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

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MIDLINE EVALUATION REPORT FOR THE MATERNAL HEALTH QUALITY OF CARE STRATEGY IN INDIA

This report presents findings from evaluation activities covering the period between April 2017 through March 2018 of the John D. and Catherine T. MacArthur Foundation's maternal health quality of care (MHQoC) strategy in India. The MHQoC strategy 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. A previous Evaluation Report provided a snapshot of achievements during the early stages of the MHQoC strategy (O'Neil et al. 2018). The current report builds on the previous report by updating information about the Strategy's progress. It also reassesses the sustainability of the portfolio of MHQoC work at this stage, when more grantees have had an opportunity to consider their next steps after their Foundation funding ends.

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 backs 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 and has led to funding for 20 grantees through 28 grants. These grants will conclude at different times, with the last ending in September 2019. The strategy's evaluation partner, Mathematica Policy Research documented early stage progress of the strategy through March 2017; a period during which all 28 grants were active.

This document follows on the previous report and provides findings from the midline evaluation, covering the period of April 2017 to March 2018, when 19 grants were active. Assessment of progress here focuses on an identified set of 28 priority indicators. In addition, this report considers review of these indicators in the context of learning priorities as shown in Exhibit 1.

Exhibit 1. Learning priorities for midline evaluation, by substrategy

Supply substrategy	• The extent to which trained providers receive continued support and mentorship • The value of accreditation or certification for improving maternal health outcomes • The nature of technical assistance (TA) being provided by grantees to facilities
Demand substrategy	• Methods for sustaining stakeholder engagement in community accountability activities • Community accountability mechanisms that achieve desired results • The way forward for scaling up legal strategies
Advocacy substrategy	• Avenues through which policymakers use evidence to influence decisions about MHQoC • New developments in grantees' efforts to identify funding and support after the MHQoC strategy ends

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, 7 of which were active during the midline evaluation period. The grants under this substrategy span 12 priority indicators.

Supply: Summary of progress

- **Providers have been trained and improved capacity.** Grants developed more new curricula and training guides since the first round of evaluation, but they trained a slightly smaller number of health professionals (about 16,000 health professionals in Phase 2 compared to 18,000 in Phase 1). Among those trained, outcomes were similar, with a majority of providers who received training reporting that their skills had improved.
- **Facilities have improved and maintained capacity.** The pace of growth to strengthen facility-based quality assurance (QA) systems has slowed relative to previous years, with fewer new training centers, training programs, and facilities instituting QA procedures. This deceleration in new efforts should not be equated with less activity among grantees, as their efforts went into maintaining and sustaining the facility-level work previously begun.
- **High quality maternal health care is delivered consistently.** Providing MHQoC technical support to facilities and training on emergency obstetric care (EmOC) helps maintain the quality of key services that prevent maternal deaths. The provision of these supports remained constant during the midline evaluation period, with almost 300 facilities receiving TA and about 150 facilities receiving training in EmOC.

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, make their voices heard, and make health systems responsive to community needs, and (3) using legal strategies to strengthen access to quality services as the highest means of recourse. The Foundation awarded 14 grants total under this substrategy, with 11 grants active and reporting on the substrategy's 10 priority indicators for the midline evaluation.

Demand: Summary of progress

- **Women, families, and communities demand for high-quality health care.** Two recent studies by grantees found that increased knowledge led to greater use of maternal health services. However, limited progress was made in promoting women's and community leaders' participation in accountability efforts.
- **Community accountability tools and mechanisms are actively used.** The strategy continued testing, implementation, and deriving learning from existing mechanisms and testing new ones. The strategy's grants continued to support community accountability efforts that led to improvements in MHQoC at district, state, and national levels.

Legal trainings provided and cases brought to trial. A recent, ongoing grant employing legal strategies to improve MHQoC continued to train new professionals in legal strategies and litigation to hold the government accountable for MHQoC.

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 evidence 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 seven active grants focus explicitly on advocacy at midline evaluation, nine additional active grants contributed some evidence to the field, and 17 grantees provided some information on the six indicators in this substrategy.

Advocacy: Summary of progress

- **Key stakeholders access and use evidence-based indicators and programs.** The strategy activities documented and disseminated findings from about 25 studies. Grantees used the evidence for purposes of scaling up activities started under the strategy.
- **Key stakeholders prioritize and increase adherence to maternal health quality of care efforts.** The strategy brought MHQoC to the forefront of some political agendas and resulted in the achievement of specific grant objectives, including effecting policies at national and state levels on patients' welfare and adhering to community accountability as set out in the National Rural Health Mission.
- **Sources of funding and support are identified.** Under Phase 2 of the strategy, grants have forged alternative paths to obtaining additional funding to achieve sustainability. Some of the grantees also worked to incorporate business concepts of self-promotion and marketing to attract attention and resources to their organization, not just the issues they address.

Concluding remarks

Grants made the most progress along several indicators, including providing trainings to health workers, educating community members about their health rights and promoting uptake of maternal health services, implementing and achieving results from community accountability activities, applying legal strategies to ensure the delivery of quality maternal health services, and generating evidence to support MHQoC and disseminating it in creative ways to ensure that policymakers use it. The strategy has experienced continued challenges in institutionalizing QA systems and processes, identifying ongoing sources of support for legal strategies to promote MHQoC, and ensuring that grantees disseminate, discuss, and act upon even unexpected or controversial research findings. The continued progress and barriers suggest that the shift from access to quality is still ongoing. The next and final set of evaluation activities will capture the grantees' ongoing MHQoC efforts under and beyond the strategy to further assess their impact on the MHQoC environment, where the future of the field might lie, and sustainability of MHQoC efforts.

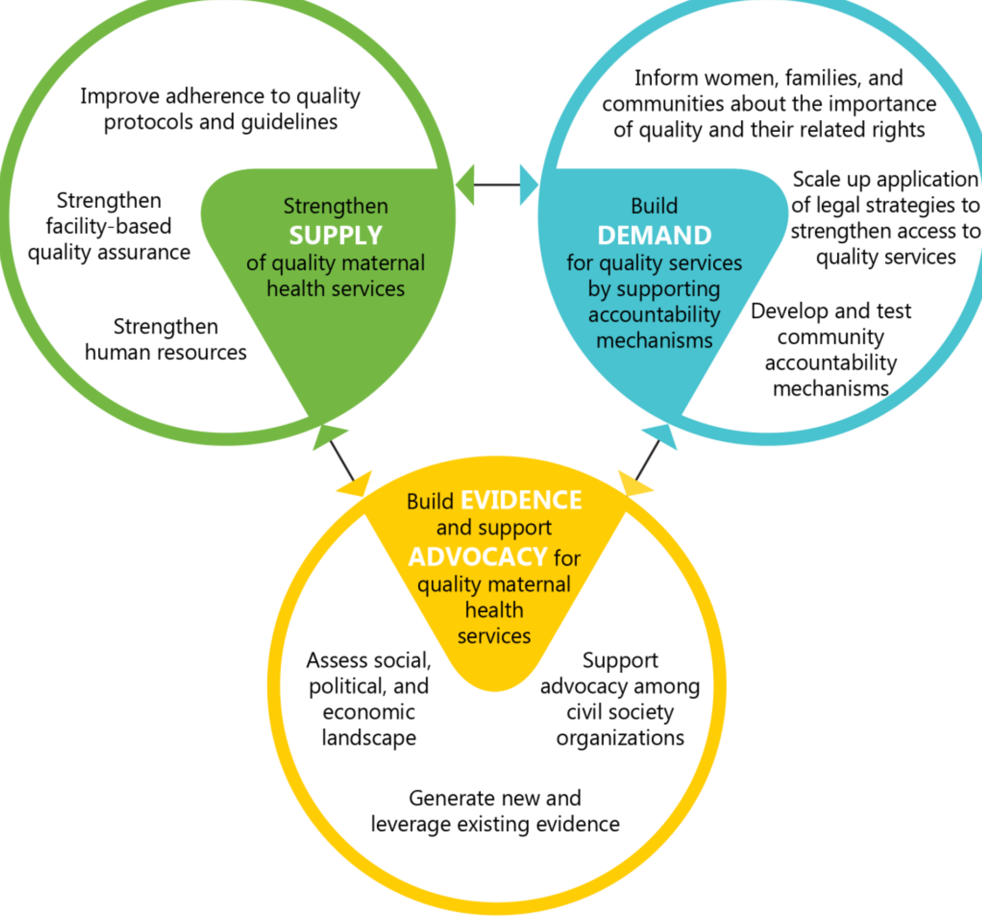
I. INTRODUCTION

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 significantly improve health outcomes. To accelerate reductions in morbidity and mortality rates, issues other than access—particularly quality of maternal health care—must be addressed. Responding to this need, the Foundation launched a four-year (June 2015 to September 2019) maternal health quality of care (MHQoC) strategy, 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 basis and momentum for further maternal health quality improvements after the Foundation exits the country. To this end, the strategy includes three key interrelated and mutually reinforcing 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 (Exhibit I.1).

