PATH/Satvir Malhotra

Partnership Profiles #2

Using implementation analyses to identify national RMNCH priorities:

a multi-stakeholder approach supported by global partnerships

In late 2010, four key donors in the health field—the Australian Agency for International Development (AusAID), the US Agency for International Development (USAID), the UK Department for International Development (DFID), and the Bill & Melinda Gates Foundation—committed to working together to accelerate progress toward MDGs 4 and 5 globally and within ten focus countries in Africa and Asia.[1] As part of their collaboration in the Alliance for Reproductive, Maternal and Newborn Health (RMNH Alliance), they jointly supported a series of national reviews on current progress and challenges in addressing key policy and implementation issues related to reproductive, maternal, newborn and child health (RMNCH).

In 2012, an initial set of national implementation analyses were conducted in six Asia-Pacific countries – Bangladesh, Nepal, India, Indonesia, Papua New Guinea and the Solomon Islands. These implementation analyses were led by ministries of health and conducted through participatory, multi-stakeholder efforts both at the global and national levels. This experience provides valuable lessons on the value of partnership in developing consensus on policy priorities and providing a platform for joint advocacy and action.

Partnership foundations

Partnership was a cornerstone of the joint RMNCH implementation analysis effort from the outset. Working together under the RMNH Alliance, maternal and child health experts from the four donor agencies identified the value of collectively conducting country-specific analyses

1. For more information please visit http://blog.usaid.gov/2010/09/international-alliance-launched/

to ground future collaborative efforts. To facilitate this work, each partner drew on existing mechanisms to provide financial and technical support. AusAID championed the process by earmarking additional funds under their grant to the Partnership for Maternal, Newborn & Child Health (PMNCH). DFID and the Gates Foundation also provided general operating support to PMNCH, and USAID gave support through its flagship Maternal and Child Health Integrated Program (MCHIP). The activity was coordinated by the RMNH Alliance Secretariat, which represented the interests of all four key donors.

The technical team also represented a broad partnership. Representatives from PMNCH, World Health Organization (WHO), MCHIP, USAID and the Alliance actively participated in the process of developing the study protocol; facilitating the work in country; and disseminating the results at the global, regional and national levels. Work at the country-level drew on the comparative advantages of the partners. In conjunction with national governments, MCHIP supported the process in countries where they maintained a presence and WHO supported it in the others. Expert consultants were contracted to support the process in each country. Country representatives from USAID, AusAID, and DFID participated in the country-level planning and consultations and in utilizing the results.

Implementation analyses

The primary objective of the analyses was to review the current status of RMNCH implementation. The process allowed ministries of health and multiple stakeholders in each country the opportunity to assess progress on RMNCH, identify two key program areas where success has been observed and two that have not responded to program inputs where priority action is required. The goal was to document successes, assist partners to identify program and policy priorities and achieve consensus among stakeholders on program areas that needed ongoing support. At the regional level, the results also informed discussions at the high-level "Asia-Pacific Leadership and Policy Dialogue for Women's and Children's Health" organized by PMNCH.

Six Asia-Pacific countries were invited to participate in the first round of implementation analyses: Bangladesh, India, Indonesia, Nepal, Papua New Guinea and the Solomon Islands. The first four were drawn from the RMNH Alliance focus countries, and the latter two represented AusAID priority countries that would benefit specifically from such in-depth analyses. Through the lead organizing partner in each country, governments were given the opportunity to take part in the implementation analyses; all six expressed interest.

The analyses were carried out under an accelerated timeframe in order to ensure that results could be shared at the "Asia-Pacific Leadership and Policy Dialogue" in November 2012.[2] Work began in August 2012 when the terms of reference and protocol were presented to the in-country stakeholder groups, led by the ministries of health. The process included two primary components:

- A synthesis of existing data and implementation experience regarding coverage of RMNH interventions, and a review of the policies and systems needed to deliver interventions. This desk review summarized the status of maternal, newborn and child health in country and examined the delivery of interventions for women and children. Additional analyses allowed stakeholders to examine trends in mortality and other indicators over time, as well as how trends differed across regions and population groups.

