



THE CHALLENGE INITIATIVE FOR HEALTHY CITIES

End of Project Report

March 2016 – September 2019

The Maternal and Child Survival Program (MCSP) is a global, \$560 million, 5-year Cooperative Agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV and pediatric HIV care and treatment.

This report is made possible by the generous support of the American people through USAID under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of MCSP and do not necessarily reflect the views of USAID or the United States Government.

Table of Contents

Table of Contents.....	3
Lists of Figures and Tables	4
Acknowledgements.....	5
Acronyms	6
Executive Summary – TCIHC India	8
Introduction	11
Goal, Objectives and Expected Results.....	11
Timeline	12
Staffing	13
TCIHC’s Approach.....	13
Key Achievements.....	18
Outcome Level Results	18
Result 1: Cities Implementing Urban FP, MNH and AYSRH HIAs On a Demand-Driven Basis Through the TCI Three-Stage Model.....	20
Result 2: Increased Access by the Urban Poor to Quality FP, MNH and AYSRH Products and Services.....	22
Result 3: Increased Demand by the Urban Poor for FP, MNH, AYSRH Products and Services.....	35
Result 4: An Enabling Environment and Health Systems Improvements that Support the Sustained Delivery and Utilization of a Quality Package of FP/MNH/AYSRH Services by the Urban Poor.....	43
Generating Evidence – Monitoring, Evaluation, Learning and Knowledge Management	52
Lessons Learned and Recommendations.....	55
The Way Forward	60
Annexes.....	63
Annex 1: Amended Results Framework.....	64
Annex 2: TCIHC-Assisted States and Cities – October 2017 to June 2019	65
Annex 3: Examples of TCIHC High Impact Approaches and Tools (How-to FP Tools)	67
Annex 4: Performance Monitoring Plan – End of Phase 1 Update	68
Annex 5: UPHC MNCH Readiness Technical Brief	86
Annex 6: Cities’ UPHC Readiness Scores	90
Annex 7: Quality Assessment for Family Planning Services	99
Annex 8: FPSA Checklist	104
Annex 9: 30 Hour Magic+ Strategy	107
Annex 10: Technical Brief: Strengthening Referral Mechanisms for RMNCH in Urban India.....	109
Annex 11: Factsheet: TCIHC’s Efforts to Strengthen Referral Mechanisms for MNCH in Urban India	114
Annex 12: Case Studies.....	116
Annex 13: ASHA Incentives under NHM Including CDP & NCD (2015 – ’16).....	120
Annex 14: TCIHC Deliverables and Products	123

Lists of Figures and Tables

Figure 1: Timeline of TCIHC activities and implementation 2016 – 2019.....	12
Figure 2: Percent distribution of facilities by overall FP scores, Oct 18 – June 19	25
Figure 3: Changes in UPHC MNCH readiness at 76 UPHCs in MP and Odisha	267
Figure 4: City UPHC readiness scores at baseline and End line – Total scores.....	27
Figure 5: Trend in the numbers of UPHCs providing FDS by month, Feb 18 - Jun 19	30
Figure 6: Uptake of IUCD and Antara, FDS and Routine Day Services, Oct 18 - Jun 19.....	32
Figure 7: Expanding basket of contraceptive choice, June 2019	32
Figure 8: Total estimated FP acceptors in 31 TCIHC cities, Sept '17 - Jun '19.....	36
Figure 9: Estimated FP acceptors in 31 TCIHC cities, UPHCs only, Sept '17 - Jun '19	36
Figure 10: Women reached during coaching of ASHAs, Jan '18 - Jun '19	38
Figure 11: TCIHC Referral System	467
Table 1: Roles & responsibilities of FPA, FPC and FPSA cadres	15
Table 2: Additional health programs 'layered on' the TCIHC platform through July 2019	178
Table 3: Increase in patient footfall in UPHCs and Civil Dispensaries	19
Table 4: UPHC Readiness Assessment Scores at Base-line and End line.....	19
Table 5: Mapping data from 19 TCIHC cities.....	23
Table 6: Thematic areas & assessment scores using final checklists	256
Table 7: Availability of human resources for health at the UPHCs and in catchment areas	278
Table 8: Availability of essential supplies at the UPHCs in intervention cities	28
Table 9: # Urban health workers trained in UP, MP and Odisha from Sept '17 - Jun '19.....	33
Table 10: MNH service improvement in	Error! Bookmark not defined.
Table 11: Distribution of FP Commodities as reported in HMIS and FP Acceptors using CYP methodology	37
Table 12: Comparing NSV acceptance in 20 TCIHC-assisted cities in the state of UP	40
Table 13: Levels of care to which clients were referred by type of service.....	478

Acknowledgements

Our sincere gratitude to the United States Agency for International Development (USAID) and the Bill & Melinda Gates Foundation for their guidance and support and for making The Challenge Initiative for Health Cities in India possible.

None of the results described in this report would have been possible without the Government of India's National Health Mission (NHM) and National Urban Health Mission (NUHM), the Uttar Pradesh, Madhya Pradesh and Odisha state health departments and the chief medical officers and health workers on the frontlines in the 31 cities where TCIHC worked in Phase 1. We are grateful for their partnership and look forward to continuing to learn with them about what it takes to reach the urban poor with quality reproductive, maternal, newborn, child and adolescent health services.

Sincere thanks to Dr Amit Arun Shah, Dr Anuradha Jain, Dr. Nahed Matta and Ms. Nefra Faltas from USAID; Patricia Taylor from the Maternal Child Survival Program (MCSP); Oying Jose Rimon, Kojo Lokko and Jennifer Guertin from the Gates Institute; Lani Crane, Rachel Taylor and Lydnsey Wilson-Williams from Save the Children; and Dr Vivek Sharma, Jesslin Grude, Tatiana Puscasu and Sara Owre from Population Services International (PSI) for their contributions to TCIHC India and this report.


Finally, MCSP would like to acknowledge the entire TCIHC team for its dedication and hard work. You have taken TCIHC from an interesting idea to a dynamic program that has already, in its first three years, reached three states, 31 cities, over 500 health facilities of different types, thousands of frontline health workers and countless beneficiaries. A special vote of thanks to TCIHC's senior management team in New Delhi (Dr. Mukesh Sharma, Hitesh Sahni, Emily Das, Devika Varghese, Deepti Mathur, Gunjan Razdan, Parul Saxena, Amit Chowdhury, Santanu Chakraborty, Dr Rahul Singh Bhadouria and Sabyasachi Behera) and to the TCIHC state managing directors and their technical advisors and field teams. It has been MCSP's pleasure to work with all of you during Phase 1 of this ground-breaking urban health program and we wish you continued success moving into TCIHC Phase 2.

Acronyms

AFHS	Adolescent Friendly Health Services
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwives
ASHA	Accredited Social Health Activist
AWW	Anganwadi Workers
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BMGF	Bill & Melinda Gates Foundation
CHC	Community Health Center
CYP	Couple-Years of Protection
DEC	[USAID] Development Experience Clearinghouse
DQAC	District Quality Assurance Committees
DQAU	District Quality Assurance Units
EAQ	Expanded Access and Quality
ECP	Emergency Contraceptive Pills
EOI	Expression of Interest
ESB	Ensuring Spacing at Birth
FDS	Fixed Day Static Services
FP	Family Planning
FPA	Field Program Assistants
FPC	Field Program Coordinators
FPD	Family Planning Day
FP-LMIS	Family Planning Logistics Management Information System
FPSA	Field Program Service Assistants
FTP	First-Time Parents
GI	Gates Institute
GoI	Government of India
GoMP	Government of Madhya Pradesh
HIA	High Impact Approach
HMIS	Health Management Information System
HUP	Health of the Urban Poor
IPU	Integrated Pediatric Units
IUCD	Intrauterine Contraceptive Device
LAO	Lead, Assist, Observe Approach
LHV	Lady Health Visitor
MAS	Mahila Arogya Samiti [community women's groups]
MCSP	Maternal and Child Survival Program
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MNCH	Maternal, Newborn and Child Health
MoHFW	Ministry of Health and Family Welfare
MoHUA	Ministry of Housing and Urban Affairs
MOiC	Medical Officers in-Charge
MOU	Memorandum of Understanding
MP	Madhya Pradesh
NCD	Non-Communicable Diseases
NFHS	National Family and Health Survey
NGIs	Non-Government Individuals
NHM	National Health Mission
NQAS	National Quality Assurance Standards
NSV	No-Scalpel Vasectomy
NUHM	National Urban Health Mission
ORC	Outreach Camp

OTS	Output Tracking Survey
PCC	Patient-Centric Care
PIP	Project Implementation Plan
PMA	Performance Monitoring and Accountability
PMIS	Program Management Information System
PSI	Population Services International
QI	Quality Improvement
RKSK	Rashtriya Kishore Swasthya Karyakram
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNH	Reproductive, Maternal and Newborn Health
SARA	Service Availability and Readiness Assessment
SBCC	Social and Behavior Change Communication
SDGs	Sustainable Development Goals
SDP	Service Delivery Point
SIFPSA	State Innovations in Family Planning Services Project Agency
SN	Staff Nurse
SNL	Saving Newborn Lives
TB	Tuberculosis
TCI	The Challenge Initiative
TCIHC	The Challenge Initiative for Healthy Cities
UHI	Urban Health Initiative
UHIR	Urban Health Index Register
UHND	Urban Health and Nutrition Day
UP	Uttar Pradesh
UPHC	Urban Primary Health Center
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary – TCIHC India

	Geographic Implementation Areas States <ul style="list-style-type: none"> 3/29 (10%)—Madhya Pradesh (MP), Uttar Pradesh (UP), Odisha Cities <ul style="list-style-type: none"> 20/75 (27% cities in Uttar Pradesh) 8/52 (15% cities in Madhya Pradesh) 3/36 (8% cities in Odisha) 	Population Country <ul style="list-style-type: none"> 1.32 billion ^[1] MCSP-supported states <ul style="list-style-type: none"> 321 million MCSP-supported cities <ul style="list-style-type: none"> 28 million 10 million slum population
---	---	--

Technical Areas



Program Dates

March 1, 2016 to Sept 30, 2019

Total Life of Project Funding

\$ 6,000,000 USAID

\$ 11,200,000 Gates Foundation

Demographic and Health Indicators

Indicator	# or %
Live births/year ^[2]	25,427,955
Maternal Mortality Rate (MMR) (per 100,000 live births) ^[3]	130
Neonatal Mortality Rate (per 1,000 live births) ^[4]	23
Under 5 Mortality Rate (per 1,000 live births) ^[4]	37
Total Fertility Rate (births per woman) ^[5]	2.2
Contraceptive Prevalence Rate (modern methods) ^[5]	47.8%
Antenatal Care (ANC) 4+ ^[5]	51.2%

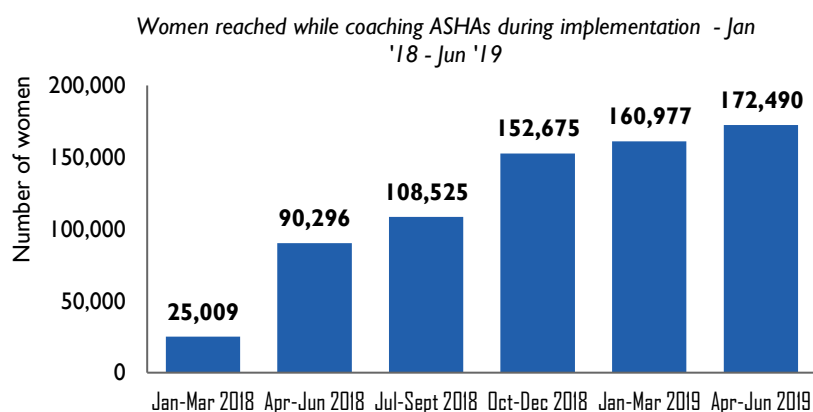
Sources: [1] *The Demographic & Development Divide in India (2019)* p. 39 [2] 2011 Census of India; [3] *Special Bulletin on Maternal Mortality, Office of RGI, -SRS (2014 – 16)* [4] *SRS Statistical Report, 2017 (Statement 48, 53 & 24 RGI), New Delhi; 2019*, [5] *IIPS and ICF.2017. NFHS-4, 2015-16, Mumbai*

Strategic Objectives through the Life of Project

- Increase the use of modern contraceptive methods and improve the coverage and quality of evidence-based Family Planning (FP) and Maternal and Newborn Health (MNH) interventions in 31 cities.
- Support cities implementing urban best practices and evidence-based interventions on a demand-driven basis.
- Increase access to and demand for quality FP and MNH products and services by the urban poor
- Establish an enabling environment and health systems improvements that support the sustained delivery and use of a quality package of FP and MNH services by the urban poor

Highlights through the Life of Project

- Helped increase the number of health facilities in the 31 cities offering fixed day voluntary FP services from 87 to 482; expanded contraceptive choice at facilities; enhanced counseling skills of more than 5,100 providers; and saw an average 2.49% increase in new FP acceptors per month by the end of MCSP's support
- Introduced the urban primary health center readiness assessment tools and processes to 66 urban local bodies; assessed 100% (n=76) of urban primary health centers in the 11 MNH TCIHC cities in Madhya Pradesh and Odisha; assisted Madhya Pradesh and Odisha to roll out a new referral mechanisms in three cities; and helped to introduce the concept of an integrated pediatric unit in one secondary hospital
- Leveraged more than USD 60 million for FP/MNH best practices during the 3-year period of TCIHC through the annual Program Implementation Process (PIP) of the National Health Mission (NHM) to expand global health best practices and evidence-based interventions



The Challenge Initiative for Healthy Cities (TCIHC) was jointly supported by USAID through its global Maternal and Child Survival Program (MCSP) and by the Bill and Melinda Gates Foundation (BMGF) through The Challenge Initiative (TCI) at the Johns Hopkins University, Gates Institute (GI). USAID's support started in March 2016 and ended in India August 31, 2019 while Gates Foundation's support started a few months later, in October 2016 and will continue with a focus on adolescent and youth sexual and reproductive health (AYSRH) through June 2021. TCIHC applies a "business unusual" approach that is demand driven, evidence-based, scalable and designed to be sustainable from the start. In a strategic shift away from the traditional model of donor-funded development, TCIHC requires state and local governments to demonstrate political commitment by bringing their own financial, material and human resources to high-impact solutions to the family planning and maternal neonatal health problems that plague India's urban poor.

During the first three years of MCSP and GI/TCI involvement, TCIHC worked to strengthen city level health systems and improve family planning (FP) services for the urban poor in 31 cities and three states of India – Uttar Pradesh (UP), Madhya Pradesh (MP) and Odisha. With USAID support and MCSP technical assistance, TCIHC also demonstrated a set of promising maternal and newborn health (MNH) practices in MP and Odisha and facilitated a multi-sectoral conversation about urban health improvement at the national level. TCIHC worked with state and city health officials to identify health service gaps and through the Government of India's National Health Mission (NHM) and its annual Program Implementation Planning (PIP) process to leverage or "unlock" available resources for urban health, FP, MNH and AYSRH. TCIHC also promoted links between private sector service providers and state government health systems and supported community outreach, quality improvement and social and behavior change activities to raise awareness and increase demand for quality FP and MNH services.

Government health management information system (HMIS) data show a 44% increase in FP acceptors across the 31 TCIHC cities between TCIHC's start up in 2017 and MCSP's close out in mid-2019 and an 80% increase when considering only the TCIHC assisted Urban Primary Health Centers (UPHCs). The increase in overall "footfall" or utilization of UPHCs also increased by 36.6% in the cities receiving TCIHC's maternal and newborn health support. TCIHC contributed to these impressive results by working with the three states and 31 cities to:

- ***Increase the supply, expand contraceptive choice and improve the quality of FP services:*** TCIHC supported the cities to map and list their urban populations, assess UPHC readiness to deliver FP and MNH services and increase the number of UPHCs, Urban Health and Nutrition Days (UHNDs), Outreach Camps (ORCs) and frontline health workers offering voluntary FP services on a regular basis. As a result, the number of UPHCs offering regular FP fixed day static services (FDS) increased from 87 to 482, with 82% of these UPHCs providing FDS weekly. TCIHC used FP readiness assessments and the 30-hour magic plus strategy – demonstrating the activation of facilities with 30 hours of effort – to rapidly scale up the FDS approach in each state; advocated for greater contraceptive choice at the UPHCs; and, improved the quality of voluntary FP services by supporting the training and actively mentoring and coaching UPHC staff. TCIHC also activated existing District Health Quality Assurance Committees (DQAC) and Units (DQAU); introduced quality improvement committees at UPHC level for the first time; and, improved the flow of contraceptives to the community level by linking Accredited Social Health Activists (ASHAs) directly to the government's electronic Logistics Management Information System and requisitioning processes. Finally, TCIHC promoted the strategic purchasing of private sector FP services by government and worked in five cities in UP to meet the special needs of newly married and first-time parents for information and access to modern contraceptives. Considering the opportunity to expand the choice of facilities to the urban poor, the FP/NUHM teams in Odisha and MP were exposed to this model. Both states are now in the advanced stage of signing an MoU with PSI to seek support in developing an online system for strategic purchase of services from private sector for urban poor.
- ***Generate and aggregate demand for FP, MNH and AYSRH services:*** The cornerstone of TCIHC's work to accelerate demand for FP methods was improving the counselling and community engagement skills of 5,789 ASHAs and 2,529 Auxiliary Nurse Midwives (ANMs). This was done through on-the-job coaching/mentoring and formal training courses. TCIHC also updated and facilitated the production and distribution of FP messages and materials by the states themselves;

conducted an innovative mid-media campaign targeting couples from 15-24 years of age in the AYSRH cities of UP, winning a prestigious national prize for its effort; supported selective mass media campaigns in three states; and demonstrated a systematic approach to referral for MNCH services, as well as voluntary FP services from community to facility level and between facilities.

- ***Demonstrate the benefits of systematic referral and the organization of integrated pediatric units (IPU) in secondary health facilities:*** In the states of MP and Odisha, TCIHC worked to improve UPHC services by introducing a UPHC readiness assessment and conducting formative, baseline and End line assessment rounds in 76 UPHCs in the 11 TCIHC assisted cities in the two states. TCIHC also adapted and demonstrated an MNCH/FP referral mechanism in three cities (two in MP and in Odisha) to decongest higher level health facilities and encourage the appropriate use of UPHCs by engaging ASHAs in the referral process and putting standardized referral procedures, forms and feedback mechanisms into place at all levels. The referral mechanism captured the attention of both states, with MP planning to expand it to reach ten cities (eight that were TCIHC assisted and two that were not) and Odisha considering doing the same. A qualitative assessment of the referral mechanism shed light on its strengths and weaknesses and highlighted some of the additional work needed to make it more effective in the future. Finally, to improve the quality of care for sick newborns and children at hospital level, TCIHC worked in Indore to demonstrate the benefits of an integrated pediatric unit that brings previously separate Special Newborn Care and Pediatric Intensive Care units, along with other specialized and ancillary units, together in a dedicated area and under unified leadership. By the end of MCSP, the Government of MP was planning for expansion of IPUs to eight more districts.
- ***Strengthen the enabling environment for FP and MNH:*** TCIHC improved coordination and planning across urban local bodies, government departments and partners in the 31 cities and three states. Through its advocacy and demonstration activities, TCIHC leveraged the equivalent of over \$60 million USD to expand evidence-based, high-impact approaches (HIA) to FP, MNH interventions and urban health systems solutions through the annual NHM PIP process. The initial goal of creating an expandable urban health platform to address not only FP and MNH but also other urban health needs was also achieved with the “layering on” of AYSRH strategies in five cities of UP and the testing of urban tuberculosis (TB), non-communicable disease (NCD) and patient centric interventions with funding from other organizations.
- ***Generate and use evidence in planning urban health improvements:*** TCIHC brought a number of quantitative and qualitative assessments and studies to its work in the three states including facility readiness assessments, output tracking surveys, facility FP quality improvement assessments, rapid assessments of urban health status and stakeholder consultations. The purpose of these assessments and studies were to generate evidence to share with key stakeholders and use to refine strategies for improved results. The findings were used by facility staff for immediate actions, by city officials to arrange necessary support and by state officials to ensure long term support to cities.

TCIHC made its Phase 1 results and learning available through a series of forums and meetings at state and national levels. They will also be posted on the GI/TCI [TCI University](https://tciurbanhealth.org/tci-university/)¹, [USAID Development Experience Clearing House \(DEC\)](https://dec.usaid.gov/dec/home/Default.aspx)², [MCSP legacy](https://legacy.mcsprogram.org)³ and MCSP partner’s websites⁴. Gates Foundation and the Gates Institute/TCI will continue to support TCIHC through June 2021, taking forward some of the current FP and expanding the AYSRH activities in the three states. At the close of MCSP, USAID-supported MNH activities transitioned to the state governments of MP and Odisha. MCSP understands that it is USAID’s intent to continue providing urban health technical support through the TCIHC platform into the future.

¹ <https://tciurbanhealth.org/tci-university/>

² <https://dec.usaid.gov/dec/home/Default.aspx>

³ <https://legacy.mcsprogram.org>

⁴ <https://www.psi.org> & <https://www.savethechildren.org>

Introduction

TCIHC was supported jointly by USAID through its global Maternal and Child Survival Program (MCSP) and by the Bill and Melinda Gates Foundation through The Challenge Initiative at Johns Hopkins University Gates Institute (GI/TCI). During the three-year period of joint USAID and Gates Foundation support, TCIHC worked with state governments, district health offices and urban local bodies⁵ in 31 cities and three states – Uttar Pradesh (UP), Madhya Pradesh (MP) and Odisha--to strengthen city level health systems and improve family planning and maternal and newborn health outcomes for the urban poor

TCIHC India is one of four GI/TCI ‘accelerator hubs’ that are working in similar ways to accelerate the uptake of proven FP and adolescent and youth sexual and reproductive health (AYSRH) interventions in India, Nigeria and countries in the Eastern and Western regions of Africa.⁶ TCIHC adopted TCI’s ‘business unusual’ approach to accelerate the scale up of high impact approaches (HIA) that had been proven to improve FP and health outcomes for India’s urban poor by past projects. TCIHC’s approach is demand-driven, with participating cities self-selecting and competing for TCIHC’s support based on defined criteria. TCIHC represents a strategic shift away from the traditional model of donor-funded development by requiring state and local governments to show their political commitment by providing significant financial, material and human resources to address the health problems plaguing their cities.

USAID India supported TCIHC’s family planning activities and added a maternal and newborn health component from the start of the effort. MCSP’s partner organization Population Services International (PSI) led the TCIHC team for both MCSP and GI/TCI. Save the Children provided MNH and health systems strengthening assistance in two of the three TCIHC assisted states, MP and Odisha.

Goal, Objectives and Expected Results

TCIHC’s stated goal and strategic objectives are to reduce preventable maternal, newborn and child deaths among the urban poor by increasing the use of modern contraceptive methods among married women 15-49 years of age - with special focus on adolescents and youth – and by improving the coverage and quality of evidence-based reproductive, maternal, newborn and adolescent health interventions.

TCIHC’s expected results during Phase 1 were as follows:

- **Result 1:** Cities implementing urban FP, MNH and AYSRH HIAs on a demand-driven basis through the [TCI three-stage model](#)⁷.
- **Result 2:** Increased access by the urban poor to quality FP, AYSRH and MNH products and services
- **Result 3:** Increased demand by the urban poor for FP, AYSRH and MNH health products and services.

⁵ From http://mospi.nic.in/sites/default/files/Statistical_year_book_india_chapters/local%20bodies.pdf Urban Local Bodies are of three types determined by state governments: Nagar Panchayat for areas in transition from rural to urban; Municipal Council in smaller urban areas; and Municipal Corporation in larger urban areas. Their responsibilities and authorities differ by type and by state.

⁶ From www.tciurbanhealth.org - The Challenge Initiative (TCI) is led by the Bill & Melinda Gates Institute for Population and Reproductive Health (GI) at Johns Hopkins Bloomberg School of Public Health. TCI builds on the demonstrated success of the Gates Foundation’s Urban Reproductive Health Initiative (URHI) and aims to provide life-saving reproductive health and family planning information and services to individuals, families and communities through “accelerator hubs” located in India, Nigeria, Senegal and Kenya. TCI’s demand-driven model calls for rapidly scaling up and sustaining proven reproductive health solutions for underserved urban poor communities by transferring key knowledge and skills; cultivating a culture of learning, exchange and continuous improvement; and incentivizing city commitment and responsibility for meeting the reproductive health needs of their citizens. The model’s three-stage process—submit an expression of interest, design a program and implement a program—primes local ownership from the outset and nurtures city leadership in program design and implementation.

⁷ Stage One – EOI (Expression of interest)-Cities submit their EOIs and are selected based on defined criteria. Stage Two – Project Design (PD) - Selected cities develop their PD with the help of TCIHC. Stage Three – Implementation, cities carry out approved strategies with technical support and coaching/mentoring from TCIHC.

- **Result 4:** An enabling environment and health system improvement that support the sustained delivery and use of a quality package of reproductive, maternal and newborn health (RMNH) services for the urban poor and AYSRH services for married and unmarried adolescents

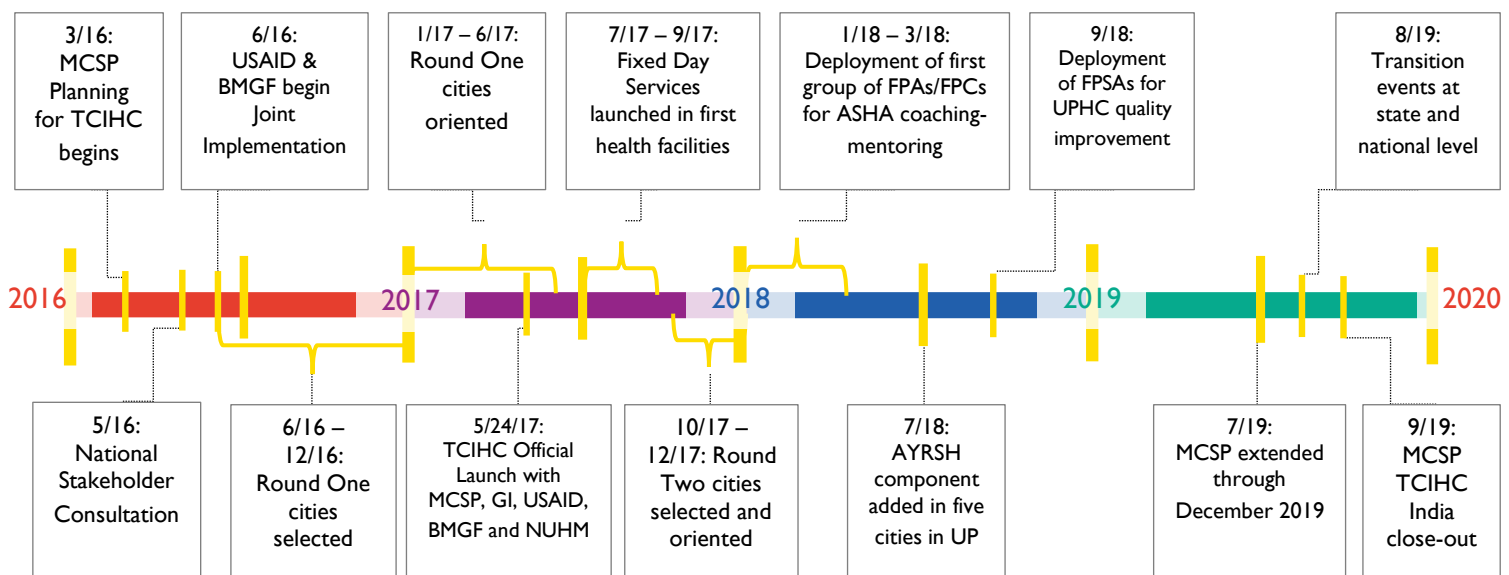
The next chapters of this report describe TCIHC’s approach and achievements under the strategic objectives and each of these results. Annex 4, Performance Monitoring Plan and Achievements through June 30, 2019, includes the indicators, targets and TCIHC’s quantitative achievements against each of these over the three years of joint USAID and Gates Foundation support.

Timeline

Planning for TCIHC started in early 2016, with a start-up work plan approved later that year. USAID and the Gates Foundation jointly funded all FP activities in the three states. USAID provided dedicated funding that TCIHC used to add a number of promising MNH approaches to the work in MP and Odisha.

Figure 1: Timeline of TCIHC activities and implementation 2016 – 2019

**Dates are written in Month/Year or Month/Day/Year format*



TCIHC started work with 12 cities in its first year -- five in UP, four in MP and three in Odisha. Cities in the first round were selected based on secondary data analysis and with the active involvement of the state NHMs. Building on experiences during the first year, TCIHC successfully expanded its FP and urban health system strengthening activities to an additional 19 cities in Year 2, for a total of 31 cities by mid-2018 – 20 in UP, eight in MP and three in Odisha. Round 2 cities self-selected (consistent with TCI’s demand driven model), submitted competitive Expressions of Interest (EOI) and were selected by TCIHC and the state NHM/NUHMs based on five criteria: 1) political commitment, 2) local contribution, 3) system readiness, 4) potential size of impact and 5) ability to implement HIAs.

In all three years, TCIHC’s MNH team worked with the 11 TCIHC assisted cities in MP and Odisha, with three of these cities receiving more intensive support for demonstration activities. In the third year, GI/TCI added an ambitious AYSRH component in five cities of UP. TCIHC teams also provided “light touch” support as states adopted specific HIAs and began to roll them out to new cities, beyond the original 31. See Annex 2 for a list of TCIHC assisted cities, their populations, the date TCIHC assistance started and the types of TCIHC support received.

USAID extended MCSP’s TCIHC end date to June 30, 2019 to coincide with the end of the first three years of GI/TCI support. Both mechanisms – MCSP and GI/TCI – were then extended again, MCSP through

September 30, 2019 and GI/TCI for at least one additional year and with the intent to fund AYSRH activities through June 2021.

In the remainder of this report, we use “Phase 1” to mean the period of joint MCSP and GI/TCI support and “Phase 2” to mean the period after USAID’s involvement when GI/TCI will become TCIHC’s primary source of support.

Staffing

TCIHC staffed each of the three states with a general manager and operations staff. Cities were staffed with city managers, Field Program Assistants (FPAs) for every two UPHCs and Field Program Coordinators (FPCs) for every five FPAs to carry out the initiative’s coaching-mentoring strategy. At the end of Year 2, TCIHC added one district-based Field Program Service Assistant (FPSA) for every 10-15 UPHCs to focus specifically on quality improvement strategies at district and UPHC level. The MNH teams in MP and Odisha included a small national team and state- and city level technical consultants according to the needs of the state. Management, advocacy, technical, communications, monitoring evaluation and administrative teams at the PSI India and Save the Children India offices in New Delhi supported state and city teams. MCSP’s home office provided management and technical oversight through a small country support team. See Table 1 in the next section for the key functions of FPAs, FPCs and FPSAs.

TCIHC’s Approach

Promoting the scale up of proven high impact approaches (HIAs): TCIHC promotes the adoption and scale up of HIAs from India’s earlier urban health projects, including the Urban Health Initiative (UHI), which was funded by the Gates Foundation from 2009 to 2014; Health of the Urban Poor (HUP), funded by USAID from 2009 to 2014; Expanded Access and Quality (EAQ), funded by the Gates Foundation from 2015 to the present; and Saving Newborn Lives (SNL), the third phase of which was funded by the Gates Foundation from 2013-2017 and included an urban MNH pilot in two cities in Odisha and Maharashtra states.

TCIHC Family Planning HIAs	
1.	Mapping and listing of urban slums
2.	Convergence – integration of FP and MNH
3.	Fixed Day Services (FDS)
4.	Enhancing capacity of Urban ASHA
5.	FP capacity-building
6.	Using data for decision-making
7.	Private sector engagement
8.	Program Implementation Plan
9.	Strengthening community women’s groups (Mahila Aarogya Samiti, MAS)

10.	City health plan
11.	Quality assurance
12.	Male engagement

Identifying and leveraging funding to fill urban health systems gaps: TCIHC works with state and city health officials to identify health service gaps and then leverages or ‘unlocks’ funding available for FP, MNH, AYSRH and urban health through the annual NHM PIP process. By playing the role of catalyst, broker and facilitator, TCIHC improves urban health planning by improving the quality and use of data in decision-making and puts cities in the driver’s seat. TCIHC also links private sector service providers to government health systems and supports community outreach, quality improvement and behavior change to raise awareness and increase demand for quality FP and MNH services.

Operationalizing the GoI's national urban health model: At the state and national level, TCIHC works with the NHM and Ministry of Health and Family Welfare (MoHFW) divisions responsible for reproductive, maternal, newborn, child and adolescent health (RMNCAH) to operationalize the National Urban Health Mission's (NUHM) service delivery model. This includes advocating to secure government buy-in for HIAs, more funding for city health systems in general and improved execution of NHM and state health plans and budgets. TCIHC also contributes to the enabling environment of policies, strategies and tools that will it possible to expand and sustain urban health improvements over time.

Advocacy to state government and urban local bodies: To bring quality health care closer to the urban poor, TCIHC started by advocating to city and state leadership, raising their awareness about the connection between FP/MNH and development goals and ensuring that they understood the importance and long term implications of making quality FP and MNH services available to all urban residents. To generate stakeholder interest and drive participation, the project held government consultations to identify areas of need, generate support and begin the process of developing city health plans.

Strengthening the urban health system: MOHFW guidelines call for Urban Primary Health Centers (UPHC) to serve populations of approximately 50,000 on a daily basis. They also mandate monthly Urban Health and Nutrition Days (UHNDs) in communities that are conducted by ANMs, Anganwadi Workers (AWW) and ASHAs at Anganwadi Centers and Outreach Camps (ORC) that are also to be held monthly in underserved communities around the UPHCs. ASHAs – or urban ASHAs in cities – are assigned to the UPHCs and should serve a population of approximately 2,000 people each. The ASHA is the individual responsible for mobilizing their communities to take advantage of UPHC, UHND and ORC services. Different types of FP and MNH services should be provided at all UPHCs, UHNDs and ORCs and during ASHA home visits.

When TCIHC started in the three states, many UPHCs were operational, but they needed guidance and coaching to improve their performance. Many were also underutilized⁸ either because of where they were located, minimal publicity about the services they offered and/or not having the right staff, supplies and infrastructure to provide quality care. As a result, potential clients bypassed the UPHCs and went directly to private health providers or public sector hospitals that were already overcrowded.⁹ Community-based services were also being provided in most cities through UHNDs, ORCs and ASHA home visits, per the national guidelines, but they were focused mostly on immunization and not reaching significant proportions of the urban poor population.

In TCIHC's work to strengthen FP and MNH services at the UPHCs, UHNDs and ORCs, one of its first activities was the mapping and listing of poor urban communities and their populations, including the triangulation of available data from a variety of sources. TCIHC also conducted assessments of different types and tapped into the knowledge of city and state health officials to identify problems, TCIHC determined UPHC readiness to provide and generate demand for voluntary FP services in all cities and in MP and Odisha, TCIHC also supported a broader UPHC readiness assessment that was based on the World Health Organization's (WHO) Service Availability and Readiness Assessment (SARA) framework.¹⁰ In all three states, TCIHC worked with cities to use the findings from their mapping/listing exercises and facility readiness assessments to plan and leverage annual PIP funding to upgrade UPHCs, increase the number of frontline health workers (including ASHAs, ANMs and medical officers) and build their capacity to better deliver FP and MNH services to the urban poor.

Coaching and mentoring frontline health workers: One of the important lessons from the earlier urban health and family planning projects--UHI, EAQ and HUP—was that frontline health workers required not only formal training courses but also intensive coaching to improve the quality of their counseling. In late 2017, TCIHC added Family Planning Assistants (FPA) and Coordinators (FPC) who thereafter provided onsite mentoring and coaching, teaching the ASHAs to:

⁸ Per the NUHM's 2013 Framework for Implementation

⁹ For example, the results of the city assessments showed that in MP, UPHCs are supposed to function from noon to eight pm. However, in some cases, there is only one medical officer and UPHCs close at 4 pm. There are also instances when the medical officer is instructed by Civil Surgeon to sit in the nearby hospital because of larger patient load.

¹⁰ WHO Service Availability and Readiness Assessment (SARA) Reference Manual, Version 2.2 Revised July 2015

- Map and segment FP clients using the Urban Health Index register (UHIR).
- Use more effective counselling techniques when interacting with different segments of potential clients, i.e., young first-time parents, users who have discontinued a FP method, users switching between methods, non-users of contraceptive methods, etc.
- Manage risks and challenges of FP method-related side effects.
- Leverage existing incentive schemes for FP, such as the poorly understood monetary incentive available to ASHAs who are successful in helping couples space births at least three years apart and.
- Promote greater convergence¹¹ among ANMs, AWWs and ASHAs, who should work together to improve and institutionalize FP counseling, method choice and FP service provision during monthly UHNDs.

TCIHC's model further evolved in Year 2 with the addition of FPSAs who focused on improving the quality of FP service delivery at the UPHCs and secondary health facilities.

Table 1: Roles & responsibilities of FPA, FPC and FPSA cadres	
Cadre	Roles
Field Program Associates	<ul style="list-style-type: none"> • Assists, coaches and mentors urban ASHAs on family planning counselling • Builds the capacity of ASHAs and gives them the confidence they need to independently and effectively counsel eligible women • Each FPA meets two ASHAs in a day and all ASHAs at least once every month • Accompanies ASHAs on at least five household visits during the normal coaching/supervision visit, thus helping ASHAs to meet and counsel at least ten women per day
Field Program Coordinator	<ul style="list-style-type: none"> • Ensures the quality of ASHA counselling and provides support to the FPAs with the help of: <ul style="list-style-type: none"> - City communication contact plans, which are used to identify vulnerable cases in catchment areas and focus on getting results - Daily activity reports that enable ASHAs and FPAs to assess their effectiveness on a daily basis - Supportive supervision tools which help the FPC to identify problems and provide solutions immediately to their coaching recipients
Field Program Service Assistant	<ul style="list-style-type: none"> • Entrusted to independently observe quality of care in family planning /related services at the UPHCs. • Visits two facilities per day, however, if one facility is holding an FDS, FPSA should focus on that facility. • On the FDS day, observes the 'process' and all the activities. • Ensures UPHC readiness (adherence to FP/FDS facility readiness checklist) especially before every FDS/FPD • Facilitates formation, supports regular meetings and oversees performance of government-mandated Quality Improvement (QI) teams, as per National Quality Assurance (NQAS) guidelines • Informs Manager - Programs (TCIHC city) and TCIHC medical teams about her observations using checklist, highlighting those that require immediate attention

Increasing the supply of voluntary FP services and expanding contraceptive choice at UPHCs and in communities: TCIHC worked to improve the demand for and quality of voluntary FP services and to increase contraceptive choice in the three states. Working with UPHCs and government hospitals in all 31 cities, TCIHC introduced Fixed Day FP Services (FDS), an important HIA from earlier projects (see [FDS toolkit on TCI University website](#))¹². FDS ensure the availability of quality FP services on a fixed day, at a fixed place, where all required supplies, trained staff and infrastructure are available and both short term and long acting reversible contraceptive methods are offered. At the community level, in addition to mentoring ASHAs and ANMs and engaging them and community women's groups – Mahila Aarogya Samiti (MAS) – in demand generation, TCIHC emphasized the importance of delivering FP counseling, services and referral at all monthly UHNDs and ORCs. TCIHC also supported microplanning to ensure that these community-based service delivery events were being carried out in areas of highest need. Finally, TCIHC worked to increase contraceptive choice through advocacy and by helping to put the GoI's policies on contraceptive choice into practice at the UPHC

¹¹ In India, the term "convergence" means collaboration and cooperation across ministries and sectors. In this case, the ANM and ASHA pertain to the MOHFW, while the AWW pertains to the Ministry of Women and Child Development. The success of the community UHND depends on good working relationships and clear roles and responsibilities between these three cadres, as well as data-driven microplanning so that the UHND team is prepared with the supplies, equipment and space needed to service the women, infants and children who attend.

¹² <https://tciurbanhealth.org/lessons/fixed-day-static-approach/>

level¹³. Adding FPSAs in Y3 was part of TCIHC’s continuing effort to ensure that all UPHCs in the 31 cities were able to meet India’s national standards for FP quality of care.

**TCIHC Maternal and Newborn
Evidence-based Approaches
from
India’s National Newborn
Action Plan**

1. Antenatal care – early and number per norms
2. Referral for maternal complications (pre-eclampsia, postpartum hemorrhage, sepsis)
3. Basic Emergency Obstetrical and Neonatal Care including the Active Management in the Third Stage of Labor, Essential Newborn Care and Newborn Resuscitation
4. Facility-based care for newborns, including inpatient care of small and/or sick newborns
5. Post-natal care at the facility for mother and newborns with counselling and early detection of complications and danger signs, postpartum family planning and pre-discharge post-natal care

Improving referral and the quality of MNH services in MP and Odisha: USAID funding made it possible in MP and Odisha to add maternal and newborn health objectives to the TCIHC platform. Working with the NUHM and RMNCAH focal points in these two states, TCIHC developed the UPHC readiness assessment tool and used it with city health officials to conduct repeat assessments in 76 UPHCs in 11 cities. TCIHC also worked to improve the quality of care for pregnant women and newborns at UPHCs and referral health facilities in three demonstration cities—Indore and Gwalior in MP and Berhampur in Odisha. They also mentored and coached medical officers and ANMs at UPHCs, community health centers (CHC)¹⁴ and referral hospitals, piloted a referral mechanism that included community to UPHC and UPHC to CHC and hospital levels and provided technical assistance to design an IPU with the management of the District Hospital in Ratlam and PC Sethi Hospital in Indore. MP’s Department of Health and Family Welfare were early acceptors of all of these approaches and had already begun rolling out the UPHC readiness assessment, referral mechanism and IPU concepts to other cities with “light touch” support from TCIHC MNH staff in Year 3 of TCIHC. For descriptions of each of the MNH approaches see Strategies 2.1, 3.2 and 3.4 below.

“Layering” other health interventions on the TCIHC platform¹⁵: India’s 2017 National Health Policy emphasizes the provision of comprehensive primary health care to avert disease and promote well-being, ensure continuity of care and enable gatekeeping to reduce the burden on secondary and tertiary level facilities and reduce costs. Consistent with this policy, TCIHC’s approach is proving successful not only for scaling up FP

¹³ In September 2017, the MOHFW added two new contraceptives, an injectable, 'Antara' and a contraceptive pill, 'Chhaya' to expand the basket of contraceptive choices offered by public health clinics. Antara releases progesterone to prevent pregnancy; Chhaya or Centchroman is a weekly, non-hormonal oral contraceptive pill that has been shown to be safe and effective and can be given to breastfeeding mothers. IUCDs were provided by government hospitals at the start of TCIHC; plans were to introduce them in rural PHCs first, with UPHCs given priority only in Y3. TCIHC worked with the states to advance the start-dates in urban areas for Antara and IUCD insertion.

¹⁴ Community Health Centers are the Government of India’s public health system’s first referral units. In addition to outpatient care, they are required to have obstetric care, newborn/childcare and blood storage capacities and to operate 24 hours a day, seven days a week. CHCs are funded by state governments and should serve around 120,000 people each in urban areas.

