MATHEMATICA
Policy Research

Evaluation and Learning for the Maternal Health Quality of Care Strategy in India: **Phase I Report**

So O'Neil, Divya Vohra, and Shamama Siddiqui

April 2018

Submitted to:
MacArthur Foundation
140 South Dearborn St. Suite 1200
Chicago, IL 60603-5285
Project Officer: Joanna Cohen
Contract Number: CON-00000199

Submitted by:
Mathematica Policy Research
955 Massachusetts Avenue, Suite 801
Cambridge, MA 02139
Project Director: So O'Neil
Reference Number: 50586

This page has been left blank for double-sided copying.

CONTENTS

EXECUTIVE SUMMARY vii

LIST OF ACRONYMS xiii

I. INTRODUCTION 1

A. Evaluation and learning to support a responsible exit 1

B. Grants under the maternal health quality of care strategy 2

II. FRAMEWORK FOR ASSESSING PROGRESS AND OUTCOMES 5

A. Logic model and indicators for assessing the strategy's progress 6

III. SUPPLY SUBSTRATEGY: PROGRESS TO DATE 9

Approach 1.1. Strengthening human resources to increase provision of quality services 10

Approach 1.2. Strengthening facility-based quality assurance systems 12

Approach 1.3. Improving adherence to existing quality protocols and guidelines 15

IV. DEMAND SUBSTRATEGY: PROGRESS TO DATE 17

Approach 2.1. Informing women and families about quality and their rights 18

Approach 2.2. Supporting development and testing of community accountability mechanisms 20

Approach 2.3. Scaling up legal strategies to strengthen access to quality services 22

V. ADVOCACY SUBSTRATEGY: PROGRESS TO DATE 25

Approach 3.1. Generating new and leverage existing evidence 25

Approach 3.2. Promoting civil society efforts for maternal health advocacy and support 27

Approach 3.3. Using evidence and advocacy to sustain maternal health quality of care efforts 29

VI. LEARNINGS AND IMPLICATIONS FOR THE FIELD 31

CONCLUDING REMARKS 36

APPENDIX A SUPPLEMENTAL EXHIBITS A.1

TABLES

I.1. Maternal health quality of care strategy grantee organizations 3
III.1. Supply substrategy priority indicators, by approach 9
III.2. Facilities offering training on maternal health practices 13
IV.1. Demand substrategy priority indicators, by approach 17
V.1. Advocacy substrategy priority indicators, by approach 25
V.2. Key state- and national-level networks and advocacy efforts (Indicator 3.2.1) 28
VI.1. Lessons learned 31

FIGURES

I.1. Grant portfolio under the MHQoC strategy, by substrategy and implementation geography 4
II.1. MHQoC strategy conceptual framework 5
II.2. MHQoC strategy logic model 7
III.1. Curricula developed under MHQoC strategy 11
III.2. Common accreditation and certification options, and number of facilities obtaining accreditation or certification to date (Indicator 1.2.2b) 14
IV.1. Strategies for engaging community leaders (Indicator 2.1.2) 19
IV.2. Community accountability mechanisms implemented and actions taken 21
IV.3. Individuals trained to use legal strategies 23
V.1. Funding sources for MHQoC strategy grantees 29
VI.1. The continuous quality improvement process for health facilities 32

EXHIBITS

A.1. Strategy-level indicators A.3
A.2. Grant reporting on strategy indicators (total grants = 28) A.5
A.3. Providers' trainings and capabilities (Approach 1.1) A.6
A.4. Participation in community accountability and awareness of rights (Approach 2.1) A.8
A.5. Publications documenting new and leveraging existing evidence (Output 3.1.1 and Outcome 3.1.2) A.9

IN THIS PHASE 1 REPORT FOR THE MATERNAL HEALTH QUALITY OF CARE STRATEGY IN INDIA

This report presents findings from evaluation and learning activities conducted during Phase 1 (June 2015 through March 2017) of the John D. and Catherine T. MacArthur Foundation's maternal health quality of care strategy (2015–2019) in India, which aims to catalyze a shift in focus within the maternal health community from increasing access to maternal health services to improving the quality of maternal health care. The report documents progress to date under each of the strategy's three substrategies (supply, demand, and advocacy), assesses overall progress toward targeted outcomes, and highlights key learnings from Phase 1 implementation efforts and their implications for the strategy and the broader field moving forward. The results draw on multiple data sources (strategy and grant documents, key informant interviews, and grantee site visits), and will serve as a starting point for assessing further progress in the remaining years of the strategy.

This page has been left blank for double-sided copying.

EXECUTIVE SUMMARY

For more than 20 years, the John D. and Catherine T. MacArthur Foundation (the Foundation) has supported work to improve population and reproductive health (PRH) in India. After making significant progress in this field, particularly in the areas of maternal health and rights, the Foundation is preparing to exit the PRH field in India and is supporting a concluding round of grant-making focused on maternal health quality of care (MHQoC). Through this four-year MHQoC strategy, the Foundation aims to advance maternal health by supporting a shift in the field's focus from access to quality of maternal health care. To accomplish this goal, the strategy supports three main areas of work, or substrategies: (1) strengthening the supply of quality maternal health services, (2) building the demand for quality services through accountability mechanisms, and (3) building an evidence base and support for MHQoC.

The MHQoC strategy officially launched in June 2015. To carry out the work of the strategy, the Foundation has funded 20 grantees through 28 grants. All grantees have worked in the field for a decade or longer and are primarily India-based nongovernmental organizations, with a handful of United States-based or international nonprofit organizations. The grants' work spans 16 of India's 29 states and addresses a variety of maternal health topics within the three substrategies. These grants will conclude at different times, with the last ending in September 2019. To measure progress toward the strategy's goals, the Foundation engaged an evaluation partner, Mathematica Policy Research, to refine a logic model to describe the strategy's specific inputs and activities, and the linkages between the activities and anticipated program outputs and outcomes. In addition, Mathematica, in collaboration with the Foundation, identified a set of 28 priority indicators for each output and outcome in the logic model for tracking progress, and using these indicators, conducted an evaluation of overall strategy progress.

This report describes progress on these priority indicators from the beginning of the MHQoC strategy in June 2015 through March 2017, which was Phase 1 of the evaluation. For grantees that conducted related MHQoC activities before the official launch, the evaluation also includes relevant indicator information from that period as part of Phase 1. The indicators that use data from Phase 1 describe the state of MHQoC at the start of the strategy and lay the foundation for assessing progress over time. Information from the same set of indicators will be collected from grantees for the subsequent years of the strategy. In this report, Mathematica summarizes achievements or challenges to date along each substrategy, providing context to understand progress during this period whenever possible.

Strengthening the supply of quality maternal health services (supply substrategy)

The supply substrategy addresses MHQoC through improvements in the *clinical services* available and provided to women, with the goal of shifting the field's emphasis from providing access to services toward ensuring that services meet nationally and internationally recognized standards of quality. In particular, this substrategy aims to do this through three approaches: (1) strengthening the number and skills of the people providing health services, (2) strengthening infrastructure and operations at facilities to support delivery of high quality services, and (3) improving adherence to quality protocols and guidelines across the health system. In this substrategy, the Foundation awarded 12 grants, which span 12 indicators.

Supply: Summary of progress during Phase 1

- The strategy has increased the capacity of health workers—training more than 18,000 facility- and community-based health professionals on MHQoC across five states. Most trained providers report that their skills improved. Continued support and mentorship are required to ensure that providers maintain their ability to deliver high quality care.
- Some progress has been made on institutionalizing quality assurance (QA) mechanisms in more than 250 facilities and applying for or obtaining accreditation for 164 facilities. It remains to be seen whether (1) facilities can continue to use these QA mechanisms in the long term and (2) these mechanisms will lead to improved maternal health outcomes.
- More than 300 facilities have received technical assistance (TA) on QA and have improved their adherence to quality standards; 54 public health centers under one grant have received TA for emergency obstetric care, a set of skills and practices considered essential to MHQoC and to preventing maternal morbidity and mortality. It is likely that TA will reach many more facilities before the strategy ends.

Building the demand for quality services through accountability mechanisms (demand substrategy)

The MHQoC strategy seeks to build demand for high quality maternal health care by holding governments and health institutions accountable for delivering high quality care. Specifically, the strategy seeks to accomplish this by developing community accountability mechanisms and empowering women and communities to participate in them, and by using legal strategies to hold the government accountable for providing quality care. This demand-building process begins with (1) informing women and their families about the importance of MHQoC and their right to high quality care, (2) supporting community accountability mechanisms that give community members a way to organize and make their voices heard, and (3) using legal strategies to strengthen access to quality services as the highest means of recourse. The Foundation awarded nine grants, which span 10 indicators in this substrategy.

Demand: Summary of progress during Phase 1

- More than 10,000 women and 300 community leaders have received information about health care quality and health rights, resulting in moderate increases in knowledge. However, it is not yet known whether observed increases in knowledge about health rights have led to greater demand for or use of health services.
- Seven grants under the MHQoC strategy are intended to test five community accountability mechanisms: (1) community-based monitoring, (2) community-based maternal death reviews, (3) social autopsies, (4) grievance redressal mechanisms, and (5) hospital management societies (tested in Uttar Pradesh, Madhya Pradesh, Odisha, Jharkhand, and Gujarat). These efforts have resulted in upgrades to facility infrastructure and additional human resources at facilities. However, some government officials have perceived some efforts as challenging their authority.
- Legal strategies to ensure access to quality health services have led to more than 1,400 legal and allied professionals trained on MHQoC rights; the development of six state-level networks focused on reproductive health rights in Jharkhand, Bihar, Uttar Pradesh, Rajasthan, Maharashtra, and Odisha; and a number of high-profile petitions and successful public interest litigations related to negligence resulting in maternal deaths and banning of sterilization camps. Support for such legal strategies in the MHQoC field is rare; other funders and supporters of these activities will have to be identified to continue this work.

Building an evidence base and support for quality maternal health services (advocacy substrategy)

To support MHQoC practices and policies, the strategy engages in advocacy activities at the community, state, and national levels to draw attention and resources to quality of care issues. The strategy strives to create an enabling environment for MHQoC in the areas of delivery and neonatal care, preconception care for young married women, and abortion, among other key maternal health areas. It does this through three intersecting approaches: (1) generating new and leveraging existing evidence that can be used for advocacy, (2) promoting civil society efforts for maternal health advocacy and support, and (3) using evidence and advocacy to sustain MHQoC efforts supported under the strategy. Although only 6 grants focus explicitly on advocacy, 14 grants have contributed some evidence to the field, and all 20 grantees provided some information on the six indicators in this substrategy.

Advocacy: Summary of progress during Phase 1

- At least 10 research articles and technical reports produced under the strategy contributed new evidence to the field of MHQoC. Another seven publications synthesized existing evidence on respectful maternity care, sex-selective abortion, and other maternal health topics. National- and state-level health officials have used the results from these studies to inform some official policies related to maternal health, but more information is needed on the extent to which policymakers use this information.
- Strategy-supported advocacy campaigns have been launched within the past 18 months; it is difficult to judge their contribution to state- and national-level policy and programming agendas at this early stage. However, these campaigns have led to some observable changes, such as the addition of relevant equipment, supplies, or human resources to state program implementation plans and budgets in Gujarat and Rajasthan.
- Eight of the 20 grantees have secured other funding sources for work related to MHQoC during Phase 1. Among grantees that have secured additional funding, the Indian government and foreign philanthropies were the most common sources of support. Most grantees find it challenging to consider sustainability and seek new funding; only four have taken advantage of resources provided by the strategy to support sustainability planning.

Learnings and implications for the field

In addition to the findings on key indicators discussed here, several key lessons have emerged that can inform future work within the MHQoC strategy and the broader field:

- **Supply substrategy.** Defined standards provide a uniform tool to help facilities achieve quality improvements; a culture of mentorship and continuous QA and quality improvement helps to maintain quality.
- **Demand substrategy.** Community accountability mechanisms have gained traction in some areas, but best practices for ensuring institutional responsiveness to community-led monitoring and planning efforts are still emerging.
- **Advocacy substrategy.** Policymakers have an appetite for evidence.
- **Cross-cutting.** Identifying and translating key elements of emerging program models and their relevance to other contexts are necessary steps to bringing these programs to a wider audience.

- **Cross-cutting.** Sustainability is a challenge for many nongovernmental organizations because they have limited capacity to incorporate it in their planning as a core program component.
- **Cross-cutting.** Aligning maternal health quality activities with priorities of the Indian government and other key decision makers can promote their engagement and uptake of activities. However, some circumstances may require an entity to challenge the status quo to catalyze change.

Concluding remarks

To date, the MHQoC strategy has demonstrated progress along most indicators, particularly on training providers, accrediting facilities, informing women about health rights and engaging them in community accountability activities, training legal and allied professionals on the use of legal strategies, and generating evidence to support MHQoC. The strategy has experienced more challenges in institutionalizing QA systems and processes, testing and gaining buy-in for some community accountability mechanisms, and obtaining long-term and systemic quality improvements through community accountability. In addition, the strategy is still in the early stages of supporting most advocacy campaigns, and the effectiveness of these campaigns at prioritizing MHQoC on the state and national stages remains to be seen. The lessons generated through Phase 1 may help guide future work under the strategy. In future years, grantees' contributions to key indicators will be used to chart the progress made after Phase 1, enable a deeper analysis of the most successful approaches and substrategies, and determine which intermediate and long-term outcomes in the logic model will be achieved.

ACKNOWLEDGEMENTS

So O'Neil, Divya Vohra, and Shamama Siddiqui at Mathematica Policy Research developed this report with funding from the John D. and Catherine T. MacArthur Foundation. The views and opinions expressed in this review are those of the authors and do not necessarily reflect the official policy or position of the Foundation. The authors gratefully acknowledge the valuable contributions of Joanna Cohen, Dipa Nag Chowdhury, and Erin Sines at the MacArthur Foundation. We also thank Kimberly Smith at Mathematica for her thoughtful comments on the draft report, and Brigitte Tran and Sheena Flowers at Mathematica for their graphical and production support. Finally, we thank the MacArthur Foundation grantees for their time and effort spent providing us with rich information during interviews and site visits, and for their insightful comments and suggestions on the draft report. For more information about the Foundation's Population and Reproductive Health program, please visit https://www.macfound.org/programs/population/.

This page has been left blank for double-sided copying.

LIST OF ACRONYMS

ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWW	Anganwadi worker
CBM	Community-based monitoring
CHC	Community health center
CSO	Civil society organization
CSR	Corporate social responsibility
EmOC	Emergency obstetric care
FLW	Frontline worker
ISO	International Organization for Standardization
JSSK	Janani Shishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana
MHQoC	Maternal health quality of care
MSAM	Mahila Swasthya Adhikar Manch
NABH	National Accreditation Board for Hospitals and Healthcare Providers
PHC	Primary health center
PRH	Population and reproductive health
QA	Quality assurance
RKS	Rogi Kalyan Samiti (hospital management society)
SABLA	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
TA	Technical assistance
WRAI	White Ribbon Alliance India

This page has been left blank for double-sided copying.

I. INTRODUCTION

The John D. and Catherine T. MacArthur Foundation has a long history of working to improve population and reproductive health (PRH) around the world. During the 1994 International Conference on Population and Development, the Foundation supported a paradigm shift in the field of reproductive health from population control to sexual and reproductive health and rights. Since then, the Foundation has worked across several countries, including India, to support innovations in PRH. The Foundation's PRH program in India, established in 2003, has funded innovative policies and programs to reduce maternal mortality, with a focus on achieving three key objectives: (1) developing community-based models for reducing maternal morbidity and mortality; (2) enhancing the skills of health professionals; and (3) supporting informed advocacy, research, and pilot interventions, including efforts aimed at delaying age at marriage and expanding access to safe abortion services.

