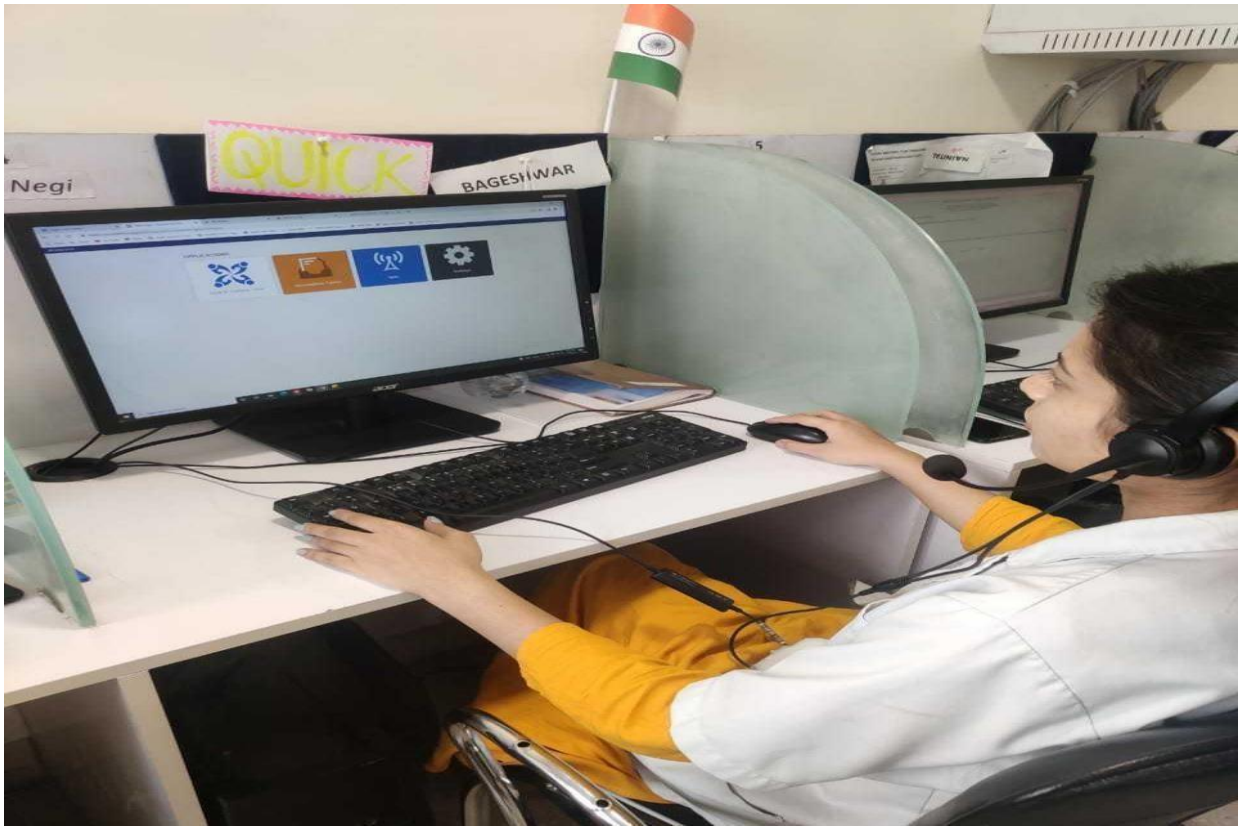


The QUICK Model
Quality Upgrade through Improvements in (Accountability and Responsiveness) & Community Knowledge

Key Insights & Way Forward

[January 2022 - October 2023]

December 2023

Contents

EXECUTIVE SUMMARY

The Quality Upgrade through Improvements in (Accountability and Responsiveness) and community Knowledge Model, referred to as the QUICK model, stands out as a key digital innovation within the RMNCHA+ domain, implemented as part of the SAMVEG project to support the Surakshit Matritva Aashwasan (SUMAN) program. This model leverages existing call centers at the State level to engage with targeted beneficiaries for feedback and counseling, aiming to enhance maternal and child health outcomes, particularly in the crucial 1000-day window of opportunity in life. Launched successfully in February 2022 with funding from USAID and led by IPE Global as the prime organization providing technical expertise, alongside Dimagi as the technological partner, the QUICK model is designed to assess service quality through beneficiary feedback, identify areas for improvement in District and Block health facilities, enhance beneficiaries' health knowledge, provide information on services and entitlements, and evaluate patient satisfaction and grievances for effective policy-to-action.

This document outlines the value proposition of the QUICK model, presenting insights and actionable recommendations based on data gathered between February 2022 and October 2023 in Haridwar, an Aspirational District of Uttarakhand. The learnings from this implementation period can be utilized to refine and scale the QUICK model across new districts and geographies. Critical observations were made during implementation, leading to actionable items for strengthening the healthcare system. These include addressing issues with data quality in RCH and SNCU portals, improving provision for essential services, increasing the involvement of ASHAs in post-SNCU discharge care, enhancing information dissemination in government facilities, revamping Information, Education, and Communication (IEC) strategy, and overall improvement in health service delivery by reducing out-of-pocket expenses for the beneficiaries.

The strengthening through the QUICK model holds great promise in contributing to India's achieving Sustainable Development Goal 3, explicitly targeting maternal, neonatal, and child mortality improvements. The successful launch of the QUICK model in the Haridwar district marks a significant stride toward this goal.

BACKGROUND

The **1,000-day window of opportunity** between conception and the child's second birthday is a unique period of opportunity when the foundations of optimum health and growth across the lifespan are established. This period requires a continuum of care through antenatal care, safe delivery, and post-natal care of mother and baby and childcare for survival and optimal development of the child and is prioritized for strengthening.

In India, despite the considerable strengthening of the Public Health Systems since the launch of the National Health Mission, problems like 1) weak community participation, 2) lack of social accountability, 3) grievance redressal, 4) suboptimal use of data for action and 5) compromised quality of care persists. The government has introduced several initiatives to address these problems, including the recently launched SUMAN program, which aims to end preventable Maternal and newborn deaths. Using a right-based approach, SUMAN is built on a robust Quality Assurance, Grievance Redressal, and accountability framework. However, despite this, challenges persist regarding the widespread coverage and effective field implementation of the SUMAN program.

States have launched several initiatives to reach out to beneficiaries, such as Call centers for sharing information on health schemes and referral linkages and the **Mera Aspataal** portal for grievance and feedback sharing. Digital data portals such as the Reproductive Child Health (RCH) portal - tracking individual women and child beneficiaries through their reproductive life cycle and up to five years of age, respectively, and the SNCU online portal for monitoring small and sick newborns admitted for special care are available with the state. However, these platforms do not converge to utilize the extensive data available for any suitable action and remain mainly at the facility level. Community participation needs to be improved, resulting in actions not aligned with the community's needs.

The hour needs to strategize and demonstrate a model that can translate policy into action by augmenting existing mechanisms, contributing towards achieving program goals and objectives, and helping address the abovementioned critical problems.

PURPOSE OF THE DOCUMENT

To guide key decision makers through listening to voices from the field for building social accountability and grievance redressal for a responsive health system using technology. The document aims to assist in delineating contextualized actions required for:

- ✓ Improving client satisfaction
- ✓ Improving client awareness through revamping the Information Education & Communication (IEC) Strategies
- ✓ Ensuring delivery of respectful care
- ✓ Improving service provision & quality across community and facility-based care.
- ✓ Reducing out-of-pocket expenditure (OOPE)

TARGET AUDIENCE

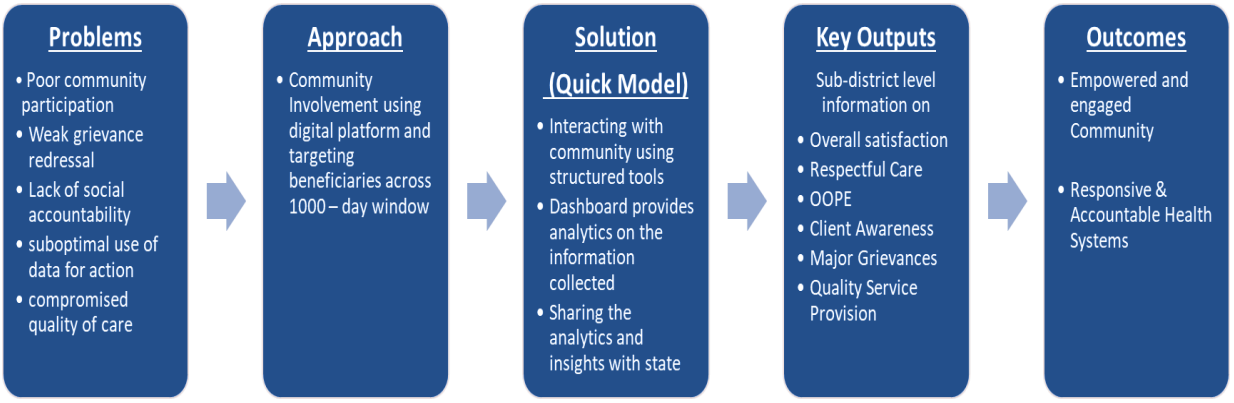
This document is intended for program managers and administrators at the block, district, and state levels, collaboratively working towards Health System Strengthening.

INNOVATION: THE QUICK MODEL

Using a human-centered design approach, the QUICK model is designed to improve maternal and child health outcomes, especially in the 1000-day window of opportunity. This technology-driven solution helps reach out to targeted beneficiaries to collect end-user feedback, provide counseling, link them to teleconsultation, and generate data for action. The model adapted a survey-based method to provide evaluated data and real-time trends related to health services delivery and program intervention coverage. The key features of the model include:

- ✓ Enabling direct communication of the health system with beneficiaries
- ✓ Strengthening knowledge base for evidence-based interventions
- ✓ Improve community awareness regarding health schemes.
- ✓ Regular use of data and its triangulation with field information
- ✓ Facilitate feedback and track progress across all levels.

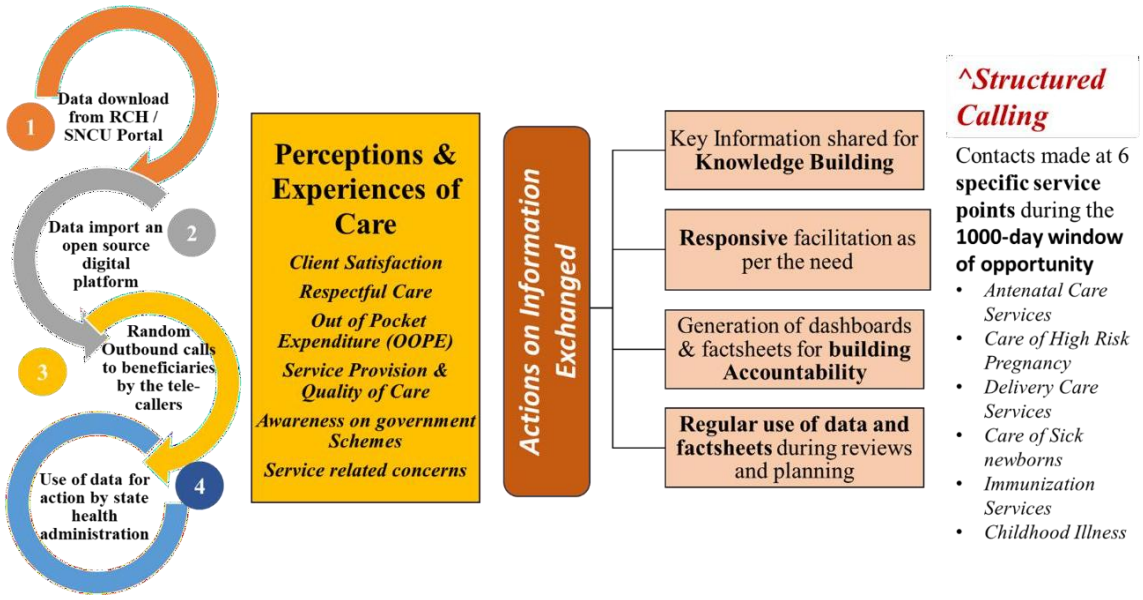
Figure 1: QUICK MODEL: Theory of Change (ToC)



Before its launch, a pilot was conducted to understand the needs of the beneficiaries vis-à-vis the type of services available at public health facilities. The provision of already existing cells and a state health telephone helpline paved the way for the inception of the **QUICK Model.**

The callers were hired to make outbound calls to pregnant women registered in the RCH Portal at specified intervals. These interactions with service users were designed to help understand the care and service experiences and provide an opportunity to share information regarding government schemes and entitlements. Furthermore, the information exchanged and feedback received during the call is used to strengthen the existing health systems.

Figure 2: The QUICK Model: An Overview



The QUICK model is being implemented by following three sequential steps:

Step 1- Identification of beneficiaries from the RCH Portal / SNCU Online portal at six service points in Figure 3.

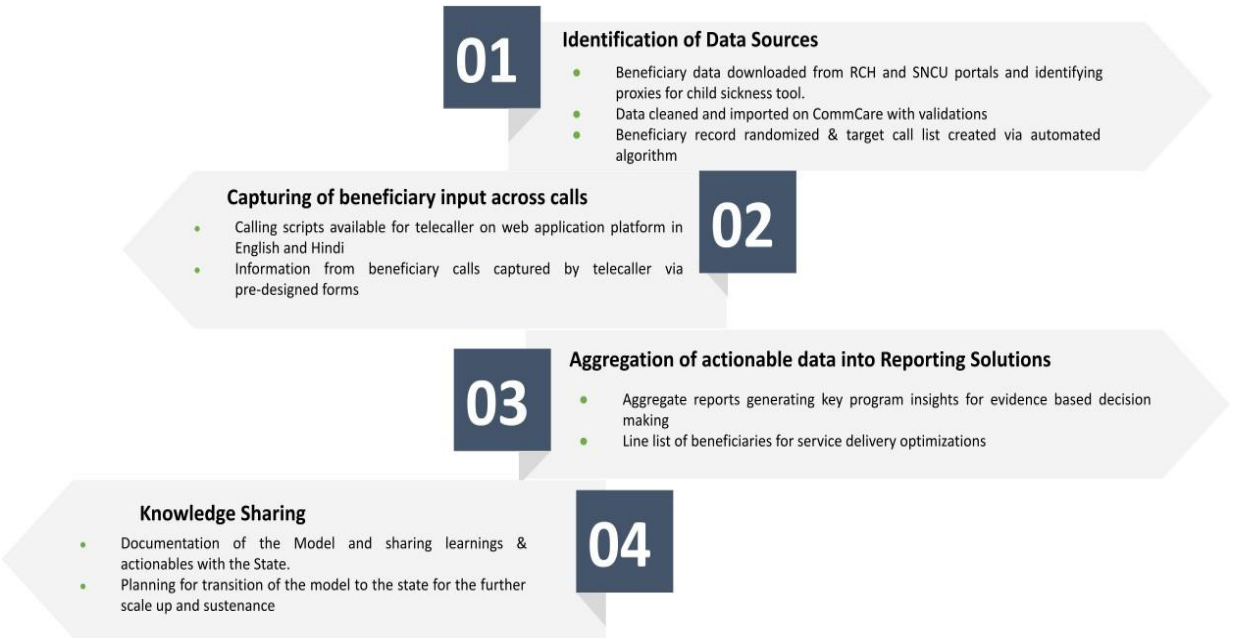
Step 2- Randomly selected beneficiaries are contacted by telecallers based on the call list generated on the **open-source CommCare web-based application**. Beneficiaries' feedback is recorded using structured outbound calling questionnaires, and need-based counseling, teleconsultation, and facilitation are provided.

