India FP PY4 Summary & Results

Geographic Implementation Areas

States

- FP and Health and Wellness Centers: 13/29 (45%)
- Technical Support Unit for Adolescent Health (TSU-AH): National

Districts (in 13 states)

- FP and Health and Wellness Centers: 66/785 (8%)

Facilities (in 13 states)

- FP: 186/1,111 (17%)
- Health and Wellness Centers: 4,743 facilities, of which 1,918 are direct intervention facilities

Population

Country

- 1,210,854,977

MCSP-supported areas

- FP and Health and Wellness Centers: 84,043,483
- TSU-AH: 25,300,000 adolescents ages 10–19

Technical Areas

Program Dates

April 2017– September 2019

Cumulative Spending through End of PY4

[redacted]

Demographic and Health Indicators

Indicator	# / %
MMR (per 100,000 live births)[3]	130
IMR (per 1,000 live births)[2]	41
U5MR (per 1,000 live births)[2]	50
TFR (births per woman)[2]	2.2
CPR[2]	53.5%
CPR (modern methods) [2]	47.8%
Early marriage (women ages 20–24 married before age 18, men ages 25–29 married before age 21)[2]	26.8%, 20.3%
Teenage pregnancy (women ages 15–19 who have begun childbearing)[2]	7.9%
CPR (currently married women ages 15–19)[2]	14.9%
Unmet contraceptive need (currently married women ages 15–19)[2]	22.2%
Anemia among girls, boys (ages 15–19)[2]	54%, 29%
High blood sugar among women, men (ages 15–49, > 140 mg/dl)[2]	5.8%, 8.0%
Hypertension among women, men (ages 15–49, systolic 140–159 mmHg and/or diastolic 90–99 mmHg) (%)[2]	6.7%, 10.4%

Sources: [1] Census of India 2011, [2] NFHS-4, [3] Niti Aayog, Government of India.

Strategic Objectives

- Expand and strengthen quality provision of family planning services at current MCSP focus facilities in five states of India.
- Provide strategic technical support to the Ministry of Health and Family Welfare in planning the implementation and monitoring of new initiatives and strengthening the six strategic priority program components.
- Provide support to the Adolescent Health Division to institutionalize robust systems and mechanisms for coordination/convergence within the Ministry of Health and Family Welfare, with other government departments and ministries and with other partners in the adolescent space.
- Provide support to develop innovative approaches in the social and behavior chance communication strategy through a National Level Advocacy Youth Campaign to improve quality healthcare for young people and strengthen health systems
- Assist the intervention states in developing roadmaps, operational plans and financial proposals for operationalizing the 'Health and Wellness Centers' to ensure delivery of comprehensive primary healthcare services.
- Build the institutional capacity of intervention states to train appropriate mid-level health providers in 6-month Certificate course in Community Health through establishment and operationalization of training sites.

Key Accomplishment Highlights

- Saw a 10% increase in immediate PPFP acceptors at focus facilities as compared to program baseline, with 5.3% of women accepting either POPs (1.9%) or centchroman (3.4%). 83% of POP and 61% of centchroman acceptors were continuing the method at 6 months.
- Achieved 16% improvement in infection prevention measures, screening, and surgical procedures, and 11% improvement in quality assurance in the performance assessment score over program baseline.
- Supported in initiation of fixed day static (FDS) services for sterilization in 89% of focus facilities.
- Received 3,412 calls on the Interactive Voice Response System platform for accessing information and sharing feedback on quality and availability of FP services.
- Supported establishment of dedicated counseling corners in 87% of focus facilities, reaching 244,427 clients.
- Supported 22 states in budgeting, coordinating, and implementing for the School Health Program under *Ayushman Bharat*.
- Leveraged $46.30 million to establish Health and Wellness Centers under the National Health Mission's annual Program Implementation Plans for the Ministry of Health and Family Welfare.
- Operationalized 952 Health and Wellness Centers across 11 states and 34 Program Study Centers across 10 states.
- Oriented 750 state and district officials on primary health care.
- Trained 294 counselors from 34 Program Study Centers on community health; 1,137 midlevel health providers on primary health care protocols.

India FP

MCSP has three program areas in India: FP, adolescent health, and Health and Wellness Centers. In PY4, MCSP expanded the supply of two new contraceptive methods (POPs and centchroman), improved quality of care for FP services, engaged communities, and promoted gender sensitivity. As part of MCSP's adolescent health programming, a Technical Support Unit consisting of public health professionals formed to support the Ministry of Health and Family Welfare's Adolescent Health Division in conducting strategic planning, implementation, and monitoring of areas of the adolescent health program; including new initiatives under the umbrella of the National Adolescent Health Program (*Rashtriya Kishor Swasthya Karyakram*). India is embarking on an ambitious goal to achieve universal health coverage by upgrading 150,000 subcenters and existing primary health centers into Health and Wellness Centers under the *Ayushman Bharat* initiative, the world's largest government-funded health care program. These Health and Wellness Centers will provide services beyond the existing RMNCAH package in the remote corners of the country, ensuring that basic health care is within reach of every household. This target will be achieved through an incremental addition of midlevel health providers trained through a certificate course in community health at Program Study Centers.

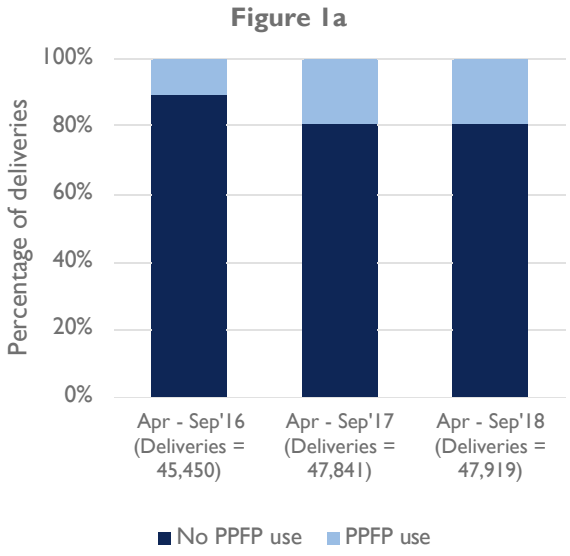
Key Accomplishments

Family Planning

Strengthening PPFP

In PY4, MCSP focused on the continued supply of POPs and centchroman at 52 focus facilities across five states (Assam, Chhattisgarh, Maharashtra, Odisha, and Telangana), increasing the number of women choosing a PPFP method 11% in April 2017 to 21% in PY4. Of the postpartum women who delivered at a focus facility (98,569), 5.3% accepted either POPs (1,881) or centchroman (3,336) in the reporting period. Continuation rate for POP at six months was 83% (1,773) while the continuation rate for centchroman at six months was 61% (976) (see Figure 2). Reasons for discontinuation included difficulty complying with the centchroman regimen, menstrual-related issues, and family reasons.