Since the MacArthur Foundation launched its PRH program in India, the country has experienced widespread improvements in access to health care, including maternal health services. However, maternal morbidity and mortality rates remain high, suggesting that further improvements in access to maternal health care are unlikely to generate significant improvements in health outcomes.[1] To accelerate reductions in morbidity and mortality rates, other issues besides access—particularly quality of maternal health care—must be addressed. Responding to this need, the Foundation launched a four-year (June 2015– September 2019) maternal health quality of care (MHQoC) strategy in June 2015, which aims to catalyze another paradigm shift, this time in the maternal health arena within India—changing the focus from increasing *access* to maternal health services to improving the *quality* of these services. The MHQoC strategy marks the final stage of the Foundation's grant-making to support PRH in India, and seeks to build a foundation and momentum for further maternal health quality improvements after the Foundation exits the country. To this end, it includes three key substrategies: (1) strengthening the supply of quality maternal health services in both the public and private sectors, (2) building demand for quality services through accountability mechanisms, and (3) building evidence and supporting advocacy for quality maternal health services.

A. Evaluation and learning to support a responsible exit

Because the MHQoC strategy is the concluding round of grant-making by the Foundation for PRH in India, and because focusing on quality of care has strong potential as a mechanism to catalyze improvements in maternal health, the Foundation incorporated a multiyear and multicomponent evaluation and learning effort into the strategy. The goal for evaluation and learning is to collect and synthesize information about the extent to which the strategy has made progress toward its intended results, and to share this information with the maternal health community to support further innovations and improvements in the field.

[1] World Health Organization, UNICEF, United Nations Population Fund (UNFPA), World Bank Group, and the United Nations Population Division. "Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division." Geneva, Switzerland: WHO, 2015.

To accomplish these activities, the Foundation has engaged an external evaluation partner, Mathematica Policy Research, to refine a framework along which progress and outcomes are assessed, gather information to assess progress along each substrategy, and synthesize overall contributions, cross-cutting learnings, and implications for the maternal health community across substrategies.

This report presents progress made by the overall MHQoC strategy along key indicators. The indicators discussed in the subsequent chapters are for the Phase 1 period, which was June 2015 to March 2017. The report also draws information from before June 2015, when the strategy officially launched, as many grantees were conducting similar work funded by the Foundation. As such, the indicators lay the foundation for assessing progress over time. Grantees will report on the same set of indicators for subsequent years of the project. Although indicators at one point in time cannot show progress or change toward goals between time periods, these initial data demonstrate achievements (as well as challenges) to date.

The rest of this chapter describes the strategy through an overview of the grants that compose its portfolio. The chapters that follow present the evaluation and learning framework (Chapter II), a discussion of progress along each substrategy (Chapters III–V), and a synthesis of learning (Chapter VI).

B. Grants under the maternal health quality of care strategy

Under its MHQoC strategy, the Foundation has awarded a total of 28 grants to 20 organizations (Table I.1). Reflecting the Foundation's interest in building local capacity and sustainability, 14 of the 20 grantee organizations selected are based in India, and most have worked on reproductive and maternal health issues for more than 20 years. The grants are spread across the MHQoC strategy's three substrategies: 12 focus on strengthening the supply of quality maternal health services, 9 aim to build demand for quality services, and 7 aim to support advocacy efforts.[2]

The sizes of the grants range from $75,000 to $2.2 million, with most grants (24 of 28) totaling $500,000 or less.[3] The grant portfolio supports activities in 16 of India's 29 states, including Andhra Pradesh, Arunachal Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Meghalaya, Odisha, Rajasthan, Uttar Pradesh, and West Bengal (Figure I.1). Organizations began to implement activities under the strategy from 2015 to 2017 and will conclude at different times, with final activities ending by 2019.

[2] For the purposes of this report, Mathematica has categorized grants according to the substrategy in the conceptual framework to which it contributes most, even if the grant work also contributes to other substrategy areas.

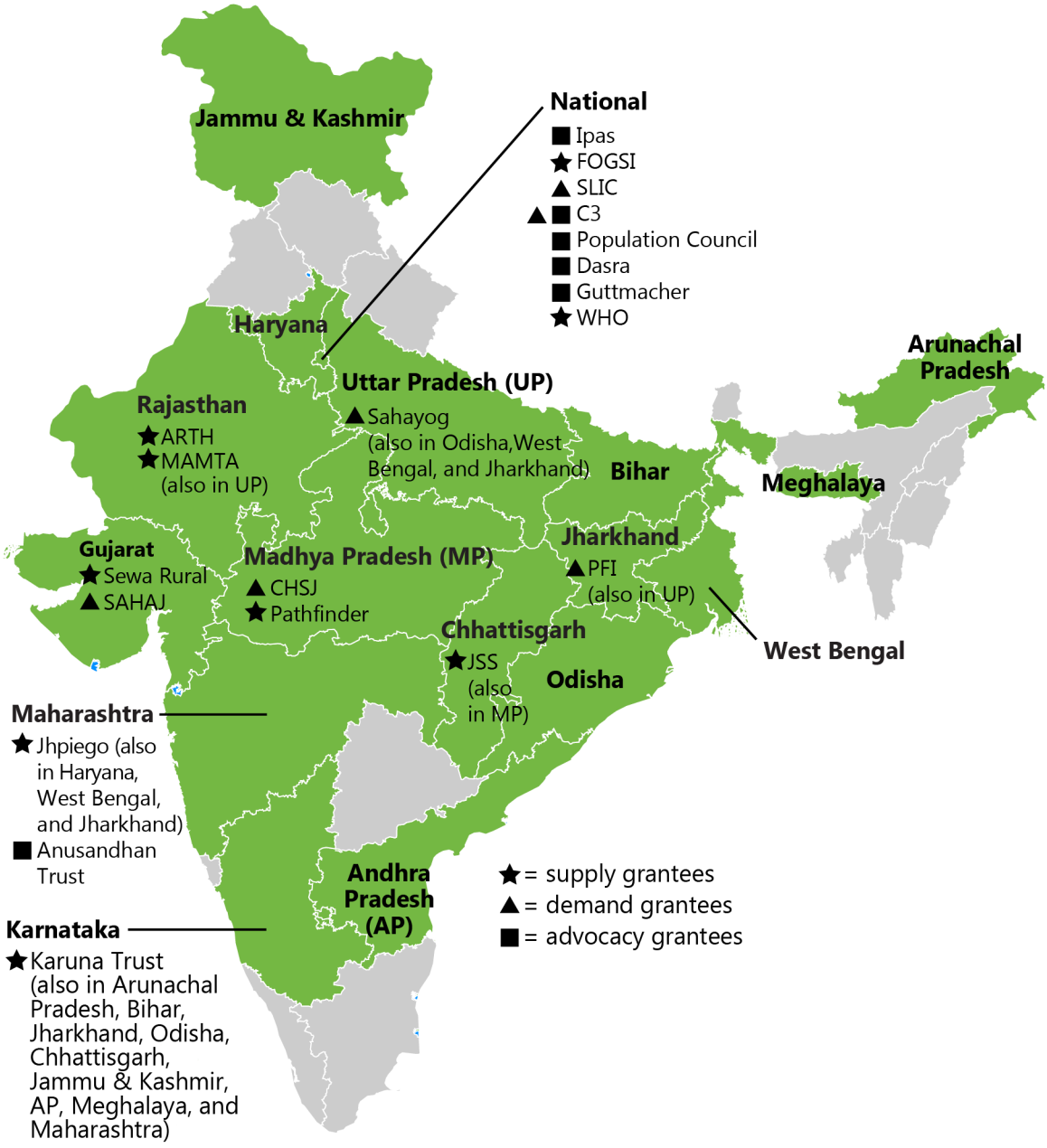
[3] Of the 28 grants, 14 began before June 2015, when the MHQoC strategy began; these grants either extend through the current strategy or include additional grants after 2015 that built on the previous work.

Table I.1. Maternal health quality of care strategy grantee organizations

Grantee	Year founded	Organization headquarters	Mission
Action Research and Training for Health Society (ARTH)	1997	Udaipur, India	To help communities access and manage health care according to their needs and capacity, by using research and training initiatives
Anusandhan Trust	1991	Mumbai, India	To undertake research on health and allied themes
Centre for Catalyzing Change (C3)	2001	New Delhi, India	To equip, mobilize, educate, and empower women and girls to achieve gender equality
Centre for Health and Social Justice (CHSJ)	2006	New Delhi, India	To strengthen civil society toward an equitable, just, and inter-dependent society, and accountable and inclusive governance; through this, the state and society will be enabled to uphold health rights, gender justice, well-being, and dignity of all, especially the marginalized and socially excluded communities
Federation of Obstetric and Gynecological Societies of India (FOGSI)	1950	Mumbai, India	To support and protect the interests of practitioners of obstetrics and gynecology in India
Guttmacher Institute	1968	New York, United States	To advance sexual and reproductive health and rights in the United States and globally
Impact Foundation India (Dasra)	1999	Mumbai, India	To drive collaborative action to accelerate social change
Ipas	1973	North Carolina, United States	To end preventable deaths and disabilities from unsafe abortion
Jan Swasthya Sahyog (JSS)	1996	Chhattisgarh, India	To develop a low-cost and effective health program that provides both preventive and curative services in the tribal and rural areas of Bilaspur and surrounding areas of Chhattisgarh in central India
Jhpiego	1973	Maryland, United States	To improve the health of women and families in developing countries
Karuna Trust	1986	Bangalore, India	To develop a dedicated service-minded team that enables holistic development of marginalized people, through innovative, replicable models with a passion for excellence
MAMTA Health Institute for Mother and Child	1990	New Delhi, India	To empower the underserved and marginalized individuals and community through gender-sensitive participatory processes for achieving optimal and sustainable health and development
Pathfinder International	1957	Massachusetts, United States	To champion sexual and reproductive health and rights worldwide, mobilizing communities most in need to break through barriers and forge their own paths to a healthier future
Population Council	1952	United States	To improve the reproductive health and well-being of the most vulnerable individuals in developing countries
Population Foundation of India (PFI)	1970	New Delhi, India	To advance people's reproductive rights within a human rights and women's empowerment framework, by building leadership and public accountability, influencing social movements, reframing discourse, and promoting an enabling program and policy environment
SAHAYOG	1992	Lucknow, India	To promote gender equality and women's health from a human rights framework by strengthening partnership-based advocacy
Society for Health Alternatives (SAHAJ)	1984	Vadodara, India	To strive for health of poor communities—health defined in a broad sense to encompass the social, spiritual, economic, and political aspects
Society for Education Welfare and Action Rural (SEWA Rural)	1986	Jhagadia, India	To reach out and assist the poorest of the poor through various health and development programs based on community needs and available manpower
Socio-Legal Information Centre (SLIC)	1991	New Delhi, India	To use the legal system to advance human rights and ensure access to justice
World Health Organization	1948	Geneva, Switzerland	To improve equity in health, reduce health risks, promote healthy lifestyles and settings, and respond to the underlying determinants of health

Source: Mathematica Policy Research's analysis of grant documents, 2017.

Figure I.1. Grant portfolio under the MHQoC strategy, by substrategy and implementation geography



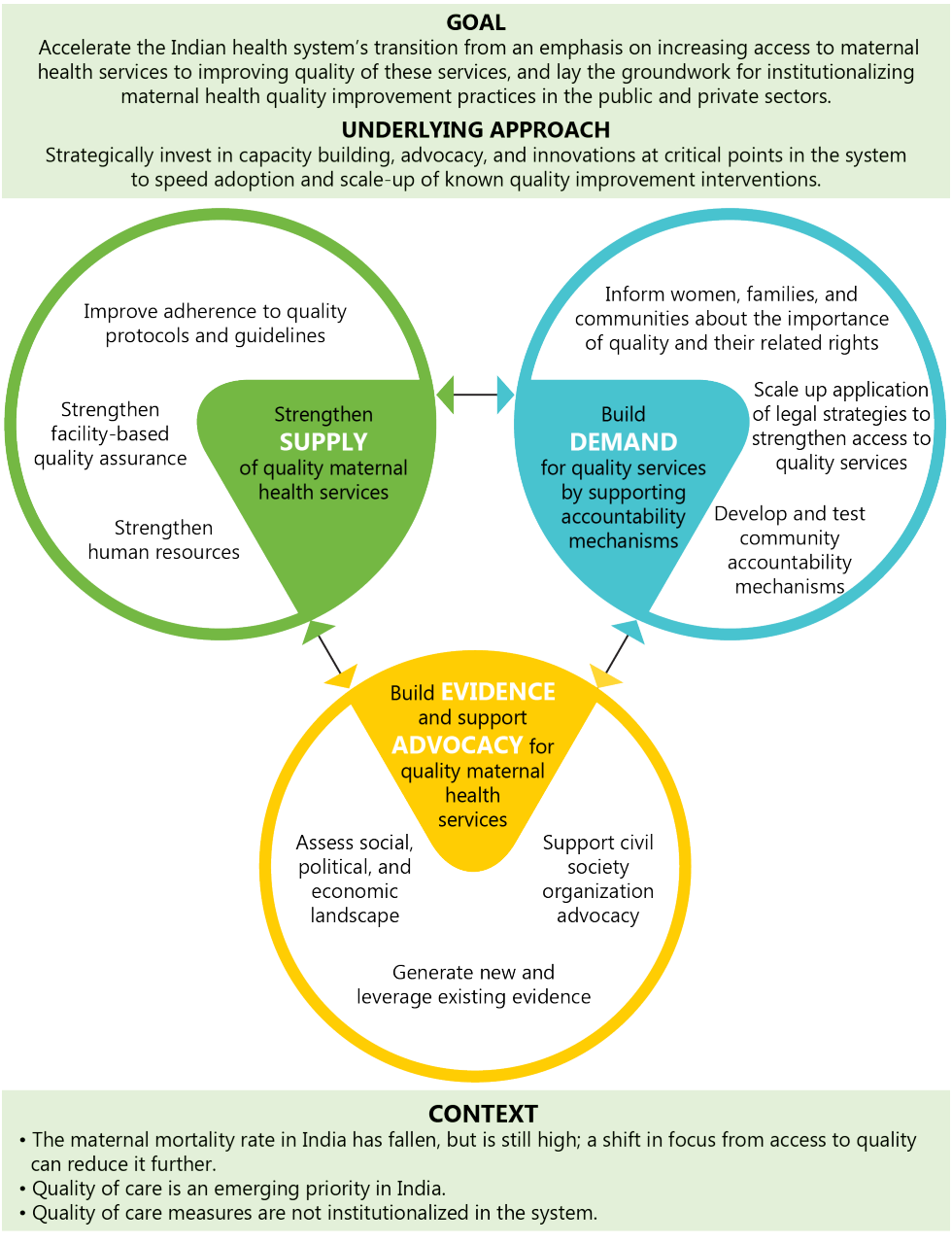
Source: Mathematica Policy Research's analysis of grant documents, 2017.

ARTH = Action Research and Training for Health Society; C3 = Centre for Catalyzing Change; CHSJ = Centre for Health and Social Justice; FOGSI = Federation of Obstetric and Gynecological Societies of India; Guttmacher = Guttmacher Institute; JSS = Jan Swasthya Sahyog; MAMTA = MAMTA Health Institute for Mother and Child; PFI = Population Foundation of India; SAHAJ = Society for Health Alternatives; SEWA Rural = Society for Education Welfare and Action Rural; SLIC = Socio-Legal Information Centre; WHO = World Health Organization.