Figure 3: Six Service Points

Step 3- Feedback collected is analyzed to develop district factsheets that provide trends on the provisions and experience of care along with beneficiaries' awareness of danger signs and associated health behaviors. These trends are regularly shared with the different stakeholders to facilitate evidence-based decision-making.

Step 4 involves documenting and disseminating the experiences and insights from implementing the Quick Model within the selected geographies. This documentation is essential for advocating the model and facilitating its sustainability and scale-up beyond the intervention geographies.

Figure 4: QUICK Model: Key Steps & Processes



METHODS

Settings & Participants

The model was demonstrated in Uttarakhand State in Haridwar District, which has a population of 1.18 million and an area identified as vulnerable geography by NITI Aayog, Government of India.

Approach

The approach includes secondary data analysis collected for program implementation between January 2022 and October 2023.

Data Collection

At specified intervals, the telecallers assigned to the specialized cell initiated outbound calls to pregnant women and young mothers registered in the Reproductive Child Health (RCH) Portal. These interactions aimed to gain insights into the care and service experiences of the beneficiaries, offering an opportunity to disseminate information about government schemes and entitlements. Beneficiaries across six service points, namely Antenatal Care (ANC), High-Risk Pregnancies (HRPs), Care around Birth (CAB), Care of Small and Sick Newborns (SNCU care), Immunization and care for Childhood Sickness were contacted monthly by tele-callers. The call list, generated through an open-source CommCare web-based application, adhered to random representative sample criteria drawn from data acquired from the RCH and SNCU portals.

Upon receipt of data by the 104 teams from the state, tele-callers conducted data cleaning and formatting according to the QUICK calling digital application's requirements. This process involved identifying beneficiaries who received services in the last month, ensuring valid phone numbers, and eliminating duplicate entries. Subsequently, the refined beneficiary sheet was uploaded onto the QUICK calling tool on CommCare, serving as the basis for tele-callers to initiate calls. Emphasizing a service-wise approach, tele-callers prioritized equal representation of all Blocks to the extent the data was available on the RCH and SNCU portals.

The aggregated data was integrated into a comprehensive dashboard, providing insights into care provision, quality, respectful care, out-of-pocket expenses, and supporting data-backed policy decisions. Monthly activities included monitoring the completion of target calls and executing quality assurance measures on a select sample of calls. These efforts aimed to gather insights guiding States toward accurate actions, ultimately striving for a higher positive impact on Maternal, Newborn, and Child Health (MNCH) outcomes.

RESULTS

We analyzed 18,869 calls conducted between January 2022 and September 2023, targeting beneficiaries contacted at six distinct points. Our objective was to gain insights into beneficiary perceptions and experiences regarding **care provision, quality, respectful care, out-of-pocket expenses, awareness of government initiatives, and overall feedback on the healthcare services** they received.

1.0 CALL STATISTICS

Of the total attempted calls, 44% (8,298) successfully connected with the beneficiaries, reaching both primary beneficiaries (28%) and family members (16%). A significant portion of calls (56%) did not connect, with 6% due to invalid phone numbers.

Call Statistics: Key Variables Examined

Total beneficiaries contacted; Number of calls connected with primary respondents; calls connected with family members; number of calls not connected; invalid phone numbers; Total calls completed disaggregated by private and public; average call duration.

Among the connected calls, 22% (4,222) matured, indicating that telecallers engaged in detailed conversations, completing the entire questionnaire. The breakdown of completed calls revealed that 74% utilized services from public facilities, while 26% opted for private services. The average call duration was 12 minutes and 27 seconds, varying across contact points, ranging from 9 minutes and 44 seconds for Immunization to 16 minutes and 6 seconds for ANC contacts. This suggests differing levels of engagement and information exchange at different stages. (Table-1)

The block-wise segregation and analysis of call statistics are provided in **Annexure 1.**

Table 1: Call Statistics – Overall & Across Six Contact Points

Reaching to Beneficiaries															
Primary	Secondary	1. ANC		2. HRP		3. CAB		4. SNCU		5. Immunization		6. Child Sickness		Total	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total beneficiaries contacted N		4395	-	2175	-	4016	-	704	-	4070	-	3509	-	**18869**	-
	Primary N (%)	28%	643	30%	1069	27%	367	52%	1097	27%	797	23%	**5210**	**28%**	**28%**
	Family Group N (%)	16%	394	18%	645	16%	30	4%	642	16%	685	20%	**3088**	**16%**	**16%**
Calls connected N (%)		1929	44%	1037	48%	1714	43%	397	56%	1739	43%	1482	42%	**8298**	**44%**
	Primary N (%)	28%	643	30%	1069	27%	367	52%	1097	27%	797	23%	**5210**	**28%**	**28%**
	Family Group N (%)	16%	394	18%	645	16%	30	4%	642	16%	685	20%	**3088**	**16%**	**16%**
Calls not connected N (%)		2466	56%	1138	52%	2302	57%	307	44%	2331	57%	2027	58%	**10571**	**56%**
	Invalid phone numbers N (%)	5%	75	3%	195	5%	6	1%	202	5%	223	6%	**928**	**5%**	**5%**
Calls completed (Primary) N (%)		**1102**	**25%**	**542**	**25%**	**840**	**21%**	**354**	**50%**	**838**	**21%**	**546**	**16%**	**4222**	**22%**
	Public N (%)	72%	416	77%	311	37%	354	100%	769	92%	470	86%	3116	**74%**	**74%**
	Private N (%)	28%	126	23%	529	63%	0	0%	69	8%	76	14%	1106	**26%**	**26%**
Average time of calls		00:16:06		00:13:49		00:12:58		00:11:12		00:09:44		00:10:51		**00:12:27**	

Call Statistics: Key Highlights

- ✓ *Out of total 18,869 beneficiaries contacted, discussion with 22% of primary beneficiaries were successfully completed.*
- ✓ *Around 56% of calls could not be connected due to invalid phone numbers, no network coverage, malware issues, and incomplete contact details provided in existing RCH and SNCU portals.*
- ✓ The average call duration was 12 minutes and 27 seconds, varying across six contact points.

2.0 STATUS OF CLIENTS SATISFACTION

The status of client satisfaction was assessed on **a five-point "Likert Scale"** by gathering and measuring satisfaction ratings from beneficiaries contacted across six contact points. Satisfaction rating was defined as when beneficiaries reported the services as **"Good" or "Very Good."**

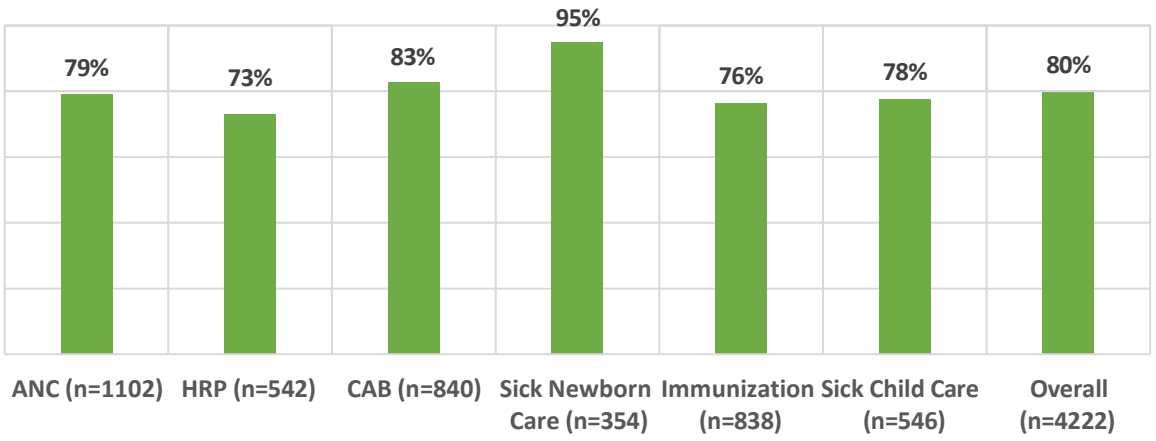
Client Satisfaction: Key Variables Examined

Status of client's satisfaction – Overall & across six contact points; client satisfaction disaggregated by healthcare services availed in Public & Private; block level distribution of client satisfaction rating.

For the 4,222 beneficiaries contacted, the overall satisfaction rating was found to be 80%. Satisfaction ratings varied across the six contact points, with SNCU discharge receiving the highest rating at 95% (n= 354) and HRP having 73% (n=542). (Figure 5) This data provides insights into the

overall service perception and satisfaction levels among beneficiaries, highlighting areas of strength and potential improvement across different stages of the healthcare intervention.

Figure 5: - Status of Client Satisfaction - overall & across six contact points



Public Vs. Private

Client satisfaction was 80% for private and 79% for public facilities. Specifically, immunization satisfaction ratings were 61% for private and 78% for public facilities. ANC services received an 82% satisfaction rating for private facilities and 78% for public facilities. For CAB, private facilities had a satisfaction rating of 85%, while public facilities received a rating of 79%. A detailed analysis of the client satisfaction rating for private and public facilities is shown in Figure 6.

Figure 6: Overall Satisfaction Rating - Private vs Public

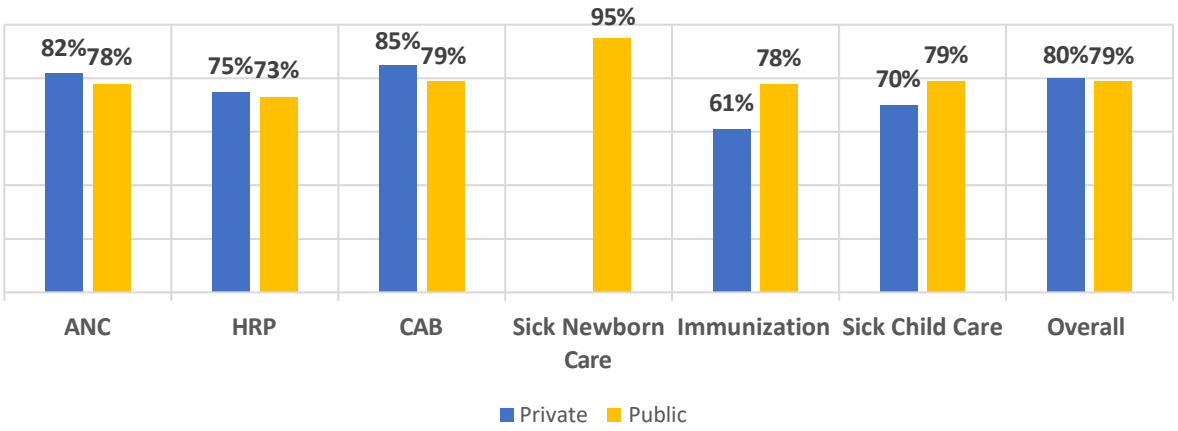


Table 2. presents the block-wise status of client satisfaction across six contact points. Data suggest that the overall client satisfaction level across six contact points was ≥ 80% in the Bahadrabad, Laksar, and Narsan districts. The remaining three districts also had overall satisfaction levels between 70% to 79%.

While looking at individual practices, the client's satisfaction rating on care at birth in **Khanpur block was the lowest (28%).** Additionally, the satisfaction level of the clients concerning care in high-risk pregnancies (HRP) was found to be less than 70% in Bhagwanpur and Narsan blocks.

Table 2: Block-wise Client Satisfaction across six contact points

	Bahadrabad	Bhagwanpur	Khanpur	Laksar	Narsan	Roorkee	Grand Total
ANC	76% (n=200)	81% (n=274)	80% (n=63)	85% (n=128)	78% (n=248)	74% (n=189)	**78% (n=1102)**
HRP	71% (n=141)	62% (n=61)	NR*	100% (n=1)	68% (n=112)	78% (n=227)	**73% (n=542)**
CAB	81% (n=153)	84% (n=209)	28% (n=7)	75% (n=24)	84% (n=186)	82% (n=261)	**82% (n=840)**
SNCU care	94% (n=316)	100% (n=1)	100% (n=7)	92% (n=27)	100% (n=1)	100% (n=2)	**94% (n=354)**
Immunization	70% (n=154)	76% (n=252)	76% (n=17)	84% (n=19)	81% (n=204)	74% (n=192)	**76% (n=838)**
Child Sickness	73% (n=103)	71% (n=156)	NR*	NR	83% (n=87)	82% (n=200)	**77% (n=546)**
Grand Total	**80% (n=1067)**	**77% (n=953)**	**77% (n=94)**	**85% (n=199)**	**80% (n=838)**	**78% (n=1071)**	**79% (n=4222)**

NR*-Not Reported

Client Satisfaction: Key Highlights

- ✓ *The **client satisfaction** rating across the six contact points is **80%**.*
- ✓ *The overall satisfaction levels between clients who availed healthcare services in public and private facilities are the same.*
  - *Immunization satisfaction ratings were higher for clients in public facilities than those in private facilities. Clients who utilized ANC and delivery-related services in the private sector reported higher satisfaction levels than those in public facilities.*
- ✓ *Satisfaction with care in HRPs was below 70% in the Bhagwanpur and Narsan blocks. The lowest client satisfaction rating for care at birth was observed in the **Khanpur block at 28%.***

3.0 STATUS OF RESPECTFUL CARE

The prevalence of disrespect and abuse during facility-based care is well-documented in low- and middle-income countries. The World Health Organization (WHO) Guidelines highlight respectful care as a key recommendation and respectful maternity care is emerging as an essential concept for ensuring the rights and safety of women during antenatal care and institutional births.