Figure 1. (a) Postpartum women who accepted a PPFP method at an MCSP focus facility and (b) PPFP method choice among women who delivered in an MCSP focus facility



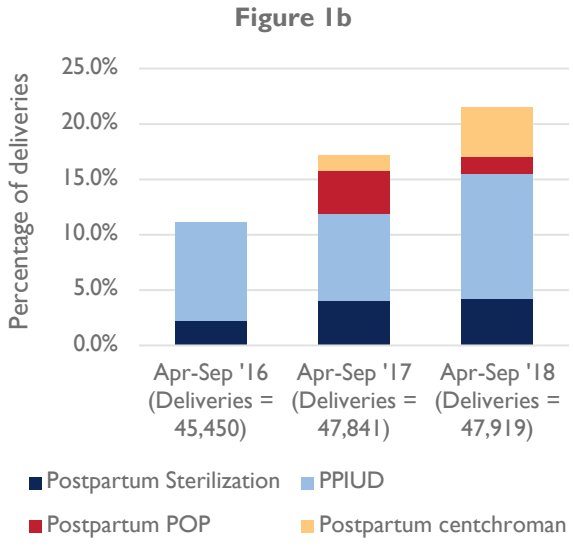
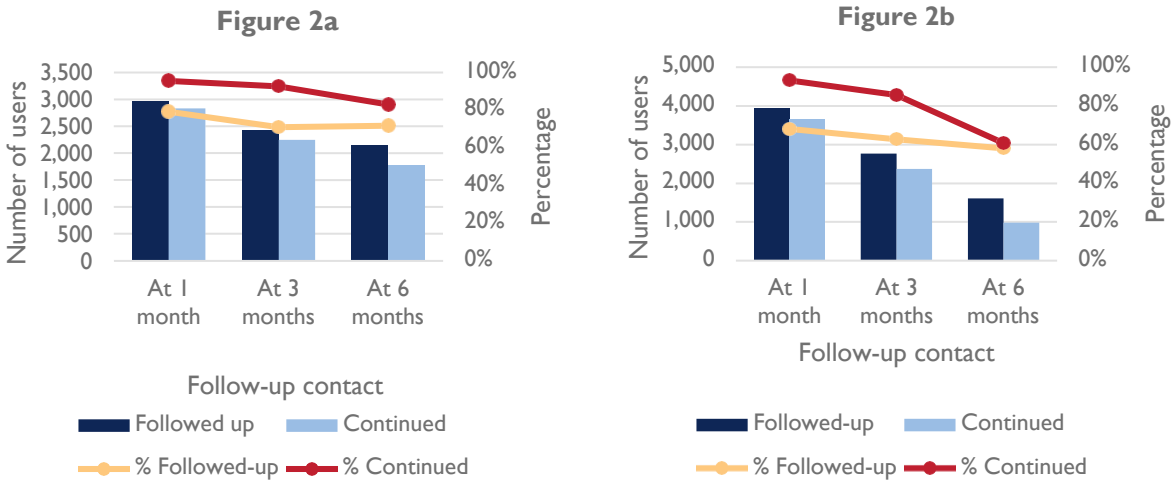


Figure 2. Continued use of chosen PPFP method reported during follow-up contact: (a) POP users and (b) centchroman users



FDS Strategy Improvement

MCSP strengthened the FDS[4] approach and service assurance at 135 facilities. During PY4, 6,272 FDS days were planned across the 135 facilities, and frontline workers preregistered 16,147 clients on 3,058 of the FDS days. Of the 14,837 clients who arrived for services on their designated days, 97% (14,388) received services.

Institutionalization of Quality FP Service Provision

Through regular facility assessment, technical support, and advocacy, MCSP has improved infrastructure, enhanced basic amenities, and strengthened existing systems at the focus facilities. As of September 2018, the fourth quarterly assessments showcase an 18% improvement over baseline; a 13% increase in FP and method-specific counseling; a 16% in infection prevention measures, screening, and surgical procedures; a 13% in client follow-up; and an 11% in quality assurance and mechanism for reporting and recording. To strengthen quality assurance at the facility level, MCSP also supported the formation of Quality Circles at 98% (182) of the focus facilities, with 75% of facilities holding a Quality Circle meeting two or more times in PY4. Twenty-three meetings were held across 14 districts, leading to mobilization of resources for strengthening infrastructure (renovation of operation theaters, procurement of equipment for theaters), regular tracking of empaneled providers, improved availability of essential commodities and logistics, and better monitoring of facility improvement plans.

Development of an Interactive Voice Response System

A mobile technology-based Interactive Voice Response System platform, *Parivar Swathya Vaani*, was developed and rolled out in Chhattisgarh and Odisha in PY4. Clients and communities use this platform to receive vital information on FP, share feedback on quality of services provisioned at project FDS facilities, and strengthen processes for FDS services by offering preregistration for services. In Chhattisgarh, an Interactive Voice Response System was integrated within the state-owned toll-free health service helpline. At the end of PY4, the platform had received 3,412 calls, of which 1,428 accessed FP information, 552 provided feedback on the quality of FP service delivery, and 785 preregistered clients to receive FP services per the facility's FDS calendar across 130 facilities.

