AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C. 20523

PROJECT PAPER

INDIA
INNOVATIONS IN FAMILY PLANNING SERVICES (IFPS)
386-0527

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: — DOCUMENT CODE: 3

2. COUNTRY/ENTITY: INDIA

3. PROJECT NUMBER: 386-0527

4. BUREAU/OFFICE: ASIA [04]

5. PROJECT TITLE (maximum 40 characters): Innovations in Family Planning Services

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 92

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4)
A. Initial FY 92 B. Quarter 4 C. Final FY 1011

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 1992 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total		20,000	20,000	86,530	238,470	325,000*
(Grant)	( )	( )	(20,000)	(86,530)	(238,470)	(325,000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country		40,000	40,000		400,000	400,000
Other Donor(s)						
TOTALS		60,000	60,000	86,530	638,470	725,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. PRIMARY TECH. CODE 2. Loan	D. OBLIGATIONS TO DATE 1. Grant	D. OBLIGATIONS TO DATE 2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	E. AMOUNT APPROVED THIS ACTION 2. Loan	F. LIFE OF PROJECT 1. Grant	F. LIFE OF PROJECT 2. Loan
(1) PN						17,595		300,000	
(2) HE						2,320		15,000	
(3) CS						85		10,000	
(4)									
TOTALS						20,000		325,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code							
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To assist the Indian State of Uttar Pradesh to significantly reduce the total fertility rate through a comprehensive improvement and expansion of family planning services.

14. SCHEDULED EVALUATIONS
Interim MM 03 YY 95 MM 08 YY 98 Final MM 08 YY 02

15. SOURCE/ORIGIN OF GOODS AND SERVICES
[X] 000 [ ] 941 [X] Local [ ] Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment)

*Includes $100,000 in contributions by R&D/POP, AID/W, of which $86,530 is estimated to be in foreign exchange and $13,470 in local currency.

Clearance: CO: WCGraham

17. APPROVED BY
Signature:
Title: Walter G. Bollinger Director USAID/INDIA
Date Signed: MM 09 DD 28 YY 92

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

PROJECT AUTHORIZATION

Country: INDIA
Project: Innovations in Family Planning Services
Number : 386-0527

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Innovations in Family Planning Services (IFPS) Project for India (the "Cooperating Country") involving planned obligations of not to exceed Two Hundred Twenty-Five Million United States Dollars ($225,000,000) subject to the availability of funds in accordance with the annual OYB allotment process, to help in financing the foreign exchange and local currency costs of the Project. The planned life of the Project is ten years from the date of initial obligation.

2. The Project is designed to assist the Government of India (GOI) and the Government of Uttar Pradesh (GOUP) in significantly reducing fertility rates in the State of Uttar Pradesh by doubling the level of contraceptive use within the ten-year term of the Project. It will focus on (i) increasing access to family planning services, (ii) improving the quality of family planning services, and (iii) promoting family planning activities. The four components of the Project are public sector, non-governmental sector, contraceptive social marketing, and research and evaluation.

3. Goods and services financed by A.I.D. under the Project shall have their source, origin and nationality in the United States, except as indicated below. Local source procurement is authorized pursuant to Handbook 1, Supplement B, Section 5D10a(1)(e) for approximately Forty-Three Million U.S. Dollars ($43,000,000) for contracts for contraceptive social marketing and audit/payment verification because success in the achievement of project objectives requires that we substitute expatriate for local expertise as little as possible. In addition, local source procurement is authorized for those categories of goods and services listed in Handbook 1, Supplement B, Section 18A1c.

Name: Walter G. Bollinger
Title: Director

Date: 9-28-92

Clearance:

PDPS:JTarter
HPN: JDumm
CO: WCGraham
RLA: MWard
PDPS: TMahoney
DD: SMintz

draft

ag:5441C

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List of Acronyms

A.I.D. or AID/W	U.S. Agency for International Development, Washington, D.C.
ANM	auxiliary nurse midwife
AVSC	Association for Voluntary Surgical Contraception
BHEL	Bharat Heavy Electricals Limited
BHL	Bajaj Hindustan Limited
BUCEN	U.S. Bureau of the Census
C.A.s	A.I.D. Cooperating Agencies (AID/W-funded)
CBD	community based distribution
CBR	crude birthrate
CCs	condoms
CD-ROM	compact-disk, read-only media (an important new information storage and fast retrieval technology)
CEDPA	Centre for Development and Population Activities
CHC	Community Health Center
CMO	chief medical officer
CPA	certified public accountant
CPR	contraceptive prevalence rate
CRS	contraceptive retail sales
CSM	contraceptive social marketing
DG	Director General
DH	A.I.D. direct-hire employee
DOHFW	Directorate of Health and Family Welfare, Uttar Pradesh
DWCRA	Development of Women and Children in Rural Areas Program
EWPI	East-West Population Institute
FHI	Family Health International
FMR	female:male ratio (sex ratio)
FP	family planning
FPAI	Family Planning Association of India
FPLM	Family Planning Logistics Management
FX	foreign exchange (currency)
GOI	Government of India
GOUP	Government of Uttar Pradesh
HAL	Hindustan Aeronautics Limited
HFW	health and family welfare
HIV	human immuno-deficiency virus
HP	health post
HW	health worker
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
IEC	information, education, and communication
IFPS	Innovations in Family Planning Services Project
IMA	Indian Medical Association

IMR	infant mortality rate
IRDP	Integrated Rural Development Program
IRMA	Indian Rural Medical Association
IRR	internal rate of return
IUD	intra-uterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Population Communication Services, Johns Hopkins University
JSI/FPLM	John Snow Associates/FPLM Project
KAP	knowledge, attitudes, and practices
KGMC	King George's Medical College, Lucknow, Uttar Pradesh
LAM	lactational amenorrhea method
L/C	local costs
LFP	labor force participation
LH	Literacy House
LHV	lady health visitor
LOP	life-of-project
LW	Link Women Scheme (grassroots women's groups)
MAM	mean age at marriage
MCH	maternal and child health
MIS	management information system
MO	medical officer
MOHFW	Ministry of Health and Family Welfare
MSS	Mahila Swasthya Sangh Scheme (grassroots women's groups)
MWRA	married women of reproductive age
NGO	non-governmental organization
NFE	non-formal education
NORPLANT®	a hormonal contraceptive implant
OB/GYN	obstetrics and gynecology
OC	oral contraceptive
OPTIONS	Options for Population, The Futures Group
OR	operations research
PACS	Primary Agricultural Cooperative Societies
PBD	performance-based disbursement
PEP	public education and promotion
PHC	Primary Health Center
PIL	project implementation letter
POL	petroleum, oil, and lubricants
PROFAMILIA	a private family planning program in Colombia
PROFIT	Promoting Financial Investments and Transfers
PSI	Population Services International
PVOs	private voluntary organizations
PY	project year

RAPID	Resources for the Awareness of Population Impacts on Development Project
R&E	research and evaluation
RFP	request for proposal
RFW	Rural Family Welfare Center
SC	Sub-center
SC	scheduled caste
SDHFW	State Directorate for Health and Family Welfare
SOCIETY	Registered Society to Implement the IFPS Project
SMUCFL	State Milk Union Cooperative Federation Limited
SOMARC	Contraceptive Social Marketing, The Futures Group
STD	sexually transmitted disease
TA	technical assistance
TA/DA	travel allowance, daily allowance
TAG	technical advisory group
TFR	total fertility rate
TOT	training of trainers
UC	Urban Center
UFWC	Urban Family Welfare Center
UNFPA	United Nations Population Fund
UPVHA	Uttar Pradesh Voluntary Health Association
USAID	U. S. Agency for International Development, overseas mission
U.P.	Uttar Pradesh
UNICEF	United Nation's International Children's Emergency Fund
VHAI	Voluntary Health Association of India
VHW	village health worker
VSC	voluntary surgical contraception
WCH	woman and child health

Executive Summary of the Innovations in Family Planning Services Project

Introduction: The Government of India (GOI) and USAID are designing the Innovations in Family Planning Services Project (IFPS) to serve as a catalyst for the GOI in reorienting and revitalizing the country's family planning services. The IFPS Project has selected the State of Uttar Pradesh (U.P.) as the primary site and testing ground for program innovations. With its population of 140 million, U.P. is the largest state in India and larger than all but six countries in the world. U.P. also is a state with one of the poorest demographic, social and economic profiles in India. If access to family planning services can be greatly increased and if couples accept and use contraception on a broad scale in U.P., other states including those slow-to-progress may also benefit from the U.P. experience.

Project Purpose: The IFPS Project proposes to assist the State of Uttar Pradesh to significantly reduce the total fertility rate through a comprehensive improvement and expansion of family planning services. In order to achieve this purpose, IFPS intends to effectively double the use of modern contraception over a ten-year period. Achievement of this purpose will result in a sharply reduced level of fertility. Current levels of fertility in the four large North Indian states, where 40 percent of the population lives, are close to the level that existed in India at the time of Independence in 1947. Thus, the IFPS Project's objective of reducing fertility in U.P., and by extension the fertility of the other large northern states, is essential if the GOI hopes to achieve its goal of lowering the national rate of population growth. Lower levels of fertility will mean fewer births than would otherwise occur each year, and a gradual slowing of the rate of population growth in U.P. The benefits associated with reduced population growth will be seen in the reduced burden on the GOI and Government of Uttar Pradesh (GOUP) in providing health care, schooling, jobs, and housing. Savings from lower rates of population growth will enable the GOI to invest more on a per capita basis in health, education, employment, and housing and thus improve the quality of the nation's human resources. Additionally, reduced population growth will mean reduced pressure on the environment.

To achieve this purpose, the project has three objectives which are to:

- Increase access to family planning services by strengthening service delivery in the public sector and developing or expanding the capacity for service delivery in the non-governmental sector. Access will also be expanded through hospitals, clinics, household and community-based distribution, social marketing, and commercial retail sales so that services will be available to a large proportion of clients living in the harder-to-reach rural, poor urban, and peri-urban areas.

- Improve the quality of family planning services by expanding the choice of contraceptive methods, improving the technical competence of personnel, ensuring

informed choice through effective counseling, and improving management and follow up of client services, and improving contraceptive logistics.

- Promote family planning by broadening support among leadership groups, increasing the public's understanding of the health and welfare benefits of family planning, creating a better image of the program, and providing information (or advertising in the case of the social marketing program) on the availability of services and methods. The project will also increase the participation of women in the implementation of the project at all levels.

The three objectives are interrelated; consequently, success in one area will be tied to accomplishments in the other areas. Furthermore, IFPS will promote a service orientation to family planning as an integral part of MCH.

Achievement of the project's objectives will be measured by the increased level of contraceptive prevalence, the number of couples using family planning, and the increased proportion of couples who are using spacing or limiting methods most appropriate for their reproductive intentions. By the end of the ten year IFPS Project, it is expected that the percent of couples in U.P. using contraception will double and that the actual number using family planning will more than double given the growing base population. Further, it is expected that the existing unmet need for spacing or limiting methods (among couples who either say they want to delay the birth of the next child at least two years or do not want any more children, but are not using contraception) will largely be filled.

Project Activities: Project activities fall into four broad components: public sector, non-governmental sector, contraceptive social marketing, and research and evaluation. All four components will have significant training, information, education, and communication (IEC), and management interventions. The type of service providers, service interventions, and focus populations are shown in **Figure 1** and **Figure 2.**

The results of these interventions will be: (1) upgrading of the existing government program and (2) initiation or expansion of services through the non-governmental sector. These will provide a varied and comprehensive choice of high quality family planning services. In addition to the clinic, outreach, and community-based service programs, a contraceptive social marketing effort will be expanded based on a segmented marketing strategy. The lower socio-economic market will be the focus of the existing government social marketing program. Under the project, this program will be reinvigorated and expanded into rural areas not presently covered. A commercial marketing program will be initiated for the higher-end of the market.

The project will have a major research and evaluation component. The most important research element will be two surveys conducted at the mid and end points of the project. These, combined with the baseline survey to be carried out in November 1992, will provide trend data on a wide range of demographic, social, and health variables. There will also be

numerous operations research projects and assessments to help plan, test, and evaluate discrete project activities.

Project Structure: The overall policy issues of the IFPS Project will be addressed by the National Steering Committee chaired by the Union Secretary of Family Welfare and consisting of senior representatives from the national and state governments and USAID. With the exception of social marketing, all project activities will be implemented through a Registered Society (the SOCIETY), a new organization to be registered under the Indian Societies Registration Act (XXI) of 1860. Staff of the SOCIETY will be recruited primarily from the private sector. Project activities will be monitored by a Governing Board composed of representatives of state government agencies, USAID, and the non-governmental sector. Technical staff from the GOUP and USAID will work with the SOCIETY Executive Director and his/her staff to assure day-to-day coordination and management of all project activities.

The IFPS Project is necessarily large and complex. The project paper does not present a detailed blueprint for IFPS; that would be very difficult to do in a single document this early in the project's development. Rather, a broad strategy is presented which establishes the project's objectives, boundaries, structure, and programmatic thrusts. For each major part of the project, e.g., services, training, logistics, contraceptive marketing, and research and evaluation, a detailed plan of action will be developed and approved by the Governing Body.

Not only is IFPS large and complex, it will take place over the space of a decade. In such an extended effort, mid-course corrections will be needed. It is critical that the project have a continuous review and the flexibility to make timely changes. The Governing Board should periodically review the project's progress in order to make any necessary programmatic modifications, referring any policy issues to the National Steering Committee.

Project Components. The IFPS Project is composed of four major components: (1) support for public sector activities; (2) support for NGO and employer-based activities; (3) support for a major contraceptive social marketing program; and (4) support for research and evaluation activities geared to key strategic and programmatic thrusts.

Each major component may have one or more U.S. organizations that will establish collaborative relationships with Indian organizations and professionals. These institutions are world leaders in their respective fields. Under the IFPS Project, it is anticipated that mutually beneficial affiliations will develop that will last beyond the life of the project. The major organizations are shown in **Figure 3**. Other U.S. organizations may be called upon as needed to participate in specific activities, e.g., the East-West Population Institute for the National Family Welfare Surveys.

An important key to the implementation of the project is the establishment of a USAID Liaison Office which will be initially located in New Delhi with the intention of relocating to Lucknow at a later date. This office will have a small staff to assist in coordinating the various externally funded inputs of the project and serve as a liaison for USAID (**Figure 4**).

Project Implementation: The implementation of such a large and complex project will demand a great deal of careful planning and execution. If some activities fall behind schedule, other areas will be adversely affected. At the same time, the project will be flexible in shifting resources from areas of little or no progress to those of greater potential. An overview of the implementation plan is found in **Figure 5.**

It is obvious from this plan that the first year of the project is critical to establishing the base on which the project will be built. Among other things, the training of physicians and auxiliary nurse midwives will begin in earnest; demonstration projects in both the public and non-governmental sectors will be initiated; the contraceptive social marketing effort will start; and a variety of research activities will commence.

The proposed implementation plan is reflected in budget levels and allocations. **Table 1** and **Figures 6 and 7** show the estimated cost levels and allocations for the life of the project by IFPS's four major components. The proposed distribution for each of the four areas is shown in **Figure 6.** The dominant role of the government in IFPS is evident from the more than 50 percent of the budget apportioned to the public sector[1]. **Table 1** also shows that $234 million (72%) of the total $325 million will be for in-country "rupee costs." The remainder is for U.S.-source materials (contraceptives and medical kits), for U.S. institutions that will be contributing to the project, and for training costs outside India.

Performance-based Disbursement. An important aspect of project implementation will be the use of performance-based disbursements (PBD) for support of public sector and for non-government sector activities.[2] PBD places emphasis on **outputs** and **accomplishments,** rather than project inputs such as financing of equipment or manpower. In brief, PBD will be used in the following manner: (a) each major project component in the public and non-government sectors will be subject to the collaborative development of detailed implementation plans by the GOUP, USAID and, where appropriate, non-government institutions. These plans will identify specific **performance benchmarks** against which disbursements will be made to the SOCIETY. Benchmarks, in the main, will be characterized by their **qualitative** as well as their **quantitative** character, i.e., they will measure real progress toward accomplishment of project objectives. PBD mechanisms to be used in this project are more fully described in Section 4, Project Management and Implementation.

Conclusion: The IFPS Project places human and monetary resources where they can have an impact. The consistent focus of the project is on activities that are explicitly designed to benefit couples throughout Uttar Pradesh and, in turn, the nation.

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[1] Substantial additional benefits to the public sector will accrue from expenditures in the private sector, particularly in the IEC and research and evaluation areas.

[2] excepting contraceptive social marketing (CSM) activities.

Figure 1.
Service Delivery Systems - Public Sector

INSTITUTION	FOCUS	PRINCIPAL APPROACH	Key Personnel
Medical colleges, related PHCs	Urban, peri-urban	Model clinics LHVs	Physicians, ANMs, LHVs
Municipal hospitals, District hospitals, UFWC, Health Posts	Peri-urban, urban	Urban outreach (pilot demonstration model #1)	ANMs, Health Workers
PHCs, SCs	Rural, peri-urban	PHC/SC outreach (pilot demonstration model #2)	ANMs, extension workers, Health Inspectors
PHCs, SCs	Rural	CBD private/public (pilot demo #3)	VHWs, NGOs

Figure 2.
Service Delivery Systems - Non-governmental Sector

INSTITUTION	FOCUS	PRINCIPAL APPROACH	REFERRAL
Cooperatives	Rural, peri-urban	CBD, outreach	PHCs, SCs
NGOs	Rural, peri-urban, urban	Promotion, CBD, outreach	PHCs, SCs, private clinics
Indian Medical Association	Peri-urban, urban	CSM campaign (OCs), model clinics	Private clinics
Autonomous public enterprises	Peri-urban, rural	Improved clinics and outreach	Private and public clinics
Employer-based	Peri-urban, urban	Policy support, outreach, model clinics	Private and public clinics

Figure 3.
Contributions from U.S. Institutions to the IFPS Project*

FUNCTION	PRIMARY U.S. INSTITUTION	COLLABORATING INDIAN INSTITUTION
Grants management, service delivery, non-clinical and management training	CEDPA	SOCIETY (NGO Division)
Clinical and non-clinical training	JHPIEGO	SOCIETY, Medical Colleges, ANM Colleges
Information, education, communications	JHU/PCS	SOCIETY, IEC NGO
Research and evaluation	Population Council	SOCIETY, R & E Institutions
Contraceptive Social Marketing	SOMARC	SOCIETY, Private Corporations

KEY

CEDPA: Centre for Development and Population Activities

JHPIEGO: Johns Hopkins Program for International Education in Reproductive Health

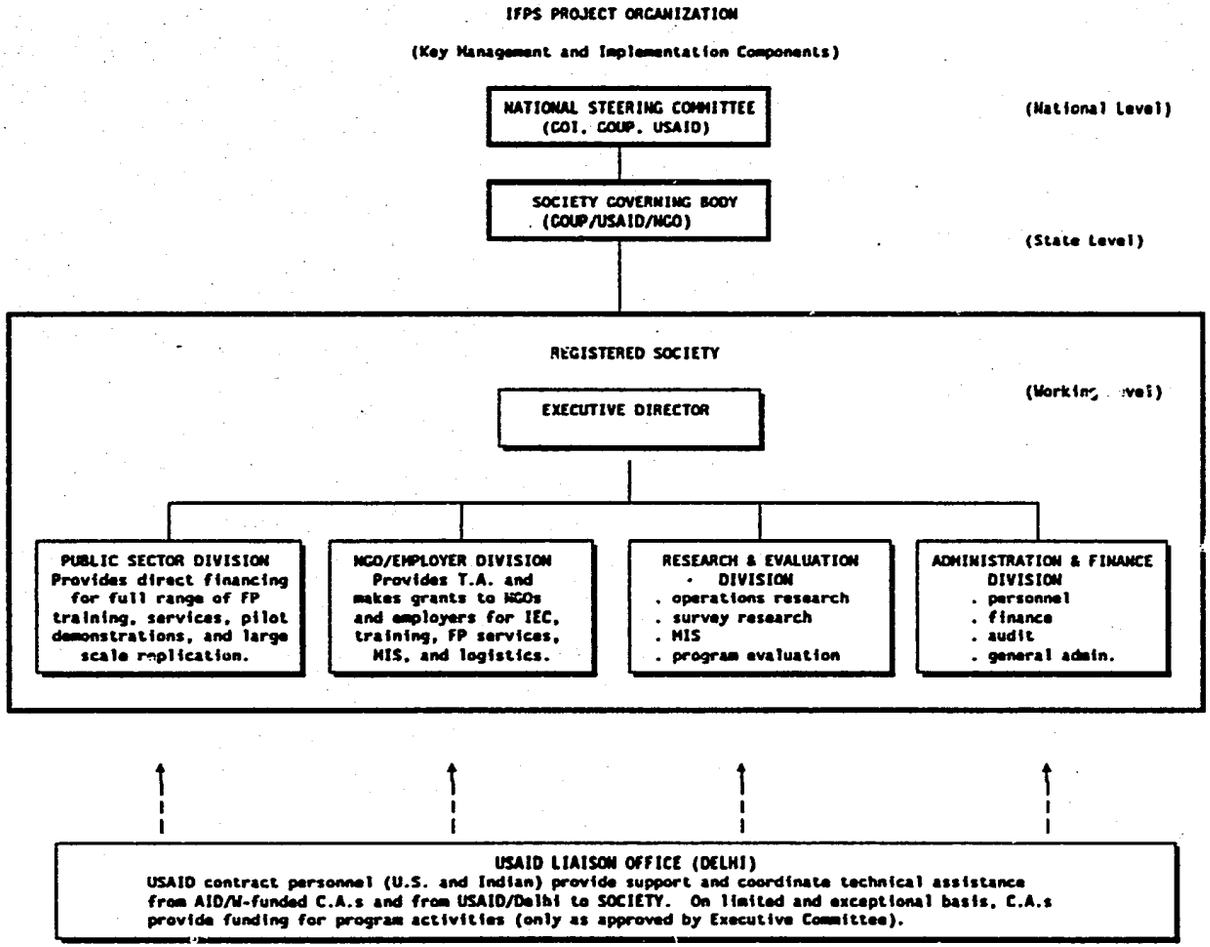
PCS: Population Communications Services, Johns Hopkins University

SOCIETY: Registered Society

SOMARC: Contraceptive Social Marketing, The Futures Group

* Since this is a 10-year project, some of the U.S. institutions may change over the life of the project. In addition, several of these primary institutions will collaborate with other technical organizations to provide additional expertise as needed.

Figure 4



IFPS8.DWG

Figure 5: IMPLEMENTATION PLAN SUMMARY FOR IFPS PROJECT

SECTOR	YEARS 1-3	YEARS 4-6	YEARS 7-10
PROJECT MANAGEMENT	1. Establish National Steering Committee 2. Establish SOCIETY as Fully Functioning Organization 3. Establish SOCIETY Governing Body 4. Establish USAID Liaison Office 5. Review Annual Workplans	1. Review annual workplans 2. Continue coordination and oversight activities	1. Review annual workplans 2. Continue coordination and oversight activities
PUBLIC SECTOR	1. Establish SOCIETY Public Sector Division 2. Assess in-service training facilities in 30-40 ANM colleges 3. Train 100 master trainers and 2,000 ANMs in clinical and non-clinical service delivery in 20-30 ANM colleges 4. Assess pre- & in-service clinical training in 9 medical colleges 5. Develop model clinics in 9 medical colleges 6. Develop standardized curricula and train 25 master trainers in 9 medical colleges 7. Train 2000 physicians per year in 9 medical colleges 8. Develop and implement 3 demonstration projects for FP service delivery in 8 districts 9. Develop and implement models for strengthening MIS and logistics systems in 14 districts	1. Expand successful service delivery models to 45 districts in Uttar Pradesh 2. Complete in-service clinical and non-clinical training for medical/paramedical staff in 63 districts 3. Implement changes in MIS, logistics systems in 30 districts 4. Continue to distribute and monitor use of IEC materials for service providers and for clients	1. Expand training for public sector personnel by non-government sector 2. Expand service delivery to all 63 districts
NON-GOVERNMENT SECTOR	1. Establish SOCIETY NGO/Employer Division 2. Launch 6 demonstration grants to large service delivery networks (coops, PVOs, etc.) 3. Provide grants to NGO for IEC activities 4. Disseminate IEC material linked to training & service delivery 5. Provide grants to NGO for establishing training center/hostel 6. Select, provide training, and implement FP service delivery in business and autonomous public enterprises 7. SOCIETY becomes proficient in making NGO grants	1. Expand CBD/outreach projects through networks 2. Diffusion of materials developed by IEC NGO to other sectors 3. Expansion of training NGO activities to train non-clinical staff of other sectors 4. Expansion of NGO sector to 22 districts 5. Continuation of institutional strengthening of non-government sector 6. SOCIETY well established and making large grants 7. GOI/GOUP funding support begins for SOCIETY	1. Further expansion of all activities 2. Coverage of all districts 3. Service to 4 million users 4. SOCIETY fully established and viable lead organization for non-governmental sector 5. SOCIETY receiving substantial contributions from government and other sources for support of NGO FP activities
CONTRACEPTIVE SOCIAL MARKETING	1. Develop/approve RFP and award contract to lead CSM firm 2. Conduct market research for public and private CSM programs 3. Improve and expand CSM public sector program and launch private sector program through selected channels 4. Establish 35,000 CSM outlets	1. Further expansion of all CSM activities in both public and private sectors to all districts 2. Consider inclusion of additional contraceptive products in CSM program	1. Further expansion of all CSM activities 2. Introduction of improved products as approved 3. Total 40,000 CSM outlets established
RESEARCH AND EVALUATION, AND POLICY SUPPORT	1. Establish SOCIETY R&E Division & select lead R&E institution 2. Conduct 10 policy seminars 3. Issue subcontracts to other R&E institutions for diagnostic studies and baseline surveys 4. Design new performance indicators 5. Provide TA to other sectors for monitoring & evaluation systems 6. Design & conduct OR studies for demonstration projects in public and non-government sectors 7. Disseminate results of studies to all sectors 8. Publish and distribute India version of *Population Reports*	1. Conduct large-scale survey of large northern states 2. Conduct additional baseline surveys as needed for new service delivery activities 3. Continue OR studies as needed 4. Disseminate results of studies in all sectors	1. Continue OR studies 2. Conduct large-scale national family health survey 3. Research reports, notes, and newsletters to 63 districts

Table 1.

SUMMARY BY MAJOR CATEGORY ONLY

IFPS PROJECT BUDGET SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	1	2	3	4	5	6	7	8	9	10	ALL YEARS
A. U.S. DOLLAR COSTS											
U.S. Personnel and Administration	3,416	3,871	3,932	3,611	2,898	2,460	2,449	2,407	2,384	2,290	29,718
Contraceptives (U.S. Source)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
Other Commodities (U.S. Source)	593	282	1,105	1,299	1,314	1,479	1,364	1,379	1,429	461	10,705
Participant (International) Training	280	780	636	573	412	394	385	352	289	296	4,397
Other Direct and Indirect Costs	2,257	2,251	2,456	2,310	1,763	1,398	1,398	1,425	1,455	1,396	18,110
Evaluation and Audit*	0	0	0	150	0	0	150	0	0	150	450
Contingency and Inflation (@5%)	0	300	325	350	375	400	425	450	475	500	3,600
SUBTOTAL: U.S. DOLLAR COSTS	7,512	8,536	10,094	9,795	8,613	8,385	8,880	9,248	9,868	9,604	90,533
B. LOCAL COSTS (L/C)	13,895	18,474	17,831	19,441	25,317	24,023	24,335	27,465	27,759	35,882	234,420
GRAND TOTAL DOLLARS + L/C	21,407	27,009	27,924	29,236	33,929	32,408	33,215	36,713	37,627	45,486	325,000

* Dollar costs shown are for evaluation only. Audits are included in local costs.

IFPS COST BREAKDOWN BY SECTOR
(in millions of dollars)

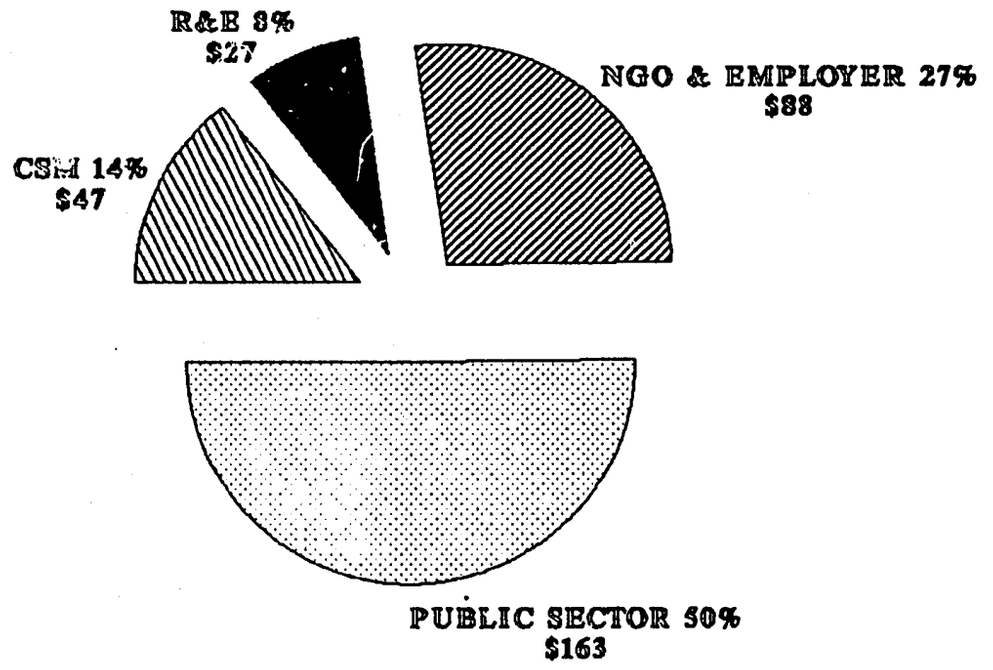


Figure 6

IFPS COST BREAKDOWN BY SECTOR & YEAR
(Total = $325 Million Over 10 Years)

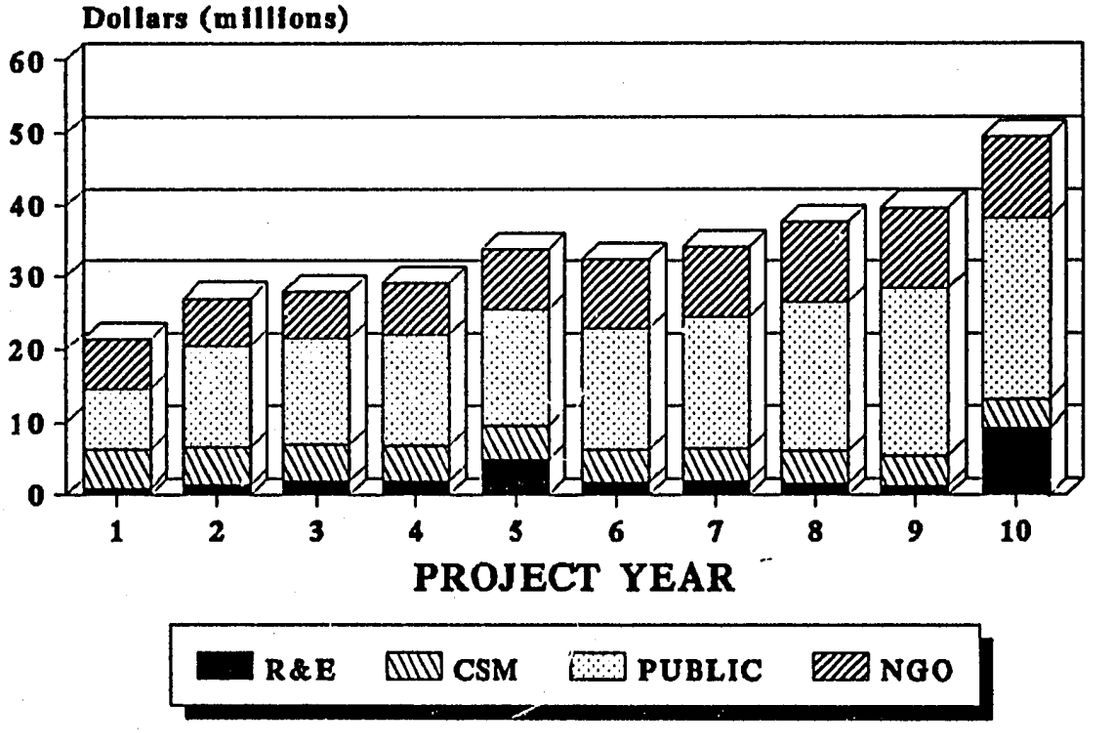


Figure 7

1. PROJECT BACKGROUND

1.1 Demographic Trends in India and Uttar Pradesh

The 1991 Indian census revealed that while there has been a marginal decline in the rate of population growth from the 1970s through the 1980s, the current growth rate is still about 2 percent per year. Given the enormous size of India's population, this level of growth means that 17 million people are added each year placing a heavy burden on the nation. The birth rate has declined only from about 39 to 31 between the early 1970s and today. Fertility, as measured by the Total Fertility Rate[3] (TFR), declined from 5.8 in the 1950s to about 3.9 today. Contraceptive prevalence has increased from 24 percent in 1981 to 42 in 1990 for the nation as a whole. Part of the increase in the use of contraception and the decline in fertility is credited to India's family welfare program, which was established in 1951 and is the oldest in the world.

The pattern of change in fertility across the states of India has not been uniform. In the four northern states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, the birth rates are close to the level that existed in India as a whole at the time of Independence in 1947. With a population of over 140 million, the state of Uttar Pradesh is the largest state in India. The state's birth rate is nearly 40 per thousand and the level of contraceptive prevalence is somewhere between 25 and 33 percent, considerably higher and lower, respectively, than rates at the national level.

1.2 Government of India Policy on Family Planning

The Government of India adopted a formal population policy in 1951 when it sought to reduce the birth rate "to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy." The policy has been consistently pursued and expanded through the years. The GOI's current long-term goal is to achieve zero population growth by the year 2050, with an estimated population of 1.3 billion. The medium-term goal is to reach a replacement level fertility of 2.1 by the year 2000 coupled with a contraceptive prevalence rate of 60 percent. While the country's population policy has always placed family planning within the wider context of health and family welfare, the government has not emphasized this context in the implementation of the national program.

1.3 National Family Welfare Program

The GOI's National Family Welfare Program was established in 1951 when the national population policy was issued. The program seeks to promote, on a voluntary basis, responsible and planned parenthood with a "two-child norm." The central and state governments are the largest providers of direct family planning services in India. Private sector and Non-Governmental Organizations (NGOs) do provide services and conduct other

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[3] The Total Fertility Rate (TFR) is the average number of children born to a woman over the span of her reproductive years.

population related activities, but are currently responsible for only a small proportion of the entire family planning (FP) effort.

The family welfare program is centralized. Broad policies and financial control rest with the central Ministry of Health and Family Welfare (MOHFW), and implementation is carried out by individual states. The government's family planning infrastructure is vast and complex. It includes an urban service delivery system and a multi-tiered rural delivery system with workers at every level down to the villages. Target setting and target achievement are key operating principles.

The urban system includes general hospitals, maternity hospitals, other specialty hospitals, Urban Family Welfare Centers and Health Posts. The rural system includes Community Health Centers (CHCs), Primary Health Centers (PHCs) and Sub-Centers (SCs). Each of these facilities provides a basic package of maternal and child health (MCH) services and an array of emergency and general care services. The referral network is from SCs up to district hospitals or specialty hospitals. Auxiliary Nurse Midwives (ANMs) based at SCs provide services to the villages and promote access to the clinic-based delivery system. All facilities except SCs, have some capacity for inpatient beds.

The clinic-based family planning services currently available in U.P. include sterilization and intra-uterine devices (IUDs). These are available in all clinics and in some SCs where the ANMs have been trained and feel capable of performing IUD insertions. Contraceptives mandated to be available in all settings include condoms and oral contraceptives. Currently, only about 70 percent of the rural service delivery facilities offer family planning services. Since 77 percent of India's population is rural (80 percent in U.P.), deficiencies in rural service delivery are a serious problem for the program.

Over the years, the GOI has given high-level support to the national program. There has been widespread acceptance, at all levels of government, of the demographic importance of the program's objectives. Following the Emergency Period in 1975-77, during which coercive measures were taken which led to a major backlash against family planning, diminishing importance was given to family planning. This decline in support from senior levels had a dampening effect on a bureaucracy that was previously very committed to implementing the program. The diminished support was reflected in a leveling off of new acceptors in the program and in continued high fertility, particularly in the four large north Indian states.

The current levels of service availability are inconsistent with national demographic goals. Serious deficiencies exist at all levels of in-service and pre-service training. The current training system is inadequate to provide a regular supply of qualified service providers and trainers commensurate with the needs and responsive to the environment for service delivery in India's complex social and cultural setting. Management and supervision need to be strengthened at all levels. There is also a recognition that the quality of family planning services at the health center level is far from satisfactory.

The GOI understands well the shortcomings of the National Family Welfare Program and is poised to make major improvements. The 1992 Action Plan of the MOHFW calls for revamping the program. The GOI recognizes that a change in strategy is needed and that the "tyranny of targets" and the overemphasis on sterilization should be eliminated. The MOHFW also realizes the importance of quality of care, training, good management and supervision at all levels, improving method mix, and providing services through varied governmental and non-governmental channels. The climate is therefore propitious for the launching of a comprehensive and diversified project such as the IFPS Project.

2. PROJECT STRATEGY AND RATIONALE

2.1 Problem Statement

Since its inception, the family welfare program of India has emphasized the importance of reducing the country's high rate of population growth and high level of fertility by making family planning services widely available and increasing awareness of contraception and of service availability. Over the past 40 years, the family welfare program has made reasonable progress in increasing the availability and use of contraception and has undoubtedly contributed to a reduction in fertility. Unfortunately, these accomplishments have not been achieved in all regions and states suggesting that program efforts have fallen far short of their objectives. The fertility levels in the northern states constituting the Hindi-belt (Bihar, Madhya Pradesh, Uttar Pradesh, and Rajasthan) are substantially above the national levels and are offsetting fertility decline in other parts of India.

The family welfare program carried out by the MOHFW is almost exclusively a public sector effort. It has relied heavily on voluntary sterilization to achieve its demographic objectives. Sterilization in fact provides more than 70 percent of effective contraceptive protection for Indian couples. Typically those who are sterilized tend to be older, higher parity women who use contraception only after achieving a relatively high desired family size. With the exception of the condom and the IUD, other methods that are most suitable for young couples wanting temporary methods for birth spacing have not been emphasized in the array of public sector services. The quality of family planning services available through the public sector is not generally perceived to be high by clients and potential clients. The program has not emphasized issues of quality (including meeting couples' needs for spacing and providing a range of methods) in its information and service delivery. Further, too little attention has been given to the interpersonal skills of providers, a key aspect of good client-provider interaction. These factors have tended to impair the image of the program with the likely consequence of dampening demand for services.

The above notwithstanding, there is good reason to believe that a sizeable unmet demand for family planning exists in the northern states (see Technical Analysis). Results from the large-scale 1989 National Family Planning Survey indicate that couples in Uttar Pradesh may be having more children than they want. The average family size is 5.4 children compared to an ideal family size of just under 3. Further, among couples saying that they want no more children, 26 percent are not using family planning. While no information is available on the percentage of couples wanting to space additional births, it can be assumed that unmet need for both limiting and spacing is far higher than the 26 percent for limiting future births. There are also enormous gaps in knowledge of family planning methods. Understanding of effective spacing methods such as the IUD and the oral contraceptive is very low. Even among those with some knowledge of particular methods, there is considerable misunderstanding about side-effects associated with methods. Finally, it is quite evident that men continue to play an important role in decisions about family size and use of contraception especially in rural areas. In fact, men report a lower ideal family size than women. These findings show a great potential for effective information and counseling programs for both women and men. Such programs should be an integral part of a quality service delivery program.

The family welfare program has frequently been criticized for being a top-down effort that does not adequately involve or take into account the needs of local communities and individual families. Services provided by the program are based in hospitals, urban family welfare centers, primary health centers (clinics) and sub-centers where there are wide variations in the quality and availability of services. Far too little effort has been made to reach out to large segments of the poor urban, peri-urban and rural populations by providing a wide range of clinical and non-clinical services.

2.2 Project Response

The GOI understands well the shortcomings of the family welfare program and is poised to make major improvements in how the program is conceived and implemented. IFPS will serve as a catalyst for the GOI in reorienting and revitalizing the country's family planning services. First, IFPS is based on a three-point rationale for family planning that encompasses not only demographic concerns but also those of the health and economic welfare of communities and families. Second, the project will support the application of program strategies that are derived from successful experience in other countries and that take into account the needs of communities. Third, the project will promote a balanced program of services with a range of contraceptive methods appropriate for spacing or limiting births so that the reproductive needs of all couples can be met. Fourth, the project will work with the public sector to extend and improve services and with the private sector to greatly expand private networks for the delivery of high-quality services. The link between public and private sector delivery will be vital to the project's implementation.

2.3 Project Rationale

The IFPS Project has selected Uttar Pradesh as the primary site and testing ground for program innovations. With its population of 140 million, U.P. is the largest state in India and larger than all but six countries in the world. U.P. also is a state with one of the poorest demographic, social and economic profiles in India. If access to family planning services can be greatly increased and if couples accept and use contraception on a broad scale in U.P., other states including those slow-to-progress may also benefit from the U.P. experience. Further, only one state has been selected jointly by the GOI and USAID in order to concentrate project resources so as to have a measurable impact.

A.I.D. is well positioned to assist in reorienting and revitalizing the family welfare program in India. With more than a quarter of a century's experience in family planning assistance to developing countries, A.I.D. can help introduce or expand various successful approaches that have either not been tried before in India, have been carried out only on a pilot basis, or have lacked the comprehensive technical, managerial, and material resources to be provided under the project. Among the lessons learned from A.I.D.'s past work in family planning are the following:

2.3.1 Lessons Learned

- Broad access to family planning services depends on the involvement of a range of public and private institutions. Further, such broad involvement permits market segmentation according to the ability of clients to acquire and pay for services and enhances the long-term sustainability of service programs.

- Multiple channels of service delivery (hospitals, clinics, household or community-based distribution, social marketing, commercial retail sales) ensure that all population groups are served including the hard-to-reach urban poor and rural populations.

- Good quality of services (including a wide range of quality contraceptive methods and good counseling) increases acceptance and continued use of contraception.

- A multi-faceted IEC program can increase the demand for and quality of services and improve the overall effectiveness of family planning service delivery.

2.3.2 A.I.D. Policy and Priorities

A.I.D.'s world-wide population assistance program has three objectives:

- encouraging a balance between population growth, economic development, and available natural resources;
- improving the health and survival of mothers and offspring by promoting

adequate birth intervals and childbearing during the safest years for women; and

- safeguarding the rights of individuals to choose the number and spacing of their children.

These three objectives address economic, health and human rights rationales for family planning. These are embraced by the GOI and will be reflected in the refocused orientation to program implementation embodied in the IFPS Project. A.I.D. priorities for population assistance are based on an allocation of resources that takes into account the unmet need for family planning services and is commensurate with the demographic size of countries. Given its continuing unmet need for family planning and its large size, India, or more specifically U.P., qualifies as no other country as a priority for A.I.D. assistance.

2.3.3 Other A.I.D. and Donor Assistance

Previous Assistance. The GOI has provided over 90 percent of the financial support for the national program. However, international donors have played an important role. Donor assistance has been critical for program innovations and for leveraging funds. In the early years, both the Ford and Rockefeller Foundations made important contributions. The major donors have included the World Bank, United Nations Population Fund (UNFPA), and USAID.

The World Bank has supported five population projects from 1973-88. These were designed to reduce fertility and mortality in selected districts in the states of Karnataka, U.P., Andhra Pradesh, Kerala and West Bengal, and in some major cities. UNFPA has provided population assistance to the GOI since 1974. The assistance included commodities and development projects in Bihar, Maharashtra, Rajasthan and Himachal Pradesh. These funds were used primarily to construct PHCs, SCs and living quarters for staff.

USAID's population assistance to India began in late 1967. Its projects financed the import of equipment for local production of contraceptives, marketing of condoms and OCs, strengthening of five central training institutes and 60 state and local ones, improving expansion of mass education and communication in 50 most populous districts in the country, supporting biomedical research at the Indian Council of Medical Research (ICMR) and supporting an MCH program for training traditional birth attendants. No assistance in family planning was provided between 1973 and 1980 due to an unfavorable political climate. In 1980 a new project was launched to strengthen and expand integrated family planning services in rural areas in five states. This project ended in 1986.

Ongoing Assistance. USAID's ongoing project, the Family Planning Communications and Marketing Project, started in 1983 and will end in March 1993. This $23 million project supports: demographic analysis and training; contraceptive availability by providing U.S. manufactured Copper T IUDs and promoting local manufacture and social marketing of

condoms; IEC programs and pilot programs with the private sector including women's groups; and various data analysis and research activities. Some elements of this project will continue with IFPS funding during the early years of the IFPS Project, including technical assistance to the Registrar General for improving its census operations and data dissemination and use.

UNFPA's future programs will be aimed at activities such as demographic research and training, population and environment, urbanization and changing population structures, research on women in development, and experimental approaches to population education. More attention will therefore be paid to human resource development rather than infrastructure strengthening.

The Child Survival and Safe Motherhood Project is a UNICEF/World Bank assisted project under which all districts in U.P. are involved in an effort to enhance the national MCH program and to improve the capacity of the maternity care system. Activities include support for the Universal Immunization Program, strengthening of the diarrheal control program (including social marketing of oral rehydration salts through the private sector), control of acute respiratory infection, and Vitamin A programs to prevent blindness. Also supported are efforts to improve maternity care (with an emphasis on high-risk pregnancies), and strengthening obstetric care.

The World Bank's National Family Welfare Training and Systems Development Project was launched in 1989 in Andhra Pradesh, Madhya Pradesh and U.P. The project is designed to strengthen the Directorates of Health and Family Welfare in each state through expansion and rehabilitation of pre-service training institutions, increasing the involvement of private practitioners, instituting a training of trainers program, and developing IEC materials. The Bank's Seventh Population Project (1991-1998) is aimed at assisting the public health systems of Bihar, Gujarat, Haryana, Jammu/Kashmir and Punjab. The Child Survival and Safe Motherhood Project (1991-1996) supports the enhancement and expansion of the GOI's MCH program for all the states and Union Territories.

As the IFPS Project is to contribute substantially to the public sector program in U.P., it is essential to ensure close coordination and collaboration between the World Bank and USAID so that duplication of effort is avoided. The IFPS Project will coordinate activities with the World Bank in the areas of ANM training and upgrading of ANM colleges and in the development of IEC materials. USAID assistance under IFPS is designed to complement activities supported by the World Bank, providing related but distinctly different and complementary assistance in areas of training and IEC.

Immediately after signing the Project Agreement, USAID and the DOHFW will hold joint meetings with the World Bank to assure macro and micro-level coordination of USAID and World Bank assistance activities.

3. PROJECT DESCRIPTION

3.1 Project Goal, Purpose and Objectives

The goal of the IFPS Project is to assist the State of Uttar Pradesh in reducing the rate of population growth to a level consistent with its social and economic objectives. Implicit in this long-term goal is the need to lower significantly the level of fertility. Current levels of fertility in the northern Hindi-belt states, where 40 percent of the population lives, are close to the level that existed in India at the time of Independence in 1947. Thus, fertility reduction in U.P. and, by extension, fertility reduction in the other large north Indian states is essential if the GOI hopes to achieve its goal of lowering the national rate of population growth. The benefits associated with a lower rate of population growth will be seen in the reduced burden on the GOI and GOUP in providing health care, schooling, jobs, and housing. Savings from slower population growth will enable the GOI to invest more on a per capita basis in health, education, employment, and housing, thus improving the quality of the nation's human resources and reinforcing its economic development.

The purpose of the IFPS Project is to assist the State of Uttar Pradesh to significantly reduce the total fertility rate through a comprehensive improvement and expansion of family planning services. In order to achieve this purpose, the project intends to double the level of contraceptive prevalence in U.P. (which will mean more than doubling the number of couples using contraception given the growing base population), thus enabling couples to achieve their reproductive intentions through use of appropriate methods for spacing or limiting births. To achieve this purpose, the project has three objectives:

a. Increase access to family planning services by strengthening service delivery in the public sector and developing or expanding the capacity for service delivery in the non-governmental sector. Access will also be expanded through hospitals, clinics, household and community-based distribution, social marketing, and commercial retail sales so that services will be available to a large proportion of clients living in the harder-to-reach rural, poor urban and peri-urban areas.

b. Improve the quality of family planning services by expanding the choice of contraceptive methods, improving the technical competence of personnel, ensuring informed choice through effective counseling, and improving management and follow-up of client services.

c. Promote family planning by broadening support among leadership groups, increasing the public's understanding of the health and welfare benefits of family planning, creating a better image of the program, and providing information (or advertising in the case of the social marketing program) on the availability of services and methods. The project will also increase the participation of women in the implementation of the project at all levels.

The three objectives are interrelated; consequently, success in one area will be tied to accomplishments in the other areas.

The IFPS Project's strategy is directed toward improving the delivery of family planning services within the context of family health and welfare. The GOI's national family welfare program clearly defines this broader context for service delivery as do many non-governmental service efforts. The IFPS Project will promote a service orientation to family planning (FP) as an integral part of maternal and child health (MCH) and will thereby enhance the value of the family planning services to the community and especially to younger, lower-parity women. The full spectrum of activities to be supported (policy, training, IEC, research, and services) will focus on the health needs of women and children. For example, training of physicians and auxiliary-nurse midwives will cover the range of FP/MCH interventions including infection prevention. Primary emphasis will be given to reducing high-risk births and promoting birth-spacing as well as birth limitation. Breast-feeding will be promoted for its health and birth spacing effectiveness. Information on the advantages and disadvantages of various contraceptive methods will be provided to ensure that women and couples are using methods most appropriate for their health and reproductive needs. A number of operations research studies will involve pregnant and postpartum women to increase their use of contraception and to ensure good prenatal, natal, and postpartum care. While the IFPS Project will not directly fund commodities for specific MCH interventions (e.g., vaccines, medical kits), it is anticipated that support from other donors will be available.

Phasing of Project Activities. During the early years of the project, activities will be focused on 32 of the 63 districts -- those believed to have the highest fertility rates.[4] These will include 8 districts selected for special pilot demonstration projects and related operations research to test innovative service delivery models (see page 29).

Initially, emphasis in the 32 districts will be put on the following project activities:

- training/re-training of ANMs, physicians, & other service providers
- equipping clinical facilities for spacing methods
- identifying NGOs to implement CBD activities
- information, education and communications
- transport, supervision, and MIS systems

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[4] The GOUP has identified 32 districts having an estimated CBR above 39 per 1000 population. Further selection of start-up districts will be done jointly by USAID and the GOUP following receipt of district-level results of the 1991 census.

- contraceptive logistics
- contraceptive social marketing (CSM)
- completing assessments and start-up of pilot demonstration projects in family planning service delivery and related operations research studies.
- replication of successful models starting by the end of the second year.

Project activities will not begin simultaneously in all 32 districts but will be expanded to them as rapidly as possible. **Figure 8** illustrates the pattern of expansion which may evolve during the first five project years.

Sustainability. The end-of-project status should be that the GOUP has in place an accessible and high quality family planning services program in the public sector and that a state-of-the-art family planning program has been developed in the non-governmental sector (both for-profit and non-for-profit). The project will assist in maximizing the likelihood of attaining a sustainable effort, i.e., family planning delivery systems that will continue beyond the life of the project. Insofar as possible, the project will support activities in the public sector that do not involve a financial burden on the state program, e.g., development of curricula and innovative IEC and training materials on various contraceptive methods, and training of clinical and non-clinical staff. By having a strong non-governmental component, the project can help ensure financial sustainability in such areas as social marketing and for-profit/employee-based provision of services. The end of project status should be a quality state-wide family planning service delivery program with considerable private sector participation that will be able to continue to provide services over the long term. This objective will be made feasible by the fact that the SOCIETY will be an autonomous body with the ability to raise funds from other sources. IFPS will also encourage the GOI to achieve its policy of providing up to 20 percent of the overall family planning budget to private sector family planning activities. This will be done by developing the capacity of the private sector to carry out effective FP activities and through incremental increases in the GOI's funding of NGOs (see Section 5).

Figure 8 - Illustrative Phasing of Project Activities During First Five Years

TOTAL # DISTRICTS INVOLVED

(cumulative)

ACTIVITY	PY 1	PY 2	PY 3	PY 4	PY 5
ANMs Trained & Equipped	0	10	30	49	49
Physicians trained, in-service	4	8	24	36	41
CSM activities (private sector)	6	15	40	63	63
Demonstration projects launched	1	3	6	8	8
Replication of successful models	0	1	5	10	15
IEC materials development	5	32	63	63	63
PHCs upgraded to model centers	3	6	18	27	27
PVO networks providing FP services	6	8	10	15	22
Logistics management staff trained	0	7	14	21	28

3.2 Project Components

3.2.1 Increase Access to Family Planning

Increasing access involves correcting weaknesses in existing family planning delivery systems and developing additional channels to deliver family planning services. Two principal sectors will be strengthened in order to achieve the objective of increasing access to family planning services: the public sector comprising the Family Welfare Directorate of Health and Family Welfare of Uttar Pradesh, and the non-governmental sector consisting of state-owned cooperatives and some parastatals, autonomous public enterprises, non-governmental organizations (NGOs), for-profit industries, private hospitals and practitioners and commercial social marketing organizations. These sectors will work collaboratively to achieve the goals of the IFPS Project.

Several innovative service delivery models will be developed to reach urban, peri-urban and rural areas with quality family planning services. Both clinical (sterilization, IUDs, and NORPLANT® when approved) and non-clinical (oral contraceptives, condoms, and injectables when approved) methods and training will be emphasized. The IFPS Project will

introduce alternative approaches to service delivery by working initially with a limited number of districts in order to facilitate the rapid start-up of activities. As results are demonstrated, successful approaches will be quickly expanded to other districts in U.P. Since IFPS is a ten-year effort, the project has retained sufficient flexibility to allow for ongoing project adjustments, refinements, and later, replication and adaptation throughout the state and in other states.

a. Public Sector

The majority of family planning services in Uttar Pradesh are delivered by the Directorate of Health and Family Welfare (DOHFW) through its 535 government hospitals, 142 Urban Family Welfare Centers and Health Posts, 2476 Primary Health Centers, 20,153 Sub-Centers, 1,555 government dispensaries as of 1989 (Health Information, India, 1989), and a cadre of outreach workers in the field.

Despite this large infrastructure, the delivery system is inadequate to provide the necessary services in the state, especially in the rural areas. The ICMR evaluated the quality of family welfare services offered at the primary health center level in 19 Indian states. This study, conducted in 1987-1989, revealed major weaknesses in the system which affect both access to services and the quality of services. These weaknesses include transportation difficulties, inadequate supplies and equipment, and the lack of trained personnel.

The plan to improve access to services through the public sector is necessarily related to the objective of improving the quality of services. IFPS proposes a three-fold strategy: (1) to assist the DOHFW to create model clinics in medical schools; (2) to assess and strengthen the ANM in-service training program in order to improve the capacity of ANMs; and (3) to create and implement CBD/outreach projects to expand access to services. Project activities to implement these strategies will be initiated in the first quarter in order to provide the DOHFW with models and early lessons upon which to build expansion efforts in later phases.

(1) Medical Center Projects

In this project, the Medical Center will be viewed as consisting of the medical college, its hospital, and the community it serves. Medical center projects will be developed in urban and peri-urban areas to expand quality FP/MCH services through medical colleges. Medical center projects will be implemented first because these centers have the capacity to serve a large number of family planning clients and because they play a leadership role in the establishment of medical practice standards. By working with medical colleges, IFPS will have the opportunity to address barriers, such as negative attitudes about oral contraceptives (OCs) and IUDs, which presently impede access to family planning service delivery.

The project will develop an improved clinical training program for medical students and will upgrade and equip facilities in model clinic sites. Since medical centers are associated with PHCs for referral purposes, the project will strengthen, upgrade, and equip the entire network and will develop these model clinics and associated PHCs as clinical practice sites.

The project will work with one or two medical colleges initially (e.g., King George's Medical College and Jawaharlal Nehru College of Medical Sciences), to develop standardized FP/MCH curriculum and clinical practice guidelines. Master trainers will be developed to prepare medical students and physicians in clinical skills, contraceptive technology and effective counseling. The project will provide technical assistance through JHPIEGO as well as supplies, equipment, training, and IEC materials needed to service the model clinics and PHCs. These centers will be upgraded and their capacity expanded to serve larger numbers of family planning clients with the full range of quality family planning services.

After the implementation of the first model clinics, other medical centers will be added rapidly so that, by the end of year four, all medical centers will have model clinic networks. These nine medical colleges will then be prepared to train thousands of medical students, physicians, ANMs, LHVs and others through clinical practice sites throughout the state.

(2) In-Service Training Program for ANMs

The Auxiliary Nurse Midwife (ANM) plays a vital role in the public sector delivery system as she is the primary health provider in Sub-centers and is the main link to the community. After 18 months of theoretical pre-service training, the ANM is expected to perform a large number of tasks related to FP/MCH such as immunizations and ante-natal care. Since in-service training is also minimal, the majority of ANMs do not have good clinical or counseling skills.

The IFPS Project will develop and strengthen the in-service training program of ANMs to improve their clinical and non-clinical skills and prepare them to expand access to services. The strategy involves re-opening the ANM Colleges (some of which have been closed in recent years) and providing the technical and financial resources to develop a competency-based curriculum and training program. The purpose is to develop a statewide training program which will result in an institutionalized training capacity to generate a continuous supply of well-trained ANMs.

In the first phase, a training needs assessment of ANMs will be conducted and ANM colleges surveyed. An estimated ten ANM colleges will be re-opened, equipped, and master trainers prepared by the end of year two.

As in the medical center project, the ANM training project will provide training and materials, commodities and supplies to ANM trainees who return to their posts. The project expects to re-open and upgrade most of the 49 ANM colleges and provide in-service training to ~.e 20,000 ANMs within the first 5 years of project activities.

(3) Service Delivery Pilot Demonstration Projects

IFPS will support the development and implementation of three types of large-scale service delivery demonstration projects to increase access to quality FP/MCH services. These three

pilot project types will be targeted at different levels of the service delivery system: (1) municipal and district hospitals in urban and peri-urban areas; (2) PHCs in peri-urban and rural areas; and (3) PHCs and SCs in rural areas.

