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Ministry of Health & Family Welfare
Government of India

NHSRC

2023

Mother and Child Tracking Facilitation Centre (MCTFC)

EVALUATION STUDY

Ministry of Health & Family Welfare
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2023

CONTENTS

1. ABBREVIATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
FLWs	Frontline Workers
HBPNC	Home Based Post Natal Care
HMIS	Health Management Information System
HAs	Helpdesk Agents
IDIs	In-Depth Interviews
IT	Information Technology
IUD	Intra Uterine Device
JSS	Jan Swasthya Sahyog
JSY	Janani Suraksha Yojana
MoHFW	Ministry of Health and Family Welfare
MMP	Mission Mode Project
MDR	Maternal Death Review
MCTS	Mother and Child Tracking System
MCTFC	Mother and Child Tracking Facilitation Centre
NHSRC	National Health Systems Resource Centre
NIC	National Informatics Centre
NRHM	National Rural Health Mission
NHM	National Health Mission
NIHFW	National Institute of Health and Family Welfare
NIPI	National Iron Plus Initiative
PMMVY	Pradhan Mantri Matru Vandana Yojana
PCPNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PHC	Primary Health Centre
PNC	Post Natal Care
RCH	Reproductive Child Health
RBSK	Rashtriya Bal Swasthya Karyakram
RMNCH+A	Reproductive, Maternal, New-born, Child, and Adolescent Health
VHND	Village Health and Nutrition Day

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CHAPTER 1
INTRODUCTION

1.1 BACKGROUND OF THE STUDY

The Ministry of Health and Family Welfare (MoHFW) is responsible for the policy planning and implementation of programmes in the areas of health and family welfare, prevention, and control of major Communicable Diseases and Non-Communicable Diseases (NCDs). Under National Health Mission (NHM), several web-based applications have been developed for monitoring the progress and supporting the programmes and ensuring the accountability and quality of the healthcare services being provided to the community.

The Mother and Child Tracking System (MCTS) was introduced in 2009, as a web-based application, to register all pregnant women, parents of children up to nine months, ASHAs, and ANMs. The MCTS was aimed at expanding the coverage of beneficiaries of health services, especially those related to mother and child healthcare, and track the services being provided to them. In recent years, an augmented version of MCTS, has been developed, as Reproductive and Child Health (RCH) Portal, to capture and monitor information related to all RCH related services which includes, Maternal Health, Child Health, Family Planning, and Immunization.

After few years of successful implementation of MCTS, MoHFW felt the need for establishing a Call Centre to reach out to the beneficiaries of health services across the country. Consequently, Mother and Child Tracking Facilitation Centre (MCTFC), was established in 2014, at the National Institute of Health and Family Welfare (NIHFW), as a call centre, to provide support services to MCTS (now RCH) portal. MCTFC provides relevant health information and guidance directly to the pregnant women, parents of children up to 9 months and to frontline workers (FLWs) i.e., ANMs[1] and ASHAs[2] registered under MCTS/RCH Portal, thus creating awareness about the health care services available and promoting healthy behaviour and practices. Feedback on services is also taken during the calls made by MCTFC.

[1] **ANM** (Auxiliary Nurse Midwife) is a village-level female health worker known as the first contact person between the community and the health services and provides safe and effective care to village communities.

[2] A trained female Community Health Activist **ASHA** (Accredited Social Health Activist) for every village with a population of 1000; works as an interface between the community and the public health system.

Mother and Child Tracking System – Data Flow

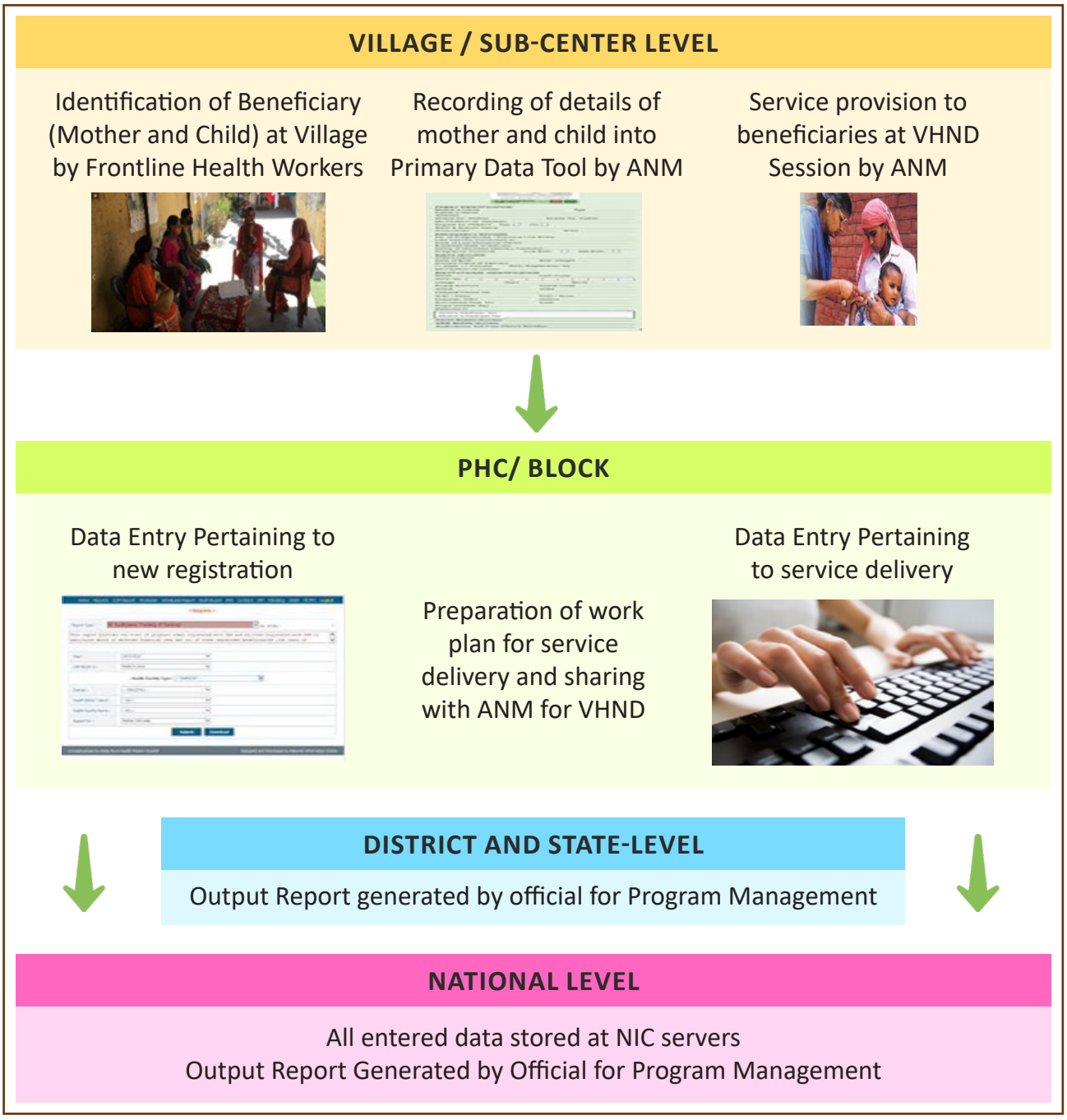

Figure 1 - Mother and Child Tracking System – Data Flow

1.2 MOTHER AND CHILD TRACKING FACILITATION CENTRE (MCTFC)

The purpose of setting up MCTFC was to create awareness about health services and promote healthy practices and behaviour among the beneficiaries and healthcare workers. External agencies were engaged through a bidding process to run the MCTFC. The present phase of operation of MCTFC started in 2016, with an agreement between MOHFW and Infrastructure Leasing and Finance Services (ILFS) for a period of 5 years (10th March 2017 to 9th March 2022).

Presently it is functioning with 86 Helpdesk Agents (HAs), 2 Medical Specialists, 2 Supervisors, and a few administrative and IT staff. The calls are made to the beneficiaries and Frontline Workers (FLWs) registered under MCTS to assess the data quality and effectiveness of healthcare service delivery and government schemes and programmes at the field level. During the calls, it also resolves the RCH-related queries of beneficiaries and health workers.

MCTFC, during the calls, covers five thematic areas:

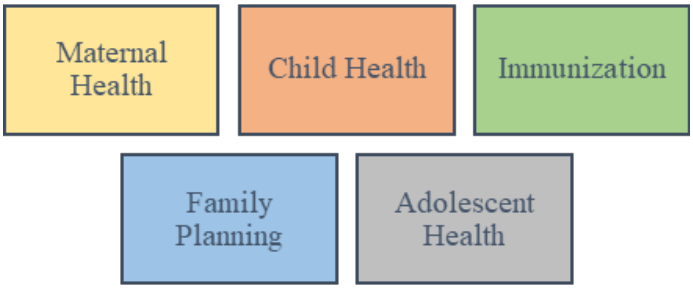

Figure 2 - Thematic Areas of MCTFC

MCTFC Team Structure

Core Team

- Project Manager
- IT Support
- IT Developer

Operational Team

- Supervisor (1 for every 43 Helpdesk Agents)
- Medical Specialist (1 for every 43 Helpdesk Agents)
- Quality Analyst

KEY FUNCTIONS OF MCTFC

The MCTFC aims at performing following functions -

1. To provide a supporting framework to Maternal Child Tracking System (MCTS) /Reproductive and Child Health (RCH) portal and help in validating the data entered in MCTS/RCH portal by making phone calls to pregnant women, parents of children up to nine months, and community health workers (ASHAs and ANMs).

2. Providing relevant information and guidance directly to the pregnant women, parents of children up to nine months and to ASHAs and ANMs, thus creating awareness among them about health services and promoting right health practices and behavior.

3. Contact the service providers and recipients of mother and childcare services to get their feedback on various mother and childcare services, programmes, and initiatives like JSSK, JSY, RBSK, National Iron plus Initiative (NIPI), contraceptive distribution by ASHAs etc. This feedback

helps the Government of India / State Governments to evaluate the programme interventions easily and quickly, and plan appropriate corrective measures to improve the health service delivery.

4. Check with ASHAs and ANMs regarding availability of essential drugs and supplies like, Iron Folic Acid, ORS packets, Contraceptives etc.

5. Promotion of government schemes and programmes.

6. Assessment of health care services being delivered and training needs of health workers.

The calls made by the MCTFC from 10th March 2017 to 9th March 2022[3] -

Target Group	Number of Calls
Total	19,48,371
Pregnant Women	9,16,774
Parents of Children under 9 months	9,68,314
ASHAs	56,508
ANMs	6,775

Table 1 - Total number of calls made by the MCTFC from 10 March 2017 to 9 March 2022

As per the numbers above, total 19,48371 calls were made during this five year's project period. This translates into – 389674 calls per year, and 1119 calls per day (based on 348 working days per year that the programme documents define as standard)[4] . Average number of calls per month, during this five year's period comes to 32473.

The call centre functions 7 days a week, except for 17-18 national holidays. But each help-desk agent works for six days a week, so about 100 calling agents are kept on the job, to run the 86 helpdesks every day.

The HAs also contact the service providers and beneficiaries for their feedback on maternal and childcare services and programmes, like Janani Shishu Suraksha Karyakram (JSSK[5]), Janani Suraksha Yojana (JSY[6]), Rashtriya Bal Swasthya Karyakram (RBSK[7]), National Iron Plus Initiative (NIPI), contraceptive distribution by ASHAs, etc. This feedback helps Government of India / State Governments to evaluate the programme interventions and plan appropriate corrective measures to improve health service delivery.

[3] Data reported from MoHFW Annual Report 2020-21

[4] As per the MCTFC contract signed between MOHFW and the agency, page 68, "298 working days for Project Manager, IT Developer & DBA and receptionist and 348 working days for other resources per annum are taken for evaluation purpose"

[5] Janani Shishu Suraksha Karyakram **(JSSK)**- pregnant women who access Government health facilities for their delivery

[6] Janani Suraksha Yojana **(JSY)** is a safe motherhood intervention implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery.

[7] Rashtriya Bal Swasthya Karyakram **(RBSK)**- early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability

The key features and functionalities available in the MCTFC application [as per the Office Memorandum issued by Mission Mode Project (MMP) Cell, MoHFW, dated 8 March 2018]:

- Outbound Calling (Calls made to the respective beneficiaries of health services and Front Line Workers (FLWs) to provide promotional health messages and create awareness of current programmes of MoHFW which benefit pregnant women/mother/child)
- Inbound Calling (Calls made by the beneficiaries of health services and Front Line Workers (\FLWs) to the MCTFC for information related to government schemes and programmes) Inbound calling will be received as missed calls and outbound calls will be made to the caller within 90 seconds of receiving the call during operational hours
- Campaign (need-based – through a telephonic survey)
- FAQs/Knowledge Base
- Performance Reports
- SMS Functionality

1.3 ABOUT THE EVALUATION STUDY

The study was carried out in five States with two districts in each State, namely, Andhra Pradesh (Vishakhapatnam and West Godavari), Chhattisgarh (Korea and Raipur), Maharashtra (Nagpur and Pune), Odisha (Bolangir and Khorda) and Uttar Pradesh (Meerut and Saharanpur). Programme managers at State and District level were interviewed, and secondary information available online was reviewed to understand the effectiveness of the programme. The primary aim was to determine the extent to which the project accomplished the intended objectives, to identify key factors that contributed to what worked and what did not work, and to give suggestions for improving the MCTFC programme.

The five States were selected out of 21 States in which calls have been made. States were selected through purposive sampling, to ensure representation from all regions of the country i.e., North, East, South, West, and the central region.

Rationale of the evaluation –

The five-year tenure of the current project has completed (on 9 March 2022). The project has been given an interim extension for one year (10th March 2022 to 9th March 2023)[8].

In view of this, NHSRC was mandated by the MoHFW, for conducting third party evaluation of the MCTFC project.

The evaluation will feed into its strengthening, including redesigning and corrections in the project operation as required.

[8] On the same terms and condition, as given in the master agreement, or till the end of time period decided after the submission of project evaluation report by NHSRC, whichever is earlier.

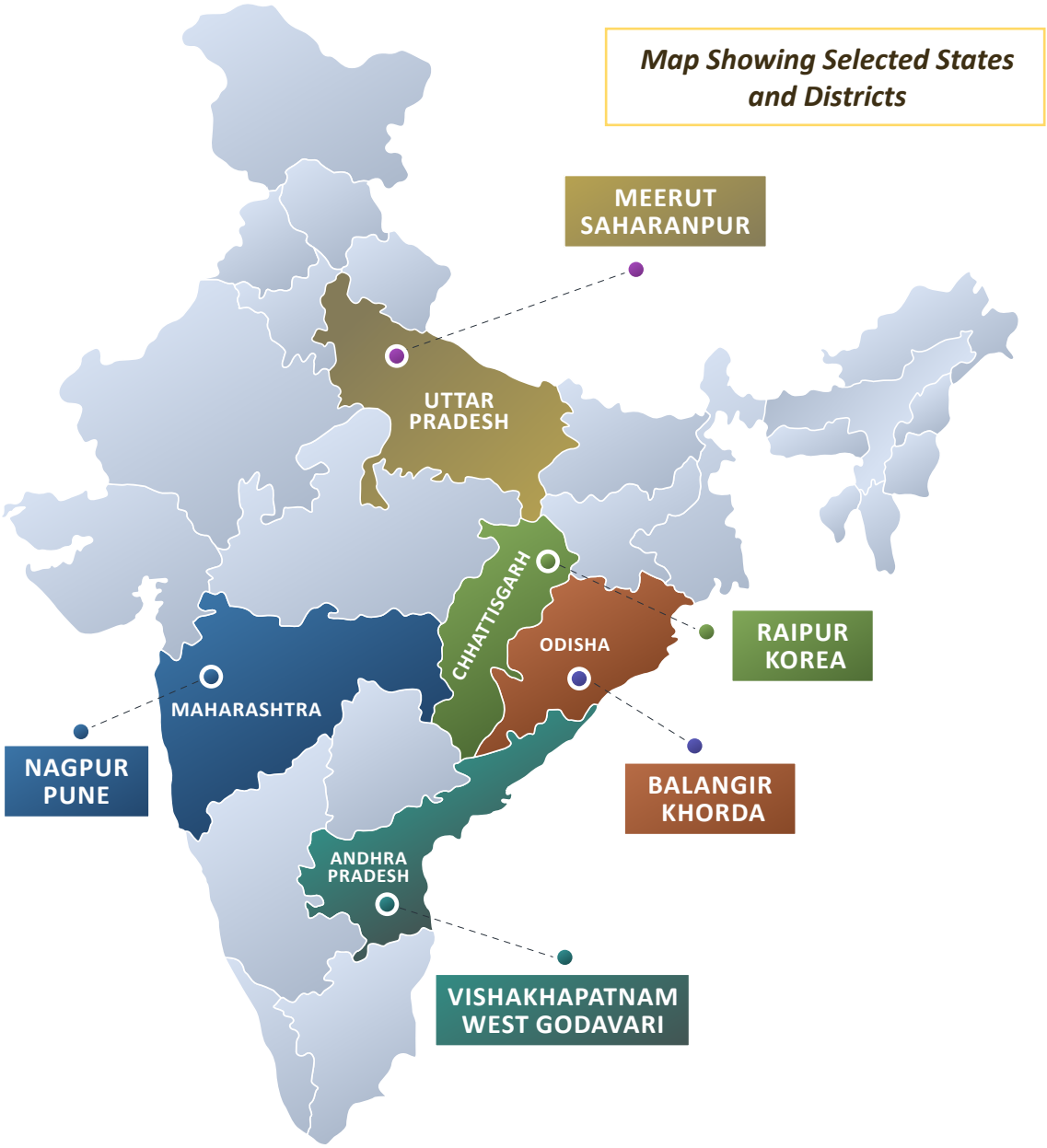

Figure 3 - Map Showing the Geographic coverage of the study

1.4 OBJECTIVES OF EVALUATION STUDY

- To assess the quality of calls being made by MCTFC, and assess -

  a) Awareness of health workers and beneficiaries on key health messages and health information imparted to them,

  b) Awareness of beneficiaries about health services available to them

- To assess the reporting mechanisms of MCTFC

  The emphasis of the study is on assessing the impact of the MCTFC programme at the community level. Therefore, focus was on assessment of the outbound calls made by the MCTFC.