¹⁵ The process of adding other interventions to the TCIHC platform is referred to as “layering on” in the remainder of this report.

and MNH HIAs, but also for improving the coverage, quality and outcomes of other important primary health care (PHC) interventions. For example, during the first three years of TCIHC, the Initiative successfully added an ambitious AYSRH component with funding from BMGF, a TB activity in collaboration with USAID’s SHOPS project, a pilot non-communicable disease activity with support from Eli Lilly and company and a small Patient Centric Care (PCC) pilot with the University of California at San Francisco. Each of these experiences with ‘layering on’ is described in detail in the next section of this report.

Table 2: Additional health programs ‘layered on’ the TCIHC platform through July 2019			
<i>Data Source: Project Records of TCIHC</i>			
Thematic Health Area	No. of cities	State	Donor/ Implementer
AYSRH	5	UP	BMGF/PSI
TB	7	MP	USAID/SHOPS
NCD (city of Varanasi)	1	UP	Eli Lilly
PCC (city of Varanasi)	1	UP	UCSF

Catalyzing a multi-sectorial urban health approach: With guidance from USAID India, TCIHC began the development of a platform at the national level that is led by the Ministry of Housing and Urban Affairs (MoHUA) to strengthen inter-ministerial collaboration around urban health. This platform is intended to strengthen policy and programmatic directions across ministries and technical areas, as this is seen as being key to achieving desired outcomes linked with Sustainable Development Goals (SDGs) in urban India. At the direction of MoHUA, Gwalior was chosen as the pilot site to develop a cross-thematic city health plan (with technical support from TCIHC), based on a conceptual framework that was designed to guide policy makers and program implementers in analyzing and identifying entry points for action and levels of intervention. The framework emphasized the social determinants of health and intersectoral, inter-ministerial and inter-departmental convergence toward the common goal of improved health.

The next section of this report describes TCIHC’s key achievements during Phase 1, or through June/July 2019. Achievements are presented first by outcomes at the Strategic Objective level and then Result by Result. Each Result section starts with key highlights, followed by a description of TCIHC’s strategies, inputs and outputs. In the final chapters of the report, we discuss some of the lessons learned during TCIHC Phase 1, make a few high level recommendations and explain what has been done during the USAID/MCSP transition and what to expect in TCIHC Phase 2.

Key Achievements

Outcome Level Results

Increased availability of voluntary FP services expanded contraceptive choice, improved quality of services and intensive demand aggregation by ASHAs and MAS contributed to increased acceptance of modern contraceptive methods in the 31 TCIHC assisted cities. Specific outcome level results by strategic objective are summarized below. The intermediate results and actions taken by TCIHC with the states and cities to achieve them are described in detail in the Result sections of this chapter that follow.

Strategic Objective: Increase the use of modern contraceptive methods among married women 15-49 years of age, with special focus on adolescents and youth.

- The total number of FP acceptors receiving services through UPHCs, UHNDs, ORCs and at first and second level referral health facilities across the 31 cities increased by 44%, up from 236,799 users at baseline (July 2018) to 340,195 by June 2019. This change was higher in Odisha and MP, with a 65% jump, than in UP, reporting a 37% change across the cities.
- TCIHC assisted UPHCs reported an even greater increase in FP users (at 79%) than the cities as a whole, with FP acceptors increasing from 104,294 during the 12-month period prior to UPHC activation (start of FDS approach) to 186,844 between July 2018 and June 2019. UPHC level changes in the numbers of FP users were highest in Odisha (183%), followed by UP (85%) and MP (51%).
- Acceptance of long acting reversible contraceptive methods--IUCD and newly introduced Antara injectable-increased as the number of FDS held at UPHC level increased. The UPHC level 12-month annual trend analysis using the Couple Years of Protection (CYP)-based adjustment methodology shows an increase in IUCD users in the 12-month period ending June 2017 from 64,094 to 91,083 in the 12-month period ending June 2019. Similarly, Antara injectable acceptors increased from only 61 users in the 12-month period ending in June 2017 to over 8,000 in the 12month period ending June 2019.

Strategic Objective: Improve the coverage and quality of evidence based RMNCAH interventions.

- Contraceptive choice expanded: UPHCs. By June 2019, 88% of the 508 TCIHC assisted UPHCs in the 31 cities were providing IUCDs, 84% were providing Antara injectable and 93% were providing either injectables or IUCDs. Over 90% of the UPHCs had also started providing Chhaya, the non-hormonal contraceptive, in addition to oral contraceptives and condoms.
- TCIHC assisted UPHCs in all three states steadily improved their readiness to provide quality voluntary FP services:
 - Facility “input readiness” improved: The percent of TCIC assisted UPHCs with high (Grade A) readiness scores increased from 21% to 81% from October 2018 to June 2019. Notable improvements were in staff availability, client charter and contraceptive supplies, with room for further improvement in the availability of equipment and infection prevention.
 - The percentage of UPHCs with Grade A “process readiness” scores also increased from 14% in October 2018 to 85% in June 2019, with all components of the service delivery process (including counseling, procedure, infection prevention, record-keeping and quality improvement meetings) improving, but additional attention to counselling, infection prevention and procedure required.
 - Of UPHCs assessed at least once in each of two quarters (January – March 2019 & April – June 2019) for input readiness (184 UPHCs), the number earning Grade A scores increased from 90 to 161. Similarly, of the 153 facilities assessed for process readiness at least once in each of these quarters, the numbers with Grade A scores increased from 84 to 127.
 - See *Annex 7: Quality Assessment for Family Planning Services* for additional information on changes in FP readiness)
- In MP and Odisha, MCSP also worked to improve the quality and utilization of MNH services at UPHCs and referral facilities. Comparing outpatient department “footfall” at baseline in 2017-18 and end line in

2018-19 shows that utilization for all services increased by an average of 37% across all 76 UPHCs and civil dispensaries in the 11 TCIHC assisted cities in MP and Odisha (Table 3)):

Table 3: Increase in patient footfall in UPHCs and Civil Dispensaries			
Data Source: Government HMIS			
State	Footfall (2017-18)	Footfall (2018-19)	% age change
1. MP (eight cities)	855,819	1,351,511	36.67%
2. Odisha (three cities)	239,609	376,085	36.28%
Total (11 Cities)	1095425	1727596	36.59%

- Between the MNCH baseline and end line assessments in June 2018 and June/July 2019, respectively, the readiness scores of TCIHC assisted UPHCs and civil dispensaries in MP and Odisha showed notable improvements:
 - The number of UPHCs and civil dispensaries that earned the highest MNCH readiness scores (>75 of 100 possible points) of the total 76 UPHCs and civil dispensaries in the two states increased from 13 (15.8%) to 48 (61.8%). Only one of the 76 UPHCs scored less than 50 at the end line.
 - Across all 11 TCIHC-supported cities in MP and Odisha, the mean improvement in UPHC readiness scores between baseline and end line was 15 percentage points, with 20 UPHCs and civil dispensaries improving their scores by 20 points or more.
 - Cumulative scores improved in all 11 intervention cities of MP and Odisha, with the most noticeable improvements in training status of UPHC staff, service availability at the UPHCs and availability of essential medicines, supplies and equipment. Smaller increases were also observed in infrastructure and community level services. Staffing also improved in some categories, but has not yet met the GoI's UPHC staffing pattern.
 - The availability of voluntary FP services and contraceptives also increased among the 76 UPHCs in the 11 cities of MP and Odisha at baseline and end line (Table 4).
 - For more information on the results of the MNCH assessments in the 11 cities and 76 health facilities in MP and Odisha, see *Annex 5: UPHC MNCH Readiness Technical Brief* and *Annex 6: Cities' UPHC Readiness Scores*.

Table 4: UPHC Readiness Assessment Scores at Base-line and End line		
Data Source: UPHC readiness assessment checklist		
FP Service	Baseline – June 2018	End line – August 2019
IUCD	32%	68%
Antara	29%	86%
Chhaya	32%	79%
Emergency Contraceptive Pill	58%	86%

Based on these trends in the provision, quality and utilization of FP and MNH services across the 31 TCIHC assisted cities, it is reasonable to conclude that TCIHC's efforts in Phase 1 have had a positive impact. More rigorous investigation would be required to prove causality, but improvements in UPHC readiness and quality of care scores, FP use rates, contraceptive choice and UPHC "footfall" are all encouraging. In the following sections of this report, we highlight some of the key strategies that seem to be making a difference in TCIHC assisted cities including: the rapid scale up of FP FDS; intensive coaching and mentoring of ASHAs; city coordination committees and other types of urban coordination groups and meetings where UPHC readiness, service delivery and quality of care data are shared and used to plan; the support that TCIHC provides during the annual NHM PIP process and regular program reviews; TCIHC's advocacy to improve the enabling environment and "unlock" funds toward lasting change; among others. All are playing different and important roles in changing readiness scores and improving the availability, quality and utilization of services by the urban poor.

Result 1: Cities Implementing Urban FP, MNH and AYSRH HIAs On a Demand-Driven Basis Through the TCI Three-Stage Model

Highlights Result 1: TCI Three-Stage Model

- The TCI three-stage model and “business unusual” approach was successfully adapted to the Indian context and used to accelerate the scale up of FP HIAs and MNH evidence-based interventions in the three TCIHC assisted states and 31 cities.
- Over USD\$60 million in GoI resources were successfully leveraged or “unlocked” in 2017 – 18 and 2018 – 19 for scale up of TCIHC-promoted HIAs and evidence-based interventions through the annual NHM PIP process.
- States used their PIP funding to expand services, improve quality of care and scale up FP HIAs and other promising MNH and health systems approaches promoted by TCIHC.
- NHM/NUHM budget execution improved annually in one of three states
- All three state governments have adopted and are beginning to roll out some of the TCIHC-promoted HIAs beyond the TCIHC assisted cities with NHM PIP resources.
- New AYSRH, TB, non-communicable disease (NCD) and patient-centered care (PCC) interventions were successfully “layered on” the TCIHC classic platform in a few cities each in Phase I.

Strategy 1.2: Support PIP Development and Approval at City, State and National Level

Significant GoI/NHM/NUHM resources leveraged/unlocked for urban health improvement through the annual NHM PIP process: TCIHC supported all 31 cities during the annual NHM PIP development, which resulted in the commitment by government of funding for FP, MNH and urban health systems strengthening in both TCIHC assisted and non-assisted cities. Across the 31 cities, TCIHC’s support helped to leverage or unlock approximately USD \$60 million¹⁶ NHM funding in 2017 – ‘18 and 2018 – ‘19. Stakeholder consultations engaged national, state and city leadership and generated extensive participation by NUHM and NGOs in discussions of urban health needs and possible solutions. TCIHC -supported formal city assessments and UPHC readiness assessments in the two states receiving MNH support – MP and Odisha— and FP FDS readiness assessments in all 31 cities were used during PIP development and as states allocated their available NHM budgets for scale up of specific approaches within and beyond TCIHC assisted cities.

Strategy 1.3: Publicize HIAs Among Different Policy Persons and Government Leaders

High impact approaches promoted across all three states and 31 cities: There were initially nine FP HIAs prioritized for TCIHC scale up. These were codified and information about them was collected and posted to the TCI University website soon after TCIHC started work in India. TCI advocated in all three states for adoption of the initial FP HIAs and for evidence based MNH interventions called for in India’s National Newborn Action Plan and other promising urban health systems strengthening approaches demonstrated earlier by Saving Newborn Lives in two cities in Maharashtra and Odisha. During TCIHC Phase 1, other FP HIAs and promising approaches were added to the list that TCIHC promoted. The final list of HIAs and MNH approaches and their current and planned coverage by state are listed in text boxes in the section above entitled “*TCIHC’s approach*”.

Strategy 1.4: Expand TCIHC Assistance to New Cities

TCIHC expanded to a total of 31 cities in Year 2: As mentioned above, TCIHC successfully expanded from the initial 12 cities to the target of 31 cities by mid-2018. In addition, in Year 3, as states announced plans to expand to other non-TCIHC-assisted cities, TCIHC state teams offered “light touch” support to them for

¹⁶ Data Source: TCIHC PMIS. Figure is reflective of the 2017-18 and 2018-19 program implementation plan periods.

government-led expansion. Annex 2 shows the dates that TCIHC initiated support in the Round One and Round Two cities.

Strategies 1.5-1.8: Addition of AYSRH Interventions to the TCIHC Platform

AYSRH component successfully added in five cities of UP in Year 3: In August 2018, TCIHC expanded its thematic scope by adding an AYSRH component to its service delivery model in five of UP's cities-- Firozabad, Varanasi, Gorakhpur, Allahabad and Saharanpur. There was rapid progress in the AYSRH component as the cities started monthly AYSRH-focused FP FDS to serve the contraceptive needs of young, first-time parents (FTPs). The AYSRH component includes orientation for ASHAs, ANMs, medical officers and staff nurse, also mid-media and multi-media campaigns, male engagement strategies and other inputs. Funding for the AYSRH component from the Gates Foundation/GI/TCI will continue through June 2021 and the component will be expanded to cover more cities in UP and extended to MP and Odisha, as well, in TCIHC Phase 2.

Result 2: Increased Access by the Urban Poor to Quality FP, MNH and AYSRH Products and Services

Highlights

Result 2: Increased Access by the Urban Poor to Quality Services

- **Locating and counting the urban poor:** A TCiHC-led mapping exercise in 19 cities identified a vulnerable population that was 38% larger than registered with city authorities. This information is leading to the reallocation of physical infrastructure, staff and other resources and PIP budget requests based on more accurate estimates of population need.
- **FP Fixed Day Services (FDS) introduced in UPHCs and secondary health facilities:** FDS became a regular feature at 97% (493 out of 508) of the UPHCs across the three TCiHC assisted states. At baseline, none of the UPHCs were conducting FDS. Voluntary FP services were also strengthened during Urban Health and Nutrition Days (UHND), during outreach camps (ORCs) and ASHA home visits.
- **Contraceptive choice expanded at UPHCs:** Antara (injectable contraceptive) and Chhaya (weekly oral contraceptive pills) were introduced in the states in late 2017. In April 2018, MP was the first state to offer them at UPHC level. By the end of Phase I, 100% of the UPHCs conducting FP FDS in the three states were offering both short- and long acting contraceptive options, with 88% providing IUCD, 84% providing Antara injectable and 92% providing Chhaya, the new weekly non-hormonal oral contraceptive.
- **UP's FP Logistics Management Information System (FP-LMIS) begins tracking FP commodities in urban areas and including ASHAs:** TCiHC mapped all 392 UPHCs in the 20 TCiHC assisted cities and successfully advocated to add them and urban ASHAs to the FP-LMIS and indent process, reducing contraceptive stock-outs.
- **Community-based UHNDs, ORCs and ASHAs increase access to voluntary FP services and short term methods:** UHNDs play an important role in FP counseling and distribution of short term FP methods. Approximately 51.6% of condoms, 54% of oral hormonal pills, 25% of Chhaya and 40% of emergency contraceptives distributed by government in the 31 TCiHC cities were distributed at UHNDs. Conducted with less frequency, ORCs delivered only 5% of condoms and pills and 10% of Chhaya and emergency contraceptives.
- **Adolescent Friendly Services introduced in UP:** 96 UPHCs in the five AYSRH districts of UP had at least one staff member trained and able to provide Adolescent Friendly Health Services.

Improved quality of care

- **UPHC readiness to provide quality services improved:** UPHC's FP readiness assessments were carried out at least once with 416 of the 493 UPHCs conducting FPS across the three states. Of the 184 UPHCs assessed between April and June 2019, 88% earned a Grade A score (80-100%), compared to only 48% the previous quarter. TCiHC also assessed the readiness of 76 UPHCs in the 11 cities of MP and Odisha to deliver quality MNCH services. In this case, the proportion of UPHCs with the highest MNCH readiness scores (>75%) increased from 15.8% in June 2018 to 61.8% by June/July 2019; cumulative scores also improved in all 11 cities. Readiness and quality assessment results are found in greater detail in outcome level results above, under Strategy 2.2 below and in Annexes 5, 6 and 7.
- **Quality of Care mechanisms established or reactivated:** District Quality Assurance Committees (DQAC) and Units (DQAU) were activated in all 31 cities and UPHC quality improvement (QI) committees were formed for the first time in 497 of the 508 TCiHC assisted UPHCs (98%). Additionally, 593 QI meetings were reported in the quarter from Jan-March 2019. TCiHC also added FPSAs to field teams beginning in August 2018 who monitored and coached UPHC teams on a regular basis to improve the quality of their voluntary FP services.
- **UPHCs certified to provide IUCD services:** DQACs visited 484 UPHCs in TCiHC assisted cities and had certified 424 to provide IUCD services by August 2019.
- **Odisha UPHCs win prestigious award and NQAS certification:** 13 UPHCs from three TCiHC assisted cities in Odisha (seven in Berhampur, four in Puri and two in Rourkela) were awarded the prestigious

Highlights

Result 2: Increased Access by the Urban Poor to Quality Services

Kayakalp prize for excellence in cleanliness and hygiene. Three UPHCs in Berhampur were also awarded NQAS certification.

- **MNH quality indicators improving in facilities with obstetric care in MP and Odisha:** Of women delivering at six secondary health facilities and maternity homes in the three MNH demonstration cities, the following improvements in quarterly averages were documented between the time of city start-up (baseline Apr-Sept 2017) and the final three quarters of Phase I (end line Oct 2018-June 2019):
 - 84% of women received oxytocin during the third stage of labor at end line in 2019 (n=2,134 of 2,539 institutional births per quarter), compared to only 37% at baseline in 2017 (n=835 of 2,247 institutional births per quarter);
 - 99% of newborns received Vitamin K at end line in 2019 (n=2,492 of 2,525 live births per quarter), up from 50% at baseline in 2017 (n=1,088 of 2,192 live births per quarter); and,
 - 92% of asphyxiated newborns were successfully resuscitated at end line 1 (n=20 of 21 newborns born asphyxiated per quarter), up from 71% at baseline in 2017 (n=18 of 25 newborns born asphyxiated per quarter).
- **Gol LaQshya guidelines launched:** TCIHC contributed to the development these guidelines, which are part of a larger Gol initiative to improve the quality of care in labor rooms and maternity operations theaters in medical colleges, district hospitals, sub-district hospitals and other high-load health facilities.

Strategy 2.1: Strengthen Urban Service Delivery System for Voluntary FP and MNH Services in TCIHC-Assisted Cities

Mapping/listing poor urban communities: TCIHC supported the mapping of vulnerable urban poor communities, existing service delivery points (SDP) and UPHC catchment areas using the TCIHC mapping/listing tool (an HIA). This exercise identified 38% more vulnerable populations than were registered with city authorities, led to the reallocation of physical infrastructure and financial resources and increased budgets. TCIHC completed the mapping exercise in 19 cities for which the results are presented below. The remaining 12 cities were scheduled to complete the mapping/listing exercise by the end of Phase 1, but this work was delayed and will be completed during TCIHC Phase 2.

Table 5: Mapping data from 19 TCIHC cities
Data Source: Government PIP 2014-15 and TCIHC Slum Mapping Data 2018-19

	Government mapping	TCIHC mapping	% change
No. of Slums / Vulnerable Population Cluster	3,766	5,217	+39%
Slum / Vulnerable Population	6,450,098	8,906,331	+38%

30-hour-magic+ strategy used to prepare UPHCs for FDS: To increase the number of service delivery points conducting FDS, TCIHC also developed the “30-hour-magic+ strategy”. This strategy calls for preparing a few demonstration UPHCs in each city for their first FDS by making sure that all necessary supplies are available, demand has been generated and there are trained staff on site. All of this is done over the 30-hour period before a first FDS. Using this strategy, TCIHC was able to “activate” UPHCs for FDS and jumpstart scale up in all 31 cities. Based on TCIHC’s success with this strategy, the “30-hour-magic+ strategy” it is being evaluated and likely to become another of TCIHC’s HIAs. See Annex 9.

UPHC readiness to provide quality FP and MNCH services improved: TCIHC developed two different readiness assessment tools. One focused on determining readiness to provide quality voluntary FP services with attention to both FDS and regular service delivery. The second tool addressed MNH work of the project,

considered a general UPHC readiness assessment tool, and based on the WHO SARA framework. TCIHC also developed and conducted an equipment readiness assessment at the request of the Odisha State Health and Family Welfare Department, which was used in Odisha only to inform the state's future procurement plans. For the purposes of this report, the FP readiness and quality of care assessment is called the FP readiness/quality assessment and the more general UPHC readiness assessment is referred to as the MNCH readiness assessment. In both cases, TCIHC disseminated assessment findings and helped the states, cities and health facilities use them to advocate and make greater investment in UPHC staffing, infrastructure, equipment, training and other aspects of readiness through their PIPs.

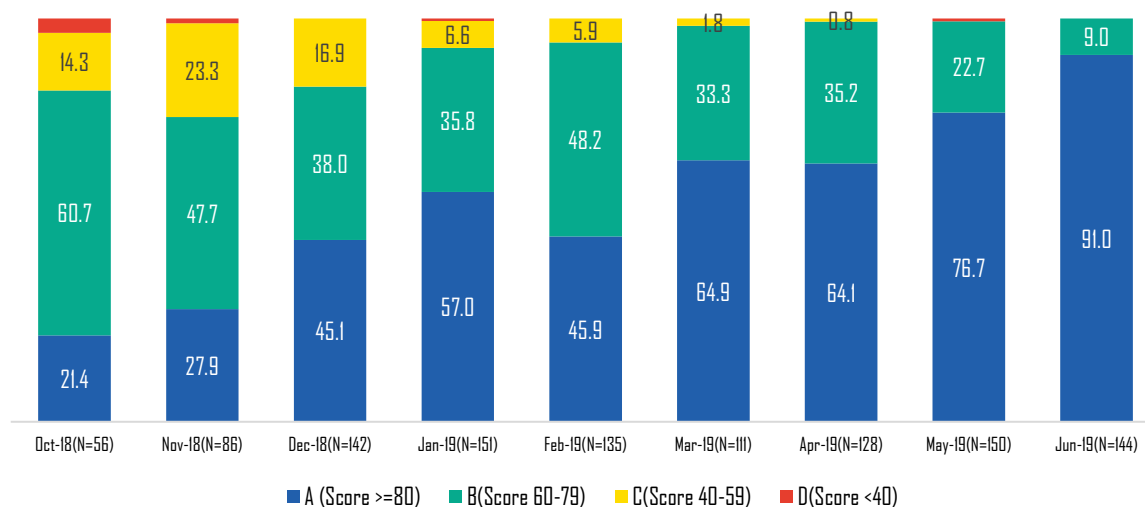
- ***FP readiness/quality assessments:*** TCIHC conducted assessments and provided technical support in all three states to improve the readiness of UPHCs to deliver FDS and regular voluntary FP services. Using a facility-based checklist, TCIHC assessed each facility's readiness to provide voluntary FP services (including IUCD and Antara injectable), the processes involved and the outcomes of service delivery. The readiness assessment looked at infrastructure, staff availability, client charter, upkeep of counselling areas, availability of contraceptive supplies and consumables, infection prevention, upkeep of procedure area and availability of equipment. Process assessment addressed the quality of counselling, adherence to procedure, infection prevention, record keeping and the formation and regularity of internal quality improvement team meetings. Outcome measures included the availability of a basket of contraceptive methods and the total number of IUCD insertions and Antara injectable doses given during FDS each month. Outcome data were extracted from the monthly service delivery activity report and merged with the readiness and process assessment data for each facility to generate an overall readiness/quality score. FP readiness, process, outcome and overall facility scores (the average of input, process and outcome scores) were categorized into four grades: Grade A (score > 80%), Grade B (60% and 79%), Grade C (40% and 59%) and Grade D (less than 40%).

Results: By August 2019, TCIHC had provided support to 508 UPHCs in 31 cities, of which 493 had been “activated” (defined as providing voluntary FP services through FDS). 416 of these participated in at least one FP readiness assessment before the end of June 30, 2019. Looking at data collected only during FDS, facility readiness across the three states improved remarkably between October 2018 to June 2019, with the percent of UPHCs with Grade A readiness score increasing from 21% to 81% over the period. The most notable readiness improvements were in staff availability, client charter and contraceptive supplies, whereas the availability of equipment and infection prevention utilities continued to need improvement. UPHCs' process performance also improved, with the percentage of UPHCs scoring more than 80 increasing from 14% in October 2018 to 85% in June 2019 and all components of the process improving. The distribution of overall facility scores as an average of the three domains--input, process and outcome—also showed significant improvement, with UPHCs earning overall Grade A scores increasing from 21% of those assessed in October 2018 to 91% assessed in June 2019 (Figure 2).

Of the 184 UPHCs assessed for FDS readiness in each of the two quarters Jan – March 2019 and April – June 2019, the number of UPHCs with Grade A (scoring ≥ 80) increased from 90 (49%) to 161 (88%). Similar results were also observed for 153 facilities assessed for processes in both quarters. The number of facilities with Grade A increased from 84 (55%) in the period from Jan-March 2019 to 127 (83%) in the following quarter. TCIHC's advocacy and work with the cities and states to increase the availability of staff, contraceptive supplies and equipment, particularly on days when FDS are conducted and the FPSAs' coaching and mentoring of UPHC staff were believed to be directly associated with the improvements observed.

For more details on the results of TCIHC's FP readiness/quality assessments, see Annex 7.

Figure 2: Percent distribution of facilities by overall FP scores, Oct 18 – June 19
 Data source: Field Program Service Assistants Report on Quality of FP services, TCIHC PMIS



- General UPHC MNCH readiness assessments used to guide MP and Odisha MNH quality improvement and health systems strengthening efforts.** TCIHC worked with 100% of the UPHCs (76) in the 11 TCIHC assisted cities of MP and Odisha to conduct three rounds of MNCH readiness assessments¹⁷. The assessment checklist and process was first developed and used in June 2017 in Indore with the District Program Management Unit, focusing on six domains – infrastructure, human resources, training status, services available at the facility, services provided in the community and equipment and supplies. Specifically, TCIHC took into account readiness to provide ANC, PNC, newborn care, diarrhea management, pneumonia management, immunization, FP, diagnostic services, referral to higher facility, and normal outpatient services. Other dimensions of readiness (e.g., HR, infrastructure, etc.) that can influence the UPHC’s readiness to deliver the full range of services appropriate for its level were also assessed. After testing the checklist in Indore, TCIHC used the same approach with the rest of the UPHCs, proceeding in a phased manner as new cities joined TCIHC. Based on feedback and lessons learned during those initial assessments, TCIHC more than doubled the number of individual parameters assessed on the checklist (from 58 to 144) and added UPHC location in relation to slum areas to the original six domains assessed. Table 6 shows a comparison of the original and the final assessment checklists and scoring by domain.

Table 6: Thematic areas & assessment scores using final checklists		
Data Source: UPHC readiness assessment checklist		
Thematic area	Initial checklist	Revised checklist
Number of parameters	58	144
Used during	Formative assessment	Baseline/End line assessment
Thematic domains	6	7
Total possible score	100	100
Total possible scores by thematic domain		
Infrastructure	18	15
- Human resource	30	30
- Training status	8	15

¹⁷ Of the 76 total UPHCs, 60 are in MP and 16 in Odisha.

Table 6: Thematic areas & assessment scores using final checklists		
Data Source: UPHC readiness assessment checklist		
Thematic area	Initial checklist	Revised checklist
- Service provision at facility	20	9
- Service provision at community	10	6
- Equipment and supplies	14	20
- Geographical location of UPHC	Not included	5

The second round of data collection, again with all 76 UPHCs, took place in June and July 2018, once the expanded checklist became available. The End line was conducted a year later, in July 2019. Because of the revisions made to the checklist, TCIHC considered the first round of assessments “formative”, the second round the official MNCH “baseline” and the third round the Phase 1 MNCH “end line”. Summary results from the baseline and end line assessments are **below**

Results: The MNCH readiness assessments conducted with 76 UPHCs in MP and Odisha in June 2018 and again in June/July 2019 are the basis for this analysis. The percentage of UPHCs with high overall MNCH readiness scores (>75%) increased from 15.8% to 61.8% between the two assessments and cumulative scores improved in all 11 intervention cities of MP and Odisha (Figure 3). The most noticeable improvements were in training status of UPHC staff, service availability at the UPHCs and availability of essential medicines, supplies and equipment. Smaller increases were also observed in areas of infrastructure and community level services.

Figure 3: Changes in UPHC MNCH readiness at 76 UPHCs in MP and Odisha
 % of UPHCs receiving high, medium and low scores based on 144 parameters
 Baseline: June/July 2018; End line June/July 2019
 Data Source: UPHC readiness assessment

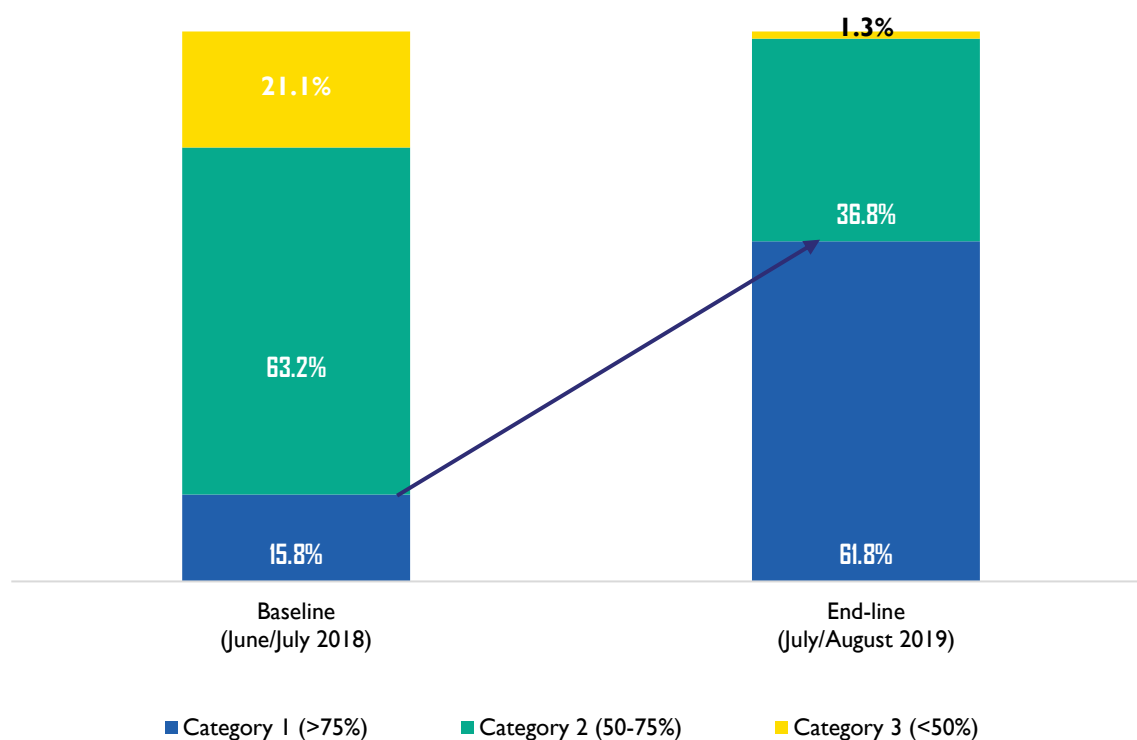
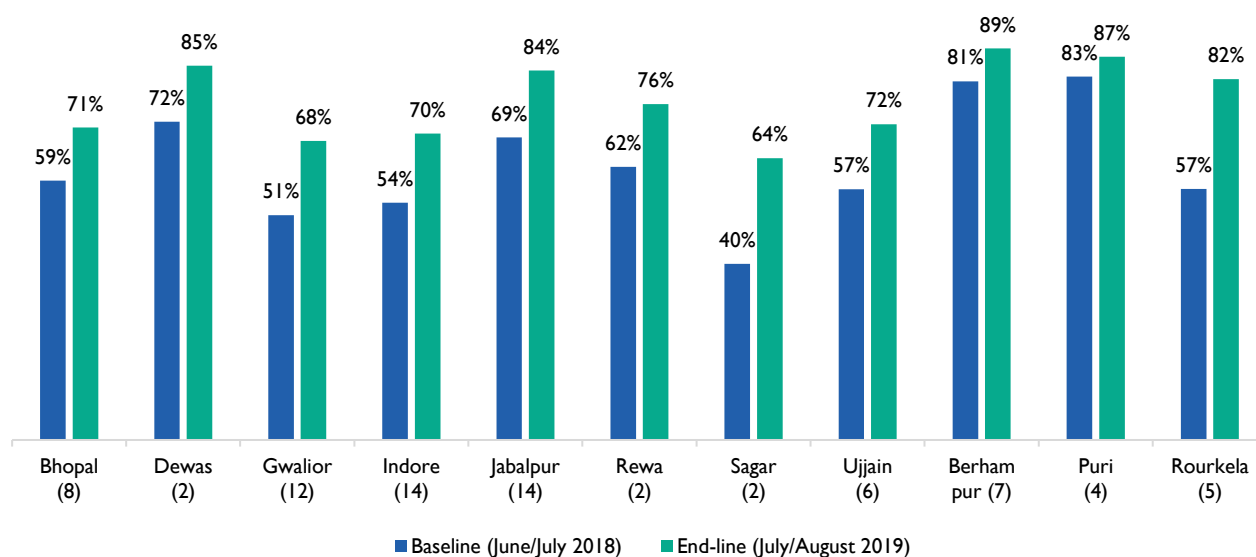


Figure 4: City UPHC readiness scores at baseline and end line – Total scores
Number in parentheses indicates the number of UPHCs in each city.

Data Source: UPHC readiness assessment



As shown in Table 7, there were increases in the numbers of key UPHC staff positions filled between the two assessments, particularly medical officers, staff nurses and ANMs. However, the numbers of lab technicians, pharmacists and to a lesser degree, staff nurses continued to be significantly lower than the GoI's standard staffing pattern for UPHCs. TCIHC used the 2018 baseline MNCH assessment findings to advocate for more staff at the UPHCs and for selection of frontline functionaries in the urban slums and habitations that lacked them. As a result, the governments of MP and Odisha took action to strengthen UPHC staffing by re-deploying their available human resources and including new funding in their PIPs to fill vacant posts and create new ones. The proportion of UPHCs having more than 50% of the sanctioned positions for frontline functionaries filled improved over the intervention period.

Table 7: Availability of human resources for health at the UPHCs and in catchment areas
Number and percent of GoI standard for UPHC staffing for each type of position
Data Source: UPHC Readiness Assessment

Type of Staff	MP (N=60 UPHC)				Odisha (N=16 UPHC)				Total (N=76 UPHC)			
	Baseline		End line		Baseline		End line		Baseline		End line	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Medical Officer	42	70%	51	85%	15	94%	15	94%	57	75%	66	87%
Staff Nurse	33	55%	42	70%	14	88%	14	88%	47	62%	56	74%
ANM	52	87%	57	95%	14	88%	16	100%	66	87%	73	96%
Lab Technician	23	38%	25	42%	14	88%	13	81%	37	49%	38	50%
Pharmacist	14	23%	18	30%	14	88%	14	88%	28	37%	32	42%
Support staff	51	85%	55	92%	13	81%	16	100%	64	84%	71	93%

The baseline and end line MNCH assessments with 76 UPHCs in MP and Odisha also showed improvement in the availability of contraceptive products at UPHCs. (Table 8)

Table 8: Availability of essential supplies at the UPHCs in intervention cities
Data Source: UPHC readiness assessment

Type of Product	MP (N = 60 UPHC)				Odisha (N = 16 UPHC)				Total (N = 76 UPHC)			
	Baseline		End line		Baseline		End line		Baseline		End line	
	Oral Contraceptive Pills	56	93%	59	98%	15	94%	16	100%	71	93%	75
Condoms	55	92%	59	98%	14	88%	16	100%	69	91%	75	99%
Emergency Contraceptive Pills	35	58%	49	82%	9	56%	16	100%	44	58%	65	86%
IUCD	17	28%	37	62%	7	44%	15	94%	24	32%	52	68%
Antara	21	35%	50	83%	1	6%	15	94%	22	29%	65	86%
Chhaya	24	40%	56	93%	0	0%	4	A	24	32%	60	79%

For more information about the UPHC MNCH readiness assessment findings and recommendations see Annex 5, page 85.

Strategy 2.2: Activate DQACs and DQAUs For Public and Private Sector with Focus on FP

District Quality Assurance Committees (DQAC) and Units (DQAU) revitalized and QI committees established for the first time at UPHCs: Quality assurance at health service delivery points is one of the GoI's priorities, including at private sector health facilities. The government's quality assurance program follows a unified structure at every level. DQACs are responsible for disseminating and ensuring that providers and health facilities are following of quality assurance policies and standards and for building district and health facility capacity to do so. They also handle adverse events, manage the government's FP indemnity scheme and conduct facility audits, record reviews, observations and client interviews to ensure facility readiness to provide quality care. Government guidelines call for quarterly DQAC meetings to identify and address issues and challenges. DQAUs are subgroups of DQACs that focus on specific thematic areas.

TCIHC supported the government DQACs and worked with the DQAU for FP, while also moving a step further and helping to establish continuous quality improvement (QI) teams for the first time at UPHCs. During monthly facility level QI team meetings, participants reviewed data and developed action plans to address gaps in infection prevention, hygiene, informed choice, patient records, client provider interactions and other important aspects of care. DQACs were activated or reactivated in all 31 cities and actively conducting facility visits to UPHCs to ensure their readiness to conduct FDS and provide other priority MNH services. As a direct result of TCIHC's QI support, 13 UPHCs in Odisha were awarded the 2018/19 Kayakalp prize¹⁸ for maintaining standards of excellence in cleanliness and hygiene and three UPHCs were awarded NQAS certification in 2019 for scoring at least 70% on all six quality indicators for MNH and voluntary FP services. GoI and external assessors conduct this assessment. The TCIHC team in Odisha was also selected and started working closely with the state government, using TCIHC's quality assurance approach, to assess health facilities for the next round of Kayakalp awards in 2019 – '20.

TCIHC coaching and mentoring at UPHCs improves the quality of voluntary FP services: TCIHC introduced the FPSA cadre to carry out quality improvement activities that included monitoring the quality of FP care provided by UPHCs and mentoring and coaching UPHC and other health staff. The first batch of

¹⁸ Kayakalp means "make over" in English. The Kayakalp award is a sub-component of the National Quality Assurance Program to promote cleanliness, hygiene and infection control practices in government health facilities across the country. Launched in 2015 primarily for rural health facilities, the scheme was extended to urban health facilities in 2017. Odisha was among the first states to incorporate the Kayakalp scheme for UPHCs.

FPSAs (14) were on board by August 2018 in 11 cities across all three states. FPSAs are qualified nurses, with valid registration from the Nursing Council and experience working in labor and delivery rooms and providing voluntary FP services. By June 2019, there were 40 FPSAs working to roll out TCIHC's QI strategy in the 31 intervention cities. Based at district level, each FPSA works with 12-15 UPHCs, coaching and mentoring ANMs and staff nurses, observing FP service delivery and monitoring quality of care and facility readiness using an observation tool/checklist adapted from an existing government checklist and simplified by TCIHC. They also support data collection and independently observe the quality of FP-related services at the UPHCs, sharing feedback with Medical Officers-In-Charge (MOiCs) and QI teams at UPHCs for their follow-up and with DQACs, through the city managers, for their action at a higher level. From September 2018 to March 2019, FPSAs visited 24 cities and 98% of the 461 UPHCs at least once. Preliminary analysis from these visits (Figure 2) indicated an improvement in the FP readiness, process and overall quality grades, as described above and in Annex 7. TCIHC is testing the addition of the FPSA cadre as the link between the DQACs and the UPHCs in the urban context. The intent is that this continuous monitoring and mentoring responsibility be shifted to a dedicated staff nurse at each facility in Phase 2.

MOHFW's national MNH quality of care guidelines for referral facilities: The MOHFW's LaQshya Initiative¹⁹ seeks to improve the quality of care in labor rooms and maternity operations theaters in medical colleges, district hospitals, sub-district hospitals and other high-load health facilities. TCIHC contributed to the development of the LaQshya guidelines, which were launched by the MOHFW in 2017. The guidelines focus on quality assurance and adherence to patient-centered norms during intra-partum and post-partum care. As part of this effort, TCIHC shared its referral mechanism approach and protocols developed for Indore city. The team also prepared and submitted concept notes on a patient-centered health care system to the MOHFW's maternal health division for its consideration, components of which were also incorporated into the LaQshya protocols. The guidelines have a referral section for critical illness and include some of the practices TCIHC influenced and demonstrated at city level.

Strategy 2.3: Work with State and District Level Stakeholders to Engage Skilled and Qualified Private Providers Through Strategic Purchase Model for Quality Voluntary FP Services

Strategic purchasing of voluntary FP services introduced to MP and Odisha: TCIHC worked with the governments of MP and Odisha to learn about and consider adopting UP's successful Hausala Sajheedari model for strategic government purchasing of voluntary FP services from the private sector. This included creating state level committees, drafting orders, considering the need for public private interface agencies and proposing criteria for private sector accreditation, empanelment and reimbursement of private providers. At the end of Phase 1, both MP and Odisha governments had issued government orders and started working to adapt the Hausala Sajheedari model to their specific policy frameworks. The electronic platforms and intermediaries that the states will need to manage strategic purchasing will be put into place in MP and Odisha during Phase 2.

Strategy 2.4: Take Steps to Ensure that Products and Services for FP are Available Across Public and Private Sector Facilities

Availability of FP products and services improved in UP: In UP, TCIHC supported the government to strengthen its FP Logistics Management Information System (FP-LMIS), which earlier tracked FP commodities only in rural areas. High contraceptive stock-out rates in UP cities made it clear that the system should be expanded to cover the urban health facilities and that some adaptation would be required, including inclusion of "UPHC" as a separate unit in the FP-LMIS. An important step was mapping each of the UPHCs, their human resources (ASHA, ANM, staff nurses, medical officers), commodity use and potential requirements. To accelerate the inclusion of UPHCs in the FP-LMIS database, the UP TCIHC team mapped all 392 UPHCs in the 20 TCIHC assisted cities; successfully advocated for the inclusion of the urban ASHAs in the FP-LMIS indent system; and provided the ASHAs with orientation to the indenting process and the SMS application. The addition of ASHAs to the system allows for forecasting and helps reduce the time between when they

¹⁹[https://www.nhp.gov.in/%E2%80%98laqshya%E2%80%99-programme-\(labour-room-quality-improvement-initiative\)_pg](https://www.nhp.gov.in/%E2%80%98laqshya%E2%80%99-programme-(labour-room-quality-improvement-initiative)_pg) The majority of the LaQshya interventions were taken from existing guidelines including the National Quality Assurance Standards, National Quality Operational Guidelines, Maternal and Newborn Health Toolkit, Guidelines for Standardization of Labor Rooms and Dakshata.

request and receive products. UPHC mapping was also completed in MP. Odisha has had an automated system for several years that includes UPHCs and ASHAs.

The independent PMA Agile study conducted by BMGF in 2018 in three cities – Puri (Odisha), Indore (MP) and Firozabad (UP)--found no stock outs of IUCDs in TCIHC assisted health facilities. Some other key findings related to the availability of supplies and equipment in these three TCIHC-support cities were:

- All six public facilities in Puri reported having sufficient stocks of IUCDs in the previous four quarters.
- With more than 10% of dispensaries reporting stock outs of IUDs in Indore at baseline, after Q1, no stock outs were reported in any of the public health facilities sampled.
- UPHCs in Firozabad experienced IUCD stock outs in Q2-Q4 at a moderate level (under 10%). Dispensaries had a higher level of stock out (10%) in Q1, but none afterward. Community health centers, medical colleges and hospitals reported no IUCD stock outs in the months before the study.

