

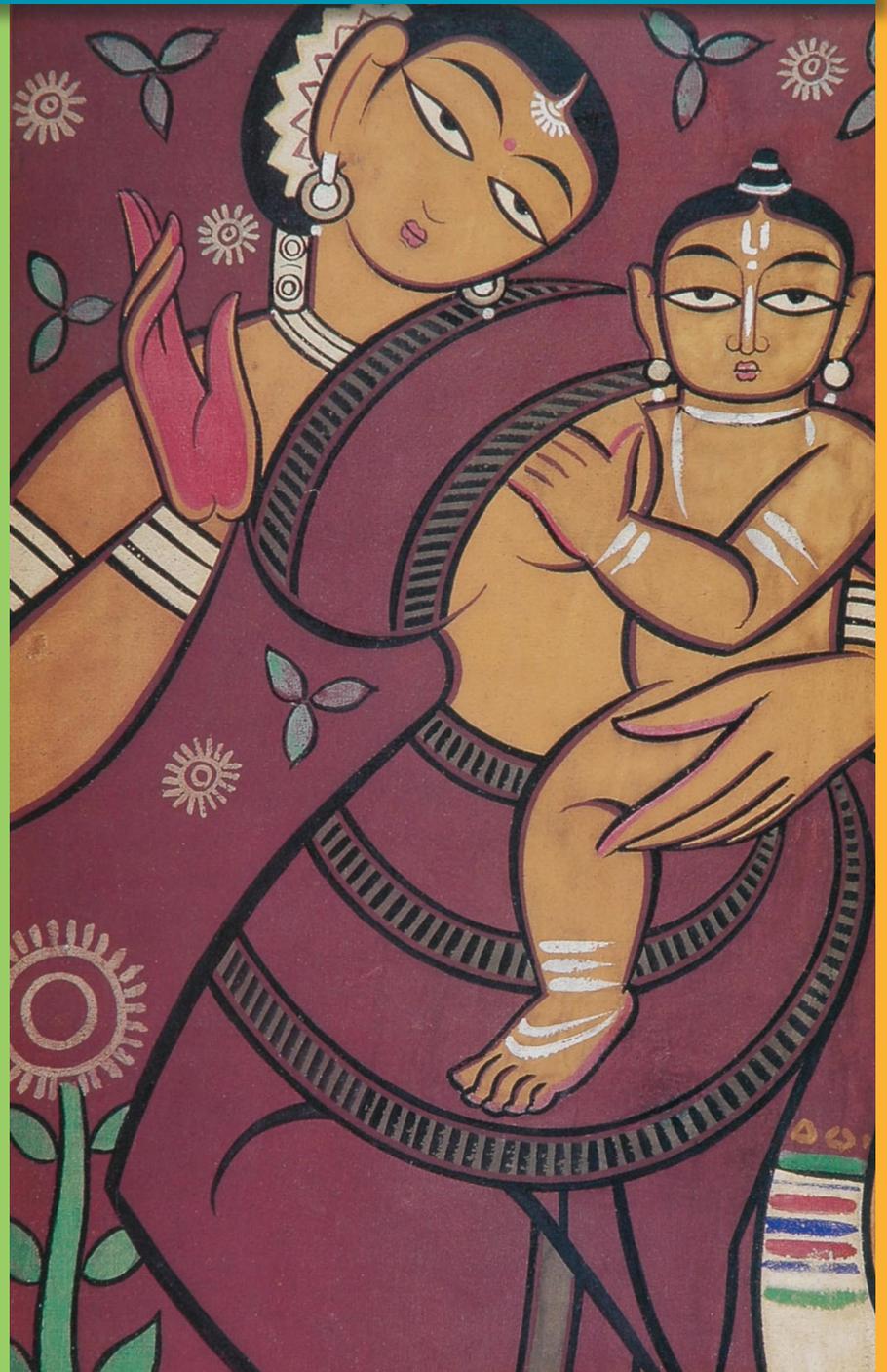


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India's Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) Strategy

A Case of Extraordinary
Government Leadership



July 2014

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal, and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health, and health systems strengthening.

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ACRONYMS

AHS	Annual health survey
AS&MD	Additional Secretary and Mission Director
ASCI	Administrative Staff College of India
BCC	Behavior change communication
CHC	Community health center
CPR	Contraceptive prevalence rate
CSO	Civil society organization
CSR	Corporate social responsibility
DFID	Department for International Development (UK)
DHAP	District health action plans
DLHS	District-level household survey
DM	District monitor
DP	Development partner
DPM	District program manager
DPMU	District program management unit
EAG	Empowered action group
FBO	Faith-based organizations
FLW	Front-line workers
FRU	First referral units
GOI	Government of India
HMIS	Health management information system
HPD	High-priority districts
HSS	Health systems strengthening
IMR	Infant mortality rate
KPI	Key performance indicator
LiST	Lives Saved Tool
MCHIP	Maternal and Child Health Integrated Program
MCTS	Mother and Child Tracking System
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MNCH	Maternal, neonatal, and child health
MOHFW	Ministry of Health & Family Welfare
NGO	Nongovernmental organization

NHM	National Health Mission
NIPI	Norway India Partnership Initiative
NMR	Neonatal mortality rate
NRHM	National Rural Health Mission
NRU	National RMNCH+A Unit
NUHM	National Urban Health Mission
PC&PNDT	Preconception and prenatal diagnostic technique
PIP	Program implementation plan
QI	Quality indicator
RCH	Reproductive and child health
SLP	State lead partner
SPMU	State program management unit
SRS	Sample registration system
SRU	State RMNCH+A Unit
SUT	State unified teams
TA	Technical assistance
TOT	Training-of-trainers
UN	United Nations
USAID	United States Agency for International Development
UT	Union Territories
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization

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DELHI STATE

Dr. Vasantha Kumar – Mission Director (DSHM)
Dr. D.K. Dewan – Director, Family Welfare
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Dr. Amita Raoot – Chief Medical Officer (Immunization) Directorate of Family Welfare
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HARYANA STATE

Ms. Navroj Sandhu – Additional Chief Secretary and Principal Secretary Health

Dr. Rakesh Gupta – Commissioner Finance Department & Mission Director (NHM), Department of Health & Family Welfare

Dr. Ravikant Gupta – Director, NHM

Dr. Suresh Dalpath – Deputy Director Child Health and State EPI Officer, NHM

Dr. Amit Phogat – Deputy Director Referral Transport, IT and M&E, NHM

HIMACHAL PRADESH STATE

Mr. Amithab Awasti – Mission Director, NHM

Dr. Deshraj Sharma – Ex-Deputy Mission Director, NHM

Dr. Anuj Gupta – Deputy Mission Director, NHM

Dr. Mangala Sood – State Child Health and Immunization Officer

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Shri B.K. Tripathi – Principal Secretary, Health

Shri Ashish Singhmar – Mission Director, National Health Mission

Shri Manish Ranjan – Ex-Mission Director, National Health Mission

Dr. Sumant Mishra – Director in Chief, Health Services

Dr. Praveen Chandra – Ex-Director in Chief, Health Services

Dr. A.K. Choudhary – Director, Health Services (I/c) MH & Nodal Officer RMNCH+A

Dr. M.N. Lal – Additional Director (In-charge Family Planning)

Dr. Ajit Prasad – Deputy Director (In-charge Child Health)

Dr. Jaya Prasad – Deputy Director (In-charge Adolescent Health)

Mr. Randhir Kumar – State Program Manager, National Health Mission

Ms. Akai Minz – State Program Coordinator, National Health Mission

PUNJAB STATE

Ms. Vini Mahajan – Additional Chief Secretary and Principal Secretary Health

Dr. V.K. Gagneja – State Program Manager, NHM

Dr. Karanjit Singh – Director Health Services

Dr. Jatinder Kaur – Director Family Welfare

Dr. G.B Singh – Assistant Director, Maternal and Child Health

UTTARAKHAND STATE

Mr. Om Prakash – Principal Secretary

Dr. Nidhi Pandey – Mission Director, NHM (Present)

Mr. Senthil Pandiyan – MD, NHM (Oct 2013-Feb 2014), District Magistrate, Haridwar

Mr. Piyush Singh – Mission Director NHM (through September 2013)

Dr. G. S. Joshi – Director General Medical Health and Family Welfare

Dr. Prem Lal – Additional Director, Maternal and Child Health

Dr. Saroj Naithani – State EPI Officer

Dr. Sushma Datta – Child Health Consultant

CONTRIBUTORS

Dr. Rajesh Singh, National Team Leader RMNCH+A, MCHIP

Mr. Niraj Agrawal, Knowledge Management Specialist, MCHIP/India

Ms. Jennifer Pearson, Program Learning and Documentation Manager, MCHIP/India

Ms. Patricia Taylor, Country Support Team Leader, MCHIP

Dr. Goverdhan K, National Technical Officer, M&E, MCHIP

Dr. Pawan Pathak, Team Leader, Newborn Health, MCHIP

Dr. Gunjan Taneja, State RMNCH+A Team Leader, Jharkhand, MCHIP

Dr. Sanket Kulkarni, State RMNCH+A Team Leader, Uttarakhand, MCHIP

Dr. Chitra Rathi, State RMNCH+A Team Leader, Delhi, MCHIP

Dr. Shailesh Jagtap, State RMNCH+A Team Leader, HR, HP, PB, MCHIP

EXECUTIVE SUMMARY

The GOI is committed to protecting the lives and health of women, adolescents, and children. At the Global Child Survival Call to Action: A Promise to Keep in 2012, India's Honorable Minister for Health and Family Welfare Shri Ghulam Nabi Azad assured the audience that India would remain at the forefront of the global war against maternal and child mortality. Eight months after the event, the Government of India held its own historic Summit on the Call to Action for Child Survival, where it launched "A Strategic Approach to Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) in India." Since that time, RMNCH+A has become the heart of the GOI's flagship public health program, the National Health Mission (NHM).

The RMNCH+A strategy is based on provision of comprehensive care through the five pillars, or thematic areas, of reproductive, maternal, neonatal, child, and adolescent health, and is guided by central tenets of equity, universal care, entitlement, and accountability. The "plus" within the strategy focuses on:

- Including adolescence for the first time as a distinct life stage;
- Linking maternal and child health to reproductive health, family planning, adolescent health, HIV, gender, and preconception and prenatal diagnostic techniques;
- Linking home- and community-based services to facility-based care; and
- Ensuring linkages, referrals, and counter-referrals between and among health facilities at primary (primary health centre), secondary (community health centre), and tertiary levels (district hospital).

In developing the RMNCH+A strategy, the GOI aimed to reach the maximum number of people in the remotest corners of the country through a continuum of services, constant innovation, and routine monitoring of interventions. In rolling out the new strategy, the GOI emphasized high impact interventions in each of the five thematic areas of reproductive, maternal, newborn, child, and adolescent health, and then focused its efforts, and those of its development partners, on improving the coverage and quality of those interventions in 184 high-priority districts (HPDs) across India. Guidelines and tools were developed and policies were adjusted. There was intensive work with state and district health teams to develop their comprehensive Program Implementation Plans (PIP) for NHM funding and development partners, medical colleges, and academic and research institutes were asked to harmonize and intensify their technical assistance to support the roll out.

