India Family Planning EOP Summary & Results

Geographic Implementation Areas

National (adolescent health)

States (FP and Health and Wellness Centers)

- 14/29 (48%)—Arunachal Pradesh, Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Sikkim, Telangana, Tripura

Districts (FP and Health and Wellness Centers)

- 73/785 (9% of the 14 states)

Facilities

- FP: 191/1,111 (17% of the 14 states)
- Health and Wellness Centers: 4,864 (1,607 direct intervention facilities)

Population

Country

- 1.21 billion

MCSP-supported areas

- FP and Health and Wellness Centers: 85.6 million
- Adolescent health: 25.3 million adolescents

Technical Areas

Program Dates

March 1, 2015–September 30, 2019

Total Funding through Life of Project

$12,797,822

Demographic and Health Indicators

Indicator	# or %
MMR (per 100,000 live births)[2]	130
IMR (per 1,000 live births)[1]	41
TFR[1]	2.2
CPR (currently married women ages 15–19)[1]	14.9%
CPR (modern)[1]	47.8%
Teenage pregnancy (women ages 15–19)[1]	7.9%
Unmet contraceptive need (currently married women ages 15–19)[1]	22.2%
Anemia among girls, boys (ages 15–19)[1]	54%, 29%
High blood sugar among women, men[1]	5.8%, 8.0%
Hypertension among women, men[1]	6.7%, 10.4%

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

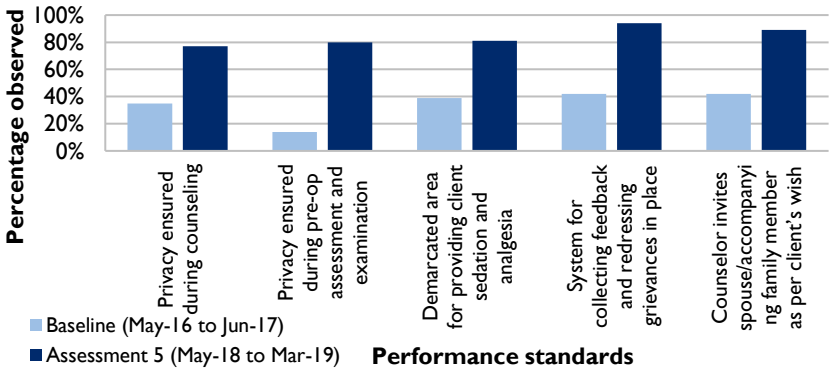
Strategic Objectives through the Life of Project

- Promote expansion of the basket of contraceptives by advocating for and demonstrating inclusion of approved modern methods.
- Strengthen quality of FP services in the public health system through improved clinical governance and other innovative processes and systems, and advocate for scale-up to other states.
- Support the Ministry of Health and Family Welfare in strengthening interventions under the National Adolescent Health Program, and institutionalize monitoring and reporting systems for convergence with other government departments and partners.
- Assist intervention states to develop roadmaps, operational plans, and financial proposals for operationalizing Health and Wellness Centers to deliver comprehensive primary care services.
- Build the capacity of intervention states to train community health officers in the 6-month certificate course in community health through establishment and operationalization of training sites.

Highlights through the Life of Project

- Increased immediate voluntary PPFP acceptors at focus facilities by 12%.
- Raised FP service assessment score by 42% and supported establishment of counseling corners at 90% of focus facilities, reaching 506,061 clients.
- Developed and implemented revised guidelines for the National Adolescent Health Program and national School Health Program.
- Operationalized 1,607 Health and Wellness Centers across 12 states and 48 training sites across 11 states.

Figure 1. Improvement in observed FP service delivery in terms of respectful care in 186 MCSP-support facilities



India—Family Planning

Background

India was the first country to launch a national FP program more than half a century ago. To increase access to voluntary FP services and respond to unmet need, the program has adopted several strategic approaches. However, couples in India continue to have significant unmet need for FP (12.9%), for both limiting family size (7.2%) and spacing births (5.7%).[20] Given the increased demand for reproductive health services in India, the quality of care for these services requires more attention. The Government of India devised strategies to accelerate progress of its FP program, realizing the urgent need to revitalize and energize programmatic efforts. As a key partner in these efforts, MCSP's initial focus was on expanding access to high-quality FP services and contributing to India's Family Planning 2020 commitments by promoting the expansion of the basket of contraceptives by advocating for the inclusion of more proven modern contraceptive options. Subsequently, other components based on Government of India priorities were added, including adolescent health programming (aligning with the National Adolescent Health Program [*Rashtriya Kishor Swasthya Karyakram*]) and Health and Wellness Centers (aimed at achieving universal health coverage by upgrading 150,000 subcenters and existing primary health centers into Health and Wellness Centers by 2020 under the Ayushman Bharat initiative, the world's largest government-funded health care program).

Key Accomplishments

Expanded FP Basket in Public Health Facilities and Strengthened PPFP

MCSP successfully advocated for introduction of newer contraceptives in India's FP basket: progestin-only pills and centchroman. The program undertook a strategic demonstration at 52 public health facilities for the introduction of these two new methods, which led to an increase in the number of women choosing a PPFP method by 12 percentage points in 24 months (see Figure 2). Of the postpartum women who delivered at a program-supported facility (198,171), 5.4% accepted either progestin-only pills (4,597) or centchroman (6,027).

