4/21/2020

RMNCH+A

CHN FOR 4TH YEAR

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REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (RMNCH+A)PROGRAMME- ISSUES & APPROACHES

HISTORICAL BACK GROUND

- 1950 : MCH services as a basic health service in PHC
- 1952: National Family Planning Programme
- 1966: All India Hospital Post Partum Programme
- 1977: National Family Welfare Programme
- 1992: National Child Survival & Safe Motherhood Programme
- 1997: RCH phase-I
- 2005: NRHM
- 2OO5 : RCH phase -II

NATIONAL FAMILY PLANNING PROGRAMME-1952

- 1st in world
- Focus on „Birth Control"
- Mostly „Sterilization"- Camp Approach
- Less priority on maternal & child survival: - Little impact on fertility trend - High MMR. High IMR

continued

All India Hospital Post Partum Programme (AIHPPP)- 1966

- It is a maternity centered, hospital based approach to Family Welfare Programme
- To motivate the eligible couples for adopting the small family norm

Objectives: 1. To improve the health of the mother and children
2. To reduce IMR and MMR

NATIONAL FAMILY WELFARE PROGRAMME- 1977

- Shift from "Planning" to "Welfare"
- Emphasis on- 1. ANC

2. ANEMIA CONTROL PROGRAMME
3. ICDS
4. MTP ACT
5. CHILD MARRIAGE RESTRAINT ACT
6. DIARROEA CONTROL PROGRAMME
7. ARI CONTROL PROGRAMME
8. UNIVERSAL IMMUNISATION PROGRAMME

Child Survival and Safe Motherhood (CSSM) Programme 1992

- All programme were implemented vertically.

Objectives:

1. To improve the health of the mothers and children below 5 years.
2. To reduce MMR,IMR and Child Mortality Rates.
3. To eliminate Neonatal Tetanus.
4. To eradicate Poliomyelitis.

TOWARDS REPRODUCTIVE HEALTH APPROACH Reproductive and Child Health(RCH) :

International Conference on Population Development (ICPD) held at Cairo in1994 2 New components added:

i) Adolescent Health

ii) Treatment of RTIs & STIs ϖ RCH defined as "A state of complete physical, mental and social wellbeing and not merely an absence of the disease or infirmity in all maters relating to reproductive system and its functions and processes."

REPRODUCTIVE APPROACH

 People have the ability to reproduce and regulate their fertility

 Women are able to go through pregnancy and child birth safely

 The outcome of pregnancy is successful in terms of wellbeing and survival of mother and infant Couples are able to have sexual relation free of fear of pregnancy and contracting diseases.

STRATEGIES-1

 Area specific Micro Planning

 Community Need Assessment Approach(CNNA)- Decentralized Participatory Plan

 Emphasis on- Remote Rural area, Urban Slum Tribal area

 Emphasis on: Out-reach Services

STRATEGIES-2

 Upgradation of facility:

1. 24 hour delivery services
2. FRU
3. Sick Newborn Care
4. Safe Abortion Services
5. RTI/STI Management

RCH PACKAGE OF SERVICES:

I. MATERNALHEALTH
II. NEW BORN & CHILD HEALTH
III. ELIGIBLE COUPLE
IV. REPRODUCTIVE AGE WOMEN
V. ADOLESCENT HEALTH
VI. BCC & COUNSELLING

RCH-II (1st April 2005)

Aim:

 Reduction of IMR,MMR and TFR

 Increase of CPR and Immunization coverage

Goals:

1. Reduction of decadal growth to 16.2%(2001-2011)
2. Reduction of IMR :<30/1000 live birth by 2010
3. Reduction of MMR to <100/100000 live births by 2010
4. Reduction of TFR to 2.1 by 2010
5. Increase CPR to 65%, Immunization Coverage to100%, ANC to 89%,Rural Institutional deliveries to 80%

Objectives of RCH-II

 Immediate objective:

- Improve Routine Immunisation
- Reduce the Unmet need for Contraception
- Provide an integrated Service delivery for basic Reproductive & Child health Care

 Medium Term Objective:

Bring TFR to Replacement level by 2010

 Long term objective: Population Stabilization

RCH-II: **Flagship programme under NRHM launched on 1st April 2005**

 Special focus under RCH-II:

1. Essential obstetric care: - Institutional delivery - Delivery by SBA
2. Emergency Obstetric Care: - Operationalizing FRU - PHC 24 x 7 delivery services
3. Essential Newborn Care / Care of the sick Newborn

Components of RCH II

 Population stabilization
 Maternal health
 IMNCI
 Adolescent health
 Control of RTIs/STIs
 Urban health
 Tribal health
 Main streaming gender and equity
 Intersectoral and donor convergence
 Behavior Change Communication (BCC)
 Public Private Partnership (PPP)
 Monitoring, Evaluation and Health Management Information System
 Community Participation
 Procurement and Logistics

NEW INTERVENTIONS

- Basic Em Obstetric Care (BEmOC)
- Comprehensive Em Obstetric Care (CEmOC)
- . Facility based Newborn Care
- Janani Suraksha Yojna
- Janani Sishu Suraksha Karyakram
- . Village Health & Nutrition Day (VHND)
- Integrated Management Of Neonatal & Childhood Illness (IMNCI)

RMNCH+A

1. This is a comprehensive strategy for improving the maternal and child health outcomes , under NRHM
2. It is based on the evidence that maternal and child health cannot be improved in isolation as adolescent health and family planning have an important bearing on the outcomes.
3. This strategy encompasses various high impact interventions across the life cycle.
4. The strategy is based on the concept of 'CONTINUUM OF CARE' What is RMNCH+A Strategic approach?