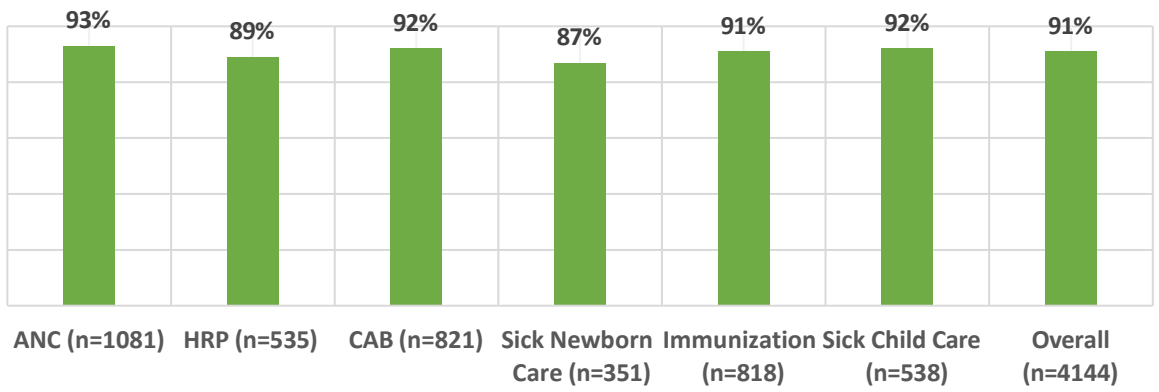
Respectful Care: Key Variables Examined

- *Staff Behaviour - Included across all six contact points.*
- *Patient Privacy – Included for ANC, High Risk Pregnancies & during childbirth.*
- *Birth Companion during childbirth.*
- *Family participatory Care – included for shared care of small and sick newborns by mothers and facility staff in SNCUs.*

3.1 Staff Behavior

Good behavior of the staff while providing services was identified as an essential indicator to determine the status of respectful care across six contact points. The information regarding staff behavior was provided to the tele-caller by 4144 of the 4222 beneficiaries. 91% of beneficiaries expressed satisfaction with the staff's behavior. Further analysis of staff behavior across different services is illustrated in Figure 7.

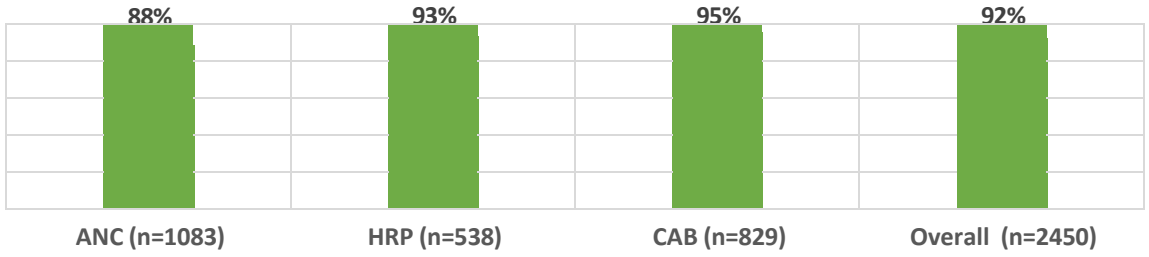
Figure 7: Proportion of Clients Happy with the Behaviour of Healthcare Providers



3.2 Patient Privacy

Overall, 92% of respondents who availed of ANC, care at birth, and HRP services felt that their privacy was respected. A service-wise analysis of privacy is shown in Figure 8.

Figure 8: % of Respondents happy with privacy

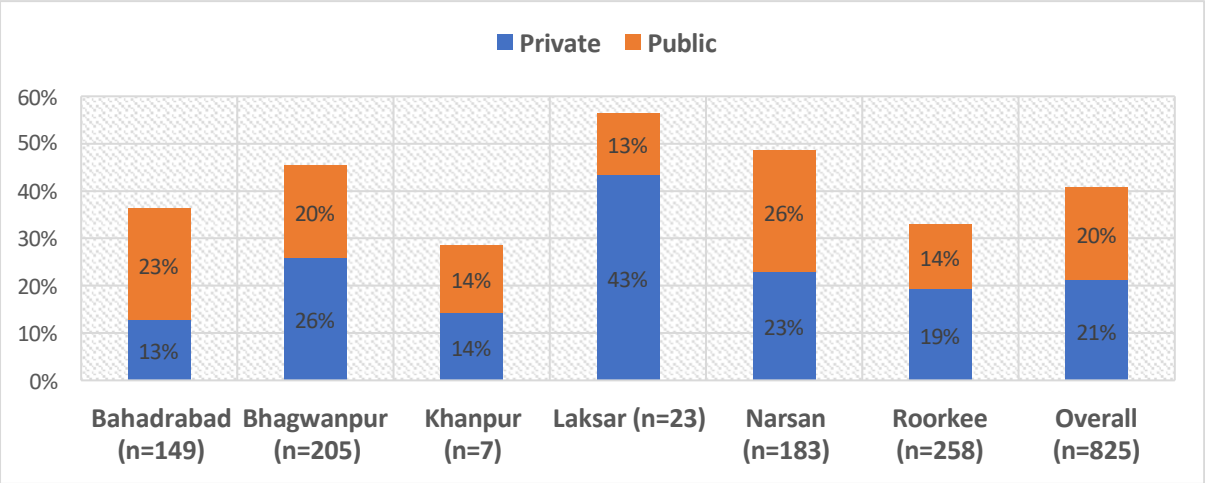


3.3 Birth Companion during Childbirth

Allowing a Birth Companion is a critical indicator to ensure respectful care during childbirth. When exploring the permissibility of a birth companion during childbirth. 825 of a total of 841 beneficiaries responded to the question. **41% of beneficiaries responded affirmatively,** signifying that the entry of a birth companion was allowed in the delivery room. The data analysis revealed a suboptimal prevalence of this essential practice across intervention blocks.

Disparities emerge upon conducting a more detailed analysis and segregating data based on blocks. Specifically, **in Khanpur, 29% of respondents reported that a birth companion was allowed**, representing the lowest percentage. In contrast, the Laksar block exhibited the highest percentage at 57%, suggesting a noteworthy variation in practices across distinct geographical areas. This disparity underscores **the need for targeted interventions and the establishment of standardized practices** to ensure consistent and respectful maternity care across all intervention blocks. (figure 9)

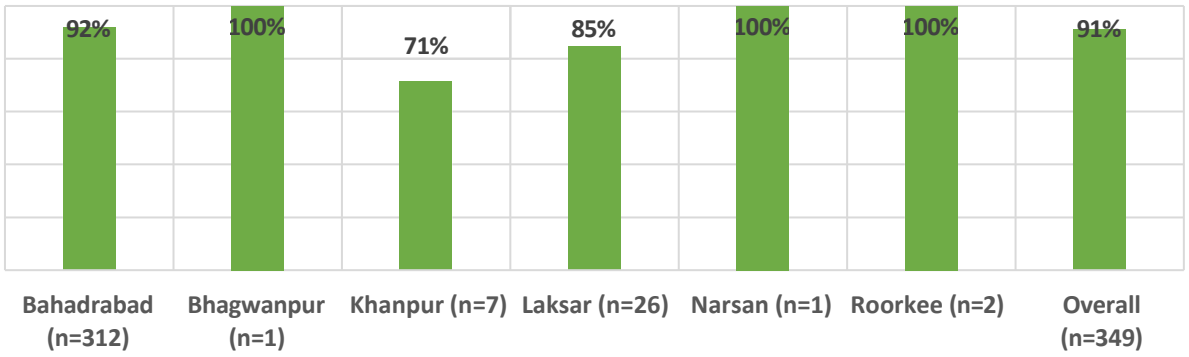
Figure 9: Proportion of clients' reported entry of birth companion during childbirth.



Family Participatory Care

FPC helps to reduce the duration of hospital stay, improve the well-being of preterm babies, improve breastfeeding rates, and improve parent-infant bonding. Data suggest that 91% of beneficiaries were allowed by the SNCU staff to visit inside the unit for joint care, including feeding and interacting with the baby, underscoring the emphasis on fostering family involvement in the care process. (figure 10)

Figure 10: The proportion of clients who reported the provision of family participatory care in SNCUs.



Respectful Care: Key Highlights

- ✓ *More than 90% of beneficiaries were happy and satisfied with the staff's behavior while receiving healthcare services across six contact points.*
- ✓ *Most respondents felt that their privacy was respected while availing of facility-based care.*
- ✓ *41% of beneficiaries acknowledged entry of birth companion during delivery across intervention blocks.*
- ✓ *90% of beneficiaries were allowed for family participatory care while caring for sick newborns in SNCUs.*

4.0 SERVICE PROVISION & QUALITY OF CARE

Assessment of service provision and quality of care provided to beneficiaries were based on positive responses from the beneficiaries on the quality of service they offered across six contact points.

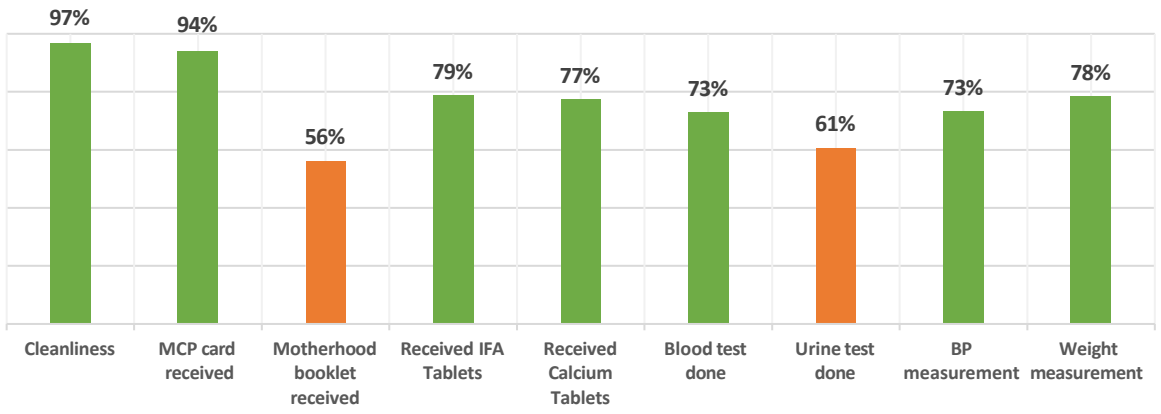
Service Provision & Quality of Care: Key Variables Examined

- *Site Cleanliness - Included across all six contact points.*
- *For ANC – Availability of MCP Card, Motherhood Booklet, Blood test, Urine test, distribution of IFA tablets, Calcium tablets, Weight & BP measurement.*
- *For HRPs– Abdomen Examination, Ultrasound Test, distribution of IFA, Calcium Tablets, Awareness on HRP, Provision of medical consultation*
  Service provision & QoC for Childbirth - Skin to skin care at birth, early Initiation of breast feeding, PPFP Counselling, distribution of IFA, Calcium, Birth Registration
- *For Sick Newborn Care - KMC practiced, Home Counselling for KMC, KMC Continued at home, Follow-up date informed at Discharge, Follow-up Examination Done, HBNC visit by ASHAs.*
- *For Immunization - Parents informed about Vaccine, Parents informed about next Vaccination date, Informed about Exclusive Breast Feeding*
- *For Sick Childcare - Vitamin A dose given, Weight Measured, Weight Plotted in MCP Card, HBYC visits by ASHAs.*

Quality of Care during ANC

94% of beneficiaries acknowledged receiving the MCP card from the facility when responding to telecallers. Furthermore, 78% reported receiving calcium tablets, and 79% confirmed the receipt of Iron-Folic Acid (IFA) tablets from the facility. Regarding diagnostic tests, 73% of respondents indicated undergoing blood tests, 74% reported that their blood pressure was measured, and 79% stated that their weight was measured during diagnostic tests at the facility. Whereas 56% responded they acknowledged the receipt of the Motherhood booklet, and 61% reported that they underwent urine examination during ANC visits. (Figure 11)

Figure 11: Proportion of beneficiaries received quality services during ANC (N= 1102)



While conducting a block-wise in-depth analysis of quality-of-care indicators for ANC services, a noteworthy barrier emerged concerning the receipt of the motherhood booklet during ANC visits across the intervention blocks, **with the least proportion (49%) of beneficiaries in block Khanpur reported receiving this essential resource.** A similar observation was noted for urine investigations during ANC visits, where less than 70% of beneficiaries in each intervention block reported undergoing such examinations. These findings underscore the need for targeted activities to enhance the consistent provision of crucial resources and diagnostic assessments during ANC visits across all intervention blocks. (Table 3)

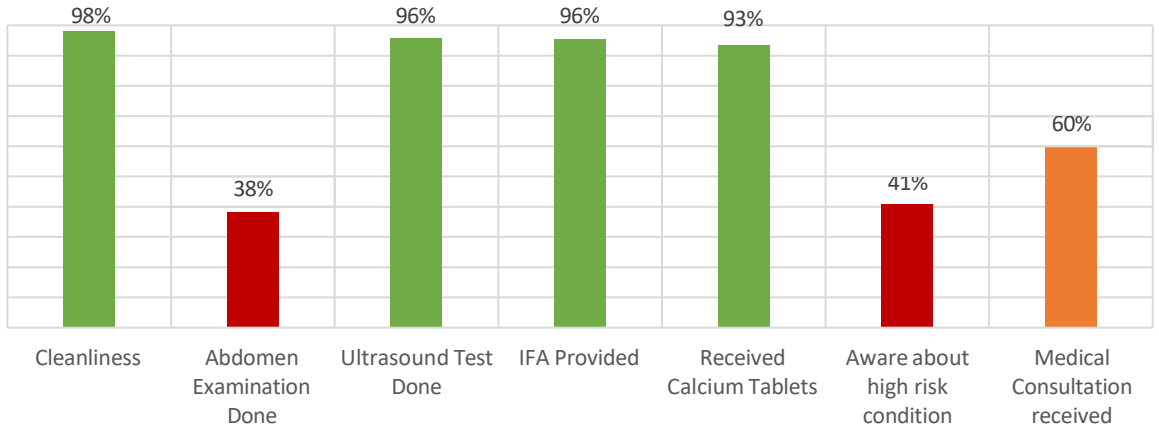
Table 3: Block-wise proportion of beneficiaries received quality services during ANC.

	Bahadrabad (n=200)	Bhagwanpur (n=274)	Khanpur (n=63)	Laksar (n=128)	Narsan (n=248)	Roorkee (n=189)	Overall (n=1102)
Cleanliness	96%	97%	100%	98%	97%	94%	97%
MCP Card	94%	93%	95%	97%	95%	92%	94%
Motherhood Booklet	63%	56%	49%	59%	52%	55%	56%
Weight measurement	77%	72%	81%	87%	77%	85%	78%
BP measurement	75%	69%	75%	80%	73%	73%	73%
Blood test	77%	66%	83%	78%	74%	70%	73%
Urine test	65%	56%	65%	68%	63%	54%	61%
IFA tablets	82%	78%	79%	80%	75%	80%	79%
Calcium tablets	81%	77%	79%	78%	72%	81%	77%

Service Provision & Quality of Care for HRPs

Among HRPs, over 93% of beneficiaries reported receiving calcium and IFA tablets from the facility. Regarding diagnostic tests, 96% underwent ultrasound, and 60% of beneficiaries received medical consultations during their HRPs. However, 38% had abdominal examinations performed by the service providers, while 41% were aware of their high-risk condition. (figure 12)

Figure 12: Proportion of HRPs received quality services (N = 542)



During the block-wise in-depth analysis (Table 4) of service provision and quality-of-care indicators for HRP-related services, it was observed that less than 50% of beneficiaries received abdominal examination for high-risk pregnancies while visiting healthcare facilities, with the lowest proportion (28%) reported in Block Bhagwanpur. Additionally, **overall awareness or information provided by healthcare providers about high-risk conditions was observed in only 40% of beneficiaries.**

In Khanpur, no beneficiaries were reported as high-risk pregnancies, and in Laksar, only one case of HRP was identified during the selected period. Therefore, this block-level analysis needs to provide more data to draw meaningful interpretations for these blocks.

