



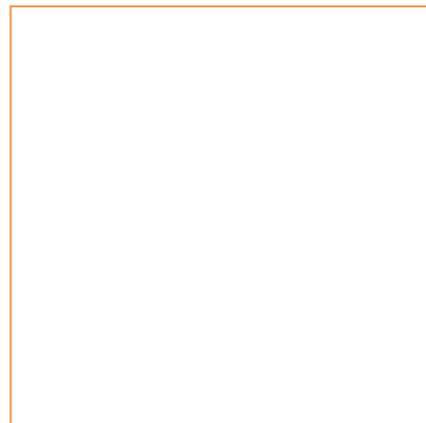
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LONDON SCHOOL of HYGIENE & TROPICAL MEDICINE



Implementation pathway report: Uttar Pradesh Technical Support Unit

India
June 2015



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Acronyms

Acronym	Definition
ACMO	Assistant Chief Medical Officer
ANM	Auxiliary Nurse and Midwife
APHC	Additional Primary Health Centre
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi worker
BCS	Block Community Supervisor
BMV	Block Monitoring Visit
BPHC	Block Primary Health Centre
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
CHC	Community Health Centre
CMO	Chief Medical Officer
CRP	Community Resource Person
DCPM	District Community Process Manager
DCS	District Community Specialist
DM	District Magistrate
DM&ES	District Monitoring and Evaluation Specialist
DPM	District Programme Manager
DPMU	District Programme Management Unit
DTS	District Technical Specialist
FLW	Frontline worker
GoUP	Government of Uttar Pradesh
HMIS	Health management information system
IAS	Indian Administrative Service
ICDS	Integrated Child Development Services
ICT	Information Communication Technology
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCTS	Mother and child tracking system
MLE	Measurement, learning and evaluation
MNCH	Maternal, neonatal and child health
MOIC	Medical Officer In-Charge
NGO	Non-governmental Organization
NHM	National Health Mission
ORS	Oral Rehydration Solution
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PPT	PowerPoint presentation
RMNCH+A	Reproductive, maternal, neonatal, child and adolescent health
SC	Sub-Centre
SPMU	State Programme Management Unit
TSU	Technical Support Unit
UP	Uttar Pradesh
UP-TSU	Uttar Pradesh Technical Support Unit
VHND	Village Health Nutrition Day
ZCS	Zonal Community Specialist
ZM&ES	Zonal Monitoring and Evaluation Specialist
ZTS	Zonal Technical Specialist

Summary

Study aim

The Implementation Pathway of the Technical Support Unit for Uttar Pradesh state (UP-TSU) was conducted with the aim of examining how the UP-TSU is being implemented in the broader contexts of maternal and newborn health programmes, health systems and the socio-cultural background in Uttar Pradesh state. Methodologically, it follows a standardised structure and format to describe the mechanisms of action and implementation details of the UP-TSU.

What is the UP-TSU?

The UP-TSU was established to provide technical assistance to Government of Uttar Pradesh (GoUP) to improve reproductive, maternal, neonatal, child and adolescent health coverage and outcomes under National Health Mission in 25 high priority districts in UP. The goal is to support the government (rather than implement its own programme), by building health system capacity to execute according to the government mandate, with strong political, bureaucratic and administrative ownership. The UP-TSU's specific objectives are to bring about improvement in: the scale and quality of front-line-worker interactions at the community level; the quality of services at facility level; strategies and systems for enhancing providers' capabilities and service delivery; engagement with private providers and mechanisms for community accountability. The GoUP with funding support from the Bill & Melinda Gates Foundation has awarded a grant for setting up the UP-TSU to the University of Manitoba, Canada and India Health Action Trust, Karnataka.

The need for a UP-TSU: the context

Uttar Pradesh is the most populous state in India, with population estimated at approximately 200 million, accounting for 16% of India's population (Director of Census Operations, 2011). 78% of the state population is rural. The overall health system and health status in Uttar Pradesh are poorer than in many Indian states. According to the Annual Health Survey in Uttar Pradesh during 2011-12, the maternal mortality ratio in the state was 300 per 100,000 live births. The infant mortality rate was 57 infant deaths per 1,000 live births in Uttar Pradesh, sharing the highest position in the country (Sample Registration System, 2012). The total fertility rate in Uttar Pradesh was estimated at 3.8 in 2008 (Sample Registration System). Poor health outcomes in the state may be due in part to poor reach and coverage of critical reproductive, maternal, newborn, child and adolescent health (RMNCH+A), family planning, immunisation and nutrition interventions and services, linked to the poor quality of public and private health service delivery in the state, and poor demand from individuals, families and communities. The UP-TSU was established to improve the state's capacity for enhanced efficiency, effectiveness and equity in health and development.

Salient features of the UP-TSU

Working together: embedded and integrated support

The UP-TSU's support to GoUP is catalytic in nature, since most execution and implementation is carried out by the GoUP except for select trainings and concurrent monitoring. UP-TSU is supporting the GoUP at state, district and block level to address several barriers such as lack of leadership; limited focus on outcomes; poor performance by frontline workers (FLWs); sub-optimal facility performance; coverage and quality of care; poor accountability systems etc. Other integrated and embedded techno-managerial support includes analysing need, supply and demand, prioritising critical innovations where outcomes are poorest, a directive

and participatory hands-on support, concurrent monitoring and problem solving. Techno-managerial support is given to deliver interventions technically by applying managerial principles.

To ensure quality of service delivery at scale and address challenges in planning, policy and coordination, the UP-TSU's strategic approach encompasses:

- 1) incorporating staff at the state and district/block levels
- 2) providing integrated technical assistance as a single functional unit, rather than through individual consultants
- 3) embedding within the government, but funded externally
- 4) leadership by staff not currently in government, but with experience of working through government processes

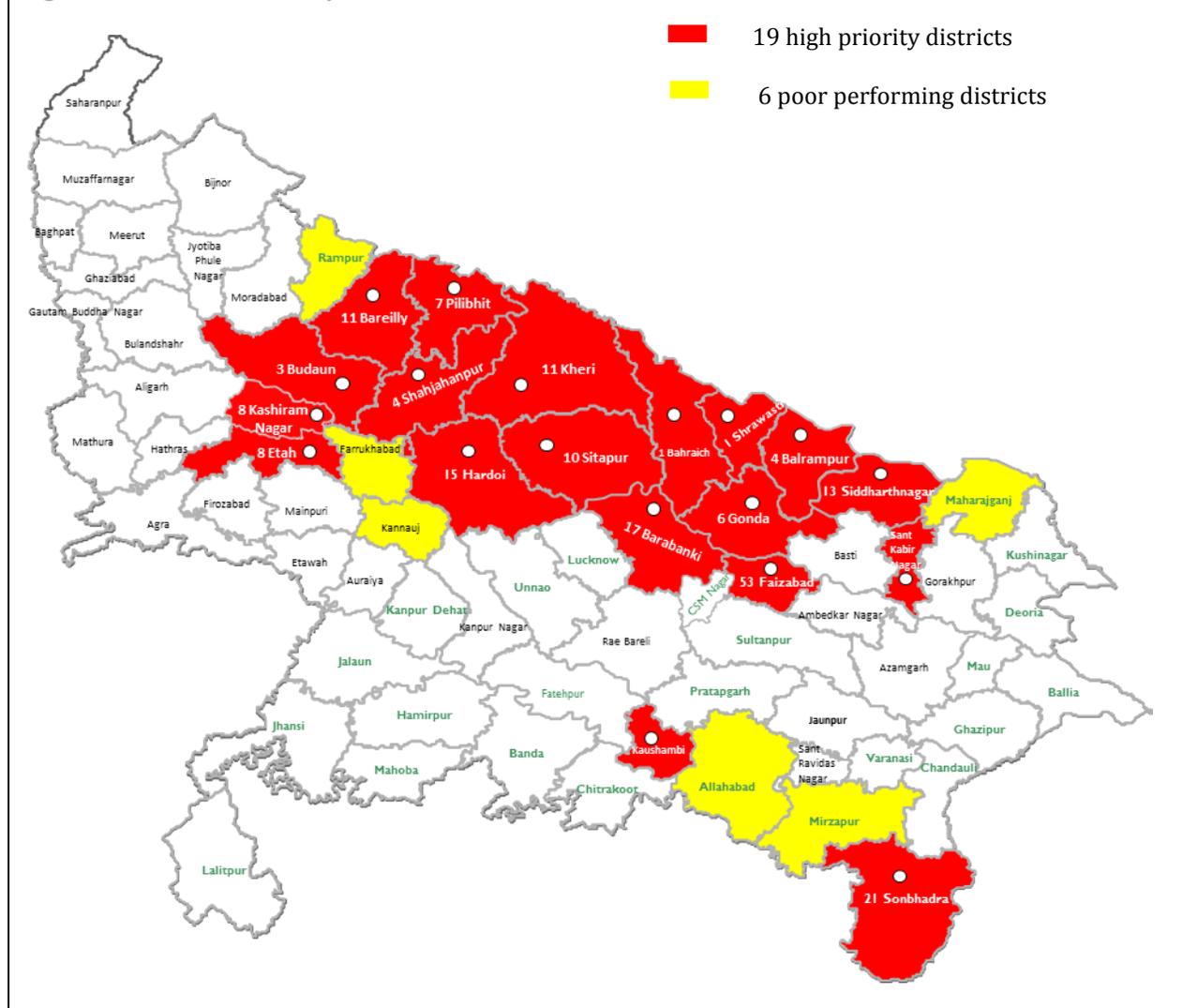
Supportive supervision and monitoring

Implementation support (supportive supervision and trainings) is primarily at block and district level and is designed to be sustainable. The aim is to institutionalise improved service delivery skills among the FLWs, their supervisors and block level managers.

1. Description of the innovation

The Uttar Pradesh Technical Support Unit (UP-TSU) was established as a consequence of the Memorandum of Cooperation between the Government of Uttar Pradesh (GoUP) and the Bill and Melinda Gates Foundation (the foundation) in Dec 2012, committed to working together to improve levels of health and development in Uttar Pradesh (UP). It was established in response to the state government's request for support to improve health services in the state. The TSU is located organisationally within the GoUP and the National Health Mission (NHM) Directorate, established and supported technically by India Health Action Trust, the University of Manitoba, and their partners. It delivers technical assistance and support to the GoUP in implementing the state's reproductive, maternal, newborn, child and adolescent health (RMNCH+A) strategy.

Figure 1: Districts covered by UP-TSU



UP-TSU is unfolding integrated and embedded techno-managerial support to GoUP by analysing gaps in terms of need, supply and demand; prioritising critical innovations where outcomes are poorest; directive and participatory hands-on support; concurrent monitoring and problem solving.