Between April 2017 and March 2019, MCSP followed up with eligible acceptors to assess continuation of their chosen method. Among progestin-only pills acceptors reached at 6 months, 91% (2,605 of 2,858) reported using progestin-only pills, with 58% (1,500) of those who continued switching to a more effective method after completion of 6 months (see Figure 3). Among centchroman acceptors contacted at 6 months, 73% (2,415 of 3,316) reported that they were still using centchroman. In line with global literature around postpartum contraceptive pill use, utilization of both methods declined near the 6-month mark, particularly for centchroman users[21,22]. The reasons cited by women for this reduction included: side effects including pain, physiological body changes, and bleeding/menstrual problems; access or supply issues; family reasons or opposition to the method; and method switching. MCSP shared the demonstration results with Government of India to advocate for the inclusion of progestin-only pills in the public-sector FP basket across the country.[23]

[20] Ministry of Health and Family Welfare. 2016. India Fact Sheet: National Family Health Survey (NFHS-4) 2015-16. New Delhi: Ministry of Health and Family Welfare.
[21] Kopp DM, Rosenberg NE, Stuart GS, Miller WC, Hosseinipour MC, Bonongwe P, et al. 2017 "Patterns of Contraceptive Adoption, Continuation, and Switching after Delivery among Malawian Women". PLoS ONE 12(1): e0170284.doi:10.1371/journal.pone.0170284
[22] Contraceptive Use Dynamics in India, Cohort Study of Modern Spacing Contraceptive Users. Population Council, March 2016
[23] Centchroman is already included in the public-sector FP basket in India.

Figure 2. (a) Postpartum women who accepted a PPFP method at an MCSP focus facility; (b) PPFP method choice among women who delivered in an MCSP focus facility

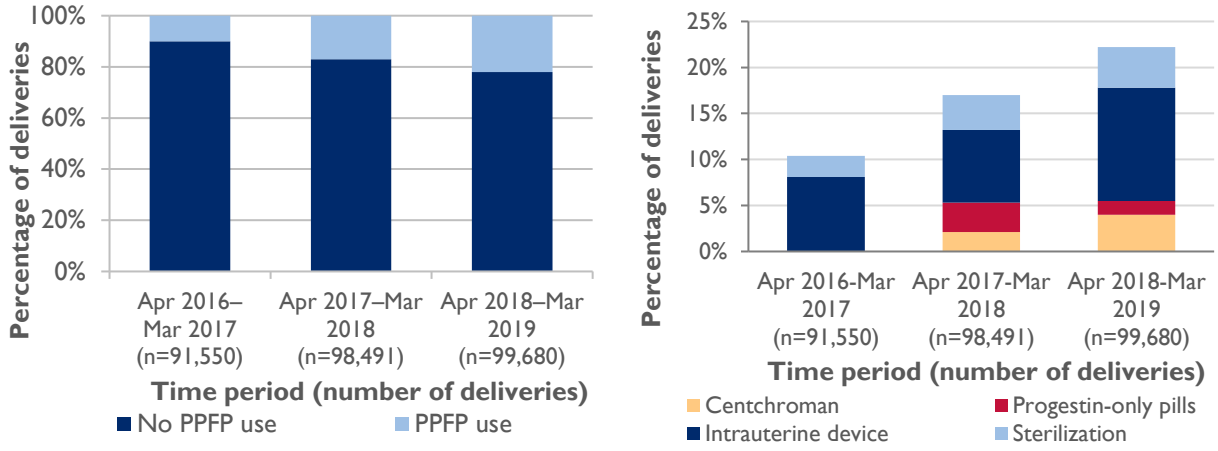
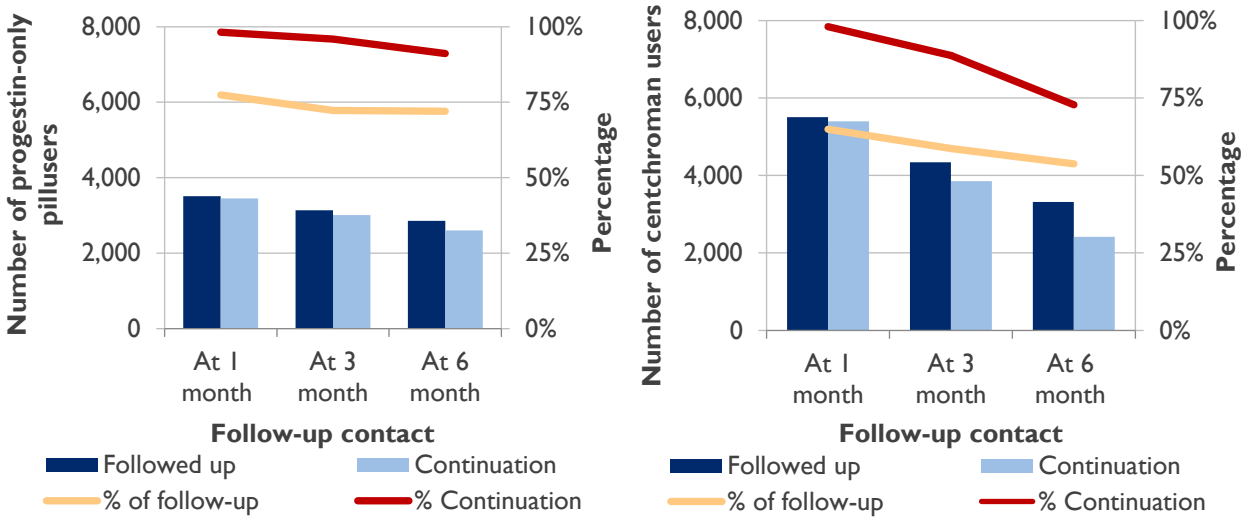


Figure 3. Continued use of chosen PPFP method reported during follow-up contact*: (a) progestin-only pill users (b) centchroman users



* Continuation data was taken from the 52 facilities where MCSP supported introduction of progestin-only pills and centchroman. In line with global literature around postpartum contraceptive pill use, utilization of both methods declined near the 6-month mark, particularly for centchroman users. The reasons cited by women for this reduction included: side effects including pain, physiological body changes, and bleeding/menstrual problems; access or supply issues; family reasons or opposition to the method; and method switching.