WHAT IS NEW IN RMNCH+A?

1. Inter-linkages between different interventions at various stages of the life cycle
2. Linking child survival to other inventions such as reproductive health, family planning , maternal health
3. Sharper focus on adolescents
4. Recognizing nurses as „pivots" for service delivery
5. Expanding focus on child development and quality of life
6. Intensification of activities in High Priority districts.

PLUS DENOTES

(1) Inclusion of adolescence as a distinct „life stage"

(2) Linking of Maternal and Child Health to Reproductive Health and other components like family planning.

(3) Linking of community and facility-based care as well as referrals between various levels of health care system.

What does RMNCH+A stands for

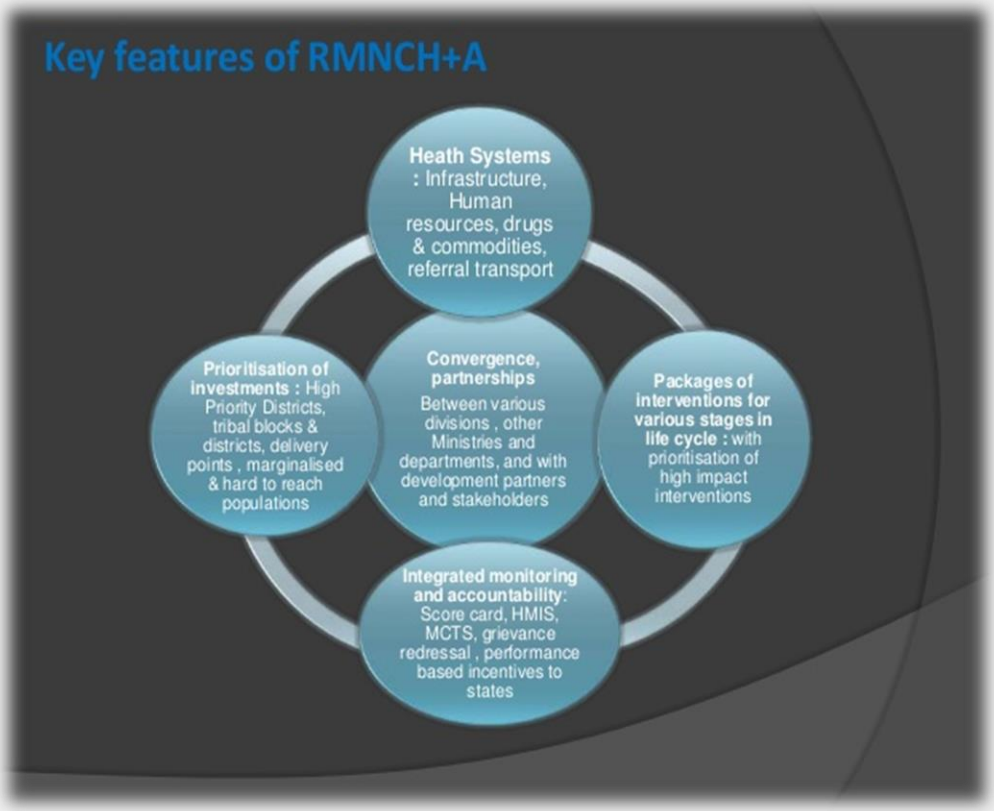
 Reproductive, Maternal, New-born, Child & Adolescent Health : Links maternal and child survival to other components (family planning , adolescent health, gender & PC & PNDT)

 Plus denotes

 inclusion of adolescence as a distinct 'life stage' in the overall strategy

 Links community and facility based care as well as referrals between various levels of health care system Adolescent Health Package Reproductive Health package Antenatal & Intrapartum care package Newborn care package Post partum family planning,spacin g methods Under five child health package

Key features of RMNCH+A



GOALS Health outcome goals established in the 12th Five Year Plan.

- Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017
- Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
- Reduction in Total Fertility Rate(TFR) to 2.1 by 2017

Coverage targets for key RMNCH+A interventions for 2017

- Increase facilities equipped for perinatal care (designated as „delivery points") by 100%
- Increase proportion of all births in government and accredited private institutions at annual rate of 5.6 % from the baseline of 61% (SRS 2010)
- Increase proportion of pregnant women receiving antenatal care at annual rate of 6% from the baseline of 53% (CES 2009)
- Increase proportion of mothers and newborns receiving postnatal care at annual rate of 7.5% from the baseline of 45% (CES 2009)
- Increase proportion of deliveries conducted by skilled birth attendants at annual rate of 2% from the baseline of 76% (CES 2009)
- Increase exclusive breast feeding rates at annual rate of 9.6% from the baseline of 36% (CES 2009)

