MCSP's Contribution to Critical Policies

Ensuring Effective Reproductive, Maternal, Newborn, Child, and Adolescent Health Policies for a Supportive Implementation Environment

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Background and Rationale

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) focuses on 27 countries,[1] with the ultimate goal of ensuring that all women, newborns, and children most in need have equitable access to quality health care services to save lives. Over the life of the program, MCSP has supported the development and adoption of over 100 policies. In an effort to move beyond simply reporting the number of policies supported, MCSP did an analysis to place this contribution within the larger reproductive, maternal, newborn, child, and adolescent health (RMNCAH) policy environment in USAID's priority countries and analyze how MCSP addressed some of the policy gaps identified.

Policy Dashboard

MSCP's interactive policy dashboard, which provides specific findings from this study, is available here.

Simply having a policy aligned with the latest evidence is not sufficient to ensure its implementation with consistency and quality. On the other hand, without a policy in place, coherent and sustained action is difficult. Policies based on the latest global and country evidence provide a framework upon which to build resilient, accountable, and responsive health systems. As the pace of evidence generation on technical and implementation issues accelerates, the need for an agile and effective policy development processes becomes more urgent. This process should bring together various actors to ensure technical rigor, effective rollout, and accountability.

It has been difficult to firmly establish the link between policies and health outcomes because policy analyses have traditionally been descriptive and systematic country-level information has been lacking. Recently, there have been efforts to fill this information gap with systematic analyses of the content and state of development of policies related to RMNCAH. Countdown to 2015 undertook a notable effort to analyze country progress toward achieving Millennium Development Goals 4 and 5 in the 75 countries where more than 95% of all maternal, newborn, and child deaths occur, including systematically describing policies and their specific content elements that relate to evidence-based RMNCAH interventions.[2] This and similar analyses have begun to offer a better understanding of the link between policies and health outcomes.

[1] USAID's 25 maternal, newborn, and child health priority countries (Afghanistan, Bangladesh, Burma, Democratic Republic of the Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, and Zambia), plus Egypt and Guinea.

[2] Singh NS, Huicho L, Afnan-Holmes H, et. al. 2016. Countdown to 2015 country case studies: systematic tools to address the "black box" of health systems and policy assessment. *BMC Public Health*. 16 Suppl 2:790. doi: 10.1186/s12889-016-3402-5.

Figure 1. Countdown Working Group definition of policy and systems "black box"

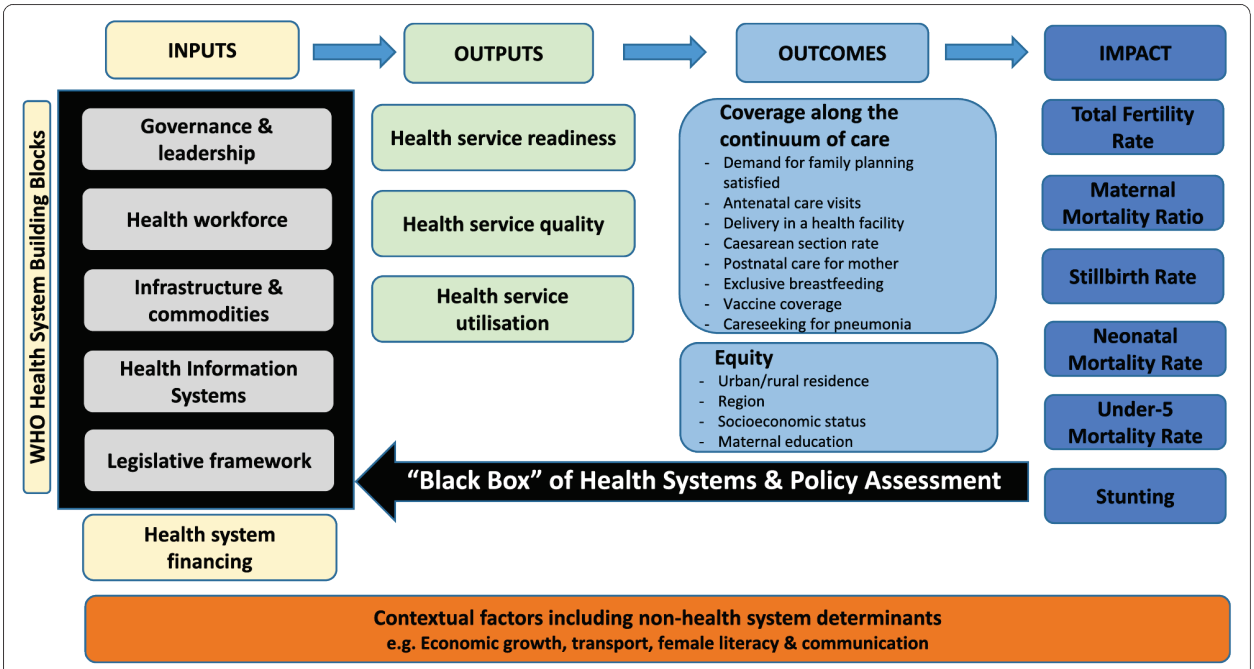


Fig. 1 Evaluationframeworkfor Countdown to 2015 country case studies

Methodology

MCSP undertook an analysis similar to the Countdown Working Group to characterize the content of policies most directly related to evidence-based interventions known to have impact on the most significant causes of morbidity and mortality for women, newborns, children, and adolescents. It took a similarly broad definition of "policy" for the scope of its study (see box at right). First, the MCSP policy team developed an initial list of key policy content across the RMNCAH spectrum through desk review of previous documents produced by previous systematic policy studies, such as the World Health Organization (WHO) RMNCAH policy database; the Partnership for Maternal, Newborn, and Child Health countdown reports; and Advancing Partners & Communities. As in these previous systematic studies, the focus was on the "policy element,"[3] not the overall policy. Criteria for inclusion of a policy element were that the element should:

