Synergies in Partnership for Maternal, Newborn and Child Health

Report of the national consultation supported by Partnership for Maternal, Newborn and Child Health, Geneva

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India Habitat Centre, New Delhi
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Background

- In April 2005, the Partnership for Maternal, Newborn, and Child Health (PMNCH) was launched at “Lives in the Balance,” a three-day international consultation convened in New Delhi. The consultation culminated with a proclamation of “The Delhi Declaration on Maternal, Newborn and Child Health.”
- These global efforts to link and expand efforts on maternal, newborn and child health (MNCH) are also reflected in Government of India (GOI) policy, programs and priorities, notably through the National Rural Health Mission and Reproductive and Child Health (RCH–II) program.
- It is important to build bridges among traditionally separate stakeholder groups.

Consultation objectives

- Sharing information about the landscape of current maternal, newborn and child health efforts in India.
- Identifying opportunities for synergies between these programs and priorities for possible partnership building on MNCH from an Indian perspective.
- Identifying opportunities and mechanisms for non-governmental organizations (NGOs) / civil society organizations to collaborate with the ongoing efforts.

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<td>Welcome; Objectives for the consultation</td>
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<td>The current MNCH scenario in India and update on the global Partnership on Maternal, Newborn and Child Health</td>
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<td>09:30–09:45</td>
<td>UNICEF India’s work on MNCH &amp; its relationship to the Partnership</td>
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<td>Building on success: prior civil society–government partnerships on MNH in India</td>
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<td>Posting of ideas / views: What can we do to strengthen networks and collaborative activities with currently available resources? What are the priorities for new activities if resources permit?</td>
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1.0 Introduction

The Delhi Declaration on Partnership for Maternal, Newborn and Child Health (PMNCH) was shared at the “Lives and Balances” conference held in Delhi in April 2005. The Declaration stated that simply learning about progress, policies, structures, and realization at the global level in this area does not respond to the real needs and priorities of people’s lives, and thus is not a way forward. The solution, rather, is in bringing together the core issues concerning maternal and newborn child health, sharing lessons learnt, and in cross-learning (across issues of maternal health, neonatal health, child health, and experiences of gynecologists, pediatrics, and neonatalogists), and across sectors (civil society learning from the private sector and vice versa). This way forward is also mentioned in the NRHM and RCH–II documents.

The public sector in India is highly committed to partnerships. The private sector too is reaching out and responding to the needs of the poor, and wants to work jointly with both the nonprofit civil society groups and the government. Opportunities exist for working together in a better way, learning to be well-organized, and doing it in a larger scale.

The White Ribbon Alliance–India (WRAI) and Program for Appropriate Technology in Health (PATH) work with both public and private sectors, through collaborations and networks.

As NRHM gets operationalized, it is very important that there is constant communication between the partners and how each can complement the efforts of the other.

There is therefore an urgent need for:
- Working together and sharing lessons.
- Using existing initiatives to promote stronger linkages.
- Appropriate and consistent involvement of civil society.
- A continuous debate and engagement.

Broadly, the PMNCH consultation was held to:
- Share information on the current landscape of MNCH efforts in India.
- Identify opportunities for synergies between these programs and priorities for possible partnerships on MNCH from an Indian perspective.
- Identify opportunities and mechanisms for non-governmental organizations (NGOs)/civil society organizations to collaborate with the ongoing efforts.

This initiative is supported by the new global partnership for MNCH, Geneva.

The following pages of this report are devoted to brief discussions on the presentations made at the consultation and the outcomes of the three group discussions. A list of participants at the consultation is given at Annex 1.
2.0 Presentations

2.1 PATH, WRAI and MNCH

Mr. Jeffrey O’Malley, Country Director, PATH

Mr. O’Malley welcomed the participants and thanked them on behalf of WRAI and PATH. “Everyone present has numerous years of experience in maternal and child health and knows what needs to be done to improve the health system in India. The thrust is on the know-how to do it. This consultation can be looked at as a forum for stakeholders to think of ways to make sure that integrated services are available on the front line to respond to people’s needs.”

The salient points of Mr. O’Malley’s presentation are given below:
- A grant was received by WRAI and PATH from PMNCH to hold consultative meetings in India and Bangladesh.
- PATH and WRAI are collaborating to bring different stakeholders together.
- The aim of this effort is advocacy for MNCH in India and Bangladesh.
- A similar meeting is planned in Bangladesh in August 2006.