II. FRAMEWORK FOR ASSESSING PROGRESS AND OUTCOMES

As mentioned, the Foundation's MHQoC strategy focuses on shifting emphasis from promoting access to maternal health services to improving the quality of services provided. Figure II.1 shows the conceptual framework underlying the strategy, which includes three substrategies: supply, demand, and advocacy. Each substrategy in turn has three approaches for building momentum around and advancing progress toward its goals and those of the overall strategy.

Figure II.1. MHQoC strategy conceptual framework



Interrelated and mutually reinforcing substrategies

The three substrategies related to supply, demand, and advocacy interact and influence one another. For instance, an increase in demand for quality services can influence the types of services supplied and generate support for advocacy efforts. Conversely, evidence of and advocacy for quality maternal health care can increase both supply of and demand for these services as awareness of these needs increases among communities and policymakers. Finally, an increase in the supply of quality services can also spur advocacy and demand as stakeholders observe the benefits of quality services and seek more of them.

A. Logic model and indicators for assessing the strategy's progress

Complementing the conceptual framework, Mathematica developed a logic model to elaborate the key elements of the MHQoC strategy and its underlying theory of change, including linkages between specific activities and targeted outputs and outcomes (Figure II.2). The outputs and outcomes in the logic model represent the key areas along which to measure and evaluate strategy-level progress during the four years of the strategy. Across the outputs and outcomes specified in the logic model, Mathematica, in collaboration with the Foundation, identified a set of 28 priority indicators to use for tracking progress and results under the strategy (Appendix A, Exhibit A.1).

Mathematica analyzed indicators for the Phase 1 period by reviewing multiple data sources, including strategy and grant documents, key informant interviews, grantee site visits, and the grantee indicator survey.[4] For each indicator, Mathematica reviewed available information across grants to assess overall strategy achievements and challenges to date. In reports on Phase 2 (April 2017 to March 2018) and Phase 3 (April 2018 to September 2019), Mathematica will analyze these indicators again to understand the strategy's progress over time.

The 28 grants awarded under MHQoC strategy cover all activity components captured in the logic model—suggesting that, if the strategy's theory of change and logic model hold, implementing grant activities successfully should eventually lead to achieving the targeted outputs and outcomes. With one exception, at least two grantees will report on each progress indicator, with an average of seven grants associated with each indicator (Appendix A, Exhibit A.2).[5]

[4] The desk review of grant documents included examining proposal materials, annual reports, and any other publications produced through a grant. Mathematica also conducted initial phone interviews with all grantees, followed by in-person, in-depth interviews or site visits with each one. Interviews with Foundation staff were conducted by phone, and interviews with beneficiaries were conducted as a component of many grantee site visits. Mathematica abstracted documents and coded and analyzed interviews to populate a table of relevant indicators and identify key issues and common threads for learning. Using this information, Mathematica asked grantees to confirm and add information about indicators assigned to their grant through a survey.

[5] The one priority indicator not reported by any grantee is 2.1.1b, "Number of family members demonstrating knowledge of their health rights." Most relevant grants have focused on measuring the knowledge of women directly targeted by these programs, rather than their family members.

Figure II.2. MHQoC strategy logic model

We aim to …	Our funding will support …	Resulting in …	
Substrategy	**Levers**	**Outputs**	**Outcomes**
1. Strengthen *supply* of quality maternal health services in public and private sectors	**1.1** Strengthen human resources to increase provision of quality services (provider level)	Providers trained	Providers have improved capacity
	1.2 Strengthen facility-based quality assurance (facility level)	Quality assurance teams trained and facilities monitored	Facilities have improved capacity
	1.3 Improve adherence to existing quality protocols and guidelines (health systems level)	Guidelines adopted and technical assistance provided	High quality maternal health care is delivered consistently in public and private sector facilities
2. Strengthen *demand* for quality services by supporting accountability mechanisms	**2.1** Inform women and families about the importance of quality and their related rights (awareness)	Information provided to women, families, and communities	Women, families, and communities demand high-quality health care
	2.2 Support development and testing of community accountability mechanisms (mobilization)	Community accountability tools and mechanisms developed and tested	Community accountability tools and mechanisms are actively used
	2.3 Scale up application of legal strategies to strengthen access to quality services (public accountability)	Legal trainings provided and cases brought to trial	Key stakeholders hold the government accountable for providing quality maternal health services
3. Build *evidence* and support *advocacy* for quality maternal health services	**3.1** Generate new and leverage existing evidence (evidence)	Evidence and research generated	Key stakeholders access/use evidence-based indicators and programs
	3.2 Promote civil society efforts for maternal health advocacy and support (social movement)	Advocacy efforts undertaken by civil society	Key stakeholders prioritize and increase adherence to maternal health quality of care efforts
	3.3 Use evidence and advocacy to sustain maternal health quality of care efforts supported under the strategy (sustainability)	Sources of funding and support are identified	Grantees are able to sustain and innovate maternal health quality of care projects

TO ACHIEVE GREATER COMMITMENT TO AND IMPROVED MATERNAL HEALTH QUALITY OF CARE

Health system: Improving infrastructure and increased financing to support maternal health quality of care

Community: Increasing community mobilization and institutionalization of effective community accountability mechanisms

Health outcomes: Reducing maternal morbidity, maternal mortality, and geographic and social disparities

This page has been left blank for double-sided copying.

III. SUPPLY SUBSTRATEGY: PROGRESS TO DATE

The MHQoC strategy engages in efforts to improve the quality of maternal health services that are available and delivered to women at the facility and community levels, with the goal of shifting the field's emphasis from women's access to services toward the quality of services. Quality can be represented by meeting nationally and internationally recognized standards. Specifically, the strategy aims to improve the quality of available maternal health services through three approaches: (1) increasing the number—and strengthening the skills—of health care providers, (2) improving infrastructure and operations at facilities providing maternal health services, and (3) promoting and strengthening adherence to quality protocols and guidelines at all levels of the health system (Table III.1). A total of 12 indicators were identified to assess progress within and across these three strategic approaches, and grantees for each of the 12 grants in this substrategy have provided information on some of these indicators. Here, we summarize progress made to date across key domains of indicators.

Table III.1. Supply substrategy priority indicators, by approach

Substrategy: Strengthen supply of quality maternal health services in public and private sectors	
Approach 1.1. Strengthen human resources to increase provision of quality services (provider level)	
	• 1.1.1b. Number and types of curricula developed for training facility-based providers to support quality maternal health services • 1.1.2b. Evidence of guidelines and standards for frontline workers (FLWs)
	• 1.1.1c. Number of facility-based providers trained on maternal health quality standards and/or technology-based job aids • 1.1.2c. Number of FLWs trained on maternal health quality standards and/or technology-based job aids
	• 1.1.1a. Evidence of facility-based providers reporting improved ability to deliver quality maternal health services • 1.1.2a. Evidence of FLWs reporting improved ability to deliver quality maternal health services
Approach 1.2. Strengthen facility-based quality assurance systems (facility level)	
	• 1.2.2c. Number of facilities or catchment areas that offer training on maternal health quality standards
	• 1.2.1. Number and proportion of targeted facilities that have adopted quality assurance models or procedures • 1.2.2a. Number and proportion of targeted facilities that regularly use quality data and/or information from quality assurance team to address service provision
	• 1.2.2b. Number of facilities prepared for accreditation
Approach 1.3. Improve adherence to existing quality protocols and guidelines (health systems level)	
	• 1.3.2b. Number and proportion of targeted facilities reporting that they have received technical assistance
	• 1.3.2a. Extent to which facilities receiving technical assistance improve quality of routine and basic emergency obstetric care (EmOC) procedures

Approach 1.1. Strengthening human resources to increase provision of quality services

Source: Mathematica's analysis of data from 12 grants reporting through March 2017.

Eight grants under the MHQoC strategy aim to strengthen human resources for maternal health care at the national level and in six states (Chhattisgarh, Karnataka, Madhya Pradesh, Maharashtra, Uttar Pradesh, and Rajasthan). Providing trainings to health workers at all levels has been a popular strategy with both health officials and the health workers receiving the trainings. Stakeholders generally regard these efforts as noncontroversial and supportive; thus, training is an important and relatively straightforward way to improve the supply of quality maternal health services. Developing or adapting curricula targeted to certain categories of health professionals, such as facility-based health workers and community-based frontline workers (FLWs), or focusing on critical topics, such as emergency obstetric care (EmOC), can improve the training of health workers. Health care workers can participate in trainings that use these and other curricula and develop their skills. An important component of the strategy has been supporting the development of curricula and trainings that build providers' ability to deliver care that meets national and international standards for key maternal health practices, such as making referrals for delivery complications. The indicator domains for Approach 1.1 map to this progression from curriculum development to health care workers' participation in training and skill development.

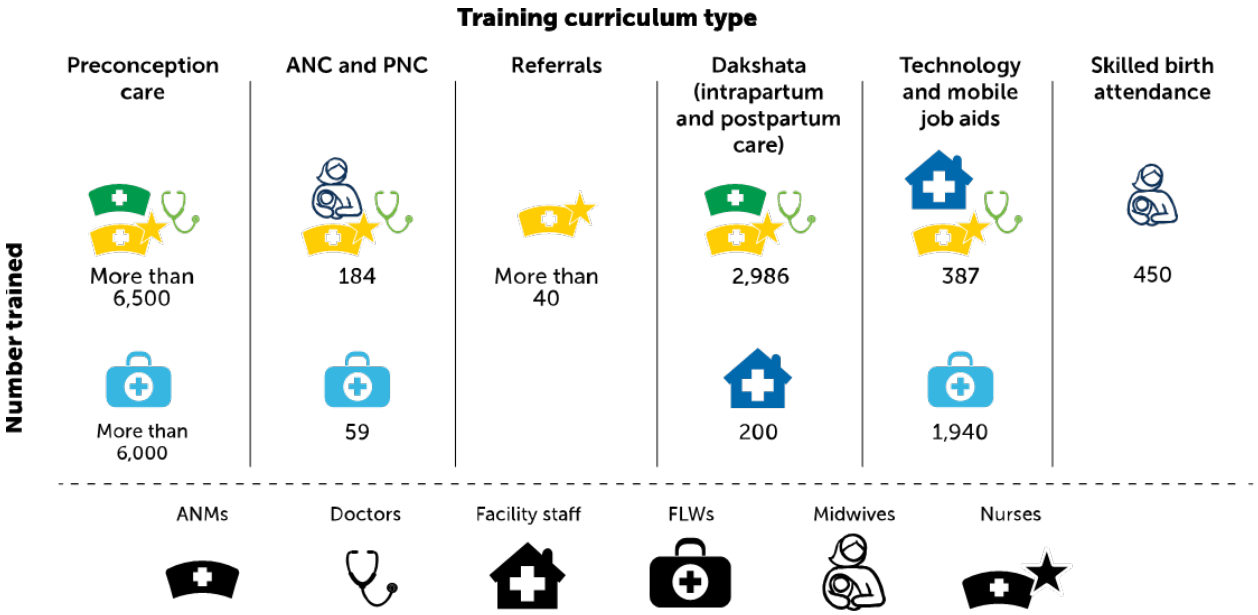
Curricula (Indicators 1.1.1a, 1.1.2.b; 7 grants). Six new curricula and training guidelines were developed under the MHQoC strategy (Figure III.1). Topics for these trainings have included preconception care, antenatal and postnatal care, referrals, intrapartum and postpartum care, skilled attendance at birth, and use of technology and mobile job aids. All trainings have included hands-on elements such as simulations and traditional classroom-style lectures, discussions, and other education elements. All of the curricula have been used to train multiple cadres of health providers, such as doctors, nurses, nurse-midwives and FLWs. In addition, a midwifery curriculum is also being developed by grantees but has not yet been used to train providers.

Dakshata

The most widespread guideline developed with strategy support is Dakshata, which provides guidance and best practices for intrapartum and immediate postpartum care. Jhpiego developed Dakshata partly through MacArthur Foundation support. Under the strategy, Jan Swasthya Sahyog and Pathfinder use Dakshata to train nurses in selected Chhattisgarh and Madhya Pradesh facilities. In addition, the Indian government is rolling out the Dakshata training package to several states.

Training (Indicators—1.1.1c, 1.1.2c; 8 grants). The curricula developed under the MHQoC strategy have been used to provide trainings to improve the clinical skills of a broad range of health workers, including more than 10,000 facility-based providers (such as doctors, nurses, and midwives), and more than 8,000 community-based health workers (such as FLWs) across six states (Chhattisgarh, Karnataka, Madhya Pradesh, Maharashtra, Uttar Pradesh, and Rajasthan). These health care professionals have been trained in the topics described previously and have focused on building clinical and management skills, using new technology-based job aids, and supervising and mentoring other health workers. Although many of these providers have received other trainings in the past, their exposure to the specific curricula developed under the strategy is new and complements other standard trainings offered to providers in public facilities. In addition, some curricula, such as the curriculum on preconception care, focus specifically on reemphasizing and reframing some common concepts, such as contraceptive counseling, to focus on patient-centered care. Others, such as the curriculum on intrapartum and postpartum care, focus on meeting defined, nationally accepted standards of care. Figure III.1 summarizes the main types and topics of trainings offered by grantees, and the number of health workers trained to date in each practice area. Appendix A, Exhibit A.3 presents the numbers of providers trained under each grant.

Figure III.1. Curricula developed under MHQoC strategy



Source: Mathematica's analysis of data from eight grants reporting through March 2017.
ANC = antenatal care; ANM = auxiliary nurse midwife; FLW = frontline worker; PNC = postnatal care.

Skills development (Indicators 1.1.1a and 1.1.2a; 7 grants). Not all grants included measures to assess whether provider trainings offered under the MHQoC strategy have improved providers' ability to deliver high quality care. However, of the seven grants that did so, all have found that trained providers have reported improved knowledge and increased confidence after the training. For example, after receiving training on preconception care under the MAMTA Health Institute

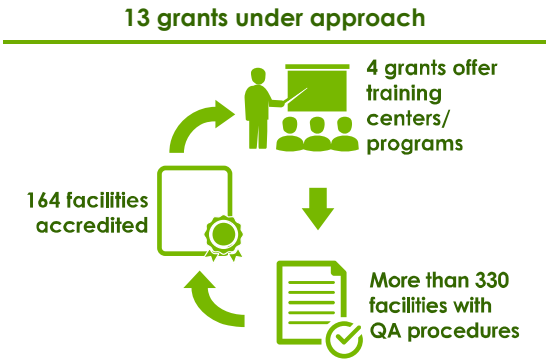
for Mother and Child (MAMTA) grant, 92 percent of accredited social health activists (ASHAs) and 100 percent of auxiliary nurse midwives (ANMs) in Rajasthan reported that they felt capable of discussing these topics with young women during home visits. Similarly, under the Jhpiego grant in Maharashtra, doctors, nurses, and midwives receiving training on intrapartum care reported greater confidence in their abilities and increased use of delivery guidelines, with more than half of providers reporting improved adherence to delivery best practices. Appendix A, Exhibit A.3 provides further details on providers' perceptions of their abilities, as well as other indicators in Approach 1.1.

Looking forward under Approach 1.1

A critical next step for sustaining the gains made in strengthening and increasing human resources is ensuring that providers have access to continued support and mentorship. Training participants require regular follow-ups, mentoring, and institutional support to maintain their abilities to deliver high quality care. The strategy includes several grants that provide ongoing education and mentoring by providing refresher trainings and nurse mentorship models, which train and equip key nursing staff to provide ongoing support and mentorship to other nurses in their facilities. However, this level of ongoing support can be challenging to sustain, as it requires a significant time investment from implementing organizations.