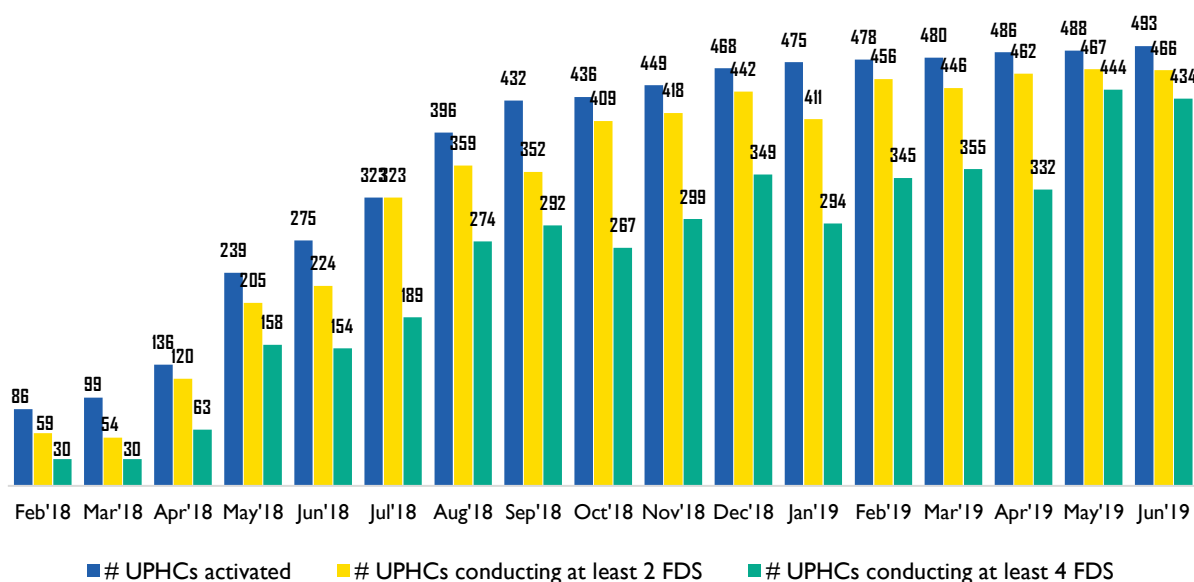
TCIHC will continue to work with the states to reduce stock outs and with the ASHAs to ensure that they are using the FP-LMIS as intended. PMA Agile will be repeated in the three cities in early January 2020.

Strategy 2.5: Promote and Institutionalize FDS, a Best Practice for FP, in the Three States

Service delivery points expanded through FP FDS: In the 31 TCIHC assisted cities, TCIHC coordinated efforts with city governments toward the goal of conducting at least one FDS per week at each UPHC and secondary level health facility. As a result, by June 2019, over 95% of UPHCs were conducting at least one FDS per month and 85% had succeeded in meeting the weekly goal. Providing voluntary FP services at UPHCs on a set date each week increased their visibility and improved access to care at those facilities closest to the urban poor—the UPHCs.

Figure 5: Trend in the numbers of UPHCs providing FDS by month, Feb 18 - Jun 19

Data source: Service Delivery Activity Report, TCIHC PMIS



TCIHC believes that FDS has been a major factor in the observed increase in FP acceptance. Between October 2018 to June 2019, a total of 113,330 IUCD insertions and Antara doses were given at the UPHC level, of which 86,934 (77%) were provided at an FDS session and the remaining 26,396 (23%) during routine service days.

Improved microplanning increases access to voluntary FP services at UPHCs, UHNDs and ORCs: UPHCs conduct FDS weekly and UHNDs almost daily, with ANMs moving out from the UPHCs to different Anganwadi Centers in the cities. UPHCs should also plan and conduct monthly outreach camps (ORCs) to reach particularly vulnerable segments of the urban poor, including those who are not easily reached by UPHCs and UHNDs. TCIHC worked with the NUHM governance teams in each state to maximize the reach of these existing services. This included encouraging the provision of voluntary FP services by ANMs and ASHAs at all monthly UHNDs and during the ORCs. TCIHC also used evidence from a variety of sources to advocate for changes that would reduce the gaps in UPHC, UHND and ORC coverage. TCIHC's advocacy contributed to local decisions to upgrade and in some cases relocate and open new UPHCs; improve microplanning; increase the numbers of urban ASHAs, ANMs and medical officers and fill vacant posts; create training opportunities for them; procure additional equipment; and guide other related actions. TCIHC worked with state governments to ensure that PIP resources were budgeted for these purposes and to train and coach ASHAs, ANMs and medical officers.

TCIHC estimates that the combined coverage--through UPHCs (FDS and non-FDS), UHNDs and ORCs—has risen to approximately 60% of the NUHM target population in the 31 TCIHC assisted cities, with increasing acceptance of all FP methods. UPHCs are conducting UHNDs more regularly than ORCs: 87% of the UHND sessions called for in UPHC micro-plans across the 31 cities were conducted as planned, but only about half of planned ORCs. UHNDs make a significant contribution to the distribution of short acting methods: 51.6% of total condoms, 54% of total oral pills, 25% of Chhaya and 40% of emergency pills. The contribution of ORCs is much less: 5% for condoms and pills and 10% for Chhaya and emergency contraceptives.

Contraceptive choice expanded at UPHCs: TCIHC supported the GoI's roll out of an expanded basket of contraceptive choice in government health facilities. In September 2017, the MOHFW added two new contraceptive methods to its basket of contraceptive options--'Antara', a progestin-based injectable and 'Chhaya', a non-hormonal oral contraceptive with Centchroman, TCIHC coordinated with the government to ensure that the UPHCs were ready to add these new FP products as well as IUCDs, which they were not yet providing. By June 2019, 435 of the 508 TCIHC assisted UPHCs had begun providing IUCDs, up from only 66 UPHCs in February 2018. Likewise, by June 2019, 413 of 508 UPHCs were providing the Antara injectable, compared to only 28 UPHCs in April 2018 while 90% were providing both Antara and IUCDs. The supply of Chhaya across the three states improved during the first six months of 2019, when 454 of 508 TCIHC assisted UPHCs (89%) reported providing Chhaya.

Figure 6: Uptake of IUCD and Antara, FDS and Routine Day Services, Oct 18 - Jun 19

N = Number of LARC clients

Data Source: PMIS

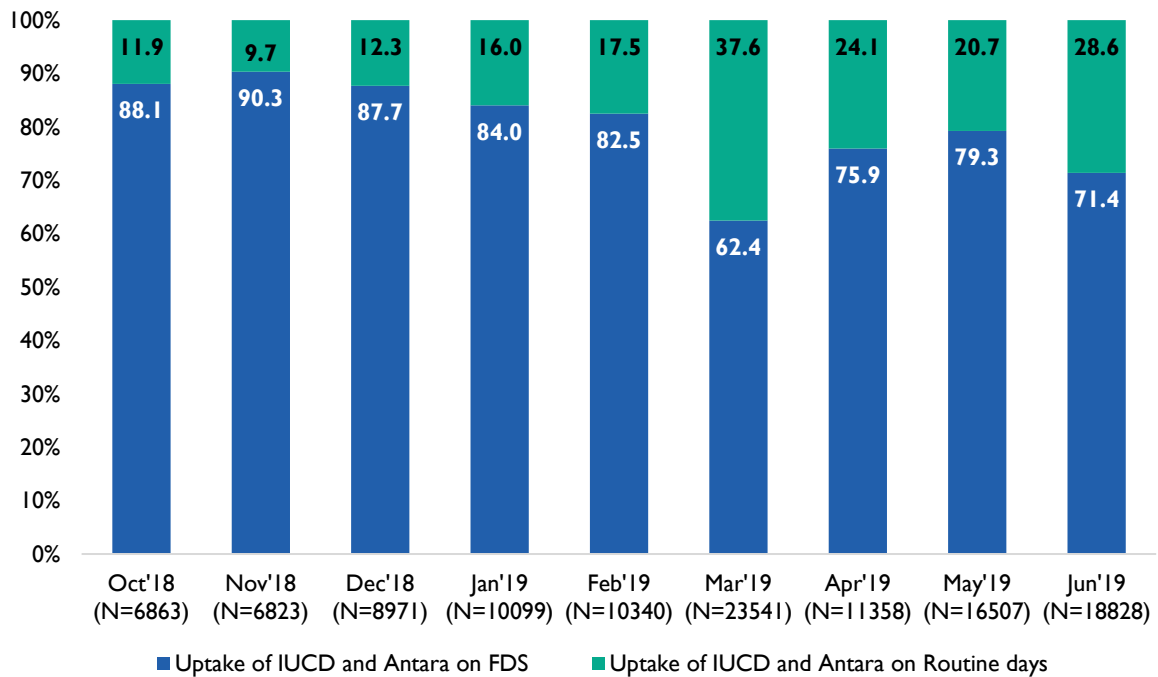
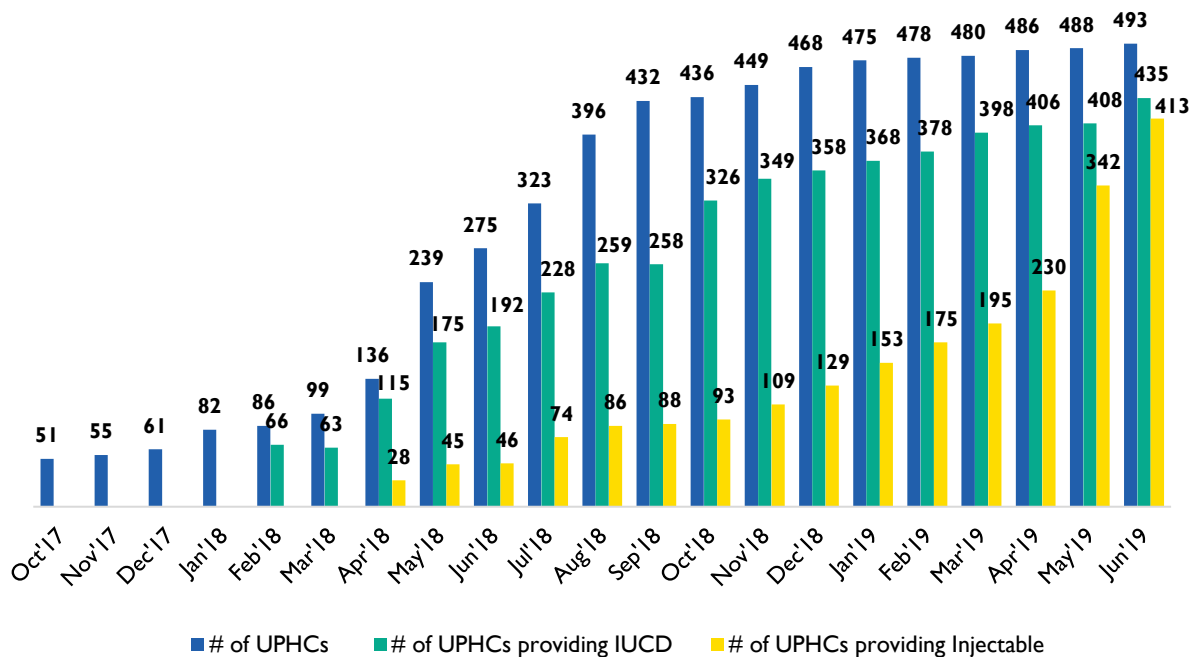


Figure 7: Expanding basket of contraceptive choice, June 2019
435 (88%) of UPHCs providing IUCD and 413 (84%) providing injectable contraceptives
 Data source: Service Delivery Activity Report, TCIHC PMIS



Accelerated introduction of injectable contraceptives at UPHCs: In 2018, Government guidelines called for the phased introduction of injectable contraceptives, with urban areas beginning in Year 3 (2019) and the service delivery points closest to the urban poor—the UPHCs—given lowest priority for introduction. TCIHC advocated for including the cities and prioritizing the UPHCs for Antara introduction and was successful in getting this policy changed in MP and Odisha. This success encouraged UP’s acceptance, but the training of the UPHCs had not been planned in UP’s 2018 – 19 PIP. As a result of TCIHC’s advocacy, the Government of UP made the decision to simultaneously train both urban and rural PHC staff. Because of this, the introduction of the Antara injectable in the 20 TCIHC cities in UP took place at the same time as the training for rural staff. By June 30, 2019, 78% of the UPHCs (304 of 388 UPHCs) in UP, 89% (93 of 104) in MP and 100% (16 of 16) in Odisha had begun offering Antara and most were also offering IUCDs.

Strategy 2.6: Support Capacity-Building of Providers (Doctors, ANMs and Staff Nurses) to Ensure Quality of FP and MNH Care.

Capacity of health providers to deliver quality FP and MNH care improved: Human capacity development was an important element of TCIHC’s approach to improving the quality of FP and MNH services. TCIHC contributed technically to: (i) the development and/or revision of relevant training packages, (ii) the training and coaching of state trainers; and, (iii) the continuous mentoring and coaching of health providers on the job, both before and after training. TCIHC worked at the state and national level on the following training materials: ASHA induction, FP module, Referral Mechanism, Quality Assurance Manual, MAS Guidelines and others. TCIHC coaches also introduced the coaching and mentoring of all levels of staff (community to state level) to improve FP and MNH counselling and referral and the quality of clinical voluntary FP services. TCIHC supported the NUHM in quick translation of training modules for ANMs, which were then used by the states to train staff in FP service provision. State PIPs financed training sessions, state trainers delivered training content and TCIHC staff monitored and then mentored trainees in their sites to reinforce new competencies. Table 9 below shows the numbers of providers trained on one or more topics by state and type of provider.

Table 9: # Urban health workers trained in UP, MP and Odisha from Sept '17 - Jun '19						
Data Source: Training Reports, TCIHC PMIS						
State	ANM	Lady Health Visitors	Staff Nurses	ASHA	AWW	MOiC
UP (20 cities) *	1,910	48	312	3,724	-	-
MP (FP)	444	16	211	1,273	-	73
MP (MNH)	54	11	59	158	148	36
Odisha	175	-	14	231	-	-

MNH services improved in secondary health facilities with establishment of IPUs and Newborn Stabilization Units: In tandem with its work to improve UPHC readiness and strengthen referral networks, TCIHC worked to improve the quality of MNH care provided by referral health facilities (district hospitals, maternal child hospitals, community health centers). As shown in Table 10, TCIHC provided technical advice on the organization of pediatric and neonatal support units, as well as maternity wings to improve client flow and the quality of care possible for women and infants during and after labor and delivery. TCIHC also developed an innovative concept in conjunction with the Ratlam and Indore city governments that brought together the specialized pediatric units that provide curative services to sick newborns, infants and young children (including Special Newborn Care and Pediatric Intensive Care) into one IPU. The first two IPUs were established by the MP health department and at PC Sethi Hospital in Indore (an established maternal and child hospital), where the hospital’s renovation and expansion were in progress at the time. The IPUs are intended to improve patient flow, coordination of care, continuity of services and efficient use of available human/financial resources and equipment. The Indore IPU was inaugurated in August 2019, so the data available on IPU utilization was extremely limited at the end of Phase 1. At the end of its first month, 21 newborns were in the SNCU and one child was in the PICU. In December 2019, after the end of TCIHC’s MNH support, those number had increased to 46 and 10, respectively. Based on their positive early experience at PC Sethi Hospital and the Ratlam District Hospital, the Government of MP has planned and budgeted

through the PIP process for similar units in a total of ten cities (four TCIHC assisted cities and six non-TCIHC cities).

Strategies 2.7-2.9 Layering of AYSRH Services on Existing Urban Health Service Delivery Model and Support Quality Adolescent Friendly Health Services (AFHS) on Existing Urban Health Service Delivery Model to Support Facilities and Providers

AFHS increased in five cities of UP: In Year 3, TCIHC started building capacities of service providers at the UPHC level to increase the provision of AFHS to both married and unmarried adolescents and youth. The AYSRH FDS orientation for UPHC staff and ASHAs prompted them to reflect on their own biases and to more effectively address the contraceptive needs of young mothers. Using a government developed curriculum, training manuals and communication materials from India’s flagship National Adolescent Health Program (Rashtriya Kishor Swasthya Karyakram (RKSK)), TCIHC trained UPHC service providers on AFHS. This included 53 MOiCs and 99 staff nurses to ensure that at least one service provider (staff nurse) from each of the 96 UPHCs in the first five AYSRH districts in UP were trained on AFHS. See section 3.6-3.8 below for additional details on AYSRH and AFHS achievements.

Table 10: MNH service improvement in secondary facilities in MP and Odisha Data source: Project Records	
Type of care unit	Location & # of cities
# of IPUs supported	Two in Indore and Ratlam, Government will expand to eight additional cities.
# of Newborn Stabilization Units supported	Two in Indore (P.C. Sethi, Malhargani) and one in Gwalior (Birlanagar)
# of Newborn Care Corners supported	Two project cities (two at CHC Banganga and Mangilal Churia hospitals in Indore and two at Laxmiganj and Madhavganj maternity hospitals in Gwalior)
# of maternity wings approved by Government of MP (GoMP) for expansion	One in Indore (P.C. Sethi) and one in Gwalior (Birlanagar)

Result 3: Increased Demand by the Urban Poor for FP, MNH and AYSRH Products and Services

Highlights Result 3: Increased Demand for FP and MNH Products and Services
<ul style="list-style-type: none">• 5,789 ASHAs trained and coached by TCIHC FPA/FPC to identify, counsel and refer couples for voluntary FP services.• ASHAs more actively identifying and counseling newly married couples and FTPs on the benefits of birth spacing, availability of voluntary FP services and contraceptive choice.• ASHAs able to claim the Ensuring Spacing at Birth (ESB) remuneration for successfully counseling newly married and FTPs who delay birth.• Increasing numbers of women and men seeking voluntary FP services during FDS, UHNDs and ORCs in the 31 TCIHC assisted cities (see figures 8 and 9 below).• During three years of TCIHC, (from July 2016 to June 2019), a total of 858,311 clients accepting an FP method at all public health facilities at city level and about 51% (437,695) of these clients received services from UPHC level.• Pilot activities in five cities of UP demonstrate the capacity of ASHAs to counsel and refer clients to both <u>public and private FP providers</u>.• Male participation model piloted with State Innovations in Family Planning Services Project Agency (SIFPSA) in 20 cities in UP increases demand for voluntary sterilization.• Successful AYSRH mid-media campaign reaching over 78,000 individuals, including 12,000 individuals through SMS messages.

Trend analysis of HMIS data using CYP-based adjustments shows an increasing number of FP acceptors in the 31 TCIHC assisted cities. This trend is visible at both city level – when we include reports from all types of public facilities (see Figure 8) – as well as at UPHC level (see Figure 9). In both figures, each data point represents 12 months of performance. Cumulative sums are calculated for IUCD and permanent methods, whereas cumulative means are calculated for short acting reversible methods such as injectable Antara. At city level, each data point shows an increasing trend for all methods grouped together and particularly for short acting methods and IUCDs, while permanent methods show a declining trend. This figure includes facilities such as district hospitals, medical colleges and UPHCs.

Analysis of HMIS data on FP acceptors at UPHCs only (see Figure 9) shows a declining trend in the initial months from September 2017 to March 2018 for all method types available at UPHCs, including short acting methods and IUCDs. With TCIHC implementation, by the end of Year 2, this declining trend started to reverse course in the majority of cities. The increase seen in and after March 2019, was a result of “*Mission March*”, a special male engagement activity carried out by TCIHC.

Figure 8: Total estimated FP acceptors in 31 TCiHC cities, Sept '17 - Jun '19
 Data source: HMIS data from Oct'2016 to Jun 2019 for all facilities (District hospitals, medical colleges and UPHCs)

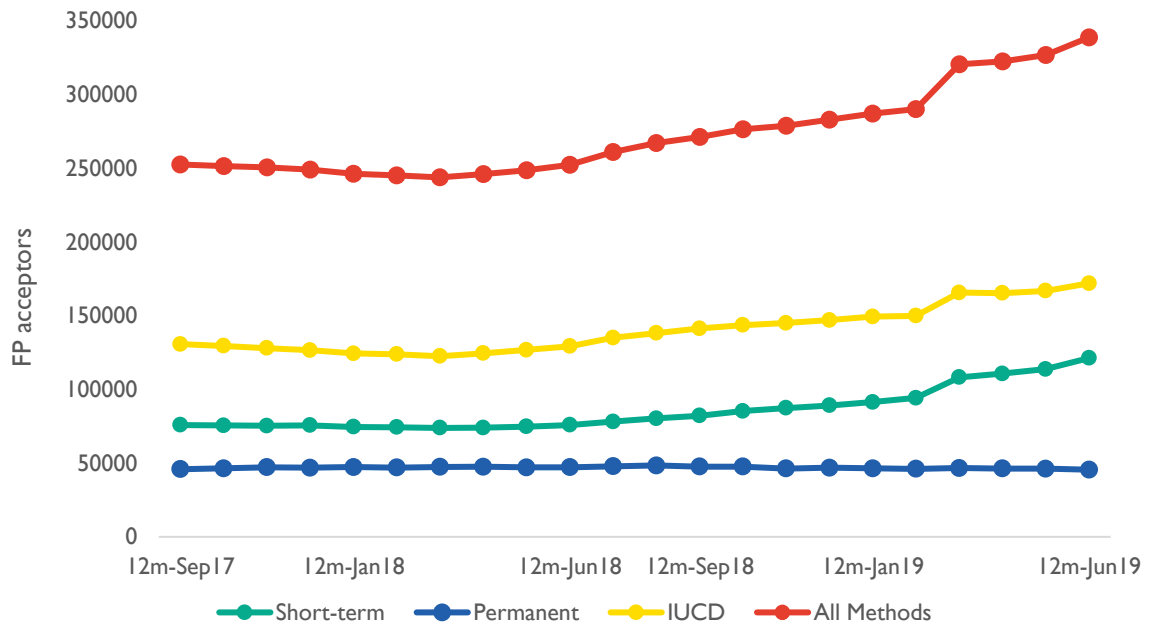


Figure 9: Estimated FP acceptors in 31 TCiHC cities, UPHCs only, Sept '17 - Jun '19
 Data source: HMIS data from Oct'2016 to Jun 2019 (TCiHC assisted UPHCs only)

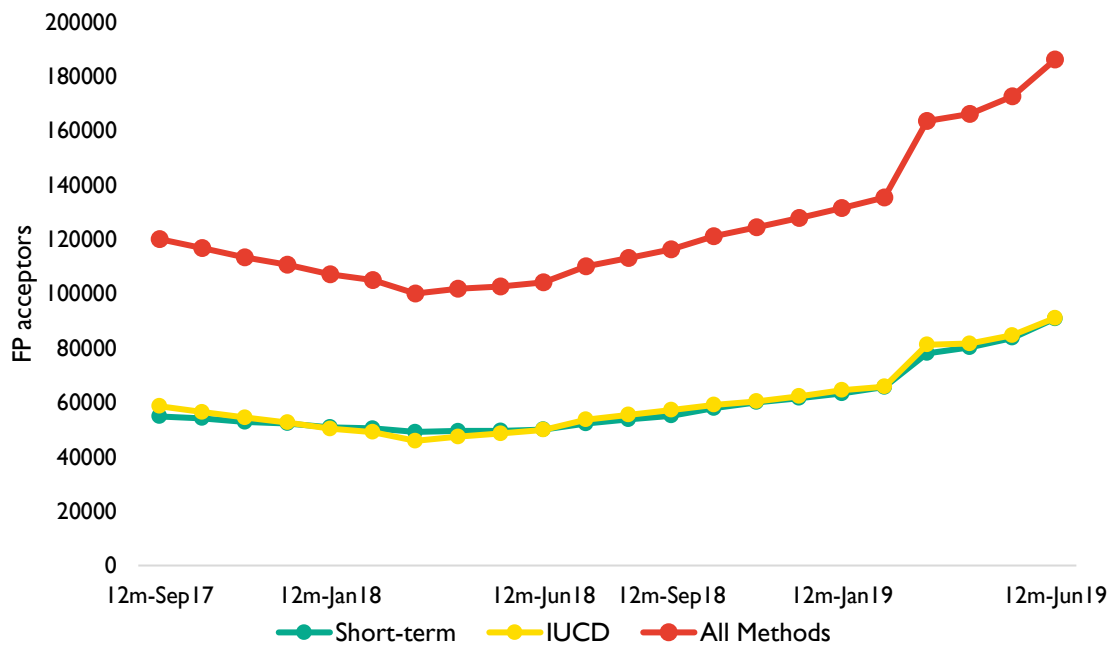


Table 11 below shows the breakdown of the 858,311 clients accepting an FP method over the three years of TCIHC implementation.

Table 11: Distribution of FP Commodities as reported in HMIS and FP Acceptors using CYP methodology									
<i>Data source: HMIS data analyzed at city level from all types of public facilities (district hospitals, medical colleges and UPHCs) from 31 TCIHC cities</i>									
TCIHC Year	Family Planning Commodities as reported in HMIS								
	Condom units distributed	Pill cycle distributed	ECP distributed	Chhaya distributed	Antara doses given	IUCD inserted	Number of Tubectomies	Number of Vasectomies	
Year-1 (Jul'16-Jun'17)	3,915,137	589,887	38,566	14,178	4,337	135,427	42,997	1,564	
Year-2 (Jul'17-Jun'18)	3,890,702	564,812	63,074	34,125	10,448	129,245	45,651	1,550	
Year-3 (Jul'18-Jun'19)	6,005,608	774,870	78,926	63,279	62,296	171,919	43,424	2,104	
TCIHC Year	Family Planning Acceptors using CYP adjusted methodology								
	Condom Users (Pieces /120)	Pills Users (cycle/15)	ECP Users (Pieces/20)	Chhaya Users (cycle/9)	Antara users (Doses/4)	IUCD users (# of IUCD inserted)	FST (# of Tubectomies conducted)	NSV (# of Vasectomies conducted)	Total Clients
Year-1 (Jul'16-Jun'17)	32,626	39,326	1,928	1,575	1,084	135,427	42,997	1,564	256,528
Year-2 (Jul'17-Jun'18)	32,423	37,654	3,154	3,792	2,612	129,245	45,651	1,550	256,080
Year-3 (Jul'18-Jun'19)	50,047	51,658	3,946	7,031	15,574	171,919	43,424	2,104	345,703

Strategy 3.1: Social Marketing and Social and Behavioral Change Communication Strategy Development and Implementation

SBCC messages and materials disseminated: The urban population's awareness of the importance of MNH and voluntary FP services is generally high, but for a variety of reasons, many have trouble accessing services. TCIHC's SBCC strategy was designed to inform slum communities about "how" (e.g. when, where, from whom) to avail hassle-free FP and MNH services from both government and private health facilities. This included publicizing the location and timing of services at UPHCs, in particular and empowering ASHAs as the link between public health services and the urban population. TCIHC also adapted and worked with the individual states to print UHI's basket of communications messages and materials promoting FP and contraceptive choice, using their annual PIP funding to print and distribute these materials and TCIHC FPAs used them in their coaching and mentoring of ASHAs and counselling of couples in the communities. TCIHC also planned and conducted an innovative mid-media campaign in the five AYSRH cities in UP (see AYSRH section below) and a mass media campaign was designed for state governments. The mass media campaign is still awaiting government approval and will be implemented during TCIHC Phase 2.

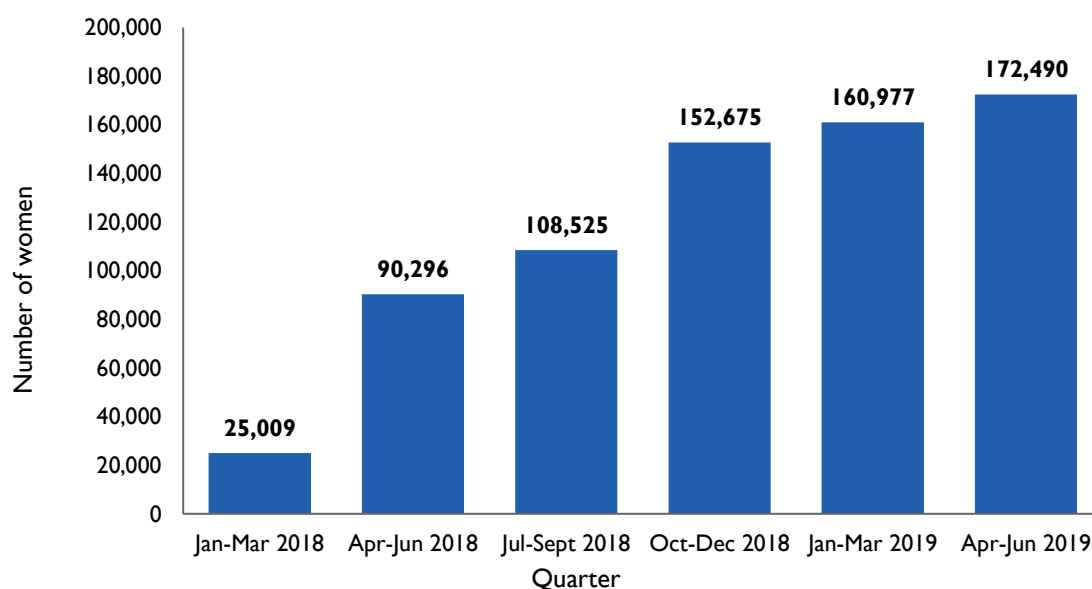
Strategy 3.2 Demand Aggregation for Voluntary FP and MNH Services Provided by Public and Private Facilities through ASHAs, MAS and Other Mechanisms

Demand for FP and MNH services increased through the efforts of ASHAs, ANMs, MAS and others: TCIHC worked with the ASHAs, ANMs and village women's groups – MAS – to identify couples for informed choice counselling and referral to voluntary FP services. Specifically, ASHAs were coached and mentored using the three-stage Lead, Assist, Observe (LAO) approach to identify households with unmet need for FP, including young, recently married couples and first time parents and to link both women and men to existing FP service delivery points. 5,789 ASHAs received coaching visits from TCIHC FPAs and FPCs and they reported reaching 709,972 women with counselling from January 2018 to June 2019. Figure 10 below shows the number of women reached per quarter in this period. This enhanced their capacity to address clients'

concerns and contributed to increased demand and more clients seeking voluntary FP services at UPHCs in TCIHC-assisted cities. TCIHC also contributed to the MOHFW's revised ASHA training guide, which the state governments used to train over 5,000 ASHAs and 2,500 ANMs during the three years of TCIHC Phase 1.

Figure 10: Women reached during coaching of ASHAs, Jan '18 - Jun '19

Data source: Daily Activity Report of Field Program Associates, TCIHC PMIS



Advocacy to increase the numbers of ASHA and disaggregate urban health service data in the HMIS:

Most cities do not yet have the numbers of UPHCs, ANMs or ASHAs dictated by NUHM policy (one UPHC per 50,000 population, five ANMs per UPHC and one ASHA per 400-500 households). Community and UHND/ORC data are also reported together, making it impossible to track the contributions of UHNDs and the ASHA to urban health services. TCIHC advocated at state level and in the cities to increase the numbers of positions for ASHAs where there were too few and to fill existing ASHA posts where they were not filled. TCIHC also encouraged the state governments to fill the ASHA supervisor/facilitator positions mandated by the NHM, but not uniformly filled from state to state. The number of ASHAs recorded in TCIHC supported geographies increased from 2,961 ASHAs in June 2018 to 5,789 ASHAs by June 2019 (source – PMIS).

Pilot – ASHA referral of clients to both public and private FP providers produces positive results in UP:

The EAQ project continued providing direct support to the Government of UP and its intermediary SIFPSA to institutionalize the Hausala Sajheedari approach. Simultaneously, in five cities of UP, TCIHC piloted a model that encouraged ASHAs to refer clients to both public and private sector FP providers. In five TCIHC-supported cities in UP where the ASHA public/private integration model was supported, 138 health facilities (37 %) provided 989 female sterilizations by the end of June 2019. To make this happen, TCIHC mapped the urban ASHAs on the Hausala Sajheedari web portal and their payments were linked with an online payment system. Results of this pilot indicate that if the ASHA payments are flawless and the private sector facilities also have their costs reimbursed, the model works. TCIHC is still supporting this strategic purchase model to ensure choice of facilities for urban poor.

Strategy 3.3: Community Mobilization for Informed Decision-Making

ASHAs prioritize households for counselling and referral to fixed day voluntary FP services at UPHCs, UHNDs and ORCs:

TCIHC promoted the formal training of ASHAs and coached them to increase their active engagement in community mobilization and to identify high-risk women and couples for FP counselling. Urban ASHAs are a relatively new cadre in urban areas and they have required some support and handholding to engage themselves in community mobilization activities. Early in TCIHC implementation period, we found

that FP related discussions and counselling were not at all a priority for most ASHAs. Lack of information was one of the key reasons for this situation. TCIHC first coached ASHAs to complete their survey register – UHIR – so that they would have a complete demographic profile of their catchment areas. Data from the UHIR was further used to segregate the population according to age, parity and user/nonuser of a modern contraception. Once this analysis was ready, TCIHC FPAs coached ASHAs to prioritize those households (HH) where poor, young and low parity women lived for visits and counselling. ASHAs were coached using the LAO model during HH visits to ensure their skills in prioritizing HHs, counselling, using available materials in their counselling, closing the counselling and connecting clients with required products, services and facilities.

LAO three-stage coaching model

Step 1. LEAD
The ASHA coach – FPA – leads a household visit, demonstrating to the ASHA how to approach, understand the fertility needs of and counsel clients on FP methods

Step 2. ASSIST
The FPA accompanies the ASHA on the home visit but steps back, assisting the ASHA only when needed

Step 3. OBSERVE
The ASHA conducts the home visit on her own with the FPA observing only. The ANM who supervises the ASHA may also be included in this step

Facilitating ASHAs’ receipt of the ESB remuneration to promote birth spacing²⁰: ASHAs receive monetary incentives when they accompany women and men for sterilization. The GoI established ESB incentives to encourage birth spacing and the promotion of long acting reversible and other temporary contraceptive methods. ESB provides result-based remuneration to ASHAs who counsel newly married couples and FTPs on the benefits of child spacing and contraception, but the financial payment is delayed. In fact, ASHAs are only eligible for remuneration if a couple’s first birth is delayed until at least two years after marriage, or if first time parents allow at least three years before a second birth. TCIHC found that ESB was not well understood by ASHAs or their ANM supervisors and that, as a result, ASHAs were neither spending much time on birth spacing nor claiming the ESB financial incentive. TCIHC supported city and state officials to provide orientation to the ASHAs and ANMs on the ESB scheme and simultaneously advocated with the FP division at city and state levels to activate ASHA ESB remuneration. As a result, urban ASHAs were for the first time in 2018 – ‘19 considered for the ESB benefit in five of the 31 cities. Gradually it started spreading in all cities and data on reimbursement will be released soon. In the five AYSRH cities where it first started, ASHA received ESB payments valued at USD \$24,640 (final figure to yet to come) for the first time in 2018.

Male participation in FP: Male engagement in FP is always a challenge in India, where women are known to take primary responsibility for FP. States like UP record less than 1% of the FP method mix being from male sterilization using the “no scalpel vasectomy (NSV)” method. Considering that NSV is an easy and effective modern method of contraception, TCIHC with SIFPSA started a joint strategy in UP to scale up the experiences of past projects with male participation in FP, including those of UHI and EAQ. Twenty (20) TCIHC assisted cities of UP piloted a male participation model in FP, in partnership with SIFPSA. In each of the cities, male engagement team leaders were appointed and trained on the HIAs that had been proven to work in early

²⁰ Under the ESB scheme, ASHA are eligible to be paid: Rs. 500/- when a couple’s first child is born two years or more after their marriage; Rs. 500/- when there is spacing of at least three years between the births of their first and second child; and Rs. 1000/- when a couple with two children opts for a permanent limiting method.
<https://mohfw.gov.in/sites/default/files/06Chapter.pdf>

projects. Team leaders and ASHAs then conducted meetings at male congregation points, including workplace interventions focused on rickshaw pullers and evening meetings in slums. Additionally, TCIHC adapted existing UHI and GoI leaflets and designed a kiosk used by the field communication teams to disseminate materials and offer counselling.

In the month of June 2019, TCIHC launched “mission June for male engagement”, which was the month of world population day. These special efforts to inform and bring more men into the FP conversation produced positive results. TCIHC assisted cities recorded a 165% increase in NSV acceptance from April to June 2019, as compared to the same quarter in 2018. The extra male engagement push clearly made a difference in these results, as there was a 213% increase in NSV acceptors in June 2019 alone, as compared to June 2018. Increases in the 20 TCIHC assisted cities helped UP achieve a 33% increase in NSV acceptance state-wide in month of June 2019 and a 12% increase in NSV over the preceding 12-month period, as shown in Table 12 below.

Table 12: Comparing NSV acceptance in 20 TCIHC assisted cities in the state of UP				
Data sources: HMIS (for government facilities); Hausala Sajhedari Government portal (for Private accredited facilities)				
Category	Apr – Jun 2018	Apr – Jun 2019	% increase	Remarks
State total (75 Cities including 20 TCIHC assisted cities)	402	855	112%	Clients were sent to both government and private accredited facilities by male engagement team (ASHAs) beginning in 2018. TCIHC supported cities introduced a) Chouraha (male gathering points) approach, b) Rickshaw puller interventions, c) workplace (small industry) interventions and d) night meetings in slums.
TCIHC supported 20 cities	283	751	165%	
June 2019 - Male Engagement Month results	June (2018)	June (2019)	% increase	In June 2019, TCIHC assisted cities launched a male engagement month during which focused on intervention at male gathering points. Clients were sent to both government and private accredited facilities by male engagement team (ASHAs)
State total (75 Cities including 20 TCIHC assisted cities)	197	460	133%	
TCIHC supported 20 cities	132	414	213%	

Strategy 3.4: Strengthen Community Level Service Delivery Points for Quality Voluntary FP and MNH Services

Vulnerable populations mapped and microplanning of UHNDs and ORCs improved: In addition to mapping and listing vulnerable populations, TCIHC worked with individual UPHCs to improve their microplanning of UHNDs and ORCs, as described under 2.5 above. At the same time, TCIHC FPAs and FPCs worked with ASHAs and MAS to ensure that none of the unlisted or slum populations were left out of the UPHC micro-planning exercises.

Referral mechanism demonstrated in Indore, Gwalior and Berhampur and adopted for implementation by the Government of UP in eight additional cities by the end of Phase 1: Building on an approach developed by the Saving Newborn Lives program in Pune (Maharashtra), TCIHC worked with local government bodies and public health facilities to strengthen referral for MNH and voluntary FP services in three cities--Indore and Gwalior in MP and Berhampur in Odisha. Referral from ASHAs to UPHCs, private providers and higher level facilities is an important aspect of the new mechanism, which has been adopted by the Government of MP for expansion to an additional eight cities in that state with PIP resources. See Result

4 for more complete information about the referral mechanism and how ASHAs have been involved in identifying and referring clients to higher level care.

Strategy 3.5: Facilitate Review Meetings at Different Levels to Ensure that ASHAs and ANMs are Functionally Engaged in Demand Generation

Regular data-driven review meetings held with ANMs and ASHAs to discuss demand generation activities, referral, achievements and issues: TCIHC's FPAs and FPCs participated in regular review meetings with ASHAs, ANMs and UPHC leadership to integrate the ASHAs into the UPHCs and improve the planning of UHNDs and ORCs. During TCIHC Phase 1, there were 6,097 ASHAs in the 31 cities. TCIHC's FPAs and FPCs helped UPHC staff to finalize ASHA meeting agenda and demonstrated the use of data during their monthly meetings. TCIHC observed marked changes in the ASHAs' capacity to manage clients and in their attitudes, as well as increased demand for family planning services at UPHCs that we believe were associated with ASHA training, coaching and mentoring and their more regular and more structured contact with UPHCs.

Strategies 3.6-3.8: Support Strengthening of Community Level AYSRH Services, Mid and Mass Media Activities and Community Engagement to Increase Demand for Voluntary FP by Married and Unmarried Adolescents

AYSRH activities launched in Year 3 in five cities of UP: TCIHC's AYSRH team worked strategically in the first five AYSRH cities in UP to understand and meet the needs of young married 15-24 year olds for contraceptive information and services, specifically the needs of young, first time parents (FTP). To accomplish this, the program elevated the visibility and health needs of young FTPs and worked with ASHAs through coaching and mentoring to identify, prioritize and highlight young FTPs in their registers. This included completion of the UHIR, segregation of lists of women based on age and parity and making sure that young FTPs are prioritized for household visits. The team also worked closely with FTPs and during FDS to influence the mindset of providers and community workers and help health facilities become more adolescent-friendly.

Meeting the voluntary FP needs of young first-time parents: Many married first-time parents, isolated in their homes and communities, face multiple barriers to accessing voluntary FP services in health facilities. In the five AYSRH cities of UP, TCIHC coached ASHAs to map and list first time parents and to proactively counsel them on voluntary FP choice and methods. Husbands and other key family members are also being encouraged to get involved. The TCIHC FPAs also mentor ASHAs to be sensitive to the needs of both young women and their husbands when counselling on FP methods.

Mid-media campaign reaches around 130,000 young parents in pilot AYSRH cities: In September 2018, a high intensity mid-media campaign was launched in the five AYSRH pilot cities of UP- Allahabad, Varanasi, Gorakhpur, Firozabad and Saharanpur. The expectation of the 100-day campaign (20 days per city) was to reach at least 100,000 young married couples with messages on the benefits of family planning (protection from unwanted pregnancy) and information about quality voluntary FP services at government health facilities. A disruptive media approach was chosen to make the campaign stand out. Estimates are that it reached around 130,000 individuals through various media vehicles including IVR (missed call and SMSs) and street theater. Significant involvement of government officials during the launch, active support from ASHAs and ANMs and follow up in the five cities ensured community acceptance and boosted reach. The mid-media campaign received multiple national and international awards for innovation and execution.



Young parents attending a mid-media campaign event. Photo credit: PSI India

Integrated marketing and communications campaign reaches over 100,000 non-FP users in the 31 TCIHC cities: TCIHC designed and executed a second round of mid-media campaigns (July – Aug 2019) in all 31 intervention cities. This campaign targeted married women, 15 – 24 years of age, from the lower wealth quintile to increase their acceptance of family planning. Launched on World Population Day in each of the 31 cities, the campaign received encouraging government support and extensive media coverage and it reached over 100,000 non-FP users in approximately 45 days. Over 70% of the women reached through the campaign were non-users of any modern method. With the objective of encouraging inter-spousal communications, a dedicated IVR-based nightline was part of this campaign. Over 6,000 unique callers accessed the nightline, listened to the stories and consumed around 3,735,740 seconds of call time.