Community Participation Improvement

To address barriers to community participation, MCSP, with the support of the Centre for Catalyzing Change, is working to activate, strengthen, and ensure regular meetings of community-based platforms, such

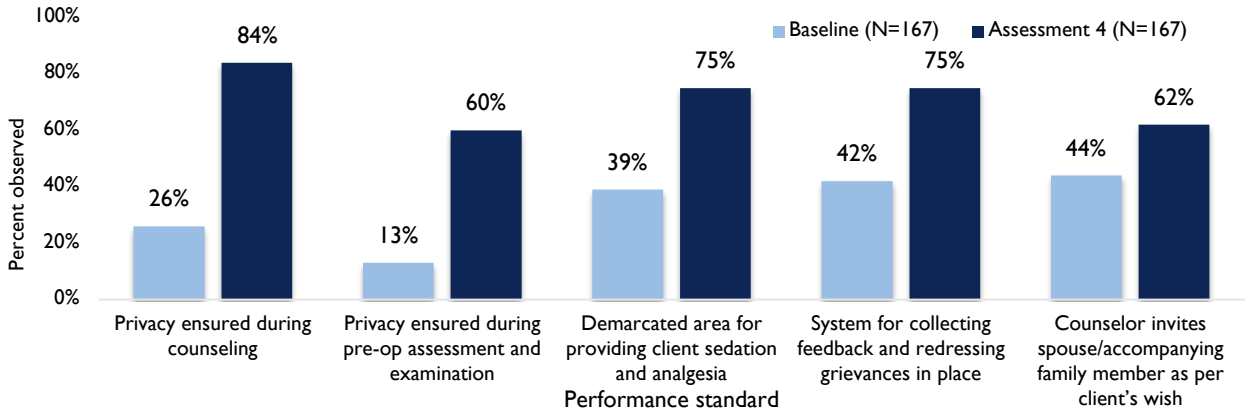
[4] The FDS approach in sterilization services is defined as "providing sterilization services in a health facility by trained providers posted in the same facility, on fixed days, throughout the year on a regular routine manner."

as *Rogi Kalyan Samitis* (patient welfare committees), at community health centers and district hospitals. During the reporting year, 1,253 *Rogi Kalyan Samitis* members were trained and 256 *Rogi Kalyan Samitis* meetings were held. These meetings provided a platform for discussion of issues such as the performance of the Interactive Voice Response System and feedback received through it, leading to identification and correction of gaps in quality and respectful care in FP.

Promotion of Gender Sensitivity and Respectful Care in FP Services

MCSP, through the Centre for Catalyzing Change, built the capacity of 2,157 facility-based service providers and 20,489 frontline workers on gender, social inclusion, and respectful care. The fourth quarterly assessment (see Figure 3) indicated an overall improvement in the quality of FP service delivery regarding counseling and strengthened existing health systems for better interactions with women and the community.

Figure 3. Improvement in FP services at facilities in terms of respectful care as observed during quarterly assessments



Adolescent Health

Support to the National and State Government in Effective Implementation of the National Adolescent Health Program

MCSP, through the TSU-AH, facilitated a National Adolescent Health Program review meeting with the Ministry of Health and Family Welfare in October 2017, which fed into the revised National Adolescent Health Program operational guidelines. In March 2018, MCSP conducted a national-level experience-sharing and learning workshop with government, donors, experts, and leading nongovernmental organization partners working with adolescents. The workshop aimed to share experiences, best practices, and perspectives to strengthen the implementation of the National Adolescent Health Program. MCSP supported the Ministry of Health and Family Welfare to develop the revised National Adolescent Health Program operational guidelines. These revisions, released by the WHO in July 2018, showcase an amendment in existing supportive supervision checklist for adolescent-friendly health clinics.

Coordination and Convergence between Ministries and Other Agencies

The TSU-AH strengthened convergence between the Adolescent Health Division of the Ministry of Health and Family Welfare and Ministry of Human Resource Development to implement the School Health Program. It also facilitated establishment of Technical Resource Group to develop the curriculum with support from National Council of Educational Research and Training, UNFPA, and other partners.

Operationalization of the School Health Program

TSU-AH developed the operational guidelines for the School Health Program under *Ayushman Bharat* and the Honorable Prime Minister Shri. released the guidelines on April 14, 2018. Under the guidance of the Ministry of Health and Family Welfare and the Ministry of Human Resource Development, the National Council of

Educational Research and Training and the TSU-AH are now working with the Technical Resource Group to develop a curriculum on health, wellness, and life skills for school-going children.

Development of Technical Documents and Advocacy Materials

TSU-AH supported the Ministry of Health and Family Welfare in developing various documents and advocacy materials. These efforts included:

- Development of a technical update on menstrual hygiene management in India, covering topics related to sanitary protection materials, disposal, and menstrual waste management.
- Creation of advocacy materials for the National Adolescent Health Program and School Health Program.
- Planning for the inaugural release of the quarterly e-newsletter *Kishor Vaani* during the PMNCH Partners Forum, December 2018 in New Delhi. The newsletter highlights state initiatives for implementing the National Adolescent Health Program and shares periodic updates on program progress.
- Advocating with the Ministry of Health and Family Welfare to integrate dashboards into the regular monitoring of the National Adolescent Health Program at the state level.

Health and Wellness Centers

Funds for Establishment of Health and Wellness Centers and Training Ecosystems

In PY4, MCSP leveraged government funds to establish Health and Wellness Centers and training ecosystems under the National Health Mission's annual Program Implementation Plans amounting to USD 46.30 million from 11 state governments after a catalytic investment of USD 2.9 million. Within a 10-month span, MCSP leveraged funds at a ratio of 1:16 through in-country government resources.

Creation of Institutional Mechanisms at State and District Levels

MCSP has been instrumental in advocating for and establishing institutional mechanisms, such as steering committees and task forces at state and district levels, and responsible for reviewing program implementation, monitoring progress, and ensuring timely corrective action. State Health and Wellness Center steering committees have been established in four states and 25 district-level task forces have been created in Chhattisgarh and Madhya Pradesh. These groups will be critical to ensure long-term quality and sustainability.