Approach 1.2. Strengthening facility-based quality assurance systems

Providers' competence alone is insufficient to ensure quality of services. The facilities where providers work must have appropriate and sufficient infrastructure, equipment and supplies, and operational processes in place to enable providers to deliver quality care. To strengthen facility-level factors affecting quality of care, the MHQoC strategy has supported 12 grants working in six states (Chhattisgarh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, and Rajasthan) to establish new or support existing quality assurance (QA) systems and processes in health facilities, with an emphasis on identifying strategies that are both effective and simple enough to be adopted and sustained. Specifically, the MHQoC strategy has established the following:



Source: Mathematica's analysis of data from 12 grants reporting through March 2017.

- Internal training programs and centers to support staff in targeted facilities on quality improvement and QA
- QA procedures and reporting processes to maintain and continually improve quality
- Facility participation in accreditation programs for external verification of quality along standard guidelines

Internal facility training programs and centers (Indicator 1.2.2c; 3 grants). To support ongoing development and maintenance of skills among providers, the Foundation has supported establishing targeted training programs and centers in health facilities at all levels of the health system, including hospitals, community health centers (CHCs) and primary health centers (PHC), and anganwadi centers. In particular, organizations receiving three MHQoC strategy grants in this area have established training centers that cover the full range of maternity care, including trainings on when and how to make referrals and ensure continuity of care across facilities. These grantees offer training to both facility-based providers and FLWs. In these training centers, the strategy has also supported train-the-trainer programs whose graduates proceed to offer additional training and support in facilities targeted by grantees. Table III.2 describes the three ongoing internal facility training programs under the strategy.

Table III.2. Facilities offering training on maternal health practices

State (grantee)	Number and types of facilities offering trainings
Rajasthan and Uttar Pradesh (MAMTA)	• Training centers supported all facilities from four districts, focusing on continuity of care and preconception care, covering 1,493 subcenters, 248 PHCs, 43 CHCs, 6 subdivisional or district hospitals, and 594 anganwadi centers
Maharashtra (Jhpiego)	• Nine district training sites for training on quality standards for intrapartum care
Gujarat (SEWA Rural)	• One training center established for FLWs and providers
ARTH (Rajasthan)	• School of Midwifery Practice provides training on skilled birth attendance and quality of care

Source: Mathematica's analysis of data from three grants through March 2017.

FLW = frontline worker; PHC = primary health center; SEWA = Society for Education Welfare and Action.

QA procedures and quality reporting (Indicators 1.2.1, 1.2.2a; 8 grants). In addition to establishing training centers to support ongoing learning and improvement, expanding facilities' capacity to deliver high quality care requires that facilities institute procedures for routinely assessing performance and making any necessary adjustments or improvements. However, not all facilities have instituted such QA procedures. Through deep, sustained engagement with facilities, about 310 public and private facilities—including PHCs, CHCs, and district hospitals in six states—have developed some models for institutionalizing QA systems, including the following:

- **Regular assessments using standardized checklists.** With technical assistance (TA) from MHQoC strategy grantees, 230 facilities implementing QA processes have adopted regular internal assessments of their capacities, using standardized checklists to determine their performance. The checklists that grantees provide to facilities are often modeled on existing tools, such as the World Health Organization checklist for safe childbirth and the Dakshata guidelines.
- **Internal information systems.** Although most public and private facilities have processes for tracking performance indicators and other monitoring data, many rely on outdated systems, including paper-based procedures, for these efforts. About 45 facilities under two strategy grants have developed electronic information management systems to track key performance indicators, enabling facilities to analyze and interpret these indicators more easily.
- **QA teams and processes.** 230 facilities targeted by the grants in this area of work have identified one person, or a small team of people, at their facilities to lead QA, under the hypothesis that QA activities are more likely to occur if a person or team is clearly assigned to this role. Fifty-four PHCs

have established quality management teams under the grant to Karuna Trust, which has also established a similar team at the state level. These teams meet quarterly to share information and best practices to ensure that they deliver high quality care. Similarly, with ARTH's support, 80 facilities in Rajasthan have adopted the Assessment-Feedback-Training-Action cycle for QA, and used reports submitted by QA teams to guide quality improvement efforts.

Preparation for accreditation (Indicator 1.2.2b; 4 grants). Training and institutionalizing QA systems can increase the delivery of high quality care at facilities, but are not sufficient for achieving a level of care that meets national standards. To support facilities to reach these levels of care, grants under the MHQoC strategy promote facility accreditation or certification as a means of motivating the facilities to adopt best practices. Working toward accreditation or certification helps facilities to meet quality standards, and maintaining accreditation or certification requires facilities to continue to deliver care according to those standards. Some accreditation programs require assessments of quality across the entire facility, such as those for the National Accreditation Board for Hospitals and Health Care Providers (NABH) and the International Organization for Standardization (ISO). Others are more specific to maternal health care, including the Federation of Obstetrics and Gynaecological Societies of India (FOGSI) Manyata certification for safe delivery, and Labour Room Quality Improvement Initiative (LaQshya) Guidelines (Figure III.2). These programs can apply specifically to private or public sector facilities. NABH and Manyata programs cover private sector facilities, and LaQshya addresses public sector facilities.[6]

Work under the MHQoC strategy primarily targets accreditation of government health facilities, but a small portion of the work led by FOGSI also focuses on private facilities, which are not subject to government regulation or standards. In total, 164 facilities across the country have received or await some form of accreditation as a result of the grantee TA and mentorship to meet the standards set by the accrediting bodies.

Figure III.2. Common accreditation and certification options, and number of facilities obtaining accreditation or certification to date (Indicator 1.2.2b)

Source: Mathematica's analysis of data from four grants through March 2017

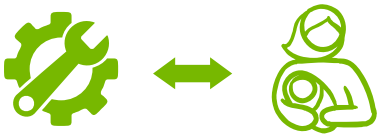
ISO = International Organization for Standardization; NABH = National Accreditation Board for Hospitals & Healthcare Providers; PHC = primary health center.

[6] Although NABH accreditation is typically reserved for private facilities, Karuna Trust has obtained accreditation for public PHCs through a public-private partnership.

Looking forward under Approach 1.2

The MHQoC strategy has made important progress in supporting facilities to adopt QA procedures and meeting goals for obtaining accreditation or certification for targeted facilities. However, it remains to be seen whether facilities can continue to use the QA systems and processes instituted by grantees in the long term—maintaining these efforts has historically been challenging for public facilities in India. It is also not yet known whether these facility-level improvements to the supply of quality maternal health care will lead to improved maternal health outcomes.

10 grants under approach



Source Mathematica's analysis of data from four grants reporting through March 2017.

Approach 1.3. Improving adherence to existing quality protocols and guidelines

Lasting maternal health system improvements require ongoing adherence to best practices and standards for quality care at both the individual health care worker and organizational facility levels. However, this adherence often depends on systems-level change and support for these practices. The MHQoC strategy supports efforts to ensure that facilities receive appropriate TA to support long-term improvements to their practices and to demonstrate the value of these practices at the systems level. The Foundation is especially interested in EmOC, a set of skills and practices considered fundamental to high quality maternity care and reducing maternal morbidity and mortality. The MHQoC has supported four grants working at the state and national levels on these topics and has achieved some success providing TA to facilities and strengthening EmOC services.

Technical assistance (Indicator 1.3.2b; 4 grants). Nearly all of the MHQoC strategy's work on improving the supply of quality maternal health care includes some TA to support facilities' ability to adhere to quality guidelines and standards, whether workforce-level TA on clinical practices or organizational-level TA, such as how to institute QA systems and obtain accreditation. These TA efforts, which typically overlap with the activities described by grantees in other indicators, have reached more than 300 facilities to date, and will likely reach many more as the strategy continues.

EmoC services (Indicator 1.3.2a; 3 grants). About 54 PHCs working with Karuna Trust have received TA specific to strengthening EmOC services. Nearly all of these PHCs now report having full EmOC capabilities. Similarly, 80 PHCs and CHCs working with ARTH in Rajasthan strengthened routine obstetric care and EmOC services. It is possible that other facilities have also received TA to improve EmOC services through training protocols and guidelines used under the strategy, but it has not been explicitly reported. For example, those participating in LaQshya training will receive several modules of training on EmOC.

Looking forward under Approach 1.3

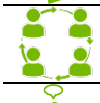
Although the MHQoC strategy supports many efforts to provide facilities with TA on adhering to quality guidelines and protocols, it is possible that many grantees conducting related work have not reported on these indicator domains to date. Further work will be necessary to fully understand the scope of this work and its impact on improving the supply of quality maternal health care.

This page has been left blank for double-sided copying.

IV. DEMAND SUBSTRATEGY: PROGRESS TO DATE

The MHQoC strategy seeks to build demand for high quality maternal health care by holding governments and health institutions accountable for delivering high quality care. Specifically, the strategy seeks to accomplish this by developing community accountability mechanisms and empowering women and communities to participate in them, and by using legal strategies to hold the government accountable for providing quality care. Community accountability refers broadly to programs that facilitate community-led, bottom-up planning and monitoring of health services. This demand-building process begins with (1) informing women and their families about the importance of quality and their right to high quality care, (2) supporting community accountability mechanisms so that community members have a way to organize and make their voices heard, and (3) using legal strategies to strengthen access to quality services as the highest means of recourse. Table IV.1 presents the 10 priority progress indicators under this substrategy. Next, we summarize the progress made to date by the nine demand-focused strategies grantees along 10 indicators.

Table IV.1. Demand substrategy priority indicators, by approach

Substrategy: Build demand for quality services by supporting accountability mechanisms	
Approach 2.1. Inform women, families, and communities about the importance of quality and their related rights (awareness)	
	• 2.1.1a. Number of women demonstrating knowledge of their health rights • 2.1.1b. Number of family members demonstrating knowledge of their health rights
	• 2.1.1c. Number of women and their families participating in community accountability processes
	• 2.1.2. Number of community leaders participating in community accountability processes
Approach 2.2. Develop and test community accountability mechanisms (mobilization)	
	• 2.2.2b. Number and type of community accountability mechanisms tested
	• 2.2.2a. Actions taken by providers, facilities, or policymakers based on community accountability efforts, including any efforts to establish or strengthen Hospital Management Societies
Approach 2.3. Scale up application of legal strategies to strengthen access to quality services (public accountability)	
	• 2.3.1a. Number of legal professionals trained in a legal strategy for promoting access to quality maternal health services • 2.3.1b. Number of allied professionals (such as social workers, activists, or public health professionals) trained in a legal strategy for promoting access to quality maternal health services
	• 2.3.2a. Number and nature of networks of legal professionals, social activists, and other allied workers for advancing maternal health quality of care
	• 2.3.2b. Number of court orders advancing implementation of policies and programs related to maternal health

Approach 2.1. Informing women and families about quality and their rights

Source: Mathematica's analysis of data from 12 grants reporting through March 2017.

The MHQoC strategy's first step toward building demand and accountability for high quality maternal health care is to inform community members, especially women and their families, about the importance of quality and their right to receive high quality care. This knowledge would ideally motivate women and other community members to participate in community accountability activities, which in turn would catch the attention of health leaders. The health leaders would also feel motivated to engage in community accountability and further promote health rights in the community. Six of the seven grants working on community accountability include activities to provide information to and engage women, families, and community leaders in accountability activities across four states (Gujarat, Madhya Pradesh, Rajasthan, and Uttar Pradesh). Community accountability is a growing area of interest in the field of maternal health in India, and the MHQoC strategy's support for engaging women and communities in these programs can help inform these efforts.

Knowledge of health rights (Indicators 2.1.1a, b; 6 grants). Six grants disseminate information about health rights to women and their families in four states (Gujarat, Madhya Pradesh, Rajasthan, and Uttar Pradesh). Five grants do so as a precursor to engaging women and their families in community accountability activities; the remaining grant (MAMTA) provides information on health entitlements as part of its preconception care program. The interventions have educated women through public announcements, meetings, and hearings. Three of these grants assessed changes in women's knowledge related to health rights; all three found some improvements in women's knowledge over the course of their programs, although many of these improvements were very small. Depending on the intervention, levels of knowledge varied from about 30 percent to more than 90 percent of women knowing about their rights after participating in the intervention (see Appendix A, Exhibit A.4 for further details). No current strategy work assesses the association between knowledge of health rights and demand for, or use of, maternal health services.

Janani Suraksha Yojana (JSY)

JSY is a conditional cash transfer scheme launched by the Indian government in 2005 to promote safe delivery. The scheme provides cash assistance to all pregnant women giving birth in states with low rates of institutional delivery, and to pregnant women who are below the poverty line (or are in scheduled castes or tribes) in states with high rates of institutional delivery.

Janani Shishu Suraksha Karyakaram (JSSK)

JSSK was launched by the Indian government in 2011 to provide free and cashless services to pregnant women, including those who have normal and caesarean deliveries, in public health institutions across India. The scheme also provides free services for sick newborns and infants in public sector institutions.

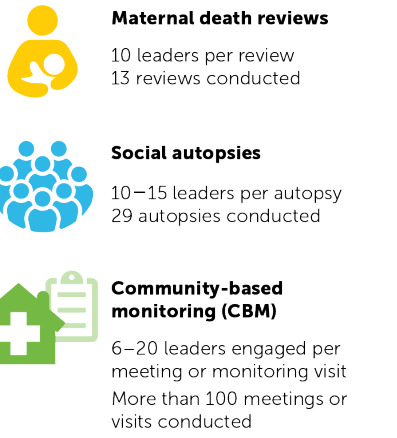
Participating in community accountability mechanisms (Indicator 2.1.1c; 5 grants). Most of the MHQoC strategy's efforts to inform women and communities about health rights occur as part of a community accountability program. Strategy-supported community accountability programs typically engage women through meetings held in targeted communities, where information is disseminated to them about current and upcoming accountability activities or results of community monitoring processes. More than 10,000 women have participated in strategy-supported community accountability programs to date[7] (see Appendix A, Exhibit A.4 for more details). The numbers of family members participating in such programs are unknown, as data on this were not available from MHQoC strategy grants.

Sahayog's MSAM groups: engaging the community

Sahayog formed Mahila Swasthya Adhikar Manch (MSAM) to support monthly group meetings with women in each catchment area. Women participating in an MSAM have gone on to lead meetings that provide information about health services targeted to their communities, present community accountability data to health officials, and engage in sustained advocacy efforts to promote the government's provision of high quality care. More than 1,000 MSAM participants gathered on International Women's Day 2017 and many spoke with senior district-level officials about quality concerns in their communities. Sahayog's model illustrates the potential influence that sustained community engagement can have.

Engaging community leaders (Indicator 2.1.2; 5 grants). Community accountability programs also seek to engage community leaders in their activities. Community leaders who are knowledgeable and skilled in community accountability activities can play a significant role in leading efforts to hold facilities and government officials accountable for providing quality maternal health care (Figure IV.1). Community leaders include elected officials, FLWs, and key community influencers, such as mothers-in-law. Under the strategy, these leaders have been trained to oversee and direct key community accountability activities. Most grants do not track the number of unique leaders trained under their programs; however, they have reported that leaders trained under the strategy to date have conducted more than 12 maternal death reviews and 29 social autopsies. In addition, more than 300 community leaders have participated in about 100 community-based monitoring (CBM) activities, such as meetings and monitoring visits.

Figure IV.1. Strategies for engaging community leaders (Indicator 2.1.2)



Source: Mathematica's analysis of data from four grants reporting through March 2017.

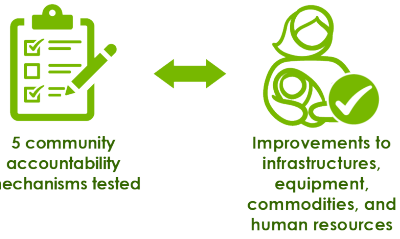
[7] The number of women participating in community accountability activities was estimated from the number of accountability-related meetings or events held and the number of women present at each meeting. This estimate might not represent a count of distinct women as some women could attend multiple meetings.