With the overall goal of providing techno-managerial support to improve the efficiency, effectiveness and equity of delivery of key RMNCH+A interventions, the five objectives of UP-TSU are outlined below:

1. Strengthen frontline worker (FLW) skills and capabilities: Strengthen FLW skills and capabilities through supportive supervision and job-aids to improve the quality and quantity of interactions in households, at village health nutrition days (VHNDs) and facilities, to increase service access and improve the eight key behaviours around maternal, newborn and child health (MNCH), nutrition, and family planning.
2. Build skills and capabilities of providers at facilities: Improve availability of services and quality of care at first level facilities e.g., Block Primary Health Centres (BPHCs) and referral facilities by offering improved training and on-site skills building (e.g., nurse mentors and skills labs) combined with improved case sheets, checklists and workflow management tools.
3. a) Improve health system management capabilities to support the efficient and effective execution of the above two areas.
 - Ensure robust project planning and funds flow (e.g., Programme Implementation Plan (PIP) processes)
 - Establish appropriate roles and responsibilities for supportive supervision at the block, district and state levels
 - Leverage information communication technology (ICT) to improve data disintermediation and demand, and to drive performance efficiencies, especially among FLWs and facilities
 - Create robust systems for data collection, analysis and planning to improve management of the programme [e.g., Mother and Child Tracking System (MCTS), Health Management Information System (HMIS)]
 - Create robust concurrent monitoring systems to validate data collection by the system and feedback information for immediate and mid-course correction
 - Assist the Government to execute existing incentive schemes at scale by improving data management and planning, and streamlining payment systems
- b) Support critical infrastructure improvements at health system level in collaboration with other development partners: support selected cross-cutting areas of the health system that act as critical bottlenecks to the first two areas listed above:
 - Improve supply chain and cold chain management to minimise stock-out of essential drugs
 - As the state's lead partner, ensure alignment with donor and partner efforts in the state; coordinate with other 'units' to catalyse the overall response especially around creating critical infrastructure e.g. Primary Health Centres (PHCs), first referral units and human resources (staff nurses, supervisors, etc.)

4. Improve the Government's ability to be better stewards of the private sector, through better management and contracting approaches:
 - Assist the Government with devising and executing schemes and contracts to outsource select provision to the private sector (e.g., Oral Rehydration Solution (ORS)/Zinc scheme) to improve distribution, institutional deliveries, clinical services for family planning, 'outsourced' management of first referral unit staff
 - Assist with improving accreditation and payment systems to enable private providers paid by the Government to increase coverage – e.g. contracting agencies (such as public private interface agencies) to oversee accreditation processes and to streamline their function
 - Explore potential options for a primary care pilot involving government and private providers under a capitation-based model
 - Work with the World Bank, the United Nations Children's Fund (UNICEF) and other partners to ensure harmonisation of efforts with other public private partnerships (PPP) in the state
5. Enable accountability measures to provide feedback on quality of services, improve external accountability and hence drive programme change:
 - The NHM construct includes an external accountability framework that includes social audits and involvement of democratic grassroots institutions (*gram panchayats*) and grievance redress mechanisms. While progress has been slow, senior politicians and bureaucrats are committed to this vision.
 - Support government to strengthen the functioning of existing government-mandated accountability structures such as Village Health, Sanitation and Nutrition Committees, patient welfare committees (*Rogi Kalyan Samiti*) and grievance redress mechanisms, where beneficiaries can directly register or log their complaints. The UP-TSU would support the state government to contract non-governmental organisations (NGOs) to build Village Health, Sanitation and Nutrition Committee capabilities.

To achieve its goal and objectives, the UP-TSU is unlocking government health system's 'execution capacity' at block, district, divisional and state levels, to accelerate progress against critical indicators in the areas of MNCH, family planning, immunisation, and nutrition interventions and services.

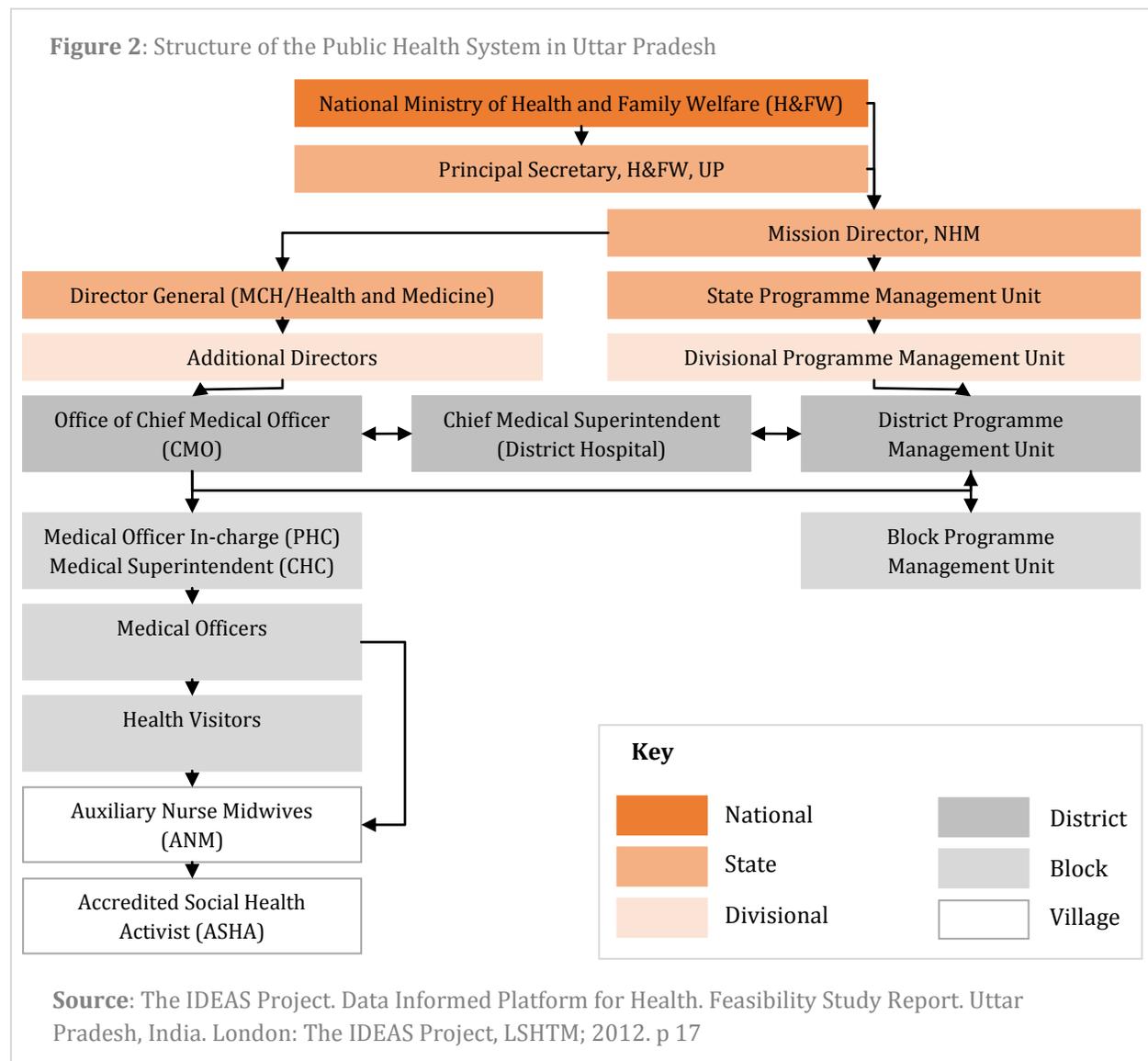
UP-TSU works closely with the health and other related departments at state level, in 100 priority blocks across 25 high-priority districts with poor RMNCH+A status. It consists of a core Technical Team, a Programme Support Team and a Monitoring and Evaluation (M&E)/Strategic Planning Team. Together, they support the Government on macro-level planning of critical RMNCH+A intervention strategies and processes; and support district and block health offices in programme implementation. Organisationally, the UP-TSU has a reporting relationship with the Principal Secretary for Health and Family Welfare, GoUP.

2. Context

2.1 Geographic area

Situated in northern India, UP is the most populous yet also one of the most underprivileged states. Agriculture is the predominant economic activity in the region, which is dominated by the fertile Indo-Gangetic plain. However, malnutrition levels are quite high with 51 percent of women aged 15-49 years reported to be anaemic¹. On average three-quarters of villages in the state have a health Sub Centre (SC) located within a 3km radius².

2.2 The health system



UP has a pluralistic health system with diverse providers including public, private for-profit and non-profit, traditional complementary and alternative medicine, informal and faith healers. The NHM is a significant public health programme implementing maternal and neonatal health services at the village level. Under NHM Accredited Social Health Activists (ASHAs) are incentive-based frontline health volunteers at the village level, linked to the Auxiliary Nurse Midwife (ANM), who is in-charge at the SC, or lowest level health centre serving a population of approximately 5,000 people. At block level there is a secondary level Community Health Centre (CHC) for every 100,000 population and a PHC for every 50,000 population. The District Hospital is the apex referral centre at the district level. It also houses the office of the Chief Medical Officer (CMO), who is the chief health administrator of the district. NHM also has a District Programme Management Unit (DPMU) located at the district headquarters and a Block Programme Management Unit (BPMU) at block level. In UP there are several grades of primary and secondary facilities – the Block PHC is equivalent to CHC, while the additional or new PHC is a sub centre that has been recently upgraded to PHC.

2.3 The population and behavioural context

UP is among India's least developed regions with low urbanisation and significantly higher maternal, neonatal and child mortality rates than the national average. Studies indicate that poor maternal and neonatal outcomes in UP are due to a complex interplay between low socioeconomic development, entrenched cultural practices and poor service delivery³. Various demographic and health surveys have shown sharp divisions of caste and class in coverage rates of basic healthcare. Recent data show that only about half of mothers (52%) gave birth in health facilities,* and almost a quarter (23%) of mothers did not have any postnatal care coverage at all. Only about half (48%) of children under three-years were fully immunised⁴. According to the Annual Health Survey in UP during 2011-12, the maternal mortality ratio in the state was 300 per 100,000 live births⁵ and the neonatal mortality rate was 49 per 1,000 live births⁵. The infant mortality rate was 57 infant deaths per 1,000 live births in UP, sharing the highest rate in the country⁶. The total fertility rate in UP was estimated at 3.8 in 2008⁶.

