-based practices.

Innovation that saves lives

Improving the quality of care in private facilities is key to reducing maternal and newborn deaths in Rajasthan. In an ambitious attempt to improve the quality of the poorest mothers and their babies, a coalition of public and private organizations, launched the Maternal and Newborn Health development impact bond (DIB), with the goal to improve the quality of care for up to 600,000 pregnant women in as much as 440 small healthcare organizations in Rajasthan.

One of them being the hospital in Gangapur, where Anju safely delivered her baby. The hospital has initially shown gaps in quality and didn't adhere to any standards. Population Services International (PSI), a leading global health organization, supported the healthcare facility by developing customized approaches focusing on their strengths and weaknesses. It soon became apparent, that clinical OBGYN practices and the skills of staff need improvement, which initially was a major challenge. PSI on its field observation found the best way to help staff understand the standards and translate them into practices was by linking training to documentation via case sheets, registers and forms. PSI also trained the hospital staff on evidence-based practices through audio, videos, presentations and demos using mannequins. Supportive supervision and monitoring visit of doctors, nurses and management staff from PSI to the facility made it possible to demonstrate areas of improvement onsite.

A powerful partnership

The structure includes a results-based finance mechanism, where the outcome funders (USAID and MSD for Mothers) only pay for successful results. These outcome funders can range from charitable foundations and private enterprises to national governments. If the outcomes are not fully achieved, funders will pay proportionate to the results which are achieved.

The working capital– much of which direct contributions from UBS clients – used to deliver the programs is provided by the 'risk' investor, in this case UBS Optimus Foundation. If successful, the Foundation is able to recover its capital and earn a return if pre-determined health outcomes are met. All returns will be rolled over into other philanthropic programs.

The implementation manager, Palladium, designed the impact bond and manages the implementation of the program throughout the three-years. Delivery of the change programs at the local level is managed by a carefully selected group of non-governmental organizations (NGOs). In this case, PSI, and HLFPPT The outcomes of facilities participating in the DIB program are independently verified by sector specialist Mathematica, ensuring the maximum impact is achieved for the investment provided. UBS Optimus Foundation, however, retains a firm grip on the stewardship and distribution of funding throughout.

[4] Office of the Registrar General & Census Commissioner, India (2013). SRS Statistical Report. Available at: https://censusindia.gov.in/vital_statistics/SRS_Statistical_Report.html. Last consulted: September 21, 2020.

*Some names in this story have been changed to maintain confidentiality. Though their names may not be real, their stories are

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