THE CHALLENGE INITIATIVE

The Challenge Initiative's Approach to City Engagement

Coaching Case Study

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The Challenge Initiative (TCI) is funded by the Bill & Melinda Gates Foundation, Bayer AG and Comic Relief to scale family planning (FP) and adolescent and youth sexual and reproductive health (AYSRH) programming.

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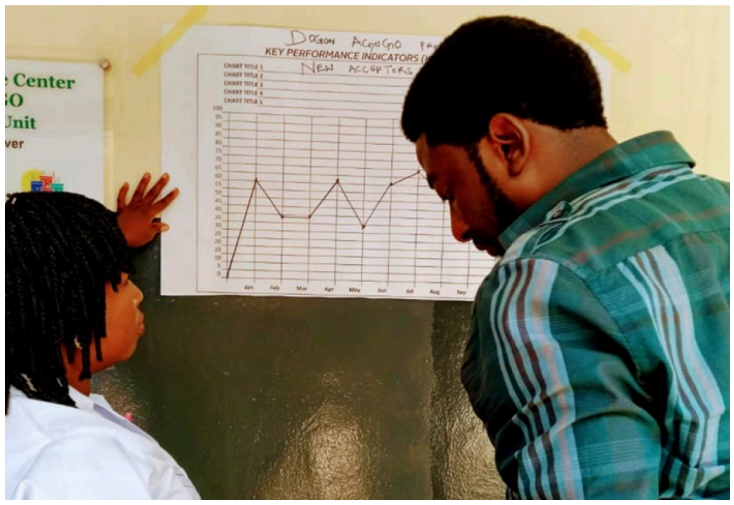
ACRONYMS

ASHA	Accredited social health activists
AY	Adolescent and youth
AYSRH	Adolescent and youth sexual and reproductive health
BSPH	Johns Hopkins Bloomberg School of Public Health
CCC	City Coordination Committees
CCP	Johns Hopkins Center for Communication Programs
CMU	Coordination and Management Units
CoP	Community of practice
D4D	Data-for-decision-making
FDS	Fixed-day services
FGD	Focus group discussion
FP	Family planning
FPLMIS	FP logistics management information system
FWA	Francophone West Africa
HIP	High-impact practice
HMIS	Health management information system
IDI	In-depth interview
IEC	Information, education and communication
IPC	Interpersonal communication
IUCD	Intrauterine contraceptive device
KII	Key informant interview
LAO	Lead, Assist and Observe
LGA	Local government area
MOIC	Medical officers in charge
MOU	Memorandum of understanding
NHM	National Health Mission
PMIS	Project management information system
PSI	Population Services International
SOP	Standard operating procedures
TCI	The Challenge Initiative
TCI-U	TCI University
UPHC	Urban primary health centers

BACKGROUND



In global health and development, traditional engagement with local governments has focused on "leading by doing." As a result, aid organizations have directly implemented supportive activities on behalf of the government, which could hinder the government's ability to deliver and sustain quality health programs and outcomes. To address this challenge, recent efforts have focused more on working together with the governments to design and manage local initiatives. Transferring capacity to enable the government to implement these initiatives takes many different forms, including mentorship, coaching, training and supportive supervision. While coaching is more often used in the business sector through executive coaching models, the principles can be extended beyond the business sector and have become more widely accepted in the health sector.[1]

Effective coaching strengthens coachees' skills and ability to complete their jobs in the face of challenges and increases their overall leadership capabilities. Previous research has identified numerous benefits, such as improving performance, motivation and sustainability. However, a gap still exists in assessing the adaptation of coaching to meet the stakeholders' specific at various levels of the health system and the effects of coaching on motivation and quality of care.[2] With coaching as its cornerstone, The Challenge Initiative (TCI) set out to understand the coaching process to better systematize it.

TCI's coaching approach aims to build the confidence and capacity of local institutions operating primarily in the public sector and their staff to adapt, manage and implement a more coordinated, results-driven, well-resourced and sustainable family planning (FP) and adolescent and youth sexual and reproductive health (AYSRH) program based on evidence-based interventions. In addition, TCI's coaching approach strengthens skills in leadership, program management, coordination, planning, budgeting and data use that can inform decisions to ensure the sustainability of implementation beyond TCI's support.

Objectives and research questions

TCI conducted this study to identify the coaching practices, processes and tools that had or had not been effective in transferring capacity and to make recommendations on how coaching might be adapted and sustained.

The specific themes and research questions of the coaching study are as follows.

[1] Baron, L., & Morin, L. (2009). The coach-coachee relationship in executive coaching: A field study. *Human Resource Development Quarterly*, 20(1), 85–106. https://doi.org/10.1002/hrdq.20009

[2] Manzi, A., Sherr, K., Chirwa, C., Baynes, C., & Awoonor-Williams, J. K. (2017). Mentorship and coaching to support strengthening healthcare systems: Lessons learned across the five population health implementation and training partnership projects in sub -Saharan Africa. *BMC Health Services Research*, 17(S3). https://doi.org/10.1186/s12913-017-2656-7

1. **Outcome:** How has TCI coaching worked to date, including which high-impact practices (HIPs) and other interventions have local government staff most commonly requested coaching for, how often, and what is the measurable impact of those interventions?
2. **Usefulness:** How has TCI's coaching approach been perceived by local governments and service providers, including whether they believe it has been beneficial, and if so, how?
3. **System change:** How has TCI's coaching led to system strengthening and improvements in the health care system and beyond?
4. **Recommendations:** What challenges have existed, and what recommendations can be made to strengthen TCI's coaching approach?
5. **Sustainability:** How will TCI-supported geographies sustain TCI's coaching approach once geographies graduate from direct TCI support?

TCI's coaching approach

TCI defines coaching as a structured yet flexible process to empower coachees to make positive changes in their motivation, knowledge, skills, and ability. Coaching may require various skills and actions, for example, addressing needs, solving problems, taking on new challenges, improving individual performance, achieving individual, team, and organizational objectives, and coaching others in their respective regions.

A coach may be a TCI staff member, a trained government staff member (e.g., program manager or health provider) or a lecturer or teacher at a health institution. The relationship between coaches and coachees is critical but not closely examined for its effectiveness in achieving outcomes.[3] Therefore, through this research, the study team aimed to reveal clear linkages between results and TCI's coaching approach.

Many health and development projects invest heavily in experienced staff from international non-governmental organizations that play a central implementation role or the "doing." But TCI recognizes that the development landscape requires new thinking and operating to support local governments and civil society organizations to become more efficient and effective. As a result, TCI created a unique, systemic and flexible approach to locally led, owned and implemented coaching. Since 2016, TCI's partners in Africa and Asia have strengthened the capacity of local governments at the system, organizational and individual levels by embedding coaching systems within local government structures.

In contrast to conventional or traditional development projects, TCI's coaching approach ensures local governments drive their programs as TCI strengthens their capacities by providing management and technical coaching. TCI works with cities to implement localized HIPs and other interventions and assists in cascading down the coaching strategy to more master coaches to ensure continued quality implementation and impact beyond the engagement with TCI.