Result 4: An Enabling Environment and Health Systems Improvements that Support the Sustained Delivery and Utilization of a Quality Package of FP/MNH/AYSRH Services by the Urban Poor

Highlights

Result 4: The enabling environment and urban health systems strengthening

- **Stakeholders at city and state level using more reliable data about urban populations, their needs and city health services in planning and monitoring**, including the numbers, locations and needs of the urban poor, the distribution of health sector infrastructure and human resources and the gaps in existing delivery systems.
- **City and state health officials in the three states with improved capacity** to plan, staff, coordinate, monitor and improve health services for the urban poor through annual PIP planning, state enclaves and city coordination meetings.
- **Over \$60 million USD equivalent leveraged or unlocked** from the annual PIP process in three states for urban health improvement and approaches promoted by TCIHC.
- **State and city coordination and review meetings more frequently held** and with multiple stakeholders to jointly share plans, track progress and make adjustments in local strategies.
- **Nine urban FP HIA tools, with government logo and buy-in and endorsed by the three state governments** unveiled at state urban health conclaves in April 2019 and July 2019. These and three additional FP and three new MNH tools in use in TCIHC assisted cities will be available on the TCI University, USAID DEC and MCSP legacy websites.
- **MNH “Referral Mechanism” successfully demonstrated in MP and Odisha, endorsed by NHM-MP and unveiled by Principal Secretary, Health and Family welfare GoMP**. GoMP is in the process of rolling out TCIHC’s referral approach to eight more TCIHC assisted and non-assisted cities, for a total of ten cities in that state. Odisha also intends to adopt the approach for scale up in Phase 2, if the Berhampur experience is positive.
- **Model partnerships forged with medical and nursing colleges**: TCIHC facilitated partnerships between NUHM and several medical colleges in Gwalior and Indore, which will guide the development of formal guidelines as to how these types of institutions can come together to improve urban service provision.
- **States and cities endorse and buy-in to TCIHC HIAs and promising MNH practices for introduction both beyond TCIHC assisted cities**: The states of MP and Odisha are introducing FDS and city health coordination groups in all cities. MP is implementing UPHC readiness assessments in all cities and IPUs in ten cities.
- **TCIHC successfully “layers on” other interventions to its “classic” urban health platform**. AYSRH successfully added in five cities in UP with funding from the Bill and Melinda Gates Foundation; TB activities added in collaboration with USAID’s SHOPS project in seven cities of MP; a pilot NCD activity supported by Eli Lilly and company successfully implemented in two cities (one with TCIHC support); and, a Patient Centric Care (PCC) piloted in one city with the University of California at San Francisco (UCSF), showing the potential that the TCIHC “classic” platform has to accelerate scale up of multiple public health interventions in cities.

Strategy 4.1: Integration of RMNCAH with Urban Health at National, State and City Level to Support Integrated FP/MNH Programming in Urban Areas

Convergence increased among RMNCAH and NUHM authorities at national and state level: States and cities follow guidelines and use resources from NUHM to align services with the needs of the urban poor, as well as from NHM and a variety of government RMNCAH-related schemes. TCIHC helped NUHM to convene three national meetings for NUHM and RMNCAH program focal points from the states including the TCIHC launch, Urban Health review meeting and national level brainstorming on AYSRH. The TCIHC

team also participated in and helped to organize state conclaves and state review meetings on specific topics over the three years. These meetings allowed state health departments to show case and raise the visibility of their work and the remaining needs before state authorities. They were also excellent opportunities for TCIHC to share its approaches and achievements and to advocate for adoption of the FP HIAs and MNH interventions.

City health coordination groups: TCIHC worked with and through city coordination committees, district health societies, urban health advisory committees and other coordinating groups in cities to move the urban FP/MNH and systems strengthening agenda forward. By the end of Phase 1, all the 31 TCIHC assisted cities had functioning urban health coordination groups of some type. TCIHC monitored and supported these groups as they reviewed progress, contributed to annual PIPs and other city health plans and worked together to solve problems. MP and Odisha are contemplating the expansion of city coordination groups to non-TCIHC assisted cities in Phase 2.

Government and other funding leveraged/unlocked to scale up HIAs: As mentioned earlier, the three states successfully leveraged over USD \$60 million of PIP FP, MNH and urban health budget allocations. TCIHC also leveraged just over USD \$70,000 from the government-contracted agency, Hindustan Latex FP Promotion Trust, for the training of 608 UPHC providers from 17 cities of UP on IUCD insertion and one-day refresher training for 221 non-performing service providers with hands-on practice and cross learning from peers. As a result of this corporate social responsibility (CSR) investment in TCIHC, 149 health facilities have at least one recently trained FP provider.

Strategy 4.2: Support Development, Adoption and Use of Appropriate Urban Health Analytic Systems

Improved quality, availability and use of HMIS data at all levels: Urban health data are rarely up-to date and, until recently, the national HMIS did not present urban health data by level of service, making it impossible to estimate the relative contributions of ASHAs, UHNDs, ORCs, or UPHCs to performance in cities. TCIHC advocated to disaggregate data by level of service with some success in UP. The team also worked to improve the data management, analysis and monitoring skills of state and city health officials and coordination groups; supported the analysis and use of routine data for decision-making during regular city and state review meetings; provided support to states to update their HMIS databases, which were generally many months behind. TCIHC also triangulated the government's Health Management Information System (HMIS), TCIHC's Project Management Information System (PMIS, see below) and its Referral Management Information System (RMIS) and other data sources and used the resulting analyses to raise awareness of the serious data quality issues facing planners and managers in the urban districts. Although the quality of the FP and MNH data reported through the government HMIS improved in the TCIHC assisted cities, there is still much work to do to sustain the improvements and encourage the systematic presentation, analysis and use of urban health data.

TCIHC's Project Management Information System (PMIS): To manage the work of its own team and track results in urban communities and health facilities, TCIHC developed a Web-based PMIS and deployed it starting in Year 2 for use by all FPAs, FPCs and FPSAs. With 31 TCIHC cities reporting using the digital PMIS mobile application, TCIHC was able to monitor the intensity of its own activities (i.e., coaching and mentoring of ASHAs by the FPAs and quality improvement work with the UPHCs by the FPSAs, etc.) and the results of those activities including numbers of FP clients counselled and followed-up in communities, antenatal care (ANC) clients seen at UPHCs, results of FDS, etc. Using PMIS data dashboards allowed TCIHC management to determine, in real time, where more work was required to produce results. The PMIS also allowed the team to triangulate and compare government reported HMIS data and PMIS data, which helped to pinpoint problems and improve the timeliness and quality of HMIS data.

Strategy 4.3 Develop and Implement a Referral Mechanism for FP and MNH Services in Three Demonstration Cities in MP and Odisha

Referral mechanism adapted and demonstrated in MP and Odisha: The lack of outreach and multiplicity of service providers in urban areas--with urban local bodies, state governments and the private sector jointly providing primary health care--have resulted in weak referral systems in most cities as well as the

underutilization of primary health care and the overloading of tertiary hospitals. Referral has long been part of the basic service guidelines of the MOHFW, but standardized referral protocols, procedures and forms do not exist in most cities and referral from the community level to health facilities has not been integrated in formal referral networks in the past.

TCIHC built on Saving Newborn Lives' (SNL's) positive experience in Maharashtra state with a facility-to-facility referral approach and also built on what already existed in the three demonstration cities of Indore and Gwalior, MP and Berhampur, Odisha. Adapted and first rolled out in one zone of Indore city in December 2017, TCIHC's referral mechanism aimed to address the related problem of congestion at higher level health facilities, under-utilization of UPHCs and weak connections between facilities and between UPHCs and the communities they serve. TCIHC focused on strengthening "facilitated referral loops" that start at the community level and include counter-referral and back-referral to UPHCs.

An effective RMNCAH referral mechanism...

- **Identifies individuals with danger signs** – pregnant women, new-borns, post-partum mothers, FP acceptors, others
- **Expedites their transfer** – moves or facilitates their movement to higher levels of care
- **Strengthens referral linkages** – between communities and health facilities and among health facilities
- **Engages the private and the public sector** - including medical colleges, corporate hospitals, individual private service providers and private nursing homes
- **Includes counter- and back- referral** – to encourage follow-up in the home and at the UPHC
- **Promotes use of primary care before hospitals** – contributes to decongesting referral facilities so that they can concentrate on those who need them most

This community focus was new, as were several other elements of the approach including: the UPHC and hospital catchment area mapping; formal linkages between certain types of facilities; recognition of the role of ASHAs and ANMs in referral; a health information systems module (registers, forms) that captures referral, counter-referral and back referral; and a simple application that can be used on a cell phone or tablet to refer and track referred clients as they move through the health system. TCIHC was also uniquely able to build on the presence of the FPAs and FPCs to support the rollout of the community-to-facility referral loop.

In each city, TCIHC worked to ensure that referral pathways were clearly defined; providers understood their roles and the objectives of the larger referral process; each level of care was prepared and empowered to deliver the appropriate services; and the needed public sector resources (human and financial) and structures were available. TCIHC fostered ownership among city health officials and supported learning visits to Pune to see a referral mechanism in action. The initiative also constituted city level technical committees that reviewed current referral practices, protocols and tools; mapped government health facilities, urban slums and habitations and private service providers; developed standard referral protocols and tools (referral slips); oriented health

staff and frontline health workers (ASHA, AWW, MAS) to the mechanism; and conducted follow up visits to coach the local partners.

In the context of referral, TCIHC developed and tested an electronic referral information system and an Android-based mobile phone app for frontline health workers to use when referring cases from the community to the UPHCs and secondary and tertiary level hospitals and medical colleges. TCIHC piloted the referral app in Indore city, through an iterative process that included multiple rounds of revisions. ASHAs, ANMs and UPHC staff involved in testing the app reported that it significantly reduced their workloads. The computerized information system and the mobile app were ready for larger scale introduction at the end of MCSP's support to TCIHC.

New Android-based Referral App Successfully Tested in Indore

60 ASHAs, 23 ANMs and two UPHC staff members were trained on the first version of a referral app, with help from Arihant College, in Indore City.

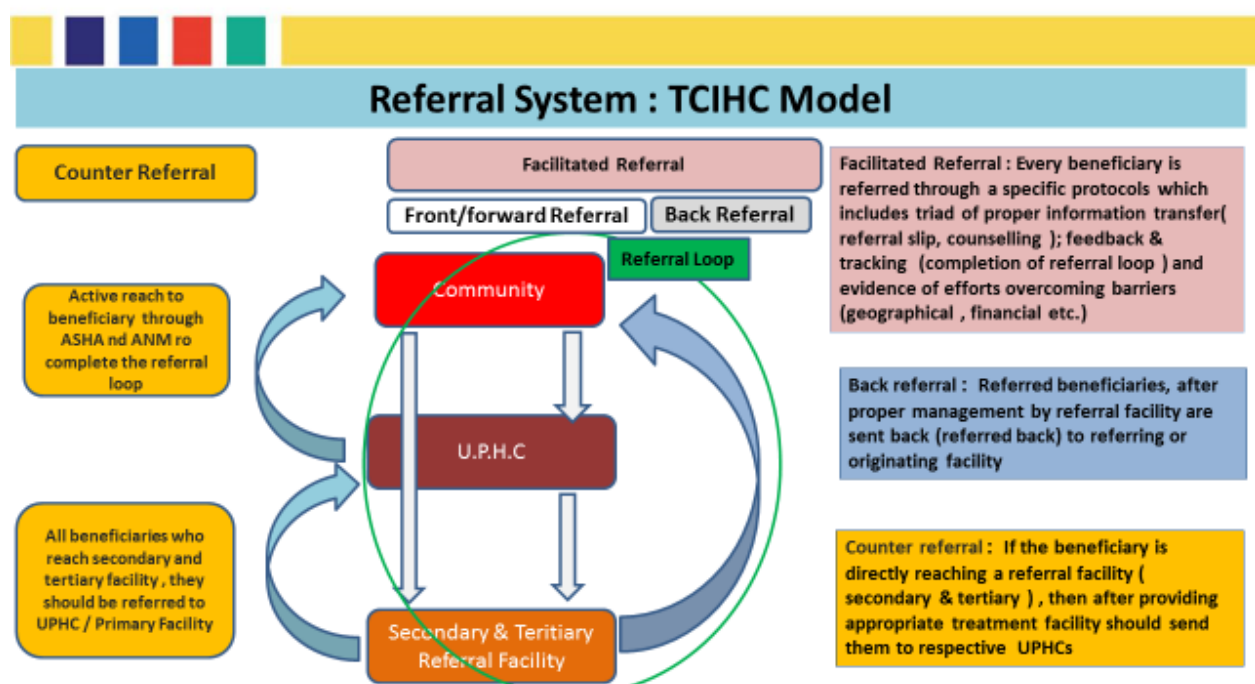
Learning from that experience informed a first round of modifications and the successful piloting of a revised app in January 2019 in Sanyogitaganj zone (with 51 ASHAs) and at UPHC Musakhedi (with UPHC staff, 30 ASHAs and three ANMs).

In the final months of Phase I, TCIHC turned the app and the web-based referral information system over to the MP NHM and, at the government's request, trained ten city program managers in its use.





ASHAs in training to use referral app. Photo credit: Save the Children, India

Figure 11: TCIHC Referral System



Results: By the middle of 2018, TCIHC had supported expansion of the referral mechanism to all four zones of Indore city and to Gwalior (both in MP). Introduction did not begin in Berhampur (Odisha) until early 2019 because of delayed approvals, but it progressed well during its first six months. The GoMP has been among the referral mechanism’s most enthusiastic adopters and has allocated funding in its 2018 – 2019 and 2019 – 2020 PIPs to expand the approach to a total of ten cities by 2020. Beyond Indore and Gwalior, government-led implementation had begun in Bhopal by the end of MCSP’s support to TCIHC.²¹

Data on community-to-facility referral provided insights into the profile of referred beneficiaries and the health conditions for which they were referred. From January to July 2019, total of 3,627 referrals were done from community-to-facility level in four zones of Indore city for reasons mostly related to maternal or newborn health (93%). Of referrals to higher level facilities, almost two-thirds were for antenatal care and checkups (67%), a service that can be managed at a UHND or UPHC. Nearly 4% of referrals were for management of high-risk pregnancies, 6.6% for sick newborns and children and 11% for family planning. As the referral mechanism is rolled out to additional cities, monitoring the patterns of referral will be important, as will taking action to shift the focus of most referrals to the UPHCs.

Table 13: Levels of care to which clients were referred by type of service N = 3,589 cases referred for which level of care is known [total 3,627 clients referred minus 38 clients with missing data] Data Source: Referral Management Information System							
Clients referred to: 	ASHA and MAS	UHND and outreach camps	UPHC and Civil Dispensary	CHC	Civil and other hospitals	District and other tertiary hospitals	TOTAL
	Clients referred for: 						
Antenatal Care (ANC) services	229	68	590	124	1,348	46	2,405
Management of high-risk pregnancies	7	0	27	13	85	5	137
PNC services	1	0	4	0	5	1	11
Routine immunization	41	27	36	54	3	0	161
Family Planning services	60	3	124	33	187	1	408
Management of sick newborn or child	27	5	111	7	76	8	234
Treatment of other conditions	15	3	98	52	61	4	233
TOTAL	380	106	990	283	1,765	65	3,589

²¹ The Government of MP requested TCIHC’s support to introduce the referral information system and mobile app beyond the initial TCIHC-assisted cities shortly before the end of MCSP’s support for TCIHC. MCSP hopes that TCIHC will be able to continue providing at least “light touch” support in Phase two to MP and Odisha cities adopting the referral approach.

Qualitative assessment of referral mechanism: In 2019, TCIHC worked with an external agency to conduct a qualitative assessment of the referral mechanism. The assessment’s purpose was to determine how the system is functioning regarding pregnant women and sick newborns, from both the demand and supply perspectives. The four cities where the referral mechanism was introduced during Phase 1 – Bhopal, Gwalior and Indore in MP and Berhampur in Odisha – were involved in the assessment through in-depth interviews (50) at all levels of the health system and with women and men receiving referrals from ASHAs for maternal and newborn care. Focus group discussions (FGD) (15) were also conducted in Indore City, where the referral mechanism had been functioning for 12 months. FGDs with ASHAs, ANMs, staff nurses and women and men experiencing a birth during the six – nine months prior to the study helped understand how the referral mechanism was working from the perspective of key stakeholders (both community and service provider) and health system managers. Assessment findings also described: (i) reasons for referral; (ii) to what levels of care referrals are made; (iii) health provider and client experiences with referral protocols and tools; (iv) interactions between clients and providers that lead to provision/acceptance of MNH referrals; (v) client experiences with community and referral care; (vi) whether the referral mechanism is resulting in the decongestion of higher level health facilities and increased care-seeking at UHNDs and UPHCs; and (vii) the barriers and facilitators to implementing TCIHC’s referral strengthening approach, as described by families, clients, frontline workers, facility-based service providers and key local program/policy decision-makers.

For more findings from the referral mechanism assessment, see Annex 10 for the technical brief on assessment of the referral mechanism for MNH services.

**Summary of Recommendations from Data Review
and Qualitative Assessment of TCIHC’s Referral Mechanism**

- There is a need to revisit and refine the approach to ensure that the feedback loop is complete from higher level facilities to primary and community levels
- Though TCIHC included a focus on readiness to deliver services at UPHCs – and demonstrated measurable achievements in this area – the qualitative assessment revealed there is more work to be done, particularly in the area of human resources. Readiness to deliver services at primary level is essential to achieving a fully functioning referral system
- The qualitative assessment suggests a need for efforts to address barriers that were outside the scope of TCIHC, particularly to enhance counseling and interpersonal communication skills among facility-based service providers and increase access to timely transportation for referral
- ASHAs have been the backbone of the referral mechanism work, by identifying cases, encouraging the community to value and complete referrals and building trust with community. However, given the strong preference for hospital care, or care from private sector sources, among beneficiaries, focused intervention is needed to ensure that clients are aware of the improving quality of care and service readiness at UPHC level; value the role of primary level facilities and referral; and ultimately, reduce their use of higher level facilities for services that can be delivered at a UPHC
- Late in the life of the program, TCIHC worked with a higher level facility in Indore to establish a help desk for referral patients, intended to guide them through the facility and ensure that they receive services on a priority basis, when appropriate (based on clinical factors and services sought). Further investment in and expansion of this strategy to other facilities may help strengthen the referral mechanism and ensure a positive experience for referred clients

Partnerships with medical colleges forged in MP: Medical and nursing colleges are uniquely positioned to provide support to NHM and health providers to improve the quality of care provided by urban health centers and strengthen the referral mechanism. TCIHC initiated a dialogue and facilitated the signing of formal MOUs between the NHM and medical colleges in Gwalior and Indore to support the establishment of referral systems that “strengthen RMNCHA service delivery, increase utilization of UPHCs and reduce the burden on secondary and tertiary health facilities”. As a first step, TCIHC contracted with the respective medical colleges to study the patterns of referral to tertiary care centers in their cities. Researchers presented their findings to joint meetings of the respective NHM leaders and medical colleges in each city and this led to the two groups working together to operationalize the referral mechanism and agreeing to develop the formal MOUs. TCIHC sees

these partnerships as a potential model for other cities and recommends development of a proposal to take partnerships between the state NHMs and medical colleges forward in TCIHC Phase 2. The Indore and Gwalior MOUs can serve as model partnership agreements for the future and as platforms on which to strengthen and continue to improve the referral process and strengthen other aspects of urban health systems.

Strategy 4.4. Document, Disseminate and Promote the Use of TCIHC Tools, Approaches and Learning

HIAs and new TCIHC tools, approaches and learning documented, disseminated and available on the TCI University and other websites: As described under Result 1, TCIHC promotes HIAs from India's earlier urban FP and health projects including UHI, EAQ, HUP and SNL. During Phase 1, TCIHC adapted nine of the earlier HIAs, added three more and produced products for service strengthening, demand generation and advocacy purposes, including three one-page briefers, 12 infographics and 19 blog posts. All of these are available to the global as well as to the Indian audience on the TCI University website and most are in English and Hindi.²² As of now, 12 approaches are codified from FP and are posted on TCI University (www.tciurbanhealth.org). Additionally, TCIHC's team prepared case studies and additional toolkits that specifically focus on the MNH and FP approaches demonstrated by the project including the UPHC readiness assessment, referral mechanism and IPUs. TCIHC has used a variety of different documentation and dissemination techniques to make the HIA topics more interesting and appealing. For example, TCIHC turned the FDS tool into a whiteboard animation as well as a written tool, produced a 'learning series' of one-page documents which quickly outline the concepts behind each topic and developed three "How we work" documents that go beyond the HIAs to provide information important to those interested in TCIHC's overall approach. TCIHC's FP HIA tools and other documentation can be found on TCI India's [Building on the Success of UHI webpage](#). MNH tools are on USAID's DEC and both sets of materials will be on the MCSP legacy website. All HIA tools are listed with their individual urls in Annex 3.

States adopt and move to scale up HIAs in and beyond the 31 cities: A coordinated set of high level advocacy activities and one-day state conclaves on urban family planning and MNH in UP, MP and Odisha led to endorsement by these state governments of specific TCIHC-promoted HIAs. Present at the conclaves were state level principal secretaries, NHM Directors and Additional Secretaries, directors of health and family welfare, commissioners and assistant commissioners for health and other senior level health officials. State level endorsement means that specific approaches and tools promoted by TCIHC are approved for use by all government health officials in UP, MP and Odisha and that TCIHC's impact will go well its original 31 cities. In fact, several states have moved on their own, utilizing government PIP resources, to replicate and scale up of some of the FP and MNH HIAs beyond the 31 cities. All nine FP HIAs including FDS, UPHC readiness assessments, IPUs in secondary health facilities and the RMNCH referral mechanism have each been considered in one or more states for scale up beyond TCIHC assisted cities. At the request of the state governments and cities themselves, in Year 3, TCIHC staff and consultants provided "light touch" support to several non-TCIHC assisted cities. This included offering short orientation sessions, facilitating study visits to TCIHC demonstration sites, providing tools for HIA implementation and training trainers and managers from the new cities. In Phase 2, monitoring the uptake of HIAs beyond the initial 31 cities that were TCIHC's primary focus would be an important objective.

New interventions successfully "layered on" the TCIHC platform: The TCIHC platform not only accelerated the uptake of FP and MNH HIAs but was also tapped to improve the coverage and outcomes of other important health interventions. In addition to successfully adding the ambitious AYSRH component in five cities of UP with funding from the Gates Foundation (described below), TCIHC also implemented a TB activity in collaboration with USAID's SHOPS project, a pilot non-communicable disease activity with support from Eli Lilly Corporation and a small PCC pilot with the University of California at San Francisco (UCSF). Each of these experiences is briefly described below:

- **TB:** Starting in October 2018 with USAID funding from the SHOPS plus project, TCIHC initiated a TB control intervention in seven TCIHC cities using the existing platforms of the UPHCs, UHNDs, ORCs and city- and state level forums. TCIHC FPAs in the seven cities also coached ASHAs on TB

²² TCI University website is an online, web-based platform that serves as a clearinghouse for "how-to" and reference materials related to FP HIAs and a platform for cross learning among TCI 'communities of practice'.

screening, patient referrals to UPHCs and treatment adherence support. Patients referred to UPHCs are counselled for treatment and Revised National Tuberculosis Control Program officers at the UPHCs dispense their monthly TB drug supplies.

- **NCDs:** TCIHC also added an NCD activity in Varanasi, UP with funding from the pharmaceutical manufacturer Eli Lilly. Focusing on the identification, testing and treatment of patients over 30 years of age with an NCD (i.e., hypertension, high blood sugar and cervical cancer). Using a community level engagement approach, TCIHC prioritized the ASHA coaching and mentoring model for NCD related counselling and referrals. The project provided additional FPAs/FPCs (one for each UPHC in Varanasi) as the need for coaching increased. In the intervention areas, the number of FPAs/FPCs doubled with funding from this project and 100% of FPAs/FPCs of selected UPHC areas are working on both FP and NCD issues. The TCIHC PMIS was modified for these cities to collect and capture near real time data.
- **Patient-centric Care** was piloted in one TCIHC assisted city in UP, starting in 2018 with funding and technical support from UCSF. With PCC “layered onto” the TCIHC coaching model, the purpose was to evaluate client footfall and satisfaction with counselling and service delivery when clients were given a basket of options and ownership of their own contraceptive choices. Working in tandem with clients, ASHAs were able to increase family planning services and client retention improved. Government training resources were leveraged for ASHA training and the PMIS was expanded to include PCC indicators and monitor progress. Plans are to have key learnings for scale up by December 2019. The findings will be shared at state level for further action steps by the government.

Strategy 4.5: Create an Inter-Ministerial Platform to Encourage Multi-Sectoral Collaboration to Address Urban Health

In all of its work, TCIHC collaborates with city planners as well as health officials to strengthen health systems and improve the provision of health services. In Year 3, TCIHC began efforts to create an inter-ministerial platform led by the Ministry of Housing and Urban Affairs (MoHUA), designed to bridge the gaps and encourage collaboration between sectors and ministries in addressing the social determinants of health in urban India. To impact the health of citizens requires cross-thematic inputs and collaboration among departments and ministries in each city. To begin developing an inter-ministerial platform for urban health improvement, TCIHC took the following actions:

Desk review completed of policies and programs across sectors that affect the health of the urban poor: TCIHC started this new work with a desk review of policies and programs that affect health, both directly and indirectly, whether they are implemented by health or non-health ministries and departments. The desk review revealed that many flagship schemes have health-related components and the resources to carry them out, but that they are silo-ed from one another. Desk review findings pointed to the need for greater convergence among these departments and schemes and the development of a Plan of Action emphasizing multi-sectoral coordination to achieve specific SDGs among the urban poor.

Multi-sectoral city plan of action drafted with Gwalior stakeholders and shared at the national level: A draft action plan that provides insights to implementers and collaborators was drawn up by TCIHC after consultative meetings with health and non-health sector representatives in Gwalior, the pilot site chosen by MoHUA. In order to develop the action plan, TCIHC began by (i) identifying the policies and programs that impact health directly and indirectly; (ii) identifying the departments and stakeholders with an interest and role to play in improving urban health; (iii) conducting individual, one-on-one discussions with the heads of each department to understand the mechanisms for collaboration that they currently use; and (iv) identifying key activities for each of the non-health departments in urban health improvement. The resulting Plan of Action for Gwalior was shared at a meeting (City Level Consultation on Implementable Plan of Action) led by the Collector for Gwalior in the summer of 2019.

Inter-ministerial group to monitor Gwalior implementation: Following these city level activities, the MoHUA formed an inter-ministerial platform that included the following ministries and departments: Ministry of Health & Family Welfare, Ministry of Women & Child Development, Ministry of Social Justice & Empowerment, Ministry of Labor & Employment, Ministry of Information & Broadcasting, Department of Drinking Water and Sanitation, Department of School Education & Literacy, Ministry of Human Resource

Development, Department of Food & Public Distribution, Ministry of Consumer Affairs, Food & Public Distribution, Department of Youth Affairs, and Ministry of Youth Affairs & Sports. The members of the platform have been provided with the Gwalior draft plan of action for their inputs and feedback and they will meet under the auspices of the MoHUA in October 2019. The MoHUA will incorporate their feedback and the Smart City Mission will implement the Gwalior plan of action. After a period of one year, MoHUA will review progress in Gwalior and determine whether replication in other Smart Cities of India is warranted.

Generating Evidence – Monitoring, Evaluation, Learning and Knowledge Management

TCIHC focuses on continuously generating evidence and learning, disseminating it to different stakeholders and using it to refine its own strategies and approaches. During Phase 1, TCIHC used a variety of methods to collect data about the urban health situation and track facility and individual practices related to FP and MNH care. The link to the strong Monitoring, Evaluation & Research/Learning teams at TCI at JHU/GI and MCSP has been a great advantage. Equally important has been the TCIHC team's own efforts to put a project-wide electronic information system into place, to proactively monitor both the results and the strength of its own implementation and to experiment with several qualitative approaches to identifying the drivers of change. The following paragraphs describe MEL activities during TCIHC Phase 1:

- **Performance Monitoring for Accountability (PMA Agile):** TCI Global partner, Indian Institute of Health Management and Research, Jaipur conducted four rounds of quarterly PMA Agile surveys in three cities – Puri (Odisha), Indore (MP) and Firozabad (UP). PMA Agile includes continuous tracking of FP service delivery and consumption through quarterly public and private health facility surveys and semi annual client exit interviews. A phone follow-up survey is conducted with consenting female clients four months after their interviews. After round one, the PMA Agile methodology was refined with TCIHC's input and based on experience with the first round of SDP assessments. PMA Agile round four was completed in April – May 2019 and findings from both rounds were shared in the context of regular data reviews in the three cities and used in conjunction with other data sources by the TCIHC teams to refine its strategies.
- **Output Tracking Surveys (OTS):** OTS tracks program outputs and outcomes. It includes a household survey, facility assessments and exit interviews with FP and MNH clients. TCIHC plans to conduct multiple OTS rounds in 14 cities across the three TCIHC assisted states. The OTS household survey provides estimates on contraceptive use, knowledge and perception of FP, spousal communication, exposure to FP messages and other FP demand-related indicators. The facility assessment provides data on service delivery indicators, including the availability of human resources and commodities, frequency of supervision and service statistics. Client exit interviews capture perceptions of service quality and levels of satisfaction. TCIHC conducted the first round OTS from September to November 2018 in the 14 cities. 8,030 currently married women 15-49 years were interviewed across the 14 cities. In addition, 1,154 currently married women 15-24 years were interviewed in nine cities of UP to develop separate estimates for the age group. Data collection was also carried out in 811 product and service delivery points (255 public facilities, 109 private facilities, 71 government outreach, 195 ASHAs and 181 pharmacies). 4,015 FP and MNH clients were interviewed at 435 public and private service delivery sites. The second round OTS was planned for September 2019 and it will have only one component (household survey). Results are expected by in early 2020. Round one and two OTS findings will be compared and used to refine TCIHC's strategies in Phase 2.
- **Program management information system (PMIS):** TCIHC developed, tested and scaled a program-wide management information system (PMIS) that includes a digital application for data entry and provides real-time data on program performance at both the UPHC and community levels. All the 31 cities have reported data on reach, quality of reach and contraceptive uptake, through this PMIS app. To strengthen the data quality and promote use at every level, data entered by FPA is validated by both FPC and city manager before it qualifies for an upload to the PMIS. An additional module for managing data from facility assessments conducted by FPSA was added to the PMIS. PMIS data was analyzed by the Monitoring, Evaluation & Learning team to examine some key implementing indicators related to ASHA coaching and mentoring and AYSRH programming. PMIS Dashboard helps to systematically measure program implementation intensity and report in the project Record Tool on a monthly basis.
- **Government HMIS data:** TCIHC staff regularly reviewed the government's HMIS to capture data points related to the urban health system's performance and provided support in some cases to bring the HMIS up to date. Triangulating PMIS and HMIS data at state, city and health facility level pointed out deficiencies

and helped improve data quality and strengthen the government’s reporting system. TCIHC’s Monitoring, Evaluation & Learning team compiles the government’s HMIS data on a monthly basis for all types of facilities in TCIHC supported geographies and at three different levels: at first level, TCIHC assesses whether interventions are translating into gains in TCIHC-supported facilities (UPHCs); at second level, TCIHC assesses the diffusion effect for TCIHC as a whole by combining data from district level facilities and medical colleges; and at third level, TCIHC seeks to determine from state urban totals what the performance of TCIHC assisted geographies is compared to non-TCIHC geographies. The quality and completeness of the government HMIS data have improved, but there is still a lot that should be done to improve HIMS data quality and use.

- **Evidence sharing and use emphasized:** TCIHC leverages available platforms including the PMIS and PMA Agile dashboards, TCI University and others to share information about progress in the 31 cities and disseminate learning to key actors and stakeholders. PMIS data are regularly discussed during TCIHC team meetings at national, state and city levels, with actions taken based on data to refocus implementation. Data were also shared with government officials during review meetings, resulting in official actions. One example of this is highlighted in the following paragraph:

Due to stock-out of depot medroxyprogesterone acetate (DMPA), a UPHC in Indore had to turn away clients interested in an injectable contraceptive on two consecutive FDS. This was captured in the Service Delivery Activity Report, which was shared with the Chief Medical Officer and MOiC of the concerned UPHC. The discussion that arose from the data helped to identify the underlying causes of the commodity stock outs and enabled the Chief Medical Officer to take necessary action. He immediately gave instruction to deliver the requisite number of vials to the UPHC and asked the TCIHC team to coach and mentor staff engaged in procurement and supply.

City level platforms including City Coordination Committee meetings and meetings on specific topics at state and national level are amongst the platforms that TCIHC uses to share city and state findings from routine data analyses and the surveys described above.

- **Formal and informal learning:** TCIHC worked hard to measure the results of its work at health facility, city and state level. However, there was limited time for implementation once TCIHC had established itself in the states, so TCIHC’s focus was primarily on monitoring the scale up of already proven approaches and not testing new ones. Nonetheless, the team was involved in several formative studies that MCSP counts among its learning activities. They included the initial city health assessments that were carried out in Year 1; the AYSRH assessment that set the stage for the launch of this new program component; the qualitative assessment of the referral mechanism carried out in the final months of MCSP’s involvement in TCIHC; and the trial carried out in five cities in UP to determine the feasibility of ASHAs referring FP clients to private as well as public service providers. The multiple rounds of UPHC readiness assessments and continuous collection of quality of care data by FPSAs during their coaching visits also permits TCIHC to monitor key outputs and learn about what is and isn’t working well in specific settings. The larger PMIS collects a wealth of data, as well and is set up to help answer important questions that will determine the initiative’s future directions.
- **Documenting TCIHC results and learning:** In addition to the studies listed above, a concerted effort was made to identify and share the “most significant changes” resulting from TCIHC’s work. This was done using three methods:
 - **Bus do minute aur** (only two more minutes) provides city managers an opportunity to share a “most significant change” update during bi-monthly state review meetings, which may or may not be human interest stories. From each state review, two to three significant change stories were selected by the state review senior team and resulted in approximately nine entries (recordings) per meeting. These entries were sent to TCIHC’s knowledge management team who finally selected three stories for development into a communications product.
 - **Pause & Reflect** is a focus group discussion with TCIHC staff to reflect on learnings they feel are emerging from the Initiative. The discussions are recorded and later converted into quotes and collated by theme.
 - **Qissa sunao** (tell me your saga) is a self-initiative of TCIHC, similar to a story-telling competition. It is a format where TCIHC team members share their stories in a format

convenient to them (document, sound byte, or an audio-visual). Three winning stories are selected by an independent jury and then developed by the KM team before posting on TCI University.

In addition to documenting program impact in this way, the TCIHC team also carefully documented key processes and learnings and plans to continue its documentation efforts through the end of the project. The table in Annex 13 highlights the deliverables and products at the end of TCIHC Phase 1 and their locations on the web. Most will be available on the TCI University, MCSP legacy and/or USAID DEC websites.

Lessons Learned and Recommendations

TCIHC merged two distinct programming approaches: the GI/TCI multi-country “business unusual” approach to accelerating scale up of evidence-based strategies from earlier projects to increase modern contraceptive use and USAID India’s broader approach to urban RMNCAH system strengthening as it had been developed under earlier USAID India-supported urban health projects including HUP, UHRC and others. One of TCIHC’s first challenges was to adapt the GI/TCI three-stage model and “accelerator hub” approach to fit India’s unique urban health context. Unlike many countries where GI/TCI was planning to work, India has:

- ***A national urban health vision, mandate and service delivery model has been articulated by NHM/NUHM.*** Promoting HIAs in the context of this existing model allowed TCIHC to take the HIAs to scale in 31 cities relatively quickly. At the same time, adapting the TCI three-stage approach to India’s urban health context and getting the necessary approvals to proceed with work in these cities, took more than a year.
- ***Significant GoI budget for urban health improvement is allocated annually, down to the district level.*** Resources available through the NHM/NUHM PIP process allow TCIHC to direct its efforts toward “unlocking” rather than raising new government resources. This includes working with the states and districts and advocating to make sure that approved funding is available and spent when needed.
- ***Multiple sources of government funding are available for urban health activities:*** Although fragmented, NHM budget allocations for the NUHM and the MOHFW’s different incentive schemes (i.e. JSY, NSSK, etc.) and thematic programs (i.e. FP, RKSK) are all available for use in urban areas. TCIHC has been able to help the states and cities to more effectively program resources from these different line items and to increase their absorptive capacity, or their ability to spend available budgets on urban health.
- ***Health in India is a “state affair”:*** Authority and resources flow from the NHM/NUHM and state budgets to the state health departments and district health offices, who ultimately control budgets. The “urban local bodies” governing Indian cities vary in size and mandate, including the degree to which they control government health services. All have a role in environmental health and should coordinate the line ministries working within their boundaries. However, Indian cities are not independent entities. Working with them on urban health issues requires state health department involvement and ownership.

In this context, TCIHC proposed slightly modified approaches compared to those originally suggested by TCI and its strategies continued to evolve in the following ways during implementation:

- ***City self-selection begins with the involvement of state health departments:*** Given the role of the states, in the first round of city selection, TCIHC could not go directly to cities to request their EOIs. Instead, state health departments were involved in the pre-selection of cities and in the development with them of their city health proposals. In the second round of city selection, cities did submit EOIs, but the planning process involved not only district health offices and ULBs, but also state health departments and NHM/NUHM state focal points in the final city selection.
- ***Non-governmental individuals (NGI) or consultants replaced NGO sub awards in the cities:*** GI/TCI originally envisioned a small in-country project staff working with a group of local NGO partners who would coach frontline health workers and mobilize communities. In the end, TCIHC opted to contract individual consultants (FPA, FPC, FPSA) to play the role that was originally envisioned for NGO partners. There were several reasons for this, including the fact that contracting NGIs made it possible for TCIHC to standardize, more closely monitor and more quickly refine its community level activities to changing circumstances when necessary. It also eliminated the need to award and then monitor 31 different organizational sub awardees on their performance and adherence to contractual provisions, which would have quickly overwhelmed TCIHC’s management.
- ***UPHC strengthening has become a primary focus for TCIHC:*** UPHCs are the health facilities closest and most accessible to the urban poor, so this is logical. TCIHC has given less attention than originally anticipated to strategic purchasing of voluntary FP services from the private sector. The original private sector focus evolved to one of urban health system strengthening more generally, as it was determined that the private sector was not the most effective way to reach the urban poor with voluntary FP services.

- ***ASHAs have become the frontline health worker of greatest interest to TCIHC:*** ASHAs were always an important element of the TCIHC demand aggregation strategy and they have become even more important than anticipated because many women contemplating FP require counselling at home. With one ASHA for every 2,000 population in urban areas, TCIHC has coached and mentored over 6,000 ASHAs in Phase 1, helping them to identify households, reach out to young and poor women, provide counselling and encourage informed choice of family planning methods. As described earlier in this report, TCIHC designed the coaching and mentoring process based on a Lead, Assist and Observe (LAO) approach, with FPAs demonstrating counselling techniques during home visits and gradually moving to only observing and providing feedback as the ASHAs gain skills. The more than 6,000 ASHAs who were coached by TCIHC have been able to reach over 600,000 women with informed choice counselling in the 31 TCIHC assisted cities. The decision to focus on coaching and mentoring ASHAs was also strategic in that they are present not only during home visits, but also at UHNDs, ORCs and UPHCs, the other community-based service delivery points for FP and MNCH services.
- ***Urban MNH interventions have evolved on the TCIHC platform:*** TCIHC has demonstrated the demand for technical assistance in this programmatic area and the potential that exists to improve the quality of MNCH care at UPHCs and secondary health facilities and referral from community level to. TCIHC's UPHC readiness assessment methodology, implemented in all TCIHC assisted cities in MP and Odisha and the referral loops from UPHCs to and from secondary/tertiary hospitals were introduced as part of TCIHC's MNH agenda. This work has been limited to only three demonstration cities in Phase 1, but it is expanding beyond these cities based on state interest and investment. The IPU at PC Seti Hospital in Indore is another MNH input. USAID's funding for MNH is ending with MCSP. GI/TCI's funding for Phase 2 will be restricted to FP/AYSRH. TCIHC's MNH activities have been turned over to the states, but there is every reason to believe that they will need continued technical assistance to expand any of the three approaches.
- ***AYSRH will be the primary focus for TCIHC in Phase 2:*** Young married couples, unmarried boys and girls and first-time parents are the demographic with the lowest contraceptive use and highest unmet need for birth spacing methods. Amongst the most vulnerable in cities due to poverty, domestic violence and exploitation of different types, the young in cities are an important group to mobilize and serve. All population surveys and MCSP's own FP landscaping study consistently show that the market is failing to meet the FP needs of young, urban and poor women. In Phase 2, TCIHC will shift its FP strategy to focus more on first time young parents, non-FP users and those below 24 years of age.
- ***TCIHC has become a platform for innovation as well as an accelerator for scaling up tried and true HIAs:*** TCIHC has helped to activate India's urban health service delivery model and successfully played its role as an "accelerator hub" for the introduction and scale up of FP and MNH HIAs. At the same time, the TCIHC team has also shown its ability to innovate and contributed new approaches to the HIA tool kit. Examples in Phase 1 have been the: a) demonstration of ASHA referral to private as well as public FP providers in five cities in UP; b) 30 hour magic plus approach to preparing UPHCs to conduct FDS; c) development and layering on of AYSRH interventions in five cities of UP; d) successful AYSRH mid media campaign; e) introduction of referral mechanism in MP and Odisha; f) development and demonstration of UPHC readiness assessment methodology; g) introduction of quality improvement committees at UPHCs; h) development and demonstration of IPU at district hospitals and CHCs; and, i) layering of other interventions on the TCIHC platform (see below).
- ***TCIHC has shown that other interventions can be successfully "layered on" its urban health platform:*** In its pilots and demonstration activities, TCIHC successfully added MNH, AYSRH, TB, NCDs and patient-centric care to the original TCIHC FP-focused platform, showing that it has the potential, at least on a small scale, to strengthen many different types of health services in India's cities. TCIHC's approach to coaching ASHAs, ANMs, AWWs and MAS and to working with the UPHCs and district health offices to increase the supply, improve the quality and generate stronger demand for services could be used to improve the coverage and quality of many different urban public health interventions. More evidence will be required, but TCIHC's initial experience demonstrates the potential that exists to "layer" additional RMNCAH interventions on the FP platform as well as those related to the other health problems of the urban poor and their social determinants.

Priorities and recommendations for Phase 2: Based on the positive results of TCIHC Phase 1, BMGF will continue to support TCIHC for an additional two to three years. During this extension period, BMGF's funding

will be channeled once again through GI/TCI. Data show the overwhelming unmet need for FP among India's urban adolescents and youth and TCIHC's positive results in the first five AYSRH cities in UP during Phase 1. On this basis, GI/TCI will expand its AYSRH support to all three states. USAID's future financial support is not clear to MCSP at this time, but we understand that the USAID Mission will continue at least some of the work started through MCSP during Phase 1.

