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U S Agency for International Development

**INNOVATIONS IN FAMILY  
PLANNING SERVICES PROJECT  
MIDTERM ASSESSMENT REPORT**

September 1997

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***Core Team***

Jinny Sewell  
Sigrid Anderson  
Harry Cross  
Keys MacManus

***Technical Experts***

Alan Bornbusch  
J S Deepak  
John Stover  
Amy Tsui  
N N Wahi

***Senior Experts***

Nils Daulaire  
Sidney Chernenkoff  
Indra Pathmanathan

## TABLE OF CONTENTS

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Abbreviations	1
Acknowledgements	iv
Executive Summary	v
Senior Policy and Technical Experts Findings	xix
Map of Uttar Pradesh	xxvii
I Introduction	1
II Assessment Purpose	2
III Design of the IFPS Project	
A State Selection	4
B IFPS Project Design Approaches	6
C Goals and Objectives	6
D Ten Year Performance Framework - Project Phases	7
E Program Components	9
E 1 Public Sector	9
E 2 Private Sector	10
E 3 Contraceptive Social Marketing	10
E 4 Research and Evaluation to Inform Partners and Document Project Progress	11
F IFPS Project Implementing Agency	13
G Role of Technical Assistance	13
IV IFPS Achievements	
Key Findings	14
Results	14
A Improved Quality	15
B Increased Access	19
C Increased Demand	25
D Inclusion of Other Reproductive Health Interventions	29
E District Focus - Essential Package of Linked Services	30

V	IFPS Program Components	35
A	Public Sector	
	Current Situation	36
	Findings	38
	Recommendations	40
B	Private Sector	
	Current Situation	41
	Findings	44
	Recommendations	49
C	Contraceptive Marketing (Social and Commercial)	
	Current Situation	52
	Findings	57
	Recommendations	61
D	Cross Cutting Areas	
D 1	Contraceptive Logistics	
	Current Situation	62
	Findings	64
	Recommendations	66
D 2	Information, Education and Communication	
	Current Situation	66
	Findings	68
	Recommendations	69
D 3	Reproductive Health	
	Current Situation	70
	Findings	72
	Recommendations	77
VI	Other Donor and Other USAID Contributions	
	Current Situation	78
	Findings	78
	Recommendations	80
VII	Sustainability and Cost Effectiveness	81
	Recommendations	83

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VIII	Decision Making on the IFPS Project	
	Current Situation	84
	Findings	86
	Recommendations	87
IX	SIFPSA Capacity	
	Current Situation	88
	Findings	88
	Recommendations	95
X	Role of Technical Assistance Support Through Cooperating Agencies	
	Current Situation	97
	Findings	98
	Recommendations	101
XI	USAID Management	
	Current Situation	102
	Findings	103
	Recommendations	104
XII	Performance Based Disbursement System	
	Current Situation	105
	Findings	106
	Recommendations	111
XIII	Technical Analysis for Impact	
	A Background	112
	B Focusing IFPS Efforts	113
	C Technical Feasibility of Achieving IFPS Project Goals	115
	D Implications	121
	E Sensitivity to Key Assumptions	121
	F Reproductive and Child Health	123
	G Findings	123
	H Recommendations	125

## ANNEXES

- 1 Scope of Work
- 2 Scope of Work for Senior Policy and Technical Experts
- 3 Team Schedule
- 4 Key Persons Contacted
- 5 Rapid Assessment Summaries
- 6 List of Training Materials
- 7 Evaluation of Achievement of Benchmark 26
- 8 District Planning
- 9 Summary of District Action Plan - Rampur district
- 10 SIFPSA Organogram
- 11 Strategic Objective 2 - Indicator list

## ABBREVIATIONS

AED	Additional Executive Director
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
CA	Cooperating agency
CBD	Community-based distribution
CEDPA	Center for Development and Population Activities
CHC	Community Health Center
CMO	Chief Medical Officer
CPR	Contraceptive Prevalence Rate
CSM	Contraceptive Social Marketing
CTU	Contraceptive Technology Update
DHS	Demographic Health Survey
DIFPSA	District Innovations in Family Planning Services Agency
DY CMO	Deputy Chief Medical Officer
EC	European Community
ED	Executive Director
FLE	Family life education
FP	Family planning
FPIS	Family Planning Information Systems
FPS	Family Planning Services
GM	General Manager
GOI	Government of India
GOUP	Government of Uttar Pradesh
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HLL	Hindustan Latex Limited
IAS	Indian Administrative Service
ICICI	Industrial Credit and Investment Corporation of India
ICS	Institute for Career Studies
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IFPS	Innovations in Family Planning Services (Project)
IMA	Indian Medical Association
IPP-VI	India Population Project-VI
ISM	Indian Systems of Medicine

ISMP	Indian Systems of Medicine Practitioner
IUCD	IntraUterine Contraceptive Device
IUD	IntraUterine Device
MCH	Maternal and Child Health
MISSION	USAID/India
MO	Medical Officer
MSS	Mahila Swasthya Sangh
MWRA	Married Women of Reproductive Age
NFHS	National Family Health Survey
NGO	Non-governmental Organization
NSV	No-scalpel Vasectomy
OCP	Oral Contraceptive Pill
OR	Operations Research
PAC	Project Appraisal Committee
PACT/CRH	Program for Advancement of Commercial Technology in Child and Reproductive Health
PCDF	Pradeshik Cooperative Dairy Federation
PERFORM	Project Evaluation Review for Organizational Resource Management
PHC	Primary Health Center
PHN	Office of Population, Health and Nutrition
PLA	Public Ledger Account
PMU	Project Management Unit
PPC	Post-partum Center
PPRC	Prerana Population Resource Center
PSI	Population Services International
PSS	Parivar Seva Sanstha
QER	Quarterly Expenditure Report
QPR	Quarterly Progress Report
RCH	Reproductive and Child Health
R&E	Research and Evaluation
REMI	Research, Evaluation Management Information Systems & Information Dissemination
RCH	Reproductive and Child Health
RH	Reproductive Health
RTI	Reproductive Tract Infection
SC	Sub-center
SDP	Service Delivery Point
SIFPSA	State Innovations in Family Planning Services Agency

SIHFW	State Institute of Health & Family Welfare
SIRD	State Institute for Rural Development
SM	Social Marketing
SO2	Strategic Objective 2
SOMARC	Social Marketing for Change
STD	Sexually Transmitted Disease
TA	Technical Assistance
TAG	Technical Advisory Group
TBA	Traditional Birth Attendant
TFA	Target-Free Approach
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UP	Uttar Pradesh
UPAA	Uttar Pradesh Academy of Administration
USAID	United States Agency for International Development
VHV	Village Health Volunteer

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We also wish to extend our thanks to all other stakeholders, within USAID and outside, in India and in the United States, who provided thoughtful reflections and provocative program ideas.

The conclusions reached in this report and those of the Team are independent of the GOI, GOUP, SIFPSA and USAID.

# EXECUTIVE SUMMARY

## BACKGROUND

In 1992 the Government of India and the U S Agency for International Development agreed to undertake the Innovations in Family Planning Services (IFPS) Project. The purpose of the project is to assist the State of Uttar Pradesh (U P ) to significantly reduce the total fertility rate and improve women's reproductive health through a comprehensive improvement and expansion of family planning and related reproductive health services. To achieve this purpose the IFPS Project identified three main objectives: (1) to improve the quality of family planning and other reproductive health services through a client centered focus, (2) to increase access by strengthening public and private service delivery systems, and, (3) to increase demand through broadening support among leadership groups and increasing public knowledge of the health and welfare benefits of family planning.

The majority of IFPS Project activities are funded and managed through an independent organization called the State Innovations in Family Planning Services Agency (SIFPSA), created to implement this project. In addition, the IFPS Project is programmatically driven by a performance based disbursement system wherein funds are disbursed against the achievement of pre-negotiated benchmarks. Benchmarks are linked to expected achievements in each of three project phases. The first phase of five years focusses on activities aimed at testing innovative means for strengthening U P 's family planning program in the public and private sectors. Innovative service improvements and expansions are introduced, evaluated and replicated in six focus districts in U P. An integral part of the effort is the provision of technical assistance to promote innovative program approaches and technology transfer. Over the ten-year IFPS Project, a large constellation of field activities will be implemented in U P in Phases II and III.

## ASSESSMENT PURPOSE

The IFPS Project is now in its fifth of its originally planned ten years, making it timely to carry out a midterm assessment. The purpose of the mid-term assessment is to evaluate progress to date, review key assumptions and implementation strategies, estimate the feasibility of achieving project objectives, and provide conclusions, recommendations and direction for the second five-years of the project.

Major national policy and program changes have occurred which impact on project approaches

- The "target free" approach to family planning services, designed to withdraw the top down, onerous targets and incentives, which limited choice and skewed the program towards female sterilization, was implemented before other service strategies and performance indicators were put in place to guide the program toward a more quality, comprehensive, and client centered effort. In the first year of the target free approach, there was a substantial decline in family planning service provision in many states but more spacing methods have been offered and service provision is again increasing in the broader context of the new GOI reproductive and child health policy
- As an outgrowth of the post-Cairo movement, the GOI has emphasized and put in place a new reproductive and child health policy to revitalize family welfare. Hence there is a need to reexamine IFPS goals and objectives to determine its linkages and contribution to this new approach

The assessment methodology included

- 10 Rapid Assessment Studies of Key Project Approaches (See Annex 5 for summary), with interviews of beneficiaries, NGO and government health providers and functionaries and private practitioners
  - 3,339 female beneficiaries interviewed
  - 309 adolescents girls interviewed
  - 158 in-depth interviews with NGO, and Government health provider personnel
  - 97 interviews with government functionaries
  - 1,858 interviews with public and private doctors
  - 240 interviews with Indian Systems of Medicine Practitioners
- Workshop on July 15-16 to review rapid assessment findings and to make recommendations to improve project approaches and scale-up sub-projects
- Interviews with project designers in Washington, D C and stakeholders in the U S
- Interviews with other donors in U S and India

- Interviews with USAID/India staff and resident technical assistance staff
- Review of all project documentation
- Multiple field visits to SIFPSA and several districts (Agra, Jhansi, Kanpur and Sitapur)
  - interviews with beneficiaries and providers
  - interviews and meetings with SIFPSA and CA staff
  - collection and analysis of data from SIFPSA
  - special analyses of SIFPSA financial and administrative management systems
- Review and Input from Senior Policy and Technical Experts

The assessment was conducted from July 14 - August 8, 1997 by a core four member team composed of Jinny Sewell, USAID/India, Sigrid Anderson, USAID/Washington, Harry Cross, The Futures Group and Keys MacManus, USAID/Washington. The core team also called upon key technical resource persons: Dr Alan Bornbusch, USAID/Washington Advisor, Mr J S Deepak, Policy Project Consultant, Dr John Stover, Vice President, The Futures Group, Dr Amy Tsui, Evaluation Project Director, and Mr N N Wahi, USAID/India Deputy Controller. During the third week of the assessment, a team of three senior policy and technical experts composed of Dr Nils Daulaire, Deputy Assistant Administrator and Senior Policy Advisor, Bureau for Policy and Program Coordination, USAID/Washington, Mr Sidney Chernenkoff, Director, Office of East and South Asian Affairs, Bureau for Asia and the Near East, USAID/Washington and Dr Indra Pathmanathan, Public Health Specialist (RCH/India), World Bank, Washington, D C also joined the exercise for one week to provide insights and comments to the core team findings and recommendations.

## **IFPS ACHIEVEMENT HIGHLIGHTS**

To date, IFPS sub-projects have tested selected innovative activities and begun expanding and replicating those with greatest promise of expanded service coverage. As of July 1997, SIFPSA has approved 170 projects, totaling Rs 1,047 million (\$30 million). Although in the first year of operations only 10 sub-projects were approved, activities have considerably accelerated with 75 sub-projects approved last year. Thirty-one out of 53 performance benchmarks have been met, and \$25.4 million

approved for disbursement. Other benchmarks are well underway toward achievement. Diverse data and information - qualitative, quantitative, macro- and micro-level - paint a compelling picture that IFPS has achieved a broad range of results that encompass both the public and private sectors. Progress has been made in increasing quality, access, and demand for family planning and other reproductive health services. **Above all, in the assessment team's view, the IFPS Project is improving the quality of life for people in U P**

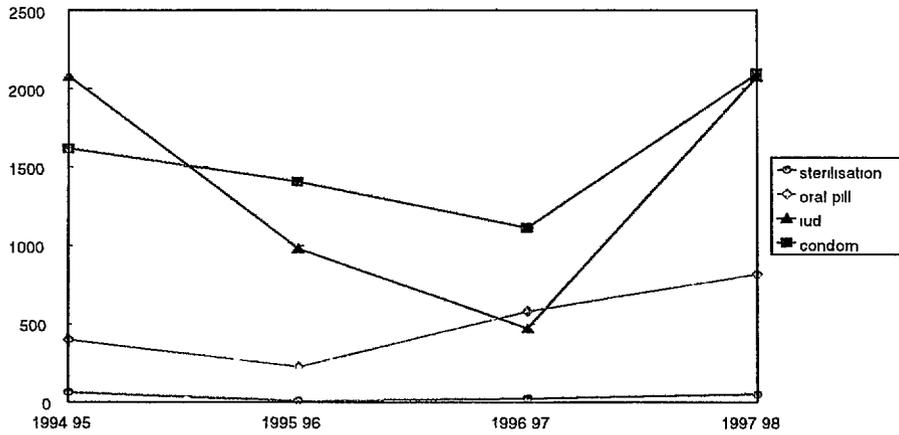
Early achievements, though many, are - not unexpectedly - limited in their coverage relative to the total state population. However, modeling projections suggest that the inputs which have to-date led to documentable achievements can, when expanded (1) have significant impact on increasing contraceptive prevalence (CPR) and lowering total fertility rates (TFR) at the state level, and (2) achieve the original goals of the IFPS Project.

The available evidence indicates that IFPS inputs have increased quality of family planning services in both the public and private sectors. Keeping in view that the public sector is the key provider of sterilization services, greater focus has been laid on improving the quality of sterilization services in the public sector, while in the private sector focus has been on improvements in the delivery of temporary methods.

The GOI in April 1996 boldly abolished method-specific contraceptive targets from its Family Welfare program. This year, a new client-oriented reproductive and child health approach is being implemented. As part of its research and evaluation work, the IFPS project is funding operations research (OR) to explore viable options for operationalizing this approach in the field - options that emphasize provision of good quality services in lieu of meeting targets.

- The removal of targets was followed by an initial decline in users in the OR areas, as illustrated in Sitapur District. However, first-quarter statistics for 1994-1997 indicate that by the first quarter of 1997-98 (April-June 1997), users generally increased to or exceeded 1994-95 levels.

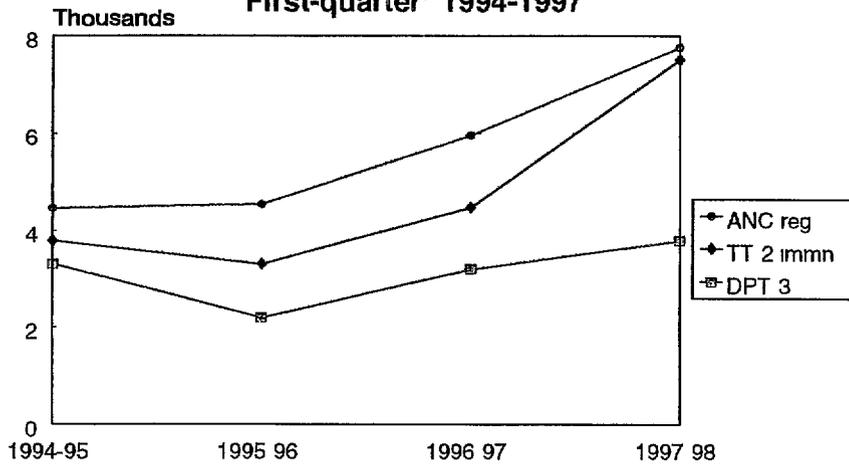
**Total Number of Contraceptive Users in Sitapur OR areas for first-quarter\* 1994-1997**



First Quarter indicates April June

- Furthermore, maternal and child health coverage has also been improved, as evidenced by antenatal care registrations and provision of tetanus toxoid and diphtheria immunizations

**Total Number of ANC-registered Women, Women Receiving TT-2, and Infants Immunized for DPT-3 in Sitapur OR Areas, First-quarter\* 1994-1997**

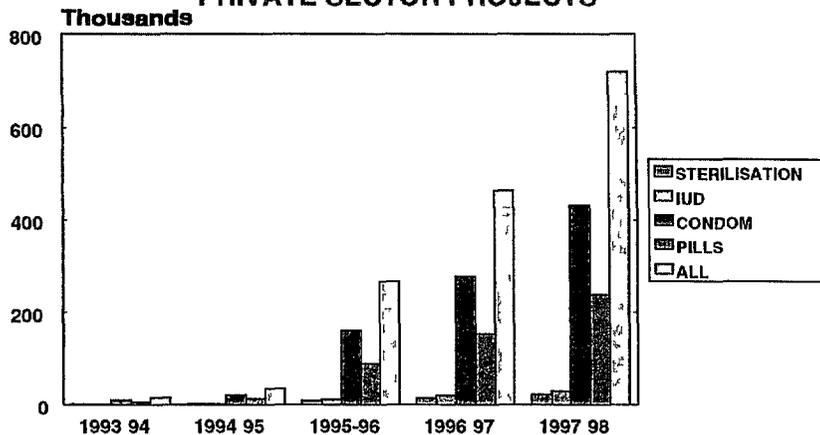


\* First Quarter Indicates April-June ANC Antenatal Care TT 2 Tetanus toxoid (2 shots) DPT 3 Diphtheria (3 shots)

IFPS service delivery sub-projects in the private sector, as documented in quarterly performance reports, are serving more people. The figure below offers annual estimates of current users served by all private sector service delivery projects (CBD, cooperative, employer-based, convergence). The estimates were calculated by extrapolating from quarterly performance reports for a representative set of 24 private service delivery projects. These estimates indicate that service by private sector projects has increased significantly, IFPS sub-projects will serve over 700,000 users in 1997-98<sup>1</sup>. Importantly, the increases in users are not solely a function of the number of projects. Review of the 24 representative projects shows that between the last two quarters of 1996/97, the number of users served by these projects alone increased by nearly 40%.

**These data also demonstrate that the private service delivery projects are contributing significantly to a major IFPS objective - increasing the use of spacing methods in U.P. Spacing users are estimated to far exceed those adopting sterilization. CBD workers from several projects, interviewed by the assessment**

**ESTIMATED FAMILY PLANNING USERS SERVED BY PRIVATE SECTOR PROJECTS**



Estimates are for all private sector delivery projects based on extrapolations from quarterly performance reports for a representative set of 24 projects.

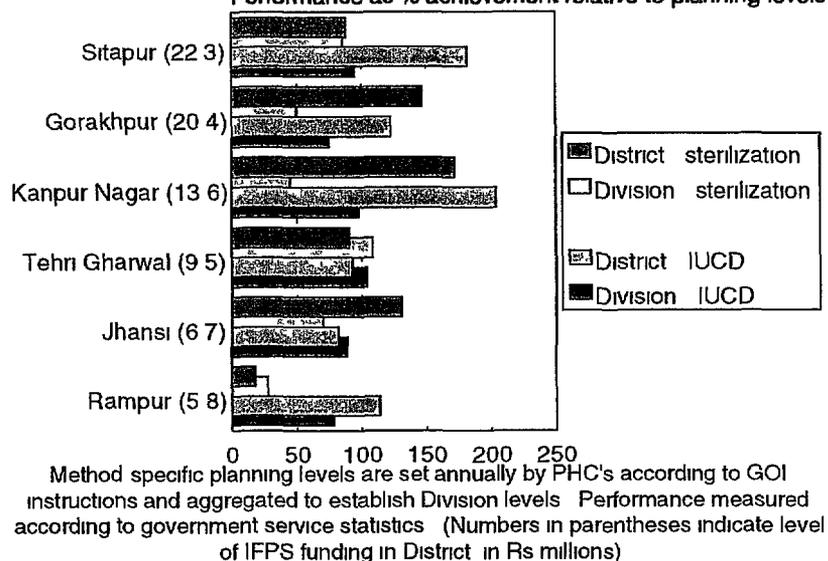
**team, routinely counsel newly married couples to delay having children by two to three years. And, women clients are aware of the health benefits to both themselves and their children of spacing.**

<sup>1</sup> GOI fiscal year April-March

In 1996-97, the six IFPS focus districts performed considerably better than other districts in their respective divisions - as measured by achievement relative to planning levels. For at least one clinical method, each focus district performed better than other districts in its division. All but one focus district also exceeded planning levels for one or both clinical methods. Gorakhpur, for example, exceeded planning levels for sterilizations and intrauterine contraceptive device (IUCD) use (performance >100%), while other districts in the same division, on average, fell short. There is also evidence of switching from limiting to spacing methods. Rampur, with a large Muslim population, did not meet sterilization planning levels, but - and again, in contrast to other divisions in the District - it exceeded those for IUCD use.

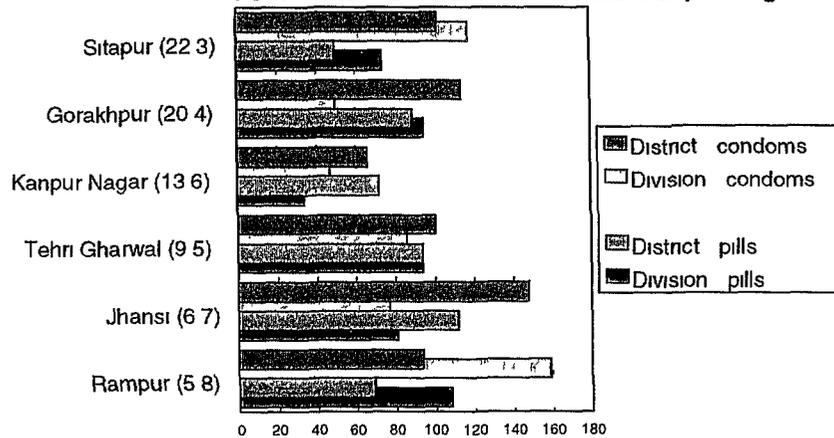
### 1996/97 Performance of IFPS Focus Districts & Respective Divisions Sterilizations & IUCD

Performance as % achievement relative to planning levels



With the exception of Rampur, which received the lowest level of IFPS inputs among the focus districts, all of the focus districts also outperformed other districts for condom and/or pill usage. Furthermore, four of the six focus districts exceeded planning levels for at least one of these temporary methods.

**1996/97 Performance of IFPS Focus Districts & Respective Divisions  
Condoms & Pills**  
Performance as % achievement relative to planning levels



Method specific planning levels are set annually by PHC's according to GOI instructions and aggregated to establish Division levels. Performance measured according to government service statistics. (Numbers in parentheses indicate level of IFPS funding in District in Rs millions)

**IFPS inputs are achieving results** Overall, IFPS service delivery activities now cover 20% of the U P population, or about 30 million people. While nearly one-third of this coverage is through public sector activities, community based distribution (CBD) and cooperative activities account for most of the remaining two-thirds. Importantly, pulling together the public-private sector interface at the district level is a critical key to the Project's success. Outreach through a range of private sector groups, practitioners or local government is critical to community mobilization, increasing awareness and demand, promoting a client orientation and informed choice and broadening services. Where a concentration of services through public-private groups has been programmed at the district level, the impact momentum is taking off and this phenomena needs to be built upon to launch into Phase II.

### SUSTAINABILITY

Because of the Government's strong commitment to the program and because of the increasing willingness of couples to purchase contraceptive supplies from the private sector, the team found the potential for sustainability of the IFPS Project to be highly likely.

### PROJECT MOMENTUM AND SCALE-UP

Considerable project momentum has been achieved over the last year. Initial emphasis

in the six focus districts demonstrated more impact from an essential package of linked public-private sector inputs. However, the focus districts contain only 8% of eligible women in U P. All 15 priority districts (6 focus plus an additional 9) contain 21% of eligible women of U P. Expansion of the program to all 28 PERFORM districts (PERFORM districts are those for which there is IFPS Project baseline survey data) will cover 50% of eligible women. Based on the assessment's technical impact analysis, it is recommended that district programming should be pursued in the 28 PERFORM districts in a focussed manner that links key public and private sector inputs so as to bring them up simultaneously and thereby achieve maximum impact. Programs in the six focus districts should be accelerated, and then expanded to 15 and then the full 28 PERFORM districts. Programs should be decentralized to the district level, and scaled up in a rational manner based on capacity and technical feasibility. The rate of district program expansion will be dependent on the extent of decentralization, and institutional capacity -- of SIFPSA, the district, and participating implementing institutions -- to develop, fund and oversee programs. The team recommends that the first comprehensive district programming being undertaken in Rampur District be assessed by December 31, 1997, and plans for further district planning be carried out based on these findings. It is clear that the expansion of the program beyond the initial focus districts in the later years of the project will be key to achieving impact at the state level.

## KEY FINDINGS

The IFPS Project is making important progress in meeting the needs of women and slowing population growth in U P. Key findings of the midterm assessment are

- 1 **The IFPS Project design is valid.** IFPS is an evolving model for public-private partnership in India, is serving the needs of the poor on a wide scale, and demonstrates the value of GOI-U S cooperation.
- 2 **The Project shows clear evidence that it has the potential to achieve its goals and objectives** for enhancing reproductive health and reducing fertility in North India over a ten year period.
- 3 **Reproductive health interventions are being implemented in both the public and private sector programs funded by IFPS.** Activities supported through the project already encompass a wide range of reproductive health services that go well beyond a sole focus on contraception, and are consistent with the post-Cairo policies of the GOI and USAID. The quality, cost effectiveness and

impact of the interventions needs to be validated and future programming should support a reproductive health approach

- 4 **SIFPSA capacity has grown tremendously and has dynamic leadership** that positions the project well for expansion SIFPSA needs to refine its management structure and systems, **placing urgent emphasis on instituting a functional management information system**, in order to rapidly accelerate implementation and move into Phase II SIFPSA also needs to become more of a technical assistance agency rather than just a grants making agency in order to more broadly bring in the innovations from Phase I to Phase II expansion
- 5 **Contraceptive logistics are not adequate for program needs, and must improve dramatically** Supplies in the public sector are erratic due to either insufficient quantities or poor management in transport of supplies to facilities, adversely affecting the government program as well as the IFPS funded private sector groups attempting to link up to free government supplies for their CBD projects Although an action plan for logistics improvement has been developed by SIFPSA in collaboration with the GOUP, very little has actually been implemented This area must be given immediate priority by the GOUP to address one of the most pressing constraints to IFPS implementation, since the current growth in demand is substantially outstripping the availability of contraceptive supplies
- 6 **Commercial and social marketing efforts can be pursued through several avenues** The original plan for Contraceptive Social Marketing (CSM) cannot be implemented as designed due to GOI constraints and a new, multifaceted approach is required incorporating commercial, partially subsidized and fully subsidized (free) contraceptive distribution A market segmentation study about to be undertaken will provide much more information from which to develop a market sensitive strategy based on potential consumer purchasing power and development of a comprehensive plan agreed to by all parties by May 1998 will be considered a critical benchmark
- 7 **Public sector services have improved**, particularly in those districts where an essential package of inputs, ie training equipment, medicines, additional female doctors, and transport have been made available, resulting in tangible improvements in client centered, quality care through counseling and infection prevention practices Those small scale innovations found to be effective and practical need to be more broadly incorporated into the program

- 8 **PVO partnerships are an essential part of the program** However, given the paucity of NGOs in U P , the project should focus principal attention on working with selected, larger NGOs and providing the necessary institutional support to strengthen them both managerially and technically Indian Systems of Medicine practitioners also have shown great promise to extend the reach to clients in U P and should be further supported by SIFPSA SIFPSA needs to serve as the catalyst for linking the public and private sector networks, for assuring that the public sector learns from and incorporates effective strategies tested by the private sector, and that the private system receives essential support and referral services from the public sector
- 9 **Technical assistance has been necessary and supportive of achievements to date** Without these inputs it is unlikely that the Project would be on a trajectory to achieving its goals However, since the technical assistance may not have always been readily utilized by implementation partners, in particular SIFPSA, there needs to be a more cohesive agreement on TA priorities through joint planning together with SIFPSA and through coordinated management of the TA input by USAID/Delhi
- 10 **The performance based disbursement system is a viable and preferred method for financing** the SIFPSA portion of the IFPS project It is working as designed The nature of the PBD system includes the need to have committed funds on hand to pay outstanding benchmarks and to negotiate new sets of benchmarks which require a necessarily large pipeline for implementation This is a necessary feature of a system which is working as designed rather than a flaw

## MAJOR RECOMMENDATIONS

- 1 **Strategic focus** IFPS subprojects and funding should be phased as agreed upon in the project strategy and action plans New subprojects should be oriented towards achieving benchmarks in the 15 priority districts Only select statewide efforts should be sanctioned, these include training and dissemination in select areas (e g , contraceptive technologies, infection prevention, client counseling), contraceptive logistics, IEC, and contraceptive social marketing
- 2 **Revising goals** IFPS goals should be revised to reflect new baseline values, the results of potential impact analyses, and new national reproductive health goals These are all consistent with the originally designated project goals End-of-

project goals should be defined for 2004, that is, 10 years from 1994 when active program implementation began. Assuming continued project momentum and further progress toward IFPS goals over the next three years, USAID should formally review the life of project duration in the year 2000 and consider a project extension to 2004 based on successful results of focussed project implementation and desired impact.

- 3 **IFPS should selectively build upon current reproductive health efforts** - especially antenatal and delivery care. In addition, efforts should be pursued to develop targeted services for women suffering complications from unsafe abortions, a major cause of mortality and morbidity. The extent and quality of all ongoing reproductive health activities should be validated and this information used to strengthen linkages among interventions. IFPS should continue to analyze how interventions can be linked at service delivery points in a cost effective manner to enhance client satisfaction and service utilization. Indicators on reproductive health should be included in the strategic objective framework.
- 4 **SIFPSA Capacity Building** Implementation of the Project's MIS should be a priority for SIFPSA in order to fully track implementation and make adjustments, build in innovations to future program efforts, and, document project achievements. A functional MIS is **urgently needed** to track and report key project performance indicators to USAID/Washington critical to justification for future funding allocations necessary to fully implement the project. SIFPSA should (a) identify its priority MIS program and financial data needs by September 30, 1997, and (b) then develop and operationalize the MIS no later than the end of December 1997. Also, to prepare for project expansion, SIFPSA should reexamine its organizational structure, delegation of authority procedures and gaps in technical expertise. To do so, SIFPSA should contract with a management consultant or firm to study its organizational procedures and staffing structure relative to the needs of the IFPS Project to make necessary changes, update job descriptions for senior level positions, and identify training needs and additional positions that may be required to strengthen their management structure, program direction (emphasizing district planning) and build staff technical depth through training and partnering with Cooperating Agency technical staff.
- 5 **Contraceptive logistics** Implementation of the IFPS contraceptive logistics plan by well-qualified Family Welfare Directorate staff should be an immediate

priority More effective contraceptive logistics management is required Consideration should be given to contracting-out logistics management by the GOUP to a private entity

- 6 **Strong, collaborative efforts to expand a rational supply of and access to fully subsidized (free), partially subsidized and commercial contraceptives are essential** to meet increasing demand generated by IFPS for family planning spacing methods Based on the market segmentation study, a detailed implementation plan should be developed by USAID making necessary adjustments in approaches and funding levels A technically and administratively sound alternative plan mutually agreed to by USAID and the GOI must be in place by May 1998 If not, expectations and project goals should be revised downward and funding levels correspondingly decreased
- 7 **Integrated District Approach** District planning should be adopted by SIFPSA to develop a critical mass of linked program inputs in select districts, and thereby maximize district-level impact Based on a district planning and budgeting exercise, a comprehensive strategy and developed set of public-private sector interventions should be agreed upon to strengthen and coordinate inputs
- 8 **Private Sector Scaling-Up** SIFPSA should place a top priority on continuing and expanding its pursuit of large networks for service delivery in the private sector Expansions of pilot projects utilizing cooperatives, large NGO's, and large employers are endorsed As specific initiatives are expanded, technical assistance must be coordinated to ensure that organizational capacities are present for implementation of expanded activities Indigenous practitioners also offer potential for significant expansion of service delivery Expansion of ISMP training should be an IFPS priority, and networks should be built in support of, for example, refresher training and supply and referral linkages
- 9 **Cooperating Agency (CA) Performance** Monitoring of CA performance needs to be strengthened by developing joint annual workplans, with quarterly results reviews by USAID and SIFPSA with the CA's Technical assistance (TA) workplans and monitoring should focus on specific activities as fundamental prerequisites to benchmark achievement And, TA should be aimed at building the capacity of SIFPSA and local organizations to conduct the work The assessment team recommends that the project continue to access technical assistance through the Global Bureau agreements

- 10 **The performance based disbursement system is an effective way to fund IFPS activities through SIFPSA**, and should be maintained as the project's principal financing mechanism. Because existing benchmarks, and benchmarks under negotiation, require committed funds, the IFPS Project must maintain a large pipeline.

## SENIOR POLICY AND TECHNICAL EXPERTS' FINDINGS

Senior Experts of Dr Nils Daulaire, Deputy Assistant Administrator and Senior Policy Advisor, Bureau for Policy and Program Coordination, USAID/Washington, Mr Sidney Chernenkoff, Director, Office of East and South Asian Affairs, Bureau for Asia and the Near East, USAID/Washington and Dr Indra Pathmanathan, Public Health Specialist (RCH/India), World Bank, Washington, D C joined the assessment team in late July to review the preliminary findings of the Core Team and the Technical and Resource Experts, to visit field sites in U P in order to make independent assessments and validate Core Team findings, and to meet with officials of the GOI, GOUP, SIFPSA, and USAID/India as well as with NGOs and CAs

The Senior Experts concur with the broad findings and conclusions of the Core Team

- The IFPS Project's approach to implementation is fully consistent with USAID's sectoral policies stressing reproductive health, quality of care, and progressive integration with child health. Further, the project is actively supporting intersectoral policies promoting the expansion of the role of civil society (particularly women's organizations) and the private sector, and is strengthening public-private linkages
- We are impressed with analysis indicating that the project has a very real potential to meet its original objectives, although the delay in start-up of significant activities until 1994 extends the ten year time frame to 2004. Our discussions with women's and other community groups make it clear that profound changes are underway in rural U P concerning perceptions of the role of women and the benefits of smaller families, making the potential for success all the greater
- The mechanisms established for project implementation -- notably the creation of the para-statal SIFPSA as the implementing agency, the use of the Performance-Based Disbursement system as leverage for achieving results rather than measuring inputs, and the deployment of technical assistance through centrally funded Cooperating Agencies funded through USAID/Washington global agreements -- are valid and important to the achievement of project goals. They have all experienced growing pains, need continued monitoring and adjustment, and could be applied more efficiently, but these are reflective of an evolutionary process rather than fundamental problems in design

## POLICY

The 1994 Cairo International Conference on Population and Development adopted a broad new consensus which made the reproductive health and rights of women, rather than demographic targets, the key focus of international population efforts. Concern had been expressed that the IFPS Project, designed several years prior to the Cairo Conference and carried out in cooperation with a Government of India family planning program known for its emphasis on meeting client targets, did not reflect these policy commitments made by USAID and the international community. The reality observed in the field was that the IFPS Project is truly engaged and committed to reproductive health and would be more accurately named the Innovations in Reproductive Health Services Project. The Mission and GOI should consider ways of making more explicit what is already clearly incorporated into project implementation. At present the project actively supports maternal health interventions, safe pregnancy and delivery services, and screening and treatment of sexually transmitted diseases. It has actively engaged in promoting male responsibility through both condom use and vasectomy.