CHAPTER 2
STUDY DESIGN

This is a cross-sectional evaluation study in which qualitative research methods were used for the data collection.

2.1 TARGET POPULATION

The target population for data collection has been classified under five categories- ANM, ASHA, Pregnant Women, Parents of children (child up to 9 months), and the State & District Nodal Officers- as Stakeholders.

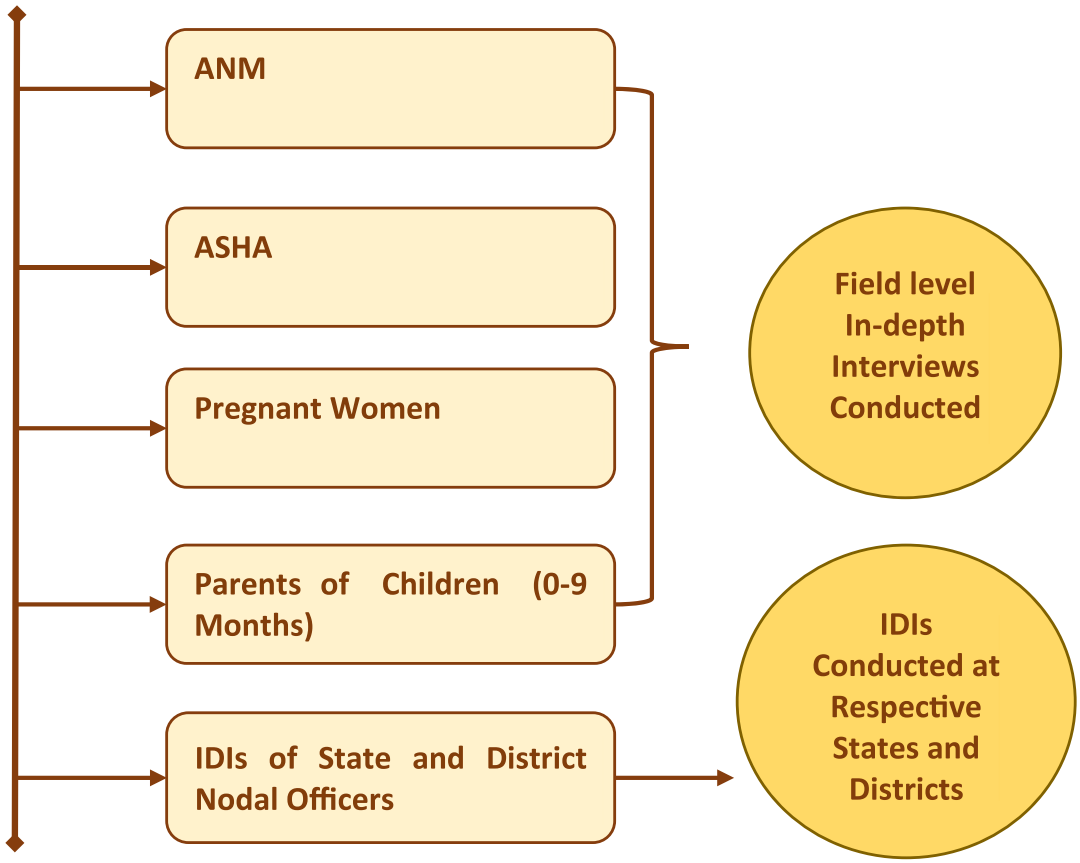

Figure 4 - Target groups

2.2 PROCESS FOR SELECTION OF STATES AND DISTRICTS

- 5 States were selected out of 21 States in which calls have been made. States were selected through purposive sampling, to ensure representation from all regions of the country i.e., North, East, South, West, and the central region. Within each State 2 Districts were chosen.

- 1st level of screening: Only those districts in which calls have been made to ASHAs in last six months were included

- 2nd level of screening: From the list of districts identified at the level of 1st screening, only those districts in which calls have also been made to ANMs in last six months. were included

- From the list of districts thus listed, 2 districts were selected; a) The district with the highest number of calls made to ASHAs and b) The district with the second highest number of calls made to ASHAs.

- For each State and two Districts individual interviews were conducted, with those, to whom calls have been made by the MCTFC, in all 4 categories (Pregnant Mothers, Parents with a child up to 9 months of age, ASHA, and ANM).

- Number of samples planned from each district - 6 ASHAs, 6 ANMs, 10 Pregnant women, and 10 parents of children upto 9 months, which adds to total 320 interviews from five States. The methodology of purposive sampling was used for arriving at the sample numbers. The actual number of interviews conducted was 289, because actual number of calls made to ANMs were zero in one State, and in certain States, number of calls made to both ANMs and ASHAs was very small.

- Number of persons called by MCTFC in the category of pregnant women and parents of children up to 9 months, in each district, is quite high, and these calls were made based on a randomized algorithm. The number of interviews in the categories of pregnant women and parents of children up to 9 months was fixed at 10 each in each district.

- The number of ANMs and ASHAs called by MCTFC in each district was not high. Especially the numbers for ANMs are very low. Therefore only 6 interviews were planned for both ANMs and ASHAs in each district.

2.3 SAMPLE SIZE

Table 2 below displays the planned sample size for the five States[9] for the target group and the sample size achieved. The evaluation study was conducted in five States, namely, Chhattisgarh, Maharashtra, Andhra Pradesh, Odisha, and Uttar Pradesh.

Interviews with beneficiaries of calls							
Target Group / No. of Interviews	Planned (In each State)	Achieved					
		AP	CG	MH	OD	UP	Total
ASHA	12	12	13	12	6*	13	56
ANM	12	2#	9	9	0@	12	32
Pregnant Woman	20	20	20	20	21	20	101
Parent	20	20	20	20	20	20	100
Total No. of Interviews							**289**
IDIs for Stakeholders							
State Nodal Officers	2	2	2	2	2	2	10
District Nodal Officers	4	4	4	4	4	4	20
Total No. of IDIs							**30**

*Calls were made to only six ASHAs in Odisha in the reference period of six months

@No calls were made to ANMs in Odisha in the reference period of six months

#Calls were made to only two ANMs in Andhra Pradesh in the reference period of six months

[9] AP- Andhra Pradesh, CG- Chhattisgarh, MH- Maharashtra, OD- Odisha, UP- Uttar Pradesh.

Table 2 - Number of Interviews Planned and Achieved

2.4 METHODS OF DATA COLLECTION

The evaluation followed a purposive sampling for selecting the beneficiaries who received the call in the past 6 months. The list of these calls was taken from the MCTFC for each of the State and study districts. The principle of saturation/redundancy of data was followed. Efforts were made to take all samples from a cluster of two neighbouring blocks. Within each block, efforts were made to take samples equally from the farthest areas within the block and the central region of the block.

For the In-depth Interviews (IDIs) of stakeholders - two State Nodal Officers and four district Nodal Officers (two from each district) were selected and interviewed at their respective States and Districts.

To review the call recordings, 10 calls from each category of the target group (ASHAs, ANMs, Pregnant women, and parents of children up to 9 months) were selected randomly from the list provided by the MCTFC helpdesk. Call recordings were analyzed to check for the call quality and the effectiveness of conversation.

2.5 DATA COLLECTION TOOLS

- The semi-structured in-depth interview guides were used for four categories of respondents (receivers of calls)- Pregnant Women, Parents of children up to 9 months, ANMs and ASHAs
- In Depth Interview (IDIs) were conducted with Programme Managers at State and District level. (Tools are enclosed as Annexures 1,2,3 and 4)

2.6 QUALITY MONITORING STEPS

To ensure the quality and accuracy of the data being collected the following steps were taken:

Quality Monitoring Steps at different Phases of Data Collection		
Before Data Collection	**During Data Collection**	**After Data Collection**
Intensive Desk Review and Pilot Testing of the Tools before finalization Two-days in-person training for all the field investigators was conducted by National level team including mock interviews Doubt clearing sessions and detailed set of instructions provided to field investigators Data Collection started immediately after training Prior Permissions and appointments with functionaries obtained	Supportive supervision by a Core team of experts Refresher sessions conducted as per requirement Regular spot checks and back checks conducted to ensure completeness and consistency of interviews Real-time syncing of data and daily review by a team of Experts Daily monitoring of Investigators' performance	Random selection of back check sample to ensure representation of each location and investigator Rigorous Cleaning and Processing of Data Tabulation plan made with Key Performance Indicators, Themes, and Subthemes identified from IDIs.

Table 3 - Quality Monitoring Steps at different Phases of Data Collection

2.7 ETHICAL CONSIDERATIONS

The evaluation study has followed the ethical principles of research in the following manner:

a. Informed consent – Informed consent was taken from all participants in a written consent form. The consent forms were filled in two copies, and one copy was given to each respondent.

b. Beneficence (Do no harm) – There was no potential for any harm to study participants. The field interviews with study participants were to discuss their experience during the phone calls made to them, and what they have learnt in terms of key health messages, and information related to health programmes.

c. Respect for anonymity and confidentiality – During the analysis, responses were analyzed in anonymity, and confidentiality of the information was maintained.

d. Respect for privacy – During the field study, and also in individual interviews (IDIs) with programme managers, their privacy was maintained.

CHAPTER 3
KEY FINDINGS

The objective of this section is to assess the calls based on interviews conducted with the target groups. Considering a few metrics like beneficiary satisfaction, Helpdesk Agent's (HA's) effectiveness, engagement, and average handling time - time HAs spent interacting with the beneficiary, the findings have been summarized broadly on two indicators

- Call Quality
- Effectiveness of Calls

The analysis in the subsequent sections of this chapter uses a matrix, defined as following –

Categories	Percentage
All	100% Respondents
Almost all	More than 90%
Most	70-90%
Majority	50-70%
Few	30-50%
Very few	Less than 30%
None	0%

3.1 CALL QUALITY

- The 'Call Quality' was evaluated with a focus on the following metrics
  - » Voice Tone
  - » Caller's pace and speech tempo
  - » Clear Enunciation (allows the caller to fully understand what's being said)
  - » Content of the call
- A total of 56 ASHAs and 32 ANMs were interviewed in the five States using the semi-structured interview guides (enclosed as Annexures 1 and 2).

- A total of 101 pregnant women and 100 parents of children aged up to 9 months were interviewed in five States for this study.
- The selected health workers had received one or more calls within the reference period of last six months. A few ASHAs and ANMs were unable to recall the phone call and had to be probed and explained about the nature and purpose of the calls, after which they could recall the phone call received by them.

3.2 VERIFICATION

All ASHAs and ANMs reported that the caller introduced themselves with their name, explained the purpose of the call and mentioned that they were making this call on behalf of the Ministry of Health and Family Welfare, Government of India. Further they shared that all the details were clearly and patiently confirmed by the caller.

	ASHA	N=56	N=13	N=13	N=12	N=12	N=6
		India	UP	CG	MH	AP	OD
If the caller clarified the name of person called	The caller clarified the name of person she wanted to speak to	100%	13	13	12	12	6
Clarity and Patience in Clarifying	The caller confirmed it clearly and patiently	100%	13	13	12	12	6

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 4 - Percentage of ASHAs that affirmed that the confirmation of the name of person called was done by the caller

	ANM	N=32	N=12	N=9	N=9	N=2	NA
		India	UP	CG	MH	AP	OD
If the caller clarified the name of person called	The caller clarified the name of person she wanted to speak to	100%	12	9	9	2	NA
Clarity and Patience in Clarifying	The caller confirmed it clearly and patiently	100%	12	9	9	2	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 5 - Percentage of ANMs that affirmed that the confirmation of the name of person called was done by the caller

Almost all respondents from the community - both pregnant women and parents reported that the caller confirmed the name of the pregnant woman and/or the mother of the child. If the husband received the call, then they were asked to speak or inform their wives or the mother of the child. The mothers were also asked about the gender of the child, the date and place of birth of the child (whether the delivery was conducted at home or at the hospital).

	Pregnant Women	**N=101**	**N=20**	**N=20**	**N=20**	**N=20**	**N=21**
		India	UP	CG	MH	AP	OD
If the caller clarified the name of person called	The caller clarified the name of person she wanted to speak to	98%	19	20	19	20	19
Clarity and Patience in Clarifying	The caller confirmed it clearly and patiently	97%	20	19	19	20	20

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 6 - Percentage of Pregnant Women that affirmed that confirmation of the name of person called was done by the caller

	Parents of children up to 9 months	**N=100**	**N=20**	**N=20**	**N=20**	**N=20**	**N=20**
		India	UP	CG	MH	AP	OD
If the caller clarified the name of person called	The caller clarified the name of person she wanted to speak to	99%	20	20	20	20	19
	The caller confirmed it clearly and patiently	99%	20	20	20	20	19

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 7 - Percentage of Parents of children up to 9 months that affirmed that confirmation of the name of person called was done by the caller

3.3 TIMING AND ATTEMPTS

Most of the ASHAs reported that they answered the phone call on the first attempt despite their busy schedules and majority of ANMs also reported having received the phone call on the first attempt itself, despite their busy schedules (being busy in Routine Immunization (RI) sessions, with a patient, or busy with household chores.

ASHA		N=56	N=13	N=13	N=12	N=12	N=6
		India	UP	CG	MH	AP	OD
Call Attempt	First Attempt	86%	13	10	10	9	6
Timing of Call	Timing of call was appropriate	77%	11	10	9	9	4

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 8 - Percentage of ASHAs that received the call in first attempt and if the timing of the call was appropriate

ANM		N=32	N=12	N=9	N=9	N=2	NA
		India	UP	CG	MH	AP	OD
Call Attempt	First Attempt	63%	8	4	8	0	NA
Timing of Call	Timing of call was appropriate	53%	5	5	5	0	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 9 - Percentage of ANMs that received the call in first attempt and if the timing of the call was appropriate

Further it was reported that the timing of the call was appropriate for most of the ASHAs, and, majority of ANMs (minimum being in Uttar Pradesh with 5 out of 12 ANMs reporting that the timing of the call was appropriate for them).

Some of the suggestions made by ASHAs and ANMs –

- "They (MCTFC) should tell us clearly that they have called from this organization from Delhi, and we are talking to ASHAs, and we want to ask information from ASHAs. It's because we keep getting calls from Mumbai or from 104 number."
- "I have talked to them for 2 to 3 minutes since there was a huge crowd when I was in the vaccination drive and since I told them that, they told me that they would call me later and they haven't called after that."
- "I was in meeting, so I didn't take the call, so next day they called again."
- "Evening is a more appropriate time to receive the call as mornings and afternoon are a busy time".

- "Due to network problem the call was disconnected but received the second call immediately and spoke with the MCTFC Helpdesk Agent (HA)"
- "If they call between 10 AM to 12 Noon then we can talk freely with them."

However, very few ASHAs and ANMs (less than 30%), reported not receiving the call in first attempt and had answered the repeat call. The most common reasons for not answering the calls were - call from an unknown number, and inappropriate timing of the call (travelling to work or in the middle of a training session or a meeting).

Most of the pregnant women and mothers received the call in the first attempt. However, the percentage of repeat calls to the pregnant women was slightly greater in Uttar Pradesh (7 out of 20), as compared to the other States. Very few calls were received in the second or third attempt. In some cases, the registered mobile number belonged to the husband, so the phone call was received by the woman later. Some women were unable to recall the time or duration of the call as the call was received months ago.