Funded by the Bill & Melinda Gates Foundation, Bayer AG and Comic Relief, The Challenge Initiative (TCI) is a "business unusual" platform that supports local governments in rapidly and sustainably scaling high-impact family planning and adolescent and youth sexual and reproductive health (AYSRH) practices for the urban poor. TCI's demand-driven model lets local governments lead while committing their own financial and human resources.

In its first phase (2016-2021), TCI supported 94 local governments in East Africa, Francophone West Africa, India and Nigeria to adapt, implement and scale its interventions, drawing on coaching and support from TCI's four regional hub partners: Jhpiego, IntraHealth International, PSI India and Johns Hopkins Center for Communication Programs. TCI is led by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health.

[3] Baron & Morin, The coach-coachee relationship in executive coaching: A field study

TCI also assists local governments in instituting a well-organized and enabled coordination mechanism to oversee and manage the implementation and scale-up of HIPs and other interventions. These mechanisms include the City Coordination Committee (CCC) in India, the Program Management and Coordination Unit in Francophone West Africa, the Program Implementation Team (PIT) in East Africa, and the State Management Team and Technical Working Groups in Nigeria. In addition, TCI University (TCI-U), an online learning platform, allows unlimited access to city teams and ensures consistent guidance on implementing the HIPs and other interventions based on each city's available resources and priorities.

TCI's coaching approach moves through the following process: "Lead," then "Assist," and eventually "Observe" (LAO) as local governments start spearheading all aspects (both technical and management) of their FP and AYSRH programs with on-demand coaching support from TCI (Figure 1).

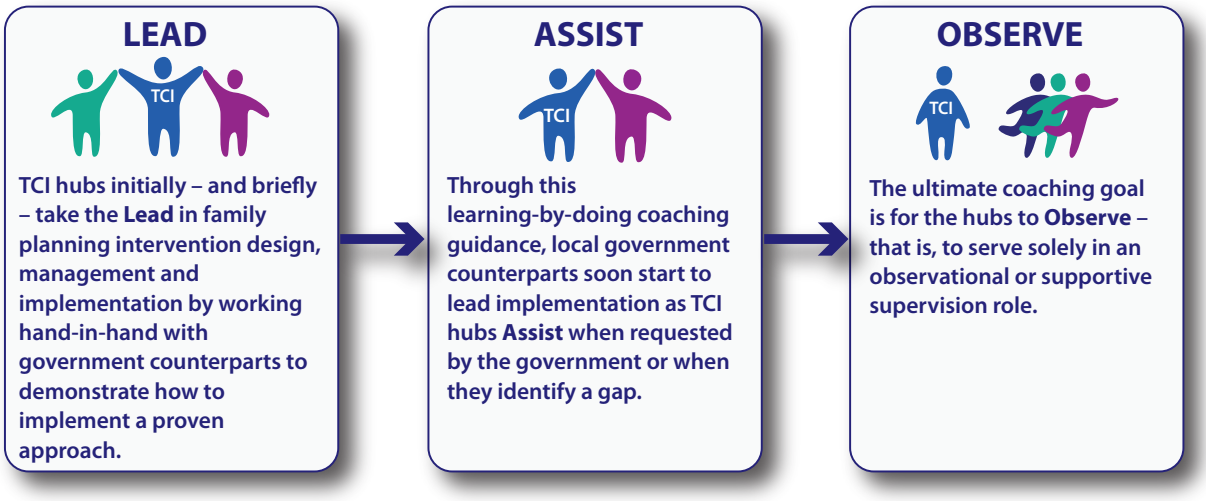


Figure 1: TCI's Lead, Assist, Observe coaching model.

To move cities along this continuum, TCI's engagement with the local government follows four defined phases: 1) start-up, 2) implementation and surge, 3) pre-graduation, 4) graduation/ post-graduation. The LAO falls within each stage at different points depending on the cities' needs and capacity to implement the HIPs and TCI interventions (Figure 2).

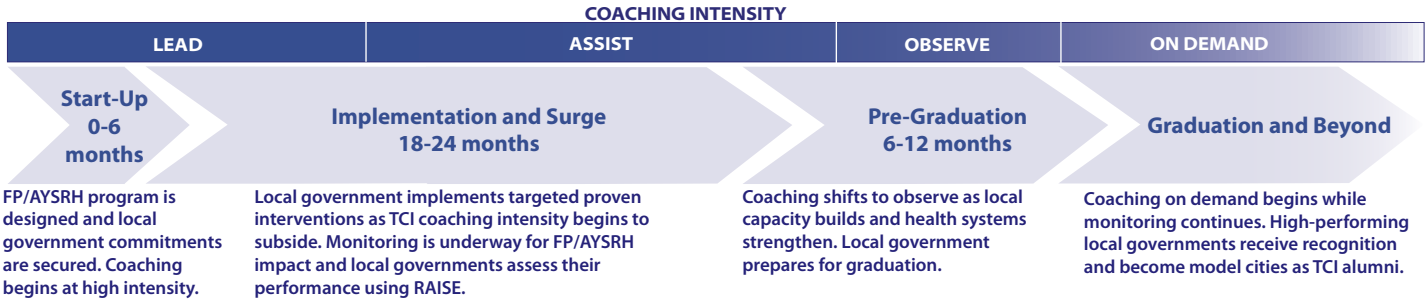


Figure 2: TCI's phases of engagement with local governments.

METHODS

Study context and design

This multi-country, cross-sectional qualitative case study was conducted as part of TCI, which is designed to scale up family planning and AYSRH (FP/AYSRH) interventions by strengthening the capacity of local governments to design, manage and implement FP/AYSRH interventions themselves. This study was conducted in 10 TCI countries: Kenya, Tanzania, Uganda, Nigeria, India, Benin, Burkina Faso, Cote d'Ivoire, Senegal, Niger. Data were collected between October 2020 to March 2021 to identify and refine TCI's coaching model. A total of 174 in-depth interviews and 33 focus group discussions (FGDs; n= 188) were conducted with men and women aged 18 and older from across four hubs – by Jhpiego in East Africa, IntraHealth in Francophone West Africa (FWA), Population Services International (PSI) in India, and Johns Hopkins Center for Communication Programs (CCP) in Nigeria.

In India, 50 IDIs were conducted and 3 FGDs (n= 4) across 5 cities and 3 states; Indore (MP), Varanasi (UP), Agra (UP), Mathura (UP), Berhampur (Odisha). In Nigeria, 60 IDIs and 3 FGDs (n=6) were conducted across 5 states including, Rivers, Niger, Plateau, Ogun, Taraba. FWA conducted 65 IDIs and 5 FGDs (n= 55) across 5 cities (Niamey, Abomey-Calavi, Ucoz, Ziguinchor, Nioro) and in East Africa, 3 FGDs (n=124) were conducted across 9 cities and 3 countries; 3 in Kenya (Migori, Kilifi, Nairobi), 3 in Uganda (Buikwe, Kiira, Kampala) and 3 in Tanzania (Ilala, Ubungo, Arusha City). A common research protocol was developed with TCI hubs and used cross-country within TCI cities. The Johns Hopkins Bloomberg School of Public Health (BSPH) Institutional Review Board reviewed the study protocol and deemed it non-human subjects research.