Looking forward under Approach 2.1

As MHQoC strategy-supported community accountability programs work to inform women and communities about their health rights and engage them in accountability activities, there is more to be learned about how best to sustain interest in these activities among women and community leaders. For example, attending regular community meetings might prove to be insufficient for sustaining women's longer-term interest and participation, as the meetings do not provide significant opportunities for interaction and feedback; more information is needed on whether deeper engagement, such as Sahayog's MSAM groups, can be more successful. In addition, no grantees working on generating demand have documented whether increased awareness of health rights has led to greater demand for or use of maternal health services. Informing women and communities about health rights remains an important goal for the India Legacy Strategy, but its relationship to building demand for high quality maternity care is still untested.

Approach 2.2. Supporting development and testing of community accountability mechanisms

7 grants under approach



Source Mathematica's analysis of data from 12 grants reporting through March 2017.

Community accountability mechanisms facilitate bottom-up planning and monitoring of health services. They empower community members to assess the quality of health services. Based on their assessments, the community members make recommendations and hold government officials accountable for taking the actions necessary to address any gaps or concerns. Common community accountability mechanisms used in India include CBM, community-based maternal death reviews and social autopsies, establishing help lines and other mechanisms to hear grievances and motivate quality improvements, and establishing hospital management societies. In particular, the government of India has supported the rollout of CBM programs across several states. Despite the national interest in community accountability, the field has limited evidence on the effectiveness of these programs for improving the availability and quality of health services. To assist in generating more knowledge about implementation and the effects of community accountability, seven grants under the MHQoC strategy (in Gujarat, Madhya Pradesh, Rajasthan, and Uttar Pradesh) test and employ these mechanisms to advocate for changes to improve the quality of maternal health care. These grantees also inform and engage women, families, and community leaders in accountability activities, as described in Approach 2.1. Here, we provide more information on the specific community accountability programs and mechanisms implemented through these grants.

Common community accountability mechanisms

CBM. These use checklists and community surveys to monitor the quality of health services, report cards summarizing health facilities' performance, and dialogues with health officials to share feedback and develop shared solutions for addressing quality issues. It is endorsed by the Indian government.

Community-based maternal death reviews and social autopsies. These use input from community members to determine the factors that lead to maternal deaths.

Help lines and grievance redressal mechanisms. These collect feedback from users of health services and use it to guide quality improvements.

Hospital management societies. These community-led organizations guide planning and monitoring of health facilities.

"The nurse, ANM and AWW initially felt that we were pointing out their bad points. But we showed that we were interested in supporting them […]. Our regular meetings with the ASHAs have changed their mindsets."

Community accountability mechanism testing (Indicator 2.2.2b; 7 grants). The strategy has supported testing several community accountability mechanisms: maternal death reviews, social autopsies, help lines as a grievance redressal mechanisms, hospital management societies, and government-supported CBM. The strategy has tested these mechanisms in several states, including Gujarat, Madhya Pradesh, and Uttar Pradesh. Among these mechanisms, CBM is the most commonly tested mechanism; it involves monitoring health services provided through the public sector, particularly community-based Village Health, Sanitation and Nutrition Days, health subcenters, and PHCs (Figure IV.2). The government of India has endorsed the CBM model; identifying and refining best practices in implementation in different contexts is a focus of strategy work. CBM and other community accountability mechanisms have met some resistance from health providers and officials, who sometimes find these mechanisms to be adversarial or accusatory, but grantees have begun to identify strategies for gaining their trust and buy-in.

Figure IV.2. Community accountability mechanisms implemented and actions taken

Community accountability mechanisms implemented	Examples of actions taken by government in response to community accountability
Community-based maternal death reviews Social autopsies Strengthening hospital management societies Help lines and other mechanisms for reporting grievances Community-based monitoring	• Improvements to facility infrastructure such as clean water and generators • Improvements to availability of key maternal health supplies • Improvements to health workers' attendance at facilities • Workshops and trainings for FLWs and nurses started • Grievance redressal processes started • Referral services improved

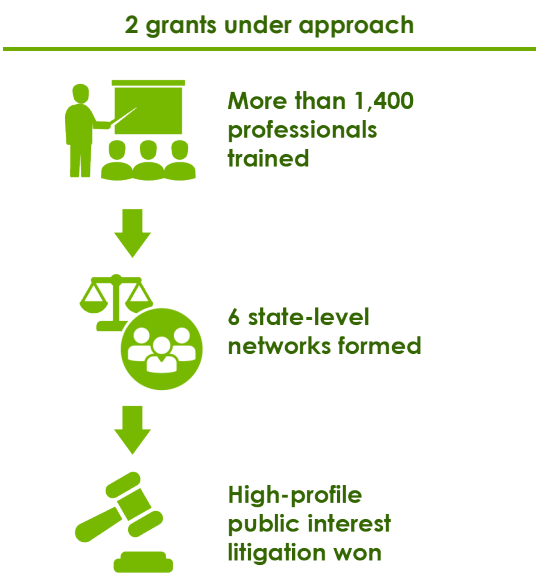
Source: Mathematica analysis of data from seven grants reporting through March 2017.

Influence of community accountability mechanisms on MHQoC (Indicator 2.2.2a; 7 grants). Community accountability efforts have resulted in observable improvements in the availability and quality of health services. In particular, the strategy-supported community accountability activities described in previous indicators have resulted in upgrades to facility infrastructure, availability of key equipment and supplies, additional human resources at facilities, and improved referral services. In some cases, the number of women seeking services at facilities has also grown due to the increase in awareness about available high quality care (Figure IV.2).

Looking forward under Approach 2.2

The CBM mechanism is a particularly popular community accountability mechanism with government endorsement. In contrast, other mechanisms, such as help lines enabling people to report demands for informal payments at health facilities, have met some resistance from district-level health officials, who see this work as an attempt to undermine their authority. Understanding the feasibility of implementing and sustaining these less-accepted mechanisms will require further testing and development, and might require grantees to take creative approaches to obtaining the support and buy-in of health officials and other key stakeholders. In addition, more work is needed to understand the extent to which community accountability can go beyond relatively small improvements in the day-to-day functioning of facilities and lead to longer-term, systemic improvements to MHQoC.

Approach 2.3. Scaling up legal strategies to strengthen access to quality services



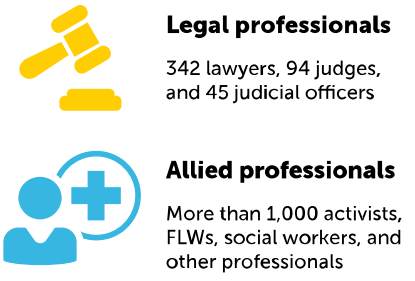
Source: Mathematica's analysis of data from 12 grants reporting through March 2017.

Legal recourse is the ultimate avenue for holding governments and health care institutions accountable for delivering quality maternal health care. In India, legal strategies such as public interest litigation have proven successful for ensuring that government bodies uphold policies and programs that promote women's access to high quality health care. Under the MHQoC strategy, the two grants under this approach have led to more than 1,400 professionals trained on legal strategies for ensuring governmental accountability for delivering high quality, equitable services to all people; six state-level legal advocacy networks launched to support collaboration and communication on public interest litigation; and successful high-profile cases on topics such as child marriage, abortion access, and sterilization. Legal strategies in the field of maternal health are a relatively underused tool; the strategy's support of these tactics is a unique contribution to the Indian maternal health community.

Training of legal and allied professionals (Indicators 2.3.1a, b; 2 grants). Trainings help equip legal and allied professionals with knowledge about using legal strategies to ensure access to high quality care. Through grants to the Socio-Legal Information Center (SLIC), the strategy has supported trainings for more than 400 lawyers and judges, and more than 1,000 allied professionals, including leaders from nongovernmental and community-based organizations, individual activists, paralegals, and FLWs (Figure IV.3). Trainings have focused on advocating for reproductive rights and on legal tools, such as public interest litigation, for holding the government accountable for delivering high quality care. These activities are one of the relatively few avenues for legal and allied professionals to learn specifically about applying legal strategies to the field of reproductive rights and maternal health.

Networks of legal and allied professionals (Indicator 2.3.2a; 2 grants). State-level networks of legal and allied professionals provide their members with access to the contacts, support, and knowledge base to apply legal strategies to improve maternal health care. SLIC, the only strategy grantee under this approach, has established and provided TA to state networks in Bihar, Jharkhand, Maharashtra, Odisha, Rajasthan, and Uttar Pradesh to promote reproductive justice. This work has included trainings for network members, establishing connections between lawyers and activists focused on MHQoC, and providing consultation for litigators. These networks, which have been started in part due to strategy support, have the potential to start coordinated efforts to promote state- and national-level legal strategies to improve the quality of maternal health care.

Figure IV.3. Individuals trained to use legal strategies



Source: Mathematica's analysis of data from seven grants reporting through March 2017.

Litigation (Indicator 2.3.2b; 2 grants). Individual petitions and public interest litigation are last resort methods that women and communities can use to hold the Indian health system accountable for providing high quality maternal health services to all women. The MHQoC strategy's support for individual petitions and public interest litigation has resulted in notable wins and fulfilled national and state government obligations related to delivering high quality maternal care. These legal victories include individual orders awarding compensation for families in which maternal deaths have occurred, orders for state- and national-level health authorities to take steps to prohibit child marriage and ensure that maternal health policies meet the needs of adolescents and young women, orders that health authorities develop policies that enable women to access abortion care after 20 weeks' gestation in some cases, and orders banning sterilization camps. Although petitions and public interest litigation have commonly been used for other topics in India, their use in the field of maternal health and reproductive rights is relatively novel. The strategy's support of these strategies, therefore, represents a new and unique form of support for holding the government accountable for delivering high quality care.

Looking forward under Approach 2.3

Support for legal strategies to hold the government accountable for providing high quality maternal health care is difficult to find; the MHQoC strategy is one of the only consistent supporters of these strategies. To continue to provide trainings and support to legal and allied professionals to undertake such strategies, other funders and supporters of these activities will have to be identified.

This page has been left blank for double-sided copying.

V. ADVOCACY SUBSTRATEGY: PROGRESS TO DATE

To support MHQoC practices and policies, the strategy engages in advocacy activities at the community, state, and national levels to draw attention and resources to quality-of-care issues. The strategy strives to create an enabling environment for MHQoC in the areas of delivery and neonatal care, preconception care for young married women, and abortion, among other key maternal health areas. It does this through three intersecting approaches: (1) generating new and leveraging existing evidence that can be used for advocacy, (2) promoting civil society efforts for maternal health advocacy and support, and (3) using evidence and advocacy to sustain MHQoC efforts supported under the strategy. Table V.1 presents the six priority advocacy indicators under this substrategy, by approach. Although only 6 grantees focus explicitly on advocacy, 14 grants have contributed some evidence to the field, and all 20 grantees provided some information about sustainability. Below, we describe progress along key indicator domains.

Table V.1. Advocacy substrategy priority indicators, by approach

Substrategy: Build evidence and support advocacy for quality maternal health services	
Approach 3.1. Generate new and leverage existing evidence (evidence)	
	• 3.1.1 Research studies conducted and reports produced on MHQoC by grantees
	• 3.1.2. Number of and extent to which grantees are using evidence to advocate for changes to policies and programs
Approach 3.2. Promote civil society efforts for maternal health advocacy and support (social movement)	
	• 3.2.1a. Extent to which policymakers and program managers report that quality of care is a high-priority issue
	• 3.2.1b. Number and types of advocacy efforts for MHQoC led by civil society organization (CSO) networks and partnerships at the state or national level
Approach 3.3. Use evidence and advocacy to sustain MHQoC efforts supported under the strategy (sustainability)	
	• 3.3.1a. Number of grantees sustaining current project work or launching follow-on projects after their strategy grants • 3.3.1b. Number of grantees receiving other funding (for example, foundation or multilateral organization) to support MHQoC

Approach 3.1. Generating new and leverage existing evidence

When advocates seek policymakers' backing on key issues, policymakers often ask for the evidence supporting the specific agenda. The quality of evidence available plays a role in the persuasiveness of the advocacy effort. To understand the influence of evidence on policymakers' decisions, the MHQoC strategy focuses on activities to generate new and synthesize existing findings to motivate improvements in MHQoC.

Research studies (Indicator 3.1.1; 13 grants). Grants under the strategy have generated new evidence related to a range of maternal health topics, including abortion, preconception care, and mobile technology (Appendix A, Exhibit A.5). At least 10 research articles have been published for academic and technical audiences in peer-reviewed journals; they are based on research conducted at the national level and in Gujarat, Rajasthan. In addition, one technical report has been published on baseline findings from an evaluation of a preconception care intervention. National-level health officials have used two of the publications to inform official policies related to maternal health, such as changes to the reproductive, maternal, newborn, child, and adolescent health initiative to make it more responsive to the needs of young married women.

New evidence supported by the strategy

The strategy has generated new evidence on the following topics:

- Abortion incidence in India
- Approaches to caring for victims of intimate partner violence
- The effectiveness of a preconception care intervention
- Postpartum and post-abortion contraceptive use
- The effectiveness of an intervention to improve adherence to best practices for childbirth
- The effectiveness of an mHealth intervention to improve maternal health care
- Effects of maternity schemes on place of delivery
- Intra-spousal communication and contraceptive use among young married women
- Review of community-based interventions for young married couples
- Quality improvement processes for delivery care

Source: Mathematica's analysis of data from 13 grants reporting through March 2017.

Leveraging existing evidence (Indicator 3.1.2; 12 grants). MHQoC strategy activities have also resulted in publications that leverage existing evidence for new audiences—supporting broad, interdisciplinary advocacy for quality maternal health care. The strategy has produced at least seven publications that synthesize existing evidence, addressing topics such as respectful maternity care, sex-selective abortion, abortion laws, and effectiveness of community-based maternal death reviews. Target audiences for these publications vary, but typically include policymakers, journalists, activists, lawyers, and other nontechnical audiences.

Looking forward under Approach 3.1

The strategy has made progress generating new and leveraging existing evidence. Moving forward, it will be important to track the extent to which policymakers use this evidence to inform decisions about MHQoC.

Approach 3.2. Promoting civil society efforts for maternal health advocacy and support

Source: Mathematica's analysis of data from 12 grants reporting through March 2017.

Along with generating and packaging evidence on MHQoC, strategy grantees use the evidence to advocate for programs and policies at the state and national levels. Efforts under the MHQoC strategy have supported and expanded dissemination of evidence through civil society advocacy networks at state and national levels, with the aim of bringing MHQoC to the forefront of policymakers' agendas. Civil society organizations (CSOs), in particular, have a long history of maternal health advocacy in India and have spearheaded advocacy efforts related to maternal health, such as movements to ban sterilization camps, expand access to abortion services, and promote institutional delivery. As a result, they represent time-tested vehicles for bringing about positive change. Ten grants under this approach have worked on advocacy campaigns to encourage policymakers to prioritize maternal health at the national level and in two states (Rajasthan and Gujarat), and have supported CSO networks at these levels. Although many of these advocacy campaigns are relatively new, they have helped secure policymakers' commitment to MHQoC in Rajasthan and Gujarat.

Prioritizing by policymakers and program managers (Indicator 3.2.1a; 5 grants). Most advocacy campaigns under the strategy have been launched within the last 18 months, making it difficult to determine the extent of their contribution to and influences on state- and national-level policy and programming agendas and actions at this early stage. However, these strategy-supported campaigns gain policymakers' attention and encourage them to prioritize MHQoC—often through visible and far-reaching public awareness campaigns and targeted outreach to key officials. A preliminary sign of progress includes a presentation by the White Ribbon Alliance India (WRAI) to the government of India of a Respectful Maternity Care charter endorsed by more than 80 national and international organizations. The leadership of C3 under the strategy gathered these endorsements. In Rajasthan and Gujarat, CSO networks have secured the commitment of several state-level officials for improving the quality of maternal health care in the state; these commitments include adding maternal health equipment, supplies, or human resources to state program implementation plans and budgets.