Scope of the Policy Review

MCSP's study analyzed national laws, policies, regulations, and strategy documents, including national service delivery guidelines and performance standards, developed or revised with MCSP support to improve access to and use of high-impact RMNCAH services.

- Be directed at increasing the quality, demand, and/or utilization of an evidence-based, high-impact intervention directed at a major cause of maternal, newborn, or child mortality.
- Have evidence (published or expert opinion) that it has an effect on one or more known high-impact interventions.
- Have systematically collected publicly available information on its presence across most or all of the 27 countries included in this policy analysis.

After assembling its initial list of policy elements, the team consulted with key informants at MCSP, USAID Washington, and WHO to refine the list. The team developed a revised list of key policy elements and again shared this list with MCSP team leaders, while also attempting to obtain information from published sources on the presence of these policy elements across all (or at least a majority) of the 27 countries of interest for

[3] A policy element refers to a key policy content within specific cross-cutting and technical areas (e.g., if an antenatal care policy includes the updated WHO recommendation from two doses to a minimum of three doses of intermittent preventive treatment of malaria in pregnancy).

this analysis. In an iterative fashion, the team arrived at the final list of 65 key policy elements. These were based on evidence of their importance in addressing the highest causes of mortality and availability of the needed information. Some initial elements had to be eliminated because sufficient information was not available, but most policy content deemed to be important was obtainable. MCSP contributions were then matched against relevant policy elements.

Limitations

A limitation of any policy analysis is the weak evidence base linking policies with RMNCAH outcomes, but MCSP mitigated this by including only policy elements related to known evidence-based, high-impact RMNCAH interventions. Additionally, due to resource constraints, data collected for this activity were limited to secondary sources, and no primary data collection was possible. As a result, the composition of the list of policy elements was heavily influenced by the availability of publicly accessible information. If an element of interest had no country-level data available across a majority of the 27 countries of interest, then that policy element was not included in the dashboard. Thus, some additional policy elements of interest could have been included had primary data collection been possible. Also, the analysis was limited to the national level, even in highly decentralized systems, such as Nigeria and India, where subnational policies are critical. Again, this was mainly because of the constraint imposed by the limited resources available for this analysis.

Ongoing definitional issues on the boundaries of policy also presented challenges throughout the analysis. Since MCSP's primary mandate is as a technical assistance and implementation support program, the large majority of MCSP's work has focused on operationalizing and implementing RMNCAH policies adopted by countries. It was difficult to draw the boundary separating the stages of policy formulation and adoption from policy implementation that operationalized those policies—for instance, supporting the development of national training curricula consistent with a newly updated antenatal care (ANC) policy. This is pertinent when considering MCSP's specific in-country policy contributions across the spectrum of policy work.

Key Findings

RMNCAH Governance and Planning (Including for Quality of Care Strategic Plans)

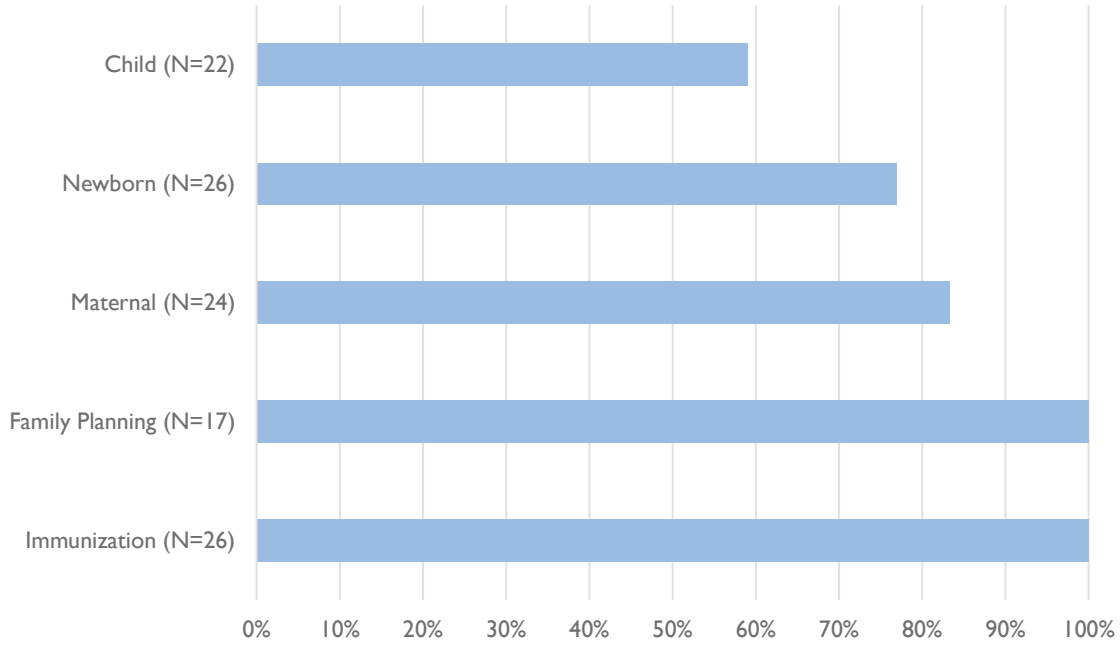
In the 27 countries researched, availability of national-level, costed plans was found to be high across the components of RMNCAH. These plans could either be standalone or part of larger integrated plans. The prevalence of comprehensive multiyear plans for immunization was high—26 of the 27 countries where data were available had plans. In the area of maternal, newborn, and child health (MNCH), 83% of countries with available data (20 of 24) had costed plans to guide maternal health programs, 76% of countries (of 26 with available data) had national newborn health plans, and 59% of countries (of 22 with available data) had national costed plans for child health (see Figure 1). [4,5] In the realm of family planning (FP), while data could only be found for 17 of the 27 countries, 100% of them had costed FP plans in place to guide programming.