2.2 Current MNCH scenario in India and update on the global Partnership for Maternal, Newborn and Child Health

Dr. Vinod Paul, Professor, All India Institute of Medical Sciences (AIIMS), New Delhi

“Newborn and maternal mortality is the highest burden for any country. For India, it is the biggest challenge. It is necessary to work together to meet both the national goal and the Millennium Development Goals (MDGs) number 4 and 5. Maternal mortality reduction needs a stronger health system at the facility level and is more challenging for India.”

Dr. Paul shared current data on MNCH in India prepared by the World Health Organization (WHO). He also highlighted the contribution by partners in India in implementing the early phase of RCH–II, including the processes involved. The achievements from the partners’ involvement are given below:

1. Strengthening the different components in RCH-II
   - Financing
   - Managerial systems
   - Equity-driven approaches
   - Private-public partnership
   - MBB tool application
   - Monitoring and Evaluation (M&E)
2. Interventions
3. Harmonization of approaches.
4. Resource pooling and uniform procedures helped in creating the vision about integrated services. Pooled resources have the ownership of national and international partners.
5. Assured ownership.

Partnership was an asset in designing and financing RCH-II, but this partnership loosened in the post-design phase.

2.2.1 Partnership initiatives taken in the RCH-II post-design phase:
- High-level visit by the Child Survival Partnership (November 2004)
- Partnership meeting on MNCH (April 2005)
  - Coincided with the launch of WHR
  - Led to the Delhi Declaration

People have realized that there are global challenges involved in achieving MDGs 4 and 5, and it is difficult for any single stakeholder to achieve them.

2.2.2 Global picture
- More than half a million women die during pregnancy and childbirth each year.
- More than 10 million children die each year before their fifth birthday, almost 40% in the first month of life.
- At least two-thirds of these deaths could be prevented.

2.2.3 History of partnerships in India
- 1987: Safe Motherhood Initiative (SMI) and Safe Motherhood Inter-Agency Group (IAG).
- 2000: Healthy Newborn Partnership.

PMNCH was established in September 2005 and was launched in conjunction with the UN Assembly Session in New York. Currently, it is hosted at WHO, Geneva.

All three partnerships (Healthy Newborn Partnership, Safe Motherhood & Newborn Health, and Child Survival Partnership) have come together as PMNCH.
2.2.4 Structure of PMNCH and how it works:

- **Aim:** To coordinate efforts toward achieving MDGs 4 and 5.
- **Role:** To provide a forum to combine strengths and implement solutions that no one partner can achieve alone.
- **Approach:** Intensify and harmonize country, regional, and global action to improve MNCH by focusing on:
  - Country support
  - Advocacy
  - Effective interventions
  - Accountability

**What the partnership does:**
1. Supports country-led efforts in accelerating universal coverage of essential interventions.
2. Advocates for increased political and financial commitment.
3. Promotes the development and adoption of evidence-based, cost-effective interventions.
4. Measures and evaluates progress on agreed outcomes.

**What the partnership offers:**
1. Greater visibility for MNCH.
2. Truly country-led efforts.
3. Increased commitment to primary healthcare.
4. Shared and agreed goals.
5. Reduced competition and duplication.
6. More efficient use of new and existing resources.

**The partnership is not:**
1. Not a one-size-fits-all solution.
2. Not an additional bureaucratic layer.
3. Not a funding agency.
4. Not a top-down approach.

The partnership should be seen as a catalyst, with the government driving the process with the partners.

**The guiding principles of the partnership are:**
1. Country-led
2. Inclusive
3. Comprehensive
4. Flexible
5. Collaborative
6. Results-oriented

**Recent developments:**
1. Dr. Francisco Songane is the new Director.
2. Working groups (interim) formed:
   i. Country support (Al Bartlett, USAID)
   ii. Advocacy (UNFPA)
   iii. M&E (Wendy Graham, IMMPACT)
   iv. Effective interventions (WHO)
3. Strategy and work-plan developed.

**The partnership provides support to the following countries, the criterion being highest burden of maternal and neonatal deaths:**

- 2006 focus on 7 countries (India, Pakistan, Cambodia, Ethiopia, DRC, Tanzania, and Mali). Senegal, too, at present.
- 2007 focus on 7 additional countries (to be identified).
- Additional multi-country engagements.