Two of the project focus districts were in the vanguard of adopting a target-free approach to family planning, starting in 1995. This approach was adopted as a national policy of the GOI starting in 1996, and U P focus districts have provided important validation that programmatic emphasis on seeking, understanding and addressing the needs of women for information and services is ultimately more effective than top-down targets and incentives. While the adoption of a national target-free approach is a consequence of the Cairo consensus rather than a direct result of this project, the project serves as an important model for how this can be accomplished and as a counterbalance to forces calling for a return to a target-driven national family planning program.

The evolving picture in project focus areas of a contraceptive method mix considerably more oriented toward spacing methods than the earlier nearly exclusive use of female sterilization, and particularly the growth of demand for condoms as a routine method of contraception, indicates that choice is playing a growing role in services provided under this project.

Quality of care is a clear priority for project activities. Given the low base from which they have started, a great deal still needs to be accomplished. However, it is evident that the knowledge, means and motivation to provide quality information and services is in the process of being institutionalized and spread to staff both within the government health services and to partners outside the government. Considerable

feedback was provided from clients who remarked on the changes in attitudes among health personnel over the past two years

A remaining important area of reproductive health which has not yet been adequately addressed under this project is the provision of quality clinical services for women suffering the consequences of unsafe abortions. Reliable data are not available for U P but there are strong indications that this is a relatively common occurrence and that the health consequences are considerable. The Senior Experts pointed out that such care is explicitly authorized under both USAID policy as well as Congressional strictures and should be incorporated into the clinical package supported by the IFPS Project at the earliest opportunity.

From its initial design, the IFPS Project has emphasized the importance of active engagement with NGOs and with the private sector. In its implementation, it is apparent that this aspect of the project has continued to be stressed in a manner consistent with USAID's policy emphasis on strengthening partnerships with civil society. The history of relations between government services and NGOs in India has been mixed, and there is a backlog of considerable mutual misunderstanding. This provides both a challenge and one of the major promises of the IFPS Project. The very existence of SIFPSA as an intermediary organization between government and non-governmental structures is a major innovation in the India context, but there is a real risk that over time SIFPSA will turn its attention away from NGOs and the private sector. Discussions with officials made it clear that this tendency is being guarded against, but this will require continued and active attention from all parties. Continued successful interaction through SIFPSA provides an important channel for government officials in the health sector to come to appreciate the value and contributions of non-governmental activities and to build a model for linkages that could have major value in India's evolution towards a more pluralistic polity.

In particular, the early emphasis placed in the project on the development and support of women's NGOs is an important concrete model for USAID's policy emphasis on women's empowerment as a major vehicle of development. Given the dynamic changes underway in U P society that offer opportunities for further strengthening the role of women, these efforts should be further reinforced and expanded as the project spreads its coverage to larger parts of the state.

## RESULTS

A major concern underlying this assessment was whether the ambitious goals set forth

for this project are in fact achievable. In light of progress made over the past two years, an analysis of rapid survey results, and modeling carried out using several independent approaches, the assessment team concluded that the objectives are achievable, and the Senior Experts found these analyses compelling. These analyses are dealt with in detail in the main report, and do not require reiteration here other than to confirm that they do indicate that by the year 2004 a U P -wide contraceptive prevalence rate of 35% (16% above the 1992 CPR of 19%) and a total fertility rate of 3.9 are achievable goals.

In areas where the project has been active for the last one to two years and where the partnership between community-based organizations and clinical health services has been established, there is clear evidence of a substantial growth in demand-driven services. This includes increases in access to and regular use of contraceptives and family planning services on the order of two-fold in individual communities, in some communities which appeared socially typical, regular contraceptive use has risen to over half of eligible couples. Among groups of women interviewed by the Senior Experts, patterns were found of regular use of spacing methods among young couples who had no children yet and who wished to delay first childbirth, as well as those with only one or two children. Survey data reflect these observations.

While the information and services provided through the IFPS Project are certainly responsible for increasing access and availability, equally striking is the apparent shift in social dynamics underway in U P. In meeting after meeting with rural women, very low levels of schooling and literacy among adult women were confirmed, but juxtaposed with high levels of reported school attendance by their daughters. While this does not represent a scientific sampling it was repeated in enough locations, particularly in poor communities, that it provided the team with a strong indication that perceptions and aspirations for girls appears to be undergoing profound changes. This, combined with the observed willingness of women mobilized by project-supported community groups to speak out publicly about their needs and concerns, holds promise for increased motivation to plan and control their reproductive lives. In this changing social context, the development of effective services could have considerably greater impact than is even indicated in the modeling analyses.

A key to achieving this impact is the continued support and expansion of services and commodities through multiple channels. The Indian Systems of Medicine Practitioners, who are the largest providers of primary health care in U P, show great potential, and the work carried out to date within the project has been very positive. Similarly, women interviewed during the assessment regularly expressed a willingness to purchase

contraceptives if they could be assured of dependable supplies. Often, the prices they are willing to pay reflects the subsidized cost. At the same time, numerous complaints were noted by community based workers concerning periodic shortfalls in free contraceptives distributed through government channels.

This highlights the importance of assuring viable private sector supplies, both at full commercial costs and at subsidized costs through social marketing channels. The social marketing component of this project has been one of the greatest problem areas in fulfilling the original project design, and it appears at this stage that the GOI will not agree to USAID/India moving forward with a social marketing contract. Given the importance of alternative private channels, the Senior Experts believe that the development of a sound and fully agreed alternative is essential to achieving project results, and that if such a plan cannot be developed and agreed on by May 1998, the expectations of results from the IFPS Project should be downgraded, and, as a consequence, the funding should be decreased as well. This plan should be based on the market segmentation study which is about to get underway, and, given the major delays in this component to date, should be considered a major project benchmark.

Finally, it is clear that maximizing the range of contraceptive options available will contribute significantly to increasing effective use. The GOI has been hesitant on moving forward with allowing Depo Provera to be made available through the IFPS Project. This is a sensitive political matter in India, and will need to be resolved through internal dialogue with those groups who support and oppose its use, it is unlikely that USAID can constructively play an active role in this process. However, it should be made clear that the scientific evidence as well as the experience from neighboring countries has clearly affirmed both the benefits to women's ability to control their own reproductive lives and the desirability of a voluntary means which can be pursued by women with considerable privacy with action needed only once every three months. Various women's advocates with whom this team met stressed the importance of providing Indian women with this additional contraceptive choice. It is to be hoped that this issue can be resolved soon.

## **MECHANISMS**

The Management Review conducted in late 1995 found many delays in the start-up of IFPS Project activities, and particularly in the establishment and staffing of SIFPSA. Enormous progress has taken place since that time, and the team concurs that SIFPSA now has dynamic leadership, an active and quite capable staff, and has begun to establish the institutional mechanisms needed to move the project forward energetically.

While SIFPSA has evolved into more of a para-statal organization than the largely independent organization originally foreseen in the project design, there are considerable advantages in this that offset many of the disadvantages. First among these is the tight linkage with the government of U P health system, which if well directed (as is currently the case) can lead to effective linkages between community based workers providing information and non-clinical services and government services providing clinical services and free supplies. An ancillary benefit is the structured and regular interactions between senior government officials detailed to SIFPSA and the non-governmental sector which could serve as a model for other public-private partnerships.

As noted earlier, there is still concern that as SIFPSA evolves it may progressively favor and emphasize the public over the private sector because of the preponderant representation of government officials among its senior management. This would be less likely with further recruitment of strong and senior management from outside the government.

An additional aspect that should be emphasized in the next phase of SIFPSA development is the technical support and assistance function. To date, SIFPSA has principally functioned as a financing institution, reviewing proposals and managing the flow of funds to public and private sector groups. Some groups, particularly NGOs, commented that SIFPSA showed little flexibility even when changing conditions warranted modifications to initial plans, and that it functions at times more as a policing than a facilitating institution. In building its own technical competence and ability to work with and help partner institutions, SIFPSA could significantly increase its contribution to the development of reproductive health and family planning services throughout U P, and could serve as the focus for development of a sustainable indigenous capacity to manage and support these services. The Senior Experts strongly recommend SIFPSA assumes this function.

The concept of innovation is at the heart of the IFPS Project, and implies far more than a new structure or certain new mechanisms. It reflects on a way of thinking, and a willingness and ability to seek out lessons from doing things differently, and then apply those lessons more broadly. In this context, SIFPSA's capacity to encourage and share innovations will also depend on a progressive development of improved technical capacity and a mind set of experimentation and flexibility. This is one of the greatest challenges posed by a large and complex project, and if it becomes a clear focus of SIFPSA activities, as the Senior Experts believe it should, it can make a major contribution to developing health services that meet public needs. We believe that the

basic elements needed to make this occur are in place, but that considerably more attention needs to be devoted to this very different way of doing business

The technical assistance provided by the cooperating agencies has also been an important contributor to progress to date. However, this has come at considerable financial cost. Not surprisingly, the quality and value of this large volume of technical assistance has not been uniform, and the challenges of managing not one but a large number of teams from different institutions have been considerable. Nonetheless, the team recommends continuing this mechanism as the best likely arrangement in the current situation, with continued selection of those functions and activities which contribute most to project achievements. While there might appear to be some benefit to centralizing all technical assistance within one or two organizations, we would advise against such an approach since the particular areas of focus and specialization provided by many of the organizations would not be readily recreated. Rather than assigning a principal lead function to one of the CAs, we believe that the management responsibility and authority for assuring that the TA is timely and on target should be squarely with the USAID/India Mission.

As SIFPSA evolves its technical support role, the TA provided to this project should increasingly be provided in close coordination with SIFPSA, and often be directed at building SIFPSA's own long-term capacities. While location of technical assistance in Lucknow appears not to be feasible at this point, progressive efforts should be made to build this technical development function in order to diminish the long-term need for external technical assistance.

The Performance Based Disbursement (PBD) process is a major innovation pioneered by the IFPS Project. The Senior Experts agree with the assessment team that the PBD has largely worked as planned in the project design. The system is now completely accepted by SIFPSA, the GOI, and GOUP as an effective way to disburse funds based on performance. Overvaluing of benchmarks in 1992-94 to capitalize SIFPSA, and in the process create the systems necessary for achieving the intended impacts, was necessary to allow it to become established and to begin project implementation rapidly. This approach permitted SIFPSA not to become dependent on the GOI for funds, and has allowed it to do long-term planning and sanctioning of projects, without full funding in hand. Moreover, this system was blessed by auditors in 1993 and paved the way for USAID's first benchmark audit now underway.

The Senior Experts also wish to emphasize that the existence of a large pipeline does not necessarily reflect a lack of movement in IFPS. PBD by design does not link

benchmarks with actual expenditures achieved by SIFPSA. Rather, it links disbursements against achievement of benchmarks. SIFPSA expenditures will accrue at a different pace, while disbursements under PBD may in fact exceed actual costs, as in the start-up phase. Thus, pipeline analysis must look not only at expenditures, but also at commitments. Without sufficient funds to commit to additional benchmarks and activities already underway in many cases, IFPS would lose momentum. Therefore, a seemingly large pipeline does not necessarily signal lack of progress. To the extent possible, however, the Senior Experts agree that USAID and SIFPSA should develop a system to tie expenditures closer to benchmarks to get a more accurate picture of the project's financial status.

The Senior Experts conclude that the IFPS Project serves as an important model for the partnership between USAID, as well as other donors, and the GOI in their common efforts to address the reproductive health needs of the people of Uttar Pradesh and to improve the lives of women. The IFPS Project has been able to support continuing improvements in the quality of public sector services while fostering linkages to and engagement of the private sector in addressing reproductive health needs at the community level. Early achievements reflect that there is considerable potential for achieving, and even surpassing, the Project's goals if this public-private effort is sustained and expanded.



## I INTRODUCTION

With a population well over 900 million, India accounts for 16% of the world's population, and adds a further 18 million people a year - one fifth of global population growth. India has had a national family welfare program, offering family planning and mother/child health services since 1952 and has made considerable progress in its efforts, as evidenced by lower population growth and fertility rates and increased child survival. However, the progress in family planning has been uneven throughout the country, and has for the last twenty years been predominantly a one-method program emphasizing voluntary female sterilization.

Since its inception, the central Government has articulated family welfare program goals and allocated budgetary resources to the states for program implementation. The family welfare program is almost exclusively a public sector effort. Female sterilization provides more than 70% of effective contraceptive protection for Indian couples. With the exception of certain spacing methods - condoms and the IUCD - temporary methods for young couples for birth spacing have not been emphasized in public sector services, and the private sector has played a limited role in the family welfare program. Limited attention has been given to client preference and need for a more comprehensive, quality program.

The Government of India (GOI) understood well the shortcomings of the family welfare program and in the early 1990s was grappling with how to reorient and improve the program. In 1991 the GOI and USAID entered into discussions to develop a bilateral program to assist the GOI in the achievement of its family welfare program goals, articulated as replacement fertility by 2016. The GOI expressed concern over the stagnant program performance in the four Hindi belt states - Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh - which comprise 40% of the population of India.

In response to the GOI interest, a bilateral agreement was signed between USAID and the GOI in September 1992 for the ten-year, \$325 million Innovations in Family Planning Services (IFPS) Project in Uttar Pradesh. The IFPS Project was designed to serve as a catalyst for the GOI to revitalize the country's family welfare program, emphasizing improved quality, increasing access to a comprehensive range of services and stimulating demand for services. With more than twenty-five years experience in family planning assistance, USAID was uniquely positioned to introduce and expand various successful approaches previously not tried in India on a large scale, supported by comprehensive technical and managerial support as well as the funding needed to invigorate the GOI program.

## II ASSESSMENT PURPOSE

The IFPS Project is now in its fifth of ten years, making it timely to carry out a midterm assessment. The purpose of the midterm assessment is to assess progress to date, review key assumptions and implementation strategies, estimate the feasibility of achieving project objectives, and provide conclusions, recommendations and direction for the second five-years of the project.

For several reasons, some components of the project design have not been implemented as originally designed. These include:

- Contraceptive Social Marketing. The project envisioned a large, USAID direct contract for massive expansion of CSM in U.P. The GOI has not agreed to USAID directly funding this component, but smaller initiatives are in place and commercial sector contraceptive sales are on the rise.
- New technologies to broaden client choice, such as injectables and Norplant, have not been approved by the GOI for use in the national program, but injectables are available through the private sector.
- Initial focus on selected districts to test innovative approaches was the project's first phase plan, focusing on 15 districts. While some activities have focused on the selected districts, much activity has been scattered with diffuse results. However, greater results have been demonstrated in districts where a core set of activities have been coordinated and programmed.

Additionally, major policy and program changes have occurred which impact on project approaches:

- The "target free" approach to family planning services, designed to withdraw the top down onerous targets and incentives which limited choice and skewed the program towards female sterilization was implemented before other service strategies and performance indicators were put in place to guide the program toward a more quality, comprehensive, and client centered effort. In the first year of the target free approach, there was a substantial decline in family planning service provision in many states but more spacing methods have been offered and service provision is again increasing in the broader context of the new GOI reproductive and child health policy.

- As an outgrowth of the post-Cairo movement, the GOI has emphasized and put in place a new reproductive and child health policy to revitalize family welfare. Hence there is a need to reexamine IFPS goals and objectives to determine its linkages and contribution to this approach.

As part of the assessment, several exercises took place including

- 10 Rapid Assessment Studies of Key Project Approaches (See Annex 5 for summary), with interviews of beneficiaries, NGO and government health providers and functionaries and private practitioners
  - 3,339 female beneficiaries interviewed
  - 309 adolescents girls interviewed
  - 158 in-depth interviews with NGO, and Government health provider personnel
  - 97 interviews with government functionaries
  - 1,858 interviews with public and private doctors
  - 240 interviews with Indian Systems of Medicine Practitioners
- Workshop on July 15-16 to review rapid assessment findings and to make recommendations to improve project approaches and scale-up sub-projects
- Interviews with project designers in Washington, D C and stakeholders in the U S
- Interviews with other donors in U S and India
- Interviews with USAID/India staff and resident technical assistance staff
- Review of all project documentation
- Multiple field visits to SIFPSA and several districts (Agra, Jhansi, Kanpur and Sitapur)
  - interviews with beneficiaries and providers
  - interviews and meetings with SIFPSA and CA staff
  - collection and analysis of data from SIFPSA
  - special analyses of SIFPSA financial and administrative management systems

- Review and Input from Senior Policy and Technical Experts

The assessment was conducted from July 14 - August 8, 1997 by a core four member team composed of Jinny Sewell, USAID/India, Sigrid Anderson, USAID/Washington, Harry Cross, The Futures Group and Keys MacManus, USAID/Washington. The core team also called upon key technical resource persons: Dr Alan Bornbusch, USAID/Washington Advisor, Mr J S Deepak, Policy Project Consultant, Dr John Stover, Vice President, The Futures Group, Dr Amy Tsui, Evaluation Project Director, and Mr N N Wahi, USAID/India Deputy Controller. During the third week of the assessment, a team of three senior policy and technical experts composed of Dr Nils Daulaire, Deputy Assistant Administrator and Senior Policy Advisor, Bureau for Policy and Program Coordination, USAID/Washington, Mr Sidney Chernenkoff, Director, Office of East and South Asian Affairs, Bureau for Asia and the Near East, USAID/Washington and Dr Indra Pathmanathan, Public Health Specialist (RCH/India), World Bank, Washington, D C also joined the exercise for one week to provide insights and comments to the core team findings and recommendations. See Annexes 1, 2, 3 and 4 for Scope of Work, Team Schedule and key persons contacted.

### **III DESIGN OF THE INNOVATIONS IN FAMILY PLANNING SERVICES PROJECT**

#### **A State Selection**

In order to concentrate project resources so as to have a measurable impact, the GOI and USAID jointly selected the State of Uttar Pradesh (U P ) as the exclusive locus for the IFPS Project implementation. The scale of the problem to be addressed by the project, in sheer numbers, is immense. With a population of 140 million, U P is larger than all but six countries in the world. More populous than Japan, Nigeria, Bangladesh, Pakistan or Mexico, U P can be thought of as akin to a separate country for programming purposes. Although it is a challenging state to work in due to its poor demographic, social and economic profiles relative to all India, both the GOI and the Government of Uttar Pradesh (GOUP) requested and fully supported the introduction of the IFPS Project. Given its distinction as India's most populous state, program success in Uttar Pradesh also spills over into national program success as well as providing models for replication in other states.

Within the state, population density is variable high in the eastern and western districts

and very low in the hilly districts in the north. Eighty percent of the population of U P lives in the rural areas. Literacy, especially female literacy is very low. Males outnumber females. And health care is spotty despite the rather extensive public health infrastructure. U P ranks relatively low on all socio-economic indicators. Per capita income \$160 is just over one-third that of India as a whole. Female participation in the work force is low (5.4%) as is female age at marriage (18.6 years) and female literacy (31.5%). Fertility rates are high (4.8), while use of modern contraceptive methods are correspondingly low (18.5%). The basic demographic indicators for U P and India are given in Table 1 (1981-1991).

**TABLE 1**

Index	U P	India
Population (1991)	139 M	846 M
Percentage population increase (1981-1991)	25.5	23.9
Density (population/km <sup>2</sup> ) (1991)	473	273
Female sex ratio	879	927
Percent female illiterate*	68.5	56.7
Female age at first marriage*	18.6	20.0
Percentage of females (20-24) married before age 18*	63.9	54.6
Crude birth rate (1992)	36.2	29.0
Crude death rate (1992)	12.8	10.0
Exponential growth rate (1981-91)	2.27	2.14
Total fertility rate*	4.8	3.4
Desired number of children*	3.8	2.6
Infant mortality rate*	99.9	78.5
Percentage of married women using contraception*		
- all methods	19.8	40.6
- all modern methods	18.5	36.5
- modern temporary methods	5.5	5.5
Unmet need for family planning*	30.1	19.5

\* NATIONAL FAMILY HEALTH SURVEY (1992)

## **B IFPS Project Design Approaches**

The IFPS Project design was based on a three-point rationale for family planning that encompasses not only demographic concerns but also those of health and economic welfare of communities and families

- 1 To support the application of program strategies that are derived from successful experience in other countries taking into account the needs of the community,
- 2 To 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, and,
- 3 To work with both the public sector to extend and improve the range and quality of services and the private sector to greatly expand their involvement in the delivery of high-quality services, particularly at the community level, thereby linking public and private sector delivery so vital to successful project implementation

During 1991 a series of technical teams worked with the USAID/India Mission, the GOI and the GOUP to design a comprehensive project that would support the goals and objectives of the GOI family welfare program, and the specific needs of the State of Uttar Pradesh

## **C Goals and Objectives**

The IFPS Project Agreement was signed by the GOI and USAID in September 1992. The IFPS Project is a ten year, \$325 million project (\$225 million bilateral and \$100 million unilateral funding), with the **goal** of assisting the State of Uttar Pradesh in reducing the rate of population growth to a level consistent with its social and economic objectives

The **purpose** of the IFPS Project is to assist the State of Uttar Pradesh to significantly reduce the total fertility rate and improve women's reproductive health<sup>1</sup> through a comprehensive improvement and expansion of family planning and related reproductive health services. To achieve this purpose, the project has three **objectives**

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<sup>1</sup> Since the original design, the IFPS Project has incorporated other reproductive health elements into the Project. For more details on RH interventions refer to Section V D 3

- I) improving the quality of family planning and other reproductive health 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
- ii) increasing access to family planning and other reproductive health services by strengthening service delivery points in the public sector and developing and 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
- iii) promoting family planning and other reproductive health 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 social marketing program) on the availability of services and methods

A **sub-purpose** 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 was given to research and evaluation activities to document successful delivery systems and to measure the degree of their impact.

Implicit in the goal of reducing the rate of population growth 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. Thus fertility reduction was thought to be essential if the GOI hoped to achieve its goal of lowering the national rate of population growth. The benefits associated with a smaller population will be seen in the reduced burden on the GOI and GOUP in providing health care, schooling, jobs and housing, enabling the GOI to invest more on a per capita basis on basic human needs, improving the nation's human resources and reinforcing its economic development.

#### **D Ten Year Performance Framework - Project Phases**

In order to achieve the goals and objectives of the IFPS Project, implementation focuses on three phases over the ten year project. These three phases are geared

toward

Phase I (years 1-5) Focus on activities aimed at testing the innovative means for strengthening U P 's family welfare program in the public and private sectors. Innovative service improvements and expansions are introduced, evaluated and replicated in U P 's districts, with first six, then 15 districts being the initial focus of this pilot phase,

Phase II (years 6-8) Focus on significant expansion in the three project objectives - service quality, access, and demand (or promotion), and finally

Phase III (years 9-10) Focus on project impact, including increased contraceptive prevalence and lowered fertility

The Project's ten-year framework provides a clear technical basis for defining and valuing a series of performance benchmarks articulated toward this phased effort resulting in project impact ultimately. In the context of this ten year performance framework, \$155 million of the \$225 million bilateral component has been designated for performance benchmark disbursements (PBD) related to improvements in quality, access and promotion. PBD was selected as the appropriate mechanism for this project because of the critical need to stimulate tangible achievements. With the PBD system, the focus shifts from inputs to the achievement of results, reducing the management and reporting burden for both the GOI and USAID.

Performance benchmarks are established collaboratively between USAID and the GOI for the achievement of important milestones that indicate significant accomplishments related to the project goals and objectives. Since the emphasis of the IFPS project is to improve quality, access, and demand, benchmarks are formulated under strategic objectives that incorporate this principle. To date, 53 benchmarks valued at \$42.2 million have been agreed to, with achievement of 31 valued at \$25.4 million. These 53 benchmarks emphasize

I) Work with the government program to

Improve family planning services (sterilizations, IUDs and pills), and medical staff skills at health facilities, and,

Improve screening and counseling skills of Auxiliary Nurse Midwives to better serve family planning clients

- ii) Work with the private sector to

Expand delivery of oral pills, condoms and referrals for family planning through rural traditional private practitioners, allopathic private doctors and clinics, non-governmental organizations, employers, cooperatives and local self-government, and,

- iii) Implement a statewide communications campaign to increase knowledge of and demand for family planning services

## **E Program Components**

The IFPS Project activities fall under four project components public sector, private sector, contraceptive social marketing, and research and evaluation. Of these, the contraceptive social marketing component and research and evaluation activities are not benchmarked.

### **1 Public Sector**

The government family welfare program has been the main supplier of clinical family planning services. Its comparative advantage still lies with clinical methods (tubectomies, vasectomies and IUCD insertions), and to a limited extent spacing methods, through its hospitals, CHCs, PHC and subcenter infrastructure and workforce that links the program down to the community. In fiscal year 1992/93 the government recorded about 355,000 female sterilizations in U P along with 28,000 male vasectomies. The annual figures for female sterilization have remained virtually constant since 1982 even though the unmet need probably increased by over 50%. With the advent of the Target Free Approach, sterilization numbers initially decreased but appear to be picking up again.

Spacing methods have not been widely and regularly available through the public sector. A weak logistics system, erratic supply of contraceptives, long distances from villages to public health facilities, and limited ANM counseling skills, mobility, and coverage have made it difficult to promote family planning methods requiring regular contact with clients and continuous supplies.

Thus far, Phase I efforts have supported training of key providers in basic contraceptive knowledge, IUCD clinical skills, infection prevention and counseling, effective supervision, provision of funding for enhanced mobility of providers and

hiring of lady doctors to fill government staffing gaps as well as initiation of upgradation of facilities and provision of equipment in select districts

## **2 Private Sector**

There is a strong preference for private providers and the use of private doctors and practitioners is high across all income groups in both urban and rural areas. The first point of contact for care is primarily with private providers while hospital in-patient clinical and curative care is provided primarily by government facilities. The private sector, because of its desirability to clients, has an important role to play in the provision of family planning services. It currently accounts for 75% of pill and condom users and 40% of current IUD users. Social marketing plays an important role in the private distribution of condoms and to a lesser extent, pills. IFPS Project is poised to take full advantage of this existing capacity and interest to spread family planning information, supplies and services through private doctors, clinics, chemists and stores. Because of the reach of rural private practitioners and retail outlets, private sector groups offer a tremendous opportunity for expanding the availability of temporary family planning methods and for improving the knowledge level of their clients.

It is interesting to note that about 7% of all sterilization reported in the NFHS occurred in the private sector. For urban areas, where people presumably have more choice and higher incomes, private providers account for about one in seven female sterilizations. There is reason to believe the sterilizations accounted for by the private sector is rising.

In U P there are few effective non-governmental organizations providing large scale health and family planning services. Although NGO services are often more comprehensive and of higher quality, their reach is not extensive and population covered is low. NGOs may be most useful if they take on supportive functions of training, IEC promotion, service delivery demonstration and technical assistance for larger service delivery networks such as cooperatives, employers and indigenous practitioners who will then provide wide-scale service delivery coverage.

In Phase I to date, the IFPS Project has funded over 100 projects in the private sector to train private providers and support service delivery through existing networks of cooperatives, employers and community based NGOs.

## **3 Contraceptive Social Marketing (CSM)**

India was the first country to develop a social marketing program as a major service

delivery mechanism for promotion and distribution of contraceptives. The GOI provides a subsidy by purchasing contraceptive products (condoms and pills) from the manufacturers and reselling them at a subsidized price to participating distributors. The recommended profit margins to wholesalers and retail outlets are currently set by the government, as is the consumer price. While social marketing and unsubsidized commercial sales have potential in U P, programs in U P have been modest to date. Efforts to promote well-conceived social marketing programs aimed at lower income groups and rural inhabitants, coupled with strong encouragement to commercial manufacturers and retailers to increase their market share (e.g. through generic advertising, etc), could have a major impact on raising contraceptive choice, availability and use.

Under the IFPS Project Agreement \$42 million of bilateral funds and \$5 million of non-bilateral funds were allocated to enhance and invigorate the GOI's ongoing CSM program in U P. As negotiated in the IFPS Project Agreement, the intent was to have USAID/India directly fund and manage the CSM contract to the private sector. However, despite repeated attempts since the summer of 1992 to find common ground on how to proceed with this component, agreement between USAID and the GOI has still not been reached and the bilateral funds remain unused. Modest efforts using non-bilateral funds through the SOMARC subcontracts with Population Services International and Parivar Seva Sanstha were initiated in November 1994. However, much more could be done to stimulate temporary methods through commercial channels, thereby increasing choice of and access to spacing methods, meeting client demand, generating further demand and building in program sustainability by shifting an increasing portion of the burden for provision of temporary methods to the private sector.

#### **4 Research and Evaluation to Inform Partners and Document Project Progress**

The IFPS project was designed to support a program of research, monitoring, evaluation, and dissemination in order to assist the various public and private sector partners in implementing service delivery. The R&E effort was to provide baseline information, help set up monitoring support in program implementation, conduct operations research and provide feedback on IFPS project impact. The four large R&E efforts currently commissioned under IFPS Project are:

- a) PERFORM The PERFORM survey was conducted in 28 districts of U P in 1995 to provide baseline data on key indicators for IFPS benchmarks at three

levels public and private sector delivery points, services providers staffing the facilities, and, the client population represented by married women of reproductive age PERFORM also included a male survey and a reproductive health survey

- b) Operations Research (OR) OR has been undertaken in two districts, Sitapur and Agra, where specific intervention models for testing the cost-effectiveness for increasing access, quality and demand are being implemented The ultimate goal of this effort is to provide an explicit strategy for scaling up of activities and producing a significant impact throughout the state during the next five years
- c) Rapid Assessments A series of rapid assessments of innovative pilot projects have been conducted to identify successful elements of effective project implementation Successful strategies to service delivery will then be incorporated into the design of future 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 To date, ten rapid assessments of the following representative projects have been completed community based NGO projects, dairy cooperatives, training of Indian System of Medical Practitioners (ISMPS), training of private sector allopathic doctors through the Indian Medical Association (IMA), Contraceptive Technology Update training for public sector medical officers and the short term strategy for strengthening public sector activities to provide quality sterilization services
- d) National Family Health Survey (NFHS) The primary objective of the NFHS is to provide national and state-level data on fertility, family size preferences, knowledge and practice of family planning, potential demand for contraception, the level of unwanted fertility, utilization of antenatal services, breastfeeding and food supplementation practices, child nutrition and health, immunization and infant and child mortality The NFHS is also designed to explore the demographic and socio-economic determinants of fertility, family planning and maternal and child health This information is intended to assist policy makers, administrators and researchers in assessing and evaluating population and family welfare programs and strategies

## **F IFPS Project Implementing Agency**

In order to assure program flexibility and funding additionality, project funding is channeled outside of the U P State budget. To do so, an autonomous society, the State Innovations in Family Planning Services Agency (SIFPSA), was registered on May 22, 1993. SIFPSA's role is to carry out program planning and coordination consistent with the IFPS Project goals and objectives, fund public and private sector activities consistent with project benchmarks, and carry out program monitoring and evaluation. In January 1994, the SIFPSA organizational structure was finalized and the first installment of funds was received by SIFPSA from the GOI on March 31, 1994. From the time the IFPS Project Agreement was signed it took 18 months to complete pre-project activities and release the first installment of funds. Although SIFPSA was originally envisioned as a private sector entity, most senior management staff have been seconded from the public sector, while most of the mid-level program and administrative staff have been recruited from the private sector. The Executive Director and Additional Executive Director are Indian Administrative Service (IAS) officers, and four of the five General Managers are seconded from the public sector.

SIFPSA's organizational arrangements include three main decision making units, the Governing Body, the Executive Committee and the Project Appraisal Committee (PAC). The Governing Body serves as a policy making body, including strategic and programmatic direction and approval of annual implementation plans and budgets. The Executive Committee, chaired by the SIFPSA Executive Director, is delegated powers by the GB for broad administrative functions including personnel and procurement policies. The Project Appraisal Committee is an advisory body that reviews all technical project proposals and makes technical and funding recommendations for projects in line with the overall project strategy and performance benchmarks. Together these committees support the activities of SIFPSA and facilitate the project decision making process.

## **G Role of Technical Assistance**

The role of technical assistance is integral to IFPS Project implementation, and for this reason, the \$100 million non-bilateral account was established to draw on as needed over the project period. Critical aspects of this role include support to SIFPSA and public and private sector partners to help develop strategies and plans for each of the major program components, project development, training and preparation of prototype materials, strengthening of planning and management systems, and on-going technical assistance during project implementation. Technical assistance is funded through

USAID/Washington agreements with a range of Cooperating Agencies (CAs) who are technical organizations with long-term funding and recognized capacity to provide technical support to USAID projects worldwide. It was understood, initially at least, that the CAs would be located in Delhi in an IFPS Project Liaison Office and that USAID and the GOI would reassess the possible relocation of this office and CA staff to Lucknow after implementation was underway. CAs have hired a range of full time technical expert staff as well as periodic consultants to provide a broad range of technical assistance, initially in planning and as programs were initiated in on-going implementation support and monitoring.

#### IV IFPS ACHIEVEMENTS

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##### Key Findings

- IFPS support for training and infrastructure improvements have increased the quality and use of family planning and other reproductive & child health services in the public sector in U P
  - Building on established community bases, many IFPS private sector projects are linking reproductive and child health interventions into broader development programs
  - IFPS projects have increased contraceptive prevalence
  - IFPS projects are increasing the percentage of family planning users adopting spacing methods
  - IFPS focus districts are, as a group, performing better than other districts in family planning service delivery under the new GOI reproductive & child health policy
- 

#### RESULTS

To date, IFPS sub-projects have tested selected innovative activities and begun expanding and replicating those with greatest promise of expanded coverage. As of July 1997, SIFPSA has approved 170 projects, totaling Rs 1,047 million (\$30 million). Although in the first year of operations only 10 sub-projects were approved, activities

have considerably accelerated with 75 sub-projects approved last year. Thirty-one out of 53 performance benchmarks have been met, and \$25.4 million approved for disbursement. Other benchmarks are well underway toward achievement. Diverse data and information - qualitative, quantitative, macro- and micro-level - paint a compelling picture that IFPS has achieved a broad range of results that encompass both the public and private sectors. Progress has been made in increasing quality, access, and demand for family planning and other reproductive health services. **Above all, in the assessment team's view, the IFPS Project is improving the quality of life for people in U P**

Early achievements, though many, are - not unexpectedly - limited in their coverage relative to the total state population. However, modeling projections suggest that the inputs which have to-date led to documentable achievements can, when expanded (1) have significant impact on increasing CPR and lowering TFR at the state level, and (2) achieve the original goals of the IFPS project.

As IFPS Project moves further forward in Phase I and into Phase II, the team has identified opportunities to strengthen implementation in key strategic areas and thereby maintain the momentum now in place. These opportunities and the team's recommendations are discussed in Sections V to XII.

#### **A Improved Quality**

The available evidence indicates that IFPS Project inputs have increased quality of family planning services in both the public and private sectors. Keeping in view that the public sector is the key provider of sterilization services, greater focus has been laid on improving the quality of sterilization services in the public sector, while in the private sector focus has been on improvements in the delivery of temporary methods.