Exhibit I.1. MHQoC strategy conceptual framework



Complementing the conceptual framework, a logic model elaborates on the key elements of the MHQoC strategy and its underlying theory of change, including linkages between specific activities and targeted outputs and outcomes (Appendix A, Exhibit A.1). 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.

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. For these outputs and outcomes specified in the logic model, Mathematica Policy Research, the strategy's evaluation and learning partner, in collaboration with the Foundation, identified a set of 28 priority indicators of progress and results under the strategy (Appendix A, Exhibit A.2). Appendix A, Exhibit A.3 lists all the grants with their close date and whether they contributed information to this midline evaluation report.

Mathematica has reviewed and analyzed the priority indicators for the early stage evaluation (June 2015 through March 2017) of the strategy and continued to assess progress along these indicators during the midline evaluation period (April 2017 through March 2018) (O'Neil et al. 2018). In this report, we assess the current status of grants, progress in context of the strategy's earlier stage, lessons learned, implications for the field, and next steps for the endline evaluation and learning.

Setting the agenda for the midline evaluation

As part of the strategy's early stage evaluation, Mathematica identified several overarching lessons learned. We also uncovered several priority topics for exploration to guide midline evaluation activities. Exhibit I.2 summarizes key early stage findings and midline learning priorities.

Exhibit I.2. Summary of early stage lessons learned and learning priorities for midline evaluation, by substrategy

	Lessons learned from early stage evaluation	Learning priorities for midline evaluation
Supply substrategy	• Defined quality standards provide a uniform tool to help facilities achieve quality improvements. • A culture of mentorship and continuous quality assurance (QA) and improvement helps to maintain quality.	• The extent to which trained providers receive continued support and mentorship • The value of accreditation or certification for improving maternal health outcomes • The nature of technical assistance (TA) being provided by grantees to facilities
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.	• Methods for sustaining stakeholder engagement in community accountability activities • Community accountability mechanisms that achieve desired results • The way forward for scaling up legal strategies
Advocacy substrategy	• Policymakers have an appetite for evidence, but identifying the best ways to reach and motivate them to prioritize MHQoC has been challenging.	• Avenues through which policymakers use evidence to influence decisions about MHQoC • New developments in grantees' efforts to identify funding and support after the MHQoC strategy ends

Considering these key learning areas identified for the midline evaluation, Mathematica reviewed grantees' reports and supplemental documents, and administered an updated grantee indicator survey for all grants that were operational for all or part April 2017 to March 2018. We reviewed grantees' progress over time along the key indicators while focusing on the learning priorities mentioned in Exhibit I.2. The subsequent chapters discuss our key midline evaluation findings by substrategy and across them.

II. SUPPLY SUBSTRATEGY: PROGRESS AT MIDLINE EVALUATION

Grants have maintained the efforts to train health care professionals—instructing more than 16,000 providers and nonclinical facility staff on key maternal health topics such as emergency management and best practices for facility management. Following these trainings, ongoing support through technical assistance (TA) and nurse mentorship models have helped to maintain skills.

At the facility level, grants have continued to institute quality assurance (QA) procedures and prepare facilities for accreditation and certification, although progress in these areas has been slower than previously due to several grants ending recently. To strengthen the health systems that support facilities, grants support TA to facilities to adhere to quality guidelines.

The groundwork: early stage MHQoC supply substrategy achievements

- More than 18,000 facility- and community-based health professionals trained on MHQoC across five states.
- Most trained providers reported that their skills improved.
- More than 250 facilities institutionalized QA mechanisms and 164 facilities applied for or obtained accreditation.
- More than 300 facilities received TA on QA and improved their adherence to quality standards.
- 54 public health centers under one grant have received TA for emergency obstetric care.

Exhibit II.1. Supply substrategy priority indicators, by approach

The supply substrategy focuses on improving the quality of maternal health services delivered to women at the facility and community levels. This substrategy includes a total of 12 priority indicators against which to assess progress.

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 QA 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 QA models or procedures • 1.2.2a. Number and proportion of targeted facilities that regularly use quality data and/or information from QA team to address service provision
	• 1.2.2b. Number of facilities prepared for accreditation

Substrategy: Strengthen supply of quality maternal health services in public and private sectors	
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 TA
	• 1.3.2a. Extent to which facilities receiving TA improve quality of routine and basic emergency obstetric care procedures

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

Grants continued to develop new curricula and use existing curricula to train more than 16,000 clinical and nonclinical health professionals after early stage implementation. Although grants developed more new curricula and training guides over the life of the strategy, they trained slightly fewer health professionals as time went on (about 16,000 health professionals during the midline evaluation period compared to 18,000 health professionals during the early stage evaluation period). Among those trained, outcomes were similar across time, with a majority of providers who received training reporting that their skills had improved.

Early stage progress	Midline period progress
9 active grants under approach	10 active grants under approach
6 curricula and training guidelines developed	10 curricula and training guidelines developed
>18,000 health care professionals trained	16,207 health care professionals trained
7 grants found that majority of trained providers report improved skills	7 grants found that majority of trained providers report improved skills

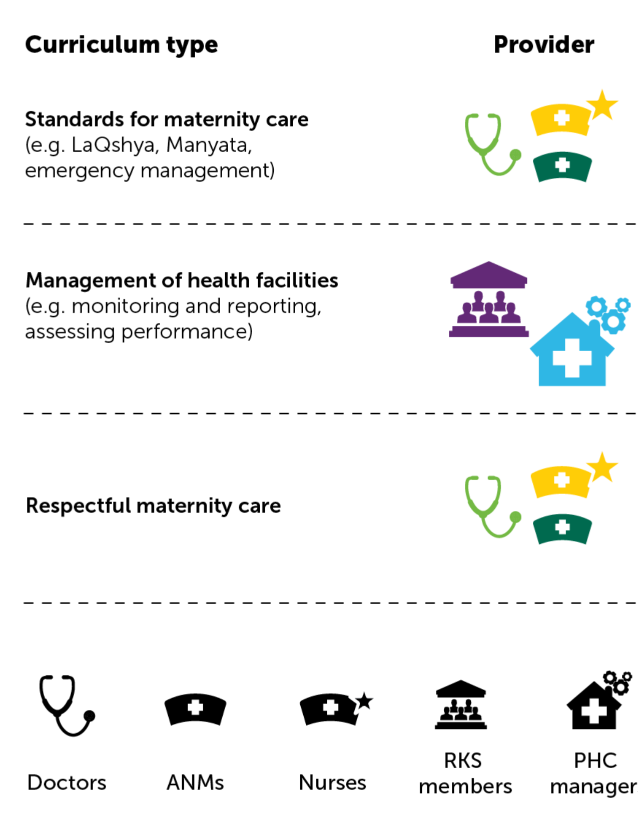
Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different measures from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

Curricula (Indicators 1.1.1b, 1.1.2b; 8 grants). During the midline evaluation period, six grants led to the development of 10 new curricula and training guidelines. Another two grantees, Action Research & Training for Health (ARTH) and MAMTA Health Institute for Mother and Child, reported using the same curricula and guidelines they developed previously. These curricula target various types of providers, such as nurses, auxiliary nurse midwives (ANMs), and medical officers, as well as nonclinical hospital staff such as primary health center (PHC) managers (Exhibit II.2). Curricula cover clinical topics such as identifying high-risk pregnancies and emergency management, as well as topics related to managing health facilities, such as reporting into health information monitoring systems (HIMS), assessing facility readiness for accreditation or certification, and more general capacity-building for managers.[1] Overtime, trainings developed shifted from those geared toward clinical staff to those for management staff.

[1]The World Health Organization is currently developing a midwifery training curriculum that will be used during Phase 3.

Exhibit II.2. Types of providers and other hospital management staff trained, by curriculum



ANM = auxiliary nurse midwife; PHC = primary health center; RKS = Rogi Kalyan Samiti.

Two grants not categorized under the supply substrategy (Population Foundation of India [PFI] and Centre for Catalyzing Change [C3]) reported having developed new curricula. PFI developed trainings for members of hospital management societies, or *Rogi Kalyan Samiti* (RKSs), to better monitor and oversee public health facilities. C3 developed a curriculum on respectful maternity care that a range of providers can use to ensure that women are treated with respect and dignity while receiving maternal health care.