Examining a newborn in Madagascar. Photo: Karen Kasmauski/MCSP

[4] Remaining countries in each category either do not have said policies (i.e., policy is absent) or data on policy status were unavailable at the time of the study (i.e., no data).

[5] In some countries, plans for individual technical areas (costed or uncosted) may be included within broader, integrated RMNCAH strategic plans rather than developed in a standalone format. In some cases, a high-level plan for a given technical area might exist but may not have been properly recognized in this search if it is embedded within a more comprehensive document.

Figure 2. Countries with costed multiyear plans



With the increased momentum around quality of care and the launch of the WHO Quality of Care Network, a growing number countries are working toward a more unified national quality framework and developing relevant plans, but quality is still an emerging area of work across countries. Of the 27 countries whose policies were reviewed, seven had high-level strategies or plans in place concerning RMNCAH quality of care, with an eighth country (Malawi) planning to develop a plan for quality improvement (QI) by 2019.[6]

MCSP Contribution to Strategic Plans

Policy Element	Specific Examples
Costed RMNCAH national plans	• **Democratic Republic of the Congo (DRC):** MCSP helped the Ministry of Health (MOH) to develop a 5-year National Child Health Strategic Plan 2017–2021, including supporting costing of the plan. The plan provides for the continuum of care from household to health facility to hospital. It indicates priorities, packages of interventions, targets, and strategies to make significant impact over the next 5 years. • **Pakistan:** MCSP provided key technical recommendations and integrated best practices (including development of an integrated training database, use of innovative training approaches, and emphasis on client choice) to inform the government's development of the National Action Plan on FP to expand women's access to lifesaving contraceptives. • **Rwanda:** MCSP finalized two national 5-year strategies: the FP/Adolescent Sexual and Reproductive Health Strategic Plan 2018–2024 and the MNCH Strategic Plan 2018–2024. These strategies support the realization of the national RMNCAH policy. MCSP facilitated a highly collaborative multistakeholder process to develop both strategies that included primary data collection with beneficiaries, desk reviews, review of data and trends, and costing. • **Nigeria:** MCSP supported the state governments of Ebonyi and Kogi to develop immediate to long-term plans for improving RMNCAH in the states, leading to the current state strategic health development plans (2017–2022) and costed child health annual plans that will reach over 5 million people. • **Tanzania:** MCSP provided technical support and brought together multiple partners to develop the One Plan II, which was used as the investment case for the Global Financing Facility. • MCSP supported multiple countries, including **Madagascar, Malawi, Mozambique, Nigeria, Tanzania, Kenya, Uganda, Zambia, and Haiti**, to develop comprehensive, multiyear immunization plans.

[6] Remaining countries in each category either do not have relevant policy or data on policy status were unavailable at the time of the study.