#### **Working Without Targets**

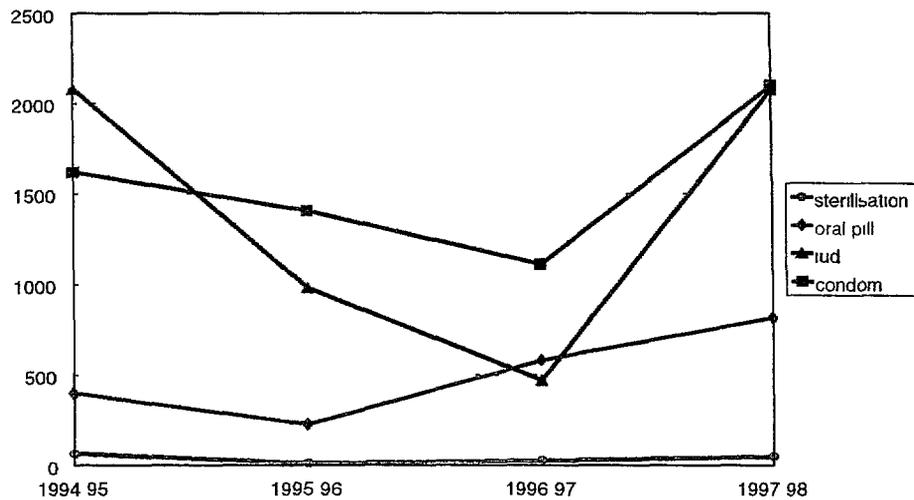
The GOI in April 1996 boldly abolished method-specific contraceptive targets from its Family Welfare program. This year, a new client-oriented reproductive and child health approach is being implemented. As part of its research and evaluation work, the IFPS Project is funding operations research (OR) to explore viable options for operationalizing this approach in the field - options that emphasize provision of good quality services in lieu of meeting targets.

In selected blocks of two OR districts, Agra and Sitapur, which went target-free a year

earlier in March 1995, ANM's are not only ensuring that the needs of active family planning users are met, but are also focussing on antenatal care for pregnant women and, using a modification of the Eligible Couple Register, identifying and providing services to couples with unmet need. In addition to these priority interventions, volunteer link workers are being employed to extend the public sector's reach to outlying communities. Results to-date are promising.

- The removal of targets was followed by an initial decline in users in the OR areas, as illustrated in Sitapur district. However, first-quarter statistics for 1994-1997 indicate that by the first quarter of 1997-98 (April-June 1997), users generally increased to or exceeded 1994-95 levels.

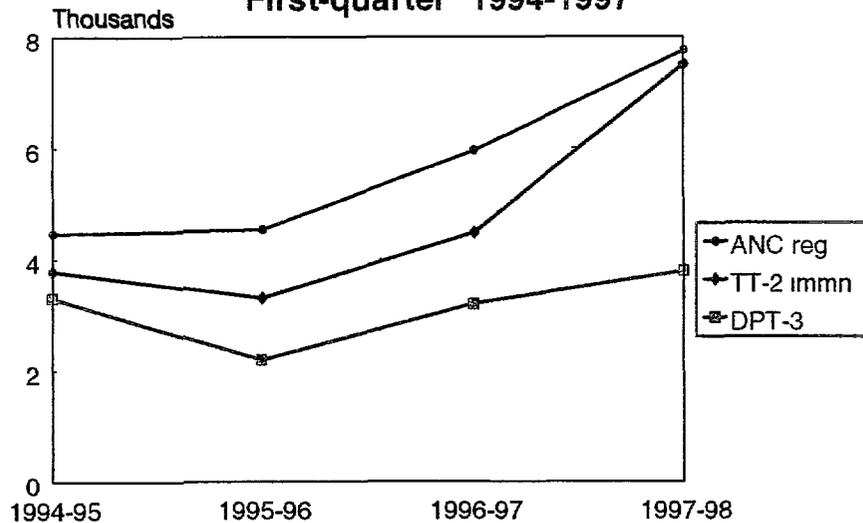
**Total Number of Contraceptive Users in Sitapur OR areas for first-quarter\* 1994-1997**



\* First Quarter indicates April-June

- Furthermore, maternal and child health coverage has also been improved, as evidenced by antenatal care registrations and provision of tetanus toxoid and diphtheria immunizations.

**Total Number of ANC-registered Women, Women Receiving TT-2, and Infants Immunized for DPT-3 in Sitapur OR Areas, First-quarter\* 1994-1997**



\* First Quarter Indicates April-June ANC Antenatal Care TT 2 Tetanus toxoid (2 shots) DPT 3 - Diphtheria (3 shots)

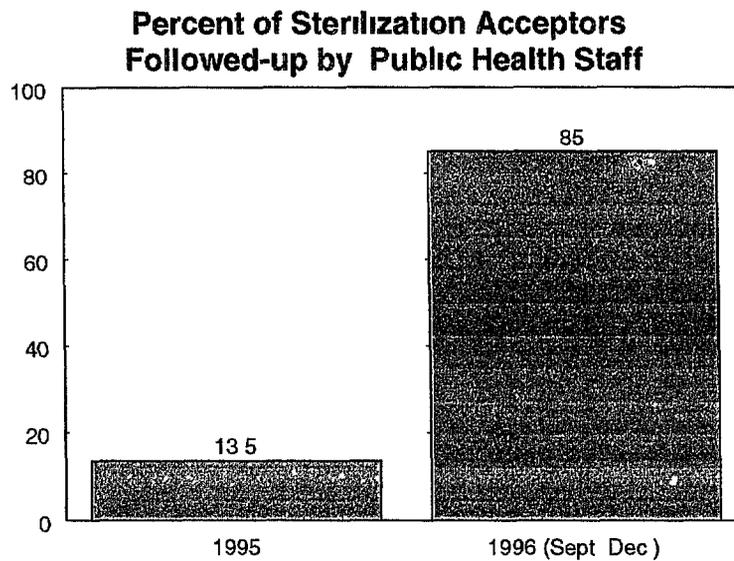
The removal of targets represents a paradigm shift that has yet to be fully operationalized. However, the overall policy change and development of new field approaches for implementation, done in part with IFPS Project support, bode well for future success in implementing a broadened reproductive and child health program.

**Strengthening Quality in the Public Health Sector**

In March 1997, an independent assessment verified that the Directorate of Family Welfare, with the assistance of IFPS Project inputs, had successfully completed implementation of a short-term plan to strengthen the public sector. According to the assessment, IFPS Project inputs considerably helped CHCs and PHCs to have basic items of equipment, medicines and improved follow-up services through transport to reach clients to provide quality sterilization services. Specific achievements were:

- Over 75% of CHC/PHC's have generator sets connected to regular power supplies, and basic equipment to provide sterilizations
- All PHC/CHC's have received follow-up medicine kits with non-literate instructions for individual sterilization acceptors

- **The survey of acceptors in 8 districts representing all Divisions found that follow-up by paramedical health staff with sterilization acceptors had increased more than six-fold**



1995 data is for 15 PERFORM Districts PERFORM Survey 1996 data is for 8 Districts Evaluation of Achievement of Benchmark 26 as detailed in Annex 7

### **Improving Reproductive Health Services at Post-Partum Centers**

Post-Partum Centers in 18 districts are being upgraded into model service delivery/training sites as part of IFPS's long-term strengthening of public services. Dramatic improvements have been observed at several PPC's, whereas multiple services were once crammed into one or a few spaces, with little client privacy, separate facilities are now established for registration, counseling, clinical procedures, and recovery. Equipment and physical layouts for infection prevention are in place, and more importantly, now a part of routine care. On a recent visit to the newly refurbished Jhansi PPC, the pride of the staff in their new facility was immediate to the assessment team. It is clear in the team's mind that such efforts as these have dramatic effect on the quality of reproductive health services, including maternal and post-natal care.

### **Strengthening Quality in the Private Sector**

Promoting informed choice is a key ingredient of quality in family planning services.

Recently completed rapid assessments of select NGO projects show that CBD workers have become information providers to substantial numbers of eligible couples. A survey of the approximately 8500 eligible couples covered by the Women's Welfare Campaign - a rural project in Barabanki District - indicates that about 6700 have met with a CBD worker, nearly 6000 have met at least once a month. In urban slums of Kanpur Nagar covered by Shramik Bharati's Family Welfare Project, nearly 4800 eligible couples report meeting with a CBD worker, 3300 at least once a month.

### Interactions Between CBD Workers and Clients

NGO Project	% eligible women ever met with CBD worker	from column (2) % who met with CBD at least once a month
<i>(1)</i>	<i>(2)</i>	<i>(3)</i>
Family Welfare Project in Kanpur Nagar Slums, Shramik Bharati	60.0	70.0
Women's Welfare Campaign in Barabanki District, St. Mary's Polyclinic	79.3	88.4

#### **B Increased Access**

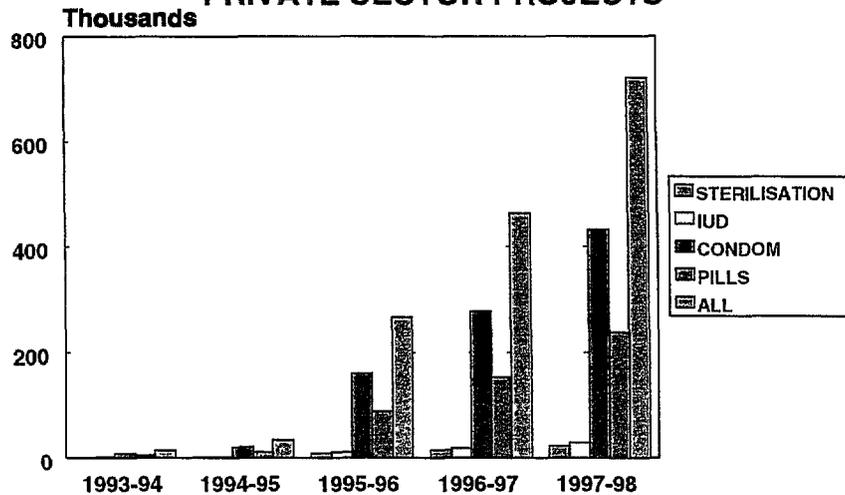
##### **Increased Role of the Private Sector**

A key IFPS Project innovation is strengthening the role of the private sector in providing reproductive health services. The private sector offers great potential for increasing access to and creating demand for quality non-clinical services. The private sector can also serve as a vital link to the public sector, through, for example, expanding knowledge of and providing referrals to clinical services. To date, IFPS Project has piloted diverse training and service delivery initiatives, some pilot projects have been completed and their results are promising for increased coverage of U.P.

IFPS service delivery projects in the private sector, as documented in quarterly performance reports, are serving more people. The figure below offers annual estimates of current users served by all private sector service delivery projects (CBD, cooperative, employer-based, convergence). The estimates were calculated by SIFPSA.

by extrapolating from quarterly performance reports for a representative set of 24 private service delivery projects. These estimates indicate that service by private sector projects has increased significantly, SIFPSA projects will serve over 700,000 users in 1997-98<sup>2</sup>

### ESTIMATED FAMILY PLANNING USERS SERVED BY PRIVATE SECTOR PROJECTS



Estimates are for all private sector delivery projects based on extrapolations from quarterly performance reports for a representative set of 24 projects

Importantly, the increases in users are not solely a function of the number of projects. Review of the 24 representative projects shows that between the last two quarters of 1996/97, the number of users served by these projects alone increased by nearly 40%.

These data also demonstrate that the private service delivery projects are contributing significantly to a major IFPS Project objective - increasing the use of spacing methods in U.P. Spacing users are estimated to far exceed those adopting sterilization. CBD workers from several projects, interviewed by the assessment team, routinely counsel newly married couples to delay having children by two to three years. And, women clients are aware of the health benefits to both themselves and their children of spacing.

<sup>2</sup> GOI fiscal year April-March

## **Expanding Access Through Large Networks**

The success of IFPS Project rests in part on taking advantage of opportunities to expand particular approaches in rural areas. One approach utilizes the well-established infrastructure of dairy cooperatives to provide family welfare services. A pilot project has recently been completed with the Pradeshik Co-Operative Dairy Federation Limited (PCDF) in Sitapur and Meerut Districts.

PCDF has 7827 cooperatives in 30 districts. The Rural Family Welfare Project covered 65 villages in 2 districts, with a population of 180,000, and 29,000 eligible couples.

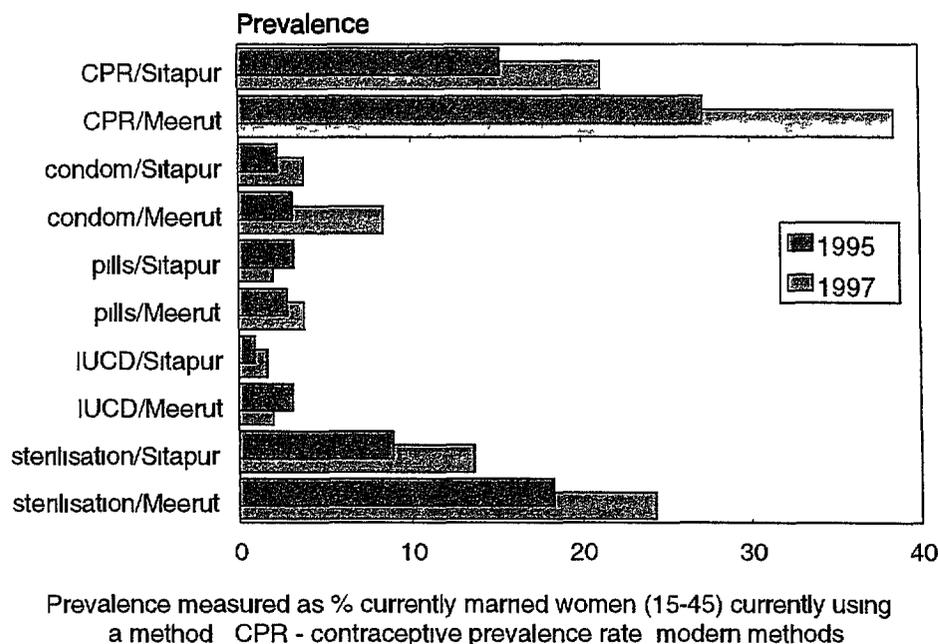
- At the core of the project was community-based delivery of services, including free contraceptives, and information by 75 village health volunteers (VHV's). VHV's engaged in door-to-door activities and were often available at milk collection points in the villages.

Village-level secretaries for the cooperatives also assisted in disseminating information at milk depots and referring clients to the VHV's, while VHV's promoted women's health, helped CHC/PHC staff organize immunization camps, and included ANM's in village meetings to provide information and take referrals.

**Basantpur Village in Sitapur - one of U P 's poorest districts - has a population of 2519 with 441 eligible couples. Literacy rates are 5-10% for women and 50% for men, there is no electricity. The village dairy cooperative membership is 125, including 50 women. Unmet need for family planning in the village has been high - lack of access and the means to purchase contraceptives have kept many women from spacing their children. One VHV has worked in Basantpur for 9 months. In this short time, she has recruited 27 new clients using spacing methods - a doubling from the baseline - while identifying low parity couples for more frequent visits.**

- Within 18 months, contraceptive prevalence for modern methods increased in the PCDF project area from 15.3% to 21.2% (Sitapur district) and 27.2% to 38.5% (Meerut district). Condom use in Meerut increased more than two-fold, in Sitapur by 65%.

## Changes in Contraceptive Use in PCDF Project Area



The dairy cooperatives, by the success of this pilot project, clearly hold potential for expansion of family welfare services in rural Uttar Pradesh. SIFPSA has sanctioned expansions of the PCDF project in 6 districts, while also sanctioning projects in 5 districts with all-women dairy cooperatives.

### Expanding Access to New Methods

Typically, men are not involved in family planning discussions and acceptance of vasectomy in U P is low. One approach to increasing acceptance is to expand choices for male clients by offering no-scalpel vasectomy (NSV). Relative to conventional vasectomy, NSV takes less time, is accompanied by fewer complications, and requires less post-operative rest. Consequently, introduction of quality NSV services, in combination with counseling, offers perhaps the best hope of increasing male acceptance of sterilization in U P.

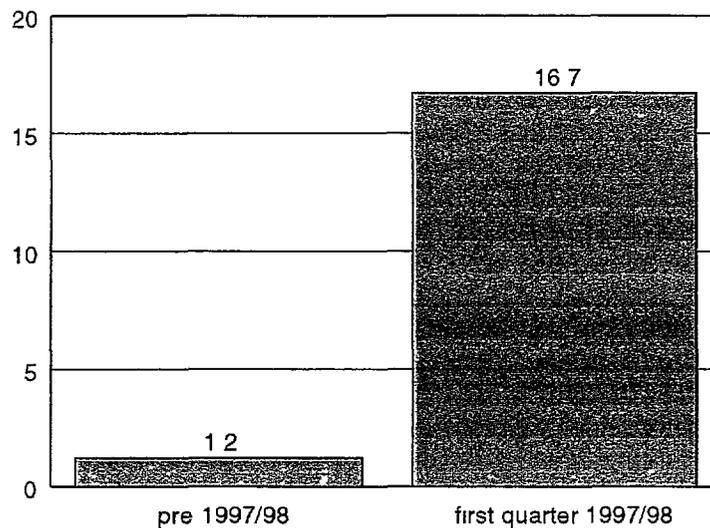
IFPS Project is supporting training in NSV for 300 doctors and the provision of NSV services in five districts. IEC activities that promote NSV and advertise the availability of services are also being undertaken. Agra's SN Medical College was one of the first

facilities to offer NSV in combination with male counseling. Four practitioners have been trained in NSV and counseling, with the expectation that one to two vasectomies can be done per day.

In past years, SN Medical College typically performed seven to ten vasectomies per year. In the first three months of offering NSV, 50 vasectomies have been performed.

Inasmuch as the Medical Colleges also serve as major training centers, the presence of NSV at SN Medical College, as well as at Meerut Medical College, increases the exposure that medical students receive to this method.

**Vasectomies at SN Medical College,  
Agra (monthly average)**



IFPS Project is thus increasing access to and demand for quality vasectomy services. Agra district officials hope to expand NSV services to PHC's and CHC's.

### **Contraceptive Sales**

IFPS Project is committed to identifying the most effective ways in which resources can provide family planning and other reproductive health services. As the population continues to grow and costs continue to increase, one powerful strategy to cope with unmet demand is to focus on the contribution of the commercial/social marketing

sector Increased coverage by this segment of the private sector can free up public sector resources which can then be directed to the poorest segment of the population IFPS Project has made several efforts in this area

Contraceptive sales - both commercial and subsidized - rose in U P from 1995/96 to 1996/97 by 5% for condoms and 20% for pills Sales of CSM brand OCPs marketed through the IFPS funded projects implemented by Population Services International (PSI) and Parivar Seva Sanstha (PSS) rose proportionately higher than did those for all brands taken together Demand generated by diverse IFPS Project activities, as well as linkages between these activities and PSI and PSS marketing and distribution, contributed to these results CSM condom sales through IFPS, however, dropped by 6% when subsidized products were unavailable for eight months although total CSM condom sales for 1996-97 was approximately 35 million pieces

#### Contraceptive Sales in U P , 1995/96 - 1996/97

Brand	% change in sales, 1995/96-1996/97	Actual Sales (in millions)	
		1995-96	1996-97
<b>Condoms</b>			
all (commercial & CSM)	+5	135.4	142.1
CSM (PSI & PSS)	-6	37.0	34.8
<b>Pills</b>			
all (commercial & CSM)	+20	2.9	3.5
CSM (PSI & PSS)	+66	21	35

SIFPSA continues to pursue ways to expand access to and demand for contraceptives in U P through commercial/social marketing campaigns and sales A recently sanctioned sub-project with Hindustan Latex Limited (HLL) will market and distribute two condom brands and an IUCD, targeting under-served rural areas and towns of 20,000 or less The project is innovative in several ways - for example, packaging single condoms for low income consumers - and will link with other SIFPSA projects by using trained CBD workers and ISMP's as depot holders for condoms and IUCD's

In addition, USAID's Program for Advancement of Commercial Technology/Child and

Reproductive Health Project supports IFPS Project objectives by seeking to expand marketing and distribution and improve the quality of contraceptives in India. An agreement scheduled for signing soon will increase marketing and distribution efforts by Wyeth for the low dose estrogen based OVRAL-L pill in four northern states, including U P. In exchange, a USAID-supported generic communications and public relations campaign will promote pill use and offer provider skill development and product detailing.

## C Increased Demand

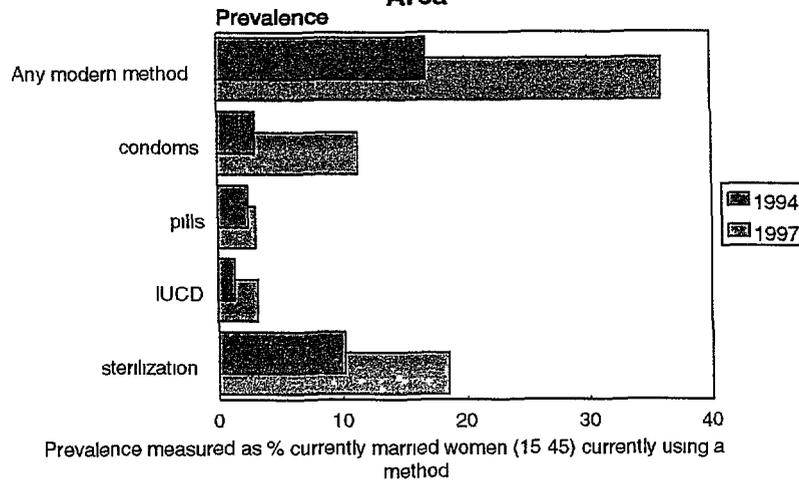
### Improving Family Welfare in Kanpur's Urban Slums

Over one-third of Kanpur City's population, or 1.5 million people, are slum dwellers. Delivering family planning and other maternal-child health services to these communities faces special challenges: basic services are essentially absent, and a significant portion of the population is transient. A Kanpur-based NGO, Shramik Bharati, has completed an 18-month pilot project with IFPS Project support to implement a family welfare program in four slums, covering a population of 50,000 and 8,000 couples.

Shramik Bharati had not previously worked in family welfare, but has a history of active involvement in community development - for example, mobilizing communities for water and sanitation improvements, and establishing savings and credit groups, the majority of which are exclusively women. Community-based delivery of family planning services, IEC activities (door-to-door, women's groups meetings, puppet shows, etc.), teaching mothers about good nutritional practices and treatment of diarrheal disease, and assistance with immunizations were combined under the family welfare project, and linked to projects in other sectors such as savings and credit groups.

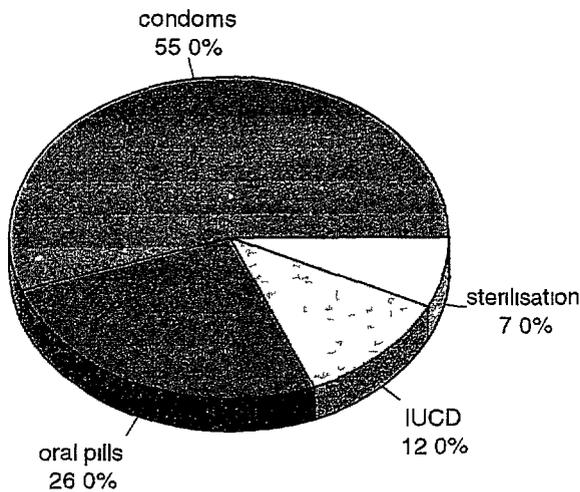
- Within two years, contraceptive prevalence for modern methods **more than doubled** (16.8% to 36.0%) in the project area. Condom use increased more than four-fold, IUCD and sterilization referrals also rose substantially.

**Changes in Contraceptive Use in Shramik Bharati Project Area**



And, supporting a major IFPS Project objective, CBD workers (some of whom are male) motivated users to adopt spacing methods. In contrast to the statewide prevalence of sterilizations, 93% of users served by Shramik Bharati workers adopted spacing methods.

**Method Mix Among Family Planning Users Served by Shramik Bharati CBD's**



Clients interviewed by the assessment team described adopting family planning after contact with CBD workers. Younger women now say they desire only one or two children, with no gender preferences. Importantly, Shramik Bharati is linking its family welfare project to other activities that empower women - for example, the savings and credit groups - and with those promoting the girl child. In the words of one CBD worker, "we say that girls are soft, but strong."

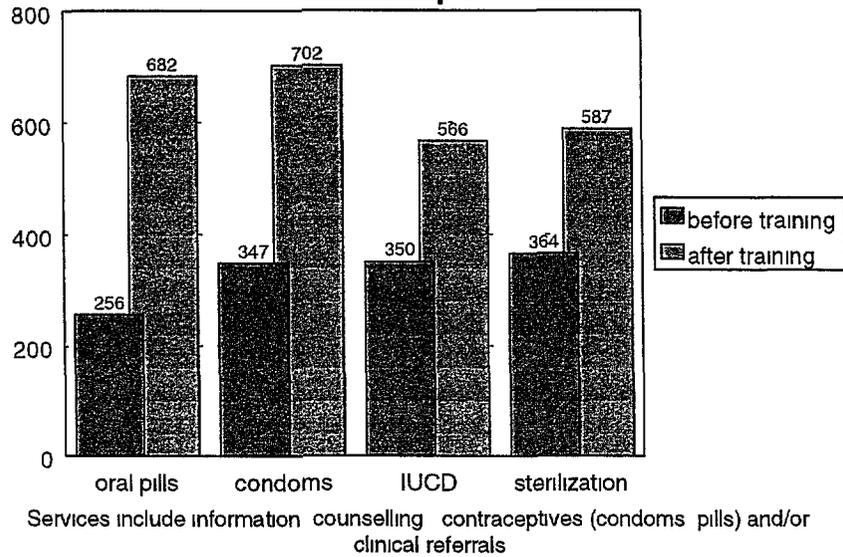
Shramik Bharati's project is one approach for linking family welfare into a broader community development program. According to Shramik Bharati, its decision to undertake family welfare activities came in part from expressed needs in the slum communities. SIFPSA has sanctioned an expansion of the Shramik Bharati project to additional Kanpur slums and one rural area, covering a population of 350,000.

### **Tapping a Vast Potential ISM Practitioners**

In U P, there are nearly 43,000 registered practitioners of Indian systems of medicine - Ayurvedic, Homeopathy, and Unani. ISMP's predominate as primary health care providers in much of rural U P. However, ISMP's had not engaged extensively in family planning counseling and provision. ISMP's are often highly regarded within their communities and the potential they hold for expanding access to family planning is vast. IFPS Project has begun exploring this potential with the training of 940 ISMP's in Jhansi and Sitapur Districts. ISMP's were trained for six days in non-clinical family planning counseling and services and in referrals to PHC/CHC's for clinical services.

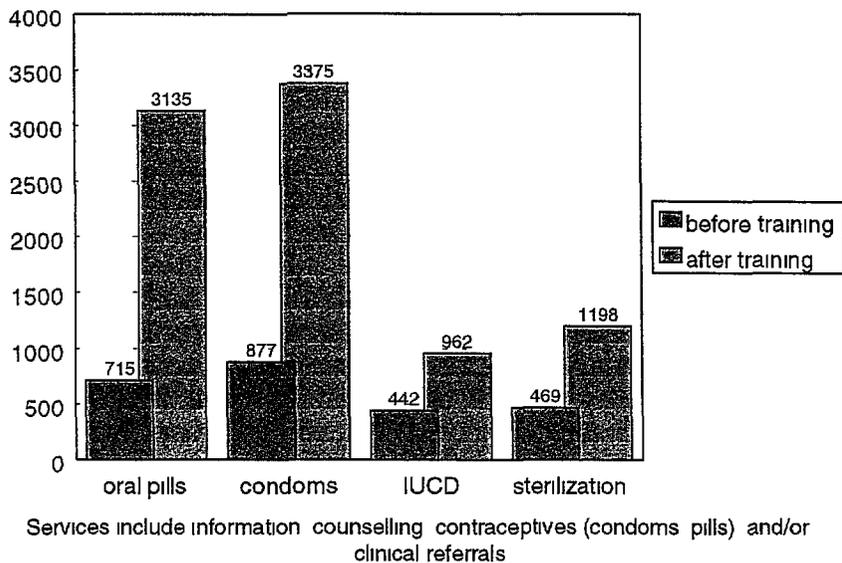
- More than one-half of the ISMP's thought that their client load increased because of the training, and that their relationships with clients had improved following training.
- Importantly, there was a substantial increase in the numbers of ISMP's reporting that they provide family planning services following training, where services included information, counseling, contraceptives (pills, condoms) and/or referrals for IUCD's or sterilizations.

### ISMP's Providing Family Planning Services in Jhansi & Sitapur



- Increased demand also led to increased use** As reported by ISMP's their clients for pills and condoms increased two-to-four fold following training, IUCD and sterilization referrals also rose more than two-fold

### Family Planning Clients Served by ISMP's in 3-month Period



ISMP's interviewed by the assessment team routinely counsel newly married couples to delay childbearing by two to three years and try to motivate couples to space children and have smaller families. One ISMP in Jhansi told the team how he teaches his clients about how the sex of a child is determined, emphasizing that there is no guarantee a child will be a boy (or girl). He described motivating one couple to limit their children to two girls.

It is clear that IFPS Project has identified an approach with great potential to increasing of and access to quality family planning services. Expansion of ISMP training has been approved for six districts. And, a recently sanctioned sub-project will link trained ISMP's as depot holders for CSM pills, condoms and IUCD's through Hindustan Latex, Ltd.

#### **D Inclusion of Other Reproductive Health Interventions**

IFPS, by increasing quality, access, and demand for family planning, is focussed on a key reproductive health intervention. IFPS Project is supporting areas of synergy and mutual impact between family planning and other, related reproductive health interventions. For example, several studies corroborate the observation that a large proportion of Indian women may have reproductive tract infections (RTI's). Identification of clients with RTI's or at risk not only guides appropriate counseling as to safe sexual behaviors and family planning method choice, but also improves acceptance of family planning by avoiding use of contraindicated methods.

- Through operations research and strengthening public service delivery, SIFPSA is testing the feasibility of providing RTI services at PHC's. Inputs include training of medical personnel in syndromic diagnosis and management of RTI's, provision of lab facilities and trained technicians at PHC's, and support for lady doctors (gynecologists) to visit PHC's for reproductive health services.

#### **Achnera PHC**

This OR effort is being implemented at the Achnera PHC, serving about 25,000 people, in Agra District. The PHC has clinical and field staff trained in RTI diagnosis and management, a functioning lab and trained technician, and once-weekly visits by a private female gynecologist.

- The lady doctor typically receives in a six hour period, 50-60 patients for gynecological and obstetric services - far more than would otherwise be seen at

the PHC in a comparable period. On any given visit, more than 10% of the patients are referred to the PHC's lab for RTI testing.

There are now plans for the lady doctor, who is highly regarded by the local community, to visit the PHC twice weekly. In her own words, she offers her services "for the people" who would otherwise not have access to quality reproductive health services.

As noted earlier in this section, OR efforts in Sitapur and Agra also support antenatal care and community based services designed to offer a broader array of reproductive health services.

### **E District Focus - Essential Package of Linked Services**

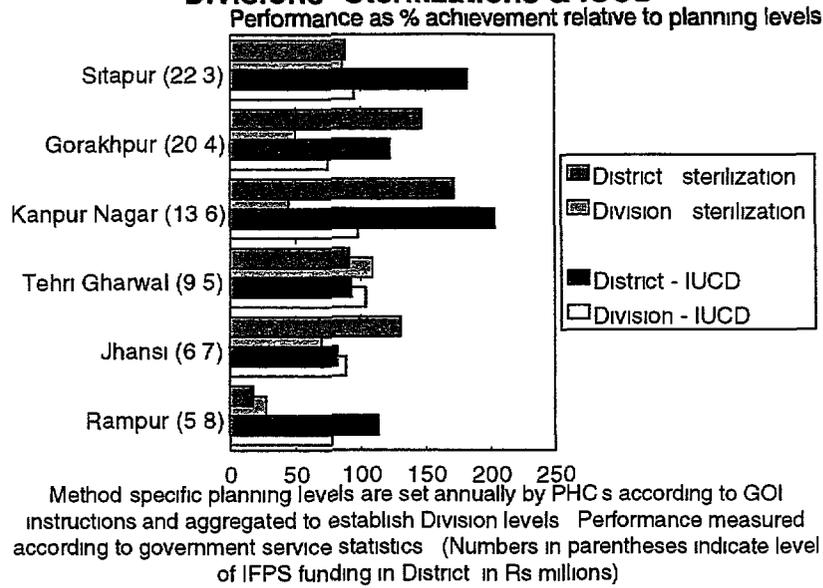
The success of IFPS Project rides on a potent combination of public-private sector partnerships designed to extend the reach of services to millions of people in U P. To do so, these combined inputs need to be carefully orchestrated and coordinated at the district level. The public sector has been and will continue to be a major provider of reproductive health services - especially clinical methods, success in the private sector also depends in part on linkages to a strong public sector. Early achievements indicate that IFPS inputs, when coordinated, can strengthen services. Government service statistics, which capture use of both the public and private sectors, offer indirect, but nonetheless highly suggestive, evidence that IFPS inputs, in the aggregate, are achieving results at the district level.

Under the GOI's target-free reproductive and child health policy PHC's are asked to establish annual planning levels for specific family planning methods against which performance is assessed. PHC levels are aggregated to establish district, division, and state levels.

In 1996-97, the six IFPS focus districts performed considerably better than other districts in their respective divisions - as measured by achievement relative to planning levels. For at least one clinical method, each focus district performed better than other districts in its division. All but one focus district also exceeded planning levels for one or both clinical methods. Gorakhpur, for example, exceeded planning levels for sterilizations and IUCD use (performance > 100%), while other districts in the same division, on average, fell short. There is also evidence of switching from limiting to spacing methods. Rampur, with a large Muslim population, did not meet sterilization planning levels, but - and again, in contrast to other divisions in the District - it

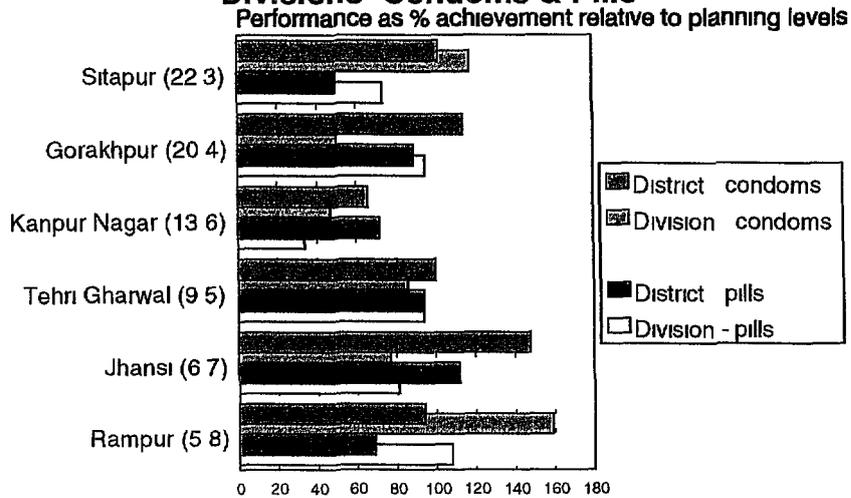
exceeded those for IUCD use

**1996/97 Performance of IFPS Focus Districts & Respective Divisions Sterilizations & IUCD**



With the exception of Rampur, which received the lowest level of IFPS inputs among the focus districts, all of the focus districts also outperformed other districts for condom and/or pill usage. Furthermore, four of the six focus districts exceeded planning levels for at least one of these temporary methods.