Qualitative instrument development

TCI developed a structured in-depth interview (IDI) guide to probe and document how TCI's coaching has changed overtime, across the four hubs. The IDI guide explored the personal experiences, perspectives, benefits and challenges, and narratives of TCI's beneficiaries – city health officials, service providers/health care professionals, community health workers – experiences with coaching and being coached. The IDI guide was also used in the Focus Group Discussions (FGDs) as well. TCI conducted an in-depth review of the guide and guides were translated into Swahili (Kenya), Hindi (India), and French (Senegal) and English (Nigeria). Each hub team then pilot-tested, conducted mock interviews and refined guides based on the results.

Participant Recruitment

TCI had three main groups of study participants in this research: (1) TCI staff supporting specific city/states within each of the four hubs, (2) local (city, state or county) government staff where TCI works, and (3) health service providers that implement TCI's interventions and high impact practices in these geographies. All participants were recruited on a voluntary basis and were informed about their right to refuse or withdraw at any time. Participants were also informed about the purpose, process and benefits of the study. TCI selected participants based on a set of inclusion and exclusion criteria and then conducted purposive samples of TCI field staff, local government staff and health service providers they support. In total, 309 participants took place in IDIs and FGDs interviews, 48 TCI field staff, 134 government staff, and 127 health service providers implementing the HIPs and TCI interventions (Table 1).

Table 1: The number of participating sites and those interviewed by hub

Country/region	No. of TCI sites (state, city, counties)	No. of interview sites per hub	No. of field staff Interviewed	No. of government staff Interviewed	No. of health service providers Interviewed
East Africa	41	9	22	54	48
Francophone West Africa	12	5	10	28	27
India	31	5	5	21	28
Nigeria	11	5	11	31	24
Total Sample	**95**	**24**	**48**	**134**	**127**

Data collection

Because this study took place during COVID, most IDIs took place virtually on Microsoft Teams or Zoom. FGDs were typically conducted in-person in a private setting of the participant's choice, however in some instances FGDs were also conducted virtually. A two-to-three-person team were present during data collection; one person interviewed the participant and the others served as the notetaker. Each IDI/FGD lasted around 60-90 minutes. Most interviews were recorded, with consent of each participant. Some participants did not consent to audio recording of interviews, and in those instances, detailed notes were used to capture conversations for inclusion in the study. All interviews were transcribed and translated into English (in the instance the interview was not conducted in English).

Focus Group Discussions and In-depth Interviews

The majority of IDIs (n=174) were conducted with individuals however, FGDs were used to delve deeper and extract specific narratives on TCI's coaching. In East Africa, FDGs were the primary method for interviews. FGDs reflected TCI's interest in capturing community health worker, service providers and government officials narratives on the length of time it took participants to feel confident and comfortable implementing the topic being coached on, identify areas or topics that require additional coaching support, understand whether the participants coach others and if so, who, hear accounts of challenges faced in being coached and any to reflect on recommendations. FGDs were organized in a way that ensured participants felt comfortable sharing their experiences with a group.

> *"I like FDS ... because with the help of FDS, we do line listing. Through FDS we came to know to which client we have to talk to and to which client we have to give IUCD. We maintain a proper system through FDS"*
>
> **Auxiliary Nurse Midwife India**

Data Analysis

Once data collection was completed, in-country team used a thematic approach to analyze data. Teams looked at preliminary themes that emerged from the transcripts which informed the development of an inductive codebook. Given differences cross-hubs, TCI created hub-specific codes for themes that came out from specific hubs. In-country teams then coded all transcripts, using a stepwise approach and summary tables were prepared which the teams used to highlight discrepancies and major findings. These were then mapped to the five main objectives of the study (intensity of TCI coaching, including HIA most commonly requested; local

governments perception of TCI's coaching; how TCI's coaching has led to system strengthening; recommendations of TCI's coaching model and how TCI's coaching has sustained). Quotes were used to expand on the identified themes. Analysis were conducted in Dedoose (India), Nvivo (East Africa, Nigeria) and content analysis (FWA). While these qualitative tools are similar, they also highlight limitations of TCI's qualitative measurements and analysis. Despite these limitations however, similar themes emerged across the four studies.

RESULTS

The study team initially drafted four separate hub-specific reports. They then consolidated key themes, compared findings, identified trends, and derived key learnings and best practices for the TCI coaching approach detailed in this report.

Effective interventions

Technical

Each hub's coaching support centered on ensuring thoughtful programming that provides the interconnectedness of services, demand generation and advocacy would lead to significant achievements in contraceptive uptake. The coaching study identified service delivery high-impact approaches that were most often requested by the government officials. Fixed-day services (India), universal referral (FWA), in/outreaches (Nigeria) and whole-site orientations (East Africa) were among those most requested for coaching across the four hubs. Other TCI interventions complemented each hub's main high-impact approach.

In India, the four most valuable interventions coached were: 1) fixed-day services (FDS), 2) mapping and listing, 3) data-for-decision-making (D4D), and 4) convergence. FDS was thought to be the most important strategy because it activates several other TCI interventions, including "capacitating of accredited social health activists (ASHAs) by the TCI India national team, government stakeholders and service providers." In addition, FDS required advocacy to ensure trained providers, adequate commodities and supplies, and quality assurance visits by higher-level authorities.

In FWA, universal referral (i.e., a systematic way of engaging all health providers to assess each client for potential FP needs and give appropriate services) was the primary service delivery intervention. Three other demand generation and advocacy-related interventions complemented universal referral: 1) demand generation by community health workers who carried out home and workplace visits in the community, 2) special FP days during which the full spectrum of free contraceptive methods was offered to individuals, and 3) young transformational leaders.

In East Africa, the most frequently coached interventions were whole-site orientations, FP integration, integrated outreaches, counseling strategy balance and reporting tools improvement.

> *"No matter what, I think that within three months to six months should be good, If on the average, you interact with the person, on the average of two hours a week, or one hour per week, and the intervention in question is a simple one to carry out, for example, whole site orientation, QIT, that one you will see that Niger state people have started running with that one because it's easier."*
>
> **TCI Coach**
> **Niger State, Nigeria**

In Nigeria, the performance improvement assessment, performance improvement plan and whole-site orientation were mentioned as highly effective TCI interventions, especially during the scale-up phase.

Management

Report writing and D4D were two skills cited as an area of substantial improvement thanks to management coaching across hubs. Reviewing activity and monthly reports were great for identifying capacity needs, for instance, the quality of the reports concerning content focusing on target achievements was used to assess the need for coaching. Participants noted a coaching strategy should focus on simple short-term coaching solutions that would yield immediate results by prioritizing coaching needs to motivate the teams until they started seeing positive results, especially at the start of any coaching engagement.