Training (Indicators 1.1.1c, 1.1.2c; 8 grants). Grants have used the curricula developed under the MHQoC strategy to improve the skills of more than 16,000 clinicians, frontline workers (FLWs), and facility administrators in eight states (Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan, and Uttar Pradesh). This represents an increase in the number of states served since the early stage evaluation; new states include Gujarat, Jharkhand, and Rajasthan.

Specifically, Pathfinder has delivered Dakshata training and on-site nurse mentorship to 290 providers as part of a new initiative that began after April 2017. In addition to reaching new providers, more than 300 previously trained providers participated in ongoing trainings under the strategy. For example, 58 female health workers received refresher training on mHealth through Karuna Trust.

Skills development (Indicators 1.1.1a and 1.1.2a; 7 grants). Not all grantees assessed whether participating in the trainings improved providers' ability to deliver high quality care. However, all seven grants that did report on this stated that the majority of providers they trained either self-reported or demonstrated improved skills. These results are similar over time with trainings reportedly leading to more than 90 percent of participants improving skills as a result of the training. Some grantees also reported that trainings improved nonclinical skills related to quality of care. For example, PFI noted that after being trained, RKS—a hospital management committee—purchased necessary commodities to

manage delivery, such as oxytocin, and instituted feedback boxes at facilities and other processes to redress grievances.

Reported skills developed

ARTH

- 93 percent of trained staff reported administering anticonvulsants for preeclampsia
- 100 percent of trained staff reported administering parenteral antibiotics and uterotonic drugs to control postpartum hemorrhage

Jan Swasthya Sahyog (JSS)

- Providers at district hospitals better able to identify and manage pre-eclampsia and eclampsia
- Providers at district hospitals frequently performed newborn resuscitation if a baby did not cry immediately after birth
- Providers at district hospitals were better at actively managing the third stage of labor.

MAMTA

- 73 percent of accredited social health activists increased knowledge of preconception care immediately after training
- 67 percent of ANMs increased knowledge of preconception care immediately after training

Karuna Trust

- 100 percent of trained FLWs reported feeling capable of delivering quality maternal health service

Looking forward under Approach 1.1

The strategy has added ongoing mentorship to one-time trainings as a strategy to strengthen human resources. Early findings from grant activities indicate that ongoing mentorship strategies help sustain knowledge and skills, but further examination of these ongoing trainings—the ideal frequency, mode, and value to MHQoC improvement—is required to optimize implementation approaches. In addition, more information will be needed to determine how feasible and sustainable this approach is in the long run.

Overtime, there has been a rise in management and capacity-building trainings for nonclinical staff, such as facility administrators. The training and support for nonclinical staff at health facilities influenced quality efforts among other clinical and nonclinical staff and facility-level infrastructure. Similar to trainings for clinical staff, further investigation is needed to understand the benefits and sustainability of nonclinician training and ongoing support.

Approach 1.2. Strengthening facility-based quality assurance systems

To strengthen facility-based QA systems, grantees continued to establish training centers, prepare facilities for accreditation or certification, and institute QA procedures and programs in new facilities. However, the pace of growth under this approach to improving the supply of MHQoC has slowed with fewer *new* training centers, training programs, and facilities instituting QA procedures overtime. This deceleration in new efforts should not be equated with less activity among grantees, as the few ongoing grants strive to maintain and sustain the facility-level work begun previously.

	Early stage progress	Midline period progress
	13 active grants under approach	2 active grants under approach
Training	4 grants offering training centers/ programs	3 grants offering training centers/ programs
Accreditation	164 facilities accredited	135 facilities accredited
QA procedures	>330 facilities with QA procedures	89 facilities with QA procedures

Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different measures from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

Internal facility training programs and centers (Indicator 1.2.2c; 3 grants). Trainings established by facilities for their staff support the ongoing development and maintenance of skills among providers. These targeted training programs and centers in health facilities can occur at all levels of the health system, including hospitals, community health centers (CHCs) and PHCs, and Anganwadi centers. After April 2017, Pathfinder initiated and facilitated Dakshata training program at district hospitals in Madhya Pradesh, and other grantees maintained programs started under their four other grants across Gujarat, Maharashtra, and Uttar Pradesh (Exhibit II.3). Specifically, Pathfinder introduced and monitored skill labs trainings, including use of simulations, at the State Institute of Health Management and Communications—these trainings complement the Dakshata trainings, which Pathfinder also supports, and provide health care professionals with the opportunity to further build their skills related to delivery. In the future, the Federation of Obstetrics and Gynaecological Societies of India (FOGSI) will establish additional skills enhancement centers that will provide training on Manyata certification, which requires complying with 16 quality standards related to the antenatal, delivery, and postpartum periods. These centers will likely cover multiple states.

Exhibit II.3. Training centers launched or supported at midline evaluation, by state

State (grantee)	Number and types of facilities offering trainings
Rajasthan and Uttar Pradesh (MAMTA)	• Training centers supported facilities in four districts covering 1,493 subcenters, 248 PHCs, 43 CHCs, 6 subdivisional or district hospitals, and 594 Anganwadi centers
Gujarat (SEWA Rural)	• One training center established for FLWs and providers
Maharashtra and Uttar Pradesh (FOGSI)	• In the process of establishing skills enhancement centers that will provide training on quality standards for quality maternal health care
Madhya Pradesh (Pathfinder)	• Training center at the State Institute of Health Management and communications, provider training support in Gwalior
Rajasthan (ARTH)	• 33 ANM training centers (1 in each district) for skills improvement refresher training by district health department

QA procedures and quality reporting (Indicators 1.2.1 and 1.2.2a; 3 grants). Instituting QA procedures and encouraging regular quality reporting enables facilities to have the mechanisms in place to promote the consistent delivery of high quality care. In addition to the 310 public and private facilities that had instituted QA procedures under the early stage evaluation period, three grants have provided support to an additional 89 PHCs, district hospitals, and medical colleges at midline evaluation, as follows:

- **Regular assessments using National Quality Assurance Standards (NQAS) checklists.** In accordance with the LaQshya program, Pathfinder has supported two district hospitals and one medical college in Madhya Pradesh to conduct NQAS assessments as part of their internal quality monitoring process.
- **QA teams, processes, and information systems.** The QA procedures include developing internal information management tools and systems to monitor key performance indicators, and establishing QA teams that implement QA activities at each facility. Karuna Trust reports that 39 more PHCs at midline now use QA models and procedures introduced previously. ARTH has provided similar support to 47 facilities, instituting QA procedures to specifically strengthen emergency readiness and pre-referral management for maternal and neonatal clients.

Preparation for accreditation (Indicator 1.2.2b; 4 grants). Accreditation or certification provide a clear milestone to motivate facilities to improve their quality. Consequently, grantees involved in preparing facilities for accreditation or certification see ongoing enthusiasm and engagement from facilities. Before April 2017, 164 facilities either received accreditation/certification or had their approval pending across the National Accreditation Board for Hospitals and Health Care providers (NABH), FOGSI Manyata program, and the Labour Room Quality Improvement Initiative (LaQshya).[2] The grantee working on NABH accreditation, Karuna Trust, ended its accreditation-related grant after this time; as a result, no new facilities were subsequently targeted for NABH accreditation. However, an additional 130 private facilities received Manyata certification, two district hospitals in Madhya Pradesh received LaQshya certification, and an additional two district hospitals and one medical college in Gwalior were prepared for LaQshya certification.

[2] NABH certification or accreditation is valid for a period up to three years; facilities can submit the application for renewal six months before their certification or accreditation expires (NABH 2013). Manyata certification is valid for two years and then requires renewal (FOGSI 2018). LaQshya certification is valid for three years subject to annual verification of scores by the State Quality Assurance Committee (Government of India 2017).

Exhibit II.4. Facilities accredited or certified at midline evaluation

Affirms that facilities meet a **broad range of standards** related to all aspects of care ISO standards are **similar but more limited** than NABH	Certification of **labor room practices** in the private sector	Certification of **labor room and maternity operating theatre** improvements in public sector
Early stage evaluation: All 54 targeted PHCs accredited or pending approval	**Early stage evaluation:** 105 of 5,000 targeted facilities certified	**Early stage evaluation:** 5 out of 12 targeted facilities prepared for accreditation
Midline evaluation: All PHCs already trained under the early stage evaluation	**Midline evaluation:** 130 of 5,000 targeted facilities certified	**Midline evaluation:** 5 out of 12 targeted facilities prepared for accreditation

ISO = International Organization for Standardization

Looking forward under Approach 1.2

Strengthening facility-based QA systems can be complex and time-intensive efforts that require ongoing TA and support. In fact, grants have continued to support such activities and noted the focus required for maintaining QA systems has led to fewer new efforts launched overtime. The next of evaluation will provide insight into the intensity of QA support needed to maintain quality and if grants include any new efforts.