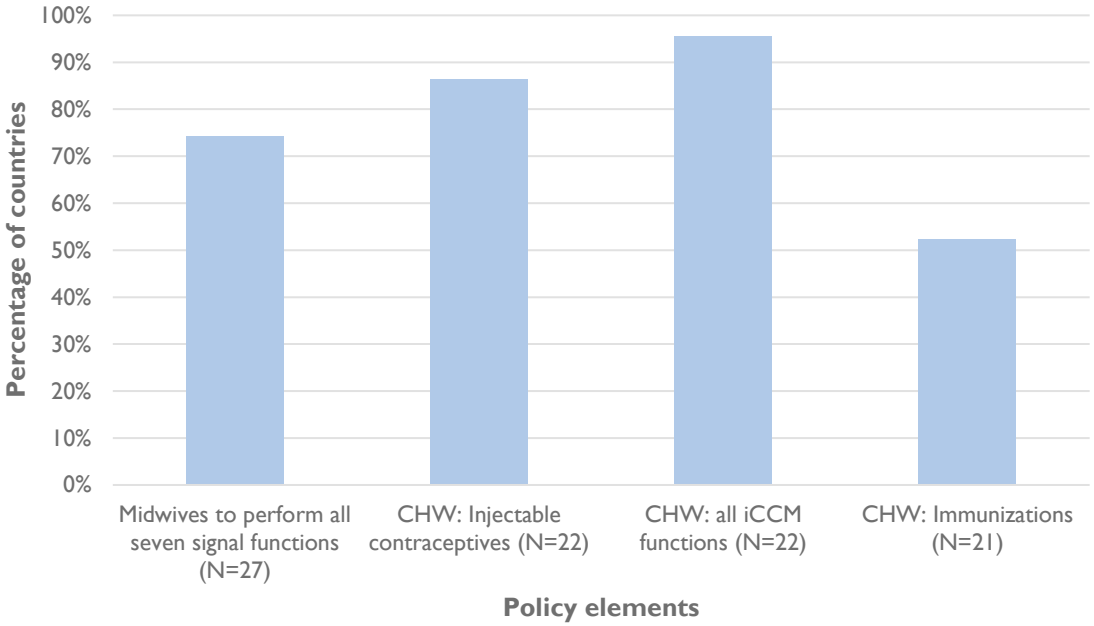
Policy Element	Specific Examples
National QI plan/strategy	• **Global:** MCSP works closely with WHO to support the design and rollout of the WHO Quality of Care Network, including development of standards and priority measures for improving the quality of RMNCAH care. • **Ethiopia:** MCSP provided technical support to the MOH Quality Directorate to develop the country's National Health Care Quality Strategy as well as tools to assess the quality of maternal and newborn health care in facilities. • **Mozambique:** MCSP supported the development and operationalization of the National Strategy for Quality and Humanization of Care 2017–2023. Advocacy by MCSP and partners also contributed to the MOH's creation of a national Quality Assurance and Management Directorate, with the mandate to lead implementation of the national quality policy. • **Nigeria:** MCSP worked with the MOH to establish a national RMNCAH QI Technical Working Group tasked with bringing together multiple stakeholders to develop a unified national RMNCAH QI strategy.

Human Resources

Progress in the 27 countries is mixed with regard to the number of policy elements in place that are conducive to increasing the number and capacity of human resources serving those most in need.[7] All countries with reported data (22 of 27 countries) have adopted policies that ensure the availability of human resources for RMNCAH services in underserved areas, though only six countries (of the 10 countries with data available) are reported to have comprehensive, updated national databases that track health workers by cadre and district. The inability to reliably track the type and location of health workers presents a barrier to operationalizing an important human resource policy element of placing health workers in underserved areas. The ability of frontline health care workers to perform certain clinical tasks depends first on the presence of national policies and strategies authorizing them to do so (Figure 3). In the case of labor and delivery services, for example, whether midwives are allowed to perform seven key obstetric services (signal functions) is a crucial matter of policy in determining whether some clients, especially those in underserved areas, receive the services. In the 27 countries assessed, 20 of the 27 countries (74%) have policies in place authorizing midwives to perform all seven signal functions. Shifting tasks to community-level health workers is another common strategy for increasing coverage of, access to, and utilization of health services. Many countries currently allow provision of select RMNCAH interventions and products at community level. Community-level treatment of pneumonia with antibiotics is now authorized in 23 of the 26 countries with data available (88%). Community health workers (CHWs) are allowed to administer injectable contraceptives in 19 countries,[8] oral contraceptive pills in 22 countries, community-integrated management of childhood illness interventions in 21 countries, rapid diagnostic tests for malaria in 18 countries, and artemisinin-based combination therapy for uncomplicated malaria in 18 countries. In contrast, policies authorizing community-level provision of other services/products still lag behind. For example, only nine countries currently allow CHWs to administer oxytocin or misoprostol for postpartum hemorrhage prevention, 10 countries allow CHWs to provide chlorhexidine (CHX) for newborn cord care, and 11 countries authorize CHWs to immunize children. (Note: WHO's Strategic Advisory Group of Experts, which is WHO's policymaking advisory group for immunization, does not have any recommendation on task shifting to CHWs.) Within this context of shifting critical tasks to CHWs, fewer than half of countries assessed (11 of 26 countries with available data) have adopted policies to pay community-based providers for services, including pneumonia, diarrhea, and malaria care, with some countries instead mandating volunteer status for CHWs.

[7] The policy elements under human resources included five elements: policy to ensure human resources are available in underserved areas for RMNCAH programming, national database with health workers by district and main cadres updated within last 2 years, policy to use paid community-based providers for child illness care (pneumonia, diarrhea, malaria), administration and provision of select RMNCAH interventions/products by a community cadres disaggregated by methods, and midwives authorized for seven signal functions.
[8] Throughout this section, remaining countries in each category either do not have said policies (i.e., policy is absent) or data on policy status were unavailable at the time of the study (i.e., no data).