The TCIHC team and its state and city partners have generated the following set of recommendations for consideration as TCIHC prepares to expand its FP/AYSRH activities into all 31 cities:

- **Continue supporting the scale up of FP & MNH HIAs and other program learning from Phase 1:** TCIHC documented its learning during Phase 1 (as well as from earlier projects) and developed a set of FP and MNH HIA tools that have been endorsed by all three state governments. TCIHC will continue providing technical assistance in Phase 2 to states and cities to scale up these HIAs. In most cases, TCIHC's support will be "light touch", except in the five new cities that will be added with GI/TCI support, where the full package of FP/AYSRH interventions will be implemented through existing systems.
- **Continue learning, adapting and refining TCIHC's approach:** TCIHC and its partners will continue generating evidence and learning about what works in influencing the health-related behaviors of the urban poor and their access to quality FP/AYSRH and other RMNCAH services. TCIHC's regular review of data from the PMIS, the government's HMIS and its surveys, coupled with its routine reflection and learning activities, will fuel the adaptive management process that has been used so successfully to refine TCIHC strategies since the start of its work.
- **Encourage innovation and support implementation research:** With its 31 assisted cities, soon to be 36, TCIHC is a natural learning laboratory for urban health improvement in India. It was not possible in Phase 1 to launch the project in 31 cities and simultaneously compare alternate implementation approaches. During Phase 2, however, this should be one of TCIHC's top priorities. To develop a learning agenda with national significance, TCIHC could work with the NUHM to compare/test different approaches to strengthening the national urban health model, as well as the TCIHC-promoted HIAs. As shown in the side bar, there will be many questions, challenges and opportunities for implementation research in Phase 2.
- **As resources permit, continue "light touch" support for MNH approaches introduced during Phase 1 in MP and Odisha:** TCIHC's MNH approaches included the UPHC readiness assessment, the referral mechanism and the integrated pediatrics units (IPU) in larger hospitals. The first two addressed not only MNH, but also FP service readiness and referral. With USAID's funding for MNH ending, in June/July 2019, TCIHC handed responsibility for its MNH work over to the MP and Odisha state governments. Although GI/TCI will not directly fund TCIHC MNH activities in Phase 2, until new funding is secured for this purpose, TCIHC management proposes to continue monitoring state investments through the annual PIP process and regular NHM review meetings. If possible, TCIHC will also providing "light touch" support to the states for their expansion efforts. MP and Odisha have scaled up the UPHC readiness approach and will roll out the referral mechanism to a total of ten cities in 2019/2020, eight that did not receive direct TCIHC support in Phase 1. Likewise, the IPU model is among the state NHM priorities and several new units are included in the 2019/2020 PIP. MCSP hopes that USAID will continue to support these MNH approaches in the future. For now, the proposal by TCIHC management is a reasonable one that should lead to improvements in both FP and MNH quality of care.
- **Support the governments of MP and Odisha to refine the referral mechanism approach as they scale it up:** The first 12 months in Indore demonstrated that simply having a formal referral system does not discourage overuse of hospitals for primary care on its own, nor does it solve the problem of underutilized UPHCs. In determining what more needs to be done, TCIHC should consider using a human-centered design approach. Not only would working with the intended beneficiaries and frontline health workers give implementers a better sense of the reasons behind health seeking and referral patterns, it would also lead to the design of possible interventions that encourage the population's increased use of UPHCs for things like ANC/PNC and sick child care. TCIHC could take advantage of its presence in the 11 TCIHC assisted cities in MP and Odisha to rapidly test and refine these interventions by measuring their effects on both referral and utilization patterns.
- **Take greater advantage of opportunities for integration (convergence) to improve access, quality and demand for urban FP, MNCH and other health services by the urban poor.** TCIHC demonstrated the potential that exist to layer other interventions on its primarily FP-focused platform,

beginning with MNH and AYSRH in three and five cities, respectively, and successfully piloting other approaches described above in one or two cities each. TCIHC also promoted an HIA tool in Phase 1 that encouraged greater convergence (coordination, integration and joint action) by government departments and programs in cities. (See convergence tool [here](#)). Support to city coordination committees of different types and their development of comprehensive city health plans was part of TCIHC's Phase 1 work and one reason that it was so successful in leveraging and unlocking PIP resources for scale up. In Phase 2, as the program becomes more focused on AYSRH, general urban health coordination and systems strengthening may receive less attention, but there will still be many opportunities to take an integrated approach within the health sector and a multi-sectoral approach in the cities, themselves. Improving the health and wellbeing of adolescents and young adults, including first time parents, will not only require involvement of other departments in each city, but also greater attention to the integration of FP, MNCH, AYSRH and other types of health information and services. TCIHC management recognizes that to achieve this level of integration, its own team members will have to work in different ways than in the past and that strong leadership, staff reorientation and new skill sets are likely to be required. TCIHC's strong learning and adaptive management approach, built with support from USAID/MCSP and GI/TCI in Phase 1, will continue to be an important factor as PSI tackles the challenge of effective integration and convergence in Phase 2.

- **Continue to work with the states and cities to improve the quality of data available for planning and monitoring future urban health activities:** TCIHC relied primarily on data from the government HMIS to monitor progress on FP and MNH indicators, and on its own PMIS data to monitor and link the activities of its staff to services delivered in communities and public health facilities. Systems readiness was monitored through UPHC readiness assessments and quality improvement tools that led to health facility action plans. Also in Phase 1, the TCIHC team used the government's HMIS and developed its own TCIHC MIS and referral MIS on digital platforms that were used to capture and analyze data in real time. In the process, the team learned a great deal about the strengths and weaknesses of each of these systems, but whether they are sustainable, and how useful the data they produce are to local managers, are questions that it was not possible to answer in Phase 1. MCSP recommends that GI/TCI and USAID, if it continues to fund TCIHC in Phase 2, invest more in answering these questions and in continually refining urban FP/MNCH/AYSRH data. This might involve testing more appropriate urban FP/MNCH/AYSRH indicators, data collection methods (digital or paper), data flows and other information systems interventions to address both the quality and the use of available data.

QUESTIONS THAT TCIHC MIGHT ANSWER IN PHASE 2

How can the coaching and mentoring that is improving ASHA performance be sustained?

What increases adolescent and young FTPs use of voluntary FP services?

How can urban health stakeholders be more actively involved in program decision-making?

How to increase referral to and use of UPHCs and reduce over-crowding at higher level hospitals?

What do states and districts need to do to ensure an uninterrupted supply of products and services at urban health facilities?

What are the government guidelines and actions required for scale up and sustained delivery of critical urban health services?

What can be done to foster multi-sectorial actions that improve health outcomes?

How to the expenditure of approved PIP budgets by states and cities?

How to successfully layer additional public health interventions on the urban health platform at scale?

The Way Forward

The Gates Foundation and GI/TCI will continue to support TCIHC's FP and AYSRH activities through June 2021. At the writing of this report, TCIHC has the advantage of a negotiated workplan with GI/TCI for the first year of Phase 2, or Year 4 (2019/2020). The following TCIHC priorities and activities come from that plan:

Overarching strategy:

TCIHC's overarching strategy in Phase 2 is to accelerate the scale up and achieve sustainability of TCIHC's high impact approaches by leveraging resources, transferring skills, driving evidence-based decision-making at all levels of government and ensuring the visibility of the program to increase uptake of modern contraceptive methods among the urban poor.

TCIHC Phase 2 programming focuses on:

- **Leveraging additional PIP monies and increasing state expenditure rates:** TCIHC will focus on leveraging a projected USD 50 million in 36 program cities from the GoI. Building on the program's efforts in Phase 1, TCIHC will go from advocating for increased budget commitments to supporting the state governments to increase the expenditure of their approved PIP budgets for both urban health and urban FP.
- **Expanding private sector service provision to the urban poor in MP and Odisha:** After exposure visits to UP's Hausala Sajheedari model, officials in MP and Odisha formed their own state teams to evaluate the approach and recommend next steps. MP has issued a letter to initiate the online accreditation system in the state and Odisha officials have agreed, in principle, to the initiation of an online system for private sector accreditation for FP. TCIHC will provide technical support to the states by developing an IT-based solution to be launched by TCIHC in collaboration with the state and then operated by state officials. By the end of Year 4, MP and Odisha will have online accreditation, empanelment and reimbursement systems in place and be able to expand private sector sexual and reproductive health services to clients in need.
- **Increasing vertical scale-up and increasing contraceptive choice:** TCIHC will expand the types of facilities (including medical colleges, district hospitals and private sector facilities) offering family planning services and will help these same facilities add new FP methods that expand the method mixes that they offer, focusing on provider and client education and updates for staff on long acting, reversible contraceptive methods.
- **Diversifying coaching support:** In Phase 2, TCIHC will customize its successful approach to coaching and mentoring at each level of the health system to ensure that states and cities that are unique in nature receive the tailored support they require. This will include providing specific types of technical support to underperforming cities and connecting higher performing city leaders to each other to exchange learnings.
- **Triaging and disseminating multiple data sources:** The TCIHC team will harness the power of data to increase the visibility of the TCIHC model at different levels through the HMIS, PMIS, PMA Agile and OTS learnings. These data will inform the program strategies and the broader community through postings on the TCI University platform including blogs, stories and other communication products. A priority in Phase 2 will be increased TCIHC visibility and the capture of key learnings for future investments.

Key activities from the TCIHC workplan for Year 4 call upon the team to:

1. Scale-up TCIHC FP HIAs to five new cities and ensure that all UPHCs are activated (conducting FDS).

2. Expand AYSRH activities to at least 15 TCIHC assisted cities (or 41% of the 31 existing and five new TCIHC cities) and initiate implementation support for unmarried men and women based on formative research findings.²³
3. Provide “light touch” support to state governments to scale-up HIAs in additional geographies (“light touch” support does not include posting TCIHC teams in cities but is provided through state level interventions and the occasional travel of the TCIHC state team to support select cities); Support state governments to take successful MNH approaches (including UPHC readiness assessment, quality assurance/QI approaches, the RMNH referral mechanism and other HIAs) to new, non-TCIHC assisted cities.
4. Expand contraceptive choice by ensuring that 100% of the UPHCs across all 36 cities are offering injectable contraceptives.
5. Provide technical assistance for the development and implementation of an urban FP communication strategy through a government-led, above-the-line and below-the-line communication program.
6. Certify 100% of facilities in TCIHC geographies by District Quality Assurance Committees (DQAC) for quality standards.
7. Develop and disseminate urban FP strategies in three states, strategies that are collaboratively developed by TCIHC and the state governments and government owned. Ideally, state conclaves in UP and MP will include an Urban FP strategy and a communication strategy before the end of Year 4.
8. Develop a capacity transfer strategy for mature cities based on defined indicators.
9. Organize Pause and Reflect, Most Significant Change stories and case study activities involving different levels of TCIHC and government staff and increase the visibility of these reflections on TCI-U (these activities will build toward the TCIHC learning agenda and provide a qualitative understanding of the impact of the program to promote scale-up).
10. Throughout Phase 2, leverage an additional USD 50 million (approximately) from government for urban health and urban FP, including at least two million for AYSRH and track the allocation and expenditure of these financial data.
11. Expand the contraceptive method mix available at an increased number of facilities, including private sector health facilities.
12. Increase the visibility of TCIHC at national, state- and city levels by conducting evidence syntheses workshops, data for decision-making (D4D) meetings and other workshops (classic and AYSRH), using HMIS, PMIS, PMA Agile and OTS data.
13. Codify new evidence-based “how to” tools (guidance on how to implement, monitor and resource high-impact approaches for city and state level officials), based on learning from TCIHC “classic” and AYSRH interventions, likely including how to activate RKS in urban areas; how to identify, reach and help first-time parents to access the FP method of their choice; and how to establish and manage Adolescent Friendly Health Clinics (AFHCs) in urban slums.
14. Provide technical support at all levels of government decision-making on data-driven evidence-based decision making.

Transitioning TCIHC’s maternal and newborn health investments:

In the absence of new investments in the maternal and newborn health work of TCIHC, the team coordinated with the state and city governments in MP and Odisha to take forward the UPHC MNCH readiness assessment approach, the referral mechanism, the involvement of medical colleges and the IPU model. MP and Odisha state governments have included funding to expand different combinations of these approaches in their

²³ 15 TCIHC cities in three states will layer on AYSRH: (1) ten cities in UP; (2) three in MP including Bhopal to compliment PSI’s Wajood program, which focuses on adolescent SRH; (3) two in Odisha including Bhubaneswar to compliment PSI’s Wajood program. Initial data show the reach and conversion of AYSRH cities beyond these geographies. Other AYSRH strategies will be developed using formative research findings.

2019/2020 PIPs. As part of MCSP's transition process, TCIHC developed handover notes outlining the importance of each of these MNH-inspired activities and describing what would need to be done to continue or expand it. TCIHC then organized meetings with government focal points to discuss next steps and the respective governments released minutes from these meetings.

TCIHC, USAID India and the MCSP partners also discussed opportunities to transition the initiative's MNH activities and learning to other projects and brainstormed ways to continue at least some TCIHC MNH support to MP and Odisha in Phase 2, at no additional cost to GI/TCI. The strategies described above and summarized here for future reference are:

- Continue to support planning and budgeting for MNH activities during the annual PIP process and track MNH and FP expenditures against final PIP budgets.
- Identify point persons within state and city governments who will take responsibility for the specific MNH activities and maintain contact with these individuals during Phase 2, responding to their requests for support as resources permit.
- Continue to provide technical assistance to the governments of MP and Odisha for the expansion of the referral mechanism and UPHC readiness assessments to additional cities, as they benefit both FP and MNH service quality, this could include training, supportive supervision, assistance with recording and reporting and others.
- Ensure that referral indicators are included in all urban health review meetings and that all MNH and FP data are disaggregated and presented by urban/rural location.

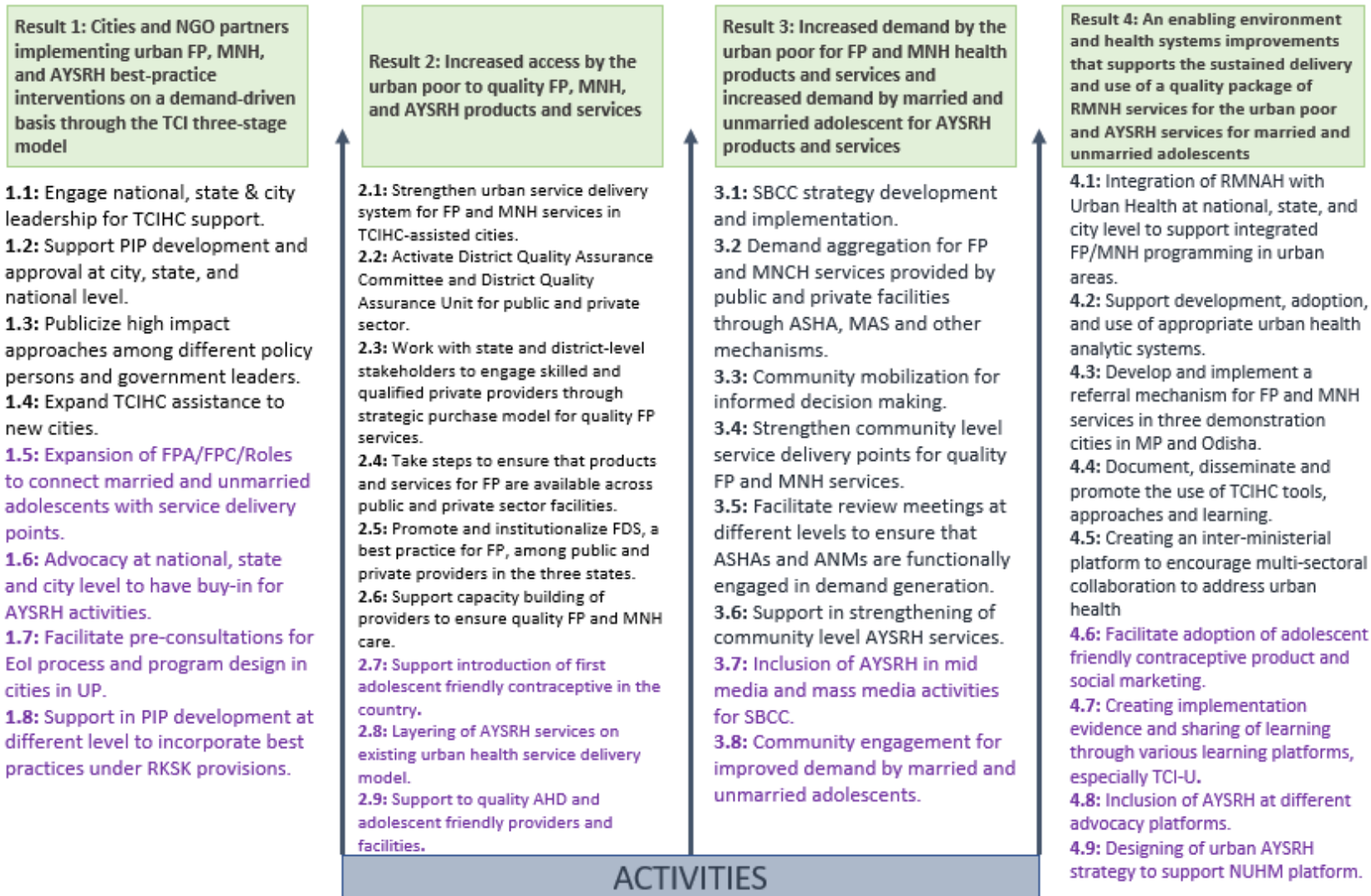
Annexes

<u>Annex 1: Amended Results Framework</u>	66
<u>Annex 2: TCIHC-assisted states and cities – October '17 to June '19</u>	67
<u>Annex 3: Examples of TCIHC High Impact Approaches and Tools (How to tools FP)</u>	69
<u>Annex 4: Performance Monitoring Plan – End of Phase 1 Update</u>	70
<u>Annex 5: UPHC MNCH Readiness Technical Brief</u>	88
<u>Annex 6: Cities' UPHC Readiness Scores</u>	92
<u>Annex 7: Quality Assessment for Family Planning Services</u>	101
<u>Annex 8: FPSA Checklist</u>	106
<u>Annex 9: 30 Hour Magic+ Strategy</u>	109
<u>Annex 10: Strengthening Referral Mechanisms for Reproductive, Maternal, Newborn and Child Health in Urban India</u>	111
<u>Annex 11: Factsheet on TCIHC's Efforts to Strengthen Referral Mechanisms for MNCH in Urban India</u>	116
<u>Annex 12: Case Studies</u>	118
<u>Annex 13: ASHA Incentives under NHM Including CDP & NCD (2015 – '16)</u>	122
<u>Annex 14: TCIHC Deliverables and Products</u>	125

Annex 1: Amended Results Framework

Goal: End preventable maternal and child death

Strategic Objective: Increase the use of modern contraceptive methods among married women, aged 15-49 years, and improve the coverage and quality of evidence-based reproductive, maternal, and newborn health (RMNH) interventions in participating cities, especially among the urban poor.



Annex 2: TCIHC-Assisted States and Cities – October 2017 to June 2019

Activities in Round One cities began October 2017. Round Two cities began activities from March through August 2018. “Light touch” technical assistance provided beginning January 2019.

State	City	Population (2019 Projection)	Start Date	Types of support			
				FP	MNH	UH	AYSRH
Uttar Pradesh	1. Allahabad	1,304,443	Oct 2017	Yes	No	Yes	Yes
	2. Firozabad	844,464	Oct 2017	Yes	No	Yes	Yes
	3. Gorakhpur	717,004	Oct 2017	Yes	No	Yes	Yes
	4. Saharanpur	1,000,658	Oct 2017	Yes	No	Yes	Yes
	5. Varanasi	1,279,919	Oct 2017	Yes	No	Yes	Yes
	6. Mathura	392,852	March 2018	Yes	No	Yes	No
	7. Shahjahanpur	354,318	March 2018	Yes	No	Yes	No
	8. Faizabad	183,723	April 2018	Yes	No	Yes	No
	9. Kanpur	2,950,476	April 2018	Yes	No	Yes	No
	10. Ghaziabad	2,523,689	May 2018	Yes	No	Yes	No
	11. Lucknow	3,450,936	May 2018	Yes	No	Yes	No
	12. Moradabad	1,151,403	May 2018	Yes	No	Yes	No
	13. Jhansi	579,839	June 2018	Yes	No	Yes	No
	14. Agra	1,887,796	July 2018	Yes	No	Yes	No
	15. Aligarh	1,083,177	July 2018	Yes	No	Yes	No
	16. Bareilly	1,085,861	July 2018	Yes	No	Yes	No

State	City	Population (2019 Projection)	Start Date	Types of support			
				FP	MNH	UH	AYSRH
Uttar Pradesh	17. Amroah	229,930	Aug 2018	Yes	No	Yes	No
	18. Meerut	1,531,961	Aug 2018	Yes	No	Yes	No
	19. Noida	1,148,891	Aug 2018	Yes	No	Yes	No
	20. Muzaffarnagar	449,658	Oct 2018	Yes	No	Yes	No
Madhya Pradesh	21. Dewas	346,102	Oct 2017	Yes	Yes	Yes	No
	22. Gwalior	1,280,587	Oct 2017	Yes	Yes	Yes	No
	23. Indore	2,496,816	Oct 2017	Yes	Yes	Yes	No
	24. Ujjain	594,110	Oct 201?	Yes	Yes	Yes	No
	25. Jabalpur	1,193,907	Apr 2018	Yes	Yes	Yes	No
	26. Bhopal	2,126,234	May 2018	Yes	Yes	Yes	No
	27. Rewa	288,147	May 2018	Yes	Yes	Yes	No
	28. Sagar	301,022	May 2018	Yes	Yes	Yes	No
Odisha	29. Berhampur	401,159	Oct 2017	Yes	Yes	Yes	No
	30. Puri	242,934	Oct 2017	Yes	Yes	Yes	No
	31. Rourkela	593,373	Oct 2017	Yes	Yes	Yes	No

Annex 3: Examples of TCIHC High Impact Approaches and Tools (How-to FP Tools)

	Name of Tool	Web-Link/Status
1.	Mapping and Listing of Urban Slums - Tool	https://tciurbanhealth.org/lessons/mapping-urban-slums/
2.	Convergence - Integration of FP and MNH - Tool	https://tciurbanhealth.org/lessons/convergence-of-services/
3.	Fixed Day Static Services/Family Planning Day-Tool	https://tciurbanhealth.org/lessons/fixed-day-static-approach/
4.	Enhancing capacity of Urban ASHAs-Tool	https://tciurbanhealth.org/lessons/enabling-social-health-activists/
5.	FP Capacity Building-Tool	https://tciurbanhealth.org/lessons/strengthening-provider-capacity/
6.	Using Data for decision-making -Tool	https://tciurbanhealth.org/lessons/utilizing-data-effectively/
7.	Private Sector Engagement-Tool	https://tciurbanhealth.org/lessons/engaging-the-private-sector/
8.	Program Implementation Plan (PIP) -Tool	https://tciurbanhealth.org/lessons/planning-and-budgeting/
9.	Strengthening Mahila Arogya Samitis (MAS)-Tool	https://tciurbanhealth.org/lessons/strengthening-womens-groups/
10.	High Impact Approach: Referral Tool	https://tciurbanhealth.org/courses/india-services-supply/lessons/establishing-a-referral-mechanism-to-deliver-rmnch-services/

Annex 4: Performance Monitoring Plan – End of Phase 1 Update

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
Goal: Prevent maternal and child death in India's secondary cities						
SO: Increase the use of modern contraceptive method among married women, aged 15-49 years and improve the coverage and quality of evidence-based reproductive, maternal and newborn health (RMNH) interventions, including referral services, among the urban poor in participating cities.						
1. <i>Modern contraceptive use (mCPR) among currently married women of 15 to 49 years¹</i> <i>MCSP indicator is all women 15-49 years</i>	Numerator: Number of currently married women 15-49 years using a modern contraceptive Denominator: Number of currently married women 15-49 years included in the survey	Survey (OTS ²⁴ 14 cities) Annual survey	3% increase from first round OTS	NA	50.6% of currently married women 15-49 using a modern contraceptive method (Sept-Oct 18)	2019 OTS pending analysis at end of Phase 1
2. <i>Number of OPD cases at UPHCs in 11 TCIHC cities of MP and OD^{25**26}</i>	<i>Number of Outpatient Department (OPD) cases at UPHCs in last three months in 11 TCIHC cities of MP & OD</i>	HMIS – 11 cities MP and OD only Collected quarterly/quarterly averages calculated to smooth effects of seasonality	300,000 est.	241,255 (Apr-Sept 2017)	252,172 (quarterly average Oct17-Sept18)	295,476 (quarterly average Oct18-June19) <i>98% of Phase 1 target achieved</i>
3. <i>Number/proportion of pregnant women registered for Antenatal Care (ANC) at public</i>	Numerator: Number of pregnant women registered for ANC at public facilities	HMIS – 11 cities Quarterly	14,866 (33%) of the est. 45,048 pregnancies	12,299 (27%) of the pregnancies expected (quarterly average Apr-Sept 2017)	11,471 (or 25%) of the pregnancies expected (quarterly average Oct17-Sept18)	9,830 (or 22%) of the pregnancies expected (quarterly average Oct18-June19)

²⁴ Endline figure from OTS Round-2 is not available as data collection will start in September'19

²⁵ Civil Dispensary data not included

²⁶ ** Indicators pertaining to MNH interventions that have been recalculated as quarterly averages with this revised report submission..

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
<i>facilities in 11 TCIHC cities of MP & OD^{2**}</i>	<i>during last 3 months in 11 TCIHC cities of MP & OD</i> Denominator: <i>Estimated number of pregnancies during last 3 months in 11 TCIHC cities of MP & OD</i>		expected per quarter			<i>70% of Phase 1 target achieved²⁷</i>
4. <i>Number/proportion of pregnant women registered for ANC in 1st trimester at public facilities in 11 TCIHC cities of MP & OD^{2**}</i>	Numerator: <i>Number of pregnant women registered for ANC in first trimester at public facilities in last 3 months in 11 TCIHC cities of MP & OD</i> Denominator: <i>Number of pregnancies registered at public facilities in last 3 months in 11 TCIHC cities of MP & OD</i>	HMIS - 11 cities Quarterly	60% of the women expected to register for ANC per quarter	6,188 women registered for ANC during 1 st trimester (50% of all pregnant women registered for ANC) <i>(quarterly average Apr-Sept 2017)</i>	6,624 women registered for ANC during 1 st trimester (58% of all pregnant women registered for ANC) <i>(quarterly average Oct17-Sept18)</i>	6,571 women registered for ANC during 1 st trimester (67% of all pregnant women registered for ANC) <i>(quarterly average Oct18-Sept19)</i> <i>111% of Phase 1 target achieved</i>
5. <i>Number/proportion of pregnant women who attended at least 4 or more ANC visits at a public facility (or UHND or ORC) in the 11 TCIHC-supported cities of MP & OD (UPHC, UHND, ORC data are combined and reported in the HMIS)^{2**}</i>	Numerator: <i>Number of pregnant women received 4 or more ANC services at public facilities in last 3 months in 11 TCIHC cities of MP & OD</i> Denominator: <i>Number of pregnant women registered for ANC at public facilities in</i>	HMIS – 11 cities Quarterly	70% of the women expected to register for ANC per quarter	7,969 women attending at least 4 or more ANC visits (65% of all pregnant women registered for ANC) <i>(quarterly average Apr-Sept 2017)</i>	7,452 women attending at least 4 or more ANC visits (65% of all pregnant women registered for ANC) <i>(quarterly average Oct17-Sept18)</i>	6,485 women attending at least 4 or more ANC visits (66% of all pregnant women registered for ANC quarterly) <i>(quarterly average Oct18-Sept19)</i>

²⁷ Decline in ANC registrations in public facilities may have to do with fewer pregnancies, fewer registrations or incomplete HMIS data, but it is a concern that should be investigated. In future, this indicator should be disaggregated by city and type of health facility so that unexpected trends can be investigated at the source.

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
	<i>last 3 months in 11 TCIHC cities of MP & OD</i>					<i>94% of Phase 1 target achieved</i>
6. <i>Number of children aged between nine and 11 months fully immunized in TCIHC cities of MP & OD^{28**}</i> <i>(USAID indicator is # children vaccinated; MCSP indicator is % of children <12 months receiving DTP3/Penta3)</i>	<i>Number of children aged between nine and 11 months fully immunized in last 3 months in 11 TCIHC cities of MP & OD (separately for female and male)</i>	HMIS - 11 cities Quarterly	Tracking only	9,353 <i>(quarterly average Apr-Sept 2017)</i>	9,156 <i>(quarterly average Oct17-Sept18)</i>	7,147 <i>(quarterly average Oct18-Sept19)</i>
7. <i>Number of women received 1st PNC between 48hrs to 14 days^{2**}</i>	<i>Number of women received 1st PNC between 48hrs to 14 days at public facilities in last 3 months in 11 TCIHC cities of MP and OD</i>	HMIS - 11 cities Quarterly	700	847 <i>(quarterly average Apr-Sept 2017)</i>	520 <i>(quarterly average Oct17-Sept18)</i>	438 <i>(quarterly average Oct18-Sept19)</i> <i>60% of Phase 1 target achieved</i>

²⁸ Although not a TC IHC commitment, immunization data were tracked using the government HMIS. However, the advent of the Intensified Mission Indradhanush (IMI), which uses campaigns to rapidly improve routine immunization coverage in both rural and urban areas made it impossible during TCOJC Phase I to reliably track immunizations given in cities only.

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
Result 1: Demand Driven Cities						
<i>Cities and NGO partners implementing urban best-practice approaches on a demand-driven basis through the TCI three-stage model</i>						
8. <i>Number of geographies introduced to TCIHC</i>	<i>Number of cities introduced to TCIHC in MP, UP and OD</i>	TCIHC records Quarterly	110 cities by end of Phase 1	12 cities	110 cities	110 cities <i>100% of Phase 1 target achieved</i>
9. <i>Number of geographies with submitted expressions of interest for TCIHC support (EOIs were only requested during second phase of TCIHC)</i>	<i>Number of cities the submitted EOI in MP, UP and OD</i>	TCIHC records Quarterly	35 cities by end of Phase 1	0 cities (Round 1 cities were not required to submit EOIs)	38 cities	49 cities <i>140% of Phase 1 target achieved</i>
10. <i>Number of geographies with approved expressions of interest for TCIHC support (EOIs were only requested during second phase of TCIHC)</i>	<i>Number of cities with approved expressions of interest for TCIHC support – three states UP, MD, OD</i>	TCIHC records Quarterly	19 (first 12 cities were not required to submit EOI)	0 cities	19 cities	19 cities <i>100% of Phase 1 target achieved</i>
11. <i>Number of geographies with TCIHC project proposals approved</i>	<i>Number of cities with TCIHC project proposals approved (approved RoP for PIP and proposal approved for utilization of program delivery fund) in MP, UP and OD</i>	TCIHC records Quarterly	31 cities approved	12 cities	31 cities	31 cities <i>100% of Phase 1 target achieved</i>
12. <i>Number of geographies implementing TCIHC-supported high impact approaches</i>	<i>Number of cities implementing one or more high impact approaches by type of approach in MP, UP and OD</i>	TCIHC records Quarterly	31 cities implementing high impact approaches	12 cities	31 cities	31 cities <i>100% of Phase 1 target achieved</i>

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
13. <i>Number of TCIHC-supported cities establishing UHACs /city coordination committees/other coordination units</i>	<i>Number of city coordination units established and meeting regularly, including UHACs, CCCs and others.</i> <i>TCIHC-supported cities have TCIHC-hired city managers, field program coordinators and field program assistants.</i>	TCIHC MIS / Meeting minutes / GOs Quarterly	31 cities with UHACs, CCCs or other coordinating groups	0	28 Total cities 17 UP 3 Odisha 8 MP	31 Total cities 20 UP 3 Odisha 8MP <i>100% of Phase 1 target achieved</i>
14. <i>Number of cities with approved PIPs that include high impact urban FP and/or MNH approaches</i>	<i>Number of cities in UP, MP & OD with approved PIPs that include FP & MNH high impact interventions</i>	Programme Implementation Plan Annually	31 cities	12 cities	31 cities	31 cities <i>100% of Phase 1 target achieved</i>
Result 2: Access to Quality FP/MNH care Increased access by the urban poor to quality family planning and MNH products and services						
15. <i>Number and proportion of existing UPHCs that are fully operational as per guidelines in TCIHC cities of MP & OD</i>	Numerator: <i>Number of existing UPHCs that scored 75 or more in facility readiness assessment in 11 TCIHC cities of MP & OD</i> Denominator: <i>Total UPHCs in OD and MP included in the assessment round</i>	UPHC MNCH readiness assessment Twice annually	40 (or 53%) of 76 UPHCs in MP & OD will score 75 or more points	11 (14%) of 76 UPHCs (June to Dec, 17)	13 (17%) of 76 UPHCs (June,18)	49 (64%) of 76 UPHCs (July,19) <i>123% of Phase 1 target achieved</i>
16. <i>Mean score of UPHC readiness in TCIHC cities of MP & OD</i>	Numerator: <i>Total score of all UPHCs across 11 TCIHC cities of MP & OD</i>	UPHC MNCH readiness assessment Twice annually	65 of possible 100 points	59.6 - Round 1 (Jun to Dec, 17)	61.5 - Round 2 (June,18)	75.6 - Round 3 <i>116% of Phase 1 target achieved</i>

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
	Denominator: Total number of UPHCs assessed <i>*Based on initial UPHC readiness assessment score</i>					
17. Number and proportion of public health facilities conducting FDS for FP services – separately for UPHC	Numerator: Number of UPHCs that are providing FP counseling, methods (IUCD, OCP, condom) and referral on fixed day(s) in a month Denominator: Total number of UPHCs in 31 TCIHC cities	TCIHC MIS Quarterly	400 (estimated at 80% of total UPHCs in 31 cities)	0 UPHCs	440 UPHCs (Sept, 18)	493 UPHCs (June, 19) <i>123% of Phase 1 target achieved</i>
18. Proportion of UPHCs/CDs conducting at least two FDS per month	Numerator: Number of UPHCs/CDs in the 31 TCIHC cities with at least 2 FDS in the reporting month Denominator: Number of UPHCs/CDs in the 31 TCIHC cities	TCIHC MIS (data for a month will be included) Monthly	75% of UPHCs/CDs	0	76%	91% <i>121% of Phase 1 target achieved</i>
19. Number of private accredited facilities with MoU and empaneled health providers for providing FP services in TCIHC cities (by types of services provided)	Number of private accredited facilities with MoU with government in place and providers empaneled (registered/eligible) for government payment for their provision of FP services	State/city accreditation records / MoU Quarterly	155 in UP 40 in MP/Odisha	115 in UP 0 in MP/OD	155 in UP 0 in MP/OD	643 health facilities 100% of facilities in 20 TCIHC cities of UP <i>415% of UP Phase 1 target achieved</i> 0 MP/OD Policies and portals in place to begin

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
						empaneling private providers in Phase 2
20. Number of accredited private facilities conducting FDS for FP services	Number of accredited private facilities providing FP counseling, methods (IUCD, OCP, condom) and referral on fixed day(s) in a month	Government record/HS portal Quarterly	30 private facilities providing FP	19 private facilities in 5 cities of UP providing FP (Jun 18)	19 private facilities in 5 cities of UP providing FP	61 private facilities in 20 TCIHC cities of UP providing FP <i>203% of Phase 1 target achieved</i>
21. Number of institutional deliveries at secondary level public facilities / maternity homes in 3 TCIHC cities of MP & OD ^{29**}	Number of pregnant women delivered at secondary level public facilities / maternity homes in 3 TCIHC cities of MP & OD	HMIS – public facilities in 3 TCIHC cities Quarterly	2,800 institutional deliveries	2,247 (Apr-Sept17)	2,159 (quarterly average Oct17-Sept18)	2,539 (quarterly average Oct18-June19) <i>91% of Phase 1 target achieved</i>
22. Proportion of mothers who received Oxytocin injection during third stage of labor at secondary level public facilities/maternity homes in 3 TCIHC cities of MP & OD (MCSP indicator)	Numerator: Number of mothers who receive Oxytocin injection during third stage of labor at secondary level public facilities/maternity homes in 3 TCIHC cities of MP & OD	TCIHC Referral MIS Quarterly	80% of women delivering at secondary public facilities and maternity homes in 3 cities in MP & OD will receive oxytocin	37% of women (835 of 2,247) delivered at secondary public facilities and maternity homes in 3 cities of MP and OD received oxytocin	47% of women (1,004 of 2,159) delivered at secondary public facilities and maternity homes in 3 cities of MP and OD received oxytocin	84% of women (2,134 of 2,539) delivered at secondary public facilities and maternity homes in 3 cities of MP and OD received oxytocin during 3 rd stage of labor (quarterly average

²⁹ District hospital data is not included for this indicator as differentiating urban and rural clients was not possible

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
<i>is proportion of women receiving a uterotonic immediately after birth in MCSP-supported health facilities)⁴ **</i>	Denominator: Number of pregnant women delivered at the same secondary level public facilities/ maternity homes in 3 TCiHC cities of MP & OD		during 3 rd stage of labor	during 3 rd stage of labor (quarterly average Apr-Sept17)	during 3 rd stage of labor (quarterly average Oct17-Sept18)	Oct18-June19) 105% of Phase 1 target achieved
23. Proportion of newborns received Injection Vitamin K at secondary level public facilities / maternity homes in 3 TCiHC cities of MP & OD ⁴ **	Numerator: Number of newborns who receive a Vitamin K Injection at secondary level public facilities / maternity homes in 3 TCiHC cities of MP & OD Denominator: Total number of live births at the same secondary level public facilities / maternity homes in 3 TCiHC cities of MP & OD	HMIS Quarterly	80% of newborns delivered at secondary public facilities and maternity homes in 3 cities of MP and OD will receive Vitamin K injection at birth	50% of newborns (1,088 of 2,192 live births) at secondary public facilities and maternity homes (quarterly average Apr-Sept17)	82% of newborns (1,756 of 2148 live births) at secondary public facilities and maternity homes (quarterly average Oct17-Sept18)	98% of newborns (2,492 of 2,525 live births) at secondary public facilities and maternity homes (quarterly average Oct18-June19) 123% of Phase 1 target achieved
24. Proportion of birth-asphyxiated newborns successfully resuscitated at secondary level public facilities / maternity homes in 3 TCiHC cities of MP & OD ⁴ ** (MCSP indicator is proportion of babies not breathing/crying at birth	Numerator: Number of birth asphyxiated newborns successfully resuscitated at secondary level public facilities / maternity homes in 3 TCiHC cities of MP & OD Denominator: Number of birth asphyxiated newborns identified at secondary level public facilities / maternity	TCiHC referral MIS Quarterly	90% of birth asphyxiated newborns successfully resuscitated	71% (18 of 25) birth asphyxiated newborns successfully resuscitated (quarterly average Apr-Sept17)	59% (18 of 31) birth asphyxiated newborns successfully resuscitated (quarterly average Oct17-Sept18)	92% (20 of 21) birth asphyxiated newborns successfully resuscitated (quarterly average Oct18-June19) 102% of Phase 1 target achieved

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
<i>who were successfully resuscitated in MCSP-supported areas.)</i>	<i>homes in 3 TCiHC cities of MP & OD</i>					
25. <i>Proportion of referred cases pertaining to high-risk/complication pregnancy from lower to higher levels of the health system in 3 TCiHC cities of MP & OD**30</i>	<p>Numerator: <i>Number of referred cases pertaining to high risk / complicated pregnancy for three months from ASHA/UHND/AWW to UPHC in 3 TCiHC cities of MP & OD</i></p> <p>Denominator: <i>Number of identified cases pertaining to high risk / complication of pregnancy for three months by ASHA/ UHND/AWW in 3 TCiHC cities of MP & OD</i></p>	<i>Analysis of data from the TCiHC referral MIS End of Phase 1</i>	Tracking only	no referral records in place until year 2	72% of high risk/complicated pregnancies detected were referred (MP & OD)	88% of high risk/complicated pregnancies detected were referred (MP & OD)

³⁰ Original indicators on referral for high risk/complicated pregnancy and newborns have been combined. They were: *Proportion of referred cases pertaining to high-risk/complication pregnancy from ASHA/UHND/AWW to UPHC (in-referral)* and *Proportion of referred cases pertaining to high risk/complicated pregnancy from UPHC/lower to higher level of facilities (out-referral), both in 3 TCiHC cities of MP & OD*. The referral MIS was rolled out in a phased manner in the three cities. It produced useful data for management purposes and to test the prototype MIS, but analyzing aggregate data, quarterly for the three cities, as originally proposed, was not meaningful. Alternatively, data collected through the referral MIS from January – June 2019 in Indore city only was analyzed in depth and MCSP undertook a qualitative assessment of the referral mechanism and its information system that produced recommendations for the future refinement and expansion of the approach. See Annex 10 for a report on the quantitative and qualitative assessment of the referral mechanism in Indore city.

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
26. Proportion of newborn cases referred from lower to higher levels of the health system in 3 TCIHC cities of MP & OD ^{29**}	Numerator: Number of newborns referred from ASHA/ UHND/ AWW to UPHC in 3 TCIHC cities of MP & OD Denominator: Number of sick newborn cases identified by ASHA/UHND/AWW in 3 TCIHC cities of MP & OD	Analysis of data from the TCIHC referral MIS End of Phase 1	Tracking only	no referral records in place until year 2	0% of newborns were referred from ASHA/ UHND/ AWW to UPHC	44% of newborns were referred from ASHA/ UHND/ AWW to UPHC
27. Numbers of health care workers trained on FP and MNH (disaggregated by type of training, level of worker, male/female workers and place of work) ³¹	Number of health workers trained on FP in 31 TCIHC cities by level of workers Number of health workers trained on case management, referral and follow-up of high risk maternal and newborn cases in 3 TCIHC cities by level of workers	Training reports Data collected quarterly; annual compilation and analysis; target and Phase 1 achievements are cumulative from start to end of Phase 1	On FP 4500 ASHA and Auxiliary Nurse Midwives (ANM) On referral 528 ASHA and ANM	NA NA	FP 1724 ANMs and ASHAs (Oct 17 – Sept 18) Referral 158 ASHAs 54 ANMs (Oct 17 – Sept 18)	Cumulative achievements: FP 5,231 ASHAs, 1,529 ANMs, 449 LHV and SNs 7,290 Total <i>162% of Phase 1 target achieved if all included</i> Referral 728 ASHA and ANM (Indore, Gwalior & Berhampur) <i>138% of Phase 1 target achieved</i>

³¹ Any training of less than a day is not included in this analysis.