**2.2.5 India – next steps**

- Visit by key persons (may be Director).
- Establishment of a coordination mechanism.
- Agree on indicators, targets and monitoring process with the consent of the Government of India (GOI).

**The partnership in India will emphasize on the following:**

1. More active role in the National Rural Health Mission (NRHM):
   i. Ensuring higher profile of MNCH.
   ii. Building, enabling the cadre of 300,000 new workers (ASHAs).
2. More active role in implementation
   i. EmOC.
   ii. SBA.
   iii. IMNCI.
   iv. Assisting states in implementation.
   v. Assisting with capacity building, M&E.

**Lessons that India can share worldwide via PMNCH**

1. MNCH strategy
   i. An integrated/harmonious MNCH strategy based on principles of continuum of care.
   ii. An IMCI approach that includes preventive/promotive home-based newborn care, connect to postpartum care.
2. Donor engagement.
3. Commitment.
4. Tools, guidelines, HR capacity building.
5. Technologies
   i. Equipment, pharmaceuticals, satellite-based education/interaction.

2.3 UNICEF India’s work on MNCH and its relationship to the Partnership

Dr. Marzio Babille, UNICEF

“India needs to build on existing strengths. There is no need to reinvent the continuum of care between maternal, newborn and child health. We need to develop a coordination mechanism between government and civil society.”

Dr. Babille envisaged a focus on platform building and a coordination mechanism as resolutions of the conference. They possibly need to be action related. To meet MDGs 1, 4 and 5, there is a need to accelerate action and build a sense of urgency among the existing partnerships at the state, district and community levels in order to have better focus and possibly translate important policy shifts into action.

The main bottleneck we face is delayed system change, he added. We should know how to impact the system if we want to reach our targets to improve strategic interventions impacting maternal, child and newborn health.

2.3.1 Goals and objectives of health system change 2006

1. Improving health status through home visiting, counseling and health services.
2. Reducing disparities in health status and access to healthcare.
3. Improving quality of care and increasing coverage.
5. Reducing the financial burden of healthcare on the lower socioeconomic groups.
6. Reducing waste and inefficiency – this can be accelerated by working with civil society.

2.3.2 India can contribute a new vision by addressing the following key issues:

1. Contribute to institution building and convergence between DHFW and DWCD to enable a new leadership role in ICDS and RCH–II.
2. Disseminate high impact strategic interventions to reduce IMR and malnutrition and decrease maternal mortality by universalizing an essential package of care and improving the household practices of the caregiver.
3. Develop an appropriate public-private sector partnership in RCH to contribute to achieving the MDGs and support national RCH and population policy goals.

4. Participate in a performance-based financing mechanism and social health insurance for expanded population coverage with efficient and effective healthcare.

There are a number of examples where UNICEF has produced solutions to various critical situations with help from others. The overall experience was:

1. Community reporting systems identify deaths both at home and facility.
2. Most families are willing to be interviewed and appreciate the opportunity to talk about it.
3. Most maternal deaths occur after the delivery – about 50% result in perinatal death.
4. Interviews identified mostly first and second delays, few third delays.

2.3.3 Ways to increase higher and more equitable coverage

1. Use local epidemiological profile.
2. Technical integration and combined delivery.
3. Community activities on care-seeking practices.
4. Special efforts to reach vulnerable sections and rural and urban poor.
5. Make the best use of every contact to deliver interventions.
6. Promote a new level of institutional coordination.
7. Establish new partnerships to ensure integration, focus, and participation.

2.3.4 New opportunities

1. Ensure that families and communities continue to support RCH–II where IMNCI works, and it is scaled up, referral improves, and EPI coverage increases.
2. Use communication efforts to make a breakthrough for routine immunization and child health in high mortality areas.
3. Sustain/participate in the large social mobilization network in Uttar Pradesh and widespread activities in Bihar, Madhya Pradesh, Orissa, and Rajasthan.
4. Build up community response in Assam, Jharkhand, Chhattisgarh and other at-risk states.
5. Adopt an FRU/partner – standardize and accreditate.

2.3.5 Risks involved

Geographic: Bihar, Uttar Pradesh, Western Madhya Pradesh, and Assam are the most likely areas where intensified programming is needed.
**Political leadership:** Due to elections, there is politicization of issues and lack of oversight in some states. There is a need for greater management of skills at the state level.

**Program oversight:** Demands will increase in 2006-07 due to the speed and scale of the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) program and routine immunization.