Approach 1.3. Improving adherence to existing quality protocols and guidelines

The provision of MHQoC technical support to facilities to support adherence to guidelines and training on emergency obstetric care (EmOC) was ongoing in the strategy.

TA (indicator 1.3.2b; 5 grants). After April 2017, five grants reported reaching a total of 281 district hospitals, PHCs, and private facilities with TA in Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan, and Uttar Pradesh. Despite the slight decrease in number of facilities reached from previous years, the coverage of states expanded with TA provided in the new states of Uttar Pradesh and Jharkland.

	Early stage progress	Midline period progress
	10 active grants under approach	5 active grants under approach
TA	More than 300 facilities received TA	281 facilities received TA
EmOC training	More than 130 facilities received emergency obstetric care (EmOC) training	~150 facilities received EmOC training

Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different measures from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

The nature of this TA continues to vary by project and facility, with most grants noting that their goal is to tailor their engagement to ensure that each facility receives the support it needs to implement and maintain the knowledge and skills learned when establishing the training centers and for obtaining certification or accreditation. The TA mode of contact varied from quarterly feedback on indicators through a dashboard, in-person mentoring visits, to TA through a video communication. Topics of the TA also differed, ranging from practices related to maternal and neonatal emergencies, best practices in delivery and postpartum care, and facility management. TA could cover a large number of these topics or focus in-depth on one.

Exhibit II.5. Mode of technical assistance at midline evaluation, by grantee

Grant	Mode of TA
FOGSI 109194	• As needed basis from National Program Office
ARTH 106482	• Feedback to district officials at the end of each quarter
JSS 109126	• 80 mentoring visits across 16 facilities
Pathfinder 151209	• Mentoring visits on a monthly basis, maternal death reviews and audits, development of software for maternal death surveillance and response
Karuna Trust 106724	• One-time refresher training on maintaining a clean and hygienic environment for quality care services

EmOC services (Indicator 1.3.2a; 4 grants). EmOC services are basic, foundational services necessary to providing high quality maternal health care, as it refers to the functions necessary to save lives during obstetric care. Although grantees do not typically separate TA for EmOC skills from other TA provided, four grantees reported that at least 150 district hospitals, PHCs, and private facilities received some kind of TA focused on EmOC during the midline evaluation.

Looking forward under Approach 1.3

The strategy has continued to support TA to a large number of public and private facilities, with about half of these facilities receiving specific support for at least some signal EmOC functions. However, a more in-depth exploration of TA activities through interviews and site visits will help shed light on the exact nature of these activities, the extent to which grants view EmOC as an important TA topic, the precise number of facilities reached with these services, the type of TA provided, and the results of these TA visits on facility practices.

Addressing supply substrategy learning priorities

- Beyond keeping up accreditation and certification at both the provider and facility levels, ongoing training, TA, and mentorship still represent an emerging concept in strengthening the MHQoC within the strategy. The focus remains on reaching and providing all health care professionals with the same knowledge and skills.
- The association between establishing QA procedures and preparing for accreditation or certification and measurable improvements in the quality of care remains unclear. A deeper exploration of these issues will be necessary in the future, through a combination of tracking key indicators and conducting a deep dive on the quality improvement ecosystem.
- The nature of TA provided to facilities under the strategy varied by mode, topic, and intensity. To assess the contribution of TA to facilities will require understanding the relative effect of these various methods on quality.

III. DEMAND SUBSTRATEGY: PROGRESS AT MIDLINE EVALUATION

The 11 active demand substrategy grants at midline have made progress in educating women about their health rights, testing existing community accountability mechanisms and using legal strategies to promote government accountability for providing high quality care when other avenues fail. Three key grants in this substrategy ended before the midline evaluation.

The groundwork: Early stage MHQoC demand substrategy achievements

- More than 10,000 women and 300 community leaders received information about health care quality and health rights, resulting in moderate increases in knowledge.
- Five community accountability mechanisms were tested, including (1) community-based monitoring, (2) community-based maternal death reviews, (3) social autopsies, (4) grievance redressal mechanisms, and (5) hospital management societies—leading to upgrades to infrastructure and additional human resources at facilities.
- More than 1,400 legal and allied professionals were trained on MHQoC rights.
- Six state-level networks were developed to address reproductive health rights in Bihar, Jharkhand, Maharashtra, Odisha, Rajasthan, and Uttar Pradesh
- High-profile petitions and successful public interest litigations were related to negligence resulting in maternal deaths and banning of sterilization camps.

Exhibit III.1. Demand substrategy priority indicators, by approach

The MHQoC strategy seeks to build demand for high quality maternal health care by holding governments and health institutions accountable for delivery of these health services. Grants identified 10 priority indicators to measure progress within the demand substrategy.

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 MHQoC
	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

Grants working on community accountability and other topics expanded women's knowledge of health rights and entitlements. In addition, studies under two grants for MAMTA and SAHAJ found that increased knowledge led to greater use of maternal health services. Because five of seven community accountability grants ended before or during the midline evaluation period, we observed limited progress in promoting community leaders' participation in accountability efforts.

Early stage progress	Midline period progress
6 active grants under approach	5 active grants under approach
All 6 grants increased awareness of rights	4 of 5 grants increased awareness of rights
>10,000 women participated in community accountability activities	9,560 women participated in community accountability activities
More than142 leaders engaged in accountability activities	1,048 leaders engaged in accountability activities

Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different measures from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

Knowledge of health rights (Indicator 2.1.1a; 3 grants). Grants under the strategy continued to disseminate information about health rights and entitlements. Notably, two grants (MAMTA and Anusandhan Trust) do not include community accountability as a core component, but disseminate information about health rights as part of their work. MAMTA and SAHAJ tracked women's knowledge of health rights through surveys and found improved awareness of maternal health entitlements and schemes. All three grants reporting this indicator provided qualitative and anecdotal findings that indicated an increase in awareness of women's rights. Two grants, MAMTA and SAHAJ, also reported an increase in the use of maternal health services, which might be linked to women's increased awareness of the availability of these services (George et al. 2018). SAHAJ found this increase predominantly among the most marginalized populations.

Participating in community accountability mechanisms (Indicator 2.1.1c; 1 grant). The grant reporting on this indicator at midline evaluation, SAHAJ, noted that attendance across village meetings reached more than 9,000 men and women, although some of these counts might not represent unique individuals if a person attended more than one meeting. Attendance at these meetings remains a light-touch method of engaging community members.

Engaging community leaders (Indicator 2.1.2; 1 grant). SAHAJ—the only active grant reporting on this indicator at midline—focused on strengthening the engagement of Panchayat and Gram Sabha, which are akin to a village council—rather than maternal death review and social autopsies that other grants had previously conducted. By developing posters and other communications materials, and by holding meetings at the village and block levels, SAHAJ promoted and facilitated discussion of maternal health issues. These conversations encouraged community leaders to take responsibility for holding their health officials accountable. SAHAJ has engaged more than 1,000 elected representatives and leaders of women's self-help groups since April 2017.

Looking forward under Approach 2.1

The four grants using this approach focused on increasing women's knowledge of health rights and entitlements. Most notably, two grants found that their efforts to provide information on these topics also led to women's increased use of maternal health services, lending support for a key assumption in the conceptual model and an emerging hypothesis that women who are educated on their rights will likely seek out and use high quality services (George et al. 2018). Beyond increasing knowledge about women's health rights, questions about the value of light-touch engagement of women and community leaders in accountability efforts remain, as well as questions about how to best identify and support women who might be willing to become more engaged leaders for accountability in their communities. Because much of the strategy work under this approach has ended, a planned in-depth study will generate additional insights to help answer these remaining questions.

Approach 2.2. Supporting development and testing of community accountability mechanisms

Grantees further tested, implemented, and learned from existing community accountability mechanisms. However, overtime the majority of grants in this substrategy have ended—seven of nine closed as of April 2017. As a result, progress has slowed slightly in terms of number of mechanisms implemented, but active grants have further positioned their mechanisms for uptake by the governments of states in which they work.

Early stage progress	Midline period progress
7 active grants reporting for Indicator 2.2.2b	2 active grants reporting for Indicator 2.2.2b
12 active grants under Approach 2.2	4 active grants under Approach 2.2
5 mechanisms tested	2 mechanisms tested

Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different measures from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

Community accountability mechanism testing (Indicator 2.2.2b; 2 grants). Two grants to SAHAJ and PFI have continued to test community accountability mechanisms. Each of the mechanisms tested under these grants differ, including two community-based monitoring [CBM], maternal death reviews, and strengthening of hospital management societies. They also cover two states: Gujarat and Uttar Pradesh. Mechanisms tested in Gujarat have involved support and guidance for implementing CBM, including training and supporting community volunteers to collect and report on feedback on the quality of health services in targeted communities, and to facilitate dialogue with health officials to address quality issues raised in the feedback process. In Uttar Pradesh, the testing has continued to focus on methods for strengthening RKSs, or hospital management societies, which monitor health services at public health facilities and implement quality improvements.