Technical Assistance for Health and Wellness Center Operations in Intervention States

During the year, MCSP supported intervention states in identifying 4,743 health facilities to be upgraded to Health and Wellness Centers. Currently, 952 Health and Wellness Centers are operational across the intervention states. The inauguration of these centers took place by eminent local leaders and state and district officials. MCSP also supported the state of Chhattisgarh in establishing three model Health and Wellness Centers to promote cross learning. Before operationalization of Health and Wellness Centers, MCSP conducted a gap analysis, developed state-specific road maps, and conducted orientation workshops for 750 state- and district-level officials on primary health care. MCSP also provided capacity-building of 1,304 medical officers and staff nurses, along with 10,214 frontline health workers on the management of noncommunicable diseases.

Creation of Training Ecosystem for Training Midlevel Health Providers

MCSP provided support to operationalize 34 Program Study Centers in 10 states where 1,137 midlevel health providers are undergoing training on primary health care protocols, including identification of Program Study Centers, submission of proposals, disbursement of funds, and candidate recruitment.

MCSP developed the comprehensive learning resource package (LRP) that standardized training sessions under the certificate course in community health. MCSP also developed a facilitator's guide, along with

comprehensive presentations for all modules, and a repository of existing training tools across different thematic areas to support the Program Study Center academic counselors and in-charges for the certificate course. This package, together with the certificate course in community health, was used for a training of trainers of 294 academic counselors and Program Study Center in-charges in eight states.

MCSP conducted mentoring and quality assurance visits across the operational Program Study Centers in Chhattisgarh, Jharkhand, Madhya Pradesh, Meghalaya, Nagaland, and Odisha. Mentoring and quality assurance visits played a key role in midcourse corrections and in bringing the desired quality to the trainings.

Way Forward

Family Planning

In the coming year, MCSP will focus on strengthening and expanding the basket of FP services at MCSP focus facilities to initiate provision of all FP services. The project will focus on improving quality of FP counseling services at MCSP focus facilities as well as strengthening contraceptive security and availability. MCSP will support the implementation of the Government of India's FP logistics management information system by advocating for capacity-building of service providers. Further, MCSP will work to strengthen the FDS strategy through increased use of the Interactive Voice Response System for preregistration and strengthened follow-up with clients. Efforts will be made to mobilize additional funds (through funds budgeted for the State Program Implementation Plan and fund available locally) to address the gaps identified during the quarterly assessments in the provision of quality FP services, such as logistics and infrastructure.

To build sustainability for the various QI and quality assurance tools, MCSP will explore opportunities for their integration with the recently implemented LaQshya QI initiative, a USAID-funded and government-led program. With quality at the center of service delivery at public health facilities, LaQshya addresses many of the processes that MCSP has been working to improve. One such area is services around the operation theater complex. With the India Mission's guidance, MCSP will work with the national government to include several of the QI processes and practices that are part of the project's existing service delivery standards.

Adolescent Health

TSU-AH will continue to focus on fostering convergence with the ministries and will work closely with the Ministry of Human Resource Development and Ministry of Tribal Affairs to implement the School Health Program. Further, the TSU-AH will explore partnerships with other ministries for community-based interventions.

A national youth campaign is underway with the support of the Centre for Catalyzing Change, aiming to understand the needs of the youth to support quality health care delivery. MCSP is working on the development of state-level program monitoring dashboards, based on previously developed national-level dashboards.

Other activities underway for MCSP include production of an advocacy film on the School Health Program under *Ayushman Bharat*, a national-level training of master trainers on the finalization of school health curricula, and job aids for counselors and peer educators for effective counseling.

Health and Wellness Centers

MCSP will support all intervention states in operationalizing 4,743 Health and Wellness Centers and 51 Program Study Centers to bring the delivery of comprehensive primary health services closer to people's homes. In addition, MCSP will work to demonstrate innovative models of service delivery and community mobilization to ensure quality service delivery of comprehensive primary health care across health sectors.

Selected Performance Indicators for PY4		
MCSP Global or Country PMP Indicators		**Achievement**
Family Planning		
Percentage of demonstration sites from which at least five providers trained in service provision of the two newer contraceptive methods (POP and centchroman)		79% (target: 80%, 99% achieved)
Percentage of demonstration sites with a dedicated FP counseling area		87% (target: 70%, >100% achieved)
Percentage of demonstration sites having at least one provider trained in FP counseling, including counseling skill on the two newer methods (POP and centchroman)		88% (target: 80%, >100% achieved)
Percentage of delivery clients who have accepted POP before discharge from the facility		2.6%
Percentage of delivery clients who have accepted centchroman before discharge from the facility		2.7%
Percentage of POP acceptors continuing to use POP, over the specified follow-up intervals	First follow-up	79%
	Second follow-up	71%
	Third follow-up	72%
Percentage of centchroman acceptors continuing to use centchroman, over the specified follow-up intervals	First follow-up	68%
	Second follow-up	63%
	Third follow-up	58%
Percentage of facilities having FDS services for sterilization where Quality Circle started monitoring sterilization services		89% (target: 60%, >100% achieved)
Percentage of PPFP (postpartum services/postpartum intrauterine device/POP/centchroman) acceptors counseled during the antenatal period		68%
Number of people trained through US Government-supported programs		26,848
Number of facility-based providers and community-based workers trained on gender		24,769
Couple-years protection in MCSP-supported areas		4,70,060
TSU-AH		
National-level Technical Action Group for National Adolescent Health Program formed and functional		Two national-level technical action group meetings conducted
National-level stakeholders review/dissemination meeting convened		Experience-sharing and learning workshop with various stakeholders was conducted on March 22–23, 2018
State Program Implementation Plans reviewed and approved for all National Adolescent Health Program activities		Reviewed record of proceedings (2018–2019) of 100% states/Union Territories (36 states)
A dashboard of adolescent indicators developed		Prepared and shared with the Ministry of Health and Family Welfare for inputs
Number of states that have budgeted for initiative under School Health Program under Ayushman Bharat		Approval of budget allocation for School Health Program under Ayushman Bharat in Record of Proceeding. Out of 36 states, 22 states have allocated budgets.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	**Achievement**
Health and Wellness Centers	
Amount of National Health Mission/state government funds leveraged for establishment of Health and Wellness Centers	USD 46.3 million
Number of guidelines/models/layouts/conceptual and policy frameworks developed for establishment and operationalization of Health and Wellness Centers	2 (target: 1, >100% achieved)
State-specific road maps and operational plans for upgradation of subcenters/primary health centers/urban primary health centers (UPHCs) to Health and Wellness Centers developed	10 (target: 6, >100% achieved)
Proportion of targeted (direct intervention) subcenters/primary health centers/UPHCs where process of upgradation to Health and Wellness Centers has been initiated (n=1,918)	618 (target: 384, >100% achieved)
Number of innovative approaches developed for Health and Wellness Centers	1 (target: 1, >100% achieved)
Number of training institutions established to initiate the 6-month certificate course in community health	34 (target: 15, >100% achieved)
Number of health care workers that completed an in-service training program (6-month certificate course) within the reporting period with US Government support	294 counselors, 1,137 midlevel health providers (target: 100 counselors, 450 midlevel health providers, >100% achieved)
Number of innovative approaches/strategies developed for training of midlevel health care providers	1 (target: 1, 100% achieved)