2.4 Challenges addressed by the UP-TSU

The UP-TSU aims to address the following health system challenges at state level:

- a) Improve the planning of interventions, in terms of realistically estimating the resources and materials required, and the service gaps that need to be fulfilled.
- b) Implementation challenges such as inadequate expenditure, unsystematic implementation and poor monitoring and supervision of ongoing programmes and services.
- c) Poor data quality and lack of utilisation of data in decision making. Government officials' lack of awareness of the importance and use of data to set indicators and therefore data processes and quality have not been prioritised.

Health system challenges at facility and community level:

- a) Harmful facility practices around delivery care, such as administering oxytocin to augment labour, applying oil to the cervix to aid the baby's passage, and wiping the newborn with oil to remove the vernix.

* Based on births in the reference period: 1 January to 31 December 2010, of ever married women aged 15-49 years.

- b) Gaps in the listing and tracking of pregnant women and young children by FLWs for maternal and child health (MCH) services.
- c) Poor coverage of home based postnatal care and lack of technical knowledge and communication skills that affect the coverage and quality of counselling by ASHAs on maternal and newborn care.
- d) Lack of coordination between the three FLWs at the community level (ASHAs, ANMs and Anganwadi Workers (AWW)), which affects the efficiency and quality of community health work.
- e) Poor compliance with protocols by ANMs while administering community based antenatal care and immunisation.

Challenges relating to the socio-cultural behaviour around maternal and child health:

- a) Poor community practices around maternal care, such as late pregnancy registration, poor birth preparedness and persistently high home deliveries.

Harmful practices around newborn and child care, such as pre-lacteal or supplementary feeding of baby with water, honey or tonic (*ghutti*); use of kohl (*kaajal*) to line the infant's eyes and poor compliance with the immunisation schedule.

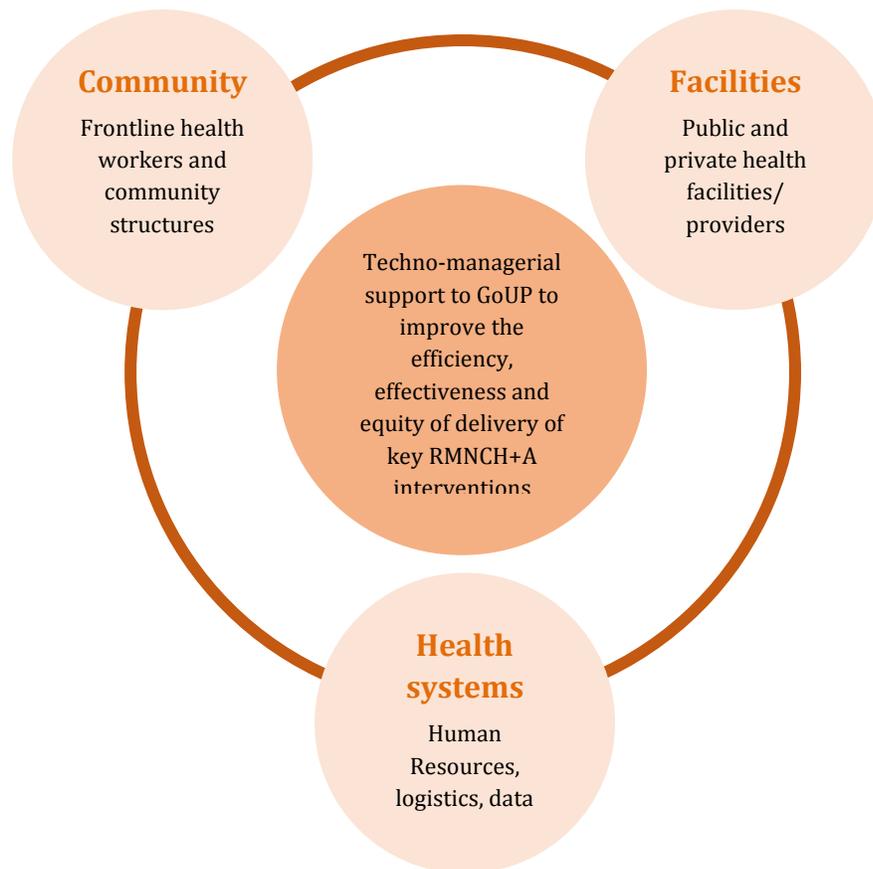
3. Description of the implementation pathway

3.1 Planning the intervention

The Government of India launched the RMNCH+A Strategic Approach in 2013 for accelerating child survival and improving maternal health, and the GoUP has followed up the national launch with its own commitment through the state RMNCH+A effort (*Hausala campaign*). The UP-TSU's mandate is to support the GoUP in supporting implementation of its RMNCH+A agenda.

The philosophy of technical and managerial assistance is similar to those TSUs managed under the foundation's *Avahan* programme, and also similar to some of the functions performed by the polio National Polio Surveillance Project. It also builds on learnings from other programmes such as the Bihar Technical Assistance and Support Team, the State Innovations in Family Planning Services Project Agency, and UP Health Systems Strengthening projects under the World Bank.

Figure 3: UP-TSU Framework



The TSU's activities are focused on the 25 most under-served districts in the state, where the aim is to improve RMNCH+A service delivery and outcomes within 100 priority blocks. These districts have been selected and agreed upon jointly by the Government of India and GoUP. Wherever possible (e.g. through state-level policy guidance) the UP-TSU is also putting in efforts at state level, even though the focus is the 25

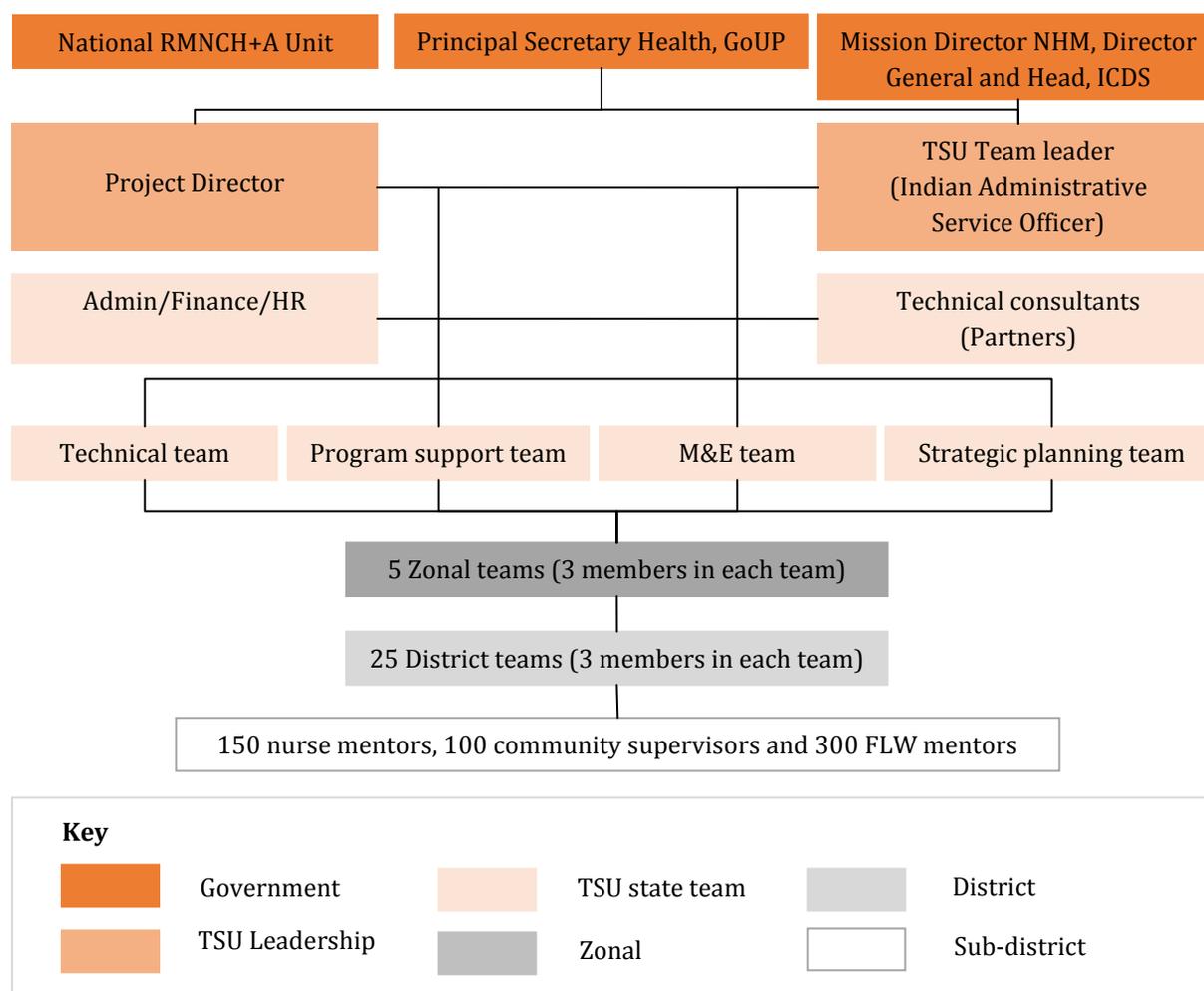
high priority districts. The block selection is based on the facility mapping survey which was conducted by the India Health Action Trust team in last quarter of 2013.

The facility mapping survey gave the team a fair idea of the UP health system and the community (FLWs interactions), facility (Staff Nurses) and overall health system challenges to be focussed on.

3.2 TSU structure

The UP-TSU is integrated and aligned organisationally within the GoUP/NHM Directorate, established and supported technically by the India Health Action Trust, with 11 other partners. The UP-TSU is comprised of a core Technical Team, a Programme Support Team and an M&E/Strategic Planning Team. Together, the teams are working with the UP NHM on macro-level planning of critical RMNCH+A intervention strategies and processes; and with the district and block health offices to provide technical support at implementation level.

The UP-TSU is headed by a Team Leader, an Indian Administrative Services officer, who has the skills and experience of managing complex interventions, and is qualified to forge a strong partnership with the Government in exploring the strategies for increasing the reach, coverage and quality of crucial RMNCH+A interventions and services. The UP-TSU Team Leader is responsible for managing the UP-TSU programmes on the ground and liaising with the GoUP on key areas. The Project Director provides overall technical and managerial leadership to the UP-TSU team. The UP-TSU Team Leader and the Project Director are assisted by three teams of technical specialists, programme specialists and M&E specialists.