- A multi-stakeholder consultation reviewed the data and used criteria to select two priority intervention or system areas where progress has been made and two intervention or system areas where there were ongoing challenges. Progress was defined as program impact or improvement, using methods or solutions that contributed to developing sustainable local systems. Challenges were defined as intractable issues that have not responded to national strategies or programs and continue to pose difficulties. Each selected intervention or systems area was then explored in more depth to identify policy and health systems factors that had contributed to observed performance and to highlight the most important lessons learned. It is these lessons and policy priorities that are intended to provide the basis for future policy and program action.

Utilizing the results

The "Asia-Pacific Leadership and Policy Dialogue" provided an opportunity to look across the countries that conducted implementation analyses to identify common challenges and transferable solution sets. Government and civil society representatives from each of the six focus countries participated in a plenary panel that highlighted issues from the analyses and promoted cross-national learning. Shared technical priorities identified in this panel included:[3]

2. For more information please visit http://www.who.int/pmnch/media/press_materials/pr/2012/20120717_asia_pacific_dialogue/en/index.html

- Reducing fertility is critical to reducing maternal and child deaths, although equitable access to FP services remains a challenge.
- Newborn deaths are an increasing proportion of under-five mortality. Providing essential newborn and postnatal care interventions remains challenging.
- Coverage along the continuum of care is limited: skilled birth attendance is below 50% in all countries except India, Indonesia and the Solomon Islands, and missed opportunities to provide essential maternal and newborn care are frequent.
- There are significant inequities for interventions that require 24-hour service availability and are lower if service can be scheduled or given in the home or community.
- Limited data on quality of care are available. Available data and field reports suggest that quality is highly variable and needs improvement. Standards and guidelines are generally in place, but not implemented on the ground.
- Across countries, a priority is to develop systems that will increase access to, quality of, and demand for facility- and community-based services, particularly in hard-to-reach areas.

In each of the six countries, the process of conducting the review itself had an impact: it brought together multiple stakeholders and allowed them a unique opportunity to consolidate, collectively review, and discuss existing data on RMNCH intervention coverage, policies and health systems. It also encouraged stakeholders to identify, and align around, a limited number of priorities for future policy or program change, a restriction that required participants to think strategically about key needs and implementation gaps. At the conclusion of this process, many participants noted that they felt mobilized around a common set of principles for change.

- In India this process was undertaken by the newly formed, government-led RMNCH+A (adolescent) multi-stakeholder coalition. As one of the group's first activities, the implementation analysis helped to validate and strengthen the coalition, raise its profile, and advance the idea of collective action in this sector. It was seen as catalytic for both the coalition and collective progress toward addressing key RMNCH+A issues in India.
- In Indonesia, senior leadership from the Ministry of Health actively led a multi-stakeholder group from the early stages until the finalized document was presented at the policy dialogue meeting. The challenge to identify a limited number of priorities for action (just two) motivated the group to keenly focus on the core issues currently facing the country. Active government involvement throughout the process has ensured that stakeholders are invested in utilizing the results.

Results from the implementation analysis in India

Progress

Through systemic interventions such as the National Rural Health Mission (NRHM) and conditional cash transfer scheme, India has made significant improvements in skilled birth attendance rates and increased coverage of immunization.

Challenges

Consistent implementation of the NRHM across the vastly different Indian states remains a challenge, especially in terms of planning, use of health information systems, and ensuring quality of care.

Effective recruitment, management and retention of human resources is an ongoing constraint. While the NRHM has allowed for some flexibility in terms of providing incentives (both financial and non-financial), including rotation positions and scholarships for health workers, the results have not been entirely satisfactory.

Complete results from the six individual country analyses are available at http://www.who.int/pmnch/media/press_materials/pr/2012/20120717_asia_pacific_dialogue/en/index4.html

The process, however, added more value in countries that had not completed similar assessments in recent years, and that were at critical junctures in their national planning processes. The challenge that faces country teams now is continuing the momentum by collectively advocating for and advancing the policy and program improvements they identified.