## 1996/97 Performance of IFPS Focus Districts & Respective Divisions Condoms & Pills



Method specific planning levels are set annually by PHC's according to GOI instructions and aggregated to establish Division levels. Performance measured according to government service statistics. (Numbers in parentheses indicate level of IFPS funding in District in Rs millions)

### Packaging Public Sector Inputs

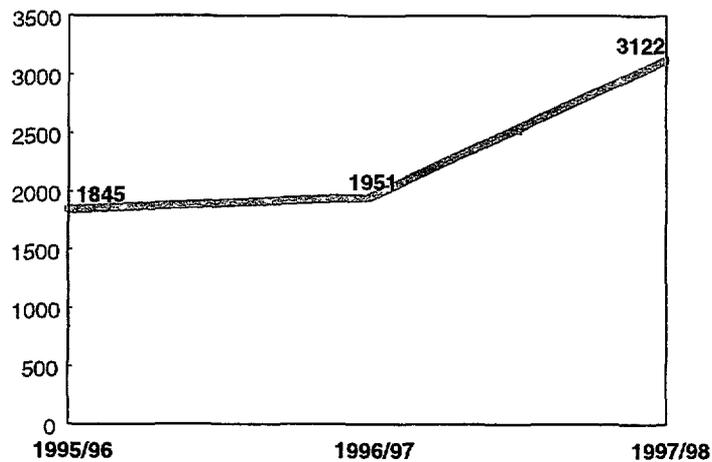
Training and increased mobility of service providers is a pre-condition for improving quality of and access to family planning services, especially clinical ones, in much of Uttar Pradesh. Approximately 80% of the population is rural, yet the majority of clinical providers are in the urban centers. The CTU/IUCD training projects funded by IFPS aim to improve knowledge and skills of all government Medical Officers. Simultaneously, IFPS is funding support for lady Medical Officers to visit outlying PHC's to provide clinical methods, as well as to hire private lady doctors to provide part-time reproductive health services where they do not presently exist.

These inputs, together with IFPS-supported physical inputs (e.g., petrol allowance for provider transport, and provision of generators, infection prevention equipment, and sterilization follow-up medicine packets) have come together to yield dramatic results. For example in Jhansi District

- First-quarter IUCD insertions increased by 60% from 1996/97 to 1997/98. Nearly all of the increase followed from the addition of IUCD services to three PHC's, covering about 300,000 people. This was itself achieved in large part by mobilizing CTU-trained lady Medical Officers to visit these

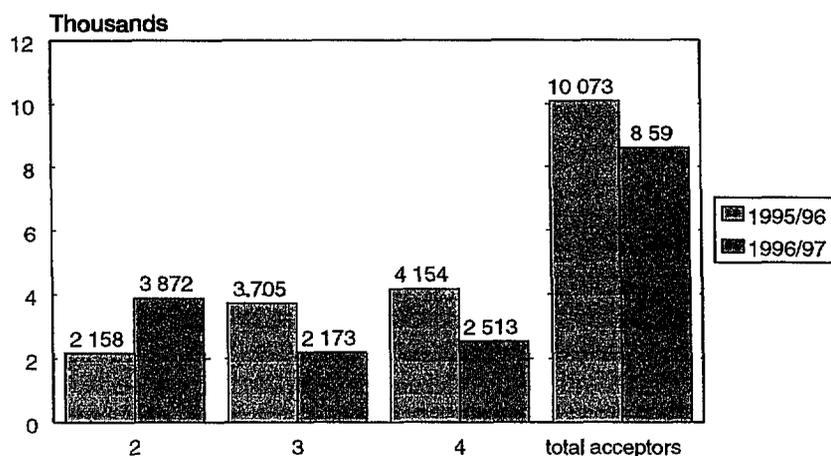
PHC's on a regular basis

### IUCD Insertions During First Quarter Jhansi District



- Following the removal of targets, sterilizations declined in Jhansi by 15% - a much lower decrease than observed elsewhere in U P. Moreover, the average parity of acceptors in the district decreased from 3.2 to 2.8. IFPS inputs added sterilization services to two PHC's, covering 200,000 people, and improved services district wide. **These inputs in combination with the removal of targets allowed providers to better identify and meet unmet need for limiting among low parity couples.**

## Sterilization Acceptors in Jhansi District by Parity



### Private Sector Linkages

Equally important is the private sector service delivery that is occurring, as detailed earlier in this section, through a mix of NGOs, cooperatives, employers, and private practitioners. Many of the approved 83 sub-projects in the private sector are community based. SIFPSA estimates these projects will cover 3 million eligible couples, recruit 800,000 new family planning users and will engage 9,000 workers based in the community.

### Conclusions

**IFPS inputs are achieving results** Overall, IFPS service delivery activities now cover 20% of the U P population, or about 30 million people. While nearly one-third of this coverage is through public sector activities, CBD and cooperative activities account for most of the remaining two-thirds. Importantly, pulling together the public-private sector interface at the district level is a critical key to the Project's success. Outreach through a range of private sector groups, practitioners or local government is critical to community mobilization, increasing awareness and demand, promoting a client orientation and informed choice and broadening services. Where a concentration of services through public-private groups has been programmed at the district level, the impact momentum is taking off and this phenomena needs to be built upon to launch into Phase II.

## V IFPS PROGRAM COMPONENTS

The IFPS Project emphasizes the public-private sector partnership essential to expand quality, access and demand for family planning and other reproductive health services. Both are equally essential to this Project's success. Jointly programming these interventions at the district to build up community support and provision of services for spacing methods through the private sector linked to the public sector for supplies and clinical services are key components to a comprehensive program. In order to extend project reach, expansion and linked services must be operationalized at the district level, thus broadening and delegating management responsibilities from SIFPSA to the district level in order to sustain these services. Programs in the six focus districts should be accelerated, and then expanded to 15 and then the full 28 PERFORM districts. Programs should be decentralized to the district level. The rate of district program expansion statewide will be dependent on the extent of decentralization and institutional capacity -- at SIFPSA, the district and with participating institutions -- to develop, fund and oversee programs.

The two overarching recommendations of the assessment related to program approaches are

- 1 **Strategic Focus** IFPS sub-projects and funding should be phased as agreed upon in the project strategy and action plans. New sub-projects should be oriented toward achieving benchmarks in the 15 priority districts. Only select statewide efforts should be sanctioned, these include training and dissemination in select areas (e.g., contraceptive technologies, infection prevention, client counseling), contraceptive logistics, IEC, and, contraceptive social marketing.
- 2 **Integrated District Approach** District planning should be adopted by SIFPSA to develop a critical mass of linked program inputs in select districts, and thereby maximize district-level impact. Based on a district planning and budgeting exercise, a comprehensive strategy and developed set of public-private sector interventions would be agreed upon to strengthen and to synchronize these inputs. See Annex 8 for more details on district planning, and Annex 9 for a Summary of the Rampur District Action Plan.

## **A Public Sector**

### **Current Situation**

The public sector health care delivery system has been the major provider of family planning services in Uttar Pradesh. The infrastructure and the corresponding workforce of U P 's 535 hospitals, 142 community health centers, 2476 primary health centers, 20,153 sub-centers and 1,555 government dispensaries is huge. This delivery system has the predominant capability in clinical contraception, and has been the major provider of female sterilization and IUCD services. Pills and condoms have been offered on a limited basis, often constrained by lack of supplies or lack of emphasis by service providers in offering these methods to clients. Service quality and the range of services has been variable.

Overall, provision of family planning services dropped off in 1996 for all methods, according to GOUP statistics. When client targets were removed, there was a notable absence of other, more appropriate performance indicators to guide program management and performance. As a result most managers and service providers did not have tools by which to monitor the program. Sterilization services previously routinely offered were limited or in some areas discontinued. Program performance declined, although there has been considerable variation among districts as to the magnitude of decline. In addition, the new GOI policy on Reproductive and Child Health was promulgated, but little training for program managers and service providers in how to implement the new policy has been provided to date. The program has not yet moved effectively from policy to program operations. These changes have created some degree of confusion and program disruption.

### *IFPS Project Approaches*

The joint USAID-SIFPSA strategy (1994) focussed IFPS attention in the public sector on clinical services, especially improving quality of and access to sterilization, while working to broaden capacity to offer a more comprehensive program. This approach, which capitalizes on the large government infrastructure and on historical service patterns, and the IFPS emphasis on quality improvement and informed choice fits well into the new Government RCH policy.

To date, SIFPSA has approved 59 public sector projects valued at Rs 3522.5 lakhs (\$9.86 million), which represents 34% of total approved project funding, with actual disbursements totaling 67% of all approved project funding. Specific IFPS Project

efforts in the public sector have included

- Operations research in two districts focused on a pregnancy based approach to provide a broader range of reproductive health services related to care during pregnancy, and care to the newborn and for women after delivery, addressing unmet need of couples for family planning services, use of community link workers to strengthen community participation and outreach services, testing the feasibility of RTI/STD screening and treatment in PHCs, and, supportive supervision to focus efforts on team building and improved provider performance,
- Statewide Strengthening of CHCs and PHCs geared toward improved sterilization service delivery by filling gaps in basic equipment and medicines, by enhancing female provider mobility for client follow-up and by hiring additional female lady doctors to improve client access to services,
- Statewide training of managers and medical officers through contraceptive technology updates, including information on all methods, orientation to a client focus, and emphasis on counseling and infection prevention practices to assure understanding of the latest scientific information and good client practices,
- Statewide training and follow-up of lady medical officers in IUCD clinical provision,
- Focussed training and follow-up of select medical officers in laparoscopy and minilaparotomy to upgrade sterilization practices and to increase access,
- Training of ANMs, in two districts initially, to upgrade contraceptive knowledge, client counseling skills, infection prevention practices, RTI/STD screening, IUCD insertion techniques, and client follow-up,
- Phased systems improvements and facilities upgrading in six districts of post partum centers, community health centers and block level primary health centers for readiness as training sites as well as improved service delivery
- Improving contraceptive logistics, and,
- Launching an information, education and communication campaign for the general public

## Findings

Public sector sub-projects did not begin in earnest until early 1995 for reasons already documented. Initial efforts focussed on training medical officers through contraceptive technology updates (with one third of all MOs trained to date) and by providing inputs to improve sterilization services. Notably, findings from the CTU Rapid Assessment showed considerable knowledge improvement of medical officers and retention when followed up in the field, and strengthened infection prevention practices. The assessment also identified the need for better information dissemination from the trained MO to other workers in the health facility.

In addition, assessment findings showed three significant and positive outcomes of: 1) increased access to services for women through hiring of part-time private lady doctors to work in government facilities with staff shortages, 2) provision of medicines for female sterilization clients during aftercare to lower pain and infection rates, and, 3) improved client follow-up by the ANM. However, the major input of purchase and installation of generator sets experienced difficulties in terms of meeting product specifications, and verifying receipt and installation at designated facilities. Overall, these inputs show positive outcomes in access to broader services and quality improvements related to infection prevention, client counseling and follow-up and provision of IEC training and materials. In 18 districts post partum centers are being upgraded to serve as model service delivery sites, and possible training sites. Further, five district programs to strengthen community health centers and primary health centers is underway to expand services more systematically at the district level. Inputs for the PPCs, CHCs and PHCs include upgradation/renovation, equipment provision, enhanced mobility, competency based staff training in clinical skills, counseling, infection prevention and supervision.

## *Constraints*

Facility upgrading at the district level has been slow, often taking up to one year from the time SIFPSA sub-projects are sanctioned. If this pace cannot be accelerated, the level of scale-up is limited.

The ANM training has not gotten off the ground for the last two years due to repeated administrative and program coordination issues related to interface with other Government training efforts. Since the role of the ANM is pivotal to expansion of services and community outreach, further delays in initiating ANM training will considerably slow down the ability to expand services.

Contraceptive logistics are not adequate for program needs, and must improve dramatically. Supplies in the public sector are erratic due to either insufficient quantities or poor management in transport of supplies to facilities, adversely affecting the government program as well as the IFPS funded private sector groups attempting to link up to free government supplies for their CBD projects. Although an action plan for logistics improvement has been developed by SIFPSA in collaboration with the GOUP, very little has actually been implemented. This area must be given immediate priority by the GOUP to address one of the most pressing constraints to IFPS implementation, since the current growth in demand is substantially outstripping the availability of contraceptive supplies. See Section V D 1 for full details on contraceptive logistics.

Funds have effectively been channeled outside the state budget to specific government institutions and district Chief Medical Officers through Public Ledger Accounts (PLA) to assure additionality and to bypass cumbersome State procedures. However, these accounts lapse on an annual basis, sometimes hampering disbursement of funds. Also, systematic reporting on utilization of funds does not appear to be in place, creating vulnerabilities that USAID and SIFPSA are now addressing.

Staff vacancies and/or high turnover especially among CMOs make it difficult to build in program continuity in the districts.

### *Conclusions*

Public sector services have improved, particularly in those districts where an essential package of inputs, ie training equipment, medicines, additional female doctors, and transport have been made available, resulting in tangible improvements in client centered, quality care through counseling and infection prevention practices. Those small scale innovations found to be effective and practical need to be more broadly incorporated into the program.

While some elements warrant statewide approaches, concentration of a package of resources and interventions at the district level is more likely to build up project momentum and impact if the interventions are located in the more heavily populated districts with the strongest public-private sector capacity. **The current benchmarks emphasize a phased, priority district approach eventually meant to reach the majority of the State's population. If diffuse statewide projects requiring significant resources and management efforts across all districts are further supported, the prospect for impact and achievement of existing public sector**

**benchmarks for service delivery improvements in six, then 15 districts as the articulated phase-up effort is likely to be diluted**

Based on experience to date, there are four major issues to address in IFPS assistance to the public sector

- Implementing a phased, strategic approach for programming public sector assistance by packaging resources and interventions at the district level to achieve maximum impact, while recognizing that some elements of assistance warrant state-wide approaches,
- Increasing the readiness of the public sector to provide a comprehensive reproductive and child health program,
- Coordinating IFPS Project public-private sector inputs to strengthen program linkages, community outreach and referral network for private sector clients to public sector facilities for clinical services
- More effective targeting of IFPS inputs to agreed-upon strategies and programs aimed at achieving performance benchmarks

**Recommendations**

- 1      **Contraceptive Logistics** Implementation of the IFPS contraceptive logistics plan by well qualified Family Welfare Directorate staff should be an immediate priority. More effective contraceptive logistics management (CLM) by the GOUP is required. Consideration should be given to contracting-out CLM to a private entity. See Section V D 1 for more details on contraceptive logistics.
- 2      **Accountability**
  - a)      **Funds Flow** Funds, as earlier programmed, should continue to flow through public ledger accounts (PLA) to specific institutions or district Chief Medical Officers for agreed upon programs. However, regular quarterly reporting and accounting procedures must be put in place and provided by each district to the Directorate and to SIFPSA. Also, all such PLA accounts must be kept current and audited annually with audit reports provided to SIFPSA.
  - b)      **Oversight and Monitoring Functions** Integrated district plans detailing

all inputs, timing and budgetary requirements and specific outcomes should be approved through the SIFPSA PAC District officials should be accountable for documenting progress on a quarterly basis In the absence of such reports, further funding should not be released

- 3 Key Staffing Since rapid staff turnover at the district level is a chronic problem and impedes planning and implementation of the IFPS program, the GOUP must make a commitment to place highly qualified staff, particularly the CMO, and maintain them for a minimum of two years to build in program continuity in priority districts
- 4 SIFPSA's role SIFPSA, or its designated district structure, should monitor public sector reporting on a regular basis to determine appropriate use of SIFPSA and IFPS inputs In the absence of such reporting, SIFPSA should not disburse funds to those institutions or districts not reporting

**B Private Sector - Non-Governmental Organizations (NGOs), Cooperatives, Indian Systems of Medicine Practitioners (ISMPs), Indian Medical Association (IMA), Employers & Training Institutions**

**Current Situation**

The private sector is the major provider of health and non-clinical family planning services in U P There is a strong preference to obtain health services from private providers, and the use of private doctors and practitioners is high across all income groups in both rural and urban areas Private providers are easily accessible to most people in U P Further, the private sector, because of its first point of contact with clients, is an important interface for information and provision of family planning and other reproductive health services Because of the reach of rural private practitioners and retail outlets, these groups offer tremendous opportunity for expanding the availability of temporary family planning methods and for improving the knowledge levels of the millions of clients that visit them every day

Private providers are currently the source of supply for over 75% of pill and condom users combined and 40% of IUD users (NFHS) Social and commercial marketing plays an important role in the private distribution of condoms and, to a lesser extent, pills While the public sector's strength is the provision of clinical services, the private sector role as envisaged in the IFPS Project is to broaden the quality of and access to spacing methods to enhance community knowledge in reproductive health decisions,

and to strengthen referral linkages to the public sector

IFPS is poised to take full advantage of this existing capacity and interest to spread family planning information, supplies and services through these channels. To date, with 108 approved NGO/private sector sub-projects totaling Rs 684.44 million or \$19.3 million, promising strides have been made. 20 million people covered by these programs have improved quality of interaction through increased number of knowledgeable service providers providing counseling and quality care, greater contraceptive choice availability, and overall better access to services.

**NGOs** While other northern states (with the exception of Bihar) have a complement of strong NGOs, U P does not have an abundance of well established NGOs in the social sector. SIFPSA developed selection criteria to screen NGOs and has indeed funded a significant number of NGOs. However, it is clear that the array of strong NGOs is limited in U P. While many NGOs competently provide services such as basic health, literacy, advocacy, clinic-based care, micro-enterprise and basic sanitation programs, the critical mass and reach of organizations needed to provide a base of support on which the IFPS project could build a widespread NGO program does not exist. The NGO contribution to service delivery and achieving both broad coverage and impact will thus, inherently have its limitations in scaling up throughout the state.

**Cooperatives** Linked to their existing infrastructure, cooperatives have the potential to incorporate family planning services into their programs. Pilot projects in Sitapur and Meerut districts working with dairy cooperatives to provide community based distribution services have been successfully implemented. From August 1996 to May 1997 the dairy cooperatives have distributed 8003 condoms, 3829 cycles of pills, and referred 968 IUCD and 759 sterilization clients. Programs expanding to six additional district dairy cooperatives are expected to cover approximately 6.8 million people and 1.1 million eligible couples.

**ISMPs** Indian Systems of Medicine Practitioners (ISMPs) offer great potential for expanding the availability of family planning services and information. Statewide sample surveys indicate that there are as many as 100,000 of these practitioners in U P, with the vast majority practicing in the 120,000 small villages of the state where 80 percent of the population lives. Of all outpatient visits to doctors in U P, 60 to 80 percent are made to these practitioners. Approximately 1200 ISM practitioners, of which 40 are female practitioners, have been trained in two districts under IFPS. For following up ISMPs trained in these two districts SIFPSA sanctioned a project in July 1997 to establish an alumni association to provide continuing education, guidance,

networking and strengthened supply linkages. Trained ISMPs now serve more clients with counseling and family planning spacing methods of oral pills and condoms. Since March 1997 three hundred additional practitioners have been trained and an additional 3,376 practitioners in six districts are scheduled to be trained by March 1998.

**IMA** Working through the Indian Medical Association, efforts were made to more actively involve private allopathic physicians in the provision of non-clinical family planning methods, as well as determine their interest and ability to provide clinical methods. IMA, working through its member network in U P, identified and trained 1562 interested members in an 18 hour participatory course covering non-clinical family planning methods. A recently conducted technical needs assessment for clinical training among IMA members found their was limited interest in participating in clinical training courses.

**Employers** The employer-based initiative was to provide company employees with health care and family planning services. Working through local chambers of commerce and with selected industries, SIFPSA has funded five employers projects in these five districts. To date, most of these efforts have been somewhat modest. Some of the factories involved in the project have shown limited interest in participating in the project, limited technical assistance has been provided to strengthen the effort, and some of the basic approaches to provide effective information and linkages to services have not proven the most effective. Recently sanctioned projects, with either larger employers that have significant numbers of staff or with a network of employers, seems to be more promising. Also, those employers that have made financial contributions are clearly more committed. This component will need to be monitored more closely, given adequate technical assistance and further investments made with larger industries that make a matching financial contribution.

**Training Institutions** Four training centers have been established. Prerana Population Resource Center (PPRC) has played a catalytic role in the start-up and implementation of the community based service delivery program in U P. Their core team has experienced, mature and committed trainers offering 9 courses that train a range of service providers. Due to the increasing need for TA to the private sector, PPRC has developed a strategy to form four regional consultant teams so that more in-field training can be accomplished. Below are their training outputs for the period January 1994 - May 1997.

Title	# of workshops	# total participants
Proposal development workshops	5	69
Training of managers	9	160
Training of trainers	10	151
Training of supervisors	15	281
Training of CBD workers	24	564
Training in MIS	10	240
Training in Quality of Care	1	22
Child Survival/Safe Motherhood	1	21
Experience sharing workshops for NGOs	1	45
<b>TOTAL</b>	<b>76</b>	<b>1553</b>

With the approval of three new apex training centers in March 1997, SIFPSA has made an attempt to meet the increasing training needs of the NGOs, managers and panchayat leaders. The U P Academy of Administration (UPAA) is responsible for training the NGOs of the hill region, cooperative and employer-based projects. UPAA will train 700 managers, supervisors and trainers and over 3,000 CBD workers. By sanctioning the Institute for Career Studies' (ICS) Leadership in Management training program, SIFPSA has taken a concrete step in bringing about a more collaborative working relationship between the NGOs and the public sector and greater linkages among activities. ICS will train 240 senior managers and 525 mid-level managers from NGOs and the public sector. The State Institute for Development (SIRD) will establish partnerships with the panchayat system for training in community based reproductive health advocacy and to mobilize greater involvement of community leaders in the IFPS project. Over 116,000 panchayat leaders will be oriented in RCH issues. It is clear from this review that PPRC is already stretched to its limits, and with further program expansion a combined strategy is needed to allow significant growth in PPRC, and to develop the other three training institutions to become fully functional.

## Findings

The recent rapid assessments for select IFPS Project programs examined seven private sector projects -- four NGO projects, dairy cooperative projects in two districts,

training of indigenous practitioners in two districts and training of allopathic doctors throughout U P by the Indian Medical Association -- in order to provide relevant information and feedback on private sector program approaches for scaling-up. A summary report, with findings, recommendations and issues for scaling up, is available as Annex 5. The assessment team participated in the rapid assessment dissemination workshop on July 15-16, 1997 in Lucknow and was able to interact directly with staff from many of the implementing agencies, as well as make several field trips to some of the organizations. Based on the rapid assessment findings and these field trips, the assessment team found several key findings of

- PVO partnerships are an essential part of the program. However, given the paucity of NGOs in U P, the project should focus principal attention on working with selected, larger NGOs and providing the necessary institutional support to strengthen them both managerially and technically. Indian Systems of Medicine practitioners also have shown great promise to extend the reach to clients in U P and should be further supported by SIFPSA. SIFPSA needs to serve as the catalyst for linking the public and private sector networks, for assuring that the public sector learns from and incorporates effective strategies tested by the private sector, and that the private sector receives essential support and referral services from the public sector.
- Contraceptive supplies must be available and linked - either free, subsidized or commercial - to the private sector groups, or their programs are severely constrained. In the rapid assessments, it was found that government supplies were not always available either due to supply shortages or an unwillingness of government functionaries to provide their limited supplies to non-government organizations. Thus, NGOs, cooperatives and ISMPs were short of essential (free) commodities that severely restricted their ability to provide regular, quality services. Some groups then purchased supplies directly from the market. Recently SIFPSA has taken an active role in encouraging the public sector to provide commodities to community based programs.
- SIFPSA has effectively broadened the public-private sector partnership by bringing in a number of key NGOs, cooperatives and to some extent employers. SIFPSA's capacity to manage current subgrants, respond to numerous queries from subgrantees and to expand private sector partnerships further is dependent on streamlining their own management structures, identifying larger networks to work through to broaden coverage, as well as through decentralization down to the district level.

- IFPS funded private sector projects are indeed serving more clients with family planning and other reproductive health services, and contraceptive prevalence is increasing in project areas, particularly for spacing methods

Specific assessment findings on key private sector interventions are

### NGOs & Cooperatives

- 1 Although NGO services are often more comprehensive and of higher quality, their reach is not extensive and coverage is low. In expanding NGO service delivery capacity, attention should be given to only larger NGOs that can reach a critical mass to achieve significant impact. Thus, NGO service delivery programs should be funded very selectively. Given the limited number of large NGOs existing in U.P. for service delivery, NGOs may be more useful in a supportive role to other larger service delivery networks such as cooperatives, ISM practitioners, and employers in related functions of training CBD workers, development of IE&C promotional efforts and technical assistance to programs.
- 2 NGOs and cooperatives with good community presence and participation within their area of influence were able to achieve the best results. For those that attempted to grow rapidly, it was difficult for them to achieve their goals.
- 3 Local politics, social and caste barriers, and cultural restrictions severely crippled the ability of some NGOs and cooperatives to effectively work in the field. This was especially strong in the selection process of the CBD workers.
- 4 Link-up with the public sector for referrals for clinical family planning services and contraceptive supplies needs considerable strengthening. Most importantly, however, was the lack of contraceptive commodities available within the public sector to support the community based efforts of the NGO and cooperative projects.
- 5 Frequency of interaction between CBD workers and female clients is extremely important, and was found indicative of better community participation and higher quality services.
- 6 NGO programs are providing a range of RH services, with 48% providing safe motherhood services, 49% providing child survival interventions and 10% providing STD/HIV/AIDS interventions. However, the quality of these services

needs to be validated In essence, IFPS needs to learn more from these interventions and build on them for future programming

- 7 Although working through the cooperative sector represents tremendous potential, key areas need to be strengthened of a) more commitment from senior management, b) the cooperatives financial solvency needs to be tracked to make sure they are a viable partner, and, c) appropriate project staff to carry out the SIFPSA funded program need to be put in place immediately overcoming labor disputes that have already delayed this process too long
- 8 Both NGOs and cooperatives benefitted from training and technical assistance to strengthen their implementation efforts (particularly the CBD component) and program management and information approaches and systems However, not all groups had the necessary level of TA required for program support

### ISMPS

- 1 ISM practitioners can play a vital role in expanding the availability and use of spacing methods
- 2 Supply and referral linkages are critical to the effectiveness of this program While the initial training went well, the implementing agencies were not expected to nor were they able to, effectively link up ISMPs to supply channels -- either free, subsidized or commercial
- 3 Local organizations in U P to implement the ISM program are limited The initial training was conducted by groups based out of Calcutta and Madras, and it took them some time to establish offices in U P and recruit staff For organizations that implement ISMP training programs, quality technical assistance is vital to their success in carrying out quality training programs as well as instituting continuing education and follow-up with ISMPs
- 4 There is a need to provide on-going continuing education and support in some organized fashion to these practitioners for some initial period after training to assure knowledge retention and institution of quality practices once ISMPs are back home
- 5 There is confusion over the what type of ISMPs should be trained, whether it should be all ISMPs, or only registered ones Since ISMPs are expected to only

counsel and provide non-clinical spacing methods, as basically a CBD function, it seems reasonable that any interested ISMP, regardless of background and certification, should be trained

### IMA

- 1 Results from several assessments indicate that IMA members trained in non-clinical family planning exhibited an increase in knowledge, a positive and sustained attitude change to family planning counseling and a higher proportion providing family planning services
- 2 IMA had difficulty in targeting and training a critical mass of OB/GYN specialists as well as general practitioners that would be most likely to incorporate family planning services into their practice It is difficult to determine how many of those trained, since all specialties were included, are actually providing family planning services
- 3 In the technical needs assessment among IMA members for clinical training, there was a very low response rate and there are numerous difficulties in establishing a core clinical training cadre and setting up quality service sites to train private practitioners in clinical skills While it was originally felt that this approach was promising, the prospects for expansion appear limited
- 4 An alternative strategy has been put in place whereby five slots have been reserved for private providers during each CTU training at the seven medical colleges for CTU/IUCD training Since many of the public sector doctors also have private practices, training them through the CTU courses should extend the integration of quality improvements and enhanced access into their private practices

### Employers

- 1 Although there was limited success achieved in the employers sector, the team believes there is potential if efforts are more focussed
- 2 Several small scale employers were both reluctant to participate and seemed to lack the resources to participate in family planning service delivery, and/or employers placed low priority on preventive care and least of all to family planning, with many not interested in instituting community out-reach activities

- 3 The "worker motivator" model adopted for industry has several limitations a) since the worker motivator is part of the regular work force, he was not given adequate time during work hours to provide services, b) when the worker motivator is from another unit, he was not allowed to enter the factory premises, and c) since all the worker motivators are males, the opportunity to reach wives of the male workers through a community outreach effort was constrained

### **Training Center(s)**

Since the three new apex training centers have yet to provide training, comments will be limited to Prerana Population Research Center (PPRC)

- 1 PPRC is doing an excellent job of training In recognition of this, SIFPSA has requested PPRC to take on more responsibilities over time, including NGO management training, initial CBD training, TBA training, and FLE training In short, they are overloaded
- 2 For NGOs that have more than 30 CBD workers, PPRC provided training to one batch of workers and trained project supervisors to train the remaining batches of CBDs Most NGOs have not provided the follow on training as anticipated, resulting in a large number of untrained CBDs While PPRC has attempted to rectify this situation by sending staff to the field to train these NGO staff, this too adds to the burden of PPRC staff

### **Recommendations**

- SIFPSA should place a top priority on continuing and expanding its pursuit of large networks for service delivery in the private sector Expansion of pilot projects utilizing co-operatives, large NGO's, and large employers are endorsed As specific initiatives are expanded, technical assistance must be coordinated to ensure that organizational capacities are present for implementation of expanded activities Indigenous practitioners also offer potential for significant expansion of service delivery Expansion of ISMP training should be an IFPS priority, and networks should be built in support of, for example, refresher training and supply and referral linkages
- Provision of contraceptive supplies and referral networks must be linked up to the private sector partners on a regular basis or their impact will be severely constrained SIFPSA should take the responsibility to solicit support from local

public sector officials and workers prior to NGO project approval Lines of contraceptive supplies should be established well before project implementation SIFPSA should obtain a commitment from the public sector to provide supplies and clinical services on a regular basis and should intervene if problems are faced by any private sector organization

- SIFPSA needs to institute a system for timely responses to partners' queries and requests Greater decision-making authority should be vested to implementing organizations so that decisions can be taken in the field, ensuring minimum delay in program response so that organizations can make appropriate modifications to project activities to achieve maximum impact at the field level Such changes should be enumerated in quarterly reports so that SIFPSA can track the progress in the field

### NGOs & Cooperatives

- 1 A Technical Advisory Group tasked with managing the provision of training and technical assistance and strengthening the cooperatives sector should be formed Membership from SIFPSA, PCDF, USAID, CEDPA and UPAА should be sought Expansion should be phased with lessons learned from the pilot program incorporated into the new activities UPAА should prioritize its activities so that training of cooperative sector staff can be achieved at the earliest date Reassess the dairy cooperatives commitment to participating in this program in the next quarter to confirm that management has come on board, appropriate staff have been hired and the program is underway Relatedly, a financial review of PCDF's operation should be done periodically by SIFPSA to assure solvency
- 2 Selection criteria for CBD workers, based on community participation in the decision making process in order to build in more likelihood of broader community acceptance of these workers should be established
- 3 Given the importance of the skill of the CBD worker and their role in community participation and quality improvements, training strategies to assure that all of these workers are indeed trained must be put in place
- 4 Strong technical support to build up the management capacity of participating organizations should be instituted Participatory supervision techniques, record keeping and data presentation should be an intrinsic part of the technical support NGO-MIS system training should be offered to all participating

organizations

- 5 Validate the quality of the RH interventions in the program through a series of field visits and then support them further as appropriate as well as build in those approaches more broadly into the overall program

### ISMPs

- 1 Expansion of ISMP training should be an IFPS priority, and networks should be built in support of, for example, refresher training and supply and referral linkages
- 2 Greater emphasis should be given to building up the capacity of local organizations to train greater numbers of ISM practitioners. This capacity building is required to reach the coverage levels necessary to meet IFPS objectives
- 3 A strategy needs to be developed to follow-up trained ISMPs to provide continuing education, networking, and field support
- 4 There should be no restriction on training of ISMPs. All ISMPs interested in receiving training should be trained, regardless of registered or non-registered
- 5 There is scope in the training curriculum for introducing other simple concepts of reproductive health, especially male participation, since most of these practitioners are men as are their clients

### IMA

- The likelihood of impact through further work with IMA is questionable since they have limited institutional capacity to sustain the program, difficulty in attracting key specialists through their network to participate in the training, and inadequate follow-up for IEC/promotional support, supply linkages and continuing education

### Employer Sector

- 1 Encourage employers to start family planning service programs, exploring cost-sharing models for program activities so as to encourage greater financial

sustainability from the onset of the project

- 2 Target those medium and large size industries that are already providing social welfare and health needs to their employees to facilitate the integration of family planning services
- 3 Reassess the "worker motivator model" and consider appointing full time Factory Health Educators who work under the direct supervision of the project coordinator

### **Training Centers**

- 1 Reassess PPRC responsibilities and workload and authorize more staff and related budgetary costs as appropriate to meet the full demands placed on PPRC as project implementation accelerates in the private sector. Aside from PPRC, the three new training centers need to come on line immediately in order to meet the increasing demand for training support. An alliance amongst these training groups to develop complementary training efforts should be fostered.
- 2 Expand the network of resource persons in each region so that all CBD workers are trained by expert trainers and all NGOs receive technical assistance through a localized system that is speedy and responsive.

### **C Contraceptive Marketing (Social and Commercial)**

#### **Current Situation**

Contraceptive Social Marketing (CSM) has been operating in India for more than 25 years, sponsored by the GOI, working closely with large private companies to draw on their existing distribution and marketing capabilities, e.g. Indian Tobacco Company, Brooke Bond India, Reliance Bulk Drugs and others. Initially the GOI purchased condoms and later (1987) oral contraceptives in bulk and supplied these to the partner marketing firms at a very low subsidized price, with a fixed sales price incorporating a small margin of profit to cover promotion and advertising. Over the years, this small profit margin has provided little financial incentive and is inadequate to fund the necessary promotion, advertising and market research, and therefore, CSM as currently organized, has not reached its potential. Several of the marketing firms have opted out of the program due to interrupted supplies of the product, inconsistent use of promotional subsidy, lack of monitoring of geographical territories, poor image of GOI

CSM brands and price under-cutting CSM sales of condoms have lagged badly and continued to decline over the past five years Recognizing this, the IFPS project built in the CSM component to address existing national CSM program weaknesses

- expand distribution and marketing of products to reach out not only to urban/peri-urban areas, but also to the underserved rural areas,
- substantially increase funding and technical assistance for market research, advertising and promotion and for building field distribution to expand the total market

The IFPS Project Agreement specified that USAID would directly fund a contract with a marketing firm to revitalize and expand subsidized contraceptive sales in Uttar Pradesh USAID emphasized direct contracting to attract strong firms through competitive procurement to build up marketing of CSM products, extend distribution reach and have in place sufficient and flexible funding to enhance the program However, as plans for implementing this component were developed, both the Ministry of Health and Ministry of Finance objected to USAID direct funding since all other bilateral IFPS Project funds flow through the GOI budget After long, difficult negotiations reaching the ambassadorial and senior ministerial levels, the Ministry of Finance informed USAID that direct funding of CSM, as originally planned, would not be possible

While the discussions about the mechanisms for implementing the CSM component went on for three years, USAID also drew on alternate mechanisms to strengthen CSM Under USAID headquarters, non-bilateral funding, the SOMARC (Social Marketing for Change) Project has provided technical assistance and direct support for sub-contracts to two social marketing firms, Population Services International (PSI) and Parivar Seva Sanstha (PSS), to expand subsidized contraceptive sales in Uttar Pradesh SIFPSA has also entered into an agreement with a contraceptive manufacturer to increase its marketing and distribution of condoms and IUCDs in the State

As NFHS data were analyzed, and more information on contraceptive sales in Uttar Pradesh became available, particularly after problems of condom and oral pill availability emerged in 1995-96 it became apparent that the contraceptive market is more complex than had been originally understood during the project design phase There are three modes of contraceptive distribution

- free, fully subsidized, distribution through public health facilities,

- partially subsidized distribution and sales through commercial and NGO outlets, and,
- full price, commercial distribution and sales through commercial outlets and providers

These three marketing modes often compete with each other in inefficient ways that do not serve clients' needs. With commercial sales on the rise, there is increasing evidence of consumer willingness to pay for contraceptives. This emerging consumer market needs to be stimulated, and based on these consumer trends many of the assumptions about social marketing in the original IFPS design need reexamination and refinement. For this reason, a market segmentation study will begin shortly to more clearly identify the various segments of the market and the appropriate mechanisms, price and distribution networks to address the needs of each of these client segments. It will answer the question: what are the relative roles of free distribution, subsidized sales and commercial marketing in serving clients in different income levels in the most cost-effective way? This study will be completed over the next several months. In the meantime, several complementary marketing approaches are continuing or being initiated.