India Healthy Cities PY4 Summary & Results

Geographic Implementation Areas

States

- 3/29—Madhya Pradesh, Uttar Pradesh, Odisha

Cities

- 20/75 cities in Uttar Pradesh
- 8/47 cities in Madhya Pradesh
- 3/36 cities in Odisha

Population

Country

- 1,210,000,000

MCSP-supported areas

- 321,270,000

Technical Areas

Program Dates

March 2016–June 2019

Cumulative Spending through End of PY4

[redacted]

Demographic and Health Indicators

Indicator	# or %
Live births/year[1]	25,427,955
MMR (per 100,000 live births)[2]	167
NMR (per 1,000 live births)[2]	28
U5MR (per 1,000 live births)[2]	49
TFR (births per woman)[2]	2.3
CPR (modern methods)[3]	47.1%
ANC 4+[4]	45.4%

Sources: [1] 2011 Census of India; [2] Office of RGI, SRS (2011–13), Census of India, New Delhi; [3] Government of India Ministry of Health and Family Welfare, DLHS 3, 2007–8; [4] RSOC 2013–14.

Strategic Objectives

- Assist cities and nongovernmental organization partners to implement urban best practice interventions on a demand-driven basis through The Challenge Initiative for Healthy Cities (TCIHC)'s three-stage model.
- Increase urban poor's access to and demand for quality FP and MNH products and services.
- Create an enabling environment and health systems improvements that support the sustained delivery and use of a quality package of reproductive, maternal, and newborn health services for the urban poor.

Key Accomplishment Highlights

- TCIHC drove the systematic scale-up of the program from 12 cities in the previous quarter to 31 cities in three states during the reporting period.
- Across three states and 31 implementing cities, 86% (435/507) of UPHCs have started providing FDS services for FP.
- 335,782 clients accepted an FP method across the three states.
- The Government of Madhya Pradesh plans to introduce the TCIHC-developed UPHC readiness assessment in 44 cities and 66 urban local bodies in the state, including many non-TCIHC-assisted cities.
- The city of Indore began scaling up a formal referral mechanism from community to UPHC and higher-level health facilities; 1,530 high-risk pregnant women and high-risk newborns were referred from the community level between December 2017 and October 2018.
- TCIHC implemented adolescent and youth sexual and reproductive health (AYSRH) interventions in five cities in Uttar Pradesh, with supplemental funding approved by the Bill & Melinda Gates Foundation.

India The Challenge Initiative for Healthy Cities

TCIHC provides technical assistance and implementation support to activate the National Urban Health Mission's service delivery model in 31 cities across three states: Uttar Pradesh, Madhya Pradesh, and Odisha. To reduce preventable maternal and newborn deaths among the urban poor, the initiative mobilizes public-sector service delivery points and links them to the private sector to strengthen city-level health systems and improve access to and demand for FP and MNH information, products, and services. TCIHC helps raise awareness and increase demand for these services through community outreach, support for QI, and behavior change campaigns.

TCIHC is funded jointly by USAID, through MCSP and the Bill & Melinda Gates Foundation via The Challenge Initiative at the Johns Hopkins University Gates Institute. The initiative aims to reach over 6,000 accredited social health activists (ASHAs) and auxiliary nurse-midwives, and to provide 600,000 women every year with informed choice FP counseling and referral services for RMNCAH. Through advocacy at the state and national levels, TCIHC secures buy-in, leverages financial and human resources, and works to ensure continuity and sustainability in the funding and functionality of city health systems and their capacity to meet the needs of the urban poor.

Key Accomplishments

Rapid Scale-Up

TCIHC saw a dramatic expansion of the program in PY4. MCSP hired state- and city-level staff, finalized a joint life-of-program work plan and budget, completed expansion from 12 to 31 cities, and initiated facility and community programming in "ready to start" UPHCs and their surrounding communities. With TCIHC management support, 30 of the 31 cities had started implementation of various high-impact approaches by the end of the PY. More than 80% of all assisted UPHCs started conducting regular FDS services for FP. UPHC readiness assessments were conducted in 76 targeted health facilities in Madhya Pradesh and Odisha. 28 of the 31 cities established urban health coordinating committees, and two demonstration cities in Madhya Pradesh adapted and introduced a formal system for RMNCAH referral from community to higher-level health facilities.

Uttar Pradesh approved a pilot in five districts where urban ASHAs are permitted and incentivized for the first time to refer FP clients to public and private health providers. Officials from Odisha and Madhya Pradesh observed and started work to adopt the successful approach to strategic government purchasing of private-sector FP services demonstrated by PSI in Uttar Pradesh. Finally, TCIHC's ambitious monitoring, evaluation, and knowledge management systems were developed, and baseline surveys and initial data analysis were completed during this first full year of TCIHC implementation. All progress is a result of TCIHC's commitment to mobilizing existing Government of India systems and health providers through an intensive coaching and mentoring approach.