Participants reported improvements in report writing, service delivery, the development and use of annual operational plans to monitor progress, the use of a prioritization matrix, and the ability to seek feedback. Some participants elaborated on the outcome of capacity strengthening, for example, a Plateau State coach in Nigeria shared that TCI coaching helped scale up from three local government areas (LGAs) to 17 LGAs. Across all hubs, government officials frequently mentioned leadership skills, program management, coordination, planning, budgeting and D4D as the most impactful approaches to ensure the sustainability of family planning and AYSRH implementation.

Coaching frequency and intensity

Coaching session frequency across all hubs ranged depending on the phase of engagement the city was in (i.e., from start-up to graduation). On average, the coach held between two and 15 sessions per month across hubs. India and Nigeria had the highest average number of 10 to 12 sessions. The coaching frequency decreased as the skills and confidence of the coachees were strengthened over time. To ensure coachees had a strong handle on both the management and technical coaching skills, it typically took between 3 to 12 months to move from assist to observe, with the average being 6 months. However, it depended on an individual's skills, availability and implementation processes or approaches that were used.

TCI India hub coaches devoted between 40 percent to 75 percent of their time to coaching,

whereas government stakeholders who had been trained as coaches spent up to 40 percent of their time cascading coaching to other stakeholders. The frequency of coaching sessions ranged from fortnightly to monthly and quarterly, with each session lasting from 30 minutes to 2.5 hours, depending on the topic.

The individuals who had been coached also mentioned seeking "on-demand" support when they faced issues with the rollout of a particular intervention. TCI India hub coaches noted they typically spend 75 percent of their time on technical coaching related to implementing interventions and 25 percent on management coaching, such as preparing budgets, reviewing expenditures and reviewing data to inform decision-making. As coachees became more confident in their abilities to plan, implement and monitor the interventions, the India hub staff shifted more toward management coaching (e.g., 70 percent management and 30 percent technical).

> *"This COVID period we have made adjustments to be able to do more virtual coaching... We are able to use WhatsApp to ... coach the participants so that we can reach more people within the groups. So, I think that digital platform especially during the COVID period [is] an adjustment [that] we've made as a team."*
>
> **TCI City Manager Uganda**

On average, a coach in East Africa could conduct a minimum of two coaching sessions per month for geographies in pre-graduation for providing technical assistance on demand, with most reporting they had been able to carry out over 10 sessions. However, during the surge phase, coaching accounts for 70-80 percent of TCI staff time and about 40 percent of government staff time.

In Nigeria, the TCI team would spend 50 to 60 percent of their time coaching during the Lead stage, about 25 percent in Assist, and Observe was 15 percent. In Plateau State, TCI coaches said it would take three to six months from Assist to Observe, depending on the coachees' availability and the intervention.

> *"What I personally have gained from them is that they have organized series of training workshops to build our capacity that is my own capacity ... through TCI, I've been able to put this training ... into practice. During my interaction with the community and the mobilizer, I have been able to impart most of this knowledge...into the community as well. So by and large, TCI has helped in a great way to improve my own knowledge and at the same time improve family planning information and uptake ..."*
>
> **Government coach Ogun State, Nigeria**

In FWA, mayors or district health officials hosted two to three management coaching sessions each month. On average, the TCI city program manager held one coaching session per week, and the rest were on-demand. Local government health system technical coaches often worked at the community and facility levels over a five-day period, including coaching sessions on how to use TCI-U and the FWA toolkit of interventions in master coaches' training. They had a monthly plan and worked daily to reinforce capacity around the interventions at the facility with health providers and community levels with community health workers.

On average, each city had about 10 coaches, and each had eight coaching sessions in their monthly coaching plans. TCI city program managers collected and reviewed these plans

and coaching reports monthly to see where support and feedback were needed and supervised the technical coaches during monthly supervision visits.

Modes of knowledge transfer

The two main modes of knowledge transfer were 1) face-to-face sessions and 2) virtual sessions, either through phone calls or WhatsApp chats, depending on the topic level.

While face-to-face, on-the-job coaching was preferred – and most often requested because it allowed for a more supportive supervision approach, where coaches would observe teams performing various activities to identify capacity gaps – due to time restrictions and COVID-19 gathering restrictions and lockdowns, most coaching sessions by TCI as well as the geography staff shifted to virtual platforms after March 2020.

Participants expressed the need to appreciate individual differences, which would also influence the best method of knowledge transfer, whereas some individuals were fast learners and comfortable with the virtual mode, others had technological challenges. Overall, coaching was noted as being highly adaptable and after COVID restrictions lifted, government staff became more open to virtual coaching, which has remained in place at least through WhatsApp Groups.

Various tools were found to be useful, including job aids, infographics, information, education, and communication (IEC) materials, TCI's how-to videos, advocacy briefs, checklists and standard operating procedures (SOPs). Both print and electronic versions (stored in one's computer or laptop) helped coaches deal with challenges related to Internet connectivity and power outages.

TCI-U also stood out as a major resource most participants relied on for coaching. As a platform with a wealth of coaching materials, participants across all hubs expressed great appreciation for TCI-U. Despite the value of the materials available on TCI-U, however, government coaches reported having experienced some technical issues in registering and logging on to the platform.

> *"I can see now that they [local government] understand the TCI model and don't wait for TCI to do everything. They are implementing and are seeing their performance improve, and everyone is executing against the milestones."*
>
> **Country Manager**
> **Francophone West Africa**

Usefulness and benefits

Positive Changes

All study participants reported that TCI's coaching approach empowered TCI hub staff, local government officials and service providers to make positive changes. Such positive changes would include increasing knowledge and skills and the ability to address pressing needs, solve problems, take on new challenges, improve individual performance, and achieve individual, team, and organizational objectives. Across all hubs, government functionaries and

service providers shared that they perceived their confidence, knowledge and ability to discuss data improved because of TCI's coaching approach. The trained coaches cited examples of improvements in their problem-solving skills and mindsets at all levels, starting from the state to the city and community levels.

In India, the coaching approach helped build good relationships between the coaches and coachees. Participants who underwent coaching identified trust, honesty, transparency, active listening, coordination ability, spontaneity, knowledge and skill as critical attributes that make coaching effective. During coaching sessions, it was essential to create a positive atmosphere and show appreciation for both the coaches and the coachees. Because of TCI's coaching, government stakeholders said their confidence and skills to advocate and present data in the state level platforms as well as at all levels of the health system were greatly improved.

In Nigeria, participants reported coachees were now more conversant and confident with happenings in interpersonal communication (IPC) management skills, as well as family planning/ AYSRH program coordination and implementation, which resulted from the enhancement of the capacity of transferring knowledge. The government coaches, service providers and social mobilizers agreed that the support received from TCI changed their coaching strategies and helped build their capacity in coaching and service delivery, as well as public speaking skills. In addition, they acknowledged that they had more patience, resilience and ability to carry out various tasks in a structured and logical manner.

In East Africa, better engagement and commitment of geography teams, better inter-sectoral and interdepartmental collaboration and a better understanding of the engagement timeline were perceived as positive changes because of coaching. TCI coaches seemed to agree that continued coaching brought a noticeable positive change in the attitudes of geography teams with subsequent ownership of TCI interventions. Therefore, geography teams could identify their capacity needs, request assistance and be more proactive in initiating activities.