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
28. Number of DQAC/DQAU functioning per MOHFW norms	Number of DQACs that conduct six monthly meetings to review quality of services (with documentation)	DQAC/DQAU reports Twice annually	31 DQAC/DQAU	NA	26 Total UP- 17 OD – 3 MP – 6	31 <i>100% of Phase 1 target achieved</i>
29. Proportion of sites meeting minimum standards of coverage of modern contraceptive services	Numerator: Number of UPHCs in TCIHC-supported cities with at least 2 providers trained to provide LARC Denominator: Number of UPHCs in TCIHC-supported cities	TCIHC MIS Quarterly	75% of UPHCs	NA	84% of UPHCs had at least one provider and 61% had at least 2 providers trained on IUCD	84% of UPHCs had at least 2 providers trained on IUCD or Antara <i>112% of Phase 1 target achieved</i>
30. Number/proportion of UPHCs reporting stock out of IUCDs in last three months	Numerator: Number of UPHCs in TCIHC-supported cities with stock-out of IUCDs for one or more days in last three months Denominator: Number of UPHCs in TCIHC supported cities that provided FP services in last three months	TCIHC MIS Quarterly	Tracking only	NA	79 of 435 UPHCs (18%) reported IUCD stockout of of least one day	20 UPHCs of 508 total UPHCs (4%) reported IUCD stockout of at least one day

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
31. <i>Couple Years of Protection</i> ³²	<i>Estimated protection provided by FP services during a one-year period based on the volume of all contraceptives sold or distributed free of charge to clients during that period</i>	HMIS – public sector in 31 cities (no. of clients and commodities mention under result 3) <i>Annual</i>	Tracking only	1,102,741	1,119,755	1,287,452
32. <i>Distribution of FP commodities (used to calculate CYP)</i>		HMIS (31 cities) includes all facilities <i>Annual</i>	NA	(Jul'16-Jun'17)	(Jul'17-Jun'18)	(Jul'18-Jun'19)
<i>Condoms distributed</i>				3,915,137	3,890,702	6,005,608
<i>Pill cycles distributed</i>				589,887	564,812	774,870
<i>ECP distributed</i>				38,566	63,074	78,926
<i>Chaya distributed</i>				14,178	34,125	63,279
<i>Antara doses given</i>				4,337	10,448	62,296
<i>IUCD inserted</i>				135,427	129,245	171,919
<i>Tubectomies</i>				42,997	45,651	43,424
<i>Vasectomies</i>				1,564	1,550	2,104

³² CYP is calculated for TCIHC years using HMIS data from all types of facilities (District hospitals, medical colleges and UPHCs/CDs) at city level

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
Result 3: Demand						
Increased demand by the urban poor for family planning and MNH health products and services						
33. Number of people reached through FP communication activities	Number of people reached through FP communication activities – IPC, mid-media and mass media	TCIHC MIS Media company (estimate of coverage) Annual	400,000	0	350,000 person contacts (200,000 through IPC as part of ASHA coaching & around 150,000 through mid-media)	589,677 person contacts through ASHA coaching <i>147% of Phase 1 target achieved</i>
34. Proportions of women who recall FP messages ¹	Numerator: Number of currently married women 15-49 years who recall FP messages Denominator: Number of currently married women 15-49 years	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	67% OTS-1 (Sept-Oct 2018)	Analysis of 2019 OTS results pending at end of Phase 1
35. Number of people benefited/reached through FP services	Number of people counseled and/or received FP methods at UPHC and district level facilities in 31 TCIHC cities	TCIHC MIS (UPHC, UHND, ORC) Annually	150,000	NA – activities did not begin until 2018	116,325 (12m prior to Sep18)	187,725 (12m prior to Jun19) <i>125% of Phase 1 target achieved</i>
36. Proportion of married women who reported discussing family planning with their spouses in last three months ¹	Numerator: Number of currently married women 15-49 years who reported discussing FP with their husbands in last 3 months.	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	24% (Sept-Oct 2018)	Analysis of 2019 OTS results pending at end of Phase 1

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
	Denominator: Number of currently married women 15-49 years					
37. Proportion of women who believe that it is important to use modern contraceptive method ¹	Numerator: Number of currently married women 15-49 years who believe that it is important to use modern contraceptive method (scored 4 or 5 on attitude towards FP) Denominator: Number of currently married women 15-49 years	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	47% (Sept-Oct18)	Analysis of 2019 OTS results pending at end of Phase 1
38. Proportion of married women who intend to use any modern contraceptive method in next 12 months from the time of survey ¹	Numerator: Number of currently married women 15-49 years who intent to use modern contraceptive method in next 12 months Denominator: Number of currently married women 15-49 years who is not using any modern contraceptive	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	12.6% (Sept-Oct18)	Analysis of 2019 OTS results pending at end of Phase 1
39. Proportion of women who would refer a family member or friend to that health facility ¹	Numerator: Number of women who would return or refer relative/friend to the facility Denominator: Number of currently married women 15-	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	72% (Sept-Oct18)	Analysis of 2019 OTS results pending at end of Phase 1

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
	<i>49 years who started using FST, NSV, IUD or Injectable since 2014</i>					
40. <i>Proportion of married women who know of a place to obtain a modern contraceptive method¹</i>	<p>Numerator: <i>Number of currently married women 15-49 years who know of a place to obtain IUD, Injectable, OCP and condom</i></p> <p>Denominator: <i>Number of currently married women 15-49 years</i></p>	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	58% (Sept-Oct18)	<i>Analysis of 2019 OTS results pending at end of Phase 1</i>
41. <i>Among women who are current users of modern contraceptive methods, proportion who know the possible side effect or problems they might have with the method; what to do if they experience side effect; and other methods they could use¹</i>	<p>Numerator: <i>Number of currently married women using a modern contraceptive who know about the possible side effect or problems they might have with the method; what to do if they experience side effect; and other method they could use</i></p> <p>Denominator: <i>Number of currently married women using FST, NSV, IUD or Injectable since 2014</i></p>	OTS Annually	10% increase from OTS-1	NA – activities did not begin until 2018	22% (Sept-Oct18)	<i>Analysis of 2019 OTS results pending at end of Phase 1</i>

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
Result 4: Enabling Environment						
An enabling environment, including health systems improvements, coordination mechanisms and financing that support the sustained delivery and use of a quality package of FP/MNH services by the urban poor						
42. Number of laws, policies, plans, regulations and guidelines developed / implemented / adopted	Number of new laws, policies, national plans, regulations and guidelines related to scale up of HIAs developed/ implemented/ adopted since TCIHC implementation started.	Government documents (NHM/NUHM, MOHFW, State Health Departments, others) Quarterly	1 per state	NA	NA	Multiple in each state (9 HIA tools endorsed, roll out of Antara at UPHC level, Pvt sector participation in MP and Odisha; see text of report for complete list)
43. Domestic (public and private) resources mobilized to support urban health HIAs and TCIHC priorities (shown in both Indian Rupee and USD values)	Standard definitions of resources “leveraged” and “unlocked” are being defined by USAID for its implementing organizations. For the moment, TCIHC defines these terms as follows: Leverage: All new funding raised during a year to address the urban health issues that TCIHC prioritizes. Unlocked: All funding included in annual PIPs and other government budgets that are allocated to address issues that TCIHC has prioritized.	Project documentation; State PIPs Annually	No target set		Apr’17-Mar’18 (US\$ equivalent) Leveraged - \$13,327,550 Unlocked - \$11,327,575	Apr’18-Mar’19 (US\$ equivalent) Leveraged - \$46,597,984 Unlocked - \$35,411,183
44. Number of new tools added to the TCI	N/A	TCI-U website Annually	2	0	3	Cumulative 3

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
<i>University and other websites</i>					(Male engagement, Quality Assurance, City Health Plan)	<i>150% of Phase 1 target achieved</i>
45. <i>Number of active TCIHC – trained coaches</i>	Number of TCI coaches who coached at least one person in the quarter	TCIHC MIS <i>Quarterly</i>	300	0	248	300 <i>100% of Phase 1 target achieved</i>
46. <i>Number of individuals in the 31 TCIHC assisted cities who are coached by TCIHC-trained coaches</i>	Number of individuals working in TCIHC assisted cities who receive coaching visit by TCIHC-supported	TCIHC MIS <i>Quarterly</i>	7000	0	4,885	7,757 ASHAs and ANMs coached <i>111% of Phase 1 target achieved</i>
47. <i>New: Number of non-TCIHC cities that are provided “light touch” technical assistance and numbers that adopt TCIHC-promoted HIAs</i>	New indicator – requires further development and testing of indicator	Consultation with state health officials <i>Quarterly</i>	No target set	0	0	33 cities of Odisha Most of MP’s received some level of support from TCIHC as the state rolled out UPHC readiness, FDS and other proven approaches
48. <i>New: Number of government ministries and schemes participating in TCIHC-</i>	New indicator – requires further development and testing of indicator	Workshop records <i>Quarterly</i>	No target set	0	0	10 ministries and departments led by the MOHUA ³³

³³ Ministry of Housing and Urban Affairs (MoHUA), Ministry of Health & Family Welfare (MoHFW); Ministry of Women & Child Development (MoWCD); Ministry of Social Justice & Empowerment (MoSJE); Ministry of Labor & Employment (MoLE); Ministry of Information & Broadcasting (MoIB); Department of Drinking Water and Sanitation; Department of School Education & Literacy, Ministry of Human Resources Development (MoHRD); Department of Food & Public Distribution of the Ministry of Consumer Affairs, Food & Public Distribution; and Department of Youth Affairs of the Ministry of Youth Affairs & Sports.

Indicator	Definition/Calculation	Data Source/Tool/ Frequency	Phase 1 Target	Baseline and End line Targets & Achievement		
				Baseline (from available data or Round 1 of data collection)	Mid-Term (around Sept 2018, unless otherwise noted)	End of Phase 1 (achievement by June 2019 and as % of target)
<i>supported cross-ministerial dialogue and planning sessions to improve urban health outcomes for the urban poor</i>						
49. <i>Number of TCIHC presentations at international conference on FP and MNH (per year and total LOP)</i>	Number of staff and government officials delivering oral presentations, posters and commentaries during international and regional conferences and workshops	Program records <i>Quarterly</i>	5	0	5	Cumulative IUHC 2017/18 ICFP 2018/19 TCI 2017/18/19 multiple presentations, panels, posters at each <i>Phase 1 target</i>
50. <i>Number of peer-reviewed scientific publications resulting from TCIHC</i>	Number of articles from TCIHC accepted in peer reviewed scientific journals	Program records <i>Twice yearly</i>	2	0	0	0 <i>0% of Phase 1 target achieved</i>

Note:

Several of the indicators proposed with the final PMP and the life of program workplan in Year 2 were removed from this update because MCSP was not able to capture or collect the data required in a consistent fashion. Problems included incomplete and poor quality data reported through the government HMIS; variables required that were not in the HMIS and that TCIHC could not collect consistently through its own MIS; unexplained or erratic fluctuations in reported values; PMA Agile survey findings less useful than originally anticipated for monitoring the situation across TCIHC-assisted cities and interventions; OTS carried out less frequently than expected; among others. MCSP recommends that USAID's future implementing partners work with the National Urban Health Mission focal points to develop and test an appropriate set of urban RMNCAH indicators, as well as new data collection, data flow and monitoring and evaluation methods that engage public and private health providers, intended beneficiaries and state health managers in urban settings in planning and data analysis. A continuing priority should be to improve the quality and completeness of government HMIS data and to demonstrate its use and use it with stakeholders in decision-making.

Annex 5: Technical Brief - UPHC MNCH Readiness

UPHC READINESS TO DELIVER MATERNAL, NEWBORN AND CHILD HEALTH SERVICES TO THE URBAN POOR

GOAL

The Challenge Initiative for Healthy Cities (TCIHC) provided technical assistance to the government at national, state and city levels, in order to improve the service delivery ecosystem for family planning (FP) and maternal, newborn and child health (MNCH) in eleven cities in Madhya Pradesh (MP) and Odisha, India. This included efforts to improve readiness to deliver services at Urban Primary Health Centers (UPHCs), to ensure equitable provision of a comprehensive package of primary healthcare services based on the norms set by the Government of India's (GoI's) National Urban Health Mission. In conjunction with other elements of the program, changes at UPHCs were expected to strengthen community level provision of key services and increase utilization of UPHCs for ANC and childhood illness (thereby reducing congestion at higher level facilities), particularly among the urban poor.

PROGRAM APPROACH, STRATEGIES and INTERVENTIONS

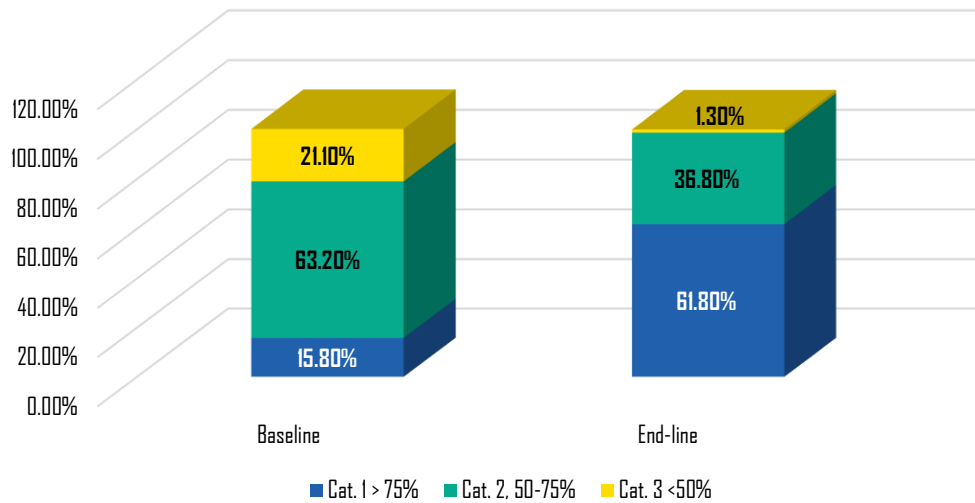
UPHCs are the foundation of public healthcare services in urban India. They are intended to provide integrative preventive, promotive and curative health services close to the targeted population. From 2016-2019, TCIHC worked in close collaboration with city health officials to develop a UPHC readiness assessment, based on the WHO's Service Availability and Readiness Assessment (SARA) framework. This included a checklist of parameters related to six domains – infrastructure, human resources, training status, services available at the facility, services at the community level and equipment and supplies – as well as standard operating procedures for using the checklist. The parameters in the checklist added up to create a total score out of 100 points.

The first round of assessments was conducted in Indore, MP in June 2017, jointly with the District Program Management Unit. This was followed by stakeholder consultations to present findings and clarify roles and responsibilities, advocate for critical improvements and provide technical assistance to develop and resource plans to address the gaps identified. In Indore, for example, UPHC relocation and human resource deployment plans were developed and implemented. Over the course of the program, this approach was then expanded to cover the 76 existing UPHCs (60 UPHC in Madhya Pradesh and 16 in Odisha) across the 11 TCIHC-supported cities. Because cities were added to the program in a phased approach, formative data collection across all cities took place from June 2017 to January 2018, when the second group (four cities) was added. TCIHC gathered feedback and lessons learned after the formative round of data collection, which identified a need to revise the UPHC assessment tool. This resulted in a substantial increase in the number of individual parameters in the checklist (from 58 to 144) and adding one domain: geographic location (in relation to slum areas). Baseline data collection took place in June and July 2018 and the end line was conducted in July 2019, with monitoring visits at the six-month mark in between.

KEY RESULTS & FINDINGS

Out of 76 UPHCs assessed, baseline findings showed that 15.8% of UPHCs had high readiness scores (>75%), 63.2% had a readiness score between 50 -75% and the remaining 21% had a readiness score of <50%. After one year of the intervention, progress was seen among UPHCs in both states, as the percentage of UPHCs scoring >75% increased to 61.8% (see Figure 1). Cumulative scores improved in all 11 intervention cities of MP and Odisha (see Figure 2), with the most noticeable improvements in training status of UPHC staff, service availability at the UPHCs and availability of essential medicines, supplies and equipment. Smaller increases were also observed in areas of infrastructure and community level services.

Figure 1: Changes in UPHC readiness to deliver MNCH services at 76 TCIHC-assisted UPHCs in MP and Odisha (% of UPHCs receiving high, medium and low scores based on 144 parameters at baseline (June/July 2018) and end-line (June/July 2019))



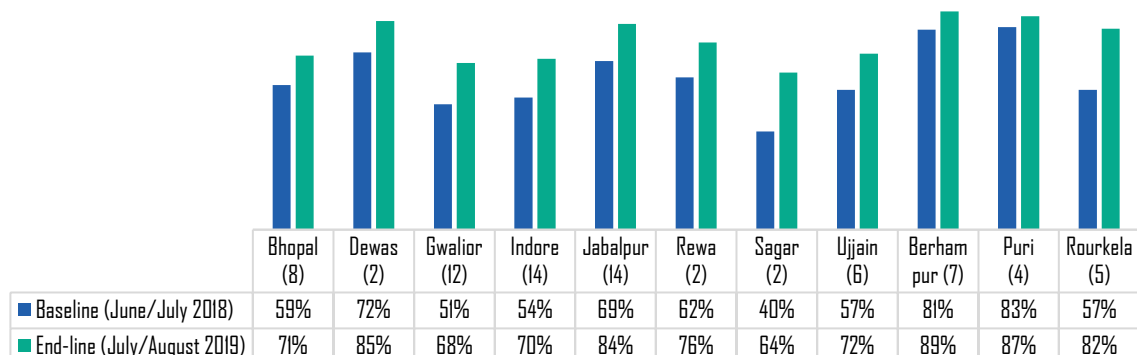
Changes in UPHC staffing were also noted but not as pronounced as those in other domains. The numbers of positions for medical officers, staff nurses and ANMs all increased by more than ten percentage points as compared to UPHC staffing standards. However, the numbers of lab technicians, pharmacists and to a lesser degree, staff nurses continue to be significantly lower than required by the GoI's staffing pattern for UPHCs. The failure to fill UPHC staff positions may be related to the time it takes states to make staffing decisions, get approval in their PIPs to create new positions and then find candidates to fill vacant posts once PIP funding is released.

While seven domains of readiness were included in the assessment tool, TCIHC put an intensive advocacy focus on **ensuring availability of primary health care services for urban poor at the UPHC level and the availability of basic equipment and supplies**. All eight cities in Madhya Pradesh registered significant improvement in these domains between baseline and end line, with an average increase of 45%. The three cities in Odisha (Berhampur, Puri and Rourkela) already exhibited a high level of readiness at the start of the program yet saw slight declines at end line. The focus of TCIHC's technical support in Odisha was NQAS certification and other higher valuations rather than basic readiness. Among those UPHCs, changes could be due to transfer or lack of health personnel or equipment breakdowns for a specific service. Overall the UPHCs in Odisha saw an increase in availability of basic equipment and supplies.

The **provision of primary maternal and newborn health (MNH) services** was measured by the availability of five service packages (i.e., antenatal care, postnatal care, newborn care, availability of diagnostic facilities and availability of referral services). Findings from the UPHC readiness assessment showed that overall, among UPHCs in MP and Odisha, there was improvement in availability of these services. Among those UPHCs assessed antenatal service availability improved by 24 percentage points (71% to 95%), postnatal services by 37 points (51% to 88%), newborn care by 60 points (20% to 80%), diagnostic facilities by ten points (79% to 89%) and referral facilities by 46 points (42% to 88%).

In-depth analysis of UPHCs providing all five service packages revealed that in Madhya Pradesh, only five UPHCs were providing all five service packages at baseline (8.3%). This improved to 38 facilities by End line (63.3%) – an improvement of 55 percentage points over a year's time. However, in Odisha, 11 UPHCs were providing the five services at baseline (68.7%) which reduced to six UPHCs by the End line (37.5%). Newborn care services were not available at some UPHCs in Odisha at the time of the baseline.

Figure 2: Total scores in UPHC readiness to deliver MNCH services at 76 TCIHC-assisted UPHCs in MP and Odisha, by city (% score of individual UPHCs based on 144 parameters at baseline (June/July 2018) and end line (June/July 2019))



The **availability of human resources** improved across the 76 UPHCs, as increases in the availability of individual staff positions occurred (shown in Table 1). These increases were due in large part to collaboration with city governments on the need to re-deploy human resources as a result of the findings from the assessments. There are, however, important gaps remaining, particularly regarding lab technicians, pharmacists and to a lesser degree, staff nurses. TCIHC also advocated for selection of frontline functionaries in the urban slums and habitations. Following these efforts, the proportion of UPHC areas having more than 50% proportion of frontline functionaries against the sanctioned positions improved over the intervention period.

	Madhya Pradesh (N=60 UPHC)				Odisha (N=16 UPHC)				Total (N=76 UPHC)			
	Baseline		End line		Baseline		End line		Baseline		End line	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Medical Officer	42	70%	51	85%	15	94%	15	94%	57	75%	66	87%
Staff Nurse	33	55%	42	70%	14	88%	14	88%	47	62%	56	74%
ANM	52	87%	57	95%	14	88%	16	100%	66	87%	73	96%
Lab Technician	23	38%	25	42%	14	88%	13	81%	37	49%	38	50%
Pharmacist	14	23%	18	30%	14	88%	14	88%	28	37%	32	42%
Support staff	51	85%	55	92%	13	81%	16	100%	64	84%	71	93%

During the formative assessment, serious gaps in **trainings and skill building** of urban facility staff were found, resulting in TCIHC focusing effort on the participation of UPHC staff in key trainings organized by the district health departments. End line findings showed an improvement in the training status of UPHC staff in the 11 intervention cities, with a mean increase of 27% across all cities. Trainings provided focused on child health, including routine immunization and labor and delivery services.

Changes in service utilization

While not attributable directly to the TCIHC program, it is likely that changes at the UPHC level as a result of this program have contributed to improvements seen in client footfall data reported in the HMIS in both states. In Madhya Pradesh, all cities except Ujjain showed improvement over the two years. Service delivery

in UPHCs of Bhopal increased by more than twice during the project period. To measure quality of ANC services at UPHCs, three HMIS indicators were considered and their performance was measured over two fiscal years. In Madhya Pradesh, reported HMIS data revealed an annual increase of six percent in the number of pregnant women registered at UPHCs. During the same period, an increase in the number of antenatal cases registered in the first trimester increased by 22%. Proportion of pregnant women who received four or more antenatal check-ups also increased by 5% in the eight project cities of the state.

Systems level changes to increase UPHC readiness to deliver services

Due to the success of the intervention in terms of improved service delivery, the Government of Madhya Pradesh and its Department of Health and Family Welfare (DHFV) have taken major decisions to scale up learnings in other cities. Some of these achievements are as follows:

- Government of Madhya Pradesh introduced UPHC readiness intervention in 136 UPHCs and 118 Civil Dispensaries in 35 new cities apart from eight project cities. This was preceded by introduction of TCIHC checklist to assess UPHC readiness in 24 new non-TCIHC cities.
- Under the aegis of MAP-IT, a government society which has been established to propel the growth of Information Technology (IT) in Madhya Pradesh and implement the State IT Policy, all urban health facilities are being mapped and tagged on GIS. MAP-IT has developed an Infra Mapping mobile application for mapping of health facilities in the urban areas. TCIHC UPHC readiness assessment tool has also been aligned with this application. In coming months readiness assessment exercise will be done by the city health staff on periodic intervals using the checklist integrated with Infra Mapping App.
- In Odisha, state health department with support from the project team have developed and piloted a tool for assessing the equipment availability as per the NQAS guidelines. 35 public health managers have been trained and this tool is being implemented in 96 UPHCs in Odisha state.
- In Indore, one of the TCIHC learning cities in MP, the catchment area for PC Sethi Hospital was divided into wards, each covered by a primary health center, helping to streamline the referral pathway. These wards were subsequently used by government to develop micro plans for IMI, a government-run immunization initiative. Recommendations based on the assessment findings led to the issuance of government orders to improve the relevant dimensions of readiness at UPHCs. Additionally, in MP the GoMP proposed in the 2018-19 PIP to upgrade all 118 state-supported civil dispensaries to UPHCs as a result of assessment findings. In Odisha, \$150,000 was mobilized from existing public funds to purchase equipment for UPHCs.

RECOMMENDATIONS

As the UPHC readiness assessment is implemented and expanded by state government, there is a need for further strengthening in the following areas:

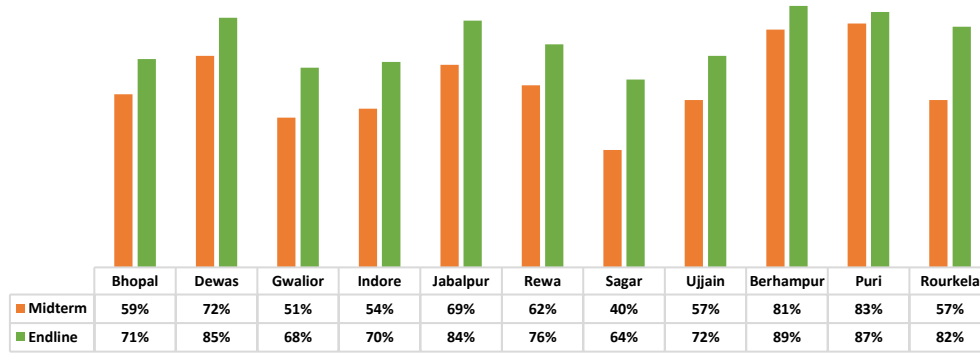
- Human resources and adequate personnel to fill positions in UPHC, is a constant problem that affects the service delivery package at UPHCs. These require long term advocacy and resource mobilization. Progress in these areas can only be revealed after sustained efforts over a significant period.
- Sustained advocacy and technical assistance, particularly around the Program Implementation Planning process, are needed in order to ensure resources and action are directed toward improving the weaker domains.
- There is a need to explore the reasons why some UPHCs do not provide the full range of services and take corrective actions to ensure that all UPHCs provide basic maternal and newborn healthcare service packages.

Annex 6: Cities' UPHC Readiness Scores

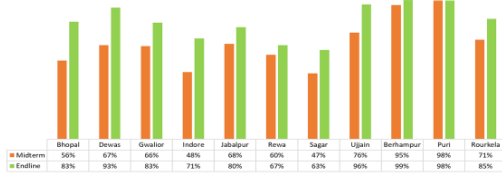


City wise progress – total score

Readiness scores improved in all intervention cities



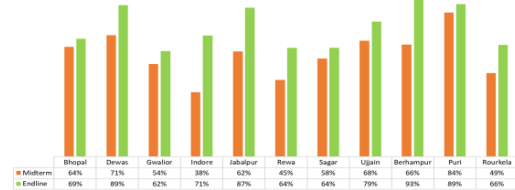
City wise progress – Infrastructure



* Since the checklist used in baseline was revised during midterm with addition of new parameters, therefore, to ensure comparability midterm and end-line status is compared

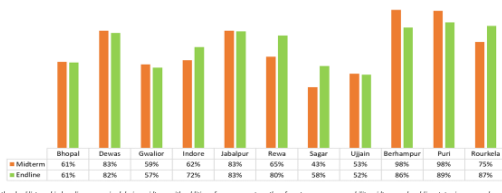
City wise progress – Supplies and equipment

Availability of supplies & equipment showed improvement over the project period.



* Since the checklist used in baseline was revised during midterm with addition of new parameters, therefore, to ensure comparability midterm and end-line status is compared

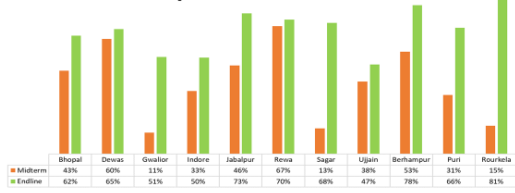
City wise progress – Health workforce



* Since the checklist used in baseline was revised during midterm with addition of new parameters, therefore, to ensure comparability midterm and end-line status is compared

City wise progress – Training status

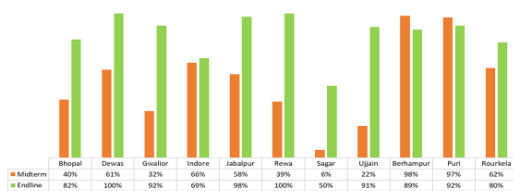
Capacity building of UPHC staff and frontline functionaries was a key support area and showed visible improvement.



* Since the checklist used in baseline was revised during midterm with addition of new parameters, therefore, to ensure comparability midterm and end-line status is compared

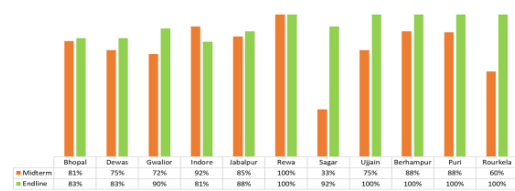
City wise progress – Facility level services

Availability of services at UPHC improved significantly in MP cities.



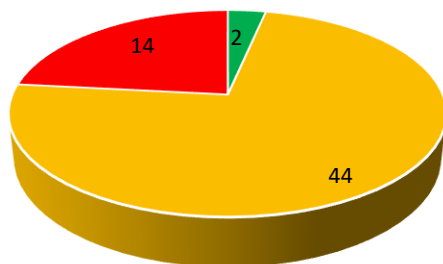
* Since the checklist used in baseline was revised during midterm with addition of new parameters, therefore, to ensure comparability midterm and end-line status is compared

City wise progress – Community level services

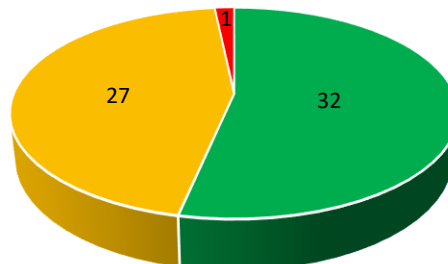


* Since the checklist used in baseline was revised during midterm with addition of new parameters, therefore, to ensure comparability midterm and end-line status is compared

UPHC Readiness Data & Fact Sheet – Madhya Pradesh



Baseline



End-line

	Category 1 (Score: >75%)		Category 2 (Score: 50-<75%)		Category 3 (Score: <50%)
--	--------------------------	--	-----------------------------	--	--------------------------

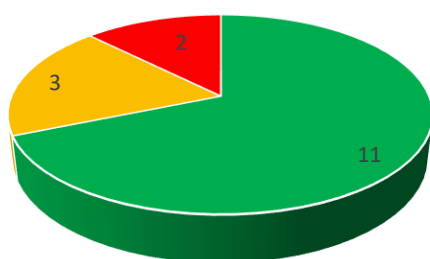
#	City	Name of UPHC	Readiness Score		Improvement (percentage point increase or decrease)
			Baseline	End line	
			Jun-Jul 2018	Jul-Aug 2019	
1	Jabalpur	Kotwali	77%	89%	12
2	Bhopal	Anand Nagar	75%	75%	0
3	Jabalpur	Moti Nala	74%	87%	13
4	Dewas	Itawa	74%	82%	8
5	Indore	Badi Gwaltoli	73%	82%	9
6	Jabalpur	Sneh Nagar	72%	84%	12
7	Jabalpur	Shanti Nagar	71%	85%	14
8	Jabalpur	Gupteshwar	71%	88%	17
9	Jabalpur	Ghamapur	71%	85%	14
10	Jabalpur	Bada Pathar	71%	85%	14
11	Indore	Nihampur Mandi	71%	79%	8
12	Dewas	Bawadiya	71%	88%	17
13	Jabalpur	Raja Chowk (Aadhartal)	69%	82%	13
14	Indore	Shivbagh Colony	69%	83%	14
15	Indore	Musakhedi	69%	74%	5
16	Jabalpur	Kajarwara	68%	78%	10
17	Jabalpur	Ukhari	67%	76%	9
18	Jabalpur	Paraswada	67%	87%	20
19	Gwalior	Horawali	67%	66%	-1
20	Bhopal	Ashoka Garden	67%	80%	13
21	Rewa	Ratahra	66%	79%	13
22	Jabalpur	Polipathar	65%	81%	16
23	Ujjain	Mitra Nagar	64%	79%	15
24	Gwalior	Hathikhana	64%	76%	12
25	Indore	Sadar Bazar	63%	71%	8
26	Jabalpur	Tilwara	62%	83%	21
27	Bhopal	Saibaba Nagar	62%	75%	13
28	Ujjain	Adarsh Nagar	61%	73%	12
29	Bhopal	Kolua kala	61%	78%	17
30	Ujjain	Pawasa	60%	65%	5
31	Rewa	Bodabag	59%	74%	15
32	Jabalpur	Suhagi	58%	85%	27

#	City	Name of UPHC	Readiness Score		Improvement (percentage point increase or decrease)
			Baseline	End line	
			Jun-Jul 2018	Jul-Aug 2019	
33	Gwalior	Pant Nagar	58%	67%	9
34	Gwalior	Gudi Guda ka Naka	58%	84%	26
35	Bhopal	Kokta	58%	59%	1
36	Indore	Sirpur	57%	76%	19
37	Indore	Shivkanth Nagar	57%	68%	11
38	Indore	Kulkarni ka Bhatta	55%	68%	13
39	Indore	Babu Morai	55%	82%	27
40	Ujjain	Jaisinghpura	54%	66%	12
41	Gwalior	Girgaon	54%	81%	27
42	Ujjain	Sanjay Nagar	53%	73%	20
43	Bhopal	Kotra Sultanabad	52%	75%	23
44	Bhopal	Barkheda Pathani	52%	63%	11
45	Gwalior	Bahodapur	51%	74%	23
46	Ujjain	Bheravgarh	50%	76%	26
47	Gwalior	Shankarpur	49%	70%	21
48	Bhopal	Bagh Sewania	47%	65%	18
49	Gwalior	Purani Chhawani	46%	52%	6
50	Sagar	Rajakhedi (Makronia)	45%	78%	33
51	Indore	Vrindvan/Bhagirathpura	45%	51%	6
52	Gwalior	Dullpur	45%	78%	33
53	Indore	Sudama Nagar	44%	80%	36
54	Indore	Jooni Indore/Niranjanpur	42%	42%	0
55	Gwalior	Gende Wali Sadak	42%	59%	17
56	Gwalior	Ohadpur	41%	54%	13
57	Gwalior	Gol Pahadia	41%	56%	15
58	Sagar	Indira Eye Hospital	35%	50%	15
59	Indore	Bhanwarkuaic/Khajrana	32%	55%	23
60	Indore	Krishnapura/Suyash Vihar	25%	68%	43

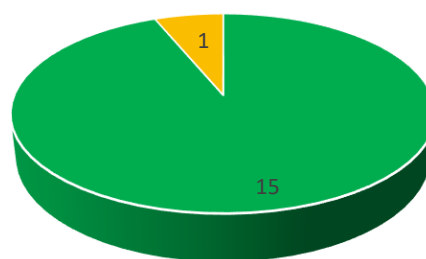
Out of 14 UPHCs in category 3 at baseline, 3 graduated to category 1 at End line (21%) and ten graduated to category 2 (71%). Only one UPHC remained in category 3. Average improvement in these 14 UPHCs between baseline and end line was 20 percentage points.

Out of 44 UPHCs in category 2 at baseline, 30 UPHCs graduated to category 1 (68%), while the remaining 14 remained in the same category. Average improvement in these 44 UPHCs was 14 percentage points.

UPHC Readiness Data & Fact Sheet – Odisha



Baseline



End-line

Category 1 (Score: >75%)	Category 2 (Score: 50-<75%)	Category 3 (Score: <50%)
--------------------------	-----------------------------	--------------------------

#	City	Name of UPHC	Readiness Score		Improvement (percentage point increase or decrease)
			Baseline	End line	
			Jun-Jul 2018	Jul-Aug 2019	
1	Berhampur	Aska Road	89%	88%	-1
2	Puri	Delabedikana	85%	85%	0
3	Puri	Swargdwara	85%	86%	1
4	Berhampur	Aga Sahi	84%	89%	5
5	Berhampur	Goodshed Road	84%	90%	6
6	Berhampur	Uttaramukhi	83%	91%	8
7	Rourkela	Basanti Colony (DAV MAC)	81%	88%	8
8	Berhampur	Amba Pua	80%	86%	6
9	Puri	Chandan Hazuri	80%	87%	7
10	Puri	KDMM	80%	91%	11
11	Berhampur	Baikunth Nagar	79%	89%	11
12	Berhampur	Khodasinghi	72%	90%	18
13	Rourkela	Koel Nagar	61%	89%	28
14	Rourkela	Tilak Nagar	58%	90%	32
15	Rourkela	Udit Nagar	47%	81%	34
16	Rourkela	Bondamunda	39%	63%	24

Out of two UPHCs in category 3 at baseline, one graduated to category 1 at End line and the remaining one graduated to category 2. No UPHC remained in category 3 at End line assessment. Average improvement in these two UPHCs between baseline and End line was 29 percentage points.

Out of three UPHCs in category 2 at baseline, all graduated to category 1 (100%) with average improvement being 26 percentage points.

**UPHC Readiness Factsheet:
City Progress Based on Scores Achieved for Different Thematic Areas**

Name of City		Building and infrastructure		Human Resource		Training status		Facility level services		Community level services		Equipment and supplies	
		Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line
1	Bhopal	56%	83%	61%	61%	43%	62%	40%	82%	81%	83%	64%	69%
2	Dewas	67%	93%	83%	82%	60%	65%	61%	100%	75%	83%	71%	89%
3	Gwalior	66%	83%	59%	57%	11%	51%	32%	92%	72%	90%	54%	62%
4	Indore	48%	71%	62%	72%	33%	50%	66%	69%	92%	81%	38%	71%
5	Jabalpur	68%	80%	83%	83%	46%	73%	58%	98%	85%	88%	62%	87%
6	Rewa	60%	67%	65%	80%	67%	70%	39%	100%	100%	100%	45%	64%
7	Sagar	47%	63%	43%	58%	13%	68%	6%	50%	33%	92%	58%	64%
8	Ujjain	76%	96%	53%	52%	38%	47%	22%	91%	75%	100%	68%	79%
9	Berhampur	95%	99%	98%	86%	53%	78%	98%	89%	88%	100%	66%	93%
10	Puri	98%	98%	98%	89%	31%	66%	97%	92%	88%	100%	84%	89%
11	Rourkela	71%	85%	75%	87%	15%	81%	62%	80%	60%	100%	49%	66%

Cities showing progress during the End line assessment (Jul-Aug 2019) as compared to baseline assessment (Jun-Jul 2018) findings are highlighted as green

Data for UPHC Readiness Factsheet:

UPHC Progress Based on Scores Achieved for Different Thematic Areas, by City and State

Name of UPHC		Building and infrastructure		Human Resource		Training status		Facility level services		Community level services		Equipment and supplies	
		Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line
Bhopal, Madhya Pradesh													
1	Anand Nagar	73%	93%	90%	73%	53%	53%	44%	89%	83%	83%	73%	65%
2	Ashoka Garden	60%	93%	70%	73%	60%	67%	44%	78%	83%	83%	68%	83%
3	Bagh Sewania	53%	73%	50%	57%	13%	67%	0%	56%	83%	83%	58%	58%
4	Barkheda Pathani	40%	67%	53%	47%	53%	67%	44%	89%	50%	83%	60%	53%
5	Kokta	53%	67%	60%	47%	47%	47%	44%	56%	83%	83%	63%	63%
6	Kolua kala	53%	93%	60%	67%	47%	73%	56%	100%	100%	83%	68%	80%
7	Kotra Sultanabad	53%	93%	50%	63%	13%	67%	56%	89%	83%	83%	60%	70%
8	Saibaba Nagar	60%	87%	57%	60%	60%	53%	33%	100%	83%	83%	68%	83%
Dewas, Madhya Pradesh													
9	Bawadiya	67%	93%	83%	90%	53%	67%	56%	100%	67%	83%	68%	90%
10	Itawa	67%	93%	83%	73%	67%	63%	67%	100%	83%	83%	75%	88%
Gwalior, Madhya Pradesh													
11	Bahodapur	73%	93%	70%	63%	7%	60%	11%	89%	67%	100%	50%	65%
12	Dullpur	80%	87%	27%	70%	7%	60%	22%	100%	67%	100%	65%	73%
13	Gende Wali Sadak	60%	93%	37%	13%	7%	47%	11%	100%	83%	100%	50%	70%
14	Girgaon	60%	93%	77%	80%	7%	67%	33%	89%	83%	100%	48%	70%
15	Gol Pahadia	53%	53%	40%	37%	7%	40%	0%	89%	83%	100%	48%	58%
16	Gudi Guda ka Naka	60%	93%	80%	90%	7%	53%	67%	89%	83%	100%	50%	78%
17	Hathikhana	67%	87%	83%	83%	7%	53%	67%	89%	100%	67%	63%	65%
18	Horawali	87%	87%	70%	57%	53%	47%	56%	89%	83%	83%	60%	55%
19	Ohadpur	67%	87%	40%	40%	13%	33%	0%	89%	67%	33%	48%	53%
20	Pant Nagar	53%	73%	77%	63%	7%	57%	56%	100%	83%	100%	63%	53%
21	Purani Chhawani	60%	60%	53%	23%	7%	43%	22%	89%	67%	100%	53%	53%

Name of UPHC		Building and infrastructure		Human Resource		Training status		Facility level services		Community level services		Equipment and supplies	
		Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line
22	Shankarpur	73%	87%	60%	67%	7%	47%	44%	89%	0%	100%	58%	53%
Indore, Madhya Pradesh													
23	Babu Morai	40%	73%	60%	73%	27%	77%	78%	89%	100%	100%	45%	90%
24	Badi Gwaltoli	53%	87%	87%	80%	40%	47%	100%	100%	100%	83%	63%	93%
25	Bhanwarkua/Khajrana	67%	53%	30%	67%	27%	43%	0%	0%	100%	83%	0%	53%
26	Jooni Indore/Niranjanpur	20%	20%	53%	53%	33%	33%	78%	78%	100%	100%	8%	8%
27	Krishnapura/Suyash Vihar	47%	80%	40%	70%	40%	47%	0%	78%	0%	83%	0%	65%
28	Kulkarni ka Bhatta	47%	73%	60%	53%	33%	47%	78%	78%	100%	83%	35%	83%
29	Musakhedi	60%	87%	80%	70%	33%	57%	78%	67%	100%	67%	63%	80%
30	Nihalpur Mandi	60%	93%	80%	83%	47%	53%	100%	78%	83%	50%	58%	85%
31	Sadar Bazar	47%	80%	80%	80%	27%	43%	67%	67%	100%	50%	55%	70%
32	Shivbagh Colony	60%	93%	77%	83%	40%	47%	100%	89%	100%	100%	55%	88%
33	Shivkanth Nagar	53%	67%	60%	63%	40%	53%	89%	67%	100%	100%	30%	70%
34	Sirpur	33%	80%	70%	73%	27%	47%	67%	78%	100%	67%	48%	93%
35	Sudama Nagar	40%	80%	50%	80%	20%	63%	44%	89%	100%	100%	45%	85%
36	Vrindvan/Bhagirathpura	40%	33%	47%	73%	27%	47%	44%	11%	100%	67%	28%	33%
Jabalpur, Madhya Pradesh													
37	Bada Pathar	67%	93%	77%	77%	60%	77%	78%	100%	83%	83%	58%	88%
38	Ghamapur	73%	93%	83%	83%	63%	60%	56%	89%	83%	83%	53%	95%
39	Gupteshwar	73%	93%	87%	87%	53%	77%	56%	100%	83%	100%	75%	83%
40	Kajarwara	73%	93%	77%	63%	53%	53%	33%	100%	83%	100%	65%	85%
41	Kotwali	80%	93%	100%	87%	50%	80%	78%	100%	83%	83%	60%	100%
42	Moti Nala	87%	93%	73%	77%	20%	87%	78%	100%	100%	100%	90%	85%
43	Paraswada	60%	93%	87%	87%	17%	67%	56%	100%	83%	100%	73%	85%
44	Polipathar	53%	7%	73%	90%	53%	93%	44%	100%	67%	100%	70%	95%
45	Raja Chowk (Aadhartal)	60%	73%	90%	77%	50%	73%	44%	100%	83%	100%	58%	85%
46	Shanti Nagar	67%	87%	90%	90%	53%	73%	67%	100%	83%	83%	50%	85%
47	Sneh Nagar	87%	87%	87%	90%	60%	67%	44%	100%	83%	83%	60%	85%

Name of UPHC		Building and infrastructure		Human Resource		Training status		Facility level services		Community level services		Equipment and supplies	
		Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line
48	Suhagi	60%	73%	70%	90%	47%	73%	56%	100%	83%	83%	50%	85%
49	Tilwara	47%	73%	90%	80%	20%	83%	67%	100%	100%	67%	48%	88%
50	Ukhari	60%	60%	83%	83%	47%	63%	56%	78%	83%	67%	55%	80%
Rewa, Madhya Pradesh													
51	Bodabag	60%	73%	60%	77%	67%	67%	33%	100%	100%	100%	38%	60%
52	Ratahra	60%	60%	70%	83%	67%	73%	44%	100%	100%	100%	53%	68%
Sagar, Madhya Pradesh													
53	Indira Eye Hospital	47%	53%	23%	33%	13%	60%	11%	22%	0%	83%	65%	55%
54	Rajakhedi (Makronia)	47%	73%	63%	83%	13%	77%	0%	78%	67%	100%	50%	73%
Ujjain, Madhya Pradesh													
55	Adarsh Nagar	67%	93%	53%	57%	53%	47%	56%	89%	83%	100%	60%	80%
56	Bheravgarh	73%	100%	43%	53%	13%	47%	11%	100%	67%	100%	80%	90%
57	Jaisinghpura	73%	93%	43%	33%	47%	40%	11%	89%	67%	100%	65%	83%
58	Mitra Nagar	93%	100%	67%	67%	47%	60%	22%	89%	83%	100%	75%	88%
59	Pawasa	67%	93%	57%	43%	53%	40%	22%	89%	83%	100%	65%	63%
60	Sanjay Nagar	80%	93%	53%	60%	13%	47%	11%	89%	67%	100%	63%	73%
Berhampur, Odisha													
61	Aga Sahi	93%	93%	100%	87%	57%	77%	100%	89%	100%	100%	68%	93%
62	Amba Pua	100%	100%	97%	87%	53%	77%	100%	89%	83%	100%	65%	93%
63	Aska Road	100%	100%	100%	87%	53%	77%	100%	89%	100%	100%	90%	93%
64	Baikunth Nagar	93%	100%	97%	83%	53%	77%	89%	89%	67%	100%	63%	93%
65	Goodshed Road	100%	100%	100%	87%	57%	77%	100%	89%	100%	100%	63%	93%
66	Khodasinghi	80%	100%	97%	83%	47%	80%	100%	89%	67%	100%	50%	93%
67	Uttaramukhi	100%	100%	97%	87%	53%	80%	100%	89%	100%	100%	63%	93%
Puri, Odisha													
68	Chandan Hazuri	93%	100%	97%	83%	13%	67%	100%	89%	100%	100%	85%	90%

Name of UPHC		Building and infrastructure		Human Resource		Training status		Facility level services		Community level services		Equipment and supplies	
		Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line	Baseline	End line
69	Delabedikana	100%	93%	93%	97%	60%	67%	100%	89%	100%	100%	75%	75%
70	KDMM	100%	100%	100%	100%	10%	70%	89%	89%	67%	100%	93%	100%
71	Swargdwara	100%	100%	100%	77%	40%	60%	100%	100%	83%	100%	85%	93%
Rourkela, Odisha													
72	Basanti Colony (DAV MAC)	80%	93%	100%	100%	67%	87%	100%	89%	100%	100%	53%	70%
73	Bondamunda	53%	67%	40%	60%	0%	67%	56%	56%	67%	100%	33%	43%
74	Koel Nagar	80%	93%	93%	100%	7%	80%	56%	89%	67%	100%	50%	68%
75	Tilak Nagar	80%	93%	73%	97%	0%	87%	67%	89%	67%	100%	55%	75%
76	Udit Nagar	60%	80%	70%	77%	0%	87%	33%	78%	0%	100%	55%	73%

UPHCs showing progress during the End line assessment (Jul-Aug 2019) as compared to baseline assessment (Jun-Jul 2018) findings are highlighted as green

Annex 7: Quality Assessment for Family Planning Services

TCIHC conducted assessments and provided technical support in all three states to improve the quality of family planning services at UPHCs, both on the day of FDS and regular services. This quality assessment was conducted using a facility-based quality assessment checklist with three broad components on readiness for providing voluntary FP services (including IUCD and Antara injectable), processes and outcome.