- Continued SOMARC-support for subsidized marketing and distribution of condoms and pills by PSI,
- SIFPSA-supported expanded marketing of condoms and IUCDs through Hindustan Latex Limited, and,
- Expanded promotion and private distribution of oral pills through commercial channels by Wyeth India, the market leader

Although the large and essential bilateral social marketing component (\$42 million) as designed has not been put in place, these current efforts underway are melding together work with the commercial sector as well as promotion of subsidized products to meet a range of consumer needs. From the inception of the IFPS Project in 1992, it was clear that the goals for increased access to, demand for and use of spacing methods in U P could not be met without adequate contraceptive supplies in ever increasing amounts. Noting frequent stock-outs at both the public and subsidized (social marketing) service delivery points, the IFPS project design strategy to put in place adequate contraceptive supplies should include supply and promotion of commercial (full-cost) contraceptives.

This diversification from the original CSM design is important, given the breakdown in CSM distribution networks and limited CSM product supplies. For example, PSI condom sales, which had captured the majority of socially marketed condoms sales in U.P. as early as 1991-92 with a total of 14.2 million MASTI brand pieces sold, dropped to 9.1 million pieces in 1994-95 and 9.6 million in 1995-96 due to product non-availability when government CSM rate contracts were not in place with manufacturers to supply product.

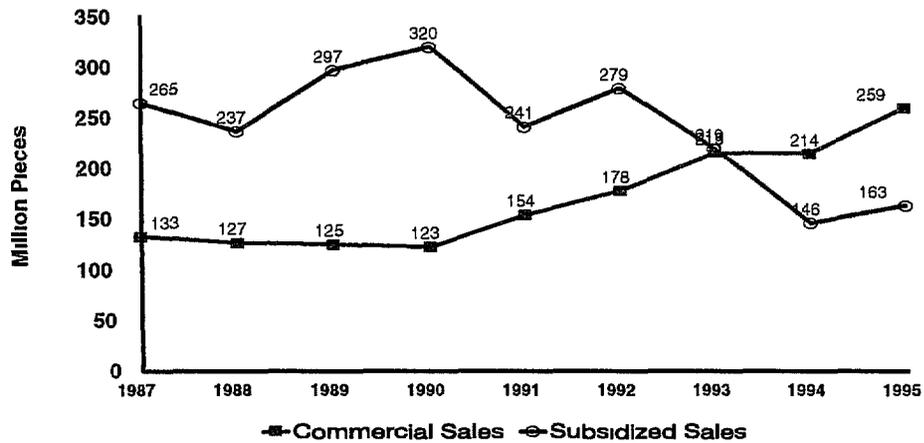
PSI was plagued by lengthy stock-outs from GOI sources, loss of key staff and perhaps a take off into the market by some of the commercial firms seizing upon an opportunity to capture part of the increasing disposable income of Indian families. In comparison to the large Indian contraceptive manufacturers, PSI lacks the capital necessary to make major purchases of contraceptives in advance so they can allow their retailers to buy on credit from PSI for resale to the ultimate user. In brief, PSI is caught in a credit crunch at both ends of the process.

Without creative financial arrangements, this could prove to be a major obstacle to large-scale social marketing, whether it is PSI or some other social marketing company. It may be possible, on the other hand, that local manufacturing/marketing firms, such as TTK-LIG Ltd. (London Rubber) or J.K. Chemicals, two major players in the condom market, have the capital to seed these upfront costs. Both TTK-LIG Ltd. and J.K. Chemicals also participate in the GOI's CSM program. These manufacturers have also secured loans under the Program for Advancement of Commercial Technology-Child and Reproductive Health (PACT/CRH) project for expanding the marketing and distribution of condoms in India.

There is no simple solution for incorporating the traditional CSM component nor an obvious marketing firm to undertake implementation. All experienced marketing/advertising companies believe, however, that the potential market for subsidized/commercial sales is enormous. Indeed, several of the large manufacturing companies have added sales units to market their own products anticipating new opportunities in the economic scene in India. Several have met with success as evidenced by growth of commercial condom sales from 215 million pieces in 1993-94 to 259 million pieces in 1995-96. As noted earlier, in order to quantify the potential consumer market across free, subsidized and commercial sectors, USAID/India is funding a market segmentation study, soon to be underway.

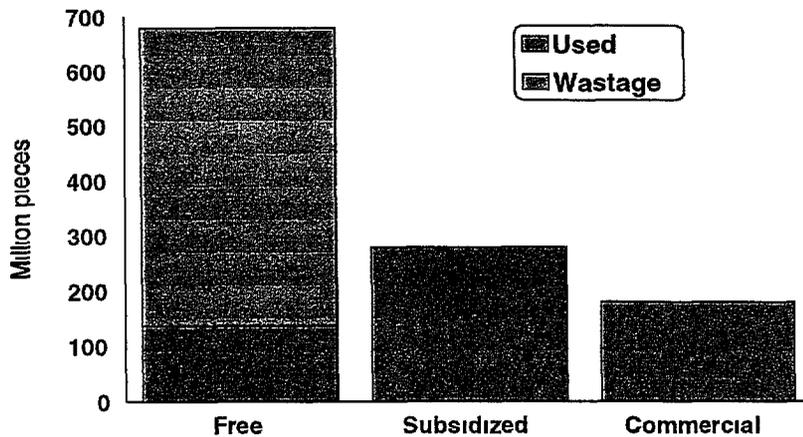
Commercial condom sales have significantly overtaken CSM condom sales over the past three years

### Trends in Sales of Condoms



Government free distribution has significantly increased from 478 million pieces in 1987-88 to 874 million pieces in 1995-96. However, the NFHS reported that only 23% of condoms used come from government free supply, indicating that nearly 85% of free

### Use and Distribution of Condoms 1992-93



condoms available through public outlets were wasted or unused. Based on this it seems that only about 126 million pieces of the 874 million condoms distributed free of cost would have actually been used. This documents a costly wastage problem as well as major distortion of the commercial/social market.

### Findings

- 1 The actual reported consumer use of free condoms and pills as compared to reported supplies distributed to public stocking points is very low.
- 2 However, the free, or fully subsidized system must be maintained to provide adequate coverage for below-poverty couples and for couples who can afford to pay but lack access to subsidized/commercial contraceptives. Over the years, it is hoped the GOI will forecast annual requirements more accurately and that the free requirements will decline as a percentage of total condom and pill requirements as discretionary income and pro-active demand increase in India. It is also expected that due to the new GOI policy of dropping method specific targets, the gap between distribution and actual use will narrow in the coming years.
- 3 The demand for condoms will increase markedly beyond the current 8.4% of total contraceptive use in rural areas and 12.4% in urban areas of U.P., as multi-media IEC gets underway.
- 4 Pill use can increase even more rapidly than condoms, if women currently not contracepting but intending to use have access to affordable brands. Currently, in U.P. only 1.5% of urban women and 0.9% of rural women are using pills, which they obtain largely from the private sector (53% from private providers and shops). Of all women not contracepting but intending to use, 40% state-wide have indicated a preference for pills. This increases to 44% in rural areas, where, unfortunately, pills are least available.
- 5 Like the condom, unmet demand can only be met if pills are made more available through the commercial, subsidized and free channels in the rural and urban areas of U.P.
- 6 Commercial and social marketing efforts can be pursued through several avenues. The original plan for Contraceptive Social Marketing (CSM) cannot be implemented as designed due to GOI constraints and a new, multifaceted

approach is required incorporating commercial, partially subsidized and fully subsidized (free) contraceptive distribution. A market segmentation study about to be undertaken will provide much more information from which to develop a market sensitive strategy based on potential consumer purchasing power and development of a comprehensive plan agreed to by all parties by May 1998 will be considered a critical benchmark.

### *Hindustan Latex Limited Program*

Although the \$42 million state-wide social marketing effort funded directly by USAID has not, nor is likely to, materialize as originally planned, the team closely examined the recent SIFPSA-approved marketing project with Hindustan Latex Limited (HLL), India's only company that both manufactures and markets both subsidized and commercial condoms, pills and IUCDs. The findings are as follows:

- 1 HLL has submitted a very ambitious, innovative proposal. Moreover, it was prepared with the advice from Ogilvy and Mather (one of India's leading advertising agencies) and R K Swamy/BBDO (US's largest marketing agency for handling brand promotion). This advice, combined with HLL's use of a well-known Japanese firm for quality control of condoms and Finishing Enterprises, USA for IUCD quality control, raises confidence that clients will respond positively to world-class products offered in rural areas for the first time. It is noted, however, that the funding for the promotional aspect of this deep rural effort is probably inadequate for a three year full state coverage at \$1.2 million.
- 2 At a cost of \$1.2 million for three years, the per capita cost for the HLL program funded by SIFPSA appears to be reasonable for the IFPS project although the following targets may not be realistic for HLL's projected sales for U.P. (The goal of this effort is to reach the majority of the people of U.P. over a three year period. As noted earlier, it may be that it is not funded adequately for the promotional part of this important task).
  - HLL's condom brand *MOODS* would grow from 3 million to 12 million pieces in urban areas in 3 years with an additional 50% of sales from rural areas, i.e., 18 million pieces annually.
  - Their new, less expensive condom, *RAKSHAK*, meaning "protector", would increase in sales from zero to 18 million pieces by the third year.

80% of which would be in rural areas

- Sales would reach 300,000 T-CARE IUCDs during the three year period with 60% in rural areas
- Non-commercial condom brands, Deluxe Nirodh and Ustad, and the subsidized pill, *MALA-D*, would also be marketed, but sales targets are not projected in the HLL proposal. This omission results from past stock-outs of the GOI subsidized products which make it impossible to project sales for these brands

- 3 The HLL marketing scheme is innovative in several ways in that it focuses on selling commercial condoms and IUCDs and targets sales in underserved rural areas and towns of 20,000 or less. These areas are physically remote and isolated in terms of access to family welfare information and services. Further HLL innovations are in the proposed use of vans to reach deeply into rural areas to carry promotional messages and products, coverage through weekly 'HAATs', or village markets, the use of CBD workers as sellers and of ISMPs as depot holders for condoms and IUCDs, and a unique packaging of a single condom for rural families. Recent research on the newly emerging rural markets has revealed that many rural buyers want to purchase consumables but can only afford them in small quantities, for example, 60% of all shampoo sales in India comes from sachets of which 70% are sold to rural families
- 4 In line with this "sachet concept", HLL will package a single *RAKSHAK* to be sold at Rs 1.50 versus 3 pieces of *RAKSHAK* for Rs 3. In spite of the cost of the extra packaging, the single *RAKSHAK* may be the biggest income generator for HLL.
- 5 Another innovative aspect of the HLL activities is the sale of IUCDs in rural areas to private sector physicians via HLL retailers and IFPS trained ISMPs as depot holders.
- 6 The differential between the HLL's cheapest condom, *RAKSHAK* at Rs 1.3 and the subsidized Deluxe Nirodh at 40 paise is marginal to the consumer.
- 7 In spite of consumers expressed desire to use, pill promotion and access has been very limited in U.P.

- 8 The HLL proposal for marketing the GOI brand *MALA-D* at Rs 2/- is taken in U P , since they are not receiving funding to market and distribute the GOI CSM products However, limited pill access may be offset somewhat in the near-future when HLL attempts to market its own new brand at Rs 12/- per cycle as a full commercial (unsubsidized) product

### *Other Commercial Avenues*

Under the Program for Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH), USAID provides funds to India's second largest development bank, Industrial Credit and Investment Corporation of India (ICICI), which in turn lends funds or provides grants to Indian firms to upgrade and/or increase the marketing and distribution of child survival and reproductive health products

Through PACT/CRH, several companies have already used loans to purchase equipment, expand marketing and distribution of condoms and IUCDs, and obtain technical expertise to improve condom and IUCD quality Through this effort, India's image for poor quality contraceptives has changed to one which meets WHO and other international standards

In addition, PACT/CRH support offers an additional commercial option for filling in the major gap in pill availability through a proposed agreement with Wyeth India for expanded distribution of the low dose estrogen brand *OVRAL-L*, which is already the best-selling commercial pill brand in India and U P , with nearly one-third market share Wyeth will increase its marketing and distribution efforts, strengthened by a USAID-supported generic communications and public relations campaign to promote the use of oral contraceptive pills in four northern states of India, including U P Provider skill development and intensified product detailing are integral components of the promotional effort This totally commercial effort will be financed through USAID's PACT/CRH project funds in the amount of \$1.7 million over two years

Instead of enhancing quality or expanding factory capacity, both of which need no improvement at Wyeth, the new ICICI four state agreement with Wyeth will be used for training of providers and detailing efforts and for the design and implementation of a generic promotion effort This generic campaign will be complemented by brand-specific promotion This will reach millions of potential users and counter prevailing misinformation about pill safety, effectiveness and convenience for all pill brands Outcomes expected at the end of the two-year effort in expanded commercial marketing of pills is that the market size for pills will expand by about a quarter in the four

northern states

One of the most attractive aspects of the ICICI effort is that it is scheduled to cover the four big northern states, with an emphasis on U P. This will serve as a natural laboratory for testing the difference in impact between U P with its blend of public, private and commercial IFPS efforts and status quo in the other three states

### Recommendations

- 1 All steps for immediate implementation of HLL activities should be pursued following the first meeting of the designated Technical Advisory Group (TAG). Thereafter, the TAG should have regular meetings with the understanding that emergency meetings of the TAG can be called as required. All members of the TAG should see themselves as facilitators in this urgent task and not delay action as though this effort was a research study. Any issues regarding HLL reaching target clients should be settled by independent surveys. Progress under the HLL contract should be reviewed by the SIFPSA Executive Director and the USAID IFPS Project Officer at least every six months to monitor sales and coverage and to determine whether funding is a constraint to planned expansion.
- 2 Continue with the independent tracking system, i.e. retail audits, to monitor the commercial/social marketing efforts.
- 3 Favorable consideration should also be given to testing the value added if the mass-media program of Thompson Social were **combined** with the rural promotion/sales vans of HLL.
- 4 A final decision on the pursuit of an additional firm to cover the population in towns of 20,000 and above should be held until findings are available from the Market Segmentation Study to be completed in the next five to six months. This study should also inform Mission discussions with the GOI regarding requirements for free contraceptives, subsidized product and commercial sales.
- 5 While the Market Segmentation Study is underway, discussions between all appropriate parties should be pursued as a top priority to work out the financial constraints inherent in a PBD system operated by a quasi-government organization to any contractor/grantee needing sufficient funds for state-wide pre-sale (i.e. purchase product, promote product, sell product on credit to retailers) costs. **The team believes that resolving this administrative**

**constraint is the single most important and urgent action for going forward with an effective effort in social marketing**

- 6 If the Market Segmentation Study to be completed by January 1998 indicates that there is a proven need for a subsidized marketing effort for towns with 20,000+ population, the procurement process should be competitive, with priority given to the firm with best offer for increasing access to and sale of pills in addition to condoms. Offers which maximize the use of CBD-like workers in an effective way should be given extra consideration in the procurement award process. This effort should provide adequate funding to reach maximum impact.
- 7 Strong, collaborative efforts to expand a rational supply of and access to fully subsidized (free), partially subsidized and commercial contraceptives are essential to meet increasing demand generated by IFPS for family planning spacing methods. Based on the market segmentation study, a detailed implementation plan should be developed by USAID making necessary adjustments in approaches and funding levels. A technically and administratively sound alternative plan mutually agreed to by USAID and the GOI must be in place by May 1998. If not, expectations and project goals should be revised downward and funding levels correspondingly decreased.

## **D Cross Cutting Areas**

### **1 Contraceptive Logistics**

#### **Current Situation**

Maximum impact of the IFPS Project depends on establishing and maintaining reliable and consistent distribution and supply systems to serve the public and private sectors. In the short term, the public sector systems will be the major source of contraceptives for the IFPS sub-projects. Hence, if current IFPS sub-projects are to achieve full impact, the public sector system must be strengthened.

For the longer term goals of IFPS, though, not only continued strengthening of the public systems is required, but also enhancing the expanding role of supply through the subsidized/commercial sectors. In terms of sustainability, the commercial supply will be more and more the main focus.

Although generally viewed as slow and frustrating, some steps have been made through IFPS to address some systemic logistics problems. Also, there appears to be an increased awareness that an effective logistics system is critical. A few major accomplishments include

- On July 12, 1995, based on the recommendations of a UNFPA study on contraceptive demand and a TA visit to select U P districts, the GOUP formed a Logistics Management Task Force, under the chairmanship of the Secretary of Family Welfare, with representatives from the GOI, GOUP, UNFPA, SIFPSA, USAID and selected NGOs. Their purpose is to review existing logistics procedures, ensure coordination between the public and private distribution systems and address major implementation problems and issues. To date, this Task Force has met eight times and, in fact, the last meeting took place on August 2, 1997, between the SIFPSA staff, led by the ED, and Directorate staff at the Amausi warehouse to critically review progress and problems with logistics management in U P.
- In August 1996, SIFPSA sanctioned a one-time, short-term project, valued at Rs 50 lakhs (\$143,000) to the GOUP Directorate of Health and Family Welfare to equip and upgrade the Logistics Management Cell and the Additional Divisional Director's offices. The faxes, typewriters, and other materials were provided to enable these offices to procure and account for PHC, CHC and NGO commodity requirements under their jurisdiction. In addition, the Additional Divisional Directors rented appropriate space which serves as a temporary warehouse for the commodities which are to be distributed out to the districts. Prior to this SIFPSA effort, commodities were directly supplied from Lucknow to each individual district CMO.
- At the June 18, 1997 Logistics Management Task Force meeting several major decisions were made. 1) under IFPS support, the GOUP will manage the day-to-day operations of the Amausi central warehouse in Lucknow, including support tasks, such as, cleaning, loading, unloading, and security. The Task Force discussed, but did not agree, whether support tasks should be contracted out to a private firm on a test basis for one year and, 2) under technical assistance, the Directorate requested that (2-3) local hire contract staff be placed in the Directorate to assist with setting up the logistics management cell and to improve the logistics capacity overall on the condition that the Directorate places qualified and sanctioned CLM staff to be headed by one Joint Director.

Although the Logistics Management Task Force has attempted to deal with several logistics problems through the years, only in February 1997 was the IFPS Action Plan for improving contraceptive logistics in the state of U P approved and \$700,000 disbursed. Some activities were implemented prior to the plan but there will be a need to focus, prioritize, and to maintain a constant vigilance with regard to some key components

- functioning of the Logistics Management Cell and staffing placed at the state/divisional levels
- functioning of the State Warehouse at Amausi
- functioning of a Logistics Management Information System
- training in logistics
- strengthening warehousing/storage facilities
- maximum-minimum inventory control
- delegation to Divisional Additional Directors
- improving transportation/distribution

### **Findings**

Overall, contraceptive logistics are not adequate for program needs, and must improve dramatically. Supplies in the public sector are erratic due to either insufficient quantities or poor management in transport of supplies to facilities, adversely affecting the government program as well as the IFPS funded private sector groups attempting to link up to free government supplies for their CBD projects. Although an action plan for logistics improvement has been developed by SIFPSA in collaboration with the GOUP, very little has actually been implemented. This area must be given immediate priority by the GOUP to address one of the most pressing constraints to IFPS implementation, since the current growth in demand is substantially outstripping the availability of contraceptive supplies.

Results of the rapid assessments of a representative set of IFPS projects indicate that (a) public sector distribution and contraceptive supply is unreliable, and (b) even when supplies are available at PHCs/CHCs, they can be difficult to obtain by private groups and providers.

The Safe Delivery and Family Welfare Services at Door Step Project in Shahjahanpur District reported

" replenishment of family planning and MCH supplies is not systematic "

" the project has encountered major problems in regard to supply of contraceptives and iron and folic acid tablets in spite of excellent rapport with government health functionaries "

Supply difficulties, while affecting all IFPS service delivery projects, have been felt most acutely by the private sector, especially CBD projects. CBD workers are quickly becoming an important source of information. If supply problems can be resolved, these workers have great potential, due to their high level of client contact, to deliver supplies. One rapid assessment found that of the eligible couples (about 6,700) covered, 79% said they interacted with CBD workers. Almost all (96%) reported that they knew the name of the CBD worker and reported the name of the CBD worker correctly. In general, the extent of interactions between CBD workers and women is very high.

In the Shramik Bharati slum project 60% of the total women had met the local CBD worker, and 86% who had ever met with CBD worker were satisfied with the information and/or service provided. Also, the higher the level of acceptance of CBD workers, more demands were made of their time for other activities, such as helping women daily wage earners to find work in a lean season, and taking women with major ailments to the hospital.

The rapid assessments reported that in one case 20% of oral pill users and 15% of condom users relied on CBD workers at the time of first use. Another reported that two thirds of current condom users mentioned the CBD worker as a source of supply, 14% depended on husband or friends, 11% purchased condoms from commercial outlets, and 8% got their supplies from government health facilities. In the case of oral pills, the dependence on CBD workers was even higher.

However, supply constraints hamper NGO efforts. The Women's Welfare Campaign in Barabanki District reported "At times CBD workers did not receive adequate supply of condoms and oral pills due to shortages at PHC level. CBD workers encouraged users to buy condoms and pills from chemist shops."

Therefore, if the potential impact of CBD workers is to be fully realized, there must be immediate attention to resolving contraceptive distribution and supply problems. Initiatives to link providers with social marketing is one important approach which has been facilitated recently through SIFPSA providing a revolving fund for NGO contraceptive supply procurement either from the commercial or social marketing retailers. Another is the strengthening of the direct free supply from the public system.

which has recently been mandated by the ED of SIFPSA, wearing her government "hat" as the GOUP Secretary for Health

Finally, there is currently a lack of vital data to develop rational interventions to improve contraceptive supply. For example, at present, there is little insight into U P population's ability and willingness to pay for contraceptives. Specifically, there is a need to better forecast effects of strengthening access to one supply source (e.g., free supply) over other sources (e.g., commercial). This need will be largely met by the forthcoming market segmentation study.

Anecdotal evidence from interviews with clients and CBD workers indicate that clients' ability to pay varies. e.g., urban CBD workers in Kanpur Nagar report wanting to sell subsidized product - clients' paying for product are more likely to use them and CBD workers can earn a small profit. However, village-based VHVs in the Sitapur PCDF project report that, without free distribution, many clients would not have effective access to product, as they cannot afford to pay.

## **Recommendations**

- 1 Implementation of the IFPS contraceptive logistics plan by well-qualified Family Welfare Directorate staff should be an immediate priority. More effective contraceptive logistics management is required. Consideration should be given to contracting-out logistics management by the GOUP to a private entity.
- 2 As recommended elsewhere, there is an urgent need to complete the market segmentation study so as to develop a more rigorous and market sensitive strategy for provision of supplies. In particular, all parties need a better sense of how dependent people are on free public sector supplies or subsidized supplies in order to rationalize/design further public sector CLM interventions.

## **2 Information, Education and Communication (IEC)**

### **Current Situation**

Despite the criticality of IEC to the success of IFPS, IEC activities experienced a slow start, particularly the private sector, mass media component. In fact, the contract with Thompson Social for the major IEC effort through multi-media channels was signed only in March 1997 after 18 months of lengthy negotiations. In the meantime, the NGO CBD and cooperatives' volunteers had already begun their counseling/promotion

activities in a timely and effective way among young, low parity couples, albeit on a more localized scale, and the rapid assessments show a positive relationship between the role of IEC and through the CBD worker and acceptance and use of family planning

At present, survey results indicate that young wives in U P have the highest unmet need in India (perhaps in the world) Given that most of them would prefer to space than limit, it was perhaps fortuitous that advocacy via one-on-one contact rather than through the mass media came first Moreover, the volunteer efforts focussed mainly in the slum and very rural areas where access to television and radio is lower, making one-on-one contact more necessary and productive This was confirmed during the Team's discussions with young acceptors who indicated that although contraceptives were known, the importance of adequate birth intervals was previously unfamiliar to them This important health concept had come to them as a result of talking with community based workers who recommended a three year interval to protect the baby and mother As a result of house to house information and delivery, more young mothers in focus areas are spacing, and where contraceptives are available, the vast majority are securing them via the community based system

As a part of non-bilateral activities, funding was provided for generic marketing of contraceptives During the past year, social marketing/commercial sales in U P increased by 21% for oral contraceptives compared to a 4% increase for all of India during the same period Although IFPS promotional efforts cannot claim responsibility for all of the remarkable increase in U P contraceptive sales, it can be assumed that these promotional activities were a major factor

Following the signing of a mass multimedia contract, three themes for mounting its "Let's Talk About It" campaign are being field-tested All three are attractive The winner will be determined in August with production to commence in September and campaign launch in November The Team believes that current IEC should be monitored on a quarterly basis in order to assure appropriate approaches and adequate funding in a timely fashion

Both the SIFPSA Executive Director and the Principal Secretary for Family Welfare for the State Government are fully supportive of the mass-media approach Without it, they contend, large scale changes in spacing behavior will not occur They are also convinced there is almost universal access to TV and radio This view is more optimistic than the low media exposure rates reported in the 1992-93 National Family Health Survey (NFHS) for U P

The future of the Family Life Education (FLE) component is yet to be decided. The FLE intervention is critical for reaching out-of-school adolescents. Initially SIFPSA gave a grant to Nehru Yuvak Kendra (NYK) to train 2,300 rural adolescents in FLE. Although this was well received, FLE components integrated into NGO programs were less successful. In view of the difficulties (cultural and logistically) of directly reaching the large cohort of young girls who have an expressed need for information, SIFPSA has decided to prepare and pretest an appropriate booklet which will discuss a responsible life-style and career planning. Workshops discussing these same subjects are also scheduled for young men. Recently SIFPSA sanctioned projects in which FLE would be imparted to college students. To date over 3,200 students have received FLE instruction. Fourteen colleges are participating in the program, in which teams of teacher/student trainers are providing peer counseling to interested participants. Because of the large numbers and greater difficulty in reaching out-of-school youths, innovative and cost effective schemes are being designed, tested and implemented to reach this group. While significant emphasis has been placed on working with adolescents through the family life education program, the initial work through college programs has limited reach for broad impact. Rather the emphasis should be on reaching girls in slums and rural areas. There needs to be better guidance on the FLE program approaches, standardized training packages, and built in assessment of this component to assess its impact.

SIFPSA, in collaboration with various CAs, has produced 17 films and 26 how-to manuals for providers, trainers, client information brochures, presentation graphics, wall charts, flip charts and three levels of target-free guides for providers and supervisors. The team did not review the films, but all the other materials are of excellent quality, some are world-class. All are refreshingly pragmatic in approach and extremely timely as India makes a quantum shift to a target-free system. SIFPSA, however, must guard against any future temptation to continue producing new documents for which the usefulness is less apparent than the current ones.

## **Findings**

After getting off to a slow start, the IEC/Advocacy/Counseling aspect of the IFPS Project, with the exception of FLE, appears to be on track and ready to make a major contribution to behavior change among the young couples of U P. Furthermore, the three levels of advice, review and implementation committees and the overall IEC Strategic Plan seems well-structured to manage an effective, innovative IEC program. USAID is likewise well covered by committed and dedicated staff. Because of its importance to the success of IFPS, all aspects of this component will require continued

attention by SIFPSA and USAID leadership

### **Recommendations**

- 1 IEC has been and will be vital to the success of IFPS. Timely and adequate funding must be assured for IEC activities if they are to achieve impact in expanded geographic areas
- 2 In terms of innovation, consideration should be given to presenting some of Thompson Social's messages in deep rural areas by coupling them with the HLL marketing vans
- 3 As a possible additional innovation, a small research study should be conducted to assess the value of an IEC component which promotes the Healthy Baby-Healthy Mother 40 Day Post-Partum Approach, similar to the successful 40 day program in Tunisia and Jordan and ready for take-off in Egypt. It is closely tied to Islamic traditions and may also have ties to Hindi health traditions. Additionally, messages via the IEC mass media promoting at least four antenatal and two postpartum visits should be institutionalized as should IEC messages on the value of deliveries attended by trained providers
- 4 SIFPSA programs should use a standardized FLE training package and target programs more toward slum and rural girls and boys rather than college age girls and boys. It is important to ensure effective training and monitoring to ensure the success of this program aimed at reaching young adults
- 5 SIFPSA should assign sensitive/creative IEC experts to oversee the FLE program to a successful launch, especially those implementing mechanisms effective in reaching out-of-school youths
- 6 All parties must also insure that IEC efforts to promote service providers do not raise demand in advance of upgrading of the services and skills of these providers
- 7 Vigilant oversight by all parties is needed to ensure that all aspects of IEC communication with potential acceptors are consistent with policy and health guidelines and that excess time is not spend in the design of a logo

### 3 Reproductive Health

#### Current Situation

Key findings from the recent PERFORM survey (1995) in U P indicate that

- Only 39 percent of births in U P receive some antenatal care during pregnancy. Most births occur at home (89%) without a medically trained attendant (76%),
- Mothers of almost one half of recent births report experiencing complications during pregnancy, another quarter during delivery, and one-sixth in the six weeks following delivery
- One quarter of recent mothers report having symptoms associated with reproductive tract infections

Visits to health facilities in five sampled districts in U P indicate that

- The availability of antenatal care, immunizations, nutrition counseling, birth delivery, and breast-feeding counseling ranges between 88 to 93 percent of health facilities
- Less easily accessible are facilities with services for detection and treatment of sexually transmitted infections (17%), emergency obstetric care (32%), and treatment of postpartum or post-abortion bleeding and infections (33%). These infrequent services tend to be more available at private facilities than public ones

The 1995 PERFORM Survey on Male Reproductive Health in U P looked at interspousal influences on reproductive health decisions and gender differences in fertility and contraceptive use intentions

- Gender differences in fertility intentions are modest, although men tend to be more definitive and women unsure
- Gender differences in future use and method intentions are very small

- Husbands' knowledge of the female reproductive system is limited--only one-fifth know the fertile period correctly, half think it is one week after menstruation and another one fifth do not know at all
- Very few men are aware of pregnancy and delivery complications. One half of the husbands could not identify a single symptom of pregnancy complications

The U P National Family Health Survey (1992-93) provides interesting data pertaining to child health

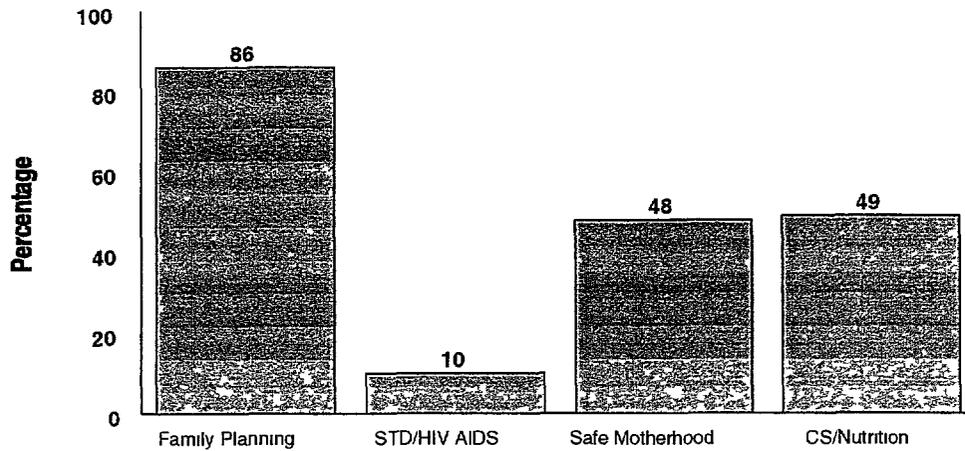
- The immunization coverage of children against the six childhood preventable diseases is very low. Only one-fifth of the children were fully immunized against all the six diseases while two fifths had not received any vaccination at all. Immunization against measles is the lowest among all vaccinations
- Six out of ten children in U P are underweight and a similar proportion are stunted. Most striking is that one in every six children under age four is excessively thin for his or her height (wasted)

The original IFPS goals, objectives, strategy and benchmarks focus on improving quality, increasing access and increasing knowledge of and demand for family planning services. However, in response to the shortcomings revealed by PERFORM, NFHS, several rapid assessments and field observations, the Project has been providing assistance for a variety of maternal and child health activities in addition to family planning services. These include safe delivery, ante-natal care, management of reproductive tract infection, child immunization, child diarrheal disease control and improved nutrition. Additionally, other endeavors, such as family life education projects for adolescents and increasing male involvement, have been established as a priority for IFPS in order to have a positive impact on improving women's lives, not only on women's empowerment in general but also on reproductive health practices and outcomes. Also, a concept paper on post-abortion care should be ready by September 1997. It is anticipated that existing training programs for ISMPs, ANMs and GOI physicians will include activities to provide quality care for women suffering complications of unsafe abortions.

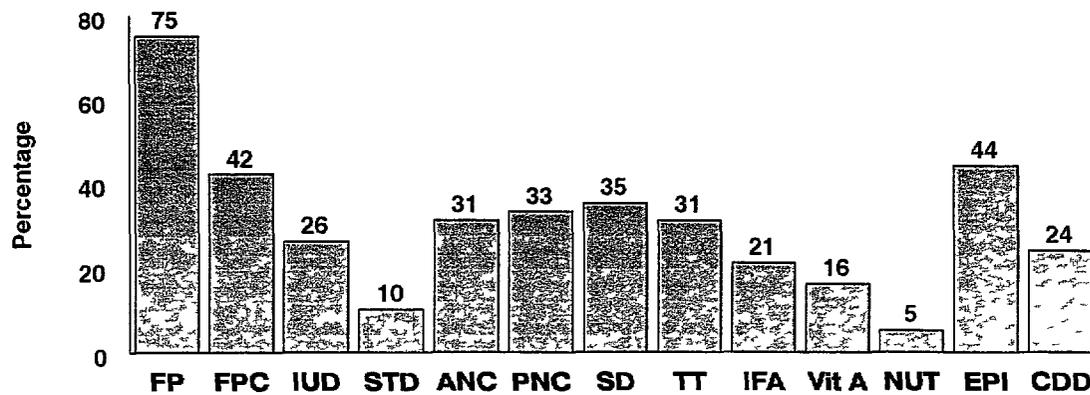
## Findings

- The Assessment found that the Mission and SIFPSA are supportive of the GOI's new Reproductive and Child Health Policy. From a wide variety of studies and on-the-ground experiences, IFPS has some concrete lessons learned from the public as well as the private sector with regard to a package of women's and child health interventions. However, since the IFPS Project's current contributions to improved reproductive health in U P are not formally acknowledged in the project's official agreement with the GOI nor in the mission's results framework, efforts have not systematically been documented.
- Reproductive health interventions are being implemented in both the public and private sector programs funded by IFPS. Activities supported through the project already encompass a wide range of reproductive health services that go well beyond a sole focus on contraception, and are consistent with the post-Cairo policies of the GOI and USAID. The quality, cost effectiveness and impact of the interventions needs to be validated.
- Even though the IFPS project was designed pre-Cairo as a family planning project, its implementation has incorporated reproductive health elements endorsed at the Cairo Conference. USAID has developed additional indicators to reflect reproductive health efforts through IFPS.
- All sanctioned sub-projects under the IFPS program were segmented into reproductive health activities as shown in the following two figures. Since this is data gathered from project documents, it will need to be validated in the field.
- Through operations research and strengthening public service delivery, SIFPSA is testing the feasibility of providing RTI services at PHCs. Inputs include training of medical personnel in syndromic diagnosis and management of RTIs, provision of lab facilities and trained technicians at PHCs, and support for lady doctors (gynecologists) to visit PHCs for reproductive health services.