Figure 3. Task-shifting policy elements



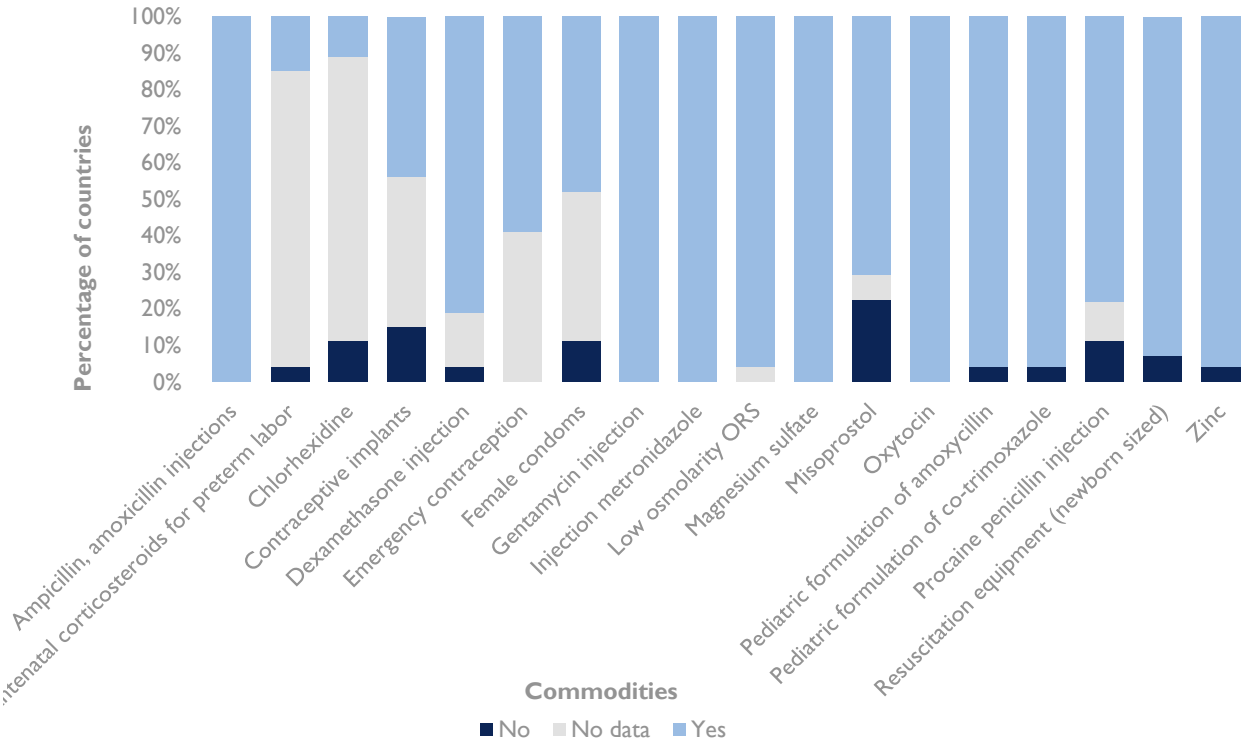
MCSP Contribution to Human Resources Policies

Policy Element	Specific Examples
Task shifting	• **Burma:** As part of the revision of the national integrated management of newborn and childhood illness guidelines, MCSP supported inclusion of new newborn guidelines that allow basic health staff (health assistants, midwives, public health supervisors, lady health visitors, and CHWs) to insert nasogastric tubes to feed small babies. MCSP also supported the MOH with updating and piloting the existing malaria volunteer guidelines to include integrated content on TB, HIV, leprosy, filariasis, and dengue hemorrhagic fever. The integration of new services is an important step to empower community volunteers, who are the first point of contact at the community level, to identify and diagnose early cases, and make necessary referrals that can lead to reduced morbidity and mortality in remote townships. • **Nigeria:** To make treatment more available at the community level, MCSP spent significant time building consensus among stakeholders to rewrite sections of the 2014 National Implementation Guidelines for Integrated Community Case Management (iCCM) of Childhood Illness, with the objective of allowing trained patent and proprietary medicine vendors to dispense amoxicillin. MCSP helped align three major policy documents—the iCCM guidelines, the Essential Medicines List (EML) and standard treatment guidelines, and the Task Shifting and Task Sharing Policy—to include consistent guidance and mandate the use of amoxicillin dispersible tablets by patent and proprietary medicine vendors and CHWs as a first-line medicine for children under 5. This change made it possible for treatment to begin sooner in many communities, potentially saving many young lives across the country.

Essential Drugs and Commodities

Of the 27 countries, 16 countries have data available on inclusion of reproductive health-related commodities on their EML (Figure 4). Within the 16 countries, all included emergency contraception (100%), 12 (75%) included contraceptive implants, and 13 (81%) included female condoms. Maternal health-related commodities have been widely adopted, with all 27 countries including oxytocin and magnesium sulfate in their EML, and 19 of 25 countries with available data (76%) including misoprostol. Inclusion of other key maternal health commodities (e.g., metronidazole, dexamethasone, and procaine penicillin injections) on EMLs was also high across countries assessed. Lifesaving newborn health commodities, such as injectable antibiotics and resuscitation equipment, are included in EMLs in a majority of countries. Very little data are available, however, about the uptake of antenatal corticosteroids and CHX in these countries; CHX is not on the list for 50% of the six countries where data are available. Finally, there has been nearly universal inclusion of lifesaving child health commodities (e.g., pediatric formulation of amoxicillin, low osmolarity oral rehydration salts, zinc, and pediatric formulation of co-trimoxazole) in the 27 countries.