Table 4: Block-wise status of service provision and quality of care for HRPs

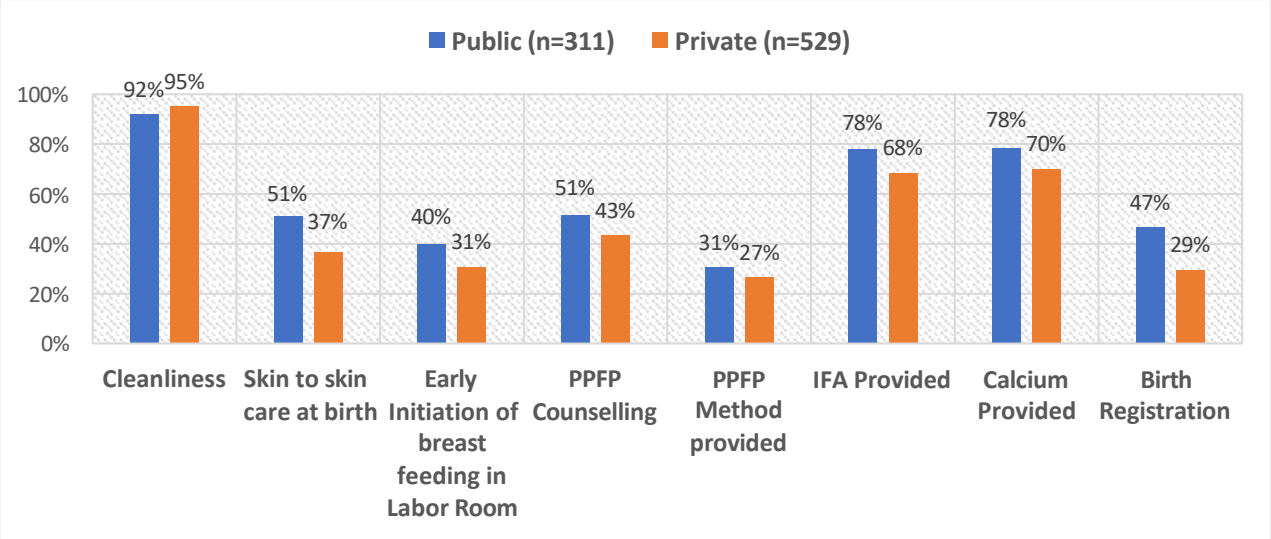
	Bahadrabad (n=141)	Bhagwanpur (n=61)	Khanpur (n=0)	Laksar (n=1)	Narsan (n=112)	Roorkee (n=227)	Overall (n=542)
Cleanliness	99%	100%	NA	100%	98%	97%	98%
Abdomen Examination	38%	28%	NA	100%	44%	38%	38%
Ultrasound Test	95%	98%	NA	100%	96%	96%	96%
IFA Provided	95%	95%	NA	100%	94%	97%	96%
Calcium Tablets	93%	92%	NA	100%	91%	95%	93%
Aware about HRP	35%	34%	NA	100%	31%	51%	41%
Medical Consultation	58%	59%	NA	100%	67%	58%	60%

Service Provision & Quality of Care During Childbirth

Regarding the quality of care during childbirth, overall, optimal cleanliness of the facilities was reported by 94% (i.e., 92% in Public health facilities & 95% in private health facilities) of beneficiaries. 73% of beneficiaries received iron and folic acid (IFA) tablets, and 74% received calcium tablets. Moreover, **38%** (i.e., 47% in Public health facilities & 29% in private health facilities) **reported completing the childbirth registration process at the facility.**

On the other hand, **43% of beneficiaries** (i.e., 51% in Public health facilities & 37% in private health facilities) **reported providing skin-to-skin care to their newborns. In comparison, 34%** (i.e., 40% in Public health facilities & 31% in private health facilities) **initiated breastfeeding in the labor room within one hour of delivery. Furthermore, 46% received counseling on postpartum family planning.** (Figure 13)

Figure 13: Proportion of beneficiaries received quality services during Childbirth (N= 840)



The crucial indicator of skin-to-skin care during childbirth was reported by less than 50% of the blocks, except for the Bhagwanpur and Narsan blocks, where it was provided to around 50% of the beneficiaries. Similarly, PPFP counseling after childbirth was reported by less than 50% of beneficiaries across the intervention blocks, except in Narsan, where 56% of beneficiaries acknowledged that PPFP counseling was provided to them during admission for childbirth.

Table 5. represents a block-wise analysis of service provision and quality of care, which revealed that early initiation of breastfeeding, postpartum family planning (PPFP) counseling, and birth registration were provided to less than 50% of beneficiaries across the intervention blocks. Regarding the provision of IFA tablets and calcium tablets, more than 70% of beneficiaries across the blocks reported that they were provided with these tablets, except for the Khanpur and Laskar blocks.

Table 5: Block-wise status of service provision and quality of care for Childbirth

	Bahadrabad (n=153)	Bhagwanpur (n=209)	Khanpur (n=7)	Laksar (n=24)	Narsan (n=186)	Roorkee (n=261)	Overall (n=840)
Cleanliness	93%	96%	100%	100%	91%	94%	94%
Skin-to-skin care at birth	41%	51%	29%	38%	50%	31%	42%
Early Initiation of breastfeeding	39%	40%	29%	25%	32%	30%	34%
PPFP Counselling	45%	46%	29%	33%	56%	42%	46%
IFA Provided	76%	72%	57%	54%	70%	72%	72%
Calcium Provided	76%	74%	57%	54%	74%	73%	73%
Birth Registration	35%	33%	29%	33%	40%	35%	36%

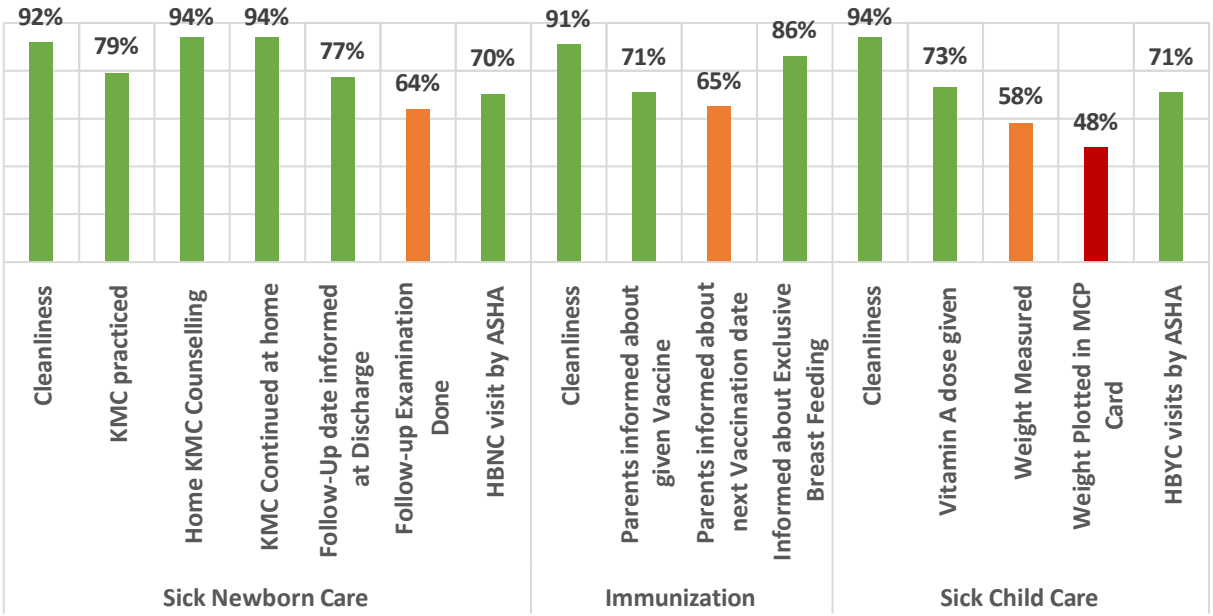
Service provision & Quality of care: SNCU discharged Babies, Immunization & Child Sickness

Inquiries regarding services and quality care for Special Newborn Care Unit (SNCU)-discharged infants revealed that **79% of parents practiced Kangaroo Mother Care (KMC) within the SNCU**. Post-discharge, 94% received counseling on continuing KMC at home, and 94% acknowledged adhering to KMC practices at home. Concerning follow-up, 77% were informed about their babies' follow-up dates at discharge, of which 64% revisited the hospital for the follow-up visit. Additionally, 70% reported that an Accredited Social Health Activist (ASHA) worker visited their home for the baby's post-discharge follow-up.

Following the discharge of infants, when contacted by telecallers, 71% of parents reported being informed about the vaccines that need to be administered to their babies. Moreover, 65% of parents were notified about the upcoming immunization dates. For strengthening IYCF, 86% of parents mentioned receiving information about exclusive breastfeeding for the recommended six months.

Similarly, concerning child care, 73% of parents stated that their baby received a Vitamin A dose. Furthermore, **58% reported their baby's weight was measured at the immunization site, with only 48% of beneficiaries confirming that the weight was recorded in the Maternal and Child Protection (MCP) card.** Additionally, 71% of parents responded affirmatively when asked if an ASHA worker visited their baby at home. (Figure 14)

Figure 13: Proportion of beneficiaries reported quality services for sick newborn, during immunization and while providing care to sick child.



During the block-level analysis (Table 6), it became evident that SNCU services were being utilized mainly from the Bahadrabad district and, to some extent, from the Laksar block. These two blocks reported the lowest home visitation rates. The follow-up rates in these blocks were better due to FPC.

For care provision to sick children, weight plotting on the Maternal and Child Protection (MCP) Card was reported by less than 50% of beneficiaries across the intervention blocks. It's important to note that this information does not apply to Khanpur and Laksar blocks, as no interviews with eligible beneficiaries were conducted.

Table 6: Block-wise status of service provision and quality of care for sick newborns during immunization and while caring for sick children.

Sick Newborn Care	Bahadrabad (n=316)	Bhagwanpur (n=1)	Khanpur (n=7)	Laksar (n=27)	Narsan (n=1)	Roorkee (n=2)	Overall (n=354)
Cleanliness	92%	100%	100%	89%	100%	100%	92%
KMC practiced	81%	0%	0%	50%	0%	0%	79%
Home KMC Counselling	94%	0%	0%	100%	0%	0%	94%
KMC Continued at home	94%	0%	0%	100%	0%	0%	94%
Follow-Up date informed at Discharge	77%	100%	86%	85%	0%	50%	77%
Follow-up Examination Done	65%	100%	57%	59%	0%	0%	64%
HBNC visit by ASHA	68%	100%	86%	78%	100%	100%	70%
Immunization	**Bahadrabad (n=154)**	**Bhagwanpur (n=252)**	**Khanpur (n=17)**	**Laksar (n=19)**	**Narsan (n=204)**	**Roorkee (n=192)**	**Overall (n=838)**
Cleanliness	94%	91%	88%	74%	92%	91%	91%
Parents informed about given Vaccine	72%	72%	59%	89%	71%	69%	71%
Parents were informed about the next Vaccination date	66%	66%	65%	79%	63%	64%	65%
Informed about Exclusive Breast Feeding	90%	85%	76%	95%	84%	86%	86%
Sick Child Care	**Bahadrabad (n=103)**	**Bhagwanpur (n=156)**	**Khanpur (n=0)**	**Laksar (n=0)**	**Narsan (n=87)**	**Roorkee (n=200)**	**Overall (n=546)**
Cleanliness	93%	96%	NA	NA	94%	93%	94%
Vitamin A dose given	75%	77%	NA	NA	70%	72%	73%
Weight Measured	56%	56%	NA	NA	60%	59%	58%
Weight Plotted in MCP Card	48%	46%	NA	NA	46%	51%	48%
HBYC visits by ASHA	68%	74%	NA	NA	72%	71%	71%

Quality Service Provision: Key Highlights

Overall, >= 90% of beneficiaries reported optimal cleanliness of the sites while availing of healthcare services.

For ANC -

- *More than 90% of beneficiaries received MCP cards.*
- *More than 75% of beneficiaries received IFA and calcium tablets.*
- *More than 70% of beneficiaries underwent blood examination.*
- *56% of beneficiaries received the Motherhood booklet.*
- *61% underwent urine examination.*

For HRPs -

- *96% of HRPs received the USG examination.*
- *More than 90% of HRPs received IFA and calcium tablets.*
- *38% of HRP cases underwent abdominal examinations performed by the service providers.*
- *41% of HRPs were aware of their high-risk conditions.*

For Childbirth -

- *More than 75% of beneficiaries received IFA and calcium tablets.*
- *36% of beneficiaries reported birth registration post childbirth.*
- *42% of beneficiaries reported providing skin-to-skin care to their newborns.*
- *34% initiated breastfeeding within one hour of delivery in the labor rooms.*

For Sick newborn Care -

- *79% of parents have practiced Kangaroo Mother Care (KMC) within the SNCU*
- *94% received counselling on continuing KMC and acknowledged adhering to KMC practices at home.*
- *70% of parents reported HBNC related home visitation by ASHAs.*
- *77% of parents acknowledged information provided on follow-up date during discharge however only 64% underwent examination during follow-up visit.*

For Immunization -

- *More than 85% of parents acknowledged that information on exclusive breast-feeding provided to them.*
- *Around 70% of parents informed about given Vaccine and 65% were informed about next vaccination date.*

For Sick Childcare -

- *73% parents reported that vitamin A dose was given to their child.*
- *58% reported their baby's weight was measured.*

5.0 OUT OF POCKET EXPENDITURE (OOPE)

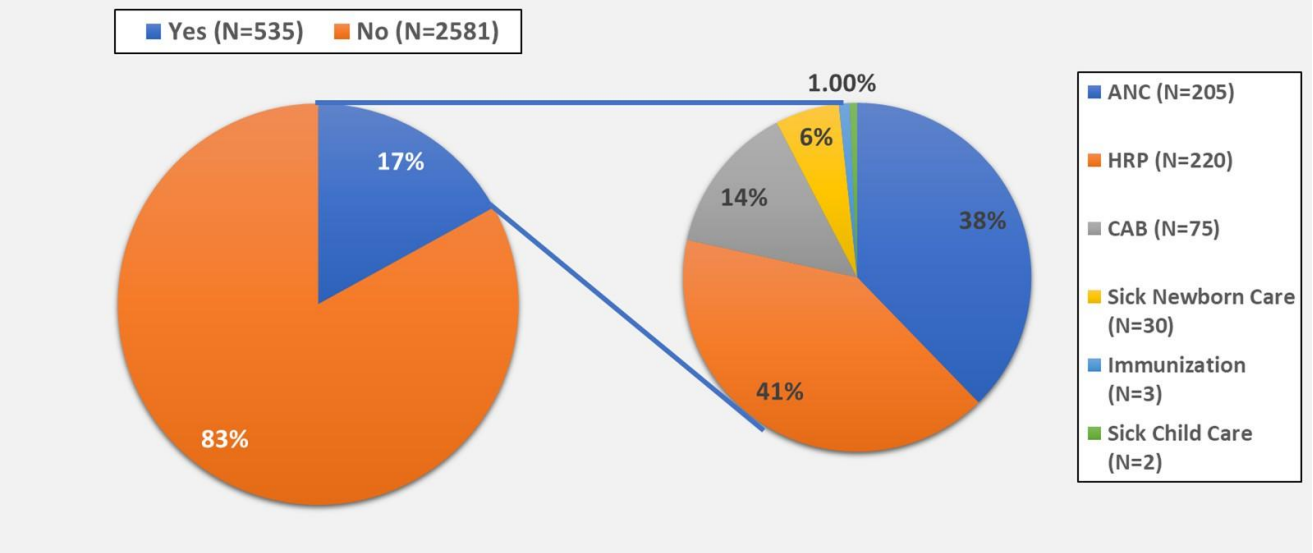
Out-of-pocket expenses for the beneficiaries who used public health facilities were ascertained by the money they spent on providing services, medicines, medical investigation, transportation, etc. 17% of beneficiaries who availed of healthcare services in public health facilities responded that they incurred out-of-pocket expenses while availing healthcare services in any of the above forms. **However, the majority, i.e., 83% of beneficiaries, reported no OOPE while availing healthcare services.**

OOPE: Key Variables Examined

OOPE incurred across six contact points; Cause of OOPE – Transportation, Medicines, Investigation, Others; OOPE associated with facility-based care, care of sick newborns, immunization & care of sick child.