Government Ownership and Support

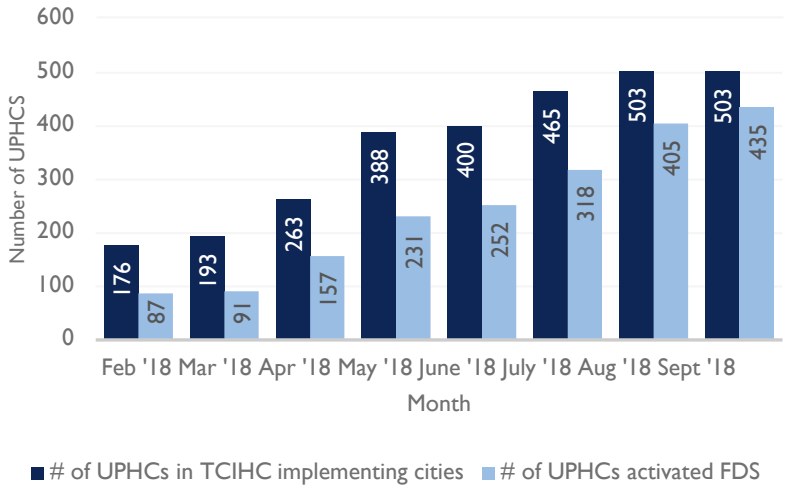
TCIHC was deeply engaged in the annual government planning process and successfully leveraged and/or unlocked the equivalent of USD 13.7 million of Government of India funding for the implementation and expansion of the activities described below. TCIHC signed agreements with the governments of Uttar Pradesh and Odisha, defining the roles of each in the initiative's activities and demonstrating government buy-in to the TCIHC model. TCIHC also supported the National Urban Health Mission to prioritize FP and MNH within its platform by capitalizing on its facility- and community-based service delivery model to implement high-impact approaches, covering 100% of slum populations in TCIHC-supported cities. The states have announced plans to replicate several of the high-impact approaches that TCIHC promotes, and they have committed their own resources to do this beyond the 31 cities that currently receive TCIHC's support. During the reporting period, all three states issued guidelines for city-level coordination mechanisms (called city coordination committees), urban health coordination committees, and urban health advisory committees, depending on the location. Twelve cities in Uttar Pradesh, six in Madhya Pradesh, and three in

Odisha initiated quarterly coordination meetings. TCIHC supported the states to draft these guidelines and set the agenda for coordination meetings.

Expanding FP Services for the Urban Poor

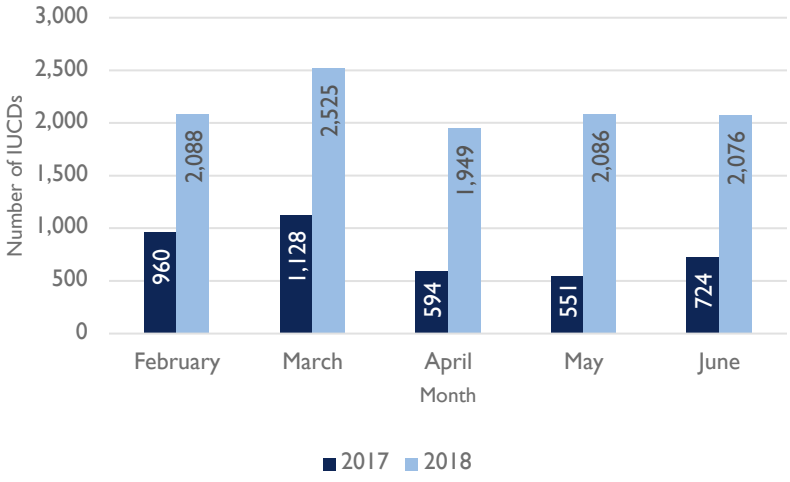
FDS FP services: FDS is a proven, high-impact approach. It requires that trained staff, equipment, supplies, and commodities be made available on preannounced days and times at UPHCs and some higher-level health facilities. From February 2018, when reporting began in the first five TCIHC-assisted cities in Uttar Pradesh, through August 2018, TCIHC helped to activate regular FDS in 30 cities and 405 UPHCs, and the three states combined conducted 5,637 FDS events. By the end of the program year, 87% (439 of 503) of UPHCs in 31 implementing cities had started holding FDS and 67% were organizing a weekly event. TCIHC is encouraged that the state of Odisha has announced plans to expand FDS to all of its cities in 2019.

Figure 1. Activated urban primary health centers (UPHCs) providing fixed day static (FDS) services



Source: Project management information system.

Figure 2. Intrauterine contraceptive device uptake in urban primary health centers in first five cities of Uttar Pradesh



Source: India HMIS 2017 and 2018.

Long-acting reversible contraception methods: TCIHC's advocacy, support for government-managed capacity-building activities, and promotion of regular FDS events resulted in increased task-shifting and expanded the urban poor population's access to long-acting reversible contraception methods. As a result, 71% of the TCIHC-assisted UPHCs in 31 cities now provide intrauterine contraceptive device services, and 79% are either providing injectables, intrauterine contraceptive devices, or both. The Government of India's HMIS showed a 140% increase in intrauterine contraceptive device uptake in TCIHC's first five cities alone between January and June 2018.

Community outreach: While FDS events made short- and long-term methods more accessible at UPHCs, TCIHC also supported the integration of FP and short-term methods during standing community events, including outreach camps and urban health and nutrition days. In PY4, TCIHC supported the integration of

FP in 811 outreach camps and 34,417 urban health and nutrition days, where antenatal/postnatal, well-child, and immunization services were also provided.