Institutionalized Improved Quality of Fixed Day Static Services

To move away from the camp approach for voluntary female sterilization services, which were provided on an ad hoc basis, MCSP strengthened the fixed day static (FDS)[24] approach for voluntary female sterilization services at 82% (152) of focus facilities. Over the life of the program, 13,351 FDS days were planned across these 152 facilities, and 8,740 days were conducted. Frontline workers preregistered 39,850 clients to receive services on these 8,740 FDS days; of these, 36,847 (92%) clients turned up for services on their designated days, and, of these clients in attendance, 36,054 (98%) received services. Improved FDS compliance (FDS days conducted as per the FDS calendar set) led to improved quality and assurance of service provision, as well as better client satisfaction due to a decline in refusal of services by the system (due to unpreparedness and lack of resources), improved provider-client interaction, and reduced out-of-pocket expenditure as a result of improving community-level screening of clients for fitness for surgery and client follow-up.

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

Developed an Interactive Voice Response System

MCSP supported the development and rollout of an interactive voice response system platform, *Parivar Swathya Vaani*, in 12 districts in Chhattisgarh and Odisha in July 2018 to provide clients and communities with information on FP, collect feedback on service quality, and preregister clients to streamline facility processes. By the end of the project, *Parivar Swathya Vaani* had received 18,164 calls, of which 3,630 provided information on FP, 2,663 collected feedback on the quality of FP service provision, and 11,871 preregistered clients to receive FDS services across 103 program facilities. In Chhattisgarh, *Parivar Swathya Vaani* was integrated into the state-owned toll-free helpline for clients. MCSP provided technical and implementation support to the Government of Odisha for scale-up of the application across all 30 districts in the state.

Institutionalized Quality FP Service Provision

Through regular assessment of facilities, technical support, and advocacy, MCSP improved infrastructure and basic amenities using system resources and strengthened existing systems at the focus facilities. MCSP supported the formation of quality circles at 98% (183) of the focus facilities, strengthening the capacity and functioning of local-level management teams. MCSP facilitated the review of the FP dashboard, capturing key FP indicators during these meetings along with client feedback received via the interactive voice response system platform, thus promoting use of data for better decision-making. At the district level, MCSP revitalized district quality assurance mechanisms—district quality assurance circles—leading to mobilization of funds and regular tracking of empaneled providers. With MCSP's advocacy to make quality a pillar of service provision, district quality assurance circles and quality circle meetings now include quality of FP service provision as a part of their agenda and discussion. As of March 2019, the fifth quarterly assessments using service delivery performance standards recorded a 42% improvement in overall facility assessment scores over baseline.

Promoted Gender Equity and Respectful Care in FP Services

MCSP, through the Centre for Catalyzing Change,[25] built the capacity of 2,336 facility-based service providers and 24,827 frontline workers on gender, social inclusion, and respectful care. The program promoted gender-sensitive FP services that respect women's autonomy, dignity, and privacy, leading to strengthened health systems for better interactions with women and communities. MCSP leaves behind a legacy of strengthened counseling services promoting voluntarism and informed choice. The program developed counseling tools and job aids, built the capacity of 461 service providers on counseling, and supported the establishment of dedicated counseling corners at 90% of focus facilities, ensuring provision of high-quality counseling services to 506,061 clients over the life of the program. (For more information, see MCSP's stories "Going the Extra Mile to Ensure Voluntary Contraceptive Uptake in India" and "Engaging Indian Women Directly is Improving Contraceptive Uptake".)

Supported the National and State Governments in Effective Implementation of the National Adolescent Health Program

In 2014, adolescent health programming in India got a much-needed fillip with the government-led *Rashtriya Kishor Swasthya Karyakram*—an initiative aimed at providing health information and services to all adolescents (10–19 years) in and out of school, married or unmarried, and within vulnerable groups. *Rashtriya Kishor Swasthya Karyakram* brought all adolescent-targeted interventions in the Indian health system under one umbrella. MCSP supported the Adolescent Health Division of the Ministry of Health and Family Welfare with rolling out the revised *Rashtriya Kishor Swasthya Karyakram* strategies, specifically the School Health Program. MCSP supported the Ministry of Health and Family Welfare to develop the revised National Adolescent Health Program operational guidelines, which WHO released in July 2018. The program also revised the existing supportive supervision checklist for adolescent-friendly health clinics and prepared a document summarizing the operationalization of adolescent health days at the community and school levels.

[25] MCSP had issued a subaward to the Centre for Catalyzing Change to conceptualize and implement innovative strategies to enhance community participation.

MCSP also supported regional review meetings, covering all states/union territories, to assess the implementation of the National Adolescent Health Program. The primary objectives were to assess critical implementation gaps and challenges encountered across states and find context-specific solutions. MCSP conducted a series of consultation meetings with individuals and organizations on new, emerging adolescent needs, such as mental health, engaging boys and parents, digital technology, and GBV. Advocacy briefs highlighting policy-level recommendations were prepared and shared with the Ministry of Health and Family Welfare as an outcome of the meetings.

Given that adolescent health is a multisectoral issue, MCSP supported the Ministry of Health and Family Welfare in drafting a memorandum of understanding (MOU) with the Ministry of Tribal Affairs that was ultimately signed by secretaries of both ministries. MCSP facilitated establishment of a technical resource group to harmonize the existing training materials and develop the school health curriculum with support from the National Council of Education, Research, and Training, and other development partners. MCSP was an integral part of the adolescent health working group under the RMNCH+A coalition of the Government of India and supported the development of a national position paper on adolescent health.

Supported Operationalization of the School Health Program

MCSP developed the operational guidelines on the School Health Program under *Ayushman Bharat*. MCSP also worked closely with the Ministry of Education to draft the curriculum and training materials for teachers under the School Health Program. An operational plan was submitted to the Ministry of Health and Family Welfare for implementation of the program in five states: Himachal Pradesh, Haryana, Chhattisgarh, Telangana, and Assam. Moreover, 28 states/union territories budgeted for the School Health Program, amounting to USD 6 million in fiscal year 2019–2020.