The three project types will be carried out in a total of eight districts as follows: (a) each type will be done as unipurpose interventions in two separate districts (total of 6 districts); and (b) in the two remaining districts, all three project types will be combined to measure their combined impact. Criteria for selection of the demonstration districts include: need as evidenced by high TFR, geographic diversity, and support for the project by district administrators. Target districts for these projects will be in or near districts where ANM training and medical center projects will be implemented to ensure the supply of trained ANMs and physicians to work in these service delivery projects. When possible, preference will also be given to districts with the strongest NGO presence. Each district will establish district-level planning committees to develop implementation plans and to monitor project results. These committees will include relevant GOUP officials from the block and district level, and representatives of the NGOs implementing CBD activities. Resources will be available to expand successful activities to other blocks so that the entire district is covered as quickly as possible.

Management and supervision systems, including MIS, will be improved and revised to track the effectiveness of these models in reaching targeted communities. Operations research studies will be conducted simultaneously with the demonstration projects to assess their effectiveness.

Replication. Successful approaches to service delivery will then be incorporated into the design of other FP program activities and expanded as rapidly as possible to other districts within U.P. Major lessons learned in these demonstration projects will also be shared with other states outside of U.P. through technical assistance from the project, the central MOHFW and the state DOHFW. USAID will provide resources to support the diffusion of innovations when demonstration models are determined to be effective. It is expected that both the pilot demonstration projects and their wide-scale replication will be financed through performance-based disbursement mechanisms. For example, disbursements may be made against the replication of a successful demonstration model in an additional five districts, then 10, 20, 35, etc. (see Section 4.3).

Demonstration Project Type #1: Urban Outreach/CBD

The urban outreach/CBD demonstration projects will test approaches to urban and peri-urban populations. The IFPS Project will introduce family planning services door-to-door in densely populated communities. Health workers from Municipal and District Hospitals, Urban Family Welfare Centers (UFWC) and Health Posts will work with health workers from the community to promote FP/MCH services, and to provide non-clinical commodities. Clients will be referred to Health Posts and UFWC for clinic services. The project will test linkages between public and private sectors by using CBD workers from PVOs and other non-governmental sectors.

Demonstration Project Type #2: PHC/SC Outreach

The purpose of these outreach projects is to strengthen the linkage between government PHCs/SCs and villages. This model will test the effectiveness of using personnel from PHCs and SCs to extend services to surrounding villages. This approach will utilize existing government personnel, i.e., ANMs, extension workers, health inspectors and sanitarians to introduce family planning as part of their regular work routine through door-to-door visits. During these home visits, these workers will distribute and explain family planning materials as well as provide condoms and pills and make referrals for clinical methods. Once a client base is established, depot holders will be established to carry on resupply activities. ANMs will be responsible for supervising and resupplying depot holders. Emphasis also will be placed on improving and equipping new health facilities in the rural areas. This model will also include post-partum family planning services. One idea is to exploit the "birth-risk approach" in which ANM's specifically target pregnant women for prenatal, natal, and post-partum services.

Demonstration Project Type #3: CBD Rural

The purpose of these rural demonstration projects is to increase access of rural villages to family planning by utilizing non-government, community-based workers to bridge the gap between villages and government family welfare activities. NGOs will establish networks of community-based workers who will educate their peers and distribute pills and condoms on a door-to-door basis. ANMs will work closely with NGO supervisors to direct the work in the field. Fieldworkers will refer clients to government clinics for clinical FP methods, and will assist in follow-up of these clients. This approach will involve significant public-private collaboration, particularly in client referral, follow-up, and record-keeping. The implementing NGO will be responsible for CBD worker selection, training, and monitoring, working closely with the ANM. NGO supervisors will coordinate field activities collaboratively with ANMs at the SC level.

b. Non-Governmental Sector

There is an urgent need to build capability in the non-governmental sector for the provision of high-quality family planning services in order to complement public sector program efforts. While NGOs now provide some services, they could be greatly expanded. Although GOI policy stipulates that up to 20 percent of the overall budget for family welfare should go to non-government organizations this is not now happening, due both to the lack of existing capability and to the rigid requirements for NGOs to obtain public funding.

Community-based, organized CBD and other outreach networks are therefore required to meet the extensive need for family planning services in U.P., particularly in rural and peri-urban areas. The IFPS Project will therefore build on existing networks such as cooperatives, PVOs, employer-based services and autonomous government organizations to introduce and expand family planning service delivery.

The Registered Society (the SOCIETY) will coordinate activities in this sector. It will develop and fund a wide variety of training, IEC, and family planning service activities to be carried out by private sector organizations and autonomous government enterprises (e.g., the Railways). The SOCIETY will develop funding guidelines for CBD/outreach programs, standardize service guidelines, issue grants to selected networks, and provide technical assistance to all grantees. It will finance the establishment of two specialized centers: (1) a training center with hostel facilities to provide non-clinical and management training to all grantees; and (2) a center to develop and coordinate education and promotion efforts for the private and public sectors (a more detailed description of the SOCIETY's functions is in the Implementation Section). Activities will be carried out through the types of networks described below.

(1) Cooperative Networks

Cooperative networks have long been recognized as potentially strong vehicles for the promotion and delivery of family welfare services because of their extensive infrastructure at all levels. Village cooperatives are managed by local committees which are, in turn, provided technical assistance and supervision from block and district level managers. Some cooperatives already provide health services such as immunization, eye care and medicines through small medicine shops and dispensaries.

The largest cooperatives are agricultural cooperatives with a total of 7.2 million members and a potential outreach of 40 million people. The dairy cooperatives have 450,000 members and a potential reach of five million people. U.P. also has a large network of sugarcane cooperatives and factories with well developed infrastructures that could be utilized for the introduction and expansion of family planning programs.

An assessment is currently underway to examine several large-scale economic networks, including cooperatives. Based on the results of these studies, the IFPS Project will provide grants and technical assistance to selected large-scale cooperatives. Village health workers from within the cooperatives will be selected and trained to serve as promotion, education and distribution agents for CBD programs. A focal point initially will be to work with women's dairy cooperatives since some of them are already providing immunization and health services, and members are very interested in adding family planning to their portfolio. Trained workers will provide condom, OCs and other health commodities such as first-aid kits, and make referrals to local PHCs and SCs for clinical contraceptive methods. Points of contact will be milk stations, in the case of dairy cooperatives, where members drop off their milk daily and at society meetings of all cooperatives where members learn new skills as well as discuss business issues.

(2) PVO Networks

The IFPS Project will work with a variety of PVOs to expand access to clinical and CBD services. Approximately 400 health-oriented PVOs are active in U.P. Nearly half of these PVOs are members of the U.P. branch of the Voluntary Health Association (UPVHA). As an umbrella organization, UPVHA organizes state-level workshops, training of health workers and managers, and conducts studies on health-related issues. The project will provide grants, training, technical assistance, and other items as needs determine to such umbrella organizations, through the SOCIETY, to actively encourage members and non-members, that have developed service networks, to participate in FP/MCH activities.

Rural development PVOs are traditionally involved in a variety of activities such as non-formal education, and agricultural extension programs, many of which are committed to improving the status of women. In addition there are numerous women's organizations at the village level that could play a key role in working to make the FP/MCH programs more community-focussed and oriented to the needs of women. The IFPS Project will assist in integrating family planning service delivery and promotion into general rural development activities. The SOCIETY will provide grants, training for CBD workers and technical assistance to these organizations and will help the women's groups in their promotional activities (see section on Participation of Women, p.49).

(3) Private Practitioner Networks

The Indian Medical Association (IMA) is a large organization with a membership of approximately 10,000 physicians in U.P. USAID is currently supporting a project to encourage and train IMA members in the distribution of OCs. The IFPS Project will expand this program into U.P. In addition, the SOCIETY will provide grants and technical assistance to selected members of the IMA to establish model private clinics for family planning service delivery.

The project also recognizes the potential of working with indigenous leaders and health care workers to promote and provide FP/MCH services. Approximately 70 percent of the population in U.P. first visits a non-allopathic practitioner for health care. Only if this approach fails do they go to allopathic health services. The non-allopathic practitioners fall within the Indian System of Medicine (ISM), of which the Indian Rural Medical Association (IRMA) is a part. When properly trained, many members of the IRMA are able to provide clinical family planning methods (including VSC and IUDs), and all could provide some level of family planning service as well as carry out promotional activities. IFPS will work with the ISM to develop capabilities in FP service delivery.

A number of community workers such as traditional birth attendants (dais), and traditional practitioners such as Ayurvedic and Homeopathic healers are functioning well and are accepted by the communities as health care agents. The IFPS Project will therefore work with the Indian Rural Medical Association to establish and train networks of these traditional

practitioners and provide them with technical assistance for the promotion of family planning and distribution of non-clinical contraceptives. The project will facilitate linkages between such networks of traditional practitioners and NGO and the commercial social marketing sector so that the practitioners are supplied with contraceptive commodities to distribute alongside their other medicines and goods. They will also be trained to make referrals to PHCs and SCs for clinical methods.

(4) Employer-Based Services

The Government of India and USAID have recognized the importance of the industrial sector not only because it employs large numbers of people, but also because of the potential for a ripple effect through its services to non-employees in peri-urban and rural areas. The typical characteristics that make the industrial sector a unique priority for family welfare programs are: (1) some of the industries have an existing health infrastructure that makes it easier to either add family welfare services or to expand existing services; (2) the workers are easier to motivate because of their socioeconomic status and relatively better environment; (3) they can yield greater return for the investment because of the multiplier effect; and (4) they are located in the contiguous area where it is easy to contact potential clients and provide services.

A small number of industries have played a pioneering role in initiating family planning programs as early as the 1930s. However, since 1970, an increasing number of industrial houses and public sector corporations have established family welfare programs for the benefit of their employees either on their own or in cooperation with the central government and/or leading voluntary organizations of the country. The level of program effort has varied considerably among the industries that initiated family welfare programs. Common features of successful programs have been: (1) involvement of top and mid-level management in the program; (2) involvement of workers for motivational purposes; (3) strong IEC programs; (4) strong management of the program; and (5) expansion to neighboring villages.

The project's approach will be to support a limited number of inputs and make limited financial investments in order to stimulate the industrial sector to use its own resources to support family planning. The principle is to leverage project resources to yield investments in family planning by industries. The project will use cost-benefit studies to demonstrate to companies that FP is to their financial advantage as well as to the health advantage of workers.

The SOCIETY will issue a grant to another private organization to coordinate and manage the activities for the employer-based sector. The organization will develop and implement an action plan for the employer-based sector. Technical assistance will be provided to these employers to give them the minimum inputs needed to start or expand family planning services.

An AID-funded assessment of the organized sector is currently underway in U.P. This study

is mapping the distribution and sizes of the industries in U.P. and collecting information on the attitudes of employers and employees regarding family planning. The lead organization will therefore utilize the results of this study and work with apex organizations, such as the Chambers of Commerce, to identify appropriate organizations for collaboration. Different approaches will be used based on the identified needs for service delivery and levels of competence.

- Where the corporation lacks the motivation and involvement of the management in family planning, the strategy will be directed at a policy level to motivate the top and mid-level managers, wives of executives and trade union leaders. The project will use policy tools such as cost-benefit models to show the benefits of family planning.

- Where the commitment of the management is well established, the strategy will focus on the introduction or expansion of quality family planning service delivery through different models such as clinic-based services, CBD or a combination of both. In these cases, technical assistance will be provided by the project to present the options available for service introduction and expansion. The emphasis will be on showing how to provide family planning services using their own resources.

- Where the program is of poor quality overall, due to reasons described above, and there is little commitment, the strategy will be to provide assistance for policy support to convince the management to provide family planning services and for some service delivery inputs such as training and IEC.

In addition to the above approaches, innovative financing schemes will also be tested. Interest of existing health insurance agencies in extending the benefits to include family planning will be assessed and utilized as appropriate. The project's role will again be to use minimal resources to stimulate private investments in family planning services.

(5) Autonomous Public Enterprises

There are several public enterprises in India that have an extensive network of medical and family welfare programs across the country. These enterprises are managed directly by their separate ministries, are independent of the state government and their medical systems are not under the jurisdiction of the MOHFW. These include the Indian Railways, the Government Postal System and other central government networks. For example, although the MOHFW provides funding to the Railway Health Services, the management and use of these monies are solely in the control of the Railway Board. These various networks have much potential for increasing family planning service delivery. The project will capitalize on such existing networks.

As one example, the project will explore the possibility of assisting the Family Welfare Program of the Indian Railways in U.P., with the assistance of NGOs. The Indian Railways, the rail transport authority in India, is a unique organization operating the biggest railway in

the world under a single management structure. The Railwaymen in U.P. number about 320,000 (20 percent of total Indian Railway staff), representing a Railway family of about 2 million. Many are not receiving family welfare services from the Family Welfare Program due to lack of access and would benefit from improved access to family planning.

IFPS will provide technical assistance to strengthen the Railway Family Welfare Program with the collaboration of the Railway Women's Organization. Specific activities will include:

- Strengthening the in-service clinical and non-clinical training capability within the Railway system in U.P. An assessment of existing training programs will be conducted initially, followed by training of a core group of master trainers. These trainers will then be expected to expand training throughout the Railways with minimal or no assistance from the project.

- Development of a quality service delivery system through clinic-based outreach and CBD approaches. Outreach workers will be trained from existing Railway staff who will be supported by trained personnel from the Railway Women's Organizations. Different models for outreach and CBD may be attempted in various divisions of the Railways.

- Recommendations will be made for upgrading facilities, MIS and logistics management, although it is not expected that the project will support these in any sizable manner.

All activities in the non-governmental sector will be phased over a ten-year period. Following initial assessments where necessary, training and other activities will be initiated. Years 4-10 represent the replication and expansion period when training and service delivery will be expanded by all the networks described above throughout U.P. and other states.

(6) Contraceptive Social Marketing and Commercial Retail Sales

India was one of the first countries to develop a social marketing program as a major service delivery mechanism for contraceptives. After 25 years of operation the socially marketed Nirodh brand of condom provides one third of all condom delivery in India. In late 1988, the GOI launched a social marketing oral contraceptive, the low dose Mala D which now represents 35 percent of the commercially sold OCs in India.

The basic premise behind the GOI social marketing program has been that the private sector could be mobilized to deliver contraceptives in an efficient manner. Government communications programs would then develop consumer demand through general family planning communications and specific brand advertising. Basically, the GOI provides a subsidy by purchasing the products (condoms and OCs) from the manufacturers and reselling them at a lower price to participating distributors. The recommended profit margins to wholesalers and retail outlets are currently set by the government, as is the consumer price.

In the case of the Nirodh condom, a small marketing subsidy is given per piece; in the case of Mala D the margin to the distributor is considered adequate for additional company marketing efforts. Currently there are ten major private companies distributing and selling Nirodh along with their other products and four participating pharmaceutical firms which have recently pledged to distribute Mala D.

The MOHFW spends considerable resources to purchase condoms for social marketing. However, the program has not been as successful as anticipated. In part, this is due to the variable quality of materials promoted. There is also a concern that the marketing efforts are not reaching the rural areas where approximately 80 percent of the population resides.

The IFPS Project will promote higher quality products and will intensify promotion and distribution for the Nirodh Deluxe and Mala D programs in the public sector. In addition the project will develop sustainable and cost-efficient social marketing channels that can complement the private sector delivery of temporary contraceptive methods. The project will structure the program in a way to ensure that there will be a reduced need for continued GOI and USAID input in the future in the marketing of contraceptives. The major elements of the CSM program are:

- Identification and competitive selection of a social marketing project management firm. Other firms will be sub-contracted as needed and technical assistance will be provided by USAID-financed cooperating agencies.

- Expansion of the market for the Nirodh Deluxe condom and Mala-D OC down to towns of 5000 people and increased demand generation through appropriate advertising and promotion channels.

- Identification or development of both a commercially viable brand of condom and OC at affordable prices, and extension of the market for both down to towns of 5000 people. Demand creation for these brands of condom and OC through appropriate advertising and promotion channels.

- Development of channels for distribution to rural villages of under 2000 population of government subsidized as well as commercial condoms and OCs. In particular, attempts will be made to link traditional practitioners, cooperatives, and NGOs working in rural areas into the social marketing network on a commercial basis.

- Market research for continued project development.

3.2.2 Improve Quality of Services

The IFPS Project will improve the quality of family planning services by: (a) providing informed choice through effective counseling; (b) expanding the choice of contraceptive methods; (c) improving the technical competence of personnel; (d) upgrading facilities and equipment; (e) improving follow up and referral of client services; (f) strengthening

management effectiveness; (g) improving management information systems; and (h) improving logistics. The various activities designed to increase access to service in both the governmental and non-governmental sectors (described in the previous section) will benefit from these efforts to improve the quality of service delivery.

Two specialized centers will be established by the SOCIETY that will assist in improving the quality of family planning information, education and services. One will be a training center to provide non-clinical and management training for family welfare staff of non-governmental organizations. The other (described more fully on p.47 in the PEP section) will develop IEC materials and coordinate all education and promotion efforts across the sectors.

a. Provide Informed Choice Through Effective Counseling

Surveys and interviews have suggested that client satisfaction with family welfare services is low because clients do not believe that the system is interested in meeting their needs. Given the limited range of methods, government emphasis on obtaining sterilization, provider insensitivity to socio-cultural differences among clients, and the lack of counseling and information for clients, it is not surprising that satisfaction with government services is low. Some private clinics and NGO service providers, such as the Family Planning Association of India in Lucknow, appear to have more satisfied clients, in part because staff are motivated and interested in client needs. Counseling and a range of methods are integral parts of their services.

Since contraception and fertility involve personal decisions for individuals and couples, services must be offered with sensitivity and privacy. Counseling is a key component of quality services because regular contraceptive use is dependent on accurate information provided through effective personal communication. Clients must be able to make informed decisions about the method that best suits their reproductive needs, and they must learn to use the chosen method appropriately. Given the role that men play in making decisions about contraception and fertility, counseling programs must also address the concerns of men and provide counseling for men as needed. The GOI's family welfare program must be strengthened to add this essential component.

The project will develop training programs in counseling and interpersonal communications designed for all levels of service delivery personnel within the private and public family welfare system. The clinical training programs at medical colleges and ANM colleges will include counseling as a core component. Training programs for non-clinicians will be developed by an NGO, and courses will be offered to NGOs and other private sector providers through the Training Center.

The focus of the training programs in counseling is to develop effective listening and communications skills in order to determine the client's reproductive needs. Training programs will incorporate participatory learning techniques, such as role playing, to help participants develop and practice new skills. The project will also supply trained personnel with adequate supplies of method-specific materials for client education.

Through demonstration projects, various methods to encourage informed choice will be developed and tested, including printed materials, one-to-one and group counseling, and audio-visual methods. Client feedback systems will be developed to assess the impact of counseling on client satisfaction, choice of method and continuity of use. Operations research studies will be designed to assess the impact of informed choice approaches and methodologies.

b. Expand Choice of Methods

The Indian family welfare program relies heavily on sterilization with little effective emphasis on other methods. Backed by a system of targets and incentives, this program has achieved considerable success in reaching older, higher parity women. However, the program has achieved only limited success in reaching younger, low-parity women who desire to space their children (surveys show that there is a significant unmet demand...see Technical Analysis section). IUDs, condoms and OCs have been used only by a small percentage of couples.

Provider bias against oral contraceptives along with misconceptions about, if not outright opposition to, injectables and other hormonal methods has limited the range of choices for couples desiring to space their families. Lactating mothers are a group with special need for effective contraception, but who have no access to appropriate hormonal methods because of provider misinformation and the unavailability of progestin-only pills in the existing program.

The project will assist the GOUP to develop a more balanced program of temporary methods to complement the existing program which relies on the permanent method of sterilization. By emphasizing a range of temporary methods, women and men of varying ages and parities will be able to meet their reproductive needs and achieve their desired family sizes.

Strategy. Expanded outreach and CBD programs in both the private and public sectors will increase access to broader method choice, with a special focus on the distribution of non-clinical methods (oral contraceptives, condoms, and injectables when approved/available) for all users. These programs will also increase the number of referrals to public and private facilities for IUDs, female and male sterilization, and other clinical methods such as NORPLANT® as they become available. The project will promote the distribution of condoms for the primary purpose of preventing pregnancies. Secondarily, the distribution of condoms will also be promoted for STD and HIV prevention. The project will also support the promotion of high quality condoms as a strategy to increase utilization and effectiveness.

A strong educational program will be developed to address provider and consumer biases about oral contraceptives and other temporary methods [see section 3.2.3(b)]. In-service training, professional workshops and articles in Hindi and English will be available to clinicians to update knowledge in contraceptive technology. Pre-service and in-service training programs will address the issue of method choice, provider bias, and client misconceptions about various methods.

USAID is currently supporting a project on oral contraceptives with the IMA in Gujarat to

train physicians in pill distribution as part of their private medical practice. The IFPS Project will build on this strategy and train the U.P. members of the IMA on oral contraceptives. This strategy will be linked to a strong promotional campaign to create demand through mass media in selected target areas.

The training programs for field workers such as VHWs and CBD agents in the public and non-governmental sectors will emphasize method-specific information and address myths and misinformation about all methods. Competency-based training curricula for these workers will also be developed to ensure that they provide accurate information about method choice.

Client misinformation will be addressed through the combined strategy of: (1) accurate information and effective counseling by health providers and CBD workers; (2) availability of appropriate educational materials prepared for a variety of literacy levels; and (3) mass media promotional campaigns. The combined effect of a person-to-person approach and targeted educational materials reinforced by mass media campaigns in selected areas will result in a growing body of clients who are more aware of the range of method choice.

The sterilization program for men and women will be improved in order to ensure quality services to those couples desiring a permanent method. As a first step, an assessment of the current program of male and female sterilization will be conducted to determine the quality of the service and recommendations made for improvements or changes in the program. A primary issue will be to assess the appropriateness of promoting minilaparatomy as a leading technique for female sterilization.

The contraceptive supply system will be strengthened to ensure the availability of commodities at all levels of the system. In particular, the project will ensure a continuous supply of IUDs and regular renewal of equipment and supplies to support an improved and expanded IUD program. As GOI policy allows, high quality products not currently in use, such as NORPLANT® and CuT-380A IUDs, will be introduced in selected sites to demonstrate their efficacy and acceptability and to give providers and clients the opportunity to compare these and other available methods.

Consistent with GOI policy, high quality products not currently in use in India, will be introduced carefully and in a phased-in manner in selected sites to demonstrate the feasibility, acceptability and effectiveness of these methods and to give providers and clients the opportunity to assess their advantages and disadvantages especially in comparison with other methods.

Prior to the introduction of new products, an introduction strategy will be developed and will address issues such as infrastructure capacity in terms of clinical needs and follow-up, training, counseling, supplies and logistics, provider and client materials. The introduction of products such as NORPLANT® will be consistent with GOI strategy and will focus on: (1) assessing the suitability of implants for eligible couples in terms of safety, acceptability and effectiveness; and (2) acquiring experience and establishing infrastructure in preparation for expanded availability of this method should it be found to appropriate for use in the Indian context. The NORPLANT® strategy supported in U.P. under this project will first follow

the overall GOI plan to introduce the method through medical schools by training doctors and nurses in counseling, insertion, removal and follow-up, and setting up appropriate monitoring mechanisms. AID/W C.A.s with extensive experience in NORPLANT® introduction (e.g., JHPIEGO, AVSC, and/or The Population Council) will provide technical assistance in U.P. Once the decision by the GOI is taken to permit continued and further expansion of NORPLANT® introduction, demonstration projects will be developed to evaluate the suitability of providing the method through other avenues. Programmatically, it is extremely important to phase in NORPLANT® in tandem with overall improvements to be implemented under the IFPS Project in the clinical, counseling and management structure of the public and private providers of family planning and MCH services.

Again, consistent with GOI policy, and pending the results of ongoing comparative IUD trials supported by the ICMR, consideration will be given to introducing the CuT-380A IUD in U.P. Although the CuT-200 IUD currently in use in India is a good device, the superiority of the 380A in terms of greater effectiveness and longer duration (eight years rather than four years) should render the device more appropriate for use in India than previously anticipated. A major issue to be addressed under the IFPS Project related to IUDs, which in part may affect GOI decisions to switch to the 380A device, is IUD continuation rates. It is anticipated that better training and IEC materials, especially in terms of counseling and of user-oriented materials, and better efforts to provide clients with other methods that are appropriate for the needs and short and long-term reproductive intentions, should result in major improvements in IUD continuation rates in India.

Another method which will be considered for introduction into the public sector program first is progestin-only pills for breast-feeding women. Breast-feeding women constitute an important group of clients with special needs for family planning. Within the context of improved maternal and child health, family planning service delivery efforts will reach postpartum women in order to promote optimal breast-feeding for birth spacing and for child health. In this context, family planning providers and users will be informed of the recently devised lactational amenorrhea method (LAM) which can provide greater than 98 percent effectiveness against unplanned pregnancy during the first six months post partum. In addition, contraceptive counseling will emphasize methods of contraception that are appropriate for lactating women. Appropriate methods are those that do not inhibit breast-feeding: non-hormonal temporary methods such as IUDs and condoms, progestin-only hormonal methods such as minipills, injectables and NORPLANT® that do not suppress lactation and do not pose significant health risks for the mother or baby; and permanent methods for couples who have achieved their desired family size. The introduction of the progestin-only pill (used in other countries for lactating women because it has no effect on the quality and quantity of breast-milk) will be explored.

The project will conduct operations research studies to assess how the expanded range of methods will affect project performance and client satisfaction.

c. Improve Technical Competence

Clinic-based services are currently the primary channel for family planning services in the

public and private sectors. Clinic facilities are the primary site for the more effective methods of contraception, yet many problems impede the clinic-based delivery system. As discussed previously, one of the major limitations is the lack of well-trained personnel in health centers and clinics. Pre-service and in-service training is a vital strategy to improve technical competence in clinical settings.

Strategy. The strategy is to strengthen significantly the clinical practice network, starting with the medical colleges and ANM training centers (see p.29). Special emphasis will be given to training women clinicians. The training focus will be designed to strengthen the clinical and counseling skills of providers and to reorient their thinking and behavior to help clients achieve their personal reproductive needs. The training strategy will build institutional capacity so that a core group of master trainers will train other trainers and thereby replicate efforts across the state. As a result, the training program will be able to generate a regular supply of proficient family planning service providers and trainers throughout the state. Training should be provided for male as well as female providers since some methods (vasectomy and condoms) will be sought and used by male clients.

As described in the earlier discussion of increasing access, IFPS will develop a master pre-service clinical training program for medical students, initially at facilities where model clinics will be developed. The focus of the program will be on developing clinical skills, counseling and interpersonal communications, contraceptive technology, and linkages between family planning and MCH. Clinical practicums will be a key aspect of the training program and training materials, supplies and commodities will be distributed to centers where participants will be working. This effort will be coordinated closely with training supported by the World Bank under its India Population Project (IPP-6) to ensure complementarity.

The plan to re-open ANM training centers for in-service education has already been described in section 3.2.1. Model in-service programs will also be developed at nursing colleges to improve the skills of LHVs. As in the physician and ANM strategies, master LHV trainers in U.P. will be prepared to teach a standardized curriculum. The initial training will target the districts where the other service delivery projects will be implemented. In-service programs will be also developed for private associations such as the IMA and RMA in order to provide the opportunity for current practitioners to update their clinical knowledge and skills in family planning on a continuing basis.

d. Upgrade Facilities and Equipment

The ICMR study referred to in para 3.2.1 (a) found that one of the major weaknesses in the service delivery system which affected both access to as well as quality of services was inadequate equipment. IFPS will attempt to address this problem at the service delivery points with regard to equipment of direct relevance to provision of family planning services. With regard to developing a clinical training program for medical students, the project will upgrade and equip facilities in the model clinic sites, as well as at the associated PHCs which will serve as clinical practice sites.

e. Improve Follow Up and Referrals

The management of a quality FP/MCH program must include special emphasis on effective follow-up systems to ensure client satisfaction and continuity of use. Good follow-up procedures are critical components of clinic and CBD management and can be used as tools to assess the effectiveness of referral linkages between community-based and clinic-based systems.

IFPS will support the development of procedures that encourage client follow-up. An initial management assessment will target problem areas in referral patterns and make recommendations for improvements. A reporting system will be developed to track referrals from CBD to SCs, PHCs and hospitals. As part of the planning for all pilot projects, follow-up procedures will be assessed and recommendations for improvement proposed.

A community-based strategy for follow-up will be developed to provide support to clients and reinforce method-specific information. Service delivery project districts will be used as test sites to determine the most effective approaches to ensure and measure continuity of method use. Operations research studies will be conducted to determine the relationship between client satisfaction, follow-up and continuity of use.

f. Strengthen Management Effectiveness

The project will develop and strengthen management training as a key strategy to improve quality of services. The Training Center funded by the SOCIETY will offer a range of management courses prepared for different levels of managers and service providers. These courses will incorporate the technical aspects of management, such as MIS and finance into the broader issues of managing family planning programs. A small number of participants will be selected annually to participate in short-term training opportunities overseas. These opportunities will contribute to institutional strengthening and professional development through sharing experiences with managers and leaders from countries around the world.

A special emphasis will be placed on the development of women managers to provide opportunities to upgrade their skills and to ensure that the needs of women are incorporated throughout the project. Special courses for women managers, i.e., Women-In-Management, will be offered to public and non-governmental sectors to develop a cadre of women leaders who can ultimately influence family planning practice and policy at all levels.

g. Improve Management Information System (MIS)

A fundamental requirement of any quality program is a well developed MIS to ensure monitoring and evaluation of key indicators, and to provide information critical to program planning. The IFPS Project will, therefore, strengthen MIS activities in each of the project sectors. The goal is to have an MIS that provides meaningful data in a timely manner for decision-making at appropriate levels. The MIS should be a vital instrument for management decision-making. Experience has shown that to be effective and sustainable, the MIS must also be simple. A special effort will be made to build a strong, modern MIS within the

SOCIETY for overall project management.

An assessment of the MIS in the U.P. DOHFW was conducted in 1991. Results of the study indicate that the existing system works reasonably well, but there are some concerns regarding the flow of information and application of data. In the existing structure, information flows well from the district level to the central level. However, there is little information or feedback that flows back to the district level. Moreover, there is no systematic effort to utilize the information to improve service delivery.

The IFPS Project will improve and strengthen the existing system in the public sector, without any major revamping. Initially, improved MIS reports will be tested in service delivery project districts, followed by expansion across the state. Feedback from all levels of the service delivery system will be incorporated into the assessment and design of reports and feedback systems, and training at all levels will facilitate the implementation of revised systems. Further, some simplification of data gathered at the service level may be tried given central and state-level support for such alterations. Improvements in the MIS will be coordinated by the SOCIETY with technical assistance from an AID/W cooperating agency as needed.

In the private sector, assessments will be conducted of the MIS in private corporations, NGOs and other organizations selected for support through the project. Following the assessments, appropriate systems will either be developed or improved. All efforts will be coordinated by the lead NGO organization in order to ensure the development of a simple system for private sector organizations which is consistent with the public sector MIS.

h. Improve Logistics

Contraceptives and related family planning equipment and supplies for the governmental, NGO/CBD and social marketing programs of U.P. are presently procured and distributed through several interrelated logistics systems. Method-specific targets are set annually for all methods by the GOI, in collaboration with the state MOHFW, CBD and social marketing distributors. Based on these targets, the GOI procures the required commodities from local producers, subsequently issuing them to the various state Central Medical Stores Depots, and directly to the social marketing distributors who maintain their own logistics systems for distribution and sales. NGO service providers obtain their supplies from and report directly to the appropriate state or local facility of the MOHFW.

The private commercial sector is completely independent of the GOI/MOHFW. This sector supplies a small portion of the total condoms and IUDs, and a rather larger portion of the OCs, purchased from both local and international sources.

Although there are supply shortages and supply imbalances, these systems in general ensure a fairly constant supply of commodities for the current program. However, the anticipated increase in the volume of services to be provided will require substantial strengthening of the contraceptive distribution and logistics management systems of the MOHFW, as well as identification or strengthening of a variety of alternate public and private sector distribution

channels.

It is estimated that there are at minimum six million active users of modern family planning methods in U.P. In order to increase the contraceptive prevalence from the present 27 percent to about 50 percent in 2002, the number of users will have grow to some 15.5 million.

Strategy. The project will strengthen the public sector distribution system to base it more closely on quantities actually dispensed to beneficiaries. This system will supply the MOHFW facilities and an expanded network of NGOs and private sector facilities. An expanded commercial retail sales program will distribute a larger range of contraceptives through their own, separate distribution system.

In the public sector the project will strengthen the systems at the state, district and PHC levels:

- At the state level, central and regional depots will be established or upgraded by the GOI/GOUP. Better forecasting procedures will be installed and a statewide policy for maximum and minimum inventory levels will be set and procedures for allocations will be based on district requirements and performance.

- At the district and PHC levels, equipment will be supplied and commodity management and distribution will be streamlined to match consumer demand. Collaboration with NGOs in the planning and forecasting will be encouraged. More participatory forecasting models will be developed and tested (bottom-up, not top-down) and indicators of service provider and supervisor performance will be based on ability to meet consumer needs rather than solely on method-specific targets.

- The capability of the government's distribution system to supply continuously the private sector and NGOs will be analyzed; supplemental or alternate distribution systems will be developed as needed.

The commercial retail sales programs will retain their separate distribution channels. These systems will be expanded and strengthened.

To implement the strategy a small Logistics Systems Task Force will be established at the state level. This Task Force will receive technical assistance from private sector Indian firms and an AID/W Cooperating Agency. In addition to local and expatriate technical assistance, the project's contribution will be the provision of equipment, dunnage, shelving, and other appropriate items for depots; vehicles for contraceptive and commodity distribution; and contraceptive commodities such as CuT-380A IUDS and NORPLANT® (when approved by GOI and until other sources become available such as direct procurement by the GOI or local production). IFPS will also support in-country and US-based training in logistics management.

3.2.3 Promote Family Planning

Demand for family planning is multi-faceted and involves attitudes of leadership groups as well as the general public. The support of various leadership constituencies is important to ensure that resources (both human and financial) are available, and that administrative, regulatory, and legal barriers are removed or do not serve as obstacles to effective program implementation. Some groups, such as political and opinion leaders and the media, can help to promote an appreciation of the importance of family planning for the health and welfare of individuals, communities, and the nation. These groups can also help to promote an image of a program that is providing a needed and quality service. (Obviously, efforts to promote a better image must be preceded by or go hand-in-hand with real improvements in access and quality of services.) Demand is also affected by activities that promote knowledge of the availability of services and particular methods. This involves public education and promotion efforts and, in the case of social marketing of contraceptives, advertising. Finally, women who are both program implementers and themselves satisfied users may also influence client demand. The IFPS Project will address each of these aspects of demand.

a. Policy Support

With technical and other support from appropriate C.A.s, the project will develop a comprehensive strategy and program of activities to address key leadership groups on a number of important policy issues. This pro-active approach will facilitate the implementation of the project by anticipating some of the most important policy barriers, rather than waiting to respond as such problems arise over the course of the project. The SOCIETY will develop a strategic plan for policy support, identifying key leadership groups, critical policy issues and barriers, and plan a program of activities to address them. An overview of these steps follows:

Leadership Groups. The primary groups whose attitudes and/or positions will have bearing on the project include: the medical profession, women's and community groups, the public health community, the family welfare bureaucracy, media, political leaders, executives from industry, the business community, and non-governmental organizations. Some of these leadership groups are, or could become, both opinion makers and service providers (e.g., doctors and women's groups).

Policy Issues. A range of issues will impinge on the successful implementation of the project. These may include:

- Characteristics of the family welfare program such as a centralized structure that overlooks community and individual concerns, method-specific target setting, and the medical orientation of management.

- Resistance to state-of-the-art contraceptive technology, and political, legal or regulatory obstacles to the promotion of particular methods.

- Poor understanding of and misconceptions about the advantages and disadvantages of particular contraceptive methods (oral contraceptives including the progestin-only mini-pill, injectables, CuT-380A IUDs, mini-laparotomy, and NORPLANT®).

Activities. The SOCIETY will support the following activities:

- Assessments of the attitudes and positions of the various leadership groups in order to identify key policy issues.

- Development of an action plan for policy support activities to address each of the key policy issues.

- Policy seminars and workshops for leadership groups.

- Training and use of microcomputer-based models and presentations (cost-benefit, resource allocation and policy options, health planning, birth spacing). These are currently being developed for various states in India with assistance from the AID/W RAPID project. The IFPS Project will support model training and applications in Uttar Pradesh.

- Public affairs program, including the preparation of articles and feature stories on the IFPS Project's successes. The project will produce press releases and a quarterly newsletter describing successes and interesting aspects of the program's implementation.

- Study tours to other countries. Possible sites include: Indonesia for outreach and record keeping; Bangladesh for the CBD/CSM programs; Morocco for household-based CBD; Colombia for CBD and sustainability of clinics; and Mexico for a public insurance program that provides family planning to improve reproductive health of women.

- Dissemination of a newsletter and other important information such as the English and Hindi versions of Population Reports. In addition, after an initial testing of their appropriateness in U.P., copies of existing materials may be used by the project.

The SOCIETY will be assisted in its policy support program by staff working in other components of the project as appropriate, local institutions, and C.A.s as required.

b. Public Education and Promotion

An India Family Planning Practices Survey conducted in 1989 provided ample evidence of the need in Uttar Pradesh for public education and information efforts to fill knowledge gaps and to correct misconceptions about family planning methods. Given the importance of

reaching the general public, the IFPS Project will develop and support a public education and promotion (PEP) program. Such efforts have traditionally been an important component of India's family welfare program. In recent years, the IEC and demand generating activities have focused more on middle-class segments of the population. There is clearly a need to refocus the PEP effort to reach poorer segments of the population including illiterates who live in rural and peri-urban areas. Further, given the important role men play in making decisions about contraception and family planning, special efforts should be made to address men, either as clients or as the partners of female clients.

The PEP program will develop a comprehensive strategy for the education and promotion efforts supported by the project to ensure a consistent theme about FP/MCH services and to reinforce the activities across sectors. Messages of many different types of media will stress the benefits of FP/MCH services for mothers and children. This means combining PEP efforts for the spectrum of maternal and child health care (ante-, delivery, post-natal care, family planning for mothers, and infant and child care interventions such as immunization, nutrition, and oral rehydration therapy).

As mentioned previously, a lead organization (such as Literacy House) will be selected as a center to develop and coordinate all education (IEC) and promotion efforts across the sectors (public and non-governmental). The lead organization will receive bilateral funds in this program area and also non-financial inputs. It will provide grants, monitor progress and ensure fiscal accountability of other organizations. It will also fund and carry out its own program of PEP activities.

Initial activities of the PEP program will include conducting studies to assess the varying ethnic, cultural and geographic characteristics of potential audiences. Small surveys or in-depth interviews may be conducted to determine husband-wife communication patterns, clients' perceptions of the family planning and the family welfare program, communication network patterns at the village level and values and lifestyles of the target audience. In addition, some studies will be conducted of communications organizations to assess IEC standards, capabilities in IEC planning, monitoring and evaluation, institutional relationships, and cost-effectiveness.

The development of the PEP program will be geared to improvements in the access to and quality of family planning services. Given the importance of improving the image of the family welfare program, it is essential that project activities not stimulate demand for new and higher quality services before they are actually in place.

The project will support a range of activities to implement the PEP program as follows:

- A series of workshops and symposia will be conducted for strategy development and materials development with various public and private sector organizations involved in the IFPS Project.

- A materials and information resource center will be established at the lead IEC organization. The resource center may be equipped with Popline on CD-ROM as

well as hard copy of various publications and materials. The center will serve as the repository for IEC materials (old and new) and other population information for providers, trainees, journalists, and the public more generally. Additional materials and information resource centers will be set up in various locations, e.g., medical colleges and ANM training centers to facilitate access to the materials.

- Educational print materials will be designed and produced for use by field workers and clients. These will include manuals, flip charts, posters, and booklets. Materials produced by the program will be distributed to public and private FP/MCH programs ensuring that all field staff have ample supplies of materials. An assessment may need to be carried out to determine how best to get the materials into and used by the various groups. These materials will be used to promote expanded choice of methods (p. 38) in both clinical and non-clinical (especially for counseling and interpersonal communications) and training programs (see p. 41). An assessment may need to be carried out to determine how best to get the materials to and used by the various groups of providers in both the public and non-governmental sectors on a continuing basis.

- Other materials will be produced for use in literacy training and other formal and non-formal education programs that are managed by LH. Radio, puppet shows, and other folk media will play an integral part in the PEP program.

- Training of Trainers (TOT) in IEC will be conducted for public and private sector groups.

- Various campaigns to promote family planning will be conducted through public and private sector organizations and NGOs such as IMA, LH, VHAI, MOHFW and others. Health providers will be featured through the mass media with the conscious effort at improving their status and image in the community.

- Mass media activities will be undertaken possibly including the development of radio and television programs, motivational docudramas, animated films, and folk media festivals.

- The use and effectiveness of the IEC materials and the communications strategies will be monitored and evaluated on an ongoing basis in conjunction with the overall research and evaluation component of the IFPS Project.

Depending upon the strength of the lead and other PEP grantees, investments will be made in organizational development and institution building to strengthen the IEC capabilities of NGOs, private practitioners' groups, and cooperatives. Institution building will take the form of support for staffing, training, and equipment. Technical assistance will be provided by JHU/PCS for institutional development of various groups involved in major IEC work and in all aspects of the IEC process including research and impact evaluation.

A PEP advisory group will be created by the government of U.P. to assist the PEP center in

coordinating IEC activities across sectors and supported by different donors. This group will review annual work plans and ensure that the materials developed by the program are consistent with the program directions. The GOUP will be encouraged to establish an IEC Directorate to enhance the status and role of IEC in family welfare activities, and to facilitate closer coordination among the service-providing agencies.

c. Participation of Women

The very traditional nature of Indian society has greatly affected women's social status and the roles they are able to play in the lives of families and villages. The early age of marriage (despite a minimum legal age of 18 years), low literacy, son preference, limited opportunities for paid employment, and low economic status combine to keep fertility high and limit women's contribution to Indian development.

Indian women's access to basic goods and services, productive assets, labor markets, even the right to sell their own labor, is contingent in a way that men's is not. This contingency is part of the social construction of gender in India. It is embedded in the interlocking religious, economic and kinship structures which combine to define the social domains of males and females. Women's association with reproduction and family grounds them in the private "inside" sphere, while men interact with the markets, governments, and courts in the public "outside" sphere. Women's links with the "outside" are mediated by male relatives. The strength of the inside/outside dichotomy is greater in northern India than in the south. There is a strong connection between a woman's access to the outside, particularly to independent income, and her control over the utilization of family resources on the inside. In fact, along with education, the ability to earn and control income appears to be one of the most powerful determinants of women's status in the family.

In order to achieve the desired fertility decline in U.P., attention will therefore be paid to some of the root causes of high fertility. The project will contribute to women's knowledge of the advantages and disadvantages of various methods of contraception, and their understanding of the health benefits of family planning, and thus increase the level of informed choice. It will also seek to enhance the status of women by increasing their decision-making abilities about the number and spacing of children, increasing their access to family planning information and services, and enhancing their employment opportunities in family planning programs. Through the promotion of women's groups and organizations, the project will indirectly promote female literacy, address the issue of the girl child, and help to enhance their economic opportunities. The project also seeks to professionalize women family planning workers in order to provide positive role models in the community and encourage women to seek work opportunities in the field of family planning at all levels.

Surveys of women NGOs in U.P. have revealed that only a handful of women are currently providing family planning services. Most of the groups identified are active in some aspect of primary health care and are interested in adding family planning to their activities (see NGO section for a detailed description).

Keeping the above factors in mind, the project will support a number of activities to enhance

women's participation in family planning. Preparatory activities that will be implemented over the first few years of the project are as follows:

- A selected number of women from the NGOs and the government will be trained each year in CEDPA's Women in Management and Institution building workshops in Washington D.C. and India. This group will include trainers at state-level training institutes.

- A women's advisory group will be formed from the network of CEDPA trainees. This group will then help plan activities under the IFPS Project designed to enhance women's participation.

- A state-level training module on family planning will be developed which will include gender issues adapted to the context of U.P. This will be used in training sessions for MOHFW and NGO staff.

- Prerana, a Delhi-based NGO providing training to other NGOs and women's groups, will be funded to provide technical assistance and training to NGOs, and establish linkages with existing training organizations to develop district and community level training.

- Two or three other selected women NGOs will receive institutional strengthening to improve existing service delivery or add family planning activities to their portfolio.

- Operations research will be initiated to determine the effectiveness of women CBD workers and whether training the wives of male CBD workers increases family planning acceptance.

- The project will support activities aimed at using Mahila Swasthya Sangh (MSS) and Link Women (LW) organizations more effectively in the promotion of family planning. The MSS scheme has over 1500 organized units in U.P. as of March 1992, while Link Women units will be active in 17 U.P. districts by the end of 1992. Both are grassroots efforts to enhance women's knowledge of and participation in health and family welfare programs.

Starting around year three, the project will support various activities designed to institutionalize efforts begun in the early years. The activities will include:

- The state-level training workshops conducted for policymakers, district magistrates, and other key leadership groups using the gender training module. One key topic to be covered in the training of policymakers and family planning managers will be the critical role of ANMs. The policymakers and managers would be better able to appreciate the need to enhance the ANMs status to make these workers more effective.

- Training of women in management conducted annually in-country.

- Professional associations of women managers, service providers, and trainers created; a program of activities developed and carried out (such as annual award presentations) to promote women's support for and involvement in family planning.

- The infrastructure of women's development agencies strengthened and effective education on women's participation in society, group formation and mobilization conducted to enable them to expand their information services and/or service delivery.

- A study carried out to develop indicators of women's participation in family planning (at all levels including policy, management, provider, and client). These indicators will then be used to track the project's experience in involving women and the possible impact of their involvement on program implementation (e.g., are female providers more effective in certain instances than male providers?) and on themselves. One type of indicator would be needed to assess changes in the status of female providers, such as the ANMs.

The results of the above activities will be the increased involvement of women leaders at the community, district and state levels in all phases of planning and implementation of the project. In addition, there will be an increased number of women in management levels of existing NGOs and public sector programs, an increased number of women's NGOs, an increased number of women participating in grass roots women's organizations and, finally, an enhanced status of ANMs and an increase in their credibility as front-line family planning promoters.

3.2.4 Research and Evaluation (R&E)

The project will support a program of research, monitoring, evaluation, and dissemination in order to assist the various public and private service delivery entities under the IFPS. Through technical assistance, studies and research projects, the research and evaluation (R&E) program will:

- Provide baseline information on the state of service delivery (in terms of provider staff and facilities) and on the attitudes and practices of clients;

- Assist service delivery entities to develop and use monitoring systems for program outputs and performance (see p. 43 for MIS discussion);

- Monitor changes in service delivery systems or parts thereof (training, IEC, logistics, service delivery and MIS) and also changes in use of FP/MCH services; and

- Evaluate the IFPS's impact.

The project will support the development of a centralized R&E capacity. A lead R&E institute will be selected to plan and coordinate the research program in close collaboration

with the other principal implementing entities of the IFPS. A centralized approach will be taken given the level of technical skills needed to plan and conduct a quality research program and given that the other implementing entities will already be heavily burdened with an array of tasks directly related to service delivery. Efforts will be made over the course of the project, principally through staff training, to build some R&E capacity in all project components.

The lead R&E institute will provide technical assistance to the other principal implementing groups in setting up monitoring systems and in planning and conducting operations research. Subcontracts, or other appropriate contractual instruments, will be given to a number of research institutions (and to individual researchers) to help carry out the various aspects of the research program. Beside issuing and monitoring these grants, the institute's staff will also conduct a number of studies. The lead institute will plan and carry out a dissemination program to ensure that results are applied throughout Uttar Pradesh and in the other north Indian states. The lead institute will produce research reports, summary research notes on results, and a quarterly newsletter to publicize research results. Seminars and workshops will be held to present results to a variety of key groups including central and state government officials, press, and other components of the IFPS Project.

While the primary geographic focus of the IFPS Project is Uttar Pradesh, it is anticipated that numerous opportunities will be created to transfer successful project experiences to other parts of India, primarily the other large northern states. To ensure diffusion of project innovations, technical assistance will be provided by the relevant service delivery entities and by AID/W cooperating agencies in order to replicate successful service delivery models and program innovations (e.g., improved training curriculum and IEC materials) in other geographic areas. Replication of successful experience to other states in India will also be accomplished with local-cost support from central and state governments and assistance from indigenous and AID/W-funded organizations.

Various methodologies will be used in carrying out research such as diagnostic studies and situational analyses; baseline, KAP, household and service facility surveys; focus groups, in-depth interviews, and observational studies; operations research on demonstration projects; and quasi-experimental studies. The program will support the following types of research:

- Diagnostic studies of various aspects of service delivery systems (public and private). For example, an assessment of the existing service statistics may be conducted as a first step in designing an operations research study to test improvements in data collection and used (including feedback of data to various staff levels).

- Operations research on pilot or demonstration projects to assess the effectiveness and impact of IFPS inputs (training, IEC, etc.) on delivery of FP/MCH services by various public and private entities.

- Quasi-experimental studies to assess effectiveness or impact of different approaches. Numerous topics will be considered for study. Some possibilities include:

  - Testing different ways of assessing the performance of providers that involved developing new performance indicators in place of the current system of targets and incentives.

  - Assessing different IEC approaches to create awareness and demand for spacing methods.

  - Assessing alternative ways to bring villagers to services or vice versa (mobile clinics).

- Large-scale surveys to assess the impact of the IFPS. The 1992 National Family Health Survey, currently being carried out in India, will provide baseline information.

The project will support two other large-scale surveys in PY 5 and PY 10. The first will be conducted in the four north Indian states, and the second will be another national survey. Each consists of a household and a community survey. The household survey provides information on contraceptive prevalence, method mix, source of services, and fertility levels as well as health information on children. The community survey provides information on the actual state of FP/MCH service availability. These surveys and other special studies will also be used to assess the impact of IFPS on women's status through their use of contraceptives and their involvement in FP/MCH programs.

The lead R&E institute will either have or will set up an office in Lucknow near the SOCIETY's training and IEC centers to facilitate collaboration among the implementing entities. A Technical Advisory Group (TAG) may be created to provide technical guidance and to review annual research plans if needed. The TAG could include staff/researchers with FP/MCH program experience from the GOI, academic and research institutions, and USAID.

The IFPS Project will support strengthening the lead R&E institute as appropriate so that it will be able to carry out the planned research program. This support may consist of funding for personnel (full-time, part-time interviewers, and consultants), training, equipment including computers for data analysis and desk-top publishing, carrying out studies, and disseminating results. Further, the lead institute will receive substantial technical assistance from a Cooperating Agency. The Population Council will play a major role in providing such technical support.

4. Project Management and Implementation

4.1 Organizational Arrangements

4.1.1 Steering Committee

To provide overall policy, financial and implementation directives, and to provide a mechanism for open and continuous dialogue among the GOI, the GOUP and USAID, a national level Steering Committee will be constituted under the Chairmanship of the Secretary of Family Welfare of the Ministry of Health and Family Welfare (MOHFW). The Steering Committee will include representation from, inter alia:

Chairman: Secretary of Family Welfare, MOHFW

Member Secretary: Joint Secretary for Family Welfare, MOHFW

Joint Secretary for Finance, MOHFW

Designate of the Ministry of Finance

Chief Secretary, GOUP

Secretary/Principal Secretary of Health, GOUP

Mission Director, USAID

This committee will meet at least once a year or as frequently as needed to help ensure achievement of project objectives by establishing policies, consistent with this Agreement, for the implementation of the project. Special invitations will be extended to representatives of other GOI Ministries (e.g. Ministry of Women and Child Development, Ministry of Education) as relevant issues to those Ministries arise for consideration.

4.1.2 Implementing Society

The project will be implemented through a society registered in the Uttar Pradesh. The Society will be officially named when registered but will be referred to in this Project Paper as the SOCIETY. Initial disbursements for the SOCIETY will be conditioned on the SOCIETY being registered as an autonomous society. The autonomy of this organization and the technical caliber of its personnel are critical to the successful implementation of the Project. The SOCIETY will establish its own personnel and procurement procedures and have the authority to manage its own budget and to disburse funds to government and non-governmental institutions in support of project objectives. The SOCIETY will be registered and operational as soon as possible after the signing of the Project Agreement.

4.1.3 Governing Body

The SOCIETY will have a **Governing Body** to provide strategic and programmatic direction, in such areas as the development of personnel and procurement policies and the review of technical strategies for project activities. The Governing Body will review and approve annual implementation plans which will include the use of Indian and foreign consultants and the use of foreign exchange and local currency budgets for the project. The Governing Body will operate under the broad policy directives outlined by the Steering Committee. The Governing Body will be chaired by the Chief Secretary of Uttar Pradesh and will include, but will not be limited to, the following members:

Chairman: Chief Secretary of Uttar Pradesh

Vice Chairman: Secretary/Principal Secretary of Health, GOUP

Member Secretary: Executive Director/Chief Executive

MOHFW designate

Director for Health, Population and Nutrition, USAID

Prominent Corporate Representative

Prominent Media Representative

Representatives of Non-Governmental Organizations (NGO)

The Corporate, Media and NGO representatives, included on the Governing Body to ensure that project objectives regarding public-private partnerships and the state-of-the-art use of communication are appropriately addressed within the context of Uttar Pradesh communities, will be named by the Chairman of the Governing Body and appointed upon the approval of the other members.

As the Governing Body will provide a mechanism for dialogue with officials, departments and organizations within the public and private sectors at the state and district level, the Chairman may invite representatives from other government agencies, NGOs, academia or other professions to participate in Governing Body meetings as observers as the need arises.

The Governing Body will meet semiannually (every six months), or as frequently as necessary, to ensure achievement of project objectives. The Governing Body will appoint a Secretariat (discussed below) to implement the project.

4.1.4 Secretariat

Day-to-day management of the project will be provided by a Secretariat consisting of an Executive Director and staff. As the implementation arm of the SOCIETY, the Secretariat will have two main functions: program and financial management, including the disbursement of funds for NGO activities. To undertake these functions a cadre of professional technical and administrative staff, and support personnel, will be employed by the SOCIETY. The Executive Director will provide overall direction to the professional staff in the implementation of the project and coordination with the Governing Body and USAID. The project management and financing functions include all those activities which must be undertaken to implement and accomplish the objectives of the project. These include, but are not limited to: development of annual workplans, the design of subprojects, selection of implementing organizations, awarding contracts and grants for subprojects, disbursing funds, auditing, monitoring progress and reporting and disseminating results.

The Secretariat will be led by the Executive Director with a staff that covers key areas relevant to project implementation, including program management, finance, training, communication, NGOs, and research and evaluation.

The Executive Director and the key administrative and technical staff will be recruited and their appointments approved by the SOCIETY's Governing Body. It is imperative that these key staff positions be held by professionals with demonstrated experience that is directly applicable to their responsibilities under the project.

4.1.5 Liaison Office

USAID will establish a Liaison Office initially in New Delhi with the intention of relocating in Lucknow at a later date. The Liaison Office will coordinate closely with the Government of India, the Government of U.P. and the Society for smooth implementation of the project and flow of funds. It may also provide technical assistance for the project with the approval of the Central Steering Committee. USAID officials and consultants will visit Lucknow for this purpose as and when necessary. The possibility of transferring the Liaison Office to Lucknow will be reviewed after the project is functioning effectively. The USAID Liaison Office will include an expatriate director, expatriate and Indian technical advisors, and Indian support staff.

4.1.6 AID Cooperating Agencies

The AID/W financed CAs will provide technical assistance and other support as required to get the project underway. During the first year until the SOCIETY is established, such assistance may be provided either directly by CAs or through the Liaison Office with the approval of the Central Steering Committee.

4.2 Start-up of the Project; Operation of the SOCIETY.

To facilitate the start-up of the project, the conditions precedent (CPs) to disbursement of the A.I.D. financing will be set forth in the Project Agreement as follows:

1. CPs to First Disbursement. The ProAg will require that the GOI provide (a) the designation of the GOI's representative and (b) verification of the creation of the National Steering Committee. When the CPs have been met, USAID may, proceed to contract directly for the services of a contraceptive social marketing organization. USAID will also begin working with the organizers of the SOCIETY to get it underway.

2. CPs to Additional Disbursements. These will call for the legal establishment of the SOCIETY and for assurances that it has, in its structure, the Governing Body, comprised of representatives of the GOI, GOUP, USAID, the corporate sector, the media and non-governmental organizations and a Secretariat made up of the principal managers of the SOCIETY, including an Executive Director. Additionally, the CPs will call for (a) a description of the SOCIETY's personnel and procurement procedures; (b) assurance that the SOCIETY has authority to receive funds from external donors and from public and private sources within India; (c) assurance that it has authority to draw up and implement its own budget and establish its own salary and benefit structure; (d) assurance of its authority to extend grants to public and private organizations and to enter into contracts without a requirement for government approval (other than by government representatives on the SOCIETY's Governing Body), and (e) asurance of its authority to employ, retain or dismiss personnel from its own staff. Finally the GOI will confirm that it has established and agrees to maintain for the life of the project a separate account and budget line item for the project in the Ministry of Health and Family Welfare.

Fulfillment of the CPs to Additional Disbursement will constitute achievement of the first performance benchmark under the project (see later discussion on concerning performance-based disbursements).