Making the case for respectful maternity care

Through its work, C3 has collected stories about the manner in which women have been treated during delivery at public health facilities. These stories help illustrate the lack of respect shown to women seeking maternal health services and the perceived authority that some providers and facility staff have over disadvantaged groups in India. This imbalance in power and lack of sensitization among providers can jeopardize the health of mothers and their infants.

"I requested that my companion be allowed to be with me during labor and delivery. For this, I was scolded and my companion was not allowed inside the labor room. During the labor, I was left unattended for a long period. When I asked for a glass of water, I was told "should I open a restaurant for you?" I was never given the water I asked for."

"During the labor pains, my legs were tied with a rope so that I was not able to move. I was hit many a times with a pair of scissors which severely injured me, so much so that I started bleeding from that wound and now am left with a permanent scar."

"I was never covered either during labor or delivery. I felt extremely embarrassed laying there. Though I felt ashamed of what was happening with me, I couldn't say a word to anyone because I feared if I complained they would not do my delivery and simply refer me to higher facility which would cost me more."

Advocacy networks/partnership managers (Indicator 3.2.1b; 9 grants). The strategy supports some portion of the activities conducted by six national advocacy networks and two state advocacy networks in Gujarat and Rajasthan (Table V.2). These networks have memberships ranging from several to about 1,500 organizations. CSOs under the strategy commonly have network leadership roles, such as being a network's founder, leading advocacy campaigns, and acting as catalysts and mobilizers. Network activities have led to developing informational materials for the public, collaborating and sharing information between CSOs, and launching advocacy campaigns.

As several grantees have noted, measurements of the number and size of CSO networks provide an initial estimate of the scope of advocacy work supported under the MHQoC strategy, but these measurements alone cannot completely capture the depth and nature of the work that CSO networks engage in, or their contributions to moving the MHQoC field forward. A more in-depth look at the ways in which CSO networks engage key players and influence decision making could help improve the field's understanding of the key drivers of success for CSOs that use advocacy as a vehicle for change in MHQoC.

Table V.2. Key state- and national-level networks and advocacy efforts (Indicator 3.2.1)

Advocacy effort/ network	Participating grantee (role)	Level of organization and coverage	Number and type of organizations in network
WRAI	C3 (head)	National	About 1,500 CSOs and individual advocates across India
Girls Count	Ipas (participant)	National	More than 400 CSOs across India
CAC Conclave	Ipas (founder)	National	Research and advocacy organizations working on abortion-related issues
Rajasthan CSO network	ARTH (founder)	Rajasthan	Rajasthan-based CSOs working on maternal health and related topics
Jan Swasthya Abhiyan (JSA)	SEWA Rural (member); SAHAJ (member)	National	21 national networks and organizations that form the Indian regional circle of the global People's Health Movement (PHM)
NAMMHAR	SEWA Rural (member)	Gujarat	CSOs working to improve accountability measures
Voluntary Health Association of India (VHAI)	SEWA Rural (member)	National	A federation of 27 State Voluntary Health Associations, linking more than 4,500 health and development institutions across the country
The Coalition for Maternal-Neonatal Health and Safe Abortion (CommonHealth)	SAHAJ (member)	National	A coalition of 110 institutions and individuals—including health care providers, researchers, nongovernmental advocates, human rights lawyers, grassroots activists, and public sector program managers—that advocates for better access and higher quality maternal and neonatal health and safe abortion services

Looking forward under Approach 3.2

Strategy-supported advocacy campaigns are still relatively new; most have begun within the past 18 months. As the MHQoC strategy progresses, it will be important to observe how well these campaigns work to convince policymakers to prioritize MHQoC, and how effective CSO networks can be at conceptualizing and implementing such campaigns.

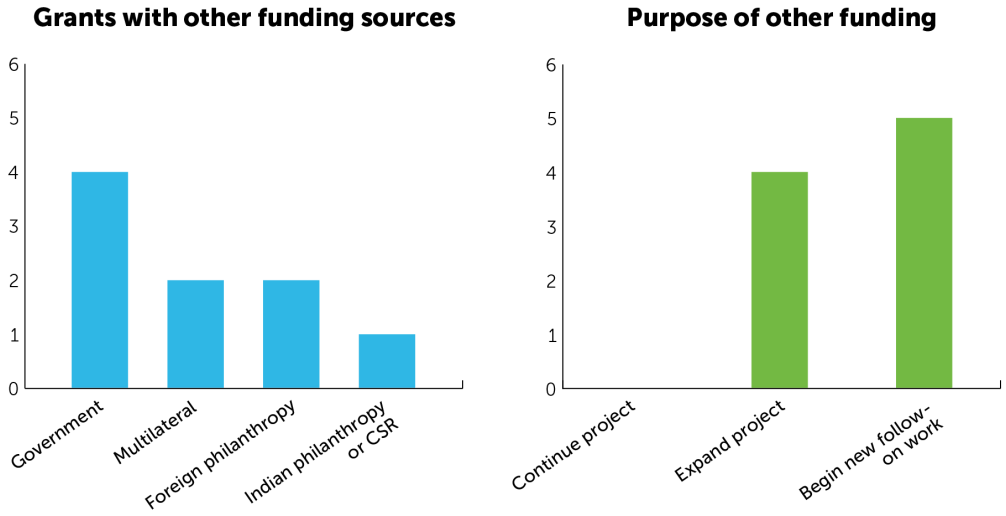
Approach 3.3. Using evidence and advocacy to sustain maternal health quality of care efforts

A key goal of the advocacy substrategy is to generate and use evidence to sustain the work started under the MHQoC strategy until the appropriate time for concluding it. Within Phase 1, planning for sustainability and securing additional funding, as needed, for continuing and advancing grantees' MHQoC efforts are crucial to sustaining gains made under the strategy.

8 of **20** grantees have secured additional funding for MHQoC work to date.

Funding for continuing or follow-on work (Indicators 3.3.1a, b; 20 grants). Of the 20 grantees, 8 reported securing other sources of funding for work related to MHQoC during Phase 1. Two used these additional resources to extend their existing strategy projects to new geographic areas, three used them to begin new follow-on work, and two used them to do both (Figure V.1). Among grantees who have secured additional funding, three reported the Indian government as a source, two reported multilaterals, three reported foreign philanthropies, and one reported Indian philanthropies or corporate social responsibility; among the eight grantees, only one obtained additional resources from more than one source.

Figure V.1. Funding sources for MHQoC strategy grantees



CSR = corporate social responsibility.

Looking forward under Approach 3.3

The Foundation has provided resources to support sustainability planning for its MHQoC strategy grantees. At this stage in the MHQoC strategy, four grantees have taken advantage of these resources. Most grantees have not secured follow-on funding or considered whether or how to continue the work they conduct under the strategy.

This page has been left blank for double-sided copying.

VI. LEARNINGS AND IMPLICATIONS FOR THE FIELD

In addition to the findings discussed in the previous chapters, several key lessons can inform future work within the strategy and the broader field. This chapter highlights these key lessons within the three substrategies, as well as cross-cutting learnings for the MHQoC strategy as a whole (summarized in Table VI.1). It discusses the underpinnings of each lesson learned and the implications for the strategy and for the broader field of maternal health in India.

Table VI.1. Lessons learned

- **Supply.** Defined standards provide a uniform tool to help facilities achieve quality improvements; a culture of mentorship and continuous QA and quality improvement helps to maintain quality.
- **Demand.** Community accountability mechanisms have gained traction in some areas, but best practices for ensuring institutional responsiveness to community-led monitoring and planning efforts are still emerging.
- **Advocacy.** Policymakers have an appetite for evidence.
- **Cross-cutting.** Identifying and translating key elements of emerging program models and their relevance to other contexts are necessary steps to bringing these programs to a wider audience.
- **Cross-cutting.** Sustainability is a challenge for many nongovernmental organizations because they have limited capacity to incorporate it in their planning as a core program component.
- **Cross-cutting.** Aligning maternal health quality activities with priorities of the Indian government and other key decision makers can help promote their engagement and uptake of activities. However, some circumstances may require an entity to challenge the status quo to catalyze change.

Supply-side lesson learned

Defined standards provide a uniform tool to help facilities achieve quality improvements; a culture of mentorship and continuous QA and quality improvement helps maintain quality.

Implications for the strategy. Accreditation efforts should be coupled with continuous quality improvement processes to ensure consistent maternal health quality of care.

Implications for the field. The same support the government provided for disseminating and adhering to quality protocols and guidelines is needed for building a culture of continuous quality improvement.

As a result of strategy-supported curriculum development initiatives, health providers now have a number of standardized training options to develop the basic skills necessary for delivering high quality maternal health care, such as midwifery, intrapartum and immediate postpartum care, and antenatal care. Health facilities also have several options for obtaining quality accreditation and certification, including NABH, ISO, Manyata, and LaQshya. Although these accreditation and certification options apply to different types of facilities (for example, public or private), and some examine the entire facility and others examine more specific services (for example, the labor room), the different accreditation and certification bodies generally have similar expectations and requirements for infrastructure and clinical practice. They provide health care organizations and health officials with a defined set of guidelines for delivering quality care. These training curricula and guidelines have been useful for standardizing the supplies, equipment, and infrastructure that facilities seek to obtain and use, as well as the skills and qualifications they look for in their staff. In addition, these curricula and guidelines have informed facilities' internal training programs and procedures for obtaining, using, and maintaining equipment.

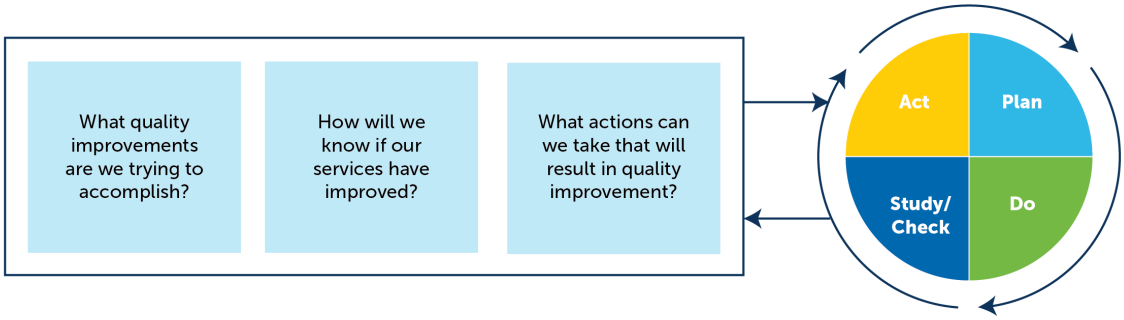
Provider trainings require regular follow-ups, mentorship, and institutional support to maintain providers' abilities to deliver high quality care. The strategy has provided grants for ongoing education and mentorship through refresher trainings and nurse mentorship models.

"What really needs to change in terms of midwifery practice is [implementing] long-term rather than short-term trainings that come and go. Something needs to change about the practice because people have been struggling to try and make lasting change."

"Midwifery care cannot be provided in a vacuum. There needs to be a lot of health systems support."

Similarly, although most activities to help facilities seek accreditation or certification have succeeded, these standards provide only a starting point for delivering quality care. Maintaining quality requires a continuous improvement process (Figure VI.1). Engaging in continuous quality improvement requires a supportive culture and tools for ongoing learning and improvement. Some tools include mentorship programs, improved monitoring processes and data systems, and protocols for regularly engaging staff in discussions about barriers to and potential solutions for delivering high quality care. To date, compared with the large numbers of providers trained and facilities receiving accreditation with strategy support, relatively few strategy efforts have implemented tools for continuous quality improvement widely in health facilities. Although grantees and facilities have had success implementing mentorship programs to provide continued support to staff, institutionalizing these kinds of tools has proven to be more difficult.

Figure VI.1. The continuous quality improvement process for health facilities



Demand-side lesson learned

Community accountability mechanisms have gained traction in some areas, but best practices for ensuring institutional responsiveness to community-led monitoring and planning efforts are still emerging.

Implications for the strategy. More research and data are needed about what makes MHQoC strategy-supported community accountability mechanisms successful, and especially about whether a multipronged approach to fostering bottom-up planning and accountability can succeed.

Implications for the field. Examining the ability of community accountability programs to improve services and increase their uptake will be critical for understanding whether and how such mechanisms can improve the quality of maternal health care.

Stakeholders, including government officials, accept community accountability mechanisms as promising vehicles for community-led, responsive health planning. The government of India has adopted one such mechanism, CBM, and rolled it out in 18 states. Although CBM and other community accountability mechanisms (such as community-based maternal death reviews, social autopsies, and hospital management societies) generally have the support of health officials, to date grants under the strategy related to community accountability have found that true bottom-up planning is challenging in practice. For example, some state-level officials have been unwilling to supply equipment or commodities based on findings from community accountability activities. In addition, the structures and committees designed to support accountability, and CBM in particular (such as *Rogi Kalyan Samitis* or Village Health, Sanitation, and Nutrition Committees), are often weak, meaning that even if organic monitoring and accountability activities are taking place in a community, local institutions' capacity to respond to the issues raised is limited.

Although these mechanisms have yielded some improvements to the quality of health services to date, most of these improvements have focused on the day-to-day operations of individual health facilities, such as improvements to infrastructure or human resources. It remains to be seen whether communities can sustain these efforts and whether community accountability mechanisms can lead to long-term, meaningful improvements in the quality of health services. Some grantees and other researchers have noted that community accountability mechanisms may be most effective when citizens have direct contact with health officials and decision makers. Additionally, a more sustainable approach to community accountability *might* require moving beyond developing tools such as facility checklists and community surveys, and instead focusing on cultivating an ecosystem that can support a community-based planning approach to improving the quality of health services. Some strategy-supported community accountability efforts have begun taking this broader view of accountability. In particular, the Centre for Health and Social Justice's holistic approach to community accountability integrates accountability tools with sustained advocacy and TA to health officials as a pathway to achieving long-term results.

"We have sought to move away from tool-based approaches towards using strategic, multipronged and iterative approaches to build pressure on the state and demand accountability. We sought to build an ecosystem of accountability towards maternal health … by leveraging relationships of the community with various stakeholders and their own collective power to hold the system accountable."

Advocacy lesson learned

Policymakers have an appetite evidence.

Implications for the strategy. Developing targeted, purposeful dissemination of evidence can be an effective strategy for achieving broad change.

Implications for the field. Policymakers require additional evidence on the approaches to and value of maternal health quality of care in order to initiate policy change.

Policymakers have demonstrated interest in strategy-supported advocacy efforts, including the Respectful Maternity Care charter developed by WRAI and incorporating quality improvement into

state-level program plans and budgets. The most effective advocacy initiatives target specific policymakers who are likely to be interested in the topic, amenable to the changes the initiatives promote, and empowered to make decisions to advance the quality improvement effort. In particular, strategy-supported efforts to develop policy briefs, handbooks, and manuals from more technical publications have proven valuable to a broad range of stakeholders who support advocacy efforts, including journalists, lawyers, and activists. Such efforts have been useful for preparing these stakeholders for advocacy campaigns and for providing policymakers with clear, easily digestible information.

To date, the strategy has generated important evidence on key topics such as abortion, preconception care, intimate partner violence during pregnancy, and community accountability. Promising areas for further research and advocacy include examining the links between facility accreditation and health outcomes, best practices for ensuring high quality care outside of facility settings, testing innovations for fostering community accountability, and the role of networks and partnerships in promoting policy change.

