FINAL REPORT

Adaptive Evaluation of State Capability Enhancement Project for Health System

January 2024

POPULATION COUNCIL INSTITUTE
Ideas. Evidence. Impact.

TABLE OF CONTENTS

KEY FINDINGS

- Consistent understanding of Rescue Mission and the salience of maternal and child health as a State priority emerged across the health system. Departments of Social Welfare and Rural Development, whose mandate includes Rescue Mission, also reflect commitment to improving maternal and child health in Meghalaya.
- Emphasis on decentralized leadership is visible, particularly from District to Block to Facility, with state intention to foster leadership. Approach includes cultivating Medical Officers as local leaders who can problem-solve locally as well as building the leadership of community institutions such as VHCs. Medical Officers display deep sense of purpose and motivation which appears to be intrinsic, but with specific opportunities to build on satisfaction.
- Meetings across health system levels appear to be effective means of collaboration and accountability, and some catalyse further actions. However, frequency, regularity and strength of participation in meetings vary widely.
- SCEP principles have taken root across facilities, as measured by the SCEP index, and reflected in regular meetings and intersectoral collaboration. Medical Officers with intrinsic motivation demonstrated several cases of innovative problem-solving; such approaches needs to be shared across other facilities.
- Data collected through the State's MOTHER app appears to be used for monitoring, but there is limited analysis or use that translates into action plans at the facility level.
- Community engagement through intersectoral collaboration emerged as a welcome contribution to reaching women, especially through the rural livelihoods program.
- Political supportability for maternal health is reflected clearly in the Chief Minister's Safe Motherhood Scheme (CM-SMS) and increasingly, at the grassroots level in the form of Village Health Councils. This support needs to be extended to other systemic challenges that affect health.
- While CM-SMS has made large contributions, challenges remain. Transit home uptake is low across the state while flexibility in funding for transportation is widely appreciated.
- Village Health Councils, though nascent, reflect high expectations amongst stakeholders as a potential path towards true decentralization.
- Shortage of Human Resources for Health and poor facility infrastructure are systemic challenges to achieving Rescue Mission Goals

KEY PRIORITIES:

- Strengthened and sustained inputs to Medical Officers and Health Facilities on the State Capabilities Enhancement approach to encourage problem-solving and support them with practical job aides to manage facilities with an SCEP approach.
- Extend intersectoral collaboration at district-level to natural areas of convergence, including other health issues.
- Build on sector meetings as key platform for collaboration, planning and monitoring with stronger use of data
- Strengthened MO inputs can include support for community engagement and data entry and analysis to promote use.
- Address challenges specific to frontline workers, related to transportation, incentives and workload
- Closely track expansion and development of VHCs to identify capacity strengthening needs and identify areas for cross-learning.
- Integrate improved measurement and monitoring systems starting with bottom-up utilisation. Adapting the SCEP scoring index and identifying simple data analysis tools for use at the facility and community level may promote greater utilisation and value of routine data collection.

LIST OF ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BDO	Block Development Officer
BPM	Block Programme Manager
CDPO	Child Development Project Officer
CGHA	Community Gender and Health Activist
CHC	Community Health Centre
CM-SMS	Chief Minister's Safe Motherhood Scheme
DCL	Decentralized Catalytic Leadership
DMHO	District Medical & Health Officer
FGD	Focus Group Discussion
HBNC	Home Based Newborn Care
ICDS	Integrated Child Development Scheme
ID	Institutional deliveries
IMR	Infant Mortality Ratio
MAM	Moderate Acute Malnutrition
MHIS	Megha Health Insurance Scheme
MHSSP	Meghalaya Health Systems Strengthening Project
MLHP	Mid Level Health Provider
MMR	Maternal Mortality Ratio
MO	Medical Officer
MOTHER	Measurable Outcomes in Transforming Health sector through a holistic approach with focus on women's EmpoweRment
MSRLS	Meghalaya State Rural Livelihoods Society
NGO	Non Government Organization
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
NRLM	National Rural Livelihoods Mission
PDIA	Problem Driven Iterative Approach
PHC	Primary Health Centre
PM ABHIM	Pradhan Mantri-Ayushman Bharat Health Infrastructure Mission
POSHAN	Prime Minister's Overarching Scheme for Holistic Nutrition
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SCEP	State Capabilities Enhancement Project
SHG	Self Help Group
ToC	Theory of Change
TBA	Traditional Birth Attendant
VHC	Village Health Council
VHND	Village Health Nutrition Day
VHSNC	Village Health Sanitation Nutrition Committee
VO	Village Organization
VRF	Vulnerability Reduction Fund

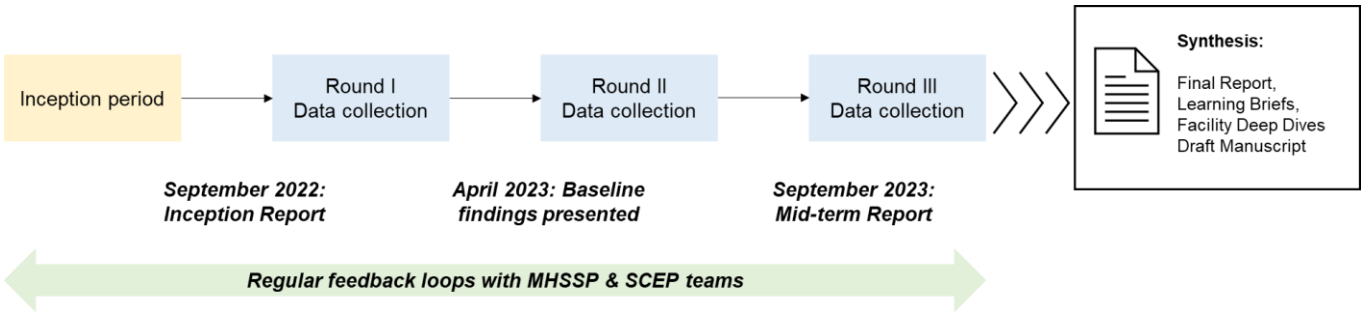
LIST OF FIGURES, TABLES & BOXES

I. STUDY OVERVIEW

The Government of Meghalaya has committed to accelerating improvements in maternal and child health through strengthening health systems and overall state capabilities. The Department of Health & Family Welfare, Government of Meghalaya, is implementing the Meghalaya Health Systems Strengthening Project (MHSSP), with support from the World Bank. The MHSSP is designed to enhance health system performance and service quality through strategic investments and iterative learning processes in Meghalaya.

Since June 2022, the Population Council Institute was engaged to examine how Meghalaya's multi-sectoral, state capabilities enhancement approach through its flagship maternal health program, Rescue Mission, is implemented to improve processes towards achieving maternal health targets. The adaptive evaluation intended to support concurrent learning for implementers and policymakers and identify enablers and barriers to improve implementation and inform cross-sectoral learning. The 18-month study period was from June 2022 to December 2023.

Figure 1: Overview of timeline and research processes



Study methods

The study aimed to track the implementation of Meghalaya's multi-sectoral efforts to improve maternal health, with a focus on informing implementers and policymakers. The evaluation design was grounded in basic principles of health systems and policy research and implementation research, with with three main objectives: (i) examine intervention content and implementation; (ii) identify barriers and enablers to implementation processes; and (iii) identify contextual factors that influence implementation outcomes.

Research questions (detailed in Table 1) spanned a range of implementation and process-related questions. The adaptive evaluation employed a longitudinal, mixed-methods approach. We traced processes at multiple levels (state, district, block, facilities, and

communities) over a period of one year, with regular feedback loops with stakeholders. The study collected a mix of primary qualitative and quantitative data and drew from secondary information from guidelines and relevant reports. Quantitative indicators (institutional delivery and maternal deaths) were tracked across all 11 districts of Meghalaya, using the MOTHER app (Measurable Outcomes in Transforming Health sector through a holistic approach with focus on women's EmpoweRment). The in-depth qualitative process tracking consisted of district, facility and community-level interviews and meeting observations, conducted in a sample of facilities across the state. Table 1 provides an overview of types of data collected to provide insight into research questions.