**Technical:** Slow detection of and response to outbreaks; ad-hoc, contingency planning; unaddressed systemic bottlenecks; swinging focus.

### 2.4 WHO India’s work in MNCH and its relationship to the Partnership

*Dr. Arvind Mathur, The World Health Organization (WHO), India*

Dr. Mathur shared WHO’s approaches and efforts to improve the existing system and what India in its mature program and evidence-based interventions can contribute globally to help achieve MDGs 4 and 5.

#### 2.4.1 Strategic priorities that WHO can contribute to in the MNCH area:

- Ensure skilled attendance at every birth.
- Develop service standards and operational and technical guidelines for MNCH interventions (continuum of care).
- Improve access to quality EmOC through availability of trained human resource.
- Provide newborn and child healthcare including IMNCI.
- Provide technical support in expanding safe abortion services.
- Make available quality services for RTI/STI.

WHO is working with several partners such as FOGSI, medical colleges, NIHFW, IMA, IPHA/IAPSM, NGOs, etc, on developing guidelines in several areas:

- Guidelines and a training package for ensuring Skilled Attendance at Birth.
- Introducing Maternal Death Reviews.
- Prevention, diagnosis and management of anaemia.
- Operationalizing emergency obstetric care.
- Expanding safe abortion services.
- Guidelines for prevention and management of RTI/STI.

Dr. Mathur felt that there was a lot of potential for partnerships to work in India under the GOI’s guidance.

Efforts made by WHO for newborn, child health and development:
• Adaptation of IMCI as IMNCI.
• Development of training materials for different levels of healthcare providers (pre and in-service).
• Alternate approaches through Distance Education Programme (IGNOU).
• Technical assistance for making IMNCI as cornerstone strategy for child health under RCH–II.
• Strengthening the availability of master trainers in the country and states.
• Planning exercise at the national- and state-level begun.
• Low osmolarity ORS launch for management of acute diarrhea in children.

Dr. Mathur shared a list of numerous partnership efforts made by WHO with GOI for improving the health system in India such as the National PIP for RCH–II, a facilitator’s guide for ASHA, and various other guidelines and training material.

2.4.2 Advocacy and partnership building efforts by WHO

• Making Pregnancy Safer “WHO Day 2005” and “Lives in Balance.”
• Launch of PMNCH in India and “Lives in Balance.”

Dr. Mathur also shared the experience of the knowledge management group at WHO and briefed the participants about the program called “Solutions Exchange” for MCH practitioners in India.

The secretariat of Solutions Exchange is WHO India, comprising 750 members from various groups: students, NGOs, research and academics, government counterparts, and UN and other multilateral and bilateral agencies.

It focuses on:
• Maternal & Child Health
• Nutrition
• Adolescent Health
• Health Systems
• Urban Health

Dr. Mathur briefed the participants about the system’s functioning in this program and the modes and timelines for feedback.

He shared an example where there have been e-discussions in this program, supported by the maternal and child health community, and wherein very good recommendations were given.
2.4.3 Role of community “Resource Group” in this program

- 30-50 “Development Influencers” in the field – government, apex organizations, NGOs, institutes/foundations, medical associations, and donor partners.
- Provides leadership to the community and monitors performance.
- Shapes the community’s profile – identifies broad “burning issues.”
- “Listens in” to learn about practical realities.

2.5 Building on success: prior civil society-government partnerships on MNH in India

Dr. Bulbul Sood, Centre for Development and Population Activities (CEDPA)/WRAI

“The White Ribbon Alliance for Safe Motherhood, India (WRAI) is working in partnership with civil society and GOI for maternal and neonatal health.” The salient features of WRAI are given below:

- WRAI was launched in 1999.
- The WRAI functions as an informal coalition, not registered, is open to all stakeholders, interested groups and individuals.
- Shared goals, collective identity, partnership, volunteerism, inclusiveness, open membership, and collaboration are among the most important guiding principles adopted by the membership.
- There are currently 76 organizations as WRAI members at the national level, with five state-level WRAs.

2.5.1 Goals of WRAI

- Raise awareness among citizens, international NGOs, national NGOs, and government of the need to ensure safe pregnancy and childbirth.
- Build alliance through inter-sectoral partnership with non-traditional groups – teachers, religious organizations, etc.
- Act as a catalyst for action to address prevention of maternal death.