	Pregnant Women	**N=101**	**N=20**	**N=20**	**N=20**	**N=20**	**N=21**
		India	UP	CG	MH	AP	OD
Call Attempt	First Attempt	79%	13	15	19	16	18
Timing of Call	Timing of call was appropriate	88%	15	19	20	18	18

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 10 - Percentage of Pregnant Women that received the call in first attempt and if the timing of the call was appropriate

The timing of the call was found to be appropriate for most of the pregnant women and parents. But very few pregnant women and parents said that the timing was inappropriate as the calls were done during morning time.

	Parents of children up to 9 months	**N=100**	**N=20**	**N=20**	**N=20**	**N=20**	**N=20**
		India	UP	CG	MH	AP	OD
Call Attempt	First Attempt	88%	17	17	19	16	19
Timing of Call	Timing of call was appropriate	84%	20	15	15	19	15

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 11 - Parents of children up to 9 months that received the call in first attempt and if the timing of the call was appropriate

In terms of the overall numbers, most of the respondents answered the calls in the first attempt. Most of the respondents said that the timings of the call were appropriate.

3.4 DURATION OF CALLS

The duration of the calls for the health workers ranged from five minutes to an hour, but in case of some of the ASHAs and ANMs the conversation extended for more than an hour. Some ASHAs and ANMs could not recall the duration of the phone call. Very few ASHAs of Uttar Pradesh stated that the duration of the call was more than one hour. In case of about half of the ANMs (4 out of 9) in Chhattisgarh the duration of call was shorter i.e., up to 15 minutes.

	ASHA	**N=56**	**N=13**	**N=13**	**N=12**	**N=12**	**N=6**
		India	UP	CG	MH	AP	OD
Duration of the call	Up to 15 minutes	16%	4	0	2	0	1
	15 minutes to 30 minutes	27%	1	3	5	7	1
	30 minutes to 1 hour	34%	3	7	5	3	2
	More than 1 hour	23%	6	3	0	2	2

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 12 - Duration of Calls made to ASHAs

	ANMs	**N=32**	**N=12**	**N=9**	**N=9**	**N=2**	**NA**
		India	UP	CG	MH	AP	OD
Duration of the call	Up to 15 minutes	29%	3	4	1	1	NA
	15 minutes to 30 minutes	34%	2	2	7	0	NA
	30 minutes to 1 hour	31%	6	3	1	0	NA
	More than 1 hour	6%	1	0	0	1	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 13 - Duration of Calls made to ANMs

	Pregnant Women	**N=101**	**N=20**	**N=20**	**N=20**	**N=20**	**N=21**
		India	UP	CG	MH	AP	OD
Duration of the call	Up to 15 minutes	53%	14	11	6	10	13
	15 minutes to 30 minutes	34%	4	7	9	8	6
	30 minutes to 1 hour	11%	1	2	4	2	2
	More than 1 hour	2%	1	0	1	0	0

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 14 - Duration of Calls made to Pregnant Women

During the interaction, one ASHA said that the duration of call should be kept shorter. "They should finish call in shorter time. They should provide more information in lesser time."

	Parents of children up to 9 months	N=100	N=20	N=20	N=20	N=20	N=20
		India	UP	CG	MH	AP	OD
Duration of the call	Up to 15 minutes	41%	8	3	1	8	10
	15 minutes to 30 minutes	49%	10	7	16	8	8
	30 minutes to 1 hour	9%	2	0	2	4	2
	More than 1 hour	1%	0	0	1	0	0

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 15 - Duration of Calls made to Parents of children up to 9 months

Very few pregnant women reported that the duration of call was up to 15 minutes (less than 15 minutes) however, majority of parents said that the duration of call was up to 15 minutes. While, only 2% and 1% respectively of pregnant women and parents reported the duration of call to be more than an hour. The larger share of respondents reported the duration of call to be between 15 to 30 minutes (34% and 49% respectively). Some women were unable to recall the exact time or duration of the call as the call was received months ago. Average duration for more than 36% calls was up to 15 minutes, in all States except Maharashtra (majority of calls in Maharashtra were of 15 to 30 minutes duration).

	ASHA	N=56	N=13	N=13	N=12	N=12	N=6
		India	UP	CG	MH	AP	OD
	Language and tone of the caller	India	UP	CG	MH	AP	OD
Language	Language easy and appropriate	100%	13	13	12	12	6
Tone	Tone easy to understand and comforting	98%	13	13	11	12	6
Pace	Pace appropriate / easy to understand	95%	13	13	9	12	6

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 16 - Perception of ASHAs on the language, tone of voice, and pace of caller

	ANM	N=32	N=12	N=9	N=9	N=2	NA
		India	UP	CG	MH	AP	OD
Language	Language (easy and appropriate)	100%	12	9	9	2	NA
Tone	Tone (easy to understand and comforting)	97%	12	8	19	2	NA
Pace	Pace (appropriate and easy to understand)	97%	12	9	8	2	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 17 - Perception of ANMs on the language, tone of voice, and pace of caller

All ASHAs and ANMs reported that the language used during the call was easy and the caller's pace and tone were also satisfactory. Almost all the ASHAs and ANMs mentioned that the tone was polite and comforting, and the pace was appropriate. They also mentioned that the callers spoke in their native languages (Telugu, Chhattisgarhi, Marathi, Odia and Hindi) which helped them understand the questions and information that was provided. Very few ASHAs and ANMs in Maharashtra found the pace as 'fast' and reported difficulty in keeping up.

		N=101	N=20	N=20	N=20	N=20	N=21
		India	UP	CG	MH	AP	OD
Language	Language (easy and appropriate)	96%	17	20	20	20	20
Tone	Tone (easy to understand and comforting)	97%	18	20	20	20	20
Pace	Pace (appropriate and easy to understand)	95%	17	19	19	20	21

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 18 - Perception of Pregnant Women on the language, tone of voice, and pace of caller

An ASHA from Pune mentioned that the calls have been of great help and the calls are connected to the doctors for an answer to a specific problem or medical condition. But the language remains a main concern- *"I was unable to understand English and then the call was transferred to a person speaking in Hindi, but his Hindi is very pure and I did not understand some words of it and then they transferred the call to a person who spoke in Marathi. Generally, we understand Hindi, but we face some problems in understanding English."*

One of the ANMs in Chhattisgarh mentioned that she found the language and pace appropriate to understand but also raised a concern that the tone of the caller during call was a bit impolite.

		N=100	N=20	N=20	N=20	N=20	N=20
		India	UP	CG	MH	AP	OD
Language	Language (easy and appropriate)	100%	20	20	20	20	20
Tone	Tone (easy to understand and comforting)	100%	20	20	20	20	20
Pace	Pace (appropriate and easy to understand)	97%	20	18	20	20	19

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 19 - Perception of Parents of children up to 9 months on the language, tone of voice, and pace of caller

Almost all pregnant women and parents said that the caller's voice, tone, and pace was appropriate, and the language used was simple and easy to understand. Most of the pregnant women and parents said during the interaction that the callers were well-informed and had adequate knowledge about the topics being discussed.

Very few respondents in Uttar Pradesh and Chhattisgarh reported the pace of the callers to be fast, and they said they were unable to understand the information completely.

During the interactions, the pregnant women confirmed that, they gained knowledge related to women health & child nutrition and development, through these calls. They mentioned that the callers spoke in their native language (Telugu, Marathi, Odia, and Hindi), and spoke politely and patiently, which made it easy for them to understand the information that was shared. From the interviews it was reported that almost all respondents found the language easy and comforting (more than 95% in all five States, with three States being at 100%), and the tone (more than 97% in all five States) and the pace (more than 95% in four States), to be appropriate. Very few respondents reported in negative about the pace during the call as compared to other two elements of language and tone.

The above figure show that most of the respondents found the language easy and comforting and tone and the pace to be appropriate. Clearly, a slightly higher percentage of respondents reported in negative about the pace during the call as compared to other two elements of language and tone.

3.5 CONTENT OF THE CALLS

Assessing the content of the phone calls, the response from the ASHAs and ANMs regarding the MCTFC call was mostly affirmative regarding the quality of the knowledge and information shared. It was observed that ANMs and ASHAs are playing a major role in promotion of reproductive health services and antenatal and postnatal care of women and children along with helping and guiding each other while delivering the healthcare services to community.

ASHAs create awareness of health, mobilize the community towards local health planning, and provide access to the rural population for existing health services.

ANM responsibilities include family planning, immunization, infectious disease prevention, and care, in addition to maternal health and childbirth.

The ASHAs were asked about the ANC, PNC, immunization schedules (BCG[10] , Tetanus etc.), administering medications like ORS[11] and zinc tablets and schedules of their prenatal visits. The MCTFC calling agents also enquired the ASHAs about the protocols followed in situations of complications during pregnancy, underweight newborn babies, and the preferred contraceptive methods.

ASHA	N=56	N=13	N=13	N=12	N=12	N=6
Main Topics	**India**	UP	CG	MH	AP	OD
ANC	93%	13	13	10	11	5
PNC	93%	13	13	10	11	5
Immunization	96%	13	13	11	11	6
Family Planning	89%	12	13	9	11	5

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 20 - Key topics of Questions and Information during calls – as recalled by ASHAs

ANMs, being the key field-level functionaries, who play a central role in delivery of reproductive & child health programs were also asked about the availability of Blood Pressure (BP) apparatus, weighing scales, and HBNC kits[12], the availability of medicines like iron, zinc, folic acid, calcium tablets and the process to administer medication in cases of anemia & dysentery.

ANM	N=32	N=12	N=9	N=9	N=2	NA[#]
Main Topics	**India**	UP	CG	MH	AP	OD
ANC	94%	12	9	7	2	NA
PNC	84%	12	9	6	0	NA
Immunization	97%	12	9	8	2	NA
Family Planning	69%	9	7	5	1	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

[#] No calls were made to ANMs during the reference period in the State.

Table 21 - Key topics of Questions and Information during calls – as recalled by ANMs

Almost all ANMs responded that the discussions included topics such as ANC, PNC, HBNC, immunization schedules, and family planning methods used (IUD, Condoms, Copper-T, Vasectomy etc.). The respondents said that the callers were also emphasizing on the challenges of pregnancy and complications during delivery along with the ASHAs and ANMs plans to approach such situations.

[10] The Bacillus Calmette-Guérin (BCG) vaccination is given to newborn babies at risk of getting tuberculosis (TB).

[11] An oral rehydration solution (ORS) is used to treat moderate dehydration. It's made of water, glucose, sodium, and potassium.

[12] Home Based Newborn Care (HBNC) is a strategy adopted by government of India to overcome the burden of newborn deaths in the first week of life, it provides continuum of care for newborn and post-natal mothers. The HBNC kit mainly contain drugs and equipment for minor ailments.

Pregnant Women	N=101	N=20	N=20	N=20	N=20	N=21
Main topics of the questions/ information visit by ASHA	**India**	UP	CG	MH	AP	OD
ANC	73%	11	13	12	20	18
PNC	73%	12	13	11	20	18
Immunization	74%	17	11	10	19	18
Family Planning	64%	16	14	5	19	11

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 22 - Key topics of Questions and Information during calls – as recalled by Pregnant Women

The pregnant women were also informed about the 'Mother and Child Protection Card (MCP Card) to help create awareness on health, nutrition, and development purposes and generate demand for uptake of essential healthcare services being provided. They were also apprised about the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) that provides fixed day assured, comprehensive and quality antenatal care universally to all pregnant women (in 2nd and 3rd trimester).

To the parents of children up to 9 months, the callers told them about ways to carry the child, emphasized on benefits of exclusive breastfeeding for 6 months, and the importance of semi-solid foods after 6 months for the child. They were also made aware of the immunization schedules for the child – BCG, hepatitis vaccine etc. They were advised about regular consultations with a doctor/ASHA. They were asked about their use of family planning methods, and were provided information on family planning methods (both temporary and permanent), spacing (maintaining a gap of at least 3 years between two children), and importance of family planning measures.

Parents of children up to 9 months	N=100	N=20	N=20	N=20	N=20	N=20
Main topics of the questions/ information	**India**	UP	CG	MH	AP	OD
Visit by ASHA/ANC	33%	7	3	9	9	5
PNC	70%	11	16	15	15	13
Immunization	87%	19	18	16	16	18
Family Planning	58%	11	13	7	13	14

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 23 - Key topics of Questions and Information during calls – as recalled by Parents of children up to 9 months

Majority of pregnant women and mothers that were interviewed, shared that key topics on which they were given information included; common tests like ultrasound test, urine test, Hemoglobin test during pregnancy, information about the health of the child and, also

importance of child's prenatal care. In Odisha, majority of the calls made to beneficiaries were of less than 15 minutes of duration.

All beneficiaries believed the call to be very informative. Some of the respondents who received the call in their first trimester, said that they had no prior knowledge about pregnancy or ANC and other check-ups during pregnancy. Pregnant women in second pregnancy too found the call beneficial as they had not followed the medical care procedures or undergone tests required during their previous pregnancies.

Most of ASHAs and ANMs across all five study States reported that questions related to ANC, PNC, immunization, and family planning were asked and clarifications were provided.

From the interviews with pregnant women and parents of children upto 9 months, it was found that the main topics discussed included, ANC, PNC, immunization, and family planning. Also, comparatively a smaller number of respondents in Odisha reported discussions on ANC, PNC, immunization, and family planning topics. In Odisha majority of the calls made to beneficiaries were of less than 15 minutes of duration, and many respondents from the State, could not provide detailed information on important topics discussed with them during calls.

All beneficiaries believed the call to be very informative. Some of the respondents who received the call in their first trimester, said that they had no prior knowledge about pregnancy or ANC and other check-ups during pregnancy. Pregnant women in second pregnancy too found the call beneficial as they had not followed the medical care procedures or undergone tests required during their previous pregnancies.

3.6 QUESTIONS AND INFORMATION EXPLAINED & CLARIFIED

	ASHA	N=56	N=13	N=13	N=12	N=12	N=6
		India	UP	CG	MH	AP	OD
Repeating / Paraphr-asing questions / information	The caller repeated / paraphrased questions/ information	100%	13	13	12	12	6
Giving sufficient time to understand	Sufficient time was given to respondent to understand after each question or information	98%	13	13	10	12	6
Confirming / Para-phrasing answers of respondents	Confirmation/ paraphrasing respondent's answers was done	100%	13	13	12	12	6

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 24 - Responses of ASHAs on whether the caller paraphrased the questions and provided enough time to understand the information

	ANM	N=32	N=12	N=9	N=9	N=2	NA
		India	UP	CG	MH	AP	OD
Repeating / Paraphrasing questions / information	The caller repeated / paraphrased the questions/information	100%	12	9	9	2	NA
Giving sufficient time to understand	Sufficient time was given to respondent to understand after each question or information	100%	12	9	9	2	NA
Confirming / Paraphrasing answers of respondents	Confirmation/ paraphrasing respondent's answers was done	100%	12	9	9	2	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 25 - Responses of ANMs on whether the caller paraphrased the questions and provided enough time to understand the information

All the ANMs reported that the callers repeated and paraphrased the questions and gave them sufficient time to understand and respond to questions during the call.

All health workers (ASHAs and ANMs) affirmed that the callers rephrased and confirmed their responses adequately and provided adequate time for them to understand the information shared. Very few ASHAs shared that the callers did not give 'sufficient time to them to understand after each question or information'.

	Pregnant Women	N=101	N=20	N=20	N=20	N=20	N=21
		India	UP	CG	MH	AP	OD
Repeating / Paraphrasing questions / information	The caller repeated / paraphrased the questions/information	97%	20	19	20	20	19
Giving sufficient time to understand	Sufficient time was given to respondent to understand after each question or information	96%	19	19	20	20	19
Confirming / Paraphrasing answers of respondents	Confirmation/ paraphrasing respondent's answers was done	93%	19	19	20	20	16

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 26 - Responses of Pregnant Women on whether the caller paraphrased the questions and provided enough time to understand the information

Among the pregnant women, almost all affirmed that the callers repeated / paraphrased the questions as well as the answers of the respondents and gave them adequate time to comprehend the information shared.

During the interaction, one of the pregnant women reported that she was not aware about the call. "I do not know about explanation or paraphrasing as my husband answered the phone and responded to all the questions and information, I did not talk to them"

	Parents of children up to 9 months	N=100	N=20	N=20	N=20	N=20	N=20
		India	UP	CG	MH	AP	OD
Repeating / Paraphr-asing questions / information	The caller repeated / paraphrased the questions/information	100%	20	20	20	20	20
Giving sufficient time to understand	Sufficient time was given to respondent to understand after each question or information	99%	19	20	19	20	20
Confirming / Para-phrasing answers of respondents	Confirmation/ paraphrasing respondent's answers was done	98%	20	19	20	20	20

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 27 - Responses of Parents of children up to 9 months on whether the caller paraphrased the questions and provided enough time to understand the information

All the respondents from the category of Parents of children up to 9 months, said that the callers repeated and paraphrased the questions. But a small section (1%) reported that sufficient time was not given to them to understand the question/ information and very few respondents said that their responses were not confirmed / paraphrased.