With support from USAID and its Maternal Child Health Integrated Program (MCHIP), as well as from UNICEF, UNFPA, NIPi and other development partners, the GOI has taken the following important steps to introduce and support RMNCH+A implementation.

High-Priority Districts: The RMNCH+A strategy addresses India's inter-state and inter-district variations. The Government of India identified districts with relatively weak performance against RMNCH+A indicators and used uniform and clearly defined criteria to identify 184 high-priority districts across all 29 states. The RMNCH+A approach is also a conscious articulation of the GOI's commitment to tailoring programs to meet the needs of previously underserved groups, including adolescents, urban poor, and tribal populations.

RMNCH+A Guidelines and Policy: The Ministry of Health and Family Welfare (MOHFW) at national level prepared guidelines and technical documents that included the *Handbook on Improving Maternal and Child Health through the RMNCH+A Approach*, *Guidance Note for Implementation of RMNCH+A Interventions in High-Priority Districts*, *Guidance Note on Block Monitoring*, and *Guidance Note on District-level Gap Analysis of RMNCH+A Implementation*. These guidelines were used in state and district consultations and with development and other partners to ensure a common understanding of the approach.

Management Tools and Job Aids: The *RMNCH+A 5 x 5 Matrix* identifies five high-impact interventions across each of the five thematic areas, five cross-cutting and health systems strengthening interventions, and, the minimum essential commodities across each of the thematic areas. The *5 x 5 Matrix* is an important tool for explaining the strategy in simple terms, organizing technical support, and monitoring progress with the states and high-priority districts.

Partner Harmonization: At the GoI's request, its development partners, including USAID, agreed to support the RMNCH+A roll-out. This represented a paradigm shift from smaller scale, decentralized programs to providing technical support to the GoI to formulate and implement national policy based on evolving global evidence. The GoI identified development partners as state lead partners (SLP) and assigned them to support the National Health Mission in each of the states. The SLPs serve as the single point of contact and accountability but coordinate with other partners and agencies working in the state to harmonize actions across the HPDs and provide the required technical support to the state NHM. USAID, supported by MCHIP, was assigned 33 HPDs in six states for the roll-out of RMNCH+A and the intensification of efforts to improve maternal and child health outcomes.

National and State RMNCH+A Units: The National RMNCH+A Unit (NRU) is supported by USAID, through MCHIP, and anchored within the MOHFW. The nine-person NRU was created to support the Ministry in monitoring the progress of RMNCH+A implementation and intensification efforts across the states. The key role of this unit is to help all 29 states plan, implement, and monitor RMNCH+A strategies. State RMNCH+A units (SRUs) were established in all six USAID-supported states to coordinate activities across the HPDs and provide technical assistance to the state's own program management unit (SPMU), particularly for planning, implementing, and monitoring the delivery of priority interventions.

Gap Analysis: The effectiveness of RMNCH+A interventions depends on availability, acceptability, and utilization of services and the quality of services delivered. Analysis at various levels is necessary to identify gaps in the delivery of a particular intervention or set of interventions. To facilitate this analysis, GOI conceptualized a district-level gap analysis and facility assessment approach and developed standardized tools. Results provide evidence for the district RMNCH+A implementation plan, which should address the key gaps through short- and mid-term actions. Gap analysis also guides the provision of technical assistance and supervision by MCHIP and other development partners. MCHIP conducted gap analyses in the six USAID-led states, covering 36 district-level facilities, 91 first-referral units, 389 non-FRUs, 406 sub-centers, 64 health system interviews, and 11,024 community interviews.

Block Monitoring: To ensure timely support to districts in implementing the most critical interventions, development partners are expected to offer need-based, district-level assistance and work alongside district- and block-level stakeholders to identify and systematically address key bottlenecks. Using a pre-determined block monitoring format prepared by the GOI, district-level monitors, assigned under MCHIP in USAID-supported states, visited one block each month in each HPD, beginning in November 2013. The objectives of block monitoring are to quickly assess facility- and community-level infrastructure, human resources, provision of services, and quality and coverage of service delivery; review progress of community outreach and home- or community-based interventions; validate data reported to the HMIS; and gauge client satisfaction with RMNCH+A services.

Scorecards and Dashboards: The RMNCH+A strategy emphasizes the use of data for planning and implementing interventions. Scorecards were introduced to act as a management tool for two-way feedback at all levels. Their use helps to locate data entry and data quality issues, and underscores the importance of data cleaning and quality improvement. In addition, 16 indicators from the health management information system (HMIS) were selected and used to develop quarterly service delivery dashboards for monitoring. The color-coded dashboard identifies performance by states, districts, and blocks as good (green), promising (yellow), poor (pink), and very poor performing (red), based on a composite index and individually for the five thematic areas.

LESSONS LEARNED

Important lessons learned during the first 12 months of RMNCH+A implementation include:

- Strong government leadership, donor harmonization, and simple tools have been key to the rapid scale up of RMNCH+A.
- The RMNCH+A 5 X 5 Matrix has proven to be an important tool for explaining the strategy in simple terms, organizing technical support, and monitoring state and HPD progress.
- Gap analysis increased awareness of quality of care. Larger gaps are now being addressed through annual district health action plans and state program implementation plans.

- Involvement of state and district health officials in routine block monitoring has resulted in some cases in immediate corrective actions to improve service delivery.
- More attention in the second year of the RMNCH+A roll out should be given to measuring health outcomes and improving the quality of care for mothers, newborns, infants, and young children in health facilities and communities.

THE WAY FORWARD

The RMNCH+A strategy was launched just over one year ago. Under the Government of India's strong leadership, initial results have been promising, but much still remains to be done to take the full RMNCH+A package to scale. The first phase of RMNCH+A involved orientation and sensitization of a diverse set of stakeholders to the RMNCH+A strategy, establishment of key processes for rolling out the strategy, and capacity building of different cadres of human resources. Moving forward, MCHIP recommends that the GOI and development partners such as USAID focus on:

- Continuous monitoring, supportive supervision, and feedback mechanisms to improve the quality of care and accountability including use of key performance and quality indicators that are linked to the RMNCH+A 5 X 5 Matrix.
- Testing performance-based incentives under the RMNCH+A mandate.
- Leveraging the strong presence of the private sector to improve the quality of health care in urban settings.
- Advocacy with multiple levels of government and all stakeholders to enhance their involvement and promote sustainability and scale up of best practices.
- Strengthening the continuum of care from community to facility through improved community mobilization and behavior change communication approaches.
- Health system strengthening including rational deployment of human resources, availability of essential commodities, infrastructure improvement, and the use of task shifting.
- Improving inter-sectoral convergence, particularly with departments of Women and Child Development and Education, and Water and Sanitation.
- Systematic documentation and sharing of innovations and best practices to enhance policy, service delivery, and financing across states and districts: Innovations in implementation achieved by various development partners should be captured, documented, and advocated for scale-up.

BACKGROUND

THE GLOBAL CALL TO ACTION: A PROMISE TO KEEP

In June 2012, the governments of India, Ethiopia, and the United States and the United Nations Children’s Fund (UNICEF) convened the “Global Child Survival Call to Action: A Promise to Keep” summit in Washington, DC to energize the global fight to end preventable child deaths through targeted investments in effective, life-saving interventions for children. More than 80 countries, including governments and partners from the private sector, civil society, and faith-based organizations, and many international agencies gathered at the Call to Action, where they challenged the world to reduce child mortality to 20 child deaths or fewer per 1,000 live births in every country by 2035.

At the summit, India’s Honorable Minister for Health and Family Welfare Shri Ghulam Nabi Azad assured the audience that India would remain at the forefront of the global war against maternal and child mortality. Eight months after the event, the Government of India (GOI) held its own historic Summit on the Call to Action for Child Survival. With over 250 participants present from approximately 40 countries and all 28 of India’s states, the GOI used the occasion to launch India’s ambitious new Reproductive, Maternal, Newborn, Child and Adolescent Health strategy, now known as RMNCH+A, to accelerate mortality reduction amongst the country’s most vulnerable women and children. This document provides an overview of the development of the strategy and the processes to roll out the strategy in 33 high-priority districts in the six USAID-supported states.



MATERNAL AND CHILD SURVIVAL

According to the 2013 Millennium Development Goal (MDG) report, although the global maternal mortality ratio (MMR) has declined by nearly half since 1990, the decline falls far short of the MDG target of 109 per 100,000 by 2015 and is still 15 times higher in developing than developed regions (UN 2013). Of the estimated 287,000 maternal deaths that occurred in 2010, India accounted for 56,000, or 19% of the global total (WHO 2012).



A child’s survival is inextricably linked to the health and the survival of its mother. Globally, 7.6 million children died in 2010 before reaching their fifth birthday (UNICEF 2011) and only five countries, including India, collectively accounted for more than half (nearly 3.75 million) of all these deaths. Child mortality rates are particularly alarming in India, where every year more than 300,000 babies die at birth and approximately 1.45 million children die before their fifth birthday (Save the Children 2013). These data underscore the need to prioritize interventions addressing maternal and child mortality in India and other underperforming and high-burden countries.

Recent global initiatives have renewed focus on global targets for maternal and child survival. The Global Strategy for Women’s and Children’s Health, launched by the United Nations (UN) Secretary-General Ban Ki-moon during the Millennium Development Goals Summit in September 2010, aims to save 16 million lives in the world’s 49 poorest countries by 2015

through enhanced financing, strengthened policies, and improved service delivery (UN 2013). At the same summit, the Every Woman Every Child movement was established to mobilize and intensify international and national action to advance the global strategy.

OVERVIEW OF INDIA’S PROGRESS

Although India ranks among the top five countries globally in terms of absolute numbers of maternal and child deaths, the country has made encouraging progress in tackling mortality among mothers and children. In 1990, India’s under-five mortality rate (U5MR) was 115 per 1,000 live births, well above the global mean of 88. By 2010, it had been cut in half, to 59 per 1,000 live births, and was just above the global average of 57. Maternal mortality also declined dramatically during the same period, with the MMR falling from 560 in 1990 to 190 by 2013 (WHO 2014). Despite these impressive reductions, because of India’s very large population and annual birth cohort, it still contributes more child and maternal deaths to the global total each year than any other country.

“India has made considerable progress over the last two decades in the sector of health, which was further accelerated under NRHM. True to its vision, NRHM improved the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. However, latest data and trends emerging from the national surveys demand a cohesive approach to manage child and maternal health care. Clear articulation of the strategic approach to reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) is an effort in this direction.”

*—Shri Ghulam Nabi Azad,
Former Union Minister of
Health and Family Welfare,
Government of India
(2009-2014)*

India’s National Rural Health Mission (NRHM) was launched in 2005 to improve the availability and quality of accessible health care, especially in rural areas. The NRHM has contributed significantly to India’s improved maternal and child health outcomes, and the Government of India (GOI) has taken advantage of the NRHM platform to launch a number of large strategic investments aligned with its MDG targets. The launch of NRHM led to numerous improvements, including:

- Improved availability of and access to high-quality health care, especially for people residing in rural areas, the poor, women, and children.
- Substantially increased financial resources for reproductive and child health (RCH), health care infrastructure, and workforce.
- Expanded program management capacity.