The readiness assessment is based on 54 items from nine broad components namely, *infrastructure, staff availability, client charter, upkeep of counselling area, contraceptive supplies, availability of consumable items, infection prevention utilities, upkeep of procedure area, availability of equipment.*

Process assessment consists of 21 items from five broad components namely, *counselling, procedure, infection prevention, record keeping and internal quality improvement team.* In this domain, approximately five different IUCD or Antara injectable clients were observed by FPSAs for assessing the processes. Additionally, record keeping of family planning services and formation of quality improvement team and regularity of quality improvement meetings were also assessed as part of process.

The outcome is measured based on *availability of basket of choices for all contraceptive methods and total number of IUCD insertions and Antara injectable doses* given on FDS in a month. This outcome data collected as part of service delivery activity report every month is merged with the quality assessment data for the observed facility to examine the overall score of the facility.

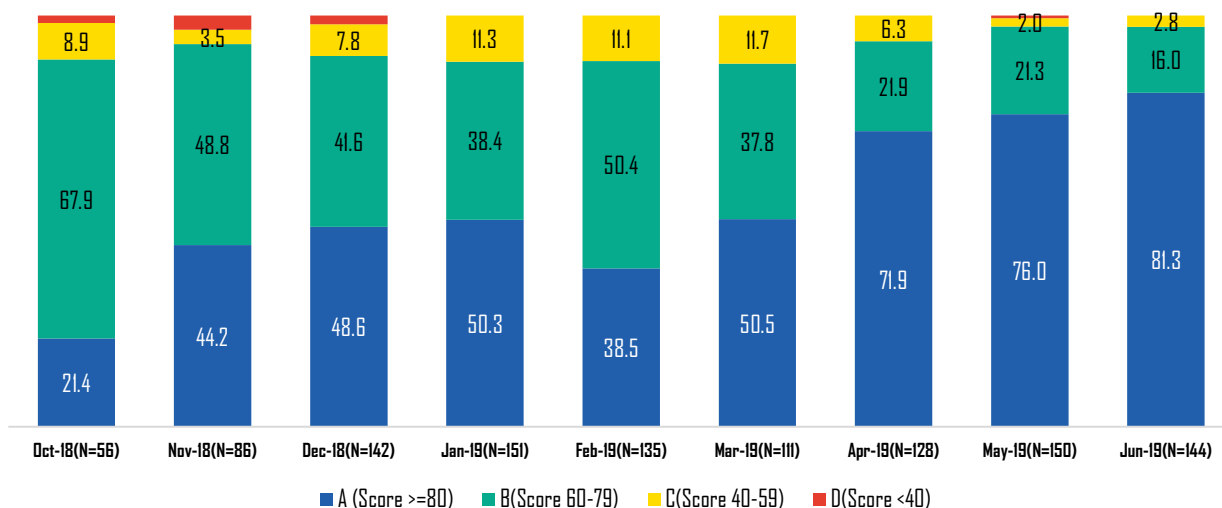
The readiness and process score for facilities upon a visit is determined as the percentage of items reported as 'yes'. The outcome score is computed as average of scores for *availability of contraceptive methods* (percentage of methods available) and *IUCD/Antara uptake* (percentage of monthly ELA achieved i.e. at least 20 IUCD insertions and Antara injectable doses in FDS).

The number of cities implementing the FPSA strategy for quality assessment have gradually increased with the expansion of IUCD and Antara injectable being offered in these facilities. The quality assessment strategy involves one to two FPSAs per city, depending on the number of UPHCs. The plan for each FPSA is to visit around 32-35 UPHCs every month including four UPHCs on the day of FDS. The facilities are selected by FPSAs on a rotating basis every month so they can observe all UPHCs on FDS in a quarter. Thus, one FPSA can observe four UPHCs on FDS each month at most and, therefore, the number of facilities observed each month is not always the same. By the end of June 2019, 416 UPHCs out of 489 activated UPHCs had undergone at least one FP FDS readiness assessment. In October 2018, 56 facilities from 11 cities were observed for quality assessment and that increased to 144 facilities from 26 cities in June 2019 with an ELA of four FDS observations per month for one FPSA.

We are providing facility assessment data only for the day of FDS in the EOP. The FP readiness, process, outcome and overall (the average of input, process and outcome scores) are categorized into four grading categories with Grade A (score more than 80%), Grade B (score between 60 and 79), Grade C (score between 40 and 59) and Grade D (score less than 40).

Figure 1 presents the distribution of facilities across different categories of input score. The results in the chart show that facility readiness across three states has improved remarkably during the period of October 2018 and June 2019: the percent of UPHCs with score A increased from 21% to 81%.

Figure I: Percent Distribution of facilities by FDS readiness score between October-18 to June-19.
Data source: Field Program Service Assistants Report on Quality of voluntary FP services, TCIHC PMIS



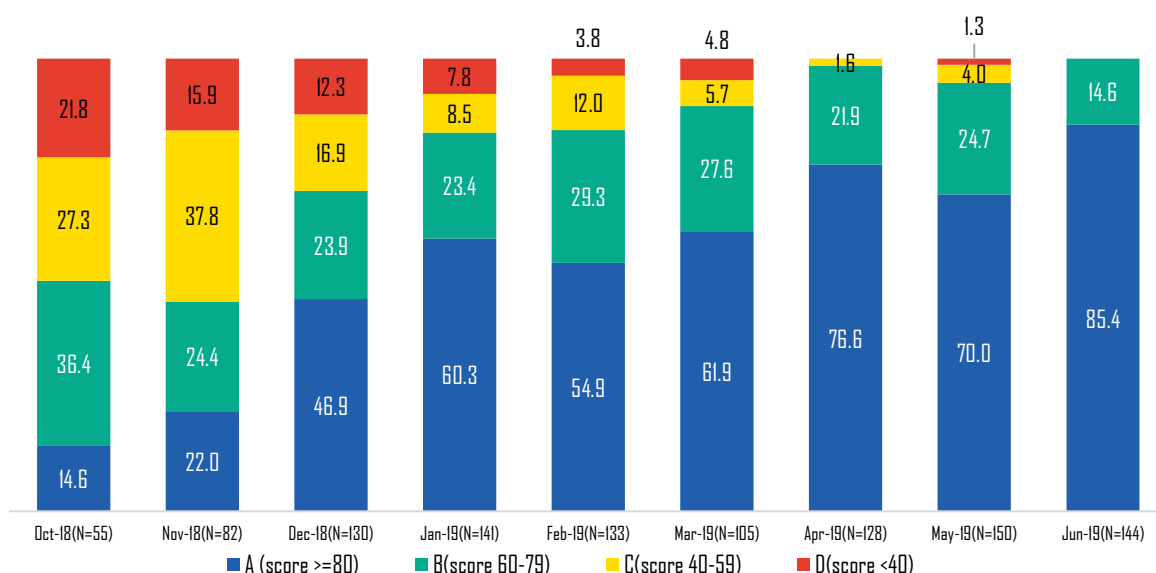
Data analyzed for average monthly scores of different components of inputs (shown in table 1) gives insight into what has contributed to changes in the facility readiness over a period of nine months. From the table, it is observed that staff availability, client charter and contraceptive supplies have improved notably, whereas, availability of equipment and infection prevention utilities need further improvement.

Table I: Month wise average of scores of different components of readiness (input)

Data source: Field Program Service Assistants Report on Quality of voluntary FP services, TCIHC PMIS

Month	Clinic Infrastructure	Staff	Client Charter	Counselling Area	Contraceptive Supplies	Consumable	Infection prevention	Procedure Area	Equipment/IUCD sets
Oct-18	90.8	74.0	53.9	49.8	67.3	93.9	58.7	87.5	78.4
Nov-18	91.6	78.2	50.8	62.4	74.1	92.7	65.9	86.0	79.7
Dec-18	92.1	76.0	56.3	70.0	75.2	93.5	65.4	89.1	77.1
Jan-19	92.7	76.2	60.7	72.9	76.6	93.6	66.1	91.7	75.9
Feb-19	93.8	72.5	68.6	74.7	77.8	91.2	58.1	91.5	71.0
Mar-19	93.5	74.7	64.7	73.9	83.9	93.4	59.1	91.7	74.4
Apr-19	92.6	88.5	64.0	84.9	81.3	95.0	69.1	97.3	77.2
May-19	95.7	92.0	67.6	84.9	84.1	94.6	72.2	94.0	79.9
Jun-19	96.6	93.1	71.3	88.3	90.2	95.5	71.5	94.0	81.3

Figure 2: Percent Distribution of facilities by process score between October-18 to June-19
 Data source: Field Program Service Assistants Report on Quality of voluntary FP services, TCiHC PMIS



Further, as shown in Figure 2, UPHCs’ process performance has also improved. The percentage of UPHCs scoring more than 80 increased from 14% in October 2019 to 85% in June 2019. The results in Table 2 show that all components of the process have improved remarkably between October 2018 and June 2019. For example, the average score for counselling increased from 37 to 87 and for infection prevention it increased from 57 to 80. However, there is room for further improvement in all three components of counselling, infection prevention and procedure. There is a significant improvement observed in record keeping of all family planning clients in FP registers. This improvement is more visible in IUD and Antara registers for ensuring follow up mechanism.

Month	Counselling	Procedure	Infection prevention	Record keeping	QI Meeting
Oct-18	36.5	56.6	56.7	70.5	6.5
Nov-18	58.8	61.1	58.5	82.9	23.1
Dec-18	73.2	68.9	65.1	84.0	48.0
Jan-19	80.0	77.2	70.5	83.7	67.8
Feb-19	78.0	76.9	69.7	83.6	67.3
Mar-19	76.4	81.3	70.4	86.0	74.0
Apr-19	81.9	91.0	81.8	87.2	75.1
May-19	81.2	84.1	75.2	90.2	83.7
Jun-19	87.3	90.0	80.0	94.2	90.9

Figure 3: Percent distribution of facilities by overall score between October-18 to June-19
Data source: Field Program Service Assistants Report on Quality of voluntary FP services, TCIHC PMIS

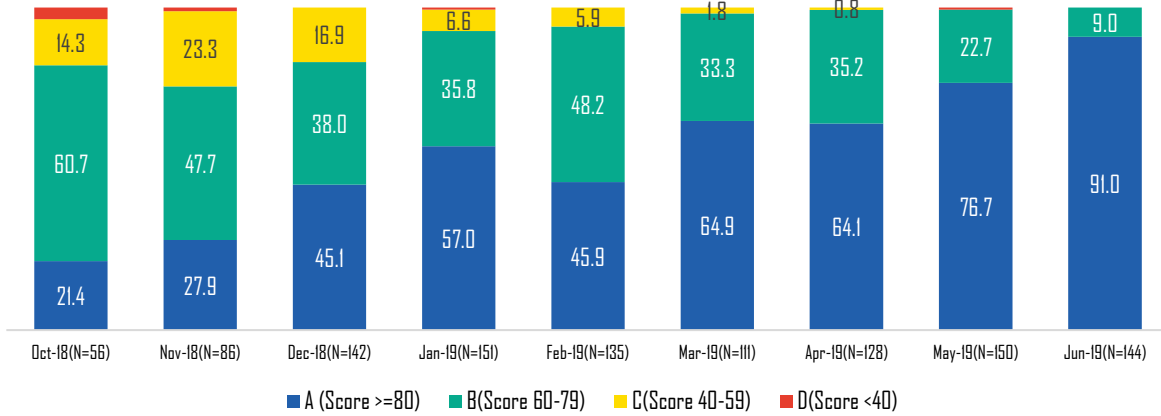


Figure 3 shows the distribution of overall facility scores as an average of the three domains namely, input, process and outcome. Overall, scores have also shown significant improvement from 21% in October 2018 to 91% in June 2019.

Figure 4: Input Scores of Facilities Observed in First Two Quarters of 2019
Data Source: Field Program Assistants Report on Quality of FP services, TCIHC PMIS

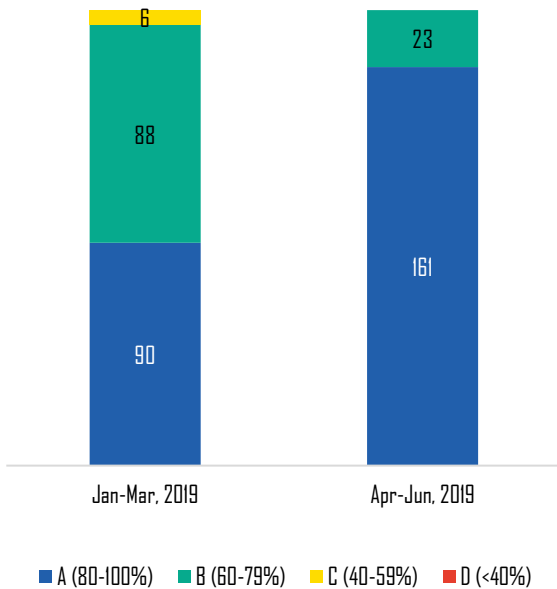
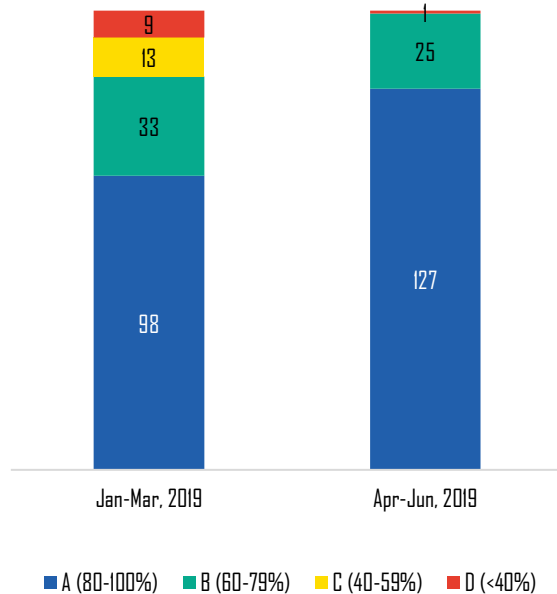


Figure 5: Process Scores of Facilities Observed in First Two Quarters of 2019
Data Source: Field Program Assistants Report on Quality of FP services, TCIHC PMIS



Finally, to have a clearer assessment of the improvement in readiness (input) and process, we compared the scores for those facilities which were observed at least once in each of two quarters, Jan – Mar 2019 & Apr – June 2019. Thus, 184 UPHCs were assessed for FP readiness and 153 facilities assessed for process at least once in both the quarters.

Figures 4 and 5 show the change in number of facilities in different grades for both FP readiness and processes. Out of 184 facilities visited for readiness assessment on the day of FDS, it was observed that the number of UPHCs with grade A (scoring ≥ 80) increased from 90 in quarter Jan-Mar, 19 to 161 in the quarter Apr-Jun, 19. The similar results are also observed for 153 facilities observed for processes in both quarters. The number of facilities receiving a Grade A increased from 84 in quarter Jan – Mar 2019 to 127 in quarter Apr – June 2019.

Annex 8: FPSA Checklist

DRAFT TOOL								
Facility Quality Assessment Checklist for Field Program Service Assistant (FPSA)								
<i>To be used for assessing the quality of services for spacing methods of FP only</i>								
State								
City								
Type of Facility (Pls tick)	U-PHC		U-CHC		DWH			
Name of Facility								
Date of Assessment								
Day of Assessment	FDS/FPD	/	Non FDS/FPD					
Facility code								
Name of FPSA				Signature				
Means of Verification: O= Observed ; I= Interview; R= Record review NO- Not Observed								
					Yes	No	Means of verification (O/R/I)	Comments if any
I- Clinic Infrastructure								
I-i	Waiting area with adequate seating facility				1	0	O	
I-ii	Clinic environment acceptably clean				1	0	O	
I-iii	Hand washing facilities (running water and soap)				1	0	O	
I.iv	Functional Toilet				1	0	O	
I.v	Electricity available/ Power back up				1	0	O/I	
I.vi	Referral linkage/ referral facility				1	0	I	
	Score							
II- Staff								
II-i	Medical Officer- MBBS				1	0	O/I	
II-ii	Staff Nurse				1	0	O/I	
II-iii	At least one provider trained on IUCD insertion				1	0	I	
II-iv	At least one provider trained on injectable contraceptive				1	0	I	
II.v	ANM Attached				1	0	O/I	
II-vi	Support Staff				1	0	O/I	
	Score							
III Client Charter								
III-i	Clients' rights / Services displayed at a prominent place at the facility				1	0	O	
III-ii	Board displaying service timings				1	0	O	
III-iii	Rooms indicating the type of service /room no. displayed				1	0	O	
	Score							
IV Counselling Area								
IV-i	Counselling area with Audio Visual Privacy				1	0	O	
IV-ii	Flip Charts/Posters/Models/Job-aids for FP				1	0	O	
IV-iii	Samples of Contraceptives/informed choice basket				1	0	O	
IV-iv	Follow up Cards-IUCD/Injectable (Wherever applicable) cards				1	0	O	
	Score							
V Contraceptive Supplies								
<i>Following products in unopened, undamaged, packages not beyond expiration dates: 30</i>								
V-i	Condoms				1	0	O/I	
V-ii	COC pills				1	0	O/I	
V-iii	EC pills				1	0	O/I	
V-iv	IUCD				1	0	O/I	
V-v	DMPA (ANTARA)				1	0	O/I	
V-vi	CHAYA				1	0	O/I	
	Score							
VI Consumables								
VI-i	Cotton				1	0	O	

VI-ii	Gloves (clean/ HLD/ sterile)	1	0	0	
VI-iii	Soap/Detergent	1	0	0	
VI-iv	Antiseptic (Chlorhexidine/ Povidone Iodine etc.) solution	1	0	0	
VI-v	Bleaching Powder	1	0	0	
VI-vi	Syringes	1	0	0	
	Score				
VIII	Infection Prevention				
VII-i	Bucket/ Tub for decontamination (for preparing bleaching solution to soak the instruments)	1	0	0	
VII-ii	Brush for cleaning hinges/ joints of instruments	1	0	0	
VII-iii	Autoclave/ Boiler functional/ Large utensils with lid + gas stove	1	0	0	
VII-iv	Waste disposal containers with coloured plastic bags (as per guidelines)	1	0	0	
VII-v	Puncture Proof Box available	1	0	0	
VII-vi	Utility Gloves	1	0	0	
VII-vii	Clean sheet/mackintosh	1	0	0	
	Score				
VIII	Procedure Area				
VIII-i	Examination table	1	0	0	
VIII-ii	Light Source / Torch (functional)	1	0	0	
VIII-iii	Privacy	1	0	0	
	Score				
IX	Equipment/IUCD sets; 60				
IX-i	Instruments at least 2 sets (on FP Day)	1	0	0	
IX-ii	Instrument tray with cover (HLD or sterile)	1	0	0	
IX-iii	Tenaculum/ Volsellum	1	0	0	
IX-iv	Uterine Sound	1	0	0	
IX-v	Vaginal Cusco's/Sim's Speculum (Large, Medium, Small)	1	0	0	
IX-vi	Anterior Vaginal Wall retractor	1	0	0	
IX-vii	Scissors (Mayo's scissors)	1	0	0	
IX-viii	Long Artery forceps	1	0	0	
IX-ix	Sponge-holding Forceps	1	0	0	
IX-x	Kidney Tray (Large)	1	0	0	
IX-xi	Small bowl for betadine	1	0	0	
IX-xii	Cheattle forceps	1	0	0	
IX-xiii	Kelly's Forceps/ Long Placental forceps	1	0	0	
	Score				
	Total Score-54				
	Score obtained-				
	Percentage (Score obtained divided by total score multiply by 100)-				
	PROCESS	Yes	No	Means of verification	Comments if any
	<i>In this section, 5 different clients (preferably 3 IUCD clients and 2 DMPA/Antara clients) are to be observed for assessing the quality of counselling, procedures and infection prevention practices adopted while providing services in the facility. In case clients are not available and FPSA is not able to observe then tick NO (Not observed) in I- Counselling, II-Procedure and III-Infection prevention under this section. For assessing quality of record keeping and whether quality improvement meeting held, no clients to be observed</i>				
	<i>Instruction for App: Individual Screen with 3 components (counselling, procedure and infection prevention) to be opened for each client with clearly identifying the type of client. Once FPSA complete this section for 5 clients then other 2 components i.e. record keeping and QI will open. These two components are not applicable for clients, to be filled one time for the facility.</i>			(O/R/I/NO)	
	Type of Client observed (IUCD or IC for each client)				
I-	Counselling				
I-i	Informed Choice given	1	0	O/NO	
I-ii	Method specific Counselling for Family Planning method (Effectiveness and Side effects)	1	0	O/NO	
I-iii	Tools used for counselling	1	0	O/NO	
	Score				
II-	Procedure				
II-i	Screening done for method chosen	1	0	O/NO	
II-ii	Bimanual examination done before IUCD insertion (<i>Applicable only for IUCD client</i>)	1	0	O/NO	
II-iii	IUCD inserted using no touch technique (<i>Applicable only for IUCD client</i>)	1	0	O/NO	
II-iv	Injectable contraceptive given using aseptic precaution (<i>Applicable only for DMPA client</i>)	1	0	O/NO	
II-v	Follow up advice given	1	0	O/NO	

	Score				
III	Infection Prevention				
III-i	Hand washing done / Hand scrub used before and after procedure	1	0	O/NO	
III-ii	Decontamination by bleaching Solution (instruments soaked for 10 mins) <i>(Applicable only for IUCD client)</i>	1	0	O/NO	
III-iii	Instruments processed by autoclave/HLD <i>(Applicable only for IUCD client)</i>	1	0	O/I/NO	
III-iv	Mopping of floors done by disinfectant	1	0	O/I/NO	
III-v	Availability of proper waste disposal mechanism	1	0	O/I/NO	
III-vi	Instruments stored properly	1	0	O/I/NO	
	Score				
IV	Record keeping				
IV-i	Family Planning Register	1	0	R	
IV-ii	IUCD Register	1	0	R	
IV-iii	Injectable Register	1	0	R	
IV-iv	Follow-up record maintained including complication management	1	0	R	
IV-v	Regular monthly reports maintained and shared	1	0	R	
	Score				
V	Internal Quality Improvement Team				
V-i	QI team Formed	1	0	I	
V-ii	QI team Monthly meeting held in last month and action plan followed	1	0	I/R	
	Score				
	Total Score-21				
	Score obtained-				
	Percentage (Score obtained divided by total score multiply by 100)-				
	OUTPUT	Number		verification	
I	Patient satisfaction				
I-i	Patient satisfaction score (average of last 30 days)				
I-i	Count the number of patient satisfactory survey records in last 30 days and write the average of score in the column Do not write in decimals.			R	

Annex 9: 30 Hour Magic+ Strategy

Introduction

TCIHC initiatives are based upon evidence-based approaches. The approaches had shown results earlier in projects such as Urban Health Initiative (UHI) and Expanded Access to Quality Family Planning Choices (EAQ). However, the approaches were not extensively rolled out for urban poor population. Consequently, TCIHC started its effort to increase uptake of family planning services in cities which were struggling to activate Urban Primary Health Centers (UPHCs) for family planning services.

Catering to the need of the situation, TCIHC decided to start with Fixed Day Static (FDS)/Family Planning Day approach out of the nine approaches to demonstrate to the cities that family planning services are possible at the Urban Primary Health Centers (UPHCs). An experienced team was engaged to ensure in developing a robust system for better family planning services at UPHC.

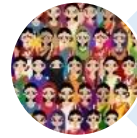
How it is done

Special FDS drive is a thirty hours' activity spread over three days.

First ten hours:

- **Ready-to-start facilities:** Identify three-four ready to start UPHCs by assessing their status on trained manpower, availability of supplies, equipment and minimum criteria required for quality family planning services.
- **Establish rapport:** Being a new concept, it is essential to explain the purpose of the activity and discuss the entire plan. Hence, seek buy-in of city officials including Chief Medical Officer (CMO/CMHO/CDMO), other Urban Health Officials, District Quality Assurance Committee (DQAC) members, Medical Officer In-Charge (MOIC) and other UPHC staff
- **Identify high performing ASHAs:** Identification of high performing Urban ASHAs with at least 30% qualifies for short orientation on UHIR updating, counselling & client mobilization
- **Taking out of non-user list** from UHIR and focusing on potential young clients primarily
- **Publicization of special FDS** by front line workers through innovative activities
- **Accommodate Referral:** Nearby facilities including DWH, MC & private accredited hospitals are informed to accommodate referral
- **Quality Assessment:** DQAC members are informed for quality assessment on the 3rd day and on the day of FDS
- **Pooling Resources:** Supplies ensured in all identified UPHCs by pooling resources from nearby places

Four Pillars of 30 Hour Magic Drive plus



Ensuring
Community
Engagement



Facilitating Facility
Preparedness



Facilitating Quality
Assurance



Ensuring monitoring
& data reporting

Next ten hours:

- Onsite mentoring to ASHAs, ANMs continued
- Group Communication Activity of non-users
- Preparation of due list by each ASHA

Last ten hours:

- Onsite coaching continued
- DQAC visits for quality assessment
- All due lists from ASHAs collected, compiled and informed respective Facilities in Charge
- Set up registration desk, counselling corner, IEC corner, screening room and procedure room
- A standardized format is prepared for listing/registering family planning client
- Exit interview checklist ready for assessing client satisfaction on FDS

Results so far

TCIHC demonstrated special FDS in few cities and each time it gave promising results as per FDS average efficiency (which is more than thirty clients), which led to activating UPHCs. Thus, “30-hour magic plus” became a formula for success and has been replicated across cities.

Learnings

- The 30-hour magic plus is an approach and a ready-reckoner, which helps demonstrate how family planning can be brought in at the UPHC in a short span of time. Involving city government, DQAC are key to getting buy-in of this demonstration approach.
- Few successful demonstrations of this approach encourage other facilities, ASHAs and city officials for organizing FDS/ FPD.
- This approach helps identify issues which need to be streamlined in the long run for making a UPHC ready for providing family planning services.

Annex 10: Technical Brief: Strengthening Referral Mechanisms for Reproductive, Maternal, Newborn and Child Health in Urban India

Goal

The Challenge Initiative for Healthy Cities (TCIHC) aimed to increase the use of modern contraceptive methods among married women, aged 15-49 years and improve the coverage and quality of evidence-based reproductive, maternal, newborn and child health (RMNCH) interventions, especially among the urban poor, in three states in India. In Madhya Pradesh and Odisha, this included a focus on establishing and strengthening referral for pregnant women and sick newborns,³⁴ from the community through the highest level of care, in four cities: Indore, Gwalior, Bhopal and Berhampur.

Program Approaches and Strategies

TCIHC's approach was based on the premise that health impacts can be accelerated in resource constrained settings through targeted technical assistance. City level implementation was carried out by unlocking and leveraging public sector resources that are available through the Government of India's National Urban Health Mission's annual program implementation planning (PIP) process and other public reproductive, maternal, newborn, child and adolescent health (RMNCH+A) schemes.

First rolled out in Indore in December 2017, TCIHC's referral mechanism aimed to address the problem of congestion at higher level facilities and under-utilization of Urban Primary Health Centers (UPHCs), as well as weak connections between facilities and the urban poor communities they serve and between the levels of the health system. It built on the approach developed through Save the Children's Saving Newborn Lives program in Pune, India, which focused on facility to facility referral. TCIHC, by contrast, aimed to strengthen facilitated referral and counter-referral starting from the community level to primary level facilities (UPHCs) and from UPHCs to secondary/tertiary level hospitals. The program worked to ensure that referral pathways were clearly defined; providers and staff at all levels understood their roles and are empowered to implement the referral mechanism; the system was ready to deliver services at the appropriate level; and the relevant public sector resources (human and financial) and structures are available and functioning. This was meant to increase care-seeking and service provision at the appropriate level of the health system and ease congestion at higher level facilities. To achieve this the program initially focused their work in four areas: fostering local ownership, establishing the referral network, developing, testing and rolling out protocols and tools and technical assistance to support implementation.

Fostering local ownership of the referral mechanism: TCIHC oriented city and state government officials on the referral mechanism and facilitated exposure visits to Pune to see the referral mechanism established under the Saving Newborn Lives program. Once administrators' approvals were obtained in each city, TCIHC provided technical assistance in establishing a city level technical committee on referral, linked with the Urban Health Common Coordination Committees supported by the program.

Establishing the referral network: In conjunction with district program management units and other stakeholders, TCIHC conducted geographic mappings to define catchment areas and referral loops for the existing UPHCs and advocated to formally link ASHAs and ANMs with specific UPHCs. TCIHC also developed and implemented an assessment of readiness to deliver services at all UPHCs in the program cities.

Developing, testing and rolling out protocols and tools: TCIHC adapted existing referral protocols in consultation with facility level stakeholders and the referral technical committee. Referral tools (e.g., slips) and materials were piloted and then revised based on provider feedback. TCIHC then worked with city government to train community level workers (Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs) and

³⁴ Though TCIHC's referral mechanism focused on pregnant women and sick newborns, it is reasonable to assume that other clients would also benefit from a strengthened referral system.

Anganwadi Workers (AWWs), primary level providers (ANMs, staff nurses and medical officers), and secondary level facility staff on the referral protocols and tools.

Technical assistance to support implementation by government: In addition to training providers, TCIHC facilitated weekly UPHC meetings that included ANMs, staff nurses and medical officers. The program also facilitated data review meetings with providers and community dialogues to troubleshoot issues. Based on the experience to date, TCIHC also advocated for procedural changes at facility level, such as prioritization of patients with referral slips and the establishment of a help desk at higher level facilities to assist patients in navigating the process. Advocacy with city and state government focused on efforts to improve quality of care, provide training on specific skills and services and to address gaps identified in the UPHC readiness assessments.

Key Results and Findings

Referral records from Indore, Madhya Pradesh, for the period January to July 2019 were analyzed to provide insights into the profile of beneficiaries and reasons for referral. Overall, 3,627 referrals were done in this period with majority comprising of female beneficiaries (94%). Out of these, nearly 70% were in the 21-30 years age group, followed by 18-20 years (14%) and 31-45 years (6%). Children up to the age of five years comprised nearly 9% of total referrals, an unexpectedly small proportion. ASHA workers were the main provider referring clients (87% of referrals), in contrast to 7% done by ANMs. Most ASHA referrals were made during home visits. Of the total number of referrals, 70% were for antenatal care, including 138 cases identified as high-risk pregnancies and 6.5% were for management of newborn and childhood illnesses. Of the 3,589 cases where data was available on the facility to which the client was referred, almost half of the beneficiaries (49%) were referred to secondary level facilities, while 27% were referred to the UPHCs. As shown in the table below, of referrals to higher level facilities, almost two-thirds were for antenatal care and checkups (67%), a service that should be manageable at a UPHC.

Levels of care to which clients were referred by type of service N = 3,589 cases referred for which level of care is known [total 3,627 clients referred minus 38 clients with missing data] Data Source: Referral Management Information System							
Clients referred for:	ASHA and MAS	UHND and outreach camps	UPHC and Civil Dispensary	CHC	Civil and other hospitals	District and other tertiary hospitals	TOTAL
	Clients referred to: 	-2	-1	0	1	2	
ANC services	229	68	590	124	1348	46	2405
Management of high-risk pregnancies	7	0	27	13	85	5	137
PNC services	1	0	4	0	5	1	11
Routine immunization	41	27	36	54	3	0	161
Family Planning services	60	3	124	33	187	1	408

Levels of care to which clients were referred by type of service N = 3,589 cases referred for which level of care is known [total 3,627 clients referred minus 38 clients with missing data] Data Source: Referral Management Information System							
Clients referred to: Clients referred for:	ASHA and MAS	UHND and outreach camps	UPHC and Civil Dispensary	CHC	Civil and other hospitals	District and other tertiary hospitals	TOTAL
		-2	-1	0	1	2	3
Management of sick newborn or child	27	5	111	7	76	8	234
Treatment of other conditions	15	3	98	52	61	4	233
TOTAL	380	106	990	283	1765	65	3589

TCIHC also conducted a qualitative assessment that aimed to describe the current functioning of referral and capture supply and demand side perspectives on referral. The objectives of the study were:

- To describe how referrals related to MNH services are currently being provided, including experiences with counter-referral and referral protocols and tools
- To describe how interactions in the system, as both beneficiaries and providers, result in the provision/acceptance of MNH referrals and care experiences
- To identify through experiences of care if the referral mechanism has resulted in decongestion of higher level facilities and increased care-seeking at appropriate levels of the health system
- To identify barriers and facilitators of implementing TCIHC's referral strengthening approach, as described by families, beneficiaries, frontline workers, facility-based service providers and key local program / policy decision-makers.

The qualitative assessment used in-depth interviews (IDIs) and focus group discussions (FGDs) to gather information from participants. Data was collected in four cities Indore, Gwalior, Berhampur and Bhopal, but given that each city was at a different stage in the process of providing referrals, in the latter three cities only service providers and government stakeholders were interviewed. In Indore, where the referral mechanism is most advanced, the sampling for this assessment was drawn from facilities city-wide and include all groups of study participants in Figure 1 below.

The participants were selected for the study with the support of Save the Children. The criteria used for selection of study participants are as follows:

Service providers

- ASHAs and ANMs who are working at selected public health facilities were selected in consultation with the Medical Officer In-Charge of the public health facilities.
- The Staff Nurses (SNs) serving in the facilities (UPHCs and secondary facility) were selected in consultation with the Medical Officer In-Charge in the health facilities.

Community Members

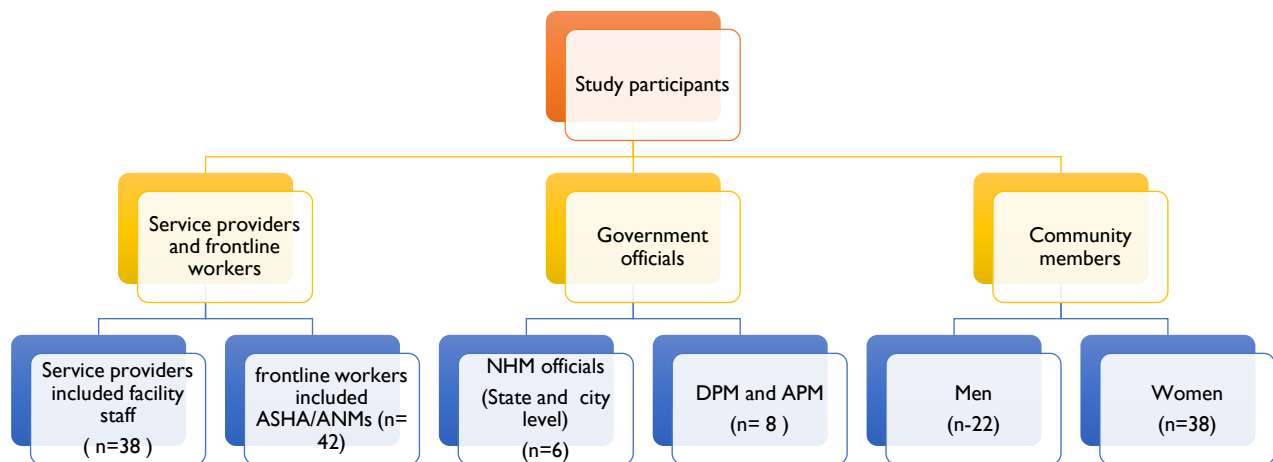
- Pregnant & postpartum women and their husbands and newborns (zero to nine months of age) who have received referral services from ASHAs / ANMs whose work is tied to selected public health facilities were selected with the help of ASHAs.

Government officials

- Government officials (city and state officials) with active roles in implementing the referral mechanism and working under the NUHM and overseeing a portfolio pertaining to program, policy, administration and finance were selected for the study.

A total of 50 In-depth interviews (26 with service providers, ten with community members and 14 with government officials) were conducted in the four selected cities of Madhya Pradesh and Odisha and 15 FGDs (seven with service providers and eight with community members) covering 104 participants were conducted only in Indore.

Figure I: Qualitative Assessment Study Participants



Among other findings, the assessment identified that many clients have a strong preference for hospital level care (particularly when a hospital is closer than the UPHC) and, when financially possible, for private sector providers. This preference may help to explain the large proportion of referrals to higher level facilities for ANC. Some beneficiaries described that poor infrastructure and human resource or service availability influence their choice not to seek services from UPHCs, while others reported that they've noticed an improvement in the quality of public sector facilities, which may be related in part to other TCIHC interventions (e.g., efforts to increase readiness to deliver services at UPHC level). Some ASHAs reported that more clients are now seeking services at the UPHCs and most medical officers expressed satisfaction with the ASHAs' role in motivating beneficiaries to visit the UPHCs. Medical officers reported an increase in the number of clients visiting the primary health care facilities, suggesting some improvement.

Generally, beneficiaries reported a high degree of trust in ASHAs and, often, a preference to first seek care from them. ASHAs appreciated the referral slips introduced by TCIHC, because they were easy to use, timesaving and convenient and also because the slips served as documentation of their work. Medical officers in all referral mechanism cities appreciated having a standardized form for referral to facilitate the initiation, tracking and follow-up of referrals. ASHAs and ANMs reported that referral trainings helped increase their capacity to recognize danger signs and other signs and symptoms, facilitating timely referral. They also reported increased confidence in the management of pregnant clients and sick newborns and children. Medical officers in Indore, Gwalior and Berhampur reported that they have noticed this improvement.

The qualitative study also identified other areas, both within and outside TCIHC's scope, where further work is needed to strengthen referral. Lack of adequate, affordable transportation and negative interpersonal interactions with facility-based providers, as reported by beneficiaries, were identified as barriers to referral. Also, while ASHAs described following up with clients after referral, they also noted that there is no formal communication through the health system to inform the ASHA of the outcome of referral. Referrals aren't tracked at UPHC level either, resulting in an information gap regarding further care of referral clients. Lastly, though referral clients are meant to be treated on a priority basis (as appropriate based on clinical factors and services sought), this practice was applied inconsistently at higher level facilities, a disincentive for beneficiaries to seek and complete referral. Late in the life of the program, TCIHC worked with a higher level facility in Indore to establish a help desk for referral patients, intended to guide them through the hospital and facilitate the prioritization process. However, this was a new strategy and was not discussed by respondents in the assessment.