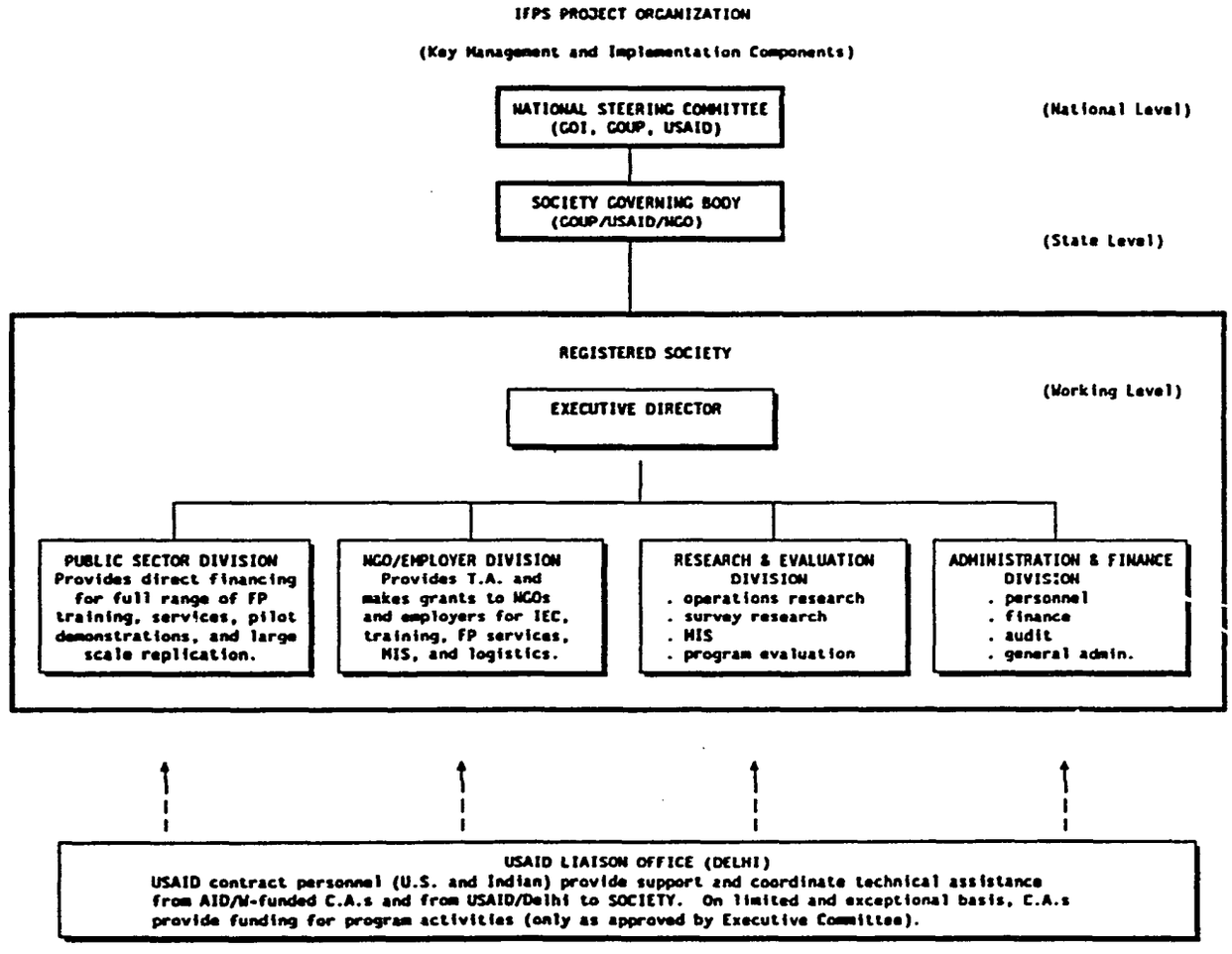
In order to ease the SOCIETY's management start-up, various alternatives may be pursued for staff recruitment. For example, selected highly qualified GOUP officers may be deputed for varying periods of time. Additionally, staffing for particular program functions may be obtained through contracts with outside organizations.

If the SOCIETY should take longer than the anticipated four to six months to begin making its first program grants, USAID may seek Steering Committee approval for the A.I.D. CAs to provide direct grants to enable critical NGO activities under the project to begin operation quickly. Of particular importance in this regard are the IEC and training center elements and the initial FP service delivery functions.

The establishment of the SOCIETY and its efficient management of the IFPS Project resources are viewed as critical elements in giving the family planning program in U.P. new impetus and effectiveness. It is expected to be a faster and administratively simpler mechanism for administering funds in family planning activities. The SOCIETY, when it is fully organized and staffed and has gained administrative experience, is expected to be able to move more rapidly than would be the case if other mechanisms were used. Moreover, by establishing an autonomous society with authority to solicit and accept funds from outside India, the SOCIETY offers the promise of sustaining family planning services beyond the project life. Nonetheless, it has to be recognized that the SOCIETY's role will be a new one in India and conceivably it could encounter unforeseen difficulties which might make it difficult or impossible for it to carry out the functions assigned to it. Should such a situation arise, other implementation options will need to be considered. Such alternative methods might include returning to more traditional methods of project implementation such as direct A.I.D. grants and contracts and working more directly with the GOUP. Any such implementation plan revision, however, would be agreed to by the GOI and A.I.D.

Figure 9 below provides an overall view of the IFPS organization and management structure.

Figure 9



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4.3 Performance-based Disbursement

It is expected that approximately 70% of the $225 million A.I.D. bilateral assistance contribution to the project will be disbursed through performance-based disbursement (PBD) mechanisms. Use of the PBD system in the IFPS Project will be governed by the following:

1. The degree to which the PBD method can be used as a means to contribute directly to the attainment of project objectives (by focusing more attention and effort on project outcomes rather than inputs);

2. Negotiated agreement with the host governments on specific performance benchmarks (points of progress toward project objectives) based on detailed implementation plans to be developed for major project components; and

3. Setting the benchmarks at levels of accomplishment which are achievable but not unambitious.

Performance-based disbursement was selected as the appropriate mechanism for this project because of the critical need to create an autonomous and sustainable society. To this end, the PBD mechanism will require the SOCIETY to establish its own internal programmatic, administrative and financial mechanisms for achieving project objectives. This in turn will stimulate the achievement of maximum operational efficiency in a shorter period of time than traditional disbursement mechanisms in which A.I.D. and/or contractors perform a significant percentage of these functions with the intention of gradually institutionalizing them. The PBD mechanism also provides for institutionalization of these functions but does so in a shorter time period by providing a direct financial incentive to the institution to perform at greater levels of efficiency sooner that is traditionally the case under standard A.I.D. implementation and disbursement mechanisms.

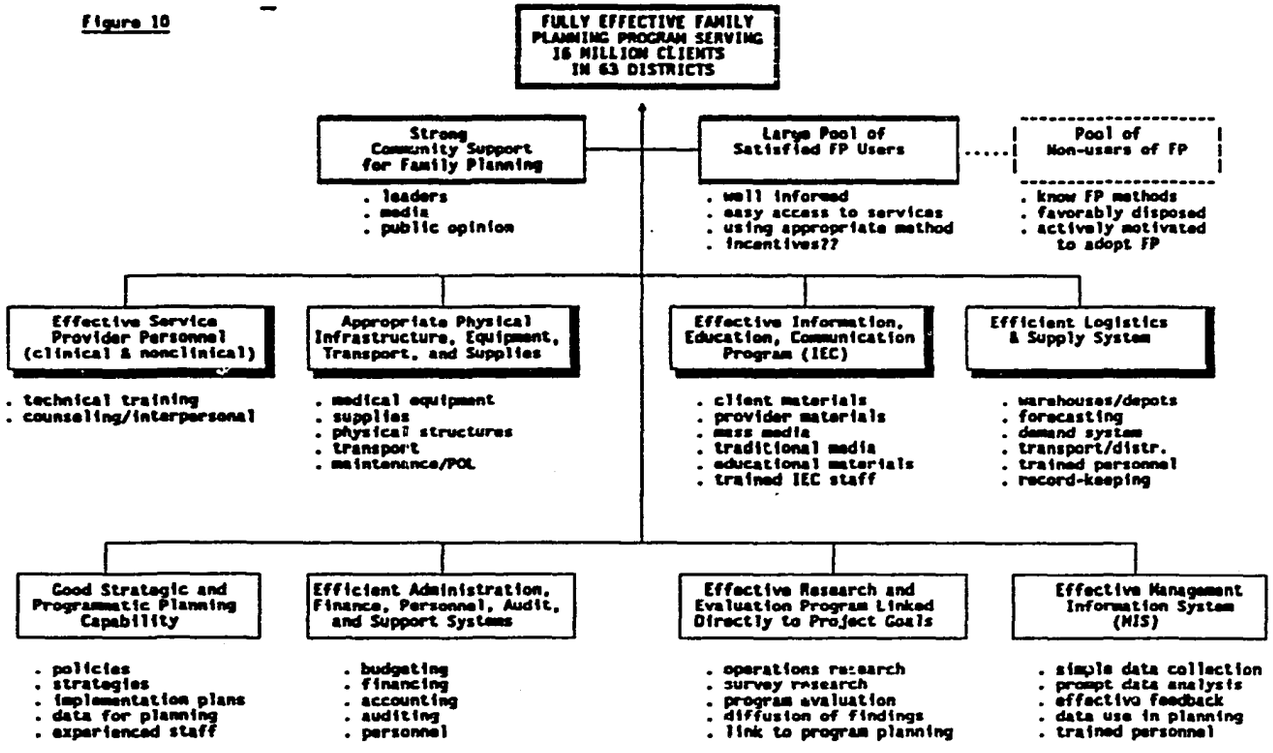
PBD benchmarks will be established in conjunction with detailed implementation plans that will be collaboratively developed by USAID, the GOUP and the SOCIETY. The collaboratively developed benchmarks will be documented in countersigned Project Implementation Letters. Benchmarks will be established for the achievement of important project milestones that indicate significant accomplishment of activities that directly relate to the accomplishment of project purpose and objectives. Benchmarks will be limited in numbers and indicative of significant accomplishments.

The amount payable for reaching each benchmark will be arrived at based on the value that benchmark has in achieving project objectives. Benchmarks will be established with a specified validity period (12-24 months in most cases) and will be reviewed, revised and/or dropped if not met within that period.

Selection of PBD benchmarks will be reflective of the GOI-GOUP-USAID shared vision as to what is the desired "End-of-Project-Status" (EOPS). For the IFPS Project the desired objectives are depicted diagrammatically on the following page in Figure 10 to provide a broad overview of what the project is seeking to achieve.

The shadow boxes represent line functions. Single-line boxes at the bottom represent essential staff functions. Together, these contribute to attainment of the outcomes at the top of the page.

Figure 10



PBD.DMG

Illustrative Use of PBD for Private Sector Portion

Objective. IFPS assistance in the private sector is designed to accomplish the following objectives (outcomes):

- to develop private sector capacity to deliver high quality family planning services in a manner complementary to those provided by the public sector;
- to demonstrate the feasibility and effectiveness of public-private sector partnerships in the provision of family planning services;
- to demonstrate the efficacy of making investments in the private sector for family planning services delivery, and to encourage incrementally greater government investment in the private sector;
- to increase the private sector share of family planning service delivery, helping to: (1) relieve some of the burden borne by the public sector; (2) improve the overall image of family planning; and (3) reinforce a segmented market of clients seeking family planning services, spanning the range from free services to heavily subsidized services to partially subsidized services to full commercial services.

The road to achieving these desired outcomes is long, and strewn with significant *waypoints*[5]: **verifiable accomplishments which can be construed to be particularly meaningful in the journey towards full attainment of desired outcomes.** It is the identification of these waypoints -- and the crafting of their description -- which is at the heart of planning for performance-based disbursements, since these waypoints represent benchmarks against which real progress can be measured and monies will be released.

What is empathetically not intended, here, is to trivialize either the benchmarks (e.g., by choosing simple but relatively meaningless ones) or the process itself (e.g., by choosing too many benchmarks to be dealt with on a practical basis).

What is intended, by contrast, is to structure PBD as a effective tool for project management with emphasis on accountability for achieving specific project outcomes. Properly done, this should serve to simplify rather than complicate project implementation.

Development of Benchmarks. To implement project activities in the private sector (exclusive of CSM/CRS), an approach has been chosen which is believed to be least-cost and

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[5] - waypoints is a term borrowed from the field of marine, land, and aeronautical navigation. Waypoints are selected geographic points, usually named, which serve as reference points through which one passes en-route to the final destination. They are used extensively in modern electronic navigation, often accompanied by a continuous readout of course, distance, and time to the next waypoint. This navigational concept seems appropriate to help explain the meaning of performance benchmarks as used in this project.

highest potential payoff. That approach involves the establishment of a new parastatal (SOCIETY) in Uttar Pradesh. This organization will be provided both funding and technical assistance to build its capacity to serve as a principal channel for funds going to private sector family planning programs. To be effective, this organization must have technical, administrative, managerial, and financial capacities commensurate with the job of running a grants program which may involve $5-15 million per annum. Gearing up to run such a program -- and to ensure the integrity and effectiveness of that program -- will be a major undertaking, requiring substantial technical as well as financial support.

There are three principal components to the private sector effort which the SOCIETY will be expected to develop and, thus, three streams of activity. These are:

- **family planning services**, provided through a variety of NGOs, cooperatives, women's groups, employers (including some public sector enterprises), and in association with the GOUP public sector program;

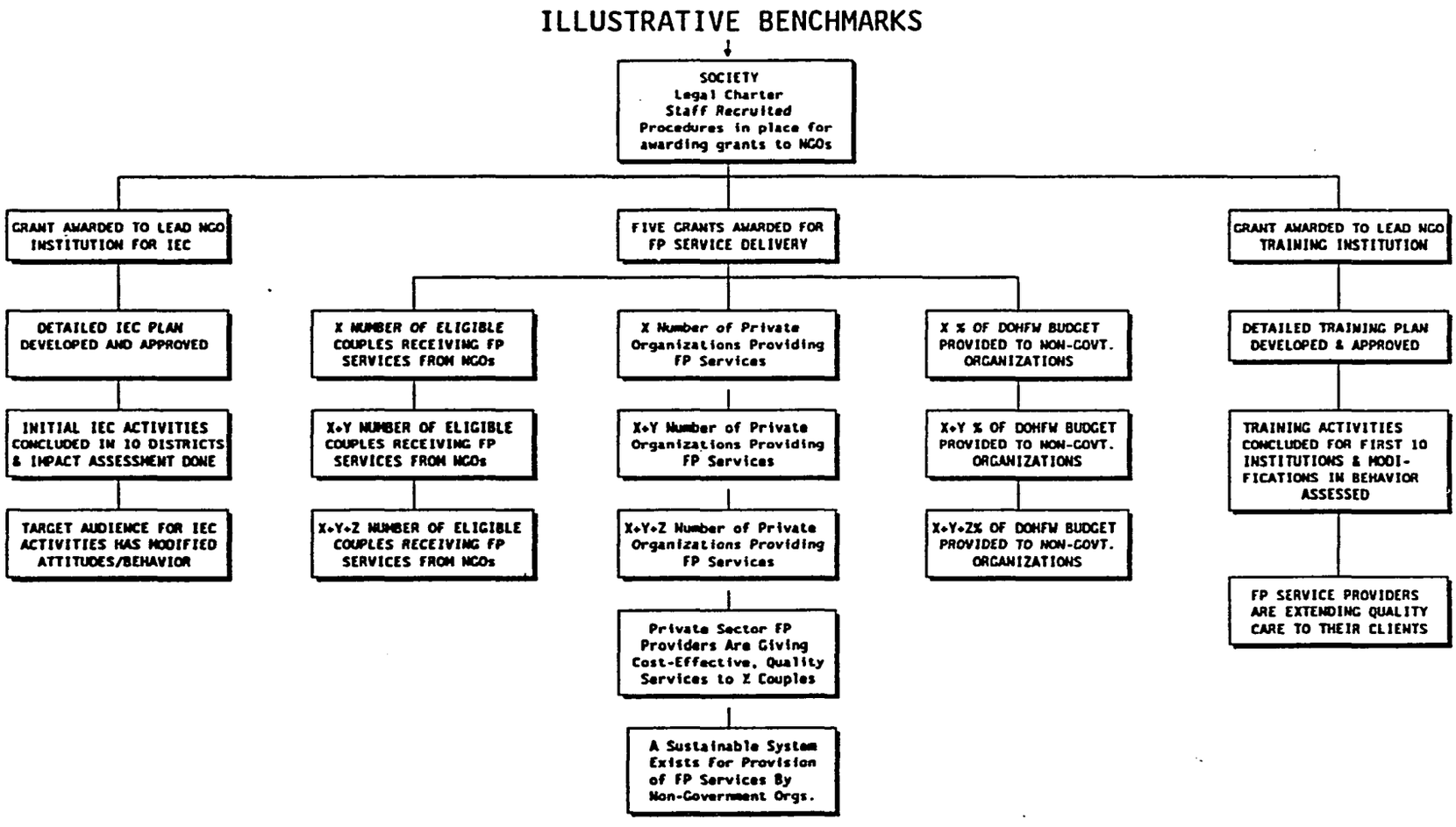
- **information, education, and communications services**, covering the gamut from client and provider materials to the mass media, and including both public and private sector utilization; and

- **training services**, required to develop the human capacities of supported NGOs and employers to deliver high-quality family planning services.

With this in mind, and remembering the **overall objectives** for the private sector program as outlined above, an attempt has been made to identify significant benchmarks which could serve as indicators of real progress, and against which USAID disbursements might be made. These are shown below in Figure 11.

Figure 11

IFPS PROJECT: ILLUSTRATIVE BENCHMARKING FOR NON-GOVERNMENTAL SECTOR ACTIVITIES



SIFPSA.DWG

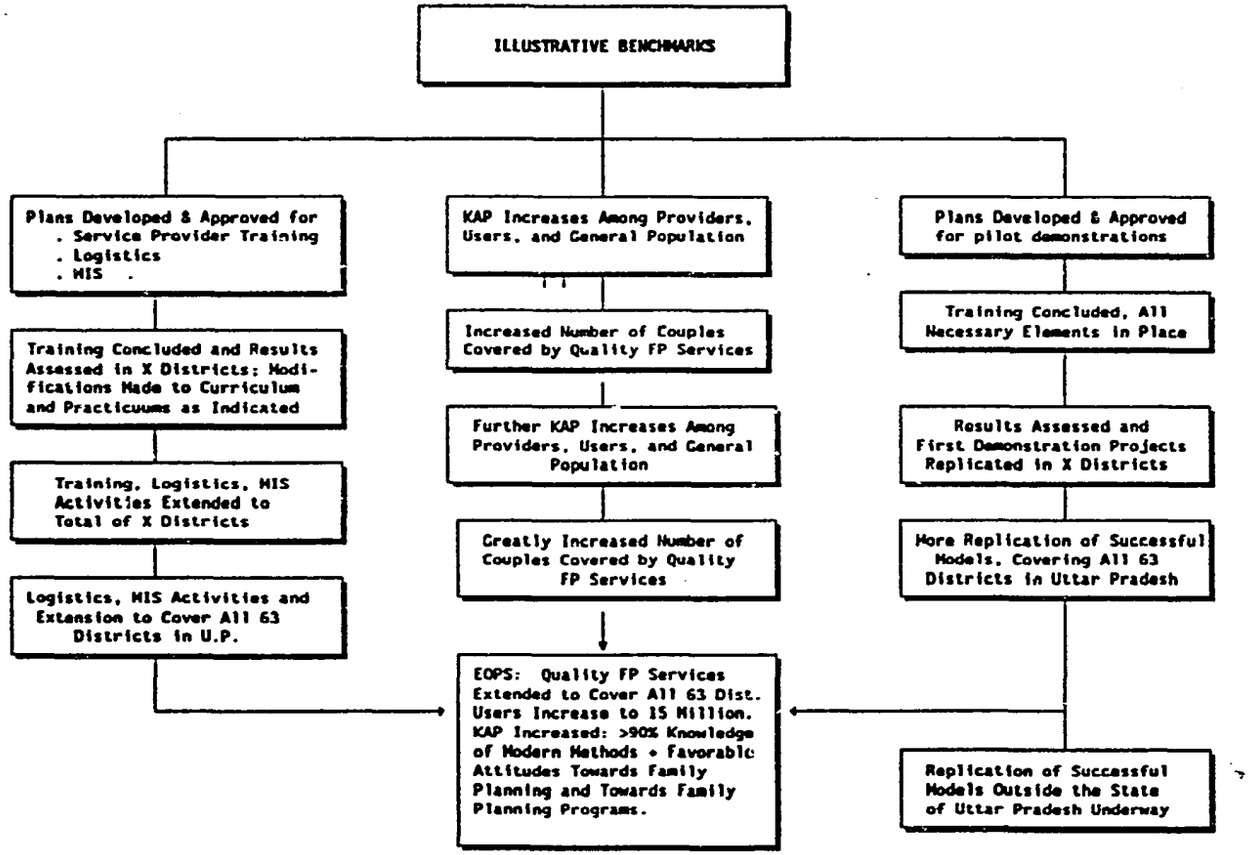
Public Sector Program. The main objectives of the public sector program are similar in many ways to those of the private sector component. They include:

- to develop a strengthened capacity to deliver high quality family planning services in a cost-effective and sustainable manner.
- to increase the knowledge attitudes and practices (KAP) of service providers to ensure choice and quality in the family planning program.
- to promote favorable attitudes and knowledge of modern contraceptives throughout the state.
- to develop the capacity for measuring the performance of the family planning program and to use this information to improve ongoing programs.

Illustrative benchmarks for the public sector program are shown in Figure 12.

FIGURE 12

IFPS PROJECT: ILLUSTRATIVE BENCHMARKING FOR PUBLIC SECTOR ACTIVITIES



PUBSEC.DWG

4.4 Phasing Plan

Figures 13 through 19 on the following pages contain detailed information on the phasing-in of project activities **by type of activity** and **by number of districts** to be covered.

It should be noted that these details are **ILLUSTRATIVE ONLY**: the actual devolution of project activities will depend upon the establishment of **detailed implementation plans** for each activity, jointly approved by the GOUP and USAID.

I. PUBLIC SECTOR

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTALS
PUBLIC SECTOR TRAINING											
1. Number of medical colleges centers assessed	1-2	2-3	2-3	1-3	0	0	0	0	0	0	6-11
(Districts)	(1-2)	(2-3)	(2-3)	(1-3)							(6-11)
2. Number of medical college centers upgraded to model clinics	1	2	3	3	0	0	0	0	0	0	9
(Districts)	(1)	(2)	(3)	(3)							(9)
3. Number of master trainers (clinically) trained	4-10	4-8	4-8	4-8	4-8	4-8	4-8	4-8	4-8	4-8	40-80
(Districts)	(1)	(2)	(3)	(3)	(4)	(4)	(4)	(4)	(4)	(4)	(33)
Number of trainers (clinically) trained	6-12	12-24	18-36	18-36	4	4	4	4	4	4	54-132
(Districts)	(2-4)	(4-8)	(4-12)	(4-12)							(14-36)
4. Number of physicians trained (pre-service) (Districts)	35	200	400	400	525	530	530	530	530	530	4210
5. Number of physicians trained (in-service)	200	480	800	1100	1160	1224	1224	1224	1224	1224	9860
(Districts)	(4)	(8)	(12)	(12)	(5)	(5)	(5)	(5)	(5)	(2)	(63)
6. Number of ANM colleges assessed	10-15	10-15	10-15	10-15							40-60
(Districts)	(10-15)	(10-15)	(10-15)	(10-15)	0	0	0	0	0		(40-60)
7. Number of ANM colleges upgraded	0	10	20	19							49
(Districts)		(10)	(20)	(19)	0	0	0	0	0		(49)
8. Number of masters trained for ANM colleges	4-10	4-8	4-8	4-8	0	0	0	0	0		16-32
(Districts)	(1)	(2)	(3)	(3)	4	4	4	4	4		(9)
Number of trainers trained for ANM colleges	6-12	12-24	18-36	18-36							54-108
(Districts)	(2-4)	(4-8)	(4-12)	(4-12)							(14-36)
9. Number of ANMs/LHWs/Others trained (in-service)	0	720	1200	1440	1500	1836	1836	1836	1836		14,040
(Districts)	(0)	(12)	(12)	(12)	(5)	(5)	(5)	(5)	(5)		(63)
10. Number of curricula developed	2	2	2	2	0	0	0	0	0		8

PUBLIC SECTOR SERVICES	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTAL
11. Number of PHCs (attached to medical colleges) upgraded to model centers (Districts)	3 (3)	6 (6)	9 (9)	9 (9)	0	0	0	0	0		27 (27)
12. Plans for pilot outreach/CBD projects developed * (Districts)	2 (2)	4 (4)	6 (6)	8 (8)							8 (8)
13. Pilot outreach/CBD projects established (Districts)	1 (1)	2 (3)	4 (6)	4 (8)							4 (8)
14. Outreach workers trained for pilots (Districts)	100 (1)	400 (3)	800 (6)	1200 (8)							2500 (8)
15. Expansion Plans developed (Districts)		1 (1)	5 (5)	10 (10)	15 (15)	20 (20)	27 (27)	38 (38)	50 (50)	63 (63)	63 (63)
16. Outreach workers trained for expansion (Districts)			+ (5)	+ (10)	+ (15)	+ (20)	+ (27)	+ (38)	+ (50)	+ (63)	+ (63)
17. MIS System Improved	1 (1)	2 (3)	4 (6)	6 (8)	10 (15)	15 (20)	25 (27)	40 (38)	50 (50)	63 (63)	63 (63)
18. Plans developed for diffusion/ replication outside Uttar Pradesh (Districts)			1	1	2 (**)	3 (**)	4 (**)	8 (**)	10 (**)	15 (**)	15 (**)

Figure 13

* includes urban, peri-urban, and rural models; includes R&E activities to measure impact
** to be determined (depends on success of models and their replication in UP)
+ depends on model(s) selected for expansion/replication

II. STRENGTHENING CONTRACEPTIVE LOGISTICS

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTAL
PUBLIC SECTOR 1. Central Procurement Process Improved	1										
2. Product Specifications Upgraded	1										
3. Lucknow Central Store Established/ Equipped		1									
4. District Stores Repaired/Equipped*	3(3)	4(4)	7(7)	7(7)	7(7)	7(7)	7(7)	7(7)	7(7)	7(7)	63
5. State Logistics Mgt Procedures Developed	1										
6. State Logistics Staff Trained	10										10
7. District Logistics Mgt Procedures Developed		1									
8. Additional District Staff Recruited											
9. District Logistics Staff Trained*		35(7)	35(7)	35(7)	35(7)	35(7)	35(7)	35(7)	35(7)	35(7)	315
10. District Logistics Refresher Training*				35(7)	35(7)	70(14)	70(14)	105(21)	105(21)	140(28)	560
11. PHC/RFW/UC/SC Logistics Procedures Developed		1									
12. PHC/RFW/UC/SC Logistics Staff Trained		2,275(7)	2,275(7)	2,275(7)	2,275(7)	2,275(7)	2,275(7)	2,275(7)	2,275(7)	2,275(7)	20,475
13. PHC/RFW/UC/SC Refresher Training*				2,275(7)	2,275(7)	w,550 (14)	4,550 (14)	6,825 (21)	6,825 (21)	9,100 (28)	36,400
NON-GOVERNMENTAL SECTOR 14. Logistics Management Staff Trained*		70(7)	70(7)	70(7)	70(7)	70(7)	70(7)	70(7)	70(7)	70(7)	630
15. Logistics Management Refresher Training*				70(7)	70(7)	140(14)	140(14)	210(21)	210(21)	280(28)	1,120

Figure 14.

*N.B.: Schedule to be consistent with JHPIEGO training schedule

III. NON-GOVE. . ENTAL SECTOR

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10 (TOTALS)
SERVICES 1. Cooperatives a. Village cooperatives (cumulative)	100 (2)	300 (4)	600 (6)	1,000 (8)	2,000 (12)	4,000 (20)	8,000 (30)	14,000 (40)	14,000 (40)	14,000 (40)
2. PVO Network a. PVO's b. Villages (cumulative)	30 1,500 (6)	50 2,200 (8)	75 3,000 (10)	100 3,700 (15)	125 8,000 (22)	125 13,500 (28)	125 19,000 (35)	125 23,000 (40)	125 23,000 (40)	125 23,000 (40)
3. Women's Groups (service) a. Villages (cumulative)		50 (2)	150 (4)	250 (6)	550 (8)	1,000 (10)	1,500 (14)	2,500 (22)	4,000 (30)	5,500 (35)
4. Women's Groups (promotion only) a. Villages (cumulative)		50 (2)	100 (3)	200 (4)	300 (6)	500 (8)	750 (10)	1,000 (14)	2,000 (20)	3,000 (25)
5. Company based a. Number of companies (cumulative) b. Outreach workers	2 20	10 60	25 100	50 200	100 350	150 500	200 600	200 600	200 600	200 600
6. Autonomous Public Enterprises a. Number of enterprises b. Outreach workers	1 20	2 100	3 200	4 400	4 500	4 500	4 500	4 500	4 500	4 500
7. Number of private practitioners trained	0	140	220	220	220	220	800	800	800	800
8. Projected new acceptors of Family Planning (cumulative)	24,000	70,250	147,250	253,000	446,750	781,000	1,298,250	2,044,000	2,920,250	4,090,750
TRAINING 9. Cumulative Number of CBD workers trained	1,600	2,550	3,750	4,950	10,550	18,500	28,500	39,500	41,000	42,500
10. Cumulative number of Outreach workers trained	40	160	300	600	850	1,000	700	700	700	700
11. Cumulative number of managers trained (women and men)	40	75	150	200	325	400	500	550	600	600
12. TOT Interpersonal/ Counseling	1 (5)	3 (5)	3 (5)	1 (5)	1 (5)					9 (25)
13. TOT/CBD (cumulative)	10 (4)	25 (6)	40 (10)	50 (20)	60 (30)	75 (40)	85 (50)	100 (60)	110 (63)	120 (63)

Figure 15 (partial).

III. NON-GOVERNMENTAL SECTOR (Cont.)

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10 (TOTALS)
TRAINING 14. No. of women managers trained overseas (cumulative)	10 (6)	20 (10)	30 (25)	40 (30)	50 (35)	60 (40)	70 (50)	80 (60)	90 (63)	100 (63)
15. No/ of women's organizations strengthened (cumulative)	10 (6)	10 (2)	25 (4)	65 (8)	125 (10)	200 (12)	300 (20)	500 (30)	1000 (40)	1500 (50)
16. No. of gender workshops/seminars held public & private (cumulative)		2 (1)	6 (4)	30 (25)	50 (45)	70 (63)	75 (63)	77 (63)	79 (63)	80 (63)

Figure 15 (last portion).

IV. INFORMATION-EDUCATION-COMMUNICATIONS

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTAL TRAINED
MATERIALS DEVELOPMENT & TRAINING											
1. TOT IEC Strategy Development		2 (5)	2 (5)	2 (5)	2 (5)						10 (20)
2. TOT IEC Material Development	2 (5)	2 (5)	2 (5)	2 (5)	2 (5)	2 (5)	2 (5)	2 (5)	2 (5)	2 (5)	20 (50)
3. Annual State Level IEC Symposium	3 (2)	3 (8)	3 (8)	3 (8)	3 (8)	3 (8)	3 (8)	3 (5)	3 (4)	3 (4)	30 (63)
4. District IEC Planning	3 (5)	3 (5)	3 (6)	6 (8)	6 (8)	6 (8)	6 (8)	3 (5)	3 (5)	3 (5)	42 (63)
5. IEC Materials Development	1 (2)	1 (8)	1 (8)	1 (8)	1 (8)	1 (8)	1 (8)	1 (5)	1 (4)	1 (4)	10 (63)
6. IEC Monitoring & Evaluation Workshop	1 (2)	1 (8)	1 (8)	1 (8)	1 (8)	1 (8)	1 (8)	1 (5)	1 (4)	1 (4)	10 (63)
PRINT MATERIALS PROVIDERS											
7. Service Provider Manuals		50K(32)				50K(31)					200K(63)
8. Stickers, Flyers, etc.		10m(32)				10m(31)					20m(63)
9. Small FW Flip Charts		200K(32)				200K (31)					400K(63)
10. TORAN			500K(32)			500K (31)					1m(63)
CLIENTS											
11. Posters	125K(6)	125K(6)	125K(6)	125K(6)	125K (32)	125K(6)	125K (6)	125K (7)	125K (7)	125K (7)	1.25m(63)
12. Method Specific Booklets		5m(32)			5m(31)						10m(63)
13. Spacing Method Flyers		12.5m (32)			112.5m (32)						25m(63)
14. Billboards		30(6)	30(6)	20(6)	20(6)	20(6)	20(6)	20(7)	20(7)	20(7)	200(63)

MASS MEDIA **15. *Half Hour Radio Programs***	100(6)	100(6)	100(6)	100(6)	100(6)	100(6)	100(6)	100(7)	100(7)	100(7)	100(63)
16. One Minute Radio Spots	25(6)	25(6)	25(6)	25(6)	25(6)	25(6)	25(6)	25(7)	25(7)	25(7)	250(63)
17. 20 Minute Television Programs	6(6)	6(6)	6(6)	6(6)	6(6)	6(6)	6(6)	6(7)	6(7)	6(7)	60(63)
18. 10 Minute Motivational Docudrama	2(6)	2(6)	2(6)	2(6)	2(6)	2(6)	2(6)	2(7)	2(7)	2(7)	20(63)
19. 20 Minute Animated Film Series	1(10)	7(10)	3(3)	3(3)							14(32)
20. 6 Feature Pilot		1(8)		1(8)		1(8)		1(8)			4(32)
21. Mobile Film/Video Showings	12K(6)	12K(6)	12K(6)	12K(6)	12K(6)	12K(6)	12K(6)	12K(7)	12K(7)	12K(7)	120K(63)
22. Folk Media Festivals	5(6)	5(6)	5(6)	5(6)	5(6)	5(6)	5(6)	5(7)	5(7)	5(7)	50(63)
COMMUNICATIONS CAMPAIGNS **23. Indian Medical Association**		5(16)		5(16)		5(11)		5(10)		5(10)	25(63)
24. Literacy House			5(16)		5(16)		5(11)		5(10)		10(63)
25. Voluntary Health Association of India	6(6)	6(6)	6(6)	6(6)	6(6)	6(6)	6(6)	6(7)	6(7)	6(7)	60(63)
26. Other NGOs		2(16)		2(16)		2(11)		2(10)		2(10)	10(63)
27. State MOHFW	5(5)	5(15)	32(32)	45(45)	45(45)	45(45)	45(45)	63(63)	63(63)	63(63)	421(63)
28. Formative Research	5(6)	5(6)	5(6)	5(6)	5(6)	5(6)	5(6)	5(7)	5(7)	5(7)	50(63)

Figure 16 (last portion).

V. CONTRACEPTIVE SOCIAL MARKETING

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTAL
1. Number of CSM Subcontracts Issued	3 (6)	7 (15)	1 (40)	1 (63)	3 (63)	7 (63)	NA (*) (63)	NA (*) (63)	NA (*) (63)	NA (*) (63)	21 + (63)
2. Number of CSM Outlets Established**	5,000 (6)	15,000 (15)	20,000 (40)	25,000 (63)	30,000 (63)	35,000 (63)	40,000 (63)	40,000 (63)	40,000 (63)	40,000 (63)	40,000 (63)
3. Number of Condoms Sold	0 (6)	22,000,000 (15)	30,000,000 (40)	40,000,000 (63)	50,000,000 (63)	65,000,000 (63)	70,000,000 (63)	75,000,000 (63)	75,000,00 (63)	75,000,000 (63)	75,000,000 (63)
4. Number of OCs Sold (Cycles)	0 (6)	500,000 (6)	1,500,000 (15)	2,500,000 (63)	3,500,000 (63)	5,000,000 (63)	5,800,000 (63)	6,800,000 (63)	8,000,000 (63)	9,200,000 (63)	9,200,000 (63)

Figure 17

(*) The number of subcontracts let in the last four years will be determined by the success and status of prior contracts
(**) These are estimates only. As yet there has been no determination of how many outlets will be necessary.

VI. POLICY SUPPORT

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTAL
1. Policy Seminars and Workshops	2(2)	4(4)	4(6)	4(8)	4(8)	5(8)	5(8)				28(43)
2. Training and Use of Policy Models	2(2)	3(4)	3(6)	4(8)	4(10)	4(10)					20(40)
3. Public Affairs Media Outreach	4(10)	4(15)	4(20)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	40(63)
4. Press Releases	4(10)	4(15)	4(20)	6(63)	6(63)	6(63)	6(63)	6(63)	6(63)	6(63)	54(63)
5. Study Tours	2(2)	2(4)	2(6)	2(8)	2(63)	2(63)	2(63)	2(63)	2(63)	2(63)	20(20)
6. Dissemination via Newsletter	4(20)	4(20)	4(23)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	40(63)
7. India Versions Pop Reports	5(20)	5(20)	5(23)	5(63)	5(63)	5(63)	5(63)	5(63)	5(63)	5(63)	50(63)
8. Adaption of PRB Materials	1(20)	1(20)	1(23)	1(63)	1(63)	1(63)	1(63)	1(63)	1(63)	1(63)	10(63)

Figure 18

VII. RESEARCH AND EVALUATION

OUTPUTS	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	TOTAL TRAINED
1. Diagnostic Studies	2(2)	2(4)	3(6)	3(6)							10(18)
2. Baseline Surveys	2(2)	2(4)	3(6)	3(6)							10(18)
3. Operations Research Studies	2(4)	2(6)	3(8)	3(8)							10(26)
4. Special Studies on Women's Issues	1(4)	3(6)	3(6)	2(6)	1(6)						10(28)
5. Training Workshops, Monitoring & Evaluation Systems	2(4)	4(4)	4(6)	6(8)	6(8)	8(10)					30(40)
6. Research & Materials Centers/POP CD-Rom	2(6)	2(6)	2(6)	2(6)	2(6)	2(6)	2(6)	2(7)	2(7)	2(7)	20(63)
7. Large Scale Surveys					1(63)					1(63)	2(63)
8. Dissemination Seminar and Workshops			3(4)	5(6)	5(8)	5(10)	6(10)	6(10)			30(48)
9. Research Reports		2(63)	2(63)	2(63)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	30(63)
10. Research Notes		2(63)	6(63)	6(63)	6(63)	6(63)	6(63)	6(63)	6(63)	6(63)	50(63)
11. Newsletter		4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	4(63)	36(63)

Figure 19

5. COST ESTIMATE AND FINANCIAL PLAN

The following assumptions govern the project budget as presented herein.

- The IFPS Project Agreement will obligate funds from USAID/New Delhi's bilateral assistance program for India for the majority of in-country costs for the public and non-government sectors.

- The Office of Population (AID/Washington) will support in-country costs related to the provision of technical assistance, e.g., office rental, locally-procured supplies and equipment, local staff and consultants, and transport). On an exceptional basis, only as approved by the Steering Committee, C.A.s may also provide direct funding for IFPS program activities, especially in the early years of the project to facilitate rapid start-up and implementation of agreed-upon activities.

- USAID/New Delhi's financing of in-country costs will include:

  - ☐ performance based disbursement to the SOCIETY for meeting agreed upon performance benchmarks for public sector activities, NGO and employer-based activities, and research and evaluation activities; and

  - ☐ with Steering Committee approval, a direct USAID contract with an indigenous Indian management firm to serve as the lead organization for CSM activities.

- The relative proportion of A.I.D. funds flowing through the SOCIETY to public versus non-governmental institutions will depend on their absorptive capacity, i.e., their ability to use project resources effectively in the delivery of family planning services. While there is no fixed formula for determining this proportion, analyses of the costs of proposed activities indicate that more than 50 percent of overall funding is likely to be apportioned to activities in public institutions. **The project will retain flexibility to shift resources from areas that are not progressing well to other more promising areas of opportunity.**

- AID/Washington contributions will be provided primarily through five U.S. organizations (CAs) with which it has direct contracts (Annex II.C) (JHPIEGO, CEDPA, JHU/PCS, SOMARC, and the Population Council). This assistance will be supplemented by other C.A.s as needed (e.g., OPTIONS, PROFIT, BUCEN, and the EWPI). With GOI approval, AID/Washington will also directly finance the procurement of U.S. source contraceptives (NORPLANT®, and Cu 380A IUDs if necessary), and medical kits for minilap and IUD insertion.

- All IFPS Project support will be provided under the principles of ensuring **additionality and flexibility in financing**, i.e., IFPS funds will be additional to

GOI/GOUP funding for family welfare activities.

Host Country Contribution. A principal objective of the IFPS Project is to restructure the overall family planning effort in U.P. in both the public and private sectors. The A.I.D. resources will be used to advance family planning in both sectors, in an attempt to provide greater momentum and scope. Private sector activities in family planning for the U.P. are numerous but difficult to quantify. In the public sector, the GOI and GOUP expended for family welfare (family planning) in U.P. the equivalent of $47.9 million exclusive of a small amount for medically-terminated pregnancies in the government's fiscal year 1990-91. All elements of the U.P. family welfare budget (except abortion) are absolutely critical to the success of IFPS in U.P.because the project is designed to be supplemental to the U.P. family welfare budget. Therefore, the project considers the U.P. family welfare budget to be the critical Host Country Contribution to the project. Without that contribution, the project could not achieve its planned objectives. The figure in the U.P. family welfare budget for fiscal year 1990-91 multiplied by ten (for the ten-year LOP), with a nominal reduction for expected exchange rate fluctuations, has been used as the basis for the $400 million host country contribution for the IFPS Project. To assure that the project does not undermine the GOI-GOUP financial commitment to family planning in Uttar Pradesh, a provision of the Project Agreement will record the two governments' agreement to maintaining family planning expenditures at levels equal to, or greater than, the 1990-91 level, exclusive of the A.I.D. funds for the IFPS Project.

Release of A.I.D. Funds. As the project proceeds, a major share of the A.I.D. funding will be tied to the achievement of mutually-agreed performance benchmarks. As the benchmarks are reached, funds will be released to the SOCIETY for public and non-governmental sector activities and for research and evaluation (R & E). One exception to this procedure will be that with the approval of the National Steering Committee, USAID will contract directly with a local management firm to serve as the lead contraceptive social marketing organization. In general, fund releases will be governed by the provisions of the Project Agreement and the review and approval of implementation plans and reports of benchmark accomplishment by the SOCIETY's Governing Body.

In addition to the funds released directly by USAID for the project, goods and services for IFPS will be provided using AID/Washington funds for purposes such as contraceptives not available in India, medical kits, computers, and other commodities not locally available. Consultant services also will be provided with the AID/Washington assistance.

Life of Project Costs. Overall A.I.D. costs of the IFPS Project are expected to be $325 million (approximately Rs. 9.1 billion at the current exchange rate of Rs. 28 per U.S. dollar) for the ten-year project period. This total A.I.D. commitment for the project will call for an annual investment of approximately $32.5 million ($22.5 million from the bilateral program and $10 million from A.I.D./Washington) for the next ten years. Actual obligations and disbursements will likely vary significantly from the $32.5 million average, as well as from the levels shown in the financial projections presented herein.

FINANCIAL PLAN

The following sheets contain summary information on the financing of IFPS Project activities. More detailed information is contained in the **Financial Analysis Annex.**

Also included are charts and graphs showing the overall financing arrangements and summary costs over the ten-year life-of-project.

For the public sector, the NGO/Employer sector and for research and evaluation activities, funds will be released incrementally to the SOCIETY, based upon attainment of agreed milestones and accomplishments (performance-based disbursement).

For CSM activities, USAID will contract directly with an indigenous management firm to serve as the lead CSM organization, and to subcontract with other indigenous organizations for relevant portions of the CSM program.

IFPS FINANCIAL PLAN - SUMMARY COST ESTIMATES

OVERALL

Table: 2. Summary Budget by **Major Category and Year**
3. Grand Total Budget by **Category and Year**
4. Grand Total Budget by **Category and Organization** (USAID, AID/W, and C.A.s)
5. **Total USAID Budget** by Category and Year
6. **Total AID/W Budget** Including All C.A.s and AID/W Direct Costs

GRAPHS AND CHARTS

Figure: 20. (Chart) **Financing Arrangements** for All Project Elements
21. (Graph) IFPS Costs by **Organization**
22. (Graph) IFPS Cost Breakdown by **Sector**
23. (Graph) IFPS Cost Breakdown by **Sector and Year**
24. (Graph) Local Costs Breakdown by **Sector**

Table 2

SUMMARY BY MAJOR CATEGORY ONLY

FINANCIAL PLAN: PAGE 1 OF 20

IFPS PROJECT BUDGET SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000s)
	1	2	3	4	5	6	7	8	9	10	
A. U.S. DOLLAR COSTS											
U.S. Personnel and Administration	3,416	3,871	3,932	3,611	2,898	2,460	2,449	2,407	2,384	2,290	29,718
Contraceptives (U.S. Source)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
Other Commodities (U.S. Source)	593	282	1,105	1,299	1,314	1,479	1,364	1,379	1,429	461	10,705
Participant (International) Training	280	780	636	573	412	394	385	352	289	296	4,397
Other Direct and Indirect Costs	2,257	2,251	2,456	2,310	1,763	1,398	1,398	1,425	1,455	1,396	18,110
Evaluation and Audit*	0	0	0	150	0	0	150	0	0	150	450
Contingency and Inflation (@5%)	0	300	325	350	375	400	425	450	475	500	3,600
SUBTOTAL: U.S. DOLLAR COSTS	7,512	8,536	10,094	9,795	8,613	8,385	8,927	9,248	9,868	9,604	90,580
B. LOCAL COSTS (L/C)	13,895	18,474	17,831	19,441	25,317	24,023	24,335	27,465	27,759	35,882	234,420
GRAND TOTAL DOLLARS + L/C	21,407	27,009	27,924	29,236	33,929	32,408	33,262	36,713	37,627	45,486	325,000

* Dollar costs shown are for evaluation only. Audits are included in local costs.

TABLE 3

GRAND TOTAL (USAID/DELHI + AID/W COSTS)

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	983	842	884	798	743	588	615	645	675	587	7,360
U.S. CONSULTANTS (pm)	1,047	1,381	1,367	1,204	886	740	701	620	596	588	9,130
TRAVEL & PERDIEM	903	1,062	1,021	914	622	518	493	475	417	388	6,813
HOME OFFICE STAFF	483	586	660	695	647	614	640	667	696	727	6,415
CONTRACEPTIVES (U.S.)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
MEDICAL EQUIPMENT (U.S.)	0	0	800	1,000	1,050	1,160	1,195	1,245	1,295	345	8,090
OTHER COMMODITIES (U.S.)	593	282	305	299	264	319	169	134	134	116	2,615
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	280	780	636	573	412	394	385	352	289	296	4,397
LOCAL COSTS											
Training/workshops/seminars	515	1,707	1,972	2,280	1,966	2,090	2,015	1,913	1,889	2,028	18,375
Local procurement**	1,268	1,084	1,108	1,102	1,026	970	875	890	888	865	10,076
Local-hire staff (pm)	749	852	860	904	805	802	806	811	815	800	8,204
Local-hire consultants (pm)	395	427	452	452	476	346	361	351	326	322	3,908
Vehicles/maintenance/POL	986	147	153	159	174	230	155	160	165	171	2,498
Institutional grants (program)	2,307	5,093	3,403	4,199	5,478	5,085	4,425	4,717	4,585	4,511	43,803
Pilot FP service grants	2,729	3,581	3,841	2,346	0	0	0	0	0	0	12,497
FP service expansion grants	0	0	0	2,000	6,392	8,706	10,056	13,356	14,434	14,732	69,676
Research/evaluation grants	300	1,125	1,575	1,575	4,575	1,375	1,325	950	650	8,652	22,102
CSH/CRS contracts	4,546	4,358	4,367	4,324	4,325	4,319	4,217	4,217	3,907	3,701	42,281
Audits	50	50	50	50	50	50	50	50	50	50	500
OTHER DIRECT COSTS	1,117	1,108	1,225	1,191	794	561	573	591	611	637	8,409
OTHER INDIRECT COSTS	1,140	1,143	1,231	1,119	969	837	825	834	844	759	9,701
EVALUATION AND AUDIT (A.I.D.)	50	50	50	200	50	50	200	50	50	200	950
CONTINGENCY & INFLATION @ 5%	0	300	325	350	375	400	425	450	475	500	3,600
TOTALS	21,407	27,009	27,924	29,236	33,929	32,408	33,262	36,713	37,627	45,486	325,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

GRAND TOTAL BY CATEGORY AND ORGANIZATION

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	USAID/ DELHI	AID/W DIRECT	C.A. JHPIEGO (Training)	C.A. CEDPA (NGO)	C.A. JHU/PCS (IEC)	C.A. SOMARC (CSM)	C.A. POPCOUNCIL (R&E)	C.A. JSI/FPLM (Logistics)	C.A. OTHERS (Misc)	AID/W TOTAL	GRAND TOTAL
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	2,716	360	1,975	423	0	0	0	1,887	7,360	7,360
U.S. CONSULTANTS (pm)	0	0	1,005	1,004	2,675	1,073	1,710	552	1,111	9,130	9,130
TRAVEL & PERDIEM	0	0	2,397	1,601	970	1,145	0	700	0	6,813	6,813
HOME OFFICE STAFF	0	0	3,692	1,455	850	142	0	276	0	6,415	6,415
CONTRACEPTIVES (U.S.)	0	23,570	30	0	0	0	0	0	0	23,600	23,600
MEDICAL EQUIPMENT (U.S.)	0	7,850	240	0	0	0	0	0	0	8,090	8,090
OTHER COMMODITIES (U.S.)	0	0	481	107	255	0	1,157	95	520	2,615	2,615
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	970	1,258	423	0	315	581	850	4,397	4,397
LOCAL COSTS											
Training/workshops/seminars	16,312	0	958	0	0	280	100	0	725	2,063	18,375
Local procurement**	6,576	0	99	970	11	76	2,018	326	0	3,500	10,076
Local-hire staff (pm)	4,732	0	142	793	920	114	1,100	403	0	3,472	8,204
Local-hire consultants (pm)	250	0	0	18	1,960	404	551	0	725	3,658	3,908
Vehicles/maintenance/POL	2,239	0	17	76	0	6	64	96	0	259	2,498
Institutional grants (program)	43,803	0	0	0	0	0	0	0	0	0	43,803
Pilot FP service grants	12,497	0	0	0	0	0	0	0	0	0	12,497
FP service expansion grants	69,676	0	0	0	0	0	0	0	0	0	69,676
Research/evaluation grants	21,652	0	300	0	0	0	0	0	150	450	22,102
CSM/CRS contracts	42,213	0	0	0	0	68	0	0	0	68	42,281
Audits	500	0	0	0	0	0	0	0	0	0	500
OTHER DIRECT COSTS	0	1,810	1,334	1,391	1,043	950	0	623	1,258	8,409	8,409
OTHER INDIRECT COSTS	0	0	2,390	4,084	2,660	278	0	289	0	9,701	9,701
EVALUATION AND AUDIT (A.I.D.)	950	0	0	0	0	0	0	0	0	0	950
CONTINGENCY & INFLATION @ 5%	3,600	0	0	0	0	0	0	0	0	0	3,600
TOTALS	225,000	35,946	14,415	14,732	12,190	4,536	7,015	3,941	7,225	100,000	325,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

TOTAL USAID/DELHI COSTS

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR 1	2	3	4	5	6	7	8	9	10	ALL YEARS ($000S)
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS											
Training/workshops/seminars	255	884	1,002	2,130	1,816	1,990	1,890	1,798	1,804	1,943	16,312
Local procurement**	658	730	730	738	722	676	580	582	580	580	6,576
Local-hire staff (pm)	169	493	493	511	511	511	511	511	511	511	4,732
Local-hire consultants (pm)	25	25	25	25	25	25	25	25	25	25	250
Vehicles/maintenance/POL	886	120	124	129	162	218	142	147	152	159	2,239
Institutional grants (program)	2,307	5,093	3,403	4,199	5,478	5,085	4,425	4,717	4,585	4,511	43,803
Pilot FP service grants	2,729	3,581	3,841	2,346	0	0	0	0	0	0	12,497
FP service expansion grants	0	0	0	2,000	6,392	8,706	10,056	13,356	14,434	14,732	69,676
Research/evaluation grants	300	800	1,550	1,550	4,550	1,350	1,300	950	650	8,652	21,652
CSM/CRS contracts	4,490	4,352	4,361	4,324	4,325	4,319	4,217	4,217	3,907	3,701	42,213
Audits	50	50	50	50	50	50	50	50	50	50	500
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)***	50	50	50	200	50	50	200	50	50	200	950
CONTINGENCY & INFLATION @ 5%	0	350	325	350	375	400	425	450	475	500	3,600
TOTALS	11,919	16,478	16,754	18,552	24,456	23,380	23,821	26,853	27,223	35,564	225,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

*** includes U.S. dollar costs (for evaluation) and local currency costs for audits

TABLE 6

TOTAL AID/W COSTS

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

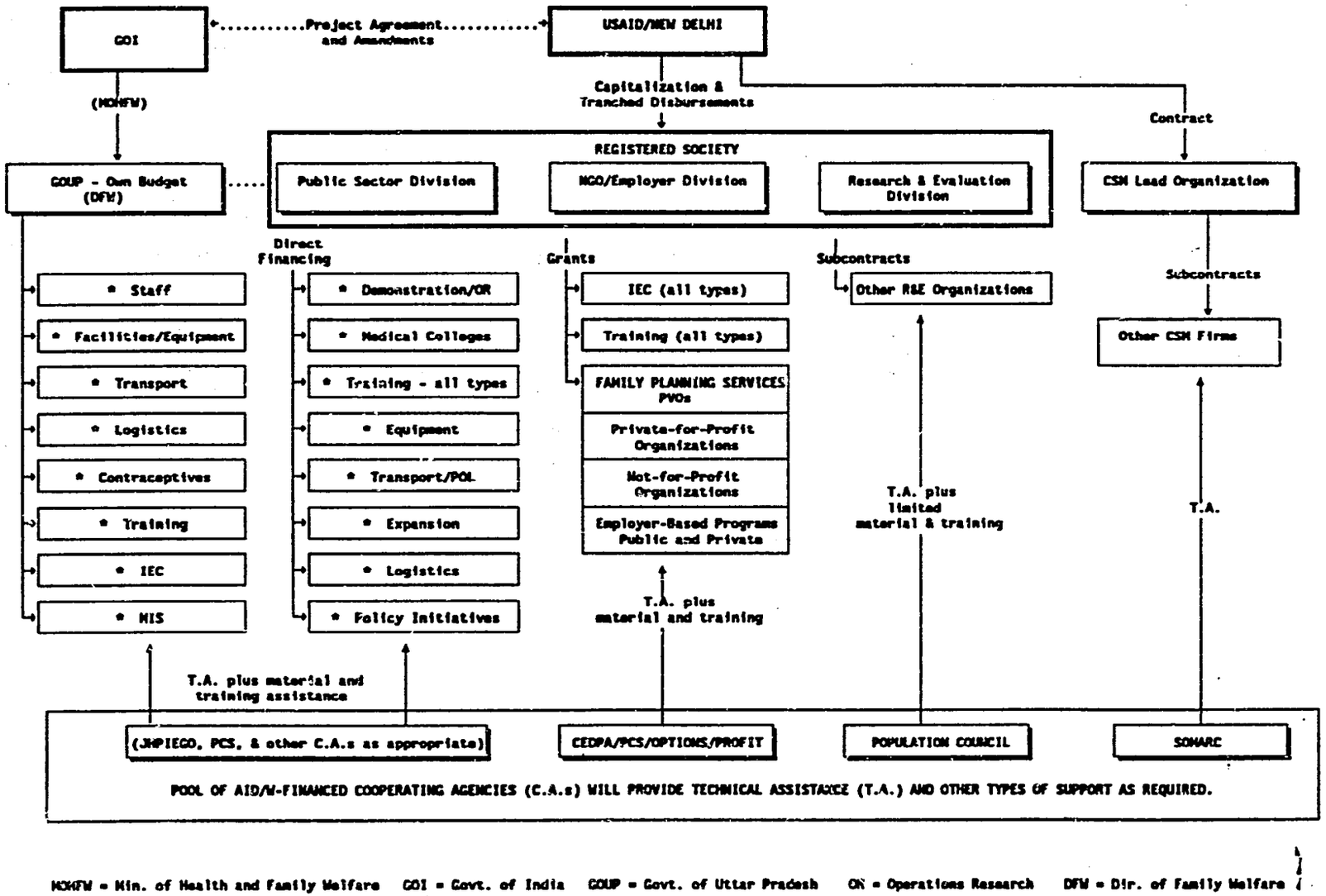
	PROJECT YEAR 1	2	3	4	5	6	7	8	9	10	ALL YEARS ($000S)
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	983	842	884	798	743	588	615	645	675	587	7,360
U.S. CONSULTANTS (pm)	1,047	1,381	1,367	1,204	886	740	701	620	596	588	9,130
TRAVEL & PERDIEM	903	1,062	1,021	914	622	518	493	475	417	388	6,813
HOME OFFICE STAFF	483	586	660	695	647	614	640	667	696	727	6,415
CONTRACEPTIVES (U.S.)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
MEDICAL EQUIPMENT (U.S.)	0	0	800	1,000	1,050	1,160	1,195	1,245	1,295	345	8,090
OTHER COMMODITIES (U.S.)	593	282	305	299	264	319	169	134	134	116	2,615
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	280	780	636	573	412	394	385	352	289	296	4,397
LOCAL COSTS											
Training/workshops/seminars	260	823	170	150	150	100	125	115	85	85	2,063
Local procurement**	610	354	378	364	304	294	295	308	308	285	3,500
Local-hire staff (pm)	580	359	367	393	294	291	295	300	304	289	3,472
Local-hire consultants (pm)	370	402	427	427	451	321	336	326	301	297	3,658
Vehicles/maintenance/POL	100	27	29	30	12	12	13	13	13	12	259
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	325	25	25	25	25	25	0	0	0	450
CSM/CRS contracts	56	6	6	0	0	0	0	0	0	0	68
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	1,117	1,108	1,225	1,191	794	561	573	591	611	637	8,409
OTHER INDIRECT COSTS	1,140	1,143	1,231	1,119	969	837	825	834	844	759	9,701
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	9,488	10,531	11,170	10,684	9,473	9,028	9,441	9,860	10,404	9,922	100,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

FIGURE 20

IFPS PROJECT: FINANCING ARRANGEMENTS FOR ALL PROJECT ELEMENTS
(INCLUDING GOI/GOUP CONTRIBUTION)



MOHFW = Min. of Health and Family Welfare GOI = Govt. of India GOUP = Govt. of Uttar Pradesh OR = Operations Research DFW = Dir. of Family Welfare

FINANCES.DOC

IFPS COSTS BY ORGANIZATION
IN MILLIONS OF DOLLARS

Total = $325 Million Over 10 Years

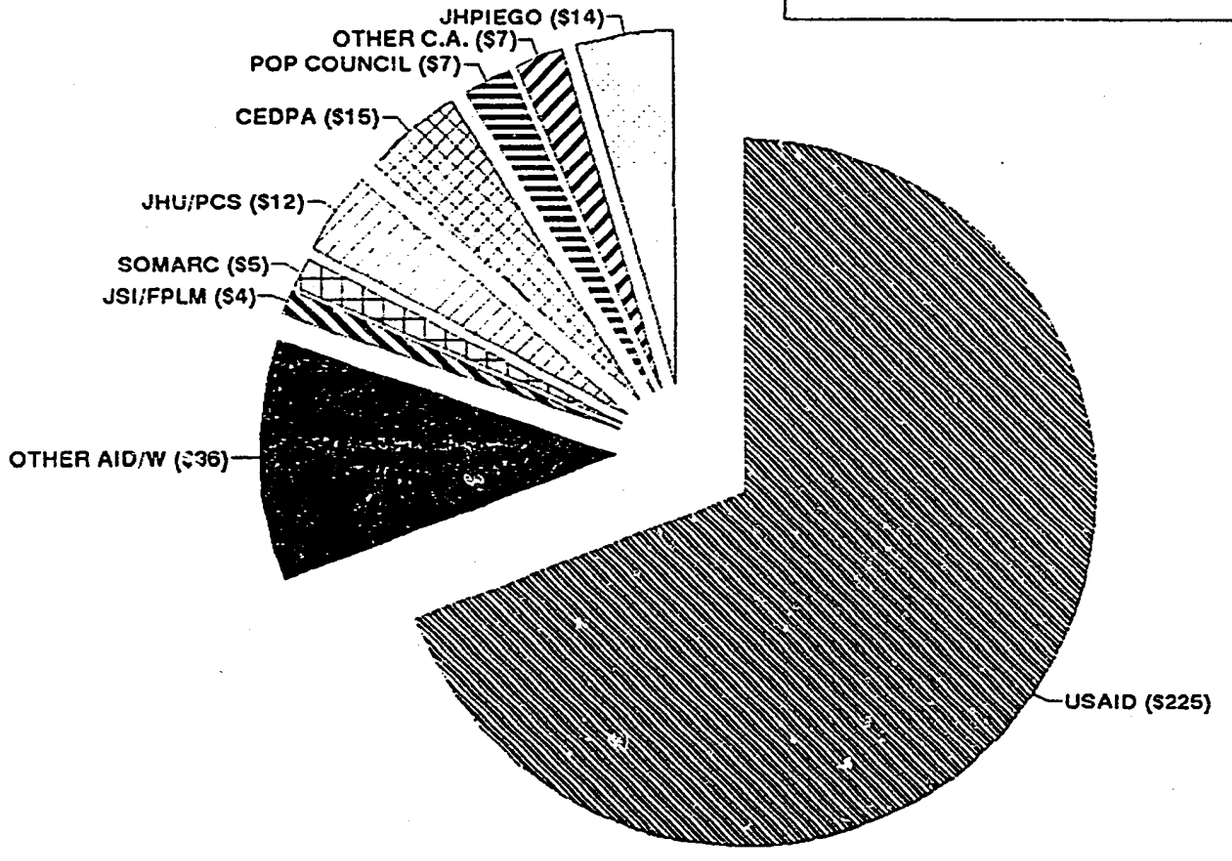


Figure 21

IFPS COST BREAKDOWN BY SECTOR
(in millions of dollars)