Influence of community accountability mechanisms on MHQoC (Indicator 2.2.2a; 2 grants). The community accountability mechanisms tested by PFI and SAHAJ have achieved important gains in health and other resources at a local level and standards for accountability at a national level (Exhibit III.2). SAHAJ's CBM has improved supply chain issues, including regular attendance of health workers at facilities and increased availability and use of ambulances. PFI has been tasked to develop and roll out national RKS guidelines, which could standardize RKS implementation and broaden the potential influence of this community accountability mechanism. In particular, PFI is providing technical support to the State Program Management Unit (SPMU) to strengthen functioning of RKSs in Uttar Pradesh. Beginning in 2017 with 27 public health facilities in Lucknow district, the intervention has now been

scaled up to 10 additional districts across 168 facilities between 2018 and 2019. Over the last year, the intervention has also been replicated by 3 state governments: Jharkhand, Goa, and Sikkim.

Exhibit III.2. Influence of community accountability mechanisms at midline evaluation

Community accountability mechanisms implemented	Examples of actions taken by government in response to community accountability
• Community-based monitoring • Community-based maternal death reviews • Strengthening hospital management societies • Help lines and other mechanisms for reporting grievances	• Improvements to availability of key maternal health supplies • Improvements to health workers' attendance at facilities and community-based outreach • Grievance redressal processes started • Improvements to facility infrastructure, such as information management systems; for example, lists of blood donors and vehicle owners • Responsiveness by health officials to gaps and policy recommendations identified through community accountability • Increase in the honorarium paid to nurse mentors

Looking forward under Approach 2.2

With more than two-thirds of community accountability grants under the MHQoC strategy concluded before the midline evaluation, the challenge will be to examine whether and how to sustain the progress of activities and outcomes. In addition, if the mechanisms started under the strategy achieve intended longer-term and widespread results, especially as few other donors have included these approaches in their grant portfolios.

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

As of April 2017, the Socio-Legal Information Center (SLIC) concluded one of its grants—a longstanding one that began before the strategy officially started—and continued on with its other more recent grant, which began in 2015. Though at a reduced pace, the more recent grant to SLIC has continued to support training of new professionals in legal strategies and litigations to hold the government accountable for providing high quality maternal health care.

	Early stage progress	Midline period progress
	2 active grants under approach	1 active grant under approach
Training	More than 1,400 professionals trained	314 professionals trained
Networks	6 state-level networks formed	No state-level networks formed
Litigation	High-profile public interest litigation won	High-profile public interest litigation won

Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

Training of legal and allied professionals (Indicators 2.3.1a and 2.3.1b; 1 grant). Under its continuing grant, SLIC trained 204 lawyers, judges, and judicial officers from across the country through the judicial colloquium about maternal health policies and potential cases for litigation. In addition, 110 leaders of community-based and nongovernmental organizations (CBOs and NGOs) received trainings on how to use legal mechanisms to advocate for maternal health.

SLIC has also provided training on litigation on maternal health issues and support to activists such as acid attack survivors; Rohingya refugees; tribal women; and Dalit community groups in Bihar, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, the Northeast states, and West Bengal.

Networks of legal and allied professionals (Indicator 2.3.2a; 1 grants). SLIC provided ongoing support and guidance to the six state-level networks it established during the early stages of implementation. These networks operate in Bihar, Jharkhand, Maharashtra, Odisha, Rajasthan, and Uttar Pradesh.

Litigation (Indicator 2.3.2b; 1 grant). SLIC continues to use individual petitions and public interest litigation to hold the Indian health system accountable when other mechanisms fail. Since April 2017, SLIC has filed 198 petitions to the High Court and 20 petitions to the Supreme Court. To date, the SLIC has received positive orders to expand the availability of abortion services and increase availability of the national maternity benefit scheme to accredited social health activists (ASHAs). These legal victories augment those documented in the earlier stage of evaluation, which included individual orders awarding compensation to 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.

Looking forward under Approach 2.3

The strategy continues to support work undertaken by SLIC to use legal strategies to promote MHQoC. Through continued trainings, it has expanded the bench of legal and allied professionals equipped to conduct this work, and SLIC has continued to file and win notable court cases that protect maternal health. However, whether this work can sustain remains unknown as few entities such as SLIC exist in India.

Addressing demand substrategy learning priorities

- Methods for sustaining stakeholders' engagement related to community accountability activities remained an area for exploration.
- Community accountability mechanisms have led to higher demand for and use of quality health services among women, as well as improved facility infrastructure to support delivery of these services (George et al. 2018).
- As grants conclude, the legal strategies to address MHQoC put forward under the strategy have decreased. Regardless, grantee organizations such as SLIC continue their work in these areas. However, because such groups are often perceived as systems challengers, there are limits sources of funding for such organizations to continue their work, making the way forward for these legal strategies uncertain.

IV. ADVOCACY SUBSTRATEGY: EVALUATION AND LEARNING PHASE 2 PROGRESS

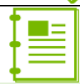
Of the 28 grants under this substrategy, almost all have either contributed some evidence to the field, promoted civil society movements, and/or advanced the sustainability of their work. Grantees participate in community, state, national, and global coalitions and other advocacy activities to promote MHQoC—often using internal resources to remain independent and be perceived as independent from the influences of outside parties.

The groundwork: Early stage MHQoC advocacy substrategy achievements

- At least 10 research articles and technical reports produced under the strategy contributed new evidence to the field of MHQoC.
- Seven publications synthesized existing evidence on respectful maternity care, sex-selective abortion, and other maternal health topics.
- Using evidence generated by national- and state-level health officials has informed some official policies related to maternal health.
- Advocacy campaigns led to some observable changes, such as adding relevant equipment, supplies, or human resources to state program implementation plans and budgets in Gujarat and Rajasthan.
- Eight grantees had secured other funding sources for work related to MHQoC, mainly from the Indian government and foreign philanthropies

Exhibit IV.1. Advocacy substrategy priority indicators, by approach

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. There are six priority advocacy indicators under this substrategy.

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 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)	
	• 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 organizations) to support MHQoC

Approach 3.1. Generate new and leverage existing evidence

Overtime, the strategy had led to a substantial increase in the number of studies publicly disseminated; the number of publications at midline evaluation was more than twice that during early stage evaluation. As time progress, these studies' focus shifted from supporting broad advocacy for high quality maternal health care to using existing and newly generated evidence to scale up activities started under the strategy. The activities targeted for scaling varied as grants differ in specific MHQoC issues addressed and region.

Early stage progress	Midline period progress
13 active grants under approach	10 active grants under approach
More than 10 research studies	26 research studies

Source: Mathematica's analysis of data from 19 grants reporting during the midline evaluation period.

Note: Grants may report on different from year to year. Grants not categorized under the substrategy or approach may contribute to measures in this approach.

Research studies (Indicator 3.1.1; 12 grants). Studies under the strategy have added knowledge to the many maternal health topics, including respectful maternity care, mHealth approaches to improving maternal health care, approaches to managing obstetric and non-obstetric complications among pregnant women, the effectiveness of a preconception care intervention, fertility intentions, birth spacing, and community accountability. Ten grants were responsible for 26 papers and conference presentations from April 2017 to March 2018. The research covered national- and state-level results; specific states included in the research were Gujarat, Madhya Pradesh, Maharashtra, and Rajasthan. Several grants, such as SEWA Rural and MAMTA, published articles that expanded or built upon articles previously published by grantees. Others produced entirely new research. For example, the Population Council has supported junior researchers to publish on topics related to MHQoC using national data sets such as the recently released National Family Health Survey. In the future, the strategy will see the release of other work currently in the pipeline for publication, such as an ARTH manuscript under review by a scientific journal.

New evidence supported by the strategy

- Abortion incidence in India
- Approaches to caring for victims of intimate partner violence
- Effects of maternity schemes on place of delivery
- Intraspousal communication and contraceptive use among young married women
- Postpartum and post-abortion contraceptive use
- The effectiveness of a preconception care intervention
- The effectiveness of an intervention to improve adherence to best practices for childbirth
- Testing mHealth interventions for delivering information and improving service delivery
- The effectiveness of an mHealth intervention to improve maternal health care
- Quality improvement processes for delivering care
- Respectful maternity care
- Reason, cost, and quality of care during obstetric referral from district hospital to higher center
- Review of community-based interventions for young married couples
- Contextualizing legal and policy developments on the role of medical practitioners
- The effectiveness of community action to improve equity for maternal health
- National trends related to maternal health using large national data sets

Leveraging existing evidence (Indicator 3.1.2; 11 grants). Although most grants leverage evidence by publishing nontechnical reports or other written documents for lay audiences, some grants have taken more creative approaches to disseminating evidence, such as ARTH's development of a documentary film to promote its work.[3] C3 has also continued to document and share individual stories of disrespect and abuse in maternity care, which it uses to advocate for respectful maternity care in a wide range of formats and settings (C3 2018). Results of these efforts have included scaling up a local intervention to the state level and expanding topics covered in trainings on maternity care. Conversely, evidence generated under one grant was considered controversial to government agencies because it established rates of abortion incidence that did not align with previously calculated rates related to reproductive health, such as total fertility and contraceptive prevalence rate. This reaction has limited this study's dissemination and use among policymakers.