As a result of engagement with TCI, several stakeholders reported that they had started working together to promote family planning service delivery. For instance, the public and private health sectors were reportedly working together, and various non-health sectors, such as education, collaborated with the health sector for the good of the communities. Similarly, different cadres within health institutions and community health workers understood the role they may play in marketing services via site-wide orientation activities.

Through the coaching of mayors in FWA, many now understood the benefits of family planning for

the population and were now family planning/AYSRH champions in the community and helped mobilize financial resources for family planning/AYSRH programs. Coaching is now standardized, and coaches come prepared with a coaching plan contextualized for the area of coaching needed. In addition, due to TCI coaching, the hub and regional staff were more accountable and performed more effectively to secure city-level impact.

Finally, all participants emphasized the need to establish timelines and expectations stipulated at the start of the engagement. Since coaching was not a lifetime venture, geography teams needed to keep graduation in mind and have a clear picture from the outset.

> *"In Niger, the DRSP (Regional Department of Public Health) is now able to tell us how to coordinate with Amplify around PPFP."*
>
> **TCI Staff**
> **Dakar, Senegal**

Health Care System

Most participants indicated that while coaching was focused on implementing the HIPs and TCI interventions in the beginning, over time, more emphasis was paid to providing management coaching that helped strengthen the overall health system. Most said that implementing the family planning interventions alone would not create the lasting impact that the cities have seen without being coupled with management coaching. Technical and management coaching were institutionalized since the coaches that received these two types of coaching support are part of the health system. Coaching had contributed to promoting family planning awareness through advocacy, which had resulted in more resource allocation from the government and improved service delivery and uptake, laying a solid foundation for sustainability. Through coaching, collaborations seemed to have been fostered within the health sector and beyond, an achievement that improved efficiency and effectiveness in service delivery. Coaching was also seen to have diffused beyond the TCI-supported locations, when government coaches were transferred or HIPs and other interventions were picked up by other locations.

In India, another credible impact of TCI's coaching on the health system was strengthening ASHAs. A participant noted that ASHAs used to be resistant to being sent around the community and people would not open doors to them. Slowly over time, they became more confident in counseling target groups and delivering tailored counseling messages on contraceptives. They also could plan their household visits better by listing and prioritizing clients. Coaching service providers, particularly staff nurses and medical officers, helped strengthen urban primary health centers (UPHCs) to expand the basket of contraceptive choices and helped introduce Antara and intrauterine contraceptive devices (IUCDs) at the UPHC level. As a result, service providers focused more on a basket of options than on sterilization, which has been the dominant method of contraception in all three states engaged with TCI.

In Nigeria, participants noted that TCI's initial coaching approach for government

officials focused mainly on strengthening the capacity of coaches to scale up TCI interventions, but coaching support now included strengthening leadership skills, program management, coordination, planning, budgeting and data use to inform decisions and ensure the sustainability of implementation beyond TCI's support. For example, one participant noted that TCI's coaching helped strengthen mobilization at the LGA level and commodity supply to LGAs. Another coach in Ogun State shared how coaching helped her advocate for family planning/AYSRH with church and community leaders. Health promotion implementers could adopt this approach for sustainable health programs in Nigeria, thus they needed to build a larger pool of coaches across the states and expand beyond family planning and AYSRH.

The positive effects of coaching in East Africa were seen to have led to self-reliance and institutionalization within the health care system. Strengthening the capacity of coaches at all levels was cited as key to sustainability of the interventions and participants also noted that the skills built were transferable and would benefit other health services beyond family planning.

Coordination

Participants mentioned that specific structures existed in cities before they partnered with TCI, such as city coordination committees and program implementation teams; however, these were generally either non-functional or organized on an ad hoc basis with little follow-up. TCI's coaching emphasized the importance of these groups having regular meetings to track outcomes and bridge gaps. In addition, TCI's coaching supported the operationalization of these meetings through clear objectives, task sharing and follow-up.

In FWA, participants reported that coaching improved overall coordination between the health system and the municipalities across the five TCI-supported countries through monthly meetings of the Coordination and Management Units (CMUs). This relationship was formalized through a memorandum of understanding (MOU) between the two entities. As a result, there were fewer coordination challenges than there used to be and a clear delineation of roles and responsibilities to ensure accountability in all aspects of TCI programming.

In East Africa, through TCI's coaching, cities operationalized program implementation teams, which ensured coordination between departments and clarity in roles. This coordination also ensured that this forum was used to provide cross-departmental coaching, learning, understanding of each other's work and the use of data for decision-making. To measure progress towards sustainability, TCI developed the Reflection and Action to Improve Self-Reliance and Effectiveness (RAISE) assessment tool and supports local governments in implementing it quarterly. TCI and cities started to use this mechanism to undertake RAISE assessments to avoid holding many additional meetings. Many participants referred to the RAISE tool in their interviews because it provided a structured platform for a systematic review to assess progress, effectively conducted actions to bridge any gaps, and made course changes if concerns were detected throughout the evaluation process. The coaching plans were agreed to at the end of the quarterly assessment and, at the same time, evaluated coaching from the past quarter and agreed on plans for the next quarter.

In India, City Coordination Committee, City Consultation Workshop and Data Review Meetings existed but met infrequently and urban family planning was rarely part of the agenda. Through TCI coaching, these coordination mechanisms are now regularized and institutionalized in the system and family planning is at the top of the agenda, part of every guideline and instructions. A participant noted that Antaral Diwas (FDS) is a good example as this is now prioritized and deemed a critical intervention in India. With family planning at the forefront, government officials continued to receive coaching from their peers and master coaches from the state level on other effective interventions including Khushhal Pariwar Diwas and Pradhan Mantri Surakshit Matritva Diwas, specific days set up to provide fixed-day comprehensive and quality antenatal care to all pregnant women (in the second and third trimesters).

> *"Initially, it was more on high-impact interventions: how do you plan, how do you organize an in-reach, etc. Now I spend … most of the time [dwelling] so much on data use and [collecting] the data [correctly]: Is it clean? Can you analyze the data? Can you use the data … to make decisions? Can you use the data to choose the right interventions, [so] that whatever you are doing is intentional and you are informed by the data so that there is value for money [and] … meager resources are really maximized?"*
>
> **City Manager**
> **Kenya**

In Nigeria, some participants noted that the coaching approach positively improved the coordination of the family planning program at the facility level, enabling social mobilizers to feel their impact in referring community members to services. In conjunction with improved coordination between social mobilizers and service delivery sites, facilities experienced a higher turnout of clients who were more aware of the benefits of family planning and interested in knowing more about methods and their use.

Data for Decision-Making

Participants mentioned the use of D4D was greatly strengthened. Before coaching, data were captured but randomly analyzed and results were not always incorporated into programmatic course corrections. As a result, well-performing government staff members experienced a lack of motivation, as their efforts were not acknowledged, nor did anyone see the importance of entering data regularly into the national health management information system (HMIS). TCI's coaching on regular data review for completeness, course correction and data audits helped tremendously improve reporting rates, ensure data quality and avoid duplicative data. For example, a participant from Niger State in Nigeria mentioned, "the introduction of a run chart to track progress monthly had increased the motivation of service providers and mobilizers to improve access. With cross-state coaching and information-sharing sessions, other states like Rivers have also adopted the use of run charts."