While these improvements have enabled the GOI to accelerate progress toward MDGs, India’s maternal and child health outcomes still vary significantly across and within its states. Most importantly, data from national surveys such as the Annual Health Survey carried out in Assam and the eight empowered action group (EAG) states, which have a high burden of maternal and child mortality, show wide inter-district variation. For example, the statewide under-five mortality rate in Madhya Pradesh is high, but rates vary widely, with a difference of 89 points between Indore (51) and Panna (140). Similar inter-district variations are found in Uttar Pradesh (AHS 2011-12) and the other EAG states. It is clear that the focus of implementation has to shift to geographical areas of greatest concern and populations that carry the highest burden of illness and mortality. Increased focus on the urban poor, who face well-documented barriers to utilization that are often due to the inequitable distribution of health services, is also needed.

Since independence, the GOI has prepared 5-year plans that outline the expenditure framework for different sectors and that have strong ownership of the President and Prime Minister. The 12th Five-Year Plan (2012-2017) lays out India’s commitment to the following goals by 2017:

- Reducing the IMR to 25 per 1,000 live births.
- Reducing the MMR to 100 per 100,000 live births.
- Reducing the national fertility rate to 2.1.
- Increasing the child sex ratio in the 0-6 year age group to 950.

Under the 12th Five-Year Plan, the GOI projects that it will spend US \$3 trillion on health between 2013 and 2017. India recognizes that achieving these goals will require a broad strategy that links reproductive, maternal, and child health services and promotes the delivery of evidence-based interventions along a continuum of care from household to community to health facility. This recognition led the MOHFW/NRHM to develop a new, more comprehensive Reproductive, Maternal, Neonatal, Child Health and Adolescent (RMNCH+A) strategy.



RMNCH+A IN INDIA

The RMNCH+A strategy is designed to fast-track India's progress toward achieving Millennium Development Goals 4 and 5, while also increasing progress toward the health targets outlined in the 12th Five-Year Plan. The RMNCH+A strategy is built upon the continuum of care concept and is holistic in design, encompassing all interventions aimed at reproductive, maternal, newborn, child, and adolescent health under a broad umbrella, and focusing on the strategic lifecycle approach.

GOVERNMENT OF INDIA'S EXTRAORDINARY LEADERSHIP

BUILDING OWNERSHIP FROM A ONE-TIME EVENT TO A NATIONAL MOVEMENT

After the global Child Survival Call to Action in Washington, DC, the GOI redefined its national maternal and child health agenda and planned its own National Summit on the Call to Action. The GOI established a secretariat for the activity with support from USAID's Maternal and Child Health Integrated Program (MCHIP), which coordinated activities with each of the subcommittees formed. The secretariat included a team leader, technical consultant (programs/child survival), technical consultant (data), partnership consultant, and media and outreach consultant).

The Government of India convened a steering committee and six subcommittees, each comprised of representatives from the MOHFW and development partners including USAID, UNICEF, UNFPA, and the Bill & Melinda Gates Foundation. The steering committee meetings provided a unique platform for collective decision making, shared responsibility by the MOHFW, development partners, media, private sector, and civil society organizations, and renewed commitment to child survival and a movement to improve reproductive, maternal, neonatal, child, and adolescent health.

Each subcommittee was charged with a set of India-specific activities to be conducted before the summit in February 2013, when the GOI would demonstrate its leadership and generate renewed commitment among national, state, and international partners to child survival.



PREPARATIONS FOR THE NATIONAL CALL TO ACTION EVENT, BY SUBCOMMITTEE ROLE

RMNCH+A STRATEGY SUBCOMMITTEE

The RMNCH+A strategy subcommittee, which was led by MCHIP, met to brainstorm the components to include in the strategy. During one of the meetings, the subcommittee realized that India's Reproductive and Child Health Program (RCH II) was not in line with the current global model, which emphasizes a continuum of care approach that includes integrated service delivery across life stages; pre-pregnancy, childbirth, post-natal period, childhood, adolescence, and throughout the reproductive years. In RCH II, adolescent health was missing despite adequate evidence of poor adolescent health indicators in India, including high rates and poor outcomes of teen pregnancy, low contraceptive prevalence rates (CPR) among adolescents, and high rates of malnutrition and anemia among adolescent girls. Given the lifelong impact of these poor health indicators, the subcommittee recognized that adolescents must receive more attention.

The subcommittee further realized that RCH II has focused on the EAG states and left out high-performing states, although evidence from surveys (AHS 2010-11) shows that even states with high overall performance have poorly performing districts that need special attention. This led to a recommendation to focus on poorly performing geographic regions and populations with the highest mortality burden. The RMNCH+A strategy document was developed describing the approach to comprehensive care across the full lifecycle and clearly articulating the roles of all partners.

SCORECARD AND DASHBOARD

The Technical and Management Support Agency (TMSA) led this subcommittee in developing a dashboard based on health management information systems (HMIS) data and a scorecard based on survey data to monitor district progress, validate data, and ensure improved quality of data. The HMIS data tracks quarterly public-sector performance and provides a short-term snapshot. The survey-based scorecard was to track medium-term performance through data sources such as the sample registration system (SRS) and survey data, and to capture outcome and output data to provide a holistic reflection of public and private sector performance.

A list of 16 HMIS scorecard indicators based on a lifecycle approach was selected. Indicators ask questions related to pregnancy care, childbirth, post-natal maternal and newborn care, and people of reproductive age.

DATA MODELING

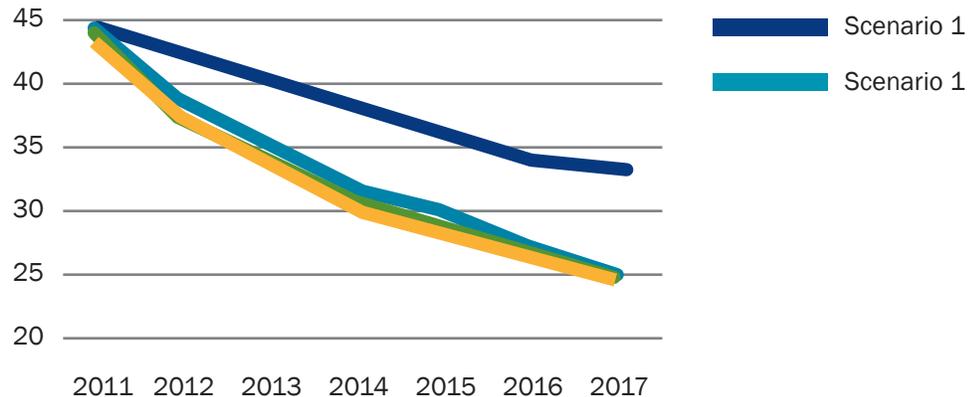
The objective of data modeling was to prioritize and create a combination of interventions that would help achieve the lowest possible under-five mortality in the selected states. Seven thematic areas—neonatal care, nutrition, maternal care, pneumonia, diarrhea, immunization, and family planning—were identified for modeling. The data modeling subcommittee, led by USAID, synthesized the indicators used for modeling and the references for efficacy rates based on evidence available for the Indian context. Efficacy rates were validated to ensure greater acceptability and wider use of updated scientific information in India. The Lives Saved Tool (LiST)¹ helped determine the possible levels of coverage required to achieve the targets set by the GOI. LiST helps estimate the mortality impact of scaling up maternal, newborn, and child health interventions. The tool requires three sets of inputs to project the impact of interventions on mortality: 1) measures of health status including mortality and causes of death; 2) effect sizes of interventions; and 3) intervention coverage that is scaled up from a baseline.

TABLE 1. DESCRIPTION OF SCENARIOS FOR DATA MODELING FOR INDIA

Scenario 1	Continuation of historical trends in RMNCH+A interventions based on the National Family Health Survey (NFHS-3) (2005-2006) and the Coverage Evaluation Survey 2009 (CES-2009). The average annual rate of change for most interventions was 4% per year, with a maximum coverage increase of 15% for institutional births.
Scenario 2	The coverage estimates were increased for all the interventions by a proportion such that the IMR of 25 deaths per 1000 live-births could be achieved by 2017. The requisite annual increase in coverage estimates for RMNCH+A interventions is 22%. The projected coverage estimates are capped at a maximum of 95% or current estimate if >95%.
Scenario 3	This scenario considers differential increase in the coverage estimates for each RMNCH+A intervention based on the health system realities while keeping in view that the goal of IMR of 25 deaths per 1,000 live births needs to be achieved by 2017. The average annual rate of change in this scenario is 21%. The projected coverage estimates are capped at a maximum of 95% or current estimate if >95%.
Scenario 4	This scenario is similar to Scenario 3 but has additional interventions (water and sanitation improvement, introduction of pneumococcal vaccine, and scale up of Haemophilus influenzae type b vaccine HiB vaccine). The average annual rate of change in this scenario is 19%, ranging from 14% to 95%. The projected coverage estimates are capped at a maximum of 95% or current estimate if >95%.

¹ For more information on the LiST tool: <http://www.jhsph.edu/departments/international-health/centers-and-institutes/institute-for-international-programs/list/>

FIGURE 1. EXAMPLE: PROJECTED INFANT MORTALITY RATES IN 2017 UNDER ALTERNATIVE SCALE-UP SCENARIOS



The data modeling was conducted at the national level. It was recommended that state-level analyses and prioritization be done to provide more insight for prioritization at the state to guide the state program implementation plans (PIPs).

CIVIL SOCIETY ORGANIZATIONS (CSOS), FAITH-BASED ORGANIZATIONS (FBOS), AND FOUNDATIONS

This subcommittee’s objective was to determine what technical assistance and other support civil society might provide, and what provisions would ensure the sustainability of their support. The subcommittee was led by Save the Children, one of the consortium partners under MCHIP. Group members decided to conduct a mapping exercise of candidate CSOs and FBOs at two levels: state level for the eight EAG states, and district level in 264 high-focus districts (selected during RCH II project as poorly performing districts) to identify and engage the community-based organizations in components of RMNCH+A strategy. Nongovernmental organizations (NGOs), CSOs, and FBOs were mapped by thematic expertise and willingness to contribute to RMNCH+A, and their written commitment was obtained. The subcommittee also recommended potential roles for participating organizations and the platforms they could provide to generate demand for RMNCH+A services at various levels.

PRIVATE SECTOR

The private sector subcommittee, led by UNICEF, focused on determining how to leverage private sector resources (including financial and human resources) and expertise in supply chain management. The India Institute of Corporate Affairs took the lead by preparing an outline for engaging the private sector in RMNCH+A. The subcommittee suggested a three-pronged approach for involving the private sector to achieve results for child survival:

- **Corporate Social Responsibility (CSR)**—to finance activities and projects under the Child Survival Call to Action. The subcommittee proposed using CSR as an obligation for companies to create a child survival fund that could be used for implementation of child survival projects. Companies are mandated to spend 2% of their average profit over the previous 3 years.
- **Market-based approaches**—including social marketing of commodities to create sustainable and long-term solutions.
- **Innovations**—leveraging skills and expertise from the private sector.