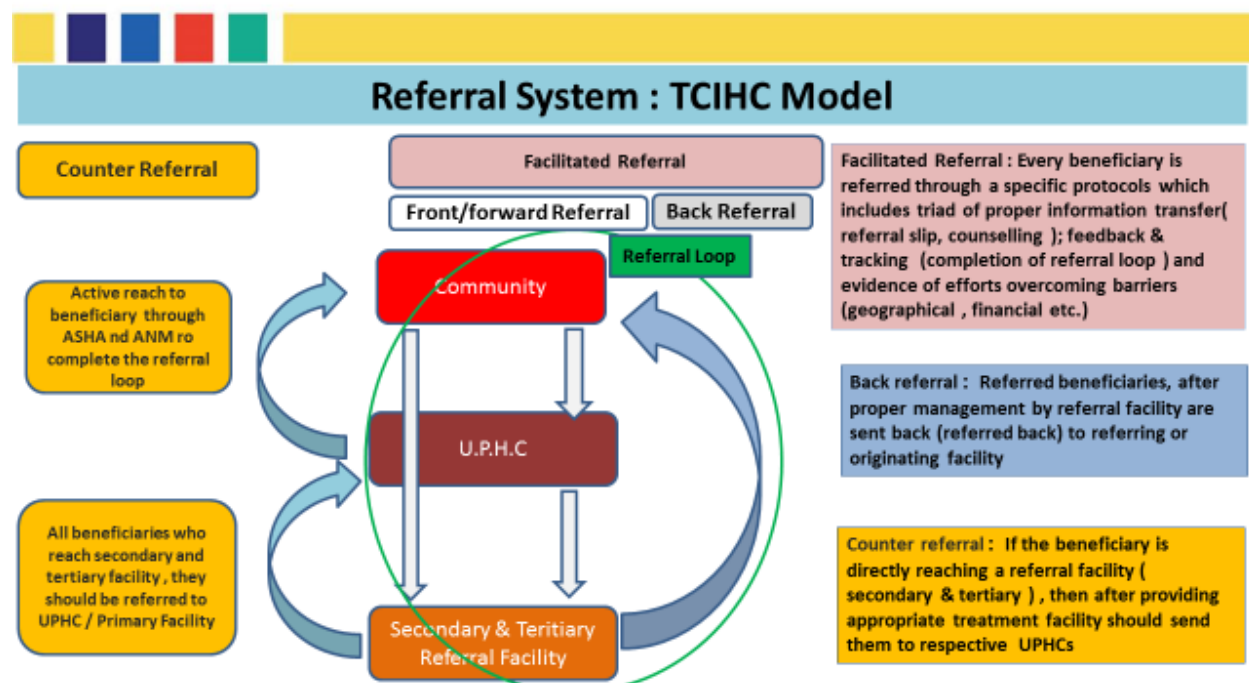
Recommendations and the Way Forward

The government of Madhya Pradesh, through the Program Implementation Plan process, has allocated resources for the expansion of the referral mechanism to other cities in the state. As the referral mechanism is implemented and expanded by state government, there is a need for further strengthening in the following areas:

- There is a need to revisit and refine the approach to ensure that the feedback loop is complete from higher level facilities to primary and community levels
- Though TCIHC included a focus on readiness to deliver services at UPHCs – and demonstrated measurable achievements in this area – the qualitative assessment revealed there is more work to be done, particularly in the area of human resources. Readiness to deliver services at primary level is essential to achieving a fully functioning referral system.
- The qualitative assessment suggests a need for efforts to address barriers that were outside the scope of TCIHC, particularly to enhance counseling and interpersonal communication skills among facility-based service providers and increase access to timely transportation for referral.
- ASHAs have been the backbone of the referral mechanism work, by identifying cases, encouraging the community to value and complete referrals and building trust with community. However, given the strong preference for hospital care, or care from private sector sources, among beneficiaries, focused intervention is needed to ensure that clients are aware of the improving quality of care and service readiness at UPHC level; value the role of primary level facilities and referral; and ultimately, reduce their use of higher level facilities for services that can be delivered at a UPHC.
- Greater exploration of why newborns and children accounted for such a small proportion of referred clients is required to determine strategies to ensure that the referral mechanism effectively serves these age groups.
- Further investment in and refinement of strategies to ensure that referral clients are treated on a priority basis at higher level facilities – when appropriate – are needed to encourage demand for referral, reduce congestion and create a positive referral experience for urban poor clients.

Annex 11: Factsheet on TCIHC's Efforts to Strengthen Referral Mechanisms for MNCH in Urban India

The Challenge Initiative for Healthy Cities (TCIHC) aimed to increase the use of modern contraceptive methods among married women, aged 15 – 49 years and improve the coverage and quality of evidence-based reproductive, maternal, newborn and child health (RMNCH) interventions, especially among the urban poor, in three states in India. In Madhya Pradesh (MP) and Odisha, this included a focus on establishing and strengthening referral, particularly for pregnant women and sick newborns, from the community through the highest level of care, in four cities: Indore, Gwalior, Bhopal and Berhampur.



The TCIHC-supported Referral Mechanism At-a-Glance:

- First launched in Indore, Madhya Pradesh in December 2017; later expanded to Gwalior (MP), Berhampur (Odisha) and Bhopal (MP), the last led by state government.
- Aim: to address congestion at higher level facilities and under-utilization of Urban Primary Health Centers (UPHCs), as well as weak connections between facilities and the urban poor communities they serve and between the levels of the health system
- In addition to TCIHC's other program interventions, TCIHC's referral efforts focused on:
 - Fostering local ownership of the referral mechanism
 - Establishing the referral networks
 - Developing, testing and rolling out protocols and tools
 - Technical assistance to support implementation by government

Levels of care to which clients were referred by type of service N = 3,589 cases referred for which level of care is known [total 3,627 clients referred minus 38 clients with missing data] Data Source: Referral Management Information System							
Clients referred to: → Clients referred for: ↓	ASHA and MAS	UHND and outreach camps	UPHC and Civil Dispensary	CHC	Civil and other hospitals	District and other tertiary hospitals	TOTAL
	-2	-1	0	1	2	3	
ANC services	229	68	590	124	1348	46	2405
Management of high-risk pregnancies	7	0	27	13	85	5	137
PNC services	1	0	4	0	5	1	11
Routine immunization	41	27	36	54	3	0	161
Family Planning services	60	3	124	33	187	1	408
Management of sick newborn or child	27	5	111	7	76	8	234
Treatment of other conditions	15	3	98	52	61	4	233
TOTAL	380	106	990	283	1765	65	3589

Key Achievements and Results

- The Government of MP allocated funding in its 2018/2019 and 2019/2020 PIPs to expand the approach to a total of ten cities by 2020.
- Referral records from Indore, Madhya Pradesh, for the period January to July 2019 show that:
 - 3,627 referrals were done in this period, 94% of which were for female beneficiaries.
 - Children up to the age of five years comprised nearly 9% of total referrals.
 - ASHA workers are the main provider referring clients (87% of referrals). Of the total number of referrals, 70% were for antenatal care, including 138 cases identified as high-risk pregnancies; 6.5% were for management of newborn and childhood illnesses.
 - Of referrals to higher level facilities, almost two-thirds were for antenatal care and checkups (67%), a service that should be manageable at a UPHC.
- TCIHC carried out a qualitative assessment of the referral work, in which some ASHAs reported that more clients are now seeking services at the UPHCs and a majority of medical officers expressed satisfaction with the ASHAs' role in motivating beneficiaries to visit the UPHCs. Medical officers reported an increase in the number of clients visiting the primary health care facilities.
- However, while some beneficiaries noted that quality has been improving in public facilities, many noted a strong preference for hospital care and care from private sector providers.

Annex 12: Case Studies

Case Study: Influencing the Influencer

This story describes how ASHAs are building relationships with family decision makers and authorities to promote FP among young and adolescent mothers.

For the past two years, Laxmi has been working as an accredited social health activist (ASHA) in the Ramnagar area of Firozabad city. Laxmi organizes community meetings for health awareness and promoting voluntary FP services and during one such meeting she met Pooja, a young mother of an infant. Her husband is a daily wage earner and due to financial constraints, the couple do not want to have another child for another three years.

After the group meeting, Laxmi visited Pooja's home where she sensed that all decisions in the household, including what to eat and what to wear, were made by her mother-in-law -- Pooran devi. Pooran devi was against the use of contraceptive methods and she prevented Pooja from adopting any method immediately after the birth of her son.

Laxmi realized that Pooran Devi had to be involved first for her to let Pooja choose any FP method. Thus, she invited her in the group meeting where there were discussions about the significance of FP in preserving a women's health and the well-being of her children. Laxmi persuaded Pooran devi by saying,

“You hold such an important position in the family and it is your decisions that have helped your children make wise choices. FP is important for the health of your daughter-in-law and your grandchildren, as well as for the financial situation of your family. The best thing you can do is to make the right decision for your son's family”.



*Pooja with her mother-in-law Pooran devi Photo Credit: PSI
India*

Laxmi also told Pooran devi about the advantages and side effects of each FP method. Thus, Laxmi included the mother-in-law and made her feel that she was making a decision for her daughter-in-law. She had learned this from TCIRC's field program associate who had coached her on effective counselling skills.

Later Pooja adopted a long term spacing method. Laxmi mentioned that she was delighted when Pooran devi herself brought Pooja on the special FDS day organized at Ramnagar UPHC (exclusively for 15-24 years old women with one child) for letting her adopt a FP method.

Laxmi is disseminating important reproductive health messages among women, men and girls wherever she goes. She **firmly believes** that in the case of young and adolescent mothers it is essential to communicate with the decision makers.

Case Study: Living My Dream through Voluntary FP Services

A staff nurse who was initially not supportive of voluntary FP services but gradually developed interest and from then onwards it became harder to turn her back.

Lucian Bastian popularly known as sister Ruby is a staff nurse in Aranyam urban civil dispensary, Indore. Ruby recalls, “*Since childhood I always dreamed of becoming a famous nurse and serving people. My mother helped me to become a nurse as she was in the same profession. This year, I completed twenty years of service.*”



*Ruby working on FDS Photo Credit PSI
India*

In February 2018, when TCIHC initiated fixed day static (FDS) services at Aranyam urban civil dispensary, Ruby was not receptive for a variety of reasons. At that time, she was managing the civil dispensary on her own, as her colleague was on maternity leave and the medical officer was irregular in her duties. In her work, she had to handle many cases of IUCD (both insertion and removal) and the related side effects. Sister Ruby felt like she needed practice with IUCD insertion under the supervision of an experienced trainer or a doctor, but she was too shy to ask. Consequently, she was hesitant to perform the IUCD insertion procedure and felt that the FDS was increasing her workload. The solution she found was to turn FP clients away.

With TCIHC’s support, Ruby was given the opportunity to be trained by Dr Asha Pandit, district health officer, on IUCD insertion techniques, client counseling skills and quality assurance practices. In addition, to manage her client load, TCIHC worked with the district to ensure that ANMs and ASHA, as well as TCIHC FPAs were available on FDS day at the dispensary. This helped Ruby to offer a range of FP methods, along with maternal care and other health services in her facility. Ever since, Ruby has become a FP champion as she has inserted 61 IUCDs to date with TCIHC’s encouragement and support.

Ruby says,

“When I did my nursing training, it was mostly focused on primary care. The training facilitated by TCIHC helped me gain confidence and acquire skills. Now I can easily address the fears of clients and myths pertaining to FP methods. In fact, I supported a nearby UPHC in Shivbagh by training their staff on contraceptive technology and providing FP services.”

According to Ruby, FDS is bringing recognition to her and the facility, due to which she has noted an increase in client traffic by fifty percent. Today, clients seek her services because they have heard about the clinic’s high-quality service provision and satisfied FP users refer their friends and neighbors to her.

In August 2018, Ruby received an award from the district government for her contribution to FP services. Sister Ruby seems contented as she says,

“Nothing gives you a better feeling than being able to see people build brighter future. Duty makes us do things well, but recognition makes us do it more responsibly. FP services have finally made me achieve what I had only dreamed of in the last twenty years,” says Ruby.

Sister Ruby is living proof of the progress that cities, states and individual health workers are making with TCIHC’s support.

Case Study: Referral Mechanism

Each year in India, roughly 28 million women become pregnant and there are around 26 million live births. Out of these, there are an estimated 67,000 maternal and one million newborn deaths recorded in the country. Although India has seen a significant decline in its Maternal Mortality Ratio (MMR), which fell from 301/100 000 in 1998/99 to 130/100 000 live births in 2016, further reduction is required to achieve the Government of India's goal of a MMR that is less than 100 maternal deaths per 100,000 live births.

One of the factors making it difficult to achieve India's maternal mortality reduction goal is delayed treatment seeking, especially by vulnerable populations in the urban areas of the country. Weak referral linkages between the different levels of the health system and between providers and slum communities are a part of this problem. They also contribute to greater congestion at secondary and tertiary level health facilities and underutilization of services at the primary care level and this has a negative impact on the quality of care available to India's urban poor population.

In 2005, the Government of India launched the National Urban Health Mission and with it a new cadre of community health volunteers called Accredited Social Health Activists (ASHA). Selected from the communities themselves, one of an ASHA's main tasks is to regularly visit each house in her area and identify women who are pregnant and therefore in need of antenatal care. This step was intended to reduce the gap between the community and government health services and to reduce delays in treatment seeking. Having the ASHAs perform this important task proved to be beneficial, but care seeking is still lower than it should be to ensure that all pregnant women receive ANC early in their pregnancies and at the recommended intervals.

In 2016, when The Challenge Initiative for Healthy Cities (TCIHC) started work in the states of Uttar Pradesh, Madhya Pradesh and Odisha, the lack of a systematic approach to documenting and tracking referrals from communities to UPHCs and hospitals was identified as a gap in the existing urban health care model. To encourage the increased utilization of available health services by pregnant women, newborns and children, TCIHC worked in partnership with the Indore city government in the state of Madhya Pradesh to develop and demonstrate a stronger referral mechanism.

System level changes of this type can have a significant impact on the daily lives of health care providers and beneficiaries – as seen in the case of Ms. Kavita, a pregnant woman who sought antenatal care in Indore earlier this year. The ASHA working in her neighborhood, Farzana, identified Kavita's pregnancy and referred her to Shivbag Urban Primary Health Center (UPHC), one of the facilities receiving support from TCIHC. When she arrived at the UPHC, she brought with her the new referral slip that TCIHC had helped to introduce. It noted a complication that Kavita faced during a previous pregnancy, one that put her at risk of a complication during her current pregnancy, too.

At the UPHC, Dr. Sadhna Banjhal, the Medical Officer, examined Kavita and recommended an ultrasound. She also gave her a new referral slip and advised her to visit PC Sethi Hospital, a government maternal and child hospital that serves all of Indore City. Dr. Sadhna also explained to Kavita the potential danger signs in pregnancy and asked her to return immediately in the event she should experience any of them. Kavita went to PC Sethi Hospital for the ultrasonography that Dr. Sadhna recommended. ASHA Farzana continued to meet Kavita and follow-up with her on her future visits to the same UPHC for the remainder of her pregnancy.

Dr. Sadhna notes the improvements she has seen due to TCIHC's support:

“With the help of referral protocols and slips, ASHAs are now identifying high risk patients and prioritizing their needs before referring them to UPHCs. These protocols are also helpful for us in prioritizing patients and focusing on providing optimal care at our facilities and also ensuring that they go to secondary facilities only if required.”

Annex 13: ASHA Incentives under NHM including DCP & NCD (2015-16)

Sl. No.	FMR Code	Activity Name	Incentive Amount		Deliverables
			Unit of Measure	Unit Cost (In Rs.)	
RMNCH+A (Maternal Health)					
1	A.1.3.4.1	For Rural area	Per case	600	Total Package for ANC- Rs.300/- (1 st ANC- Rs. 150, 2 nd ANC- Rs.50, 3 rd ANC- Rs.50, 4 th ANC- Rs.50) Facilitating institutional Delivery- Rs.300
	A.1.3.4.2	For Urban area	Per case	400	Total Package for ANC- Rs.200/- (1 st ANC- Rs. 50, 2 nd ANC- Rs.50, 3 rd ANC- Rs.50, 4 th ANC- Rs.50) Facilitating institutional Delivery- Rs.200
2	B1.1.3.1.1	Incentive for mobilization of beneficiaries to VHND	Per ASHA per qtr	150	80% eligible beneficiaries turned up to VHND Session sites
3	B1.1.3.1.3	ASHA incentive for confirmation of maternal death	Per case	150	
4	B1.1.3.6.2	Mobilise and accompany suspected high risk pregnant women to ICTC or FICTC and ensure HIV and RPR testing during ANC	Per case	100	Accompanying pregnant women for testing in ICTC / FICTC for confirmation of HIV
5	B1.1.3.6.3	Accompanying cost to ASHA for IV iron sucrose supplementation to identified severe anaemic cases. (At least 4 visits by 4th ANC).	Per ASHA	200	Motivating for IV Iron Sucrose administration and have improved anaemia status. (At least 4 visit by 4th ANC).
6	B1.1.3.6.4	Incentive for accompanying abortion case for surgical intervention	Per ASHA	150	Accompany for MTP by MVA / EVA
7	B1.1.3.6.5	Incentive for accompanying abortion cases through medical method	Per ASHA	150	Accompany for MTP by MMA
RMNCH+A (Child Health)					
8	B1.1.3.2.1	Incentive for Home Based Newborn Care programme	Per Newborn	250	6 visits in case of Institutional Delivery / 7 visits in case of Home Delivery
9	B1.1.3.2.2	Incentive for follow up of LBW babies	Per case p.m.	50	Monthly visit from 3rd month onward up to 1 year
10	B1.1.3.2.3	Incentive to ASHA for follow up of SNCU discharge babies	Per case p.m.	50	22 visits within 2 years
11	B1.1.3.2.5	Incentive for follow up of discharge SAM children from NRCs	Per NRC discharged child	150	1. Accompanying cases to NRC 2. Motivating for minimum seven days stay at NRC 3. Regular follow up after discharge for 6 months (3 visits)
12	B1.1.3.2.8	Incentive of ASHA for IDCF	Per ASHA	200	For completing at least 80% of household @ Rs. 100 per ASHA
13	B1.1.3.5.2	Incentive for mobilizing children (6-60 months)	Per child per qtr	3	
RMNCH+A (Immunization)					
14	C.1.h	Mobilization of children through ASHA or other mobilizes	per session	150	80% eligible cases mobilized to session site for vaccination
15	C.5.1	For full immunization in first year	Per beneficiary	100	Ensuring complete immunisation of a child
16	C.5.2	For ensuring complete immunization upto 2nd year of age	Per beneficiary	50	Ensuring complete immunisation of a child
17	C.6	Pulse Polio operating costs	Per Day	75	Case mobilisation to the booth on the day 1 & home visits on day 2 & 3
RMNCH+A (Reproductive Health)					
18	B1.1.3.3.1	ASHA PPIUCD incentive for accompanying the client for PPIUCD insertion	Per ASHA	150	Woman accepted PPIUCD who are escorted for institutional delivery

Sl. No.	FMR Code	Activity Name	Incentive Amount		Deliverables
			Unit of Measure	Unit Cost (In Rs.)	
19	B1.1.3.3.2	ASHA incentive under ESB scheme for promoting spacing of births	Per ASHA	500	1. Ensure spacing of 2 years after marriage 2. Ensure spacing of 3 years after the birth of first child
20	B1.1.3.3.3	ASHA Incentive under ESB scheme for promoting adoption of limiting method upto two children	Per ASHA	1000	Motivating couple to opt for permanent limiting method upto 2 children
21	B1.1.3.3.4	Motivation for Male sterilisation at public health institutions	Per Case	300	Motivated for sterilization
22	B1.1.3.3.5	Motivation for Female sterilisation at public health institutions	Per Case	200	Motivated for sterilization
RMNCH+A (Adolescent Health)					
23	B.1.1.3.4.1	Incentive for support to Peer Educator	Per PE	100	
24	B.1.1.3.4.2	Incentive for mobilizing adolescents for AHD	Per AHD	150	
Disease Control Programme					
NVBDCP					
25	F.1.1.b	Blood sample collection, report and treatment	Per ASHA Per Case	Rs. 15/- per Blood test. Rs. 75/- for complete treatment of each positive case.	
26	F.1.4.j	Line listing of Lymphoedema and Hydrocele cases in non-endemic districts	Per ASHA per Case	200	Line listing of cases
NLEP					
27	G 1.3	Incentive to ASHA (NLEP)	Per ASHA Per Case	Case Diagnostic - 250	Identification, referral and drug administration as per prescription for due term of suspected cases.
28				PB-400	
				MB-600	
RNTCP					
29		Incentives to Community Dot provider providing treatment support to category I TB patients.	Per Case	1000	For successful completion of treatment for new cases (42 contacts for cat -I TB patients over 6 - 7 months of treatment)
30		Incentives to Community DOT provider providing treatment support to category II TB patients	Per Case	1500	For successful completion of treatment of previous treated cases (57 contacts for cat -II TB patients over 8 - 9 months of treatment including 24-36 injections in intensive phase)
31		Incentives To Community DOT Provider Providing Treatment Support To Drug Resistant TB patients	Per Case	5000	For completed course of treatment (Rs.2000/-at the end of IP and Rs.3000/-at the end of the CP) for successful completion of MDR patients
32		Incentive to volunteers for sputum sample transport in tribal and difficult areas	Per sample	25	Per sample transported to the DMC
33		Incentive related to injection prick	per injection prick	25	

Sl. No.	FMR Code	Activity Name	Incentive Amount		Deliverables
			Unit of Measure	Unit Cost (In Rs.)	
NPCB					
34	11.1	Identification, organizing, motivating & transporting the case for cataract operation, support during post operative stay at institutions	Per Case	250	Identification and accompanies the case for cataract operation. Support during post operative stay at institutions.
NIDDCP					
35	D.6	Salt Test	Per 50 tests	25	Salt testing - minimum 50 samples in a quarter in 17 endemic districts
Others					
36	B1.1.3.6.6	Accompanying freedom fighters to health institutions for treatment	Per visit	100	Accompanying freedom fighters for treatment from their residence to the nearest govt health institutions.
37	B1.1.3.6.7	Performance Incentive for ASHA for ensuring issuance of minimum 80% birth & death certificates in her target area	Per ASHA Per Annum	500	Issuance of minimum 80% Birth & Death certificates in her target area
38	B1.1.3.6.1	Incentive to ASHA for supporting ANM in updating RCH Register	Per ASHA per qtr	300	ASHA has to furnish the required information to ANM and she herself has to keep and update the following records on regular basis <ul style="list-style-type: none"> · Eligible couples · Line listing of high risk mothers, LBWs, Discharged cases from NRC / SNCU · PNC and HBNC details · Contraceptive distribution details
39	B1.1.3.7.4	Attending Monthly Sector Meeting	Per Meeting	150	Attending monthly sector meeting
40	B2.6	Organising GKS Meeting	Monthly Meeting	150/ Per month	Facilitating for organizing GKS Meeting

Annex 14: TCIHC Deliverables and Products

Products shaded green required USAID approval. All others were approved by GI/TCI before posting to TCI University website. As of March 4, 2020, there were still a number of products that had been completed but not yet posted to the TCI University website. Products without locations were produced, shared with stakeholders, and can be obtained from the TCIHC lead partner, PSI.

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
1	Quality assurance: Tool	Providers & Government	This tool is designed to help systematically assess existing mechanisms / systems and ensure continuous quality voluntary FP services to the clients.	TCI university/ City and State meetings/Dissemination events/DEC	Complete and posted on TCI-University	Family planning	https://tciurbanhealth.org/lessons/quality-assurance/
2	Male engagement: Tool	Providers & Government	To provide guidance on devising male engagement strategies to increase the uptake of Family Planning (FP) methods in urban areas, especially non-scalpel vasectomy.	TCI university/ City and State meetings/Dissemination events/DEC	Complete and posted on TCI-University	Family planning	https://tciurbanhealth.org/lessons/male-engagement/
3	30-hour magic-tool	Internal team, Providers, Govt	To coach people on how to demonstrate to the city government rapid upscale of family planning services at urban primary health centers (UPHC).	TCI University/ City and State meetings/Dissemination events/DEC	Complete and Posted on TCI-University	Family planning	https://tciurbanhealth.org/courses/india-services-supply/lessons/30-hour-magic-plus/
4	Hindi Infographics for HIA tools: Infographics	Govt, providers, stakeholders	To provide guidance on process, implementation on nine HIAs	TCI University/ City and State meetings/Dissemination events/DEC	Complete and posted on TCI University with HIA tools	Family planning	https://tciurbanhealth.org/india-toolkit/
5	30-hour magic plus: One-pager	Providers, Govt	Learning document to activate facilities for voluntary FP services and demonstrate quick results	TCI University/ City and State meetings / Dissemination events / DEC	Complete and Posted on TCI-University	Family planning	https://tciurbanhealth.org/wp-content/uploads/2020/01/tci-30-hour-mag_43006039.pdf

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
6	Male engagement strategy: One-pager	Govt, providers	Learning document to increase male participation by using proven high impact interventions	TCI University/ City and State meetings/Dissemination events/DEC	Complete and Posted on TCI-University	Family planning	https://tciurbanhealth.org/courses/india-demand-generation/lessons/male-engagement/
7	FPSA concept: One-pager	Govt, providers	Learning documents on the FPSA concept adopted in India to improve quality in services	TCI university/ City and State meetings/Dissemination events/DEC	Complete, used in state meetings, but not yet posted to TCI University	Family planning	
8	Communication plan: One-pager	Govt, providers	Learning document on the role of marketing and communication in establishing UPHCs as facilities for quality family planning services	TCI university/ City and State meetings/Dissemination events/DEC	Complete, not yet posted to TCI University	Family planning	
9	Learning agenda- Process adopted for capturing project learnings One pager	Global	Process adopted for capturing project learnings	TCI university / MCSP Blog / PSI Blog	Completed and shared with GI and MCSP team; not yet posted to TCI University	Family planning	
10	Key definitions of words in Indian context -One pager	Global	A glossary of terms often used / heard in TCIHC	TCI university	Complete, not yet posted to TCI University	Family planning	
11	Whole site family planning orientation of high case load facility	Global	To explain the WSO approach used for training clinical and non-clinical staff of high load facilities on family planning knowledge and build enabling environment for family planning	TCI university / Dissemination events	Complete, not yet posted to TCI University	Family planning	
12	PMIS- a learning document	Donor/State Govt./ Global audience	To describe use of PMIS to understand "how fast, how far and how well "we are moving. The learnings from PMIS implementation with its strengths, limitations and how PMIS can be made flexible in terms of capturing more details/indicators. The effectiveness of PMIS to be presented to Govt. in the	TCI university/ City and State meetings/Dissemination events/DEC	Completed and posted to USAID DEC	Family planning	USAID DEC

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technica l Areas	Locations
			form of learnings so as to improvise and strengthen the present HMIS.				
13	Integrated V/s Single day services for family planning- a learning document	Donor/State Govt./ Global audience	Learnings from system, functionary and client level on which approach is most beneficial along with cost-benefit analysis.	TCI university/ City and State meetings/Dissemination events/DEC	Completed	Family planning	
14	Listing and mapping of slums and vulnerable population	Donor/State Govt./ Global audience	Learning document for understand how to do listing and mapping in urban setting and identify the slums/vulnerable population for better planning of health services including Family Planning (FP) for urban poor.	TCI university/ City and State meetings/Dissemination events/DEC	Completed and posted to TCI University and USAID DEC	Family planning	https://tciurbanhealth.org/courses/india-advocacy/lessons/mapping-urban-slums/ https://tciurbanhealth.org/wp-content/uploads/2018/11/Mapping-Info-Eng_1Page.pdf https://tciurbanhealth.org/tcis-mapping-and-listing-approach-helps-indore-india-more-accurately-allocate-health-resources/ USAID DEC
15	Giving additional choice to women on injectable contraceptives	Donor/State Govt./ Global audience	A learning document to capture how the introduction of new method of contraception at UPHC level has strengthened the basket of choice for family planning increasing the uptake of LARC.	TCI university/ City and State meetings/Dissemination events/DEC	Completed and posted on USAID DEC	Family planning	USAID DEC

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technica l Areas	Locations
16	Relocation of UPHCs –reaching client’s doorstep	Donor/State Govt./ Global audience	A learning document to capture how the TCIHC efforts in listing and mapping of both registered and unregistered urban poor areas led to relocation of various UPHCs with redistribution of resources proportionate to the population size being served.	TCI university/ City and State meetings/Dissemination events/DEC	Shared with USAID for review; not yet posted on TCI University website	Family planning	USAID DEC
17	Findings from Output tracking survey round -I	Donor/State Govt./ Global audience	To share the key findings of OTS round I and how these were utilized in taking programmatic decisions.	TCI university / PSI Evidence working group	Completed and posted to USAID DEC, not yet on TCI University	Family planning	USAID DEC
18	Referral Implementation guide	Service providers, program managers, national & state government, city officials	How-to guide for providers, managers and government on implementing the referral mechanism	Dissemination events, TCI University	Completed and posted to TCI University and USAID DEC	MNH	https://tciurbanhealth.org/?s=referral+implementation+guide USAID DEC
19	Gwalior Plan of Action	City & Natl. Govt.	Communicating city government’s plan of action for inter-ministerial convergence	Inter-ministerial convergence events at city / national levels	Shared with USAID for review; not yet posted on TCI University website	MNH	USAID DEC
20	Desk review of the existing schemes of all relevant departments	City & Natl. Govt.	Review analyzing the existing schemes of all relevant department to illuminate platforms for cross-thematic convergence	Inter-ministerial convergence events at city / national levels	Completed	MNH	
21	Madhya Pradesh rapid assessment full report	State & Natl. Govt. / Donor	Sharing the findings and recommendations of TCIHC's initial city assessments	Dissemination events	Completed	MNH	
22	Madhya Pradesh rapid assessment 4 pager	State & Natl. Govt. / Donor	Sharing the findings and recommendations of TCIHC's initial city assessments	Dissemination events	Completed	MNH	

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technica l Areas	Locations
23	Odisha State rapid assessment full report	State & Natl. Govt. / Donor	Sharing the findings and recommendations of TCIHC's initial city assessments	Dissemination events	Completed	MNH	
24	Odisha State rapid assessment 4 pager	State & Natl. Govt. / Donor	Sharing the findings and recommendations of TCIHC's initial city assessments	Dissemination events	Completed	MNH	
25	High Impact Approach: Referral Toolkit	Providers & Government	Brief learning document for gov't and providers communicating TCIHC's approach to referral (complement to the more in-depth toolkit)	TCI University, dissemination events (as part of HIA package)?	Completed, posted to USAID DEC	MNH	USAID DEC
26	Technical Brief: Referral Mechanism	Donor / Global / Internal	Brief learning document for USAID, global technical and internal audiences relating TCIHC's approach to referral, results and recommendations.	Webinar, MCSP website, dissemination events, MCSP HQ brown bag	Completed, posted to USAID DEC	MNH	USAID DEC
27	Factsheet: Referral Mechanism	Donor / Govt. / Global	Highly pictorial at-a-glance document on TCIHC's referral mechanism work	Webinar, MCSP website, dissemination events, MCSP HQ brown bag	Completed, posted to USAID DEC	MNH	USAID DEC
28	High Impact Approach: UPHC Readiness	Providers & Government	Brief learning document for gov't and providers communicating TCIHC's approach to increasing UPHC readiness	TCI University, dissemination events (as part of HIA package)?	Completed, posted to USAID DEC	MNH	USAID DEC
29	Technical Brief: UPHC Readiness	Donor / Global / Internal	Brief learning document for USAID, global technical and internal audiences relating TCIHC's approach to UPHC readiness and related results and recommendations.	Webinar, MCSP website, dissemination events, MCSP HQ brown bag	Completed, posted to USAID DEC	MNH	USAID DEC
30	Factsheet: UPHC Readiness	Donor / Govt. / Global	Highly pictorial at-a-glance document on TCIHC's work on UPHC readiness	Webinar, MCSP website, dissemination events, MCSP HQ brown bag	Annex 6 of this report	MNH	

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
31	High Impact Approach: Integrated Pediatric Unit (IPU)	Providers & Government	Brief learning document for gov't and providers on the establishment of Integrated Pediatric Units	TCI University, dissemination events (as part of HIA package)?	Completed, posted to MCSP intranet	MNH	USAID DEC
32	IPU implementation guide	Donor / Global / Internal	Brief learning document for USAID, global technical and internal audiences relating TCIHC's work to establish IPUs.	Webinar, MCSP website, dissemination events, MCSP HQ brown bag	Completed, posted to MCSP intranet	MNH	USAID DEC
33	Eight - 12 Success Stories (Indore and Puri / Provider and Beneficiary Perspectives)	Donor / Global	To communicate the progress achieved through TCIHC, through personal narratives	MCSP Website, USAID	Complete	MNH	Included with TCIHC annual and EOP reports
34	Report from Inter-ministerial convergence events at city / national levels	Donor/National and State Govt/City Officials	To guide future donor support and government action to promote convergence and multi-sectorial efforts at city level	Reports to USAID, NHM/NUHM, state governments, urban local bodies	Completed and submitted to USAID India	MNH	
35	Fixed day static approach: Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO/CS) Chief Medical Superintendents (CMS) Nodal Officer Urban Health Persons In-charge of Private facilities District Program Managers (DPM)	To provide specific guidance on planning and organizing of effective strategies for implementation of Fixed Day Static (FDS) services (also referred to as Family Planning Day) for expanding access to quality Family Planning (FP) services.	TCI University	Completed, shared with MCSP and GI team with TCIHC branding, and posted to TCI University	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-fixed-day_15Oct2018.pdf
36	Engaging the Private Sector: Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health	To provide guidance on engaging the private sector under government schemes, towards providing Family	TCI University	Completed, shared with MCSP and GI team with TCIHC branding, and	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
		Nodal Officer – Family Planning District Program Managers Persons In-charge of Private Health Facilities Office bearers of The Federation of Obstetric and Gynecological Societies of India (FOGSI) Office bearers of the Indian Medical Association (IMA)	Planning (FP) services to the urban poor to address their unmet needs.		posted to TCI University		i-private-sector_9Oct2018.pdf
37	Facilitating Integration of services at the community level among all relevant departments- Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Chief Medical and Health Officers (CMHO/CDMO/CMO) Chief Medical Superintendents (CMS) Heads of the different departments (Integrated Child Development Service, District Urban Development Agency, National Urban Livelihoods Mission, Health, Municipal Corporation, Education) Nodal Officer-Urban Health and Family Planning Persons In-charge of Public Health Facilities District Program Managers (DPM)	To facilitate integration of Family Planning (FP) and other Maternal, Newborn and Child Health (MNCH) services at the community level, through coordination and integrated actions among all relevant departments.	TCI University	Completed and posted to TCI University	Family planning	https://tciurbanhealth.org/courses/india-services-supply/lessons/convergence-of-services/ USAID DEC

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
38	Utilizing Data Effectively: Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To help district officials to monitor performance of Family Planning (FP) strategies as per Expected Level of Achievement (ELA), to analyze relevant indicators and to take timely corrective measures to meet the FP objectives of the district and the state.	TCI University	Completed and posted	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-data_9Oct2018.pdf
39	Planning and Budgeting (PIP): Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Chief Medical Superintendents (CMS) Nodal Officers -Urban Health and FP Persons In-Charge of Facilities Medical Officers in Charge (MOIC) District Program Managers (DPM) NGO representatives	To provide guidance to district officials and NGO partners on the specific steps of planning and budgeting for Family Planning (FP) through the annual Program Implementation Plan (PIP) of the National Health Mission (NHM).	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-planning_9Oct2018.pdf
40	Mapping and Listing of Urban Slums: Infographic	CMHOs/CDMOs/CMOs District Program Managers Urban Health Coordinators ASHA Facilitators/ANMs Health Education Officers Other concerned authorities	To assist the Chief Medical and Health Officers (CMHO/CDMO/CMO) in identifying all the slums (registered/unregistered) and poverty clusters and categorizing them based on their vulnerability to achieve better planning of health services including Family Planning (FP).	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-mapping-14May2018.pdf

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
41	Enabling Urban ASHA -Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To aid district health officials in strengthening the role of Urban Accredited Social Health Activists (ASHAs) in facilitating the utilization of Family Planning (FP) services among marginalized and vulnerable populations in urban slums.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-ashas_9Oct2018.pdf
42	Strengthening Women's Groups (MAS)-Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide guidance on how to establish Mahila Arogya Samitis (MAS), build their capacity as health advocates and develop them into self-governing institutions that work towards addressing and meeting the health and Family Planning (FP) needs of the community.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-women-group_9Oct2018.pdf
43	Strengthening Provider Capacity-Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide guidance on implementing training for providers and staff towards improving the quality of family planning (FP) services.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/tci-capacity-building_9Oct2018.pdf

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technica l Areas	Locations
44	Involving Men to Increase the Uptake of Family Planning Services-Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	Devising male engagement strategies can increase the uptake of family planning methods in urban areas, particularly non-scalpel vasectomy.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/11/male-engagement-info.pdf
45	Strengthening Systems to Ensure Quality Family Planning to Clients-Infographic	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	Continuous assessment of quality services provided by healthcare providers is fundamental to ensuring client satisfaction and in the provision of providing quality family planning services to the clients.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/12/Quality-Assurance-Approach.pdf
46	MAPPING & LISTING OF SLUMS-Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To assist health officers to achieve better resourcing and planning of health services, including voluntary FP services by mapping and listing of slums to identify residents in need of services	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/mapping-urban-slums/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
47	CONVERGENCE- Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To facilitate integration of FP and other Maternal, Newborn & Child Health (MNCH) services at the community level, through coordination and integrated actions among all relevant departments.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/convergence-of-services/
48	FIXED DAY STATIC SERVICES/FAMILY PLANNING DAY- Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide specific guidance on planning effective strategies for implementation of Fixed Day Static (FDS)/FP day services for expanding access to quality FP service	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/fixe-day-static-approach/
49	URBAN ASHAs- Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To aid district health officials in strengthening the role of urban ASHAs in facilitating the utilization of voluntary FP services among marginalized and vulnerable populations in urban slums	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/enabling-social-health-activists/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technica l Areas	Locations
50	CAPACITY BUILDING-Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide guidance on implementing training for providers and staff towards improving the quality of voluntary FP services.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/strengthening-provider-capacity/
51	USING DATA-Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To help district officials in monitoring the performance of FP strategies as per the Expected Level of Achievement (ELA) by analyzing relevant indicators and thus enabling timely corrective measures to meet the FP objectives	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/utilizing-data-effectively/
52	PRIVATE SECTOR ENGAGEMENT	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide guidance on engaging the private sector under government schemes, towards providing voluntary FP services to the urban poor. The engagement include accreditation, empanelment, reimbursement for services provided & legal protection	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/engaging-the-private-sector/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
53	PROGRAM IMPLEMENTATION PLAN (PIP) - TOOL	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide guidance to district officials and NGO partners on the specific steps of planning and budgeting for FP through the annual PIP of the National Health Mission (NHM)	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/planning-and-budgeting/
54	STRENGTHENING MAHILA AROGYA SAMITIS (MASs)- Tool	Chief Medical and Health Officers (CMHO/CDMO/CMO) Nodal Officer – Urban Health and FP District Program Managers (DPMs), District Health Officers (DHOs) Assistant Research Officers (AROs) Data Entry Operators	To provide guidance on how to establish MASs, build their capacity as health advocates and develop them into self-governing institutions that work towards addressing the health and FP needs of the community.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/strengthening-womens-groups/
55	Strengthening the capacity of urban health management system by city health plans	Global, Govt, providers & internal staff	To provide a ready reckoner for developing the city-specific health plan with operational guidance for making health services available to the urban poor population by optimal use of available resources.	TCI University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/lessons/city-health-plan/ USAID DEC
56	Uttar Pradesh and Madhya Pradesh Officially Endorse Nine of TCI's Proven Approaches for All Cities	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/uttar-pradesh-and-madhya-pradesh-officially-endorse-nine-of-tcis-proven-approaches-for-all-cities/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
57	TCI's Mapping and Listing Approach Helps Indore, India, More Accurately Allocate Health Resources	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/tci-is-mapping-and-listing-approach-helps-indore-india-more-accurately-allocate-health-resources/
58	Completed ASHA Diaries Help Reach More of Agra's Eligible Couples with Family Planning Services	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/completed-asha-diaries-help-reach-more-of-agras-eligible-couples-with-family-planning-services/
59	New Family Planning Champion Addresses Myths in Indore, India, With Reliable Information and Counseling	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/new-family-planning-champion-addresses-myths-in-indore-india-with-reliable-information-and-counseling/
60	In Their Own Words: The Secret to Success in Kanpur Is to Demonstrate Quick Results	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/in-their-own-words-the-secret-to-success-in-kanpur-is-to-demonstrate-quick-results/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
61	If It's Thursday, It Must Be Family Planning Day in Uttar Pradesh's Saharanpur	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/ifs-its-thursday-it-must-be-family-planning-day-in-uttar-pradeshs-saharanpur/
62	Firozabad's Auxiliary Nurse Midwives Help Alleviate Staff Burden on FDS Days	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/firozabads-auxiliary-nurse-midwives-now-help-alleviate-staff-burden-on-fds-days/
63	Madhya Pradesh's Expanded Method Mix Brings Injectables to Urban Primary Health Centers	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/madhya-pradeshs-expanded-method-mix-brings-injectables-to-urban-primary-health-centers/
64	After Inadvertently Increasing Doctor's Workload, TCIHC Strengthens Capacity of other Facility Staff	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/after-inadvertently-increasing-doctors-workload-tcihc-strengthens-capacity-of-other-facility-staff/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
65	TCIHC Advocacy Leads to IUCD Provider Training in Uttar Pradesh UPHCs	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/tcihc-advocacy-leads-to-iucd-provider-training-in-uttar-pradesh-uphcs/
66	TCIHC-Coached ASHA Raises Awareness Among MAS of Available Family Planning Services	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/tcihc-coached-asha-raises-awareness-among-mas-of-available-family-planning-services/
67	Firozabad's Chief Medical Officer Quickly Remedies Lack of Injectables at UPHCs	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/firozabads-chief-medical-officer-quickly-remedies-lack-of-injectables-at-uphcs/
68	Simple Planning Ensures Availability of Family Planning Methods in Uttar Pradesh	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/simple-planning-ensures-availability-of-family-planning-methods-in-uttar-pradesh/
69	Ushering in a New Era of Public-Private Family Planning Partnerships in Uttar Pradesh, India	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/ushering-in-a-new-era-of-public-private-family-planning-partnerships-in-india/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technical Areas	Locations
70	TCIHC's New MIS System Shows Promising Results in India with Data for Decision-Making	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/tcihcs-new-mis-system-shows-promising-early-results-in-india-and-provides-data-for-decision-making/
71	ASHAs Provide Family Planning Counseling to Women in Gau Ghat – an Urban Slum in Allahabad	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/family-planning-services-through-ashas-reach-gau-ghat-an-urban-slum-in-allahabad/
72	Family Planning Services on a "Fixed Day" Brings Certainty to Firozabad's Urban Poor	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/providing-family-planning-services-on-a-fixed-day-brings-certainty-to-firozabads-urban-poor/
73	TCI Healthy Cities India's Program Director Shares His Story on FP Voices	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/tci-healthy-cities-indias-program-director-shares-his-story-on-fp-voices/
74	India's Challenge Initiative for Healthy Cities to Provide High-Quality Health	Global, Govt providers, service providers & internal staff	To showcase TCIHC work & learnings globally	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/indias-challenge-initiative-for-healthy-cities-to-provide-high-quality-health-services-in-urban-slums/

	Product	Audiences	Objectives	Dissemination Plan	Status March 2020	Related Technica l Areas	Locations
	Services in Urban Slums						
75	City Selection Process in India-One Pager	Global, Govt providers, service providers & internal staff	To explain how TCIHC use demand-driven approach where participating cities self-select to participate and develop simple proposals for implementing cost-effective interventions customized to their urban needs.	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/08/India-City-Selection-Process_30Aug2018.pdf
76	Coaching Model in India-One pager		To explain how to execution Coaching & Mentoring Process using bottom-up approach	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/08/India-Coaching-Model_30Aug2018.pdf
77	FPA & FPC Concept in India-One Pager		To demonstrate 'Lead-Assist-Observe' Model of Coaching by operationalizing FPA and FPCs for strengthening the frontline functionaries under TCIHC	TCI- University	Completed and posted on TCI University website	Family planning	https://tciurbanhealth.org/wp-content/uploads/2018/08/India-FPA-and-FPC-Concept_30Aug2018.pdf