Six grants leveraged evidence to support state-level MHQoC advocacy versus national-level efforts (Exhibit IV.2). For example, SEWA Rural has used the findings from its randomized controlled trial on an mHealth application to advocate for scaling up the intervention to the entire state of Gujarat. The state government has supported this plan and has funded initial work to scale up the intervention. Similarly, JSS has used learnings from a continuing medical education (CME) program for doctors in Madhya Pradesh to advocate to scale up the CME program statewide.

[3] The video developed by ARTH is available at https://www.youtube.com/watch?v=sq3z7oZah_M&feature=youtu.be.

Exhibit IV.2. Leveraging of evidence for advocacy at the state-level at midline evaluation

Grant	State	Evidence Used	Result
ARTH 106482	Rajasthan	• Quarterly monitoring reports using quality improvement indicators	• Used by district health manager and RCHO to advocate for MHQoC
IPAS 108851	Tripura	• Continued and strengthened support to the national and state governments for improved availability and quality of comprehensive abortion care (CAC) services at the state and district levels, especially to states where need is high	• Used to assist the government of Tripura in conducting a state-level training for trainers on CAC
JSS 109126	Madhya Pradesh	• Results from a descriptive study of CME program for doctors (Sethuraman et al. 2015)	• Used to advocate for statewide scale-up of the CME program
Karuna Trust 106724	Andhra Pradesh	• Results from multiple studies of mHealth tools such as coordinated primary health model developed and piloted at Karuna Trust-run PHCs in Gumball (Karuna Trust n.d.; 2018)	• Assisted the government of Andhra Pradesh in deciding to run a Non-Communicable Diseases-based program for 9 million women
PFI 108897	Uttar Pradesh	• Results from study on the functioning of QA mechanisms in 5 selected health facilities in Lucknow district in November 2017 (Population Foundation of India 2017)	• Assisted state mission director of National Health Mission and State Program Management Unit to advocate for a plan to address the issues and gaps in facility QA
SEWA Rural 108398	Gujarat	• Results from randomized controlled trial on an mHealth application (Modi et al. 2017)	• Used to advocate for scaling up the intervention to the entire state

Looking forward under Approach 3.1

Policymakers have used evidence generated under the strategy to support scale-up and advocate for maternal health care quality improvements. However, evidence generated that deviates from accepted norms or reveals flaws in existing policies and programs can be met with great resistance. Capitalizing on grantees' knowledge of how to leverage information—balancing being challenging and reconciliatory—within India's cultural norms and policy contexts can further promote the effectiveness in evidence's use.

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

Early stage progress	Midline period progress
10 active grants under approach	1 active grant under approach
▸ 5 policymakers' support for some advocacy efforts	▸ 8 policymakers' support for some advocacy efforts
▸ 10 national and state advocacy networks established	▸ 10 national and state advocacy networks established

Source: Mathematica's analysis of data from 19 grants reporting in Phase 2.

Note: Grants may report on different measures in each Phase. Grants not categorized under the substrategy or approach may contribute

Time for civil society efforts to mature has enabled grants to bring MHQoC to the forefront of some political agendas and even resulted in achieving concrete objectives, including affecting patient welfare policies at national and state levels. The states with policies affected include Chhattisgarh, Gujarat, Madhya Pradesh, Maharashtra, Rajasthan, Tripura, and Uttar Pradesh.

Prioritizing by policymakers and program managers (Indicator 3.2.1a; 10 grants). Although many grants reported how advocacy efforts resulted in successful prioritization of MHQoC issues by policymakers and program managers, the nature and depth of these commitments have varied significantly. Some grantees have expanded or institutionalized the MHQoC

efforts, such as establishing RKSs and scaling up to ensure incorporation of respectful maternity care in the government's LaQshya labor room guidelines. Other efforts have targeted local-level government, such as identifying MHQoC champions at block and district levels (Exhibit IV.3). Given the diversity in advocacy efforts grantees have used and the wide range of targeted outcomes and achievements to date, it is difficult to draw conclusions about the extent to which policymakers and program managers have embraced the full MHQoC agenda. A more in-depth investigation of advocacy efforts will shed more light on prioritization of MHQoC by policymakers and program managers.

Exhibit IV.3. Advocating for MHQoC among policymakers and program managers, by grant and level of government at midline evaluation

Grant	Level of government	Result
ARTH 106482	• Block and district	• Advanced MHQoC efforts at local levels of government
JSS 109126	• Block and district	• Advanced MHQoC efforts and programs at local levels of government
SAHAJ 109340	• District and state	• Local certified district health officials attended SAHAJ advisory meetings
MAMTA 107329	• District and state	• District officers and state leaders made quality of care for young married women a priority area
SEWA Rural 108398	• State	• State department of health and family welfare decided to scale up ImTeCHO interventions and other policies and training programs
Anusandhan Trust 107328	• State	• Findings presented to the head of the department of medical education in Maharashtra so that screening for domestic violence tool can be integrated in to the academic medical teaching for Bachelor of Medicine and Bachelor of Surgery students
PFI 108897	• State	• Supported and funded scale-up efforts to improve RKS functioning
C3 108898	• National	• Incorporated respectful maternity care as an essential component of the government's LaQshya initiative
Pathfinder 151209	• State and national	• Included in the national and state mentoring teams for the LaQshya program • ANM induction trainings monitored • Part of a maternal death surveillance and response committee for periodic maternal death review in all intervention districts • Monitored skill lab trainings of LaQshya initiative for medical colleges

Advocacy networks (Indicator 3.2.1b; 7 grants). The strategy, through seven of its grants, managed or participated in 11 national- or state-level advocacy networks at midline evaluation, including networks in Chhattisgarh, Madhya Pradesh, and Rajasthan (Exhibit IV.4). Some of these networks began early on in the strategy, such as the White Ribbon Alliance India (WRAI), a large national coalition working to promote respectful maternity care. New networks include the RASTA initiative, a program that supports program research and policy formulation by supporting researchers across the country.

Exhibit IV.4. Key state- and national-level networks and advocacy efforts at midline evaluation (Indicator 3.2.1)

Advocacy effort/network	Participating grantee (role)	Level of organization and coverage	Number and type of organizations in network	Phase of initiation
WRAI	C3 (head)	National	~1,500 CSOs and individuals	Phase 1
National stakeholders' meeting	C3, in collaboration with Indian Council of Medical Research	National	~85 health care providers, researchers, national NGOs, international NGOs, and government representatives	Phase 2
Discussion meetings	Population Council (host)		About 20 representatives, over the course of 8 meetings, from the department of health and family welfare, donor representatives, United Nations bodies and civil society partners and academics	Phase 2
Media workshops on safe abortion	IPAS (head)	Rajasthan Chhattisgarh	39 media representatives	Phase 2
Common Ground Meeting against sex selection	IPAS (head)	Rajasthan	26 NGO representatives brought together	Phase 1
RASTA	Population Council (head)	National	12 young researchers	Phase 2
CAC core committee	IPAS (assisting MoHFW)	National	Various government officials	Phase 1
Regional workshop on CAC operationalization	IPAS (head)	Northeastern states	25 state- and district-level program managers and service providers	Phase 2
Voluntary Health Association of India (VHAI)	SEWA Rural (member)	National	27 state voluntary health associations, linking more than 4,500 health and development institutions	Phase 1
National Alliance for Maternal Health and Human Rights (NAMHHR)	Sahayog (previous secretariat) Center for Health and Social Justice (current secretariat) SEWA Rural (member)	Gujarat	Various CSOs	Phase 1
Jan Swasthya Abhiyan (JSA)	SEWA Rural (member); SAHAJ (member)	National	21 national networks and organizations of the People's Health Movement	Phase 1

The growth in the number and nature of the advocacy networks supported by MHQoC grantees provides some initial insight into the breadth and depth of advocacy work being conducted under the strategy. However, a more in-depth exploration of how grants have built coalitions and used them to advance the MHQoC agenda will provide further information about the contribution of these advocacy networks to advancing MHQoC.