2.5.2 Efforts of WRAI

- Launching campaigns.
- Sharing best practices.
- Advocating with the government.
- Launching the National Safe Motherhood Day 2004 and 2006.
- Advocating for change:
With the Ministry of Health and Family Welfare (MH&FW), WRAI works as an informal technical expert group on safe motherhood.

- Workshop with nurses compared WHO midwifery standards of practice to Indian nursing standards and verified major gaps in skills.
- Re-looks at the legalities of the assignment of life-saving skills to different levels of health workers.
- Issues paper on skilled attendance at birth.
- Participated in the Consensus Meeting held on Community-Level Skilled Birth Attendant (CLSBA).
- Helped the MH&FW to develop the curriculum for CLSBA.
- WRAI members participated in the GOI consultations for the RCH–II program.

- Developing Guidelines and Protocols for MCH. In 2004, WRAI was invited by the MH&FW to develop evidence-based guidelines and protocols for their essential package of maternal and child health services.

WRAI constituted a “core committee” with WRAI members to lead the process. This committee had clinical experts, representatives from multi-lateral and bi-lateral agencies, UN agencies, and national and international NGOs as members.

A small “technical group” with members from MH&FW, UNFPA, WHO India, UNICEF, practitioners, FOGSI, TNAI, and others was formed to give technical advice to this process.

**Documents prepared by WRAI as part of RCH–II:**

1. Guidelines for antenatal care and skilled attendance at birth for ANMs and LHVs.
2. Guidelines for pregnancy care and management of common obstetric complications by medical officers.
3. Guidelines for operationalization of a primary health center for providing 24-hour delivery and newborn care under RCH-II.

**ANMs/LHVs are now:**

1. Legally empowered to work as SBAs.
2. Permitted to administer certain life-saving drugs and perform certain life-saving interventions under clearly specified situations.

**WRAI has been working with MH&FW to develop a:**

1. Training package to operationalize the GOI’s guidelines for ante-natal care and skilled attendance at birth by ANMs and LHVs.
2. Facilitator’s guide for training of ANMs and LHVs.
3. Handbook for ANMs and LHVs to provide skilled attendance at birth.
4. Teaching aids.
5. Certification process, format of session plan.

**WRAI is supporting state governments in implementing guidelines on:**
1. State-wide dissemination.
2. Orientation and training through workshops.
3. Dissemination plan for state at all levels.
4. Simplified guidelines for grassroot health workers.
5. Pilot in one block/district.

### 2.6 Government of India priorities for operationalizing policy and actions on maternal, newborn and child health

*Dr. Manchanda, Ministry of Health and Family Welfare, Government of India*

Dr. Manchanda began with how the MNCH program has historically worked with partners:
- In 1978, EPI was launched. The main partners were UNICEF and WHO.
- In 1998, UIP was launched, with UNICEF and WHO as partners.
- In the Child Survival and Safe Motherhood Program, the key partners were the World Bank, UNICEF, and WHO.
- As MHFW approached RCH–II, the World Bank, DFID and UNFPA became an integral part of this. Today, MNCH is a part of RCH–II.

#### 2.6.1 India’s challenge

- 27 million births.
- 1.1 million die before 4 weeks of age.
- 1.7 million die before completing 1 year.
- 2.2 million die before completing 5 years.
- >110,000 mothers die during pregnancy and childbirth.

IMNCI implementation has greatly helped in accelerating the decline of neo-natal mortality and reducing maternal mortality by identifying post-natal complications among mothers.

#### 2.6.2 Key Strategies in RCH-II

**Maternal health:**
1. Skilled attendance at birth (SAB) – community and institutions.
2. Promote institutional deliveries – *Janani Suraksha Yojana*.
4. Referral systems.
5. Safe abortion services.

**Child health:**

1. Sustain high immunization coverage.
2. Essential newborn care – including care at birth.
3. IMNCI.
4. Exclusive breast feeding and timely complimentary feeding.
5. Promotion of ORT.
6. Vitamin A supplementation.

### 2.6.3 Areas of critical focus

1. Skilled attendance at birth: facility and home level.
3. Strengthening facilities and improving access.
4. Equity.
5. Quality Improvement.

### 2.6.4 Skilled attendance at birth

1. ANMs and LHVs have now been legally permitted to administer certain life saving drugs and perform certain life saving interventions under clearly specified situations – in the community.
2. A large training program is being undertaken.
3. Strengthen UG education.
4. Strengthen facilities for SAB.