Table 1: Data source overview

Domain	Research Question	*Interviews*	*Focus Group Discussions (FGDs)*	*Meeting Observations*	*Guidelines or Reports*	*MOTHER app Data*
Intervention content/uptake	What was implemented and where, by whom?	✓		✓	✓	
Context	What varied across sites? Why?	✓		✓		✓
Implementation Processes	Enablers and barriers to intervention; what worked, what did not?	✓	✓	✓		
Process Changes	What changes over time?	✓	✓	✓		✓

Sampling strategy

We had selected a sample of 30 Primary Health Centres (PHCs) and Community Health Centres (CHCs) from 6 districts: North Garo hills, West Garo hills, West Jaintia hills, Ri Bhoi, East Khasi Hills, South West Khasi Hills. These six districts were chosen purposively to ensure geographic diversity *and* logistical convenience for repeated interviews. Within the six districts, we used Stratified Probability Proportional to Size sampling to select 30 facilities (PHC and CHC), using institutional delivery as our primary indicator of interest. [Annexure 1] In April 2023, we updated the sample in consultation with the MHSSP team. [Annexure 2] Seven facilities across the six districts which were part of the first round of data collection were replaced due to eligibility criteria (urban PHC, Non-government organization PHC and Civil Hospital conversion).

Data Collection

Data collection was initiated in mid-November 2022 across 6 districts – East Khasi Hills, South West Khasi Hills, Ri Bhoi, West Jaintia Hills, West Garo Hills and North Garo Hills – covering 30 facilities.

Table 2: Data collection overview

Levels	Department/Participant	Round I	Round II	Round III
State	Health and Family Welfare, State Rural Livelihood Society, Social Welfare and State Capability Enhancement Project	4		
District	Deputy Commissioner, Medical & Health Officer, Maternal & Child Health Officer, District Community Process Coordinator, District Programme Manager (NHM/National Health Mission), District Programme Officer (ICDS/Integrated Child Development Scheme), District Mission Manager (NRLM/National Rural Livelihoods Mission)	16		
Block	Block Programme Managers (NHM, NRLM), Child Development Project Officer (ICDS)	35		
Facility	MO, MO (AYUSH/Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy), Staff Nurse, ANM/Auxiliary Nurse Midwife	56	43	2
Frontline cadres	ASHA (Accredited Social Health Activist)	27		
	CGHAs (Community Gender & Health Activists)		11	
Community	Women and VHCs (Village Health Councils) - FGDs	10		
Total IDIs and FGDs		***194 IDIs, 10 FGDs***		

Observations	**November 2022 – November 2023**
All District and State Review Meetings*	27
All Sector Meetings*	66
State Workshops	2
Field visits by State Capabilities Enhancement Project (SCEP) and MHSSP team	5
Field observation of health providers	5
VHC meetings	1
Total	***106***
Note: Annexure 3 includes a map of meetings observed by the study team	

Throughout data collection, our team engaged closely with MHSSP and other government agencies for feedback on tools, findings and data collection activities, to ensure an adaptive approach that provided insight into implementation and potential changes required. We

worked with MHSSP to observe field visits to districts and communities as well as accompanying a maternal death review audit team.

The Population Council Institute team was led by Dr Sapna Desai, with a team comprised of: Dr Sowmya Ramesh (Co-Principal Investigator), Mr Ankit Nanda (Project Coordinator), Ms Sharmada Sivaram (Qualitative Researcher) and Ms Patricia Dohtdong (Research Investigator/State Coordinator). Field investigators were: Ms Deiinesha Marwein (Khasi Hills region); Ms Dorafiona Bamon (Jaintia Hills region) and Mr Witna Marak (Garo Hills region).

This Report

We previously submitted an Inception Report, Mid-term Findings Report and synthesis presentations to MHSSP. The Inception Report details the study methodology and approach, while the Mid-term Report details insights from data collection over one year.

This Final Report includes: an overview of key interventions; an updated Theory of Change; findings focussed on process analyses and adoption of the State Capabilities Enhancement Project (SCEP) approach; and priorities for action. We include linked outputs that synthesise findings in short briefs on: measuring and tracking SCEP adoption across facilities; institutionalizing intersectoral convergence; motivation amongst Medical Officers (MOs); community engagement for health; a deep dive on sector meetings and action planning (Annexures 4a-e); along with a sector meeting checklist (Annexure 5) and five in-depth facility reports (Annexure 6).

II. RESCUE MISSION AND STATE CAPABILITY ENHANCEMENT PROJECT: KEY INITIATIVES

The Rescue Mission operates across all levels of the health system, from State policy to community engagement, through regular review meetings, use of data for feedback and inter-departmental collaboration. We mapped key initiatives through document review, stakeholder inputs at each level and field visits.

We observed that the Rescue Mission's key innovation, drawing on the SCEP, is a focus on problem-solving through **building local leadership** capability and a sense of purpose within the health system and through intersectoral collaboration. Interventions address the "supply" of services **within and beyond** the health sector along with community engagement through different channels. An underlying focus on **political support**, both through grassroots mobilization and commitment from political leaders, extends beyond government services. In a departure from demand-driven maternal health interventions, this approach aims to change the approach to how problems are solved, to empower motivated/driven decision-makers to address local issues with locally developed solutions. The Rescue Mission employs several mechanisms to improve accountability and decision-making to improve maternal health. These include review meetings held at the district-, block- and facility-levels, a key aspect of which is inter-department collaboration between the National Health Mission, Social Welfare (Integrated Child and Development Services, ICDS) and Meghalaya State Rural Livelihoods Society (MSRLS).

Data initiatives

The MOTHER app, locally referred to as Sangrah app, is an application used to collect individual-level data on pregnant women in the State. This app is meant to integrate real-time data from the field by ASHAs and ANMs to MOs and other health officials across governance levels on a dashboard. The app was developed to aid in timely monitoring the health of expectant mothers as earlier methods of analog/manual data logging was sometimes inconsistent and not available regularly enough. This app further allows ASHAs, ANMs and MOs to view pending follow-ups for every pregnant woman as well as allowing them to view critical details such as days since last ante natal care (ANC), home based newborn care (HBNC) visit due for a newborn, vaccinations due, etc.