Supported Institutionalization of Robust M&E Systems

MCSP developed dashboards and fact sheets using adolescent program data and secondary data. The dashboard provides at-a-glance information on progress on performance indicators for the adolescent health program. To improve the quality of adolescent-friendly health clinics data, a mobile app was developed and is currnetly being implemented by the Ministry of Health and Fmaily Welfare in five states as a pilot.

MCSP also implemented the data use interventions in select public health facilities in providing minilap services within two districts of both Chhattisgarh and Odisha. MCSP aimed to improve the use of data for action in its project focus facilities and districts through the development and use of FP data dashboards that included user-friendly visualizations of the compiled monthly data for FP indicators. With health facility staff and FP stakeholders, MCSP identified routine FP program data for a small set of actionable indicators. MCSP conducted a study in collaboration with Governments of Odisha and Chhattisgarh introducing two different types of data FP dashboards to compare approaches for visualizing FP data. The study help to improve use of FP data for programmatic review, improve interpretation and analysis of routine FP data, improve data quality, and inform decision-making at the facility level. Implementation research briefs highlighting the results from three formal learning questions are forthcoming.

Leveraged Funds for Establishing Health and Wellness Centers and Training Ecosystems

MCSP leveraged government funds to establish Health and Wellness Centers and training ecosystems under the National Health Mission's annual program implementation plans. This amounted to USD 46.3 million from 11 state governments after an initial investment by USAID of USD 2.9 million. These Health and Wellness Centers will bring comprehensive primary health care closer to people's homes (within 30 minutes) via an expanded package of 12 services coupled with provision of free essential drugs and diagnostics.

Created Institutional Mechanisms at State and District Levels

MCSP was instrumental in advocating for and establishing institutional mechanisms for Health and Wellness Centers, 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. By the end of the

project, 70 district-level committees and eight state-level committees were formed in states where MCSP supported the establishment of Health and Wellness Centers (Chhattisgarh, Madhya Pradesh, Odisha, Jharkhand, Nagaland, Meghalaya, Mizoram, and Sikkim). These mechanisms will be critical for ensuring the program's long-term quality and sustainability.

Provided Technical Assistance for Health and Wellness Center Operations in Intervention States

MCSP's supported almost every element of the process to establish well-functioning Health and Wellness Centers. Beginning with enhancing the capacity of state governments to address the gaps in establishing a robust primary health care system through regular mentoring support; providing prototypes for infrastructural upgrades and internal branding; ensuring the production of adequate, competent, confident, and skilled community health officers to run the centers; and supporting the establishment of actual service delivery. A total of 1,607 facilities in 64 MCSP demonstration districts have been made fully operational, while the remaining 584 facilities have initiated upgrades to Health and Wellness Centers. MCSP also built the capacity of 27,270 service providers and frontline health workers (1,174 medical officers, 661 staff nurses, 4,699 auxiliary nurse-midwives [ANMs], and 20,736 accredited social health activists [ASHAs]) to manage noncommunicable diseases. (For more information, see MCSP's stories "Health and Wellness Centers 'Reach the Unreached' in India" and "No matter age, gender, religion, or caste: Improving access for all in India".)

Created an Ecosystem for Training Community Health Officers at Health and Wellness Centers

Each Health and Wellness Center will be led by a community health officer who successfully completed a 6-month certificate course in community health imparted at the training sites known as program study centers. MCSP supported the intervention states to roll out the certificate course and establish a training ecosystem. To date, MCSP has supported establishment of 48 program study centers, which trained approximately 2,500 community health officers. MCSP developed a comprehensive learning resource package with standardized training sessions and used it with the community health certificate course to train 1,228 academic counselors and program study center in-charges across intervention states.

Recommendations for the Future

MCSP in India successfully expanded access to quality FP services, demonstrated the inclusion of newer modern contraceptive methods in the public-sector health basket, provided technical support to the national government for adolescent health programming, and supported the government in bringing comprehensive primary health care closer to communities. The following recommendations are made in light of the overall experience gained in implementing MCSP in India:

- **Invest in capacity-building around informed choice/voluntarism among frontline workers and service providers.** To ensure that informed choice and voluntarism are maintained and promoted during FP messaging and counseling, MCSP recommends that the Ministry of Health and Family Welfare and state governments invest in the capacity-building of frontline workers and service providers.
- **Engage communities and bridge gaps between facility and community.** Taking lessons from MCSP's model facilities,[26] the program recommends developing collaborations between facility-based quality circles and patient welfare societies to develop sustainable models for improved accountability of health systems and community participation. This would lead to institutionalization of community engagement for incorporating client feedback and standardization of the community perspective of quality into the system, and help facility administration to identify gaps in the provision of quality FP services and take corrective action in a timely manner. MCSP recommends developing robust institutional mechanisms at all levels of service delivery to capture client feedback on services, initiate corrective measures, and harness the potential of digital technology to reach out to adolescents.

[26] Selected facilities in Chhattisgarh and Odisha were identified to demonstrate improved practices related to community engagement and respectful care in FP service provision, with the purpose of sharing results from these facilities with the state governments for institutionalization of the processes adopted in the public health systems and scale-up across all public health facilities in the respective states.

- **Mobilize and ensure commitment of domestic resources—public and private—at the outset.** National and state governments need to ensure increased and sustained financial resource allocation for strengthening primary health care initiatives to achieve sustainable results. MCSP's initial advocacy efforts for leveraging government funds played a critical role in establishing the Health and Wellness Centers and institutionalizing project efforts. Furthermore, there is a need for increased commitment from the private sector to strengthen primary health care initiatives in the country.
- **Develop dynamic and contextualized interventions.** Working across 12 states meant 12 different contexts, geographies, populations, and health-seeking behaviors. Keeping in mind these diverse settings, MCSP, in consultation with its government counterparts, customized and contextualized interventions based on local needs. This ultimately resulted in increased acceptability among beneficiaries. To increase use of essential health services among vulnerable populations, especially in India, given the dynamic population with large pockets of marginalized and vulnerable communities, it is critical to develop dynamic and contextualized interventions, which will go a long way in ensuring health for all.
- **Co-design health care solutions with the community.** Local ownership and partnership, and a comprehensive systems strengthening approach, are necessary to achieve sustainable results. Along with building resilient health systems, it is essential to co-design health care solutions with the community through concerted community engagement efforts and social and behavior change campaigns to ensure effective and optimum use of quality primary health care services.