Among those who reported OOPE (N=535), the highest proportion, i.e., 41% of beneficiaries, reported OOPE during HRPs, followed by ANC (28%) and while availing the facilities-based services for CAB (14%). The figure below presents the proportions of beneficiaries who reported OOPE by service type. (Figure 15)

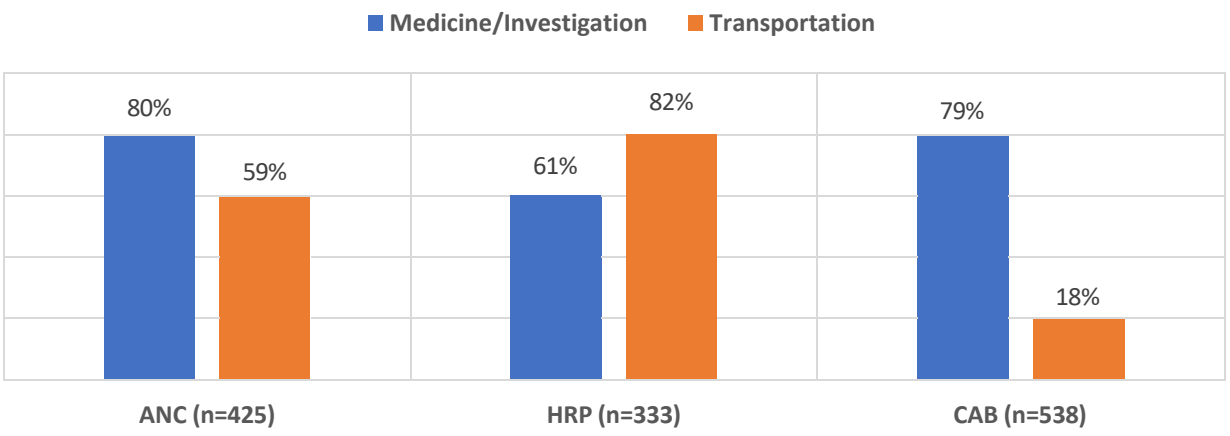
Figure 14: Proportion of beneficiaries reported OOPE in public sector health facilities – overall and by service type.



Cause of OOPE during facility-based care

Data reflects that out of the total OOPE spent on ANC, 80% of beneficiaries reported that OOPE incurred costs for medicine and investigations, and 59% said that OOPE incurred costs due to transportation. In HRP cases, 61% of respondents stated that they had incurred OOPE on medicine and investigations, while 82% reported spending money on transportation. However, 79% of beneficiaries said that OOPE incurred costs for medicine and investigations, and only 18% said that OOPE incurred costs due to transportation while visiting facilities for childbirth. (Figure 16)

Figure 15: Cause of OOPE reported by beneficiaries during facility-based care.



A block-wise analysis of OOPE incurred by the beneficiaries while availing facility-based care during ANC, HRP, and childbirth in public health facilities is presented as **Annexure 2.** Amounts of expenditures incurred were unavailable, and the same has not been analyzed.

OOPE: care of sick newborns, immunization & care of sick child

Out of 354 beneficiaries, only 30 were identified to have incurred OOPE while caring for sick newborns admitted in SNCUs. Among all reported, 47% indicated expenditure on medicines, 13% of beneficiaries said spending on transportation, and 13% reported OOPE related to investigations. A very minimal proportion (only 4 out of 838 beneficiaries) reported spending money on immunization services. Likewise, the occurrence of OOPE during the care of sick children was also low, with only 5 out of 546 beneficiaries reporting such expenses.

Block-wise analysis of OOPE incurred by the beneficiaries during the care of sick newborns, immunization & care of sick children in public health facilities is presented as **Annexure 3.**

OOPE: Key Highlights

- ✓ *Only 17% of respondents from public health facilities indicated incurring OOPE when accessing healthcare services.*
- ✓ *The highest proportion of OOPE, accounting for 41%, occurred among HRPs, followed by 38% during ANC and 14% for CAB cases.*
- ✓ *Beneficiaries **reported minimal spending on immunization services and while receiving care for sick children.***
- ✓ *Expenditures were reported mainly for medicine and investigations and for transport.*
  Among ANC beneficiaries, 83% reported incurring OOPE for medicine and investigations, with 59% attributing expenses to transportation.
    - *In HRP cases, 61% stated spending on medicine and investigations, while 82% reported expenditures related to transportation.*
    - *79% of beneficiaries reported that OOPE incurred on medicine and investigations and only 18% reported that OOPE incurred due to transportation while visiting facilities for childbirth.*

6.0. CLIENT AWARENESS RELATED TO GOVERNMENT SCHEMES

Community awareness plays a pivotal role in ensuring the success and effectiveness of government health schemes. When people are well-informed about government health programs, they can actively participate and take advantage of the available resources, leading to a healthier and more resilient society. Under QUICK, we asked beneficiaries and their family members about their awareness of different government health schemes running in their states.

Client Awareness: Key Variables Examined

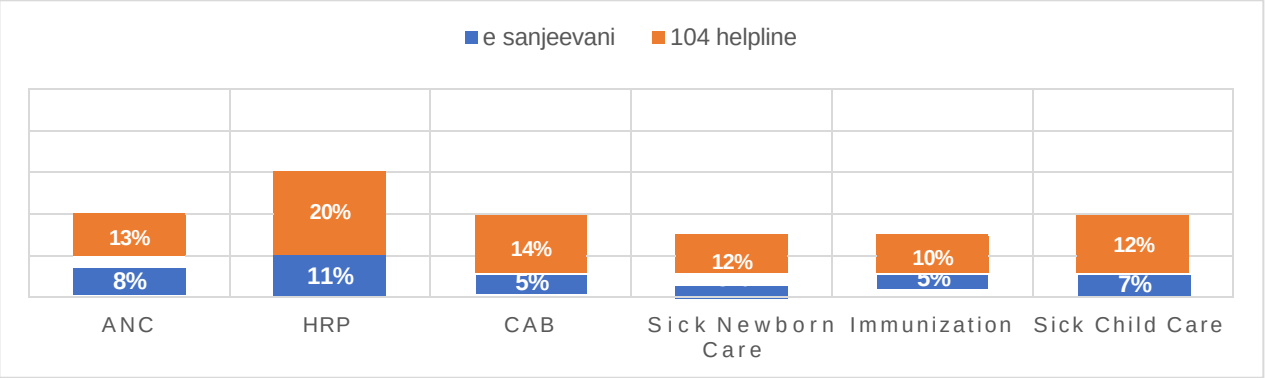
Status of beneficiary's awareness on – e-Sanjeevani; 104 Helpline; Awareness about Free Delivery & Transport Services provision under JSSK

Awareness about e-Sanjeevani & 104 Helpline

Overall, the community awareness about the e-sanjeevani scheme was low. Among High-Risk Pregnancy (HRP) calls, 11% indicated awareness, while for Antenatal Care (ANC), it was 8%. Additionally, only 5% of Care around Birth (CAB) calls, 3% of SNCU calls, 5% of Immunization calls, and merely 7% of Childhood Sickness calls reported awareness of E-Sanjeevani. (figure 17)

Beneficiaries' awareness regarding 104 helpline services was also deficient. Among all High-Risk Pregnancy (HRP) calls, 20% of beneficiaries knew 104 helpline services. The awareness percentages for Care around Birth (CAB), Antenatal Care (ANC), SNCU, and Childhood Sickness were 14%, 13%, 12%, and 12% respectively. Immunization calls reported that only 10% of beneficiaries knew the 104-helpline services.

Figure 16: Proportion of beneficiaries aware about e sanjeevani & 104 helpline across six contact points



Awareness about Free Delivery & Transport Services

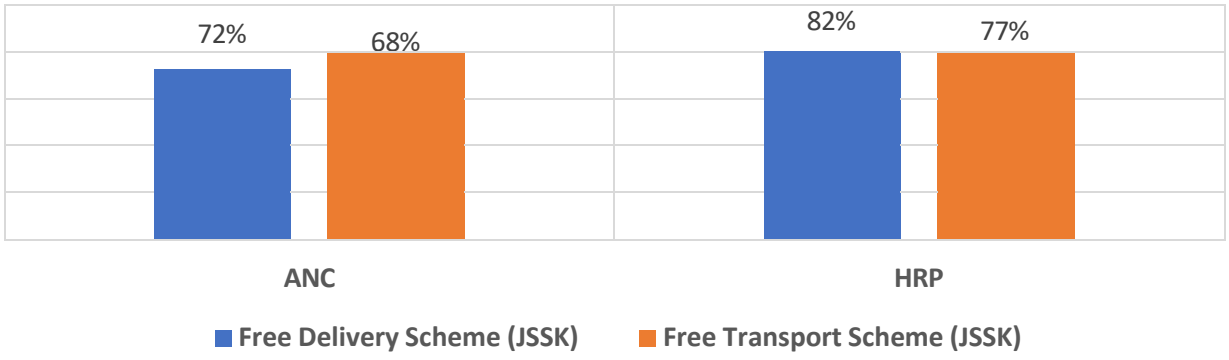
Telecallers interviewed beneficiaries who utilized ANC and HRP services in public health facilities to gauge their awareness of free delivery and transport schemes under Janani Shishu Suraksha Karyakaram (JSSK).

72% of ANC beneficiaries and 82% of HRP cases were aware of free delivery services. Notably, Laksar block exhibited the highest awareness, with 81% of ANC beneficiaries and 100% of HRP cases aware of the government's free delivery schemes. However, in Khanpur, no HRP cases were contacted; therefore, their awareness status is not reported.

Regarding free transportation under JSSK, 68% of ANC beneficiaries and 77% of HRP cases knew about free transport services. Notably, Laksar block exhibited the highest awareness, with 78% of ANC beneficiaries and 100% of HRP cases aware of the government's free transport schemes. However, in Khanpur, no HRP cases were contacted; therefore, their awareness of free transport is not reported.

The block-wise status of beneficiaries' awareness regarding free delivery and transport services provisioned under JSSK is presented as **Annexure 4.**

Figure 17: Beneficiary's Awareness of Free Delivery and transport Services under the JSSK Scheme



Client Awareness: Key Highlights

- ✓ *Overall, majority i.e. 72% of ANC beneficiaries and 82% of HRP cases were knowing about the available free delivery services.*
- ✓ *68% of ANC beneficiaries and 77% of HRP cases knew about free transport services.*
- ✓ *The awareness about e sanjeevani and 104 helpline services was found to be low across the intervention blocks.*

7.0 CONCERNS RAISED BY BENEFICIARIES

Throughout the discussions, tele-callers probed beneficiaries for any concerns they might have encountered while accessing healthcare services. The data highlights that out of the 4,222 beneficiaries interviewed, only 5% (n=233) expressed specific concerns regarding the services they wished to address during the discussion. The majority, constituting 61% of beneficiaries, had no problems to report, while approximately 34% did not respond to this question.

Client Concerns: Key Variables Examined

Key concerns raised across six contact points; Concerns with respect to site cleanliness; staff behaviour; service provision & quality of care; out-of-pocket expenditure.

Call-wise data analysis of concerns raised by respondents showed that the maximum issues, 30%, were raised by beneficiaries who availed services for Care around birth (Child delivery). Other percentages include 22% for High-Risk Pregnancy (HRP), 28% for Antenatal Care (ANC), 10% for SNCU discharge, 8% for childhood immunization, and 2% for childhood sickness. (Figure 19)

Figure 19. Below is a categorical analysis of the type of concerns reported by the beneficiaries contacted across six contact points.

Figure 18: Proportion of beneficiaries with Concerns – overall and by service type.

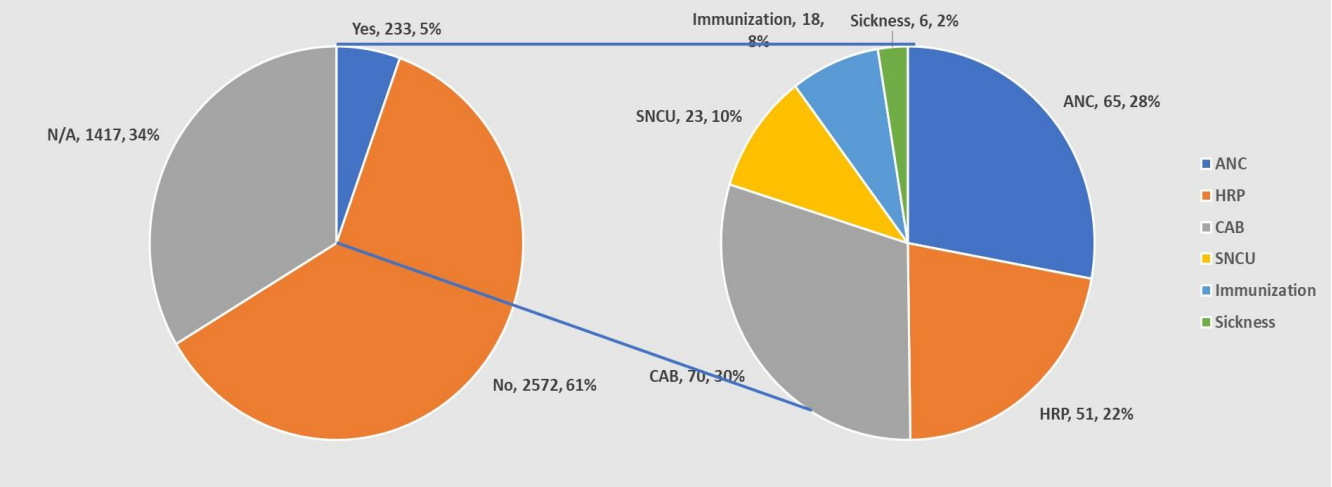


Figure 19: Types of Concerns raised by the beneficiaries across six contact points.