### 2.6.5 SAB at home/facility level

1. Permission to use drugs for prevention of PPH.
2. Permission to use drugs in emergency situations before referral.
3. Permission to undertake basic procedures at community level in emergency situations.
4. A large training program is being undertaken.
5. Strengthen UG education.
6. Strengthen facilities for SAB.

UNICEF recommends the following based on a pilot in seven districts:

1. Full-fledged implementation of IMNCI.
2. Training of all district staff such as AWW, health workers, doctors, etc.

These are valuable insights and experiences from UNICEF’s implementation of IMNCI in the remaining districts of the country.
According to Dr Manchanda, Tamil Nadu will be permitted to implement IMNCI in two parts instead as a whole: first, health workers on home visits will be trained under IMNCI, followed by training for the rest of the staff. Partners can take it up in smaller areas and look at how we can do things faster without diluting the skills and quality of training.

2.6.6 NRHM

ASHA is our hope for home visits as part of the team with AWW, ANM, and others. The focus will be on strengthening facility and improving access. CHC is being strengthened.

On human resources, states have been permitted to have additional manpower in terms of doctors, nurses or health workers as contractual staff for which funding will be available under NRH. Each sub-center in India is given Rs 10,000 as a flexible fund to be used in consultation with the local panchayat for activities of the sub-center only. Mobility of the health worker and transportation for pregnant women will also be included.

2.6.7 Interventions by GOI

**Strengthening facility/improving access**

1. Strengthening infrastructure – IPHS.
2. Improving availability of human resource.
3. Untied funds at sub-centers.
4. Emphasizing that *Rogi Kalyan Samitis* (private welfare committees) should be there.
5. 50% of PHCs to be operationalized as 24-hour functioning health facilities for deliveries and basic obstetric and child healthcare.
6. 2000 CHCs to be operationalized as FRUs for EmOC and Em child health services.

**Improving Access/Equity Issues**

1. *Janani Suraksha Yojana* for low income families (BPL).
2. Public-Private partnership.
3. NGO involvement for referrals.
4. Inter-sectoral convergence.

Physical infrastructure for First Referral Units (FRUs) is now available. There is no problem of drugs but of storing blood, and the law regarding this has been amended. Now FRU can have a blood storage area, and guidelines on how to do this have been issued by the GOI.
2.6.8 Target – RCH–II is to operationalize

2000 FRUs:
1. Provision of blood storage at FRUs.
2. Training for MBBS doctors in the following areas:
   i. Life-saving anesthetic skills for emergency obstetric care.
   ii. Performing a caesarean section.

Some states have started offering graduate doctors a 4-5-month training on the basics of giving anesthesia when necessary at an FRU. A 16-week course has also been developed in consultation with FOGSI for skills enhancement, including performing a caesarean section at an FRU.

The GOI plans adopt the above procedure to meet the shortage of specialists and requests partners to come forward and provide additional inputs. Major help is needed in testing various methods/models. While testing models, it is important to check that they are replicable and sustainable where they are being implemented.

GOI is committed to a larger budgetary allocation in the health sector as listed below:

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<th>USD (Bn)</th>
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<td>RCH–I (1997-2005)</td>
<td>5,300</td>
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<td>RCH–II (2005-2010)</td>
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<td>NRHM (2005-2012)</td>
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3.0 Group discussion

All participants at the consultation were divided into three groups, and each group was given a topic to discuss. The viewpoints of each group are listed below.

3.1 Opportunities for convergence among maternal, newborn and child health interventions

The group felt that MNCH was demonstrating convergence and a broader and comprehensive way of implementing MCH. The following issues need to be addressed:

1. Issue prioritization: Though a comprehensive healthcare and integrated approach is necessary, yet in a life-cycle approach, the focus should be on:
i. Ante-natal care.
ii. Post-natal care.
iii. Safe and unsafe abortions.
iv. Neo-natal care.
v. Adolescent health.

2. Convergence at policy and program level: There should be convergence of policies (e.g., on population, health, and national) through the various forums available such as the state NGO committee, the gram sabha, etc.

3. Perspective building and capacity building of various stakeholders and functionaries involved in MNCH, including the government/NGOs/academics, and other professional bodies, including donor agencies and international organizations.

4. IMNCI-related home visits should be utilized for maternal and post-partum care and breast-feeding counseling.

5. Orientation should be given to SBAs, and an essential newborn care component should be added to this training. Opportunities at the district level, that is the District Project Implementation Plan, should be integrated with NRHM and the PIP plans.