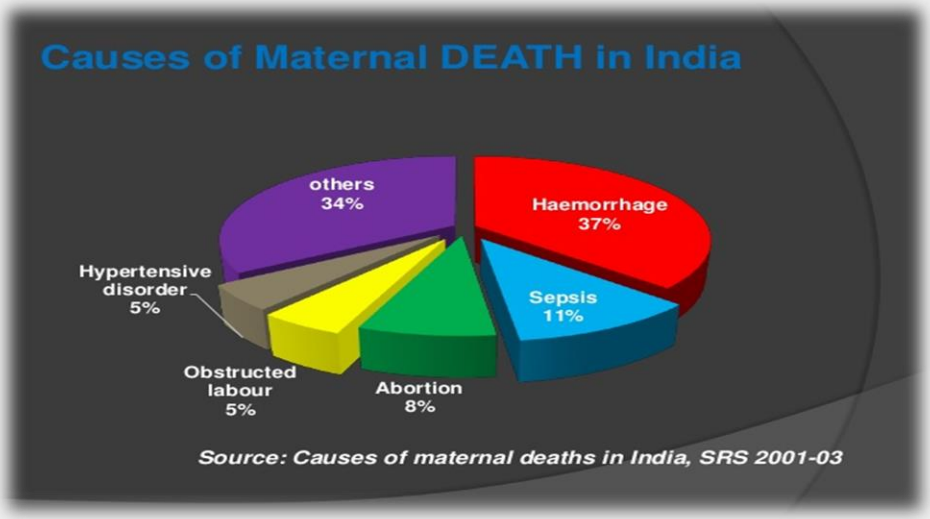
GOALS

- Reduce prevalence of under-five children who are underweight at annual rate of 5.5% from the baseline of 45% (NFHS 3)
- Increase coverage of three doses DTP (12–23 months) at annual rate of 3.5% from the baseline of 7% (CES 2009)
- Increase ORS use in under-five children with diarrhoea at annual rate of 7.2% from the baseline of 43% (CES 2009)
- Reduce anaemia in adolescent girls and boys (15–19 years) at annual rate of 6% from the baseline of 56% and 30%, respectively (NFHS 3)
- Decrease the proportion of total fertility contributed by adolescents (15–19 years) at annual rate of 3.8% per year from the baseline of 16% (NFHS 3)

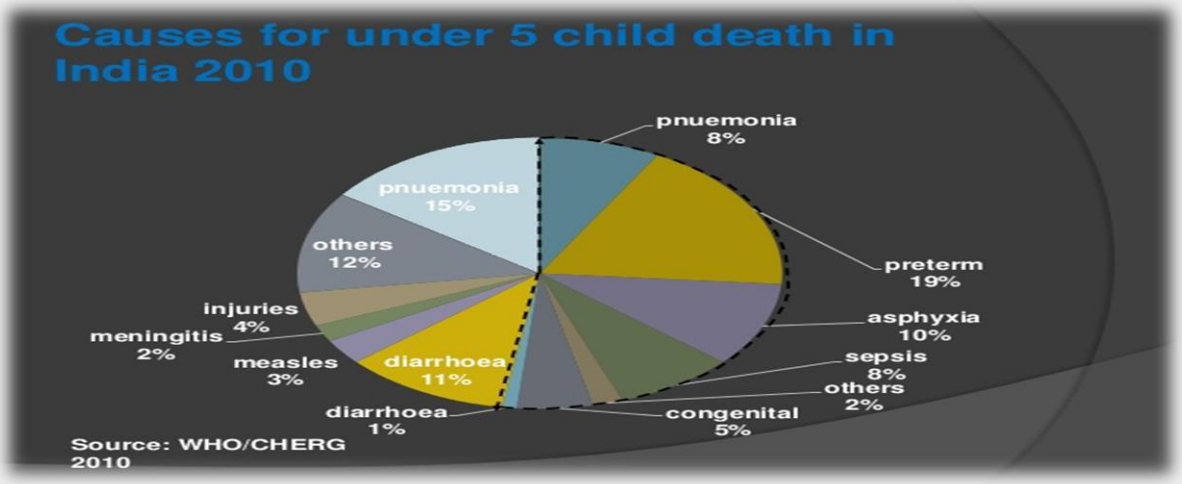
Situation of Reproductive, Maternal and Child Health in India

- Maternal mortality ratio (MMR) declined from 254 (SRS 2005) to 212 (SRS 2007–09)
- U5MR is 55 per 1,000 live births (SRS 2011)
- IMR is 44 per 1,000 live births (SRS 2011)
- NMR is 31 per 1,000 live births (SRS 2011)
- TFR is 2.4 (SRS 2011)
- Seven high focus states have the TFR of 3.0

Causes of Maternal DEATH in India



Causes for under 5 child death in India 2010 (WHO-2010)



Causes for Maternal and Child Deaths in India

 A large number of maternal and child deaths are attributable to the three delays :
(1) The delay in deciding to seek care
(2) The delay in reaching the appropriate health facility
(3) The delay in receiving quality care once inside an institution

Rational of RMNCH A+ strategies

 In order to bring greater impact through RCH programme, it is important to recognise that reproductive, maternal and child health cannot be addressed in isolation
 RMNCH+A strategic approach focuses on what the Health Delivery System can do to help achieve maternal and child health goals
 Purpose RMNCHA +A approach is to provide an understanding of comprehensive approach to improve child survival and safe motherhood

Strategic RMNCH+A Interventions Across Life Stages Adolescence/ pre pregnancies Pregnancy Birth Newborn/ post natal Childhood There are two dimensions to healthcare:
(1) stages of the life cycle
(2) places where the care is provided These together constitute the „Continuum of Care'

ADOLESCENT Priority interventions:
1. Adolescent nutrition; iron and folic acid supplementation
2. Facility-based adolescent reproductive and sexual health services (Adolescent health clinics) 3. Information and counseling on adolescent sexual reproductive health and other health issues 4. Menstrual hygiene
5. Preventive health checkups

Adolescent Friendly Health Services (Adolescent Health Clinics)

 Services at sub centre: ANM
 Adolescent Information and Counseling Centre will be made functional by MO and ANM at PHC on weekly basis.
 At CHC, DH/SDH/ and Medical College: Adolescent Health Clinics(daily basis)
 Special focus will be given to establishing linkages with Integrated Counseling and Testing Centres (ICTCs) and making appropriate referrals for HIV testing and RTI/STI management