Cross-cutting lesson learned

Identifying and translating key elements of emerging program models and their relevance to other contexts are necessary steps to bringing these programs to a wider audience.

Implications for the strategy. Not all strategy-supported initiatives are likely to work well on a large scale; the key is to determine the scalable components and their potential value.

Implications for the field. More can be done to identify models that work, implementation factors that affect the success of scaled-up programs, and necessary external conditions for scale-up.

Many strategy-supported programs have demonstrated successes in improving supply, building demand, or strengthening advocacy for MHQoC. Some of these interventions have attracted the attention and interest of state and national health officials, paving the way for potential replication and scale-up. For example, state and national governments have begun adopting some training curricula and community accountability mechanisms tested through the strategy, such as the Dakshata guidelines and community-based maternal death reviews. However, to successfully bring these programs to scale, implementing organizations and other stakeholders must consider the components that make their programs successful, and how to replicate and scale these elements across larger populations, in different contexts, and with available resources. They must also consider external factors that might affect how well a scaled-up program could function. For example, the community health model developed under a Jan Swasthya Sahyog grant has worked well in the facilities it runs in Chhattisgarh, but translating this collaborative model to hierarchically structured public health facilities in Madhya Pradesh and Chhattisgarh has been difficult; public facility staff face a common challenge in obtaining support and buy-in for quality improvements from higher-level health officials. As a result, Jan Swasthya Sahyog has been working to define the specific components of their model, such as staff mentorship and professional development, and testing each one in public health facilities.

Cross-cutting lesson learned

Sustainability is a challenge for many nongovernmental organizations because they have limited capacity to incorporate it in their planning as a core program component.

Implications for the strategy. Purposeful consideration of sustainability is a core value of the strategy and some grantees require continued TA on this topic.

Implications for the field. Providing key organizations, particularly smaller organizations, with the resources to conduct long-term planning and to set a clear vision for their role in the movement to improve maternal health quality of care will be necessary to avoid losing promising practices.

Although many strategy grantees plan to continue working on maternal health issues, few have developed sustainability plans to continue and advance their current MHQoC work. For small organizations in particular, the ability to be flexible and to seek funding across a wide range of topic areas is critical for survival; long-term strategic planning and a relatively narrow focus on MHQoC can seem infeasible to these organizations. To maintain a strong, sustained movement focused on MHQoC, these organizations will need time and support to carefully consider their mission and vision with respect to MHQoC, the direction of this work, and the resources they need to continue it. If grantees do not continue work they started under the strategy, potential learning related to best practices may be lost to the field. Continuity in grant activities provides further opportunities to document and share the lessons learned. Dasra, a grant provided under the strategy for supporting other grantees in strategic planning, has provided TA on these issues and will continue to provide support to individual grantees, as needed, to plan for their future beyond the MHQoC strategy.

Cross-cutting lesson learned

Aligning maternal health quality activities with priorities of the Indian government and other key decision makers can promote their engagement and uptake of activities. However, some circumstances may require an entity to challenge the status quo to catalyze change.

Implications for the strategy. The progress of strategy initiatives depends partly on the decision makers' interest in and willingness to support these topics, and partly on grantees' ability to encourage decision makers to support initiatives they may find new or controversial.

Implications for the field. Donors' willingness and ability to fund new or controversial topics could be key factors in pushing forward maternal health quality of care.

The various substrategies and approaches supported by the MHQoC strategy have received varying levels of interest and enthusiasm from the Indian government for national or state-level adoption. For example, government officials at all levels have supported the development and widespread use of quality standards and guidelines, and the National Health Mission has adopted the Dakshata guidelines developed by Jhpiego. The central government has also demonstrated some level of commitment to community accountability mechanisms, even though it has been challenging to obtain buy-in from some lower-level health officials. Emphasizing that MHQoC efforts align with government interests and priorities can facilitate adoption and garner support for these efforts from policymakers.

In some circumstances, advancing an MHQoC agenda may require stakeholders to share evidence and conduct advocacy to challenge existing policies and catalyze change. Government unpreparedness

for such efforts can pose a significant barrier. For example, the Foundation-supported Guttmacher abortion incidence study found a higher number of abortions and greater proportion of abortions taking place outside of the medical sector than anticipated by the government and some other stakeholders based on previous estimates. Although Guttmacher had planned to conduct dissemination activities and formulate policy recommendations based on the report's findings, these activities have been curtailed for the moment. To continue to advance the field of MHQoC, stakeholders will have to strike the right balance between collaborating with policymakers to advance their agenda and introducing information and innovations with less traction in the current climate.

CONCLUDING REMARKS

To date, the strategy has demonstrated progress along most indicators, with the most significant progress made in training providers, accrediting facilities, engaging women in community accountability activities, training legal and allied professionals on the use of legal strategies, and generating evidence to support MHQoC. The strategy has experienced more challenges in institutionalizing QA systems and processes, testing and gaining buy-in for some community accountability mechanisms, and obtaining long-term and systemic quality improvements through community accountability. In addition, the strategy is still in the early stages of supporting most advocacy campaigns, and the effectiveness of these campaigns at prioritizing MHQoC on the state and national stages remains to be seen. The initial lessons generated at this stage could help guide future work under the strategy and assist in course correction along key indicator areas that have not progressed at anticipated rates.

In subsequent years of the evaluation partnership, as more data on key indicators become available, a fuller picture of the progress toward the goals and objectives will emerge. Grantees' future reporting on key indicators will be used to assess progress made after Phase 1 and will enable a deeper analysis of the most successful substrategies and approaches, and any that face continued challenges. In addition, as grantees make more progress on implementation and some grants near completion, they will likely generate more information on the intermediate and longer-term outcomes in the strategy's logic model and on the sustainability of the MHQoC movement. This will allow for an assessment of the extent to which the strategy's activities and outputs can contribute to its ultimate objective of improving the quality of maternal health care in India.

APPENDIX A

SUPPLEMENTAL EXHIBITS

This page has been left blank for double-sided copying.

Exhibit A.1. Strategy-level indicators

Strategy component	Priority indicator
Substrategy 1: Strengthen supply of quality maternal health services in public and private sectors	
Approach 1.1. Strengthen human resources to increase provision of quality services (provider level)	
Output 1.1.1. Facility-level providers (for example, doctors and nurses) trained using improved guidelines, standards, and technology-based job aids for the provision of quality care Output 1.1.2. Community-level providers (for example, FLWs) trained using improved guidelines, standards, and technology-based job aids to provide quality care Outcome 1.1.1. Facility-level providers (for example, doctors and nurses) have improved capacity to provide quality maternal health service Outcome 1.1.2. Community-level providers (for example, FLWs) have improved capacity to provide quality maternal health services	Number and types of curricula developed for training facility-based providers to support quality maternal health services (for example, in-service midwifery curriculum) Number of facility-based providers trained on maternal health quality standards and/or technology-based job aids Evidence of facility-based providers reporting improved ability to deliver quality maternal health services Evidence of guidelines and standards for FLWs Number of FLWs trained on maternal health quality standards and/or technology-based job aids Evidence of FLWs reporting improved ability to deliver quality maternal health services
Approach 1.2. Strengthen facility-based quality assurance systems (facility level)	
Output 1.2.1. QA trainers and mentors to support state quality assurance teams are identified and trained Output 1.2.2. Facilities conduct monitoring to assess their performance in delivering quality care Outcome 1.2.1. Facilities implement QA models and procedures Outcome 1.2.2. Facilities use monitoring information to improve their capacity to provide quality maternal health services Outcome 1.2.2. Facilities are accredited to provide quality care	Number of facilities or catchment areas that offer training on maternal health quality standards Number and proportion of targeted facilities that have adopted QA models and procedures Number and proportion of targeted facilities that regularly use quality data and/or information from QA team to address service provision Number of facilities prepared for accreditation
Approach 1.3. Improve adherence to existing quality protocols and guidelines (health systems level)	
Output 1.3.1. Service delivery guidelines for quality maternal health care adopted by state governments Output 1.3.2. Technical assistance provided to improve intrapartum and immediate post-partum services, including referrals Outcome 1.3.1. High quality maternal health care is delivered consistently in public and private sector facilities Outcome 1.3.2. Facilities receiving technical assistance improve delivery of services during childbirth	Number and proportion of targeted facilities reporting that they have received technical assistance Extent that quality of routine and basic EmOC procedures are improved among facilities receiving technical assistance
Substrategy 2: Strengthen demand for quality services by supporting accountability mechanisms	
Approach 2.1. Inform women and families about the importance of quality and their related rights (awareness)	
Output 2.1.1. Women and their families are provided with information about their health rights Output 2.1.2. Community leaders are provided with information about their health rights Outcome 2.1.1. Women and families know about and participate in efforts to demand high quality health care Outcome 2.1.2. Community leaders know about and participate in efforts to demand high quality health care	Number of women demonstrating knowledge of their health rights Number of family members demonstrating knowledge of their health rights Number of women and their families participating in community accountability processes Number of community leaders participating in community accountability processes
Approach 2.2. Support development and testing of community accountability mechanisms (mobilization)	
Output 2.2.1. Technical assistance provided to support development and maintenance of hospital management societies Output 2.2.2. Tools and mechanisms tested to gather community feedback for quality improvement, including technology solutions, are developed	Number and type of community accountability mechanisms tested Actions taken by providers, facilities, or policymakers based on community accountability efforts, including any efforts to establish or strengthen hospital management societies

Strategy component	Priority indicator
Outcome 2.2.1. Hospital management societies monitor and work to improve the quality of health services Outcome 2.2.2. Community accountability tools and mechanisms for quality maternal health services are actively used	
Approach 2.3. Scale up application of legal strategies to strengthen access to quality services (public accountability)	
Output 2.3.1. Trainings at the state or national level conducted for lawyers and other allied professionals (such as social workers, activists, or public health professionals) about government accountability related to quality maternal health services Output 2.3.2. Public interest cases related to maternal health are brought to trial Outcome 2.3.1. Increased awareness among judiciary members, legal professionals, allied professionals, and government representatives about legal obligations related to respectful maternal health care Outcome 2.3.2. Network of lawyers, social activists, NGOs, and communities use public interest litigation to hold the government accountable for providing quality maternal health services	Number of legal professionals trained in a legal strategy for promoting access to quality maternal health services Number of allied professionals (such as social workers, activists, or public health professionals) trained in a legal strategy for promoting access to quality maternal health services Number and nature of networks of legal professionals, social activists, and other allied workers for advancing MHQoC Number of court orders advancing implementation of policies and programs related to maternal health
Substrategy 3: Build evidence and support advocacy for quality maternal health services	
Approach 3.1. Generate new and leverage existing evidence (evidence)	
Output 3.1.1. Research on MHQoC conducted Output 3.1.2. Existing evidence on MHQoC used to support updates and changes to programs and policies Outcome 3.1.1. Expanded availability of evidence on key indicators of maternal health, including quality of maternal health services Outcome 3.1.2. Increased availability of evidence-based programs to improve quality of maternal health care	Research studies conducted and reports produced on MHQoC by grantees Number of and extent to which grantees use evidence to advocate for changes to policies and programs
Approach 3.2. Promote civil society efforts for maternal health advocacy and support (social movement)	
Output 3.2.1. CSO networks and partnerships are active in advocating for improved maternal health policies and programs and greater funding Outcome 3.2.1.a. Policymakers, program managers, and practitioners prioritize MHQoC in developing strategic plans Outcome 3.2.1.b. Increased adherence to existing policies and implementation of programs to improve quality of maternal health services	Number and types of advocacy efforts for MHQoC led by CSO networks or partnerships at the state or national levels Extent to which policymakers and program managers report that quality of care is a high-priority issue
Approach 3.3. Use evidence and advocacy to sustain maternal health quality of care efforts supported under the strategy (sustainability)	
Output 3.3.1. Grantees identify sources of funding and support to sustain their work at the end of their strategy grants Outcome 3.3.1. Grantees can sustain their specific project work and/or launch new, related projects after the end of their strategy grants	Number of grantees sustaining current project work or launching follow-on projects after their strategy grants Number of grantees receiving other funding (for example, from foundation or multilateral organization) to support MHQoC

Source: MacArthur Foundation grant proposals, reports, and other documents (2009–2016).

CSO = civil society organization; EmOC = emergency obstetric care; FLW = frontline worker; MHQoC = maternal health quality of care; NGO = nongovernmental organization; QA = quality assurance.

Exhibit A.2. Grant reporting on strategy indicators (total grants = 28)

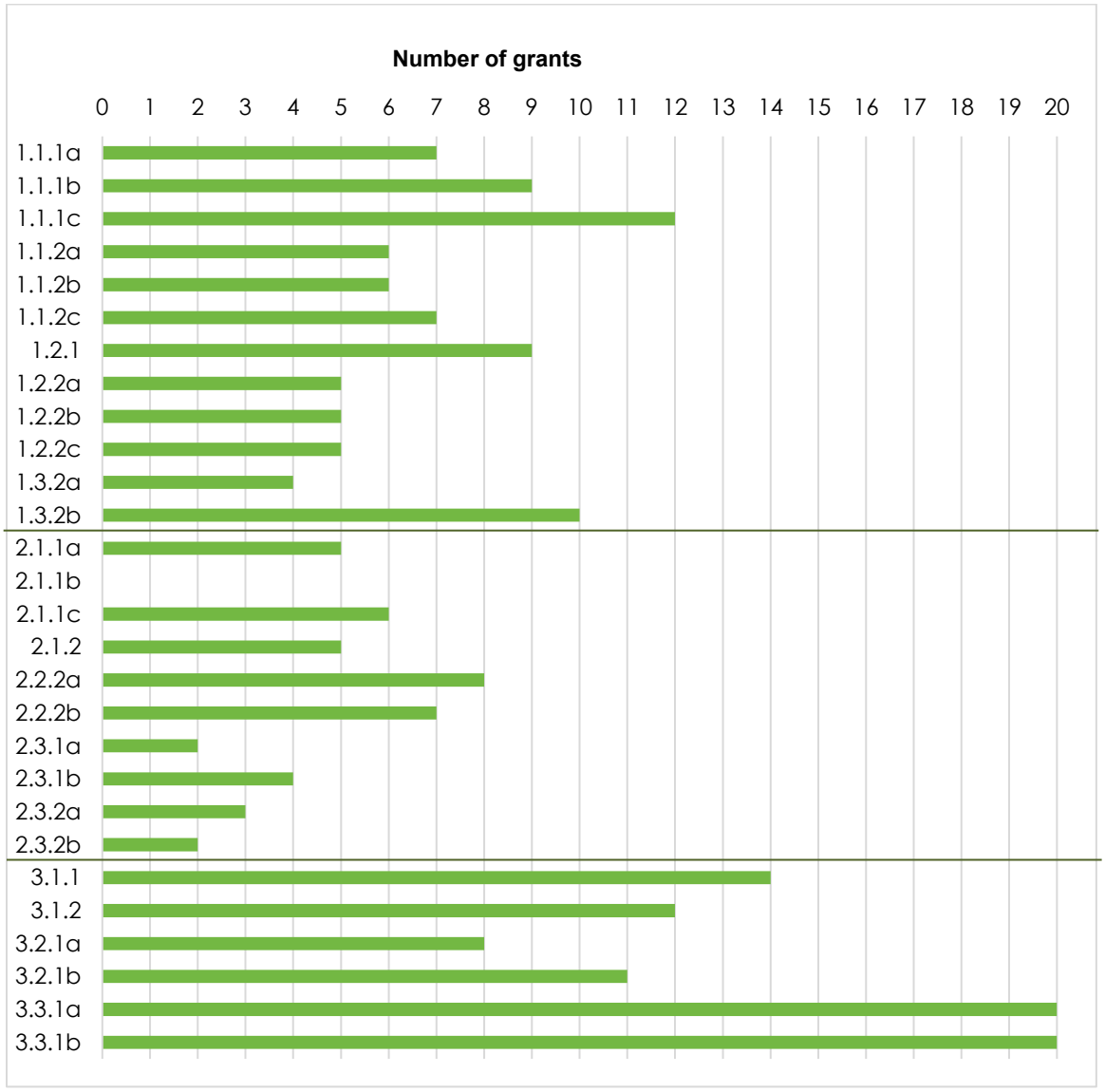


Exhibit A.3. Providers' trainings and capabilities (Approach 1.1)