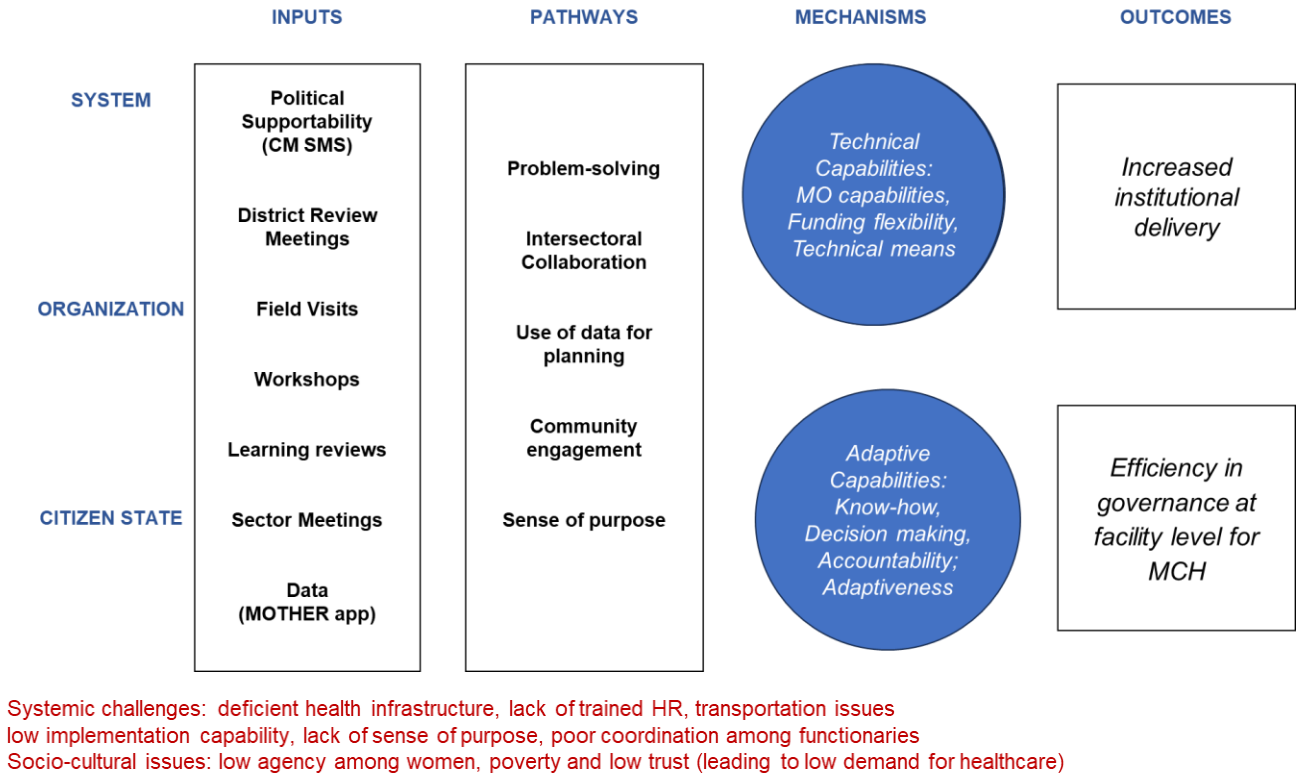
Community-based initiatives

Village Health Councils (VHCs), established by the Government of Meghalaya in 2022, are envisioned as the nodal community institution to mobilise action on health and nutrition and serve as a link between the health system and communities. They have replaced previous Village Health, Sanitation and Nutrition Committees (VHSNCs), which have been widely reported as ineffective. VHCs are viewed cross-sector initiative of the State's NHM to implement the State Health Policy at the community level. VHCs were established to build community ownership over health, identified to be missing from VHSNCs – and in an important distinction, engage with male leaders to promote their involvement in health. VHCs comprise of elected, rather than appointed, officials, including leadership from Meghalaya's traditional institutions and village organization presidents from women's self-help groups. Their mandate includes anchoring programmes geared towards human development and health, with the specific aim to formally engage communities in articulating their health needs. In addition, ASHAs have been encouraged to intensify efforts at conducting home visits to those mothers who are out of reach of the facilities and have refused services such as ANCs and immunization in the past. In addition, members of local Self Help Groups/SHGs (particularly the CGHA cadre) are also asked to support the efforts of health staff/workers in reaching pregnant women at their houses.

Theory of Change

During the inception period, we had developed a preliminary Theory of Change (ToC) which drew on the six pillars of the SCEP as pathways of the Rescue Mission to improve maternal and child health at the population level. The ToC also noted systemic challenges related to health infrastructure, human resources, transportation issues and implementation barriers. We noted socio-cultural factors that affect the influence of process changes on long term outcomes including women's agency, trust in health care, and norms regarding health care services related to reproductive health and family planning. Over the course of two rounds of data collection, observations, and discussions with the SCEP team, we revised the Theory of Change to better reflect the observed inputs, pathways and mechanisms that are envisioned to lead to increased institutional delivery and efficiency in governance at the facility level for maternal and child health.

Figure 2: Updated Theory of Change



Building on our observations of Rescue Mission processes and discussions with the SCEP team, we outlined inputs which overlap at the System, Organization (Facility) and Citizen-State (Community) levels: political supportability, accountability platforms such as District Review Meetings, Field Visits, Sector Meetings and learning platforms such as Workshops (SCEP, Problem Driven Iterative Approach/PDIA, Decentralized Catalytic Leadership/DCL), Learning Reviews and the MOTHER app. We see these leading into pathways of local problem-solving; intersectoral collaboration between Health, Social Welfare and Rural Development; use of data for planning; engaging with communities; and building a sense of purpose. These pathways trigger two broad and complementary mechanisms for outcomes: technical capabilities (skills, use of technical resources etc.) and adaptive capabilities, the latter reflecting principles of leadership, adaptiveness, and accountability.

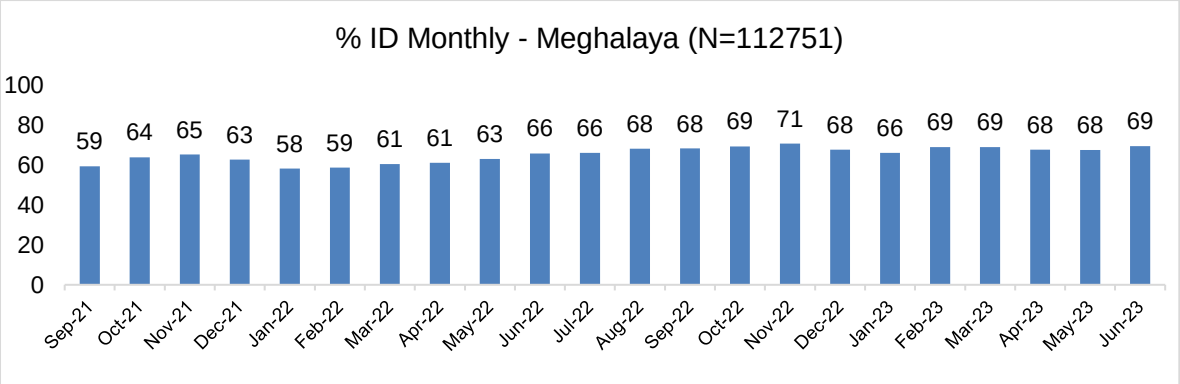
III. SYNTHESIS OF FINDINGS

This report presents a synthesis of our findings in three parts. First, we summarise status of institutional delivery and changes over the study period. Second, we synthesize improvements, enablers and barriers observed over the study period organised by SCEP pillars/pathways from the ToC. Lastly, we present analyses of how MOs/facilities have adopted the SCEP approach. This report builds on the last submission to MHSSP, which provided in-depth findings, and focuses on implications for the future.

A. Institutional Delivery

Over the period of 22 months from September 2021 to June 2023, 1,12,751 women had reported deliveries in Meghalaya. The State had an institutional delivery (ID) rate of 65.4% over this period. The ID rate for the State steadily increased from September 2021 (59%) to June 2023 (69%) with a slight decline in the first quarter of 2022. In this period, districts in the Garo region had an ID rate at 67% which was slightly higher than districts Jaintia (65.2%) and Khasi regions (64.6%). However, ID rates from fourth quarter of 2021 to second quarter of 2023 increased for Jaintia (60% to 71%) and Khasi (62% to 69%) regions and declined for Garo (71% to 66%) region.

Figure 3: Monthly Institutional delivery from Sep 21-Jun 23 in Meghalaya

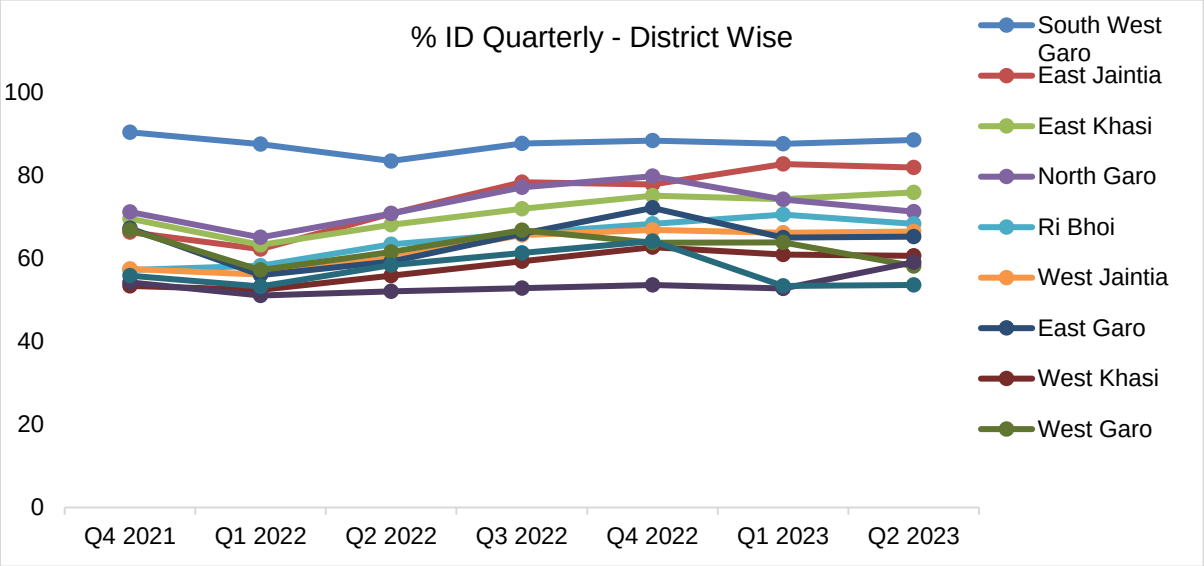


a. <u>District variation</u>

South West Garo Hills (88%) had the highest ID rate followed by East Jaintia Hills (74%) whereas South Garo Hills (54%), South West Khasi Hills (57%) and West Khasi Hills (57%) districts had comparatively lower institutional delivery rates. ID rates showed an uptrend for multiple districts including East Jaintia Hills, Ri Bhoi, East Khasi Hills, and West Khasi Hills. East Jaintia Hills district showed the strongest positive uptrend in institutional deliveries with an increase from 66% in fourth quarter of 2021 to 82% in second quarter of 2023. South

West Garo Hills district consistently had the highest ID rates. Institutional delivery rates did not show consistent improvement for South Garo Hills, West Garo Hills, and South West Khasi Hills.