Following discussions at the "Asia-Pacific Leadership and Policy Dialogue," the United Nations Children's Fund has adopted the same methodology to conduct implementation analyses in four Pacific Island countries: Fiji, Kiribas, Vanuatu and the Federated States of Micronesia. These

3. RMNCAH Country Case-Studies: Summary of Findings from Six Countries. Presented at: Asia-Pacific Leadership and Policy Dialogue for Women's and Children's Health, November 8, 2012; Manila, Philippines. Available at: http://www.who.int/pmnch/media/press_materials/pr/2012/asia_pacific_dialogue_casestudies_summary.pdf.

results will not only inform discussions at the national level, but will be presented at the Pacific Health Ministers' meeting in July 2013.

The opportunity to conduct similar implementation analyses, drawing on the lessons learned from the first round, is now being extended to the RMNH Alliance's focus countries in Africa. Efforts are also being made to link the process with related country case studies that will be conducted as part of the Countdown to 2015 effort. The protocols and tools are being revised to reflect initial experience, and are being prepared as how-to guides so that regional- and national-level partners can conduct similar assessments without external technical assistance.

Lessons learned

Whereas the experiences of each of the six countries differ significantly, key factors that both promoted and inhibited the work can be identified.[4] Drawing on the framework for collaboration developed by the RMNH Alliance, these factors include:

- **Presence of strong and shared leadership**
  At the global level, strong and shared leadership was central to the success of this effort. The RMNH Alliance actively coordinated all partners and ensured the progress of the work, while technical leads from MCHIP, WHO and PMNCH collectively oversaw its quality. This coordinated effort allowed for the identification of additional resources and the establishment of a team of expert consultants to share leadership of this process in country. It also ensured that this effort was conducted as efficiently as possible, and did not detract from other ongoing activities being undertaken by the government. This coordination also ensured that the analyses were completed under a limited timeframe.

  Where similar leadership was present at the country level, the process of conducting the analyses was most successful and meaningful. In Indonesia and India, for example, where the government actively led the process, the team produced a set of recommendations that clearly supports and advances government priorities. In other countries, where the government or other key stakeholders did not shepherd the process as actively, results did not appear to have the same level of support and relevance in the national context, and consequently, may not contribute to long-term outcomes.

- **Interdependency and complementarity**
  A hallmark of this process was its ability to draw on the strengths of the different partners to meet a shared objective, while also contributing to individual organizational needs at both the global and country levels.
  - This interdependency was demonstrated from the outset of the activities, as the donors and implementing partners invested time and resources into a process that met their collective desire to identify and address RMNCAH challenges in key countries. The outcomes of the process also contributed to the "Asia-Pacific Leadership and Policy Dialogue," a meeting in which all partners had a vested interest.
  - The process also brought specific benefits for each of the partners: AusAID was able to increase the evidence base and focus on two underserved island nations; PMNCH generated empirical evidence that could be shared widely; and the RMNH Alliance produced a tool and process that met their objective of supporting country partners.

- **Shared problem definition and approach**
  The activity had two primary goals: 1) to collectively identify priority gaps and challenges at the country level in order to inform future advocacy and action; and 2) to provide country-level experiences for cross-learning and discussion at the "Asia-Pacific Leadership and Policy Dialogue." The latter goal was most fully achieved, which can be attributed to its clear articulation, time-bound nature, and well-defined set of deliverables. The former goal, which was less defined, did not resonate in the same way with country-level partners. In some countries, such as India, stakeholders found the process to be useful for articulating collective priorities; while in others it did not clearly address a country-level problem or felt need. A clear lesson from this experience is that a shared problem definition is critical for driving action at the national level.

For more information

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This profile was prepared by Jill Keesbury and Molly Canty.

4. Based on a comprehensive literature review conducted by USAID, the elements of successful partnership include: clear decision-making processes, shared and compelling vision, presence of strong and shared leadership, shared problem definition and approach, power equity and influence, interdependency and complementarity, mutual accountability and transparency, communication, and joint learning.