Looking forward under Approach 3.2

Advocacy campaigns supported under the strategy address a wide range of MHQoC issues and have achieved successes in key areas, such as labor room and hospital management to promote patients' welfare. Moving beyond the start of these campaigns to outcomes of the campaigns, the endline evaluation will include an in-depth assessment of the nature and characteristics of these campaigns associated with achieving results.

Approach 3.3. Using evidence and advocacy to sustain MHQoC efforts

As more grants conclude and the strategy enters its final two years, assessing the ability of the investments in the strategy to catalyze and sustain positive change in MHQoC comes to the forefront. The

question of sustainability often comes in the form of additional funding to carry on the work. However, grants under the strategy have forged alternative paths to achieving sustainability.

Funding for continuing or follow-on work (Indicators 3.3.1a, 3.3.1b; all grants). At early stage evaluation, 8 of the 20 MHQoC strategy grantees reported having secured funding to continue their MHQoC work. No other grantees have reported identifying funding at midline evaluation. However, 4 of the 8 that had previously obtained funding secured additional funds at midline.

Exhibit IV.5. Grants securing funding, April 2017 through March 2018

Grant	Purpose of funds	Source
PFI 108897	• Expanding the project	• Government
Population Council 109245	• Begin new follow-on work	• Multilateral (US Agency for International Development [USAID])
SEWA Rural 108398	• Expand the project	• Government
C3 108898	• Continue the project	• Multilateral (White Ribbon Alliance Global & Health Policy Project/USAID)

Despite the lack of additional funding secured for many grantees to continue their MHQoC efforts, some have reported planning to continue their work after their current grants end or devised strategies to sustain their work without additional funding. For example, several grantees mentioned integrating their MHQoC work into existing activities and other work the organization undertakes. For two grants, the government has taken on expanding or scaling up work that began under the strategy. Furthermore, five grantees to date have work with Dasra—the grant under the strategy tasked with capacity building, sustainability, and identifying potential funding sources with other grantees. Several of the grantees working with Dasra have mentioned that incorporating the corporate mentality of self-promotion to gain funding along with their nonprofit mentality of providing services to disadvantaged populations was challenging at first, but ultimately helpful.

Looking forward under Approach 3.3

Sustainability continues to pose a challenge for MHQoC grantees. The majority of grantees have not yet secured their own additional funding for this work after the strategy ends. However, acquiring additional funding might not be the only way to assess sustainability and including the transfer of efforts begun under the strategy to other entities can help to develop a more comprehensive understanding of strategy efforts' sustainability.

Addressing advocacy substrategy learning priorities

- Policymakers show a willingness to use evidence to influence supply-side provision of quality maternal care, such as guidelines for delivery of maternal care and scale-up of promising strategies in facilities.
- Grantees have a firm commitment to sustaining efforts started under the strategy, and are exploring avenues beyond additional funding to fulfill this commitment.

V. MIDLINE EVALUATION LESSONS LEARNED AND IMPLICATIONS FOR THE FIELD

The mid-evaluation provide compelling evidence of the MHQoC strategy's progress although it relies heavily on grantee self-reported information. In particular, synthesis of the information in this chapter highlights the key lessons within the three substrategies, as well as cross-cutting learnings for the MHQoC strategy as a whole (summarized in Table V.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 V.1. Lessons learned

- **Supply.** Provider training curricula should consider and incorporate modules to promote maintaining learned skills and delivering maternal health care consistently.
- **Demand.** Community accountability mechanisms can generate desired outcomes in improving MHQoC.
- **Advocacy.** Varying frames of reference among policymakers, implementers, researchers, and the community can lead to differences in interpreting, accepting, and using evidence.
- **Cross-cutting.** What is means to make progress and to sustain an intervention can take different paths depending on the original purpose and evolution of an investment in an intervention; thus, making progress does not always mean increasing reach, but could mean sustaining it over time.
- **Cross-cutting.** For-profit concepts require translation for adoption and use to improve nonprofit work; though NGOs are accustomed to branding the issues they work on to mobilize people, they are not used to concepts of branding and self-promotion of their own organizations to raise additional funding.

Supply-side lesson learned

Provider training curricula should consider and incorporate modules to promote maintaining learned skills and delivering maternal health care consistently.

Implications for the strategy. Knowledge and skill-building curricula should identify content that requires refresher trainings and incorporate these trainings at appropriate frequencies.

Implications for the field. Further testing and implementation of new curricula should consider and coordinate with other existing efforts to reduce duplication, promote standardization, and strengthen promising strategies.

The strategy has supported the development of 17 health professional training curricula. The absolute number of health professionals trained remained similar from year to year. The strategy also supported similar numbers of facilities in getting TA and achieving accreditation overtime.

> **"India's commitment to the Sustainable Development Goals requires improvements in the quality of intrapartum and immediate postpartum care in public health facilities to decrease maternal and neonatal mortality and morbidity."**
>
> **–Grantee**

Much of the TA has been topical and targeted to specific skills, such as those for maternal and neonatal emergencies and developing quality improvement tracking systems. The focus has been less on maintaining these skills and using tools developed—though some grantees and curricula, such as Karuna Trust and Dakshata, have recommended refresher trainings; and reaccreditation or recertification is often required at set intervals to demonstrate maintenance of quality standards.

From the midline evaluation, we learned that a growing group of health professionals and facilities is becoming knowledgeable in the practice of high quality maternal health care. As this reach continues, the

key workforce supply issue will shift to how to maintain these skills over time—analogous to the shift from a focus on access to maternal health care to its quality.

Demand-side lesson learned

Community accountability mechanisms can generate desired outcomes in improving MHQoC.

Implications for the strategy. Further testing of relative value of various community accountability approaches could lead to a better understanding of how to sustain efforts.

Implications for the field. Efforts from external parties to empower communities should break down the sequence of steps that lead to decision makers becoming accountable and acting upon that accountability.

The efforts begun under strategy have matured and demonstrated community accountability's promise in prompting improvements in infrastructure and resources in local and national health systems. Approaches to community accountability are also becoming further codified with PFI's work to develop and roll out national RKS guidelines for implementation. These changes also signal that community accountability can move beyond inducing small, day-to-day improvements in service delivery and drive longer-term and meaningful quality improvements in health systems.

Unintended benefit of community accountability

The increase in knowledge from community accountability efforts also has an unintended benefit. Although intended to address systematic issues by helping community members understand that they can hold policymakers and decision makers answerable, these mechanisms also promote healthier behaviors among engaged individuals by imparting knowledge to them about the services to which they have access and, thereby, increasing their use of appropriate health services.

At the same time, engaging women and leaders in MHQoC community accountability efforts continued to gain traction in the strategy's target areas. In particular, the participation of leaders increased almost 10-fold from early stage to midline evaluation due to the efforts of one grant. SAHAJ achieved the highest degree of leader engagement by focusing on the Panchayat and Gram Sabha—rather than maternal death reviews and social autopsies that required intensive engagement of community members. These efforts increased women's and leaders' knowledge of maternal health rights and women's use of health services.

Thus, the midline evaluation continued to supply evidence to support community accountability's proof of concept to MHQoC. However, the emerging evidence raises new questions, such as: (1) What is the relative value of light-touch approaches versus high-touch community accountability approaches for cultivating community members' sustained engagement and promoting government responsiveness? (2) Under which circumstances might some mechanisms perform better than others? (3) How can community accountability mechanisms best promote continued, long-term responsiveness from government bodies at the local, state, and national levels? (4) What are the key milestones under which to understand progress of community accountability mechanisms for MHQoC in India? (5) Do different mechanisms follow the same pathway or have the same milestones to success? To the extent possible, the endline evaluation will explore the answers to these questions.

Advocacy lesson learned

Varying frames of reference among policymakers, implementers, researchers, and the community can lead to differences in interpreting, accepting, and using of evidence.

Implications for the strategy. Anticipating policy-makers questions to research methods, results, and interpretation can facilitate (though not guarantee) application of new evidence.

Implications for the field. Beyond the strength of the evidence, researchers should also consider the circumstances and the potential time horizon under which policymakers will become ready to use it.

Grant-dissemination activities have included creative new vehicles beyond traditional peer-reviewed journals, such as videos, to publicize findings. These activities resulted in more information about MHQoC issues reaching nontechnical audiences and the advocacy messages feeding into community accountability efforts. Through its audiences—technical or nontechnical— , a primary goal of the strategy's advocacy is to improve adherence to or update policies to support the improvement of maternal health, ultimately aiming to influence the decisions made by policymakers.