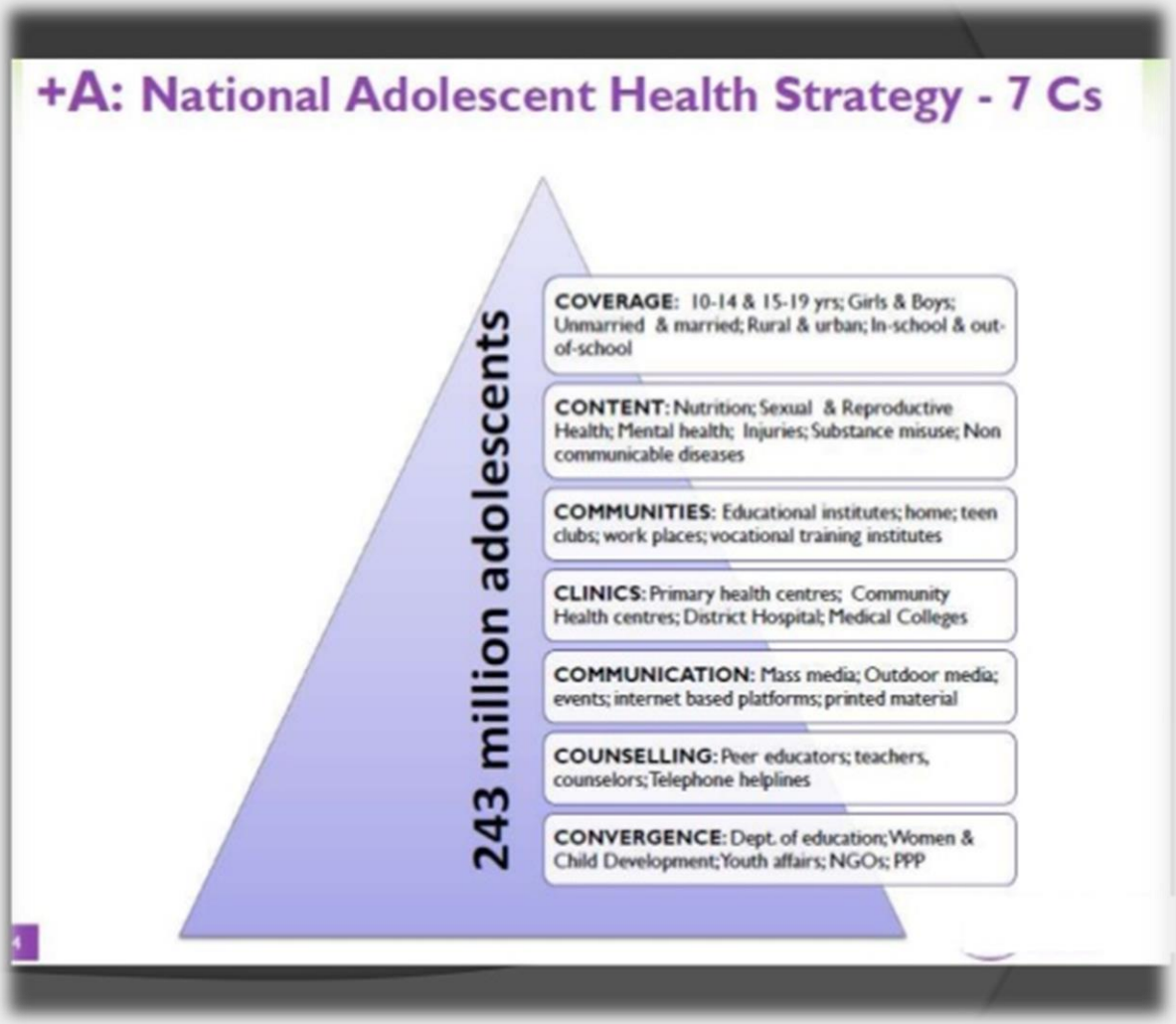
Scheme for promotion of menstrual hygiene among adolescent girls in rural India:

 This scheme promotes better health and hygiene among adolescent girls
 Sanitary napkins are provided under NRHM"s brand 'Free days'.
 These napkins are being sold to adolescent girls by ASHAs

Pregnancy and Childbirth Priority interventions:

1. Preventive use of folic acid in peri-conception period
2. Delivery of antenatal care package and tracking of high- risk pregnancies
3. Skilled obstetric care
4. Immediate essential newborn care and resuscitation
5. Emergency obstetric and new born care
6. Postpartum care for mother and newborn
7. Postpartum IUCD and sterilisation
8. Implementation of PC&PNDT Act