Types of Concerns Raised by the Beneficiaries	ANC	HRPs	Care at Birth	Care of sick newborn	Care of sick child	Immunization
Site Cleanliness						
Cleanliness in the facilities including wards, toilets, and premises	√	√	√	√	√	√
Staff behavior						
Rude behavior of the health staff	√	√	√	√	√	√
Out of pocket expenditure						
Demand for money by hospital staff as perks & grafts.	√	√	√	√	√	√
Directed to private hospitals for investigations and or services	√	√	√	√	√	√
Service Quality						
Overcrowding, Long waiting time for services	√	√	√	√	√	√
Denial of services despite being available	√	√	√	√	√	√
Lack of proper communication regarding follow-up and referral	√	√	√	√	√	√
No information and support being provided by ASHAs	√	√	√	√	√	√
Non-availability of doctors and nursing staff	√	√	√	√	√	X
Medicines are being asked to purchase from outside	√	√	√	√	√	X
Only limited blood investigations available	√	√	√	√	√	X
Renumeration provisioned under government scheme not received	√	√	√	√	√	X
Take Home Ration is mostly unavailable and of poor quality	√	√	√	√	√	X
Non-availability of IFA and Calcium tablets	√	√	√	X	X	X
Non-availability of USG services	√	√	√	X	X	X
Privacy concerns	√	√	√	X	X	X
ASHA does not conduct home visits and counselling	X	X	X	√	√	X
Weight is not being measured during VHSND	X	X	X	X	X	√
Vaccine often goes out of stock	X	X	X	X	X	√

√ *Concerns reported as "Yes" by majority of beneficiaries during the contact.*

X *Concerns reported as "No" by beneficiaries during the contact.*

CONCLUSION

The first year of the QUICK implementation was primarily focused on getting the implementation right to connect with more beneficiaries. Implementing any new model and technology is a continuous learning experience, and our efforts are consistent towards constantly improving the experience for the user, the beneficiary, and the program teams. From the second quarter onwards, the model has generated observations and insights through the dashboard and shared this data with the District and State teams to improve health outcomes. The QUICK model has been strengthened to get valuable information and guide the district for responsive action, which, when scaled up, may be implemented within the existing government framework. The state has also recognized and reflected this as a 'Best practice' during the MoHFW marketplace event in Delhi in November 2022. Given the value added demonstrated by the model implementation through systematic data collection and analysis, sharing of learning, and actionable, it is advocated for the implementation to be taken to scale across all Districts in the State by exploring the opportunities to synergize with the existing operations at NHM, Uttarakhand.

Suggested Actions

The following actionable suggestions are emerging from an in-depth analysis of data derived from QUICK implementation:

1. Improve beneficiaries' contact details' correctness and completeness in government portals.

The QUICK model uses data downloaded through RCH and SNCU portals to connect with the beneficiaries. Our analysis suggests that 22% of the calls matured (the caller could speak to the beneficiary). Many calls could not be connected due to incomplete records or invalid contact details provided in the RCH and SNCU portals. There is an urgent need to look at the data and take corrective actions. The QUICK model relies on secondary data sources like RCH and the SNCU portal to gather beneficiaries' contact details. Therefore, it is necessary to ensure that beneficiaries' mobile numbers are correctly recorded/updated during registration.

2. Include details of social welfare schemes as an integral component of the Information Education and Communication (IEC) strategy.

Lack of awareness and information about government health schemes is the primary barrier to adequate access to healthcare services. Our analysis found that community awareness about online medical consultation and 104 helpline services could have been more robust across the intervention blocks. This deficiency in the awareness and implementation of the government initiative adds to the dissatisfaction and disappointment experienced by the beneficiaries. There is a greater need to revisit strategies to provide information and education to beneficiaries regarding government facilities and improve the IEC materials to disseminate information about government schemes.

3. Improve laboratory testing and ultrasound services during ANC and essential clinical examination to improve the quality of services.

Availability of ultrasound services in government facilities: This is an acute challenge pregnant women face. Hence, they have no other option but to spend a substantial amount on USG services from a private facility.

Facilitate check-ups of pregnant women: During ANC check-ups, 73% of the beneficiaries responded that their blood test was done, and 61% responded that the Urine test was done. The situation needs improvements in the case of HRP check-ups, where only an abdominal examination of 38% of beneficiaries was done. It is important to note these are significant tests that talk about the health of the mother and child; steps should be taken to ensure that all the beneficiaries are given these tests. Investigations in ANC and HRP calls have come up as an OOP expense.

Educate HRPs on high-risk conditions: overall awareness or information provided by healthcare providers about high-risk conditions was observed in 40% of beneficiaries, and only 60% of beneficiaries received medical consultations during their visit to health facilities.

4. **Facilitate birth registrations through information on the registration process in delivery sites.**

Only 36% of beneficiaries who delivered reported to have received a birth registration certificate, which is listed as an assured service under SUMAN and other programs. Efforts must be streamlined to complete the birth registration process per the expected timelines.

5. **Strength Implementation of Skin-to-skin contact, early initiation of breastfeeding, and counseling on PPFP in all facilities for accelerating Evidence-based MNCH Practices.**

Only 42% of beneficiaries reported providing skin-to-skin care to their newborns, while 34% initiated breastfeeding in the labor room within one hour of delivery. Furthermore, only 46% received counseling on postpartum family planning methods, with 28% being offered the actual process. This necessitates an urgent need to establish a structured mentorship & supervisory visits mechanism to periodically monitor practices and provide supportive supervision in improving the quality of facility-based care.

6. **Include KMC and awareness of government schemes as an integral component of family counseling during home visits.**

Beneficiaries have also expressed grievances about the lack of mobilization and information dissemination by ASHAs. This comes out in SNCU calls where only 70% of the beneficiaries said that ASHAs visited them. Also, 19% received counseling on continuing KMC at home post-discharge, and 19% acknowledged adhering to KMC practices at home. Efforts should be made to create awareness amongst the ASHAs about the government schemes and sensitize and supervise them in assisting pregnant beneficiaries to avail government facilities and benefits.

7. **Strengthen the supply chain for IFA and calcium to improve ANC quality service provision.**

Stock monitoring of essential medicines and supplements like Iron and calcium tablets is required. Another recurring complaint from pregnant women is the non-availability of essential drugs during their antenatal care visits. Medications such as IFA (Iron-Folic Acid), calcium, and other necessary drugs are reported to be out of stock, causing inconvenience and concern among the beneficiaries.

8. **Strengthen referral systems with referrals to sites with service provision and using single vehicles during the referral process.**

A significant number of pregnant women and their family members have raised complaints about the need for using multiple vehicles during transportation from the primary facility to higher centers. However, despite being referred to these higher centers, they still need to get the requisite services due to the non-availability of service provisions. This discrepancy in the referral system raises questions about the service assurance at referral centers and the efficiency and effectiveness of the healthcare system. Need to create systems for ensuring proper documentation and tracking all referral cases, including re-return cases.

9. **Improve staff behaviors for the provision of respectful care.**

Although overall satisfaction is 76% across all calls, among the grievances reported, the most common issue revolves around the behavior of service providers. Instances of rude behaviors of health staff, abusive language, and non-attendance in indoor wards were frequently mentioned, causing distress and discomfort to the beneficiaries. Pregnant women often encounter the unfortunate situation of being denied necessary services.

The voice of beneficiaries holds immense value in shaping the quality of healthcare services, and the QUICK application serves as a conduit for their concerns and grievances. Weekly discussions with the 104-calling person are held to address the grievances and concerns recorded in the QUICK application. This proactive approach ensures that beneficiary feedback is promptly acknowledged and acted upon. These discussions culminate in gathering beneficiary feedback, which is shared with State teams. This transparent sharing of feedback enables the identification of improvement areas within the healthcare system. The recommended actions resulting from this process have been discussed with State teams at various intervals.

ANNEXURES

Annexure 1. Call Statistics- Blockwise

primary	Secondary	Bahadrabad		Bhagwanpur		Khanpur		Laksar		Narsan		Roorkee		Total	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Calls Made		4183	-	4314	-	568	-	1626	-	3714	-	4464	-	**18869**	-
	Primary	1269	30%	1211	28%	118	21%	238	15%	1037	28%	1337	30%	**5210**	28%
	Family Group	639	15%	770	18%	114	20%	274	17%	595	16%	696	16%	**3088**	16%
Calls connected		1908	46%	1981	46%	232	41%	512	31%	1632	44%	2033	46%	**8298**	44%
	Primary	1269	30%	1211	28%	118	21%	238	15%	1037	28%	1337	30%	**5210**	28%
	Family Group	639	15%	770	18%	114	20%	274	17%	595	16%	696	16%	**3088**	16%
Calls not connected		2275	54%	2333	54%	336	59%	1114	69%	2082	56%	2431	54%	**10571**	56%
	Invalid phone numbers	217	5%	182	4%	58	10%	176	11%	154	4%	141	3%	**928**	5%
Calls completed (Primary)		1067	26%	953	22%	94	17%	199	12%	838	23%	1071	24%	**4222**	22%
	Public	916	22%	634	15%	71	13%	128	8%	623	17%	744	17%	**3116**	17%
	Private	151	4%	319	7%	23	4%	71	4%	215	6%	327	7%	**1106**	6%
Average time of calls		00:11:23		00:14:49		00:09:47		00:12:45		00:14:08		00:11:46		**00:12:26**	

Annexure 2: Block-wise status of OOPE during ANC, HRP, and Care at Birth (Public Health Facilities)

Block Name	ANC (n=796, OOPE =205)				HRP (n=416, OOPE =220)				CAB (n=311, OOPE =75)					
	N	Med / Invest	Trans.	Total	N	Med / Invest	Trans.	Total	N	Med	Trans.	Invest	Others	Total
Bahadrabad	161	28	35	49	113	39	48	58	82	3	1	0	9	13
Bhagwanpur	185	26	30	44	38	16	12	21	68	8	1	1	12	19
Khanpur	44	6	3	6	0	0	0	0	3	0	0	0	0	0
Laksar	78	9	12	17	0	0	0	0	4	0	0	0	0	0
Narsan	184	31	38	52	92	41	36	55	77	2	0	0	23	24
Roorkee	144	23	17	37	173	67	57	86	77	9	1	5	10	19
Total	796	123	135	205	416	163	153	220	311	22	3	6	54	75

Annexure 3: Block-wise status of OOPE during admission in SNCU, Immunization & Care of Sick Child. (Public Health Facilities)

Block Name	SNCU (n=354, Expense =30)					Immunization (n=769, Expense =3)					Sickness (n=470, Expense =2)				
	N	Med	Trans	Invest	Other	N	Med	Trans	Invest	Other	N	Med	Trans	Invest	Other
Bahadrabad	316	13	3	3	13	149	0	1	0	0	95	0	1	0	0
Bhagwanpur	1	0	0	1	0	212	0	0	0	0	130	0	0	0	0
Khanpur	7	0	0	0	0	17	0	0	0	0	0	0	0	0	0
Laksar	27	1	1	0	2	19	0	0	0	0	0	0	0	0	0
Narsan	1	0	0	0	0	192	0	0	0	0	77	0	0	0	1
Roorkee	2	0	0	0	0	180	1	0	0	1	168	0	0	0	0
Total	354	14	4	4	15	769	1	1	0	1	470	0	1	0	1

Annexure 4. Beneficiaries' awareness regarding free delivery and transport services provisioned under JSSK.

	Bahadrabad	Bhagwanpur	Khanpur	Laksar	Narsan	Roorkee	Total
Awareness about the Free Delivery Scheme (JSSK)							
ANC (n=1094)	71%	70%	71%	81%	76%	65%	72%
HRP (n=537)	84%	92%	NR	100%	76%	81%	82%
Awareness about the Free Transport Scheme (JSSK)							
ANC (n=1092)	65%	66%	71%	78%	72%	59%	68%
HRP (n=537)	78%	82%	NR	100%	71%	77%	77%
Awareness about e-Sanjeevani							
ANC (n=1077)	9%	9%	5%	7%	7%	6%	8%
HRP (n= 527)	8%	14%	NR	100%	7%	14%	11%
CAB (n=811)	5%	4%	0%	0%	7%	7%	5%
Sick newborn care (n=349)	3%	0%	14%	4%	0%	0%	3%
Immunization (n=823)	3%	4%	6%	6%	6%	6%	5%
Sick childcare (n=536)	6%	8%	0%	0%	8%	8%	7%
Awareness about 104 Helpline Service							
ANC (n=1084)	12%	18%	13%	10%	10%	10%	13%
HRP (n= 533)	21%	15%	NR	0%	21%	21%	20%
CAB (n=823)	11%	15%	0%	4%	16%	16%	14%
Sick newborn care (n=349)	10%	0%	29%	23%	0%	50%	12%
Immunization (n=821)	8%	12%	13%	11%	10%	11%	10%
Sick childcare (n=532)	14%	12%	0%	0%	13%	12%	12%

Annexure 5. QUICK Technology Solution

The web application is designed and developed on CommCare, an open-source platform for telecallers (existing 104 users of Uttarakhand State) as the primary users of the solution. The application is built for last-mile social impact and as a job aid with the ability to empower frontline users to track micro-level data and report. It allows the telecallers to record information collected during their telephonic interaction with the beneficiaries who have received services across the six service points.