MEDIA

The GOI recognized that media needed to be involved as a stakeholder before, during, and after the National Summit. Subgroups were formed to prepare strategies for different phases: before the event to create a buzz and generate awareness of the upcoming summit; during the event to support coverage and take advantage of heightened attention; and after the event to sustain momentum and assure follow through on commitments made. Key components of the

“There are many areas in which the private sector can add a lot of value, either by filling a critical gap or supplementing efforts of the government.”

—Ms. Anuradha Gupta,
Ex-Additional Secretary and
Mission Director, NHM

“Reproductive health—which primarily addresses family planning—was being promoted more as a population stabilization strategy and less as a strategy to improve maternal and child health outcomes. Thus, it was implemented as a stand-alone, isolated program without articulating the critical inter-linkages with our interventions in maternal and child health.”

—Ms. Anuradha Gupta

media plan included creating a branding concept for India’s child survival initiative (“For Every Child in India” was chosen); developing messages and materials; outlining a media outreach plan; developing a digital platform; and engaging celebrities in the event and message.

CONVERGENCE AND COMMITMENT AT NATIONAL AND STATE LEVELS

During preparations for the National Summit, the RMNCH+A strategy subcommittee recognized the need for the involvement of other ministries. These included the Women and Child Development Ministry, which operates a vast network of Anganwadi Centres in every village and provides immunization, well-child care, antenatal care, and nutrition services including iron and folic acid supplements to adolescents; and the Ministry of Rural Development, which works to improve water, sanitation, and hygiene practices in the communities. The MOHFW worked with these ministries from the planning phase to the launch the RMNCH+A strategy through the roll-out. This collaboration ensured that all stakeholders understood the policy and their roles and responsibilities.

POLICY INTO ACTION

INDIA’S CALL TO ACTION - FEBRUARY 2013

In order to galvanize unified efforts of all stakeholders, the Call to Action: For Every Child in India Summit took place in February 2013 in Mahabalipuram, Tamil Nadu. The summit was led by the MOHFW with participation from the Department of Women and Child Development. Policymakers, international and national experts, public health practitioners, representatives from private sector, and media professionals attended the landmark meeting. Major topics of presentations and discussions included leadership dialogue, the roadmap to child survival and development, partnership building, accountability, tracking progress, and innovation and research.

The consensus at the summit was that while India has made impressive progress, it must focus on key high-impact interventions, with special emphasis on poorly performing locations and key populations. Such a focused approach would lead to substantial reductions in maternal, neonatal, infant, and under-5 morbidity and mortality resulting from the most common causes. Another key theme was that though India has launched many flagship health and nutrition programs that have led to improved maternal and child survival, the country still needs to develop and implement a strategy to link various interventions and schemes under one umbrella to provide holistic and comprehensive services to the entire spectrum of beneficiaries, including infants, children, adolescents, adult women, and pregnant women.

The GOI launched its new RMNCH+A strategy at the summit to meet this need. India’s Call to Action was the beginning of a national movement, becoming a shared platform for ministerial collaboration and inter-ministerial dialogue at national and state levels. The summit was designed as a forum for broad participation combining global and Indian expertise at which goodwill ambassadors, the private sector, civil society, the media, and faith-based organizations would share experiences and challenges; celebrate successes in maternal, newborn and child survival; and commit themselves to the challenges of implementation.

The planning stages for the RMNCH+A strategy did not focus on urban populations as a priority group. However, during the Call to Action Summit, it was agreed that India cannot accelerate reduction in MMR and NMR without addressing the needs and health status of the urban poor and migratory populations, and furthermore that services for the urban poor must be tailored because traditional service delivery is not possible. The need for full access suggested opportunities for involving the private sector, including NGOs and CSOs. Hence, in June 2013, the National Urban Health Mission merged with the National Rural Health Mission (NRHM) to become the National Health Mission (NHM) to take a holistic approach to services for and give equal attention to urban poor and migratory populations.

WHAT IS THE RMNCH+A STRATEGY?

The RMNCH+A strategy promotes links between various interventions across thematic areas to enhance coverage throughout the lifecycle to improve child survival in India. The “plus” within the strategy focuses on:

- Including adolescence as a distinct life stage within the overall strategy.
- Linking maternal and child health to reproductive health and other components like family planning, adolescent health, HIV, gender, and preconception and prenatal diagnostic techniques.
- Linking home- and community-based services to facility-based services.
- Ensuring linkages, referrals, and counter-referrals between and among health facilities at primary (primary health Centre), secondary (community health centre), and tertiary levels (district hospital).

CONTINUUM OF CARE APPROACH

The RMNCH+A strategy promotes links between interventions across the lifecycle and integrates child survival with other important health interventions. This approach reflects evidence showing that mother and child health cannot be improved in isolation—data show, for example, that high-risk pregnancies and maternal mortality rates are twice as high in adolescent mothers than in women above age 20; that anaemia is prevalent across all age groups; and that malnutrition is responsible for 34% of under-5 deaths. (MOHFW 2013).

INCLUSION OF ADOLESCENTS

The health of adolescents has always been the weakest pillar in the continuum of care approach, and has often been ignored and neglected, leading to early age of marriage, early childbearing, lack of access to contraception, and lack of birth spacing. With this realization, India added “A” (adolescents) to the continuum of RCH.

“The interdependence of various components of continuum of care is well recognized. In other words, reproductive, maternal, newborn, child, or adolescent health can be ensured only if all the life stages are healthy. RMNCH+A initiative aims to focus equally on all life stages across the continuum of care.”

—Ms. Vini Mahajan, Principal Secretary to Govt. of Punjab, Department of Health & Medical Education

“Central tenets guiding this programme have been equity, universal care, entitlement, and accountability. Our aim is to protect the lives and safeguard the health of women, adolescents, and children and this has been the driving force for reaching out to the maximum numbers in the remotest corners of the country through constant innovation and calibration of interventions.”

—Dr. Rakesh Kumar,
Joint Secretary (RCH),
MOHFW

KEY FEATURES OF THE RMNCH+A STRATEGY

The RMNCH+A strategy approaches include:

- Health systems strengthening (HSS) focusing on infrastructure, human resources, supply chain management, and referral transport measures.
- Prioritization of high-impact interventions for various lifecycle stages.
- Increasing effectiveness of investments by prioritizing geographical areas based on evidence.
- Integrated monitoring and accountability through good governance, use of available data sets, community involvement, and steps to address grievance.
- Broad-based collaboration and partnerships with ministries, departments, development partners, civil society, and other stakeholders.

Overall, the entire strategy can be visualized as having three major components: design, implementation mechanisms, and performance monitoring.

The RMNCH+A strategy provides a strong platform for delivery of services across the entire continuum of care, ranging from community to primary health care, as well as first-referral level care to higher referral and tertiary level of care. This

“The RMNCH+A document directs states to focus their efforts on the most vulnerable population and disadvantaged groups in the country. The document also emphasizes the need to reinforce efforts in those poor performing districts that have been identified as the high-focus districts.”

**—Mr. P. K. Pradhan,
Ex-Secretary Health and
Family Welfare,
Government of India**

integrated strategy is expected to promote greater efficiency while reducing duplication of resources and efforts in the ongoing program. The RMNCH+A document provides a comprehensive approach to improving child survival and safe motherhood, and operational guidance to implement this approach during the next phase of the National Health Mission.

IDENTIFICATION OF HIGH-PRIORITY DISTRICTS: FOCUS ON EQUITY

Districts lag behind in terms of health and possibly most other development indicators require additional planning and implementation support and receive a 30% higher budget allotment for implementing the strategy. The RMNCH+A approach is a conscious articulation of the GOI's commitment to tailoring programs to meet the needs of previously underserved groups including adolescents, the urban poor, and tribal populations.

The RMNCH+A strategy addresses India's inter-state and inter-district variations. The Annual Health Survey (AHS) 2010-11 shows uneven progress both between and within Indian states. The GOI identified 184 high-priority districts (HPDs) across 29 states. This was a landmark shift because the 264 previously designated HPDs were all from the eight EAG states and Assam. RMNCH+A recognizes that high-performing states also have poorly performing districts that need attention and vice versa.

The 184 HPDs were selected based on a relative ranking of districts within a state using AHS 2010-11 data and data from the eight EAG states (Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chattisgarh, Rajasthan, Odisha) and Assam. District Level Household Survey (DLHS-3) 2007-08 data for other states and Union Territories (UTs) in India were also considered. Based on these indicators, the lowest-performing 25% of districts within each state were designated as HPDs. Tribal districts and those affected by left-wing extremism lying within the bottom 50% were also incorporated in the overall list of HPDs.

HARMONIZATION AND COMMITMENT OF DEVELOPMENT PARTNERS AND INTENSIFICATION OF EFFORTS

Following the summit, a national consultation on intensifying efforts to improve MCH outcomes in HPDs was held in April 2013. The meeting was attended by representatives of MOHFW and development partners. The objectives of this consultation were to:

- Discuss the road map for actions to follow the Call to Action Summit.
- Orient partners to HPDs and the government's plan to intensify action for improving maternal and child health.
- Discuss mechanism for harmonizing partners' technical assistance for integrated programming and monitoring for RMNCH+A interventions.

A principal meeting topic was that harmonizing technical support with RMNCH+A activities would add value to NRHM and accelerate achievement of the desired health outcomes, especially in high-priority districts. GOI expects that development partners will go beyond their individual expertise and complement other development partners within states to provide technical support on the entire spectrum of RMNCH+A interventions. The MOHFW makes sufficient resources available to the states under the NRHM, meaning that development partners can draw upon their existing strengths and local presence in states and districts to assist the government at various levels in

“We are very glad that development partners have aligned their approaches to ours. They are now working with the state governments as a consortium led by a partner and we have assigned different states to different partners so that together we can get move forward with this shared vision of RMNCH+A and make sure that it is implemented in earnest.”

—Ms. Anuradha Gupta

planning, implementing, and monitoring the entire spectrum of RMNCH+A interventions. Strategies adopted or approved by the MOHFW should be promoted at national scale, but there is significant scope under health systems strengthening for innovation of service delivery mechanisms. Successful innovations must be recognized and best practices shared at the national level through a formal mechanism.

Development partners including USAID, UNICEF, and UNFPA realized that they could play a significant role at the national, state, and district levels as the country accelerates the pace of implementation. The need was to establish a mechanism for harmonized technical support to national and state government efforts to achieve the MDG and 12th Five-Year Plan goals. Partners immediately agreed to shift priorities to commit to the RMNCH+A roll-out. This represented a paradigm shift from assistance with small-scale, decentralized interventions to direct coordination with government of India to build country ownership and country-led ability to develop policy based on evolving global evidence.