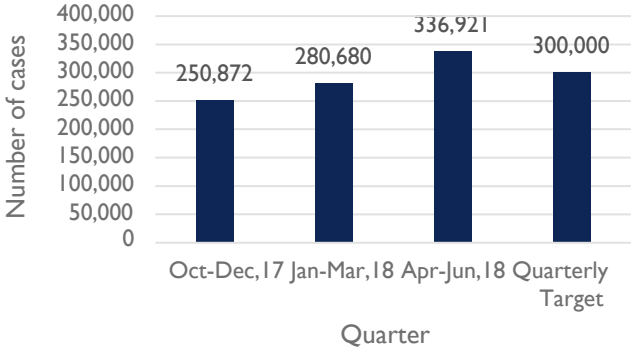
Combined FP results: The number of reported FP acceptors increased by 32% in TCIHC's first 12 cities when comparing HMIS results from July to September 2018 to those for the same quarter in 2017. From February–September 2018, 335,782 clients were reported to have accepted an FP method during FDS services, outreach camps, and urban health and nutrition days from 30 TCIHC-supported cities. This does not include FP services provided at district hospitals, which also added to the number of referrals for higher-order RMNCH services.

Strengthening MNH Services (Madhya Pradesh and Odisha)

Side by side with its work to accelerate the uptake of high-impact FP approaches in Madhya Pradesh and Odisha, TCIHC provided technical assistance to the two states' governments to ensure the readiness of their respective UPHCs and referral health facilities to deliver quality MNH services.[5]

UPHC readiness assessments: From October 2017–June 2018, there were 868,473 outpatient visits to UPHCs and civil dispensaries in the 11 cities where TCIHC works in Madhya Pradesh and Odisha. TCIHC's support in PY4 included conducting mappings and generating recommendations on the definition of catchment areas and locations of UPHCs, developing tools for and implementing UPHC readiness assessments, advocating for improvements based on the findings of the assessments, and coaching UPHC medical and nursing staff.

Figure 3. Number of OPD Cases at UPHCs, by quarter, 11 cities



TCIHC completed two rounds of readiness assessments in PY4 in Madhya Pradesh and Odisha, with 76 UPHCs participating. The average UPHC score was 59.6 out of 100 points at baseline in July 2017 and 61.5 at the time of the second round in March 2018. As readiness assessments are a relatively new concept, the state governments recognize that there is still much to be done to improve UPHC readiness and performance. Recommendations from the readiness assessments led to the issuance of government orders in both states to improve the relevant dimensions of readiness at UPHCs. The Government of Odisha also mobilized USD 150,000 from existing public funds to purchase equipment for its UPHCs. The Government of Madhya Pradesh plans to introduce the TCIHC-developed UPHC readiness assessment to 44 cities (66 urban local bodies) in the state, most of which are non-TCIHC-assisted cities.

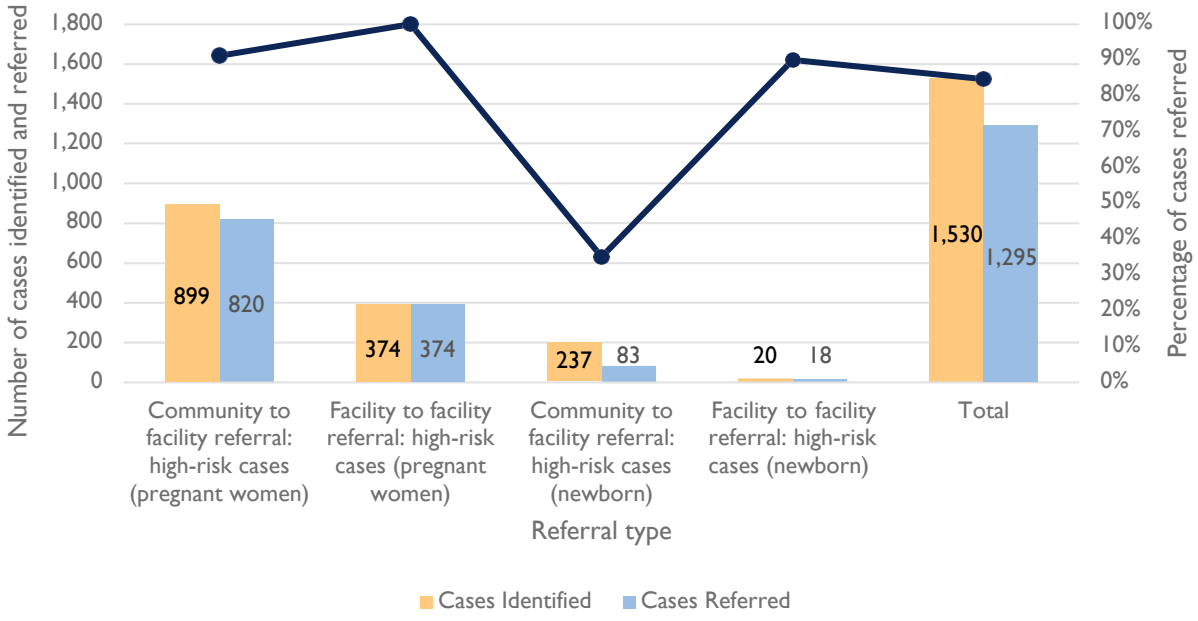
Referral mechanism introduced to improve quality and continuity of care: In two cities of Madhya Pradesh—Indore and Gwalior—TCIHC provides technical assistance to local government bodies and public health facilities to strengthen referral for MNCH and FP services. This has included facilitating learning visits for city officials to Pune to see the referral mechanism supported through Save the Children's Saving Newborn Lives program, establishing city-level technical committees on referral, conducting advocacy to formally link ASHAs and auxiliary nurse-midwives with UPHCs, and developing and rolling out referral slips and protocols. By the end of PY4, 477 providers had been trained on referral; about 75% (n=360) were ASHAs, auxiliary nurse-midwives, or *Anganwadi* workers, and the rest were medical officers, senior nurses, and others. TCIHC also developed a mobile phone-based information and tracking system as part of this referral intervention.

[5] MNH data source is the Government of India's HMIS. HMIS data are available from October 2017 to June 2018. To fully reflect MCSP's PY, the statistics reported in this summary will have to be updated once the HMIS data set is up-to-date.