Despite policymakers expressing a desire for evidence to support their decision making related to MHQoC, midline evaluation findings emphasized that the audience, packaging, and timing of the evidence has a large role in its interpretation and use. A key research study supported through the strategy estimated the incidence of abortion in India at a significantly higher rate than previous reports (Singh et al. 2018). Though the *Lancet* published the article and the Guttmacher Institute had used its methodology previously to estimate abortion prevalence in multiple countries, some government officials questioned the validity and generalizability of the results. In particular, these estimates of abortion's incidence did not align with previous government calculations of total fertility, contraceptive prevalence, and family planning acceptance rates.

> **"We have learned about the difficulty of capitalizing on the investment in relationships within the Ministry of Health and Family Welfare (MoHFW) as individuals in the Ministry are reassigned new posts with some frequency. This has required us on multiple occasions to start forming new relationships and educating new officials at the MoHFW on the importance of the study and the methodology."**
>
> **–Grantee**

This reaction has limited the influence of the evidence on decision makers in India; the Guttmacher Institute has significantly scaled back plans for disseminating this research, and it has advised its local partners to avoid drawing additional media attention to this research as this would likely have negative consequences for them. In spite of this, donors and NGOs have used the findings alongside data from the Nation Family Health Survey to help develop interventions related to maternal care, abortion, or contraceptive services.

Cross-cutting lesson learned

What it means to make progress and to sustain an intervention can take different paths depending on the original purpose and evolution of an investment in an intervention; thus, making progress does not always mean increasing reach, but could mean sustaining it over time.

Implications for the strategy. Defining the various pathways to sustainability can help grantees assess the ones most applicable to their circumstance.

Implications for the field. Understanding progress of maternal health quality improvement should include mapping out the timeline, outputs, and outcomes for each phase; clearly defining the inclusion and conclusion of various stakeholders' involvement; and defining indicators of success and sustainability.

As the strategy nears its end, stakeholders would like two large questions answered: What have been the contributions of the strategy to MHQoC? What legacy will it leave? Additional funding and resources to continue the work started under the strategy is one measure of the strategy's impact and sustainability, but it would be simplistic to say that it is the only measure. In fact, as maternal mortality declines in India and a more comprehensive view of health and care coordination develops further, efforts to improve maternal health have become integrated into primary care, family planning, child health, and other areas.

Reflective of this trend, few grants obtained additional funding to continue solely their MHQoC strategy activities. At the same time, most grants reported planning to continue with their activities after the strategy ends. These results necessitate further definition and clarification about what the different avenues to sustainability might look like under the strategy.

- **No further activities required, or the work has been adopted by another agency or organization.** Several grants had discrete purposes, such as providing training, support, and guidance to implement a tested MHQoC intervention being adopted and funded by the government, such as PFI and Pathfinder. Others, such as SEWA Rural, have developed and tested interventions that government agencies adopted. In these cases, further funding for this work might no longer be critical, as the work has either been completed or is being taken up by others.
- **Institutionalization into grantee organization's existing practices.** Like the previous result, additional funding might not be critical if activities started under the strategy have become integrated into the daily processes of their organization, the work of other community partners, or policies of the government.
- **Further resources required to continue.** However, some efforts might need additional funding to reach their stated goals and objectives. The need for additional funding to continue strategy-initiated activities could be targeted for maintaining, improving, or scaling up the activity. Examples of this might include *catalysts* who use legal approaches that require independence from the government to prompt improvements, *administrators* who require funds to support a body to maintain and coordinate a coalition, and *innovators* who test a clinical quality improvement in other settings to further its proof of concept and support scale-up.

Based on this learning, the endline evaluation will take the opportunity to reflect upon all grants to further understand the strategy's contribution and sustainability in light of original goals set under each grant across the strategy and within each substrategy.

Cross-cutting lesson learned

For-profit concepts require translation for adoption and use to improve nonprofit work; though NGOs are accustomed to branding the issues they work on to mobilize people, they are not used to concepts of branding and self-promotion of their own organizations to raise additional funding.

Implications for the strategy. Dasra should continue to work with grantees to translate and adapt business sector concepts to ongoing MHQoC efforts.

Implications for the field. For-profit marketing and investment approaches can help increase sustainability of MHQoC and other social sector efforts.

Several grantees expressed a lack of familiarity with the language and concepts Dasra introduced as it began to provide them with TA related to sustainability. For example, branding of their organization appeared as a particularly foreign concept to NGOs and nonprofits that place great emphasize on their mission and being mission-driven and less on self-promotion and marketing and public relations.

> **"Having established relationships at multiple levels has [helped] to sustain the engagement and work. These are essential—especially in view of the vision of scaling up and sustainability of the program."**
>
> **–Grantee**

However, some grantees have come to understand that a brand can reflect their mission's promise or perspective and the image that they want the external world to see about their organization and its work. Brand recognition can help both for-profit and nonprofit organizations that have a need to raise revenue, though often with different goals. Given this, some of the for-profit approaches naturally could have relevance to nonprofit organizations. The work of Dasra has opened the door for grantees to explore further ways in which business sector concepts could benefit and be translated to their nonprofit work.

VI. CONCLUDING REMARKS

As grants ended and others moved beyond planning to full implementation by March 2018, the strategy indicators demonstrated change, some increases and decreases. Review of these indicators showed that grants made the most progress providing trainings to health workers, including management training for nonclinical staff and ongoing support and mentorship for all staff; educating community members about their health rights and promoting uptake of maternal health services; implementing and achieving results from community accountability activities; applying legal strategies to ensure the delivery of quality maternal health services; and generating evidence to support MHQoC and disseminating it in creative ways to ensure that policymakers use it. The strategy has experienced continued challenges in institutionalizing QA systems and processes, identifying ongoing sources of support for legal strategies to promote MHQoC, and ensuring that even unexpected or controversial research findings are disseminated, discussed, and acted upon.

However, the indicators do not necessarily capture the entire narrative of activities begun under the strategy. For example, some grantees are continuing their work from an ended grant, but the indicators do not capture these efforts because they report only on active grants' work. In the next and final phase, the evaluation will capture the grantees' ongoing MHQoC efforts under and beyond the strategy to further assess sustainability and impact.

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APPENDIX A. SUPPLEMENTAL EXHIBITS

Exhibit A.1. MHQoC strategy logic model

We aim to ...	Our funding will support ...	Resulting in ...	
Substrategy	**Approaches**	**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

Exhibit A.2. 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 to provide 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 QA 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

Strategy component	Priority indicator
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 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	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
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 a foundation or multilateral organization) to support MHQoC

Sources: 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.3. Status of grants in MHQoC portfolio

Grant number	Grantee	Close date	Status
93784	Karuna Trust	9/30/2012	Closed*
101465	Jhpiego	4/30/2014	Closed*
97735	Centre for Health and Social Justice	5/31/2014	Closed*
95544	Action Research & Training for Health	12/31/2014	Closed*
106484-0	Jhpiego	9/30/2015	Closed
99541-0	SAHAJ-Society for Health Alternatives	12/31/2015	Closed
100982-0	Centre for Catalyzing Change	3/31/2016	Closed
104990-0	Sahayog	8/31/2016	Closed
108813-0	Centre for Health and Social Justice	12/31/2016	Closed
103736-0	Guttmacher Institute	2/28/2017	Closed**
101049-0	Socio Legal Information Centre	3/31/2017	Closed
108851-0	Ipas	5/31/2017	Closed
106701	Population Council	8/31/2017	Closed
107329	MAMTA Health Institute for Mother and Child	9/30/2017	Closed
106724-0	Karuna Trust	9/30/2017	Closed
108398-0	Society for Education Welfare and Action (SEWA)-Rural	6/30/2018	Ongoing
109340-0	SAHAJ-Society for Health Alternatives *	7/31/2018	Ongoing
108830-0	Socio Legal Information Centre	7/31/2018	Ongoing
107328-0	Anusandhan Trust Centre for Enquiry into Health and Allied Themes*	8/31/2018	Ongoing
106482-0	Action Research & Training for Health	9/30/2018	Ongoing
108898-0	Centre for Catalyzing Change	10/31/2018	Ongoing
109194-0	Federation of Obstetric and Gynecological Societies of India	11/30/2018	Ongoing
1511-150369	Impact Foundation (India)	12/31/2018	Ongoing
1609-151209	Pathfinder International	12/31/2018	Ongoing
109245-0	Population Council	1/31/2019	Ongoing
108897-0	Population Foundation of India	3/31/2019	Ongoing
109126-0	Jan Swasthya Sahyog	5/31/2019	Ongoing
1703-151795	World Health Organization	9/14/2019	Ongoing

Note: Shaded rows refer to grants that contributed data to the Evaluation and Learning Phase 2 report.

* These grants are considered as precursors to the grants made in the MHQoC strategy and, thus, included in Phase 1 analyses.

** Although the grant's end date has been extended, grant activities largely ceased early in the Phase 2 period. The grant contributed data to the Phase 2 report.

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