Total = $325 Million Over 10 Years

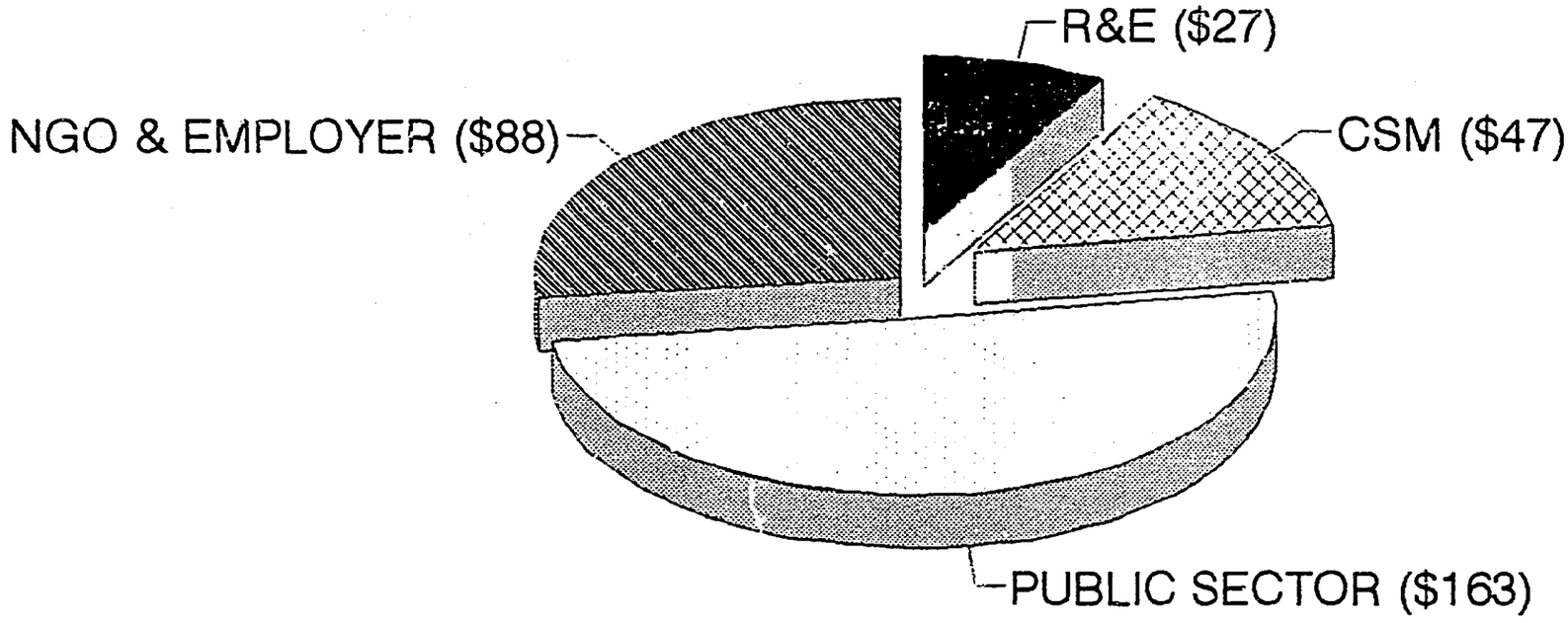


Figure 22

IFPS COST BR[illegible] BY SECTOR & YEAR
(in millions of dollars)

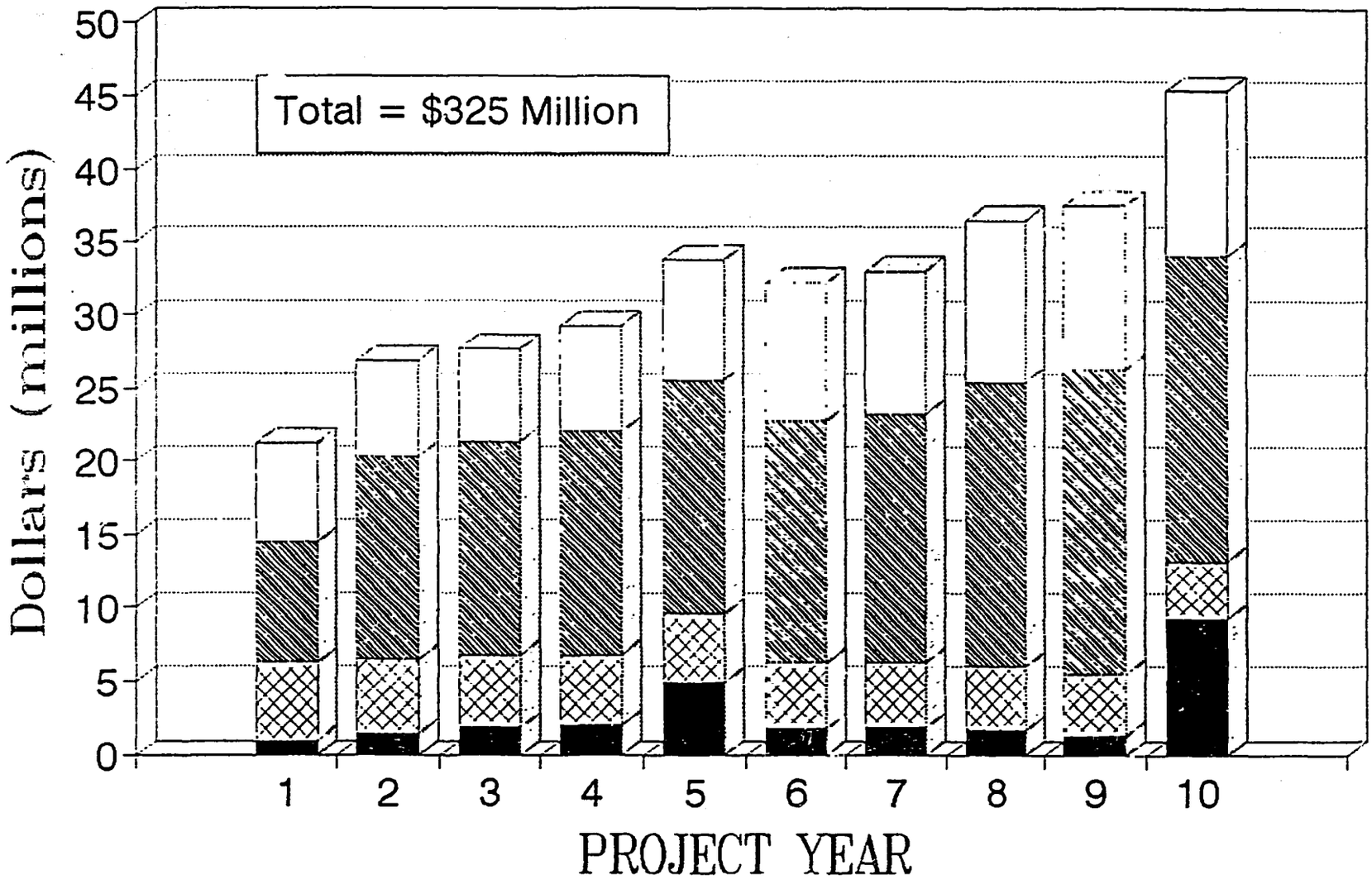


Figure 23

LOCAL COSTS BREAKDOWN BY SECTOR
(in millions of dollars)

Total = $234 Million

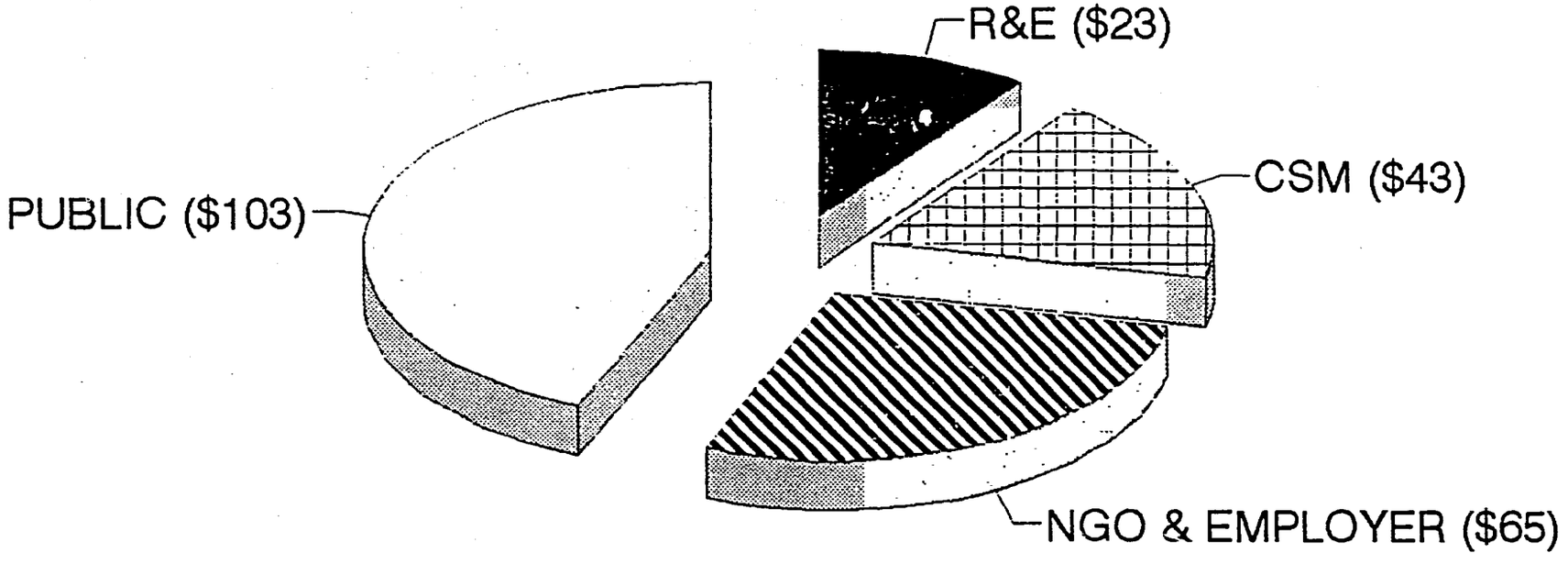


Figure 24

METHODS OF IMPLEMENTATION AND FINANCING

(ILLUSTRATIVE TABLE)

	Implementation Method	Method of Financing		Approximate Cost
IFPS SOCIETY	Project Implementation Letters	Performance Based Disbursement		
- Public Sector Activities	-do-	-do-		
- NGO & Employer-based activities	-do-	-do-		
- Training	-do-	-do-		
- Equipment	-do-	-do-		
			Subtotal	$156,085,000
- Lead Research & Evaluation Organization	-do-	Direct Payment		$ 21,652,000
Contraceptive Social Marketing	AID Direct Contract	Direct Payment		$ 42,213,000
Evaluation and Audit	AID Direct	Direct Payment		$ 950,000
Audits of SOCIETY	HC Contract	HC Reimbursement		$ 500,000

FIGURE 25

6. Evaluation and Audit Plan

A. Project Evaluation. Three project evaluations are envisaged over the ten-year life of this project, to take place in years four, seven, and ten. A revision of the project's numeric targets will take place at the end of the first year, based on the availability of reliable demographic data from a national survey now underway. The three A.I.D. evaluations, to be conducted by an outside team consisting of AID/W personnel plus contractors, will benefit both from the availability of better survey data and from early results from the extensive research and evaluation activities built-into the project, which are designed to measure the impact of alternative approaches to family planning service delivery. A total of $450,000 has been budgeted for the three evaluations.

B. Auditing. Three of the four project components, namely those involving the public sector, the non-governmental sector and research and evaluation, will be implemented through the SOCIETY. Funds for these components will be released to the SOCIETY upon satisfaction of agreed upon benchmarks to be set forth in a of letter from A.I.D. and countersigned by the SOCIETY. The SOCIETY will be required to maintain accounting books, records, and systems in accordance with generally accepted accounting principles prevailing in India and these will be viewed for their adequacy at the start of project implementation. In addition, the SOCIETY will be required to have annual audits made by the Comptroller & Auditor General of India or independent CPA firms to review the adequacy of accounting records and accuracy of financial statements, and to determine if the funds disbursed by the SOCIETY were used for meeting the project objectives. The audits will also review the SOCIETY's procedures to assess the adequacy of financial systems and controls of organizations to which it provides contracts and grants under the project and a limited testing of these organizations' financial accounts. Copies of the audit reports will be provided to USAID. An amount of $50,000 per year will be provided in the SOCIETY budget for such annual audits, the first of which will be made in the second year of its operations.

The fourth project component, contraceptive social marketing, will be implemented through a direct contract between USAID and a private sector organization. The audit needs for this activity will be assessed based on the type of contract awarded. For instance, if a fixed price contract is awarded, there will be no need for audits. However, if it is a cost reimbursement contract, annual audit will be required and funds therefor will be provided in the contract.

7. SUMMARIES OF PROJECT ANALYSES

7.1 Technical Analysis Summary

Although the Indian State of Uttar Pradesh with a population of 140 million is larger than all but six countries in the world, USAID has over two decades of experience in assisting country programs of roughly similar size. In some of these, dramatic successes have taken place. Thus

the IFPS Project should be taken in context and, if convenient, thought of as another large-country program.

U.P. is India's largest state in terms of population; in geographic size, it is roughly comparable to the State of Colorado. It is also one of the most underdeveloped areas of the country, on virtually all demographic, economic, and social indices. Most 73 percent of the population lives in two of the five regions: the Eastern and Western Regions. These two regions comprise 40 of U.P.'s 63 districts.

Fertility rates are generally high throughout the state, but appear to vary markedly from district to district. Available census, survey, and administratively-derived data do not agree on either the level of fertility or the use of contraceptive methods. A comparison of crude birthrates, total fertility rates, and contraceptive prevalence rates found very low correlations among the various district-level and state-level estimates. It is believed that the National Family Health Survey, now underway, will yield reliable estimates which can be used for program planning (and re-planning) by the summer of 1993.

Despite the absence of reliable estimates of fertility and contraceptive practice, there is good reason to believe that a substantial demand for modern contraceptive methods, especially non-terminal methods, does in fact exist. For purposes of this analysis, a special study was made of results in U.P. of the (believed to be reliable) large-scale 1989 National Family Planning Practices Survey. It was found that desired family size is less than three children while actual size is 5.4. Twenty-six percent of couples who desire no more children are not using a family planning method. Fifty-five percent of couples **have never used a family planning method.** These data, together with what is known of the deficiencies in services provided heretofore by the family welfare program in U.P., suggest that there is a large built-in demand for family planning which could be tapped by the IFPS Project.

The Technical Analysis examines the three principal IFPS strategies: those to **increase access,** those to **improve quality,** and those to **promote family planning.**

With respect to access, it concludes that:

- "There is every reason to expect that [strategies chosen to increase access in the public sector] can be effective in the Indian context";

- "In U.P it remains to be seen how fully the private sector can be made to contribute to the overall success of family planning. IFPS has adopted technical and managerial strategies which seem appropriate to put the private sector to the test"; and

- "Based on experience to date, USAID believes that the CSM program is one of the IFPS Project components most ready to proceed immediately upon signing the Project Agreement. The chosen strategy appears to be appropriate, and affords many opportunities for innovation and strengthening during the project out-years."

With respect to **quality of services**, it concludes that:

- "...it is difficult to predict how successful IFPS may be in achieving the goal of improving the quality of services across-the-board. However, there are specific strategies and program activities within the project which are aimed at achieving each of the above-listed elements of high-quality family planning services".

With respect to **promoting family planning**, it concludes that:

- "If all the above-cited activities are successful, as they have been elsewhere, they will undoubtedly lead to a major shift in support for family planning, including at the grassroots."

A sub-purpose of the IFPS Project is to develop family planning service delivery activities which will be widely replicated in the large northern states and elsewhere in India. While it is too early to predict how quickly or how extensively this might take place, there are precedents elsewhere as well as in India to suggest that the GOI might be eager to adopt and to diffuse successful approaches to family planning. In part, the success of replication efforts will depend on the continued employment of key personnel who have experienced and managed the initial change.

The overall conclusion of the Technical Analysis is that "The IFPS Project is technically sound as presently conceived.....(and it) embodies strategies and resources appropriate to the chosen objectives of expanding access, improving quality, and promoting family planning". It is further suggested that at the end of the first project year it will be necessary to reassess the demographic targets of IFPS, based on information from the 1992 National Family Health Survey and on the first full year of project activities.

7.2 Institutional Analysis Summary

The IFPS Project will collaborate with various Indian public and private sector institutions. The institutional capability of these organizations is therefore relevant to the success of the project. Although a detailed analysis will be conducted of each institution's capacity to contribute to the project, a preliminary analysis shows that both the public and private sectors can be assisted successfully to expand their family planning service delivery.

The U.P. public health system and public enterprises: The health systems of the U.P. DOHFW and other public enterprises such as the Indian Railways, have vast and complex infrastructures. The health networks are well established and have the capacity to reach a large number of people. The infrastructures consist of hospitals, health centers of various types, small dispensaries, and health posts. Logistics systems and MIS are also in place, for the most part.

Although the manpower of the public health system and the Railway health system seems to be impressive, it is still inadequate to serve the vast population of the state and the large number of Railway employees. Inadequate staffing patterns are therefore a major constraint to effective family planning service delivery. In addition, training programs for staff are poorly designed, and in some cases, not in operation at the present time. Motivation of staff and quality of services provided are very poor. Facilities and equipment in many of the health centers are substandard or absent. The image of family planning providers is poor due to the focus of the program on sterilization and the target-oriented approach of the providers. There is a lack of an appropriate method-mix at all levels. In spite of these drawbacks it is essential for the IFPS Project to collaborate with the public sector in order to have a significant impact on the TFR of U.P.

The non-governmental sector: The family welfare programs of private corporations, PVOs, and parastatal organizations are, on the whole, not well established and represent a very small fraction of the total family planning service delivery in U.P. Nevertheless, this sector has great potential for expansion and can be utilized profitably by the IFPS Project.

The strengths of the non-governmental sector are: they have greater access to rural and peri-urban areas as many of them are grassroots organizations and present in the villages and peri-urban areas; some of them (such as the cooperatives) have large, well established networks that are currently being utilized for other purposes and could be used to introduce family planning services; the credibility of these organizations is good among villagers and employees; some of the organizations are currently offering MCH services and it would be relatively easy to add family planning services.

The weaknesses of this sector include: the majority of the organizations will require extensive training and technical assistance to establish and expand family planning services; management staff need to be motivated to add family planning to their current programs; existing services are of poor quality and programs lack effective monitoring and MIS systems. The IFPS Project will attempt to rectify these drawbacks to expand family planning service delivery in U.P. through this sector.

7.3 Financial Analysis Summary

The financial analysis assesses:

- the overall financial soundness of the project's approach, and the extent to which project resources will be used cost-effectively;
- the flow of project resources, including the mechanisms for funds disbursement, cost estimates, and contributions of centrally-funded projects and the GOI;
- the financial management capacity of implementing agencies; and
- long-term prospects for project activities to become institutionally and financially sustainable.

The analysis concludes that among the possible alternatives for achieving project objectives, the IFPS Project has chosen a "least-cost" approach. The project will, insofar as possible, build upon existing structures and capacities, thus maximizing the effect of investments at the margin. This appears to be the case even with respect to institution-building activities for the lead R&E organization and for the SOCIETY, since these capacities do not now exist in the form required for successful implementation of the project.

The analysis details the flow of A.I.D. resources totaling $325 million over the LOP, and estimates the GOI/GOUP contribution at some $400 million, mostly in-kind. It projects an increase in the cost per family planning user (from $4-5 to $8-10) by the end of the project due to the increased emphasis on spacing methods and FP promotion noting, however, that the cost increase will be associated with large payoffs to the government which will far exceed the expected cost increases.

With respect to the financial management capacity of implementing agencies, the analysis concludes that there is reason to believe that both the public and private sector entities to be involved in project implementation (not including the SOCIETY which does not now exist) have the requisite capacity to manage A.I.D. finances. Several examples are cited.

In regard to sustainability, the analysis outlines strategies in both the public and private sectors. It concludes that sustainability will depend on: (a) increased government investment in family planning, coupled with increased emphasis on cost-recovery; (b) successful implementation of cost-recovery schemes in the private/NGO sector; (c) degree of success in building family planning into the private/commercial and public enterprise sector; and (d) an increase in the demand for family planning services....all of which are specifically included in the IFPS Project strategy.

7.4 Social Soundness and Gender Analysis Summary

Socio-Cultural Context and Issues. In U.P. as elsewhere, the practice of family planning is constrained by a lack of knowledge and awareness of modern methods, traditional attitudes favoring large families, and poor access, particularly of women, to health and family planning services. Underlying these proximate determinants are several social and economic factors, the most important among them being illiteracy, poverty and a low status of women.

The project directly addresses the proximate determinants mentioned above by undertaking Information, Education and Communication (IEC) activities to increase knowledge and awareness of modern contraceptive methods. By offering high quality and personalized counseling, it aims to modify traditional attitudes. And by expanding the reach of family planning services and their quality (including the range of method choice available) it tackles the most important problem of families' and women's access. The project does not address basic problems such as illiteracy and poverty except through its support of the efforts of non-governmental organizations involved in 'integrated' activities including non-formal education and income-generation. However, issues of women's status will be addressed on a somewhat larger scale by the project through its encouragement of women's group formation and the participation of women at all levels of project implementation. Intended to empower women to gain better knowledge and access to health and family welfare (HFW) services and to improve other aspects of their lives, these groups will be catalyzed by both the private and the public sectors involved in the project. Indeed, this approach promises to be one of the most important for creating a widespread climate of family planning acceptance and practice in U.P. The adoption of family planning, in turn, is expected to improve the quality of women's lives and those of their families by reducing their heavy reproductive and child-care burden, enabling them to participate to a greater extent in economic activity.

Beneficiaries. The project also addresses other problems in the social landscape of U.P. such as caste and community factors through its strategies of increasing access and information and improving quality. In the past, low caste, minority, tribal, and illiterate groups have benefitted less from HFW services because of social 'distance' from service providers and inadequate efforts to provide them the relevant knowledge and counseling. These issues will be addressed by appropriate training of service providers and the expanded reach and choice of family planning methods.

It is expected that families and women from all socio-economic strata will benefit from the project. In general, a 'segmented market' approach is envisioned in which those who can afford to pay for services and contraceptives will utilize private and commercial channels, while those who cannot afford these will be reached by the subsidized or completely free services provided by the government. The distribution of private and public services is, in fact, consistent with this vision - government services reach into villages and slums where the poorest reside whereas private providers are clustered in towns as well as villages. The commercial social marketing activities will reach into towns and larger villages only and not into smaller poorer villages. Employer-based services will cater primarily to the better-off, organized sector and to a limited

extent to other groups through outreach services. Other non-governmental organizations will address a wide range of socio-economic groups including some of the poorest.

Distribution of Project Benefits. Thus, project benefits are expected to be distributed equitably across social and economic groups. The project recognizes that fertility decisions in the Indian (U.P.) household are dominated by husbands and parents-in-law and involve young women to a lesser extent. Thus, while strengthening women's abilities to participate in such decision-making, the project also addresses men through IEC strategies and by increasing their access to condoms and vasectomy.

Participation. The Indian government is committed to a broad-based, secular and voluntary approach to family-planning. The implementation structure of the project envisions the participation of officials of the GOI and GOUP in policy-making and planning throughout the project. Other participants in these processes will include representatives of NGOs, industries, social marketing firms, and technical advisory/research organizations. Government and non-government workers at all levels will be involved in the implementation of the project and will have opportunities to influence the activities of the project during their training and service delivery activities. The ultimate beneficiaries of the project will participate through groups formed at the local level and as CBD workers. Indeed, the success of the project is synonymous with their participation as users of HFW services.

Feasibility. As the project builds on existing HFW service delivery channels in the public sector, and on organizational forms in the private sector, its activities are entirely feasible. The project will directly address constraints on the 'supply side' by improving provider attitudes through training, as well as improving the facilities and conditions in which providers work. The project will also address provider and 'opinion-maker' biases towards some contraceptive methods (e.g., OCs and other hormonal methods) by introducing these methods only in circumstances providing full knowledge to providers, users, and the public and where high technical competence is ensured.

The main challenges to the success of the project lie in changing traditional behaviors while their underlying factors are not addressed. However, there is evidence from small projects in India, the experience of some other Indian states, and from countries around the world that improving knowledge of family planning and access to services can encourage and assist even traditional families to space and limit the number of their children.

Impact. Besides increasing family planning acceptance in U.P. and thereby decreasing fertility, the project is expected to improve the delivery of family planning services by enhancing quality of care, expanding the choice of methods, developing innovative methods, and expanding the range of 'actors' involved in family planning service delivery. Increasing the 'positive' experience of those who come forward for FP services can go a long way to spreading demand for - and consequent utilization of - contraception. All these efforts can be expected to have an impact beyond the life of the project and beyond the boundaries of U.P. The keen interest of the GOI in this project will ensure these processes. The project also provides for the diffusion of

innovation to other states of India. Replication is made possible by the fact that the project is building on existing delivery systems and organizational forms.

7.5 Economic Analysis Summary

The economic analysis attempts to estimate the benefits of IFPS investment in family planning based on reduced public sector expenditures for health and education. In so doing, **only a fraction of total benefits are measured.** The analysis is also hampered by a lack of up-to-date and comprehensive data on education and health costs in U.P.

Three demographic models are developed based on assumptions of continued high fertility, moderate fertility decline, and rapid fertility decline for the years 1991 to 2026. Next, costs are estimated on a "per user" basis for family planning, education, and MCH services. These costs are then applied to the estimated number of users of these services over time for each of the three demographic scenarios. Differences between the scenarios represent the stream of costs and the stream of benefits expressed in terms of savings in the public education and MCH sectors.

The annual added recurrent costs of family planning grow to $22 million by 2001 and to $60 million by 2026. The corresponding savings for these years grow to $26 million and $992 million, respectively. The rapid expansion of savings after the first ten years is due to the age-related delay in the full effect of fertility change in these two service sectors.

The IRR for the stream of savings and costs observed over this 35-year period is 34 percent. This means that one would have to discount future benefits by more than 34 percent annually for the investment in family planning not to be cost-beneficial. **Hence, the return on investment in family planning in U.P. is extremely favorable.**

INNOVATIONS IN FAMILY FAMILY PLANNING SERVICES (386-0527)

LIST OF ANNEXES

D.O. No. 2(16)-AID/89

भारत सरकार Government of India
वित्त मंत्रालय Ministry of Finance
आर्थिक कार्य विभाग Department of Economic Affairs

SUMATI MEHTA
DY. SECRETARY(AC)
TEL. NO. 3014443

नई दिल्ली / New Delhi, 28th Oct. 1992

Dear Mr. Mahoney,

This is to confirm our request for assistance for the following three projects :-

1. Innovations in Family Planning Services;
2. AIDS Prevention and Control;
3. Trade in Environmental Services and Technologies.

With regards,

Yours sincerely,

(SUMATI MEHTA)

Mr. Timothy M. Mahoney
Director
Program Development and Project Support
USAID
American Embassy
New Delhi.

ACTION: AID [illegible] DCM POL ECON SCI FAS (7)

VZCZCNE0751
FF RUEHNE
DE RUEHC #1051 3522325 19-DEC-91 TOR: 01:49
ZNR UUUUU ZZH CHRG: AID.
P 182326Z DEC 91 DIST: AID
FM SECSTATE WASHDC
TO AMEMBASSY NEW DELHI PRIORITY 2270
BT Prjo. 386-0527
UNCLAS STATE 411051

IFPS

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: INDIA INNOVATIONS IN FAMILY PLANNING SERVICES (386-0527); AD HOC DELEGATION OF AUTHORITY

ANNEX II.B.

REF: NEW DELHI 25312

1. AS REFTEL CORRECTLY POINTS OUT, THE BUREAU APPROVED USAID/NEW DELHI'S NPD FOR THE BIMARU FAMILY PLANNING PROJECT LAST JUNE AND DELEGATED PID AND PP APPROVAL AUTHORITY TO THE MISSION DIRECTOR. WE SEE NO REASON TO RESCIND THAT DECISION.

12/19/91
14:30
ACTION:
HPN-3
INFO:
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DD
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HPNS
CHRON

2. IT IS UNDERSTOOD THAT CHANGES WILL OCCUR DURING PID DEVELOPMENT WHICH MAY AFFECT BOTH THE CONCEPT AND FUNDING LEVEL APPROVED IN THE NPD. IN THE CASE OF THE SUBJECT PROJECT, REFTEL DESCRIBES A GREATLY EXPANDED PROJECT WHICH EXCEEDS MISSION DIRECTOR'S DELEGATED AUTHORIZATION APPROVAL LIMIT. THE REVISED PROJECT, ENTITLED INNOVATIONS IN FAMILY PLANNING, CARRIES A LIFE-OF-PROJECT FUNDING LEVEL OF DOLS 325 MILLION OVER TEN YEARS WITH BILATERAL USAID FUNDS AT A LEVEL OF DOLS 225 MILLION AND R D POP FUNDS AT A LEVEL OF DOLS 100 MILLION. SINCE REGIONAL BUREAU ALLOCATIONS FROM PN ACCOUNT FOR MISSION'S OYB ARE NOT EXPECTED TO INCREASE COMMENSURATELY, ASIA BUREAU APPROVAL OF INCREASED LEVEL PRESUMES BULK OF BILATERAL FUNDING WILL BE TRANSFERRED FROM R D/POP FUNDS.

3. BASED ON NPI AND SUBSEQUENT BRIEFINGS BY BUREAU AND R D/POP OFFICIALS, AA/ASIA HEREBY GRANTS AD HOC DELEGATION OF AUTHORITY TO MISSION DIRECTOR, WALTER BOLLINGER, TO APPROVE AUTHORIZATION OF SUBJECT PROJECT AT LEVEL NOT TO EXCEED DOLS 325 MILLION. YOU MAY PROCEED WITH PID APPROVAL.

4. UPON RECEIPT OF THE APPROVED PID IN AID/W, ASIA/DR/SA WILL SCHEDULE A REVIEW AND USE THE MEETING AS AN OPPORTUNITY TO BRING ADDITIONAL AGENCY EXPERIENCE TO BEAR ON THE PROJECT. THERE HAS ALREADY BEEN DEEP INVOLVEMENT OF THE R&D BUREAU IN THIS ACTIVITY, AND WE EXPECT THE PID REVIEW TO PROVIDE AN IMPORTANT FORUM FOR INTER-BUREAU COORDINATION.

89

5. NOTE: DUE TO THE DIFFICULTY OF SCHEDULING REVIEWS DURING THE HOLIDAYS, ASIA/DR/SA WOULD APPRECIATE ADVANCE WARNING FOR SUBMISSION OF THE APPROVED PID AND MEANS BY WHICH DOCUMENT WILL BE TRANSMITTED. IF ANY MISSION STAFF PLAN TO BE IN WASHINGTON ON LEAVE AT THAT TIME, THEIR ATTENDANCE WOULD BE EXTREMELY USEFUL. EAGLEBURGER
BT
#1051

NNNN

ANNEX I. B.

UNCLASSIFIED STATE 411051

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.	(a) No effect (b) No effect (c) Cooperatives will be asked to participate in family planning promotion under the project. (d) No effect (e) No effect (f) No effect
2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	The project will have little effect on U.S. private trade and investment. It will enlist a number of private U.S. research institutions, however, as cooperative agencies, in the A.I.D. population program.

3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)? — YES

b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? — N/A

c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted? — N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — Yes

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action — Legislative action is not required.

will be completed in time to permit orderly accomplishment of the purpose of the assistance?

6. Water Resources (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) — N/A

7. Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? — N/A

8. Capital Assistance (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? — N/A

9. Multiple Country Objectives (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. — See response to paragraph 1 in this checklist.

10. U.S. Private Trade (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

See Paragraph 2 above.

11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

The project is an addition to India's ongoing Family Welfare Program. In 1991, the GOI allocated the equivalent of $228 million for family welfare, nation-wide, of which $42 million went to the state of Uttar Pradesh. Total expenditures in U.P. in 1991 totalled $44 million. Over the ten year term of the project the GOI is expected to provide atleast $400 million on in-kind basis for family planning in addition to the $325 million AID will spend for the project.

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

NO

c. Separate Account (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of NO

textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

NO

14. PVO Assistance

a. Auditing and registration (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

N/A

b. Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

N/A

15. Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

The confirmation of signing of the project agreement will be cabled as required.

The full text of the agreement will be pouched to the offices as required.

16. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

To the extent practicable, metric measurements will be used in all procurements, grants and other activities under the project.

17. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

Yes

18. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

This Project is a major population undertaking directed at problems in one highly populated Indian state. Regional and multilateral organizations are also providing assistance for India's population program but on a broad national basis or for other specific purposes.

19. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):	
a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	No
b. Will any funds be used to lobby for abortion?	No
20. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?	Cooperatives which reach rural and urban poor will be asked to participate in family planning promotion under the project.
21. U.S.-Owned Foreign Currencies	
a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.	See para 11.a above
b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No
22. Procurement	Yes
a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	
b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?	Yes

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	N/A
d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)	No
f. Cargo preference shipping (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?	No
g. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the	Yes. Yes..

facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

h. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? — Yes

i. Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — Yes

j. Consulting services (FY 1991 Appropriations Act Sec. 524): If maintenance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — Yes

k. Metric conversion (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest — See para 16 above

documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

1. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? — Yes.

23. Construction — N/A

a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?

24. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? — N/A

25. Communist Assistance (FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? — Yes

26. Narcotics

a. Cash reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes

b. Assistance to narcotics traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes

27. Expropriation and Land Reform (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes

28. Police and Prisons (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes

29. CIA Activities (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes

30. Motor Vehicles (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes

31. Military Personnel (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel?	Yes
32. Payment of U.N. Assessments (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues?	Yes
33. Multilateral Organization Lending (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	Yes
34. Export of Nuclear Resources (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology?	Yes
35. Repression of Population (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes
36. Publicity or Propoganda (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?	No

37. Marine Insurance (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? — Yes

38. Exchange for Prohibited Act (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? — No

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. Agricultural Exports (Bumpers Amendment) (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers? — N/A

2. Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?	No
3. Appropriate Technology (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Yes
4. Indigenous Needs and Resources (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	The project is directed at the continuing high rate of fertility in one of India's most populous states. It builds on Indian intellectual resources in establishing more active and more research driven programs to combat rapid population growth.
5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	The Project gives reasonable promise of slowing population growth in a highly populous state. The results will yield major savings in expenditure for education, health and other programs.
6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local-governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the ; of developing countries	(a) Through the Project, the reach of existing population control programs will be substantially extended and thereby bring such services to more of those who are poor and or in rural areas. (b) It will involve democratic private and local governmental institutions in the national population control effort. (c) It will support India's ongoing population control program. (d) The smaller families which should result from the Project will enable women to plan a more active role in development and improve their health status.

and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	(e) Little or no effect
7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes
8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes
9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):	
a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	No
b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	No
c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	No

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?	Yes
e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?	No
f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No
g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?	No
10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes
11. Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	A specific portion of Project funds has not been set aside for disadvantaged enterprises. Hoever, if any contract for services in excess of $500,000 is to be financed under the Project, the USAID Mission will ensure that such contract contains a requirement for 10% of the contract to be sub-contracted to disadvantaged enterprises unless AID regulations provide otherwise.

12. Biological Diversity (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N/A

13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):

a. A.I.D. Regulation 16: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Yes

b. Conservation: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions N/A

which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded

N/A

forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment? Yes

14. Energy (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? N/A

15. Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage N/A

private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) to be provided in a manner that takes into account, during the planning process, the local-level perspectives of the rural and urban poor, including women, through close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) to be implemented in a manner that requires local people, including women, to be closely consulted and involved, if the assistance has a local focus; (e) being used primarily to promote reform of critical sectoral economic policies, or to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities; and (f) to be provided in a manner that, if policy reforms are to be effected, contains provisions to protect vulnerable groups and the environment from possible negative consequences of the reforms?

16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management. N/A

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? Yes

18. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from

(1) The family planning activities under this project will reach out to the poor by providing services closer to their homes. Smaller families among the poor will enable them to participate more fully in development.

cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

(2)Existing cooperative organizations will be enlisted to expand the reach of family planning activities, thereby helping the rural and urban poor; (3) the project will build upon existing family planning efforts with the objective of improving their quality and increasing general access to such services; (4) the role of women in family planning will be emphasized in promotional activities; (5) the Indian family planning program has benefited from such experience in other countries. In turn, India's experience may lead to changes elsewhere in the region.

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

Population/Family Planning services will be made available under the Project through the existing health network of cooperatives, private medical practitioners, employers, public enterprises and Government-operated public medical centers, sub-centers and clinics in urban, peri-urban and rural areas. Commercial distributors of contraceptives will be involved as well. The Project will extend the reach of the existing system seeking out those elements of the population, notably the poorest people, whose access to family welfare services has been limited heretofore. Paramedical and auxiliary medical personnel will receive further training under the Project and play active roles.

22. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

N/A

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a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

N/A

1. Economic and Political Stability (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

2. Military Purposes (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

3. Commodity Grants/Separate Accounts (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec. 575(a), see Sec. 575(a)(5).)

4. Generation and Use of Local Currencies (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1991, this provision is superseded by the separate account requirements of FY 1991 Appropriations Act Sec. 575(a), see Sec. 575(a)(5).)

5. Cash Transfer Requirements (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer:

a. Separate account: Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

b. Local currencies: Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. U.S. Government use of local currencies: Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

d. Congressional notice: Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

DRAFTER:GC/LP:Ellonnold:5/17/91:2169J

UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

NEW DELHI, INDIA

ANNEX I. D.

June 25, 1992

ACTION MEMORANDUM FOR THE ASIA ENVIRONMENTAL OFFICER

Through: Steven P. Mintz - Acting Director, USAID/India

From: John Grayzel - USAID/New Delhi Environmental Officer

Action: To approve a Categorical Exclusion from Environmental Procedures for USAID/India's Innovations in Family Planning Services Project (386-0527).

Background: The Innovations in Family Planning Services Project is intended to assist the Government of India and the Government of Uttar Pradesh in reorienting and revitalizing its family planning program. The purpose of the project is to significantly reduce fertility rates in Uttar Pradesh by doubling the level of contraceptive use. Special emphasis will be placed on the use of temporary modern contraceptive methods by younger women experiencing fewer pregnancies and permanent contraceptive methods by couples who have already achieved their desired family size. The Project will focus on (1) increasing access to family welfare services; (2) improving the quality of family planning services; and (3) promoting family planning through influencing policymakers, service providers and clients.

Section 22 of the CFR, Part 216.2(G) (2) (vii) identifies projects involving nutrition, health care or population and family planning services as ones which are categorically excluded from an environmental examination, assessment or impact statement, except to the extent that any activity (for example, construction of facilities, water supply systems, waste water treatment, etc.) may directly affect the environment. The project will fund no activities that have a direct effect on the environment and is, therefore, eligible for a Categorical Exclusion.

Recommendation: That you sign below indicating your approval of a Categorical Exclusion for the project.

Approved/Disapproved

7/10/92

ASIA Environmental Officer

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ANNEX I.E. CONDITIONS PRECEDENT AND COVENANTS

A. Conditions Precedent: The Project agreement is expected to provide:

1. First Disbursement. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agaree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

   (a) A statement of the name(s) of the person(s) holding or acting in the office(s) of the Grantee specified in Section 8.2, and of any additional representatives, together with a specimen signature of each person specified in such statement; and

   (b) A letter certifying that the Grantee has created a national steering committee consisting of representatives of the Government of India (GOI), Government of Uttar Pradesh (GOUP) and U.S.A.I.D., which committee will have authority to provide overall direction for, and make policy decisions with regard to the project.

2. Additional Disbursements. Prior to disbursements to the autonomous society discussed below, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

   (a) A letter certifying that the Grantee has created an autonomous society to carry out project management functions, and that the structure of the Society includes (1) a Governing Body with representatives from the GOI, the GOUP, USAID, the corporate sector, the media and non-governmental organizations, and (2) a Secretariat.

   (b) The memorandum of association and charter for the autonomous society, and such other documents as necessary to describe the Society's detailed personnel and procurement policies and procedures.

(c) A letter from the Grantee certifying that the autonomous society has authority to accept contributions from external donors and from public and private sources within India; authority to draw up and implement its own budget and establish its own salary and benefit structure; authority to extend grants to public and private organizations and to enter into contracts without a requirement for governmental approval (other than by government representatives on the Society's Governing Body); and authority to employ, retain or dismiss personnel for or from the Society's staff.

(d) A letter confirming that the Grantee has established and agrees to maintain for the life of the project a separate account and budget line item for the project in the Ministry of Health and Family Welfare.

B. The Project Agreement shall contain the following covenants:

1. Evaluations. Within eighteen (18) months of the date of this Agreement, the Grantee will establish a monitoring and evaluation program which will be financed as part of the Project. Except as the Parties may otherwise agree in writing, this program will include an annual review of the project over the life of the project besides in-depth mid-term evaluations and a final evaluation at the end of the Project. The monitoring and evaluation program will include:

(a) An evaluation of progress towards attainment of the objectives of the Project;

(b) Identification and evaluation of problem areas or constraints which may inhibit such attainment;

(c) Assessment of how such information may be used to help overcome such problems or constraints; and

(d) Evaluation, to the degree feasible, of the overall development impact of the project.

2. Grantee's Expenditures for Family Planning. For the term of the project, the Grantee agrees to maintain GOI and GOUP expenditures for family planning in the State of Uttar Pradesh at levels equal to, or greater than, GOI and GOUP expenditures for such purposes in GOI

Fiscal Year 1990-91, said levels exclusive of disbursements to the SOCIETY from the new separate account to be established in the Ministry of Health and Family Welfare. Amounts budgeted for and disbursed to the SOCIETY from the new separate account will be additional to the GOI and GOUP budgetary expenditure levels referred to above.

3. **Reporting of Grantee's Project Contribution.** The Grantee agrees to furnish to A.I.D. in writing, annually during the life of the project a report of the Grantee's contribution (in cash and in kind) which is provided pursuant to Section 3.2. The format and content of such report will be mutually agreed to in a Project Implementation Letter.

4. **Prohibition on Abortion Related Activities.** None of the funds made available under this Agreement may be used to finance any costs relating to (a) performance of abortion as a method of family planning, (b) motivation or coercion of any person to undergo abortion, (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning, or (d) active promotion of abortion as a method of family planning.

5. **Training.** The Grantee agrees to make all training under the Project available without discrimination on the basis of gender.

6. **Post-Training Agreement.** The Grantee agrees to make every effort to require that each person trained under the Project shall work in activities related to the Project or in activities approved for financing under the Project, in India, for not less than three times the length of his or her training.

IFPS PROJECT LOGICAL FRAMEWORK

PROJECT ELEMENTS	INDICATORS (OVIs)	DATA SOURCES (MOVs)	MAJOR ASSUMPTIONS
GOAL: To reduce the rate of population growth in Uttar Pradesh to achieve greater consistency with the social and economic goals of that State.	RNI decreases from 2.5 to less than 2 by the year 2002. Total Fertility Rate (TFR) reduced from 5.4 to under 4.0 by 2002	National Family Health Survey Reports from Registrar General	IFPS successfully implemented. Results are of magnitude anticipated. Consistent support for FP provided by GOI/GOUP, including budgetary support. Provision of FP services leads to lower fertility and population growth rates.
PURPOSE: To assist the Indian state of Uttar Pradesh to significantly reduce the total fertility rate through a comprehensive improvement and expansion of family planning services. (CONTINUED NEXT PAGE)	CPR increases from 27% to 50% by 2002, including large number of younger, lower–parity women. Users increase from 6.0 million to 15.5 million by 2002. 8 demonstration projects completed and replicated elsewhere in India.	National Family Health Survey Reports from Registrar General MIS reports (client record system)	Outputs achieved as planned. Significant (active or latent) demand for FP services exists in both urban and rural areas. NGO, parastatal, and public–sector programs proceed as planned. The GOUP and GOI will replicate successful FP delivery system models.

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OUTPUTS		(Private and Public Sectors)	
(1) Public and private FP service points expanded (staffed, equipped and regular supplies) (a) public service points increased (clinical and non-clinical) (b) private service points increased (clinical and non-clinical) (c) social marketing outlets increased (d) pilot demonstration projects done and replicated in U.P. (e) number of women's organizations & women managers providing FP services increased (2) Public and private institutions providing high quality services (a) IEC – client and service provider information materials; IEC training for service providers and promoters. (b) TRAINING – curricula prepared and adopted; master trainer pool trained; service providers trained. (c) CLINICAL/NONCLINICAL SERVICE SITES – preceptors trained; service sites used as models. (d) LOGISTICS/MIS – contraceptives available at service points; MIS established; regular reports produced; reports used for decisionmaking. (3) Demand generated (a) POLICY SUPPORT – strengthened support of key groups (b) IEC – campaigns (traditional and mass media) (4) Research and evaluation completed (a) ASSESSMENTS of svc systems (b) O.R. STUDIES w/demo projects (c) RESULTS DISSEMINATED	(1) FP SERVICE EXPANSION: The quality of family planning service delivery improved in all the existing 24,326 public service points. 40,000 CSM outlets established. MODEL SERVICE SITES: 9 major clinical centers established (staff trained, facility equipped, supplies available, quality standards of care met). (2) TRAINING: 8 curricula developed (service providers, TOT, FP motivators); 112 master trainers trained; 28,242 clinical service providers trained; 43,000 outreach and CBD workers trained; 20,000 proprietors of CSM outlets trained; 40,000 other staff trained/supervisors,managers, CSM outlet managers, etc.) (3) IEC: 120,000 mobile film/video showings. 500 mass media programs spots, articles, and inserts (newspaper), billboards, etc.; 58 million copies of printed materials for clients and service providers; 40 specialized IEC workshops to strengthen specific IEC skills. (4) LOGISTICS/MIS adequate supplies of contraceptives available at all service points; MIS designed and implemented; monthly reports produced on acceptors, users, contraceptive distribution; annual workplans produced using MIS data. (5) DEMAND GENERATION: 576 mass media campaigns conducted; 5 new policies adopted (better services and socio-economic incentives); POLICY: 28 seminars; 20 study tours; newsletter; newspaper articles produced (6) R&E: 2 National Family Health surveys completed; 10 diagnostic studies; 10 major O.R./demonstration projects; 30 workshops; 30 seminars; 30 research reports; 50 research notes; 36 issues of research newsletter.	(1) FP SERVICE EXPANSION Data on number of sites collected and analyzed by VAFAH personnel quarterly; FP service statistics from all service providers; evaluation documents; survey data on availability and use; interviews. IEC: copies of IEC products (materials, articles, etc.); financial records and training statistics. USAID, GOUP and CAs' records. TRAINING: training statistics, VAFAH and USAID records; records from NGOS, GOUP, parastatals, etc. LOGISTICS/MIS: VAFAH, public sector, CA, and USAID data. (2) DEMAND: USAID and VAFAH records (3) RESEARCH and EVALUATION contractor and USAID data	NGOs VAFAH idea works in Indian setting. Curricula development takes place early in Phase 1. Training program gets underway early. Common training methodologies, materials employed. Coordination with other donors and MOH occurs. IFPS is successful in MIS efforts to standardize and simplify reporting procedures. SERVICE POINTS in-country training program gets underway as planned and is effective. No severe obstacles on equipment or supplies. Effective working links can be developed between public and private FP service delivery institutions. CSM private sector program launched early in project period. Significant demand for FP services exists and numerous agencies are desirous (and can be made capable) of meeting that demand. GRANTS MECHANISM VAFAH formula works in Indian context. Personnel are recruited and trained. Grants program is effectively administered. No unpenetrable policy or administrative barriers raised during project implementation. Grant proposals can be generated in a timely manner.

INPUTS (1) PERSONNEL technical assistance local staff and consultants (2) LOCAL COSTS* public sector private sector (3) CONTRACEPTIVES (4) VEHICLES** (5) OTHER COMMODITIES*** (6) CONTINGENCIES, INFLATION (7) GOI/GOUP/NGO/Private Sector Contribution *including support for: – institutional development – policy development – training – IEC – service delivery – operations research – logistics management – monitoring and evaluation ** all types: 4–wheel and 2–wheel motorized and bicycles *** medical kits, examining tables, IEC MIS, etc.	(SEE DETAILED BUDGET ESTIMATES)	USAID, GOUP, C.A., and NGO records	IFPS approved and implemented as planned. No serious impediments to obtaining qualified contractors on schedule. Contractors perform as expected. **Mechanisms for grants approval and administration are perfected and functioning early in project period.**

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IFPS IMPLEMENTATION PLAN

	I. Project Management Year 1	Completed by Quarter	
1.	IFPS Project authorized	July	USAID
2.	Project Agreement signed and first year funds obligated	Aug.	USAID/GOI
3.	PIL#1 signed	Sept.	USAID
4.	Establish IFPS Steering Committee	Sept.	GOI
5.	Establish Liaison Office	Oct.	USAID/CEDPA
6.	Draft SOCIETY Memorandum of Association	Sept.	GOI
7.	Register SOCIETY	Sept.	GOI/USAID
8.	Establish SOCIETY Governing Board		Steer. Comm.
9.	Hire SOCIETY Executive Director (ED)	2	GOVERNING BOARD
10.	Hire SOCIETY Technical Directors (TD)	2	GOVERNING BOARD
11.	Establish PBD benchmarks for Year 1	2	USAID/GOI/GOUP
12.	Establish SOCIETY Office Site	3	SOCIETY
13.	Hire Support Staff for SOCIETY	3	GOVERNING BOARD
14.	Develop Financial/administrative systems for SOCIETY	3	GOVERNING BOARD
15.	Review project targets and revise based on survey data	4	USAID/SOCIETY/CAs
16.	Approve Annual Work Plan	4	Steer. Comm.