QUICK Technology Solution

The QUICK Model has wo key components

Web Application as a job aid for Telecallers

Reporting Dashboard for Program Team and State Officials

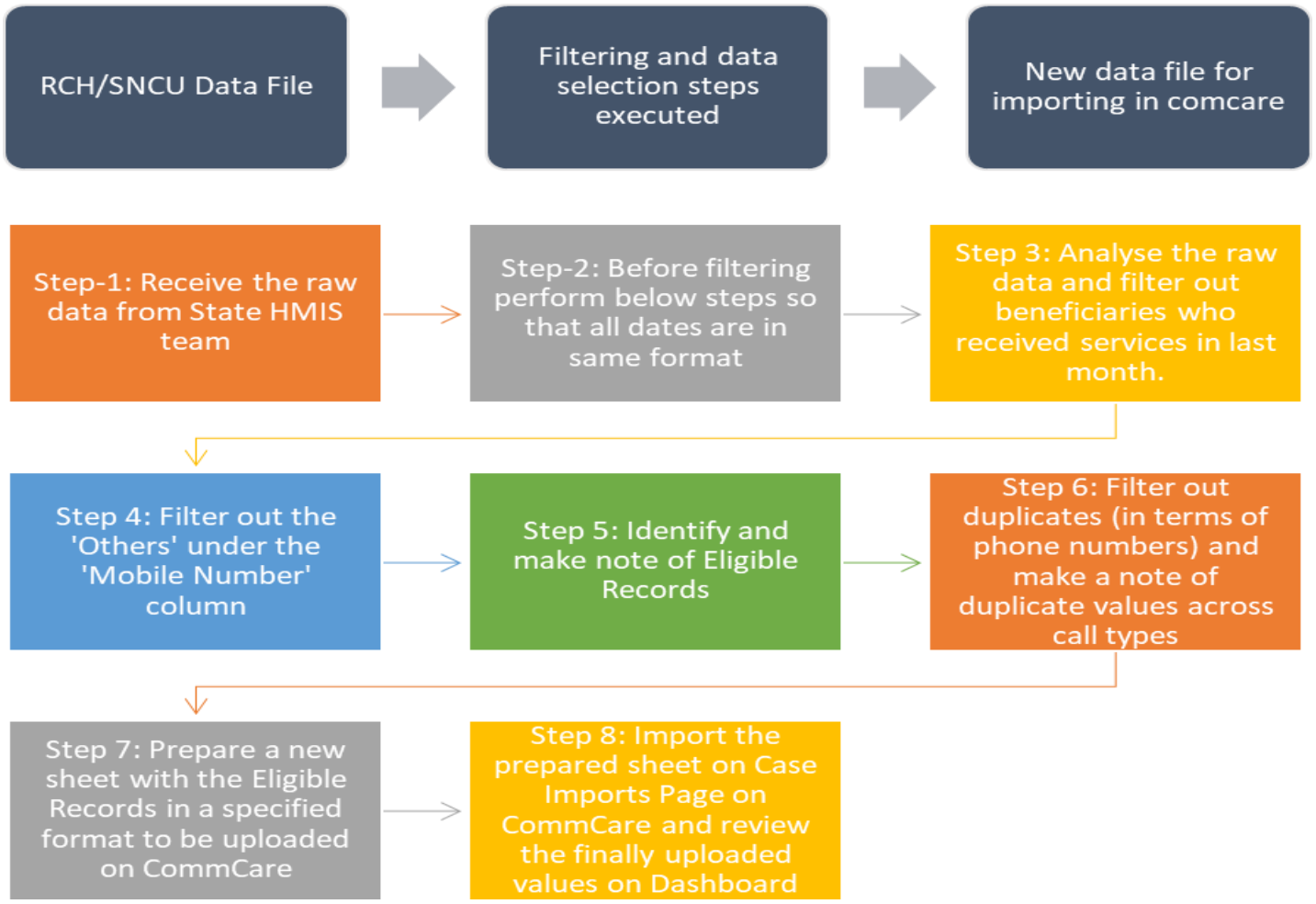
Data Recording Tools

Following types of data recording tools used in QUICK -

- Call 1 – Antenatal Care (Annexure-1)
- Call 2 – High Risk Pregnancy (Annexure-2)
- Call 3 – Childbirth (Annexure-3)
- Call 4 – SNCU discharge babies (Annexure-4)
- Call 5 –Immunization – Penta 3 (Annexure-5)
- Call 6 – childhood illness – OPV Booster (Annexure-6)

QUICK Process

The following eight steps are used to import data in the QUICK application.

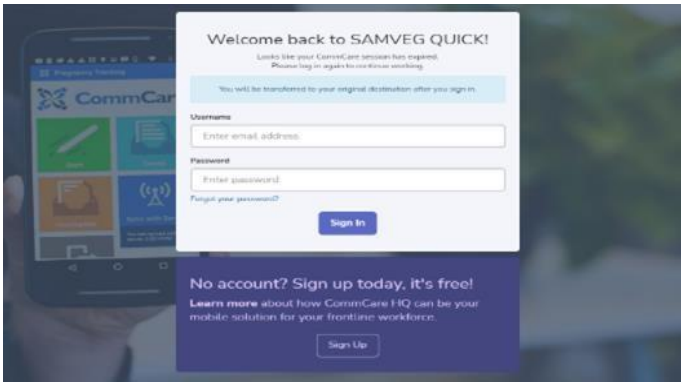


How to use QUICK web application

Telly callers use QUICK web applications to collate information for all the data collection tools.

I. Logging In, Updating, and Syncing the Web App

a) **<u>Application Login</u>**: Go to the Web Application using the QUICK Calling Tool and login using your username and password.

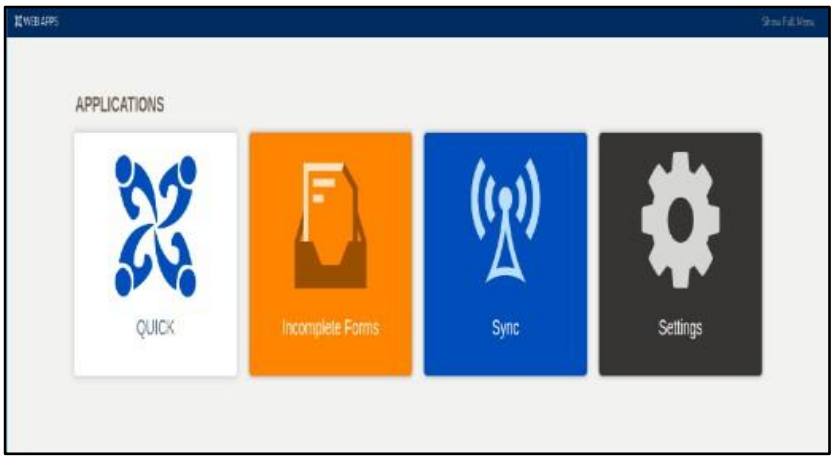


This screen presents options such as entry into the application, sync (with server), and settings. Users select the first option with the app name to access it.

After logging in, click on QUICK Calling Tool to enter the application.

b) **<u>Server Synchronization:</u>**

Click the Sync button, as shown in Figure 2. When successful, a message should be displayed on top of the screen.



- **Pressing sync pushes** entered data from the web application to the server.
- **Pulls** new data from the server onto the web app.
- All users should **manually sync *<u>at least</u>* 2x daily:**
    - When logging into the web app at the beginning of a workday,
    - Before logging out of the web app at the end of a workday,
    - Anytime you notice a red text alert near the sync button

c) **<u>Application logout</u>**

If you see that you are already logged in with another user's credentials, you can log out of the application and then log in again with the proper credentials.

To Log out: Click on '**Show Full Menu**', which is located on the top right **corner of the blue bar.**

After clicking on 'Show Full Menu,' another white bar appears just above the blue bar.

Figure 19 : Log out option highlighted in main screen.

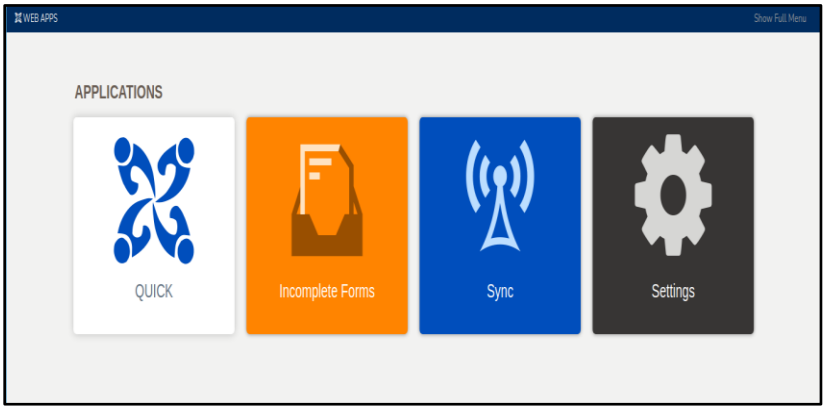
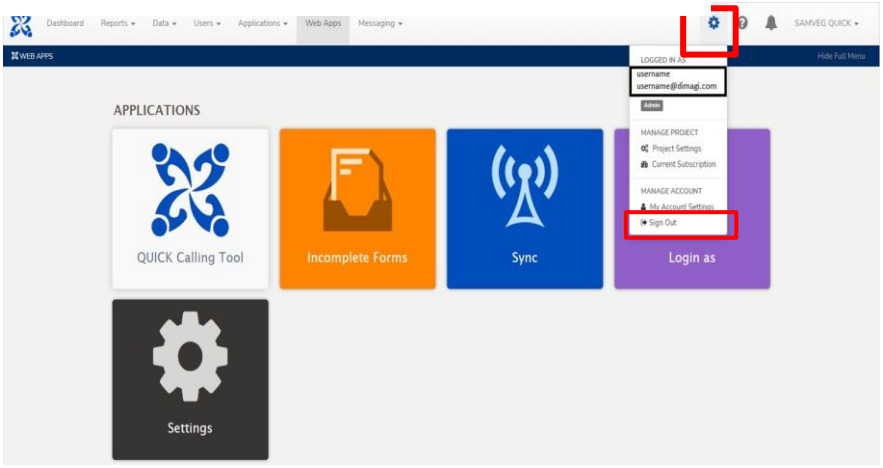


Figure 20 : Gear icon shown in main screen



On the White bar, click on the '**Gear icon**' (located in the top right corner, just beside the question mark icon).

Then click on the '**Sign Out**' option from the drop-down menu to log out of the application.

II. Navigating the Application

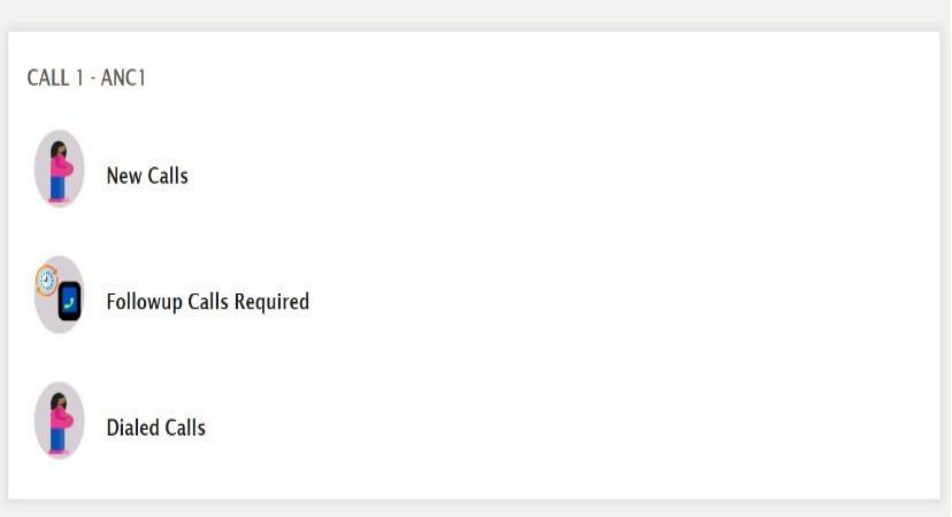
Figure 21 : Menu screen of QUICK calling tool

a) **Menu Screen:** This is a MENU Screen of the QUICK Calling Tool. A Menu consists of three Sub-menus: New, Follow-up Calls Required, and Dialled.

Click on a Menu to enter the Sub-Menu Screen.

b) **Sub-Menu:**

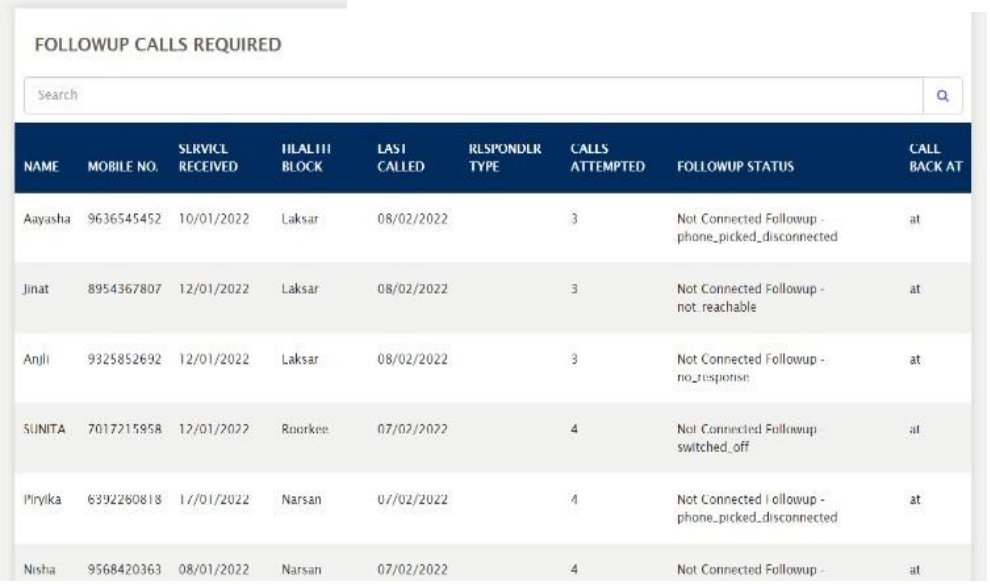
Figure 22 : Sub-menu options in each call



Clicking on a Menu brings you to a Sub-Menu Screen. This screen consists of three Sub-Menus.
Click on the name of a Sub-Menu to see its CASE LIST screen.
CASE LIST is a list of beneficiaries with information necessary for tele- callers, such as phone numbers, important dates, IDs, and locations. To proceed further, select a beneficiary from the prioritized list.

c) Navigation into a data entry form

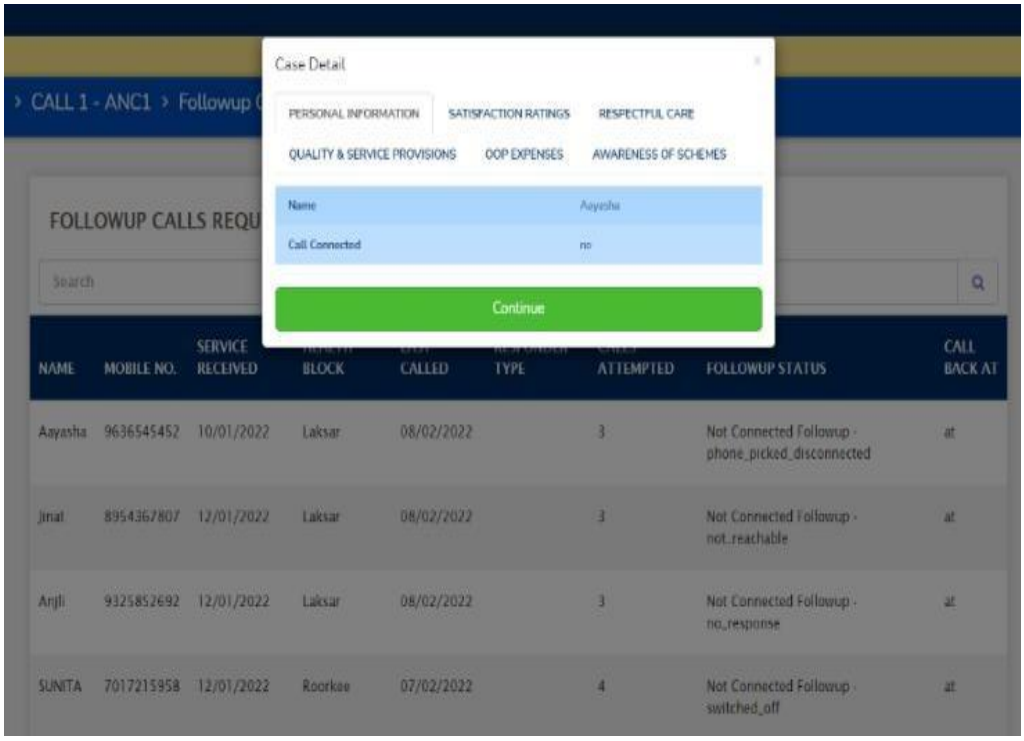
Figure 23 : Screen with case-list



Clicking on a Sub-Menu brings you to a CASE LIST.
For 'Follow-up Calls Required' and 'Dialed Calls' Sub-Menus:
Click on the CASE name to see its CASE DETAILS screen with summary information.