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Percentage of demonstration sites having at least one provider trained in FP counseling, including counseling skills on the two newer methods (progestin-only pill and centchroman)	98% (target: 80%; target exceeded)
Percentage of women delivering at an MCSP-supported health facility who accept progestin-only pill or centchroman as a method of FP	5.3% (actual; no target defined)
Percentage of frontline workers attached to MCSP-supported health facility trained in key messages about all FP methods, including newer contraceptives	96.6% (target: 80%; target exceeded)
Percentage of FDS sites that have a functional redressal mechanism to strengthen quality of FP services	99% (target: 70%; target exceeded)
Percentage of female sterilization clients receiving sterilization services on the assigned FDS day who were preregistered with the facility	68% (target: 70%; 97% achieved)
Number of states that have budgeted for initiative under the 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, 28 states have allocated budgets.
Amount of National Health Mission/state government funds leveraged for establishment of Health and Wellness Centers	USD 46.3 million (no target defined)
Number of targeted (direct intervention) subcenters/primary health centers/urban primary health centers where process of upgradation to Health and Wellness Centers has been initiated (n = 1,607)	1,607 (target: 964; target exceeded)
Number of training institutions established to initiate the 6-month Certificate Course in Community Health	48 (target: 29; target exceeded)
Number of health care workers who completed an in-service training program (6-month certificate course) within the reporting period with USG support	1,228 counselors, 2,500 community health officers (targets: 200 counselors, 870 community health officers; targets exceeded)

For a list of technical products developed by MCSP related to this country, please click here.

India The Challenge Initiative for Health Cities EOP Summary & Results

Geographic Implementation Areas

States

- 3/29 (10%)—Madhya Pradesh, Odisha, and Uttar Pradesh

Cities

- 20/64 (31% cities in Uttar Pradesh)
- 8/52 (15% cities in Madhya Pradesh)
- 3/30 (10% cities in Odisha)

Population

Country

- 1.21 billion

MCSP-supported areas

- 321 million

Technical Areas

Program Dates

March 1, 2016–September 30, 2019

Total Funding through Life of Project

$ 6,000,000

Demographic and Health Indicators

Indicator	# or %
Live births/year[1]	25,427,955
MMR (per 100,000 live births)[2]	130
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 (2014–2016), Census of India, New Delhi; [3] Government of India Ministry of Health and Family Welfare, DLHS 3, 2007–2008; [4] RSOC 2013–2014.

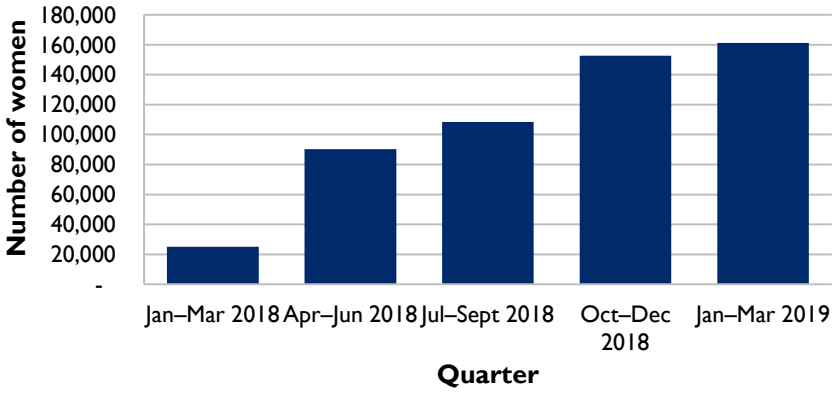
Strategic Objectives through the Life of Project

- Increase the use of modern contraceptive methods and improve the coverage and quality of evidence-based FP and 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 FDS 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 The Challenge Initiative for Healthy Cities (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 of the National Health Mission to expand global health best practices and evidence-based interventions.

Figure 1. Women reached with FP counseling during TCIHC implementation in India



India—The Challenge Initiative for Healthy Cities

Through TCIHC, MCSP provided technical assistance and implementation support to activate the National Urban Health Mission's service delivery model in 31 cities across three states: Madhya Pradesh, Odisha, and Uttar Pradesh. The initiative aimed to prevent maternal and newborn deaths among the urban poor by strengthening city-level health systems to improve access to and demand for FP and MNH care, information, products, and services, especially by the urban poor.

TCIHC was supported until September 30, 2019, by USAID's MCSP and by the Bill & Melinda Gates Foundation through The Challenge Initiative at the Johns Hopkins University, Gates Institute; the Gates Institute will continue support of TCIHC through June 2021. TCIHC works with state and city health officials to identify health service gaps and, through the annual program implementation planning process, works to mobilize or "unlock"[27] resources available for FP; MNH; adolescent, youth, and sexual reproductive health; and urban health through the National Health Mission and other government health schemes. TCIHC also links private-sector service providers to the government health system and supports community outreach, QI, and behavior change campaigns to raise awareness and increase demand for quality FP and MNH services.

Key Accomplishments

Supported Rapid Introduction and Scale-Up

TCIHC formally launched in May 2017. In the first year of implementation, TCIHC focused on informing national, state, and city government leadership about the program and its "business unusual" model. This demand-driven model is based on local governments self-selecting to participate in and demonstrate political commitment by bringing their own financial, material, and human resources. In return, TCIHC provided technical assistance. By October 2017, TCIHC had secured government buy-in for the first 12 cities that would benefit from program support and promoted adoption by the National Urban Health Mission of the evidence-based high-impact approach. Thereafter, TCIHC completed expansion into a total of 31 cities and initiated facility and community programming in "ready to start" urban primary health centers and their surrounding communities. With TCIHC support, all 31 cities started implementation of various high-impact approaches that aim to improve FP and MNH service provision.