While looking at the overall picture of responses on whether the caller paraphrased the questions and provided enough time to understand the information, it was found that almost all respondents across all categories, affirmed that, paraphrasing and clarification were done, for the questions asked, as well as for the answers of the respondents.

3.7 MAIN QUESTIONS ASKED

Some of the key issues and areas of health care information which were revealed by large number of respondents during interview (when they were asked during the call to share the healthcare information or questions that they remember from the call) are listed below-

Some of the key topics covered by the callers included maternal and child health related knowledge of ANM and ASHAs – like, services provided at the hospitals such as ultrasonography, blood tests, and identification of danger signs during pregnancy (swelling of feet, high temperature, high BP). They were asked about vaccinations like BCG, OPV[13], Hepatitis-B

[13] Oral poliovirus vaccines (OPV) are the predominant vaccine used in the fight to eradicate polio.

and Vitamin K doses. The topics discussed with ASHAs also included knowledge regarding premature births, care and precautions for low-birth-weight babies.

ASHAs and ANMs were also asked questions on family planning methods and exclusive breastfeeding of newborns for six months and complementary feeding for the child after 6 months. They were asked about the training they have attended and how it has benefitted their work.

Some ASHAs shared that they were asked about the PCPNDT Act[14] (Pre-Conception and Pre-Natal Diagnostic Techniques Act), and how they would work to stop prenatal diagnosis and female feticides and help in improving the declining sex ratio in their region. They were briefed on how they should build awareness in the community about prenatal sex determination.

ASHA	N=56	N=13	N=13	N=12	N=12	N=6
	India	UP	CG	MH	AP	OD
Tests & Check-ups/Facilities at hospital/Delivery at the hospital/paid for services	82%	13	13	1	6	4
Danger Signs during pregnancy & for the new-born	21%	13	13	12	12	6
Family Planning methods	86%	3	5	9	0	1
Breastfeeding/diet for mother & child	52%	13	13	7	10	5
Trainings	2%	0	1	0	0	0

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 28 - Responses from ASHAs on main questions asked

ANM	N=32	N=12	N=9	N=9	N=2	NA
	India	UP	CG	MH	AP	OD
Tests & Check-ups/Facilities at hospital/Delivery at the hospital/paid for services	84%	12	9	5	1	NA
Danger Signs during pregnancy & for the new-born	25%	7	0	0	1	NA
Family Planning methods	69%	8	8	5	1	NA
Breastfeeding/diet for mother & child	25%	2	5	1	0	NA
Trainings	28%	8	0	1	0	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 29 - Responses from ANMs on main questions asked

[14] Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 is an Act enacted by of the Parliament, to stop female foeticides and arrest the declining sex ratio in India.

The ANMs were informed about steps they should take to improve the health of the mother & child, vaccination schedules and other topics including health and nutrition education, immunization for the control of communicable diseases, etc. They were told about JSY, JSSK, Pradhan Mantri Matru Vandana Yojana (PMMVY) scheme, and Intra Uterine Contraceptive Device (IUCD)/ Family Planning etc. They were also given information about keeping a record of home visits and management of Gram Sabha and HBNC visits.

Pregnant Women	N=101	N=20	N=20	N=20	N=20	N=21
Main questions asked	**India**	UP	CG	MH	AP	OD
Tests & Check-ups/Facilities at hospital/Delivery at the hospital/paid for services/Visit & advice by ASHA	70%	18	8	8	20	17
Danger Signs during pregnancy & for the new-born	41%	4	4	11	20	2
Family Planning methods/ female sterilization or male vasectomy	55%	14	12	1	20	9
Breastfeeding/diet for mother & child	50%	8	10	0	20	12
Medicines/Vaccines	69%	16	16	1	20	17

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 30 - Responses from Pregnant Women on main questions asked

Pregnant Women were asked questions on their knowledge of family planning methods, diet during pregnancy for the mother and the child, their knowledge about the cash support given to pregnant women, under Janani Suraksha Yojana (JSY) after institutional delivery.

Parents of children up to 9 months	N=100	N=20	N=20	N=20	N=20	N=20
Main questions asked	**India**	UP	CG	MH	AP	OD
Tests & Check-ups/Facilities at hospital/Delivery at the hospital/paid for services/Visit & advice by ASHA	46%	11	10	10	10	5
Danger Signs during pregnancy & for the new-born	15%	7	3	1	3	1
Family Planning methods/ female sterilization or male vasectomy	41%	11	7	9	13	1
Breastfeeding/diet for mother & child	66%	17	10	10	12	17
Medicines/Vaccines	50%	7	7	13	8	9

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 31 - Responses from Parents of children up to 9 months on main questions asked

Parents were asked about their knowledge of family planning methods, breastfeeding/ complementary feeding, diet followed during pregnancy and nutritious diet for the mother and the child. One of the parents mentioned that they were asked all the details about the place (hospital- government or private) of delivery, type of delivery (normal or C-section) and the mode of transport used to reach the hospital (ambulance services like 108).

In terms of the information/questions asked from ASHAs and ANMs during the call in 5 States, overall, it was observed that mainly questions were related to tests conducted in pregnancy, delivery, family planning methods and exclusive breast feeding for the child etc. The information asked about the danger signs during pregnancy/child and trainings has been reported by comparatively a smaller number of the ASHAs and ANMs.

Pregnant women and parents of children said that the most frequently asked questions were about diagnostic tests in pregnancy, delivery methods, family planning methods, breastfeeding/ diet for mother and child, and medicines and immunizations.

3.8 KEY QUESTIONS AND INFORMATION RETAINED BY RESPONDENTS

At the end of the interview, each respondent enquired about the key questions that they were asked and health information they were provided during the phone call from MCTFC, to understand what the respondents have retained through the call they have received.

Most of the ASHAs and ANMs could remember the information shared during call which is mostly related to health of mother and child including their diets, vaccinations schedules, etc.

Some of the key questions/areas of information which were revealed were regarding the health of mother & child, vaccination schedules, diet plan for the mother and child and benefits/ schemes for delivery/women, ambulance services (102 & 108) etc.

ASHA	N=56	N=13	N=13	N=12	N=12	N=6
Information Provided	**India**	UP	CG	MH	AP	OD
Health of mother & child	88%	13	13	10	8	2
Vaccination schedules	89%	13	13	11	7	6
Diet plan for the mother and child	30%	9	7	6	0	1
Benefits/schemes for delivery/ women	27%	4	9	10	1	0

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 32 - Responses from ASHAs on Key Information that were provided

ANM	N=32	N=12	N=9	N=9	N=2	NA
Information Provided	**India**	UP	CG	MH	AP	OD
Health of mother & child	81%	12	9	4	1	NA
Vaccination schedules	91%	12	9	7	1	NA
Diet plan for the mother and child	22%	1	5	1	0	NA
Benefits/schemes for delivery/ women	34%	9	1	1	0	NA
Ambulance services (102 & 108)	9%	3	0	0	0	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 33 - Responses from ANMs on Key Information that were provided

Additionally, respondents also mentioned that the caller also explained to them the difference between the two ambulance services that can be availed- 108 as Emergency Medical Response Ambulance Service and 102 as free ambulance service for pregnant women and infants (both services work as a complement to each other dealing with emergency and non-emergency situations). Collectively, the ASHAs and ANMs were briefed on reproductive health including maternal and neonatal care.

Pregnant Women	N=101	N=20	N=20	N=20	N=20	N=21
Information Provided	**India**	UP	CG	MH	AP	OD
Health of mother & child	79%	17	15	9	20	13
Vaccination schedules	39%	2	3	2	19	13
Diet plan for the mother and child	56%	2	13	4	19	15
Benefits/schemes for delivery/ women	54%	17	13	7	9	2
Ambulance services (102 & 108)	31%	10	9	2	9	1

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 34 - Responses from Pregnant Women on Key Information that were provided

The pregnant women were informed about how to wrap the baby and keep them warm, maintaining proper hygiene to avoid infections, and consuming green leafy vegetables and fruits. They were also told about the various government schemes and benefits which are being provided to the pregnant women and the availability of ambulance services by the GoI.

Parents of children up to 9 months	N=100	N=20	N=20	N=20	N=20	N=20
Information Provided	**India**	UP	CG	MH	AP	OD
Health of mother & child	66%	13	16	16	9	12
Vaccination schedules	80%	18	18	17	15	12
Diet plan for the mother and child	34%	3	10	1	16	2
Benefits/schemes for delivery/ women	28%	12	2	1	13	0
Ambulance services (102 & 108)	4%	2	0	0	1	1

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 35 - Responses from Parents of children up to 9 months on Key Information that were provided

One of the parents said that- "Yes, my son was suffering with dysentery, I asked them about its treatment, then they told me about that."

Overall, it was observed that most of the ASHAs and ANMs across States could remember the questions related to health of mothers and child and about the child vaccination status. A section of ASHAs and ANMs also mentioned the questions related to dietary plans for mother and child and ambulatory services. The pregnant women and parents clearly remembered the questions related to the health of mother and child, about maintaining hygiene, diet plan and knowledge regarding the government health schemes.

3.9 EFFECTIVENESS OF CALL

One of the objectives of the study was to evaluate the effectiveness of the MCTFC calls received by the target groups, on their awareness of health services provided by the Government.

The 'Effectiveness of the Call' was evaluated with a focus on the following metrics:

- Clarity and strong diction
- Skills of Communication
- Retention of Information and Healthcare messages given through calls

3.10 EXPLANATIONS DURING CALLS

All ASHAs and ANMs felt that the calls from the MCTFC were beneficial and helped them in increasing their knowledge, skills and helped build their confidence and skills of community level rapport building and leadership. Almost all respondents shared that the callers made efforts to explain each question, they were audible and understandable and shared the information with clarity during the calls.

	ASHA	N=56	N=13	N=13	N=12	N=12	N=6
		India	UP	CG	MH	AP	OD
Explanation of Questions	Each question explained	100%	13	13	12	12	6
Explanation of Information	Information explained clearly/ patiently	95%	12	13	12	12	6

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 36 - Responses of ASHAs on whether questions and information were explained clearly and patiently

The ASHAs and ANMs were asked if they remembered the conversation, they had with the MCTFC callers. All ASHAs and ANMs were able to recollect the information shared and the questions asked. Retaining the information also meant that they understood the topics.

	ANM	N=32	N=12	N=9	N=9	N=2	NA
		India	UP	CG	MH	AP	OD
Explanation of Questions	Each question explained	100%	12	9	9	2	NA
Explanation of Information	Information explained clearly/ patiently	100%	12	9	9	2	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 37 - Responses of ANMs on whether questions and information were explained clearly and patiently

All pregnant women and parents said that the callers explained well (with clarity and patience), each question that they asked, and each information that they gave. The ASHAs and ANMs believed that the calls from MCFTC have considerably improved their productivity and the quality of work and helped them develop an understanding of the health system and the right approach to health.

	Pregnant Women	N=101	N=20	N=20	N=20	N=20	N=21
		India	UP	CG	MH	AP	OD
Explanation of Questions	Each question explained	100%	20	20	20	20	21
Explanation of Information	Information explained clearly/ patiently	98%	20	20	20	20	19

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 38 - Responses of Pregnant Women on whether questions and information were explained clearly and patiently

- All pregnant women felt that the callers explained well each question that they asked. But on the question related to information that they were given, very few pregnant women felt, that the information was not explained to them clearly and patiently. Pregnant women also expressed that, they were pleased to receive the call as they received useful information and knowledge about pregnancy.

- Pregnant women were explained about routine check-ups done as a part of Anti Natal Check-up (ANC), Hemoglobin test (helps in early detection of Anemia), Blood Pressure (BP), Urine test, Weight, Iron Folic Acid (IFA) tablets (that addresses Anemia in women and ensures healthy delivery of the child), Tetanus vaccine (protects mother and child from life-threatening conditions). They were explained the importance of abdominal examination to assess fetal development, a well-balanced diet that helps in the growth of the child, personal hygiene that prevents acquiring infection and transmitting to the child. They were also briefed on the benefits of institutional delivery and advised to stay at the facility post-delivery for regular check-ups.
- Danger signs like weakness, fatigue, excessive swelling in legs, convulsions, high BP, continuous abdominal pain, high fever, were discussed with pregnant women and they were advised to seek help immediately in case they have any of these symptoms.
- All the pregnant women and parents agreed that the callers repeated all the questions and confirmed their responses and explained the information clearly and patiently.

	Parents of children up to 9 months	**N=100**	**N=20**	**N=20**	**N=20**	**N=20**	**N=20**
		India	UP	CG	MH	AP	OD
Explanation of Questions	Each question explained	100%	20	20	20	20	20
Explanation of Information	Information explained clearly/ patiently	99%	20	20	20	19	20

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 39 - Responses of Parents of children up to 9 months on whether questions and information were explained clearly and patiently

3.11 SUGGESTIONS AND FEEDBACK

The ASHAs and ANMs were also asked for their suggestions and feedback on the calls from MCTFC.

Few ASHAs of Maharashtra and Odisha felt that calls should be done with prior appointment, and majority of ASHAs and ANMs have suggested that the frequency of the calls should be more to enable them to refresh their skills and help them improve their understanding of various concepts.

ASHA	**N=56**	**N=13**	**N=13**	**N=12**	**N=12**	**N=6**
Suggestions/Feedback	**India**	UP	CG	MH	AP	OD
Should make prior appointment before call	18%	2	1	4	1	2
Calls should be more frequent	45%	4	11	9	5	3
No suggestions	38%	8	2	5	6	1

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 40 - Responses of ASHAs on Suggestions and Feedback

ANM	N=32	N=12	N=9	N=9	N=2	NA
Suggestions/Feedback	**India**	UP	CG	MH	AP	OD
Should make prior appointment before the call	13%	4	0	0	0	NA
Calls should be more frequent	28%	3	3	2	1	NA
No suggestions	59%	5	6	7	1	NA

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 41 - Responses of ANMs on Suggestions and Feedback

- The ASHAs and ANMs reported the caller's voice to be clear and the diction comprehensible.
- The callers had good communication skills and were good listeners. They helped them solve problems and clear any confusion/ ambiguity on their roles and responsibilities.
- The calls helped them to understand the incentives, streamlined payment mechanisms and the point of contact/ways to solve issues of any delayed payments.
- They understood their role in the community and seemed well-informed on the important aspects of reproductive, maternal, newborn, and child health.
- On the other hand, some of the ASHAs and ANMs thought that the calls were not very informative and helpful. There was no additional information that they were not aware of.

Similarly, the Pregnant women/parents were also asked for their suggestions and feedback on the calls from MCTFC. Some women faced problems in attending the calls as the registered phone number is used by their husband, which led to either missing the call or getting second-hand information from the husband. Most of the pregnant women in Uttar Pradesh felt that the calls should be made with prior appointment. But the majority of women in the other States did not feel the necessity of prior appointment for the call. Very few parents suggested that calls should be made more frequently to enable them to help them take better care of themselves and their children.

Pregnant Women	N=101	N=20	N=20	N=20	N=20	N=21
Suggestions/Feedback	**India**	UP	CG	MH	AP	OD
Should make prior appointment before the call	19%	17	0	0	0	2
Calls should be more frequent	10%	3	1	1	5	1
No suggestions	71%	1	19	19	15	18

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 42 - Responses of Pregnant Women on Suggestions and Feedback

Parents of children up to 9 months	N=100	N=20	N=20	N=20	N=20	N=20
Suggestions/Feedback	**India**	UP	CG	MH	AP	OD
Should make prior appointment before the call	4%	20	0	1	1	2
Calls should be more frequent	17%	5	5	2	2	3
No suggestions	79%	15	15	17	17	15

UP- Uttar Pradesh, CG- Chhattisgarh, MH- Maharashtra, AP- Andhra Pradesh, OD- Odisha

Table 43 - Responses of Parents of children up to 9 months on Suggestions and Feedback

Information provided to pregnant women and parents with a child (up to 9 months):

- They were provided with information on the immunization schedules for the children like polio, BCG etc. Details were also shared for the counseling on cord care, nutrition and family planning, and post-delivery care to ensure good health for the mother and the child. For the care of the Newborn, the caller helped the parent to identify the danger signs like fever, diarrhoea, eye infection, difficulty in breathing, jaundice. It was suggested for them to seek advice from ANM/ASHA/MO immediately if any complications occur.
- Information was also shared regarding exclusive breastfeeding for 6 months and its benefits that decrease chances of Diarrhea and other infections. The mothers were informed about complementary feeding (solid food after six months for the child).
- Family planning methods (Spacing methods)- were discussed and emphasis was given on the 3 years spacing, to ensure healthy mother and child.

3.12 CHALLENGES/ ISSUES

There were some challenges faced by the beneficiaries during the call by the target groups.