In FWA, data availability, quality and reliability also improved from coaching on data collection tools (such as HMIS, the project management information system (PMIS), and project records) and organizing data validation meetings. Tracking program performance and D4D coaching by TCI country and city managers during the quarterly steering committee meetings and other meetings improved programming decisions by the municipality. For the first time, the municipalities looked closely at family planning/AYSRH data from their city and understood how to use it for decision-making and course correction. During the steering committee meetings, the district health teams or the data manager from the health district presented their program

data and results to the mayor and his team. Also, the mayors and their teams could see how their local financial contributions yielded results, encouraging them to become even further engaged.

In India, earlier, evidence-based decision-making was restricted to the upper levels of health governance. TCI's coaching model helped government staff prioritize and regularize data review meetings with all levels of health workers, including the UPHC level where all facility level officers, including ASHAs discussed the results of their own areas on a bi-monthly basis. Through systematic trickle-down coaching, planning, and critical budgeting of HIPs and TCI interventions, enhanced the capacity of service providers to understand and own their results. Also, there was an increased circulation of documentation, letters, and guidelines by government stakeholders engaged in providing family planning services that enhanced the promptness of government actions.

In East Africa, through TCI coaching, there was better awareness and ownership of the data and results being generated which resulted in an increase in quality of data. Coaches understand the right data to collect, clean, analyze and use to make intentional and informed decisions and course corrections. Participants said there is more ownership of the results being generated and an increase in quality data, they are confident in making more informed decisions and understanding the data so there is value for their money, and resources are maximized.

Financial planning and budgeting

TCI's coaching successfully and positively impacted financial management, including getting the family planning budget line into the cities' overall health budget and helping them plan fund disbursement against program design and do financial reconciliations. In Francophone West Africa, participants noted that the municipalities could plan activities in advance and manage their programs more effectively and efficiently than before. In addition, cities now could manage their progress against milestones, know how to implement a health program, including the budget, and look at data for decision-making. The new CMU that met monthly was institutionalized and now led by the city.

In India, the major achievement of TCI's management coaching around financial planning and budgeting was involving local leaders in owning and leading their family planning activities in urban cities from the outset. Earlier budgets for family planning were geared toward rural areas specifically, and urban health was observed as a separate wing. Changing the mindset of local authorities contributed to developing further program designs and implementation plans under National Health Mission (NHM), where a sizable portion of government funds was allocated for the urban program.

In East Africa, getting governments to commit more resources to family planning service delivery stood out as critical strategy for sustainability,

however, participants noted that the government health management teams need to continue coaching on planning and financial management.

TCI's initial coaching approach in Nigeria focused mainly on strengthening the capacity of coaches to scale up TCI interventions, however, the coaching support received by these government officials now includes planning and budgeting along with other management and technical coaching to ensure the sustainability of implementation beyond TCI's support.

Overarching Benefits

Participants unanimously recognized coaching as contributing to health systems strengthening; it equipped the local government teams with both technical and management skills to provide health care in a more efficient manner, coupled with better documentation and quality data generation for more informed decision-making. For example, nearly all participants noted that by prioritizing building local government capacity and continually improving resources to support TCI's coaching approach, most government staff and TCI cities could not only successfully scale up the interventions but also improve the quality of work produced at the various levels of coaches. The Lead, Assist and Observe coaching model also instilled a problem-solving approach that created a mindset shift in both government and hub coaches at all levels. Strengthening skills rather than doing the work for the coaches further ensured the sustainability.

Through coaching, collaborations were fostered within the health sector and beyond, an achievement that improved efficiency and effectiveness in service delivery. The impact of TCI had diffused beyond supported geographies through deliberate efforts or by accident when already coached individuals were transferred to other stations or pursued opportunities elsewhere. Participants noted that even non-TCI cities expressed interest in the potential of receiving coaching and learning more about scaling up TCI's approaches.

Challenges

All hubs shared some challenges unrelated to coaching but impacting its progress.

Changes in human resources: The turnover of staff and government leaders specifically caused a challenge in continuing cascading coaching. New coaches were continually trained as they were brought on; however, institutional knowledge was often left with those who moved on. The turnover of staff and government leaders caused a challenge in continuing cascading coaching. It takes up to one year of coaching government on a weekly and monthly basis to reach the Observe phase, so new coaches were continually being trained as they were brought on. But institutional knowledge often was left with those who moved on. A transfer of a coach to a new city meant the master coach had to start from scratch to build a new coach's capacity. This happened more often with the first and second line of coaches. Government coaches were coached weekly and monthly for up to one year to get them to the Observe phase. A transfer of a coach to a new city meant that the master coach had to start from scratch to build the new coach's capacity. This happened more often with the first and second line of coaches.

Internet connectivity: Difficulty accessing resources on coaching due to Internet connectivity persisted in most hubs; however, using printed versions of training aids and tools helped to mitigate some of these problems. Some hubs noted minimal use of the TCI-U resources made available online and attributed this to a lack of computers, mobile devices or the Internet to access the platform. This resulted in some government teams relying heavily on TCI staff for information rather than accessing these resources independently.

Time constraints and competing priorities: Taking the time for coaching and learning was

another common challenge. Local government and facility staff already had overburdened workloads and tasks that might be deemed more important. Irregularity in meetings could lead to gaps and inconsistencies in cascaded training. For example, steering committee meetings were not happening routinely in every city due to busy schedules or other emerging priorities. Providing timely, high-quality coaching sessions was also difficult due to the requirement to replace these gaps and maintain the abilities of present coaches. Apart from the RAISE tool, there seemed to be no standard or prescribed means of identifying capacity needs or prioritizing them when it came to coaching. As a result, coaching would take time and require the coachees to be receptive and available and their supervisors to approve. Coaching sessions were also time-intensive for new cities. For example, in Indian cities like Varanasi, even though a coach frequented political leaders and dignitaries, government officials were often overly occupied and too busy for coaching sessions. This was especially true during COVID-19, as everyone was preoccupied with managing the pandemic and therefore had less availability for receiving coaching support from the India hub staff.

Limited monitoring tool: A gap at lower levels could be explained by another gap – the lack of a database or system listing the staff who had been coached and were qualified to cascade knowledge and skills to lower levels. Going forward, participants noted that the coaching model must address developing a proper monitoring and tracking system to ensure that the coaching knowledge provided was not lost, given the frequent transfer of coaches. This system would ensure that the coaching model's management and technical coaching aspects could be replicated in geographies where TCI has not worked.

TCI coaching sustainability plan

Coaching and training sessions were instrumental in implementing the family planning and AYSRH programs across the cities. To sustain TCI's coaching model, participants pointed out the need for creating a cadre of master coaches in the system responsible for institutionalizing regular coaching. Identifying coaching champions at various positions in the public health systems who were least likely to be transferred would help retain coaching skills and coaching capacity and ensures the family planning and AYSRH program continues to run smoothly. It was equally important to institutionalize interventions within the system as well.