Figure 4: Structure of UP-TSU (key positions and teams)

Planning and advisory committees

The project advisory committee (PAC) has been formed to suggest various ways of overcoming major gaps and challenges experienced by the TSU, and to identify elements of project learning that could be advocated for scale-up in various national and state-level programmes. The PAC also advocates approaches and strategies which are more effective for the UP-TSU's mandate. The PAC includes representatives of the national, state and district governments (both NHM and the Women & Child Development Department), national experts on RMNCH+A and nutrition, representatives of the private health sector, etc. This committee meets every six months and is being headed by the Chief Secretary.

The Programme Planning Committee consisting of members from the UP-TSU, State Innovations in Family Planning Project Services Agency, the Directorate of Health and the State NHM meets once every two months. Data generated by the UP-TSU and HMIS bulletin are usually presented in the meeting, around which planning-related concerns are discussed.

Apart from this, an International Advisory Group/ Technical Advisory Group has been constituted of 15-20 experts at national and global level from universities and institutions like the World Health Organization, the World Bank etc. This group meets once every six months, mainly to advise the UP-TSU on technical aspects.

The TSU consortium Core Committee has been formed with representation of all consortium partners – India Health Action Trust, EngenderHealth, John Snow International Research & Training Institute Inc., Marie Stopes International, Janani, King George’s Medical University, Clinton Health Access Initiative, BBC Media Action, Global Health Services, Oxfam and Centre for Advocacy and Research. The committee meets every month for the UP-TSU’s internal task planning and management.

Collaboration with the Government of Uttar Pradesh

The UP-TSU has developed joint teams with State Health System Resource Centre for capacity building and training, and with NHM officials at state and district levels for designing strategies and work plans. Joint review meetings, participatory programme reviews and structured field visits are being planned with NHM key personnel. Such joint efforts promote effective working relationships with the GoUP and NHM counterparts in the state.

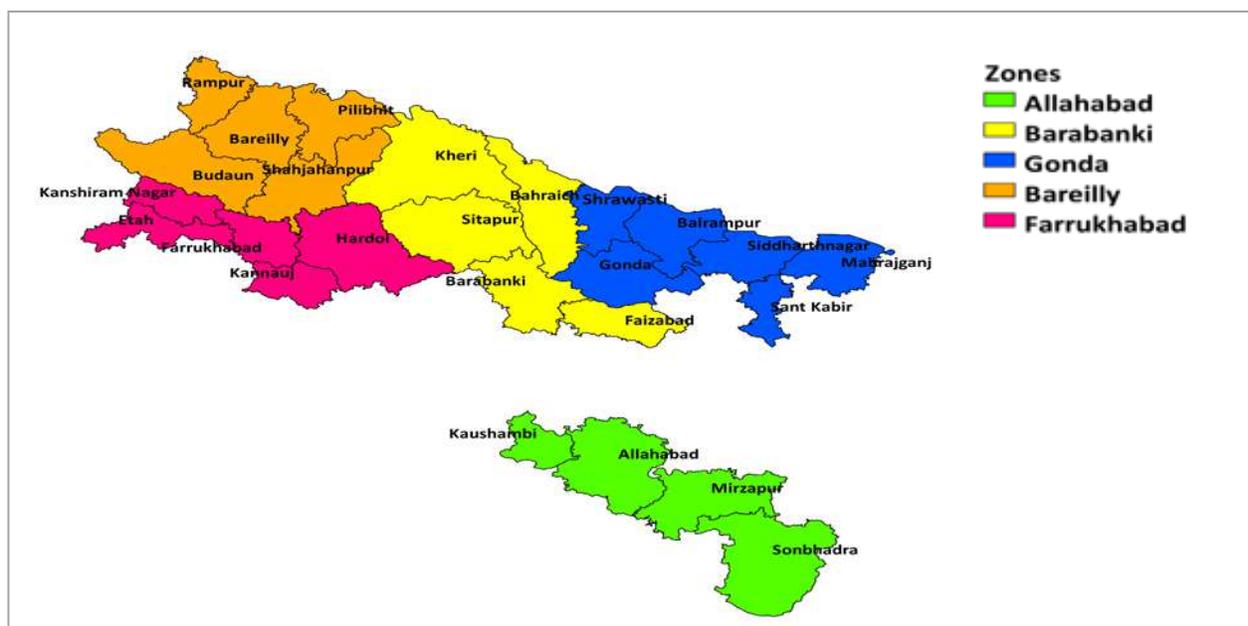
Staffing structure

UP-TSU staff are co-located with the UP NHM/Department of Health at various levels. While the state level teams work closely with the state NHM office, the district level teams are co-located with the CMOs in each district, the block level supervisors are placed within the BPHC/CHCs, and the FLW mentors are placed within the PHCs.

At state level, the UP-TSU has a technical team, a programme support team and a M&E and strategic planning team. The technical team ensures technical content of the system and facility-based interventions, the programme support team oversees the supportive aspects of communication, demand generation and management, while the M&E and strategic planning team looks after programme monitoring and also ensures ownership by the GoUP of critical interventions.

The 25 focus districts are grouped into five zones, such that each zone covers an equal number of geographically contiguous districts. At zonal level, the zonal team provides supervisory support to the district teams. Teams at district and block levels are responsible for implementing the UP-TSU interventions at facility and community levels, and carry out field based M&E activities.

Figure 5: UP-TSU divided 25 high priority districts in five zones



Tables 1-3 summarise the staffing structure of the UP-TSU at state, zonal and district levels.

Table 1: UP-TSU staffing structure and key responsibilities at state level

Position name	Key responsibilities	Government or other partners with whom they liaise
Project Director	<ul style="list-style-type: none"> From the University of Manitoba. Responsible for overall project leadership and direction, both managerial and technical. Provide strategic leadership to achieve project goals and objectives. Work with the TSU team leader, in partnership with the Principal Secretary, Health and Family Welfare, GoUP. 	Director General (Medical Health and Family Welfare) Mission Director- NHM
TSU Team Leader	<ul style="list-style-type: none"> An Indian Administrative Service Officer who manages TSU programmes on the ground and liaises with the GoUP on all areas. Reports to the Principal Secretary, Health and Family Welfare, GoUP. 	Director General (Medical Health and Family Welfare) Mission Director- NHM
TSU Technical Team	<ul style="list-style-type: none"> A team of 11 technical specialists, including a Technical Team Leader, who reports to the TSU Team Leader. The members of the team include one each in the areas of quality improvement, obstetrics, newborn care, nutrition, immunisation, family planning, adolescent health, infection control, agriculture and financial inclusion. The team also has a Programme Officer to support the nurse mentoring. The role of team members is to ensure appropriate and current technical content in all the activities of the TSU related to the area of their specialisation. The team is also responsible for designing and implementing health systems and facility-based interventions, and providing support to the zonal and district level technical teams. 	State Programme Officers (Directors/Joint Directors) of Directorate General Managers (General Managers)/ Deputy General Manager of State Programme Management Unit (SPMU)
TSU Community Processes Team	<ul style="list-style-type: none"> A 10-member team including the Team Leader who reports to the TSU Team Leader. Other members cover the areas of community outreach, communications, community mobilisation, training and advocacy. Designing and implementing interventions related largely to FLWs and community support structures. Providing leadership to the zonal, district and block level community processes teams. 	State Programme Officers (Directors/Joint Directors) of Directorate General Managers (General Managers)/ Deputy General Manager of SPMU
TSU M&E Team	<ul style="list-style-type: none"> A team of 10 specialists in M&E (2 each in the areas of programme monitoring, surveys and HMIS/MCTS, 3 data analysts and 1 for ICT). Designing and implementing the overall M&E strategy for the TSU, concurrent monitoring (community behaviour tracking surveys and rolling facility surveys), HMIS/MCTS support and 	State Programme Officers (Directors/Joint Directors) of Directorate General Managers (General Managers)/ Deputy General Manager of SPMU

	<p>the ICT roadmap of GoUP.</p> <ul style="list-style-type: none"> • Providing technical inputs to the M&E specialists at zonal and district offices. 	
<p>TSU Strategic Planning Team</p>	<ul style="list-style-type: none"> • A team of five specialists in the areas of project implementation plans (PIP), dashboards, RMNCH+A monitoring and advocacy. • Work towards ensuring ownership by GoUP of critical interventions and approaches/innovations – e.g., inclusion of budgets in the PIP, convening critical meetings, and support for PIP development and other planning support. • Together with the M&E and other teams, identifying the key RMNCH+A interventions and programme approaches (based on gap analysis and concurrent monitoring) using evidence. • Facilitating the inclusion of these interventions and approaches in the state and district PIP processes. • Engaging with stakeholders (other development partners and government) to build consensus on key program interventions and assists the foundation in playing its role as the state lead partner, which requires managing the State Unified Response Team and coordinating the functions of the team in filling district gaps (identification of technical resource partners for RMNCH+A thematic areas, capacity building, monitoring and feedback based on Government of India guidelines). • Ensuring that the Government of India's vision, guidelines and strategies are understood and implemented by the state and districts, and that they receive regular feedback (through analysis of concurrent monitoring done by district and M&E teams) and use it to shape policies, plans and programme activities. 	<p>State Programme Officers (Directors/Joint Directors) of Directorate</p> <p>General Managers (General Managers)/ Deputy General Manager of SPMU</p>

Table 2: UP-TSU staffing structure and key responsibilities at zonal level

Position name	Key responsibilities	Government or other partners with whom they liaise
Zonal Community Specialist (ZCS)	<ul style="list-style-type: none"> • Provide overall management of CRP intervention in all five districts of assigned Zone • Provide on-site supportive supervision to District Community Specialist (DCS), BCS and CRP as and when required • Should also lead training and orientation of DCS and CRPs on RMNCH+A areas 	<p>CMO, ACOMO, Assistant Directors of Directorate</p> <p>Divisional Programme Managers of SPMU, DPM, District Community Process Manager (DCPM)</p>
Zonal Technical Specialist (ZTS)	<ul style="list-style-type: none"> • Provide overall management of Nurse Mentor intervention in all five districts of assigned Zone. • Provides on-site supportive supervision to the District Technical Specialist (DTS) and Nurse Mentor as and when required • Should also lead training and orientation of DTS and Nurse Mentors on RMNCH+A areas 	<p>CMO, ACOMO, Assistant Directors of Directorate</p> <p>Divisional Programme Managers of SPMU, DPM, DCPM</p>
Zonal M&E Specialist (ZM&ES)	<ul style="list-style-type: none"> • Designing and implementing the overall M&E strategy for the districts under his/her zone, concurrent monitoring (community behaviour tracking surveys and rolling facility surveys), HMIS/MCTS support. • Provide technical inputs to the M&E specialists at district offices. 	<p>CMO, ACOMO, Assistant Directors of Directorate</p> <p>Divisional Programme Managers of SPMU, DPM, DCPM</p>