Figure 4: Quarterly Institutional delivery from Q4 2021 to Q2 2023 for 11 districts in Meghalaya



b. <u>Institutional delivery across facilities</u>

Institutional delivery across the 30 sampled facilities varied considerably over the period of 22 months from September 2021 to June 2023. Gabil PHC (100%), Laitkynsew PHC (95%), Laskein CHC (92%) were among the facilities with highest institutional deliveries. Khonjoy PHC (18%), Dadenggre CHC (31%) and Namdong PHC (32%) were among the facilities with low institutional deliveries included over this period. 12 out of the 30 sampled facilities had higher institutional deliveries than the state ID rate of 65.4% in the period.

As the overall ID rate of the state increased over time, most facilities also showed an increase in institutional delivery. The chart 5 below highlights three facilities namely Nangbah PHC (65% to 81%) in West Jaintia Hills, Jongksha PHC (39% to 52%) in East Khasi HillS, and Dadenggre CHC (25% to 45%) in West Garo Hills in which ID rate increased over time. The following chart 6 highlights two facilities Selsella CHC (56% to 40%) and Purakhasia PHC (49% to 35%) in West Garo Hills which showed a decline in institutional delivery rate in this period.

Figure 5: Quarterly Institutional delivery from Q4 2021 to Q2 2023 for three facilities

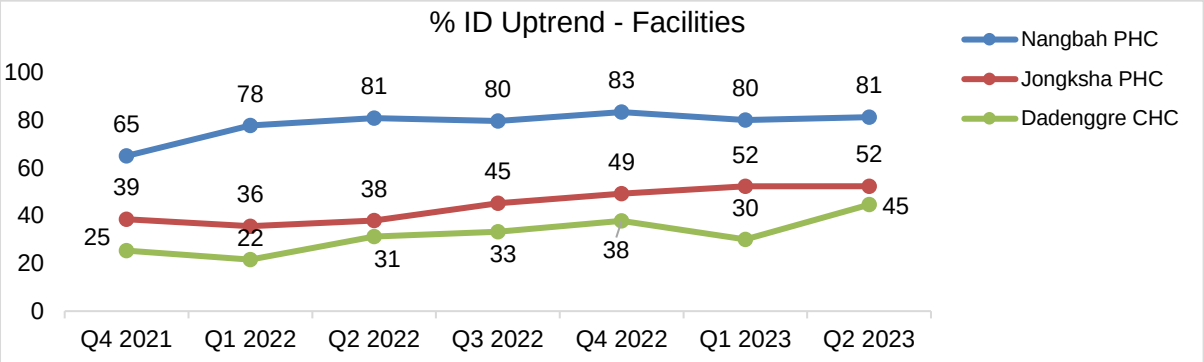
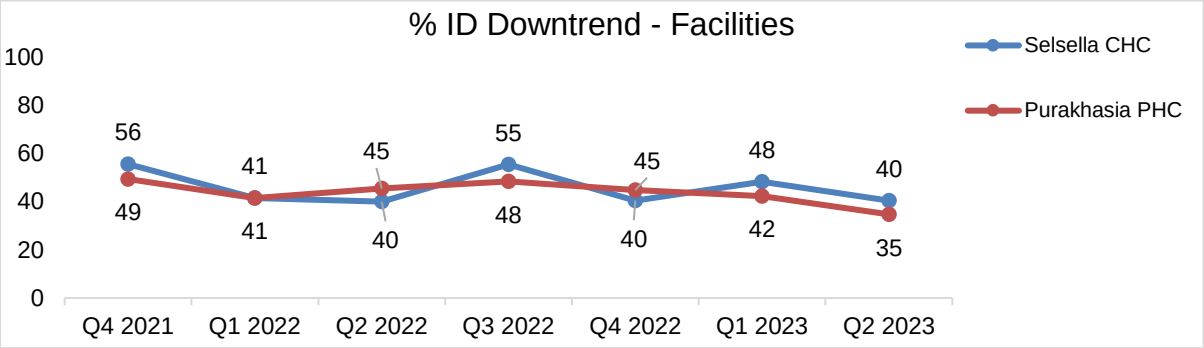


Figure 6: Quarterly Institutional delivery from Q4 2021 to Q2 2023 for two facilities



Multiple facilities showed wide variation in their institutional delivery rates across months: Manikganj PHC, Sualmari PHC and Resubelpara CHC in North Garo Hills, Khatarshnong PHC and Laitkynsew PHC in East Khasi Hills and Khonjoy PHC in South West Khasi Hills. A common factor among all these facilities is the low number of total deliveries in their catchment area and a small change in in absolute numbers, which resulted in seemingly large changes in delivery rates. For Manikganj PHC, in Feb-2023, 2 out of 5 women had institutional delivery, resulting in 40% ID rate whereas in Jun-2023, all 3 women had institutional deliveries resulting in a 100% ID rate. For Sualmari PHC in Aug-22, 3 out of 9 women had institutional deliveries resulting in 33% ID rate whereas in Nov-22, 7 out of 8 women delivered in an institution which resulted in an ID rate of 88%. Thus, variations in ID reflects a small number of deliveries in each of these catchment areas.

Table 3: Facilities with wide variation in institutional delivery rates

Facilities	District	Total Deliveries in catchment area (Sep21-Jun23)	Average deliveries per month	Highest ID% in a month	Lowest ID% in a month
Khatarshnong PHC	East Khasi Hills	239	11	100%	8%
Laitkynsew PHC	East Khasi Hills	116	5	100%	0%
Khonjoy PHC	South West Khasi Hills	139	6	100%	0%
Sualmari PHC	North Garo Hills	281	13	94%	17%
Manikganj PHC	North Garo Hills	94	4	100%	40%
Resubelpara CHC	North Garo Hills	242	11	100%	0%

B. Process changes

This section summarizes findings across the SCEP pillars/pathways in the ToC [local leadership; accountability and agency; information and data; community engagement; political supportability; and intersectoral collaboration] building on the mid-term report's detailed findings.

a. Local leadership through problem-solving

The SCEP approach introduced decentralized catalytic leadership within the Rescue Mission. The emphasis on decentralization, flexible and autonomous decision-making intended to support locally identified or tailored solutions for local problems. The case for decentralization stemmed from the recognition that Districts, and by extension Deputy Commissioners, have several responsibilities and therefore strengthening Block level leadership became critical. The approach went from 11 districts to 40 blocks: "*strengthening MOs, giving them authority, again and again talking to them… otherwise the government it only functions at the top level"* - State official.

We observed local ownership of the Rescue Mission across departments and governance levels. Participants often described Rescue Mission as being about saving or "rescuing" the lives of women and children, with a particular focus on reducing maternal and infant deaths and ensuring women's wellbeing and uneventful pregnancies. Some others also reflected on improvements in indicators such as institutional deliveries and routine immunization. Others, including those outside the Health department, perceived the Rescue Mission to mean expanded outreach to communities, prioritizing high risk pregnant women, intersectoral meetings and an emphasis on accountability for maternal and child health.

We also observed increasing decentralization from the district level to the block- and facility-levels, with a stated intention to foster leadership locally. This approach emphasizes on cultivating MOs as the leaders of their facility and areas, who have the capacity to problem-solve locally, while building the leadership of community institutions such as VHCs. Some participants admitted being initially confused about breaking hierarchy but continued to slowly push for decentralization to the grassroots level.

At the facility-level, we observed that MOs, by and large, took their own decisions on task delegation, supervision of staff and day-to-day functioning of the facility. Some MOs reported being able to take decisions on their own for minor infrastructure-related issues such as minor repairs or the purchase of low-cost equipment. For clinical and outreach programmes,

decision-making often appeared to be a team effort at health facilities. For instance, ANMs develop micro-plans which MOs sign off on, whereas for larger purchases and actions, MOs defer to the Block- or District-level decision-makers. In NGO-run facilities, day-to-day functions are largely independent while following larger government guidelines. Block-level participants felt they were unable to take some decisions related to basic infrastructure without deferring to the district. In contrast, under the NRLM, grassroots level leadership and ownership appears to lie with the Village Organization (VO). *"In our understanding, if we give them [VOs] the power, they own the programme*."- District official, NRLM. Participants from Social Welfare felt that their department had always had a decentralization approach.