I. Project Management

Year 2

1.	Bi-annual review implementation status of all sectors		Steer. Comm.
2.	Approve Annual Work Plan		Steer. Comm.
3.	Technical Advisory Group meeting		GOVERNING BOARD
4.	Conduct Leadership Seminars		CEDPA/TC

Year 3

1.	Bi-annual review implementation status of all sectors		Steer. Comm.
2.	Approve Annual Work Plan		Steer. Comm.
3.	Technical Advisory Group meetings		TAG
4.	Conduct Leadership Seminars		CEDPA/TC
5.	Assessment of Project design and Accomplishments		Steer. Comm.
6.	Redesign project as appropriate		USAID/GOI/GOUP/SOCIETY

II. NGO/EMPLOYER

Year 1

1.	Proposals developed for Pilot Projects	2	SOCIETY
2.	3-4 NGO Pilot Grants funded	3	SOCIETY
3.	RFP for Training Center/hostel (institutional grant #1)	3	SOCIETY
4.	Proposals developed for IMA, Railways	3	SOCIETY
5.	Grants awarded to IMA, Railways	3	SOCIETY

6.	NGO Grants systems developed	3	SOCIETY
7.	Hire, train NGO staff	3	SOCIETY
8.	Women's Advisory Group developed	4	SOCIETY
9.	Participants selected for international training (5 weeks)	4	SOCIETY/Steer. Comm.
10.	Develop T.A., monitoring systems to grantees	4	SOCIETY
11.	Grants solicitation process initiated: Recruitment plan developed Orientation Workshops Site Visit to organization T.A. in project desing	4	SOCIETY
12.	First Annual Work Plan submitted	4	SOCIETY
	Year 2		
1.	Grants solicitation process		SOCIETY
2.	6-8 Service Grants funded		SOCIETY
3.	Establish Regional Office for TA/train		SOCIETY
4.	Conduct Women's Leadership seminars		SOCIETY
5.	Review implementation status of grants		SOCIETY
6.	Submit Annual Workplan		SOCIETY
7.	Select participants for international training		SOCIETY/Steer. Comm.
	Year 3		
1.	Grants solicitation process		SOCIETY
2.	Fund 15-20 Service grants		SOCIETY

3.	Evaluate results of pilot projects		SOCIETY
4.	Fund 1-2 Expansion grants		SOCIETY
5.	Establish Regional Office #2, 3		SOCIETY
6.	Review implementation status of grants		GOVERNING BOARD
7.	Submit Annual Work Plan		SOCIETY
8.	Review NGO, private sector status, accomplishments, design		GOVERNING BOARD/Steer. Comm.
9.	Select participants for inter-national training		SOCIETY
	III. Training Center/Hostel		
	Year 1		
1.	Preparation of training/hostel facilities, equipment procured	4	SOCIETY
	Year 2		
1.	Curriculum developed for Counseling	1	TC/SOCIETY
2.	Curriculum developed for Management and Women-In-Management	2	TC/SOCIETY
3.	Training of Trainers begins	1	TC/SOCIETY
4.	3 groups trained in above curriculum	2	TC/SOCIETY
5.	6 workshops each conducted in Counseling, Management and WIM	2-4	TC/SOCIETY
6.	Develop training capacity in regional office #1		TC/SOCIETY
7.	Develop Gender Workshop for Public/ private sector managers, leaders		TC/SOCIETY/CEDPA

Year 3

1.	12 workshops each conducted in Counselling, Management and WIM	1-4	TC
2.	Develop training capacity in regional office 2, 3		TC/SOCIETY
3.	Assess results of training program		TC/SOCIETY/CEDPA
4.	Conduct 6 Gender Workshops in other sectors		TC/CEDPA

IV. Public Sector
Year 1

1.	Assess clinical and PHC services in medical college and associated PHCs	2	KGMC/JHPIEGO
2.	Assess in-service training needs of ANMs	2	ANMC/JHPIEGO
3.	Order commodities, equipment	2	JHPIEGO
4.	Sector 10 ANM colleges for training activities and assess equipment needs	2	DOHFW/JHPIEGO
5.	Develop standardized clinical FP guidelines	3	KGMC/JHPIEGO
6.	Assess training skills and needs of medical college/ANM staff	4	KGMC/JHPIEGO
7.	Develop curriculum for clinical/ counseling training including training materials	4	KGMC/JHPIEGO
8.	Train 25 master physician trainers on clinical/non-clinical and establish clinical practicuum	4	KGMC/JHPIEGO

9.	Develop training program for ANMs on clinical/counseling skills	4	ANMC/JHPIEGO
10.	Develop 50 master ANM trainers	4	ANMC/JHPIEGO
11.	Select districts for public sector models, develop district planning comm.	3	USAID/SOCIETY/ Steer.Comm.
12.	Assess needs in model districts and design demonstration model	4	Districts/SOCIETY/CAS
13.	Assess MIS and make recommendations for new reporting applications	4	JSI/DOFW/SOCIETY
14.	Assess needs of logistics/commodities storage system and develop warehousing plan	4	JSI/DOFW/SOCIETY

Year 2

1.	Implement 1 model clinic/3 PHCs	KGMC/JHPIEGO
2.	Develop first model clinic/PHC as clinical training site for pre-service physicians	KGMC/JHPIEGO
3.	Conduct training of Trainers on master curriculum	KGMC/JHPIEGO
4.	25 master physician trainers train 1250 physicians	KGMC
5.	50 Master ANM trainers train 5000 ANMs	ANMC
6.	Provide training materials, equipment, commodities to trained staff	TrainInstn PCS/JHPIEGO
7.	Implement plan for FP rotations at pre-service for physicians	KGMC/JHPIEGO
8.	Select and prepare 10 more ANM colleges to open as training sites	DOFW/JHPIEGO

9.	Select and prepare 3 more medical colleges to develop as model clinics	KGMC/JHPIEGO Medical Colleges
10.	Trainers train 1250 physicians	Med Center
11.	Trainers 5000 ANMs	ANMC
12.	Implement district demonstration models Sites equipped, staff trained monitoring systems, referrals linkages developed	TA/districts
13.	Develop follow-up systems and referrals mechanisms in demonstration districts	TA/districts
14.	Design and conduct Operations Research	DOHFW/SOCIETY/PC
15.	Implement plan to improve MIS reporting and feedback to districts	TA/DOHFW
16.	Professional seminars with physicians on contraceptive update	DOHFW/JHPIEGO
17.	Annual Meeting w/ international speakers	IMA/Med.Colleges
18.	Nominate persons to Infection prevention training (9 mo degree program overseas)	SteerComm./JHPIEGO
19.	Observational study tour #1 for physicians	JHPIEGO
20.	Annual Work Plan submitted	Med.College/JHPIEGO
21.	Professional Seminars on clinical updates	IMA/JHPIEGO/DOFW

Year 3

1.	Expand model clinics into 5 medical colleges and related 3 PHCs	JHPIEGO/Med.Colleges
2.	Expand in-service training program in 10 more ANM colleges	ANMC/JHPIEGO

3.	Monitor referral linkages in demonstration districts		KGMC/JHPIEGO
4.	Two persons to Infection control programs in US		SteerComm./JHPIEGO
5.	Observational study tour #2		JHPIEGO
6.	Assess the progress of project to date		JHPIEGO/SEC
7.	Annual Work Plan submitted		DOHFW/JHPIEGO
	V. Information Education Communications Year 1		
1.	Establish IEC capability within Society	3	SOCIETY/PCS
2.	Conduct surveys to determine client, provider, public target needs/themes for educational materials	1-4	SOCIETY
3.	Develop collaborative plan with NGOs, DOHFW to design materials/messages	3	SOCIETY
4.	Establish Media Materials center	3	SOCIETY
5.	Develop IEC Advisory Group	3	SOCIETY
6.	Develop print materials plan, targets and schedule	4	SOCIETY
7.	Develop plan for use of mass media and other strategies	4	SOCIETY
8.	Submit Annual Work Plan	4	SOCIETY
9.	Develop and disseminate Hindi version of Population Reports	4	SOCIETY

Year 2

1.	Make subgrants to other NGOs to assist in print materials development	SOCIETY
2.	Develop materials for key target populations including client, provider, public, method specific guides, flipcharts, posters, booklets	SOCIETY
3.	Conduct TOT for public/private sector to use materials	SOCIETY
4.	Develop and implement dissemination plan	SOCIETY
5.	Test first promotional campaign to support model programs or other upgraded services in demonstration districts	SOCIETY
6.	Produce radio spots to support CSM or other specific project activities	SOCIETY
7.	Conduct folk media festival	SOCIETY
8.	Statewide media conference	SOCIETY
9.	Submit Annual Work Plan	SOCIETY
10.	Select participants for international training	SOCIETY

Year 3

1.	Complete development of print materials for clients, providers	SOCIETY/Grantees
2.	Launch promotional campaign consistent with service quality improvements	SOCIETY/Grantees
3.	Produce additional mass media spots based on market research/targetting	SOCIETY/Grantees

4.	Develop institutional campaign for IMA or other institutions ready for promotion		SOCIETY/GRANTEES
5.	Expand mass media activities based on experience and market research/targets		SOCIETY/GRANTEES
6.	Statewise media conference/media awards		SOCIETY/GRANTEES
7.	Select participants for international training		SOCIETY/GRANTEES
8.	Submit Annual Work Plan		SOCIETY/GRANTEES
9.	Assess the accomplishments of projects to date		SOCIETY/GRANTEES/ Steer. Comm.
	VI. Private Sector Service Delivery Year 1		
	A. NGO/Cooperatives		
1.	Implement 3-4 pilot NGO/cooperative projects	3	SOCIETY
2.	Technical assistance to implement grants	3	SOCIETY
3.	Develop standardized monitoring, reporting, logistics, CBD guidelines	4	SOCIETY
4.	Design Operations Research studies for CBD midels	3	SOCIETY
5.	Conduct Training of Trainers	3	SOCIETY/CEDPA
6.	Train grantee managers and field staff	3	SOCIETY/TC
7.	Provide equipment, commodities as needed	3	SOCIETY
	B. Employer-based Sector		
1.	Assess FW programs in 5 corporations in UP	3	SOCIETY

2.	Companies selected based on results of pre-project survey	4	SOCIETY
3.	RAPID model developed and presented to 5 target companies	4	SOCIETY/TA
4.	Train master trainers for clinical and non-clinical service delivery	4	SOCIETY/TC
5.	Give grants to equip clinics as needed	4	SOCIETY/TA
6.	Implement outreach program in companies	4	SOCIETY/TA
	C. Railways		
1.	Assess family welfare program in one zonal railway	3	RR/TA
2.	Training of Trainers from railways centers (clinical and outreach)	4	Training TA
3.	Management training for RR womens' organization	4	RR/TC
4.	Policy seminar for senior RR executives	3	RR/TA
5.	Monitoring, logistics, MIS established for RR	4	RR/TA
	D. Indian Medical Association (IMA)		
1.	Develop 10 IMA model clinics	4	IMA/TA
2.	Develop materials	4	IMA/SOCIETY
3.	Develop training program to promote oral contraceptives through IMA	3	IMA/TA
4.	Training master trainers from IMA for clinical and non-clinical service	4	TC/IMA JHPIEGO

Year 2

	A. NGOs, Cooperatives	
1.	Implement 6-8 Service Grants	SOCIETY/Grantee
2.	Technical assistance, monitoring, logistics	SOCIETY/CEDPA
3.	Training of trainers from new NGOs	TC
4.	Training of managers and field staff	Grantee/TA
	B. Employer-based sector	
1.	Expanded employer based clinics/outreach to villages surrounding companies	SOCIETY/TA
2.	Select 10 more corporations for development	SOCIETY
3.	RAPID presentations to 10 companies	SOCIETY/TA
4.	Train master trainers in new companies	SOCIETY/TA
5.	Implement outreach program in new companies	SOCIETY/Companies
	C. RAILWAYS	
1.	Assess second zonal RR FW program	RR/TA
2.	Training of Trainers for 2nd zonal RR (clinical and outreach)	Training
3.	Management training for RR women's organization	RR/TC
4.	Policy seminar for senior RR executives	RR/TA
5.	Train 200 RR outreach workers	RR/TC
6.	Outreach program implemented in second RR	

D. IMA

1.	Develop 20 IMA model clinics	IMA/TA
2.	Provide materials	IECNGO
3.	Develop training program to promote oral contraceptives through IMA	IMA/TA
4.	Train IMA members (100/trainer - 1,000)	TC/IMA JHPIEGO
5.	Implement plan to link with CSM	Contractor/ IMA

Year 3

A. NGOs, Cooperatives

1.	Implement 15-20 Service Grants	SOCIETY/Grantee
2.	Technical assistance, monitoring logistics, service guidelines	SOCIETY/CEDPA
3.	Implement 1-2 Service Expansion Grants	SOCIETY/Grantee
4.	Technical assistance, monitorinng, logistics, service guidelines	SOCIETY/CEDPA

B. Employer-based programs

1.	Expand employer-based models to 10 new companies	Private/SOCIETY
2.	RAPID presentations to 10 companies	Private/SOCIETY
3.	Implement training and outreach programs	Private/SOCIETY

C. Railways

1.	Expand outreach in zonal RR #1, 2	RR/SOCIETY
2.	Assess third zonal RR FW program	RR/SOCIETY

3.	Training of Trainers for 3rd zonal RR		RR/SOCIETY/TC
4.	Train 200 RR outreach workers and implemented outreach program		RR/SOCIETY
	VII. Contraceptive Social Marketing Year 1		
1.	Establish office for TA within CSM/NGO	3	SOM
2.	Conduct market research for project development	2	SOM/Contr
3.	Finalize CSM strategy and design components	3	SOM/Contr
4.	RFPs to develop and market condoms/OCs	4	Contr
5.	Subcontracts signed	4	Contr
	Year 2		
1.	Implement project		
	Year 3		
	VIII Research and Evaluation Year 1		
1.	Establish R&E Division within SIFPSA	1	SOCIETY/TA
2.	Design OR and quasi-experimental studies for private sector service delivery	3	SOCIETY/TA
3.	Design new performance indicators for project impact	4	SOCIETY/TA
4.	Design OR and quasi-experimental studies for public sector demonstration models	4	SOCIETY/TA
5.	Collect baseline data for private/public sectors	4	SOCIETY/TA

6.	Technical assistance to public sector for monitoring systems/evaluation systems	4	SOCIETY/TA
	Year 2		
1.	Technical assistance to public sector for monitoring/evaluation systems		SOCIETY/TA
2.	Design OR studies to assess IEC approaches to create awareness		SOCIETY/PCS
3.	Conduct studies in private and public sectors		SOCIETY/TA
4.	Conduct workshops on OR methodology for public/private sector institutions		SOCIETY/TA
	Year 3		
1.	Analyze results of initial studies on service delivery models		SOCIETY/TA
2.	Disseminate results of studies to all sectors		SOCIETY
3.	Technical assistance to grantees to incorporate lessons learned from OR in service delivery expansion		SOCIETY
4.	Conduct follow-up workshops to expand institutional capacity to develop own OR studies		SOCIETY
	IX. Logistics, MIS, Commodities Year 1		
1.	Analyze survey results of public sector MIS	2	DOHFW/TA
2.	Develop plan to improve and apply MIS reports and improve information flow	3	DOHFW/TA
3.	Assess MIS needs in private sector grantees	4	SOCIETY/Grantees/TA

Year 2

1.	Develop plan to develop or improve private sector MIS	SOCIETY/Grantees/TA
2.	Implement MIS improvement plans in public and private sectors	SOCIETY/DOHFW/TA Grantees
3.	Train managers to utilize MIS reports	SOCIETY/DOHFW/TA Grantees

INNOVATIONS IN FAMILY PLANNING SERVICES PROJECT

COOPERATING AGENCIES

CENTRE FOR DEVELOPMENT AND POPULATION ACTIVITIES — CEDPA

In the past 15 years CEDPA has trained over 3000 leaders in 100 countries around the world to be better managers of family planning programs. CEDPA directs its efforts specifically at ensuring that women's concerns and skills are incorporated in the design and management of family planning service delivery projects, placing particular emphasis on assuring quality of medical services, follow-up mechanisms, information education, counseling, and strengthening the sustainability of in-country institutions.

JOHNS HOPKINS UNIVERSITY

JHPIEGO — The Johns Hopkins Program for International Education in Reproductive Health

JHPIEGO works closely with developing country medical and nursing schools to incorporate family planning into their curricula. JHPIEGO trains developing country physicians, nurses, midwives, and medical administrators in family planning through a network of local and regional training centers in an effort to strengthen the links between training and service delivery and encourage self-sufficiency through the institutionalization of training for medical, nursing and midwifery schools.

JHU/PCS — Johns Hopkins University/Population Communication Services

JHU/PCS provides country-specific assistance in: 1) identification of communication needs of family planning programs; 2) marketing and audience surveys; and 3) design, implementation and assessment of activities. These activities include small-scale studies for testing effective communication methods and large-scale communications campaigns; development, pretesting and revision of materials and methods; evaluation of effectiveness of communications programs; and exchange and adaptation of methods and materials among countries.

JOHN SNOW, INC.

JSI/FPLM — John Snow, Inc./Family Planning Logistics Management

JSI/FPLM works to improve the capability of LDC public and private sector organizations to: 1) manage and implement more effective and efficient contraceptive logistics systems; 2) institutionalize the capacity of family planning programs to forecast their contraceptive requirements; 3) develop the capacity of family planning programs to implement sound quality assurance programs; and 4) implement and maintain A.I.D.'s commodities MIS (management information system) which tracks the procuring, shipping, storing and financing of A.I.D.-supplied contraceptives.

THE FUTURES GROUP

SOMARC — Contraceptive Social Marketing

SOMARC utilizes the techniques and resources of commercial enterprises to increase the availability and use of contraceptives. This is achieved mainly through: 1) using commercial distribution channels to increase modern-method contraceptive prevalence rates; 2) design and implement cost-recovery and self sufficiency plans for projects; 3) maximize the use of alternative sources of commodities; 4) increase the knowledge and correct use of contraceptives; 5) develop innovative promotion and advertising techniques; and 6) enhance local marketing and management skills.

OPTIONS — Options for Population Policy

OPTIONS works to assist developing countries in formulating and implementing population policies that increase access to and use of voluntary family planning services and to encourage the mobilization of national resources to support the expansion of family planning service delivery.

THE POPULATION COUNCIL

The Population Council's project in Operations Research (OR) works to improve, through OR and technical assistance, the quality, accessibility, and cost-effectiveness of family planning and maternal child health delivery systems; and to strengthen institutional capabilities to use OR as a management tool to diagnose and solve service delivery problems.

U.S. BUREAU OF THE CENSUS — BUCEN

BUCEN provides assistance to strengthen the capability of developing countries to process, evaluate and analyze demographic and family planning data as well as other social and economic data. Support in these areas is provided mainly through: workshops and technical consultations; development and dissemination of software packages and instructional materials for taking censuses and surveys; and on-going contact and support for users of BUCEN software packages.

EAST-WEST POPULATION INSTITUTE — EWPI

EWPI provides assistance to strengthen the capacity of institutions in the Asia-Pacific region to analyze and utilize demographic and family planning data in population policy and family planning program applications. Support in these areas is provided mainly through: technical assistance, including research, design and data analysis; training; collaborative research; and dissemination through conferences and publications.

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ANNEX III.A. TECHNICAL ANALYSIS

OVERVIEW Only six countries in the world have populations greater than the Indian state of Uttar Pradesh (*China*, 1.2 billion; *India*, 860 million; *United States*, 252 million; *Indonesia*, 181 million; *Brazil*, 153 million; and the new *Russian Federation*, 150 million). Uttar Pradesh is more populous than Japan, Nigeria, Pakistan, Bangladesh, or Mexico (Fig. 1). It is this population of some 140 million persons which will be targeted almost exclusively by the IFPS project. The scale of the problem to be addressed by this project, in sheer numbers, is immense.

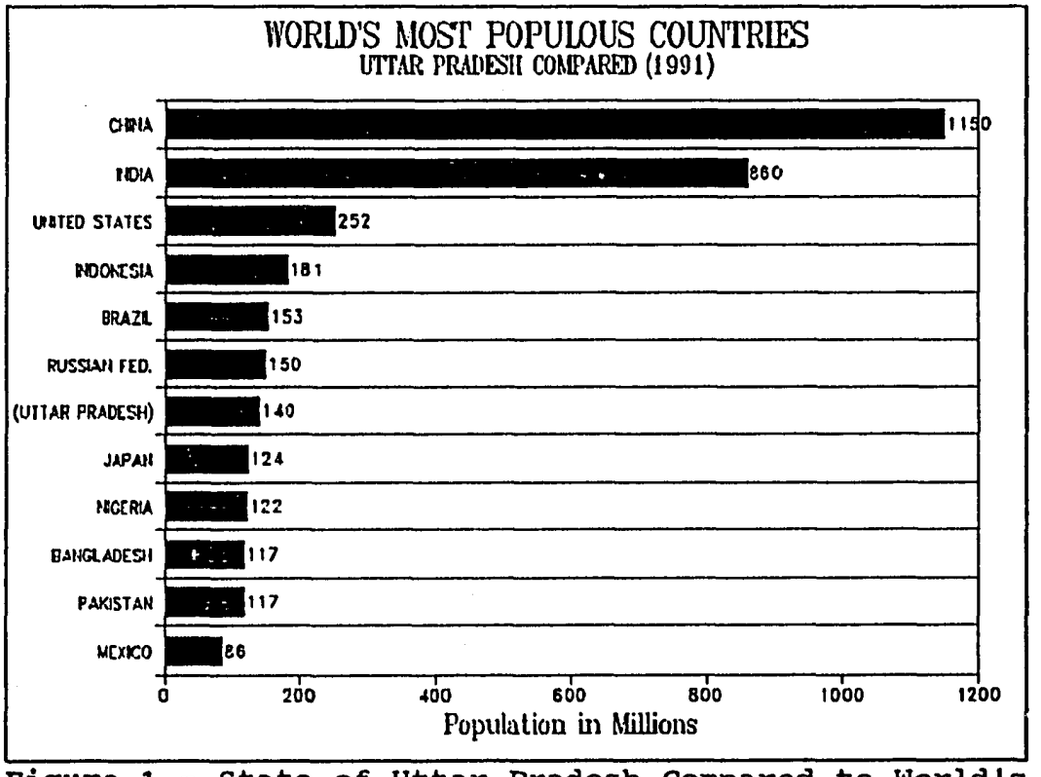

Figure 1 - State of Uttar Pradesh Compared to World's Most Populous Nations

While the numbers are in one sense staggering, in another they seem quite manageable. One can think of U.P. as simply another country. A.I.D. has decades of experience in assisting country programs of roughly similar size. Indonesia, Brazil, and Bangladesh are examples of programs which have received large-scale, sustained population support from A.I.D. over the years. It is encouraging to know, also, that these very large programs have achieved measurable and sometimes dramatic successes. Yet this optimism must be tempered by the realization that large country programs such as Pakistan and the Philippines have achieved far less than hoped for. The IFPS Project will attempt to build upon successful experiences, in India and elsewhere, while managing to avoid the technical and -- more often -- bureaucratic traps which have undermined well-intentioned programs in the past.

The IFPS **Project purpose** is to assist the state of Uttar Pradesh to significantly reduce the total fertility rate through a comprehensive improvement and expansion of family planning services. This is to be achieved through three key strategies:

- increasing real **access** to family planning services;
- improving the **quality** of services provided; and
- **promoting** family planning use.

A **subpurpose** of the project is to demonstrate successful urban and rural family planning delivery models for wide replication throughout the state of U.P. and elsewhere in India. For this purpose, substantial support will be given to research and evaluation activities to document successful delivery systems, and to measure the degree of their impact.

DEMOGRAPHIC AND CONTRACEPTIVE PROFILE OF UTTAR PRADESH (U.P.)

With an overall population estimated at well over 142 million (1992), U.P. is the largest state in India. This population lives in an area the size of Colorado. Only twenty percent of the population is classed as urban. Though population concentrations occur in several large **cities** (Allahabad, Lucknow, etc.), most people live in the **rural areas and smaller towns** where access is comparatively more difficult than in the urban centers. **Males outnumber females** (882 females per 1000 males). **Literacy** is very low in general (33.8 %) and abysmal among females (20.9 %). **Infant mortality** is high, with 13% of infants failing to reach their first birthday. **Health care** is spotty (despite the rather extensive public health infrastructure), with most families coming into contact with traditional healers and other service providers far more than with the "modern" health system. As might be inferred from the above, U.P. ranks relatively low on virtually all **socio-economic indicators**. Per capita income is just over one-third that of India as a whole. Female participation in the work force is very low (5.4%) as is female age at marriage (16.7).

U.P. is divided **administratively** into five regions and 63 districts. Most of the population (73 %) is to be found in the Eastern Region and the Western Region. Only four percent of the total population lives in the Hill Region, where **population density** is very low (115 persons per square kilometer). However, there are numerous districts where densities well above 500 are found. While there is considerable **ethnic diversity** in U.P.'s population, Hindi is almost universally understood. Hindus represent the largest group by far (83.3%), with Muslims representing only 15.9% of the total population of the state. Animism is prevalent as well, particularly among the hill tribes (unscheduled castes).

Table 1 presents a summary of the population of U.P., along with selected demographic indicators as reported by the GOI and GOUP.

TABLE 1: UTTAR PRADESH STATE - BASIC DEMOGRAPHIC INDICATORS (page 1 of 2)

DATA SOURCES: 1991 and 1981 Census of India, Uttar Pradesh (cols. 3,4,5,6,7,16)
Eval. & Intelligence Div., MOH&FW New Delhi (cols. 8,9,10)
D&E Cell, Directorate of F.W.U.P., Lucknow (cols. 11,12,13,14,15)

(1) EGION	(2) DISTRICT	(3) POP 1991 (000s)	(4) 1981-91 GROWTH (%)	(5) DENSITY sq.km.	(6) SEX RATIO F/000M	(7) AREA sq.km. (000s)	(8) CBR	(9) TFR	(10) IMR	(11) CPR	(12) VSC	(13) IUD	(14) CON	(15) PILL	(16) AGE AT MARR.
estern	Ghaziabad	2760	49.5	1062	835	2.6	40.5	6.7	114	34.9	20.2	11.1	2.7	0.9	0.0
estern	Meerut	3400	23.0	970	837	7.9	37.3	4.7	122	0.0	22.7	10.2	0.0	1.2	18.5
estern	Muzaffarnagar	2830	26.0	700	861	4.0	38.7	4.9	106	34.4	19.6	11.5	2.6	0.7	18.5
estern	Moradabad	4110	30.6	689	852	6.0	42.5	5.1	126	33.7	18.4	11.0	3.3	0.9	18.4
estern	Bareilly	2820	24.2	685	843	4.1	39.8	5.3	146	32.8	17.0	11.0	2.8	1.0	17.6
estern	Agra	2700	19.8	672	832	4.0	41.1	4.2	115	39.1	21.6	12.6	3.9	1.0	18.1
estern	Aligarh	3300	28.0	657	844	5.0	40.6	4.8	129	29.5	15.5	9.9	3.1	0.8	17.9
estern	Bulandshahar	2840	20.5	653	860	4.4	40.6	5.3	127	31.4	16.9	10.9	2.8	0.8	17.9
estern	Firozabad	1530	21.6	649	832	2.3	0.0	0.0	0	26.8	14.7	8.9	2.5	0.7	0.0
estern	Rampur	1500	27.1	633	867	2.4	43.6	5.5	158	39.4	22.5	13.4	2.7	0.8	14.7
estern	Farukhabad	2430	24.7	569	939	4.3	39.5	4.2	122	33.1	17.8	11.7	2.8	0.8	17.1
estern	Saharanpur	2300	26.2	563	860	4.0	39.2	4.2	96	30.3	17.3	9.6	2.7	0.7	18.5
estern	Haridwar	1120	26.1	563	845	1.9	0.0	0.0	0	28.4	15.1	9.3	3.1	1.0	0.0
estern	Bijnor	2440	26.9	519	873	4.7	43.0	5.2	120	35.4	19.9	11.9	2.8	0.8	19.0
estern	Mathura	1920	23.3	505	819	3.8	38.5	4.5	122	31.9	17.3	10.8	3.1	0.9	17.3
estern	Etah	2240	20.5	504	829	4.4	39.7	4.7	170	30.9	17.3	10.0	2.8	0.7	17.1
estern	Etawah	2130	22.1	492	836	4.3	38.0	4.8	117	32.9	18.9	10.7	2.5	0.9	17.0
estern	Mainpuri	1310	23.0	473	843	2.8	39.5	4.8	121	30.3	17.1	9.6	2.6	0.8	16.9
estern	Badaun	2440	23.7	472	911	5.2	41.1	5.7	155	31.3	17.9	9.7	2.7	0.9	16.8
estern	Shajahanpur	1980	20.3	433	818	4.6	40.4	5.3	167	28.2	14.9	9.6	2.9	0.8	16.7
estern	Pilibhit	1280	26.7	365	851	3.5	39.9	4.8	147	31.1	16.9	10.7	2.8	0.7	17.1
estern	ALL	49380	25.5	601	844	82.2	40.3	4.9	129	32.1	18.0	10.5	3.0	0.8	17.5
ill	Dehradun	1010	33.2	329	851	3.1	33.7	3.2	67	39.9	27.2	9.3	2.5	0.9	20.2
ill	Nainital	1560	37.0	229	874	6.8	37.4	4.2	93	43.6	29.4	10.2	3.1	0.8	18.9
ill	Almora	820	8.8	153	1106	5.4	36.1	4.2	92	37.5	24.3	9.3	3.0	0.9	17.8
ill	Tehrigarhwal	580	15.6	130	1073	4.4	41.2	5.0	99	34.3	22.3	8.7	2.5	0.8	17.4
ill	PauriGarhwal	670	6.0	123	1112	5.4	36.9	4.3	94	36.2	23.2	10.3	2.0	0.5	18.6
ill	Pithoragarh	560	13.9	63	1031	6.9	35.0	3.9	91	43.3	30.2	9.5	2.9	0.7	17.7
ill	Chamoli	440	18.2	48	1059	9.1	38.9	4.7	97	44.0	30.4	10.2	2.4	1.0	17.5
ill	UttarKashi	240	24.5	30	928	9.0	33.5	4.0	101	49.1	34.5	10.6	2.7	1.2	17.2
ill	ALL	5880	21.7	115	974	51.1	36.8	4.2	90	40.3	27.1	9.7	2.7	0.8	18.2

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TABLE 1 (cont.)

(1) REGION	(2) DISTRICT	(3) POP 1991 (000s)	(4) 1981-91 GROWTH (%)	(5) DENSITY sq.km.	(6) SEX RATIO F/000M	(7) AREA sq.km. (000s)	(8) CBR	(9) TFR	(10) IMR	(11) CPR	(12) VSC	(13) IUD	(14) CON	(15) PILL	(16) AGE AT MARR.
istern	Varanasi	4800	29.7	943	896	5.1	37.7	3.3	96	35.2	23.5	9.0	2.0	0.7	15.7
istern	Gorakhpur	3070	24.7	923	929	3.3	40.4	4.1	123	32.8	20.9	8.9	2.4	0.6	15.0
istern	Mau	1440	27.9	834	972	1.7	0.0	0.0	0	32.2	18.2	10.3	3.0	0.7	0.0
istern	Deoria	4430	26.6	817	967	5.4	40.0	4.0	120	37.2	22.8	10.5	3.2	0.6	15.5
istern	Jaunpur	3200	26.5	784	995	4.0	41.8	3.8	118	34.3	20.8	10.1	2.4	0.9	14.9
istern	Ballia	2250	21.6	753	952	3.0	34.1	3.1	68	33.2	19.5	10.0	3.0	0.7	0.0
istern	Azangarh	3150	25.3	747	1010	4.2	40.2	4.4	110	28.9	16.7	8.9	2.7	0.6	14.7
istern	Ghazipur	2400	23.3	710	961	3.4	37.7	3.5	111	34.9	21.2	10.1	2.8	0.7	15.5
istern	Allahabad	4910	29.3	676	877	7.3	39.7	3.7	110	33.8	21.1	9.5	2.4	0.8	17.0
istern	Faizabad	2980	25.2	661	926	4.5	37.3	3.9	116	25.9	12.0	9.9	3.2	0.9	14.2
istern	Basti	2750	25.0	642	913	4.3	41.3	4.5	164	30.7	15.3	11.1	3.4	0.8	14.0
istern	Pratapgarh	2210	22.7	595	991	3.7	40.2	3.9	126	35.7	21.8	9.7	3.3	0.9	14.7
istern	Sidharth Nagar	1710	23.9	580	914	2.9	0.0	0.0	0	34.3	19.0	12.2	2.3	0.7	0.0
istern	Sultanpur	2560	25.4	577	936	4.4	40.2	4.0	151	33.2	18.9	11.4	2.1	0.8	13.7
istern	Mahrajganj	1680	25.8	570	923	3.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0
istern	Gonda	3570	26.0	486	872	7.4	39.7	3.9	157	29.2	15.2	11.4	2.0	0.6	14.6
istern	Bahraich	2750	24.0	400	841	6.9	38.6	4.6	150	33.3	17.8	11.9	2.8	0.9	0.0
istern	Mirzapur	1650	31.1	334	875	4.9	37.3	3.5	105	32.9	21.5	8.4	2.4	0.6	15.4
istern	Sonbhadra	1070	37.4	168	857	6.4	0.0	0.0	0	35.5	20.7	9.4	1.8	0.6	0.0
istern	ALL	52580	26.2	613	925	85.8	39.3	4.2	122	29.0	17.3	9.0	2.3	0.7	15.0
entral	Kanpur (Nagar)	2490	27.4	2390	839	1.0	37.2	2.9	91	32.8	19.3	9.7	2.7	1.1	18.1
entral	Lucknow	2740	36.2	1086	857	2.5	36.4	3.3	101	37.6	25.3	9.5	2.2	0.7	19.1
entral	Barabanki	2420	21.6	551	859	4.4	35.4	3.7	135	35.9	20.8	11.9	2.5	0.7	15.4
entral	Rae Bareli	2320	23.0	503	933	4.6	40.9	4.7	172	33.9	19.9	11.0	2.3	0.7	15.6
entral	Sitapur	2850	21.8	496	833	5.7	39.4	4.4	143	31.6	17.9	10.0	2.7	0.8	16.6
entral	Unnao	2200	20.5	482	875	4.6	38.0	4.2	149	33.6	20.7	9.7	2.4	0.8	17.4
entral	Hardoi	2740	20.4	458	819	6.0	42.1	4.0	173	31.7	18.2	9.6	3.1	0.8	16.6
entral	Fatehpur	1890	20.2	455	884	4.2	38.0	4.5	111	36.2	22.0	10.5	2.7	1.0	17.5
entral	Kanpur (Dehat)	2140	19.3	416	844	5.2	0.0	4.5	0	35.2	23.3	11.1	2.9	0.9	0.0
entral	Kheri	2410	23.6	314	845	7.7	38.1	4.5	117	37.1	22.3	11.0	2.7	1.0	16.7
entral	ALL	24200	23.5	527	856	45.9	38.3	4.2	132	34.3	20.3	10.5	2.7	0.8	17.0
undelkhand	Jhansi	1430	25.5	284	865	5.0	38.1	4.3	120	44.1	29.6	10.7	2.9	0.8	17.5
undelkhand	Jalaun	1220	23.4	267	831	4.6	37.4	4.1	115	35.1	22.5	11.6	3.0	0.9	16.3
undelkhand	Banda	1850	20.7	243	842	7.6	39.9	4.3	98	35.4	18.8	12.4	3.4	0.8	15.5
undelkhand	Hamirpur	1470	22.7	205	942	7.2	38.0	6.3	126	42.5	26.9	12.0	2.9	0.7	15.7
undelkhand	Lalitpur	750	29.7	149	863	5.0	42.3	6.2	138	43.0	23.1	13.6	4.6	1.7	14.6
undelkhand	ALL	6720	23.7	229	847	29.4	38.9	5.0	119	40.1	23.9	11.9	3.3	0.9	15.8
LL U.P.	ALL	138760	25.2	471	882	294.4	39.6	4.5	130	33.7	19.9	10.4	3.8	0.8	16.7

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Fertility rates are generally high (TFR 5.4 and CBR 35), while use of **modern contraceptive methods** is correspondingly low (believed to be around 27% at present). However, there is much uncertainty regarding the accuracy and utility of currently available demographic measures within the state. Depending upon the source, total fertility rates (TFR) range from 4.5 to 6.0, while estimates of current contraceptive prevalence range from 27 percent of married women of reproductive age (MWRA) to over 33%. Most distressing, perhaps, is the absence of correlation amongst the various estimates of the crude birthrate, the total fertility rate, and the contraceptive prevalence rate (see Figure 2). Correlation rates (r^2) of .30, .35, and .14 were found when the various estimates were compared.

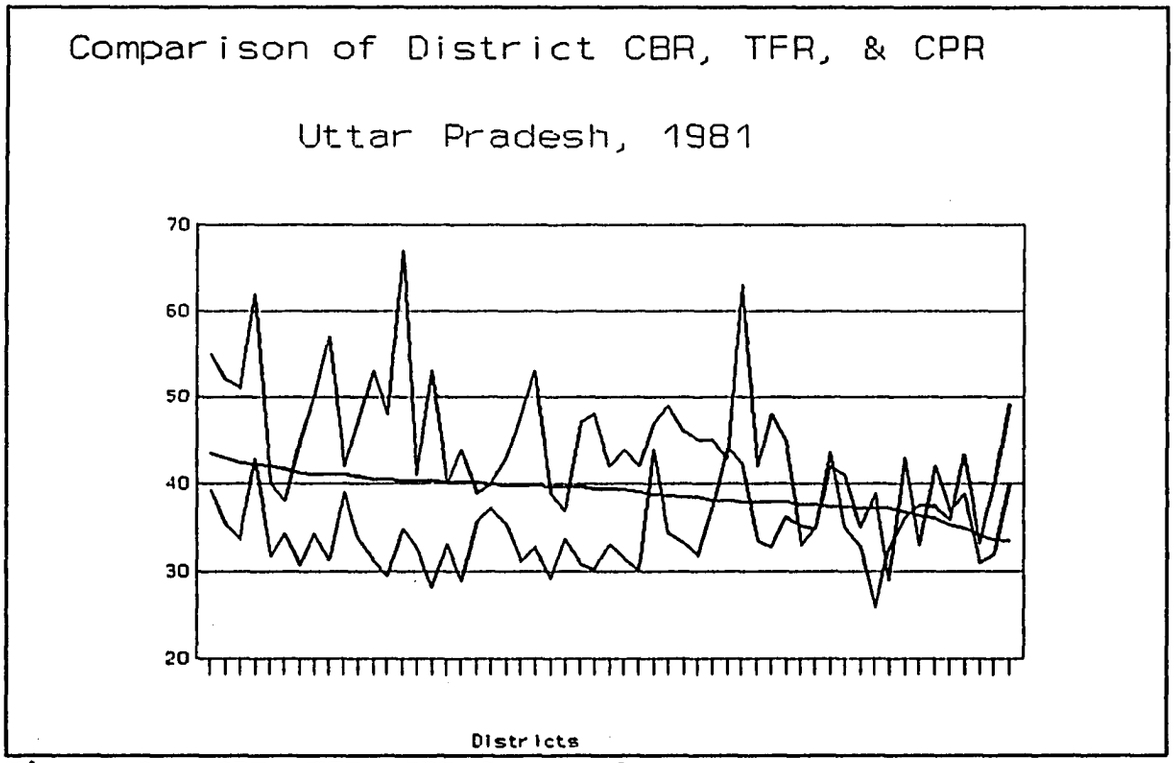

Figure 2 - CBR, TFR, CPR Compared

In general, Ministry of Health estimates of current contraceptive prevalence are considerably higher than other estimates. As these are derived from a client record system in an administrative environment which places considerable pressure on providers to achieve numeric targets, it is perhaps to be expected that these estimates are optimistic. Figures 3 and 4 present a graphic comparison between MOH estimates of TFR in 1981 and those generated by the Indian Institute of Health Management Research (Jaipur) based on the 1981 Census of India.

Further complications. Discrepancies between fertility and contraceptive practice levels are not the only data and programmatic problems. Recent studies and the MOH's own statistics show that sterilizations are going down (see **Figure 6**). It has been reported that statistics on spacing methods (IUD, pill, condom) are often inflated, sometimes by nearly 100%.

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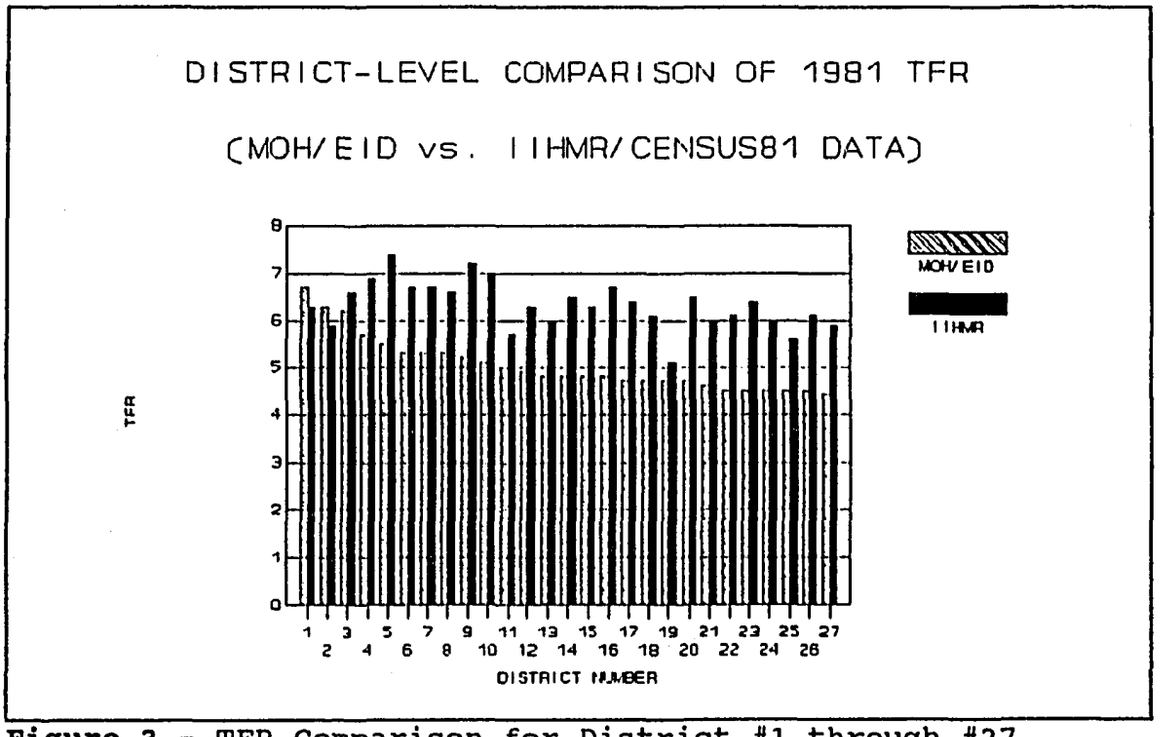

Figure 3 - TFR Comparison for District #1 through #27

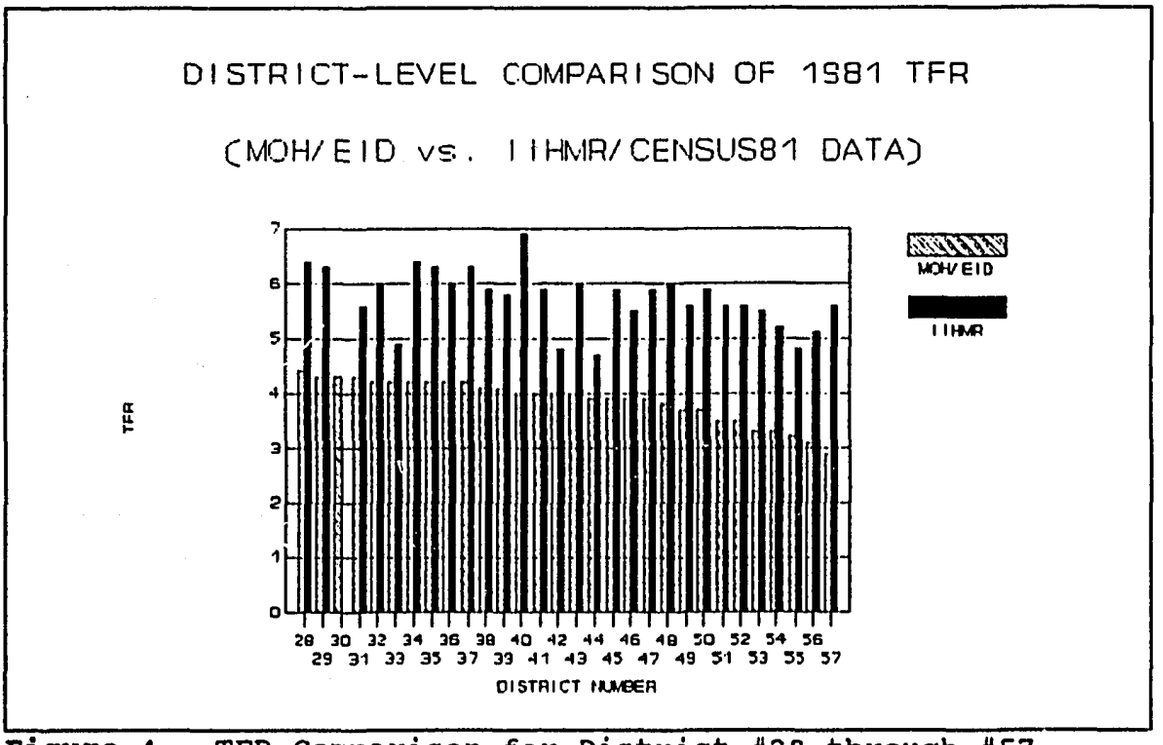

Figure 4 - TFR Comparison for District #28 through #57

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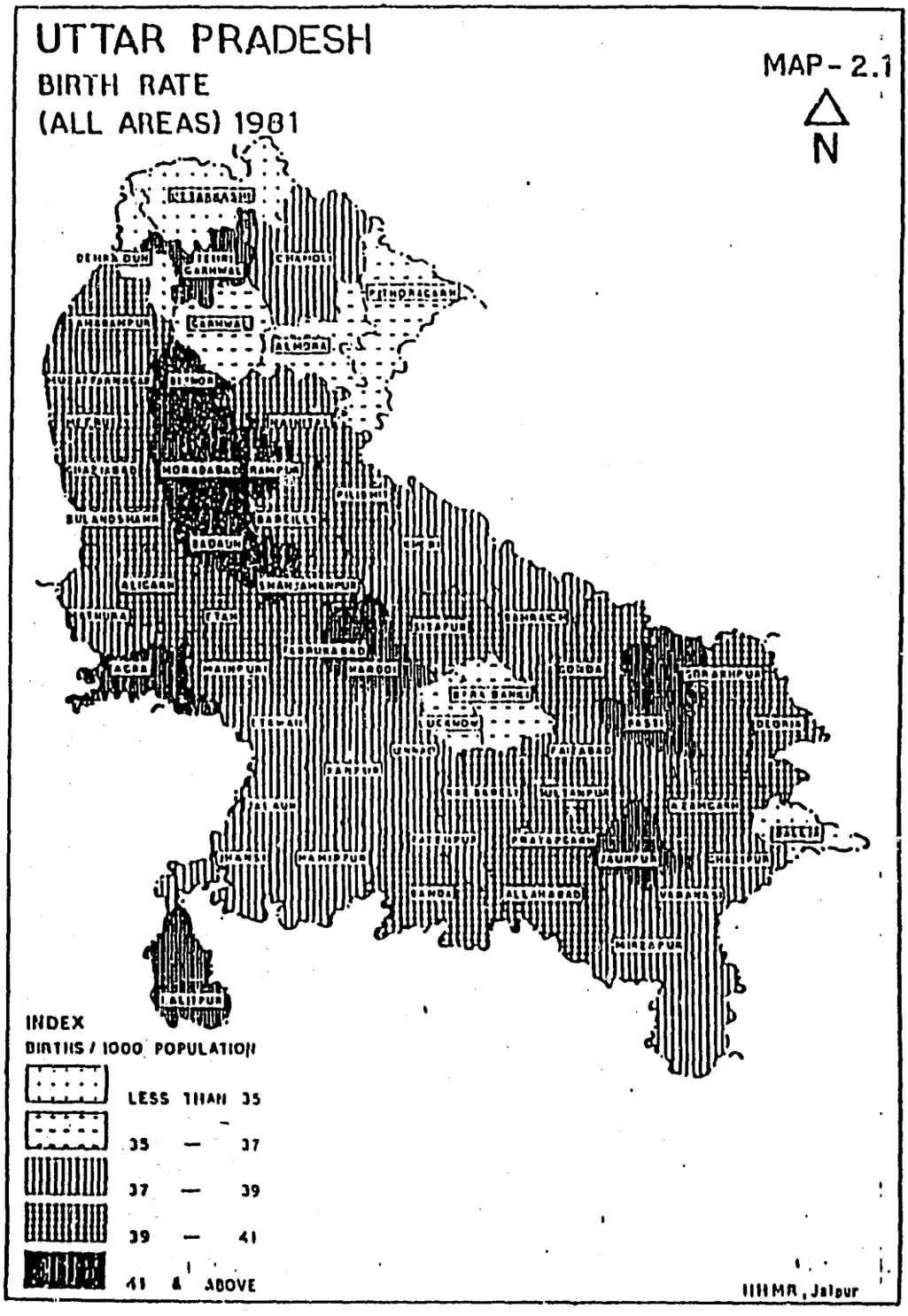
Clearly, the direction of the family planning effort in Uttar Pradesh is not known with certainty, but appears to be going awry. The GOI and the GOUP, to their substantial credit, have recognized this problem and are determined to do something about it. This appears to be the principal reason for their solicitation of USAID support.

Demand for modern contraception. If utilization rates are stalled or are indeed declining, as some suggest, where then is the evidence of an existing demand for modern contraceptives? This is particularly germane since the IFPS Project is structured on the premise that a substantial unmet demand does in fact exist. Data from the large-scale National Family Planning Survey (1989) suggest that there is a real unmet demand in U.P. Desired family size is just under 3 children (while actual family size is 5.4), and 26 percent of couples who report that they want no more children are not using any family planning method. Fifty-five percent of couples have never used a family planning method. While not available from these survey data, there are undoubtedly many candidates for spacing methods to delay the next birth. The national family health survey scheduled later this year will provide additional evidence of the unmet demand. The survey should also provide the most reliable estimates to date concerning certain key demographic measures (including TFR) and contraceptive utilization.

Designers of the IFPS Project base their belief of a large unmet demand not only on survey data, but also on knowledge gained through international experience over several decades and on what is known of the character of the family planning program in U.P. It is the general experience that a **substantial unmet demand exists wherever a choice of quality FP services is not readily available to potential users.** This is very likely the case in U.P. where the program to date has focused almost exclusively on a single terminal method (sterilization), and where outreach services have not been organized to effectively place services within easy reach of clients. In addition, there have been serious deficiencies in the quantity and quality of training (e.g., only 6% of ANMs are trained to insert IUDs), in the range of contraceptives offered, and in the logistics system which has sometimes resulted in stock outages. The program has been driven by a strong system of rewards and sanctions built mostly on target achievement. This has often undermined efforts to improve the quality of services as well as attempts to monitor real achievements through the statistical reporting system (since actual performance falls far short of reported achievement). Additionally, serious problems have been experienced in funding of the program, with the GOUP sometimes running out of funds to carry on program activities.

Taken together, the above factors suggest strongly that the program has not been able to recruit and to retain substantial numbers of new clients in recent years. The corollary suggestion is that large numbers of potential clients remain unserved, thus there is in fact a large unmet demand. **Further evidence of demand** may be inferred from the apparently real variations in levels of fertility by geography, variations too great to be explained except by access to contraception.

All available data sources, while they may not agree on absolute levels, have in common a wide variation in estimated fertility levels amongst the various districts in U.P. District-level TFR estimates range from a low of 2.9 to a high of 6.7. Similar variations occur in estimates of the crude birthrate (CBR). The IIHMR in Jaipur has mapped these geographic variations (**Map 1**)



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Family Planning Service Statistics. Information on new acceptors and current users of modern contraception methods in Uttar Pradesh comes principally from the Ministry of Health's Family Welfare Directorate in Lucknow. It is here that data are collected from various service-rendering facilities, and compared against established targets by method. Available survey data (from the 1989 National Family Planning Survey) contrast significantly with official statistics, providing reason to believe that the actual number of new acceptors and current users is smaller than the official data would suggest. It is anticipated that the National Family Welfare Survey will by summer of 1993 provide more reliable baseline data on the use of contraceptives in U.P. Fieldwork is due to begin in November of 1992; preliminary analyses should be available by the following spring. Of particular interest among the various measures to be covered by the survey is the percentage of target couples who wish to delay the next birth by at least two years (they are potential acceptors of spacing methods) as well as those who wish to have no more children (they being candidates for terminal methods as well as spacing methods in the event they do not wish to use VSC).

Official FP service statistics and targets for the past five years are presented in **Figures 5 and 6** on the next page. Several observations seem to follow from the data:

- for 3 of the 5 program years, **targets** were "exceeded"
- **sterilization** (VSC) rates are declining, especially during the last 2 years
- **orals** represent only a very small percentage of total acceptors (the potential for this method is large)
- while **condom use** appears to be growing, it is extremely difficult to verify actual condom distribution or use
- overall, reported "**new acceptors**" in 1990-91 total nearly 4 million, or two-thirds of estimated total users
- **IUD** acceptance rates as shown in the official statistics appear to be very high, given the small percentage of providers trained in IUD insertion, and available survey data which estimate IUD use as under 1% of MWRA.

It is probably not useful to attempt a more detailed analysis of family planning program acceptors and users as the present numbers are of uncertain reliability. However, it would be useful -- following examination of survey data in early 1993 -- to formulate small-scale intensive research efforts to better estimate key program factors such as client continuation rates by method, quality of counseling related to client choice of methods and continuation, etc. The survey data should also facilitate a re-examination of the overall demographic targets of the IFPS project, with adjustments up or down as indicated.

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EVALUATION OF PROJECT STRATEGIES

STRATEGIES TO INCREASE ACCESS. The IFPS Project aims at increasing access to family planning services by:

- expanding the numbers and geographic distribution of clinical FP service-providing facilities; and

- expanding the number and size of outreach networks providing non-clinical FP services in small towns, villages, and at the doorstep.

These strategies will involve all sectors: public, parastatal, NGO, and private-for-profit institutions. Since it is the public sector which by far has the greatest potential for service delivery, this will be examined first.

The **public sector infrastructure** in U.P. is extensive, comprising the following pertinent categories:

- 13 Divisions
- 63 Districts
- 267 Urban Centers
- 3639 Primary Health Centers (PHCs)
- 907 RFW Main Centers
- 20153 Subcenters
- 223 Post-partum Centers
- 9 Medical Colleges
- 7 RHFW Training Centers
- 229 Upgraded PHCs
- 313 ICDS Projects
- 23000+ Auxiliary Nurse Midwives
- 55 Rural Female Hospitals
- 2 Regional MCH Centers
- 46 ANM Training Centers
- 4 Health Visitor Training Schools
- 56 Laproscopic Training Centers
- 8 Recanalization Service Centers

Potential for FP Service Delivery. While the public health infrastructure is extensive, its potential for delivery of family planning services has just begun to be tapped. Only 6% of ANMs are trained to insert IUDs. Only 60% of facilities provide any FP services. Outreach is not carried out on a systematic basis (often due to poor supervision, lack of supplies and equipment, lack of transport, task overloading for some workers, etc.). Regular in-service training is not carried out. No training has been given to service providers in advanced techniques of counseling and interpersonal communications (especially for spacing methods). Field workers and clinic workers lack adequate IEC materials to use in counseling, and client IEC materials to reinforce messages.

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Budgetary and financial constraints lead to occasional stock outages and other disruptions to service delivery (e.g., unavailability of travel allowances and per diem (TA/DA) for training or for outreach, lack of POL or funds for vehicle maintenance, etc.). Despite these problems, the tremendous potential of the public health system remains. The challenge to the IFPS Project will be to find ways to energize the system: through training and retraining, provision of equipment and supplies, transport, IEC materials, and financial resources for program activities. Specific activities have been identified in the project paper (detailed in the various annexes) which aim at correcting or minimizing the above-cited problems. JHPIEGO and one or more C.A.s, for example, will assist in a major effort to train physicians, ANMs, and other key service providers in all 9 medical colleges, the 46 ANM training centers, and other selected institutions. The objective of this critical training effort will be not only to impart technical skills in the various family planning methods, but to improve: (1) the ability of service providers to give quality counseling to their clients; (2) the tarnished image of the family planning program; and (3) client continuation rates. In terms of access, the result of this training effort will be to greatly increase the percentage of trained and equipped service providers within the public health system, as well as the percentage of public health facilities offering a range of family planning services.

Similarly, intensification and expansion of outreach efforts will be carried out in selected demonstration districts. Models have been developed to test outreach effectiveness of several categories of workers (ANMs, HWs, VHWs) in providing non-clinical services at the village level. If, as has occurred in other countries, effective outreach programs can be developed and demonstrated, it is anticipated that these will be replicated throughout U.P. and elsewhere in India as applicable.

The Railways and Other Government Enterprises. IFPS proposes to increase access to family planning services by working through one or more large government enterprises. The Indian Railway system is enormous, reaching deep into urban and rural areas across the country. This system is relatively self-contained and autonomous providing, among other things, its employees and their families with comprehensive health services. The quality of care in Railway facilities is generally regarded as being considerably above that available in the public health system. Facilities are available to non-Railway families as well.

IFPS proposes to consider this (and similar enterprises) in the same manner as it will other large employers in the private sector. The plan is to provide minimal assistance (training, some equipment, IEC materials) sufficient to permit these enterprises to initiate or expand the provision of high-quality family planning services to the millions of families they serve. It is thought that these are among the most easily sustainable programs, since the Railways and other such public enterprises are already providing comprehensive health services for their employees. While employer-based programs have not met with much recent success, it is believed that there remains great potential, particularly among the public sector enterprises.

In sum, the strategies presented for **increasing access in the public sector** appear to be targeted appropriately on the major problem areas. The approaches chosen are in

accord with successful international experience. There is every reason to expect they can be effective in the Indian context.

Non-government Sector. Strategies to increase access in the non-government sector are necessarily more diverse, following the pattern of the sector itself. There are few large networks of NGOs and PVOs in U.P. Rather there are thousands of small organizations having small catchment areas. This is true both of the voluntary and non-profit sector as well as the private-for-profit sector where there are few really large employers. The Family Planning Association of India has achieved good success in providing quality family planning services in the private sector. Expansion of FPAI activities would be desirable, but currently there are legal constraints on A.I.D. assistance to that institution. Nevertheless, FPAI has proven that FP services can be provided by the private sector in a manner which is attractive to the general public (some large FPAI clinics are reportedly bursting at the seams with client demand).

While the GOI has adopted a target of 20% of the family welfare budget to support non-governmental organizations providing family planning services, this has not been easily implemented. Only about 2% of the budget now goes to NGOs, largely because: (1) there has been no systematic effort to develop the capacity of the private sector to carry out large-scale family planning activities; and (2) government funding regulations and procedures are so burdensome as to frighten off potential NGO applicants for government support. These two constraints will be addressed in the IFPS Project by: (1) developing private sector capacity through technical and financial support from the Society; and (2) encouragement of increased GOI/GOUP support to NGOs, perhaps through matching formulas and PBD.

To tap the potential of the private sector, IFPS proposes to initiate a small grants program through a lead indigenous institution, reaching out initially to the few large networks which do exist (e.g., the milk cooperatives). These grants will provide funding, technical assistance, commodities, and related support to non-government institutions wishing to develop and/or expand family planning services. In part these activities will focus on larger employers, helping them to build quality family planning services into their existing health services for employees and their families.

The strategy of concentration on both public and private sector channels for service delivery makes good logical and programmatic sense. Private channels can be used to supplement and reinforce services available from the public health system. They can also reach into the private-for-profit sector, where investments in relatively more self-sustainable programs can be made. The difficulty comes in trying to coordinate a wide range of actions across literally hundreds of institutions, each having its individual character. There are numerous examples, however, where such an approach has been quite successful, even under adverse circumstances. In Haiti, for example, umbrella NGO organizations coordinate a large number of member NGOs that provide family planning services. Approximately $5 million per year in USAID assistance moves through this mechanism. Madagascar has developed a similar mechanism to channel grant monies to the NGO sector for family planning service delivery. And, in Latin

America, NGOs have carried the lion's share of the burden for family planning service delivery for many years.

In Uttar Pradesh it remains to be seen how fully the private sector can be made to contribute toward the overall success of family planning. IFPS has adopted technical and managerial strategies which seem appropriate to put the private sector to the test. **Contraceptive Social Marketing (CSM).** The CSM strategy in the IFPS Project is to build upon the existing (government) social marketing system, while launching a complementary effort in the private sector. India has a long experience with social marketing, and has had substantial success in marketing condoms and oral contraceptives (see details in CSM annex). However, marketing efforts do not reach far into the rural areas where most of the population of U.P. resides. The GOI program has also been in part restrained by the variable quality of products promoted.

The IFPS Project will promote higher quality products, and will intensify promotion and distribution of the Nirodh Deluxe condom and the Mala D oral contraceptive in the public sector. In the private sector, IFPS will foster a CSM program using commercially viable brands of condoms and orals which reaches down to towns of 5000 persons and, hopefully, to smaller villages. An objective of this effort is to reduce the need for continued GOI and USAID inputs in future marketing of contraceptives.

Based on experience to date, USAID believes that the CSM program is one of the IFPS Project components most ready to proceed immediately upon signing the Project Agreement. The chosen strategy appears to be appropriate, and affords many opportunities for innovation and strengthening during the project out years.

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STRATEGIES TO IMPROVE THE QUALITY OF FAMILY PLANNING SERVICES

Improving the quality as well as the quantity of family planning services is crucial to the success of IFPS objectives. The concept of **high quality services** has several dimensions:

- a range of choices of contraceptive methods must be available to the prospective client;
- only high-quality contraceptives should be promoted (those with a proven track record of effectiveness and quality control in manufacture);
- providers must be well trained in the methods they offer, and must be well equipped to carry out both clinical and nonclinical work;
- providers should be skilled in client counseling, to ensure that clients are well-informed regarding their options, and to improve continuation rates;
- good client counseling implies the ready availability and employment of information, education, and communications materials to inform and to reinforce client knowledge; and
- for high-quality services to be provided over time, it is imperative to have functioning supervision, logistics, MIS, and pre- and in-service training systems.

Improvement of the quality of FP services will be one of the toughest technical problems IFPS will have to face. The program has for nearly 40 years been providing limited and sometimes indifferent FP services. What IFPS is proposing to do is to completely turn around these well entrenched behaviors, and to build a new spirit of community service where little has existed in the past. This may be somewhat easier to do in the private sector where activities often will be starting from scratch. In the public sector, however, one can confidently predict the need for extraordinary measures and perseverance if the new behaviors are to be solidly institutionalized.

At this point it is difficult to predict how successful IFPS may be in achieving the goal of improving the quality of services across-the-board. However, there are specific strategies and program activities within the project which are aimed at achieving each of the above-listed elements of "high-quality FP services".

Breast-feeding is one example. Studies have shown that breast-feeding programs have a measurable impact on maternal and child health. The influence of breast-feeding on lowering fertility is well known. Breast-feeding is a natural resource that is highly cost-effective for public health programs. The health benefits are high in comparison to the low demands on public health resources. Research has repeatedly shown that fewer infants die when breast-fed because breast-feeding protects infants from diarrhea and common life-threatening infectious diseases. It also promotes growth and development by providing the infant with all the nutrients and fluids required in the first six months of

life. Further, it may reduce the risk of post-partum hemorrhage and is associated with lower risks of ovarian and breast cancer.

For family planning programs, the fertility-suppressing quality of breast-feeding provides an option for an expanded program. In 1988 the Bellagio Consensus Conference proposed guidelines that formed the basis for the lactational amenorrhea method (LAM) as a method of family planning. Based on clinical data, it was agreed at the conference that a mother who is fully or nearly fully breast-feeding her infant and who remains amenorrheic has less than a two percent chance of pregnancy during the first six months post partum. In India, where most women breast-feed for at least a year and where there may be some resistance to modern methods of family planning, LAM could be promoted as an interim method of birth spacing. ANMs and other service providers could be trained to present breast-feeding as a an effective family planning technology during the first six months post partum, instructing mothers in breast-feeding techniques which are most effective in maximizing infant well-being and in avoiding unwanted pregnancy.

STRATEGIES TO PROMOTE FAMILY PLANNING

The preceding strategies to improve access and **quality** of family planning services are important ingredients in the promotion of family planning. The availability of high-quality services as a result of IFPS-supported activities will contribute directly, it is believed, to changing public attitudes towards the program from indifference or disdain to a more positive condition. The growing pool of satisfied contraceptive users will comprise a positive dynamic among families and friends. This is perhaps the most important, though not only, component of promoting family planning over the long-term.

Additionally, selected policy and public education activities are planned. IFPS will seek to have the GOI modify the current system of new acceptor targets. The present system seems to result in numerous problems both among service providers (focus on numerical achievement, not quality; falsification of records; etc.) and among both clients and potential clients who view the program as demographically driven, of poor quality, and not relevant to their health needs. **Thus, modification of the target system is crucial to the improvement of the image of the FP program, including self-image.**

Another dimension to be addressed is that of public perception of family planning itself, as distinct from that of the family planning *program*. IEC efforts will be directed, through the mass media and otherwise, to foster a change in public attitudes toward the concepts of **birth spacing and birth limitation**, particularly as these relate to family health and welfare. The health advantages (to mothers and their offspring) of family planning are not immediately apparent to the general public, but are real and can be convincing if properly presented. With the new emphasis on **spacing methods as well as sterilization**, these health messages become relevant whereas before they would have been largely moot.

Finally, in the effort to promote family planning IFPS will undertake a series of activities aimed at the **leadership levels** in U.P. These policy-related actions will be directed at

several levels toward **those who shape policy and public opinion**. Mechanisms will include seminars and workshops, study tours, and targeted information dissemination, (e.g., of survey and OR findings, technical materials such as *Population Reports*, etc.).