The GOI identified six development partners (USAID, BMGF, DFID, UNICEF, UNFPA, and the Norway India Partnership Initiative) as state lead partners (SLP) for implementing the strategy. These SLPs were assigned to support the health department in the respective states, particularly the NRHM (NHM) (See Annex 1). The SLPs are the single point of contact and accountability. The lead partner coordinates with other partners and agencies working in the state to harmonize the actions across HPDs and provide the required technical support to the state NRHM. The SLP also convenes a monthly meeting with all the district partners (DPs) in that state to review progress and discuss any challenges. Each HPD is assigned one technical expert, called a district monitor (DM), who is drawn from DPs in the state. DMs are responsible for overall monitoring of RMNCH+A interventions in that district under the guidance of the state lead partner.

USAID, supported by MCHIP, was assigned 33 HPDs districts in six states (shown in Table 1) for the roll-out of RMNCH+A strategy and intensification of efforts to improve MCH outcomes in the targeted districts (see Annex 2 for maps of USAID-supported states).

TABLE 2. USAID-SUPPORTED HIGH-PRIORITY DISTRICTS (33)

STATE	DISTRICTS	
Delhi (2)	North East	North West
Harayana (7)	Bhiwani* Hissar Jind Mahendargarh*	Mewat Panipat Palwal
Himachal (4)	Chamba Kinnaur	Lahaul & Spiti Mandi
Jharkhand (11)	Paschimi-Singhbhum, Saraikela-Kharsawan Godda Sahibganj Pakaur Palamu	Latehar Lohardaga Gumla Simdega Dumka
Punjab (6)	Sangrur Muktsar Gurdaspur	Barnala Mansa Pathankot*
Uttarakhand (3)	Haridwar Pauri	Tehri

*Proposed by state governments and included as HPDs

Technical support was to be provided at multiple levels to allow a flow of information from the block level through the national level. Attendees agreed that the SLPs would, in coordination with DPs working in a given state, spearhead the establishment of mechanisms at the district, state, and national levels to provide technical support for intensification. At the district level, a RMNCH+A coordinator, identified from among the DPs, would monitor specific activities in the district. A technical advisor located at the state level would provide support. SLPs and DPs constitute the state-level RMNCH+A Unit (SRU) and are tasked with engaging the state government and ensuring the flow of information to the central level through a newly created National RMNCH+A Unit (NRU).

OPERATIONALIZING THE STRATEGY: TRANSLATING COMMITMENTS INTO ACTION

DEVELOPMENT OF THE RMNCH+A 5 X 5 MATRIX AS A MANAGEMENT TOOL

“The 5 X 5 matrix serves as a ready reckoner. We use it in our internal meetings. All interventions mentioned in the matrix have been planned and are being implemented or are in pipeline for implementation.”

—Dr. Suresh Dalpath, Deputy Director, CH&I, Government of Haryana

To facilitate the implementation of the RMNCH+A strategy across the continuum of care, MCHIP worked with MOHFW and other DPs to develop the RMNCH+A 5 X 5 matrix. The matrix guides health officials, partners, and programmers in the selection of:

- Five high-impact interventions across each of the five thematic areas.
- Five cross-cutting and health systems strengthening interventions.
- The minimum essential commodities across each of the thematic areas.

The matrix is easy to remember and allows states and development partners to continuously focus on 25 actions for desired outcomes. When implemented with high coverage and high quality, these interventions are

expected to have a great impact on reducing maternal and child mortality and morbidity.

The RMNCH+A 5 X 5 matrix has been translated into Hindi and regional languages for use by front-line workers (FLWs) and managers. During its supportive supervision and review visits, the GOI tracks the FLWs’ orientation on the matrix to ensure that all cadres of health functionaries are familiar with the matrix and are using it as a planning and management tool.

The matrix has been widely circulated and is displayed in offices of the MOHFW, state, district, and block health offices including health facilities.

5 X 5 Matrix for High Impact RMNCH+A Interventions
To be Implemented with High Coverage and High Quality

Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
<ul style="list-style-type: none"> • Focus on spacing methods, particularly PPIUCD at high case load facilities • Focus on interval IUCD at all facilities including subcentres on fixed days • Home delivery of Contraceptives (HDC) and Ensuring Spacing at Birth (ESB) through ASHAs • Ensuring access to Pregnancy Testing Kits (PTK-“Nischay Kits”) and strengthening comprehensive abortion care services. • Maintaining quality sterilization services. 	<ul style="list-style-type: none"> • Use MCTS to ensure early registration of pregnancy and full ANC • Detect high risk pregnancies and line list including severely anemic mothers and ensure appropriate management. • Equip Delivery points with highly trained HR and ensure equitable access to EmOC services through FRUs; Add MCH wings as per need • Review maternal, infant and child deaths for corrective actions • Identify villages with high numbers of home deliveries and distribute Misoprostol to selected women in 8th month of pregnancy for consumption during 3rd stage of labour; Incentivize ANMs for home deliveries 	<ul style="list-style-type: none"> • Early initiation and exclusive breastfeeding • Home based newborn care through ASHA • Essential Newborn Care and resuscitation services at all delivery points • Special Newborn Care Units with highly trained human resource and other infra structure • Community level use of Gentamycin by ANM 	<ul style="list-style-type: none"> • Complementary feeding, IFA supplementation and focus on nutrition • Diarrhoea management at community level using ORS and Zinc • Management of pneumonia • Full immunization coverage • Rashtriya Bal Swasthya Karyakram (RBSK); screening of children for ADBs (birth defects, development delays, deficiencies and disease) and its management 	<ul style="list-style-type: none"> • Address teenage pregnancy and increase contraceptive prevalence in adolescents • Introduce Community based services through peer educators • Strengthen ARSH clinics • Roll out National Iron Plus Initiative including weekly IFA supplementation • Promote Menstrual Hygiene
Health Systems Strengthening <ul style="list-style-type: none"> • Case load based deployment of HR at all levels • Ambulances, drugs, diagnostics, reproductive health commodities • Health Education, Demand Promotion & Behavior change communication • Supportive supervision and use of data for monitoring and review, including scorecards based on HMIS • Public grievances redressal mechanism; client satisfaction and patient safety through all round quality assurance 		Cross Cutting Interventions <ul style="list-style-type: none"> • Bring down out of pocket expenses by ensuring JSSK, RBSK and other free entitlements • ANMs & Nurses to provide specialized and quality care to pregnant women and children • Address social determinants of health through convergence • Focus on un-served and underserved villages, urban slums and blocks • Introduce difficult area and performance based incentives 		

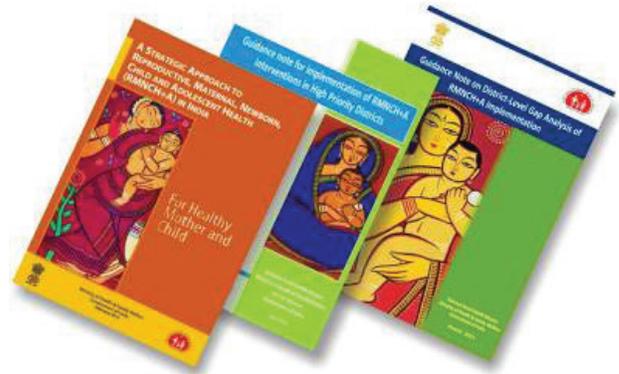
DEVELOPMENT OF RMNCH+A GUIDELINES AND TECHNICAL DOCUMENTS

The following guidelines and technical documents were prepared by the MOHFW in collaboration with development partners, including USAID through MCHIP:

- **Handbook on Improving Maternal and Child Health through RMNCH+A approach:** This is a shorter version of RMNCH+A strategy document that provides guidance to a broad range of stakeholders. The handbook is suitable for medical officers and program managers at various levels of implementation because it describes the strategic approach and the continuum of care concept. The handbook is expected to facilitate understanding of the seemingly complex set of interventions required to improve maternal and child health in India.
- **Guidance Note for Implementation of RMNCH+A Interventions in High-Priority Districts:** This note provides information on how the HPDs were selected and details the roles and responsibilities of DPs and other stakeholders in RMNCH+A implementation. The note gives a brief overview of steps to assess gaps in implementation and develop a district action plan that clearly specifies the technical support that the district will create to address these gaps and improve overall coverage, utilization, and quality of services.
- **Guidance Note on Block Monitoring:** To ensure that districts receive timely support to implement the most critical interventions, the DPs are expected to offer need-based district-level assistance, and to work alongside district- and block-level stakeholders to identify key bottlenecks and address them systematically. This guidance note outlines how to conduct this collaboration
- **Guidance Note on District-level Gap Analysis of RMNCH+A implementation:** This document offers broad guidance on the processes and expected outcomes of the district-level gap analysis, a rapid assessment of gaps in service availability, accessibility, utilization, and quality. The results of this initial rapid assessment are used to develop the district RMNCH+A implementation plans that address key gaps through short- and mid-term actions.
- **Key Performance Indicators and Quality Indicators:** To monitor the performance of the interventions identified in the RMNCH+A 5 X 5 matrix, MOHFW, with support from the BMGF Innovations Project, has developed a list of key performance indicators (KPIs) and quality indicators (QIs) for use by program managers at all levels across the country, with special focus on the 184 HPDs. Key performance indicators are ways to periodically assess the performance of organizations, departments, employees, or programmes. Quality indicators are statistical measures that give an indication of output quality or process quality. Accordingly, KPIs and QIs need to be defined in a way that is understandable, meaningful, and measurable.

Scorecards and Dashboards: All RMNCH+A activities emphasize effective use of data for planning and implementing interventions. The RMNCH+A strategy provides an opportunity to identify action points. Data from DLHS and AHS data were used to develop a 19-indicator National Child Survival Scorecard, and states are encouraged to develop similar state-level scorecards.

In addition, the focus is on using critical HMIS indicators across the lifecycle to develop quarterly service delivery dashboards to aid concurrent monitoring. The color-coded dashboard identifies performance by states, districts, and blocks as good (green), promising (yellow), poor (pink) and very poor performing (red) based on a composite index and also individually for the five thematic areas. Because it is based on concurrent data, performance can be tracked on a quarterly basis and variations or downturns can be identified and analyzed to ensure that intervention areas are prioritized accordingly.



“The aim of introducing key performance indicators (KPIs) and quality indicators (QIs) documents is to provide a better understanding of the progress and performance of RMNCH+A implementation at state/district level. KPIs and QIs will identify where performance is good and meeting desired standards, and where performance requires improvement to assure accessible high-quality health care throughout the country.”

—Dr. Rakesh Kumar

- Screened state PIPs to ensure that gaps identified through gap analysis exercises were reflected in the DHAPs.
- Supported the drafting of key performance indicators and quality indicators to assess progress of RMNCH+A at the district and state levels.

FORMATION AND FUNCTION OF STATE RMNCH+A UNITS (SRUS) AND STATE UNIFIED TEAMS (SUTS)

State RMNCH+A Units (SRUs) were established in all six USAID/MCHIP-supported states. The SRU coordinates RMNCH+A activities across all the HPDs within the states and provides technical assistance to the state program management unit (SPMU) particularly for planning, implementing, and monitoring strategies for delivery of priority interventions in the HPDs.

State Unified Team (SUTs) were formed throughout the states including those supported by USAID/MCHIP. The SUTs comprises representatives from state governments, medical colleges, state program management unit (SPMU), and DPs working in the state. SUTs functions as the overarching technical body supporting and reviewing implementation of the RMNCH+A strategy in each state.