Overall, participants associated Rescue Mission with flexibility which aids local-level problem solving: *"But now with Rescue Mission the flexibility is there. We can take the money and earlier it was unsure if the fund will be there."* – District official, NHM. For instance, some participants noted that community members were either unaware of the transportation services available through the Chief Minister's Safe Motherhood Scheme (CM-SMS) or were not keen on online reimbursement as they had little faith in such mechanisms and would prefer cash reimbursement. Flexibility in spending funds on arranging transportation has led to local solutions for local problems such as hiring bikes for ANMs to reach communities in an area with very poor roads. There were also reports of instances where the flexibility has resulted in arranging transport for children to Nutrition Rehabilitation Centre (NRCs) for checkups. In hard-to-reach areas, community members carried pregnant women and children on their backs to the facilities and were remunerated under the CM-SMS. Lastly, monetary support to ANMs through the CM-SMS was well-appreciated, as this has reduced their out-of-pocket expenses on community outreach and home visits.

Box 1: Motivation amongst Medical Officers [Annexure 4c]

A key area of focus in the SCEP approach is building a sense of purpose and motivation amongst the workforce which can potentially transform public service delivery. MOs interviewed in the evaluation appeared to draw their motivation from serving the community and treating patients to the best of their ability. They found encouragement from positive feedback from patients and the community's trust. Some MOs noted that it was their staff who motivated them; teamwork with extra efforts in order to complete tasks, reach targets and provide exceptional care tirelessly were appreciated. MOs also appeared to take independent decisions on task delegation, day-to-day functioning of the facility as well as minor infrastructure-related issues. However, most MOs perceived not having the required finances or human resources to implement actions for tackling bigger issues.

A key source of *de*motivation that many MOs identified was shortage of human resources. Inadequate staff, on-call nature of their work, and administrative responsibilities meant they constantly felt overworked. Many MOs also noted facing challenges regarding data monitoring and reporting including community resistance to government programmes, requests for reporting in multiple formats with tight deadlines, and poor network connectivity.

Many MOs also highlighted poor facility infrastructure, including poor living and working conditions, as sources of demotivation. Erratic or absent electricity and water supply in some villages impacted service delivery and facility operations. Some MOs also felt discouraged when there was low strength participation by other departments for collaboration, slow government processes, and inadequate compensation. Additionally, some highlighted needing support and capacity strengthening to handle the managerial, financial, and administrative aspects of their jobs for which they often felt unprepared for.

Overall, nearly all MOs appear to be driven by an intrinsic motivation and sense of purpose, particularly driven by wanting to serve the community. Sustained engagement will be key to bolstering the existing motivation amongst MOs.

b. Accountability and Agency

The Rescue Mission emphasised inter- and intra-departmental communication to promote accountability and community engagement to build local ownership and leadership. We observed engagement (1) within departments (2) across departments and (3) with communities. In the first, processes include In-Depth District Review meetings, Sector Meetings, and District Review Meetings. They serve as systemic opportunities for information sharing and evaluation of activities by the State over Districts, by Districts over Blocks/Sectors and by Facilities over its health providers. Regular meetings have ensured a continuity of activities on particular issues. For instance, in terms of the agenda of VHCs, we observed an initial focus on formation. Towards the end, focus had shifted to trainings and bank account activation, and even further for some VHCs, their role in health centre activation. Facility visits by State officials also served as a direct line of communication

between the health providers and the State. In particular, facility visits by technical health consultants proved beneficial in providing hand holding support to the MOs in these health facilities, who have been able to voice their grievances directly to those with authority.

Across departments, MSRLS, the State Social Welfare Department and the Health Department collaborated in review meetings, outreach programs and program implementation. In the In-Depth District Reviews, we observed every department presenting its department-related agendas. For instance, MSRLS reported on CGHA and SHG activities for health and Social Welfare on SAM (Severe Acute Malnutrition), MAM (Moderate Acute Malnutrition) and Anaemia related activities. This was observed in a few sector meetings as well, though not widely. We also observed SHGs and CGHAs mobilizing communities along with ASHAs and Anganwadi workers (AWWs) for different health programs, for home visits and counselling of pregnant women. However, this varied considerably, particularly across CGHA/SHGs.

The third type of engagement we observed includes outreach by facilities and other levels of administration with communities. Field visits by the Principal Secretary and the Director NHM, for example, were identified by community members as important opportunities for inter-learning. These visits also served as a direct bridge between the State and the communities it serves. Maternal death review visits to communities and facilities stood out as a positive push towards overall state responsibility to reducing maternal deaths. Interactions between the family members of the deceased and the State Officials have been beneficial in analysing gaps in the health system of the State. For instance, the relatively high cost of expenditure for scans, medicines and other technical tests even in Government Hospitals emerged as a critical concern.

Some VHCs have been activating Sub Health Centres under PM-ABHIM (Pradhan Mantri-Ayushman Bharat Health Infrastructure Mission) with support from MHSSP Community Associates. In these instances, we found the headmen to be active leaders who built on previous experience creating community-owned assets through the Village Employment Councils. We observed active participation of VHC members during these meetings, with modifications to suit their communities, back and forth interaction for procurement, labour, and much more. VHCs have shown to have great potential for translating community ownership over health into practical activities for health headed by the communities and supported by the health system.

Regular organizational engagements, whether inter- or intra-department, have proven to be effective in monitoring data reporting as well as evaluating outcomes and outputs. State and District review meetings, as a whole, have catalysed further actions and, according to stakeholders, are crucial to monitoring progress and intersectoral collaboration. We noted that meetings reflect a sense of purpose and motivation across departments.

Engagement across levels: experiences from review meetings

Sector meetings were clearly useful tools to encourage District administration to increase the efficiency and regularity of implementation processes. At the inception period of the study (June-July 2022), we found West Garo Hills, for example, to have not conducted any sector meetings but by the end of our study period in November 2023, sector meetings were regularly conducted, that too, in a particular date, for all facilities. This District was also one where we observed strong inter-sector collaboration, both in the meetings and in the communities.

Meetings are often led by either the MOs of the facility, the Block Medical Officer or the Block Program Manager/BPM (NHM). They would often start with a discussion or presentation of the Rescue Mission issues, followed by discussions on them. Activities done by ANMs, ASHAs and AWWs would often be discussed followed by advice or any suggestions from the MO. Discussion is led by whoever is presenting their agenda. We observed Child Development Project Officers (CDPOs) and Lady Supervisors leading discussions in some meetings as well.

Regularity of meetings varied from facility to facility due to reasons such as lack of time to inability to decide on a date which would suit all departments. Going by directions received from the State, some districts have mandated a particular day in the month as a sector meeting day. We also observed that a lot of facilities would combine sector meeting agendas with their Block Task Force meeting agendas to save time. Additionally, some sector meetings were held at the CHC of a particular block for all facilities under it. Participation of all three departments varied from facility to facility as well. Cluster Coordinators and CGHAs were the most common participants from the MSRLS whereas Lady Supervisors were the most common participant from the Social Welfare Department. Some NGO-run facilities also participated in the sector meetings.

Sector meetings were observed as platforms for voicing facility level issues, department level issues as well as any other health related issues such as lack of Aadhar registration, MHIS registration (Megha Health Insurance Scheme), lack of ASHAs for villages with high

population and much more. MOs and BPMs suggested solutions to their staffs. In-depth discussions on any maternal and infant deaths were also common agendas. ASHAs were often asked to report on support given to the deceased. Additionally, in some facilities, action plans were made and broken down into numbers, the person responsible for those activities and a person to follow up on those responsible. These would then be reviewed at the start of the next Sector Meeting and any issues preventing the achievement of the targets would be discussed. However, in many more, action plans were found to be vague as in the MO would direct ANMs to follow up on drop-outs for immunization but would not specific how many were to be followed up and specifically in what communities.

Beyond sector meetings, we observed active participation in periodic reviews for MOs, Block Development Officers (BDOs), a workshop for District Medical & Health Officer (DMHOs), and other related workshops intended to disseminate the message of the Rescue Mission. During the DMHO conference in February 2023, specific district/DMHO level issues that were usually not touched upon in other meetings emerged, including concrete plans being made to address such issues. Similarly, discussion was held on placement policies for MOs, nurses and other paramedical staff, the outcomes of which were intended to inform Human Resources policy for the Department.

However, we found that MOs were reluctant to be as open during their MO Review Meetings. This was in stark contrast to our interviews, in which they were open and expressive about enablers and challenges. Their hesitance in workshops could be due to the lack of experience in dealing with State officials directly, in particular the Principal Secretary, who usually chairs these meetings. Such meetings appear to be a step in the right direction to build confidence and promote a sense of leadership, accountability and agency among MOs. Interviews consistently noted that the successful implementation of CM-SMS has been due to the agency given to MOs to direct contextual implementation of the scheme.