If all the above-cited activities are successful, as they have been elsewhere, they will undoubtedly lead to a major shift in support for family planning, including at the grassroots.

ASSESSMENT OF PROJECT IMPACT

Achieving demographic targets. IFPS aims at doubling the (rate of) use of modern contraceptive methods (orals, IUDs, condoms, VSC, Norplant, etc.) from approximately 27% in 1989 to 50% by 2002. The **number of users** is expected to increase from 6 million to over 15 million. These figures are generally consistent with a reduction of the total fertility rate (TFR) from 5.4 to 4.0 during the same period (see TARGET analysis by Stover, 4/10/92). During this same period, the total number of married women of reproductive age (MWRA) will increase from 24 million in 1992 to over 31 million by 2002. Thus, a doubling of the contraceptive prevalence rate (CPR) involves increasing the number of continuing users by 2.6 times! **Figure 7** shows these trends graphically. The assumption is that by the end of the project there will be an equal number of users and non-users (target couples).

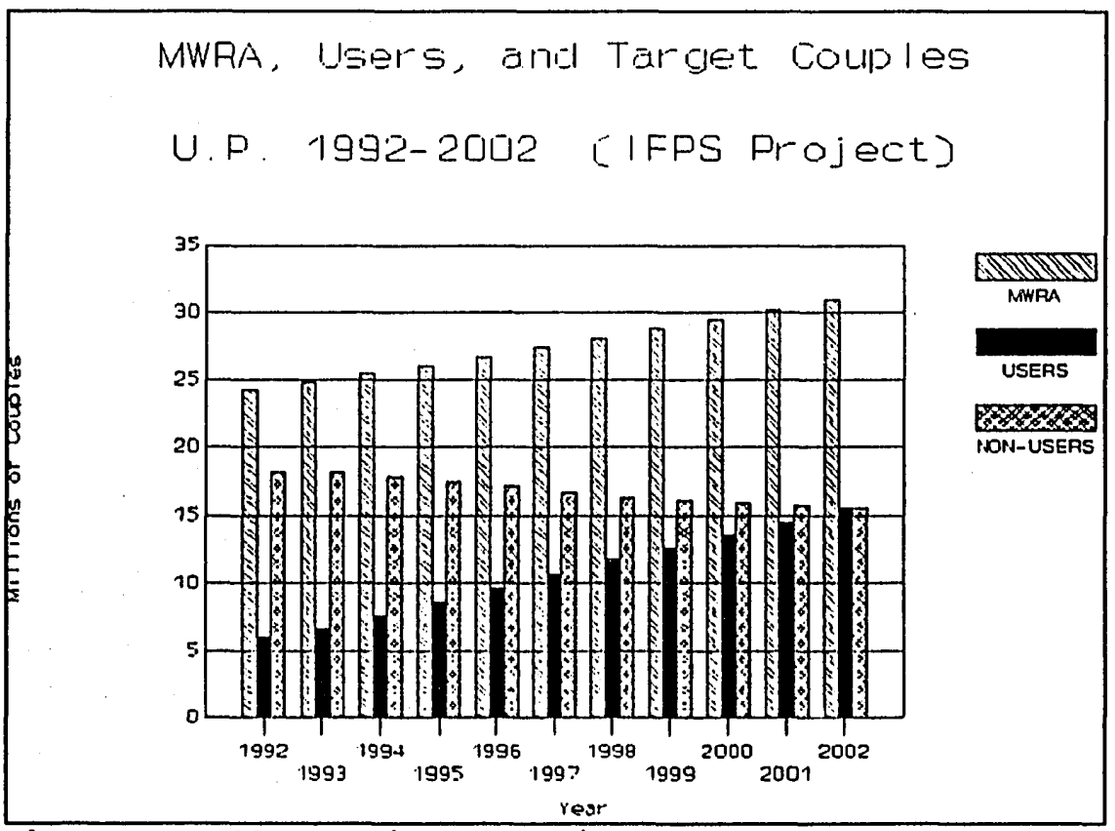

Figure 7 - Illustrative Evolution of Users, Non-users, and MWRA During IFPS Project

Achieving these demographic targets will be very difficult, but not impossible (Stover, 4/10/92). **However, it should be remembered that data used in calculating the above scenario are not fully reliable.** The actual level of CPR may be somewhat higher or lower that the 27% used above. Better estimates will have to await results of the national survey next year.

In accord with survey results, **targets will be reset towards the end of the first project year.** Once the targets are recalculated (spring-summer 1993), IFPS will have a clearer idea of the scale and pace of activities required to achieve the desired TFR of 4.0 by 2002. Plans for demonstration projects and their replication can then be modified accordingly, and more realistically given the first full year of project activities.
Two major surveys are built into the project (Year 5 and Year 10). These are designed to yield reliable data which can be used to **measure progress** and to assist in re-directing future activities.

Replicating IFPS Successes. A subpurpose of the project is to develop FP service delivery activities which will be widely replicated in the large northern states, and elsewhere in India. Strategies to achieve this outcome involve: (1) developing and demonstrating programs which are truly replicable (in terms of cost, sustainability, etc.); (2) documenting the process and disseminating the results widely; and (3) assisting the GOI/GOUP financially and through technical assistance to begin the replication process. This latter assistance will be through **performance-based programming.**

While it is too early to predict how widely the successful results will be replicated, there are precedents which suggest that the GOI will quickly adopt program strategies which it sees as likely to improve the overall impact of the national family planning program. Good intentions aside, however, experience elsewhere has shown repeatedly that the successful replication of FP program activities is **highly dependent on the continued employment of key personnel who have experienced and managed the original change.** This is a critical factor which must be taken into account by IFPS and its GOI/GOUP collaborators.

Strengthening trust and collaboration between Indian and U.S. institutions is an important project objective. Not only will this help to ensure technical and programmatic competency in the family planning area, but important spinoffs can be anticipated with respect to other current and future projects. The strength of these relationships will be influenced by the **degree of success achieved in this project** as well as other human and institutional factors.

CONCLUSION

The IFPS Project is technically sound as presently conceived, based on currently available information. It embodies strategies and resources appropriate to the chosen objectives of expanding **access**, improving **quality**, and **promoting family planning.**

Reassessment of demographic targets will be needed by the end of the first project year. Although the numbers might change ... even considerably ... the strategies as laid out in the Project Paper will in all likelihood continue to be appropriate, though perhaps with minor modifications and mid-course program corrections.

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Annex III. B. Institutional Analysis

During the course of the project USAID will be collaborating with several public and private Indian institutions. The organizational structure and functional capacity of these indigenous institutions are, therefore, relevant to the success of the project.

The Public Health System: The family planning infrastructure in the public health system is vast and complex. The Ministry of Health and Family Welfare (MOHFW) is headed by a minister and secretaries. A vast array of other functionaries operate under these persons at the central office in New Delhi. At the state level, in U.P., a similar array of officials represent various offices of the state government. One unit of the state government is the State Health Office operated by the Director General (DG). One of the 8 directors under the DG is in charge of family planning.

The urban health service system includes general and specialty hospitals and maternity hospitals with 30 beds as the norm. In addition, urban areas have Urban Family Welfare Centers(UFWCs) which are out-patient facilities with a doctor, 4 ANMs and 2 LHVs, and Health Posts (HPs) which are also out-patient facilities located almost exclusively in slums. These HPs are staffed by a Lady Doctor, 2 LHVs and a public health nurse. There are about 534 government hospitals in U.P.

The rural health system includes: Community Health Centers with 1 superintendent, 1 surgeon, 1 pediatrician, 1 radiologist, 1 lady doctor, 1 X-Ray technician, 2 laboratory technicians, 3 staff nurses, 4 LHVs, 2 ANMs, 2 health inspectors and 8-10 basic health workers; Primary Health Centers (PHCs) with 2 doctors, 4 LHVs, 2 ANMs, 1 laboratory technician, 1 extension educator, 1 sanitarian, 2 health inspectors and 8-10 basic health workers.

There are 1555 government dispensaries, 142 CHCs, 2476 PHCs and 20,153 SCs in U.P. as of 1989. (Health Information India, 1989). The referral system works upwards from the SCs to the CHCs. There are 2263 doctors, 259 Nurse Midwives, 23,645 Female Health Workers (ANMs), 11,363 Male Health Workers, 1026 Block Extension Educators, 3567 male Health Assistants and 3068 female Health Assistants in U.P. (Health Information, MOHFW, 1990).

The strengths of the public health system are: the infrastructure is vast and has the potential to reach very large numbers of people; MIS, logistics and management systems are in place; training institutions are present; being a government institution, it has the complete support of central and state governments. The weaknesses of the system are: in spite of the large inffastructure the number of clients per PHC or SC is too large for efficient service delivery; training programs are very poorly designed and, in some cases, not in operation at the present time; motivation of staff is very poor; quality of services is poor; in many SCs and PHCs facilities and equipment are sub-standard or missing; the image of family planning providers is very poor due to the skewed focus of the program on sterilization and the target-

oriented approach of providers; there is a lack of an appropriate method-mix at every level of service delivery. In spite of these drawbacks it is essential for the IFPS project to work with the public sector in order to have a significant impact on the TFR of U.P.

The Railway Health System: Family health care programs were initiated for all the railway staff members and their families in the 1950s and extended in the 1960s. The Railways own 114 hospitals, 62 family welfare centers, 38 subcenters and 668 health units across the country. Of the nine zones that the day-to-day administration of the Indian Railways is divided into, U.P. is served mostly by 3 zonal railways, Northern, North-Eastern and Central.

At the apex of the health services is the health directorate in Delhi, under the administrative control of the Medical Superintendent (MS) and is headed by the DG (RHS) and assisted by the Executive Director (Health) and Director (Health and Family Welfare). Each zone is headed by the Chief Medical Officer (CMO), who is assisted by the Dy.CMO/Technical advisor, Dy.CMO/Health and Dy.CMO/Family Welfare. There are a series of staff below these officials. Each zone has its own central hospital, followed by divisional hospitals and under the divisional hospitals are a series of sub-divisional hospitals, polyclinics, health units and dispensaries. All methods of contraception are provided at the hospitals. At the lower levels some of the clinical methods are absent.

The strengths of the Railway Family Welfare program are: As in the case of the public health system the Railway Health System has a vast infrastructure; facilities and equipment are usually far better than in the public health system; management, MIS and logistics systems are in place; the system has the potential to reach over two million people and can be expanded further. The weaknesses of the system are: all the facilities are understaffed; quality of training and services are marginally better than in the state health system but require extensive upgrading; method-mix is poor and emphasis has been solely on sterilization. However, in spite of these drawbacks, the Railway Health Service provides a unique opportunity to expand family planning service delivery in U.P.

Dairy Cooperatives: The dairy cooperatives were established to facilitate the marketing of milk by local farmers. Broadly, all the districts in U.P. may be divided into two categories: Operation Flood Districts, where the milk cooperatives come under the control of the State Milk Union Cooperative Federation Limited (SMUCFL), and Non-operation Flood districts under the Dairy Development Department of the state. The SMUCFL is governed by a chairman and board of directors elected by the affiliated district milk unions. The district Milk Unions Cooperatives have a similar structure and supervise the village milk cooperative societies comprising of at least 30 members each. The structure of the Non-operation flood unions is similar to the other category. There are 51 milk unions in U.P. with 34 districts under Operation Flood and the remaining under Non-operation Flood. The two together have 19,698 milk societies with a membership of about 1,900,000. The potential outreach of this network is about five million people.

The strengths of these dairy cooperatives are: they are successful grassroots organizations with a remarkable ability to organize local farmers; they are particularly well suited to support CBD activities; community participation is an average 30% of all village households and non-members are allowed to market their milk through the society outlets; most village cooperatives are managed by local committees and have a small building and at least one paid staff member; there are Women's Dairy Cooperatives now in 5 districts of U.P. which would enable the project to target rural women. The weaknesses of this network are: they do not currently provide family planning services and would require assistance to set up family planning activities.

Agricultural Cooperatives: The Primary Agricultural Cooperative Societies (PACS) are also established at the village level. They supply agricultural inputs, provide short-term loans to farmers and supply consumer items to members and non-members through their fair-price shop system. A minimum of 30 members are required to form a cooperative society. The PACS are coordinated by the Secretary/Manager at the lowest level, the Assistant Registrar's office at the District level, the Joint Registrar at the Divisional level and the Registrar Cooperative at the state level. There are 8146 registered PACS in U.P. with a total membership of about 7 million and with an estimated outreach to about 40 million people.
The strengths of the PACS are: 90-95 percent of the societies own their own premises; some of the PACS in western districts of U.P. have a good infrastructure and provide MCH services and even family welfare services; the estimated reach of the PACS is very large; they are good grassroots organizations and have access to rural U.P. The weaknesses of the PACS are: there is a wide variation in the management capabilities and efficiency of PACS across districts; they are not as well organized as the dairy cooperatives; although some PACS currently provide family welfare services, quality of services are questionable and a majority of the PACS would need extensive training and technical assistance to set up family welfare programs. The PACS, however, present a good channel for the extension of family planning at the village level to a large number of people.

Sugarcane Societies at the village level: Sugarcane societies are mainly entrusted with marketing sugarcane, providing agricultural inputs for sugarcane production and short-term loans for farmers. The senior sugarcane development inspector is the chief executive at the society level. He reports to the sugarcane union federation at the state level. Besides the chief executive there are supervisors and other staff at the society level. Each society covers 50-200 villages.

The strengths of the sugarcane societies are: sugarcane societies in U.P. have their own buildings, a staff strength of 50-200 and an annual turnover of 25 lakhs to one crore; some of the societies have Ayurvedic dispensaries; the sugarcane factories which belong to the societies have their own health units with medical and paramedical staff and some of these factories provide family planning services to their employees and neighboring villages. The weaknesses of these societies are: most of the societies are in financial trouble; many of

them would require extensive technical assistance to set up family welfare programs. In spite of the problems these societies and factories present another important network for the expansion of family planning service delivery due to their infrastructure and manpower.

Bharat Heavy Electricals Limited (BHEL): One of the branches of BHEL, a large public sector corporation, is situated in Haridwar, U.P. It specializes in the manufacture of power generation equipment. It has a 200-bed hospital that currently provides curative, preventive and promotional services to the 12,251 employees and their families and to two neighboring villages. Family Welfare is part of the MCH program of the Medical Department. There is a special cell under the Chief Medical Officer for implementing family planning programs. There is a part-time OB/GYN, a full-time Public Health Visitor, a full-time medico-social worker and an accountant attached to this cell. All methods of contraception are available. The curative services of the Medical Department are of very high quality.

The strengths of their family welfare program are: an existing infrastructure; the good credibility of the curative services which will make it easier to promote family planning; extension of services to villages. The weaknesses are: lack of involvement and commitment at top and mid-level management; lack of involvement of workers in the planning process; limited, poor quality IEC; lack of an effective monitoring system. In spite of these failings this institution provides ample opportunity for USAID to improve and expand high quality family planning services.

Hindustan Aeronautics Limited (HAL): The Lucknow branch of HAL has 3855 employees with an annual budget of 300 lakhs, of which nearly 100 lakhs is spent on medical and family welfare programs. HAL is a public sector corporation and manufactures aircraft equipment for the Indian Air Force. It has a dispensary with 6 permanent doctors, 15 part-time doctors and 15 paramedical staff. Apart from the doctors at the dispensary, there are a team of doctors working in various parts of the city to cater to the medical needs of the HAL staff who live outside the premises of the HAL colony.

All methods of contraception, except sterilization, are provided by the dispensary. The strengths of the program are: the size of the medical and para-medical staff is large; the doctor have established a good rapport with the employees and are trusted. The weaknesses of the program are: lack of sterilization services in spite of available medical staff; lack of outreach to non-employees in spite of a large number of medical and para-medical staff; management and trade-unions are not involved in the planning and management of the program; there is complete absence of an IEC program. It is obvious that HAL presents a unique opportunity for the expansion of quality services to a large number of clients in urban and peri-urban Lucknow.

Bajaj Hindustan Limited (BHL): is situated in the Kheri District of U.P. It is a leading private sugarcane manufacturer with 1745 employees. It has a hospital that provides medical and family planning services to its employees and to 1300 villages on a periodic outreach

basis (through camps). The contraceptive services provided are VSC, condoms and OCs. The strengths of the program are: a strong rural development component; good credibility with workers; special training for motivators; a reasonably strong IEC program; and special emphasis on women for educational and motivational purposes. The weaknesses are: lack of coordination in the IEC activities; lack of involvement of top-level management and trade unions; absence of a monitoring system and an incomplete method-mix. BHL could be assisted to improve and expand its services to a larger number of people in a systematic manner.

The Indian Medical Association (IMA): The IMA is a voluntary organization with a membership of about 83,000 physicians across the country. It has 7,219 members and 138 branches in U.P. The affairs of the IMA are managed by the elected members of the Central Council and the Working Committee. It has a number of Standing Committees which are entrusted with specified objectives. Each state and local branch holds regular scientific and medical meetings and elects its Office Bearers once a year. The IMA has many activities include publishing a scientific journal, providing continuing education for its members through its academic wings, organizing study tours, holding conferences etc. In addition the IMA and its branches have been running many community service projects. A number of branches have established family welfare centers, immunization centers, ambulance services, blood banks, etc. This organization will therefore play a major role in establishing model clinics in the private sector and for the expansion of service delivery through private practitioners.

Literacy House (LH): is a NGO established and managed by the India Literacy Board, in Lucknow, U.P. It has been identified as the NGO to lead all IEC activities for the project, with technical assistance from JHU/PCS. It has extensive experience in the field of education and promotion. The principal functions of LH are preparation of teaching/learning materials, preparation of training materials, support to continuing education programs, preparation of mass media programs of functional literacy, motivation and environment building for Adult Education, multi-media work including traditional and folk-media, management training programs for educators, management of field programs, evaluation of and research in teaching/learning materials and learning impact and production/dissemination of information on Adult Education. It has a history of collaboration with many governmental and non-governmental institutions. It has been a participant in varied field programs such as the ICDS project and the Women Welfare Extension Program. It has some Balwadis and Mahila Mandals under its jurisdiction. LH therefore seems well placed to be the lead IEC NGO for the project.

Voluntary Health Association of India (VHAI): is a leading health NGO in India, with its headquarters in New Delhi. The public policy unit of VHAI is involved in the prevention and control of communicable diseases such as Kala-Azar, and AIDS. VHAI works closely with drug and health action groups, and with a variety of international donors on issues such as maternal and child health, pesticide control etc. VHAI has a training unit that has been

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responding to the growing needs for creating health awareness among diverse groups by training health workers, non-health groups, school children, etc.

It holds a series of Training of Trainers workshops every year for planning and management, monitoring and evaluation etc. It offers diploma courses in Community Health Management. The Documentation Center of VHAI has a collection of 8000 books, 600 journals and newsletters and 400 other materials. This center organizes exhibitions and fairs to raise public awareness about health issues and is also responsible for advocacy functions to bring the issues to the attention of policy makers. Of the total income of the VHAI (Rs. 148,59,340), last year, 53 percent was from foreign grants, 12 percent was from Indian grants, 32 percent was publication income and 3 percent was other income. Production of materials accounted for 39 percent of expenditures, personnel costs were 24 percent, workshops and meetings accounted for 14 percent, administration was 12.6 percent, grants and scholarships were 6 percent and library purchases and travel accounted for 4.4 percent of all expenses.

VHAI has a number of branches in the various states. The UPVHA has offices in Lucknow, Varanasi and Dehradun. There are a total of 9 program staff and 10 supporting staff in the UPVHA. All three offices have been very active over the last few years in training programs and in awareness raising campaigns. They are not currently involved in family planning service delivery. Their activities have been restricted to family life education and promotion of family planning. The project will utilize the existing network of UPVHA to promote family planning service delivery in the NGO sector, and in the process, strengthen the institutional capability of the UPVHA.

King George's Medical College (KGMC): The college was founded in 1911 and was administered by the state government until 1922. The college is currently administered by the Lucknow University and is financed by the Government through grants to the University.

The college has both undergraduate and post-graduate programs in medicine. The teaching is done through lectures, demonstrations and clinical rounds. There are approximately 200 undergraduate students admitted every year to the program. Four hospitals are attached to the medical college. In addition the Rural Health Training Center in Sarojini Nagar, Lucknow, is administered by the University and is used as a field practice site for the students. This center covers a population of 100,000 people. There are 4 hostels for the students and a large library with 17,110 books and 9,034 journals. The project will develop the KGMC into a model training center for clinical training in family planning service delivery.

ANNEX III.C. FINANCIAL ANALYSIS

The purpose of this financial analysis is to assess:

- The overall financial soundness of the project's approach, and the extent to which project resources will be used cost-effectively;
- The flow of project resources including the mechanisms for funds disbursement, cost estimates, and contributions of centrally-funded projects and the GOI;
- The financial management capacity of implementing agencies; and
- Long-term prospects for project activities to become institutionally and financially sustainable.

I. Overall Cost-Effectiveness of Project Approach

The IFPS Project adopts a "least cost" approach to its implementation. That is, of the possible alternatives for achieving project objectives, those chosen represent the most cost-effective approaches, to the extent that this could be determined. Three of the project's four main components (public sector, NGOs, and commercial private sector) represent marginal investments in existing systems and networks. For example, the public sector delivery system (sub-centers, primary health centers and health manpower) is extensive, and project activities will focus on improving the quality of services delivered and, by doing so, promoting service utilization. Among non-governmental organizations, milk cooperatives, employers and other existing networks will be utilized to distribute information and contraceptives. Thus, the majority of project funds will be expended on activities carried out through infrastructures and organizations already providing services or distributing family planning or other kinds of commodities.

There is one major exception, however. The State IFPS Project implementing organization (the Society) is to be established in U.P. as a new society. The Society is the principal means of channeling IFPS support for both public sector and private sector activities (excepting CSM which will be under a direct USAID contract). This organization will play a pivotal role in channeling technical assistance and funding to a wide variety of public and private sector organizations. It will receive intensive support during the early years of its existence from CEDPA and other C.A.s as needed.

The IFPS Project is one of the largest bilateral population efforts ever undertaken by A.I.D. Its intent is to have a major impact on the rate of population growth and health status in Uttar Pradesh. As such, the project needs to take a comprehensive approach over its ten-year life by utilizing all major channels which can be effectively mobilized to achieve project objectives. This comprehensive approach balances project investments between the public and private sectors.

The public sector is represented by the State Directorate of Health and Family Welfare (DOHFW) which has more than 3,000 Primary Health Centers and 20,000 Sub-centers throughout U.P. Surveys show that these facilities have enormous unused capacity which can be tapped through the types of marginal inputs presented in the project description. The addition of better staff training, commodities management and quality, a wider range of contraceptives, and strengthened supervision can increase the effectiveness of the public family planning system at low relative cost. At the same time, if the project is successful in its public sector activities, expanded family planning services will be institutionalized in the DOHFW by the end of the project with most costs being borne by the Central and State governments. Finally, as U.P. is one of the poorest states in India, it will be many years before millions of its lower income couples can afford to pay for family planning services. Therefore, achieving project objectives necessarily requires investment in the public sector which will be the only feasible source for family planning for a large portion of the population.

The project's non-governmental activities will take place with both the commercial sectors including employers and private practitioners, and non-profit groups. This strategy is cost-effective because like the public sector, the private sector offers solid opportunities to tap into existing service and distribution networks through investments at the margin. The commercial private sector including private medical practitioners offers the best possibilities for financial sustainability. The majority of expenditures on health care in U.P. occur in the commercial private sector through out-of-pocket and third party payments (mainly employers, either directly or through Employees State Insurance). If sufficient demand can be generated by project activities, social marketing and other private distribution approaches such as employer-based services will produce the first significant private financing of family planning in the state.

In countries with low prevalence, and a mixed record in the public sector, NGOs have often played a catalytic role in stimulating demand and widening the acceptance of various family planning methods. The more than 400 NGOs in U.P. offer an opportunity to utilize another possibly potent channel for achieving project objectives. Many of these NGOs are functioning organizations which have the capability of promoting and providing family planning services with the types of inputs envisioned by the IFPS Project.

Of the four project components, the research and evaluation activity will least take advantage of existing structures and capacities. The project will assist a local organization to build up its capacity to perform the required research and evaluation activities planned in the scope of work. Whereas this may require substantial building of organizational capacity, the outputs of this activity will have a major influence on improving cost-effectiveness as the results of policy, operations, and survey research are fed back into the implementation components.

At present, more than 90 percent of family planning services are financed and provided directly by the central and state governments. The cost per family planning user is very low by any world or Asian standard at about $4.00 - 5.00. The principal reason for the low cost is the preponderance of sterilizations which represent a one-time cost, and the relative lack of temporary (supply) method use which represents higher average annual costs. In the first several years of the project, costs per user will necessarily increase to absorb the costs associated with attracting new users, improving delivery systems, and greater proportions of temporary method use. It is not unlikely, therefore, that costs per user will be in the $8.00 -$10.00 range at the end of the project. As the previous economic analysis demonstrates, increasing costs of family planning will have large payoffs for U.P. in terms of reduced population growth rates and better health status.

Among the project's research and evaluation activities will be an attempt to track and analyze change in costs per user and/or per CYP. Over time, this analysis of cost-effectiveness will be used to guide decisions about where to invest project resources.

II. Flow of Project Resources

Over the ten-year life of the IFPS Project, approximately $325 million will be disbursed by USAID/Delhi and AID/W. USAID/Delhi will contribute 69 percent of this amount, primarily in funding local costs of public and private sector activities. A large portion of the local costs allocated to the public sector and to the private sector will be handled through performance-based disbursements, based on achievement of specific performance targets or other program benchmarks.

AID/W will contr' ıte 31 percent of all project costs. The AID/W contribution will come indirectly through centrally-funded cooperating agencies (about 26 percent), and directly in the form of contraceptive commodities and medical equipment (about 4 percent).

Inputs and Budget Estimates

In developing budget estimates, unit costs based on current U.S. and local prices, and recent USAID/Delhi project experience were used for long- and short-term personnel salaries, travel, contraceptives, training, grants and other inputs. Cooperating agencies were asked to estimate inputs over the life of the project, and then to apply standard unit costs to arrive at budget estimates. The budget estimates are summarized in Tables A and B. Cost data are disaggregated into projected expenditures by each type and source in Tables 1-20 (attached).

Mode of Payment

Public sector and non-governmental sector activities, excepting CSM, will be funded through performance based disbursement to the Society which will itself be capitalized by USAID

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through the MOHFW upon its establishment as a viable organization. USAID will contract directly with a local firm to serve as the lead organization for CSM activities. This organization will subcontract with other local firms to carry out the CSM program. Research and evaluation activities will be also be funded through the Society, and through contracts with local research organizations (supported by technical assistance from the Population Council -- AID/W-funded). The Society will contract with a lead R&E organization to manage most R&E activities, which will in turn subcontract for some research, and will itself conduct some R&E activities. Technical assistance will be provided through centrally-funded projects carried out by AID/W-funded cooperating agencies. Contraceptive commodities and equipment will be provided directly by AID/W.

Host-Country Contribution

In its Fiscal Year 1990-91, the GOI expended the equivalent of $51.3 million (Rs. 1.483 billion) for the family welfare program in U.P. Excluding amounts for medical termination of pregnancies, the balance was $47.9 million. This figure, multiplied by ten and nominally reduced for expected exchange rate fluctuations, has been used as the basis for the host country contribution level of $400 million over the ten years of the IFPS Project. All elements of the U.P. family welfare budget (except abortion) are critical to the success of IFPS because the project is designed to be supplemental to the items funded in the U.P. budget. Thus the U.P. budget for family welfare (excluding abortion) is the crucial Host Country Contribution to the project. Continued support by the GOI/GOUP at or above the 1990-91 level is considered critical to the achievement of project objectives. The Project Agreement will commit the GOI and GOUP to maintaining such levels, exclusive of the support AID will provide under the project.

Host Country contributions will be accounted for through systematic tracking and recording procedures in USAID. An annual report on the GOI contribution, in cash and in kind, will be required by the Project Agreement. We have examined the U.P. reporting mechanisms for this Host Country Contribution and are satisfied that they meet with reporting requirements. The form and content of the report will be agreed to in a Project Implementation Letter.

Private Sector and Employer-Based

The Society will act as an umbrella funding organization and will manage a large portfolio of private sector grants totaling approximately $150 million over the life-of-project. Capitalized through performance-based disbursements (PBD), the Society will disburse funds for institutional development grants and family planning service grants, with technical assistance provided by CEDPA and others.

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Management capacity, including ability to meet A.I.D.'s financial management standards, will be a primary consideration in establishing the Society, and will receive a great deal of attention from CEDPA and other C.A.s. The new organization will be required to ensure that the public and private sector entities receiving support under the project meet project needs for accountability and proper financial management. Guidelines will be set up by the Society, with USAID technical assistance. The USAID controller will carry out appropriate assessments to ensure this condition is met.

Through the first and second Private Voluntary Organization for Health (PVOH-I & -II) Projects, USAID/Delhi has acquired considerable experience in assessing and monitoring the finances and accounting practices of NGOs providing health and family planning services in India. Under the PVOH-I Project (1983-87), 31 NGOs were subject to the following procedures: an appraisal visit by an independent Certified Public Accountant (CPA) to assess financial management capabilities and practices; quarterly financial and performance monitoring reports; and, annual audits by a CPA. In 1988, the financial monitoring procedures were evaluated by an independent accounting firm and were found to be "generally satisfactory"[1]. Under the PVOH-II Project, currently underway, it is expected that some 40 NGOs will be financially monitored and managed using this approach. The value of individual grants provided under PVOH-I and -II have ranged from $200,000 to about $1 million.

Among the PVOs in 17 states supported under PVOH-I and -II, six have been in Uttar Pradesh. These have included private educational institutions and health service providers. USAID/Delhi has found that these U.P. PVOs, which are similar to organizations that will be supported through the Society grants, have been capable of following the financial accounting guidelines established by the GOI and USAID.

Lead Research and Evaluation Organization

. . private Indian research organization, operating under a grant from the Society and with technical assistance from the Population Council (AID/W-funded), will serve as the lead research and evaluation institution, assisting service-delivery components of the project to undertake operations research and such other research and evaluation activities as are required to measure progress and identify problem areas in service delivery. The activities supported under the lead R&E organization will account for approximately seven percent of total expenditures. It is anticipated that the organization will both carry out its own research and evaluation activities, and provide grants to other organizations for operations research and related activities.

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[1] A.F. Ferguson & Co., Report on Review of Financial Monitoring Systems Under PVOH I, report prepared for USAID/India, December 1988.

In addition to technical capacity, management abilities (including competence in meeting the Society's financial management standards) will be a primary selection criterion for the lead R&E organization. The lead R&E organization will be required to ensure that the research entities receiving subgrants also conform to these standards. This will be done through the direct financial management TA to be provided by the Society and the Population Council.

Contraceptive Social Marketing Organization

Contraceptive social marketing (CSM) activities will be managed through a contract between USAID/Delhi and a private Indian organization, selected through a competitive process. This activity will be approved by the Society prior to issuance of the contract. A series of subcontracts will be negotiated by the organization to handle the marketing and distribution of condoms and oral contraceptives. CSM activities will account for approximately 15 percent of project expenditures.

USAID/Delhi has recent experience in overseeing and monitoring financial management aspects of CSM activities carried out by a U.S. and local contractor. In 1989, the USAID/Delhi Controller's Office reviewed the financial management of both Population Services International (PSI) in the U.S. and the PSI affiliate organization in India. The review was carried out to: (1) ascertain whether costs reimbursed by USAID to the grantee were eligible; (2) determine the adequacy and effectiveness of internal controls and payment procedures employed by the grantee in financial management of the grant; and (3) ensure compliance with other provisions of the grant agreement. In short, the review was designed to determine whether PSI and its Indian affiliate were complying with all AID financial management guidelines.

The review found that PSI/I systems and internal controls were "generally sound and in conformity with practice followed by other professional marketing organizations."[2] This indicates that Indian marketing organizations are able to comply with USAID standards. This capacity will be sought in the CSM contractor under the IFPS Project.

IV. Sustainability

Because income and demand for family planning among the majority of the U.P. population are so low, it is anticipated that much of the initial expansion in service provision undertaken in this project will be partially subsidized. Despite low income levels, however, the project design includes major efforts to develop family planning services that will ultimately be fully paid for by users and the government.

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[2] Office of the Controller, USAID/India, "Payment Verification of Population Services International Grant," Financial Review and Analysis Division Internal Review Report #90-2. December 22, 1989.

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Public sector: The Government of Uttar Pradesh recognizes, as many governments in the world have, that when the demand for family planning rises, it may be necessary to test and implement cost recovery programs. The GOI has already introduced cost recovery into its national program through social marketing. During the life of the IFPS Project, the GOUP is expected to undertake efforts to charge fees to higher income clients with the objective of generating program revenues, and shifting higher income clients to the private sector. It is anticipated that improvements in the quality of services offered through the public sector (along with IEC activities) will lead to increased demand and thus open the potential for recovering some costs. In addition, sustainability will be sought through greater government financial commitments to the family welfare program. At present, the state government contributes only a small share of the U.P. family welfare budget. The increase in family planning use envisioned by this project will ultimately require larger investments by both state and central governments.

In addition to cost recovery plans and increased government expenditures, the project will foster financial sustainability in two other ways. First, the anticipated rise in the utilization of public sector services will lower unit costs for family planning through increased public sector efficiency. The assumption here is that lower unit costs will enhance prospects for a sustainable public program by reducing the financial burden on the public budget. Further, the Project and GOUP strategy to shift a large proportion of users to the private sector will also reduce budgetary requirements of the public sector.

Non-Governmental Organizations: NGOs will be supported and strengthened through one of the project's main components. While NGOs rarely operate without subsidies, the NGOs receiving grants and technical assistance through the IFPS Project will be assisted in broadening their base of financial support. This will be achieved by increasing the flow of GOI and GOUP funds to NGOs, and by assisting NGOs to attract additional contributions from the community. In addition, the project will encourage and directly assist NGOs to experiment with and implement cost recovery activities within their programs. By the end of project, then, it is expected that NGO beneficiaries of the IFPS Project will have substantially improved their financial positions and their long-term sustainability by diversifying their sources of income.

Commercial Private Sector: One of the main rationales for expanding family planning services through the private sector is to develop financially sustainable family planning services. All of the proposed project approaches for working with the commercial private sector aim to achieve high levels of cost recovery. Past A.I.D. experience in a other countries and in India has shown that the proposed IFPS approaches can be successful if carefully designed and monitored. In the social marketing component, it is anticipated that consumers will initially pay a part of the total costs, but that by project end, higher demand and higher quality of products will result in a financially self-sustaining social marketing program.

Similarly, private employers may initially receive subsidized inputs such as training and commodities. However, once employers have established family welfare services and recognize their value both from humanitarian and economic perspectives, they will be expected to pay for the services as they already do in many parts of India. Public sector companies and government-sponsored cooperatives will be included in this activity and will also be expected to eventually finance services out of operating expenses.

Finally, the project will mount a major effort to incorporate private medical practitioners into the effort to increase access to and raise demand for family planning services. At present, the large majority of health care expenditures in U.P. occur with private practitioners who represent the principal source of medical care for more than 80 percent of the population. All of this health care is, of course, paid for out-of-pocket by consumers and is by definition financially self-sufficient. The project intends that these private practitioners become major providers of family planning services (mainly supply methods) and information. If successful, thousands of private providers will be prescribing and selling contraceptives by the end of the project.

As the Society becomes well established and begins to demonstrate its prowess in managing resources for family planning service development, one can reasonably expect that the GOI, the GOUP, and other donors will become interested in utilizing this channel. It is therefore likely that the Society will survive even after the termination of A.I.D. assistance.

The above assessments of financial sustainability are dependent on assumptions about rising demand for family planning services, and the long-term commitment to the family welfare program by the state government of U.P. The project contains several activities specifically designed to raise demand for services, along with a policy component which will continually raise awareness about the value of project activities.

ANNEX III.C.

TABLE A: SUMMARY COST ESTIMATE AND FINANCIAL PLAN (USAID/DELHI, AID/W AND HOST COUNTRY CONTRIBUTIONS)

ELEMENTS	FX	L/C	TOTAL
Contraceptives and Equipment	34,305	0	34,305
Management and Technical Assistance	52,225	233,920	286,145
Evaluations and Audits (A.I.D.)	450	500	950
Contingency and Inflation @ 5%	3,600	0	3,600
SUBTOTAL	**90,580**	**234,420**	**325,000**
Host Country Contribution (* = in kind)	0	400,000	400,000
TOTAL	**90,580**	**634,420**	**725,000**

(Budget detail is provided in Table 1)

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ANNEX III.C.

TABLE B: SUMMARY COST ESTIMATE AND FINANCIAL PLAN (USAID/Delhi ONLY)

ELEMENTS	FX	LC	TOTAL
Contraceptives and Equipment	0	0	0
Management and Technical Assistance	0	220,450	220,450
Evaluations and Audits	450	500	950
Contingency and Inflation @ 5%	3,600	0	3,600
TOTAL	**4,050**	**220,950**	**225,000**

(Budget detail is provided in Table 1, IFPS Project Budget Summary, Years 1-10).

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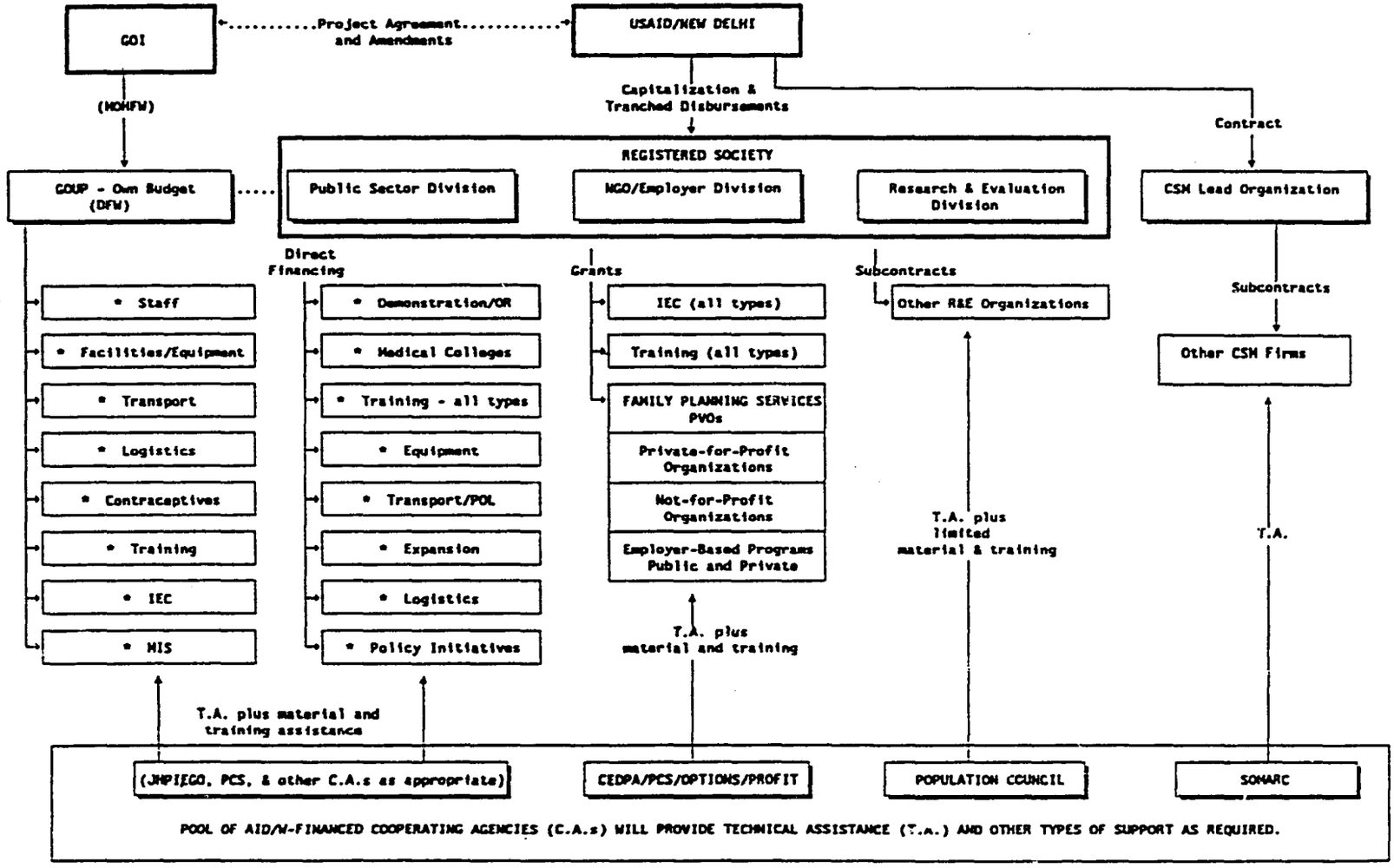
TABLE C: MODE OF PAYMENT FOR IFPS PROJECT

IMPLEMENTING AGENCY	MODE OF PAYMENT
Government of U.P.	Direct payments from the Society (capitalized by USAID/Delhi)
Society	Enabling grants (tranched PBD)
NGOs	Grants from the Soceity
CSM	Contract with USAID/Delhi
Lead R&E organization	Society Contract

NOTE: Additional inputs of technical assistance will be provided through centrally-funded (contracted) projects; contraceptive commodities and equipment will be provided directly by AID/W.

FIGURE 20

IFPS PROJECT: FINANCING ARRANGEMENTS FOR ALL PROJECT ELEMENTS
(INCLUDING GOI/GOUP CONTRIBUTION)



MOHFW = Min. of Health and Family Welfare GOI = Govt. of India GOUP = Govt. of Uttar Pradesh OR = Operations Research DFW = Dir. of Family Welfare

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INTRODUCTION

PLEASE READ THIS FIRST!!!

IFPS is a complex and ambitious undertaking. Part of its complexity derives from the involvement of numerous Cooperating Agencies (C.A.s) financed directly by AID/Washington, not by USAID/Delhi.

The attached tables show cost estimates by each participating C.A. and by AID/W for direct costs such as contraceptives and medical equipment. TO UNDERSTAND THESE TABLES, TWO THINGS ARE REQUIRED:

(1) understand that each AID/W table is paired with a USAID/Delhi table, i.e., the JHPIEGO C.A. table should be read in conjunction with the USAID/Delhi Clinical Training table, and the CEDPA C.A. table should be read in conjunction with the USAID Private Sector table (dotted lines).

(2) the attached budget organization chart should be studied carefully to see how the individual tables are grouped under each of the two subtotal tables (AID/W and USAID/Delhi), which lead to the grand total tables (Tables 1, 2, and 3).

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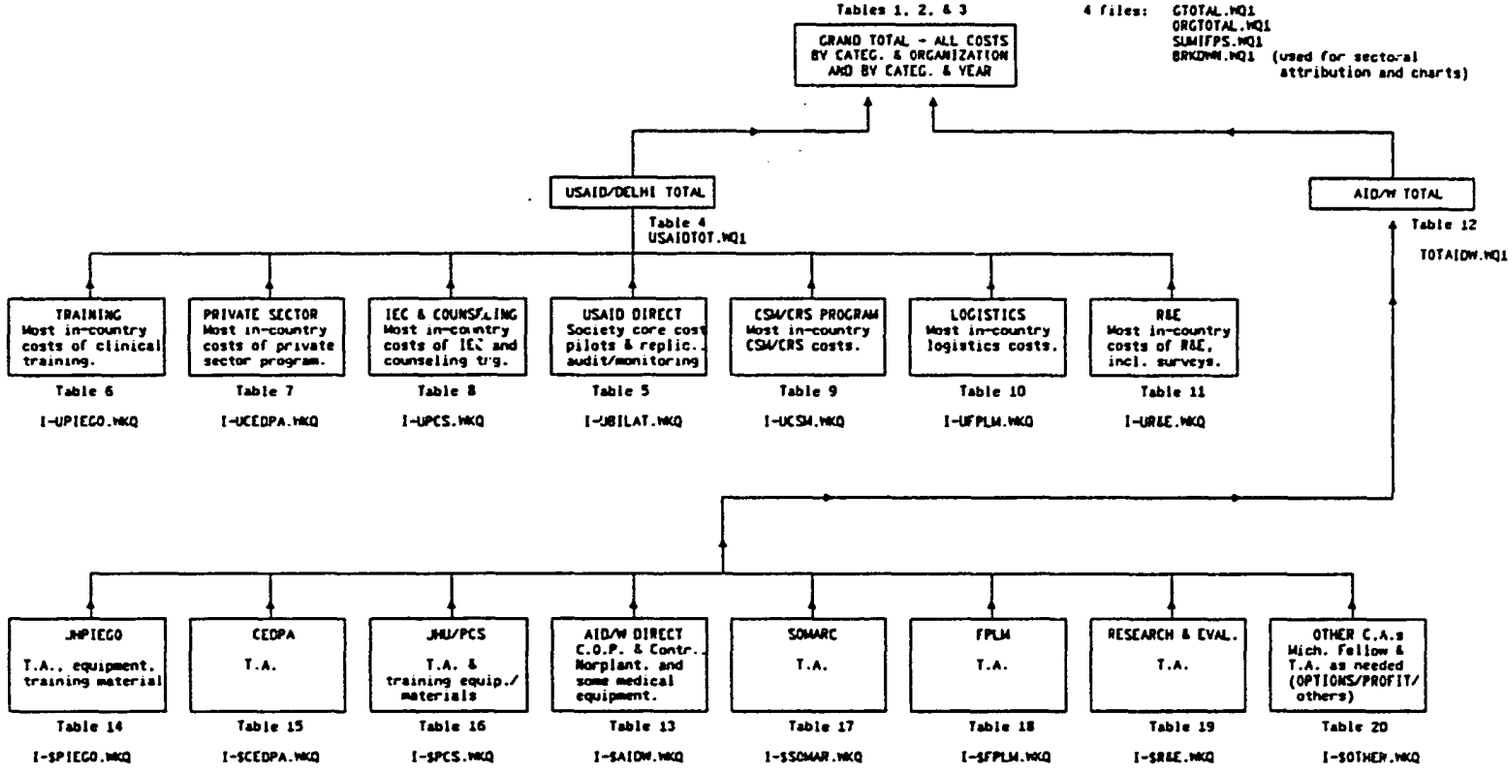
IFPS FINANCIAL PLAN: ORGANIZATION OF BUDGET TABLES



SUMMARY BY MAJOR CATEGORY ONLY

IFPS PROJECT BUDGET SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000s)
	1	2	3	4	5	6	7	8	9	10	
A. U.S. DOLLAR COSTS											
U.S. Personnel and Administration	3,416	3,871	3,932	3,611	2,898	2,460	2,449	2,407	2,384	2,290	29,718
Contraceptives (U.S. Source)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
Other Commodities (U.S. Source)	593	282	1,105	1,299	1,314	1,479	1,364	1,379	1,429	461	10,705
Participant (International) Training	280	780	636	573	412	394	385	352	289	296	4,397
Other Direct and Indirect Costs	2,257	2,251	2,456	2,310	1,763	1,398	1,398	1,425	1,455	1,396	18,110
Evaluation and Audit*	0	0	0	150	0	0	150	0	0	150	450
Contingency and Inflation (@5%)	0	300	325	350	375	400	425	450	475	500	3,600
SUBTOTAL: U.S. DOLLAR COSTS	7,512	8,536	10,094	9,795	8,613	8,385	8,927	9,248	9,868	9,604	90,580
B. LOCAL COSTS (L/C)	13,895	18,474	17,831	19,441	25,317	24,023	24,335	27,465	27,759	35,882	234,420
GRAND TOTAL DOLLARS + L/C	21,407	27,009	27,924	29,236	33,929	32,408	33,262	36,713	37,627	45,486	325,000

* Dollar costs shown are for evaluation only. Audits are included in local costs.

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IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	993	842	884	798	743	588	615	645	675	587	7,360
U.S. CONSULTANTS (pm)	1,047	1,381	1,367	1,204	886	740	701	620	596	588	9,130
TRAVEL & PERDIEM	903	1,062	1,021	914	622	518	493	475	417	388	6,813
HOME OFFICE STAFF	483	586	660	695	647	614	640	667	696	727	6,415
CONTRACEPTIVES (U.S.)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
MEDICAL EQUIPMENT (U.S.)	0	0	800	1,000	1,050	1,160	1,195	1,245	1,295	345	8,090
OTHER COMMODITIES (U.S.)	593	282	305	299	264	319	169	134	134	116	2,615
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	280	780	636	573	412	394	385	352	289	296	4,397
LOCAL COSTS											
Training/workshops/seminars	515	1,707	1,972	2,280	1,966	2,090	2,015	1,913	1,889	2,028	18,375
Local procurement**	1,268	1,084	1,108	1,102	1,026	970	875	890	888	865	10,076
Local-hire staff (pm)	749	852	860	904	805	802	806	811	815	800	8,204
Local-hire consultants (pm)	395	427	452	452	476	346	361	351	326	322	3,908
Vehicles/maintenance/POL	986	147	153	159	174	230	155	160	165	171	2,498
Institutional grants (program)	2,307	5,093	3,403	4,199	5,478	5,085	4,425	4,717	4,585	4,511	43,803
Pilot FP service grants	2,729	3,581	3,841	2,346	0	0	0	0	0	0	12,497
FP service expansion grants	0	0	0	2,000	6,392	8,706	10,056	13,356	14,434	14,732	69,676
Research/evaluation grants	300	1,125	1,575	1,575	4,575	1,375	1,325	950	650	8,652	22,102
CSH/CRS contracts	4,546	4,358	4,367	4,324	4,325	4,319	4,217	4,217	3,907	3,701	42,281
Audits	50	50	50	50	50	50	50	50	50	50	500
OTHER DIRECT COSTS	1,117	1,108	1,225	1,191	794	561	573	591	611	637	8,409
OTHER INDIRECT COSTS	1,140	1,143	1,231	1,119	969	837	825	834	844	759	9,701
EVALUATION AND AUDIT (A.I.D.)	50	50	50	200	50	50	200	50	50	200	950
CONTINGENCY & INFLATION @ 5%	0	300	325	350	375	400	425	450	475	500	3,600
TOTALS	21,407	27,009	27,924	29,236	33,929	32,408	33,262	36,713	37,627	45,486	325,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	USAID/ DELHI	AID/W DIRECT	C.A. JHPIEGO (Training)	C.A. CEDPA (NGO)	C.A. JHU/PCS (IEC)	C.A. SOMARC (CSM)	C.A. POPCOUNCIL (R&E)	C.A. JSI/FPLM (Logistics)	C.A. OTHERS (Misc)	AID/W TOTAL	GRAND TOTAL
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	2,716	360	1,975	423	0	0	0	1,887	7,360	7,360
U.S. CONSULTANTS (pm)	0	0	1,005	1,004	2,675	1,073	1,710	552	1,111	9,130	9,130
TRAVEL & PERDIEM	0	0	2,397	1,601	970	1,145	0	700	0	6,813	6,813
HOME OFFICE STAFF	0	0	3,692	1,455	850	142	0	276	0	6,415	6,415
CONTRACEPTIVES (U.S.)	0	23,570	30	0	0	0	0	0	0	23,600	23,600
MEDICAL EQUIPMENT (U.S.)	0	7,850	240	0	0	0	0	0	0	8,090	8,090
OTHER COMMODITIES (U.S.)	0	0	481	107	255	0	1,157	95	520	2,615	2,615
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	970	1,258	423	0	315	581	850	4,397	4,397
LOCAL COSTS											
Training/workshops/seminars	16,312	0	958	0	0	280	100	0	725	2,063	18,375
Local procurement**	6,576	0	99	970	11	76	2,018	326	0	3,500	10,076
Local-hire staff (pm)	4,732	0	142	793	920	114	1,100	403	0	3,472	8,204
Local-hire consultants (pm)	250	0	0	18	1,960	404	551	0	725	3,658	3,908
Vehicles/maintenance/POL	2,239	0	17	76	0	6	64	96	0	259	2,498
Institutional grants (program)	43,803	0	0	0	0	0	0	0	0	0	43,803
Pilot FP service grants	12,497	0	0	0	0	0	0	0	0	0	12,497
FP service expansion grants	69,676	0	0	0	0	0	0	0	0	0	69,676
Research/evaluation grants	21,652	0	300	0	0	0	0	0	150	450	22,102
CSM/CRS contracts	42,213	0	0	0	0	68	0	0	0	68	42,281
Audits	500	0	0	0	0	0	0	0	0	0	500
OTHER DIRECT COSTS	0	1,810	1,334	1,391	1,043	950	0	623	1,258	8,409	8,409
OTHER INDIRECT COSTS	0	0	2,390	4,084	2,660	278	0	289	0	9,701	9,701
EVALUATION AND AUDIT (A.I.D.)	950	0	0	0	0	0	0	0	0	0	950
CONTINGENCY & INFLATION @ 5%	3,600	0	0	0	0	0	0	0	0	0	3,600
TOTALS	225,000	35,946	14,415	14,732	12,190	4,536	7,015	3,941	7,225	100,000	325,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

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IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS											
Training/workshops/seminars	255	884	1,802	2,130	1,816	1,990	1,890	1,798	1,804	1,943	16,312
Local procurement**	658	730	730	738	722	676	580	582	580	580	6,576
Local-hire staff (pm)	169	493	493	511	511	511	511	511	511	511	4,732
Local-hire consultants (pm)	25	25	25	25	25	25	25	25	25	25	250
Vehicles/maintenance/POL	886	120	124	129	162	218	142	147	152	159	2,239
Institutional grants (program)	2,307	5,093	3,403	4,199	5,478	5,085	4,425	4,717	4,585	4,511	43,803
Pilot FP service grants	2,729	3,581	3,841	2,346	0	0	0	0	0	0	12,497
FP service expansion grants	0	0	0	2,000	6,392	8,706	10,056	13,356	14,434	14,732	69,676
Research/evaluation grants	300	800	1,550	1,550	4,550	1,350	1,300	950	650	8,652	21,652
CSM/CRS contracts	4,490	4,352	4,361	4,324	4,325	4,319	4,217	4,217	3,907	3,701	42,213
Audits	50	50	50	50	50	50	50	50	50	50	500
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)***	50	50	50	200	50	50	200	50	50	200	950
CONTINGENCY & INFLATION @ 5%	0	300	325	350	375	400	425	450	475	500	3,600
TOTALS	11,919	16,478	16,754	18,552	24,456	23,380	23,821	26,853	27,223	35,564	225,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

*** includes U.S. dollar costs (for evaluation) and local currency costs for audits

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USAID/DELHI DIRECT COSTS FOR:

. Core Funding .
. Public Sector FP Pilots & Expansion
. AID Evaluation & Audit
. Contingency & Inflation

YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (salary plus fringe)											0
U.S. CONSULTANTS (pm)											0
TRAVEL & PERDIEM											0
HOME OFFICE STAFF											0
CONTRACEPTIVES (U.S.)											0
MEDICAL EQUIPMENT (U.S.)											0
OTHER COMMODITIES (U.S.)											0
VEHICLES (U.S.)											0
PARTICIPANT TRAINING (pm)*											0
LOCAL COSTS											
Training/workshops/seminars											0
Local procurement**											0
Local-hire staff (pm)											0
Local-hire consultants (pm)											0
Vehicles/maintenance/POL											0
Institutional grants (program)***	1,254	909	904	954	954	1,104	904	904	904	904	9,695
Pilot FP service grants	1,000	2,000	2,000								5,000
FP service expansion grants				2,000	3,000	4,000	5,000	7,000	7,953	8,000	36,953
Research/evaluation grants											0
CSM/CRS contracts											0
Audits	50	50	50	50	50	50	50	50	50	50	500
OTHER DIRECT COSTS											0
OTHER INDIRECT COSTS											0
EVALUATION AND AUDIT (A.I.D.)****	50	50	50	200	50	50	200	50	50	200	950
CONTINGENCY & INFLATION @ 5%		300	325	350	375	400	425	450	475	500	3,600
TOTALS	2,354	3,309	3,329	3,554	4,429	5,604	6,579	8,454	9,432	9,654	56,698

* includes long-term, short-term, study tours ** includes office rental, equipment, maintenance, utilities, other commodities

*** SIFPSA Core Funding ($1 million per year) plus Other C.A.-related activities (e.g., policy)

**** Includes U.S. Dollar costs for evaluation and local currency costs for audits.

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE COSTS	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS											
Training/workshops/seminars	0	242	1,130	1,265	957	1,004	903	834	840	804	7,979
Local procurement**	0	203	203	211	195	72	53	55	53	53	1,098
Local-hire staff (pm)	0	324	324	342	342	342	342	342	342	342	3,042
Local-hire consultants (pm)	0	0	0	0	0	0	0	0	0	0	0
Vehicles/maintenance/POL	0	2	2	2	10	12	2	2	2	2	36
Institutional grants (program)	0	350	780	1,100	1,165	1,242	1,292	1,294	1,349	1,407	9,979
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	250	700	600	600	400	150	0	0	0	2,700
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	0	1,371	3,139	3,520	3,269	3,072	2,742	2,527	2,586	2,608	24,834

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS											
Training/workshops/seminars	0	0	0	0	0	0	0	0	0	0	0
Local procurement**	0	0	0	0	0	0	0	0	0	0	0
Local-hire staff (pm)	0	0	0	0	0	0	0	0	0	0	0
Local-hire consultants (pm)	0	0	0	0	0	0	0	0	0	0	0
Vehicles/maintenance/POL	0	0	0	0	0	0	0	0	0	0	0
Institutional grants (program)	300	400	500	700	800	900	1,000	1,000	1,000	900	7,500
Pilot FP service grants	1,729	1,581	1,841	2,346	0	0	0	0	0	0	7,497
FP service expansion grants	0	0	0	0	3,392	4,706	5,056	6,356	6,481	6,732	32,723
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	2,029	1,981	2,341	3,046	4,192	5,606	6,056	7,356	7,481	7,632	47,720

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS											
Training/workshops/seminars	240	465	495	516	510	465	465	270	270	273	3,969
Local procurement**	10	0	0	0	0	10	0	0	0	0	20
Local-hire staff (pm)	0	0	0	0	0	0	0	0	0	0	0
Local-hire consultants (pm)	0	0	0	0	0	0	0	0	0	0	0
Vehicles/maintenance/POL	205	25	25	25	25	25	25	25	25	25	430
Institutional grants (program)	703	3,374	1,144	1,370	2,484	1,764	1,154	1,444	1,272	1,242	15,951
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	1,158	3,864	1,664	1,911	3,019	2,264	1,644	1,739	1,567	1,540	20,370