Grant	Curriculum or guidelines developed	Number of providers trained	Evidence of providers' improved abilities
Facility-based providers			
MAMTA 107329	**Pre-strategy launch:** Developed 3 training modules and comprehensive mentoring protocol for medical officers, program managers, master trainers, and FLWs on continuum of care	**Pre-strategy launch:** 6,560 providers, including program managers, medical officers, master trainers, and FLWs trained on continuum of care with a special focus on preconception care for young married women **Phase 1**: 378 providers received refresher training	**Pre-strategy launch:** Self-reported knowledge of doctors and medical officers increased knowledge in post-training assessments
Jhpiego 101465	**Pre-strategy launch:** Developed a clinical skills standardization package for a two-day workshop for providers in intervention facilities **Phase 1:** Used lessons from the two-day workshop package to develop a three-day Dakshata training package that rolled out nationwide	**Pre-strategy launch:** 727 doctors and nurses trained on clinical standards; 301 received a refresher training	**Pre-strategy launch:** • 30% of the clinical performance standards were adhered to in the health facilities; this increased to 53% after 6 months • Self-reported confidence and knowledge of doctors and nurses increased in post-training assessments
Jhpiego 106484	**Pre-strategy launch:** Developed a clinical skills standardization package for a two-day workshop for providers in intervention facilities **Phase 1:** Used lessons from the two-day workshop package to develop a three-day Dakshata training package that rolled out nationwide	**Phase 1:** 2,043 providers (585 doctors and 1,458 nursing staff) were trained across 263 facilities	NA
WHO 151795	NA	NA	NA
Karuna Trust 106724	**Phase 1:** Three types of curricula developed for PHC staff, including nurses, with 40 training topics	**Pre-strategy launch:** 8 health workers trained on mhealth **Phase 1:** 51 health workers trained on m-health and quality management; 328 PHC staff trained on ANC, PNC, and use of E-partograph	NA
Karuna Trust 93784	NA	**Pre-strategy launch:** 184 PHC staff trained on quality across 6 trainings	NA
Pathfinder 151209	NA	NA	NA
ARTH 95544	**Pre-strategy launch:** Skilled MNH training manual and trainers' guide for nurse-midwives developed	**Pre-strategy launch:** Trained 288 doctors and health officials; trained 190 nurse midwives in training of trainers on skilled birth attendance	**Pre-strategy launch:** Facilities showed improved adherence to quality—suggesting improved provider capabilities
ARTH 106482	NA	Trained nurses on prereferral care 41 hospital-based support staff trained	**Phase 1:** Positive change ranging from 6% to 31% across three districts
JSS 109126	**Phase 1:** Working with Jhpiego to develop training modules for providers on medical illnesses in pregnancy	**Phase 1:** 216 providers trained (37 medical officers, 155 staff nurses, 23 ANMs, 1 principal of nursing school); 200 maternity wing staff trained across 20 training sessions	NA
PopCouncil 106701	NA	NA	NA
SEWA Rural 108398	NA	**Phase 1:** 8 medical officers trained in IVRS (phone-based tool)	NA
Frontline workers			
Karuna Trust 93784	NA	**Pre-strategy launch:** 34 ANMs and 25 mobile health unit staff trained on ANC, PNC, and immunizations	NA

Grant	Curriculum or guidelines developed	Number of providers trained	Evidence of providers' improved abilities
MAMTA 107329	NA	**Pre-strategy launch:** 5,832 FLWs (113 ANM, 3,282 ASHA, and1,437 AWW) were trained on CoC with a special focus on preconception care for young married women **Phase 1:** 1,968 FLWs (165 ANMs, 1,316 ASHAs, and 487 AWWs) were trained on CoC with a special focus on preconception care; 219 ASHAs were trained on IVRS (phone-based tool)	**Phase 1:** Self-reported knowledge of FLWs increased in post-training assessments; 92% of ASHAs reported that they are delivering services to young married women during their routine home visits; 100% of ANMs reported that they are focusing on preconception care component of CoC
SEWA Rural 108398	**Phase 1:** 11 training modules and 15 hours of training videos developed for FLWs	**Phase 1:** 548 ASHAs trained; 265 ASHA received refresher training; 78 ANMs trained on IVRS (phone-based tool)	**Phase 1:** 288 ASHAs feel more empowered to provide care
ARTH 95544	**Pre-strategy launch:** Guidelines on evidence based care practices for FLWs developed	**Pre-strategy launch:** ASHAs oriented on evidence-based MNH over 20 meetings	**Pre-strategy launch:** Midwives who participated in skilled birth attendance reported improved skills
Ipas 101050	NA	**Pre-strategy launch:** Oriented 247 community health intermediaries over the course of the project on CAC	NA
Karuna Trust 106724	**Phase 1:** Three curricula and standard guidelines were developed for health workers (including FLWs) on ANC, PNC, use of E-partograph, use of management app, and high-risk pregnancies	**Phase 1:** 437 FLWs and PHC staff were trained on ANC, PNC, and immunizations	**Phase 1:** 100% of FLWs reported they feel capable of delivering quality maternal health services
ARTH 106482	NA	**Phase 1:** 82 Yashodas trained	NA
PopCouncil 106701	NA	NA	**Phase 1:** 78% to 87% of ANMs and 77% to 89% of ASHAs reported that they felt more confident about counseling young women after attending the MAMTA training
Jhpiego 106484	**Phase 1:** A three-day Dakshata training package was developed to improve practices during intra- and postpartum periods	NA	NA
JSS 109126	NA	**Phase 1:** 23 ANMs trained	NA

ANC = antenatal care; ANM = auxiliary nurse midwife; ARTH = Action Research and Training for Health Society; ASHA = accredited social health activist; AWW = Anganwadi worker; CAC = comprehensive abortion care; CHSJ = Centre for Health and Social Justice; CoC = continuum of care; FLW = frontline worker; IVRS = interactive voice response system; JSS = Jan Swasthya Sahyog; MNH = maternal and neonatal health; MSAM = Mahila Swasthya Adhikar Manch; PHC = primary health center; PNC = postnatal care; SAHAJ = Society for Health Alternatives; SEWA = Society for Education Welfare and Action; VHND = Village Health and Nutrition Day; WHO = World Health Organization.

NA = not available.

Exhibit A.4. Participation in community accountability and awareness of rights (Approach 2.1)

Grant	Women participating in community accountability processes	Community leaders participating in community accountability processes	Women demonstrating knowledge of health rights
SAHAJ 109340 (3/16–9/17)	• **Phase 1:** Held 90 meetings on MH topics, covering 600 women (10 to 35 women attended each meeting)	• **Phase 1:** At least 10 community leaders were involved in each of the 13 maternal death reviews • **Phase 1:** At least 10 to 20 leaders participated in each of the 43 meetings on community accountability	• **Phase 1:** 705 women were aware of health entitlements, which represents 70% to 86% of all women in targeted districts
SAHAJ 99541 (12/14–2/16)	• **Pre-strategy launch:** Held 13 PHC-level meetings (attended by about 15 women each) and 44 community-level meetings on accountability (attended by 60 to 70 women each) • **Phase 1:** Monthly community-level meetings continued	• **Pre-strategy launch:** 10 to 15 community leaders participated in each social autopsy (29 autopsies performed, reaching 290 to 335 leaders in total) • **Pre-strategy launch:** 6 to 8 community leaders were involved in the systematic monitoring of each VHND	• 683 women were aware of health entitlements, which represents 30% to 77% of all women in targeted blocks
SAHAYOG 104990	• **Pre-strategy launch:** 4,880 women participated in MSAM • **Phase 1:** 1,000 MSAM participants gathered on International Women's Day; 200 MSAM leaders presented data to health providers and FLWs	• **Phase 1:** 454 community leaders gave input for the final report	Not addressed by this grant
CHSJ 97735 (6/11–5/14)	• **Pre-strategy launch:** An average of 184 to 206 men attended village-level group meetings in each district	• **Pre-strategy launch:** 3 to 5 leaders attended monthly meetings to discuss social and health issues in 30 villages , and 5 to 8 leaders shared report cards on social and health indicators at every village	Not addressed by this grant
PopCouncil (9/14–8/17)	Not addressed by this grant	Not addressed by this grant	• **Pre-strategy launch:** 97% and 99% of women in intervention and comparison arms were aware of JSY at baseline of evaluation; 16% and 19% were aware of JSSK, and 30% and 32% were aware of SABLA • **Phase 1:** At the end of the evaluation, 97% and 95% of married young women in intervention and comparison arms were aware of JSY; 34% and 33%, respectively, were aware of JSSK; 30% and 34%, respectively, were aware of SABLA
C3 100982	• 8,000 women participated in public hearings, death audits, and community-level dialogues on entitlements	• 120 elected representatives from local and district levels participated in public hearings, community-level dialogues, and monitoring of RKS	Not addressed by this grant

CHSJ = Centre for Health and Social Justice; FLW = frontline worker; JSSK = Janani Shishu Suraksha Karyakaram; JSY = Janani Suraksha Yojana; MH = maternal health; MSAM = Mahila Swasthya Adhikar Manch; PHC = primary health center; RKS = Rogi Kalyan Samiti/Hospital Management Society; SABLA = Rajiv Gandhi Scheme for Empowerment of Adolescent Girls; SAHAJ = Society for Health Alternatives; VHND = Village Health and Nutrition Day.

NA = not available.

Exhibit A.5. Publications documenting new and leveraging existing evidence (Output 3.1.1 and Outcome 3.1.2)

Publication title (publication year)	Grantee	Description	Type	Intended audience and dissemination	Use of information
Publications on new evidence					
Abortion in India: A Literature Review (2014)	Guttmacher 103736	Synthesis of the literature on abortion in India	Peer-reviewed publication	Researchers and policymakers	
Baseline Assessment of MAMTA Evaluation (2015)	Population Council 106701	Baseline assessment report for evaluation of MAMTA's continuum-of-care model	Technical report	Researchers and policymakers, including MOHFW	Findings are used to inform implementation of government RMNCH+A initiative
Study of Postpartum/ Postabortion Contraception (2016)	Population Council 106701		Peer-reviewed publication	Researchers and policymakers; *Studies in Family Planning*	
Literature Review (2017)	Anusandhan Trust 107328		Peer-reviewed publication	Researchers and policymakers	
Adherence to Evidence-Based Care Practices for Childbirth Before and After a Quality Improvement Intervention in Health Facilities of Rajasthan, India (2014)	ARTH 95544	Paper documenting ARTH's intervention to improve quality of delivery care	Peer-reviewed publication	Researchers and policymakers; *BMC* Pregnancy and Childbirth	
The Incidence of Abortion and Unintended Pregnancy in India (2017)	Guttmacher 103736	Estimates of abortion incidence in India	Peer-reviewed publication	Researchers and policymakers; *Lancet Global Health*	
Cluster Randomized Trial of a mHealth Intervention "ImTeCHO" to Improve Delivery of Proven Maternal, Neonatal, and Child Care Interventions Through Community-Based ASHAs by Enhancing Their Motivation and Strengthening Supervision in Tribal Areas of Gujarat, India: Study Protocol for a Randomized Controlled Trial (2017)	SEWA Rural 108398	Study aimed to implement and evaluate an innovative intervention based on mobile phone technology (mHealth) to improve the performance of ASHAs	Peer-reviewed publication	Researchers and policymakers; trials	Findings are used to advocate for scaling up the program
Effect of Maternity Schemes on Place of Delivery in a Tribal Block of Gujarat (2013)	SEWA Rural 108398	Study examined effectiveness of recently launched maternity schemes and NGO initiatives to increase institutional deliveries	Peer-reviewed publication	Researchers and policymakers; *Indian Journal of Community Medicine*	
Encouraging Young Married Women (15–24 Years) to Improve Intra-Spousal Communication and Contraceptive Usage through Community Based Intervention Package in Rural India (2016)	MAMTA 107329	Study was conducted to understand the effect of a community-based intervention package on awareness and motivation for contraceptive use to delay pregnancy among young married couples through improving intra-spousal communication	Peer-reviewed publication	Researchers and policymakers; *Journal of Contraceptive Studies*	

Publication title (publication year)	Grantee	Description	Type	Intended audience and dissemination	Use of information
Community-Based Reproductive Health Interventions for Young Married Couples in Resource-Constrained Settings: A Systematic Review (2015)	MAMTA 107329	Presents a review of the available evidence on the effectiveness of community-based health interventions to improve the reproductive health status of young married couples in LMICs	Peer-reviewed publication	Researchers and policymakers; *BMC Public Health*	
Publications leveraging existing evidence					
State Fact Sheets on Abortion Incidence Study (forthcoming-2018)	Guttmacher 103736	State-level fact sheets on findings from abortion incidence study	Briefs	Policymakers and nontechnical audiences; shared at dissemination meetings	
"Ready Reckoner" on Conflation of Sex Selection with Safe Abortion (fall 2016)	Ipas 108851	Information about MOHFW guidelines on the conflation of selection with access to safe abortion	Handbook	Journalists, advocates, and other nontechnical audiences; disseminated at state-level workshops	
Abortion Laws in India- a Review of Court Cases (2017)	Ipas 108851	Detailed compilation of legal judgments and orders related to MTP Act, disseminated in July 2017	Handbook	Shared at CAC Conclave	
The POCSO Act and The MTP Act: Key Information for Medical Providers	Ipas 108851	Explains the provisions of the Protection of Children from Sexual Offences (POCSO) Act, 2012, and the MTP Act, 1971, with specific reference to young women's access to safe abortion services	Policy brief	Policymakers and medical providers	
Situational Analysis on Respectful Care (date TBD)	C3 108898	Desk review, media scan, and key informant interviews on respectful care, focusing on maternal health, family planning, and abortion	Report		Used to develop an advocacy strategy for the WRAI to promote respectful maternity care in India
Capacity-Building for Providers (date TBD)	Population Council 106701		Report		
Chronicles of Death Foretold: A Civil Society Analysis of Maternal Deaths in Seven Districts From the States of Odisha, West Bengal, Jharkhand and Uttar Pradesh, India (2016)	Sahayog 104990	Documents stories of maternal deaths in 7 districts from 4 states	Report	Policymakers, advocates, and other nontechnical audiences	Evidence was used to advocate with state-level officials in the 4 states and with key officials in the MOHFW, including the deputy commissioner of maternal health, technical experts from WHO, and medical superintendents of various medical colleges

ASHA = accredited social health activist; CAC = comprehensive abortion care; LMIC = low and middle income countries; MAMTA = MAMTA Health Institute for Mother and Child; MOHFW = Ministry of Health and Family Welfare; MTP = medical termination of pregnancy; NGO = nongovernmental organization; RMNCH+A = reproductive, maternal, newborn, child, and adolescent health; SEWA = Society for Education Welfare and Action; TBD = to be determined; WHO = World Health Organization; WRAI = White Ribbon Alliance India.

www.mathematica-mpr.com

Improving public well-being by conducting high quality, objective research and data collection

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ SEATTLE, WA ■ TUCSON, AZ ■ WASHINGTON, DC ■ WOODLAWN, MD

MATHEMATICA
Policy Research