Further, while not all MOs, BDOs and BPMs were not well versed in SCEP, we found such meetings to be useful to guide them in the right direction. Q&As/Polls in such meetings have been simple yet effective tools to monitor activities and learnings of the MOs. MO reviews can potentially be an effective platform for this communication and any other updates. For example, during one MO review meeting in May 2023, participants learned about the Escalation Protocol for refusals, which was a crucial addition to the state's efforts to reduce Maternal Mortality Ratio (MMR) and Infant Mortality Ratio (IMR). Additionally, MOs need administrative handholding support as well, as reflected by the fact that many have not been

as active in interacting with the communities/VHCs around them, uptake of CM-SMS is low, etc., as seen during polls taken in these reviews. Jongksha PHC's initiatives on improving accountability is an example of MO driven initiatives that had led to better facility performance. The PHC has a system of regular meetings, delegation of responsibilities, monitoring and follow up, a feedback mechanism and a system of accountability for the staff.

We have had varied responses from all departments regarding review meetings. Participants have reported seeing meetings as opportunities for learning, particularly those from the MSRLS: *"Since it is there it makes work more enjoyable and it keeps us working on and on. … The review meetings remind us to do those activities. It reminds use to finish the work we have."* - District official, NRLM.

For the Health Department, it paves the way towards self-evaluation: *"So it is a kind of review and it actually helps us a lot. It is a kind of training also. It helps us to improve"* - District official, NHM.

Some participants, however, were of the opinions that such review meetings were only useful for indicators that could change in a short period of time, usually in discussions about SAM, MAM and Anaemia. In Purakhasia PHC, Sector Meetings have been held with active participation from all three departments and monitoring is done for all three as well.

> *"If there is no meeting then the three line departments would not have come together and worked but because of this meeting we are getting opportunity and utilizing it so we can see improvement but still we cannot achieved each and every target, we still have to work hard but we are trying slowly"* - Health Provider

Based on our observations of sector meetings, we developed a **sector meeting checklist tool** [Annexure 5] to support regular implementation and monitoring.

Box 2: Sector meetings and action plans [See Annexure 4e]

What's working:

- Regular meetings, where they occur, have led to a continuity of discussions on maternal & child health issues
- In-depth discussions on maternal and infant deaths led to more community-based action plans to prevent them in the future
- Monitoring of activities acts as an accountability mechanism for health providers and front line workers
- Action plans when broken down into targets, deadlines and accountable individual leads to better monitoring
- Presentations using MOTHER App data leads to better understanding of facility-level performance
- Initiatives such as conducting meetings in SHCs and Communities

What needs support:

- Regularity of meetings in some facilities
- Active participation from MSRLS and ICDS in sector meetings such as leading discussions or proposing agendas
- Breaking down of action plans to targets and period of action
- Use of data for evaluation of work and planning activities and assessing overall facility performance

c. Information sharing and data use

Data utilization, particularly, from the MOTHER app has increased amongst health providers, particularly in review meetings. Data has been used to monitor facility, District and overall State performance in terms of maternal and child health indicators and to prioritise issues. MOs have recognized the need for data reporting to understand their strengths and weaknesses as well as using data to prioritize service delivery and monitor staff performance. At the sector level, data is shared with the MSRLS and ICDS to track pregnant women, women with expected due dates for the month, refusals and drop-outs and any other relevant information to Rescue Mission.

However, interviews highlighted multiple challenges to data monitoring and reporting, particularly dual reporting. MOs and other health staff reported feeling overburdened with the data reporting processes. In the absence of a data entry operator, the onus of reporting data falls on the health facility staff. Another challenge identified include the process being time consuming and poor network connectivity. We did find exceptions to this, however. In Dawki PHC, there was a clear delegation of reporting according to activities between the indoor and outdoor staffs. Similarly, in Gabil PHC, we found that MOs and staff nurses would report only on inpatient department and outpatient department services whereas ANMs would

solely report on outreach services. In this case, MOs only provided clinical services with limited participation in outreach programs, the bulk of which was delegated solely to ANMs.

Staff in both facilities were also well versed in using digital apps. One common issue in all 30 sampled facilities was reporting through use of apps by ASHAs and older ANMs. They also reported very little use of apps for record keeping due to poor network connectivity or lack of training on how to use them. Overall, they seem to be the most in need of regular handholding and training for data reporting and use.

Block level officials reported delays in data flows from facilities to district to state. Several officials complained of too many reporting formats and large volumes of information to be reported. At the sector level, data is used by MOs and BPMs, but not much data use was reported by ANMs and ASHAs. Data is used mainly for monitoring and in a few facilities, for evaluation. Data analysis was limited, but quality checks were more common, such as the comparison of MHIS and MOTHER App data, for example. During sector meetings, use of data varied from facility to facility.

From our observations of some sector meetings, we found MOs were not confident about their use of Mother App data in these meetings. Such MOs would benefit from clear cut information and guidance on data use.

> *"We still need to know more to improve our usage of the data"* – District official, NHM

> *"They asked us for the data, but how they utilize the data we do not even know, where they are sending it or why they want this data. There was no response."* – MO

Other departments did not report particular challenges, as they largely used, but did not enter, the data. However, we did find data reporting issues by CGHAs and SHGs who were providing services in uncovered villages, as they were not fully trained on reporting. The Social Welfare department has access to the Mother App at the block level to follow up on high-risk pregnant women; however, Anganwadi workers do not have similar access.

Lastly, districts appeared to use data for problem identification compared to the sector level; at the facility level, individual leadership of the MO and the BPM NHM influenced data use. Some participants reported noticing trends from data and using them to create action plans. *"For us all, these activities have become regular"* – District official, NHM, which indicates the potential of further expansion and deepening use of data.

d. Community engagement

The aim of Rescue Mission's community engagement interventions has been to transform citizen-state relationships, with the ultimate goal of converting community engagement to community ownership. Respondents noted that Rescue Mission's focus on community engagement has led to a wider reach of health services in uncovered villages as well as in engaging with more women particularly through the MSRLS. Since the initiation of Rescue Mission, sector level emphasis on enhanced community engagement has meant delivery of health services to the communities' doorstep, bypassing the design of keeping the facility at the forefront. There is reported increase in home visits, counselling of pregnant women, Village Health and Nutrition Days (VHNDs) and other outreach activities with the aim of achieving goals that would be monitored in the next review meeting.

> *"Now, when they conduct home visits they have a specific objective in mind, whereas earlier, they would conduct home visits for the sake of completing their work."*- Block Official

> *"This is the first-time people from health dept are truly coming out to speak to the community."* District NHM Official

Meeting observations and interviews reflected the importance of intersectoral collaboration for community mobilization. At the community level, ASHAs, AWWs and SHG members were reported to track and counsel high risk mothers together, although this was not consistent across facilities. The introduction of the CGHA cadre has led to positive acceptance of counselling and healthcare services as they are seen as part of the community in contrast to their perception of ASHAs, who are seen as health workers. However, high attrition among CGHAs is a concern which leads to delays in program implementation.

Community engagement is also an important agenda in review meetings at all levels. Targets for VHNDs, home visits are common discussions along with community targeted interventions whether in the form of awareness programs, engagement with VHCs or field visits by State officials. At the sector level, ANMs have been directed to submit their planned VHND a month ahead of time, which is then shared with other departments.
Community visits by State and District Officials have led to communities' direct interaction with those in authority bypassing several levels of administration. We observed community leaders utilizing this opportunity to vocalize their community's issues to the concerned department heads.

VHCs have the potential to generate community ownership by translating policies into actual ground activities for health. An excellent example has been sub-centre activation through VHCs. We have observed VHCs initiating their own activities for health. For instance, Pyntei VHC in West Jaintia Hills has been receiving donations from private donors and using it to help vulnerable families. They have also facilitated transportation services under the CM-SMS scheme.

In North Garo Hills, we found community leaders working towards creation of a sub health centre for their communities long before Rescue Mission. Identifying leaders in the communities and empowering them has been leading the way towards community ownership. Dujong Akong VHC, for instance, is headed by a strong leadership, had plans for activation of the SHC before receiving MHSSP's support. They had interacted with their MLA, DC and Sualmari PHC as well. With the introduction of the PM ABHIM, they are well on their way to constructing their first sub health centre within a year of their inception. Support from the State has been crucial in empowering VHCs.