TCIHC initiated support using the demand-driven approach. Cities submitted an expression of interest to receive support to scale up and implement the high-impact approaches. Once a city was selected, TCIHC conducted a city consultation workshop, which is an interdepartmental meeting of government stakeholders to review the city as a whole by mapping urban stakeholders and their roles and responsibilities. These workshops aimed to identify bottlenecks and solutions through complete analysis of a city's strengths and opportunities. TCIHC also conducted city mapping and listing exercises to identify vulnerable populations. After the city consultation workshops were held and city mappings had been conducted, TCIHC worked to activate urban primary health centers and initiated coaching and mentoring of frontline workers. The activation of city health systems resulted in improved city capacity and, ultimately, FP service provision. The specific outcomes are outlined through the rest of this summary.

Achieved Government Ownership and Support

TCIHC supported state and city officials across the 31 cities to prepare for the 2017/2018, 2018/2019, and 2019/2020 National Health Mission program implementation plans. TCIHC's engagement in the annual program planning process resulted in the successful leveraging and/or unlocking of approximately USD 60 million[28] of Government of India funding for the implementation and expansion of FP, MNH, and urban health programming.

[27] Leveraging: using existing financial and human resources, and/or platforms for FP and MNH activities. Unlocking: obtaining appropriate public (through the program implementation plan process) and private resources that have already been allocated for urban health services to specific FP and MNH activities.
[28] Source: TCIHC project management information system. Figure is reflective of the 2017/2018 and 2018/2019 program implementation plan periods.

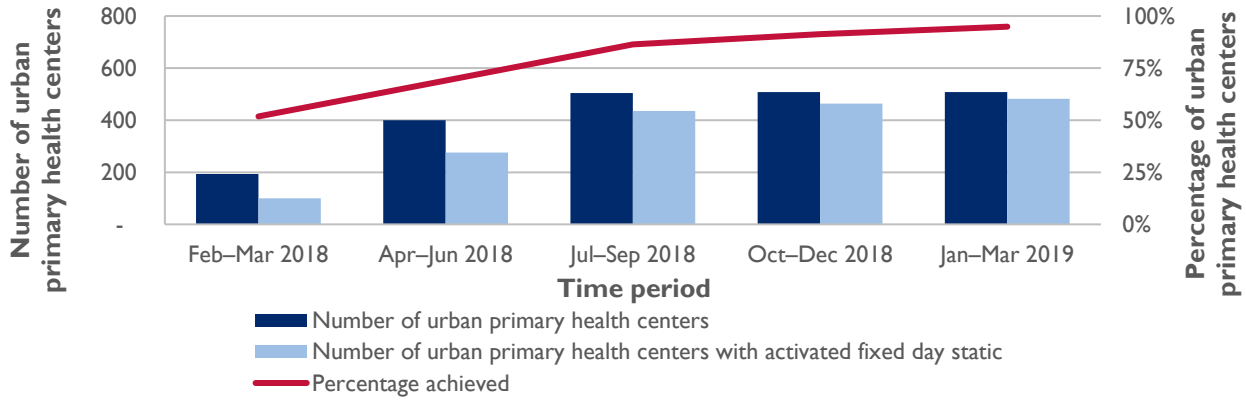
TCIHC's approach is based on the use of high-impact approaches and proven health solutions for the urban poor in resource-constrained settings. High-impact approaches include tools for service strengthening, demand generation, and advocacy. TCIHC promoted high-impact approaches from India's earlier urban health projects, including the Urban Health Initiative, Expanded Access and Quality, and SNL, funded by the Bill & Melinda Gates Foundation, and Health of the Urban Poor, funded by USAID. A coordinated set of high-level advocacy activities led to TCIHC's approach being endorsed by the governments of Uttar Pradesh, Madhya Pradesh, and Odisha. The states are moving to scale up and replicate some of the FP/MNH high-impact approaches, including FP FDS services, facility readiness assessments, maternal and newborn care units in secondary facilities, and the reproductive and MNH referral mechanism in non-TCIHC cities using government resources.

Increased Access to Quality FP and MNH Services for Urban Poor

In working with the cities to roll out the National Urban Health Mission urban service delivery model, TCIHC introduced the urban primary health center readiness assessment and supported the mapping of urban poor communities, existing service delivery points, and urban primary health center catchment areas. TCIHC then supported the activation of FP and MNH services at urban primary health centers (each urban primary health center having a catchment area of 50,000), at urban health and nutrition days (catchment area of 2,000 people), and at outreach camps.

- **Conducted urban primary health center readiness assessments.** TCIHC developed an urban primary health center readiness assessment approach, based on the WHO Service Availability and Readiness Assessment framework, and an assessment of equipment availability, the latter developed at the request of the state government in Odisha for use in that state. By the end of the program, 100% (n = 76) of urban primary health centers in the 11 MNH TCIHC cities in Madhya Pradesh and Odisha had undergone an urban primary health center readiness assessment. Based on the findings, TCIHC supported district health offices to map health facilities and define catchment areas, generated recommendations on the definition of catchment areas, advocated for specific improvements, and trained urban primary health center medical and nursing staff. From April–June 2017 to October–December 2018, the number of outpatient department cases seen across all urban primary health centers and civil dispensaries in the 11 cities more than doubled, from 207,225 to 475,234.