- One of the common challenges faced by the respondents was the timing of the calls. The ASHAs/ANMs that received the calls in the morning & expressed they were busy with either household chores or had visits/meetings scheduled. Some were occupied either with a patient or at a Routine Immunization (RI) session.
- Most households have only one mobile phone which they share with the husband, thus, the pregnant women and parents at times either miss the call (received the repeat call) or the second-hand information was shared by the husband.

3.13 SUGGESTIONS BY RESPONDENTS

Frequency of the call

- For all the target groups, the calls from the MCTFC were reported to be beneficial, and the information shared effective. But receiving just one call in 6 months does not suffice the purpose.

- They demand that the frequency of the calls should be increased. ASHAs and ANMs felt that these calls act as a revision and make them aware of any new program or changes in any guidelines.

Time of call

- It was also shared by the Front Line Workers (FLWs) and the women that the preferable time to receive the calls was late afternoon, as mornings are a busy time for all.

Schedule the call

- In some cases, it was brought to attention that the registered mobile number was of their husband, due to which the call was either missed or left unanswered. It was suggested that the callers should inform the receiver and ask for the beneficiary or maybe schedule an appointment a day before the call thereupon preventing any loss of information.

3.14 ASSESSMENT OF CALL RECORDINGS BY MCTFC CALL CENTRE

A. Collated analysis of MCTFC recorded CALLS (N - 40)

	Parameter	Response
1	Verification of the respondent – was it done correctly and patiently	» Done correctly – 96% » Not done correctly – 3.8%
2	Duration of call (in minutes)	» 1-5 Minutes - 16.7 % » 5-10 Minutes – 13.3 % » 10-15 Minutes – 10 % » 15-20 Minutes – 20 % » 20-25 Minutes - 13.3 % » 25 - 30 Minutes - 16.7 % » < 30 Minutes – 10 %
3	Was the call answered in first attempt, or repeat call was made?	» First attempt – 81 % » Repeat call – 19 %
4	Were the questions stated correctly and clearly and were explained, if required?	» Stated correctly & clearly and explained well – 71% » Yes, but explained only when requested – 29%
5	During the call, how did you find the following – • Language (was it easy and appropriate • Tone (was it easy to understand and comforting) • Pace (was it appropriate and easy for you to understand)	1. Language easy to understand – 92% Difficult to understand – 8% 2. Tone of caller – - Comforting – 70% - Not comforting – 30% 3. Pace of caller – - Normal / appropriate – 75% - Fast paced – 25%

6	In case of respondent having difficulty in understanding the questions, were they explained again and well - Patience, Politeness and Accuracy in explaining.	» Explained well – 71% » Not explained well – 29%
7	Did the caller explain every time - the question / issue of discussion, clearly and patiently? (Giving adequate time to the beneficiary to understand)	» Explained with patience – 52% » Not explained with patience – 48%
8	Were the answers being given by the respondent confirmed clearly by the caller	» Confirmed clearly – 62.5% » Not confirmed clearly – 37.5%

B. Thematic Analysis of qualitative observations made in Assessment of Call Recordings

1	Timing of Call / Repeat Call	» The respondent was facing difficulty in understanding the questions as she was busy in COVID Vaccination – said "mam, kuch samjh nahi aa raha". » In many instances, the call was not completed, but the repeat call was not found. It's not clear, if a repeat call was made.
2	Language, Tone, and Pace of the call	» The tone and pace of the caller was bad she was asked repeatedly to clarify the question / information. » Tone of the caller was often dominating, and she was speaking as if reading textbook Hindi. » The caller had to keep the call on hold for a few times, and during the repetition of questions the caller at times raised her voice. » The caller raised her voice, at some places when the respondent was unable to understand the question. The caller asked the respondent to answer the questions spontaneously. » Some information was being narrated at very fast pace, in an insensitive manner. » The caller was fatigued. Her tone was plain and dull, and not happy or positive. » The caller did not allow the respondent to complete her sentence a number of times.
3	Confirmation and paraphrasing of the answers of respondents	» Caller was not trying to verify if the lady really understood. In most cases she did not explain the questions or issues again, even when it was clear that the respondent has not understood. » In some instances when the responses from the woman were not clear, the caller clarified by repeating the answers.
4	Overall Quality of Call and Conversation – other challenges	» In case of answers not as expected, caller behaved very roughly and rudely. » Caller was commanding at some points. Caller was generally insensitive to how well the ASHA understood her question or message. Showed some irritation. when she had to repeat or explain.

		» Sometimes, the sound of the caller was quite feeble (weak). Explained each time, as required. But largely stuck to the written draft. Pace was a little hurried. » Background noise was prominent – it was noted in a number of calls. » There was a lot of disturbance during the call but caller did not stop, and was continuously asking questions. » At times the caller spoke rudely while explaining the question especially when there were dual answers, one from the respondent and the other from her husband (Number of respondent's husband was registered therefore he had to connect the call to his wife). » When the respondent was asking questions during the call, the caller answered all questions, but she was not sure while answering some questions. For example- She asked the caller "for how long I have to take calcium and iron tablets?" She answered- "When you feel like you have recovered from your pain" and after that she clarified that you can contact your ANM and nearest health facility. » During a repeat call to pregnant women, the caller just started the questions which were left unanswered in the previous call. Her husband picked up the call and he was driving his vehicle on road, and he mentioned the same to caller as well. But she was not concerned at all, she told him to stop at a quiet place and answer the questions that were left from the last call. » When the ANM said she has other job to do, the caller was very rude and commanding. » The caller was very patient and was clearly explaining the questions and information to the ASHA. The respondent ASHA even mentioned her grievance of not receiving the salary since last 3 months. » The caller got irritated a number of times when the respondent gave incorrect answer to the questions. » It was very poor-quality interview, where the caller was not concerned about anything except completing her questions.
5	Other observations	» Caller needs major upgrade / training on reading of English language text. She could not read English words with ease and confidence. » The phrases like, Main apko batana chahungi (I would like to tell you), Main janna chahungee (I would like to know), were added after / before questions needlessly. They were acting as irritants. Phrases like, theek hai, after giving information or asking question every time, were also sounding needless and irritants. » The callers need more detailed training about all questions and information they use.

		» Information that the callers have needs to be updated, as the caller did not have updated information about HWC, and CHOs. » In Hindi States they can address the receiver as Behan ji, rather than Madam. Addressing the women as Madam, may be alienating them, rather than engaging. » We need to assess, if the callers are under pressure, and under what type of pressures, to understand their behaviour. The recruitment process of the callers also needs to be seen, to understand how the quality of the calls, and callers can be improved. » The caller needs more training on correctly pronouncing and reading out the technical words, and about the programmes, and their popular names (like JSSK). » The caller was sounding listless, and uninterested. Such tone cant give positive vibes to the call receiver. The ASHA called was very well informed, still the caller did not become positive in her attitude, and tone. » It needs to be assessed, if the generally neutral, and often dull and listless attitude and tone of callers related to their work environment - overall ambience, daily workload, and lunch breaks etc. Monitoring and support by the call centre team may need to be assessed, on how it impacts the quality of calls. » During a call to the Parent (Mother), the tone and voice was very listless, and style of conversation was very uncommunicative. Pace was quite fast, and tone was also commanding. The caller did not try to verify if the lady really understood. All questions were asked in very formal language. No effort made to communicate in easy-to-understand language, or to listen to / understand what the respondent lady was saying. The caller was very fatigued and sleepy, and was yawning repeatedly. She was sometimes confronting and commanding in her dialogue. Caller also had some nagging language / phrases. Why training or supervision does not identify and address such issues. In her advice, the caller mentioned Biscuit for child – which is a wrong messaging. » It needs to be assessed whether monitoring system of the MCTFC tracks the fatigue level of callers and its impact of the quality of calls. » Duration of call (call was to Pregnant Woman) was short due to clubbing of questions (e.g., Did the ANM/SN/Doctor check your BP, weight, abdomen; Are you consuming iron and calcium tablets?). After confirming the parity from the respondent, the caller skipped the questions - PW2O, PW2P, PW2Q that check her awareness on danger signs, and whom to reach out if any such sign manifests.

		» Similarly, questions checking awareness of breast feeding, hepatitis vaccines, birth defects were skipped (PW2V, PW2W, PW2X). The caller did not enquire on the respondent's intention to adopt any family planning methods, and neither checked the facilitation by the heath workers for FP services nor enlisted the options available (PW2Y, PW2Z). Instead, the respondent was suggested to take up a surgical procedure after delivery. » The caller shared a toll-free number to the respondent for reaching out to them in case of any queries. » During the 17 minutes of call, almost 6 minutes were used in confirming the place of delivery and the village. Even though the respondent was busy, it ultimately led to the call being left incomplete. » The caller was not able to pronounce the technical terms. » In a number of calls the registered mobile of the pregnant woman was actually the number of either ASHA or ANM. » The caller took a long time (< 5 minutes) to update the information in the system, and the respondent was kept waiting for the next question. » In a call to the parent of child, the caller confirmed the age of the child, and the child had turned 6 months that day. So, she told the mother that you will receive call next day when your child completes 6 months of age.

C. Overall Findings

- In majority of calls, essential protocols were followed, and the callers administered the modules as expected. In the assessment of more than half of the calls, it was observed that the call receivers were generally satisfied with the quality of call.
- In close to half of the calls (48%), it was found that the caller did not clearly and patiently explain each question. In 30% of calls, the tone of the caller was found as 'not comforting'.
- 25% of calls were assessed in negative with respect to the parameter "In case of the respondent having difficulty in understanding the questions, were they explained again and well - with Patience, Politeness and Accuracy".
- 30% of the assessed calls were found to be of less than 10 minutes in duration, although the, minimum expected time to complete a call for any of the four categories, is not less than 20-25 minutes.
- The findings mentioned above demonstrate that at least about 30% of calls had significant problems related to quality of calls.
- A number of calls were observed to be facing poor sound quality due to a weak network signal on the device or inconsistent network coverage in the area.

- In large number of calls, the respondents seemed contended with the information they received.
- In many of the calls, the respondents were visibly unhappy and demoralized with the tone, pace, and attitude of the caller.
- In a number of calls, in case of answers not being as expected, the caller behaved rudely.
- In many calls, the callers were commanding in their attitude, and got irritated when they had to repeat or explain. In many cases, they did not explain the questions or issues despite this being clearly required.
- A number of times, the sound of the caller was quite feeble (weak), and she continued without bothering about it.
- Many callers were stuck to the written draft very rigidly, and their pace was hurried.
- Many times, the questions or statements were leading in nature, and the caller did not bother to wait or give time for the respondent to think and answer.
- The callers did not seem confident while answering queries from the respondents. For example – A respondent asked the caller "for how long I have to take calcium and iron tablets?", and the caller answered- "When you feel like you have recovered from your pain".
- Most of the callers could not read Technical Terms and English words with clarity.
- The callers used phrases like, "Main apko batana chahungi, and Main janna chahungee", after/before questions pointlessly, which was clearly an irritant. Phrases like "Theek hai", after giving information or asking questions, every time, also came across as an irritant.
- In the case of calls to ANMs, callers were not bothered, even after ANM expressed her difficulty, that she was busy with COVID work / Vaccination or other tasks in the field.
- The caller shared a toll-free number with the respondent for reaching out in case of any queries.

3.15 PERSPECTIVES OF THE STATE AND DISTRICT OFFICIALS

The IDIs with State and District level programme managers covered a wide range of issues related to the design and operation of the MCTFC programme.

Most common observation across States is that, the MCTFC programme is being run directly, with no, or very limited communication with States. Systems for sharing of programme reports generated from the feedback coming from the MCTFC calls, with States have been almost non-functional since a long time.

The States still see a substantive value and potential in the MCTFC programme, but they also make a wide range of corrective suggestions and recommendations to make this programme more useful and effective. They also strongly recommend that the overall coverage and total number of calls should be increased, and systems should be built for greater space for local priority-based content and generation of feedback disaggregated for blocks / districts.

A collated thematic analysis of views expressed in IDIs across States is given below.

State	Theme-wise Collated Analysis of IDIs
	Theme 1 – Programme Implementation (Programme activities/status/role of State and District teams)
Andhra Pradesh	» The State and District officials are not aware of the MCTFC activities in the State, and have no direct involvement in its activities. » The State has its own 104 call centre and calls are made randomly to pregnant women using the RCH portal's data. » District officials said that, during the monthly meetings ANMs share about the calls made by MCTFC to them and ASHAs. » The State and District teams have not received any data or a report from MCTFC in the last few years.
Chhattisgarh	» MCTFC calls are made directly to the beneficiaries and health workers, there is no involvement of the State. » A report comes from MCTFC with details about the calls made, and calls which didn't connect. » The State has 104 helplines in place with a call-center. It also makes calls for health education, especially to young mothers on healthcare issues during pregnancy. The pregnant women are called to inform that they should call the toll-free number 108, at the time of delivery. » Sometimes, the State writes to districts with low registration in the RCH portal. » Block Data Managers interact with ANMs to ensure that all details of pregnant women, including the phone number, are correct and updated.
Maharashtra	» State team is aware that there is a call centre at the national level that collects feedback from clients about RCH, and the services being provided. » Calls are made to 4 categories - pregnant women, parents of children, ASHAs, and ANMs. The MCTFC reports contain district-wise information » The State has a call center of 104 helpline, similar to the MCTFC. » The State officials monitor the registrations under the MCTS/RCH portal, the delivery of services of maternal and child health programmes, and undertake gap analysis. » At the district level, RCH officers work as district monitoring officers, who manage the RCH portal, and also look after the RCH programs. » At the field level, ANM is the key person who fills the RCH register with data on eligible couples, pregnant women, and ANC registration.
Odisha	» The officials are aware of the MCTFC program, run by the Government of India, and its calls being made to pregnant women and parents. However, they were not aware of calls being made to ASHAs and ANMs » Initially, the frequency of reports was on an annual basis and sometimes half-yearly basis till 2018. Later-on one report was received in 2020 and recently, report was received in July 2022. » Some MCTFC calls were received before covid. Presently no calls are being received. In the initial phase of MCTFC, there were no callers in Odia. Later 1-2 Odia speaking callers were appointed.

	» There is 104 Call Centre run by State, started on the lines of MCTFC which is presently calling all four types of beneficiaries. » The State officials' role is to share analysis reports with districts. » The district official ensures the up-dation of data in the RCH portal and the accuracy of data without any duplications or errors. » At the ground level, ASHAs conduct door-to-door visits, ANM records all data related to services, and Block Data Managers analyze the information.
Uttar Pradesh	» State team is aware of the MCTFC call-centre at the national level that collects feedback on RCH services being provided. » Calls are made to pregnant women, parents of children, ASHAs, and ANMs. » There is no direct involvement of State in calls being made by MCTFC. » The State has its own State-level call centre, similar to MCTFC. It is a helpline on which people make calls related to their health conditions. » There are four call centres at the district level, somewhat similar to MCTFC. Outgoing calls are also made from time to time. » The MCTFC reports received by the State include, the number of calls made and a status report on a set of indicators. » Reports on the indicators is shared with concerned depts at the District / State level. » State and District teams are responsible for data entry and program management of MCTS system/RCH Portal.
	Theme 2 - Programme Outputs and Outcomes (Benefits & Impacts at community/families' level, at FLWs level)
Andhra Pradesh	» The State and District officials think that MCTFC makes calls to the beneficiaries to provide knowledge on services, and provide feedback to ASHAs and ANMs, which will help them in enhancing their skills. » The number of calls being made to ASHAs and ANMs is small, so the outcomes cannot be measured using this data. » Most of the call sessions are very long, and getting time from the beneficiaries and health workers is a challenge because of their busy hours. » MCTFC calls may have helped in increasing the RCH portal registration (<92% of the pregnant women are registered). » MCTFC calls to pregnant women is likely to have improved their knowledge and increased their willingness to visit the health facility for services. » It's a good initiative to provide knowledge to ASHAs and ANMs and helps in increasing their knowledge and acts as a refresher.
Chhattisgarh	» MCTFC program enables the State to check the extent (%) of pregnant women registered on RCH portal.