Box 3: Community engagement [See Annexure 4d]

Whats working:

- A revival of purpose for community engagement
- Ramping up of outreach activities through purposeful planning and monitoring of VHNDs and home visits
- Intensive and purposeful field visits by District and State
- Broadening scope of community based institutions
- Activating Sub Health Centres through better infrastructure to facilitate higher institutional deliveries

What needs support:

- Strategic posting of MOs with priority towards low performing facilities
- Emphasis on soft communication skills by health care providers
- Regular and quality home visits by ANMs, ASHAs, AWWs and CGHA
- Awareness and implementation of escalation protocol
- Identifying and engaging with community leaders for better community participation

e. Political supportability

Over the course of the study, political supportability consistently influenced the progress towards improved maternal and child health in the State – and that too, across political regimes. Meghalaya appears to have a demonstrated history of political will to support initiatives: the salience of maternal and child health reflects a continued commitment at the highest levels to improve health indicators.

Launched in 2022, the Chief Minister's Safe Motherhood Scheme (CM-SMS) is the clearest reflection/actualization of the State's priority. Improvements after the initiation of the Rescue Mission similarly reflect a singular focus and a sense of accountability initiated by the top of the State's political and administrative machinery. Community acceptance of the transportation service through CM-SMS has been most successful, particularly in areas that have motorable roads but lack transportation.

At the grassroots level, developing community leadership in the form of VHCs is a strong example of political supportability, as detailed above. There was recognition amongst participants that the leadership and ownership of the village headman was crucial to implement any scheme. Headmen and BPMs have also worked together to ensure availability of vehicles to transport pregnant women and children to facilities and vaccinations.

While there is political supportability for maternal and child health, there is a sense that this hasn't yet extended to the broader determinants of health such as improving infrastructure and therefore improving access to care.

f. Intersectoral collaboration

Overall, we observed that the Departments of Social Welfare and Rural Development, whose mandate includes Rescue Mission in the State, also reflect a commitment to improving maternal and child health in Meghalaya. Sector meetings, as detailed above, proved to be a critical platform for intersectoral collaboration. Despite variation across meetings, overall there has been a consistent, and perceptible, increase in collaboration due to joint planning, review and monitoring during meetings.

There is a recognition of the clear link between livelihoods and health amongst officials of NRLM and an emphasis on prioritizing maternal and child health. Within the federated structure of the NRLM, VOs are encouraged to tag high risk pregnant women as vulnerable groups to be eligible to receive VRF (Vulnerability Reduction Funds) to address financial needs towards transportation expenses to reach facilities or nutrition, amongst others. The Cluster Level Federation can exercise flexibility to decide whether this is given as an interest free loan, loan or grant (community ownership).

> *"We see that it is a priority to help those people. We have to adjust our action plans."* - District official, NRLM

NRLM recognizes that it has strong social capital at the grassroots level which can be used as a means for mobilization and sensitization/awareness on the Rescue Mission. However, some participants did mention that this diverts from their main activities and adds to the workload, particularly since human resources are short and there are increased demands for reporting and monitoring.

Participants from the Department of Social Welfare typically viewed their contribution to the Rescue Mission as convergent health checkups for anaemia screening and POSHAN (Prime Minister's Overarching Scheme for Holistic Nutrition) activities. In Meghalaya, national ICDS guidelines when implemented resulted in several villages being left out of the programme as they didn't fit criteria for enough beneficiaries. Under Rescue Mission, the two departments collaboratively came up with a solution to identify SHGs in these uncovered villages to provide rations to children.

A key feature of the intersectoral convergence under the Rescue Mission involves drawing on the combined intersectoral strength of community mobilization. This is particularly demonstrated in instances of high-risk pregnancy tracking by SHG members go along with ASHAs. CGHA cadres were created to focus on gender and health, convergence, and Rescue Mission. There were efforts made to ensure this doesn't duplicate the work of the ASHA but rather act as a support system to ASHA and Anganwadi worker. Only villages with VOs have CGHAs, in some cases one CGHA looks after multiple villages. There is also a perception that the ASHA is someone from the health department, but the CGHA is viewed as someone from the community. The Department of Social Welfare has been actively working with the Health Department for overlapping beneficiary group through convergent health checkups for anaemia screening, and POSHAN Abhiyan.

Box 4 Intersectoral collaboration [See Annexure 4b]

What's working:

- Sense of purpose across departments to improve maternal and child health
- Transit homes in select geographies where run by SHGs
- VHCs and community ownership

What needs support:

- Working conditions for CGHAs require improvements
- Sustaining participation by other departments in sector meetings

g. Challenges

We highlight key challenges related to the health system and beyond.

Frontline workers ANMs, ASHAs and CGHAs reported heavy workloads, pressure to complete work, and long working hours. Other difficulties they expressed were lack of transportation to conduct field visits, walking long distances in hard-to-reach areas, and spending out of pocket on taxis. CGHAs and ASHAs also found the process to claim payments as tedious. Discouraged by this, some ASHAs reported not submitting claims for several home visits and spending out of their pocket. A CGHA mentioned that it could take up to a year to receive payments and some reported not submitting claims for small amounts. CGHAs and ASHAs also found it difficult to find childcare support in order to work long hours.

> "*I feel like quitting … from MSRLS side they are being good to us when we work also they don't pressure us they understand our time also. It's not like working with the health department from the health whenever they assign us any activity we have to complete it at that time itself. They don't understand about how much hard work we do and how much payment we get and also they ask report everyday. If we fall sick also they will cut our payment so it's not like the MSRLS they understand very well and we can work in anytime we want also.*" - CGHA

> *"We come 2 days a week to this facility. Monday and Wednesday we attend here and on 9th of every month we do a teenage programme that we had to attend. We also have monthly meetings on 16th of every month. So we do not have enough time to 28 work at home. It is like whole week we have to work. Lots of survey like 0 to 5 years survey, population survey, eligible couple, 5 to 30 years survey so we have do lots of surveys it is like whole day we have to work along with our household work so we are very busy. Compared with the amount of work that we do our incentives are less."* - ASHA

CM-SMS related: Persisting challenges include preference for home deliveries in some communities and resistance from families and husband of mothers, *"My husband says it is troublesome to go and refuses"* (Woman participant, FGD, West Garo Hills); *"And sometimes we also feel neglected by the sisters as when we go to them when the mother is ill, they will say things like the time has not come yet"* (Woman participant, FGD, West Garo Hills) Further, different challenges emerged depending on the terrain. For instance, in one area *"most of the terrain only supports 4*4 pick-up but patients don't want to come in those; people want ambulances and in X district it is basically an Eco van, so they can't traverse with ease."* - District official, NHM.

Box 5: Transit homes under CM-SMS

Transit homes were introduced as an intervention to support institutional delivery as part of CM-SMS in 2022. Women who used transit homes were largely from areas that have non-motorable roads. In Blocks with hard-to-reach areas but motorable roads, communities preferred to rely on vehicles than stay in transit homes. Some SHGs and VOs were observed to be running transit homes, taking an active part in providing food and support to the pregnant women.

Nearly 94 transit homes were being run by VOs and SHGs at the time of data collection. Where Transit Homes are managed by SHGs, they were seen as better run but still underutilized due to variety of factors related to distance, comfort and women not being able to leave families and livestock behind. NRLM officials perceived a difference in transit homes run by MOs/NHM compared to that run by the VO/Self Help Groups (SHGs). According to them, MOs run the transit home in a rather clinical manner whereas VO members engage with pregnant women and support them during their stay. Further, CGHAs reported feeling constrained by the low amount of funds they're given for running transit homes and transport to and from the facility. Some facilities invited Traditional Birth Attendants (TBAs) – trusted by the community – to run transit homes as a potential solution to increasing comfort amongst women.

In light of overall low utilisation, findings indicate that handing over Transit Homes to the community could build community ownership and awareness to encourage use, especially in areas where women feel they are needed.

Human Resources: Availability, Capacity and Workload A key challenge to service provision was shortages in available human resources for health, reported by participants across levels. Some participants noted a shortage of specialists (gynecologists) for whom communities expressed preference. Within facilities, MOs often reported being unable to perform their multiple responsibilities which comprise a mix of clinical service provision, facility and staff administration/supervision, and community outreach. Some ANMs reported requiring capacity building support, particularly with conducting births as Skilled Birth Attendants. MOs, ANMs and ASHAs reported feeling overwhelmed by the different format requirements for reporting facility data. Block level officials reported heavy workloads being managed by one manager for each block whereas the perception is that district and state levels have nodal officers for different programmes.