STATE AND DISTRICT CONSULTATION MEETINGS: A BEST PRACTICE

To fast-track the implementation of the RMNCH+A approach, the Departments of Health, Medical Education and Family Welfare, in collaboration with USAID through MCHIP, organized state consultations on intensifying and harmonizing efforts in HPDs for improved maternal and child health outcomes. Key objectives were:

- Orienting state and district government officials, partner agencies, educational institutions, and other stakeholders on the RMNCH+A approach.
- Educating participants on HPDs and the government's plan to intensify action for improving maternal and child health outcomes.
- Discussing mechanisms for harmonizing technical assistance for integrated programming and monitoring for RMNCH+A interventions.

The consultations were a platform for discussing child survival and development in the states. During the consultations, participants were sensitized to the importance of intensification of efforts in HPDs through health system planning mechanisms, such as additional financial allocations, priority interventions across RMNCH+A, accreditation of private health institutions, improved demand for services, and intensive monitoring and evaluation. The consultations also emphasized the importance of developing blocks as units for implementation of all government programs.

The consultations emphasized the role of DPs in supporting implementation of the RMNCH+A strategy, and of the SLP, who acts as catalyst, and mentors who provide technical and managerial support to the state program management units (SPMUs) and the district program management units (DPMUs) using resources provided by the government. The consultations also emphasized the central role of deputy commissioners in planning and implementing the strategy. They also brought the medical colleges to the forefront to provide technical guidance to the HPDs and to strengthen the managerial skills of district functionaries. Each district will be assigned one of the state medical colleges.

Consultations also covered several steps to be taken by each state:

- **Identifying gaps** through situation analysis in the HPDs by assessment of health facilities, community services, and resource mapping. Based on the resulting evidence, district health plans need to be revised. Health system strengthening, addressing gaps, increased demand for services through behavior change communication (BCC), multi-sectoral planning, and supply chain management must also be addressed.

The state RMNCH+A consultations received strong support from the GOI, which sent high-level delegations led by Ms. Anuradha Gupta, IAS, Ex-Additional Secretary and Mission Director, MOHFW in three states (Punjab, Haryana, and Delhi). Dr. Rajesh Kumar, IAS, Joint Secretary, MOHFW in two states (Jharkhand and Himachal Pradesh) was present during the consultation at Punjab. Deputy commissioners from MOHFW took part in these consultations, as did senior members of the USAID India Mission.

- **Strengthening delivery points** through infrastructure upgrades, building human resources, providing essential drugs and commodities, and setting up state-specific targets as benchmarks for RMNCH+A interventions.
- **Improving monitoring** by strengthening the online Mother and Child Tracking System (MCTS) to follow high-risk pregnancies, children with low birth weight, and sick neonates.
- **Collaborating** with other stakeholders such as Panchayati Raj, the Ministries of Rural Development, Women and Child Development Departments, and NGOs.

The state consultations were held between July and October 2013 and attended by delegates from the entire health spectrum. These visits leveraged involvement and motivation of senior government officials.

DISTRICT-LEVEL CONSULTATIONS FOR ROLL OUT OF THE RMNCH+A APPROACH



District-level RMNCH+A orientation workshops were conducted in HPDs with MCHIP support between November 2013 and January 2014. The workshops were organized by the district administration in collaboration with the lead district partner. These events provided a platform for the formal launch of the RMNCH+A strategy in the districts. In the majority of the districts, workshops were chaired by the district collector with participation of important district administrators and officials including the civil surgeon cum chief medical officer, members of DPMU, district health officials, representatives of allied departments like Water & Sanitation, Social Welfare, Rural Development, and Education as well as partner and local NGO representatives. At most consultations, technical leads from the MCHIP national team and representatives from USAID shared their perspective and insights.

GAP ANALYSIS: PROCESS AND DISSEMINATION OF FINDINGS

The effectiveness of RMNCH+A interventions will depend on availability, acceptability, utilization, and quality of services. Analysis at various levels to address gaps in the delivery of a particular intervention or set of interventions is necessary.

The GOI conceptualized the district-level rapid gap analysis and facility assessment approach and developed standardized tools to facilitate it. Results from the rapid assessment provide evidence for the district RMNCH+A implementation plan, which should address key gaps through short- and mid-term actions.

MCHIP conducted gap analysis in the six USAID-supported states to assess the availability of infrastructure, human resources, equipment, service capacity and quality, and resources of key RMNCH+A interventions in facilities and communities, and to assess health system capacities at the district and state levels. MCHIP began the process with a training-of-trainers (TOT) for consultants and SRU team members on the GOI guidelines and tools. Assessment tools and schedules were developed according to the MOHFW guidance note on gap analysis.

The assessment was conducted between October and April 2014 at the designated delivery points. Primary data was collected with MCHIP support at 36 district-level facilities, 91 first-referral units (FRUs), 389 non-FRUs, and 406 sub-centers. In addition, 11,024 community-level interviews were conducted among pregnant women, mothers of children under five years of age, and adolescent girls in five USAID states.

Interviews with key stakeholders at state and district levels were conducted to assess the functioning of health systems. The MCHIP team established mechanisms for quality assurance during the assessment exercise. The national MCHIP team conducted joint field visits to 10% of the assessment sites and organized briefing meetings at the end of each day with the team of investigators to provide guidance and support. District officials including the district program manager (DPM) and members of district program management unit (DPMU) were updated periodically. In addition, data collected at 5% of the assessment sites were re-validated by the MCHIP national/state teams in the five states.

The findings were compiled and analyzed to identify critical gaps in service delivery. MCHIP prepared data and fact sheets and shared these with the DPM, civil surgeon, chief medical officer of health, and other officials to facilitate DHAP development, and with officials at the SPMU in preparation of state PIPs.

LEVERAGING NHM RESOURCES THROUGH STATE PIPS/DHAPS

Findings from the gap analysis across districts and blocks provide a sound evidence base, enabling district administrators to set targets and strategies to be used in DHAPs, including budgets for addressing structural, programmatic, and service weaknesses within facilities, communities, and health systems.

While planning RMNCH+A interventions, DHAPs and state PIPs can leverage NHM resources. States can allocate a 30% higher resource envelope per capita allocated for each HPD (within the overall state resource envelope under NHM). This provides flexibility in planning; states can use the higher resource envelope to offer incentives to medical and paraprofessional staff as part of the difficult area allowance; incentives could include free residential facilities or educational allowance for two children; and support staff motivation and retention in HPDs. This increased resource envelope aims to increase equity by ensuring that additional resources are available to people who live in areas with the greatest need.

The higher financial allocation for HPDs also facilitates creative strategies for infrastructure upgrades and provision of essential drugs and commodities. The assumption is that the package of financial and non-financial incentives offered will help attract and retain skilled workers in challenging and inaccessible areas.

BLOCK MONITORING

The RMNCH+A's District Intensification Plan designates the block, or district subdivision, as the primary unit for implementation and management of RMNCH+A interventions, and calls for local capacity development through mentoring support by the district and state management units along with SRU and SUT.

OBJECTIVES OF BLOCK MONITORING:

Quickly assess infrastructure, human resources, and provision of services at the facility and community level.

Assess quality and coverage of service delivery.

Review progress of community outreach and home- or community-based interventions.

Validate reported HMIS data.

Gauge client satisfaction with RMNCH+A services.

To ensure timely support to districts in implementing the most critical interventions, DPs are expected to offer needs-based, district-level assistance and work alongside district- and block-level stakeholders to identify and systematically address key bottlenecks.

Using a pre-determined block monitoring format prepared by the GOI, district-level monitors, assigned under MCHIP in USAID-supported states, visited one block each month in each HPD beginning in November 2013. Working with state- and district-level government representatives, the team visited first-referral units, primary health centres, community health centres, and a sample of sub-centres, and interacted with the community.

As of March 2014, MCHIP staff had conducted 55 block monitoring visits in 72 facilities in the USAID-supported states of Jharkhand, Himachal Pradesh, Haryana, Punjab, and Uttarakhand. Findings from the block monitoring visits were shared with the DPMU and SPMU, and action plans prepared for implementing corrective actions in a phased manner. Follow-up visits were made to ensure that gaps and suggestions have been addressed.

USE OF HIGHER RESOURCE ENVELOPE

In Tehri Garhwal, PHC Philki conducts more than 100 deliveries per month with only four beds. The Uttarakhand SRU raised this issue with the additional director, MCH, and a joint visit to PHC Philki was made. After the visit the state added a new ward of 20 beds to the PIP. Uttarakhand has also proposed 30 new delivery points in the three HPDs and is budgeting for set up of newborn corners.

ACCOUNTABILITY OF DEVELOPMENT PARTNERS THROUGH MONTHLY DP MEETINGS: AN INNOVATIVE BEST PRACTICE

One of the GOI's successful innovations in the implementation of RMNCH+A was the monthly meetings with DPs. The meetings are chaired by AS&MD with participation of senior officials from the MOHFW, DPs, and NRU and SRU members. This mechanism provides a very useful platform, enabling each SLP to discuss progress on HPD activities, challenges in implementation, and to plan for next month. During these meetings, the MOHFW shares the analysis of monitoring data from each state, sets priorities, and agrees on a corrective action plan.

PROCESSES TO RESULTS

States and districts have implemented key processes and mechanisms to utilize the data collected and address key gaps in PIPs and DHAPs. Action plans are being updated and efforts are being made to improve service delivery and quality.

Common gaps identified by the gap analysis process included:

Infrastructure

- Lack of habitable staff quarters
- Inappropriate disposal of biomedical waste

Delivery Facilities

- Lack of toilets attached to labor and delivery facility
- Lack of partograph charts
- Stockouts of key commodities including magnesium sulphate, vitamin K, misoprostol, and delivery kits

Newborn Care Services

- Absence of self-inflating bag and mask
- Absence of newborn digital weighing machine
- Absence of mucus extractor and suction tube

Availability of Essential Medicines

- Stockouts (during last three months) of amoxicillin/ampicillin
- Stockouts (during last three months) of betmethsone
- Stockouts (during last three months) of choramphenicol eye ointment

Availability of Essential RMNCH+A Commodities

Supply chain management was poor with wide gaps in the availability of required essential drugs and surplus supplies of some of medicines, leaving dead unused stock.

- Stockouts (during last three months) IFA tablets (large)
- Stockouts (during last three months) of IUCD kits (Suraksha)
- Stockouts (during last three months) of zinc sulfate and vitamin A syrup
- Stockouts (during last three months) of emergency contraceptive pills
- Stockouts (during last three months) of oral contraceptive pills

Health Systems

A high degree of disparity was observed between the sanctioned staff and staff in position in many districts. Quality of service provision is affected by inadequate capacity of the service providers at all levels (specialists, general, and paramedical staff) as trainings mandated under the MNH Toolkit guidelines for the respective category of specialists and other staff were not provided as required. Record maintenance at all levels, especially sub-center level, was a major issue due to lack of awareness among the ANMs to complete required forms and registers, high patient load, and extensive documentation to be maintained. This shortcoming has a negative impact on patient outcomes, project progress, and future planning for strengthening services. There were also major gaps in reporting of expenditures, and maternal, infant, and neonatal death at all levels.