	» The MCTFC program helps to determine success of programmes being implemented. » Focus on educating pregnant women to register themselves on RCH portal is leading to change in people's mentality and helps to reduce the number of deaths at the time of delivery. » The MCTFC program has made a significant impact on the health system and the health workers. It has led to establishment of call centres related to many disease programmes. » Because reports are not being received regularly, the output and outcome of the programme cannot be commented upon.
Maharashtra	» The MCTFC calls help beneficiaries on availability and timelines of services and also alert them about the services due. » The calls benefit ASHA and ANM to refresh the existing knowledge, and services that are due to their beneficiaries. » They also create alertness amongst the ASHA and ANM, as they know that information they provide is being recorded. » The State and District managers said - cannot comment on the outputs and outcomes of programme, as have received the report for the first time. » Around 85% of pregnant women are registered in the MCTFC portal. » Programme managers felt - calls are likely to benefit ASHAs and ANMs.
Odisha	» The programme managers felt that program benefits intended beneficiaries. » There are no mechanisms to measure the level of awareness in the community (Pregnant women and parents). » Beneficiaries in remote areas were also benefitting from calls, by generating awareness to avail benefits from government services. » Many programme managers were not aware of the calls to ASHA/ANM. But thought that such calls will benefit them by raising awareness, widening knowledge base, and revising existing knowledge. » The MCTFC calls created a sense of being heard among the beneficiaries.
Uttar Pradesh	» MCTFC calls also act as a reminder of due services. They also talk about the benefits of services, and help in spreading the awareness. » The calls do not tell directly about the immunization, but explain the benefits like, protection against diseases, and when is immunization due. » State team said they have no information about the details and main agenda of calls, so cannot comment on benefits of the calls to community and families. The content of the calls is not shared or coordinated with State / District team. » State does not know how and why the ministry started MCTFC, and the vision of the national government behind the programme. » Calls related to COVID 19 were being made during the COVID period. They were helpful in awareness building.

	» The programme helps by giving the health workers knowledge about the services and they in turn help pregnant women by informing them about the services, giving guidance about child vaccination, and childcare. » MCTFC calls ask beneficiaries about the services received. This enhances their confidence in the health system and services. » Sometimes, MCTFC calls are made to ASHAs and ANMs, at odd hours during work, and it can irritate them.
	Theme 3 - Success of Programme in meeting Objectives
Andhra Pradesh	» The objective of Validation of the RCH portal data through MCTFC calls is not fulfilled, because of the small number of calls made to beneficiaries. » The State updates data on RCH portal on its own by making random calls to beneficiaries. It sees no role of MCTFC in updating RCH portal. » Programme managers do not think, that MCTFC calls succeed in providing information and guidance to beneficiaries and health workers - "information is provided to less than 0.5% of pregnant women". » The information provided through MCTFC calls about the Government healthcare schemes are reaching ASHAs and ANMs. It may not be reaching 100 %, but the information they get is beneficial. » A district Official said, "We are getting the feedback and the insights are really helpful, but we should get it more periodically, an annual / biannual update is not very useful in taking corrective actions on a periodic basis". » The programme managers are not aware of topics covered and questions asked on training needs, in the calls made to healthcare workers. But they feel, it has potential for identifying training needs of health workers.
Chhattisgarh	» The MCTFC calls are not very effective, as they are not linked to the healthcare services that are due to the beneficiaries, or their healthcare needs and priorities. » The MCTFC callers are not fully able to answer the queries of the beneficiaries or heath workers.
Maharashtra	» MCTFC calls validate the data of the beneficiaries registered under the MCTS/RCH Portal. » MCTFC calls provide guidance and information. » The activity or the calls made by the call center helps with the promotion of various schemes and programs.
Odisha	» MCTFC calls help in validation of data of the beneficiaries registered in the MCTS/RCH Portal. It also puts pressure on health workers to add correct data of the beneficiaries. » Some programme managers felt that calls have no role in validation of beneficiary data, as the MCTFC reports received by States does not contain data of individuals - "I don't think it has achieved the objective, because the data we are getting is for the State level and now it is for the district as a whole so how we can validate the beneficiary data from that? We cannot validate or make a correction or update it".

	» The information given to beneficiaries through calls might be beneficial. The questions should be updated periodically. » States should know the questions being asked in MCTFC calls. » Verifying availability of medicines with ASHAs and ANMs, through MCTFC calls, has its own problems, as they may not give correct information. » The providing information about the government programs, and their promotion through MCTFC calls, may be useful, but there is possibility of confusion due to significant overlap between State and central programs.
Uttar Pradesh	» MCTFC calls help in the validation of data of the beneficiaries registered under MCTS/RCH Portal. There is pressure on health workers to add correct data of the beneficiaries, as this is used by MCTFC for calls. » The MCTFC calls provide information to beneficiaries and help in awareness building. » There is a positive effect of calls on ANMs and ASHAs, as they get this feedback from the top, and it motivates them to improve these indicators. » The information about the Central Government's healthcare schemes is reaching ASHAs and ANMs through these calls. It may not be reaching 100 %, but the information they get is beneficial. » MCTFC reports provide no information on the number of beneficiaries whose phone numbers have been validated.
	Theme 4 - Reporting and Monitoring Systems / Follow-up Action
Andhra Pradesh	» There is no reporting or monitoring system for MCTFC programme at State and District level, as they have no direct role in the programme. » The monitoring of MCTFC programme should also follow a pattern similar to RCH portal monitoring. At the district level, the statistical officer and Deputy Director at State level should be responsible for monitoring and reporting the data related to the MCTFC program. » At the block level, the health officers, and supervisors to be responsible for monitoring and reporting the data, and ANMs at the community level to be responsible for monitoring and reporting the data. » The MCTFC programme has linkages with the immunization programme, Government schemes like JSSK & JSY, all services such as ANC or PNC, PNC visits, and iron supplementation.
Chhattisgarh	» MCTFC performance reports have not been received by the State, regularly. No report received in more than 2 years. Recently, one report has been received. » There are no other monitoring systems for the MCTFC programme in place, as the State has a limited role in the MCTFC calls. » MCTFC reports have been received only rarely, so there is no system in place in the State for follow-up action on the report.
Maharashtra	» Annual review meetings/workshops conducted at the national level, and the RCH portal meeting conducted annually have a session discussing the MCTFC program, and data from the MCTFC centre is presented. » There are no meetings on the MCTFC programme held at the State level.

	» There is a linkage of the MCTFC program with programs such as JSY (the State also gives Rs. 500 incentives to the beneficiary), and Pradhan Mantri Matru Vandana Yojana, (an incentive of 5000 rupees is given). » There is no other reporting or monitoring system for the MCTFC program at the State and District level
Odisha	» There is no reporting or monitoring system for the MCTFC program at the State and District level, and they have no direct role in the program. » The State does not get details on the validation of beneficiaries' data done by MCTFC. MCTFC reports have only the number of calls. » MCTFC reports were not received at regular intervals. » MCTFC calls cover a very small sample of ASHAs and ANMs in State. » Reports have district-wise data, but no village-wise segregated data. » Programme managers were not aware of linkages of MCTFC with other programs. Some managers said, it is linked with RMNCH program - maternal and child health, adolescent health, and immunization.
Uttar Pradesh	» Reporting system is not regular. Before COVID, the reports were received every 2-3 months. No reports received in the last 2 years. No knowledge about the benefits to health workers, community, and families. » There is no reporting or monitoring system for the MCTFC programme at the State and District level, as they have no direct role in programme.
	Theme 5 - Challenges
Andhra Pradesh	» Language barrier is one of the key challenges. » Sample size of the beneficiaries and health workers covered by calls is small, and is not enough to make the findings generalizable. » There is no clarity on the calls that are being made to ASHAs and ANMs. » The State and District reports are not shared regularly and in a timely manner. » Lack of a proper monitoring and reporting system at State and District level.
Chhattisgarh	» Mobile numbers of beneficiaries and frontline workers see frequent changes (due to new schemes / attractive tariffs), leading to failed calls. » The CUG scheme for ASHAs was withdrawn, and ASHAs changed numbers, which led to 50% of numbers not being validated.
Maharashtra	» In many cases, the registered number is of a family member and not the beneficiary. » Poor network coverage in some remote areas poses challenges. » The language barriers severely limit the effectiveness of the calls. » The beneficiaries do not have awareness of the MCTFC program.
Odisha	» There is substantial information dissemination through the calls, however, no feedback mechanisms are in place, and no follow-ups are done. » There is no validation mechanism in case of a mismatch of data. » The mobile numbers of the beneficiaries are not valid in a number of cases.

	» Language barriers play a critical role in remote tribal districts. » No mechanisms are in place to measure the level of awareness among the beneficiaries. » The number of ASHAs and ANMs who received MCTFC calls, is very small, (1/2 calls made to only a few 5-6 districts).
Uttar Pradesh	» The compiled report shared by MCTFC does not give details about which ASHA / ANM said what. They report overall numbers for the State. This makes it difficult to draw action points and limits the follow-up action. » MCTFC programme reports are not received regularly. » No program orientation or review workshops are organized. » The State has no engagement in designing the modules of the calls. » There is no mechanism for issues or questions important for the local context to be included in the MCTFC calls.
	Theme 6 – Recommendations
Andhra Pradesh	» An identifier for the calls should be inbuilt into the system so that receivers don't miss the call and do not consider it spam. » Prior fixing of a suitable time with beneficiaries will help. » The number of beneficiaries and health workers called needs to be increased. » If target groups, such as high-risk pregnant women are called, and are followed up at critical steps, it will have a greater impact compared to contacting random pregnant women. » The reports should be shared regularly, annually, half-yearly or quarterly. » Marginalized communities like tribal populations, can be called on priority, and feedback on their health issues can be shared for action. » The questionnaires need to be short, so critical information is retained. » Use of local language will ensure beneficiaries interact with the callers and understand the questions easily. » "Overall MCTFC is a good program and being part of the MCTFC program, we always try to provide better services to the mothers and their children. But in order to improve our services and get better results, we have to do 100 percent implementation at the ground level." – District Official. » Number of calls should be increased, and the duration of the calls be decreased for effective implementation of the program. » Periodic engagement with States is recommended. A State official said, "Sharing the results, what is the areas of improvement for the State and what is the percentage of increase in the health-seeking behaviour, all those things should be scientifically drawn and shared with the States".
Chhattisgarh	» MCTFC Calls should be used for awareness building and to provide important information and messages to beneficiaries and health workers, related to service delivery and health promotion. » Important messages linked to due services should be given to beneficiaries at appropriate times (2-3 days before the due service).

	» MCTFC calls should be short, to enable the retention of messages. Calls should be made only in the local language. » The call should be displayed on the phone of the receiver, as a government program-related call, to ensure that call is not missed. » MCTFC, and Kilkari programmes both use the same database of those registered under the RCH portal, so both should be integrated. » Health education for children and adolescent girls, should be given priority. It will help them later deal with health and pregnancy issues. » There should be mechanisms to add questions on healthcare issues or programmes important for local context, in the MCTFC calls. » States should also have the flexibility to add questions related to local campaigns as per the local needs and priorities. » States should have options to generate reports from the MCTS portal, at any time / monthly. » Calls should be made with samples taken from every block of the State. » During MCTFC calls, calling agents or health experts available, should be able to give answers to any healthcare issue faced by call receivers. » Mechanisms should be created for including information about new programmes in the MCTFC calls. » Reports of the MCTFC should be generated on a district-wise basis, and also provide information about incorrect phone numbers, the issues on the feeding of the child not being done properly, etc. » MCTFC should use new technologies for awareness building and information dissemination, like short videos on issues of healthcare and health promotion to educate beneficiaries and health workers. » MCTFC should run its call centres from the State level, which will enable it to make calls in the State's local language, and in various languages and dialects of the State (the State has Gondi, Halbi, etc. as other major languages / dialects). » MCTFC should also make calls to district-level programme managers, and inform them about the findings from the calls made in the district.
Maharashtra	» There should be greater integration of MCTFC with other programs, especially with Kilkari and Mobile Academy. » State should be enabled to generate reports from the RCH portal periodically / at any time. » Quarterly or annual reports should be sent, with number of calls made, Number of calls answered, number of calls which did not answer, the accuracy of RCH Portal data, etc. » There should be 100% updating of all these services in the RCH portal.
Odisha	» Overall, the program is good and it must be continued, however, the reports must be accessible at all levels. » Scrutiny of the recorded calls made previously, needs to be undertaken, on parameters like, how questions are being asked, and how far the beneficiary understands them and gives the reply.

	» Field information and discrepancies in the data must be shared. » Feedback mechanisms should be in place so that it aids in the rectification of challenges. » Proper mechanisms should be put in place for sharing of information. » Quarterly reports should be shared so that regular follow-up activities can be conducted. » More emphasis must be laid on awareness generation activities (IEC) through MCTFC calls.
Uttar Pradesh	» Training component should also be introduced along with the MCTFC Calls, to sensitize ASHA/ANMs. Recently calls related to COVID-19 were being made, which proved useful in awareness building and information sharing. » Performance Report shared by MCTFC should have a program-wise and indicator-wise breakdown. It should be sent to the respective divisions. It should also be in a line-listed method. This will improve the impact of the report and program. » Information on gaps/mismatches in phone numbers of beneficiaries and FLWs registered in the MCTS/RCH portal, identified through MCTFC calls, should be provided on a line-listed basis for follow-up action. » MCTFC program should periodically organize orientations and reviews with States and strengthen coordination and communication with them. » The MCTFC reports shared with States should provide more actionable feedback. » Mechanisms should be created for issues or questions important for the local context to be included in the MCTFC calls.

Main Findings across thematic areas :

Sl. No.	State	Programme Implementation	Programme Outputs and Outcomes	Success of Programme in meeting objectives	Reporting and monitoring systems/Follow up action	Challenges	Recommendations
1	Andhra Pradesh	• State and District officials not aware about the MCTFC programme • No data/report shared in last few years	• State and District officials felt that outputs may be increase in: - Knowledge of community and CHWs - Uptake of services from health facility by beneficiaries - Assessing the outcomes cannot be as the number of calls made are less	• The programme managers were unaware of the MCTFC objectives • As per their opinion the objectives were not fulfilled, because of the small number of calls made to beneficiaries	• No reporting or monitoring system for MCTFC is in place at State and District level	• Language barrier • Results are not generalizable, due to small sample size • Reports not shared regularly • Lack of clarity of calls content	• An identifier for the calls (as a govt program call) should be built in • Prior fixing of a suitable time with beneficiaries • Increase the number of beneficiaries and CHWs • Marginalized communities can be called on priority • Use of local language

2	Chhattisgarh	• State officials were aware of the MCTFC, but district officials have no idea about the programme • Report has been shared with State and District officials recently	• Outputs and outcomes cannot be assessed as reports were not shared regularly by MCTFC • But it could benefit the community by changing their mentality and help in reducing maternal deaths	• The MCTFC calls are not very effective, as they are not linked to due services • The State and District officials were unaware of the programme activities as well as their status of achieving objectives	• There are no monitoring systems for the MCTFC programme in place, as the State has a limited role in the MCTFC calls	• Reporting of failed calls as under the calls made • Mobile numbers of ASHAs and ANMs frequently change	• Calls should be of shorter duration. • Calls be linked with healthcare related due dates. • Calls should also focus on adolescent girls • Reports should include district wise data on calls made • Should use technology for creating awareness among the beneficiaries regarding calls

3	Maharashtra	• State officials were aware of the MCTFC programme whereas the district officials were unaware of the programme activities however, they have received a report from the State a month ago	• The State and District officials did not comment on outputs / outcomes of the programme, as they have received the report for the first time • However, they agreed to that it could lead to change in knowledge of community and CHWs • Calls increase the alertness in both the groups	• The State and District officials agreed that the programme is creating awareness among beneficiaries about healthcare services and is promoting government schemes and programmes	• No reporting or monitoring system for the MCTFC program at the State and District level exists • No meetings on the MCTFC programme held at the State level so far	• Poor Network coverage • Language barrier • Lack of awareness on MCTFC Programme	• Integration of MCTFC with Kilkari and Mobile academy programmes • Sharing of reports on quarterly basis

4	Odisha	• The State and District officials were aware of the MCTFC programme but were unaware of the calls being made to CHWs • The State has received a report from MCTFC few months back, after the pandemic. However, no report has been shared with district officials	• The State and District officials explained the outputs in terms of - Creating a sense of being heard among the beneficiaries. - Raising awareness in the beneficiaries of remote areas - Increasing the knowledge of CHWs	• The State and District officials did not have any idea about the content of the calls, so were not very sure about MCTFC's success in achieving the objectives • As per their opinion, the programme might have an impact on increasing the awareness among the beneficiaries	• No reporting or monitoring system for the MCTFC program at the State and District level, and they have no direct role in the program	• No feedback mechanisms are in place • No validation mechanism in case of a mismatch of data • Very few ASHAs and ANMs are being contacted	• Reports should be made accessible at all levels • Feedback mechanisms should be in place • Regular follow up and quarterly report sharing should be done

5	Uttar Pradesh	• State officials were aware of the MCTFC programme but recently have not received any report. The last report was of 2018, shared before pandemic • The district officials were unaware of the MCTFC programme activities and have not received any report so far	• The State and District officials did not comment on outputs and outcomes	• The programme managers at State and District level felt that MCTFC objectives being fulfilled at State and District level, except for the validation of the RCH portal's data through calls	• There is no reporting or monitoring system for the MCTFC programme at the State and District level	• No meaningful interpretation provided in MCTFC report • Reports not received regularly • No orientation workshop conducted so far	• Report should have program-wise and indicator-wise analysis • MCTFC program should periodically organize orientations and reviews with states • MCTFC reports should provide more actionable feedback

CHAPTER 4
CONCLUSIONS

4.1 STRENGTHS OF MCTFC PROGRAMME

- Reach of the programme – the programme, through its calls, is reaching out to 23 States (Nagaland and Maharashtra added recently), making calls in 7 languages, (including Hindi).
- MCTFC makes a very important and effective use of the huge data base of beneficiaries and frontline workers registered in the MCTS system (which has now been upgraded as RCH portal).
- MCTFC is a major initiative under NHM, with the total value of the 5 year's contract at Rs. 38.48 Crores (Total Infrastructure cost is Rs. 6.78 Crores, Operational Expenses Rs. 30.93 Cr. and Other Expenses – Rs. 76.80 Lakh, and total operation cost for year 14.85 Cr, with a provision for 5% increment per year).
- MCTFC has a very well-equipped call centre (situated in the National Institute of Health and Family Welfare) and has developed a robust system of generating calls in 22 States. It has also built system for making calls in regional languages.
- MCTFC has provided services for periodic special campaigns of MOHFW, and, also other one-time campaigns, as and when required.