It was noted that in India, several aspects of the coaching model were already incorporated into the PIP, so there was a strong base for interventions to be institutionalized in the system due to set budgetary allocations; this will ensure program continuity. Participants noted that there are now budget allocations for trainings, service delivery and D4D interventions as well as for the Family Planning Logistics Management Information System to ensure continuity of supply for family planning methods. It was also noted that a budget has been set aside for CCC, to ensure that at the city level, family planning data is regularly reviewed and discussed.

In Nigeria, the sustainability of TCI's coaching approach would depend solely on the cooperation and collaboration of the state government, Ministry of Health, facility directors, family planning stakeholders, and individuals involved. They took ownership of the coaching approach, ensuring the family planning and AYSRH program continuity. This would provide a stable system of care to users and give direction to those who will continue implementing the program. For example, participants from Niger and Ogun States shared similar examples of TCI's legacy in terms of sustainability, which included program structures that supported coordinating interventions and adopting the makeover approach by other facilities and facility units beyond the family planning unit. Both states also shared insights on human resources. TCI's coaching support enabled states to plan and implement interventions to fill the gaps and, at the same time, monitor and assess the effectiveness of the interventions without directly implementing them.

The technical and managerial coaching was anchored in the FWA coaches at all levels of the health system and the health system has benefited from learning how to collaborate with government officials in the municipality to support family planning. The collaboration between the municipality and the health system will be sustained due to TCI's coaching model. Interventions were institutionalized in the national family planning strategy and TCI family planning indicators were included in regional family planning plans.

> *"Since I have been trained [coached] so well at this time, if anyone talks with me about family planning, I won't hesitate instead I... want to talk about family planning because I am aware now"*
>
> **FPLMIS Manager India**

Building the technical capacity at the geography level was cited as being key to the sustainability of the activities TCI had initiated, noted participants in East Africa. It was also highlighted that applying skills acquired was transferable and would benefit other health services besides family planning. Furthermore, since the teams were empowered, they seemed to be using available resources that maximized the returns since there now seemed to be a culture of demanding value for every coin spent. Participants also agreed that with continued coaching, there was a noticeable positive change in the attitude of geography teams with subsequent ownership of the project.

DISCUSSION

Across TCI's four hubs, participants agreed that there was no "one size fits all" for its coaching model, and several factors need to be considered. Family planning program implementers should prioritize coaching as a sustainable means to build capacity and reinforce best practices through continuous coaching. Other means of strengthening the capacity of local governments and service providers exist; however, whenever and wherever possible, coaching should replace trainings to ensure long-term and cost-efficient programming. At all points of engagement, integrating a unified coaching plan with the government team in all program activities is critical for sustainability.

Key Theme 1 – **Outcome:** How has TCI coaching worked to date, including which high-impact interventions governments most commonly request coaching for, how often, and their impact?

TCI's coaching model empowers and increases the engagement of local government stakeholders through technical and management coaching. TCI's interventions are organized by four program areas: 1) service delivery, 2) demand generation, 3) advocacy and 4) essentials which refers to leadership and program management soft skills. These areas are core competencies. Of these program areas, service delivery and management skills were the most requested program areas across the four hubs. TCI's coaching model has contributed to forming a community of practice (CoP) network where the coaches support each other, strengthening the linkages between these program areas and ensuring a more coordinated approach to health service delivery.

The coaching study identified that government officials most often requested coaching for service delivery interventions. Of those, FDS, family planning special days, in-reaches and outreaches, whole-site orientations, universal referral, D4D and performance improvement plans were most often requested for coaching across the four hubs. Although the frequency and mode of coaching varied, face-to-face, on-the-job coaching was preferred and most often requested.

The main materials used for coaching sessions were soft and hard copies of job aids, infographics and TCI-U. Although TCI-U stood out as a major resource relied on by most participants for coaching, despite the value of the materials available on TCI-U, government coaches experienced technical issues in registering and logging onto the platform as well as Internet connectivity. Coaching was noted to be highly adaptable. During COVID-19, coaching shifted to virtual platforms where coaching and supportive supervision were conducted over the telephone or WhatsApp. A coach would engage a coachee from as few as two coaching sessions per month to as many as 15 times per month. To ensure coachees had a strong handle on the management and technical coaching skills, on average, it typically took between three to 12 months to move from Assist to Observe, depending on an individual's skills, availability and the implementation processes or interventions being coached on. For internal staff, the time was often shorter, within three months, whereas government stakeholders or frontline workers being coached could average anywhere from 12 to 18 months to move into Observe stage.

Key Theme 2 – Usefulness: How has the TCI coaching model been perceived by local governments and service providers, including whether they believe it has been beneficial, and if so, how?

The study identified positive perceptions of the coaching model, including improving government functionary and service provider confidence, knowledge, problem-solving and public speaking skills. An overall mindset shift to coaching among local government was reported. TCI coaching has improved motivation and patience among those coached, increasing their efficiency and productivity and growing trust, respect, active listening and feedback between the coach and the person being coached. Furthermore, more confidence in coaches in discussing and presenting data and a gain of valuable skills in leadership and management helped them better engage more stakeholders and advocate for family planning and AYSRH. This led to better engagement and commitment of geography teams, better inter-sectoral and interdepartmental collaboration, a better understanding of the timeline of engagement and, over time, greater ownership of TCI interventions.

Key Theme 3 – System change: How has TCI's coaching led to system strengthening and improvements in the health care system and beyond?

The study also sought to document how the health systems were strengthened, especially in family planning and AYSRH program performance. Participants shared how the TCI coaching model impacted the health systems through knowledge sharing and skills transfer to enhance government and health care worker capacity. They described how coaching contributed to promoting family planning awareness through advocacy, which positively impacted resource allocation from the governments. Now, more than ever, TCI sees activities and interventions incorporated into city work plans and budgeted program implementation plans, costed implementation plans and annual operational plans. Government staff and service providers now prioritize family planning services in health governance through systematic trickle-down coaching. Governments have

witnessed the importance coaching, which is now part of job descriptions, coaches are also part of budgets and annual plans which has become institutionalized within the government system.

Through coaching, collaborations have been fostered within the health sector and beyond. Regular management meetings are now happening where family planning is on the agenda, data are reviewed and discussed, challenges are identified, and action plans are created and followed up on by the government and key stakeholders. Coaching of service providers also helped strengthen more quality and effective family planning services by ensuring all clients are provided bias-free counseling and are offered an expanded choice of methods at health facilities that are well equipped and stocked, thereby improving the entire health system.

Key Theme 4 – Challenges and recommendations: What have been the successes and challenges, and what recommendations can be made to strengthen TCI's coaching model?

One of the biggest successes of TCI's coaching interventions identified across all geographies was how coaching strengthened and fostered inter-sectoral and interdepartmental collaboration and engagement. As a result, there is better engagement and more streamlined and efficient coordination mechanisms, such as the City Coordination Committee in India, the Advocacy Core Group in Nigeria, the Program Implementation Team in East Africa, and the Program Management and Coordination Unit in FWA.