Table 3: UP-TSU staffing structure and key responsibilities at district level

Position name	Key responsibilities	Government or other partners with whom they liaise
District Community Specialist (DCS)	<ul style="list-style-type: none"> Improve the quantity and quality of interactions between FLWs and households in the assigned district. Support the CMO/DCPM in the planning and review of the community processes in the district through regular data sharing, joint field visits (including block monitoring and supportive supervision visits) and review meetings. Support the BCSs and CRPs in the TSU focus blocks through regular data analysis, field visits, trainings and review meetings. Support the MOICs/Block Community Process Managers in the other blocks through joint field visits and review meetings and through sharing the learnings from the TSU focus blocks through exposure visits. 	<p>CMO, ACOMO, DPM, DCPM, MOIC, Block Programme Manager (BPM) and Block Community Process Managers of blocks</p> <p>District Programme Officer-Integrated Child Development Services (ICDS)</p>
District Technical Specialist (DTS)	<ul style="list-style-type: none"> Provide management support to the nurse mentors in the district through regular data analysis, field visits and review meetings. Support the CMO/ACMO in (a) the implementation of facility-wise activation and strengthening as per the approved PIP, (b) preparation and implementation of training of facility staff, (c) supportive supervision at district hospitals of the services related to delivery and newborn care, family planning, child health, nutrition and adolescent health. Support the district RMNCH+A review meetings. 	<p>CMO, ACOMO, DPM, DCPM, MOIC, BPM and Block Community Process Managers of blocks</p> <p>District Programme Officer-ICDS</p>
District M&E Specialist (DM&ES)	<ul style="list-style-type: none"> Improve the quality and use of HMIS/MCTS in the district by: Supporting the CMO/DPM in the regular block-wise and facility-wise analysis of the HMIS/MCTS data in the district, including the HMIS dashboards. Supporting the BCSs and nurse mentors in improving the quality and use of HMIS/MCTS in TSU focus blocks. Supporting the BPMs in improving the quality and use of HMIS/MCTS in other blocks. Facilitating the district health department to take corrective measures based on data through dashboard indicators. Analysing and sharing data from the Community Behaviour Tracking Survey, Rolling Facility Survey, Enumeration Tracking Tool, Case sheets, Block monitoring visits, supportive supervision visits and other data sources with the District Magistrate (DM)/CMO/DPM on a regular basis. Facilitating the use of TSU-developed dashboards at the district and block levels. Analysing and sharing the PIP tracking data for improved implementation of the District Health Action Plan. 	<p>CMO, ACOMO, DPM, DCPM, MOIC, BPM and Block Community Process Managers of blocks</p> <p>District Program Officer-ICDS</p>
District RMNCH+A Monitor	<ul style="list-style-type: none"> A specialist from the district team is identified as the District Monitor for coordinating RMNCH+A activities in the district. 	<p>DM, CMO, ACOMO, DPM, DCPM</p>

	<ul style="list-style-type: none"> • Facilitate the regular RMNCH+A review meetings at district and block levels. • Organise supportive supervision and block monitoring visits in the district. • Coordinate and align with the other development partners in the district. • Regularly share the HMIS dashboards and child survival score cards with district health officials. 	
Block Community Supervisor (BCS)	<ul style="list-style-type: none"> • Improving the quantity and quality of interactions between FLWs and households in the assigned block by: • Supporting the CRPs through regular data analysis, field visits, training, and review meetings. • Supporting the MOIC/BPM in planning based on community gap analysis and through joint field visits. • Improving the process to promote continuum of care between the community and health facility; and follow up at community level in the assigned block, by supporting regular feedback mechanisms between the FLWs and the facility (MOIC, staff nurses, BPMs etc.), to support the quality and use of HMIS/MCTS at the sub-centre level. 	MOIC ,BPM and Block Community Process Managers, Health supervisors, ANM, ASHA and Supervisors of ICDS
Nurse Mentors	<ul style="list-style-type: none"> • Improve the quality of available RMNCH+A services. • Activate the “missing” RMNCH+A services as per the approved district health action plan. • Improve the quality of newly activated services in the facilities that need to be “activated” as delivery points in the block as per the approved district health plan. • Support the MOIC in the implementation of the “activation” plan. • Improve the quality of services in the newly “activated” facilities. • Enhance the clinical skills and practices of ANMs including the identification and tracking of high risk pregnancies. • Support the CRPs in enhancing selected skills of ASHAs. • Support the quality and use of HMIS in delivery points. • Support the establishment of a mini skills lab at the BPHC/CHC. 	MOIC and BPM of block, Staff nurse of health facility, ANM and ASHA
Community Resource Person (CRP)	<ul style="list-style-type: none"> • Improve the coverage and frequency of outreach/home visits by ASHAs in the assigned cluster by supporting them with the use of Village Health Information Register. • Improve the quality of interactions between ASHAs and households during home visits in the assigned cluster by supporting them with the home visit checklists and family-focused behaviour change communication materials and tools. • Improve the quality and coverage of Village Health and Nutrition Days (VHNDs). • Improve the coordination/ problem solving among FLWs in the assigned cluster by supporting the conduct of ASHA, ANM, AWW forum meetings. • Improve the community processes planning and review through real-time data in the assigned cluster from gap analysis and Village Health Information Register summary. 	MOIC and BPM of blocks, ANM, ASHA and AWW Supervisors

3.3 Functions of the UP-TSU

At state level, the UP-TSU is providing policy support to the state NHM and Directorate of Health. This includes, but is not limited to supporting government:

- In drafting evidence-based PIPs for relevant RMNCH+A areas based on local district and block needs.
- In strengthening its information systems such as the MCTS, HMIS and human resource information system.
- To strengthen and reinvigorate implementation of existing schemes. For instance, the UP-TSU may assist the government to execute existing incentive schemes at scale by improving data management, planning and streamlining payment systems.
- To launch and scale proven innovations for RMNCH+A health delivery. For instance, clinical mentors who travel to public facilities to provide on-the-job training for medical officers and nurses are being introduced.
- In strategically engaging private organisations and NGOs to improve development outcomes. For instance, in association with the World Bank's Health System Strengthening project, the UP-TSU will support the Government in designing guidelines for PPP projects. Another example of activities could be supporting the Government in the launch of social marketing schemes for ORS/Zinc, contracting of management agencies for first referral units, etc.
- In creating effective ICT-based solutions to empower the health machinery at all levels, from the FLW to state planners. For instance, support for rolling out mobile phone-based job-aids for ASHAs will be provided. Another area of support in this category could be the introduction of an integrated call-centre that acts as a resource for FLWs and a mechanism for grievance redressal.
- By providing regular survey data to be used for planning and concurrent monitoring purposes.
- Selectively, in improving in-facility availability of essential RMNCH+A commodities such as magnesium sulphate, dispersible amoxicillin, uterotonics, etc.
- With demand generation activities that improve uptake of public services.
- With strengthening existing grassroots mechanisms such as Village Health, Sanitation and Nutrition Committees and *Rogi Kalyan Samiti*.
- In implementing transformational pilots in areas such as urban health care.

At district level, the UP-TSU is co-located within the CMO's office and provides relevant execution support at district level. This could include but is not restricted to supporting the district in:

- Strengthening of FLW skills/capabilities through the development and implementation in selected blocks of
 - simple-to-use tools and job aids to improve the quality and quantity of interactions, and
 - a FLW mentoring and supportive supervision system

- Building the skills and capabilities of primary care providers through the development and implementation of on-site clinical mentoring
- Data management and use of dashboards, including improvements to the MCTS, HMIS and human resource information system
- Concurrent monitoring and supportive supervisory systems for review and feedback
- The preparation of the district PIP and tracking performance
- Improving the availability of infrastructure, supplies, drugs and commodities at facilities
- Responding to state-level requests.

At block level, the UP-TSU has appointed staff to engage with clinical workers as well as FLWs. For instance, UP-TSU staff are working with FLWs to improve their skills and capabilities through supportive supervision and job-aids to improve quality and quantity of their interactions in households, at VHNDs and facilities. UP-TSU staff are also working to ensure and improve the availability of services and quality of care at first level facilities (e.g., block PHCs) and referral facilities by offering improved training and on-site skills building (e.g., nurse mentors and skills labs) combined with improved case sheets, checklists and workflow management tools.

Table 4 outlines the UP-TSU teams' functions and key activities at district and zonal levels, along with the teams responsible.

Table 4: Functions and activities of district and zonal level UP-TSU teams

TSU functions	Activities	Essential or Supportive	Staff responsible	Technical area (whether R, M, N, CH or A)	Operational level (community / facility / programme)
Concurrent monitoring	BMV and facility visit [Two blocks per month- 1 focus block and 1 non-focus block in every month]	Essential	DTS, DCS and DM&ES ZTS, ZCS and ZM&ES if help required by district team	RMNCH+A	Community, facility and programme
Implementation support	Supportive supervision and hand-holding support to the Nurse Mentor for mentoring programme	Essential	DTS and ZTS	R, M, N	Facility
Planning	Preparation and review of monthly programme facility report	Essential	ZTS, DTS and DM&ES	RMNCH+A	Facility and programme
Integrated support	Follow up of mannequins and establishment of mini skills labs at six intervention blocks	Essential until establishment thereafter supportive to follow up	DTS and ZTS	RMNCH+A	Facility and programme
Planning, Techno-managerial support, Integrated support, Implementation support, Techno-managerial support, Support at different levels	Meeting with district officials regarding monthly progress report and existing status of all delivery points in TSU blocks; Discussion with MOIC and BPMU regarding identified gap through self-assessment tool	Essential	DTS and ZTS	RMNCH+A	Facility and programme
Techno-managerial support, Support at different levels	Attending meetings such as ANM meetings, Staff nurse meetings	Supportive	DTS and ZTS	RMNCH+A	Facility
Implementation support	Supportive supervision and hand-holding support to BCS and CRPs for mentoring CRP programme	Essential	DCS and ZCS	RMNCH+A	Community
Implementation support	Back check of community resource mapping	Essential	DCS, ZCS and ZM&ES	RMNCH+A	Community
Techno-managerial support,	Supportive supervision and feedback sharing of VHNDs, ASHA, ANM, AWW meetings	Essential	DCS & ZCS	RMNCH+A	Community