4.2 CHALLENGES AND LIMITATIONS OF MCTFC PROGRAMME

- Across the States, the IDIs with programme managers revealed that, no orientation of States has been done (or very limited at best) on MCTFC programme. On a regular basis, no coordination is in place between MCTFC programme and States.
- The performance reports are generated by the MCTFC system on parameters identified by various division of MOHFW, based on the calls made by it. But the system and practice of sharing of these reports with States is almost non-functional. MCTFC reports were sent to States last in Dec 2019. Recently in August 2022, some States have received reports. State felt that this seriously affects the usefulness and impact of the MCTF programme.
- States felt that the calls being made to States have no definite pattern, and total number of calls made to a State, District or block is too small, to make any real impact. States also felt

there is a duplication of efforts, as many States have their own call centers.

- Sample size of the calls is small and is not enough to make the findings generalizable.
- The compiled report shared by MCTFC does not give details about responses of the beneficiaries or ASHA / ANM, in a line-listed manner. They report overall numbers for the State. This makes it difficult to draw action points, and limits the follow-up action.
- There is no definite system for verification and updation of the phone numbers registered in the MCTS system/RCH portal. A large number of phone numbers are found to be incorrect, and in many cases either ASHA's or ANM's number is registered in the name of beneficiary. This severely limits the effectiveness of MCTFC programme. MCTFC system itself has no protocol for verification of these nos. registered under RCH portal.
- The MCTFC has not been able to realize its full potential, in terms of total number of calls, as outlined in its contract with MOHFW.
- The present MCTFC contract specifies the expected level of outgoing calls to be made as 30 calls per day by each help desk agent', therefore, total calls expected to be made by the MCTFC call centre will be 897840 (@ 30 calls per day by 86 calling agents for 348 days). Against this expected level, actual calls made per year is 389674 which comes to 43% achievement on this critical benchmark (with total calls made in the 5 years period being 1948371, which comes to 389674 calls per year).
- Based on an assessment of recorded calls, major gaps have been observed, in more than 30% of the calls, in terms of overall quality of the dialogue, the attitude of the callers, and their language proficiency. This flags the issue of quality of the human resource among the calling agents.
- As per the discussions with the MCTFC team, the process of recruitment for the Calling Agents is very ad-hoc, and the recruitment is undertaken on 'as and when required' basis, through personal references of the company. It does not involve any open recruitment process and has no external recruitment agency involved.
- The remuneration structure in implementation for the calling agents, was not shared by the agency. But as per reports from previous discussions with the MCTFC team, the monthly remuneration paid to calling agents is about Rs. 10000 to 11000 per month, which is a major departure from the remuneration approved in the contract, which is @ Rs. 27144 per month.
- The centre makes calls to a wide variety of States in terms of their culture and language. Calls are made presently in seven languages (Hindi, English, Assamese, Oriya, Telugu, Bengali and Gujarati). Despite this, the IDIs in States underscored the language barriers as a major challenge for effectiveness of the calls.
- The MCTFC has not been able to deliver effectively on some of the objectives outlined in the programme contract. The system of incoming calls, through the national helpline, as planned has not taken off, except, that at the end of the MCTFC calls, the callers tell the respondents about this helpline on which they can call for any health-related information. But this system has not been advertised in any other way, so it has not become operational

in a substantial way.

- State felt that the MCTFC system has not built any mechanism to include local State priorities and issues in the content of MCTFC calls, though this is a felt need, and many States have started their own call centres similar to MCTFC with focus on content and information as per local context and also use this for running their periodic special campaigns.
- All States felt that MCTFC programme and its calls have no integration with Kilkari and Mobile Academy, despite the fact that, calls are made to beneficiaries under all three programmes, and these programmes can complement each other in many ways.
- In a number of States, calls need to be made in more than one distinctly different languages (like, in different regions within Chhattisgarh, Halbi, Gondi, Chattisgarhiya, and different dialects of Oriya spoken in Tribal areas of Odisha). Such local language-enabled calls can be made only if sub-units of the MCTFC call centre are operated from different State headquarters.

  A brief note on MCTFC Contract and its operations is enclosed below as Annexure 7

4.3 CONCLUSION

The MCTFC program has built a robust model of reaching out to beneficiaries and health workers throughout the length and breadth of our vast country. The technical infrastructure and protocols developed by it, for making such huge number of calls, on a diverse range of topics, has great potential for expanding programs and activities of the health sector.

The two pictures of the programme that emerge from this evaluation, have a divergence from each other. The field study, through 289 semi-structured interviews conducted with receivers of MCTFC calls, reports an overwhelming level of satisfaction on the calls made to them, with respect to the key protocols followed during the call, and the quality of call, in terms of language, clarity, tone and pace, and explanations. On the other hand, the assessment of recordings of calls, reveals substantial gaps, in terms of quality of calls, and the quality of human resource among the calling agents (with major gaps of competence, attitude, and dialogue revealed in case of more than 30% calls).

During the field level supervision of the conduct of interviews with the receivers of calls, it was observed that, the receivers of calls in the community, were expressing strongly, their happiness and satisfaction that Government of India reached out to them through these calls and felt valued and cared for. Their understanding of the purpose of the calls, was very limited, despite the explanation in this regard given by the field researcher conducting the interview, which consequently led to their low expectations from the calls. This explains their overwhelmingly positive responses on questions related to the quality of calls. Similarly, ASHAs, and ANMs, both being part of the health system's community level team, were expressing overall satisfaction on the protocols and quality of calls. It is also noteworthy, that these interviews were asking question, which were to be replied based on their recall of the conversation during the call (made within last six months).

The recorded call on the other hand gave an opportunity to assess the actual conversation during the call. Therefore, there can be no recall bias, in case of assessment of recorded calls.

The other key challenges lie in still limited reach of the programme, and highly dispersed coverage of calls, which leads to their limited impact. Other major weak link of the programme is the limited sharing of the performance reports of the programme with States, which limits the follow-up action and course corrections based on the feedback coming from the programme.

Improvements in the quality of calls are also required, which are linked to the quality of the human resource among the calling agents. Overall, substantive restructuring of the programme, to improve its governance and management and expanding its reach and scope is the need of the hour.

CHAPTER 5
RECOMMENDATIONS

1. MCTFC calls should be short, to enable retention of messages. Calls should be made only in the local language.
2. The call should be displayed on the phone of receiver, with an identifier, as a government programme related call, to ensure that call is not missed.
3. MCTFC, Mobile Academy and Kilkari programmes, all use the same database of those registered under RCH portal, they should be integrated to complement each other.
4. There should be mechanisms to update and add questions on healthcare issues or programmes important for local context, in the MCTFC calls. States should also have the flexibility to add questions related to periodic local campaigns if required. States should be involved in designing the topics and contents of the calls.
5. States should be given options to generate reports from the MCTF portal, at any time / monthly. The reports should also be shared with States regularly - on annual, half-yearly and quarterly basis along with periodic programme review.
6. Total number and coverage of calls should be increased substantially. Calls should be made with samples taken from every block and district of the State, and reports be generated block/district-wise.
7. The MCTFC can undertake special campaigns for marginalized communities like, tribal populations, and feedback on their health issues can be shared for action.
8. MCTFC should explore the possibility to establish and run its sub-units / call-centres from State level. From these units, calls should be made in State's language, and also in different languages and dialects of State.
9. Systems for scrutiny of recorded calls needs to be strengthened, and course corrections be done based on the gaps identified.
10. Information on gaps/mismatches in phone numbers of beneficiaries and FLWs registered in MCTS/RCH portal, identified through MCTFC calls, should be provided in a line-listed basis for follow-up action.
11. MCTFC program should periodically organize orientations and reviews with States and strengthen coordination and communication with them.

12. Overall programme governance and management of the MCTFC programme should be restructured with improved recruitment and Human Resource Management Systems, to ensure improved quality of calls, and increased effectiveness of the programme.

13. The systems for periodic review of the MCTFC programme should be strengthened. The MCTFC, which operates presently as stand-alone operation, should be integrated with other similar programmes, and the thematic programme divisions.

Annexure 1

Format for Assessment of MCTFC CALLS - ASHA

1. Name of ASHA_____
2. Age _____
3. State: _____
4. District: _____
5. Date: (DD/MM/YYYY) ____ / ____ / _____
6. Name of the evaluator_____

Sl. No.	Question	Response
	Did you receive a call from Health Department of Government of India within last six months (or more than one calls) (explain the nature and purpose of such calls and help the respondent in her recall of the call received by her)	
	When did you receive the call (Explain and help the respondent recall month of the call - do not ask the date. Local calendar can be used by investigators as supporting aid) Who called you (Callers introduce themselves as calling from health department, Govt of India)	
	How long did the call last (Approximate duration of call- minutes/hours - If required, help by giving options - about 10 mins/ about 20 mins/about 30 mins/more than 30 mins/around 1 hour/more than 1 hour)	
	Did the caller clarify the name of the person he/she wanted to speak to Did the caller confirm it clearly and patiently	
	Was the timing of the call appropriate for you (Early morning/evening – were you busy in work/ involved in some activity)	
	Did you answer the call in first attempt, or the caller had to make repeat call Why were you not able to take the call in first / earlier attempts (if repeat call had to be made)	
	a. Did the caller explain the questions (which you could reply), & b. Explained the information clearly and patiently each time, so you could understand it (Probe: yes, all/no, only some/none)	

	Did the caller repeat / paraphrase the question or information when you found it difficult to understand	
	Did the caller give you sufficient time to understand after each question or information	
	Did the caller confirm/ paraphrase your answer	
	During the call, how did you find the following – Language (was it easy and appropriate) Tone (was it easy to understand and comforting) Pace (was it appropriate and easy for you to understand)	
	What were the main topics of the questions/ information (Probe: ANC/ PNC/ immunization/ family planning etc.)	
	Do you remember – 2-4 main questions that were asked 2-4 key information that was provided (Probes to be used - based on detailed schedule that callers use)	
	Any problems that you faced in the process of these calls	
	Any other feedback/suggestions you want to give (only with respect to the MCTFC calls)	

Annexure 2

Format for Assessment of MCTFC Calls - ANM

1. Name of ANM _____
2. Age _____
3. State: _____
4. District: _____
5. Date: (DD/MM/YYYY) ____ / ____ / _____

Sl. No.	Question	Response
	Did you receive a call from Health Department of Government of India within last six months (or more than one calls) (Explain the nature and purpose of such calls and help the respondent in her recall of the call received by her)	
	When did you receive the call (Explain and help the respondent recall the Month of the call – do not ask the date. Local calendar can be used by investigators as supporting aid) Who called you (Callers introduce themselves as calling from health department, Govt of India)	
	How long did the call last (Approximate duration of call- minutes/hours - If required, help by giving options - about 10 mins/ about 20 mins/about 30 mins/more than 30 mins/around 1 hour/more than 1 hour)	
	Did the caller clarify the name of the person he/she wanted to speak to? Did the caller confirm it clearly and patiently	
	Was the timing of the call appropriate for you? (Early morning/evening – were you busy in work/ involved in some activity)	
	Did you answer the call in first attempt, or the caller had to make repeat call Why were you not able to take the call in first / earlier attempts (if repeat call had to be made)	
	To what extent did the information provided through calls help you in your work	

	a. Did the caller explain the questions (which you could reply), & b. Explained each question clearly and patiently, so you could understand it (Probe: yes, all/no, only some/none)	
	Did the caller repeat / paraphrase the question or information when you found it difficult to understand?	
	Did the caller give you sufficient time to understand after each - Question Information	
	Did the caller confirm/ paraphrase your answer	
	During the call, how did you find the following – Language (was it easy and appropriate) Tone (was it easy to understand and comforting) Pace (was it appropriate and easy for you to understand)	
	What were the main topics of the questions / information? (Probe: ANC/ PNC/ immunization/ family planning etc)	
	Do you remember – 2-4 main questions that were asked 2-4 key information that was provided (Probes to be used - based on detailed schedule that callers use)	
	What do you perceive as your capacity building requirements	
	Any problems that you faced in the process of these calls	
	Any other feedback/suggestions you want to give (only with respect to the MCTFC calls)	

Annexure 3

Format for Assessment of MCTFC CALLS - Beneficiary (Pregnant Woman)

1. Beneficiary name_____
2. Age _____
3. State: _____
4. District: _____
5. Date: (DD/MM/YYYY) ____ / ____ / _____

Sl. No.	Question	Response
	Did you receive a call from Health Department of Government of India within last six months (or more than one calls) (Explain the nature and purpose of such calls and help the respondent in her recall of the call received by her)	
	When did you receive the call Explain and help the respondent recall month of the call - do not ask the date. Local calendar can be used by investigators as supporting aid) Who called you (Callers introduce themselves as calling from health department, Govt of India)	
	How long did the call last (Approximate duration of call- minutes/hours - If required, help by giving options - about 10 mins/ about 20 mins/about 30 mins/more than 30 mins/around 1 hour/more than 1 hour)	
	Did the caller clarify the name of the person he/she wanted to speak to Did the caller confirm it clearly and patiently	
	Was the timing of the call appropriate for you (Early morning/evening – were you busy in work/ involved in some activity)	
	Did you answer the call in first attempt, or the caller had to make repeat call Why were you not able to take the call in first / earlier attempts (if repeat call had to be made)	
	a. Did the caller explain the questions (which you could reply), & b. Explained the information clearly and patiently each time, so you could understand it (Probe: yes, all/no, only some/none)	
	Did the caller repeat / paraphrase the question or information when you found it difficult to understand	

	Did the caller give you sufficient time to understand after each question or information	
	Did the caller confirm/ paraphrase your answer	
	During the call, how did you find the following – Language (was it easy and appropriate) Tone (was it easy to understand and comforting) Pace (was it appropriate and easy for you to understand)	
	What were the main topics of the questions/ information (Probe: ANC/ PNC/ immunization/ family planning etc.)	
	Do you remember – 2-4 main questions that were asked 2-4 key information that was provided (Probes to be used - based on detailed schedule that callers use)	
	Any problems that you faced in the process of these calls	
	Any other feedback/suggestions you want to give (Only with respect to the MCTFC calls)	

Annexure 4

Format for Assessment of MCTFC CALLS - Parents of Children up to 9 months

1. Beneficiary name_____
2. Age and gender _____
3. State: _____
4. District: _____
5. Date: (DD/MM/YYYY) ____ / ____ / _____

Sl. No.	Question	Response
	Did you receive a call from Health Department of Government of India within last six months (or more than one calls) (explain the nature and purpose of such calls and help the respondent in her recall of the call received by her)	
	When did you receive the call (Explain and help the respondent recall month of the call - do not ask the date. Local calendar can be used by investigators as supporting aid) Who called you (Callers introduce themselves as calling from health department, Govt of India)	
	How long did the call last (Approximate duration of call- minutes/hours - If required, help by giving options - about 10 mins/ about 20 mins/about 30 mins/more than 30 mins/around 1 hour/more than 1 hour)	
	Did the caller clarify the name of the person he/she wanted to speak to Did the caller confirm it clearly and patiently	
	Was the timing of the call appropriate for you (Early morning/evening – were you busy in work/ involved in some activity)	
	Did you answer the call in first attempt, or the caller had to make repeat call Why were you not able to take the call in first / earlier attempts (if repeat call had to be made)	
	a. Did the caller explain the questions (which you could reply), & b. Explained the information clearly and patiently each time, so you could understand it (Probe: yes, all/no, only some/none)	
	Did the caller repeat / paraphrase the question or information when you found it difficult to understand	