Figure 4. Percentage of countries with lifesaving commodities included in the Essential Medicines List



MCSP Contribution to Essential Drugs and Commodities Policies

Policy Element	Specific Examples
Essential drugs	• **Bangladesh:** Through the Maternal and Child Health Integrated Program (Associate Award), worked in partnership with multiple stakeholders (Saving Newborn Lives; Johns Hopkins University; International Centre for Diarrhoeal Disease Research, Bangladesh; Bangladesh Paediatric Association; PATH through the CHX Working Group) to support the MOH to add CHX to the EML. • **Nigeria:** MCSP played a key role and communicated with states to get CHX included in state EMLs. • **Liberia, Mozambique, Burma:** MCSP supported the national government to adopt and adapt the revised WHO guidelines for treatment of pneumonia to using amoxicillin dispersible tablets to treat childhood pneumonia. • **Mozambique:** Before 2016, when the new National EML was approved, misoprostol only existed as a specialty drug. During 2016 and 2017, MCSP successfully advocated through its senior commodity advisor at the MOH to include misoprostol as an oxytocin alternative for community use.

Financing

There are many potential aspects of financing, such as results-based financing and insurance schemes that could have been looked at, but due to the limited availability of secondary data concerning these elements, they were excluded from this review. Policies establishing user fee waivers have been adopted by many countries to ensure equitable access to health care services for poorer and more vulnerable populations, including pregnant women, infants, and children. Overall, policies for user fee waivers are most widespread for immunization, well-child visits, ANC, and childbirth, and are moderately widespread for pharmaceuticals and supplies for mothers, newborns, and children. Fee waiver policies for services for adolescents ages 15–19 are less common, with only 12 of 27 countries (44%) providing complete fee waivers (Figure 5).

Figure 5. Complete user fee waivers in public system

MCSP Contribution to Financing Policies

Policy Element	Specific Examples
Financing	• **Ghana:** Community-based Health Planning and Services (CHPS) is a strategy to improve delivery of primary health care services. The shift from facility-based to community-based health service delivery is an important health system reform adopted by the Ghana Health Service to reduce maternal and child mortality. Efforts to roll out CHPS in Ghana were constrained by lack of national costing and implementation guidelines. MCSP played a key role in supporting the Ghana Health Service to develop CHPS implementation guidelines and cost estimates. MCSP introduced the CHPS Planning Tool, an Excel-based tool that helps stakeholders to easily project investment and annual operating costs. At subnational level, the tool helps districts identify and mobilize resources, informing decision-making and supporting implementation. To assist the Government of Ghana to make the health system more efficient, accountable, and responsive, MCSP is conducting an actuarial study of the CHPS model and mapping CHPS providers. Results of the study will help determine the contents of the national health insurance scheme benefit package, its financing and payment mechanisms, and service delivery system. • **Nigeria:** In Ebonyi State, MCSP worked with the state MOH and State Primary Care Health Care Development Agency to develop and disseminate a strategy and planning tools to improve financing for essential primary care and RMNCAH drugs through a drug-revolving fund pilot. In addition to obtaining the state MOH's endorsement of the strategy, MCSP also led the institutionalization of financial, logistics management, and monitoring and evaluation tools with the state MOH as it began implementation of the strategy.

Health Information Systems

MCSP undertook a review across 24+ countries to better understand maternal and newborn health (MNH), FP, nutrition, and child health-related content (data elements) in routine health management information systems (HMISs) across USAID-supported countries. The review highlighted widespread gaps in the availability of basic essential data across FP and MNCH. All countries have information systems that help national immunization programs plan, implement, monitor, evaluate, and refine their activities. In the

majority of MCSP-supported countries, vaccine information management systems rely heavily on manual, paper-based, and sometimes fragmented components/tools.
Countries examined in the review have adopted different approaches to health information management, with 18 of the countries electing to track and display RMNCAH-related data through national RMNCAH scorecards, compared to nine countries that have not adopted this information tool.

Policies that enable integration of health data collected at the community level into national HMIS are also widespread. Of the 22 countries with data available on this topic, 21 countries allow community-level data to be routinely collected and integrated into the national HMIS. However, though community-level data are collected and reported, there are still widespread gaps in the linkages between community health information systems and country HMISs.