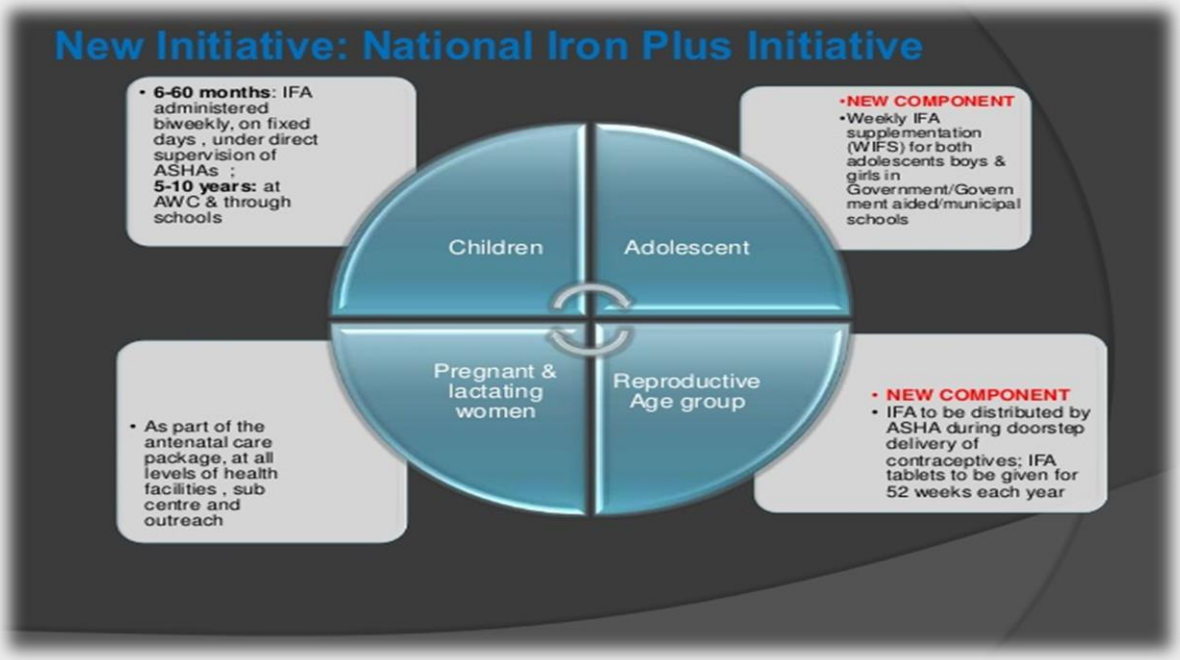
ADOLESENT HEALTH STRATEGY



Preventive health checkups and screening for diseases, deficiency and disability

 Components of School Health Programme include screening, basic health services and referral Bi-annual health screening is undertaken for students (6–18 years age group)
 Implementation of School Health Programme
 Team consist of: - 2 Medical Officers (MBBS / Dental / AYUSH qualified) - 2 paramedics (one ANM and any one of the following Pharmacist/ Ophthalmic Assistant/Dental assistant)

New Initiative: National Iron Plus Initiative



Preventive use of folic acid in peri- conception period
 To promote use of folic acid in planned pregnancies during peri-conception phase by frontline workers and facility-based service providers.
 A new scheme for delaying first birth after marriage and ensuring spacing between first and second child was launched in May 2012 and has provision for incentivizing ASHAs for their efforts

Delivery of antenatal care package and tracking of high-risk pregnancies
 Pregnancy Testing Kits (Nishchay) to all sub centres and through ASHAs.
 Universal access to full antenatal package
 Mother and Child Tracking system (MCTS)

 Tracking pregnant women with severe anaemia by ANM and PHC in charge
 Universal confidential HIV screening

Skilled obstetric care and essential newborn care and resuscitation
 Delivery points are to be prioritised.
 Delivery points should be saturated with Skilled Birth Attendance
 Janani Suraksha Yojana (JSY)
 Janani Shishu Suraksha Karyakram (JSSK) is an initiative to reduce out-of-pocket expenses related to maternal and newborn care.
 Newborn Care Corners are established at delivery points and providers are trained in basic newborn care and resuscitation through Navjaat Shishu Suraksha Karyakram (NSSK).

Emergency obstetric & new born care
 Sub centres and PHC designated as delivery points
 CHC (FRUs) and District Hospitals have been made functional 24 X7
 MCH Wing, with integrated facilities for advanced obstetric and neonatal care & also ensure 48hrs stay for mother and newborn at hospital

Emergency obstetric & new born care
 Multi skilling of doctors in public health system: - 8week training programme of MBBS qualified doctors in Life Saving Anaesthetic Skills (LSAS) - 16week training programme in Obstetric Management Skills including Caesarean section - 10 day training for Medical Officers in Basic Emergency Obstetric Care (BEmOC) - 3 week Skilled Birth Attendance training for ANMs/Staff Nurses.

Postpartum care for mother and baby
 To ensure postpartum care for mothers and newborns, forty- eight hours of stay at health facility for institutional delivery
 At least three postnatal visits to mother and six postnatal visits to newborn are to be made within six weeks of delivery/birth

Postpartum IUCD insertion and sterilization
•Placement of trained providers for post-partum IUCD (PPIUCD) insertion at district and sub- district hospital level
•Training of Medical Officers in „Minilap" for provision of Post- Partum Sterilisation in high case load facilities
•RMNCH counsellor ensure healthy timing and spacing between pregnancies

Implementation of preconception and prenatal diagnostic techniques (PC&PNDT) Act
 Key action: - Formation of PC&PNDT cells at state/district level, - Strengthening of human resources as well as trainings & establishing appropriate infrastructure at all levels - Building community opinion against sex selective abortion and foeticide by sensitising and mobilising self-help groups and empowering women

Newborn and Child care Priority interventions:
1. Home-based newborn care and prompt referral
2. Facility-based care of the sick newborn
3. Integrated management of common childhood illnesses (diarrhoea, pneumonia and malaria)
4. Child nutrition and essential micronutrients supplementation
5. Immunisation 6. Early detection and management of defects at birth, deficiencies, diseases and disability in children (0–18 years)

Home-based newborn care and prompt referral
 Home-based newborn care scheme launched in 2011 provides immediate postnatal care and essential newborn care to all newborns up to the age of 42 days

 ASHAs are trained and incentivised to provide special care to pre terms and newborns
 ASHA are also trained in identification of illnesses, appropriate care and referral through home visits

Facility-based care of the sick newborns
 Special Newborn Care Units (SNCU): District Hospitals and tertiary care hospitals
 Goal: one SNCU in each district of the country and in health facilities with more than 3,000 deliveries per year
 Newborn Stabilisation Unit (NBSU): Community Health Centres / First Referral Units (4 beded)

Child nutrition and essential micronutrients supplementation
 Follow up of LBW baby by ASHA and ANM
 Bi-weekly iron and folic acid supplementation for preschool children of 6 months to 5 years as part of the National Iron + initiative.
 Administration of deworming tablets/syrup combined with Vitamin A supplementation during biannual rounds.