Introduced in Indore in December 2017, the referral mechanism is now operational in all four zones of the city. It was also launched in Gwalior in June 2018 and is slated for introduction in Berhampur, Odisha, in PY5. The referral management information system identified 1,530 high-risk pregnant women and high-risk newborns who were referred at both the community and facility level between December 2017 and October 2018. Around 75% of these referrals originated at the community level and were made by ASHAs, auxiliary nurse-midwives, or *Anganwadi* workers, who referred 91% of identified high-risk pregnant women and 35% of identified high-risk newborns to a facility. Of community-level referrals, half of the high-risk pregnant women were referred directly to a secondary facility, and all high-risk newborns were referred to UPHCs. At the facility level, 100% of identified high-risk pregnant women and 90% of identified high-risk newborns were referred to either a secondary or tertiary health facility. The management information system indicates that UPHCs referred more high-risk/complicated pregnancies (6% to 21%) to higher-level facilities since the start of TCIHC.

The Government of Madhya Pradesh expressed great enthusiasm for this work and budgeted approximately USD 103,000 through the annual state program implementation planning process to expand the referral mechanism to additional cities in 2019, including several that are not currently receiving TCIHC support.

Figure 3. Identification and referral of high-risk cases (pregnant and newborn) by community and facilities, December 2017–October 2018



Improving MNH service quality in secondary-level facilities: TCIHC engaged in advocacy and provided technical assistance to strengthen MNH services at six secondary-level facilities in Indore and Gwalior in Madhya Pradesh and Berhampur and Puri in Odisha. This has catalyzed the improvement or renovation of key health facilities in Madhya Pradesh, including the establishment or expansion of maternity wings. TCIHC also collaborated with the child health division of the Government of Madhya Pradesh to design integrated pediatric units in certain higher-level facilities. These units will increase the provision of high-quality newborn and pediatric services while increasing linkages between specialized units and ancillary pediatric services, and maximizing human and financial resources through the greater integration of these services. From October 2017–June 2018, 6,270 pregnant women delivered at six secondary-level public facilities or maternity homes in the three TCIHC-supported cities in Madhya Pradesh and Odisha; 42% of these women received oxytocin during the third stage of labor, and 75% of newborns received vitamin K. These numbers have increased since the beginning of the project, when they were 36% and 50%, respectively.

Addition of AYSRH to TCIHC

A supplemental grant was received by TCIHC from the Gates Institute to add AYSRH services in five TCIHC cities in Uttar Pradesh to increase the availability of FP services for young and first-time parents. AYSRH interventions started in Allahabad, Firozabad, Gorakhpur, Saharanpur, and Varanasi, with a focus on first-time parents. TCIHC started by coaching and mentoring ASHAs to prioritize household visits to younger women and first-time parents who are not already using a modern contraceptive method. Additional staff and consultants were hired in all five cities and at state level to conduct special FDS services for first-time parents at UPHCs. AYSRH interventions also focus on supporting the government to establish adolescent-friendly UPHCs and conduct whole-site training for UPHCs, keeping adolescent and first-time parents in mind. The TCIHC team is working closely with the Government of India's National Adolescent Health Program (*Rashtriya Kishor Swasthya Karkram*) to ensure government resources are leveraged for adolescent and youth services, a political nonstarter in urban India in the past. Although USAID is not directly funding TCIHC's AYSRH activities in Uttar Pradesh, those activities were developed and added to the existing TCIHC "classic" work plan and platform that USAID does support.

Way Forward

In this last year of MCSP's involvement, TCIHC will continue to work to increase access to quality FP and MNH services, expanding services and contraceptive choices provided by both public and private facilities and in the community. This will be done through ASHA coaching and mentoring by TCIHC's field program assistants and field program coordinators, and through the rollout of social and behavior change communications tools, including counseling tools, with support from the state governments and National Urban Health Mission/National Health Mission program implementation planning funding. TCIHC will continue working to introduce and refine the community-to-health facility and health facility-to-health facility referral and counterreferral mechanisms in Indore, Gwalior, and Berhampur, and to improve the quality of referral care provided by their secondary- and tertiary-level health facilities. The newest TCIHC component, AYSRH, will get underway on the classic TCIHC platform in five cities in Uttar Pradesh.

TCIHC advocacy efforts will continue to focus on securing state- and national-level endorsement for key approaches and learning, fostering the state and national government's continued engagement and ownership of the high-impact approaches promoted by TCIHC, and intensifying efforts to improve the quality and use of available FP and MNH data at city level. Odisha's plan to expand FDS services to all of its cities and Madhya Pradesh's recently announced expansion of UPHC readiness assessments and the referral mechanism beyond TCIHC-supported cities demonstrate accelerated uptake and commitment by the states to continuing the expansion of TCIHC-promoted high-impact interventions. This is a positive indication that TCIHC is playing the desired role of a demand-driven accelerator hub and furthering local uptake and sustainability.

MCSP's support to TCIHC will end by June 30, 2019. MCSP's responsibilities for the 31 city and three state governments that currently receive TCIHC support will be transitioned before that date to Gates Institute/The Challenge Initiative and/or other USAID mechanisms to be determined. Intensive planning for this transition will begin January 1, 2019.

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	**Achievement**
Number and proportion of public health facilities conducting FDS for FP services	87% (439/503) of UPHCs in 31 cities (target: 400 UPHCs [80%], >100% achieved)
Number of people benefited/reached through FP services using existing service delivery model (FDS, urban health and nutrition days, outreach camps)	335,782 FP acceptors from Feb-Sep 2018 (target: 150,000, >100% achieved)

Selected Performance Indicators for PY4	
MCSP Global or Country PMP Indicators	**Achievement**
Proportion of referred cases pertaining to high-risk/complication pregnancy from UPHC/lower to higher level of facilities	At facility level: 100% (target: 20%, >100% achieved) At community level: 91% (target: 10%, >100% achieved)
Number of TCIHC-supported cities establishing urban health advisory committees/city coordination committees/other coordination units	12 cities in Uttar Pradesh, 6 in Madhya Pradesh, and 3 in Odisha (target: 31, 68% achieved)