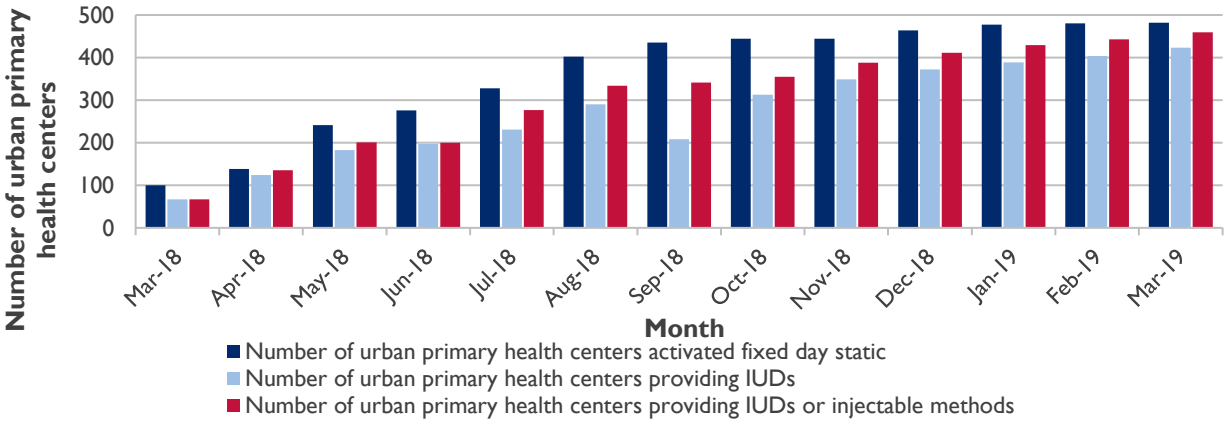
Figure 2. Expansion of urban primary health centers conducting FDS services in Madhya Pradesh, Odisha, and Uttar Pradesh, February 2018–March 2019



- **Instituted FDS services.** In the 31 activated cities, TCIHC coordinated efforts with city governments to conduct at least one FDS per week at each urban primary health center. As a result, by March 2019, more than 95% of urban primary health centers were conducting at least one FP FDS per month, and on average, 58% were conducting four or more FDSs per month (see Figure 2). Providing FP services on a set date improved accessibility of services and increased voluntary acceptance of FP methods. From February 2018–March 2019, 719,589 clients accepted an FP method during FDS services, outreach camps, and urban health and nutrition days. (For information, see the TCIHC learning page on FDS.)

- **Increased contraceptive choice at urban primary health centers.** TCIHC efforts led to increased availability of FP services through FDS in all three states, and the team advocated with city and state governments to expand FP options by adding the provision of IUDs and injectable contraceptives to the existing methods of pills and condoms at most urban primary health centers. As a result, by March 2019, 89% of urban primary health centers were providing IUDs, and 95% were providing either injectables or IUDs. The expansion of FDS and method choice dramatically increased acceptance of LARC, from 67% at the start of the project to 95% in March 2019 (see Figure 3 for the number of urban primary health centers offering these services).

Figure 3. Urban primary health centers providing IUDs or injectable contraception in Madhya Pradesh, Odisha, and Uttar Pradesh



- **Improved access to quality maternity and pediatric care.** TCIHC provided support to strengthen existing secondary-level facilities for maternal and pediatric care, advocated for the establishment of specialized units in these facilities, and provided technical advice on the organization, layout, and functions of the enhanced units. At six secondary-level public facilities/maternity homes in Indore, Gwalior, and Berhampur (three MNH learning cities) and one urban primary health center providing delivery services in Puri, Odisha, 15,673 pregnant women delivered from April 2017 to December 2018. At baseline (July–September 2017), 36% of women who delivered at the facilities received oxytocin during the third stage of labor, and 50% of their newborns received vitamin K. These figures rose to 52% and 96%, respectively, during the October–December 2018 quarter as a result of TCIHC's service delivery strengthening work.

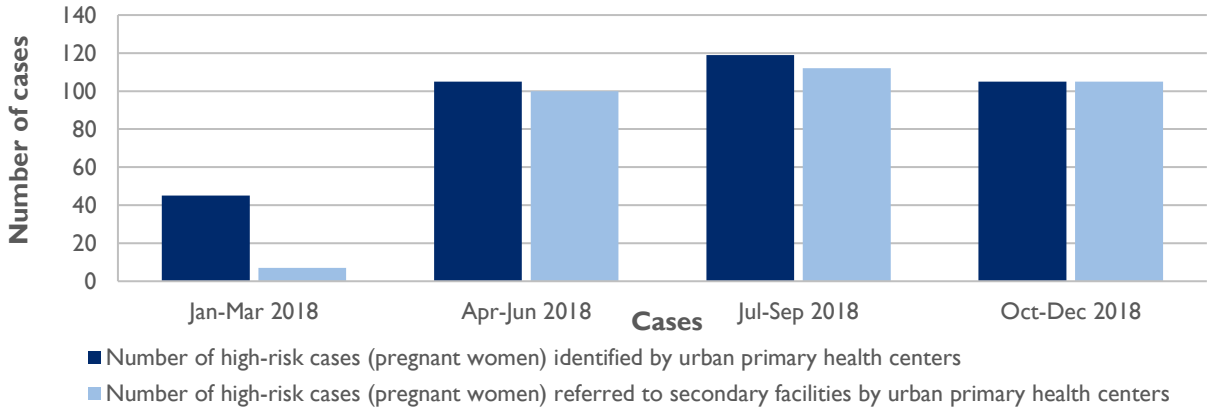
  With the Government of Madhya Pradesh, TCIHC co-designed and piloted an integrated pediatric unit in Prakashchandra Sethi Hospital in Indore. This brought together all newborn and pediatric services within one unit in the hospital to improve patient flow, coordination of care, continuity of services, and efficiency of human/financial resources. The Government of Madhya Pradesh budgeted, through the program implementation plan process, for similar units in a total of 10 districts (four TCIHC cities and six non-TCIHC cities). At the end of the program, the facilities were operational in Indore and Ratlam.

- **Established a referral mechanism.** Building on the model of the SNL program, TCIHC worked with local government bodies and public health facilities to strengthen referral for MNH and FP services in Madhya Pradesh (Indore and Gwalior) and Odisha (Berhampur). This included facilitating learning visits, establishing city-level technical committees on referrals, formally linking ASHAs and ANMs with urban primary health centers, and developing and rolling out referral slips and protocols. The referral mechanism was established in the learning cities, and it has been operational in the first city, Indore, since December 2017.