Integrated management of common childhood illnesses (pneumonia, diarrhoea and malaria
 Availability of ORS and Zinc should be ensured at all sub-centres and with all frontline workers Timely and prompt referral of children with fast breathing and/or lower chest in-drawing should be made to higher level of facilities.
 Training of health service providers (doctors and nurses), especially those at FRUs and District Hospitals in F-IMNCI

Immunisation
 Second dose of measles has been introduced and Hepatitis B vaccine is now available in the entire country
 To strengthen routine immunization, newer initiatives include - provision for Auto Disabled (AD) Syringes to ensure injection safety - support for alternate vaccine delivery from PHC to sub-centres as well as outreach sessions - mobilization of children to immunization session sites by ASHA
 Coverage of vaccine beyond first year of life must be emphasised and monitored
 Investigation report of every serious „adverse event following immunisation" (AEFI) case must be submitted within 15 days of occurrence to **district AEFI Committees**

Child Health Screening and Early Intervention Services (Rashtriya Bal Swasthya Karyakram)
 This initiative aims to reach 27 crore children annually in the age group 0-18 years
 Child health screening and early interventions services will be provided by mobile health teams at block level
 These teams will include - at least 2 doctors (MBBS /AYUSH qualified) - 2 paramedics
 The health screening will be conducted to detect 4Ds: defects, deficiencies, diseases, development delays including disabilities

Through the Reproductive Years Priority interventions:
1. Community-based promotion and delivery of contraceptives
2. Promotion of spacing methods (interval IUCD)
3. Sterilisation services (vasectomies and tubectomies)
4. Comprehensive abortion care (includes MTP Act)
5. Prevention and management of sexually transmitted and reproductive infections (STI/RTI)

Community based doorstep distribution of contraceptives
 ASHAs are utilised to deliver contraceptives at the doorstep of households.
 ASHA charges a nominal amount from beneficiaries to deliver contraceptives at the doorstep, that is, - INR 1 for a pack of 3 condoms - INR 1 for a cycle of OCPs - INR 2 for a pack of emergency contraceptive pills (ECP)

Promotion of spacing methods (interval IUCD)
 Training of health personnel in IUCD insertion at all levels of health facilities

 Ensure availability of IUCD CuT380 A
 Ensuring IUCD services on fixed days at all sub centres and PHCs
 CHC, SDH and DH will provide regular IUCD insertion services
 Strengthen the counselling system at the facilities with high case load

STERILIZATION SERVICES

 Promotion of non-scalpel vasectomy for increasing male participation
 Emphasis on Minilap tubectomy services
 Accreditation of private providers and NGOs for service delivery
 Increasing the pool of trained service providers (Minilap, Laparoscopic sterilization and non-scalpel vasectomy)
 Operationalising fixed day centers for sterilization is an essential step in this direction

Comprehensive abortion care

 Manual Vacuum Aspiration (MVA) facilities and medical methods of abortion in 24 X 7 Primary Health Centres.
 The comprehensive Medical Termination of Pregnancy (MTP) services are to be made available at all District Hospitals and Sub-district level hospitals with priority given to „delivery points".
 Capacity building of Medical Officers, to equip them with skills necessary to provide safe abortion services at PHC level and above.
 Medical abortion drugs (Mifepristone + Misoprostol for upto 7 weeks and Ethacridine lactate for 12 to 20 weeks)are to be included in the essential drug list

Management of sexually transmitted and reproductive tract infections (RTI and STI)

 RTI/STI services to be provided at all CHCs and FRUs and at 24 X 7 PHCs.
 For Syndromic Management availability of colour-coded kits, RPR testing kits for syphilis and HIV test should be ensured first at delivery points
 Service providers should be trained in Syndromic Management of STI and RTI.
 Importantly services should be made available across entire reproductive age group including adolescents, youth and adults.

Health Systems Strengthening for RMNCH+A Services

 The key steps proposed for strengthening health facilities for delivery of RMNCH+A interventions are as follows:
a) Prepare and implement facility specific plans for ensuring quality and meeting service guarantees as specified under IPHS
b) Assess the need for new infrastructure, extension of existing infrastructure on the basis of patient load and location of facility Health Systems Strengthening for RMNCH+A Services
c) Equip health facilities to support forty-eight- hour stay of mother and newborn.
d) Engage private facilities for family planning services, management of sick newborns and children, and pregnancy complications.
e) Strengthen referral mechanisms between facilities at various levels and communities.
f) Provision for adequate infrastructure for waste management

Resources

 The creation of regular posts under state government so that contractual appointments can be slowly reduced and sustainable HR structure is developed
 Strengthening sub centres through additional human resources: In sub centres of remote and hilly area, will have 2 ANMs, 1 male multipurpose worker, 1 pharmacist and 1AYUSH doctor
 Capacity building of MO for reproductive, adolescent, maternal, newborn and child health
 Training of nurses and ANM for SBA, IMNCI, Navjaat Shishu Suraksha Karyakram and IUCD insertion