	Did the caller give you sufficient time to understand after each question or information	
	Did the caller confirm/ paraphrase your answer	
	During the call, how did you find the following – Language (was it easy and appropriate) Tone (was it easy to understand and comforting) Pace (was it appropriate and easy for you to understand)	
	What were the main topics of the questions/ information (Probe: ANC/ PNC/ immunization/ family planning etc)	
	Do you remember – 2-4 main questions that were asked 2-4 key information that was provided (Probes to be used - based on schedule that callers use)	
	Any problems that you faced in the process of these calls	
	Any other feedback/suggestions you want to give (only with respect to the MCTFC calls)	

Annexure 5

Interview Guide for In-depth Interviews (IDI) of State and District Level MCTFC Nodal Officers

In-depth Interview Number	State -_____/District -_____No. -____
Name of participant	
Email id of participant	
Contact Number of participant	
Date of IDI	_____/_____/2022
Start Time: ____ / ____ AM / PM	End Time: ____ / ____ AM / PM
Name & details of Interviewer	
Notes (any additional remarks/observations, if any)	
(Expected time duration for IDI – 45 to 60 minutes)	

Schedule for In Depth Interviews (IDIs) with programme managers

1	Please describe briefly the MCTFC programme in your State.	
1.1	Activities of the programme at different levels.	
1.2	Role, you play as State / District programme manager.	
1.3	Who are involved at different levels & roles they play.	
1.4	Outputs and outcomes of the programme and benefits to the community / families.	
1.5	How does the programme help the health workers / health system – in short term and long term..	
1.6	Monitoring and reporting systems in place – from the field level to District / State and upwards.	
1.7	What are the linkages of the programme with other programmes.	
1.8	Challenges being faced and suggestions for corrective action / long term changes.	
	What is your overall opinion about the programme.	
2	Your views about the activities / success and challenges of the MCTFC programme with respect to its following stated objectives[15]	
2.1	To provide a supporting framework to MCTS/RCH portal and help in validating the data entered in MCTS/RCH portal by making phone calls to pregnant women and parents of children and health workers;	
2.2	To be a powerful tool in providing relevant information and guidance directly to the pregnant women, parents of children and to community health workers, thus creating awareness among them about health services and promoting right health practices and behavior;	

[15] These objectives are as stated in the MCTFC programme documents

2.3	To contact the service providers and recipients of mother and child care services to get their feedback on various mother and child care services, programmes and initiatives like JSSK, JSY, RBSK, National Iron plus Initiative (NIPI), contraceptive distribution by ASHAs etc. (This feedback would help the Government of India / State Governments to easily and quickly evaluate the programme interventions, and plan appropriate corrective measures to improve the health service delivery).	
2.4	To check with ASHAs and ANMs the availability of essential drugs and supplies like ORS packets and contraceptives;	
2.5	To promote government schemes and programmes;	
2.6	To assess the health care services being delivered and training needs of health worker.	
3	Are there mechanisms in place through which you get any reports / feedback or suggestions from the MCTFC programme.	
4	What are your suggestions to improve operational efficiency and effectiveness of MCTFC programme.	
5	Your inputs and views on following specific areas.	
5.1	What percentage of pregnant women in your State / District are registered under MCTFC system. Has the MCTFC calling programme helped in increasing the percentage of registration.	
5.2	How has MCTFC helped in improving the awareness of mothers on services provided at the health facilities, and their uptake of services.	
5.3	Your views on the information being provided to the ASHAs, and ANM through MCTFC call.	

Annexure 6

A Note on some key issues of MCTFC Contract and its operation.

A review of the contract between MOHFW and ILFS / Terracis (called HSP subsequently in this document), was done to understand the operational terms of conditions of the centre, and the benchmarks and monitoring systems in place. Discussions were also done with the MCTFC Team to understand these issues and take relevant information. The MCTFC is mandated as a call centre with 86 help desks, and is provisioned to work for 7 days a week, for about 345 days every year. Some of the key provisions as per the contract, and relevant issues which need to be placed on record are being listed here.

- The total value of the 5 year's contract is Rs. 38.48 Crores. Total Infrastructure cost is Rs. 6.78 Crores, Operational Expenses – Rs. 30.93 Cr. and Other Expenses – Rs. 76.80 Lakh.
- The total operation cost for year 1 was 4.85 Cr. A provision for 5% increment per year was made for manpower and annual maintenance costs.
- As per the details of the operational costs (given in Form C 1., page 68 - enclosed below as Annexure 1), hourly unit rate for honorarium of help desk agents is Rs. 117 per hour. With mandated 8 Hours per day (six days a week), total 2784 working hours are provisioned (for 348 days in a year). Therefore, the total budgeted annual cost per help desk agent comes to Rs. 3.26 lakh per year (Rs. 27144 per month).
- During the discussions with MCTFC team, the process of recruitment and the quality of human resources of the calling agents were discussed. They have shared that, the recruitment of agents is done on 'as and when required basis', through personal references of the company. The recruitment is not undertaken in any institutionalized manner, no open advertisement is given out, and no open recruitment is done. No external recruitment agency is used either. The minimum eligibility is BA pass, with one year of experience in call centre industry. The discussions revealed that, the turn-over rate of calling agents, is only about 6% per annum.
- The MCTFC team did not share the salary scale or net salary/honorarium being paid to calling agents, despite repeated requests for this information. They said that, as per their corporate policy, they cannot share details of salaries. But they pay honorarium to agents, as per the government rules.
- The MOU document, in its page number 115, clause 12.7.4 (under Annexure 8: Existing MCTFC operations) under the heading - SLA requirement for existing MCTFC Operation, mentions, that "Minimum 6 hours of actual calling and 30 calls per day will be done by each help desk agent."
- As per the performance reports, total number of calls made by the MCTFC from 10 March, 2017 to 9 March 2022, were: Pregnant Women - 916774, Parents of Children - 968314, ASHAs - 56508, ANMs - 6775. Therefore, the total calls made in the 5 years period were – 1948371, which comes to 389674 calls made per year.
- For the expected level of '30 calls per day. by each help desk agent', total calls expected to

be made by the MCTFC call centre will be 897840 (@ 30 calls per day by 86 calling agents). Against this expected level, actual calls made per year, is 389674, which comes to 43% achievement on this benchmark.

- The SLA Monitoring framework as given in the contract on page 53, Clause 10.2, does not make it clear, if the existing conditionality of 'Minimum 6 hours of actual calling and 30 calls per day will be done by each help desk agent' will be applicable or not.
- The MCTFC team, shared that the key benchmark for SLA / performance of the MCTFC is total calling time of 516 hours per day for the entire call centre (86 help desk agents). They said that there is no benchmark related to number of calls made by each agent.
- The MCTFC team shared that, they do not send any reports to MMP Cell. All reports are generated by MMP Cell, at any point they want. It's only the MMP Cell, that shares the reports and coordinates with States. MCTFC Cell has no mandate or role to speak to and coordinate with States. The MMP Cell holds monthly review meeting, for MCTFC programme at their office, which is attended by Programme Manager of MCTFC.
- A brief note on the discussions held with MCTFC team, including brief discussion with their Quality Analyst and Medical Officer is enclosed as Annexure 2.

Annexure 6.1

S. No.	Description	Total Amount (INR)
Capital Expenditure		
1	Total Infrastructure cost: IT and non-IT (F_1)	6,78,00,120.00
Operational Expenditure		
2	Operational expenses (F_2)	30,92,69,716.00
3	Other expenses (F_3)	76,80,140.00
Total Cost (F_T) = F_1+ F_2 + F_3		**38,47,49,976.00**

Annexure 6.2

III. Form C: Table for calculating per hour calling rate

S. No.	Description	Manpower Cost per year (O)	Maintenance and Recurring Cost per year (P)	Total Amount with Taxes and duties (A=O+P)	Per hour calling rate {=A/(86*6*348)}
1.	Year 1	4,84,76,865	74,93,160	5,59,70,025	311.69
2.	Year 2	5,09,00,708	78,67,818	5,87,68,526	327.28
3.	Year 3	5,34,45,743	82,61,209	6,17,06,952	343.64
4.	Year 4	5,61,18,030	86,74,269	6,47,92,299	360.82
5.	Year 5	5,89,23,932	91,07,982	6,80,31,914	378.86
Total Operational Expense				**30,92,69,716**	

Annexure 6.3

IV. Form C.1: Table for cost of operational manpower (O)

S. No.	Description	Man Hour Rate (X)	Total Hours in an Year (Y)	Total (in INR) (D=X*Y)	Taxes and Other Duties (T)	Total Amount with Taxes and duties (O=D+T)
1	Project Manager	658.9688411	1 X 2384	15,70,982	2,27,792	17,98,774
2	Receptionist	164.7422103	1 X 2384	3,92,745	56,948	4,49,694
3	Supervisor	164.7422103	2 X 2784	9,17,285	1,33,006	10,50,291
4	IT Support	395.3813046	1 X 2784	11,00,742	1,59,608	12,60,349
5	IT Developer & DBA	461.2781888	1 X 2384	10,99,687	1,59,455	12,59,142
6	Medical specialist	988.4532616	2 X 2784	55,03,708	7,98,038	63,01,745
7	Quality Analyst	395.3813046	2 X 2784	22,01,483	3,19,215	25,20,698
8	Helpdesk Agents	117.2964537	86 X 2784	2,80,83,586	40,72,120	3,21,55,706
9	Admin	263.5875364	2 X 2784	14,67,655	2,12,810	16,80,465
Total cost of Operational Manpower per annum (O_1)						**4,84,76,865**

Annexure 6.4

A brief note on the discussions held with MCTFC team

Discussion 1 - Respondents – Project Manager (Mr Sharad Sachdeva), and Quality Analyst (Ms. Ruby Farooqui). Date - 06/10/2022.

Q- Operational brief given by MOHFW to the agency, on - functions, activities, protocol to be followed on number and coverage of calls across States/Districts.

› Copy of the operational Instructions
› Response-

- The centre started with the 19 States and currently making calls in 22 States. There is no set target on number of calls to be done each day to the States in the RFP but based on talk-time a total of 516 hours by all the agents are spent over the calls (each caller 6 hours). The call centre is functional for all 7 days in a week, except for the 17-18 national holidays. The timing of the call centre is morning 9 AM to 6 PM. Later on, UT of Ladakh and State of Telangana were added. Nagaland was added in 2018 and recently Maharashtra has been added.

- The calling is done based on the modules prepared separately for ASHA, ANM, Parent of child (Date of birth of child to 45days and 6-9months) and pregnant women (2nd and 4th ANC visit).

- ASHAs and ANMs, after they have been called, are taken out of the calling pool. They are included in the calling pool, only after 3 months. For all the unanswered calls, a maximum of 10 attempts are made at the interval of 4hr. For rescheduled call, the convenient time from the beneficiary is noted and reattempt is made accordingly. If rescheduled call is left unanswered, 10 attempts are made to the specific number. The reason for unanswered calls as stated by the team can be the network issues.

- As per the information received from the team, the validation of phone number is not a responsibility of MCTFC. However, before every call, IVR system calls the phone number selected through a random computerized system, and makes a verification of the intended person.
- Calling procedure: Calling is done in two steps -
- First: IVRS call: For the verification of the name of the beneficiary. The IVRS call is made in Hindi and English only.
- Once verified on first call,
- Second call: Live call is attempted. The outbound call in Hindi, English and regional languages is made to only those numbers which are verified by IVR system.
- Other activities conducted by the MCTFC Centre:

    1. Inbound calling facility for queries related to health. The inbound call are short and are lesser in number therefore, a limited number of calling agents (1/2) are deputed for this.
    2. Campaigns such as OOPE (Out of Pocket Expenditure campaign for all the States on child delivery expenditure in last one year. This is conducted every year by MCTFC) and COVIN. In the campaigns they also took support from the NHSRC in recruiting the short-term HR for the same.

- If the call made to Pregnant women or parents were answered by the ASHA or ANM then the calling agent notes down the basic demographic details and ends the call. Such a call is also considered and recorded in the system as a complete call (therefore the system gives no information on the number of calls where the mobile number of ASHAs / ANMs are registered as mobile number of PW / Parent of child).

Q- Review and monitoring system between ministry / MMP Cell and agency on defined functions and protocols, and reports that MCTFC has to submit / generate.

› Annual / Biannual / Quarterly Review system, reports. Review and monitoring visits.

› Issues of improvement identified in last 5 year's contract period. Actions taken.

› Response-

› MCTFC reports to the MMP cell.

› At MCTFC-

- Daily review of 60 calls by two Quality Analysists by using quality analysis form and the feedback is shared to individual agent one to one. As per the RFP their mandate is to maintain the daily talk-time and to achieve the overall 90% score as per the quality parameter form.
- Quality parameters- Call quality, call opening, information delivery, soft skills (RFP has a designed format for assessing the quality and that is being filled).
- As and when required, the live calls are being observed by the quality analysts.

› At MMP cell-

- There is a reporting portal that generates reports. The user id and password for all the States was provided to the MMP cell in the year 2018 and was updated 6 months back. In case of any issues the MCTFC team visits the MMP cell and resolves the issues.
- There is no specific process monitoring format. (Annual revision in the questionnaire was proposed however, due to covid, no annual review has taken place in recent years).
- The modules were prepared in the beginning of the project and minor changes have been made since then. It was decided in the FIC Committee meeting that the modules will be updated every year. However, it is not being done because of the COVID.
- The team of MCTFC is not aware of any evaluation or assessment of the project being done at the level of MMP Cell / ministry, as no reports have been shared by the MMP cell with the MCTFC. However, monthly review meetings are conducted in the MMP cell, which is attended by Project Manager of the MCTFC.

Human Resource

Name	Required	In position (additional buffer staff)
Project Manager	1	1
Supervisors	2	3
Quality Analysists	2	3
IT Support	1	2
Receptionist	1	1
Admin	2	3
Doctors (MBBS)	2	3
Agents	86	100+

Q- Process of dissemination of reports generated by MCTFC to States.

› Number of reports generated and sent to States. Records kept at the centre of the reports sent.

› Response- The MCTFC do not share any report with the States as it is not under their responsibility. As per the Project manager, they have shared the State specific login with the MMP cell twice.

Q- Process for recruitment and training of Calling Agents. Process for refresher training or course correction, based on supervisory and monitoring feedback.

› Records on protocols for recruitment .

› Records kept on trainings conducted.

› Records on actions identified for course correction, and action taken.

› Response-

› Recruitment process of the callers:

  • Recruitments are done on the basis of references from the HR team. There is no institutionalized system of recruitment, through an agency or through direct recruitment. Recruitments are done, as required, on as and when basis. Turn-over rate among the calling agents is only about 6%. Many agents are there from 3-4 years.

› Qualification criteria: Graduation is mandatory with minimum of 1yr of experience in a call centre.

› Age: Upper limit: 40 yrs.

› Duty hours: 9 hrs (9-6 pm) Overall break 1 hr. 6 days a week.

› Training program: 5-day training program including 2 days training with the team of doctors for medical terminology training and 3 days on MCTFC system and quality training etc.

› Salary: As per the government norms, annual increments based on performance. The salary scales or average salary was not shared by the MCTFC team, despite repeated requests. They said its part of their internal corporate policy.

Any feedback

Overall opinion:

- Modules are long, so call duration is long. The ANM modules take almost 45 minutes.
- Modules have up to 100+ questions, no of questions should be reduced.
- POP ups during the questions must be minimized. POP Ups are also repeated, which callers have to repeat too, as per the protocol given to them.
- Calls with shorter duration, which are incomplete, are also considered as completed call. The system has no mechanism to filter them separately.

Discussion 2 - Dr. Ala Mubin (MBBS). Date - 06/10/2022.

Brief background:

Name: Dr. Ala Mubin (MBBS)

› Involved with MCTFC since 3 years

› Duty hours: 9hrs

Most common (inbound) queries received:

Family Planning- Measures for family planning, better options for family planning, FP measures with least side effects.

Vaccination- Vaccination schedule, missed vaccination doses etc.

Pregnancy- Symptoms of pregnancy, dos and don’ts in pregnancy etc.

The percentage of inbound calls is around 25-30% of the total calls.

Challenges: It is difficult to give definite diagnosis without clinical examination, sometimes the symptoms are vague, the questions posed are by some of the family member of the patient therefore it is difficult to comprehend the actual problem.

Overall opinion: Good experience working with the MCTFC.

Discussion 3 [Ms. Ruby, Quality Analyst]

Quality related Challenges: Most common are the soft skill issues, resolved by refresher trainings.

- Quality of calls attempted depend on the educational qualification, in this case though graduation is a basic minimum criterion however, many of the callers are non-medicos.
- For, ASHA/ANM calls a basic minimum knowledge of medical terminologies is required, therefore people with minimum of 6 months of experience with MCTFC, usually make calls to ASHA/ANM.
- New joinees are usually given the responsibility to make calls to the pregnant and lactating mothers.

Challenges: The pop-ups for 4-5 questions are similar, as per instructions, each pop-up is to be read, therefore there is a repetition of the information that is being delivered.

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