Implementation support, Integrated support	Supportive supervision and facilitating CRPs on Enumeration Tracking Tool / Village Health Information Register, identification of couple with unmet need for family planning, preparing due list etc.	Essential	DCS	RMNCH+A	Community
Techno-managerial support, Support at different levels, Integrated support, Embeddedness	Sensitisation and orientation of district and block government officials (CMO, ACOMO, MOICs, DPMU, ICDS, BPMUs etc.) regarding new guidelines on VHND, BMV feedback sharing, areas of improvement	Essential	DCS	RMNCH+A	Community and programme
Concurrent monitoring, Implementation support	ANM orientation on HMIS /MCTS, strengthening on data quality, validation errors and data capturing	Essential	DM&ES and ZM&ES	Programme	Programme
Concurrent monitoring, Implementation support	Follow up of monthly HMIS data quality uploading with all blocks of the district	Essential	DM&ES and ZM&ES	Programme	Programme
Concurrent monitoring, Implementation support	Facilitate the error correction with the blocks as per discussion with DPMU	Essential	DM&ES	Programme	Programme
Concurrent monitoring, Implementation support	MCTS data monitoring on a daily, weekly and monthly basis of entries, update, and capturing of quality issues	Essential	DM&ES and ZM&ES	Programme	Programme
Concurrent monitoring, Implementation support	Analyse and present HMIS/MCTS data at district/block review meetings (monthly) for programme performance, including dashboard and data quality issues with nodal officers	Essential	DM&ES and ZM&ES	Programme	Programme
Concurrent monitoring, Techno-managerial support,	Prepare and share list of facilities, from HMIS/MCTS data that need support by the Nurse Mentor, BCS and block level government officials such as Assistant Research Officer, BPM etc. (Focus blocks)	Essential	DM&ES	Programme	Programme

Concurrent monitoring, Support at different levels	Identification of facilities who are not performing as per the protocol in MCTS and HMIS especially in focus block	Essential	DM&ES	Programme	Programme
Concurrent monitoring	Prepare HMIS bulletin and share with the CMO and DPMU officials as well as block personnel	Essential	DM&ES	Programme	Programme
Concurrent monitoring, Support at different levels	Follow-up of supportive supervision and back check of 2% of the supportive supervision data from Nurse Mentor and BCS every month (in focus blocks)	Essential	ZM&ES	Programme	Programme
Techno-managerial support, Support at different levels,	Monthly RMNCH+A review meeting	Essential	DTS, DCS, DM&ES alongside zonal team if available	RMNCH+A	Community, facility and programme
Planning	District level monthly review and planning meetings	Essential	District and Block TSU team (DTS, DCS, DM&ES, Nurse Mentor, BCS)	Programme	Community, facility and programme
Planning	Zonal level technical team monthly review and planning meetings	Essential	ZTS alongside all respective DTS	Programme	Facility
Planning	Zonal level community team monthly review and planning meetings	Essential	ZCS alongside all respective DCS	Programme	Facility
Planning	Zonal level monitoring and evaluation team monthly review and planning meetings	Essential	ZM&ES alongside all respective DM&ES	Programme	Facility
Planning, Embeddedness, Integrated support	Participation in workshop/ training programmes e.g. Quality assurance workshop	Supportive	District and Zonal TSU team	Programme review	Programme
Implementation support, Support at different levels	Support GoUP trainings by acting as trainers and providing methods and tools (Maternal Death Reviews/HMIS/MCTS)	Essential	Zonal specialists	Programme	Programme

3.4 Monitoring and supervision systems

Monitoring and evaluation processes are seen as integral to the success of the UP-TSU model. The theory of change principles (gap analysis, prioritisation, hands-on support, concurrent monitoring, and problem solving) are applied to the evaluation of the UP-TSU's interventions throughout their roll out. Issues identified by monitoring processes are being utilised to adjust the programme as needed. UP-TSU accordingly has a concurrent monitoring component, in addition to an external measurement, learning and evaluation (MLE) partner who is continuously monitoring the programme processes and outputs.

An integrated monitoring system is established with the NHM to monitor progress in key domains, including reach, scale, quality and utilisation of critical RMNCH+A services. The UP-TSU is using and also constantly developing government MLE initiatives such as the RMNCH+A monitoring dashboard.

- Concurrent monitoring is a critical component of the UP-TSU. This activity entails the UP-TSU establishing processes through the FLW mentors and Block Supervisors to aggregate critical indicators of service provision, on the basis of enumeration and tracking tools, which are aggregated further at higher levels to understand the trends in various indicators at various levels of implementation and the gaps in quality and use of those indicators.
- In addition, data that are already collected as part of the HMIS/MCTS are being used to measure key indicators of scale and coverage.
- The UP-TSU plans to design and implement periodic short surveys to monitor coverage of key interventions at population, facility and FLW levels. In addition, the UP-TSU, in coordination with its external MLE partners, will use data from the District Level Household and Facility Survey and National Family Health Survey to explore change in project outcomes, subject to their being conducted in a timely fashion in relation to project activities. The external MLE partner is tracking and interrogating outcome level changes, triangulating evidence being generated and used through state systems, and undertaking needs based studies (possibly including experimental designs) to understand how trajectories of change are unfolding. The external MLE partner is also focusing on tracking the administrative and governance performance of the UP-TSU specifically and the health system generally.

3.4.1 UP-TSU supportive supervision and reporting mechanism at state level

The UP-TSU has a hierarchical structure for supportive supervision. At state level, all team members have to report to their respective team leaders about their assigned tasks. The four team leaders spend about one-fifth of their time supervising and supporting the zonal teams of the UP-TSU. The zonal teams supervise and support the district and block level teams. The supervisory role of the zonal teams over the district and block level teams has been increased lately, to allow the state team more time to interact with and support the state government's ongoing, completed and future plan of action.

3.4.2 Supportive supervision and monitoring of the programme

Block Monitoring Visits (BMV): The UP-TSU district level team conduct two BMVs every month to make a quick assessment of the infrastructure, human resources and provision of services at facility and community level; and review progress of community outreach, to validate data reported at HMIS. It is mandated to complete BMV in all blocks in the district at least twice a year. The district UP-TSU team briefs the CMO, the Assistant CMO (ACMO) and the District Programme Manager (DPM) on the findings of the BMV.

HMIS dashboards: At state level a dashboard has been prepared and senior state officials are being oriented (including Chief Minister and Principle Secretary-Health) in its utilisation for which pilot trainings are going on. HMIS, Community Behaviour Tracking Survey, UP-TSU's concurrent monitoring data, BMV and all data will be integrated into this system. UP-TSU District M&E Specialists (DM&ES) are supporting the CMO and DPM in regular block-wise and facility-wise analysis of HMIS/MCTS data in the district, including the HMIS dashboards. They are also helping the Block Community Supervisors (BCSs) and Nurse Mentors in improving the quality and use of HMIS/MCTS in UP-TSU focus blocks; moreover support is extended to the Block Programme Managers (BPMs) of NHM in improving the quality and use of HMIS/MCTS in all blocks.

Apart from this, government counterparts at state and district level along with the UP-TSU team are constantly engaged in hand-holding and supportive supervision of community health workers.

3.4.3 Supportive supervision, monitoring and reporting mechanism of the Nurse Mentor and Community Resource Person intervention

In each project district, three Community Resource Persons (CRPs) and one Nurse Mentor have been placed in each block for community and facility based interventions respectively. One BCS has been placed in each of the selected 100 blocks to provide supportive supervision to the CRPs. The BCS is the first line of support for CRPs and provides on-the-job hand-holding in their field visits, data collection for community resource mapping and on-site mentoring of FLWs on a daily basis.

The District Technical Specialist (DTS), placed at district level, supervises the Nurse Mentors, providing overall management support, supervision and on-the-job support. A system of weekly and monthly meetings of the DTS and Nurse Mentor has been put in place to give regular feedback to the programme. The DTS, in turn is supported and guided by the Zonal Technical Specialist (ZTS) and the state technical team. Nurse Mentors are being monitored through three concurrent monitoring strategies: case sheet audits, the rolling facility survey and the programme review.

CRPs are monitored through weekly cluster meetings and monthly progress reports. A system of weekly and monthly meetings of the District Community Specialist (DCS), BCS and CRP has been put in place to give regular feedback to the programme. Moreover, a meeting between the Nurse Mentor, CRP and BCS is held on a monthly basis to improve coordination.

3.5 Tools and job-aids

There are no particular job-aids for the state level UP-TSU team. However all state team members have to work on the tasks assigned by their respective team members and report on the work done. An ongoing, completed and future plan of action should be shared with the team leaders.

3.6 Training

Induction training was conducted for UP-TSU staff at state level between 8th and 31st January, 2014. Altogether 45 employees from the zonal and state teams participated. Staff were taken to Bengaluru for a week to see the Karnataka programme. They also visited programmes of the other development partners in UP, like MANTHAN and Better Birth, PATH, the Urban Health Initiative. One full day's session was held with the GoUP where challenges and strategies were presented and discussed. Five days of planning meetings were held at the State Programme Management Unit (SPMU) Directorate. Towards the end of the training a draft work plan for UP-TSU was prepared and presented to the Mission Director of NHM and other senior officials.

4 Linkages with the implementation pathway

This chapter describes the stakeholders in the implementation of the UP-TSU, its beneficiaries and their linkages in terms of the material and infrastructure supplied to the programme, supportive supervision and implementation linkages with the government or public health system. [Figure 4: Linkages in the UP-TSU implementation pathway]

4.1 Description of key stakeholders

The two stakeholders in the implementation of the UP-TSU intervention are the Government and the UP-TSU. There are also the beneficiaries of the intervention. Their structure and roles at different levels are described in this section.

Government

State: The state health and family welfare department is responsible for all planning and decision making around health at state level. Besides the Directorate of Medical, Public Health and Family Welfare, Uttar Pradesh also has the NHM SPMU, headed by a Mission Director. At state level government stakeholders provided the necessary permissions and intellectual inputs in conceptualising and finalising the different intervention details, including Nurse Mentor and CRP technical skills, training manuals, tools and job aids. The Government is also the prime beneficiary of techno-managerial support provided by the UP-TSU at state level, to improve planning, management and delivery of health services.

District: The CMO's office is engaged by the UP-TSU and is updated regularly about all the UP-TSU activities in the district. District UP-TSU staff also liaise with the CMO's office and DPMU to help meet supply and other gaps at district and block level.

Block: At block level, the UP-TSU field staff engage with block facilities and Medical Officers In-Charge (MOIC) to facilitate the implementation of UP-TSU interventions. The BCSs, in consultation with district UP-TSU staff, usually interact frequently with the BPMU on CRP and Nurse Mentor activities. The MOIC at the block PHC holds weekly cluster meeting to discuss CRP activities and suggest feedback for ANM and ASHAs.