Policies on drugs, procurement system and logistics management

 Availability of free generic drugs for out/in patients in public health facilities is to be made by states for minimising out of pocket expenses.
 Rational prescriptions and use of drugs
 Timely procurement of drugs and consumables
 Distribution of drugs to facilities from DH to sub centre; and uninterrupted availability to patients is to be ensured.
 Placing essential drug lists (EDL) in the public domain
 Computerised drugs and logistics MIS system

Quality assurance
 Quality assurance at all levels of service delivery
 Quality certification/ accreditation of facilities and services - Certification for achievement of Indian Public Health Standards - Certification should be on comprehensive quality assurance for both infrastructure and service delivery - Recommended that health facilities should be first certified by District and State Quality Assurance Cells

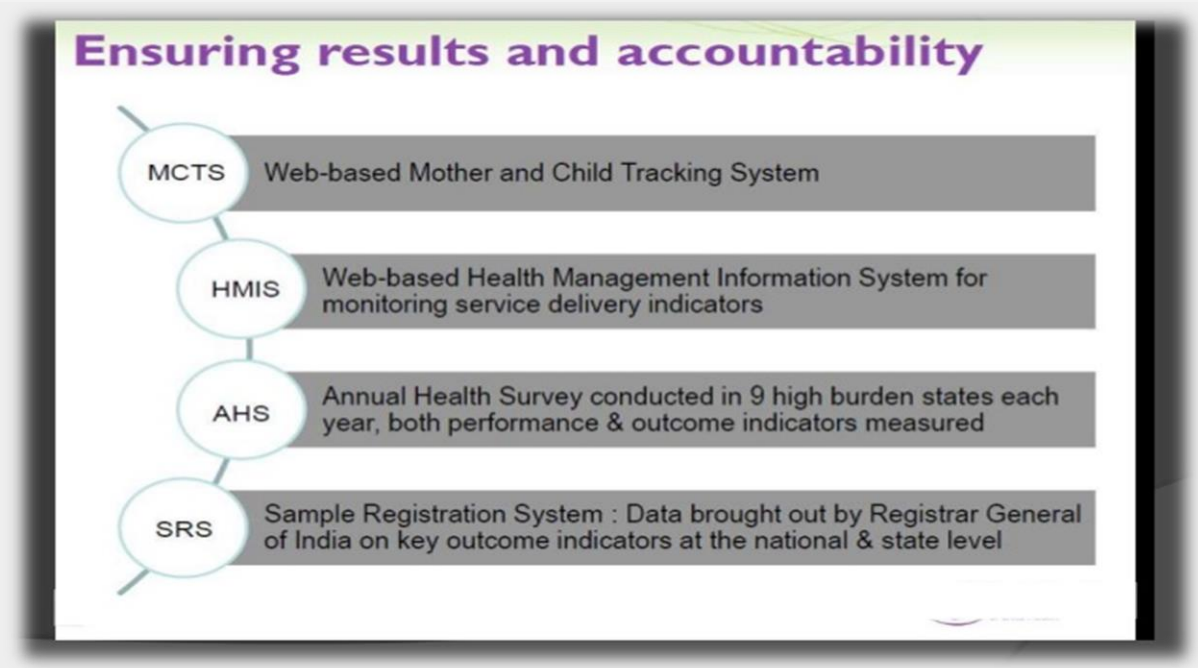
Community participation
 Engage Village Health Sanitation and Nutrition Committees and Rogi Kalyan Samiti
 Utilize the Village Health and Nutrition Days as a platform for assured and predictable package of outreach services
 Social audit: social audits can be centred around activities like
i) Conduct of maternal death audits via verbal autopsies
ii) Utilization of health facility checklists

Monitoring, Information & Evaluation Systems

 Civil registration system: Efforts to ensure 100% registration of births and deaths under Civil Registration System.
 Web enabled Mother and Child Tracking System (MCTS): A more recent initiative is to link MCTS with AADHAR in order to track subsidies to eligible women Monitoring, Information & Evaluation Systems
 Maternal Death Review (MDR): identify causes of maternal deaths and the gaps in service delivery
 Perinatal and Child Death Review: Death reports with cause of death for any child under five
 Review missions: Annual Joint Review Missions by the RCH Division and Common Review Missions under NRHM .Monitoring, Information & Evaluation Systems

 Health Management Information System (HMIS) based monitoring and review: Following things monitored and interpreted at National, State & District levels:
⎫ Full Antenatal Care
⎫ Institutional Delivery,
⎫ Sterilization procedure
⎫ IUCD insertion
⎫ Full Immunization
⎫ Child & Maternal Death.