When PIPs and DHAPs are approved, GOI will track implementation and allocation see if funds are being used for their intended purpose. The process continues to evolve as GOI has provided supportive supervision checklists and block monitoring guidance, and findings are shared at the state and district levels.

GOI is finalizing KPIs and QIs that were developed with the BMGF Innovations project. KPIs/QIs track both quality and coverage and were developed as per the RMNCH+A 5 X 5 Matrix. When they are formally released, states will be able to track critical high-impact interventions. Other gaps observed include:

- No defined district-level policy to fill contractual and permanent staff; no retention policy.
- Inadequate emergency ambulance service; ambulance staff not trained in emergency care.
- No verification or validation checks applied to check quality of data collected at various levels.
- Fund flow utilization at district and block levels delays release of funds.
- Resources are not allocated as per projections made to the state authority
- Non-availability/delay in implementation of district-level guidelines.

In areas of cultural or geographical isolation, beneficiaries may be unable to access services. Access challenges contribute to the low institutional delivery rates in some areas. Mechanisms to overcome this have been institutionalized such as in Janani Shishu Suraksha Scheme (JSSK), which provides referral transport services for pregnant women through the Mamta Vahan network (private vehicles have a memorandum of understanding with the state to ferry pregnant women to health facilities at time of delivery). This service is also provided for infants.

Birth spacing methods are being promoted in tribal areas because permanent family planning methods are not to be pursued. Such provision of services that can be taken up by the target population reflects a change in approach at the state level.

Antenatal Care

- Inadequate comprehensive emergency obstetric care (CeMOC)-trained doctors to manage high-risk and complicated pregnancies.
- Lack of blood sugar testing kit.
- Lack of urine albumin testing kit.

ADDRESSING GEOGRAPHIC ISOLATION

In Uttarakhand, a palanquin service has been included in the state PIP to transport patients through difficult terrain to meet an ambulance on the road. A palanquin is a box-like structure with poles that four or five men carry on their shoulders and is an ancient mode of conveyance to transport a single person. Today these are used symbolically for weddings and are known as dolis.

Uttarakhand is also addressing rational positioning of ambulance service in Pauri Garhwal District to reduce travel time and is planning to train dais (traditional birth attendants) in remote areas in safe delivery and basic newborn care.

Jharkhand has advanced distribution of misoprostol for safer home birth.

Immunization

- Vaccine stockouts, especially BCG.
- No standard record-keeping registers for vaccine stock and distribution.
- Incomplete microplans. Important annexure like vaccine logistics estimation, vaccine delivery plan, supervisory schedule, and communication and contingency plans lacking.
- Inadequate number of immunization sessions being monitored by supervisors.
- Poor injection safety and immunization waste management practices.

Postnatal care

- Beneficiaries not staying in the health facilities for 48 hours post-delivery
- Low early initiation of breastfeeding
- Not all newborns are examined before discharge
- Large gap between reported home-based newborn care (HBNC) visits by ASHA and actual home visits.
- Poor supportive supervision for HBNC by ANM/ASHA /district officials.
- Poor linkages to referral facilities for transportation of sick neonates.

Family Planning

- Low rates of IUCD insertion.
- Need for increased capacity of delivery point health staff.
- Low level of knowledge of PPIUCD services at community level.

Community-Level Interviews

- Pregnant women: low report of receipt of safe motherhood booklet.
- Pregnant women: low report of guidance and referral services provided with birth preparedness.
- Mothers of children under five: low report of visits by ANM/ASHA within 2 days of home delivery.
- Mothers of children under five: low awareness of at least two danger signs of diarrhea.
- Mothers of children under five: low report of currently using any type of contraceptive method
- Adolescent girls (10-19 years): low awareness about ARSH clinic at the government health facilities.
- Adolescent girls (10-19 years): low report of visit to any ARSH clinic.
- Adolescent girls (10-19 years): low report of counseling on menstrual hygiene by ASHA.
- Adolescent girls (10-19 years): low report of procurement of sanitary napkins from ASHA during last six months.

At the facility level however, the gap analysis approach measures readiness but not quality of care provided or outcomes. This is a limitation, but the gap analysis has proven to be an important tool in focusing state and HPD attention on small doable actions to correct long-standing problems, including allocating their own budgets to fill gaps, requesting supplemental resources through their PIPs, modifying their human resource strategies, and requesting technical support from the national programs, their SRU, and development partners. The GOI has introduced block monitoring and supportive supervision tools for continuous assessment to address gaps seen during the gap analyses and those that might arise in the future. The table below provides an list of actions that states and HPDs have elected to close identified gaps.

TABLE 3. ILLUSTRATIVE TABLE OF HOW USAID-SUPPORTED STATES AND DISTRICTS ARE ADDRESSING GAPS SEEN DURING GAP ANALYSIS AND BLOCK MONITORING (MAY 2014)

INFRASTRUCTURE UPGRADES

Jharkhand State Health Department took action to improve labor room practices in 16 district hospitals, community health centers, and primary health centers across six districts.

In 3 districts of Jharkhand, hospitals have shifted to new buildings to improve the physical infrastructure.

Bed occupancy in malnutrition treatment centers has improved from 46% in Q2 to 95% in Q4 (against state average of 60%) in Lohardaga District in Jharkhand due to constant emphasis on optimizing MTC services during the block monitoring visits and district review meetings.

In Uttarakhand, infrastructure-related gaps are being addressed in the DHPs that are funded by the state government. One short-term action is to set up blood storage facilities and training centers in each HPD.

There was no blood bank at the district hospital of Palwal in Haryana state. After feedback and regular follow-up, the district hospital has procured the license for the blood bank and is recruiting staff.

DELIVERY FACILITIES

Ultrasound machine at maternity home in Mangolpuri (Dehli State) was non-functional. MCHIP advocated for district to make it operational by end of May, 2014?

In Pauri District, Uttarakhand gaps identified during block monitoring led to plan for infrastructure upgrades at delivery points to ensure 24/7 running tap water in labor room and purchase of hydraulic operating theater table and ceiling lights.

Maternal and Newborn Health Toolkit has been made available at all block-level health facilities to strengthen delivery points in Uttarakhand according to national guidelines.

Proposal to create MCH wing at PHC Pilkhi (highest case load PHC facility in the state) included in Uttarakhand's 2014 PIP.

Partographs have been printed and distributed to all facilities in the State of Punjab.

NEWBORN CARE FACILITIES

Newborn care corners (NBCCs) established/operationalized in 8 facilities across 6 districts in Jharkhand.

NBCC established and provided with majority of essential equipment and commodities at delivery points in Uttarakhand districts of Tehri Garhwal, Haridwar, and Pauri Garhwal.

Two demonstration sites for NBCC proposed and one established in Tehri Garhwal District.

The guideline on vitamin K in the HPDs is now available and being used within 1 hour of birth in Punjab State.

COMMODITIES

Availability of essential equipment and commodities has improved. The Uttarakhand PIP proposes the hiring of a district-level logistic manager to strengthen supply chain management of RMNCH+A commodities.

Purchase of key RMNCH+A commodities from the United Funds and provisions under JSSK including purchase of magnesium sulfate and vitamin K in Uttarakhand. Procurement process for vitamin A and zinc has also been initiated.

In Haryana, all commodities in the 5 x 5 Matrix are now included in the essential drug list. After the dissemination of the gap analysis findings in Punjab State, the essential drug list was modified to include commodities as per the RMNCH+A 5 X 5 Matrix.

After feedback to education department authorities and district health officials in Mandi and Kinnaur Districts of Himachal Pradesh, implementation of the weekly iron and folic acid (WIFS) program has been regularized in some schools.

HEALTH SYSTEMS STRENGTHENING

District health action plans (DHAPs) of 11 HPDs prepared in a systematic manner for the first time in Jharkhand State.

Block monitoring visits found that staff nurses are conducting deliveries in Delhi State yet the training calendar did not plan to train staff nurses on PPIUCD. Plans have been made and approved by state officials to do so going forward.

Training need assessment for health staff has been planned in Uttarakhand.

A systematic review of existing data sources in Haryana was done by MCHIP. Based on some the recommendations, an exercise of rationalization of the various indicators in HMIS (i.e. reduction of indicators that are never reviewed or reported) was conducted. Development of an integrated portal capturing indicators from various sources across the spectrum of RMNCH+A programs has been initiated.

LESSONS LEARNED

When the Government of India launched the RMNCH+A strategy at the National Summit on the Call to Action for Child Survival in February 2013, there were no concrete plans or guidance for its introduction. Very soon after the national summit, senior MOHFW and NRHM officials mobilized, enlisting the health development partners, including USAID and MCHIP, to support the national RMNCH+A roll out, assigning a lead development partner for each state, creating national, state, and district RMNCH+A resource units with partner support, and subsequently, as described in earlier sections of this case study, preparing the guidelines, tools, and procedures that have turned the RMNCH+A strategy from a mere concept to an emerging reality in 29 states and 184 HPDs across India.

With little over a year since most of the initial state RMNCH+A consultations, it is clearly too early to measure the impact of RMNCH+A on health outcomes or even coverage levels. Nonetheless, individual states and HPDs are showing improvements and there have been important lessons learned or reinforced that should guide RMNCH+A refinement and expansion. The authors of this document believe that the Gol's experience, including the lessons learned, are important to share with other governments and partners who are also launching ambitious national efforts to accelerate reductions and eventually end preventable maternal and child death.

India's lessons during its first twelve months of RMNCH+A implementation include the following:

- Strong government leadership—at both national and state level—is critical when introducing a change of the magnitude that RMNCH+A represents. From the perspective of its development partners, the GOI has provided extraordinary leadership in the case of RMNCH+A. Not only did the strategy reach all states and HPDs in a short period of time, the Gol also ensured collective involvement across the political spectrum through an inclusive, consultative, and—crucially—apolitical process. This increases the likelihood that even with government change, the RMNCH+A strategy will continue. Involving and engaging district magistrates, the bureaucratic heads in the districts, and senior administrative officers from the beginning has been part of the RMNCH+A approach. More attention should be paid to engaging officials and community representatives in defining and monitoring the quality of RMNCH+A care as the strategy is expanded and taken to scale.
- To ensure a continuum of care through all life stages, a technical strategy like RMNCH+A's must include operational guidelines, training modules, job aids, and an information system that guides and supports implementation. These tools were prepared during RMNCH+A roll out, thanks to the leadership of the GOI and the active engagement of priority MOHFW programs and development partners. The 5 X 5 matrix of high-impact RMNCH+A interventions is an important tool for prioritizing interventions and explaining the strategy to all involved in simple terms. It also provides a simple framework for organizing technical support, identifying program gaps, and monitoring progress with the states and HPDs.