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS	0	0	0	0	0	0	0	0	0	0	0
Training/workshops/seminars	0	0	0	0	0	0	0	0	0	0	0
Local procurement**	0	0	0	0	0	0	0	0	0	0	0
Local-hire staff (pm)	0	0	0	0	0	0	0	0	0	0	0
Local-hire consultants (pm)	0	0	0	0	0	0	0	0	0	0	0
Vehicles/maintenance/POL	0	0	0	0	0	0	0	0	0	0	0
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	4,490	4,352	4,361	4,324	4,325	4,319	4,217	4,217	3,907	3,701	42,213
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	4,490	4,352	4,361	4,324	4,325	4,319	4,217	4,217	3,907	3,701	42,213

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	0	0	0	0	0	0	0	0	0	0	0
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS	0	0	0	0	0	0	0	0	0	0	
Training/workshops/seminars	15	177	177	349	349	521	522	694	694	866	4,364
Local procurement**	648	527	527	527	527	594	527	527	527	527	5,458
Local-hire staff (pm)	169	169	169	169	169	169	169	169	169	169	1,690
Local-hire consultants (pm)	25	25	25	25	25	25	25	25	25	25	250
Vehicles/maintenance/POL	681	93	97	102	127	181	115	120	125	132	1,773
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	1,538	991	995	1,172	1,197	1,490	1,358	1,535	1,540	1,719	13,535

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm)											0
(salary plus fringe)											
U.S. CONSULTANTS (pm)											0
TRAVEL & PERDIEM											0
HOME OFFICE STAFF											0
CONTRACEPTIVES (U.S.)											0
MEDICAL EQUIPMENT (U.S.)											0
OTHER COMMODITIES (U.S.)											0
VEHICLES (U.S.)											0
PARTICIPANT TRAINING (pm)*											0
LOCAL COSTS											
Training/workshops/seminars											0
Local procurement**											0
Local-hire staff (pm)											0
Local-hire consultants (pm)											0
Vehicles/maintenance/POL											0
Institutional grants (program)	50	60	75	75	75	75	75	75	60	58	678
Pilot FP service grants											0
FP service expansion grants											0
Research/evaluation grants	300	550	850	950	3,950	950	1,150	950	650	8,652	18,952
CSM/CRS contracts											0
Audits											0
OTHER DIRECT COSTS											0
OTHER INDIRECT COSTS											0
EVALUATION AND AUDIT (A.I.D.)											0
CONTINGENCY & INFLATION @ 5%											0
TOTALS	350	610	925	1,025	4,025	1,025	1,225	1,025	710	8,710	19,630

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	983	842	884	798	743	588	615	645	675	587	7,360
U.S. CONSULTANTS (pm)	1,047	1,381	1,367	1,204	886	740	701	620	596	588	9,130
TRAVEL & PERDIEM	903	1,062	1,021	914	622	518	493	475	417	388	6,813
HOME OFFICE STAFF	483	586	660	695	647	614	640	667	696	727	6,415
CONTRACEPTIVES (U.S.)	966	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,600
MEDICAL EQUIPMENT (U.S.)	0	0	800	1,000	1,050	1,160	1,195	1,245	1,295	345	8,090
OTHER COMMODITIES (U.S.)	593	282	305	299	264	319	169	134	134	116	2,615
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	280	780	636	573	412	394	385	352	289	296	4,397
LOCAL COSTS											
Training/workshops/seminars	260	823	170	150	150	100	125	115	85	85	2,063
Local procurement**	610	354	378	364	304	294	295	308	308	285	3,500
Local-hire staff (pm)	580	359	367	393	294	291	295	300	304	289	3,472
Local-hire consultants (pm)	370	402	427	427	451	321	336	326	301	297	3,658
Vehicles/maintenance/POL	100	27	29	30	12	12	13	13	13	12	259
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	325	25	25	25	25	25	0	0	0	450
CSM/CRS contracts	56	6	6	0	0	0	0	0	0	0	68
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	1,117	1,108	1,225	1,191	794	561	573	591	611	637	8,409
OTHER INDIRECT COSTS	1,140	1,143	1,231	1,119	969	837	825	834	844	759	9,701
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	9,488	10,531	11,170	10,684	9,473	9,028	9,441	9,860	10,404	9,922	100,000

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (180 pm)*** (salary plus fringe)	300	315	331	347	365	191	201	211	222	233	2,716
U.S. CONSULTANTS (pm)											0
TRAVEL & PERDIEM											0
HOME OFFICE STAFF											0
CONTRACEPTIVES (U.S.)	936	1,052	1,640	1,502	1,851	2,254	2,756	3,234	3,835	4,510	23,570
MEDICAL EQUIPMENT (U.S.)			800	1,000	1,050	1,100	1,150	1,200	1,250	300	7,850
OTHER COMMODITIES (U.S.)											0
VEHICLES (U.S.)											0
PARTICIPANT TRAINING (pm)*											0
LOCAL COSTS											
Training/workshops/seminars											0
Local procurement**											0
Local-hire staff (pm)											0
Local-hire consultants (pm)											0
Vehicles/maintenance/POL											0
Institutional grants (program)											0
Pilot FP service grants											0
FP service expansion grants											0
Research/evaluation grants											0
CSM/CRS contracts											0
Audits											0
OTHER DIRECT COSTS	200	210	221	232	243	128	134	141	148	155	1,810
OTHER INDIRECT COSTS											0
EVALUATION AND AUDIT (A.I.D.)											0
CONTINGENCY & INFLATION @ 5%											0
TOTALS	1,436	1,577	2,991	3,081	3,509	3,673	4,241	4,786	5,454	5,198	35,946

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

*** contract Chief-of-Party for Lucknow Liaison Office + contracting officer for 5 years USAID Contracts Office

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IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	98	83	87	92	0	0	0	0	0	0	360
U.S. CONSULTANTS (pm)	28	196	200	170	139	106	72	37	34	23	1,005
TRAVEL & PERDIEM	189	364	380	385	280	220	203	177	117	82	2,397
HOME OFFICE STAFF	179	270	340	357	374	393	413	433	455	478	3,692
CONTRACEPTIVES (U.S.)	30	0	0	0	0	0	0	0	0	0	30
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	60	45	45	45	45	240
OTHER COMMODITIES (U.S.)	6	91	96	100	100	88	0	0	0	0	481
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	250	200	150	100	100	100	70	0	0	970
LOCAL COSTS											
Training/workshops/seminars	165	703	25	15	15	15	15	5	0	0	958
Local procurement**	99	0	0	0	0	0	0	0	0	0	99
Local-hire staff (pm)	142	0	0	0	0	0	0	0	0	0	142
Local-hire consultants (pm)	0	0	0	0	0	0	0	0	0	0	0
Vehicles/maintenance/POL	17	0	0	0	0	0	0	0	0	0	17
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	300	0	0	0	0	0	0	0	0	300
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	104	252	343	329	151	31	31	31	31	31	1,334
OTHER INDIRECT COSTS	151	335	412	358	261	210	180	170	159	154	2,390
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	1,208	2,844	2,083	1,956	1,420	1,223	1,059	968	841	813	14,415

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	364	215	230	155	166	175	183	193	202	92	1,975
U.S. CONSULTANTS (pm)	136	133	126	126	110	74	69	73	77	80	1,004
TRAVEL & PERDIEM	180	169	166	175	171	148	140	147	149	156	1,601
HOME OFFICE STAFF	141	150	150	165	173	122	128	135	142	149	1,455
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	107	0	0	0	0	0	0	0	0	0	107
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	100	105	110	116	121	128	134	141	148	155	1,258
LOCAL COSTS											
Training/workshops/seminars	0	0	0	0	0	0	0	0	0	0	0
Local procurement**	146	76	82	86	90	94	95	108	108	85	970
Local-hire staff (pm)	111	49	52	74	77	81	85	90	94	80	793
Local-hire consultants (pm)	18	0	0	0	0	0	0	0	0	0	18
Vehicles/maintenance/POL	29	4	5	5	5	5	6	6	6	5	76
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSH/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	255	170	146	129	112	109	108	113	119	130	1,391
OTHER INDIRECT COSTS	558	396	413	398	420	362	380	399	419	339	4,084
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	2,145	1,467	1,480	1,429	1,445	1,298	1,328	1,405	1,464	1,271	14,732

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	71	71	71	30	30	30	30	30	30	30	423
U.S. CONSULTANTS (pm)	276	276	276	276	276	259	259	259	259	259	2,675
TRAVEL & PERDIEM	125	125	125	100	100	79	79	79	79	79	970
HOME OFFICE STAFF	85	85	85	85	85	85	85	85	85	85	850
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	45	31	14	14	14	81	14	14	14	14	255
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	50	45	41	41	41	41	41	41	41	41	423
LOCAL COSTS											
Training/workshops/seminars	0	0	0	0	0	0	0	0	0	0	0
Local procurement**	11	0	0	0	0	0	0	0	0	0	11
Local-hire staff (pm)	92	92	92	92	92	92	92	92	92	92	920
Local-hire consultants (pm)	196	196	196	196	196	196	196	196	196	196	1,960
Vehicles/maintenance/POL	0	0	0	0	0	0	0	0	0	0	0
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	150	108	148	91	91	91	91	91	91	91	1,043
OTHER INDIRECT COSTS	302	286	298	262	262	250	250	250	250	250	2,660
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	1,403	1,315	1,346	1,187	1,187	1,204	1,137	1,137	1,137	1,137	12,190

* includes long-term, short-term, study tours

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	193	185	137	103	75	76	76	76	76	76	1,073
TRAVEL & PERDIEM	233	213	186	85	71	71	71	72	72	71	1,145
HOME OFFICE STAFF	14	14	14	14	15	14	14	14	14	15	142
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	0	0	0	0	0	0	0	0	0	0
LOCAL COSTS											
Training/workshops/seminars	60	60	60	50	50	0	0	0	0	0	280
Local procurement**	23	13	13	13	14	0	0	0	0	0	76
Local-hire staff (pm)	15	15	15	15	15	8	8	8	8	7	114
Local-hire consultants (pm)	81	81	81	81	80	0	0	0	0	0	404
Vehicles/maintenance/POL	4	1	1	1	1	0	0	0	0	0	6
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	56	6	6	0	0	0	0	0	0	0	68
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	125	125	125	125	75	75	75	75	75	75	950
OTHER INDIRECT COSTS	52	48	43	32	26	15	15	15	16	16	278
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	856	761	681	519	422	259	259	260	261	260	4,536

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	114	191	128	119	0	0	0	0	0	0	552
TRAVEL & PERDIEM	176	191	164	169	0	0	0	0	0	0	700
HOME OFFICE STAFF	64	67	71	74	0	0	0	0	0	0	276
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	50	15	15	15	0	0	0	0	0	0	95
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	100	255	110	116	0	0	0	0	0	0	581
LOCAL COSTS	0	0	0	0	0	0	0	0	0	0	
Training/workshops/seminars	0	0	0	0	0	0	0	0	0	0	0
Local procurement**	131	65	65	65	0	0	0	0	0	0	326
Local-hire staff (pm)	110	93	98	102	0	0	0	0	0	0	403
Local-hire consultants (pm)	0	0	0	0	0	0	0	0	0	0	0
Vehicles/maintenance/POL	45	16	17	18	0	0	0	0	0	0	96
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	183	138	132	170	0	0	0	0	0	0	623
OTHER INDIRECT COSTS	77	78	65	69	0	0	0	0	0	0	289
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	1,050	1,109	865	917	0	0	0	0	0	0	3,941

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (pm) (salary plus fringe)	0	0	0	0	0	0	0	0	0	0	0
U.S. CONSULTANTS (pm)	100	200	300	285	200	150	150	125	100	100	1,710
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)	75	125	150	150	125	125	125	100	100	82	1,157
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	30	50	100	50	50	25	10	0	0	0	315
LOCAL COSTS	0	0	0	0	0	0	0	0	0	0	
Training/workshops/seminars	10	10	10	10	10	10	10	10	10	10	100
Local procurement**	200	200	218	200	200	200	200	200	200	200	2,018
Local-hire staff (pm)	110	110	110	110	110	110	110	110	110	110	1,100
Local-hire consultants (pm)	50	75	75	75	100	50	40	30	30	26	551
Vehicles/maintenance/POL	5	6	6	6	6	7	7	7	7	7	64
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	0	0	0	0	0	0	0	0	0	0
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	580	776	969	886	801	677	652	582	557	535	7,015

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

IFPS PROJECT BUDGET - SUMMARY (in U.S. $000s)
YEARS 1 THROUGH 10

	PROJECT YEAR										ALL YEARS ($000S)
	1	2	3	4	5	6	7	8	9	10	
U.S. LONG-TERM PERSONNEL (120 pm)*** (salary plus fringe)	150	158	165	174	182	191	201	211	222	233	1,887
U.S. CONSULTANTS (pm)*****	200	200	200	125	86	75	75	50	50	50	1,111
TRAVEL & PERDIEM	0	0	0	0	0	0	0	0	0	0	0
HOME OFFICE STAFF	0	0	0	0	0	0	0	0	0	0	0
CONTRACEPTIVES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
MEDICAL EQUIPMENT (U.S.)	0	0	0	0	0	0	0	0	0	0	0
OTHER COMMODITIES (U.S.)****	310	20	30	20	25	25	30	20	20	20	520
VEHICLES (U.S.)	0	0	0	0	0	0	0	0	0	0	0
PARTICIPANT TRAINING (pm)*	0	75	75	100	100	100	100	100	100	100	850
LOCAL COSTS											
Training/workshops/seminars	25	50	75	75	75	75	100	100	75	75	725
Local procurement**	0	0	0	0	0	0	0	0	0	0	0
Local-hire staff (pm)	0	0	0	0	0	0	0	0	0	0	0
Local-hire consultants (pm)	25	50	75	75	75	75	100	100	75	75	725
Vehicles/maintenance/POL	0	0	0	0	0	0	0	0	0	0	0
Institutional grants (program)	0	0	0	0	0	0	0	0	0	0	0
Pilot FP service grants	0	0	0	0	0	0	0	0	0	0	0
FP service expansion grants	0	0	0	0	0	0	0	0	0	0	0
Research/evaluation grants	0	25	25	25	25	25	25	0	0	0	150
CSM/CRS contracts	0	0	0	0	0	0	0	0	0	0	0
Audits	0	0	0	0	0	0	0	0	0	0	0
OTHER DIRECT COSTS	100	105	110	116	122	128	134	141	148	155	1,258
OTHER INDIRECT COSTS	0	0	0	0	0	0	0	0	0	0	0
EVALUATION AND AUDIT (A.I.D.)	0	0	0	0	0	0	0	0	0	0	0
CONTINGENCY & INFLATION @ 5%	0	0	0	0	0	0	0	0	0	0	0
TOTALS	810	683	756	709	690	694	765	722	689	708	7,225

* includes long-term, short-term, study tours

** includes office rental, equipment, maintenance, utilities, other commodities

*** Michigan Fellow (for Research & Evaluation Mgt.)

**** includes $300 thousand in computers & info tech equipment in year 1

***** includes $350 T.A. info technology in years 1-4

ANNEX III.D. SOCIAL SOUNDNESS AND GENDER ANALYSES

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ANNEX III.D. SOCIAL SOUNDNESS AND GENDER ANALYSES

1. SOCIO-CULTURAL CONTEXT OF UTTAR PRADESH

1.1 General Information

1.1.1 Population Size and Composition

The March 1991 census population count for U.P. was 138.76 million. In March 1992 the population would be expected to be about 142 million; and if the state's 1981-91 decennial growth rate were maintained over the next decade, its population in 2001 would be about 174 million.

Over five million births occur every year in U.P. With the state's high infant and child mortality rates, only about four million survive beyond their fifth birthdays. However, like India, U.P. typically has a young population. The 1981 Census found about 13.5 per cent of the population was under the age of 5 years, and almost 28.3 per cent between 5 and 14 years. The size of the first age-group, amounting to about 19 million today, has implications for the quantum of child health services that a state such as U.P. must have available, while that of the second, approximating 40 million, has a bearing on educational services required. This young population is both the effect of the state's high birth rate (37.0 per 1000 population in 1989, which is markedly higher than India's overall birth rate of 30.5) and will be a cause of continued high growth in the future. In the year 2000 there will be over 47 million people between the ages of 15 and 29 years in U.P. The state has a considerably higher dependency ratio (946) than the rest of India (854).[1]

There are currently about 66.5 million females in U.P. Of these, about 24 million are between the ages of 15 and 45 years, ie. of 'reproductive age.' This is also, therefore, almost the number of couples 'eligible' for family planning services as almost all women in this age range are married.

About 15.9 per cent of the state's 1981 population were Muslims, and about 21.4 per cent belonged to Scheduled Castes and Tribes.[2] In general, these groups suffer disadvantages which decrease their access to social services and economic opportunities. In 1991, 80.1 per cent of the state's population was rural, and only 19.9 urban (about 28 million people). Thus, U.P. is considerably less urban than most of the other major states of India and the country as a whole (25.7 per cent). Nevertheless, the urban population is distributed in 753 towns and cities. The rural population is dispersed over more than 112,000 villages, with 47 per cent living in villages of less than 500 people and 74 per cent in villages with less than 1000

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[1]. The dependency ratio is the number of 0-14 year olds plus over-60 year-olds per 1000 people in the 15-59 year age-group.

[2]. 1991 Census figures are not yet available for these groups.

people. These figures indicate the wide net that must be cast to reach the people of U.P. with services whether in rural or urban areas.

U.P. contains one-sixth of India's total population. Its population density is 75 percent higher than that of the country overall (471 compared with 267 people per square kilometre). As noted above it has a considerably higher birth rate and total fertility rate. It also has higher death and infant mortality rates (12.6 and 118, respectively in contrast to India's 10.2 and 91), but despite these it experienced faster growth in the 1981-91 decade (25.2 per cent compared with 23.5 per cent). U.P. has a lower sex ratio and lower female and male literacy rates than India as a whole. In 1984, 45.3 per cent of people in U.P. were estimated to be 'below the poverty line.' U.P's overall official couple protection rate of 35.5 in 1991 is lower than the Indian average (41.3, 1990).

1.1.2 Administrative and Geo-Cultural Divisions

The basic unit of public administration in U.P. as elsewhere in India is the district, of which there are 63 in the state. The average population of a district in U.P. is 2.2 million. For administrative purposes, these districts are grouped into 13 administrative divisions (with between three and seven districts each) and five geo-cultural regions, namely

(1) the Hill region, containing 8 districts and 4.2 per cent of the states' population;
(2) the Western region: 21 districts, 35.6 per cent;
(3) the Central region: 10 districts, 17.4 per cent;
(4) the Bundhelkand (south-central) region: 5 districts, 4.8 per cent;
(5) the Eastern region: 19 districts, 38.1 per cent.

These regions are significant largely for their geographical and cultural parameters which have implications for infrastructure and for family planning service delivery. Some statistical parameters describing the different regions are shown in Table 1. The hill region containing less than 6 million people is characterised by a low population density, dispersed across difficult terrain. Difficulties of access have meant that facilities such as hospitals, schools and roads have had to be provided, resulting in relatively high facility:population ratios (not shown in the table). There is a low percentage of Muslims and Scheduled Castes in this population, but a high percentage of hill tribals. A relatively high sex ratio attests to better female status than elsewhere in U.P., largely because women are central to hill agriculture, but this is also related to a high out-migration rate among males. Higher female status is also shown by the higher than average female literacy rate.

Table 1
Demographic and Socio-Economic Characteristics of U.P. Regions

	U.P.	Hill	West	Central	Bundhel	East
POP	138.8	5.88	49.38	24.20	6.72	52.88
ARE	294.4	51.1	82.2	45.9	29.4	85.8
DEN	471	115	601	527	229	613
URB	17.9	19.5	23.3	18.6	19.9	11.9
DGR	25.2	21.7	25.5	23.5	23.7	26.2
MUS	15.9	3.2	21.0	14.6	6.1	12.8
SCT	21.4	19.4	8.5	26.8	25.7	21.1
PCI	1114	1378	1365	1012	1321	905
FMR	882	974	844	856	847	925
FLT	20.9	35.7	21.7	24.1	19.5	17.5
IMR	130	90	129	132	119	122
TFR	4.5	4.2	4.9	4.2	5.0	4.2
STX	19.9	27.1	18.0	20.3	23.9	17.8
SPA	15.0	13.2	14.3	14.0	16.1	12.0

Key: POP=1991 Population, ARE=Area, DEN=1991 Population Density, URB=1981 Urban Percent of Total Population, DGR=Decadal Growth Rate 1981-91, MUS=1981 Muslim Percent of Total Population, SCT=1981 Scheduled Castes and Tribes Percent of Total Population, PCI=1986-87 Per capita Income in Rupees, FMR=1991 Female: Male Sex Ratio, FLT=1991 Percent of Females Literate, IMR=1981 Infant Mortality Rate, TFR=1981 Total Fertility Rate, STX=1990 Percent of Eligible Couples who have been Sterilised, SPA=1990 Percent of Eligible Couples who have adopted Spacing Methods of Contraception.

Out-migration also partially explains the low decennial growth rate of the hill population. The total fertility rate is lower than the U.P. average, and family planning acceptance, particularly sterilisation (probably female sterilisation), slightly higher.

The general population profile of Bundhelkhand is similar to that of the hill region, but problems of access and infrastructural under-development abound in this area because of its thick forests. Its status of women and infant mortality indicators are poor. Fertility is high although the official couple protection rate is 40 per cent.

U.P.'s western and eastern regions accomodate roughly 50 million people each at densities over 600 per square kilometre. Both have experienced high decennial growth rates. While in the west the high level of urbanisation (drawing in migrants) and higher-than-average TFR have together contributed to this, in the east a lower TFR has been offset by in-migration (eg. from Bihar and Nepal). A very low percentage of the population in the east is urban, while a high percentage belongs to minority and Scheduled Caste and Tribe groups. With a low economic base, the East demonstrates the lowest per capita income level of all the state's regions. The FMR in the East is surprisingly high - perhaps because women enjoy a more egalitarian status among tribal populations. However, the low female literacy and high infant mortality are testimony to the general under-development of this area. Family planning acceptance has also been the lowest in the state. The low sex ratio, low female literacy, high infant mortality and high TFR of the western region (despite higher urbanisation and per capita income) suggest considerable inequalities in this population and, in particular, the persistence of traditional attitudes towards women and child-bearing. While a high proportion of the population is Muslim, this proportion is not sufficient to explain the high TFR etc., demonstrating that the unfavourable circumstances apply to a much larger population.

The central region contains about a quarter of U.P's population, with a density, social, gender and rural:urban composition, vital rates and economic level similar to that of the state as a whole. Indeed, the central region most closely resembles U.P., and is also its political 'centre,' including its capital, Lucknow, and the state's largest and most industrialised city, Kanpur, which also has a high proportion of urban poor.

While these regions are important geo-cultural entities, it must be recognised that when the districts within them are examined by the above indicators, there is a wide range within each region, and thus considerable overlap between the regions. District-level considerations will be discussed below.

1.2 Socio-Economic Situation: Determinants of Fertility

This section will briefly review some indicators of U.P's fertility and the socio-economic factors considered to be determinants of fertility. While fertility indices clearly demonstrate the need for its limitation, the state's overall socio-economic situation indicates the complexity of bringing about changes in fertility.

1.2.1 Fertility

U.P.'s overall Total Fertility Rate is a high 4.5. The hill, central and eastern regions on the whole have a lower TFR than this average (4.2 in all cases) while the western and Bundelkand areas have much higher overall TFRs (4.9 and 5.0 respectively). At the district level, the spread is wide, ranging from about 2.9 in Kanpur Nagar (essentially an urban district) to levels well above 5.0 in eight of the western regions 21 districts. All districts in the Western and Bundelkhand regions have TFRs above 4.0, while in the hill and central

regions 6/8 and 7/10 do, and in the eastern region six out of 15 districts for which data are available do. As one would expect, the urban TFR is lower than the rural - in 1988 these rates were 4.2 and 5.6 respectively. Similarly, the Crude Birth Rates for urban and rural areas were 32.1 and 38.2 respectively (SRS).[3]

Concern with U.P's high fertility is often expressed in terms of the large number of districts that have a crude birth rate (CBR) over 39 per 1000. 32 of U.P's 63 districts fall into this category, accounting for over one-third of 90 such high fertility districts in India. These 32 districts are dispersed throughout the five regions, two falling among the hill regions's eight districts, 16 among the western regions 21 districts, three among the ten central districts, two among Bundhelkand's five, and nine among the 19 eastern districts. While a focus on the high CBR districts could be achieved to large measure by concentrating on the western and eastern regions of the state, coverage of all 32 would require a fair dispersal of activities throughout the state.

The factors and inter-linked 'processes' that determine high fertility are described below.

- A high proportion of the population of the state (and its component districts) remains rural - largely synonymous with 'traditional' and 'poor.' The rural and urban poor continue to favour large families because children are economic assets, contributing to the family economy as well as to parents' social security in old-age. This is particularly so among scheduled castes and poor families, among whom children are regarded as necessary for family economic survival. Children assist their parents from early childhood, and are sent to work as domestic servants or daily labourers as soon as they are old enough. Families habituated to a very low standard of living do not consider that the costs of raising children outweigh the benefits. Landowning families both discourage poor labourer families from practising family planning because of the need for labour, and also fail to practise it themselves.

  Thus, 'ideal family size' remains high. In the Indian context, given exogamous marital patterns, this largely translates into a demand for sons. The desire to have sons is strong even among the highly-educated. Perpetuation of the family lineage, old-age support to parents and performance of religious (particularly funeral) rites are key reasons for the desire for sons. A daughter is also considered essential in the Hindu social system, as kanyadaan, the gift of a daughter in marriage, is considered the greatest gift, achieving great merit. Thus, a couple without son or daughter is considered unfortunate. These deep-rooted socio-religious beliefs appear to be declining only among the very well-to-do, among whom consciousness of the costs of raising children and providing for their futures is increasingly resulting in family

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[3]. These rates are based on data from the Sample Registration Survey which is believed to be more reliable that of the E & I Division, MOHFW, which have been cited above.

limitation after two sons or even after two daughters.

- The status of women is low as a result of the 'preference for sons,' but also emanating from the traditional view of women as 'reproducers' rather than as producers. This results in low value being attached to any investment in girls or women, including education, nutrition and health care, manifest in low female literacy, poor nutrition and health status and higher mortality of women (compared with men) upto the age of 35 years. Women's work is also under-valued at the same time as women undertake a triple burden of domestic work, economic work and child-bearing. The low availability of employment for women and lower wages (than men's) associated with women's work are both causes and effects of this situation.

- The lack of motivation on the part of parents to invest in daughters has 'early marriage' as its corollary - parents want to 'disinvest' in daughters by marrying them off early. Daughters are also considered a bane because of the prevailing practice of dowry, which leads parents to consider them a financial drain. If a girl is not married young the dowry demanded by a prospective groom increases. Delayed marriage also has its risks for a girl's sexual security within the context of a male-dominated ('macho') society. Early marriage inevitably leads to early child-bearing because a primary objective among in-laws is to ensure the family's lineage, placing responsibility on the young bride to prove her fertility.

- The early inception of reproduction among Indian women increases the length of the effective reproductive span. Along with the high demand for children, this brings about high fertility, also because births are closely spaced. Although breast-feeding is almost universal among mothers, particularly in rural areas, it does not serve to increase the intra-partum period to effect any significant 'control' on fertility.

- The poor access of women to nutrition and health care and their lack of education and economic opportunities, coupled with their early, rapid and frequent pregnancies result in high infant mortality, another determinant of high fertility. The risks of infant death and maternal death are especially high among primiparous, young (largely 'adolescent') mothers. Female infants are especially susceptible because of their 'unwanted' status.

- The primacy of women's reproductive role and their low economic independence lead to their low power to make or influence decisions regarding the bearing and nurturing of children. This translates into a low ability to seek out family planning services except where they receive the support of husbands or mothers-in-law or, increasingly, of other women through women's organisations.

- Women's poor social and economic access to health services is accentuated by poor physical access in rural areas where health centres may be far away and require considerable time to reach, expenditure, and waits to be served. The attitudes of service providers may increase 'social' distance. While this is generally applicable to

public health services, private services abound in most villages and towns. However, a 'segmented market' exists in private health care - with the poor largely being at the mercy of traditional practitioners and modern health care being available only to the better off. Generally, the private sector provides little education and motivation or services for fertility regulation, with the exception of abortion.

- Indeed, abortion is a major way in which women limit the number of their births. An estimated 5 million abortions take place in India annually of which only 20 per cent are performed in legally-licensed facilities. The 'illegal' abortions are unhygienic and endanger the lives of women.

- In addition to having inadequate coverage in rural areas, the public health and family welfare service system has emphasized terminal methods of contraception in its service delivery, thereby not addressing itself to younger and lower parity groups for whom spacing methods are more appropriate. Family planning education, especially about birth spacing and its benefits and technologies, has been poor.

- Societal norms as well as programme factors have influenced people's perceptions about family planning and thereby its acceptability. Surveys and small-scale studies in U.P. and elsewhere have revealed a large number of reasons for the non-acceptance of 'formal' family planning methods. In addition to the demand for children described above, and the consequences of low female status, there are other factors that constrain demand for family planning. These include societal 'beliefs' such as:

  -- A fear of being outnumbered. Hindus feel that they should not accept family planning as the Muslim population is increasing. This feeling is strong among fundamentalist groups and even among highly-educated urban Hindus. Higher caste Hindus feel that Scheduled Castes, Scheduled Tribes and Other Backward Castes also are not adopting family planning, and so will outnumber caste Hindus in time. Conversely, the scheduled and other backward castes feel that they should not limit their numbers in the search for greater political power. A section of the intelligentsia is against family planning on similar grounds, fearing that as contraception is largely adopted by the better-off rather than the poor, it is undesirable as the former will be grossly outnumbered by the 'unintelligent,' etc.

  -- Children are a gift from God. According to Hindu belief, a child is a gift from God and brings good luck to the family. Birth control is regarded therefore as undue interference in the will of god, tantamount to a crime, according to the orthodox. This is true among Muslims and Christians as well.

  -- Children ensure the 'marriage bond.' Women who do not produce a child within the first two or three years of marriage are often divorced by their husbands. By extension, continued production of children (especially in view of the high risks of child mortality) ensures that a marriage will continue. In particular, Scheduled Caste and Tribe women who are vulnerable to being abandoned by husbands are opposed to

family planning for this reason.

-- Fear of Promiscuity or Social Ostracism. Coupled with the fear of impotence (see below) is a fear that wives of vasectomised men will become 'promiscuous.' Furthermore, particularly in rural areas, women among the extremely poor/Scheduled Castes are sexually exploited by the better-off (though possibly paid for sex). This is sometimes with the knowledge of husbands who would normally shield their wives. However, if the wife of man who is known to have been vasectomised were to get pregnant, he would lose face among his caste fellows.

Some beliefs relating specifically to available family planning measures are:

Fear of an operation. Both tubectomy and vasectomy engender fear as they are surgical in nature. Surgery is considered particularly undesirable as the person is not 'ill.' People are also afraid of sepsis, particularly during the hot season, and of other complications and debility. As back pain is a frequent post-operative complaint of women who have had tubectomies, other women fear this.

It is also feared that sterilisation may lead to health problems such as high blood pressure or obesity.

Vasectomy causes impotence. The misconception among both men and women that vasectomy causes impotence and reduces (the man's) sexual enjoyment is strong. As virility is not a subject women discuss, such rumours are not easily dispelled by vasectomised men who continue to enjoy a happy sex life.

Spacing methods are considered unsatisfactory. For example, IUDs are associated with menstrual cramps, irregularity or heavy flow, and pelvic or back pain, or irreversible damage to the woman's reproductive tract despite assurances from health workers that the method is temporary. The Copper-T is more acceptable than earlier methods. The use of condoms is considered to require privacy which a couple may not have. And oral pills are poorly managed by health workers or clients.

The major programme-related reasons why people eschew family planning are:

Lack of care after sterilisation or IUD insertion. The neglect of acceptors after sterilisation, which has been the main emphasis of the official family planning programme, or IUD insertion is seen to constrast sharply with the efforts put in by family planning workers to motivate the acceptor. The lack of follow-up by a doctor, ANM or even other health workers/motivators disenchants the acceptor and creates a bad impression also on friends, relatives and neighbours. The dangers of sepsis, problems experienced by diabetics, etc. accentuate the problem.

Disdain that 'those who preach do not practise.' It is pointed out by people who are approached that family planning workers and officials have not undergone sterilisation

even when they have several children. People feel that if sterilisation were 'such a good thing,' officials should be the first to accept it.

Backlash against 'excesses,' targets and incentives. The indiscriminate sterilisation of old men and young boys at sterilisation camps in the race to achieve targets during the Emergency (1975-77) led to an unfavourable view of the family planning programme and of programme implementors. The monetary incentives have engendered rumours about the 'ulterior motives' of government, especially as no other health service has an incentive associated with it. Motivators are not paid for follow-up visits.

Clearly, the programme-related reasons must be addressed by improvements in implementation, and the 'programme-related beliefs' must be dealt with by appropriate communication and motivation strategies. While some of the 'societal reasons' can be addressed by appropriate communication, their underlying causes require wider social and economic changes.

In sum, India's and U.P's unbridled fertility has to be viewed in the context of the 'demand for labour' and consequent emphasis on women's childbearing role as the means to status, as well as the context of high child mortality. While the government family planning programme over the past four decades has attempted to meet latent demand for contraception, it has done this poorly because the emphasis on sterilisation failed to take into account the numerous influencing factors described above. Rightly, attention has turned more recently to spacing methods, but a great deal still needs to be done to assure people that spacing methods are beneficial and not 'dangerous.' The lack of after care is a particularly serious drawback. While the programme has attempted to create demand for services through IEC efforts, the population control effort did not address factors underlying the lack of demand for family planning.

In the rest of this section, some data which relate to the phenomena described above are presented.

Ideal Family Size. The Third All-India Family Planning Practices Survey (FPPS3)[4] ORG, 1990) reports that the ideal family size in U.P. is 3.2 children. While this is higher than the two-child ideal sought by India's family planning programme, it is considerably lower than the current TFR of 4.5. This points to the scope that exists for family planning services to assist in bringing family-building practices in line with people's ideals. In fact, the FPPS3 found that 49.5 per cent of couples with three or more children said that they did not want any more children. This constitutes some of the 'unmet demand' for family planning.

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[4]. Operations Research Group (1990) Third All-India Family Planning Practices Survey, Baroda, ORG.

Son Preference. According to the FPPS3, U.P. couples expressed 2.1 as the ideal number of sons. The survey found that 29 per cent of couples in U.P. who had two sons and 16 per cent of those with three sons desired more sons. For India as a whole the percentages of couples in these categories were 10 and 7, respectively. The percentages in other northern states were also lower than U.P's.

Son preference is related in large part to the absence of social security measures: 61 per cent of rural couples in U.P. felt they will depend on children for old-age support. Even in urban areas 51 per cent of couples expressed this likelihood (ORG, 1990).

The emphasis on women's reproductive role is shown by their high parity at young ages. In U.P., the average number of children born per woman among women of different age-groups is shown in Table 2. These data disclose that by the age of 29 years women have exceeded the number of births conducive to a 'small (two-child) family norm.' Thus, the inculcation of this norm and the adoption of family planning must clearly take place well before this age.

Table 2
Average Number of Children Born per Woman
Five-year age groups, Uttar Pradesh

	Rural	Urban
15-19	0.20	0.14
20-24	1.24	1.06
25-29	2.58	2.44
30-34	3.70	3.57
35-39	4.61	4.38
40-44	5.07	4.83
45-49	5.32	5.02
50 +	5.05	4.69

The sections which follow present U.P. data and discuss some of the main socio-economic factors which are correlated with high fertility.

1.2.2 Literacy

U.P. has among the lowest literacy rates of India's states, considerably below the Indian averages. 33.8 per cent of its total population, 45.1 per cent of males and only 20.9 per cent of females are literate (1991). In 1981 (when the state's overall literacy was about 25 per cent) about 40 per cent of households had no literate person, 43 per cent in rural areas and 25 per cent of urban households.

There is also considerable intra-state variation in literacy in U.P. The hill region shows significantly higher literacy than other areas of U.P. Forty-nine of U.P.'s 63 districts have a total literacy rate below 40.0 percent and 45 have a female literacy rate below 25 per cent. Only one district in U.P. has higher than 50 per cent female literacy, four have rates between 35 and 50 percent, 28 between 20 and 34 percent, 26 between 10 and 19 per cent and 4 below 10 per cent.

U.P's low achievement in literacy is related to the inadequacy and poor quality of its educational infrastructure. In 1981, 40 per cent of U.P. villages had no educational facility. In 1986 about 50 per cent of girls aged 6-11 years and 86 per cent of boys were enrolled in schools[5] . Among 11-14 year-olds the percentages were 23 and 56, respectively. Attempts have been made during the 1980s to rectify the quantity and quality of schooling available but progress in school enrolment has nevertheless been slow.

The highest drop-out among girls occurs between Classes III and VI. At this point schools cease to play a 'day care' function and young girls are in fact kept home to assist their mothers in domestic chores, including younger sibling care. As they approach puberty there is also a need to protect them from the risk of sexual abuse and to prepare them for marriage. Thus, young girls' education is hampered both by their mothers' excess fertility and truncated by societal values prizing their own early marriage and motherhood. There is evidence in India, as elsewhere, that girls' education does reduce fertility by delaying the age of marriage as well as by reducing 'desired family size' and increasing the acceptance and use of family planning.

1.2.3 Economic Levels

An estimated 45 per cent of U.P's population is 'below the poverty line,' ie. an income line below which minimum household nutritional requirements are not met. About 18 per cent is estimated to be in 'extreme distress.' There is little difference between regions in the percentage of people below the poverty line.

About 75 per cent of 'main workers' in U.P. are employed in agriculture and its allied activities. Land distribution is highly skewed, with 70 per cent of land-holdings being

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[5]. National Council of Educational Research and Training (1986) Third All India Educational Survey, New Delhi, NCERT.

below one hectare - too small to sustain a family without additional income. The total area of these small holdings is equivalent to that of the top four per cent of holdings (27 per cent of total operated area each). Small holdings are most common in Eastern U.P.

U.P's economic growth rate has been lower than the Indian average throughout the past four decades, barely compensating for population growth. As agriculture plays an important role, the small size of land-holdings coupled with inadequate irrigation and the lack of access of small farmers to inputs such as credit are some of the factors stymying economic growth in the state.

The government implements employment and income-generation schemes (the Integrated Rural Development Programme and the National Rural Employment Programme/Rural Landless Empoyment Generation Programme now combined into the Jawahar Employment Scheme) aimed specifically at this population. A sub-scheme of the IRDP, the Development of Women and Children in Rural Areas, which aims specifically to provide income-generation for women and social services for women and children, is also being implemented in 21 districts of U.P. However, these schemes have been slow in raising the economic levels of these low socio-economic groups.

It is of interest that the fertility levels of U.P's five regions do not relate well to economic levels. The Western region, widely regarded as the 'most developed' because of higher per capita industrial and agricultural production and high urbanisation, still has amongst the highest fertility. Conversely, the eastern region which has few employment opportunities outside of agriculture, the greatest proportion of small land-holdings and the lowest per capita net domestic product in the state has lower overall fertility. The Bundelkhand region is under-developed and has high fertility. The hilly region has a horticulture-based economy generating the highest regional per capita income in the state and has lower than average fertility. This is, however, not direct cause and effect as other factors such as women's status and male out-migration undoubtedly play important roles.

1.2.4 Status of Women

Labour Force Participation.

Besides the low literacy of females and high male-female disparities in literacy described above, U.P. has a low female labour force participation (LFP; 5.4 per cent in 1981). Although 29 per cent of women in the hill districts participated in the labour force (in 1981), in the western region female LFP was only 1.3 per cent, in the central region it was about 4 per cent and in the eastern and Bundhelkand regions it was about 7 per cent.

Female Mortality. The low status of adult women is also summed by their considerably higher risk of mortality. Between the age of 20 and 29 years it is about two and a half times that of a male, between 15 and 19 years it is about 90 per cent higher, and between 30 and 39 years it is about 35 per cent higher. Thereafter, female mortality risk falls to about half that of males. Maternal deaths account for some of this higher female mortality

risk during the reproductive years, but a preponderance of deaths are due to other causes. Besides succumbing to common diseases more frequently, probably on account of their poorer nutritional status, women also appear subject to death from 'Accidents and injuries' more frequently than men at this stage of the life cycle.

Sex Ratio. The higher mortality of females - at all stages of the life cycle but particularly in early childhood and during the early reproductive years - is demonstrated by the skewed sex ratio. Like the other northern states of India, U.P. has a sex ratio that is distressingly low: 882 females per 1000 males. This female:male ratio (FMR) is considerably lower than the all-India average of 935.

The sex ratios of U.P's regions vary markedly. Women are best off in the hill region with a sex ratio of 974 and five of the eight districts having ratios over 1000. However, the out-migration of males from these hill districts where employment is low to jobs in the plains contributes to the female-favourable sex ratio. Women's better-off economic status contributes to their overall higher status and survival. The sex ratios of districts in the Western, Bundelkhand and central regions and of these regions as a whole are appallingly low - 35 of the 36 districts have ratios below 884. The situation in the eastern region, while somewhat better, averages out to 925 females per 1000 males.

1.2.5 Age at Marriage

The mean age at marriage (MAM) among females in U.P. was a low 16.7 years in 1981 in comparison with the Indian average of 18.3 years. The eastern and Bundhelkand regions had MAMs of 15.0 and 15.8 respectively, while in the central, western and hill regions the average ages were 17.0, 17.5 and 18.2, respectively. Only 11 of the 63 districts had mean ages above 18 years, the age above which it is 'legal' for females to be married.

The low age at marriage is also summed in the statistic that 60.5 per cent of 15-19 year-old girls in U.P. are married (compared with 43.5 per cent in India as a whole. The proportion is slightly lower in U.P. than in the other northern states of Bihar, Madhya Pradesh and Rajasthan.)

The relatively low fertility level in the hill region is related to the higher average age at marriage among women as well as greater acceptance of family planning. These are undoubtedly due to the higher female literacy and labour force participation rates brought about by the overall better status of women among the tribal populations of this area. The higher fertility of the Western region compared with the East and Central regions despite a slightly higher age at marriage suggests differences in marital fertility.

1.2.6 Infant Mortality

The two-way relationship between infant mortality and fertility is well known. U.P's infant mortality is extremely high at 132 in rural areas and 81 in urban areas (1988). This can be compared with all-India rates of 102 and 62 respectively. In U.P. female children have about a 10 per cent higher risk of mortality upto the age of 2 years, 15 per cent upto 3 years and 20 per cent upto 5 years of age.

At the regional level, infants have the lowest risk of death in the hills (IMR=90), but very high risks in the other regions. The IMR is 119 in Bundhelkand, 122 in the east, 129 in the west and 132 in the central region. Twenty-five of U.P's districts have an infant mortality rate over 120 deaths per 1000 live births and only 12 have a rate below 100.

1.2.7 The High Fertility Districts

As there is great concern for the 32 districts in U.P. which have very high fertility, patterns in the determinants and underlying factors could usefully suggest strategies to address the high fertility. Unfortunately, no clear patterns are readily visible.[6] These districts do not clearly manifest a 'worse' situation than the other districts of U.P. with regard to the socio-economic indicators discussed above, literacy, infant mortality, economic levels, etc. In fact both across these districts and the others the range of such indicators is wide and over-lapping.

However, the actual levels of these various indices can be used to derive a 'priority' list for a programme focus. Accordingly, Table 3 lists the 32 districts and derives a score for each using key socio-economic indicators, finally dividing them into smaller groups.

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[6]. However, regression analysis would disclose the strength of various relationships and such an exercise should be undertaken to facilitate planning of project activities.

Table 3
A Socio-Economic Score for U.P's 'High CBR' Districts

	CBR	FLT	MAM	FMR	IMR	Total	Group
Budaun	3	5	2	5	5	20	A
Hardoi	4	4	2	4	5	19	A
Lalitpur	4	4	4	3	4	19	A
Basti	3	5	3	2	5	18	A
Rampur	5	4	1	3	5	18	A
Shajahanpur	2	3	2	5	5	17	A
Gonda	1	5	3	2	5	16	A
Sultanpur	2	4	4	1	5	16	A
Etah	1	3	2	4	5	15	A
Moradabad	4	3	1	3	4	15	A
Philbhit	1	4	2	3	5	15	A
Bareilly	1	3	2	4	4	14	B
Bijnor	4	3	1	3	3	14	B
Bulandshar	2	3	2	3	4	14	B
Rai Bareli	2	3	3	1	5	14	B
Sitapur	1	4	2	3	4	14	B
Agra	2	2	2	4	3	13	B
Aligarh	2	2	2	3	4	13	B
Gorakhpur	2	3	3	1	4	13	B
Pratapgarh	2	4	4	0	3	13	B
Banda	1	4	3	3	1	12	B
Farrukhabad	1	2	2	4	3	12	B
Ghaziabad	2	1	2	4	3	12	B
Mainpuri	1	2	2	4	3	12	B
Deoria	1	4	2	1	3	11	C
Jaunpur	2	3	3	0	3	11	C
Allahabad	1	3	2	2	2	10	C
Azamgarh	2	3	3	0	2	10	C
Tehri Garhwal	3	4	2	0	1	10	C
Meerut	1	1	1	4	2	9	C
Saharanpur	1	2	1	4	1	9	C
Nainital	1	1	1	3	1	7	C

Key: CBR=Crude Birth Rate: 1=39, 2=40, 3=41, 4=42, 5=43;
FLT=Female Literacy Rate:1=>20, 2=16-19, 3=10-15, 4=8-9, 5=<7 percent;
MAM=Female Mean Age at Marriage:1=>17, 2=16, 3=15, 4=14, 5=13;
FMR=Female: Male Sex Ratio:1=>940, 2=890-940, 3=840-889, 4=820-839, 5=800-819;
IMR=Infant Mortality Rate:1=<100, 2=101-110, 3=111-120, 4=121-150, 5=>150;
Grouping based on Total Score: A=20-15, B=14-12, C=11-7.

A higher score demonstrates a worse social situation, deserving greater priority for action.

1.3 Social Stratification

In U.P. 21.2 per cent of the population belongs to the Scheduled Castes (SCs). There is a very high proportion of landless or marginal farmers (62 per cent) among the scheduled castes, with 35.0 per cent of workers being agricultural labourers.

0.2 per cent of the state's population belong to Scheduled Tribes. 45 per cent are landless or marginal farmers. Almost 80 per cent of workers are cultivators. However, the scheduled tribes in the hill region of U.P. are culturally and socio-economically very different from the tribes of the eastern and Bundhelkand regions. The former are generally better off and their women have higher status on the whole.

Literacy is especially low among the SCs - it was roughly half the level of that of the state's population as a whole in 1981. In that year while 14.0 per cent of all females were literate, only 3.9 per cent of SC females were literate.

Various studies suggest that the fertility of higher castes is lower than that of intermediate or low (scheduled) castes. While the Scheduled Castes have traditionally been subjected to numerous indignities, their lower social and economic status still limits their access to various types of services, including schools and health centres. As they usually live in different sections of villages, they may not be served equally by extension workers, particularly if the latter are higher caste. Conversely, if a health worker is scheduled caste, she may not be welcomed into higher caste homes or be able to serve higher caste people.

Muslims constitute an important religious minority - 15 per cent of the state's population. Super-imposed on socio-political tensions between the Hindu majority and Muslims, socio-religious and cultural differences make family planning a sensitive issue. Muslim fertility is found to be higher than that of Hindus, but in large part this is due to their greater poverty and lower educational status.

Urban Slums. Nearly 16 per cent of the total urban population of U.P. lives in slums, compared with 23 per cent of the urban population of India as a whole (1981 Census data). The proportion living in slums increases with the size of towns. It is about 7.5 per cent among towns below 100,000 people, 17.5 percent in towns of between 100,000 and 1 million, and over 40 per cent in the largest cities of Kanpur and Lucknow.

1.4 Awareness and Use of Family Planning

1.4.1 Use of Family Planning.

The Third All-India Family Planning Practise Survey found the following use-rates for different family planning methods in U.P. in 1988:

Sterilisation = 16.4 of which 40.5 per cent were vasectomies and 59.5 per cent were tubectomies;
IUD = 0.9 per cent
OCs = 1.2 per cent
CCs = 6.4 per cent

In contrast with the official government CPR of 33.8 (1990), the FPPS3 found a CPR of 24.9 for all methods in 1989.

1.4.2 Characteristics of Acceptors

In the FPPS3, 90 per cent of FP acceptors had three or more children and 45 per cent of women in acceptor couples were aged over 30 years. The distribution of acceptors by the method they adopted and the number of their living children is shown in Table 4.

Table 4
Distribution of FP Acceptors by Method and Number of Living Children
U.P. 1989

	Number of Children					
	1	2	3	<3	4	5+
Vasectomy	0.1	7.8	30.9	38.7	34.4	26.9
Tubectomy	0.2	10.1	34.0	44.3	32.8	22.9
IUD	19.4	32.0	24.7	76.1	16.0	7.9

These data show that the majority of sterilisation acceptors have more than three children. Fewer than ten per cent have only one or two children. Among IUD acceptors, however, about 50 per cent have one or two children.

Table 5 shows FP acceptance by method and the age of the wife. The majority of vasectomy acceptors have wives aged over 30, while about 25 per cent have wives under 30 years of age. The majority of tubectomy acceptors on the other hand are under the age of 30. The pattern of acceptance for IUDs is similar to that for tubectomy in the 20-29 year age-groups, suggesting that many of these women may in fact be 'terminators' as well.

Table 5
Distribution of FP Acceptors by Method and Age of Wife
U.P. 1989

	Wife's Age (Five-year age group)						
	15-19	20-24	25-29	30-34	35-39	40-44	45+
Vasectomy	0.1	4.1	19.0	37.7	36.2	1.7	1.2
Tubectomy	0.8	19.4	35.0	25.2	10.7	2.6	6.3
IUD	4.0	22.3	31.0	19.2	19.3	3.4	0.7

Table 6
Literacy Levels of Eligible Couples and FP Acceptors by Method, U.P. 1989

	Illiterate	Primary level	Above Primary
Elig. Couples	71.0	12.8	16.2
Tubectomy	41.5	34.0	24.5
IUD	43.4	35.7	20.9

Table 6 shows the literacy levels of eligible couples in U.P. and that of acceptors of tubectomy and IUDs. Literacy levels are higher among FP acceptors than in the general population of eligible couples, suggesting that literacy is a significant motivator for FP acceptance. It is significant that primary level education alone is sufficient to motivate FP acceptance. There is little difference in the literacy levels of those who accept tubectomies and IUDs.

A study which sought to explain official district-level variations in family planning acceptance rates found that female labour force participation, female literacy and per capita income contributed significantly to explaining the couple protection rate[7]. Another study found that district family planning acceptance levels were related to high female literacy, a high percentage of scheduled castes, a low percentage of Muslims, high female work participation, and a high percentage of agricultural area under commercial crops (including better economic levels)[8].

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[7]. Saseendran, P.P. and M. Kumar (1989) "Determinants of Family Welfare Program in U.P.: An Analytical Study of CPR and Socio-Economic Variables", Lucknow, Population Centre.

[8]. Jolly, K. G. (1989) "Family Planning Performance in Uttar Pradesh: New Strategies", in Present FW Program Strategy - Some Alternatives (N. Sawhney etal. eds.), Lucknow, Population Centre and Directorate of Medical Health and FW.

1.4.3 Awareness of Family Planning.

However, a lack of awareness of family planning methods does not appear to be the major constraint to use. According to the FPPS3, awareness of non-terminal methods of family planning in U.P. was as follows:

IUD: 51 per cent (Indian average = 60)
OCs: 59 per cent (" " = 55)
CCs: 74 per cent (" " = 66)

Levels of awareness were higher in U.P. than in the other northern states.

Only 36 per cent of people had been exposed to family planning messages through TV and radio, 14 per cent through family planning camps, 20 per cent through films, and 4 per cent through wall hoardings (bill-boards). Differences between males and females were particularly large in the case of films and camps.

1.4.4 Attitudes to Family Planning.

On the other hand, a fear of adverse physical effects is a constraint to the adoption of family planning. Of all couples surveyed in U.P. by the FPPS3, the percentages that believed in adverse effects of different methods:

Vasectomy	63 per cent
Tubectomy	66 per cent
IUDs	70 per cent
Condoms	46 per cent
Oral pills	57 per cent.

It is clear from these data that there is general dissatisfaction among the 'target' population with the available methods of family planning, perhaps largely due to disinformation and to the lack of follow-up and after care of acceptors.

It is believed that the Muslim population is generally against surgical sterilisation because of the terminal nature of this method. However, it is also true that workers in the public health system have maintained (consciously or unconsciously) a social distance from this minority population.

These findings in brief point to to the need for India's (U.P's) family planning programme to increase levels of 'correct' information among consumers about family planning, to focus on younger parity women and to ensure quality service delivery and good follow-up.

1.5 Institutional Context

A wide variety of institutions in U.P. are or can be involved in family planning. Foremost among these is the government health and family welfare service system which is currently the major 'actor' in the field of family planning. The Department of Health and Family Welfare which manages the HFW system is one of over 25 departments charged with administering public services. It prepares an annual and a five-year plan, for which it receives funds from the state's department of finance. Some schemes of the department are centrally funded - the national family welfare programme being one such. Besides the managing bureaucracy, the HFW system has an adjunct technocracy - several 'Directorates' (eight in U.P.) of which one is charged with the responsibility for Family Welfare. The technocracy is a cadre of medical and public health physicians who, like the bureaucracy, make a career of government service. While both bureaucrats and technocrats oversee HFW services at the state level, the technocratic cadre is more firmly in charge at the district and block levels. But even here, generalist public administrators oversee overall planning and development of services (the District Collector/Magistrate and the Block Development Officer, respectively). Indeed, as a national priority, the family planning programme has received considerable attention from these officials. Many other government departments have, in fact, collaborated in the past, particularly to assist districts to meet their family planning targets.

The family planning program has been largely top-down. Targets calculated on the basis of population size, current levels of fertility and FP coverage and past performance in the FP programme by the Central Ministry of Health and Family Welfare in New Delhi are allocated to the state governments, and by the latter to the districts, and so on downward to workers in the health system and other departments. These targets have driven the family planning programme, particularly as they have been associated (in some places and at some times) with the punishment of workers who did not meet them.

This stressful situation, coupled with the poor training of workers in motivation as well as technical matters, has led to a programme that has largely ignored the socio-economic context of the people it is intended to serve. People have been viewed as 'targets' and not as participants or even beneficiaries in the programme. Community participation - of individual potential acceptors, opinion leaders, 'local government' (which is functioning only limpingly in U.P.) or other local groups or organisations has been virtually nil. Village health committees are mostly non-functional, and the recently-proposed *Mahila Swasth Sanghs* (Women's Health Committees) have not yet been formed. Besides their targetted clients, government health workers tend to contact only helpful or influential village leaders rather than communities as a whole. Not surprisingly, because the public system has viewed itself as the major 'missionary' of family planning, and because it is so widespread with actual facilities in almost a quarter of the state's villages and workers assigned to cover almost every village in the state, there have also been few other actors in the family planning field.

A notable exception to this have been a few non-profit non-governmental organisations (NGOs) which have been established for the prime purpose of FP service delivery. These include the Family Planning Association of India and Parivar Seva Sanstha (formerly the

Marie Stopes Society) which have branches in U.P. A few other NGOs - of hundreds of groups involved in development work all over rural and urban U.P. including health service delivery - also provide FP services. But by and large, these groups have shied away from family planning - largely because of a fear of being tainted with the poor image that the subject has obtained as a result of the 'excesses' of the government programme. Many groups, however, are concerned with improving women's lives, and these and others with providing good health care. Within these contexts they can be encouraged, trained and supported to undertake family planning motivation and service provision. However, it must be remembered that such NGOs have very limited coverage - they have small staffs, their programmes are usually confined to a few villages or an urban ward. A large number of districts in U.P. appear to have virtually no NGOs. (One survey shows: 30 out of 63 U.P. districts with none, 17 with 1-3 NGOs, and only 10 with 5 or more.[9]) All together NGOs probably do not reach even 10 per cent of U.P.'s population.

Another exception is a sub-section of for-profit health providers, both institutions (hospitals, clinics) and individual practitioners, who are probably providing some family planning services (IUDs, prescriptions for oral pills, and some surgical sterilisation) on demand from consumers. Only 'modern' practitioners - and among them most probably only gynecologists, general practitioners and general surgeaons - are likely to be involved in providing these services, but the actual number of such providers and of institutions is not known. Nor is the number of persons they serve. In general, these private providers assess fees for their services. While in many cases they graduate the fees according to the income level of the 'patient' and they may even provide free services, it is fair to assume that they reach a better-off population, largely urban and peri-urban because of their location. There is considerable scope in the project to increase the involvement of these practitioners and institutions by providing training and 'motivation,' at the same time as demand is created among the population to approach them for services.

Another group of 'private practitioners' are chemists - well-known in India to be 'first-line health care providers.' However, they are unlikely to be involved in providing contraceptives other than condoms except on the prescription of a physician. This situation may have changed recently - and can be changed significantly in the future - with the removal of the prescription requirement for the public sector low-dose estrogen-progesterone pill, Mala D. However, bona fide drug shops are rarely found below villages of 5,000 people. In smaller villages, the 'general store' maintains a small cachet of 'popular' medicines. These retailers offer an opportunity to get contraceptives at least condoms - down to smaller villages. So do 'roving' salesmen and the makeshift, periodic (usually weekly) markets that serve the majority of rural people.

Among other institutions reaching villages are government-supported producer cooperatives such as those in dairy, sugar-cane, oilseeds, silk, handlooms, leather, crafts, and so on. In addition, the Public Distribution System has outlets in many villages but is particularly widespread in towns. There are also other public service personnel located in

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[9]. Information provided by Parivar Seva Sanstha.

villages, such as agricultural extension workers, school teachers, *Anganwadi* workers, postal and railway employees. These workers and systems are potential channels for family planning information and supplies.

In U.P. about 12 per cent of workers are in the organised labour force, almost entirely in urban areas or 'industrial estates.' A small proportion of these workers are covered by employer health systems, while others are entitled to reimbursement of medical expenses incurred on private services. These mechanisms also offer opportunities to expand family planning acceptance.

2. BENEFICIARIES OF PROJECT ACTIVITIES

2.1 Participants and Their Characteristics

The Project will be led and managed overall by the Ministry of Health and Family Welfare (MOHFW) of the Government of India. As family welfare is a central subject under the Constitution of India, the central MOHFW sets policy objectives and guidelines. In the past it has entirely financed the National Family Welfare Programme from funds allocated by the Planning Commission for each five-year plan. The central ministry has also routinely monitored the FW programme through its Evaluation and Intelligence Division. It has set state-level targets for family planning acceptance on the basis of demographic data and goals.

Funds for the national FW programme have supported the establishment and maintenance of specific health facilities and training and employment of specific cadres of staff in the family welfare and health infrastructure of India's states. The states are responsible for the implementation and management of all programmes on a day-to-day basis. In family welfare, they apportion targets among their districts (usually, again, on a demographic basis, but also on the basis of 'past performance') and among different cadres of workers, including cadres outside the health system. At the district level, the implementation of the family welfare programme is the responsibility of the District Health and Family Welfare Office. The District Collector also plays a role in ensuring that family welfare-related inter-departmental activities are carried out.