Uttar Pradesh Technical Support Unit

The state level UP-TSU team consists of three main divisions – the community processes team, technical team and the team for M&E and strategic planning. Zonal teams largely play a coordination and supportive supervision role. District staff include coordinators at district and block level, and the field staff for implementing the Nurse Mentor and CRP interventions and any other activities taken up by the UP-TSU.

Beneficiaries

State Directorate of Medical, Public Health and Family Welfare, Uttar Pradesh and the NHM SPMU; district and block level facilities covered by UP-TSU interventions; Staff nurses and ANMs at delivery points in UP-TSU blocks; the community health workers - ASHAs, ANMs and AWWs.

4.2 Materials and infrastructure

The physical material and other inputs from both stakeholders that come together to enable programme implementation, are discussed in this section. They have been categorised as those by the Government only, those by UP-TSU only and those by both stakeholders together.

Government

Key government inputs included the technical content of UP-TSU interventions for CRPs and Nurse Mentors, as both are based on government guidelines. Government infrastructure and supplies are utilised in field programme implementation. Government funds are also utilised, such as state government funding for 50 Nurse Mentors.

UP-TSU

Key inputs from the UP-TSU are funds and administrative and implementation support (arranging logistics, trainers, training material, other material) towards implementing government programmes, as well as its own interventions. The UP-TSU purchased mannequins and models for mini-skills labs at block level.

UP-TSU and Government

UP-TSU worked in consultation with government on designing all tools, training modules, protocols and job aids for the health system, as well as specifically for UP-TSU interventions. Government officials also participated in conducting trainings.

4.3 Supportive supervision

Supportive supervision refers to the role of both stakeholders in supervising and guiding the UP-TSU model and its intervention implementers.

Government

At district level, the MOIC are involved consultatively in supportive supervision of Nurse Mentors and CRPs. The Government is not directly supervising any staff or activity of the UP-TSU; however, government officials are periodically given progress updates by UP-TSU in review meetings and also participate in the annual review of the programme.

UP-TSU

The UP-TSU conducts supportive supervision through a hierarchy of block, district, zonal and state teams in (i) the community intervention, involving CRPs; (ii) facility intervention of Nurse Mentors (iii) overall status of RMNCH+A programme implementation through BMV; (iv) programme implementation and outcome through process documentation and pre-post evaluation.

4.4 Linkages with government, workforce and health personnel

State level

State level government stakeholders provided the necessary permissions and intellectual inputs in conceptualising and finalising the UP-TSU programme and its interventions. Programme tools and a training plan were designed in consultation with state and district health officials. Throughout the intervention state level officials are briefed about progress and consulted on any facilitation that may be required for implementation, or strategic changes that may be required to improve the programme.

District level

The CMO is briefed periodically about UP-TSU's activities at the district level. District TSU staff also liaise with the CMO's office and the DPMU to help meet system level gaps identified by them through their interventions.

Block level

All field activities in both the community and facility intervention at block level are carried out in consultation with the MOIC. Weekly reports by Nurse Mentors and CRPs are also shared with the MOIC. CRPs share their activities with MOIC during weekly cluster meetings to address community level gaps. Similarly, Nurse Mentors work at block facilities extending coverage to all delivery points coming under block facilities.

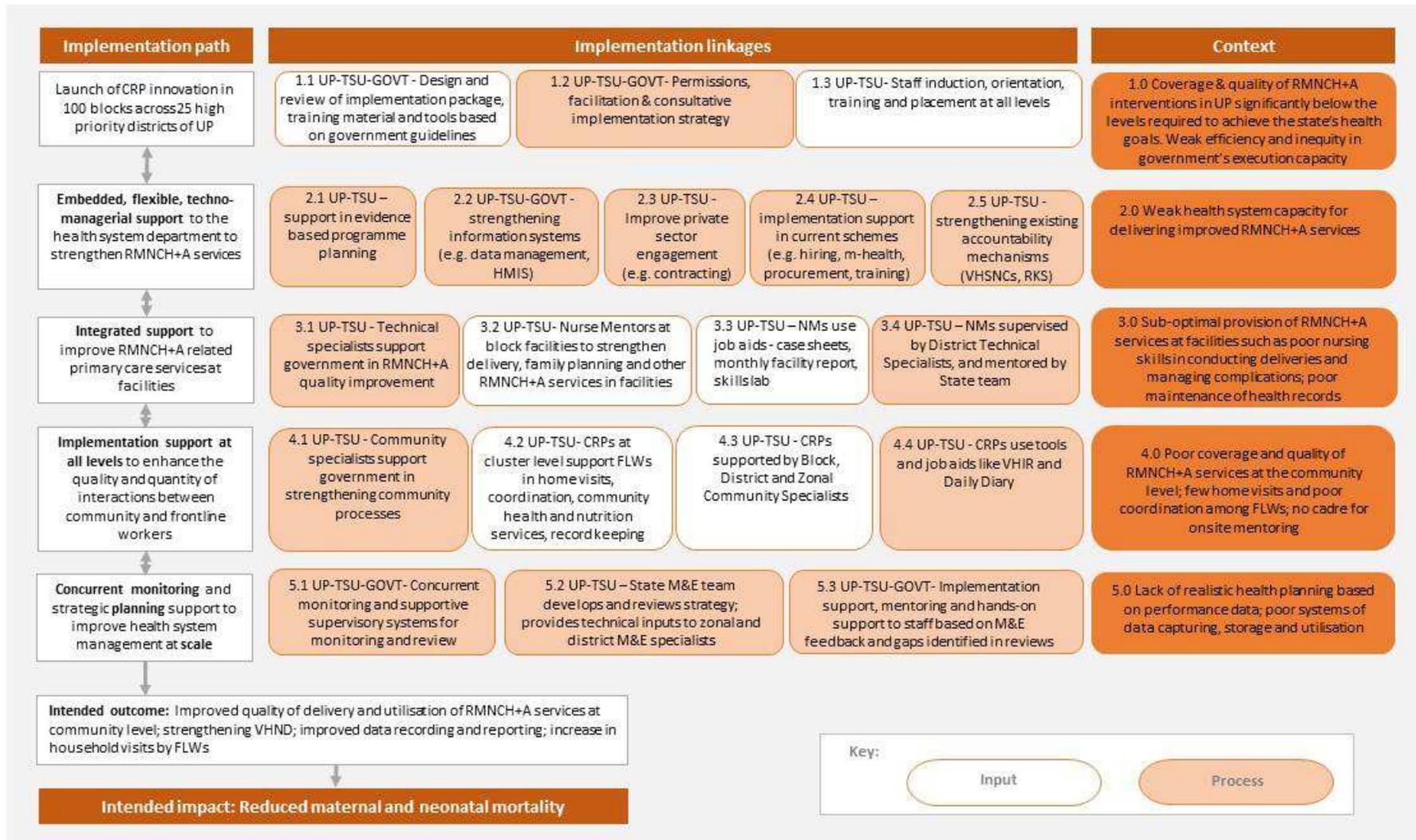
Facility level

A monthly meeting is conducted between CRP, BCS and Nurse Mentor at facility level to share observations on community RMNCH+A practices and obtain guidance and suggestions on improving the technical knowledge and skills of ASHAs.

Community level

At community level the CRP assists ASHAs, ANM and AWW in their day-to-day activities and record keeping, and provide onsite mentoring. The BCS provides her with day-to-day implementation support.

Figure 6: Linkages in UP-TSU implementation pathway



5 Description of databases

5.1 Nodal information sources which can capture the implementation effort of the innovation

Multiple data sources from government and the UP-TSU exist to understand the implementation of the UP-TSU. These include reports of trainings held, supervisory, monitoring and reporting formats, baseline data, meeting notes and financial records. Some are listed below:

Concurrent monitoring: three data sources-

1. Aggregated data from the job-aids used by FLWs and facilities: Enumeration Tracking Tool at community level and case sheet audits at facility level
2. Rolling Surveys: Community Behaviour Tracking Survey and Rolling Facility Assessments contain semi-annual data on critical indicators for programme management
3. Programme Reviews: The UP-TSU annual programme review, block monitoring visits, supportive supervision visits and other joint field visits

Data from HMIS: The HMIS captures information generated from the health system. All facilities including SC, PHC and CHC report their data to the block level in prescribed formats. These are then consolidated and sent to the DPMU. The DPMU consolidates all block level data and adds district level data, which is further transmitted to state level. Some indicators that can be captured through the HMIS include the number of institutional deliveries, pregnancy outcomes, completed immunisations, family planning procedures etc.

Financial data: All costs of the intervention can be obtained from two sources: UP-TSU financial reporting and government spending on the basis of the PIPs.

Details of trainings conducted: Training data included the number of participants, training sessions and hours of training given. Quality of training was assessed through pre- and post-training evaluation and concurrent evaluation is also conducted by the MLE partner.

6 Impact of UP-TSU on the health system, processes, maternal and newborn outcomes

6.1 Expected impact on the health system

The UP-TSU is expected to improve health system capacity in the following areas:

- Enhanced government capacity in the preparation of state PIP and District Health Action Plans that define service delivery models, activities and resource allocation at various levels.
- Increased use of management tools during routine field visits for review, such as BMV, and tracking the progress of fund utilisation.
- Improved RMNCH+A related primary care services at facilities, with effective referral and follow-up systems, quality family planning services, and in-service and refresher training for health personnel.
- Improved health system management abilities with robust system of quality data (MCTS, HMIS) capturing, analyses and transmission in the system, with greater potential for utilisation in decision making (e.g. identifying areas of improvement).
- Improved government capability in engaging with the private sector.
- Improved coordination and supervision of ANMs, AWWs and ASHAs.

6.2 Expected impact on health personnel and community health workers

The expected improvement in the skills and supervision of health personnel and community health workers through the UP-TSU interventions is as follows:

- Improved quality and quantity of FLW interactions at community level and within households to drive priority RMNCH+A behaviours.
- Increased and active use of job-aids and tools by FLWs for updated enumeration, home visit planners, more VHNDs and routine immunization observed through correctly made due lists.
- Improved knowledge of ASHAs on maternal and newborn care, improved recording and submission of ASHA dairy and Village Health Information Register.
- Better tracking by ASHAs and AWW, of home visits and overall coordination between ASHAs, AWWs and ANM.
- Improved contemporary supportive supervision and on-site hand-holding to FLWs by supervisors.
- Increased accessibility, utilisation and coverage of RMNCH+A services at community level.