Facility infrastructure Participants from some districts reported insufficient, functional SHCs. In one district, participants felt poor infrastructure in SHCs resulted in non-conversion into delivery points; communities therefore had to travel far to CHCs to give birth. Erratic or absent electricity and water supply in some villages was seen to impact service delivery and functionality. Staff quarters too then became inhabitable for ANMs and Mid level health providers (MLHPs). Some ANMs reported being required to travel to remote areas, typically

near the State border, and having no quarters to stay in. There is an understanding that these systems-related issues extend beyond the purview of the health department but are viewed as critical to improve care.

Poor road and transportation infrastructure: Across districts, difficult terrain and road conditions and lack of public transportation were identified as critical barriers to accessing care at facilities by most participants, particularly remote areas close to domestic or international borders. Some participants highlighted villages so remote they could only be accessed once a year or during certain months only. Lack of appropriate and timely transportation as well as poor road infrastructure has also been identified as reasons for maternal deaths. However, it was acknowledged that schemes like CM-SMS have helped arranging transportation.

C. Tracking SCEP adoption

At baseline, we mapped the extent of variation across the thirty sampled facilities in six districts. We selected performance on institutional deliveries as a key service outcome indicator and drew data from the MOTHER app for September 2022 – November 2022. Drawing on in-depth interviews conducted with MOs at these facilities, sector meeting minutes and observations by the data collection team, we developed an index of SCEP adoption: facilities were scored as having either high- or low-SCEP adoption. *See Annexure 4a for a Key Lessons Brief on the SCEP Scoring Index.*

Box 6: SCEP adoption index at baseline

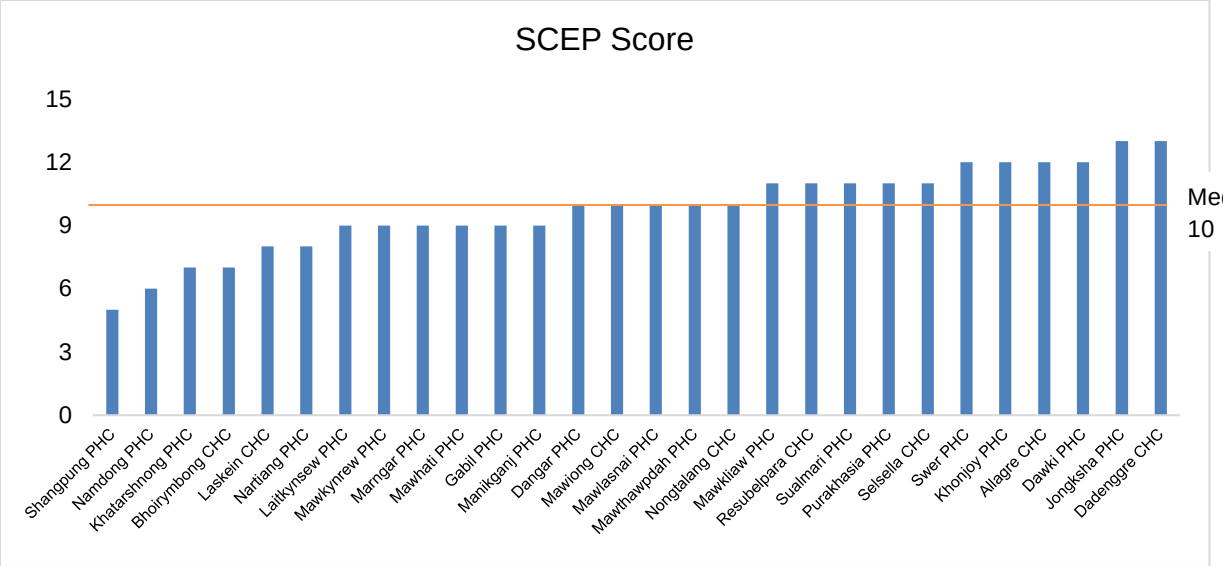
<table>
<tr><td colspan="2">Based on in-depth interviews, sector meeting minutes, and our understanding of the SCEP approach, we teased out the following characteristics.</td></tr>
<tr><td>High SCEP adoption:</td><td>Low SCEP adoption:</td></tr>
<tr><td>• Working in mission mode
• Local adaptive solutions
  • Involves intersectoral collaboration
  • Community engagement
• Working together with TBAs as part of the health system
• Accountability: assigning tasks and following up
• Ownership
• Leadership
• Information sharing
• Data and action plans</td><td>• Limited problem-solving
• Decision-making not always facility-led (dictated by/deferred to Block/District)
• Sector meetings not very regular
• Limited intersectoral collaboration and community engagement
In some facilities, low SCEP adoption could be due to contextual factors such as urban/urban adjacent facility, easy access, receptive community</td></tr>
</table>

After a second round of data collection with MOs and more sector meeting observations, we modified our index of SCEP adoption on the following variables:

- Problem-solving approach
- Extent of intersectoral collaboration
- Use of data for planning
- Community engagement
- Sense of purpose

Team members discussed scoring for each variable and facility iteratively. Each variable could be scored between 1-3, 1: no SCEP adoption, 2: SCEP adoption/business as usual, 3: exceptional/going above and beyond.

Figure 7: SCEP Score across thirty sampled facilities



Note:

1. The MO interview in Nangbah PHC was a short interview and thus we did not have sufficient information to rate them across all the parameters.
2. The MO interview was not done in Ummulong CHC.

The SCEP scoring indicates a widespread uptake of SCEP principles (median score= 10). The variation aligns with programmatic experience, as noted in feedback meetings, which confirms that the SCEP adoption index is a useful and feasible tool.

D. Reflections and Priorities

This study provided a unique opportunity to closely observe the development and implementation of—and changes and challenges linked to—MHSSP's Rescue Mission through the lens of the SCEP approach. Following principles of implementation research, we aimed to document processes as they were, with the aim to uncover enablers and barriers to intended interventions. Findings, therefore, are spread between the Inception, Mid-term and Final reports; staying true to an adaptive approach, we did not "update" findings as we observed changes in the progress of Rescue Mission. Actionable insights were relayed to the Principal Secretary, Director NHM, SCEP and MHSSP staff during regular check-in meetings, such as the importance of MO inputs and teething challenges with the MOTHER app.

The variation in Meghalaya's institutional delivery rates, geographic regions and sociocultural/demographic characteristics provided a rich context to study variation in how health interventions and SCEP processes took root. Context, interestingly, did not indicate the success or failure of an SCEP approach across facilities. We found facilities with difficult terrain and infrastructure using innovative problem-solving, while others in historically high-performing areas did not actively use planning tools or monitoring data. This observation was surprising, and by the mid-term data collection it led us to focus on understanding individual motivation of MOs along with systemic challenges. As a result, we adapted the MO interview tool and SCEP tracking index to incorporate more indicators of individual motivation.

Another change during data collection was capturing outliers that could serve as models for other facilities, blocks or districts. We subsequently conducted five facility "deep-dives" [Annexure 6] and collected a list of innovations across all 30 facilities. In addition, we offer reflections on key priorities for the future:

- At the state level, strengthened and sustained inputs to MOs/Facilities on SCEP. MOs, as the backbone of intervention success, require closer engagement from the program as a whole to operationalise the art of problem-solving, planning and data use. As noted in the midterm report, most MOs felt they had limited exposure to SCEP ideas.
- At the district level, extend intersectoral collaboration to natural areas of convergence, such as other health issues and related departments, while allowing for flexibility in role clarity and coordination at the facility level.

- At the block level, build on sector meetings as the key platform for collaboration, planning and monitoring. Positive cases indicate the potential of these meetings to catalyse action; the next priority will be to identify and strengthen meetings where they are not regularly held or used according to need.
- At the facility level, strengthened MO inputs can include support for community engagement and data entry and analysis to promote use.
- For frontline workers (ASHA/CGHA in particular), address challenges related to transportation, incentives and workloads.
- At the community level, closely track the expansion and development of VHCs to identify capacity strengthening needs and identify areas for cross-learning.
- Integrate improved measurement and monitoring systems starting with bottom-up utilisation. Adapting the SCEP scoring index and identifying simple data analysis tools for use at the facility and community level may promote greater utilisation and value of routine data collection.

Moving forward, the findings from this study will be analysed from different perspectives, particularly using state capability and governance frameworks, as well as with direct application to maternal health strategies. While an 18-month period, as well as the nature of the intervention, prevented measurement of changes in maternal health or service delivery outcomes, the findings consistently point to a future with sustained uptake of SCEP approaches. As problem-solving and leadership continue to percolate to the facility and community level—along with system strengthening within and beyond the health sector—our findings support continued investment in Rescue Mission as a *sustained* catalyst for both strengthened state capabilities and improved health outcomes.