Thus, responsibility for family welfare activities and expenditures actually rests with the state Department of Health and Family Welfare (DOHFW). As the IFPS Project is focussed on the state of Uttar Pradesh, the DOHFW of this state will be the main participant in the project, receiving project funds from USAID through the IFPS Project Agency. It will be responsible for implementing the majority of project activities, thus making the major contribution toward the achievement of project goals.

Both the Central MOHFW and the Uttar Pradesh DOHFW are well committed to the Project. There is widespread and high-level concern about India's rapid population growth and recognition of the stagnation in India's family welfare programme. Thus, innovative approaches are being sought to increasing family planning acceptance, resulting in considerable interest in this Project. As the poor past performance of states such as U.P. has caused major concern, the Project has been particularly welcomed. U.P. is not only

demographically critical in reducing India's population growth but is also important in the country's development goals and politics. We know of no policies or practices which may interfere with equitable distribution of the Project's benefits.

2.2 Institutional Channels for Project Benefits

The Project will be implemented through

- o the government health and family welfare service system;
- o government or quasi-government institutions such as medical colleges and research institutes;
- o non-governmental organisations involved in health service delivery or other development work;
- o grass-roots organisations such as cooperatives and village groups;
- o commercial firms interested in promoting or providing FP services or related activities;
- o private medical organisations and individual practitioners.

2.3 Project Beneficiaries

All eligible couples in the state of Uttar Pradesh are intended to benefit from the Project, without discrimination as to their age, socio-economic status, education, community or location. The Project recognises the differing needs of individuals and the varying degrees of difficulty involved in reaching them, and is constructed to equitably improve the access of all to family planning services. Hence the eclectic approach to service providers and channels. Activities are phased in order to continuously expand coverage, in some cases beginning with the most disadvantaged areas (eg. some of the 32 high-fertility districts), in others with the most-developed channels (eg. medical colleges for physician training) in keeping with the technical needs of the activity.

In general, a 'segmented market' approach has been adopted in developing the Project. This recognises that different channels will reach different consumers. For example, the social marketing activities will cover towns and villages with populations over 5,000, but are unlikely to reach into villages below this size. However, community-based distribution activities through the government health system and NGOs will cover these smaller habitations. Within villages or towns, undoubtedly the most 'aware' people - the most educated, better-off - will avail of services first. But the project includes education and motivation activities aimed at those who previously have had limited knowledge of and poor access to family planning. All communities and castes are to be addressed by both educational and service delivery activities, 'without fear or favour.' Attempts will be made during training and advocacy workshops to address biases which constrain workers from reaching out to groups with whom they do not immediately identify.

The Project aims to reach younger couples in order to enhance demographic impact, and to this end it focusses on providing spacing methods. Within households, both men and women will be approached as both are important in decisions to adopt contraception. Both male and female methods are being promoted by the Project: condoms and vasectomy for

men, and the IUD, oral pills, Norplant and tubectomy for women.

The 'needs' which the Project fulfills have largely been assessed on the basis of demographic data and evidence from qualitative research, as well as discussions with policy-makers and implementors in the governmental and non-governmental sectors. The Project thus caters to a wide range of 'needs,' providing all available forms of contraception and utilising all feasible and potentially effective delivery channels. Project beneficiaries will thus have maximum opportunities to express demand. Flexibility in the project allows for those activities which are proving effective (ie. which are most in demand and hence are meeting the expressed needs of beneficiaries) to be scaled up and implemented at a faster pace than others. Project activities and resources will provide knowledge about family planning and contraceptives directly to individuals, thus giving them all the benefits of birth spacing and small families.

No adverse effects are anticipated as all the methods to be made available in the Project are 'tried and tested.' In fact, the Project aims to reduce the perceived side effects of contraceptive methods used previously in the Indian FP programme by providing counselling to enable choice of the method most suitable to an individual, improving technical skills of providers and ensuring follow-up. The only new method, Norplant, is to be introduced with the utmost of care, ensuring skills through training 'centres of excellence' and with a good monitoring system in place.

3. PARTICIPATION

3.1 During Project Development

Officials from the Central Ministry of Health and Family Welfare and the U.P. Department of Health and Family Welfare have collaborated during all phases of project preparation. They include the highest central officials, the Secretary and Special Secretary of Family Welfare, the Joint Secretaries in charge of Maternal and Child Health, Media and NGOs, and the Director for Policy. The state has been represented by the Health Secretary and the Director of Family Welfare. Heads of other departments which will be involved, such as Medical Education, have also been consulted.

Visits were paid by members of the project design team to many of the institutions likely to be involved such as medical colleges, research and training centres, NGOs, commercial firms, the Indian Medical Association, etc. and the views of leaders and staff in these institutes taken into account during preparation of the Project. A number of individuals from key institutes such as the National Institute of Health and Family Welfare and the Indian Institute of Health Management Research also acted as consultants to the project. Field visits were also made to some government health facilities such as District Health Organisations and Hospitals, Community Health Centres, Primary Health Centres, Sub-Centres, Urban Family Welfare Centres and discussions held with management and implementing personnel at these institutions. Leaders and staff of non-governmental organisations have also participated in developing project concepts and strategies. Members of the project design team also interacted with potential project beneficiaries in villages and urban areas.

While project goals are widely shared by these various constituencies, the details of the project (activities, phasing) are yet to be shared with all the participants. Given the size of the area to be covered by the Project (the state of U.P.), the large numbers of providers and beneficiaries who will be involved, and the wide spectrum of activities, this can only happen during the course of the project.

3.2 During Project Implementation

Exercises (eg. informal discussions, formal workshops and seminars, etc.) to obtain 'feed-in' from participant groups are a feature of the Project. These groups are in turn expected to be involved in activities which 'hear and understand' the Project's intended beneficiaries. In this way Project activities will be responsive to the needs and preferences of beneficiaries and also take account of the capabilities and interests of providers. As noted above, flexibility built into the Project will allow for continuous modifications in order to maximise effectiveness in providing wanted services.

The views of providers will also, importantly, be taken account of during training activities, while technical, managerial and motivational skills are being honed. All technical assistance contractors will work with Indian counterpart institutions and individuals. The Project depends on a wide variety of persons and institutions for its implementation. As the body in overall charge of the Project, the state IFPS Project Agency (SIFPSA) will collaborate with relevant government agencies as well as private organisations and individuals during project implementation. Although the Indian public health system is essentially a 'top-down' decision-making organisation, it has been recognised that all levels of the system must be encouraged and 'taken into confidence' in order for effective performance. The Project will attempt to widen the sphere of consultation to include community leaders and members, particularly through the participation of NGOs and organised local groups.

4. SOCIO-CULTURAL FEASIBILITY OF THE PROJECT

4.1 Suitability of Proposed Interventions

4.1.1 Within the Social and Ideological Contexts of Beneficiaries

Family planning in India has been hampered by societal traditions that have emphasised the importance of children, particularly sons, for a variety of social purposes. These traditions engender high fertility in a context of high child mortality. Thus, to the extent that families and communities remain 'traditional,' contraception goes against their social and ideological values.

However, Indian society is dynamic and traditional beliefs are giving way to modern ones which are based on the recognition that too many children means less investment in

each even to the point of denying them life; and that repeated pregnancies take their toll of women's health and productivity, and hence of family productivity and survival. Whereas the mass of society may appear unchanging, within it numerous individuals and particularly women express interest in limiting births to improve the quality of life of their children and their families. This constitutes the 'unmet demand' for family planning, which is estimated to be at least 15 per cent of all eligible couples in U.P. The Project assumes that the provision of accessible and quality services will, in the first instance, cater to this demand, increasing couple protection rates commensurately. Side by side it is expected that a spread effect will occur which will increase interest in family planning among other couples and ultimately create demand among them, too, for family planning services. The Projects aims to fuel this interest directly through its IEC activities. There is adequate evidence from the experience of small-scale projects in U.P. and of the family planning programme in other parts of the country (where societies are also 'traditional') to believe that these assumptions are not misplaced.

4.1.2 Within the Economic Context of Beneficiaries

A major reason for the perpetuation of large families and high fertility has been the 'economic value of children' to poor families, struggling to make a living. The returns to poor families of children's labour have been perceived to offset their costs. However, this too has been in the context of an unchanging society. Increasingly, as families economic opportunities improve - and particularly as returns to women's work increase, and access of children to schooling improves, families have begun to recognise that the 'costs' of children may outweigh their 'benefits.' In addition, there is increasing consciousness of the 'costs' of children in terms of suffering - child deaths, maternal health, sibling malnutrition, and so on. Thus, the stage is set for educational and motivational campaigns that stress the economic benefits of smaller families, and the health benefits to mothers and children of spacing births, as the Project intends to do. The focus of the project on birth spacing is particularly appropriate to assist families in having children when they want to ensure quality care and survival of the children born.

4.1.3 Within the Available Organisational Context

As described above, the Project aims to use almost all available organisational forms to promote the practice of family planning and distribute contraceptive technologies. Each organisational form has its unique advantages and limitations.

The governmental health system is by far the most pervasive delivery system, reaching down to the village level, and structured in a formal, multi-tiered way to provide increasingly specialised services from bottom to top. It has been providing family planning services for the past four decades, including all the methods proposed in this Project (condoms, IUDs, orals and sterilisation) except Norplant. The last method is to be introduced through physicians trained at medical colleges. The FP programme has been using new approaches and building new 'apparatus' from time to time, evidence of its ability to evolve as opportunities, resources and ideas present themselves. However, it is not easy to change this

large and widespread structure rapidly. Accordingly, the Project envisages that changes will be introduced in a phased manner and at several levels of the system (from the ANMs at the lowest level to medical colleges which produce and train physicians for the system). The sheer size (in terms of manpower and facilities), long-standing involvement and ubiquitous nature of this system make it an important channel in the IFPS Project.

Non-governmental channels include commercial firms, non-profit organisations (NGOs), private practitioners. The last of these is also a ubiquitous category - there are private traditional or modern medical practitioners in every town and almost every village in U.P., although most would not be providing family planning services. The Project thus includes efforts to encourage these individuals to provide FP services (condoms, orals and IUDs where possible) or motivation, and strengthen their skills to do so. They are to be reached through associations such as the Indian Medical Association. Those who are not members of such organisations will be reached by education programmes using mass media. Similar approaches are to be used to reach private clinics and hospitals in order to encourage them to undertake family planning work and ensure/improve their abilities to provide services (condoms, orals, IUDs and VSC where feasible). These private institutions may be registered societies or trusts (non-profit) or firms (for profit, commercial providers). The non-profit category would receive technical and financial support under the Project, while it is expected that the commercial category would receive technical assistance mainly.

Other NGOs involved in health or development work will also participate in the Project. U.P. has several hundreds of these, only a few of which have been involved in FP in the past. However, many have the advantage of being close to the people they work with and thus could effectively motivate FP acceptors and distribute condoms and oral pills if they are assisted to do so.

Commercial firms are to be involved in social marketing of condoms and pills. Other commercial enterprises will be motivated to encourage their workers to accept family planning and to provide services to these workers. The government railway system has been included among such employers as it already has an extensive service-provision infrastructure. Its potential to provide services to others (non-employees) will also be explored.

It is important to note that each organisation involved in the Project would undertake those activities and promote those contraceptive methods which it deems appropriate to its skills and to its clients expressed needs. This choice ultimately ensures that the interventions proposed under the Project will be suitable to providers and clients alike.

4.1.4 Within the Prevailing Administrative Context

The government's family planning programme has experienced ups and downs related to policy changes at the central and state levels. These have affected the attitudes and motivation of service providers at all levels. While 'targets' ensured a certain level of performance, workers have resented their mandatory nature. In this Project (and elsewhere in India), policy changes are envisaged which will remove the terror of targets while

maintaining their managerial usefulness. The Project is designed to enable central and state-level administrators who have been concerned about population growth to delivery good quality and humane family planning services in innovative ways. A major aim of the Project is to improve the capacities of implementing personnel to provide FP services. This includes technical skills as well as the attitudes and motivation of the persons concerned.

4.1.5 Within the Extant Technological Context

Several of the spacing methods to be promoted in the Project (condoms, oral pills, IUDs) and surgical sterilisation have long been part of the Indian FP programme. However, problems of poor quality, poor motivation and delivery skills, and poor management have plagued the dissemination of these methods. The Project aims to rectify these problems, including improving the quality of condoms, IUD insertion and surgical skills, prescription of OCs and follow-up of all acceptors. In addition, a 'new' technology (Norplant) will be introduced. This will be done only in circumstances which guarantee appropriate screening, proper insertion and follow-up (for ultimate removal of the implant). At present, such facilities are available at several medical college hospitals and training centres in U.P. With the training of additional physicians as proposed under the Project the technological context appropriate to this method will be expanded.

4.2 POSSIBLE IMPLEMENTATION OBSTACLES

4.2.1 Arising from Intra-Family Socio-Economic Forces

As discussed above, social and economic forces affecting families in U.P. tend to ordain large families. Although these forces are changing, many families will remain tradition-bound and unable to accept modern family planning methods and outcomes. However, for this reason, the specific goal of this project has been set at a modest 50 per cent of eligible couples.

Another obstacle relates to the position of women within the family and intra-familial decision-making processes. Although women in their reproductive years often express their desire to prevent pregnancy temporarily or permanently, they do not approach family planning services because of social and familial norms linking their status to continued child-bearing and 'rules' circumscribing their mobility and inter-personal interactions. They lack the 'power' to break these rules, and often the economic solvency to take time off from domestic or productive work in order to seek out services. While the Project's emphasis on outreach, community-based distribution and IEC will go some way to bringing family planning services closer to women and creating a social climate for FP acceptance, such resistances are likely to persist as long as women's reproductive role remains paramount and women's status low.

4.2.2 Local Socio-Economic Forces

The intra-familial forces that influence the decision-making processes of beneficiaries are derived from societal values which support a 'high demand for children' and low women's status. Within U.P., however, the strength of these forces appears to vary somewhat, as demographic and social data presented in Section 1 above indicate. For example, in the hill region of the state where women are economically very active they have overall higher status and are more likely to accept family planning. In urban areas, pockets where literacy is higher, and areas where employment is available or being created, similar favourable situations are likely to exists. Thus, 'local socio-economic forces' are likely to create a serious obstacle to family planning acceptance only where poverty and society are unchanging .

4.2.3 State and National Socio-Economic Forces

The Project calls for U.P. to meet the recurrent costs of its existing health and family welfare infrastructure. Although the state's financial situation is currently weak and the health sector is usually a residual sector in terms of financial allocations, the government is committed to doing so. The additionality of Project funds and their extra-budgetary management should ensure smooth conduct of project activities. Although India is quite concerned about its burgeoning population and has the will to strengthen its family planning programme, its current economic crisis is likely to constrain its efforts.

Many activities call for coordination between the government and non-governmental institutions. These are likely to be approached with considerable caution by the government, and delays are possible. SIFPSA has a crucial role in bringing about timely and effective collaboration.

While certain policy changes, emanating from the national level, could assist the Project (eg. removal of targets), the Central Ministry is likely to be circumspect about these as it must consider the situation in states other than U.P. and implications beyond the life of the Project.

5. IMPACT OF PROJECT

The IFPS Project aims to double the couple protection rate in U.P. from a current conservative estimate of 25 per cent to 50 per cent of all eligible couples. It plans to do this by increasing people's access to family planning services, by improving the quality of services being provided and by promoting family planning use (ie. creating demand for FP services). Thus, the Project will have major impact on the pool of beneficiaries, increasing the number of contracepting couples from 6 million to 15 million over the ten-year period. It will expand the network of family planning providers, including new 'actors' such as private providers, commercial institutions and NGOs. It will also extend the reach of the public health system in U.P. and improve the range and quality of the services it provides. Finally, it will impact India's national family planning programme through the diffusion of

innovations developed and tested in U.P. and related policy changes.

5.1 On Participants

The Project will improve the capabilities of those currently working in the field of family planning in U.P. This includes, primarily, government health service providers, and some non-governmental individuals and agencies. The technical skills of several cadres of government personnel are to be strengthened including physicians who will receive training in surgical sterilisation techniques and ANMs who will be trained in IUD insertion. In addition, some physicians will be trained in Norplant insertion. ANMs and other staff of the primary health centre system and urban family welfare system will receive training in counselling skills and be provided more information as well as materials on different methods of contraception to enable them to help clients make appropriate choices. Improved technical and counselling skills will enhance the effectiveness of service providers, vastly improving their self-image and, thus, motivation to provide family planning. As female health workers at the lowest level of the formal health system ANMs, in particular, have suffered from self-perception problems which have hampered their performance in the past. An improved self-image will enable these workers in turn to encourage and assist women to overcome some of their traditional disadvantages.

In addition the Project will draw many new people into the arena of FP service delivery, providing them skills through training and financial assistance to undertake FP activities, thereby enhancing their role in communities. These include private physicians, NGOs, community-based workers and commercial organisations.

The Project also aims to develop model approaches to family planning service delivery in urban and rural areas which will be documented and assessed for impact. These approaches are to be replicated throughout the state of U.P. and could be implemented elsewhere in India as well. This will act as a fillip to the national family planning programme, increasing the likelihood that the central MOHFW can obtain national and international funds for improvements elswhere. The support available for research and evaluation activities will enable researchers from several other parts of India to work within the context of a critical family planning programme, strengthening their capabilities and experience.

Most importantly, the Project is expected to demonstrate new ways of 'doing' family planning to India's (and particularly U.P's) family planning policy-makers and service-deliverers. The checkered history of India's long-standing family planning programme makes this challenging, and India's weak success in controlling population growth makes it imperative. The emphasis on quality of services in place of target-driven approaches will be of paramount importance. The supplanting of a single-method approach (sterilisation) with a larger 'cafeteria' of methods in which couples will receive enough information and guidance to make the right choice for themselves is also an important strategy of the Project.

5.2 On Beneficiaries

The impact of the Project on beneficiaries will be achieved through improvements in

outreach, communications, choice of methods and quality of services. Making FP services more available - at village shops, through workers visiting homes or acting as 'depot-holders' in villages and urban neighbourhoods, through private practitioners and local institutions - will make it much easier for couples to decide to contracept, and for those who have decided to actually practise family planning. Better supply will also turn latent demand into effective demand for - ie. use of - family planning. In this way, supply will help overcome a major social obstacle to family planning - women's lack of familial/societal 'permission' to venture out of villages or to contact strangers for services.

These societal proscriptions will also be affected by education strategies which canvass entire communities, opinion leaders including doctors, intra-familial decision-makers (husbands, mothers-in-law), and so on.

Other ways in which supply will generate demand are through improvements in choice and quality. The Project's intention to enhance use of spacing methods is very significant in the Indian social context. By relieving a woman of child-bearing without foreclosing her option to bear children it enables her to lead a healthy, productive life without the stigma of 'barrenness' or the fear of being child-less (or son-less) if her children were to die. Once a woman has experienced the joys of not being pregnant, and has been able to give proper care and attention to ensure the survival of her children, the chances of her adopting contraception permanently are substantially increased.

The benefits of this Project are likely to be widely distributed as the activities and strategies are diverse. As described above, people in all locations, socio-economic groups and communities will be assisted to make decisions about their families and carry out their decision. The impact on individual families is likely to be far-reaching as couples who begin to use contraception usually work out their family-building strategy - with life-time effects. At a population level, the Project's effects are likely to spread as long as activities are sustained and quality is ensured. There are also likely to be spread effects among institutions. For example, many NGOs which have been reluctant to undertake family planning activities in the past would feel more encouraged to do so when they see others of their kind implementing family planning activities successfully. If it proves successful in U.P., one of the country's most socially and economically backward states, the Project's potential for replication certainly extends to the rest of India. Replication in the three other northern states alone (Bihar, Madhya Pradesh, Rajasthan) would cover 40 per cent of India's population and the fastest growing portion!

5.3 Risks

In the implementation of the Project there are provider-related risks as well as beneficiary-related risks. On the side of providers, the Project assumes that training, improved skills and management will bring about positive changes in attitudes towards the performance of family planning tasks and enhance provider motivation. This is not an unreasonable assumption but, as in all human resource development efforts, there is a likelihood of 'winning some and losing some.' Bringing about changes in attitudes and ways of doing things among personnel in established systems is no easy business. Ultimately, the

success of this Project will depend on the individual efforts of providers and on the establishment of a collective, 'critical mass' of people devoted to family planning provision.

With regard to beneficiaries, the Project assumes the existence in U.P. of unmet demand for family planning. The evidence for this stems largely from the Third All-India Family Planning Practice Survey (ORG, 1990). This assumption is not untenable as experience in other parts of India and the world have shown that such unmet demand exists where family planning services are poor in quality and inadequate in reach. However, the size of this unmet demand will determine the medium-term impact of the Project.

Another assumption is that people can be educated and motivated (through IEC strategies, improved services, etc.) into forms of behaviour (contraception) that go against 'tradition' and the socio-economic reasoning established over centuries. This Project undoubtedly comes out on one side of the debate on whether people have smaller families on the way to development or as a result of it. Suffice it to say that although this debate is unresolved, there is ample evidence from India and around the world that family planning can be well accepted in dynamic developing societies.

6. ISSUES

This section summarises the issues that derive from the information and analysis presented above.

6.1 Social Issues Bearing on the Project

6.1.1 Rapid Population Growth and its Consequences

India continues to experience a population growth rate of about 2.1 per cent per annum. The growth rate is even higher in some of the major states, among them U.P., which had a decadal growth rate over 25 per cent between 1981 and 1991. Given the already large population base, the environmental and economic consequences of such rapid growth are of concern for the country as a whole. They are particularly so in a state such as U.P. which has a poor economic base and is already experiencing problems of environmental degradation.

The social consequences of economic and environmental problems exacerbated by a rapidly-increasing population are significant. In a situation where almost half the population already lives in poverty - without adequate access to basic daily needs - high fertility can be expected to increase the numbers in poverty. The proportion of people in poverty may also increase as the better-off have smaller families while the poor remain unserved. Thus, this Project is addressed to bringing at least family planning services within the reach of all. Side-by-side it may bring health services and a general awareness of routes to a better quality of life.

Economic and environmental problems also take their toll on women's lives, producing an additional 'layer' of social consequences. Particularly among the poor, the unavailability of employment or poor-paying employment or subsistence farming place a

tremendous burden on the women of the household to provide economic support to the family in addition to being responsible for domestic chores. These chores are made all the more difficult in rural areas which are experiencing the denudation of forests and grasslands and diminishing water supplies due to population pressure: women bear the major responsibility for fetching water, fodder and fuel in rural areas. Added to this double burden are the energy demands of repeated pregnancies and periods of lactation and child care. The Project hopes to relieve women of at least some of this third burden by increasing their awareness of and access to contraceptive services.

6.1.2 Status of Women

However, women in India, and in a state as 'traditional' as U.P. are viewed largely as 'reproducers,' with little recognition accorded to their productive roles particularly if the latter are related to domestic or subsistence production. Hence, society and families place a premium on high fertility, ensuring it through early marriage and pressure to conceive and bear a child within a year or so after marriage (to 'prove' fertility) and repeatedly thereafter. In addition the greater value placed on bearing sons (because low women's status accords daughters little value) places pressure on women to produce several children to ensure the survival of atleast one or two sons, particularly within the context of high infant mortality.

There are several ways out of this vicious circle. Perhaps the most effective (but most difficult) route is the provision of female employment as the availability of work and incomes draws women out of the home into an arena where awareness increases and a powerful incentive exists for the family at large to reduce her burden of pregnancy. Another is female education, which serves to delay marriage and increases the chances that women will work and have access to better paid work. This route is, however, a long-term one. A third is the provision of proper health services for women and children within which family planning services are also provided. This will help women ensure the health and survival of children and improve their own health. Increasing awareness of family planning and positing it as a means of achieving these goals can encourage women to accept it. Spacing children better and having fewer of them can help women improve their health status, increase their productivity and thereby enhance their overall status. The Project fits into this approach, focussing specifically on making family planning services more available, more acceptable and of better quality.

6.1.3 Access to Health and FP Services

However, there is a 'Catch-22' situation at work here. Because of their low status, women have limited access to health service providers; and if they have low access, how can they avail of services to improve their status? Families do not readily permit women to travel to distant health centres or approach unknown male providers. Women are conditioned to bear pain and illness; they are usually treated only with home remedies; if necessary, they may approach a village practitioner, usually someone who is known to them, and whose qualifications may be quite doubtful. Only among the better-off or more-educated or in exceptional circumstances among the rural poor are they taken to reliable, far away health

facilities. Different strategies are used for different illnesses and depending on the seriousness of the problem. Often, by the time appropriate medical care is sought, it is too late. If family planning requires travelling and interactions with strangers, it is unlikely to be sought, particularly since it is 'preventive' rather than 'curative.'

Thus, the Project must use creative ways of breaking the 'Catch-22.' It aims to do this by bringing services closer to homes in villages as well as urban neighbourhoods through community workers and trained para-medicals. It proposes to use a wide range of service-deliverers so that couples can chose their provider. And it plans to reduce resistances to approaching health services in general and family planning services in particular by improving their quality.

6.1.4 Demand for FP

Indeed, a low demand for family planning has been a major problem experienced by India's family planning programme to date. Or rather, a low 'effective demand' - ie. use of available services. There are 'supply-side' reasons for this, such as inadequate dissemination of knowledge, particularly of spacing methods, poor availability, again especially of temporary methods, poor quality, and so on. The Project intends to address most of these.

But there are also more fundamental reasons - the high demand for children as working hands for a poor family and sons for parents' eventual social security. But parents are beginning to realise that more children means 'lower quality' children, whom they cannot afford to feed, clothe or educate. Thus, modernisation is bringing with it a consciousness that families should be smaller - and that this can be achieved through family planning. Demand for FP is emanating from those who are educated - particularly where women have been educated and those who seek a better quality of life. It is this 'unmet demand' for FP that the Project first proposes to meet.

There is alsc evidence that a large number of married women obtain abortions - usually from unqualified practitioners, at considerable risk to their lives. Making safe contraceptive services more available could reduce the incidence of this and the associated risks.

6.2 Issues Requiring Special Attention during Project Implementation

The two most significant socio-cultural issues which will require special attention during implementation of the service-delivery component of the Project are:

- The difficulties women experience in approaching family planning service providers, including the distance, time-costs and monetary costs of obtaining services, and the sex of the provider.

- The attitudes of service providers towards women, lower castes and the poor.

In addition, particular attention should be paid in the IEC component to the following:

- Early marriage and 'immediate' child-bearing.
- Preference for sons/neglect of daughters.
- High demand for children vs. 'quality' children.
- Birth spacing as a means to improve child health.
- Family planning for women's health.

6.3 Additional Information Needs

In the initial phase of the Project, additional information should be sought on the following topics in order to design socially-sound programme strategies:

- Information on the attitudes of FP providers such as ANMs to family planning, to their clients (eg. poor women), to their jobs, etc. (as part of a training needs assessment) in order to design training and motivation programmes to facilitate the work of this important group of providers. Also, a systematic survey of their infrastructural and equipment/supply needs should accompany the KAP study so that their work situations can be improved side by side with re-training.
- Post-partum sexual practices and taboos in different regions and communities of U.P. in order to elucidate appropriate approaches to family planning counselling and service provision.

6.4 Role of Project Monitoring and Feedback Systems in Identifying Socio-Cultural Problems

To ensure that the Project remains 'socially sound,' continuously cognisant of social constraints and innovating to overcome them, it will be important for it to build into research and evaluation activities the following questions:

- Are family planning services reaching all segments of society (eg. different classes, castes, religious groups, tribes, micro-regions)? If not, why not?
- Is the access of women to services improved - at centres and clinics? at the household level? Where changes have been brought about in service delivery patterns, what constraints do women continue to face?

Research studies could be addressed to the following, more difficult, issues:

- Intra-household decision-making processes regarding 'family building' ie. spacing and size limitation.

Operations research could examine:

- Approaches to overcoming the 'caste factor' and 'community factor' ie. the difficulties faced by workers of one group in catering to other groups.

- Approaches to establishing women's groups and the roles that can be played by such groups in furthering the aims of the Project.

7. GENDER ANALYSIS

7.1 Sex-disaggregated Data on Participants and Beneficiaries

7.1.1 Availability

Data on the sex of participants are available as follows:

- The sex of government health workers is known as male and female cadres are separate. Among doctors, in addition to 'Lady MOs' women may be included in the general MO category (especially at higher-level facilities) so that the actual number of female doctors may be higher than the Lady MO classification indicates.

- There is no published source of sex-disaggregated data on health administrators in the government secretariat or directorate. As the incumbents in these posts are drawn from the general pool of Indian Administrative Service officers and the central and state health services, respectively, and promotions are usually based on seniority, it can be inferred that over the life of the Project the proportion of males and females occupying managerial posts would be roughly that of the pools as a whole. However, there are occasional allegations that women are superceded by men for top posts. On the other hand, posts which specifically relate to women's health services (eg. Director MCH) can be earmarked for women.

- Data on quasi-government or non-governmental institutions including field NGOs, commercial firms, medical associations, research or training institutes, etc. can only be obtained directly from the concerned institutions. There are no general or specific published sources.

- Although the numbers of female medical graduates and graduates of nursing colleges etc. can be ascertained from the relevant institutions and state medical and nursing councils, the actual numbers practising in the private sector are not known with certainty.

- Data on beneficiaries (family planning acceptors) are collected routinely by the

government health system. The numbers and sex of individual acceptors are known at the service delivery point. Figures reported upward are disaggregated by contraceptive method, and based on certain assumptions regarding use. There is obviously no ambiguity about the number and sex of sterilisation acceptors (reported separately for vasectomy and tubectomy) and IUD acceptors. However, the numbers of oral pill and condom acceptors, based on dividing the total annual number of commodities distributed by 13 and 104 respectively, may underestimate the number of acceptors while overestimating their actual coverage with the method.

- Data on beneficiaries of private sector services are only available from the institution/individual directly. There is no source of aggregated data. Where private agencies obtain grants, motivation money or supplies from government, the number of beneficiaries is reported to the appropriate health facility and merged with its figures.

7.1.2 Actual Information

Participants: Health Decision-Makers. In the Central Ministry of Health and Family Welfare, women currently occupy senior management positions such as: Joint Secretary (MCH) and Joint Secretary (Media and NGOs). Two of the five persons from the MOHFW who have participated in the preparation of this Project have been women. At the state level, there have been no women participants and women currently do not occupy any of the top positions in the secretariat or directorate. This situation may change as positions are rotated. It would be helpful if the Project Coordinator at the state level were a woman.

Health Personnel. Women are represented in the management of district health organisations, among doctors at district hospitals, urban FW centres, CHCs and PHCs. CHCs are assigned one lady doctor, three staff nurses, four LHVs and two ANMs - 10 female posts of a total of 19 medical and paramedical staff. PHCs are assigned four LHVs and two ANMs out of a total of 13 staff. Where these facilities have been established, most staff positions for women doctors, LHVs and ANMs are filled.

Non-Governmental Institutions. We have no information currently on the male: female breakdown of managers or staff at the wide variety of non-governmental institutions which will be involved in the project. It is likely that many participating NGOs will have a strong representation of women at all levels. Women are also usually well represented in research and training institutions, particularly at ANM training colleges, but also in medical colleges. While women participate in medical associations, this could be further encouraged in a general association like the IMA. (There is some sex-stereotyping among medical specialities so that, for example, Ob-Gyn and Pediatric associations have a larger proportionate representation of women.)

Women's participation in commercial institutions is likely to be low, and could be encouraged in the Project. In general, sex-disaggregated data should be collected on institutions participating in the Project.

Beneficiaries. Data on family planning acceptors in U.P. for the last five available years

(1986-87 to 1990-91) show that IUD and oral pill acceptors exceed the number of condom acceptors every year. When surgical sterilisation figures - preponderantly tubectomy - are added, women accounted for twice as many acceptors as men between 1986-87 and 1988-89 and about 60 per cent of acceptors in 1989-90 and 1990-91, when the proportion of condom users increased markedly. One must assume that women also benefitted from male use of condoms!

7.2 Constraints to Women's Participation in the Project

7.2.1 Mobility Constrained by Tradition - Household 'Permission'

In the Indian context, and particularly in a state as socially and economically backward as U.P., women are steeped in traditional roles as 'reproducers,' mothers and home-makers. Even the economic work in which they are engaged is predominantly home-based or on the family farm. Tradition circumscribes women's mobility to a great extent, preventing them from venturing much beyond the household, their farms, *anganwadis* and the small shops of villages. Most of the major transactions with 'outside' agencies such as extension agents, banks, traders from beyond the village, etc. are done by men. Thus, women are not completely free to visit health centres or hospitals in other villages and towns - unless accompanied by a man or unless the need is acute. This is particularly true when going to a health centre involves taking public transport. Thus, a major constraint to women's participation in the Project is their lack of mobility.

It is this constraint that has led the Project to emphasize the need to improve the reach of family planning services through both public and private providers working at the village level. Women may visit centres within reach of their homes more easily and interact with providers who come to their doorsteps. As there are also proscriptions against interacting with male outsiders, female providers are preferable. However, male providers can reach couples through the husbands at first, interacting with wives when they are known and accepted.

7.2.2 Women's Work Burden and Economic Constraints

Another constraint to women venturing to distant health centres or hospitals is the opportunity cost of doing so. The time spent travelling and waiting for services is often a deterrent as work time or wages are lost in the process. Poor families can seldom afford to do without the day's wages. The double burden of domestic and economic work which women face makes them further reluctant - or even unable when a large family, including a mother-in-law have to be contended with. Any associated direct costs for transport, medicines, etc. may also be an obstacle among the poor.

However, there is increasing consciousness that women's economic opportunities and incomes on which immediate survival depend are hampered by recurrent pregnancies. Families increasingly recognise that ensuring child survival takes up mothers' time and/or deprives siblings of schooling. Thus, the demand for large families ('ideal family size') is declining and some 'unmet demand' for family planning emanates from the poorest groups in addition to those who are better-off and aspiring to 'quality' children. Even traditional Indian

society has recognised that pregnancy during seasons of hard work are detrimental to the mother, the fetus and the work. IEC strategies in the Project can build on this theme. Advocacy for policy and planning to increase women's economic opportunities would also be useful.

7.2.3 Knowledge of Family Planning

A major constraint to the adoption of family planning in the past has been the lack of knowledge particularly about spacing methods. While people even in fairly remote villages have become aware of the availability of sterilisation, and in many instances of condoms, knowledge of the IUD is poor and of oral pills almost non-existent. Thus, a stress in the IEC component of the Project on spacing methods will be most useful. With appropriate knowledge and availability of services and supplies close to homes sizeable demand could be created eg. for OCs among young women who have already had one or two children and who are not yet willing to accept termination (many such women would still be under 25 years of age).

7.2.4 Availability and Quality of Services

A major constraint - indeed, one that underlies all the constraints discussed above -has been the poor availability of family planning services within reach of the majority of women and their poor quality. Availability of spacing methods such as OCs at village-level centres has been limited. Not enough ANMs have been trained in IUD insertion. Because ANMs are diffident about their communication and motivation skills they have not reached enough men in their villages with the condoms they stock. At Primary Health Centres equipment, hygiene and skills are inadequate, and the quality of counselling and after-care very poor.

All these constraints have resulted in little demand for family planning, so that the programme to date has been a 'push' rather than 'pull' programme. The Project addresses all of these constraints, aiming to create a climate in which women and men have knowledge of the range of family planning methods, are counselled to select what is appropriate to their family-building strategy and their particular physical and social circumstances, and can obtain the method of their choice in a clean, congenial and quality atmosphere.

7.3 Opportunities to Enhance Women's Participation

Clearly then, the main strategies to ensure women's participation in the Project are to expand service availability, increase their choice of methods, improve the quality of services, increase their knowledge. Many of these strategies would be well served by efforts to organise women to gain access to the knowledge and services being provided.

7.3.1 Expanding Service Availability

The goal of expanding service availablility is to put family planning methods and supplies within easy reach of women. Supplies which need to be obtained on a recurrent basis (condoms, oral pills) should be readily available within villages and urban

neighbourhoods. Given the current eclecticism with which consumers in India - even the poorest in U.P. - choose their health service providers, a wide range of outlets for FP supplies can be utilised. These include a local person working as a community distributor, other local health and development workers, village shops and, wherever available, chemists, banks, postal and other offices, etc. Functionaries of village organisations such as cooperatives and clubs could also hold supplies. Other methods such as IUDs and surgical sterilisation should be available at the appropriate level health facility closest to households. IUDs can be inserted by properly-trained ANMs at sub-centres, primary health centres and community health centres in rural areas and urban family welfare centres and the entire range of hospitals. Surgical sterilisation can be made available at all these facilities except sub-centres and the 'new' (30,000 population) PHCs.

A key strategy to 'expand service availability' if 'service' is equated in the first instance with family planning services alone, is to provide FP services in connection with women's health (including maternal) and child health ('WCH') services. Indeed, including FP services with good quality WCH services could achieve family planning objectives while 'putting contraception in its place' - in a package that ensures that women are healthy and that their children will survive and be healthy. Such a package is most likely to draw women to health centres as families view child health as a legitimate, even desirable, reason to grant mothers 'permission' to approach them. Fathers often also participate in efforts to obtain child health services. Hence, women's access to health services will increase accordingly and information and motivation for birth spacing or even termination can be given in the context of advice to benefit their children's and their own health. This is also an important aspect of improving knowledge about family planning and the 'quality' of services.

7.3.2 Increasing Knowledge

Efforts to increase knowledge of family planning also should utilise a range of channels. Many of the persons associated with the village 'institutions' listed above could function as inter-personal communicators and motivators if they are provided adequate information. Appropriately-designed pamphlets and posters could be made available for household distribution. While the reach of mass media such as radio and television into small villages is limited, these are powerful communicators where they are available.

Health personnel in both the public and private sectors are 'authoritative' communicators and come into contact with women and men while providing other health services. Appropriate information could be provided through them. Giving FP information in the context of WCH services, as noted above, improves the likelihood of FP acceptance as families see it as a 'child survival' and health-protection strategy. The corollary - that FP should be projected in communications - as a health-protecting activity is also important.

A difficult task - but one which certainly needs to be tackled within the Indian context - is the provision of information for young 'adolescent' girls. By age 15, many rural girls are married; most bear their first child by age 16. The FP programme has propagated messages aimed at parents and potential in-laws to delay girls' marriages at least to age 18. But the subject of 'delaying the first birth' has been neglected because of the strong emphasis on a young girl having to prove her fertility soon after marriage. Communication efforts which

explain the hazards to a young mother and her infant of early pregnancy could, however, be directed at parents, in-laws and husbands as well as the young women themselves. This may in turn lead to marriages being delayed!

7.3.3 Increasing Choice

The emphasis in the past of India's family planning on terminal sterilisation (recently, mostly tubectomy) created demand primarily among couples with an already large family size. To increase the participation of younger, lower parity couples, expanding the range of contraceptives available is an important strategy. Not only will this draw in women (or men) who have had the number of children they desire but are not yet prepared to go in for sterilisation, but it will also, importantly, bring in those who understand the value of birth spacing even between first and second children.

7.3.4 Improving Quality

Improvements in the inter-personal skills of village-based workers and regular availability of supplies would help to make women more at ease about family planning and facilitate their practise of it. At health centres, services must be provided in a more humane way and under hygienic conditions, as well as be skilled, regularly available and efficiently provided. These measures would help overcome the major criticisms women voice about the public health system which include the non-availability of medicines, long waits and the 'rude behaviour' of staff.

The 'quality' of family planning services can also be greatly enhanced by integrating them with women and child health services. Experience world-wide has shown that people are motivated to practise family planning (particularly birth spacing) if they understand its role in ensuring child health and women's health. They also have greater faith in health providers if the latter are seen to be concerned about the welfare of the family. Thus, the image of health personnel is improved and the actual health benefits acruing to the family are a powerful motivation to accept family planning.

7.3.5 Strengthening Action through Organisation

In the Indian family planning programme, the responsibility for adopting contraception has largely been placed on individual couples. Although little is known about husband-wife communication and intra-family decision-making processes, it is believed that some 'unmet demand' exists among women who, while they are willing to adopt family planning, do not have or cannot expect the active support of husbands. In other development spheres where women have been diffident to approach service agencies (or even 'prevented' from doing so), they have derived 'strength from numbers.' Women's organisations and local groups have assisted them to obtain services. They have offered service providers opportunities to discuss a wide range of topics including family planning, maternal and child care, etc. They have been active recipients of non-formal education classes, another forum in which family planning has been discussed.

In addition to *mahila mandals* which have been formed under the aegis of local government, other women's groups have been established in connection with some development programmes (eg. NFE, ICDS, DWCRA) with government workers helping to catalyse them. The health and family welfare system has proposed to establish 'Women's Health Committees' (*Mahila Swasth Sanghs*) at the village level. Women's groups are often also formed by NGOs to implement a wide variety of activities. Thus, this strategy can be utilised to communicate with women about family planning, to motivate them, and to strengthen their access to services. Local women's groups can also help to plan services and monitor them.

7.4 Project Strategies to Overcome Constraints and Use Opportunities

The Project proposes to undertake several of the activities listed in section 7.3. To increase access to services it will utilise a number of channels to reach into villages and widely in towns, including all levels of the government health and family welfare system, community workers, independent private practitioners as well as those who work in clinics and institutions, NGOs and social marketing channels. It is expected that marketing channels will not reach down below villages of 5,000 people. Employer-based services and approaches through public enterprises will also reach a limited number of people. However, the wide range of channels should ensure maximum coverage of the population with services.

The Project has a sizeable IEC component to improve knowledge of potential acceptors about family planning. Both conventional and modern media will be used, and attractive messages and materials prepared. Perhaps most important, the interpersonal communication skills of workers are to be strengthened through training and the provision of good materials.

Increased choice is envisaged as the Project emphasizes spacing technologies which have received less attention in the past. This goes hand-in-hand with improve quality of services as counselling and motivation skills and technical skills are to be improved.

The Project will also encourage women's organisation in a variety of ways. The government's proposal to establish women's commitees is likely to be adopted. NGOs working at the grass-roots will undoubtedly utilise this strategy. Indeed, NGOs with a strong women's orientation will be selected for funding under the Project. Women's dairy cooperatives are to be a focus for family planning activities. The Project will also explore the possibility of introducing family planning education and services through women's groups established under other government programmes and projects.

In general, the Project takes the view that preventing pregnancies which take their toll of women's health and survival (and child health and survival) serves women's interests. It does not provide funds for wider MCH or WCH services. It is envisaged that these will continue according to the Central and state governments' mandates, with funding from national sources. Any enhancement of services in this area would also be met from indigenous resources. None are currently planned. The state government has to meet the recurring costs of the existing health and family welfare infrastructure, including the salaries of workers who will provide FP services under the Project and who are also responsible for

providing MCH and other services.

However, there are many opportunities in the Project to strengthen the integration of FP and WCH services. In the training activities envisaged - particularly those for ANMs and PHC/CHC staff, there will be opportunities to 'position' FP within WCH services both for better counselling and improved service delivery. IEC activities and messages could also do so. Research activities could investigate the role of WCH services in increasing FP acceptance. Operations research could be conducted specifically on integrated service delivery and on an 'integrated target' approach (ie. the provision of sequential services to pregnant women, beginning with ante-natal care, through delivery, post-natal and infant care to adoption of a family planning method).

7.5 Benchmarks Against Which to Measure Progress

As the Project should seek to enhance women's participation - both as 'Participants' and 'Beneficiaries' an important benchmark is the hiring of women managers. This should be an objective at all levels beginning with the USAID Office, the Central MOHFW and the State DOHFW and Directorate of Family Welfare. In particular, women should be well represented in the senior management of the IFPS Project Agency. Other project-related managerial posts that could be staffed by women include the Director of Family Welfare and MCH, District Health Officers, Superintendents of District Hospitals, and so on. Indeed, an 'affirmative action' policy in which women are given preference for all project-related managerial posts is strongly recommended.

Similarly, among quasi-governmental and non-governmental institutions, particularly training institutions, research institutes, NGOs and commercial firms (eg. those involved in social marketing), preference should be accorded women managers. Indeed, in the selection of participating institutions preference could be given to organisations with women at higher levels of management and those who propose to increase women among their managers. This could then be used as a benchmark.

As the training of ANMs is a key strategy in the Project for expanding FP services and improving their quality, the extent, content and quality of training can be the bases of important benchmarks. Similarly, training of women at other levels of the health service system (LHVs, Registered Nurses and Doctors) can be used to establish benchmarks. These should be monitored continuously (possibly with the assistance of the computerised manpower (sic!) management programme proposed under IPP-VI) and assessed on an annual basis. Among non-governmental providers as well, the numbers of women trained and involved in service delivery should be assessed.

The actual performance of these workers - particularly ANMs - in terms of the number of women they contact, provide services (WCH as well as FP) to, and motivate for family planning, assessed on a sample basis before and particularly after training, can also constitute benchmarks.

7.6. Project Activities to Ensure...

7.6.1 ...Availability of Sex-disaggregated Data

The Project will collate data on the gender of health service managers and health personnel at all levels of the public health system and review these data on an annual basis. It will also collect data from other institutes participating in Project activities and receiving grants under the Project.

Under the Research and Evaluation component of the Project, data will be collected on the gender of family planning acceptors by method.

7.6.2 ...Analysis of Women's Participation

The Research component of the Project is very likely to include studies that investigate women's preferences in family planning and the constraints they face in accepting contraception. This will provide information about 'what women want,' in terms of FP services and 'what prevents them from coming forward for what is available in the way of services.' Operations research studies would usefully include approaches to overcoming women's constraints in order to strengthen programme design to increase women's participation.

7.6.3 ...Measurement of Women's Participation

Women's participation can and should be measured in terms of

- -- the number of women who fill managerial posts related to the Project (as described above);
- -- the number of women trained in the Project;
- -- the quality of the training, and the quality of workers' performance, with attention to the 'women-sensitivity' of both;
- -- the number of women coming for services to 'fixed' centres;
- -- the number of women reached by outreach activities; and, ultimately
- -- the increase in FP acceptance by women in Project areas.

The effectiveness of Project strategies in reaching women beneficiaries will be measured primarily on the basis of monitoring data collected on FP acceptance. These data as well as more qualitative information collected through specific studies can be analysed and utilised to continuously improve women's participation in Project activities.

ANNEX III.E. ECONOMIC ANALYSIS

Numerous economic benefits are associated with averting unwanted births and postponing mistimed births. Benefits differ in their timing. Some are realized immediately, such as averting costs relating to the pregnancy and childbirth. Some are realized in the short-term, such as averting costs relating to child health, nutrition and education. Benefits can be realized on various levels -- some, such as foregone school fees, are realized at the family level; others, such as reduced recurrent public education and public health costs are realized at the state or national level. Benefits also differ in ease of measure. Some, such as recurrent education costs are more easily measured. Others are more difficult to quantify, such as reduced medical costs related to reductions in high-risk births or increased opportunities for women to pursue education and employment.

The present analysis compares the costs of expanding the family planning program in Uttar Pradesh (U.P.) with the savings associated with reduced government expenditures in the education and health sectors. The analysis is limited in a number of ways. Most notable is that the savings associated with averted and postponed births are estimated for the State Government of Uttar Pradesh. Ignored are the savings realized by families and private service providers through reduced expenses for education and health care. Education is largely provided through the public sector, although families are generally expected to pay for books. Health care, on the other hand, is provided predominantly by the private sector -- only 22 percent of health care expenditures in all of India are made within the public sector. **So by confining this analysis to the public sector, only a fraction of total benefits are measured.**

The analysis is also limited by up-to-date and comprehensive information on family planning, education, and health costs for U.P. Where data are not timely, an effort has been made to project costs forward. Where data are only available for India on a national level, they have been applied to U.P.

As a first step, the current U.P. population is constructed, disaggregated by age and sex. At the time of this analysis only aggregated results were available from the 1991 India census. The population of U.P. totaled 139 million. To obtain age-sex disaggregation, the age distributions revealed in the 1983 census were projected forward based on with assumptions of moderate declines in fertility and mortality over the intervening period.

From this starting point, populations are projected over the 35-year period 1991-2026 under three different scenarios. Summary statistics for these scenarios are presented in **Table A.** Each presumes a similar decline in mortality, resulting in a life expectancy increase from 55.6 years in 1991 to 70 years by 2026. What distinguishes the three projection series is the

path of fertility -- the first presumes no change in fertility (fertility remains at 5.4 children per woman throughout), the second a moderate decline (fertility declines to 4.5 by the year 2001 and to 2.5 by 2026), and the third a more rapid decline (fertility declines to 4.0 by the year 2001 and to the near replacement level of 2.2 by 2026).

Total population size grows from 139 to nearly 350 million under the first "no change" scenario. This compares with an increase to 234 million under the third "rapid decline" scenario. Similar trends are noted among three key population subgroups presented here (although the onset and magnitudes of the variations across the scenarios depends upon the age group considered): reproductive-age women, school-age children, and MCH client populations. By contrast, modern family planning users increase more rapidly under the "rapid decline" scenario, since the effect of rising contraceptive prevalence over this period overwhelms the effect of a slower growth in numbers of reproductive age women.

Although not computed in this table, modern contraceptive prevalence rates begin at 26 percent in 1991. By 2002, prevalence increases to 28 percent under the "no change" (owing to a shift from traditional to modern methods), to 39 percent under the "moderate decline", and to 43 percent under the "rapid decline" scenario.

All three projection series assume an identical shift in method mix. Sterilization declines from a 56 percent share of users in 1991 to 46 percent in 2002. Traditional method use also declines in percentage terms over this period from 14 to 10 percent. All other methods expand in their share of users: condoms from 13 to 15 percent, IUDs from 15 to 20 percent, NORPLANT from 0 to 4 percent, and orals from 2 to 5 percent.

Next, costs are estimated on a "per user" basis for family planning, education, and maternal-child health (MCH) services. Family planning costs per user is estimated to be $4 based on national-level data from MOHFW and the Urban Institute. Education costs per student are estimated to be $37 based on state-level data from the MOE. MCH service costs per client (children under age 5 plus women age 15-49) estimated to be under $1 based on state-level data from the MOHFW. This low cost is due to the heavy reliance on the private sector -- estimated to provide 78 percent of health in India. The total expenditure by public and private sources combined amounts to $7 per user.

These costs are then applied to the estimated number of users of these services and over the 1991-2026 time period for each projection scenario. The results are displayed in **Table B** for the "rapid decline" and "no decline" projection scenarios. The differences in these two scenarios is presented in the third panel of the table. These differences represent the stream of costs for an expanded program of family planning for U.P. and the stream of benefits expressed in terms of savings in the public education and MCH sectors.

The annual added recurrent costs of family planning grow to $22 million by 2001 and to $60 million by 2026. The corresponding savings for these two years grow to $26 and $992

million, respectively. The rapid expansion of savings after the first ten years of the program is due to the age-related delay in the full effect of fertility change in these two service sectors.

Annual and cumulative benefit-cost ratios for these comparisons are presented in **Table C.** The annual savings does not exceed added annual costs until the year 2000 -- the breakeven point. Cumulative savings begin to exceed cumulative costs in the year 2003 -- the payback point. Thereafter savings (annually and cumulatively) outpaces costs. These estimates, of course ignore discounting, and in effect equate future with present values of both savings and costs. The internal rate of return (IRR), which is the discount rate that equates the present value of projected costs with the present value of projected savings, provides a single measure of returns on investment. **The IRR for the stream of savings and costs observed over this thirty-five year period is 34 percent. This means that one would have to discount future benefits by more than 34 percent annually for the investment in family planning not to be cost-beneficial. Hence, the return on investment in family planning in U.P. is extremely favorable.**

A benefit-cost summary is presented in **Table D.** This table summarizes the initial or "baseline" results. For the baseline analysis, the IRR is calculated over various intervals of time. If measured over a ten-year period alone, the investment would not be cost-beneficial -- but becomes so when measured instead over fifteen years.

Three variations on this analysis were carried out. The first expands the MCH savings to include those that would be realized by the private sector (including individual families) in addition to government savings. This results in a substantial improvement in benefits, with the ten-year IRR rising to 48 percent. The second variation presumes that FP costs per user doubles over the 35-year period, reflecting the higher costs associated with a shift toward non-permanent methods. This results in a slight dampening of returns on the investment, with the 35-year IRR dropping to 30 percent. The final variation compares the "rapid decline" with the "moderate decline" (rather than the no change scenario), which might be argued to be more realistic since the effect of the proposed project is to strengthen a program that already has some amount of momentum. This results in a slight improvement in the IRR estimates.

Table A.
Population Estimates under Three Projection Scenarios: 1991-2026 (in millions unless noted)

Year	TFR*	Total Pop	Women 15-49	FP Users	School Pop**	MCH Pop***
		No Change in Fertility				
1991	5.4	139	32	8	37	44
1996	5.4	157	35	10	41	51
2001	5.4	179	39	11	48	60
2006	5.4	204	45	13	56	69
2011	5.4	232	51	15	65	79
2016	5.4	264	59	18	74	89
2021	5.4	303	67	21	83	102
2026	5.4	349	75	24	96	118
		Moderate Decline in Fertility				
1991	5.4	139	32	8	37	44
1996	5.0	156	35	11	41	50
2001	4.5	174	39	14	48	57
2006	4.1	192	45	20	53	63
2011	3.6	210	51	27	56	68
2016	3.2	228	57	36	57	72
2021	2.7	244	62	40	57	76
2026	2.5	260	66	42	57	80
		Rapid Decline in Fertility				
1991	5.4	139	32	8	37	44
1996	4.7	155	35	12	41	49
2001	4.0	171	39	16	47	54
2006	3.3	186	45	23	51	58
2011	2.6	199	51	32	51	61
2016	2.5	210	56	36	48	64
2021	2.3	222	59	38	45	68
2026	2.2	234	60	39	44	70

* Total Fertility Rate is the average number of children per woman.

** Shool-Age Population: ages 6-17.

*** Maternal & Child Health Population: children under 5 plus women 15-49.

Table B.

Estimated Annual Expenditures in Family Planning, Education, and Health Sectors under Two Fertility Scenarios: 1991–2026 Uttar Pradesh State, India (all estimates in millions)*

Year	Family Planning		Education		Health: MCH		Total Ed&He
	Users	Costs	Students	Costs	Clients	Costs	Costs
Rapid Decline in Fertility							
1991	8.5	$34	18.2	$668	43.8	$39	$707
1996	11.9	$48	20.5	$752	49.4	$44	$796
2001	16.3	$66	23.6	$864	54.4	$49	$913
2006	22.9	$93	25.0	$917	58.1	$52	$969
2011	32.4	$131	25.0	$915	60.8	$54	$969
2016	35.8	$145	23.5	$861	63.7	$57	$918
2021	37.8	$153	21.8	$799	67.6	$60	$859
2026	38.5	$156	21.4	$783	70.0	$63	$846
No Change in Fertility							
1991	8.5	$34	18.2	$668	43.8	$39	$707
1996	9.5	$38	20.5	$750	51.2	$46	$796
2001	10.9	$44	24.2	$885	60.4	$54	$939
2006	12.7	$51	28.0	$1,024	69.3	$62	$1,086
2011	15.0	$61	32.2	$1,179	79.0	$71	$1,250
2016	17.7	$72	36.4	$1,335	89.3	$80	$1,415
2021	20.5	$83	41.1	$1,507	102.1	$91	$1,599
2026	23.7	$96	47.3	$1,732	118.2	$106	$1,838
Difference							
1991	0.0	$0	0.0	$0	0.0	$0	$0
1996	2.4	$10	0.0	$1	(1.8)	($2)	($0)
2001	5.4	$22	(0.6)	($21)	(6.0)	($5)	($26)
2006	10.2	$41	(2.9)	($107)	(11.2)	($10)	($117)
2011	17.4	$71	(7.2)	($265)	(18.2)	($16)	($281)
2016	18.1	$73	(12.9)	($474)	(25.6)	($23)	($497)
2021	17.3	$70	(19.3)	($709)	(34.5)	($31)	($740)
2026	14.8	$60	(25.9)	($949)	(48.2)	($43)	($992)

* All costs are expressed in 1990 U.S. dollars.

Table C.
Annual and Cumulative Benefit-Cost Ratios: Comparing Rapid with No Change in Fertility (1991-2026)

Year	Annual Added FP Costs	Annual Ed & He Savings	Annual Ben/Cost Ratio	Cumul Ben/Cost Ratio
1991	$0	$0	0.00	0.00
1992	$1,863	$60	0.03	0.03
1993	$3,766	$119	0.03	0.03
1994	$5,669	$179	0.03	0.03
1995	$7,694	$239	0.03	0.03
1996	$9,840	$298	0.03	0.03
1997	$12,026	$5,482	0.46	0.16
1998	$14,375	$10,665	0.74	0.31
1999	$16,764	$15,848	0.95	0.46
2000	$19,275	$21,031	1.09	0.59
2001	$21,907	$26,214	1.20	0.71
2002	$24,660	$44,358	1.80	0.90
2003	$28,305	$62,501	2.21	1.13
2004	$32,279	$80,645	2.50	1.35
2005	$36,679	$98,789	2.69	1.56
2006	$41,363	$116,932	2.83	1.75
2007	$46,391	$149,743	3.23	1.96
2008	$51,849	$182,553	3.52	2.18
2009	$57,713	$215,364	3.73	2.38
2010	$63,956	$248,174	3.88	2.58
2011	$70,536	$280,984	3.98	2.75
2012	$71,419	$324,230	4.54	2.95
2013	$72,237	$367,475	5.09	3.17
2014	$72,904	$410,721	5.63	3.40
2015	$73,332	$453,966	6.19	3.64
2016	$73,452	$497,212	6.77	3.88
2017	$73,260	$545,701	7.45	4.14
2018	$72,806	$594,191	8.16	4.42
2019	$72,093	$642,680	8.91	4.70
2020	$71,127	$691,170	9.72	4.99
2021	$69,907	$739,660	10.58	5.29
2022	$68,430	$790,165	11.55	5.61
2023	$66,694	$840,671	12.60	5.94
2024	$64,702	$891,176	13.77	6.28
2025	$62,453	$941,682	15.08	6.63
2026	$59,945	$992,187	16.55	7.00

Table D.
Benefit-Cost Summary:
Baseline Compared with Three Variations

	Year		Internal Rate of Return			
	Break-Even	Pay-Back	10-YR	15-YR	20-YR	35-YR
Baseline	2000	2003	-6.6	25.2	31.7	34.4
Variation A	1997	1999	48.3	59.2	60.9	61.2
Variation B	2002	2004	-27.1	18.1	26.4	30.2
Variation C	1999	2002	0.2	28.5	34.2	36.5

Variation A: expands health care benefits to include private savings.
Variation B: FP costs per user doubles over period.
Variation C: compares rapid with moderate decline projection.