6. Review and convergence of existing modules such as adolescent health, and maternal and newborn care.

7. Documentation of Best Practices: Since a number of organizations are involved, the Best Practices must be adopted and mainstreamed in various states. Integrated and comprehensive documentation with adoption is important.

### 3.2 Opportunities for civil society networking and links to government on MNCH in India

This group made the following observations:

1. The framework set by NRHM and RCH-II for maternal and child health at both the state and district level to promote the continuum of care should be accepted. NRHM is scheduled till 2012, and all groups need to see where they can pitch in to promote the framework that resulted from various consultations among the groups.

2. Role of partnership with civil society groups: Civil society should familiarize itself with NRHM and RCH–II, and focus on how existing guidelines and tools can be disseminated instead of creating new ones. One way of sharing is Solutions Exchange.

3. We have expertise in implementing small programs, but the aim should be to transform ourselves from implementing vertical programs to making a program that spans the whole continuum of child to maternal health.

The following examples should be seen as focus points:

i. How we rationalize the training system.
ii. How to work in partnership with the government – can we adopt an FRU? Where does the civil society come in, and what can we do to support governments?

iii. How to work with villages and districts to develop their health plans.

iv. Taking similar messages in health campaigns.

v. There are a number of government programs. How do we get communities in those places to demand for services?

vi. How to educate society about programs such as Janani/Suraksha.

There are currently more challenges with the civil society than solutions.

3.3 Opportunities for private sector networking and links to government on MNCH in India

This group felt that when we talk of the private sector and health providers, we must recognize that there exists a class of rural medical practitioners, midwives, and quacks. We must know where this class figures in the larger plan of action in the national implementation and MNCH plans. Under NRHM, district action-plans are being prepared and the GOI has formed a committee to map the presence of these practitioners at the ground level, who they are, and what they are providing. This is a solution. This will help us in assessing how they can fit into our larger plan of action.

The group made the following recommendations:

1. Recognize the presence of local health practitioners and see how best they can be incorporated in the overall plan.

2. Public–Private partnership (PPP) is a buzz word today. Some models are working in some states whereas in others they are not. It needs to be found out whether there is a possibility of documenting models that have worked. For example, in Tamil Nadu and Gujarat. The learning from the working models must be documented and disseminated, besides finding out ways to do PPP on a wider scale.

3. How to talk about PPP in a more collective and combined manner. There are a number of Government Orders on this, but how do we build into a system which talks about not as contracting/outsourcing but partnership where accountability of both sides is clear from the beginning?

4. ANMs, medical officers, LHVVs, staff nurses should be trained in life saving skills. Existing private nursing institutions, ANM training schools and FOGSI could look at training and support supervision. Look for examples of successful models.

5. There should be adequate communication on how to build a platform where sharing of traditional knowledge on maternal and child health is brought together to a new scientific understanding.
6. Caution must be exercised on how to deal with over-medicalization; how to deal with high rates of c-section; how to balance institutional deliveries and skilled care at home and in institutions.

7. Examples where such partnerships have worked at the community level must be studied, with ASHA being a link between the sectors.

8. Involve for-profit institutions and use their expertise.

9. Accreditation – how private institutions can be regulated for training. How to involve them? What kind of regulatory system to use and whether there is a regulatory body at all?

10. Associations such as FOGSI/NNF/NIM have been involved in the recent past. FOGSI has helped the GOI to design a management structure under RCH–II and NRHM. Such bodies should be brought closer and everyone work in a more coordinated manner.

### 4.0 Next steps/Closing remarks

**Dr. Aparajita Gogoi**

The partnership in India will take the immediate step of organizing visits by key partners to India to discuss a work-plan for India, establish a coordination mechanism, and agree on targets, indicators and monitoring processes in India.

It is hoped the partnership would encourage wide participation including offering the civil society a platform to voice in the partnership.

It is evident from the presentations that a lot of work has been done in India and building new ones are not necessary. But, there is a need to strengthen and progress. Challenges need to be looked at and all efforts linked. There is a need to think how to create a common platform and connect all the things that are happening at the community level to global activities.

There is a need to work together under the umbrella of NRHM and RCH–II; and it is important to understand how to translate the health policies on reproductive, maternal, child and neonatal into action on ground that will actually save the lives of mothers, children, and newborns in this country.
Annex 1

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