### Key RCH Interventions as Percentage of IFPS Sub-projects



### All RCH Interventions as Percentage of IFPS Sub-projects



FP = family planning FPC family planning clinical STD = sexually transmitted disease  
 ANC = antenatal care PNC = postnatal care SD = safe delivery TT = tetanus toxoid  
 IFA = iron/folic acid tablets Vit A = Vitamin A NUT = child nutrition EPI = expanded  
 program on Immunization CDD = care of diarrhoeal disease

- As a result of another OR study in Sitapur and Agra on client oriented alternatives to improve family planning services, plans are now underway to

institutionalize a pregnancy-based approach with the goal of improving antenatal, delivery, and post natal services and access to family planning services

Community-based advocacy efforts are an important vehicle for incorporating women's needs and interest in program planning and results to date are promising

- Under operations research, the "link person" concept was introduced in Agra and Sitapur districts to increase access and improve quality of family planning and MCH services. The link person is to assure that at least once a month an ANM will meet women in their neighborhood for antenatal care, post natal care, immunizations and family planning services, information and advice at a fixed location and day
- In the recently approved Rampur District Action Plan, one of the key elements of the plan is to involve community members, primarily women, through Mahila Swasthya Sanghs (MSS) groups. Each Mahila Swasthya Sangh will consist of a core group of 7-9 women members selected by the community to organize activities for a large number of women within their village. They will also serve as a link between the public and private sectors to ensure integration of services and accountability. The MSS will be involved in the villages innovative listeners club program on the commercial channel of Rampur Radio Station that will be both informative and interactive with discussions on issues raised by the MSS members
- The IFPS Rapid Assessments found that for many of the organizations that have female CBD workers, conducting activities for women in their communities is empowering and has a positive impact on these CBD workers lives. For example, CBD workers from the Safe Delivery and Family Welfare Services At Door Step in Shahjahanpur District were asked to mention the reasons for joining the project. The focus of the project on the welfare of women and their desire to serve women were mentioned as the most important reasons

Increasing male involvement in family planning is a priority for IFPS. The consensus is that the issue of male involvement in family planning is much broader than the use of male methods, noting that RTI/HIV/AIDS concerns have really brought the whole issue of male reproductive health into the limelight. Therefore, the challenge is to understand men's perceptions of RH needs and how men's attitudes and behaviors

influence women's health At this point in time more work needs to be done to understand the decision making process related to RH

- One avenue is the introduction of quality non-scalpel vasectomy services, thereby expanding contraceptive choices for male clients
- Other activities incorporate appropriate messages to increase knowledge of reproductive health matters into training manuals, training sessions, IEC activities, from individual counseling to mass media campaigns, etc
- As stated, IFPS has taken on male involvement as a priority This has been operationalized by the formation of a Male Involvement Working Group at the national level with membership from GOI, AVSC, The Population Council, USAID and a public relations firm An IFPS male involvement working group will be formed in September 1997 to facilitate dialogue and initiate activities in this sector
- Under the IFPS statewide communications strategy, interpersonal communication and counseling is built into various training programs and the mass multimedia campaign interpersonal dialogue theme, "Let's Talk About It", will support stronger partner communication

Behavior of both clients and providers is critically important for an effective program

- At present, 21 benchmarks contain indicators which track counseling efforts At this time, 7 of the 21 benchmarks valued at \$3.7 million have been met For example, some benchmark indicators are
  - Establishment of procedures for sterilization counseling (including referrals when needed), education and follow-up, and drawing up of training and reference manuals appropriately written and provided to clinic and field staff,
  - Procedures to emphasize counseling to assure informed choice, and,
  - A 50% increase in proportion of TBAs offering family planning services and counseling at the block level

- To date, numerous training manuals, clinical protocols and research studies have been produced under the project, including information on counseling, client-provider relations, etc (See Annex 6 for a complete listing)
- Having very little experience in providing reproductive health services, NGOs require regular, sustained technical assistance in the area of management and quality of care. A pilot program was initiated by CEDPA wherein 10 consultant doctors at the district level were paired off with local NGOs to provide ongoing technical assistance until an acceptable level of care was attained. The doctors were provided with checklists for scoring critical skills (correct information on contraceptive method use, side effects and warning signs, management of side effects, follow-up, resupply and interpersonal counseling skills) and providing feedback and on-site technical assistance and training. It is the intent of the program to have regional teams that would be responsible for providing technical assistance in all three identified areas of shortfall based on analysis of TA visits to date: quality of care, management/MIS and contraceptive logistics/social marketing.

RH programs are operationally constrained by inadequacies and inefficiencies in management, supervision, training and logistic support.

- Issues systemic to managing health delivery systems which affect the implementation of any program are not unique to the IFPS project. The rapid assessments clearly point out that many of the organizations need technical assistance for institutional capacity-building and solving related systemic problems. Improving the institutional capacity of these organizations requires targeted technical assistance and lots of patience but will ultimately pay off as IFPS turns its attention to issues of sustainability. It must be recognized that some may suffer setbacks or failures and need to start over with new partners or revised systems.
- One of the critical issues for quality of care and coverage is ensuring that the necessary supplies and equipment are available. Good logistics management ensures that the right quantity of the right quality goods are sent to the right place at the right time and at the right cost. Without supplies and equipment, quality care cannot be provided.

## Recommendations

- 1 IFPS should assess and selectively build upon current reproductive health efforts - especially antenatal and delivery care. In addition, efforts should be pursued to develop targeted services for women suffering complications from unsafe abortions, a major cause of mortality and morbidity. The extent and quality of all ongoing reproductive health activities should be validated and this information used to strengthen linkages among interventions. IFPS should continue to analyze how interventions can be linked at service delivery points in a cost effective manner to enhance client satisfaction and service utilization. Indicators on reproductive health should be included in the strategic objective framework, as detailed in Section XIII and Annex 11.
- 2 Support NGOs, especially women's groups, are doing innovative work. However, better monitoring and indicators are needed to determine which aspects of their programs are achieving the greatest impact and how to scale up those activities and how to strengthen basic systems (technical, management, financial and monitoring and evaluation capacities) within these organizations. Expansion should be based on performance. Careful analysis of NGOs is essential in deciding on the plans for expansion in order to sustain culturally acceptable health services.
- 3 Strategic thinking and planning exercises need to be conducted in order to strengthen present reproductive health IEC and services and to address other societal factors that influence healthy decision making. A better combination of qualitative and quantitative information is needed for designing culturally accessible RH messages and services for defined populations.
- 4 Continue to analyze how various programs and interventions can be integrated at the point of service delivery to enhance client satisfaction and service utilization and to improve providers' abilities to deliver and monitor enhanced quality services.
- 5 The GOI/State RH program is now just in its early stage of implementation and, as this program unfolds, SIFPSA should use its experience and technical capability to strengthen the RH program.

## **VI OTHER DONOR AND OTHER USAID CONTRIBUTIONS**

### **Current Situation**

USAID's design of the IFPS Project in 1991-92 in response to critical problems of family planning services - quality, access and choice, communications and promotion -- coincided with extensive ongoing activities or planning of major efforts by other key donors. In 1990, the World Bank began its five year (1990-1995, later extended to 1997), \$33 million India Population Project-VI (IPP-VI), the third of its major loans to support development and strengthening of training and infrastructure in the GOUP's Family Welfare Program. In 1991, UNICEF and the World Bank also launched the nation-wide Child Survival/Safe Motherhood Program (CSSM), a five year (1991-96, extended one year to 1997), \$218 million program to support expansion and strengthening of the state's public maternal health and child survival services. In addition to other donors, USAID has provided an estimated \$4 million to U P annually since 1992 (1997 level \$ 6 2 million) to the Integrated Child Development Scheme (of the Women and Child Development Department, Ministry of Human Resource Development), a Title II food based program of mother and child feeding and health services managed by CARE/India. UNICEF, likewise, was providing substantial support to the ICDS program and to primary education. Although not directly related to family planning and women's and children's health, the Japan International Cooperation Agency (JICA) had begun a five year (1991-96 extended to 1997), \$5 million program to strengthen, with equipment and technical assistance, the curriculum and teaching program for physician specialists at Lucknow's Sanjay Gandhi Post-Graduate Medical Institute (PGMI).

### **Findings**

In planning the IFPS project in the early 1990s, USAID thus reviewed the substantial ongoing Mission and other donor programs in U P to identify areas where service needs were greatest, and where USAID's population technical and financial resources could most productively complement existing programs. Recognizing the substantial support already in place to strengthen public sector child survival and maternal health services through U P 's Family Welfare Program and Integrated Child Development Schemes, as well as the limited range of Family Welfare support through IPP-VI, USAID chose to focus its support in relatively less-emphasized areas of family planning services, quality, access and promotion through both the public and non-government sectors. It is clear that USAID's program under IFPS gave emphasis to critical areas

of need for family planning that fit into and complemented the established program to address women's and children's health needs

Since the IFPS Project Agreement was signed in 1992, dramatic changes resulting from the Cairo International Conference on Population and Development (ICPD) and internal GOI/NGO/Donor dialogue have strongly modified the Indian policy and program environment, defining new needs and opportunities for donor support and intensified cooperation. All donors, including USAID, have adapted their programs to the post-Cairo agenda, and this is reflected in program activities in Uttar Pradesh and in increased inter-donor cooperation.

In April 1996, the GOI's Ministry of Health and Family Welfare declared the Target Free Approach (TFA) policy which withdrew the top-down contraceptive targets and incentives, establishing a new emphasis on client-centered, high quality services to the community. This important policy milestone set the stage for revamping the delivery of family planning services, but it also poses a challenge to reorient and shift the system away from targets to serving the community. All donors, including USAID, have expressed support for helping to make this target free policy a reality in the field. As a first step, SIFPSA, at the request of the GOUP has agreed to provide funding support and technical assistance to develop approaches and content in training programs to reorient service providers.

In 1996-97, the GOI established a new Reproductive and Child Health (RCH) initiative, which builds on the Child Survival/Safe Motherhood program and further reorients the family welfare program to address key priorities identified in Cairo. The World Bank, UNICEF, UNFPA and British ODA have pledged funding to support this \$1.2 billion, five year program. Although the World Bank and other donor funding have not yet been finalized, at the State's request SIFPSA is already involved in supporting several training aspects of the program in U.P., and in ongoing operations research, demonstration activities and funding of selected reproductive health activities that will contribute key lessons and recommendations as the program unfolds in 1997-98. Under their new Five Year Country Program (1997-2002), UNFPA will provide support to the GOUP RCH program in a limited number of districts, USAID and UNFPA technical staff are currently collaborating with the GOUP to improve the State contraceptive logistics system.

Although not yet finalized, the EC-supported National Health Sector Reform program support (first phase \$250 million), planned to begin in 1998, will also reinforce the

policy side of both the TFA and RCH program. USAID has worked closely with the EC sector planning team, particularly in relation to their plans for performance based disbursement, and has pledged to participate in the one-year Program Preparatory Phase (PPP) -- April 1997-April 1998

In addition to and complementary to the IFPS Project, USAID has also broadened its support for women's and children's health in U P through several new initiatives funded by USAID

- CARE's Integrated Nutrition and Health Program (INHP) to improve coverage of children under 2 years and pregnant and lactating women and to strengthen nutrition and health services in coordination with Title-II food supplements,
- A new CARE reproductive health initiative in two districts of Uttar Pradesh, and,
- The new \$1 million USAID's Girls Education Activity to develop, test and implement a teacher training module in U P focusing on improved instructional practices and school interactions that increase girls' formal primary school attendance, retention, and completion
- A \$ 20 million Program for Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) to increase commercial marketing and distribution and improve the quality of child survival and reproductive health products and services in India

## **Recommendations**

- 1 With a number of important reproductive health interventions already part of the IFPS Project in U P , information from IFPS operations research, ongoing demonstration activities, and the PERFORM and NFHS-II surveys should be regularly disseminated by SIFPSA and USAID to broadly share results and plan complementary activities with the GOI, GOUP and other relevant donors to contribute to the emerging Reproductive and Child Health program
- 2 In Lucknow, the Principal Secretary for Health, Family Welfare and Medical Education should establish a committee to coordinate on a regular basis the

inputs, activities and results of all partners participating in family welfare, reproductive health, ICDS and women's education and empowerment activities, taking into consideration available resources and expectations of the community. This committee should ideally include key GOUP representatives, SIFPSA, major donors, selected NGO partners, and community/consumer group representatives, and should meet quarterly.

## VII SUSTAINABILITY AND COST-EFFECTIVENESS

The fundamental underlying principle for all successful efforts to reach full sustainability in social/behavioral change is internalization by clients--that they see the changed behavior as in their own best interest. The same internalization must also take place within government, i.e., that they must continue to invest in making client-changed behavior possible. These principles are just as valid in the fields of environmental conservation and safe sex behavior as in family planning.

There are three progressive phases toward full sustainability. Initially, phase one consists of determining the demand for and effectiveness of various program interventions. Once this is done, then the program should consolidate efforts to increase and satisfy demand and build in efficiencies and cost effectiveness in phase two. In the final phase, efforts at full sustainability can be realized through focusing on the range of financing options, such as cost recovery and building up the base of resources to cover program costs beyond when USAID funding is no longer available.

What are the chances for the IFPS Project in U.P. and the government's family welfare program in general for making real progress toward sustainability during the next few years of the IFPS project? The task is daunting, in part because of the population momentum factor. There are two encouraging signs, however. First, the GOI, having internalized the importance of reaching population stabilization, shows every indication of increasing resources and adjusting most policies to allow effective use of these resources. This is clearly evident in U.P., where the State government has taken strong measures to increase the continuity of Chief Medical Officers (CMOs) for more effective program management. Two years ago, CMOs rotated on average every six months. This year only 13 of 76 District CMOs were transferred. The goal is to have CMOs remain in position for three years. CMOs are recognized as essential to the success of both public and private sector efforts at the district level. On the financial side, the GOI host-country contribution committed for family welfare activity has increased from Rs 47,572,000 in 1991-92 to Rs 65,728,000 in 1994-95.

Even more important than the internalization of the importance of the family planning at official levels is that which occurs within individual families. Here, there is very encouraging news from U.P. Data from the 1992-93 National Family Health Survey shows a significant decline in ideal family size among the younger cohorts. Given their ever increasing numbers, this is a highly positive development. Married women under age 20 prefer 3 children (2.9 in urban areas) compared to 3.8 children desired by those over age 45. Actual children ever born is much higher.

Currently, this positive news from U.P. is tempered by the fact that in the age group 15-19 only two percent of women use contraceptives following the first birth, the number of users barely increases after the second birth, and does not reach 15% until parity four. In many ways, this lack of contraceptive use is not unexpected given the lack of access for temporary methods in all areas and the misinformation concerning their use. Both of these constraints are being systematically addressed by IFPS. Early results show that this should improve if these trends under IFPS, which indicate a significantly greater CPR among young low-parity couples, continues.

World-wide, expressed intent by non-users to use contraception is the second most reliable predictor of future use, topped only by past use. As noted earlier in this section, use by women in U.P. is so low as to represent only the most determined women. **Intention to use, at 37 percent of non-users, is very high.** The combination of the couples' internalization of the value of a three-child family or lower, coupled with the high level of intent to use demonstrated by couples preference to obtain their contraceptives from commercial sources and the GOI/private sector's determination to provide access to quality services, bodes well for the full sustainability of family planning efforts in U.P.

The various systems under IFPS for training, IEC enhancement, management skills development and infrastructure improvement, while costly at present, will yield a balanced, effective system for the delivery of services through the GOI and private sectors (particularly the commercial system for re-supply of temporary methods) for years to come. This system will be used and supported in part by spacers pro-actively meeting their own needs. The sterilization component is likely to become more demographically effective under the target-free approach as young couples decide in increasing numbers that two children are the ideal family size.

For the most part, sterilizations will remain a GOI-provided method for which, in the not-too-distant future, there will be at least a token charge, open proof that any

pressure formerly associated with the method no longer prevails. The quality of sterilizations, male and female, is being improved throughout U.P. From recent use data, already noted under the Achievements Section, we can expect increased use of sterilization by men and by low-parity women. These trends, if continued on a State-wide basis, could result in a very cost- and program-effective effort, in brief a program which could continue in a sustainable manner after IFPS concludes.

Much can also be done to make the NGO sector more cost-effective and therefore more sustainable. Because increasing NGO sustainability is a long-term, labor-intensive effort, the process should begin early with major attention to diversification of NGO income, rationalization of expenditures, quality improvement, expansion where appropriate and cross-financing of reproductive health services with income generation from other products or services.

The future sustainability of SIFPSA itself depends on its ability to provide highly needed services either for the government and/or other donors. Such a role for SIFPSA is increasingly probable as India, like countries all over the world, turns away from its very costly, direct public provision of services to contract mechanisms that provide a more focussed set of services. Simultaneously, clients will look to secure their own health services through the private sector, i.e., well-run NGOs, private practitioners and the commercial sector for re-supply. Data from the 1992-93 National Family Health Survey (NFHS) indicate that the vast majority of users prefer the private sector. With technical assistance, USAID can commence a dialogue with GOI/GOUP officials to assist them in internalizing the need for this new cost-effectiveness approach to quality sustainable services.

### **Recommendations**

1. USAID/SIFPSA should jointly design strategic models for implementing NGO sustainability measures. NGOs which show little aptitude for strategic planning after training and appropriate technical support over a reasonable period of time should not be renewed.
2. USAID should dialogue with GOI officials concerning their interest in health care reforms leading toward sustainability.
3. USAID/SIFPSA should closely review the findings of the Market Segmentation Study to be completed by January, 1998 to assess the greater potential for costed

contraceptives and a decrease in the percentage of couples requiring free ones

- 4 In any case, to the extent feasible, community-based workers should be encouraged to sell subsidized/commercial products, reserving free supplies only for the needy. In this way, the NGO sector will make a real contribution to India's progress along the sustainability continuum
- 5 USAID should not undertake a program cost-effectiveness study at this time because it would grossly skew results. Essential, but high initial capitalization costs of any start-up program--when averaged out against relatively low client levels--distort the expanded use that will result from the capital investment in the long term

## VIII DECISION MAKING ON THE IFPS PROJECT

### Current Situation

Whereas SIFPSA manages and administers the sub-activities of the IFPS Project, four other decision making and advisory bodies play important roles in implementation. These bodies are

*Steering Committee* The top IFPS policy group, chaired by the GOI Secretary of Family Welfare, with the USAID Mission Director, the Secretary of Finance designee, the Chief Secretary and Principal Secretary of Health, GOUP, the Executive Director of SIFPSA, and others as members

*Governing Body* A fifteen-person group headed by the Chief Secretary, GOUP. There are seven representatives of the private sector and seven representatives of the public sector in this body. USAID is also represented in this group.

*Executive Committee* Led by the SIFPSA Executive Director, and comprised of representatives of USAID, the GOI, GOUP, and selected other project partners

*Project Appraisal Committee (PAC)* Chaired by the Principal Secretary of Health, Family Welfare and Medical Education, GOUP. Other standing members of this committee include representatives of USAID, the Executive Director of SIFPSA, and invited outside technical professionals including USAID CAs and local experts

Members of SIFPSA's and USAID's technical teams also participate on an *ad hoc* basis

*Project Appraisal Advisory Committee* Headed by the Executive Director of SIFPSA, this group is comprised mainly of SIFPSA General Managers and technical staff along with occasional outside experts and CAs as appropriate. In 1997, USAID and CAs have been regularly invited to participate in these meetings

These bodies encompass the great majority of all decision-making on the Project, they are listed hierarchically in terms of decision making authority. The Steering Committee has the ultimate authority over the project. It sets policies and overall technical direction, and it meets once or twice a year.

The Governing Body approves major activities of SIFPSA including its organizational, management, and administrative structure, and its operational policies. Importantly, the Governing Body also approves SIFPSA annual work plans, budgets, and sub-projects of Rs 5 crores (approx \$1.5 million) and above. This group usually meets two to three times a year depending on the volume of approvals solicited by SIFPSA.

The Executive Committee was formed to handle the many project issues and decisions that involve the IFPS partners, but do not warrant the convening of the Governing Body. This committee meets on an as needed basis.

To review, assess, and approve proposals, SIFPSA constitutes periodic sessions of the Project Appraisal Committee. SIFPSA staff prepare detailed technical, institutional and financial analyses of proposals and proposing organizations. These analyses and a recommendation are submitted to the PAC which in turn either approves the sub-project, suggests revisions, or rejects it. In some cases, proposing organizations are invited to participate in the PAC. There have been 12 PACs during the life of the project. The convening of PACs has increased dramatically in the past year, four of them in 1997 alone. In the June 1997 PAC, 29 sub-projects were approved.

The Project Appraisal Advisory Committee was formulated to ensure that the conceptual approaches of proposing organizations are in line with IFPS strategies, and to assure that the organizations submit adequate institutional, financial, administrative and technical documentation with their proposals. This Committee is comprised of SIFPSA staff, GOI, GOUP, USAID and CA representatives. It meets on a regular basis.

## Findings

The IFPS Project has faced an enormous technical, management and administrative challenge in the past two years. Given the magnitude of the effort (including about 150 sub-projects in the past two years), the policy and sub-project approval systems as outlined have been up to the task. These systems assure that there is adequate review at each stage of the approval process, and that a minimum level of rigor is sustained in the development of new and expanded activities. However, the respective roles of the IFPS partners have not always played out as originally envisioned.

USAID is an official member of each of the decision making groups, and its representatives participate in reviewing and approving the various policies, program directions, and specific sub-project proposals. USAID managers report, and USAID-SIFPSA correspondence shows, that in some cases major funding decisions and program directions were undertaken despite the reservations of USAID representatives. The major example of this decision making process involved the approval of the \$2.3 million "Short-term Strengthening of the Public Sector" sub-project which was signed by SIFPSA in early 1995, and a related \$1.2 million program aimed at strengthening the supervisory capacity of Government field offices approved in March 1997. Both proposals were approved despite USAID reservations.

In addition, USAID and other Board Members have not been informed of certain technical initiatives and expansion of projects until just before either a Governing Body or PAC meeting. This timing of notice did not allow sufficient time for review and response to what was being proposed. USAID staff state that they are concerned that policies, technical initiatives, and sub-project development be directed toward meeting the benchmarks that jointly have been agreed upon to achieve project objectives.

Partly as a result of these decision making processes, which at times excluded USAID inputs, significant amounts of PBD payments have been spent on activities not obviously related to pending benchmarks.

This situation has changed dramatically in the past four months. The new Executive Director became aware of this problem and took immediate steps to assure that USAID views and concerns are meaningfully addressed at all levels of decision making. Her statements were backed up by actions. In June, she rescinded an approval decision for the expansion phase of the "Strengthening of Supervisory Capacity of Field Offices" sub-project to which USAID had not agreed.

USAID has continuously recommended since late 1994 that the bulk of sub-project activities be directed toward the 15 initial PERFORM districts. However, an analysis of SIFPSA-funded sub-projects carried out by USAID/PHN revealed that as of the end of the Indian fiscal year 1996 on March 31, 1997, only 50% of the value of sub-projects had been allocated to the 15 PERFORM districts (PHN document, March 31, 1997). Upon being notified of this distribution, the Executive Director again took immediate action and instructed her staff to appraise only those sub-project proposals that supported programs in the 15 PERFORM districts. As a result, 28 of the 29 sub-projects approved at the July 3, 1997 PAC meeting will be implemented in the phase I districts.

In discussions with SIFPSA managers and with USAID PHN staff, and by reviewing project documentation, the Assessment team concluded that USAID's views and recommendations are now an integral part of the decision making process as it regards technical directions, and sub-project approvals.

During the IFPS Project's first full two years of implementation, there were several instances where USAID and SIFPSA did not agree on program directions and certain sub-projects. **The situation has been addressed quite effectively by SIFPSA and USAID PHN managers, and it no longer appears to be an implementation issue for the project.**

The approval systems in place at present results in decision making by consensus of the project's four major partners: the GOI, the GOUP, SIFPSA, and USAID. They are now functioning according to the spirit of the bilateral agreement.

### **Recommendation**

- To assure the continued decision making by consensus of the partners, the Assessment Team recommends that USAID and SIFPSA agree that within 5 days of receiving the minutes of a PAC or Governing Body meeting, USAID will furnish a written concurrence for the major decisions undertaken as they affect program directions and sub-project approvals.

## **IX SIFPSA CAPACITY**

### **Current Situation**

SIFPSA, the State Innovations in Family Planning Services Agency, was registered as a society in May 1993 to provide program and financial management over activities in the public and private sectors necessary to accomplish the IFPS Project objectives. These include the development of annual workplans, the design of sub-projects, selection of implementing organizations, awarding contracts and grants for sub-projects, disbursing funds, auditing, monitoring progress, reporting and disseminating results. As a new organization SIFPSA has grown tremendously from its inception to current operations, managing an annual budget of \$7.5 million (Rs. 268,324,000) in 1996/97, as compared to its budget of less than \$600,000 (Rs. 21,225,000) in 1993/94.

Based on information provided from two USAID management and financial reviews, the assessment concluded SIFPSA is generally well established. However, SIFPSA still needs to take some critical actions to effectively meet the demands of its increased operations and responsibilities. The most important among these are the need to ensure that there is continuity in top leadership to guide and manage the project during the remaining project period, and to put in place the program MIS as soon as possible to significantly improve its monitoring, follow-up and evaluation of activities as well as for making informed programmatic decisions for the future. The MIS is critical to documenting IFPS achievements for USAID in order to receive further funding. Support to build this capacity can be strengthened through quality, timely technical assistance. Technical assistance must be positioned and responsive - in type, location and quantity - to address program priorities for the next phase of implementation. This technical assistance must be planned for by all parties to be readily available.

### **Findings**

**1 Organizational Structure** SIFPSA capacity has grown tremendously and has dynamic leadership that positions the project well for expansion. SIFPSA needs to refine its management structure and systems, placing urgent emphasis on instituting a functional management information system, in order to rapidly accelerate implementation and move into Phase II. SIFPSA also needs to become more of a technical assistance agency rather than just a grants making agency in order to more broadly bring in the innovations from Phase I to Phase II expansion.

SIFPSA's organizational structure was established in January 1994 and the human resources, procurement and administration policies were finalized shortly thereafter. SIFPSA received the first installment of funds for the project from the GOI on March 31, 1994. Thus, it took almost 18 months from the signing of the project agreement for SIFPSA to be in a position to start project activities on a modest scale. SIFPSA's organizational structure includes three principal decision-making bodies, as detailed in Section IX, Decision Making. See Annex 10 for SIFPSA's organizational chart.

**2 Staffing Structure** SIFPSA is managed by an Executive Director (ED) who is assisted by an Additional Executive Director (AED), both of whom are seconded Indian Administrative Service (IAS) Officers, and other senior level staff comprising of five General Managers and two Deputy General Managers besides a number of technical and support staff. SIFPSA has experienced considerable difficulty in filling the principal staff positions either because it was not getting people with the right background, was not able to meet their salary expectations or could not attract them to live in Lucknow. Even after recruitment, it was difficult to retain many of the professionals as is evident from the high turnover rate with 10 of the 28 (35%) professionals leaving during 1996 and 5 of 31 (16%) in 1997. As a result, SIFPSA has never really had the full complement of professionals on board which has slowed the pace of project activity and restricted its ability to provide effective program oversight and follow-up.

As of July 1997, all 31 professional positions were filled. However, as mentioned above, both the positions of the ED and AED are filled by posting of IAS officers from the GOUP and thus are transferrable. For example, there have been three Executive Directors since May, 1993, likewise, the previous AED, who was appointed in August 1996, was transferred in June 1997 even before completing one year in that position. The current ED is holding a dual charge, that of the ED/SIFPSA and Secretary (Health), GOUP. As Secretary (Health), the ED/SIFPSA has retained responsibility related to staff transfers. This dual charge was purposefully combined by the GOUP in recognition of the need for stronger public sector coordination and oversight in relation to IFPS Project activities. It has proven extremely effective in strengthening SIFPSA's ability to coordinate and oversee public sector activities related to IFPS. However, the current and planned expansion in SIFPSA's activities require substantial involvement of top leadership and continuity during the remaining project period to provide programmatic direction and ensure maximum impact. In order to build in continuity either the AED position should be filled from the private sector or a second AED position filled from the private sector should be created.

Overall, 66 of the 73 approved positions (including professional, administrative and all other support staff) are filled, of which ten positions are filled on posting from the GOUP. This is not a desirable practice from the standpoint of SIFPSA's autonomy and it is also inconsistent with the project's design and intent of staffing of SIFPSA primarily from the private sector. Current staffing practices have created a multiplicity of personnel and compensation systems bringing in distortions and inequities which can affect staff morale, operational efficiency and close working relationships that are absolutely vital to the success of the project. This is particularly relevant under the performance-based disbursement (PBD) system which demands a high degree of coordination in planning, monitoring and evaluation of activities.

Finally, now that all the senior level positions are filled, it is essential to clarify the ambiguities in role definitions and individual responsibilities that crept in during the period when work of several independent divisions was being handled by other divisions. For example, as the General Manager (GM), Training is looking after private sector NGOs, he has limited time available for training. Similarly, the recently-filled GM-Research, Evaluation and Monitoring position has MIS as one of his responsibilities, which is being performed by the Dy GM-Family Planning Information Systems. In view of SIFPSA's expanded operations during the project's remaining life, there is an urgent need to reexamine its organizational structure and staffing needs.

**3 Technical Capacity** As noted above, SIFPSA has staffed up considerably over the last three years. The staff come from varied backgrounds and there is a range of professional experience in the area of family planning and reproductive health. The staff has taken on a tremendous level of effort to search out a wide range of partners and develop the number of sub-projects currently sanctioned. While the overall quality of the sub-project proposals has significantly increased, there needs to be better technical analysis of project goals and objectives, the interface of interventions and more coordinated planning between public-private sector program inputs, and a better effort at sustainability planning. Relatedly, SIFPSA technical staff need to be able to provide technical support to subgrantees during project implementation monitoring support to help build local capacity. In doing so, they can also effectively build in innovative approaches to program planning and new projects they are responsible for developing. While there is now breadth of staff, more technical depth needs to be developed.

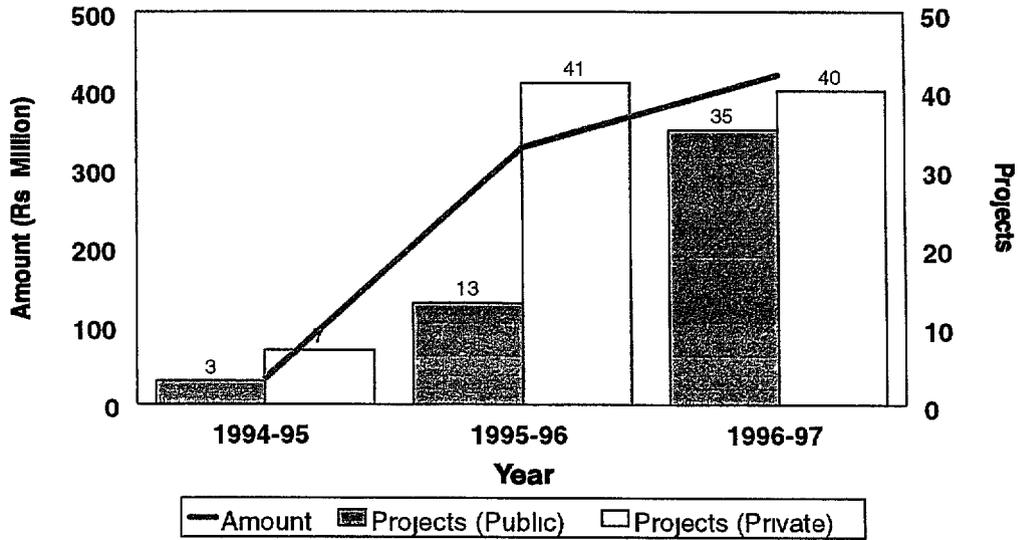
**4 Delegation of Authority** Delegations of authority relating to finance, procurement and contracting are established. The delegations are strictly adhered to by the staff and

in case of any doubt/clarification, the matter is referred to senior management. However, there are no written delegations relating to program issues, therefore, most matters are brought to the level of the AED/ED thereby causing delays. Also, while SIFPSA has a system to record the receipt of all correspondence, it has no system to track if timely action is taken. As a result, several subgrantees repeatedly complained that they were not receiving responses from SIFPSA on key issues in a timely manner and this may be adversely affecting program implementation. The current ED supports management by exception and has taken some steps to delegate responsibilities. It would be useful to do this formally to avoid any ambiguity and fix specific responsibilities.

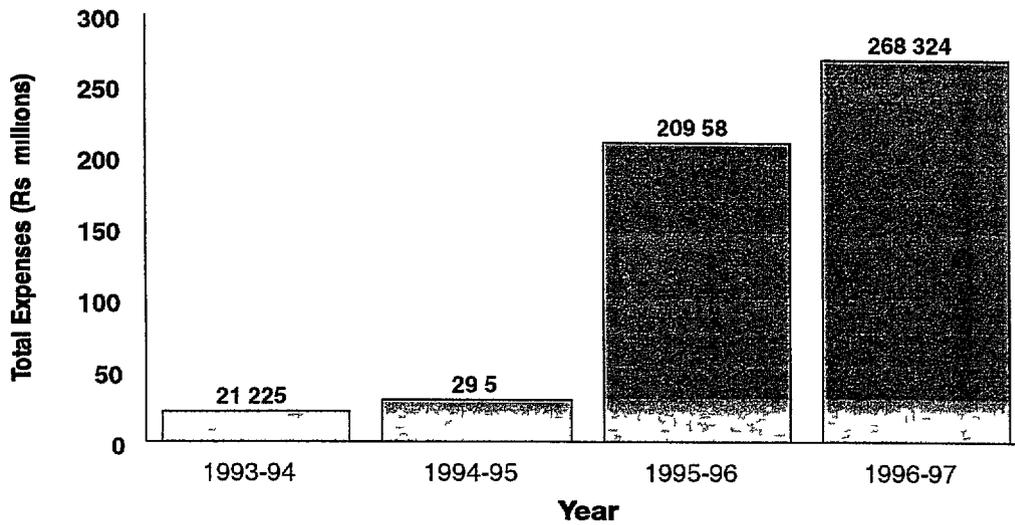
**5 Capability Assessments** SIFPSA has formalized procedures for the review and approval of NGO projects but these do not cover the cooperatives, government training institutes and public sector activities. Thus, capability assessments of these agencies were not being done even in cases where SIFPSA may have faced implementation problems with some of them in activities approved earlier. Capability assessments are important to identify and resolve any problems at the time of activity design and as such the procedures should apply uniformly to all subrecipients and not be limited to the NGO sector.

**6 Use of Funds** The rate of expenditures and the pace of approval of program activities have increased substantially over the last two years. Of the Rs 565 million received from the GOI as of March 31, 1997, SIFPSA had approved activities worth Rs 856 million (151%) in the public and private sectors and expended Rs 529 million (94%) for program and operating costs. In the first three months, April 1 to June 30, 1997, SIFPSA received Rs 291 million from the GOI, against which it had approved additional activities costing Rs 267 million. Thus, SIFPSA had already over committed the funds available to it as of June 30, 1997, and will need to carefully monitor its use of resources for priority activities geared toward benchmark achievement in order to assure receipt of new funds against achieved benchmarks to meet all commitments.