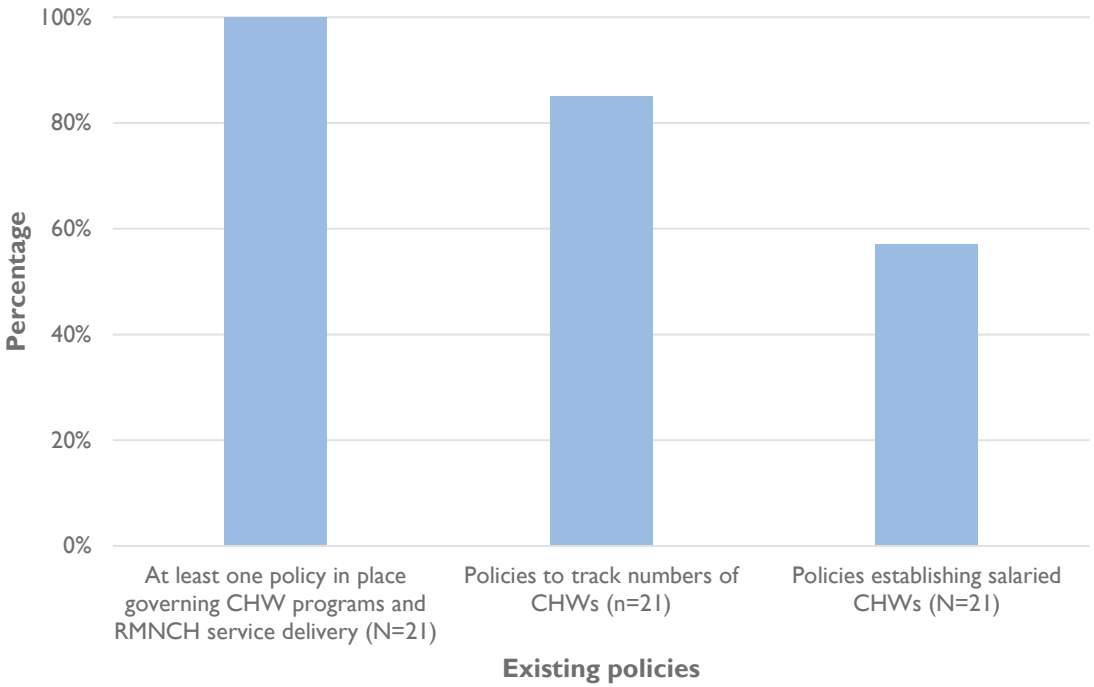
MCSP's Contribution to Strengthening the Health Information System

Policy Element	Specific Examples
Inclusion of key RMNCAH metrics in national HMIS	• **Kenya:** MCSP successfully advocated for the inclusion of key FP indicators in the national HMIS. • **Mozambique:** MCSP was instrumental in supporting the MOH to ensure routine collection of child health data for well and sick children, and their inclusion or availability in Mozambique's national HMIS for the first time. • **Rwanda:** MCSP played a key role in the revision of child health indicators in the HMIS and subsequently standardized reporting tools for child health interventions. MCSP successfully advocated for the inclusion of key FP and maternal and newborn health indicators in the national HMIS. • **Ethiopia:** MCSP successfully advocated for the inclusion and revision of key FP and newborn indicators (specifically possible severe bacterial infection, kangaroo mother care, asphyxia, and postnatal care) in the national HMIS. • **Nigeria:** MCSP successfully advocated for inclusion of key FP and maternal and child health indicators in the HMIS. • **Tanzania:** MCSP successfully advocated for the inclusion of key malaria indicators in the national HMIS. In addition, because there are several parallel data collection information systems for immunization, MCSP supported the MOH to pilot a new vaccine information management system that combines and streamlines data collection into one visualization platform to reduce the duplication of efforts for data management required by health workers. The new system provides immunization program stakeholders with a Web-based, one-stop source of information on vaccine and immunization commodities, cold chain assets, and routine immunization data. • **Namibia:** MCSP provided technical support to the Namibian MOH and Social Science's Health Information and Research Directorate to develop, test, and refine a key piece of the national health information system architecture: the Master Facility List (MFL). The 582 unique health facility identifiers from the MFL are being used across the health system to reduce duplication, map infrastructure and services, and enable data sharing and interoperability between systems such as DHIS 2.0, ePMS, and pTracker. The MFL is hosted by the office of the prime minister.

Community and Civil Society

Effective community-based approaches are critical to improving RMNCAH, both in terms of engagement of key civil society actors and community-based service delivery. Policies that facilitate engagement of CHWs, community members, civil society organizations (CSOs), and the private sector in public health programs are needed if interventions are to be effective, accepted, equitable, and sustainable. Of the 21 countries included in this assessment with relevant available data (Figure 6), 100% have at least one policy in place governing CHW programs and RMNCAH service delivery, 81% have policies that provide for the tracking of CHW-related data, and 57% have a policy establishing salaried CHWs. In contrast, less is known about the state of policies regarding government engagement of CSOs and the private sector in health programs. For example, data on policies related to meaningful government engagement of CSOs could only be found for 14 of 27 countries. Regarding government engagement of the private sector in health programming, data from 13 countries indicate that in the majority (85%), the government provides sufficient and timely information to private-sector partners to facilitate their input into health policy processes. In only two of these 13 countries (15%) does the government not engage private-sector partners in this way.

Figure 6. Community health policies



MCSP Contribution to Community and Civil Society Policies

Policy Element	Specific Examples
Government supports meaningful engagement of CSOs	• **DRC:** In support of DRC's action plan developed at the Institutionalizing Community Health Conference in South Africa in March 2017, MCSP provided technical and financial assistance to develop the National Community Health Strategic Plan. The strategic plan guides implementation of key activities in community health and clarifies roles of key actors at all levels of the system. • **Rwanda**: MCSP worked with the Government of Rwanda to draft and finalize the national community mobilization strategy. • **Nigeria:** For Bauchi and Sokoto states, MCSP provided key technical leadership and inputs to develop and finalize community mobilization and engagement strategies.
At least one policy governing CHW programs and RMNCAH service delivery	• **Egypt:** MCSP supported the Ministry of Health and Population in assessing 15 components of Egypt's national Raedat Refiat (RR) CHW program. Findings from this assessment informed development of a new RR strategy, including policies on hiring new CHWs and providing CHWs with transportation incentives. The Ministry of Health and Population and MCSP jointly launched the new RR strategy in December 2017. • **Ghana:** MCSP supported the development of the CHPS implementation guidelines to help standardize the CHPS strategy. MCSP also developed the CHPS Planning Tool, identified and utilized resources effectively, and planned for sustainability.