ENSURING RESULT AND ACCOUNTABILITY

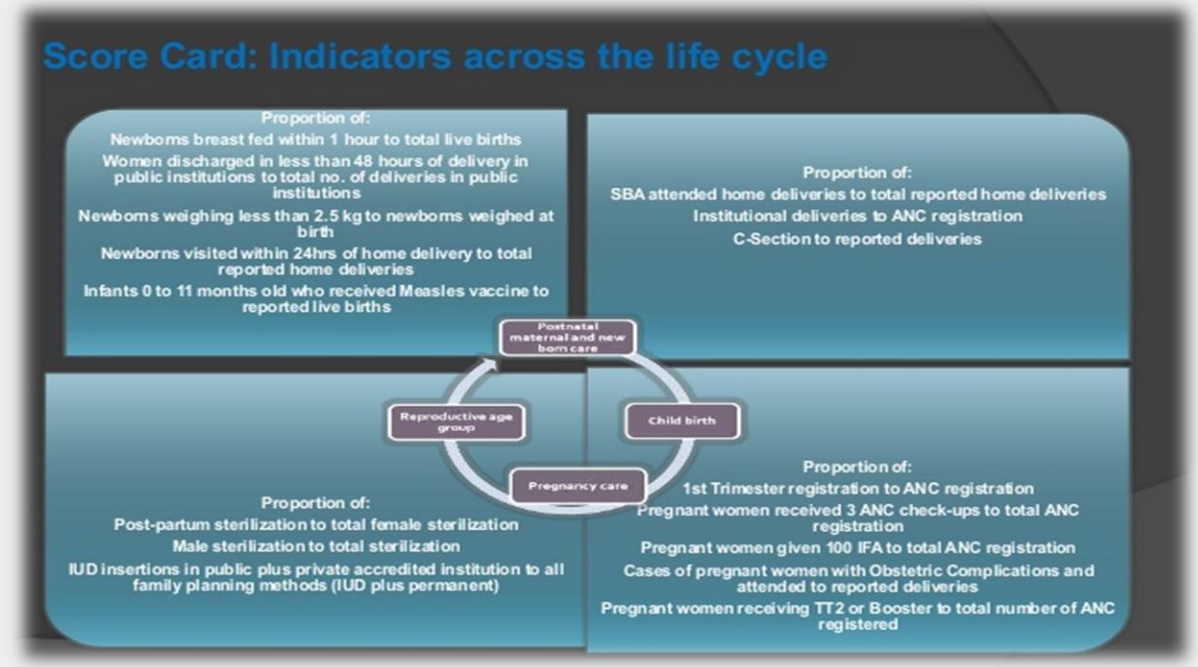


Score Card: HMIS Based Dashboard Monitoring System Score card: HMIS based score card captures only service delivery indicators and assists in comparative assessment of state and district performance

— 16 indicators selected based on life cycle approach (RMNCH+A) representing various phases — State average is the reference point for each indicator ; Each indicator is scored based on its contribution towards the state average: Positive scores (> state average)|Negative scores (< state average)

— Indicators score aggregated as district score (all indicators given same weightage)

— Districts classified into four categories based on total score ; Total score for a district can range between +64 to -64 (4^x16 indicators).



RMNCH+A GAP ANALYSIS :

OBJECTIVES

1. Resource Availability in terms of infrastructure, human resources, capacity, fund availability

2. Health Systems Capacities at district and state levels to manage infrastructure, human resources, capacity building, supportive supervision, supply chain, demand generation, implementation of incentive schemes for providers and beneficiaries, quality and use of data, fund flow and utilization
3. Capacities, Information and Communication Strategies for behavior change at block level to ensure utilization, timeliness continuity and quality implementation of the essential interventions.

STEPS IN DISTRICT GAP ANALYSIS

- Planning at the state level
- Orientation to the district gap analysis coordinators
- Initial planning for district gap analysis
- Data entry and analysis
- Report writing
- Preparing a plan of action

Suggested Tools For District Level Gap Analysis

1. Sub Centre Level Checklist
2. First Referral Unit (FRU) level Checklist
3. Primary Health Center/Community Health Center (Non-FRU) Level Checklist
4. District Hospital Level Checklist
5. Rapid Household Assessment Checklist

Bottlenecks : limiting skills and good practices

- Skills not practiced
- Motivation of the functionaries ○ Weak supportive supervision ○ No mechanism for on job skill building ○ No recognition of performance/ quality of care ○ No culture of quality for more deprived groups
- Irrational distribution of Human Resources ○ some overworked and many underworked ○ No system for attracting HR in remote area (tribal) ○ No system for sustaining quality of services in remote area
- Attitudinal challenges ○ Adapting to culture, dialog to empowerment of women ○ Lot of myths
- Lacking skills
- Quality of trainings
- Training capacity to match the load

Leading towards Managerial skills:
State and District

- Inspiring leaders (CMO) to ensure quality of care up to most deprived
- Mapping gaps, constraints
- Identification of key bottlenecks– evidence based approach
- QUALITY DATA analysis for decision making
- Evidence based planning for imparting skills
- Definition of adjusted strategic solution, towards sustainable results
- Denominator based outcome monitoring
- Rational deployment of skilled HR in adequate infrastructure
- FOCUS on sustainable quality
- Mechanism for quality training leads to skills sets
- Mechanism for post training follow up and performance ○ Supportive supervision ○ Performance incentives (manager and staff)

Expected Skills:

Districts, Blocks , PHC

- Applying RMCNH+A strategies throughout the continuum
- Convinced on monitoring

 Real time monitoring for action
 Increasing access to service (additional infrastructure, well staffed, equipped with quality technology)
 Strengthening SHC capacity (HRs)
 Effective use of innovative technologies
 Mobile technology for monitoring and for quality BCC
 Innovative and functional equipment (quality)
 Culture of quality services

Role of Development Partners

 Bottleneck analysis:
 Evidence based data analysis ○ up to block level ○ up to facility level ○ Down -> UP -> Down
 Innovative strategies to address bottlenecks
 Information based decision making
 Use of technology options, mobile units
 Measure Track for change & documentation
 Innovative mobile tech to monitoring
 Creating Social movement for increased demand for sustained utilization of quality service Support Quality Analysis Support Documenta tion for scaling up Communica tion Strategy

Role of Development partners:

 Information
 Behavior change : CMO focus on ○ Interpersonal communication ○ Empowerment of Staff, empowerment of women Supplies
 Monitoring of quality equipment, quality commodities
 Distribution till most remote place
 Quality supportive supervision for quality equipment
 Quality Services Skills set throughout the CONTINUUM OF CARE
 Baseline assessment for skills
 Training and supportive supervision
 MONITORING Communication strategy Innovation in Supplies management Quality training & quality supervision Quality data analysis