### Projects & Amounts Sanctioned By SIFPSA



### Expenses Incurred By SIFPSA



*GOI fiscal year April - March  
 Currency conversion (as of July 1997) 1 US \$ = approx 35.5 Indian Rupees*

**7 Financial Management** SIFPSA has improved its financial management over the last six months. The overall reporting from the field has improved although these are not always received in a timely manner or in the prescribed format. SIFPSA has tightened controls over disbursement of funds and now releases subsequent grant installments only after receiving and verifying quarterly expenditure reports (QERs) with accountant certification. However, the Project Ledger, where individual subrecipient accounts are kept, was not being updated by recording expenditures from QERs to liquidate installments paid earlier and adjusting any disallowances from inception to date. Since the majority of funds are disbursed through subrecipients, this is an area that needs to be addressed immediately.

SIFPSA maintains manual books of accounts which were current and reconciled periodically. It has not yet computerized the accounting operations although Tally software was procured in December 1996 and some people trained in its use. SIFPSA indicated that accounting operations will be computerized and historical data entered by November 30, 1997. This schedule should be adhered to as computerization of accounts will enable faster processing and greater accessibility of data, linkage with the program MIS, detailed reporting options, and development of better tracking and follow-up systems.

SIFPSA has streamlined procedures for the review and approval of project proposals submitted by NGOs. Similarly, procedures followed for forecasting cash flow requirements and investing surplus funds in interest-bearing accounts were adequate for the current level of operations. However, a more formal system will need to be developed in view of the fact that SIFPSA has already approved activities in excess of the funds received by it to date, the number of activities is increasing, and the value of future benchmarks is expected to be lower. This need should be kept in mind while developing the integrated financial and program MIS.

**8 Reporting** Currently the following two monthly reports are being provided to senior management, the GOUP and the GOI:

- Current Status of Projects, Sanctions and Disbursements
- Statement of Receipts and Disbursements

While these reports are useful, we feel the following additional reports will enhance senior management decision making and assist in tracking and follow-up of any critical actions. These reports could be produced by the financial MIS once it is fully

functional

- Status of QERs/QPRs
- Status of audit findings
- Status of internal audit/review findings

Of the 103 projects approved in the four PACs since January 1997 (35 in the public sector and 68 in the private sector), only eight NGO assessments were made by SIFPSA's Internal Auditor although the financial checklists were completed for all by the Project Coordinators

**9 Evaluation** Continuous evaluation of approved activities is critical for documenting achievements and impact, and for learning from and spreading effective innovations. This is particularly true for activities that have been completed or are close to completion. In early 1997, SIFPSA entered into an arrangement with the State Institute of Health and Family Welfare (SIHFW) to carry out 20 evaluations of its activities during each Indian fiscal year. In reality, however, only one evaluation was done during April to July 1997 and at this rate it may not be possible to achieve the annual target of 20. Moreover, the major criterion for selecting an activity for evaluation presently is the money disbursed to it. Instead, the selection criteria should also include other factors to ensure that all types of activities are evaluated.

**10 Automated Data Processing Resources and Management Information Systems** The present level of ADP resources are inadequate relative to staff size and functional requirements. SIFPSA currently has only eight functional PCS and five printers for its 66 professional and administrative support staff out of the total 73 posts, of which two PCS and a printer were in the GM (Finance) office. The remaining six PCS and four printers were located in the computer section for which users have to walk down to the basement to use them. This is not conducive to efficient operations nor in line with SIFPSA's stated objective of having a work station for each professional and administrative support staff.

A PBD benchmark required SIFPSA to develop a detailed MIS plan that identified, among other things, specific types of data/information needed for tracking project performance and outlined potential for computerization and reporting. The progress in achieving this benchmark was very slow and the plan was finally approved only in April 1997. SIFPSA appointed a committee in January 1997 for planning the development of the program MIS. It expects that a prototype of the MIS for NGOs

will be ready by August 31, 1997 but has not made a commitment as to when the overall program MIS will be fully developed and functional. The absence of the program MIS has adversely effected SIFPSA's ability to analyze the data/information received from the field and effectively monitor progress in the approved activities whose number has now increased substantially. There is a critical need to finalize a unified MIS quickly that can collate key program and financial management data to meet the requirements of SIFPSA and USAID.

**11 Audits** SIFPSA has taken steps to comply with the audit requirements under the project. A contract for the program audit was finalized with a chartered accounting (CA) firm in June 1997 and the audit is expected to be completed by August 21, 1997. The annual financial audit is carried out by a CA firm and the U.P. Accountant General's Office. Audits of subrecipients in the private sector have already been initiated and are to be completed by December 31, 1997. Also, at SIFPSA's insistence, the GOUP has issued instructions for audits of funds disbursed for public sector activities for which an additional six CA firms are being identified. We noted, however, that timely corrective action is not being taken on audit findings. At the time of USAID's most recent financial review in July 1997, only six compliance reports were received out of the 27 audit reports issued. Of the six, action was taken only on two and the remaining four were under review.

SIFPSA has also started internal audits and reviews which were currently infrequent and covered NGOs only. With the recent addition of accounting staff now on board, the Internal Auditor will also review SIFPSA's internal operations as well as public sector activities starting from this fiscal year.

## **Recommendations**

- 1 To prepare for project expansion, SIFPSA should reexamine its organizational structure, delegation of authority procedures and gaps in technical expertise. To do so, SIFPSA should contract with a management consultant or firm to study its organizational procedures and staffing structure relative to the needs of the IFPS Project to make any necessary changes, update job descriptions for senior level positions, and identify training needs and additional positions that may be required to strengthen their management structure, program direction (emphasizing district planning) and build staff technical depth through training and partnering with Cooperating Agency technical staff.

- 2 Consideration should be given to either filling the AED position from the private sector or creating another AED position to provide continuity in program and administrative management
- 3 Responsibilities to handle program matters should be formally delegated to the General Managers, Deputy General Managers and Project Coordinators as appropriate
- 4 SIFPSA should initiate a system of tracking all correspondence received in the office by attaching the letter on an action board with 'due date' and 'action office' identified to ensure that the required action has been taken promptly Overdue actions should be sent to the next level of authority for appropriate disposition
- 5 SIFPSA should complete capability assessments of potential subgrantees likely to receive significant funding BEFORE grants are made in order to assure sound management practices and financial solvency are in place so as to avoid problems during implementation If SIFPSA does not have the staff to do this, it should consider contracting chartered accountant firms to do the assessments
- 6 SIFPSA should (1) update the Project Ledger for subrecipients by September 30, 1997 and maintain it on a current basis thereafter, and (2) finalize computerization of the accounting records, training of staff and data entry for historical data latest by November 30, 1997 in order to strengthen its financial control measures and oversight mechanisms to avoid over commitment of funds
- 7 SIFPSA should expand the criteria for selecting activities to be covered by evaluation and take steps to ensure that at least the minimum number of activities are evaluated annually SIFPSA should use this criteria to periodically develop an evaluation plan showing projects that should be taken up for mid term or final evaluation
- 8 SIFPSA should develop and implement a time bound plan to meet its target of providing a work station to each professional and administrative support staff The plan should also include the training of staff so that they are positioned to effectively use the MIS when that is ready

- 9 Implementation of the Project's MIS should be a priority for SIFPSA in order to fully track implementation and make adjustments, build in innovations to future program efforts, and, document project achievements. A functional MIS is urgently needed to track and report key project performance indicators to USAID/Washington critical to justification for future funding allocations necessary to fully implement the project. SIFPSA should (a) identify its priority MIS program and financial data needs by September 30, 1997, and (b) then develop and operationalize the MIS no later than the end of December 1997.

## **X ROLE OF TECHNICAL ASSISTANCE SUPPORT THROUGH COOPERATING AGENCIES**

### **Current Situation**

During the design process of the IFPS Project, it was recognized that technical assistance would be integral to stimulating new directions and innovations in the Indian national family welfare program. Although the GOI Family Welfare Program had achieved a number of accomplishments, many elements of successful programs elsewhere in the world had yet to be incorporated into the Indian program, such as the role of the private sector, a broad based comprehensive approach and a client-needs orientation. To incorporate these elements, the IFPS design specified a major role for USAID-funded cooperating agencies recognized for their technical leadership.

Cooperating Agencies' (CAs) assistance for strategic planning, program development and implementation, and technical support is provided to the IFPS Project through USAID centrally funded mechanisms. Cooperating agencies are technical organizations funded by USAID/Washington to provide specific technical support to USAID programs worldwide or regionally. In the case of the IFPS Project, \$100 million of the \$325 million was allocated in what is like a credit account to be drawn on as needed over the project's duration. Funds do not come into the project directly, but are primarily provided in-kind for technical orientation, training, etc. This mechanism was agreed to by all parties--the GOI and USAID--during the design phase as a means for accessing high quality technical assistance immediately. With this agreement in place, the central funding mechanism has also reduced USAID/India contracting burdens and administrative oversight. Also, long standing reluctance of the GOI to use bilateral funds for external technical assistance presented this as the most viable option. As a result, a range of technical assistance became available soon after the signing of the agreement.

To date, IFPS has had technical assistance support directly from eleven CAs providing technical assistance in a broad range of activities, including service delivery, training, communications, logistics, MIS, research and policy, with indirect support from three other CAs in research and evaluation. This mechanism has also supported international training, study tours and other travel. With so many CAs in the field, it has been confusing at times to prioritize and manage CA involvement in IFPS. Conflicting directives also emerge from CA headquarters, the Mission and SIFPSA. CA performance has been mixed and at times coordination difficult. CA staff energy has also not been adequately focused on IFPS benchmark achievement.

However, recently SIFPSA's acceptance of CAs and performance and coordination of TA has improved considerably. Over time USAID has rationalized CA workplans, adjusted the number and type of CAs involved, and built stronger linkages among them. However, issues of coordination and strategic coherence remain. CAs have built up staff capacity, focussed efforts more effectively on benchmark achievements and developed working coalitions amongst themselves and with SIFPSA and local organizations. Some CAs have staff or consultants working out of U P, for example the Policy Project, the Population Council, CEDPA and PROFIT. Technical assistance must be positioned and responsive - in type, location and quantity - to address program priorities for the next phase of implementation.

Initially, due to senior management staffing vacancies at SIFPSA, utilization of CA technical assistance was limited. Presently, SIFPSA appears to be better positioned and proactive in accessing more targeted technical assistance for project formulation and monitoring. All parties--USAID, CAs and SIFPSA--feel there is a need for closer coordination between SIFPSA and the CAs, with technical assistance tied to tangible outputs and results.

## **Findings**

**1 Contribution of TA** Technical assistance has been necessary and supportive of achievements to date. Without these inputs it is unlikely that the Project would be on a trajectory to achieving its goals. However, since the technical assistance may not have always been readily utilized by implementation partners, in particular SIFPSA, there needs to be a more cohesive agreement on TA priorities through joint planning together with SIFPSA and through coordinated management of the TA input by USAID/Delhi. The assessment team recommends that the project continue to access technical assistance through the Global Bureau agreements.

Additionally, because CA technical assistance is centrally-funded, it addresses some of the global issues and brings the latest development initiatives, e g , gender, RCH, male involvement, or new clinical/medical technologies, to SIFPSA and other implementing institutions. In turn, these innovations influence IFPS Project programming in new directions.

**All CAs under IFPS**

No Of CAs	Full-time Prof Staff	No of Consultants (6/96-7/97)	Partner Institutions
11	75	50	56

**2 Rationale for Use of Global TA mechanisms** Historically, through the use of central technical assistance mechanisms, USAID has learned how important it is to remain at the cutting edge in applying the most recent developments in RH technologies to international PHN programs. For technical assistance, USAID/ India has relied on over eleven USAID/Washington centrally-funded projects implemented by Cooperating Agencies. This arrangement of TA through Washington has proven workable for Phase I of the IFPS Project and for many participating institutions. These groups have brought in a range of technical advisors, the majority of whom are skilled, experienced Indian professionals, and latest technical know-how to invigorate the India Family Welfare Program. These strong inputs have directly resulted in key project accomplishments, specifically:

- SIFPSA is now established and functioning,
- Program momentum has increased and attention is focused on quality of services, especially at the District level, and,
- An extraordinary number of partners in the public, private and commercial sectors have been developed and supported.

These accomplishments have greatly enhanced the potential for providing reproductive health services in U P through the IFPS Project.

For the next two years technical assistance needs to continue and build upon this

progress and capitalize on the program's momentum to network public and private initiatives at the district level. Technical assistance should continue to expand the role of commercial markets, see that RH technologies are adapted to IFPS project activities, and institutionalize a Project MIS and data collection system at all levels, to build and strengthen NGO's, particularly those addressing women's needs

**3 Relationships** Some concerns expressed in the Management Review of 1995 by SIFPSA, USAID, and the CAs, though moderated, remain

- SIFPSA has expressed concern about the quality and timeliness of some of the technical assistance received to date. SIFPSA contends that the lack of knowledge of local conditions at times results in unrealistic plans. At the same time, SIFPSA sees the CAs as their partners and feels fewer CAs with larger numbers of staff would be more effective than a larger number of CAs with a small presence
- While some CAs have expressed concern about the lack of clarity with respect to their roles and responsibilities and sharing of information, both with respect to USAID and SIFPSA, several have formed very strong working relationships among themselves and with SIFPSA and USAID. CAs feel the ability to articulate and access technical assistance is hampered by SIFPSA's centralized decision making, insufficient senior staff in place and their ability to program technical assistance

USAID carried out the Management Review recommendation to hold a retreat in June 1996 to focus on strategic planning, formation of partner teams and development of agreed upon coordination mechanisms. This retreat successfully focussed on strategic planning and formation of key working groups that agreed to meet periodically to discuss implementation issues and plan joint activities. The public sector group has moved ahead quite successfully with this mechanism, while other groups have functioned on a more ad hoc basis. Based on technical assistance needs and performance, USAID has phased out two CA groups and shifted implementation responsibilities to other existing groups. As part of the planning process, CAs have been clearly associated with achieving to specific benchmarks and carried out planned activities towards their achievement. At this stage of the project, as implementation accelerates, technical assistance is in high demand. However, this needs to be carefully planned among USAID, SIFPSA and the CAs, along with local implementing organizations, to ensure responsiveness and to target resources. Sudden and

unexpected demands are difficult to respond to quickly. The TA can be strengthened through this joint planning process, managed by USAID.

**4 Performance monitoring mechanisms** CAs and their staff efforts have been oriented and geared toward specific benchmarks relative to their area of expertise. Over the last year particularly, CAs and SIFPSA have developed a better understanding of CA inputs, specific field activities and timelines for completion. CAs have supported the total support package from planning to training to implementation to outputs of improved quality and service delivery. Periodically, SIFPSA has requested ad hoc shifts based on perceived priorities and needs. While some of these shifts have been warranted, they may have also been extremely time consuming, such as development of the target free approach orientation training for 80,000 state functionaries and the revision of the TBA training approaches and mechanisms. When more advance planning has taken place, focused technical assistance has been easier to sustain. Based on performance and changing technical assistance support needs, funds have been allocated to CAs accordingly by USAID.

## **Recommendations**

- 1 USAID, SIFPSA and CAs need to find ways to disseminate lessons learned, best practices, and experience about service delivery and apply them to continued IFPS Project development and expansion. There are two discrete aspects to this: one is public relations and broad technical information sharing and the second is utilization of findings for shaping future project directions. Selected information and communication efforts should be expanded, such as the Innovations Newsletter through mass mailing and introduction of a Hindi version, participation in Indian and international forums having ties to development and social sector programs, and donor coordination. Regarding program expansion, on-going IFPS funded operations research and policy formulation should be widely disseminated in India and such efforts in the future should be integral to and designed around service delivery initiatives.
- 2 Use of Global Bureau Cooperating Agencies has by and large been useful and effective in the provision of technical assistance. Because these groups represent access to high quality, cutting edge innovations in the field, they should be maintained as a valuable resource that both USAID and SIFPSA can call upon. However on an on-going basis, needs should be reviewed, the participating groups adjusted, and resources allocated accordingly. As the

program matures and other Indian institutions take on broader implementation roles, the need for a large number of CAs is likely to decrease, although the staff required for each remaining CA may increase

- 3 USAID, SIFPSA and Cooperating Agencies working under IFPS need to embrace the art of consensus-building and problem-solving, which requires broad participation, dialogue, collaboration and negotiation. It is recommended that a team building and implementation meeting be scheduled soon with a professional management-partnership-building group facilitating a new *modus operandi* for all partners for the next phase of implementation. The outcome should be the development of a common strategy with defined roles, responsibilities and resources.
- 4 Monitoring of CA performance needs to be strengthened by developing joint annual workplans, with quarterly reviews by USAID and SIFPSA with the CA's. Technical assistance (TA) workplans and monitoring should focus on specific activities as fundamental prerequisites to benchmark achievement. And, TA should be aimed at building the capacity of SIFPSA and local implementing organizations to conduct the work.

## **XI USAID MANAGEMENT**

### **Current Situation**

USAID/India has principal responsibility for the management and implementation of the IFPS Project. However, unique partnerships across USAID were fostered from the beginning when key Agency offices -- USAID/India, the Asia Near East Bureau and the Global PHN Center -- came together at the design stage of the Project when the Mission actively involved USAID/Washington representatives in conceptualization and development of the entire project. As a result, there are complementary USAID resources of bilateral funding for in-country implementation costs supported by technical assistance provided through Global Bureau CAs.

The USAID/India Office of Population, Health and Nutrition oversees IFPS, with day-to-day responsibility vested in the Family Planning Services Division of the Office (FPS). The FPS division oversees all implementation of the Project, plans, manages and evaluates technical assistance, travels extensively to monitor field activities and works directly with the GOUP and SIFPSA on program planning and implementation.

Supportive functions are provided by the Policy, Research and Evaluation Division in the areas of operations research, program documentation through periodic rapid assessments, the PERFORM Survey and the National Family Health Survey (NFHS), and development and validation of IFPS performance benchmarks is collaboratively done with FPS

One of USAID/India's key strategic objectives is to assist the nation in achieving population stabilization and improved reproductive health. The Strategic Objective Team for reduced fertility and improved reproductive health in North India has active membership across the Mission including staff from the Offices of Population, Health and Nutrition, the Controller, Project Development, and Social Development. Other key partners include SIFPSA, partner government institutions, private organizations and technical advisors. This team has periodically met on validation of performance benchmarks and key issues related to implementation and the performance based disbursement system.

The ANE Bureau has taken the lead role in supporting the Mission's annual program results report and required budgetary resource request. The Global Bureau has been responsible for managing the Mission's request for technical assistance based on assessed project needs. USAID/Washington has participated on the IFPS Project Management Review and the IFPS Project Midterm Assessment. All of these interconnected Agency efforts represent an extensive partnership within USAID.

### **Findings**

With IFPS being the largest project in the PHN Office, the level of staff support needs to be commensurate with the investment. At present, although seven out of ten PHN professional staff members have some responsibility for IFPS, only three work exclusively on IFPS, and four devote less than 40% of their time to the project. One of the full time staff members has defacto assumed the role of chief of party for the technical assistance team, placing more staff demands on USAID/India than originally envisioned for this Project. There appears to be insufficient staff in terms of number and distribution of workload across the PHN office and in linkages among divisions to carry out the workload of this immense project.

The Management Review recommendation to field a USAID staff member to Lucknow for stronger day-to-day follow-up is still valid. At present the Mission plans to place a PHN staff member in Lucknow beginning mid-August for a three month trial period.

Assuming a full time PHN staff member is eventually placed in Lucknow, this should be an additive staff position to the FPS Division. It is envisioned that in addition to focusing on IFPS, this staff member will serve as the USAID State Representative supporting USAID activities more broadly in the State of U P.

USAID/Washington continues to believe that the pipeline represents an overcommitment of funds when in reality these funds are needed up front to negotiate and commit to performance benchmarks. Without sufficient funds to commit to additional IFPS benchmarks and activities, the project would lose momentum and start to restrict rather than expand. At the time of annual resource allocation, all parties in USAID must be committed to meeting the budgetary needs of the project if it is to succeed. The technical assistance component from USAID/Washington has been critical to Phase I achievements, maximized technical inputs, extended the reach of the PHN office, and minimized the Mission's contracting burden. However, the Mission has found that managing divergent organizations and their staff is time consuming, and shifting resources and composition of TA partners lacks flexibility.

Because of the many partners across the Agency focussed on IFPS, there needs to be open communication between all partners. At times there has been lack of information or misinformation, and crossed signals between all parties, creating some degree of confusion on program status, budgetary requirements and roles and responsibilities.

### **Recommendations**

- 1 The Mission needs to rationalize existing staff workload in PHN to make sure the human resources are available for this project to succeed. In addition to rationalizing workload of existing staff, the team recommends that a position for Lucknow be added and the Mission also recruit an International Development Intern (IDI) for placement in FY 98/99.
- 2 The Team reaffirms the Management Review recommendation that USAID should consider establishing a presence in Lucknow.
- 3 USAID/Washington should play an active role in disseminating the findings of this assessment, both within the Agency so issues related to funding and technical assistance needs are fully understood, and with outside interest groups to share progress to date.

- 4 USAID - all parties - need to come to consensus on the current status of the project based on the midterm assessment findings Building on that, people need to stay informed on project momentum and funding requirements and take timely and appropriate actions to support this important program

## **XII PERFORMANCE BASED DISBURSEMENT SYSTEM**

### **Current Situation**

The Performance-Based Disbursement (PBD) system involves payment, upon verifiable achievements, for mutually agreed project outcomes For this purpose, benchmarks, indicators of achievements and level of payments are developed by the IFPS partners, and approved in advance The PBD system was chosen for this project for the following reasons

- To focus on results rather than inputs,
- To directly channel funds from the GOI to SIFPSA so that steps to implement sub-projects could be taken rapidly,
- To ensure that the Society would not be constrained by cumbersome governmental procedures in planning and implementing activities,
- To avoid the administrative burden and manpower resources that would have been required for input financing under a cost reimbursement method, and,
- To shift financial risk for achieving project objectives to the implementing agencies

To date, a total of 53 benchmarks have been approved and committed for \$42.2 million Their status as of July 31, 1997 was as follows

Particulars	Number	Amount Million US\$
First set	19	18 7
Second set	24	12 6
Third set	10	10 9
<b>TOTAL</b>	<b>53</b>	<b>42 2</b>
Achieved to date	31	25 4
Under implementation*	22	16 8

\* These benchmarks, sequenced around strategic sub-objectives, are in the process of being implemented. Additional benchmarks will be formulated and negotiated following this assessment.

## Findings

The PBD system has largely worked as planned in the project design, specifically,

- SIFPSA is presently adequately capitalized and receives funds directly from the GOI,
- SIFPSA has developed policies which allow them operational freedom for effective decision-making,
- SIFPSA is responsible for funding of activities and ultimate achievement of results,
- USAID's management and reporting burden has been reduced, hence, staff can focus on planning for results and qualitative review of activities, and,
- The PBD system seems to promote the fundamental requirement that IFPS funds be **additional** to GOUP and GOI expenditures on family welfare

At the same time, however, there are some key PBD issues that require a better understanding by USAID and its partners

## **1 Front End Loading**

At the end of FY 92, USAID obligated \$20 million. Another \$29.2 million was obligated in FY 93 and FY 94. The assumption made by USAID was that SIFPSA would become established and fully operational within the first year. Given the realities of the local bureaucracy and required procedures, this assumption was overly optimistic.

First, SIFPSA had to be established by the project partners under the Societies Act of 1860. This procedure took months. Once created, there was a multitude of time-consuming steps that needed to be taken before SIFPSA could expend any funds. These included appointing management staff, recruiting and hiring technical, financial and administrative personnel, locating and leasing office space, establishing the organization and structure of SIFPSA, preparing the various procedural manuals, establishing developing and funding sub-projects, and agreeing on funds flow mechanisms.

At the same time, USAID negotiated a series of benchmarks which called for the preparation of the various workplans and strategies to get the project up and running. Some of these benchmarks were deliberately valued somewhat higher than it would cost the Society to achieve them in order to adequately capitalize SIFPSA so that it had funds to begin implementation of activities at a quick pace.

Because of unrealistic expectations, the first two years of the IFPS Project resulted in a significant pipeline of obligated funds, and a large amount of benchmarks to be achieved by SIFPSA before it had become fully capable of meeting them. In fact, SIFPSA did not receive any USAID project funds until March 31, 1994. As a result, before it was even established or had a staff, SIFPSA was significantly lagging behind the ambitious schedule of activities, expenditures, and benchmark achievements that had been set for it by USAID and the GOI.

## **2 Monitoring and Tracking of Budgets and Expenditures**

Under the PBD system, there is no direct correlation between achievement of a benchmark, the actual expenditures incurred by SIFPSA and the value of each benchmark achieved. At times, disbursements against benchmarks may exceed actual costs incurred by SIFPSA (as in many of the initial round benchmarks) and at other times, the costs may be higher. Also, because of the magnitude of some of the

benchmark efforts, there can be a considerable period of time between the initiation of activities and their completion as envisaged under a benchmark. Thus, while a number of activities are being implemented at any given point in time and SIFPSA is spending money on them, USAID does not have a system to accrue expenses incurred on them. It may therefore be useful to review this matter and develop a system to partially accrue for benchmarks likely to be met in the near future so that financial progress may be accurately reflected. Similarly, the issue may be addressed through lower value benchmarks of shorter duration.

### **3 Size and Duration of Benchmarks**

Some of the benchmarks will take a year or two to achieve even if no implementation difficulties are encountered. The length of duration is also related to the size of the pipeline that USAID must maintain to honor agreed upon benchmarks.

The project is moving in a technical direction that is much clearer than it was at the time of the first and second round of benchmarks. Thus, it would be possible in the near future to develop more specific benchmarks of shorter duration. An example of this is district planning and programs which will be benchmarked in the next round. At present, there is a three-year district-based program in Rampur. This activity could easily be broken into three benchmarks of 6-12 months duration. Under this scenario, money would move more constantly through the PBD system, which would help maintain USAID's pipeline and at the same time help SIFPSA's impending cash flow constraints.

### **4 Pipeline**

Meaningful pipeline analysis must look not only at expenditures but also **commitments**, both existing and planned, to determine if there are surplus funds. This is especially true for the IFPS Project where USAID has adopted the innovative and successful PBD mechanism. Agreement on benchmarks by USAID and the GOI must be accompanied by an up-front commitment of funds for the benchmarks. Thus, although the IFPS pipeline may seem large, most of the funds have been committed or will be committed in FY 97 or early FY 98.

The attached schedule shows that based on planned commitments in FY 97 and FY 98, USAID will have a shortfall of \$3.7 million. If unearmarked funds are not available to negotiate additional benchmarks, forward planning will stop and project

implementation will lose the momentum that has been rapidly built up during the last two years of intensive efforts by the Society, GOI, GOUP and USAID. A continued shortfall will be detrimental to the achievement of project results and its future success.

**Pipeline Analysis as of 6/30/97**  
(thousands of dollars)

Category	Total
Obligations	62,800
Commitments	42,200
Uncommitted/Unearmarked	20,600
Accrued Expenditures	25,400
<b>Pipeline</b>	<b>37,400</b>

**Analysis of Unencumbered Funds Available, 6/30/97**  
(Thousands of Dollars)

Category		Total
Unearmarked		20,600
Planned Commitments		
FY 97	23,500	
FY 98	5,000	28,500
Shortfall		7,900
Less FY 97 Planned Obligations		4,200
<b>Net Shortfall FY 98</b>		<b>3,700</b>

The PBD process involves considerable forward planning. Benchmark negotiations can take from 12 to 18 months from initiation to finalization. Funds are committed based on the countersigned Project Implementation Letter (PIL) between USAID and

the GOI. If unearmarked funds are not available, the PIL cannot be issued and funds cannot be committed for the Society to begin implementing the related activities.

Accordingly, the PBD design of IFPS purposely projected that significant amounts of funds were provided to the Society in the early years (1) for start-up activities such as baseline assessments, development of plans and initial implementation in focus districts, and (2) to have sufficient up-front working capital to be able to expand project planning and implementation while at the same time implementing the approved and funded benchmarks. This line of reasoning would apply throughout the Project's life and thus we expect a similar pattern of forward funding to continue in the future. Moreover, as noted above, while a number of activities are being implemented at any given point in time and the Society is incurring expenditures on them, we have only accrued the value of benchmarks completed. Consequently, under the PBD system, expenses reported by USAID and used to compute the pipeline are not a correct index of project implementation status or funding needs.

New benchmarks are under development which will result in an additional commitment of about \$20 million in FY 98. (Note the current round of benchmarks were to be negotiated and finalized by June 1997, but have been delayed due to the Midterm Assessment). At the same time, extensive discussions have been held with the GOI on the two major non-PBD components of Contraceptive Social Marketing (CSM) and Research & Evaluation (R&E). The R&E activities, mainly the next National Family Health Survey, and an expanded CSM program should start in FY 98. These components will also require up front commitments of funds for contracts with private sector research organizations (\$3.5 million) for the surveys, and with commercial firms for CSM (\$5.0 million). In sum, even with the additional obligation of \$4.2 million planned in FY 97, the project will fall short in FY 98 for which additional funds will be needed early in that year to sustain project momentum and achieve results.

Although expenditures and pipeline are one measure of progress in the case of traditional input-financing projects, they are not so in the case of IFPS for the reasons mentioned above. Without sufficient funds to commit to additional IFPS benchmarks and activities, the project would lose momentum and start to restrict rather than expand. This would be especially counterproductive as the third set of benchmarks, directed primarily at further expansion of family planning and reproductive health service delivery, is being negotiated. Considering the global importance of the IFPS project and its innovative approaches, the Assessment Team feels it would be short-

sighted to be guided solely by the narrow definition of the pipeline and ignore the operating structure of IFPS and the significant progress it has made to date

### **Key Findings**

- 1 Performance based disbursement is a viable and preferred method for financing the SIFPSA portion of the IFPS Project. It is working as designed. The nature of the PBD system includes the need to have committed funds on hand to pay outstanding benchmarks and to negotiate new sets of benchmarks which require a necessarily large pipeline for implementation. This is a necessary feature of a system which is working as designed rather than a flaw.
- 2 Because of the large size and duration of the individual benchmarks, the project must carry a significant pipeline. Part of the reason is that benchmark expenditures are not partially accrued. That is, expenditures accrued against portions of a benchmark may appear as unexpended funds in the USAID system. And, USAID does not pay against a benchmark until all of the benchmark's indicators are achieved.
- 3 The nature of the PBD mechanism, including the need to have committed funds on hand to pay outstanding benchmarks and to negotiate new rounds of benchmarks, results in a necessarily large pipeline for the project.

### **Recommendations**

- 1 The performance based disbursement system is an effective way to fund IFPS activities through SIFPSA, and should be maintained as the project's principal financing mechanism. Because existing benchmarks, and benchmarks under negotiation, require committed funds, the IFPS Project must maintain a large pipeline.
- 2 Certain key benchmarks, such as integrated district programs, should be developed with lower values and shorter durations to expedite disbursement.
- 3 USAID and SIFPSA need to develop the means to partially accrue expenditures for benchmarks nearing completion to obtain a more accurate picture of the project's financial status in relations to USAID reporting.

formats

- 4 Because existing benchmarks, and benchmarks under negotiation require committed funds in the pipeline, the IFPS Project must maintain a large pipeline
- 5 SIFPSA and USAID, and the project partners such as CAs, should only fund sub-projects aimed at achieving benchmarks USAID can use its position on the various advisory and approving committees to ensure adherence to this principle

### **XIII TECHNICAL ANALYSIS FOR IMPACT**

#### **A Background**

At the time the IFPS Project was signed on September 30, 1992, there was little recent survey data to enable project designers to incorporate an accurate picture of the demographic and health conditions in U P into the Project documents Key data such as the Total Fertility Rate (TFR) and contraceptive prevalence were taken from GOI service statistics and a five-year-old survey The National Family Health Survey was carried out in U P in late 1992 and early 1993 The results became available in 1994 In 1995, USAID sponsored the PERFORM survey which was carried out in 28 districts and yielded a representative sample for the entire State These two sources now permit a re-examination of the goals and objectives of the Project

The original indicators contained in the IFPS Project Agreement are shown in the table below

**IFPS Goals as Stated in the Project Agreement, 1992**

<b>Indicator</b>	<b>1993</b>	<b>2002</b>
Total fertility rate	5.4	4.0
Contraceptive prevalence	35%	50%
Number of users		Double number in 1993

## Base Year Values

The 1992-93 NFHS for U P found that the total fertility rate was 4.8, somewhat lower than originally estimated. It also found that the contraceptive prevalence rate was 20%, considerably lower than estimated from service statistics for the IFPS Project Agreement. Since there is uncertainty about the prevalence of traditional methods and IFPS does not include interventions to promote traditional methods, using the prevalence of modern methods is recommended rather than all methods as an indicator of project impact. From the NFHS the total number of family planning users can be estimated at 4.4 million.

### Revised Baseline Values

Indicator	1993 Value
Total fertility rate	4.8
Contraceptive prevalence of modern methods	18.5%
Number of modern method FP users	4.4 million

## End of Project Values

The original goals of the IFPS Project were based on the international experience that successful family planning programs can raise contraceptive prevalence by about 1.5 percentage points per year. This was the best approach available since data specific to U P were scarce at the time. Now however, information from the NFHS and PERFORM survey allow a more detailed look at the potential for project impact. PERFORM data can be used in two ways to estimate the likely impact of the project: (1) cross-sectional analysis of PERFORM data to estimate the impact of key project interventions on contraceptive prevalence and (2) district-level projections based on the proportion of unmet demand for family planning that could be met during the project period.

### B Focusing IFPS Efforts

The IFPS Project recognizes that it is not possible to conduct all activities in all areas

of the state. Some activities, such as training medical officers, are naturally statewide in scope. Others require intensive implementation at the district level. Rather than try to implement these intensive activities in all districts at once, the project has developed a phased approach to implementation that starts some activities in certain focus districts and then expands them to additional districts as they are shown to be successful. In U P there are 76 districts. The initial six focus districts are Gorakhpur, Jhansi, Kanpur Nagar, Rampur, Sitapur and Tehri Garhwal. In addition, nine other districts were designated as priority districts. These nine districts receive more attention initially than the rest of the state and are next in line for intensive efforts after the six focus districts. These focus and priority districts were selected to give geographic balance to early project implementation.

<b>Focus Districts</b>	<b>Priority Districts</b>	
Gorakhpur	Aligarh	Shahjanahpur
Jhansi	Allahabad	Sultanpur
Kanpur Nagar	Etawah	Unnao
Rampur	Meerut	Varanasi
Sitapur	Moradabad	
Tehri Garhwal		

Through March 1997 the six focus districts have accounted for 22% of expenditures and 22% of the value of sanctioned projects. The nine additional priority districts have accounted for 17% of expenditures and 28% of the value of sanctioned projects. Together these 15 districts have accounted for 40% of expenditures and 50% of the value of sanctioned projects.

It is worthwhile to ask whether an emphasis on these districts should continue or whether some other districts would be more appropriate for intensive efforts. Given the investment in these districts already and the need for sustained efforts to produce maximum impact, it would be counter-productive to stop efforts in any of these districts. However, it is useful to ask whether some districts are likely to show more impact than others and which additional districts should be the first candidates for expanded programs.

## C Technical Feasibility of Achieving IFPS Project Goals

Three modeling exercises were done as part of the technical analysis. The models are presented in more detail below. Briefly, model one looked at three key characteristics - intent to use family planning, contraceptive prevalence rate, and number of married women - in the 28 PERFORM districts and then developed a composite ranking of districts to recommend future districts for scale-up. The second model is based on a cross-sectional analysis of PERFORM data from 28 districts on contraceptive use, fertility, access, demand, quality of services and community factors. The third model looked at district projections and potential impact based on intention to use and future contraceptive use. These exercises concluded that providing the IFPS package of program interventions in a focussed, phased manner at the district level will achieve IFPS Project goals.