6.3 Impact on RMNCH+A outcomes

The following are some of the key specific impact indicators which the UP-TSU is aiming to improve:

- Percentage of women receiving antenatal care checkups at the Anganwadi Centre (AWC)/SC/APHC/CHC/BPHC.
- Percentage of institutional deliveries and normal vaginal deliveries where active management of third stage of labour was applied.
- Percentage of newborns receiving clean cord care, early initiation of breastfeeding.
- Percentage of identified weak newborns managed correctly as per Home Based Newborn Care guidelines.
- Percentage of mothers using post-partum contraception from six months after delivery.
- Percentage of women and children receiving routine immunisation at the AWC/SC/APHC/CHC/BPHC.
- Percentage of adolescent girls consuming at least 50% of expected doses of iron and folic acid supplements.
- Percentage of still births, neonatal and maternal deaths in the SC/APHC/CHC/BPHC.

6.4 Challenges in implementing UP-TSU interventions

The following challenges in implementing UP-TSU interventions have been identified on the basis of our field observations and interviews:

- Building a multi-disciplinary team of the UP-TSU, subscribing to agreed principles, mission and vision for supporting the Government in an integrative manner is sometimes a challenge.
- Willingness of the GoUP to accept inputs from an external body - the UP-TSU - may change, depending on changing leadership at state or national level.
- The GoUP may at times make demands on UP-TSU staff that are extraneous to their roles and positions; their technical support needs may differ or change over time. Careful discussion and negotiations are required to ensure that UP-TSU staff meet health system requirements without exceeding their remit.
- The relationship between the UP-TSU and GoUP may be difficult at times. Mutual acceptance, collaboration and cooperation will be needed to jointly achieve the project goal. This will require constant attention and perseverance.
- The planned duration of the project may not be sufficient to establish and measure impact, especially as the project is focused on some of the poorest areas in Uttar Pradesh. The pace of programme development and implementation will need to be closely monitored, and corrections made as required.
- Improving the utilisation of data by the system is a big challenge. Some effort would be required in establishing the strength and importance of data among government officials and encouraging its utilisation.

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Annexes

Annex 1: Availability of data relating to activities at district and zonal level in UP-TSU

TSU functions	Data source	Nature of database	Level of aggregation (block / district / zone / state)	Frequency of collection
Concurrent monitoring	BMV report	Electronic	District	Monthly
Implementation support	Tour plan, accomplish report	Electronic	District	Monthly
Planning	Monthly programme facility report	Electronic	Zonal	Monthly
Integrated support	Tour plan, accomplish report	Electronic	District	Monthly
Planning, Techno-managerial support, Integrated support, Implementation support	Tour plan, accomplish report	Electronic	District	Monthly
Techno-managerial support, Support at different levels	Tour plan, accomplish report	Electronic	District	Monthly
Implementation support	Tour plan, accomplish report	Electronic	Zonal	Monthly
Implementation support	Tour plan, accomplish report	Electronic	District	Monthly
Techno-managerial support	District monthly progress report, tour plan	Electronic	District	Monthly
Implementation support, Integrated support	District monthly progress report, tour plan, accomplish report	Electronic	District	Monthly
Techno-managerial support, Support at different levels, Integrated support, Embeddedness	District monthly progress report, tour plan, accomplish report	Electronic	District	Monthly

Concurrent monitoring, Implementation support	Tour plan	Electronic	District	Monthly
Concurrent monitoring, Implementation support	Status sheet, PowerPoint presentation (PPT) of respective month	Electronic	District	Monthly
Concurrent monitoring, Implementation support	Validation sheet	Electronic	District	Monthly
Concurrent monitoring, Implementation support	Status report, PPT of respective month	Electronic	District	Weekly and Monthly
Concurrent monitoring, Implementation support	PPT of respective month	Electronic	District	Monthly
Concurrent monitoring, Techno-managerial support	Validation list and Nurse Mentor, BCS tour plan	Electronic	District	Monthly
Concurrent monitoring, Support at different levels	PPT of respective month, status report	Electronic	District	Monthly
Concurrent monitoring	HMIS bulletin report	Electronic	District	Monthly
Concurrent monitoring, Support at different levels	Supportive supervision checklist, compile report	Electronic	District	Monthly
Techno-managerial support, Support at different levels,	Monthly summary report, tour accomplish report	Electronic	District	Monthly
Planning	Meeting minutes, tour plan, accomplish report	Electronic	District	Monthly
Planning	Meeting minutes, tour plan, accomplish report	Electronic	Zone	Monthly
Planning	Meeting minutes, tour plan, accomplish report	Electronic	Zone	Monthly
Planning	Meeting minutes, tour plan, accomplish report	Electronic	Zone	Monthly
Planning, Embeddedness, Integrated support	Tour plan, accomplish report	Electronic	District and Zone	Whenever workshop or training is planned
Implementation support, Support at different levels	Tour report	Electronic	District	Monthly

Annex 2: UP-TSU model implementation pathway - methodological note and interview guides

Note on the methodology

The UP-TSU model report was prepared on the basis of data collection at state, zonal and district levels, including meetings with state, zonal and district level staff, and state and district health system representatives. In-depth interviews were conducted to capture different aspects of information on the UP-TSU, from contextual information to staffing structure, functions, key staff responsibilities and the nature of activities conducted. Stakeholders interviewed included district and zonal level technical, community and M&E specialists from the UP-TSU, and the CMO, DPM and block MOICs from the district health system. At state level, stakeholders from the UP-TSU included the Project Director and TSU Team Leader, while government stakeholders included members of the NHM SPMU. The initial draft of the pathway narrative was prepared on the basis of this information.

The draft was then verified through further meetings with key stakeholders. The implementation pathway was narrated from the report with respect to the stakeholder's role and she/he was asked if it was correct or if she / he would like to add to, or modify it in any manner. The feedback was noted and any change or new information was recorded in the narrative report. The last stage was consensus building. For consensus building the process is to organise a focus group discussion with representatives of all stakeholder groups as participants. Details of the implementation pathway are then described and consensus sought from all participants on each step.

Annex 2a: District and zonal teams

1. What are the key health system challenges that the UP-TSU aims to address at the district level?
2. What is the hierarchy and composition of UP-TSU workforce at the district and zonal levels?
3. What is the specific role of the zonal team?
4. What are the various trainings provided to staff at district and zonal levels? Is there any system of refresher trainings? What is their timeline/frequency?
5. What are the various functions and activities performed by the UP-TSU staff at the district level and who are the staff responsible for implementing them?
6. What is the system of monitoring and supportive supervision of the district and zonal teams in UP-TSU?
7. How have the district and zonal teams engaged with the district health system? [probe: permissions, training, consultation, monitoring and supportive supervision, any other]
8. What are the job aids and tools used for each activity under UP-TSU in district and zonal levels?
9. What types of data are generated under each activity at the district level? How are these records maintained and shared, and at what frequency, to the zonal and state levels?
10. How do the district teams support the government health workers? What is the frequency of interaction and joint meetings?
11. Is UP-TSU team giving feedback to the government stakeholders on field observations and programme implementation?

12. How many joint visits are planned by UP-TSU with government health officials for the supportive supervision to the districts?
13. What are the challenges in implementing the UP-TSU activities at the district level?

Annex 2b: State team

1. Health system context: What were the challenges in UP's health system that TSU aims to address? What was the rationale for TSU?
2. Planning of the TSU intervention: How was the TSU intervention planned? Was the GoUP involved at that stage? If yes, in what manner?

[We have some information from the proposal / strategy document. Is there anything that needs to be added to it?]

3. TSU structure and functions: [we have some information from the proposal / strategy document. Is that sufficient?]
 - a. Has a Project Advisory Committee been formed? What are its functions?
4. Embedded and integrated support
 - Co-location with the Department of Health (Directorate / SPMU)
 - Participation in developing strategies under RMNCH+A; joint planning / review / decision making (membership of committee / joint forum with GoUP; also if there are other development partners)
 - Techno-managerial support – what activities define this?
5. Supportive supervision and monitoring of programs
 - How is TSU helping the GoUP strengthen its monitoring approach? E.g. HMIS strengthening. What are the activities at the state level?
 - How is the TSU-collated data being shared with the GoUP? Is it on a concurrent basis? How is the GoUP involved in joint review or monitoring (e.g. Review mission)? What is the frequency of such activities?
 - Is GoUP supervising any TSU staff at state level directly or partially? How would you describe the manner of interaction?
6. Any other activities at the state level?
 - a. Trainings at the state level
7. Tools; job aids (if any, reflecting overall TSU, not specific interventions)
8. Linkages with implementation pathway:
 - a. Key stakeholders (TSU, GoUP, Bill & Melinda Gates Foundation, other development partners, beneficiaries) and their roles
 - b. Materials and infrastructure inputs
9. Description of databases

- a. Nature of data maintained on overall TSU activities and progress at the state level; what are the key indicators to trace TSU's performance at the state level?
10. Impact of TSU on the health system, processes and outcomes:
- a. What are the key indicators to trace TSU's impact at the state level? (health system / population RMNCH+A outcomes)
11. Challenges: What are the challenges in implementing a technical assistance program? What has the TSU's experience been in this regard?

Annex 2c: UP-TSU model implementation pathway - interview schedule: SPMU

1. What do you think are the health system challenges that TSU aims to address?
2. Did the Govt (SPMU) give any specific inputs while finalizing the TSU's work plan? How was the GoUP involved at that stage?
3. TSU structure and functions:
 - a. Which staff from TSU regularly interacts with SPMU / General Managers? What are their roles?
 - b. Executive committee at SPMU
 - c. Program Planning Committee
4. Support provided by TSU:
 - Some examples of the nature of daily support tasks
 - Any activity reflecting embedded support
 - Some examples of larger system level support (implementation / techno-managerial)
 - How did TSU contribute to developing the RMNCH+A strategy in UP?
 - How did TSU contribute in developing the PIP?
 - Any kind of orientation or exposure visit was conducted by the TSU?
5. Supportive supervision and monitoring of programs
 - What is the TSU's role in improving the monitoring and supervision of Government programs?
 - How is the GoUP involved in joint review or monitoring of TSU activities? What is the frequency of such activities?
 - Do you make any field visits to TSU districts? If yes, then how frequently and for what purpose?
6. Impact of TSU on the health system, processes and outcomes:
 - a. How has TSU helped improve the system of capturing MCH indicators? Has there also been an impact on utilizing the data for decision making?
7. Is there a formal channel for the Government to convey it's feedback on TSU's functioning? What do you feel are the key advantages of TSU support to the SPMU?

IDEAS project

IDEAS (Informed Decisions for Actions) aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, northeast Nigeria and the state of Uttar Pradesh in India, IDEAS uses measurement, learning and evaluation to find out what works, why and how in maternal and newborn health programmes.

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