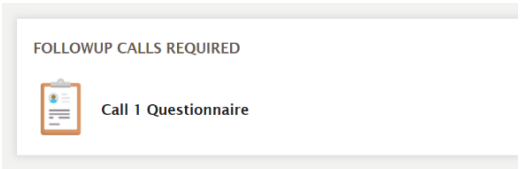
Note: This navigation is only relevant for the Followup Required and Dialed Calls Sub-Menus; it is unsuitable for New Calls.

Figure 24: Case detail screen



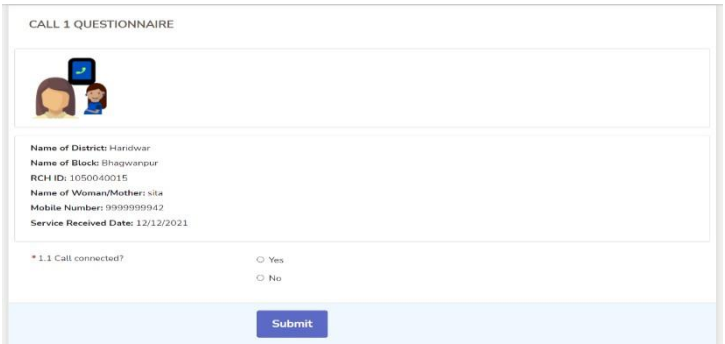
The CASE DETAILS screen appears after selecting a case from the case list. It usually includes more information than the case list and helps check if the user has selected the correct case and providing additional information.
Click on different TABS on the CASE DETAILS screen to view information pertinent to that TAB name/category.

Click on Continue to enter the Forms Screen.

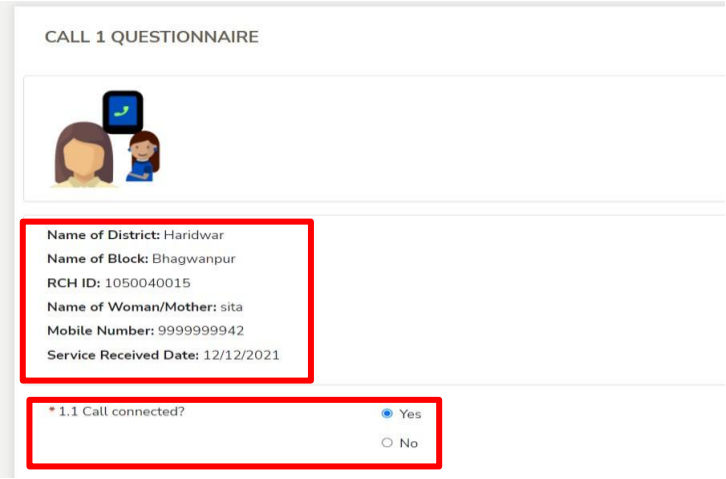


Click on the case you'd like to act on to see available Forms. After clicking on Continue, various available forms are displayed.

Click on the desired Icon/Form name to enter the form.



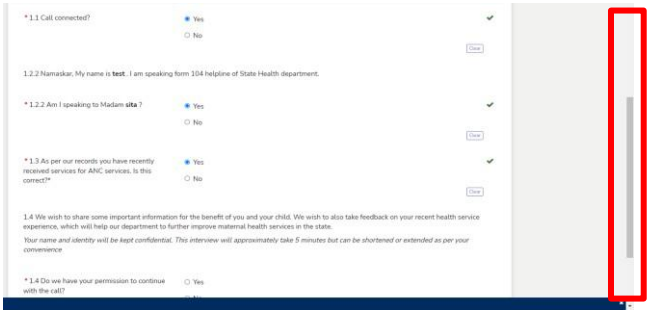
Things to keep in mind after Entering a Form



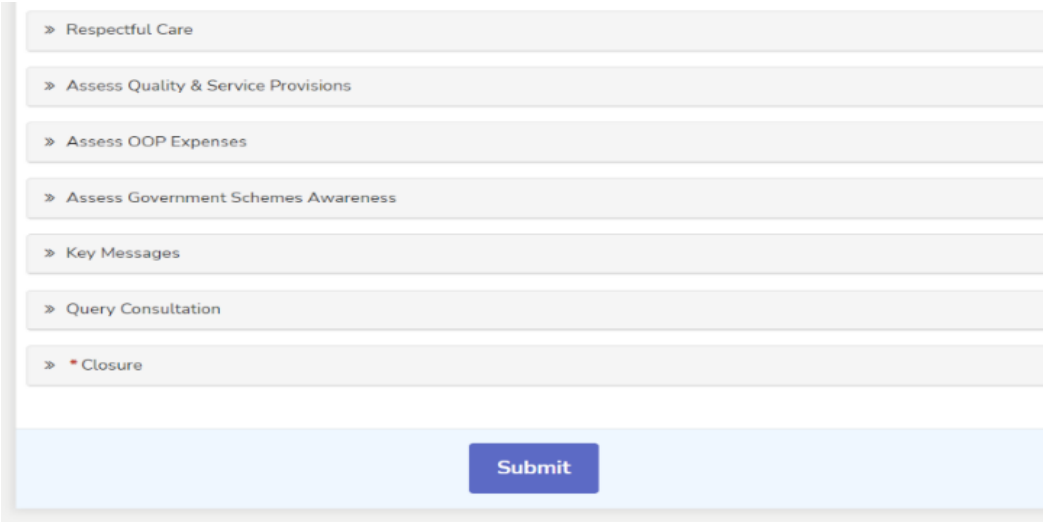
- Subsequent questions are displayed as per the responses provided by the user in previous questions.
- Labels are provided at the beginning of the form to inform the user about the selected case's basic details.
- Questions that are marked by an asterisk (*) are mandatory. If the user tries to click 'Submit' before answering all required fields, they will be asked to respond to those mandatory questions that they've missed.

- In the questionnaire, a list of different types of questions (drop down, multi-select, text entry) will enable the user to converse with the beneficiary and record information.

Scroll down to see more information present below, or hold and drag the scrolling bar, which is present on the right side of the screen for moving up/down.



After going through the entire form, when the user clicks on the ‘Submit’ icon, the form will be submitted.



To exit a form, click the very top left ‘go back’ arrow of your web browser which will bring you to your previous screen.

To get back to the home screen click on the ‘Home’ symbol on the top left of the blue bar.

QUICK Dashboard

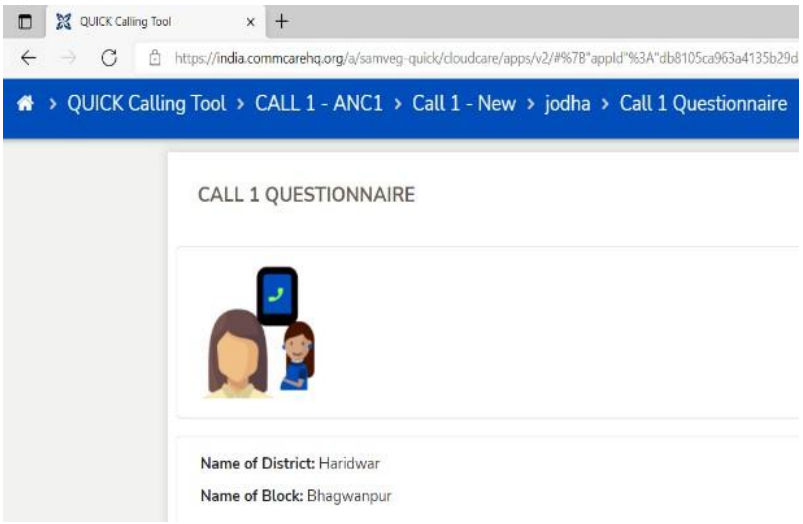
Another component of the digital solution is a comprehensively curated dashboard as the data reporting and visualization element. The data collected on CommCare is integrated with a third-party analytical tool to monitor the program implementation and to enable data-backed decision making by the program team.

The dashboard provides the following broad functionalities:

- Aggregate reports generating key program insights for evidence-based decision making.
- Line list of beneficiaries for service delivery optimizations

The key features of the Dashboard are outlined below:

- Aggregated data across locations and service types



- Ticker for important information (eg: current ongoing status of calls)
- Visualization of the Data
- Downloadable formats
- Customization of Data
- Filter Options
- Anecdotal Evidence

This is an aggregated Dashboard which has various reports based on calling frameworks in the QUICK calling application, such as:

- Satisfaction Rating
- Respectful Care
- Out Of Pocket expense report
- Government Scheme Awareness
- Query, Consultation & Grievance
- Service Care Provisions
- Call Record Details
- Beneficiary Details
- Trends of monthly calls to a static cohort of beneficiaries

The same has been made available to the State officials for monitoring the implementation of the innovative model.

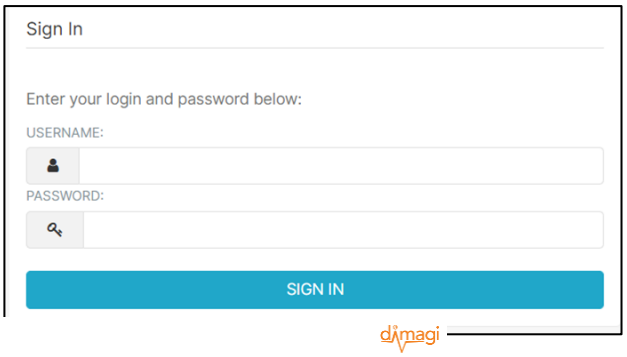
A. Indicators and their definitions

Satisfaction Rating	Respectful Care	OOP Expense report	Government Scheme Awarness	Query, consultation & Grivances
Service Care Provisions	Call Record Details	Beneficiaries Details	Call 7 Details	

How to use QUICK Dashboard Application

I. Dashboard Login

Go to the dashboard by using the link:
SAMVEG QUICK - Dashboard

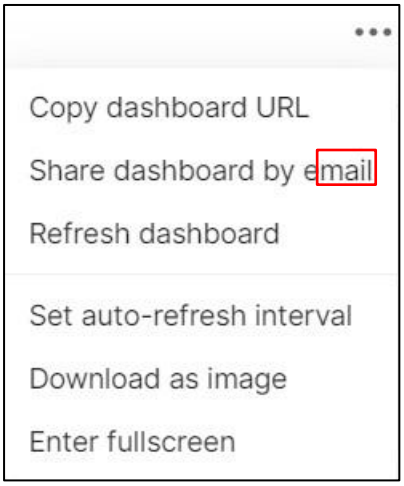


DASHBOARD LOGIN

II. Dashboard Utilities

At the top right of the dashboard is an option to access the utilities available for the dashboard. These are as follows:

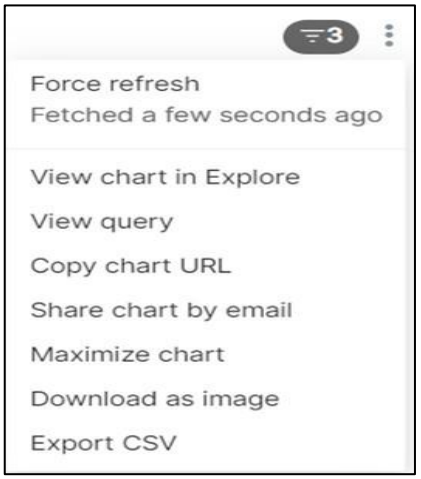
- **COPY DASHBOARD URL**: Copies the link to the dashboard which can be shared to anyone.
- **SHARE DASHBOARD BY EMAIL**: Provides options to email the dashboard.
- **REFRESH DASHBOARD**: Manually refreshes the dashboard to fetch latest data.



- **SET AUTO-REFRESH INTERVAL**: Set time interval to automatically refresh the dashboard with the latest data.
- **DOWNLOAD AS IMAGE**: Download the current tab as a .jpg image.
- **ENTER FULLSCREEN**: Displays the dashboard in Fullscreen mode.

III.Indicator Utilities

At the top right of every chart is an option to view the utilities available for the chart. These are as follows:



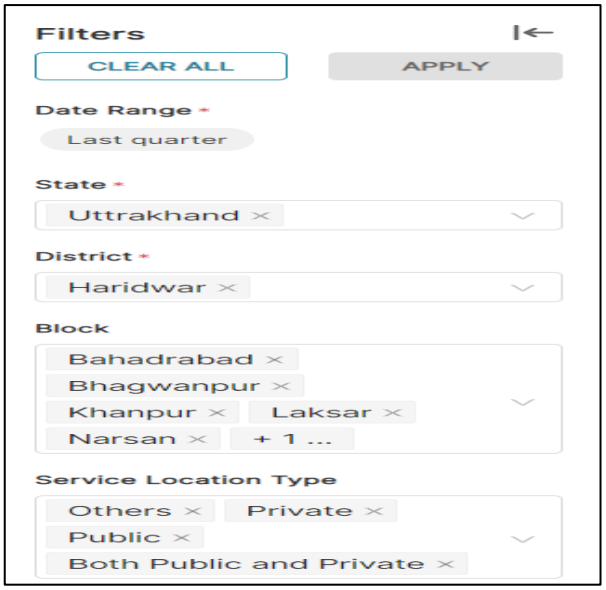
FORCE REFRESH: Used to fetch the latest data manually.

- **VIEW CHART IN EXPLORE**: Allows to edit the chart.
- **VIEW QUERY**: Displays the SQL Query that is used for the visualization of the chart.
- **COPY CHART URL**: Copies the link to the chart.
- **SHARE CHART BY EMAIL**: Provides options to share the chart to someone.
- **MAXIMIZE CHART**: Displays the chart in a full-screen view.
- **DOWNLOAD AS IMAGE**: Download the chart as a .jpg image.
- **EXPORT CSV**: Exports the indicator data as a .csv file.

IV.Filters on Dashboard

The charts on the dashboard can be filtered based on State, District, Block, and Service Location Type to visualize the data about a particular location. By default, these are set to show the data for all Blocks and all Service Location Types (wherever applicable)

Date Range filter can be applied to visualize the date for days, weeks, months, or any custom date range. By default, it is set to display the data for the last quarter.



B. TABS ON THE DASHBOARD

Each tab on the dashboard displays charts based on indicators pertaining to the tab heading. Our dashboard comprises of the following indicator groups:

SATISFACTION RATING	RESPECTFUL CARE	OOP EXPENSE REPORT
GOVERNMENT SCHEMES AWARENESS	QUERY, CONSULTATION & GRIEVANCE	SERVICE CARE PROVISIONS
CALL RECORD DETAILS	BENEFICIARIES DETAILS	CALL 7 DETAILS

QUICK – DASHBOARD

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