- Harmonization of development partner and GoI efforts succeeded in mobilizing external technical resources to support the RMNCH+A roll out. However, because technical direction and support were provided by different development partners at state, district, and block levels, coordination and harmonization across partners was sometimes a challenge. Regular program planning and review meetings between partners, led by state and national health officials, will be extremely important to ensure success and optimal use of technical support as RMNCH+A continues implementation.
- Multi-level gap analysis and continuous block monitoring played important roles in identifying strengths and weaknesses and increasing awareness among national, district and block officials of the need to improve the quality of RMNCH+A care. Increased involvement of state and district health officials in block monitoring (covering delivery points/health facilities) in many cases resulted in immediate corrective actions to improve service delivery, while larger gaps, affecting multiple blocks, were addressed through annual district health action plans and state program implementation plans in all of the USAID-supported states. Intensive technical assistance and mentoring of functionaries at various levels was an integral part of this component. The process is on-going and evolving.
- Monthly meetings led by the MOHFW with development partners and increased supportive supervision by GoI officials resulted in increased accountability for implementation of the RMNCH+A components. Scorecards were constructed and used to visually compare and discuss the performance of blocks and HPDs during review meetings. The degree to which the scorecards are understood and have affected the pace and results of RMNCH+A implementation should be evaluated over the next year.
- In the first year of RMNCH+A implementation, the focus has been on making the elements of the strategy known and identifying serious gaps in the availability and use of life-saving interventions. The quality of care provided to women, newborns, infants, young children and adolescents in health facilities and communities continues to be a serious concern for the GoI, one that deserves more attention in the second year of the RMNCH+A roll out.

RECOMMENDATIONS—THE WAY FORWARD

The RMNCH+A strategy was developed and rolled out very quickly, yet it is already yielding important results. The first phase of RMNCH+A involved orientation and sensitization of a diverse set of stakeholders to the RMNCH+A strategy, establishment of key processes for rolling out the strategy, and capacity building for different cadres of human resources. MCHIP recommends that GoI and development partners such as USAID focus during the next phase of RMNCH+A scale up on the following issues and actions:

- **Continuous monitoring, supportive supervision, and feedback mechanisms to improve quality of care and accountability:** The GoI is finalizing a set of key performance and quality of care indicators that are linked to the RMNCH+A 5 X 5 Matrix. These should be rolled out and used, along with simplified feedback mechanisms to raise awareness and hold officials and providers accountable for RMNCH+A results. Supportive supervision through continuous block monitoring, the Rapid Appraisal of Implementation in District (RAPID) approach, and other approaches are not only important for data collection and monitoring, but also in that they offer important opportunities for structured, on-site mentoring and coaching.
- **Test performance-based incentives under the RMNCH+A mandate:** The GoI has developed a strategy and indicators for incentivizing district performance and proposes to test it during the next phase of the RMNCH+A roll out. Performance-based incentives could be an important to ensure accomplishment of targets set out by the GoI under RMNCH+A and the 12th Five-Year Plan. Getting the incentives right is an important aspect of the new strategy that should be carefully studied during a pilot phase.
- **Increase attention to the availability and utilization of high-quality health services in urban areas:** The Urban Health Mission has been added under the National Health Mission to ensure equal focus on rural and urban health care needs. Urban health cannot be a replica of rural health because the contexts are different. The strong presence of the private sector must be leveraged to improve the quality of health care in urban settings. Likewise, intersectoral convergence and the active engagement of civil society, while important in rural areas, is even more important in efforts to improve the health of women, children and adolescents in urban settings.



- **Increase attention under the RMNCH+A mandate to the nutritional status of women and children:** In particular, the needs of severely anaemic women and severely acute malnourished (SAM) children require increased attention. The Government of India is initiating calcium and iron supplementation to improve maternal and infant survival, but successful operationalization will require greater convergence with the Department of Women and Child Development, given its presence in every village of India. Infrastructure and behavior change/communication interventions will also be required to improve the population's access to clean water and sanitation as these are also important in reducing the currently high levels of maternal and child malnutrition.
- **Strengthen the continuum of care from community to facility through improved community mobilization and behavior change communication approaches:** to ensure that messaging and delivery channels are consistent with and comprehensive enough to cover the full range of RMNCH+A interventions and services.
- **Increase the involvement of the private sector and CSOs in the RMNCH+A roll out to ensure saturation of services in both urban and rural areas:** In 2014, the GOI added a 6% allocation within the revised NHM guidelines for community-based organizations that is intended to facilitate their engagement and sustain their efforts in the execution of the RMNCH+A strategy. The degree to which this allocation has reached community-based organization and how they have used the additional resources is not yet know, but should be studied. USAID should support the GOI to facilitate the involvement of private sector and civil society organizations in expanding service availability to all areas. An evaluation of the initial 6% allocation for community-based organizations would be a good starting point in the effort to institutionalize and maximize this CSO investment in the future.
- **Continue to focus on larger health system strengthening issues, including the rational deployment of human resources, availability of essential commodities, infrastructure improvement, and the task shifting.** The Gap Analysis exercise in each state highlighted serious deficiencies in all of these areas. USAID implementing partners and other development agencies should continue to provide support not only to highlight but also to help state governments address these problems.
- **Foster innovations and systematically evaluate, document and share best practices to enhance policy, service delivery, financing and accountability mechanisms across India:** Innovations in implementation achieved by various development partners should be captured, documented, and advocated for scale-up. Advocacy with multiple levels of government and all stakeholders to enhance their involvement and promote sustainability and scale up of best practices will be required.

Finally, the authors of this paper—USAID and MCHIP—believe that India's RMNCH+A experience should be shared widely outside of India, to inspire other countries and development agencies to develop similarly ambitious national efforts. As a co-sponsor of the "Global Call to Action for Child Survival" in 2012, the Government of India has successfully harnessed the global momentum and commitment to ending preventable child and maternal deaths and focused it at home. India's experience is uniquely its own, of course, but we believe that there are many elements of India's RMNCH+A strategy, including its guidelines, tools, job aids, and processes, that could be adapted and transferred to other settings to produce similar results. The critical ingredient to success in India and elsewhere, however, is always strong government leadership. The GOI has demonstrated its commitment and played an extraordinarily proactive leadership role from the beginning of the RMNCH+A strategy development through its national roll out. We applaud their efforts and look forward to continuing USAID's support at national and state level during the exciting next phase of India's national RMNCH+A implementation.

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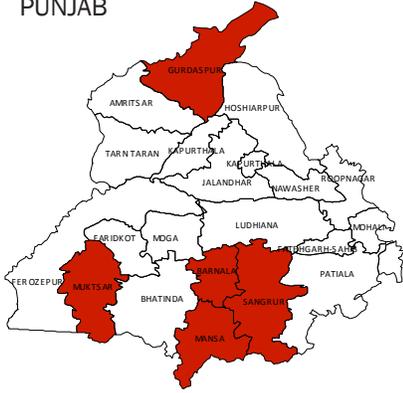
ANNEXES

ANNEX 1. HIGH-PRIORITY DISTRICTS AND STATE LEAD PARTNERS

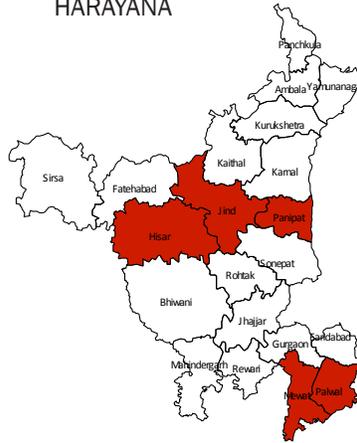
DEVELOPMENT PARTNERS	STATES	HIGH-PRIORITY DISTRICTS	BLOCKS
UNICEF	17	84	607
USAID	6	30	212
Bill & Melinda Gates Foundation	2	29	368
DFID	2	25	176
UNFPA	1	10	65
Norway India Partnership Initiative	1	6	27
TOTAL	29	184	1455

ANNEX 2. USAID SUPPORTED HIGH PRIORITY DISTRICTS FOR RMNCH+A IN SIX STATES

PUNJAB



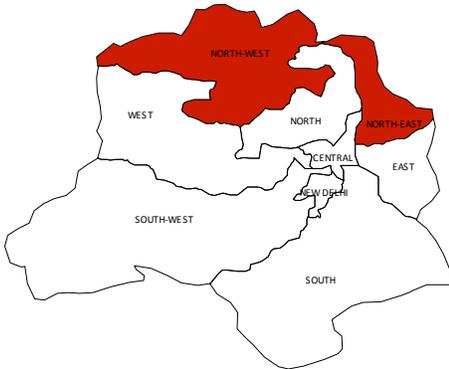
HARAYANA



HIMACHAL



DELHI



UTTARAKHAN



JHARKHAND



ANNEX 3. RMNCH+A 5 X 5 MATRIX



5 X 5 Matrix for High Impact RMNCH+A Interventions

To be Implemented with High Coverage and High Quality



Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
<ul style="list-style-type: none"> Focus on spacing methods, particularly PPIUCD at high case load facilities Focus on interval IUCD at all facilities including subcentres on fixed days Home delivery of Contraceptives (HDC) and Ensuring Spacing at Birth (ESB) through ASHAs Ensuring access to Pregnancy Testing Kits (PTK-"Nischay Kits") and strengthening comprehensive abortion care services. Maintaining quality sterilization services. 	<ul style="list-style-type: none"> Use MCTS to ensure early registration of pregnancy and full ANC Detect high risk pregnancies and line list including severely anemic mothers and ensure appropriate management. Equip Delivery points with highly trained HR and ensure equitable access to EmOC services through FRUs; Add MCH wings as per need Review maternal, infant and child deaths for corrective actions Identify villages with high numbers of home deliveries and distribute Misoprostol to selected women in 8th month of pregnancy for consumption during 3rd stage of labour; Incentivize ANMs for home deliveries 	<ul style="list-style-type: none"> Early initiation and exclusive breastfeeding Home based newborn care through ASHA Essential Newborn Care and resuscitation services at all delivery points Special Newborn Care Units with highly trained human resource and other infra structure Community level use of Gentamycin by ANM 	<ul style="list-style-type: none"> Complementary feeding, IFA supplementation and focus on nutrition Diarrhoea management at community level using ORS and Zinc Management of pneumonia Full immunization coverage Rashtriya Bal Swasthya Karyakram (RBSK): screening of children for 4Ds' (birth defects, development delays, deficiencies and disease) and its management 	<ul style="list-style-type: none"> Address teenage pregnancy and increase contraceptive prevalence in adolescents Introduce Community based services through peer educators Strengthen ARSH clinics Roll out National Iron Plus Initiative including weekly IFA supplementation Promote Menstrual Hygiene
<h3>Health Systems Strengthening</h3> <ul style="list-style-type: none"> Case load based deployment of HR at all levels Ambulances, drugs, diagnostics, reproductive health commodities Health Education, Demand Promotion & Behavior change communication Supportive supervision and use of data for monitoring and review, including scorecards based on HMIS Public grievances redressal mechanism; client satisfaction and patient safety through all round quality assurance 		<h3>Cross Cutting Interventions</h3> <ul style="list-style-type: none"> Bring down out of pocket expenses by ensuring JSSK, RBSK and other free entitlements ANMs & Nurses to provide specialized and quality care to pregnant women and children Address social determinants of health through convergence Focus on un-served and underserved villages, urban slums and blocks Introduce difficult area and performance based incentives 		



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