Gender

Gender policies and standards are still in the early stages in most countries. Despite the importance of gender issues within public health, publicly available data on adoption of gender-related policies around the world are sparse. In this assessment, MCSP was unable to find publicly available data on availability of national gender strategies for RMNCAH, standards for the provision of gender-based violence (GBV) treatment services, and standards for provision of gender-sensitive service delivery in the 27 priority countries. The absence of available data tracking uptake of gender-related policies and standards at country level highlights a critical gap in knowledge in this policy area.

MCSP Contribution to Gender Policies

Policy Element	Specific Examples
Standards for GBV services	• **Global:** MCSP worked with the US Centers for Disease Control and Prevention and WHO to develop GBV quality assurance standards and gender service delivery standards for improving gender-sensitive/inclusive RMNCAH care. • **Guinea:** MCSP played a key role in revising GBV management standard operating procedures and integrating GBV prevention and management with the Reproductive Health Norms and Procedures (Guinea's key guidance on primary health care delivery).
Policy for implementation of standards for gender-sensitive service delivery/MOH gender strategies for RMNCAH	• **Mozambique:** MCSP supported the development of the second National Gender Strategy for the Health Sector 2018–2023 and helped integrate gender into the sector annual plan that guides annual priorities and activities. The program contributed to male engagement standards for RMNCAH services with the MOH and partners to ensure that key aspects of male engagement are met in all facilities. • **Nigeria:** MCSP supported the MOH to develop the country's first gender and health policy as well as a strategic implementation framework for it. MCSP also helped integrate gender into the 2017–2022 Ebonyi and Kogi states strategic health development plan that guides priorities and activities in the next 5 years. • **Rwanda:** MCSP integrated gender considerations into the FP and adolescent sexual and reproductive health strategic plan and the MNCH strategic plan.

Conclusion

This review highlights the need for the global RMNCAH community to collectively address some key policy gaps and advance the operationalization of those policies. It is also important to generate evidence on what policy elements contribute most to impact. The table below summarizes areas of progress and gaps in RMNCAH policies across various health system areas. It is also important to keep in mind that new interventions and strategies are always being developed, which necessitates robust mechanisms to review and update policies. These updates may require including new commodities in EMLs, incorporating new indicators, and other similar actions.

A mother and her daughter in Nigeria. Photo: Karen Kasmauski/MCSP

Within such a dynamic environment, a program like MCSP that mainly supports implementation can make meaningful contributions not only to policy implementation but also to policy evaluation, agenda setting, formulation, and adoption. The program's participation in global working groups means it is informed of new developments. Within countries, MCSP's presence means it is well-placed to assist governments to effectively and efficiently operationalize and iteratively refine their polices, taking into account results from initial policy implementation. Thus, programs with a mandate to support implementation of or increase demand for services should be involved in helping countries to assess the adequacy of current policies, formulate new or update old policies, and adopt, implement, and refine those policies.

Governance/ Planning	**Costed multiyear RMNCAH plans:** Existence of national-level, costed plans was found to be high across the components of RMNCAH. The existence of costed plans is still a large gap in the areas of child health, along with the absence of more comprehensive and integrated RMNCAH plans. **Quality of care national policies:** The availability of national-level quality of care strategies in alignment with the WHO Quality of Care Network framework was still low as of 2018, though momentum is growing in this area.
Human Resources	Progress is mixed regarding policy elements currently in place to ensure sufficient human resources where needed and authorize them to deliver critical services. Most countries have adopted policies that ensure availability of human resources for RMNCAH services in underserved areas, though much fewer have comprehensive, updated national databases that track health workers by cadre and district to operationalize the policy. In the realm of task shifting, a majority of countries have policies in place authorizing midwives to perform all seven signal functions. In contrast, policies authorizing community-level provision of certain RMNCAH services/products still lag behind.
Essential Drugs	Overall, there is a high level of inclusion of most of the UN Commission on Life-Saving Commodities for Women and Children's drugs in EMLs. The biggest gaps are seen in CHX, misoprostol, and reproductive health-related commodities.
Financing	Complete user fee waivers are widespread for immunization and well-child care; moderately widespread for ANC, maternity care, and newborn and sick-child care; and least established for adolescent care.
Health Information Systems	There are widespread gaps in the availability of basic essential data elements across the RMNCAH spectrum.
Community	All countries examined had at least one policy in place governing CHW programs and RMNCAH service delivery, along with policies that provide for the tracking of CHW-related data. Countries that have a policy establishing salaried CHWs are limited. Less information was available about the state of policies regarding government engagement of CSOs and the private sector in health programs.
Gender	There was an absence of standardized data around availability of national gender-related policies and standards.

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