Building strong inter-sectoral and interdepartmental partnerships proved to be crucial not only in transforming service delivery but also in creating a mindset shift in the working environment and attitude in the government system. These master coaches within the system advocated for family planning to be part of the agenda at meetings and for data to be regularly reviewed. As a result, teams could identify their capacity needs and assistance request and be more proactive in initiating activities. Better activity implementation coupled with target achievement was also a coaching success maker. Coaches now clearly understand what they are coaching on the technical side (e.g., interventions) and management side (e.g., well-versed in data). Also, they now have the competence and confidence in the coaching content and can listen to challenges and provide solutions. TCI saw successes in transferring skills to its coaches over time, reducing the number of such requests, which indicates successful coaching efforts. Also, over time, coaches saw a reduction in the number of coaching requests as the government began to lead its family planning and AYSRH programs and as TCI coaches began to observe and provide ad hoc coaching support when needed.

All hubs identified the transfer of coaches as a major challenge. Once transferred, there is no tracking mechanism for these skills or individuals. Moving forward, TCI is developing tools for tracking and evaluating coaching and receiving feedback. Strengthening its coaching monitoring and reporting mechanisms to measure the impact of coaching accurately and developing action plans related to pending gaps identified is critical to monitoring the quality and improvement of coaching. TCI will continue to document these efforts in the future.

Difficulty accessing coaching resources online due to lack of or poor Internet connectivity and power cuts persisted in most hubs, therefore using printed versions of training aids and tools helps to mitigate some of these problems.

Finding time to conduct coaching sessions is challenging due to overworked government officials and service providers. Meetings were sometimes irregular, leading to gaps in capacity. To overcome these challenges, TCI will continue to advocate for the importance of coaching and improvement of skills and training to ensure that coaches and coachees can find ways to set aside more time, rapidly identify bottlenecks, provide solutions, and make course corrections. It is important to build a larger pool of coaches across the various sectors that can expand beyond family planning and AYSRH to help compensate staff who are transferred or where gaps in

knowledge exist. These master coaches can step in to provide the necessary coaching to others in need of a refresher session.

Key Theme 5 – Sustainability: How will TCI-supported geographies sustain TCI's coaching model once cities become self-reliant?

Coaching sessions have been instrumental in the implementation of the family planning and AYSRH programs across the cities. To sustain TCI's coaching model, creating a cadre of master coaches in the system who take the responsibility of institutionalizing regular coaching has been and will continue to be critical. By identifying coaching champions at various positions in the public health systems who are least likely to be transferred, helps retain coaching skills and coaching capacity and ensures the family planning and AYSRH program continues to run smoothly.

Providing continuous cross-learning and sharing of best practices through face-to-face interactions, CoPs through WhatsApp or TCI-U, and peer-to-peer engagements help to build interactions between coaches and coachees and further diffuse capacity strengthening related to the interventions. Overall, TCI is seeing that, over time, more coaching champions are taking the initiative to lead their own coaching sessions due to improved knowledge, skill sets and confidence, while TCI staff coaches are providing more ad hoc coaching sessions.

RECOMMENDATIONS

Overall, TCI made significant progress in enhancing family planning and AYSRH service delivery by collaborating with government officials, achieving set targets, better documentation and reporting and more financial and in-kind resource allocation for family planning and AYSRH programming. Some recommendations to improve the overall coaching strategy also emerged and could be implemented in the future.

Better systematize coaching processes

- Ensure program implementers have a shared coaching plan with the government team providing the coaching and integrating coaching into all program activities.
- Formalize and monitor coaching plans to ensure they are kept up, and tools are shared promptly, for example, by developing a tool for city managers to supervise coaches regularly and help them know where their skills need improvement.
- Clearly define supervision of coaches, how it happens and what tools can ensure coaching quality, as these are sometimes unclear.

Improve monitoring and tracking system

- Develop a more standardized tracking system that captures coaching frequency, type and related information such as the subject matters and follow-up actions.
- Explore more about what kind of coaching is needed most at each phase of engagement with TCI along the LAO model.
- Develop a database of trained coaches and hand it over to each geography to continue to populate and draw upon as needs arise.
- Strengthen data quality and management so that individual progress, or that of the collective coaching support, can be observed and measured.

Allow for flexibility while striving for greater standardization

- Maintain flexibility, given the different education levels/learning styles of coaches, yet also use a more structured planning process and tools to ensure clear expectations for

the coaches and coachees in reaching goals related to the capacity strengthening of the coachees.

- Make sure not to skip any of the coaching steps and listen before developing solutions.

Continue to strengthen relationships

- Foster collaboration between TCI- and non-TCI-supported facilities and promote inter-geography learning. These are potential ways to enhance diffusion and ensure that TCI uses the capacity it has built at the geography level to achieve its objectives more efficiently.
- Use coaches from one geography to coach another as a convincing way to show new geographies that whatever they are being coached on has been done in another place they are familiar with and has worked.
- Use face-to-face sessions for coaching in the beginning to build better relationships during the Lead stage of the model.

Improve use of TCI-U by coaches within the government system

- Improve geography teams' use of TCI-U to ensure that teams are well introduced to this platform from the outset to embrace it as their primary source of the material. Track performance of individual geography evaluation to gauge the access and use of TCI-U by teams to identify teams that were not using the platform and assist them if they have any challenges.
- Make learning materials available offline so that more providers can access them, especially when data subscription has lapsed, or Internet coverage is limited.

Further capacitate coaches

- Provide more opportunities for mentorship and coaching across hubs.
- Seek out mentors within the local system who intend to be long-term placements to ensure that these coaches are available for assistance, given staff turnover rates.
- Offer continued coaching sessions beyond graduation for ongoing support and empowerment to advocate for family planning, as government leadership and priorities can sometimes shift, and efforts can be lost.

Use clearly defined terminology

- Clarify the use of the term "coach." The word is used for all levels because all involved are, in fact, coaches. However, it sometimes is not clear in documents who is coaching whom, and it may help to develop some language to make it clearer. Consider levels to further classify, such as Level 1 coach (TCI hub), Level 2 coach (TCI country manager and city manager), Level 3 coach (technical coaches, most likely service providers), and Level 4 coach (managerial coaches, most likely local government or municipality staff).
- Further define what qualifies for each level for coaches and coachees, including at what point someone is a master coach and how they help to further cascade coaching.
- Better understand what is meant in some more project-specific terminology like "local government." A lexicon of definitions could be useful for TCI to keep and share so language is standardized across hubs and coaches.

CONCLUSION

This study aimed to establish clear connections between outcomes and TCI's coaching methodology. The purpose of TCI's coaching approach is to improve leadership abilities, program administration, coordination, planning, budgeting and data utilization to guarantee the sustainability of implementation after TCI engagement and direct support.

TCI successfully collected concrete instances to illustrate how its coaching approach impacts local government and the health care system, empowering hub staff, local government officials and service providers to make positive changes. In essence, the coaching model has proven critical in energizing health systems and public health workers to provide family planning services more efficiently and effectively.

To improve TCI's coaching in the future, this report offers key recommendations that will further strengthen the quality and value of the TCI coaching model.

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