  By the end of March 2019, 828 providers in the MNH learning cities had received training on referrals (about 88% [n = 735] were ASHAs and ANMs, and the rest were medical officers and staff nurses). In Indore, TCIHC identified 2,353 high-risk pregnant women and sick newborns who were referred at either

the community or facility level between December 2017 and December 2018. ASHAs and ANMs identified most cases at the community level. Among those cases, 80% of identified high-risk pregnant women and 90% of identified sick newborns were referred to urban primary health centers for treatment, while the remaining were referred to secondary or tertiary facilities (see Figure 4 for the number of pregnant women identified as high-risk cases and referred). As a result of TCIHC support, the Government of Madhya Pradesh included funding to continue the referral mechanism after project close in its budget.

Figure 4. Number of referred cases pertaining to high-risk/complication pregnancy from urban primary health centers to higher facilities in Madhya Pradesh, Odisha, and Uttar Pradesh



Ensured Quality in Service Delivery

The Government of India's quality assurance program follows a unified structure at every level, with QI teams on the city and district quality assurance committees. In support of the government, TCIHC assisted cities to establish QI teams and monthly meetings. QI teams were formed at 454 of the 508 TCIHC-assisted facilities, with 593 QI meetings conducted from January–March 2019. During the QI meetings, the participants reviewed and developed action plans based on identified gaps, and decided on next steps to improve infection prevention, hygiene, informed choice, and patient record maintenance.

The district quality assurance committee is responsible for disseminating quality assurance policy/guidelines, ensuring the standards for quality of care, and capacity-building on quality assurance issues. With TCIHC support, committees were activated in all 31 cities, and committee team members started conducting facility visits to urban primary health centers to ensure their readiness to conduct FDS. They also certified 224 urban primary health centers for FP services according to Ministry of Health and Family Welfare standards.

Additionally, TCIHC, in consultation with city National Urban Health Mission teams, introduced a new cadre of field program service assistants (qualified staff nurses) to increase quality assurance at urban primary health centers. Field program service assistants provide coaching to ASHAs, observe FP service delivery, and ensure facility readiness using an observation tool/checklist. During the September 2018–March 2019 period, 24 cities were visited, and a field program service assistant visited 98% of 461 urban primary health centers at least once in a 6-month period. Preliminary analysis from these visits indicated an improvement in the facility readiness scores. In September 2018, only 14% of facilities were provided a grade-A score, which increased to 49% by the end of January 2019. For more information, see TCIHC's learning page on quality assurance.)

Recommendations for the Future

The Gates Institute will continue to support TCIHC during the second phase of The Challenge Initiative through 2021. The Gates Institute is only planned to take forward FP and adolescent, youth, and sexual reproductive health activities, but TCIHC has proposed to the Gates Institute that select MNH activities are picked up with various levels of support—strictly technical assistance to the government to ensure smooth transition/uptake or full support to continue the activity. TCIHC has developed a transition plan to hand

over all MNH activities to the government. To improve FP and MNH services moving forward, TCIHC recommends that the Government of India and the Gates Institute take the following actions:

- **Identify a point person within the government to carry forward MNH activities that will be transitioned from TCIHC.**
- **Include referral indicators in the HMIS and disaggregation of MNH and FP indicators by urban/rural location.**
- **Continue technical assistance to the governments of Madhya Pradesh and Odisha.** This should be done for the expansion of the referral mechanism and urban primary health center readiness assessments, including training, supportive supervision, recording, and reporting.
- **Support the state governments to take successful approaches beyond TCIHC-assisted cities.** This should include FDS, urban primary health center readiness assessment, quality assurance/QI approaches, the reproductive and MNH referral mechanism, and other high-impact approaches.
- **Evaluate the first 3 years of TCIHC to inform the second phase.**

Selected Performance Indicators	
Global or Country Performance Monitoring Plan Indicators	**Achievement (Target)**
Number of TCIHC-supported cities establishing urban health advisory committees/city coordination committees/other coordination units	31 (target: 31; target achieved)
Number of public health facilities conducting FDS for FP services	482 (target: 400; target exceeded)
Percentage of public health facilities conducting FDS for FP services	95% (target: 80%; target exceeded)
Number of health care workers trained on FP and MNH (disaggregated by type of training, level of worker, male/female workers, and place of work)[1]	ANMs and accredited social heath activists on FP: 3,113; on referral: 735 Doctor and staff nurse on referral: 93; on adolescent, youth, and sexual reproductive health: 75; on injectable/IUD: 99
Number of people reached through FP communication activities[2]	700,000 (target: 400,000; target exceeded)
Number of people benefited/reached through FP services using existing service delivery model (FDS, urban health and nutrition days, outreach camps)[3]	719,589 (target not defined)
Percentage of referred cases pertaining to high-risk/complication pregnancy from urban primary health center/lower to higher level of facilities[4]	100% (target: 20%; target exceeded)
Number of outpatient department cases (all urban primary health centers and civil dispensaries, in all TCIHC cities)	475,234 (target: 300,000/quarter)

[1] Any training of less than 1 day is not included in this count.

[2] This is the volume of contacts made through IPC and mid-media activities from February 2018–April 2019, with adjustment for the estimated repeat visits (30%). The target was conservatively set using assumptions around the team size, pace of programming, and staff turnover. However, skills building, supportive supervision, and advocacy helped field program associates to perform at their optimal level and cities to recruit more ASHAs, expanding the reach of these activities.

[3] This is a cumulative number of people who received an FP method at a public facility or outreach site in TCIHC cities during February 2018–March 2019. It includes client revisits for short-term methods (injectables, oral contraceptive pills, and condoms).

[4] There was no evidence on the potential increase in the beginning. Therefore, a low target was set for this indicator.

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