### MODEL 1 District Selection - Ranking by Characteristics

One reasonable criterion for selecting districts for additional efforts is the amount of impact that can be expected from program implementation. One approach to examining expected impact is to rank districts according to characteristics that should be related to eventual program impact. There are several district characteristics that are likely to be related to eventual program impact. The most obvious is the proportion of women who say that they intend to use a method in the future. To the extent that "intent to use" represents unfilled demand for contraception, those districts with high levels of "intent to use" should represent opportunities for rapid increases in contraceptive prevalence.

The figure below shows the districts ranked by "intent to use". Thus, Etawah, with the highest value (47% of eligible women say they intend to use in the future), is the best candidate for IFPS assistance by this criteria. See Figure 1.

A second criterion that could be used to indicate potential for program impact is contraceptive prevalence. International experience shows that countries with very low or very high prevalence generally have slower rates of increase in prevalence than countries with middle levels of prevalence (*Levels and Trends of Contraceptive Use as Assessed in 1996*, United Nations, New York, 1996). This suggests that districts with prevalence around 30% to 40% are better candidates for rapid increases in prevalence than those with lower or higher values. Figure 2 shows the districts ranked by prevalence.

A third criteria that might be used is population size. Success in districts with large populations will have greater impact on the statewide figures than in those with small populations. Figure 3 shows the districts ranked by the number of married women aged 13-49. By this criteria the largest districts, such as Varanasi, would be better candidates for project focus than the smallest ones, such as Tehri Garhwal.

Other criteria would also be important, such as the dedication and interest of the district CMO and the existence of active NGOs. However, these characteristics are subject to change during the lifetime of the project.

A combined ranking of the districts based on intent to use, prevalence and size is shown in Figure 4. The districts with the highest scores, such as Bareilly and Etawah, have the best potential for project impact.

Of the top 15 districts ranked by potential impact, 10 are either focus or priority districts. The other five districts are the best candidates for new emphasis districts as the project expands. They are Bareilly, Firozabad, Saharanpur, Mirzapur and Ballia.

There are two limitations of this analysis that should be mentioned. First, the conclusions from this technical analysis need to be combined with the judgements of those familiar with the political and administrative environments in each district to make a final determination. Second, this analysis has been confined to the 28 districts for which PERFORM data are available. There may well be other districts not on this list, which would be good candidates.

## **MODEL 2 Cross-Sectional Analysis of PERFORM Data to Calculate Future Contraceptive Prevalence Rates**

The PERFORM survey collected information on indicators related to contraceptive use, fertility, access, demand, quality of service, and individual and community factors. This information can be analyzed to answer the following questions:

- Do respondents who live in areas with higher levels of family planning service inputs have higher levels of contraceptive use?
- Do inputs of the type targeted for improvement under IFPS influence the use of contraception?

An analysis found that contraceptive use was significantly influenced by service factors targeted by IFPS, such as the number of family planning (FP) staff in the area, the number of health staff at each facility, the availability of essential sterilization equipment, the average number of staff trained in FP counseling and IEC, the number of staff knowledgeable about side effects, IEC activity in the facilities, and the availability of FP methods from private sources. By adjusting the current mean levels of women's availability to these different IFPS inputs to levels desired under IFPS, the analysis can project the contraceptive prevalence and method mix that can be obtained. The assumed increase in FP program inputs, possible through IFPS or the GOUP family welfare program or both, that would influence contraceptive prevalence and method mix for all eligible women, includes

- At least one commercial SDP in her area offers 1 or more FP methods
- At least one private SDP in her area offers 2 or more FP methods
- An average of 10 FP staff available in her area (as opposed to the current 6)
- Stockout proportion among SDPs in her area is only 10%
- At least one FP staff person in her area recently trained (in past 3 years)
- An average of 4 FP staff in her area are knowledgeable about contraceptive side effects (as opposed to the current 2)
- At least one public sector SDP carries out mass media IEC activities

The projected improvements reflect IFPS intervention areas, i.e., those intended to improve the quality of FP services, increase private sector involvement in FP service delivery, and to promote demand for FP.

Implementation of IFPS and GOUP improvements to FP services at these levels--without factoring in the on-going social improvements that will themselves raise contraceptive use--can increase from 25% prevalence documented by the 1995 PERFORM Survey to 32%. Prevalence of sterilization will rise from 17% to 21% and spacing method use will rise from 7% to 10%. While the projected levels may not seem substantial, if the inputs are in place by 2004, the levels require the current

program to be able to serve the needs of 9.3 million users at that time, or almost twice the current number of 5 million users

The IFPS and GOUP RCH program will not operate in a social vacuum. Other forces of modernization will boost contraceptive prevalence, such as delayed marriage, improved female education, and raised household incomes. By including a significant upward shift in female education (more than halving female illiteracy), the effectiveness analysis also found that contraceptive prevalence would increase by another 3 points, to 35%, as shown in the last column of the table below

**PROJECTED CONTRACEPTIVE METHOD MIX LEVELS (PERCENT DISTRIBUTION) FOR UTTAR PRADESH WITH INTENSIFIED INPUTS IN FAMILY PLANNING**

Method mix	Observed 1995 (%)	Projected IFPS (%)	Projected IFPS + reduced female illiteracy (*) (%)
No use	75	68	65
Permanent	17	21	24
Temporary	7	10	11

(\*) Reduced female illiteracy assumes decline from 70 to 30% no schooling, increase from 10 to 30% primary schooling, increase from 14 to 25% middle school level, and increase from 7 to 10% college or better schooling

It should be noted that this analysis estimates the impact of GOUP service delivery factors in 1995 that IFPS seeks to influence but predates the latter's implementation. Second, changes in the FP environment, such as the target-free approach and raised effectiveness of FP inputs through IFPS implementation, may affect the impact of these interventions in the final assessment. Nevertheless, this analysis supports the idea that IFPS is designed to improve factors that currently and substantially influence contraceptive use and method mix

### MODEL 3 District Projections

The PERFORM survey provides information on the demand for family planning through data on current contraceptive use and intention to use family planning in the future. "Intention to use" is measured as the percentage of eligible women who are not currently using family planning who state that they plan to use it in the future. For the entire state, about 37 percent of non-users stated an intention to use in the future. This information is also available for each of the districts included in PERFORM.

The level of "intention to use" family planning indicates potential demand for family planning in the future. Whether that potential will be fulfilled depends on the strength of the family planning program. To use this information to project future contraceptive use in U.P. we need to know the relationship between "intention to use" and future increases in prevalence. An analysis of DHS data for countries with more than one DHS survey shows that, on average, about 6% of "intention to use" is converted to a net increase in prevalence each year. The range is from about 3% to 14%.

This international experience has been used to develop district-level projections. The districts of U.P. are divided into four categories, (1) the six focus districts, (2) the nine priority districts, (3) Phase II districts (the 13 remaining districts surveyed by PERFORM which are assumed to get greater concentration of activities in the second phase), and (4) the rest of the state. The focus districts will have the most intensive interventions for the longest period of time. Therefore, they should experience the maximum level of converting unmet demand into actual use. The districts in the last category (rest of state) will benefit from the statewide activities from IFPS but will not have many additional interventions or will not have them for many years. Therefore, the rate at which unmet demand is converted to actual use will be near the lower end of international experience. The exact assumptions used in the projections are shown in the table below. When these different assumptions are applied to the appropriate districts the result for the entire state is that about 46% of "intent to use" is converted to net prevalence increase. This is less than the 65% that might be expected by using the average of all the DHS countries, thus the projection is conservative.

Category	Percent of Intention to Use That is Converted to Net Increase in Prevalence Over 10 Years
Focus districts	100%
Priority districts	60%
Phase II districts	50%
Remaining districts	35%

A projection for each district was created by adding to current prevalence the percentage of eligible women who intend to use contraception in the future multiplied by the conversion factors in the above table. These district-level projections are used with appropriate weighting to estimate the state-level prevalence. These projections estimate the impact of the IFPS Project over a 10 year period. Since project activities in the field did not get started until 1994, the projection period used here is 1994-2004. The results are shown below.

Category	Modern Method Prevalence - 1995	Modern Method Prevalence - 2004
Focus districts	25%	53%
Priority districts	38%	50%
Phase II districts	20%	32%
Remaining districts	22%	34%
U P Total	18.5% (1993)	35%

The total fertility rate and number of modern method users can be calculated from the modern method prevalence using assumptions about the changes in the value of the other proximate determinants of fertility (marriage, postpartum amenorrhea, abortion, sterility) and method mix. The details of the assumptions and the methodology used are given in *Estimated End of Project Indicators for the IFPS Project*, the POLICY Project, December 1996. This analysis shows that if modern method prevalence

increases to 35% by 2004, then the total fertility rate will drop to 3.9 and the number of users of modern methods will increase to 10.2 million.

## **D Implications**

Meeting the demand indicated by these projections will require a rapid increase in family planning service provision by most sectors. The required growth rate in sterilizations to meet projected demand will be about 4% per year in the public sector. The annual growth rates required for other methods will be high, particularly in the commercial sector. IUCD insertions will need to increase 11% per year, pill sales/distribution will need to increase by 15% per year and condom sales/distribution will need to increase by about 8% per year. The high rates of increase required for pills may be achievable, based on the low rates of pill use today, but will require a major effort focussed on the commercial sector. The addition of injectables as another option for spacing available through the private sector would facilitate the achievement of these goals.

## **E Sensitivity to Key Assumptions**

**1 District focus and phased expansion** The projections shown above assume that a strong family planning effort is made in the focus districts for a ten year period, and that this effort is expanded to additional districts over time. The initial emphasis in focus districts is needed to demonstrate the impact of a package of linked interventions. However, the focus districts contain only 8% of eligible women in U.P. The priority districts contain 21%. Expansion of the program to all 28 PERFORM districts will cover 50% of eligible women. District programming should be pursued in the 28 PERFORM districts in a focussed manner that links key public and private sector inputs so as to bring them up simultaneously and thereby achieve maximum impact. Programs in the six focus districts should be accelerated, and then expanded to 15 and then the full 28 PERFORM districts. Programs should be decentralized to the district level. The rate of district program expansion will be dependent on the extent of decentralization, and institutional capacity -- of SIFPSA, the district, and participating implementing institutions -- to develop, fund and oversee programs. The team recommends that the first comprehensive district programming being undertaken in Rampur be assessed by December 31, 1997, and plans for further district planning be carried out based on these findings. It is clear that the expansion of the program beyond the initial focus districts in the later years of the project will be key to achieving impact at the state level.

**2 New contraceptive technology** The original project design envisioned that injectables and Norplant would be added to the contraceptive mix. The addition of Norplant now seems unlikely while the addition of injectables is still uncertain. If injectables do not become available to the project, it will certainly make it harder to achieve maximum impact, especially in stimulating greater use of spacing methods. It is difficult to estimate the effect of not having new technologies available on the ultimate impact of the project since neither of the two methodologies used here consider method mix as a separate factor. However, international studies have shown that the addition of new contraceptive choices to the method mix facilitates increases in contraceptive prevalence. Therefore, efforts to obtain approval for IFPS to support the distribution of injectables, at least in the commercial sector, should be pursued vigorously.

**3 Commercial sector and social marketing** This projection assumes a major increase in spacing methods provided by the commercial sector. In the original design of IFPS the commercial sector was to be stimulated by a large social marketing program implemented by direct funding from USAID. It has not been possible to implement this design. Instead, as described in Section V C, several different activities have been undertaken to stimulate the commercial sector. These projections assume that some combination of activities will be implemented to enhance commercial sector growth. This may be a combination of social marketing programs that sell directly to consumers, those that sell to NGOs, and activities to support the expansion of the purely commercial sector. In these projections, the number of users served by the commercial sector grows by one million from 1993 to 2004. Expansion of the commercial sector accounts directly for about three percentage points of prevalence increase from 18% to 35%. Marketing efforts will also support NGO programs, so the total impact will be somewhat larger. A slower or more rapid expansion of the commercial sector would affect the ultimate prevalence achievement accordingly.

**4 Target-free approach** The removal of the target approach has led to a decline in family planning use throughout the state. However, there is some indication that project activities in focus districts have kept the amount of decline to a minimum relative to other parts of the state. Furthermore, the removal of the target approach creates an environment that is much more conducive to IFPS efforts to improve quality and enhance the use of spacing methods. The removal of targets may have a short-term adverse impact on prevalence, but was probably necessary to create the type of environment required for IFPS to succeed. Therefore, in the long run, it should be seen as a positive factor that will multiply IFPS impact.

## **F Reproductive and Child Health**

The original goals of IFPS focussed on TFR, prevalence and number of users. As a result, the reproductive health impact of IFPS was not well represented. Several modifications to the project focus are recommended in order to better capture the RH impacts. First, the indicators "modern method prevalence" and "users of modern methods" should be disaggregated by method, in order to capture the indicator of increasing the use of modern spacing methods. This will provide greater emphasis on the importance of the birth spacing activities as an RH intervention. Second, two new RH indicators should be added:

- 1 The proportion of recent births receiving antenatal care, and
- 2 The proportion of recent births attended by trained providers at delivery

Baseline values for both of these indicators are available from the NFHS. For births in the four years before the NFHS, 30% of mothers received ante-natal care and 17% of deliveries were assisted by a trained health provider. U P ranks quite low on both of these indicators as demonstrated in Figures 5 and 6.

It is difficult to suggest achievements for these indicators at this time since no special studies have been conducted linking the RH interventions that will take place in IFPS to these outcomes. However, using values for other Indian states in the middle range on these indicators, we have suggested target values for these indicators -- 40% for antenatal care and 30% for attended delivery by trained health providers. Additional details on indicators are provided in Annex 11. Further study may be useful for validating the targeted levels.

## **G Findings**

- 1 The IFPS Project design is valid. IFPS is an evolving model for public-private partnership in India, is serving the needs of the poor on a wide scale, and demonstrates the value of GOI-U S cooperation.
- 2 The Project shows clear evidence that it has the potential to achieve its goals and objectives for enhancing reproductive health and reducing fertility in North India over a ten year period.

- 3 Project baseline values and project impact indicators need to be revised, as noted in Table 1, as a result of additional information available from the NFHS and PERFORM surveys

**Recommended Revised IFPS Project Goals**

Indicator	1993	2004
Total fertility rate	4.8	3.9
Modern method prevalence		
Total	18.5%	35%
Permanent	13.1%	24%
Spacing	5.5%	11%
Number of modern method users		
Total	4.4 million	10.2 million
Permanent	3.1 million	7.0 million
Spacing	1.3 million	3.2 million
Percent of births in the last four years receiving antenatal care	30%	40%
Percent of deliveries in the last four years assisted by a doctor or nurse/midwife	17%	30%

- 4 Both the NFHS and PERFORM surveys confirm that there exists considerable unmet demand for contraception in U P
- 5 Statistical analysis of PERFORM data indicates that the interventions in IFPS can have a significant impact on increasing prevalence in U P
- 6 The original goals of the project (reducing TFR to about 4.0 and increasing prevalence by 15 points) are achievable. The expected increase in spacing methods and the commercial sector may be less than originally anticipated

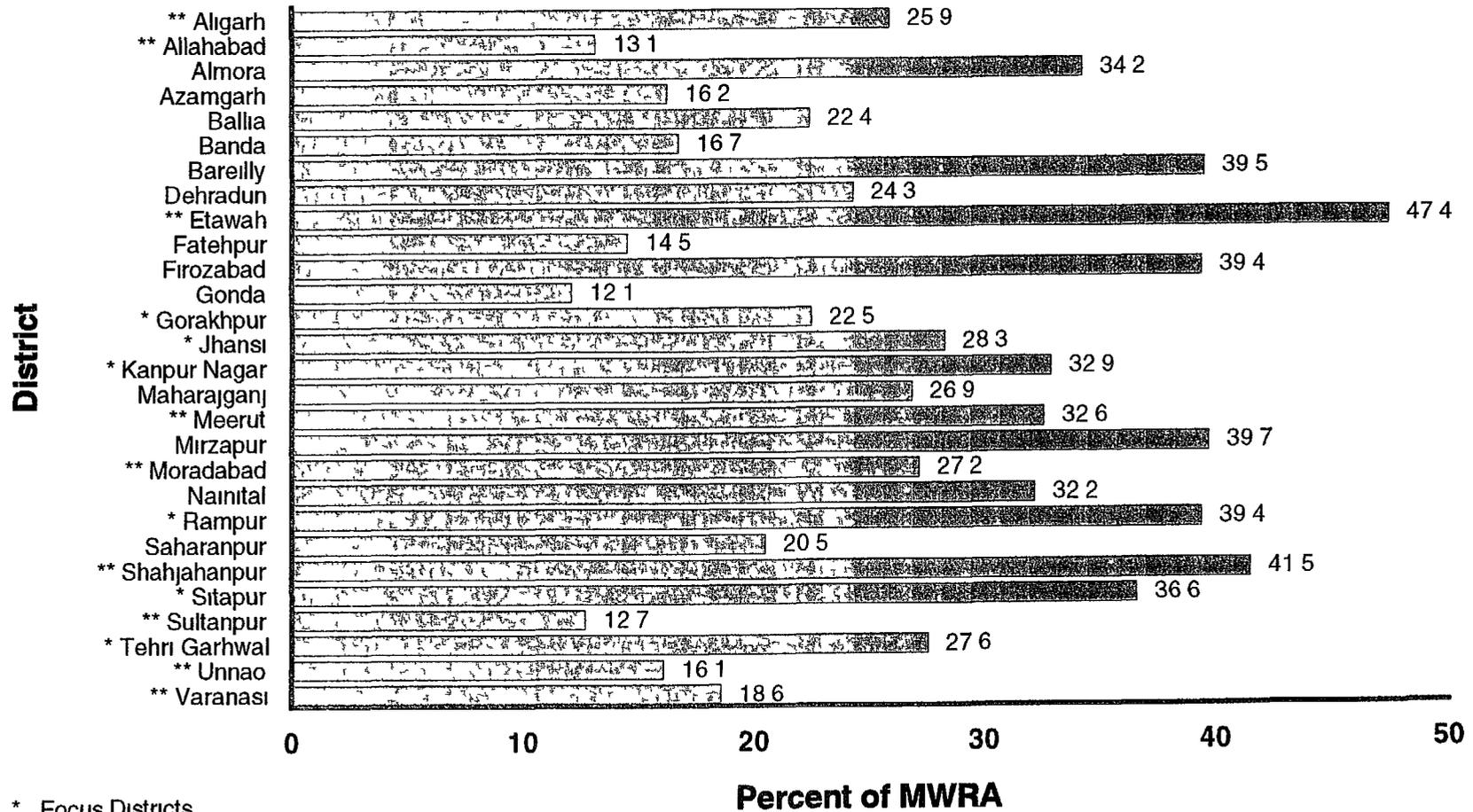
## H Recommendations

- 1 Strategic focus IFPS sub-projects and funding should be phased as agreed upon in the project strategy and action plans. New sub-projects should be oriented towards achieving benchmarks in the 15 priority districts. Only select statewide efforts should be sanctioned, these include training and dissemination in select areas (e.g., contraceptive technologies, infection prevention, client counseling), contraceptive logistics, IEC, and contraceptive social marketing.
- 2 Revising goals IFPS goals should be revised to reflect new baseline values, the results of potential impact analyses, and new national reproductive health goals. These are all consistent with the originally designated project goals. End-of-project goals should be defined for 2004, that is, 10 years from 1994 when active program implementation began. Assuming continued project momentum and further progress toward IFPS goals over the next three years, USAID should formally review the life of project duration in the year 2000 and consider a project extension to 2004 based on successful results of focussed project implementation and desired impact.
- 3 Further study may be useful for validating the recommended goal levels for antenatal care and assisted deliveries.
- 4 Strategic Objective 2 performance indicators and intermediate results, as revised and detailed in Annex 11, should be approved by USAID/Washington based on the technical analysis and overall findings of the IFPS Project Midterm Assessment.

FIGURE 1

# Percent of MWRA Intending to Use FP

## 28 PERFORM Districts



\* Focus Districts

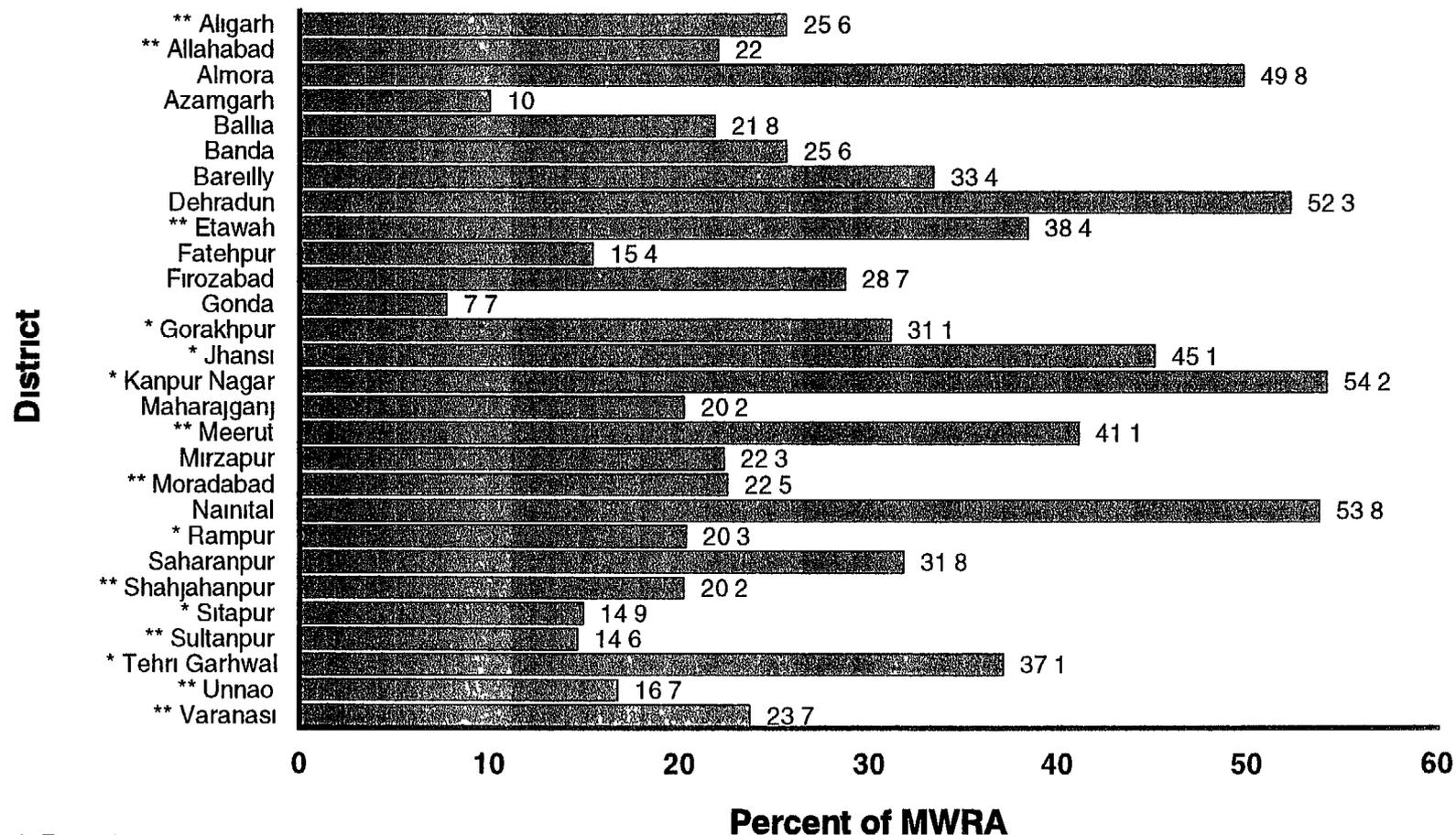
\*\* Priority Districts

MWRA Married Women of Reproductive Age

FIGURE 2

# Contraceptive Prevalence

## 28 PERFORM Districts

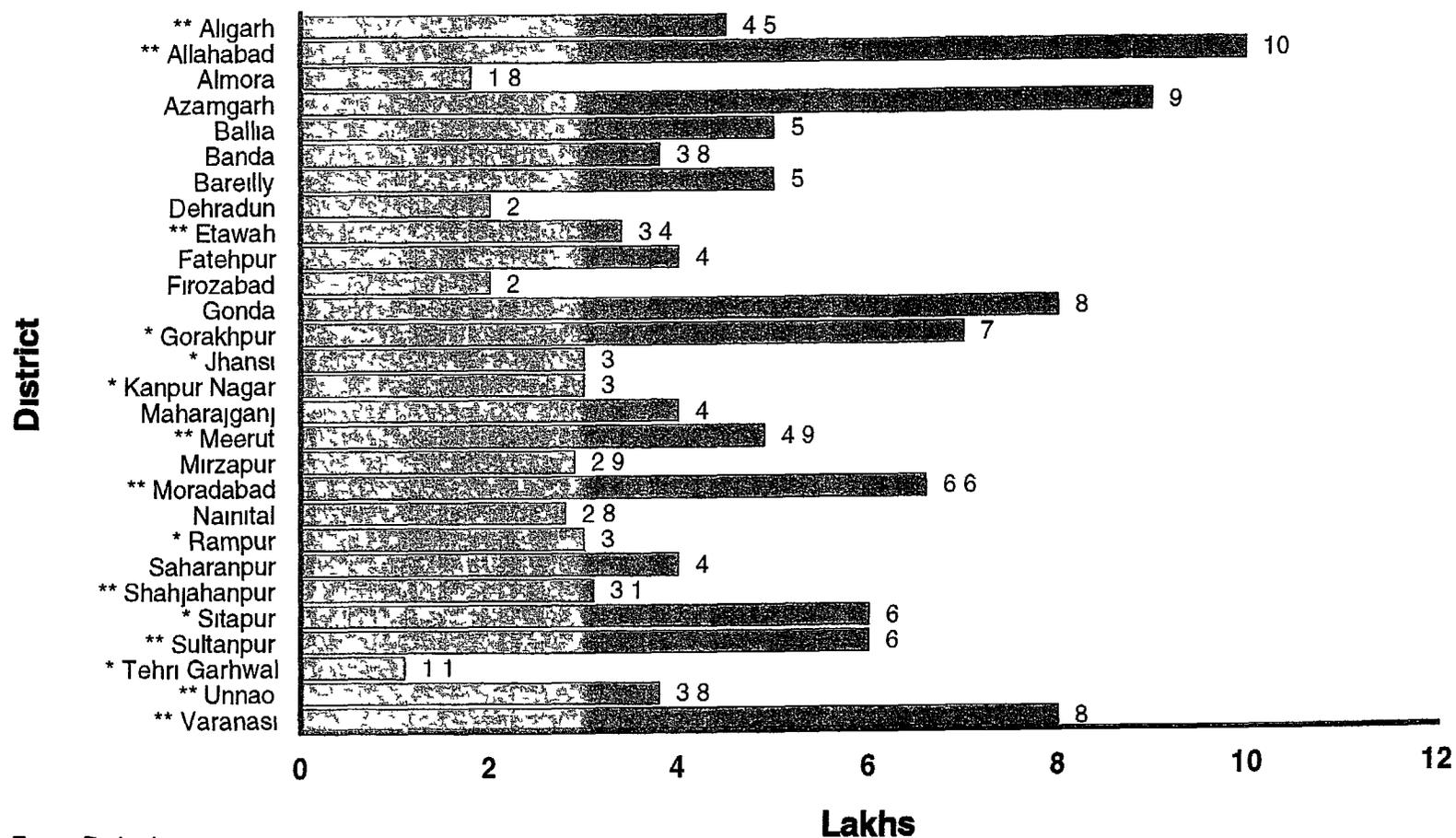


\* Focus Districts  
 \*\* Priority Districts

FIGURE 3

# Number of Married Women 13-49

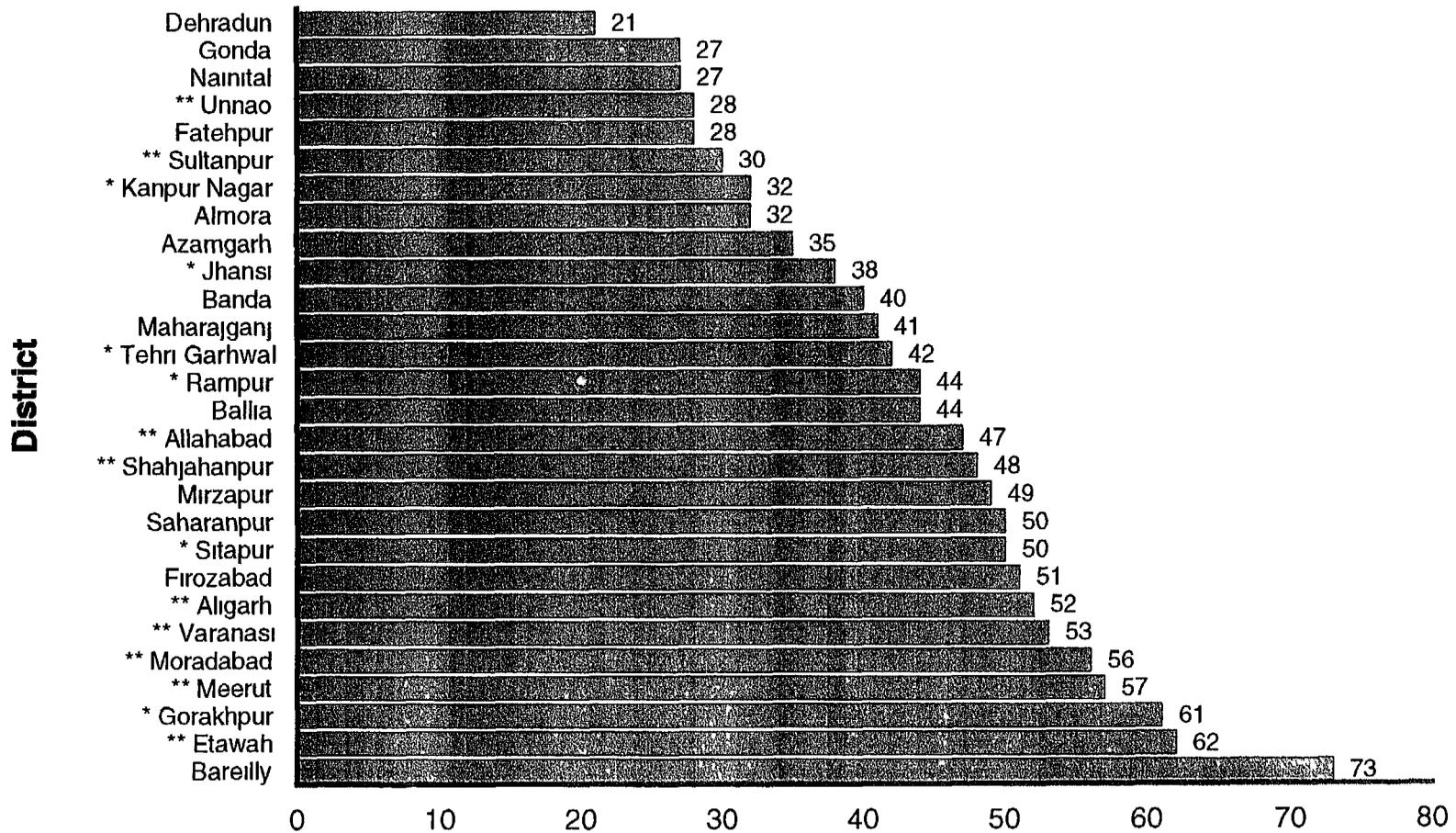
## 28 PERFORM Districts



\* Focus Districts  
 \*\* Priority Districts  
 1 Lakh = 100 000

FIGURE 4

# Composite Score: Potential Project Impact 28 PERFORM Districts



\* Focus Districts  
\*\* Priority Districts

FIGURE 5

# Percent of Live Births in Last Four Years Receiving Antenatal Care

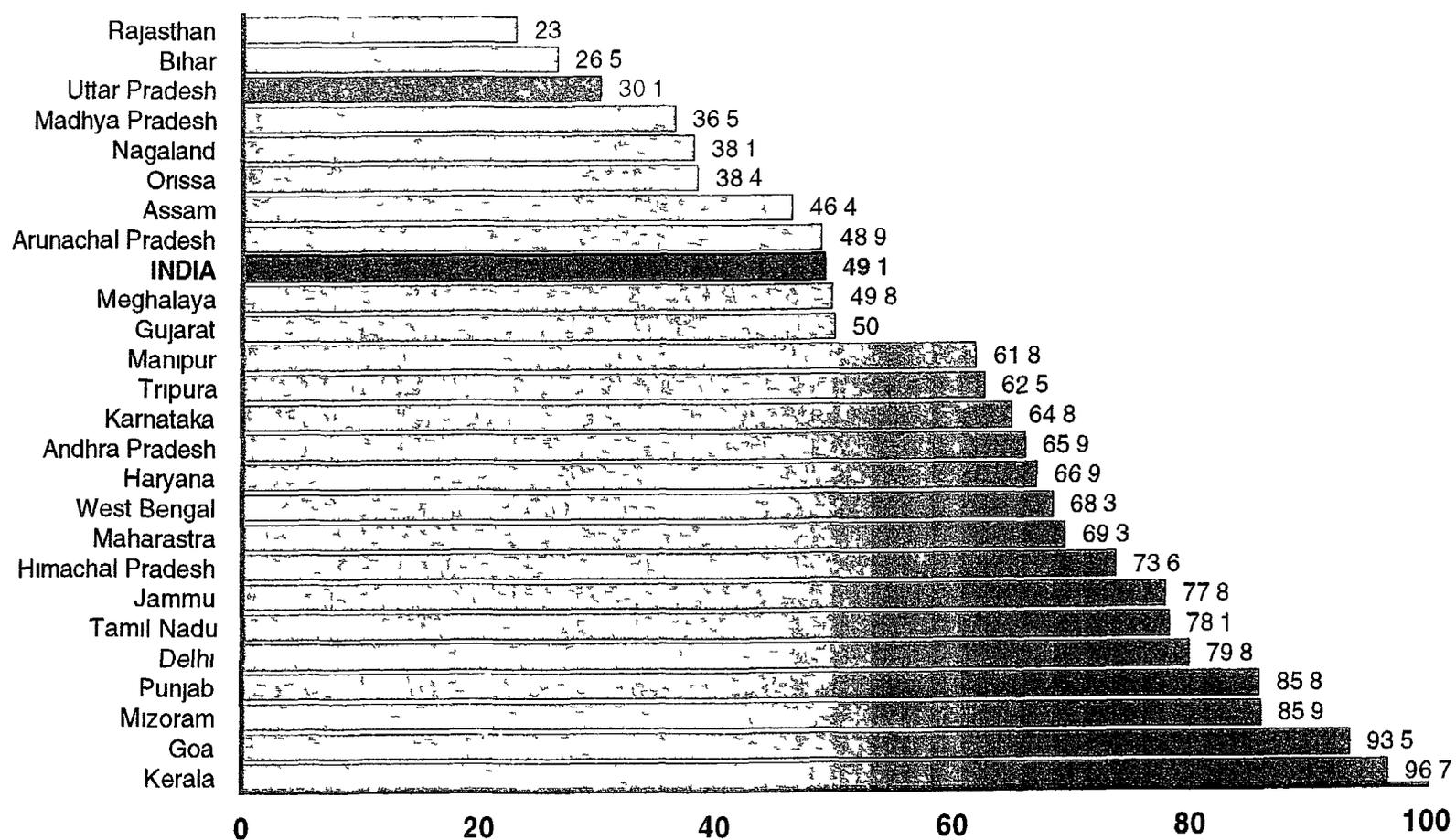
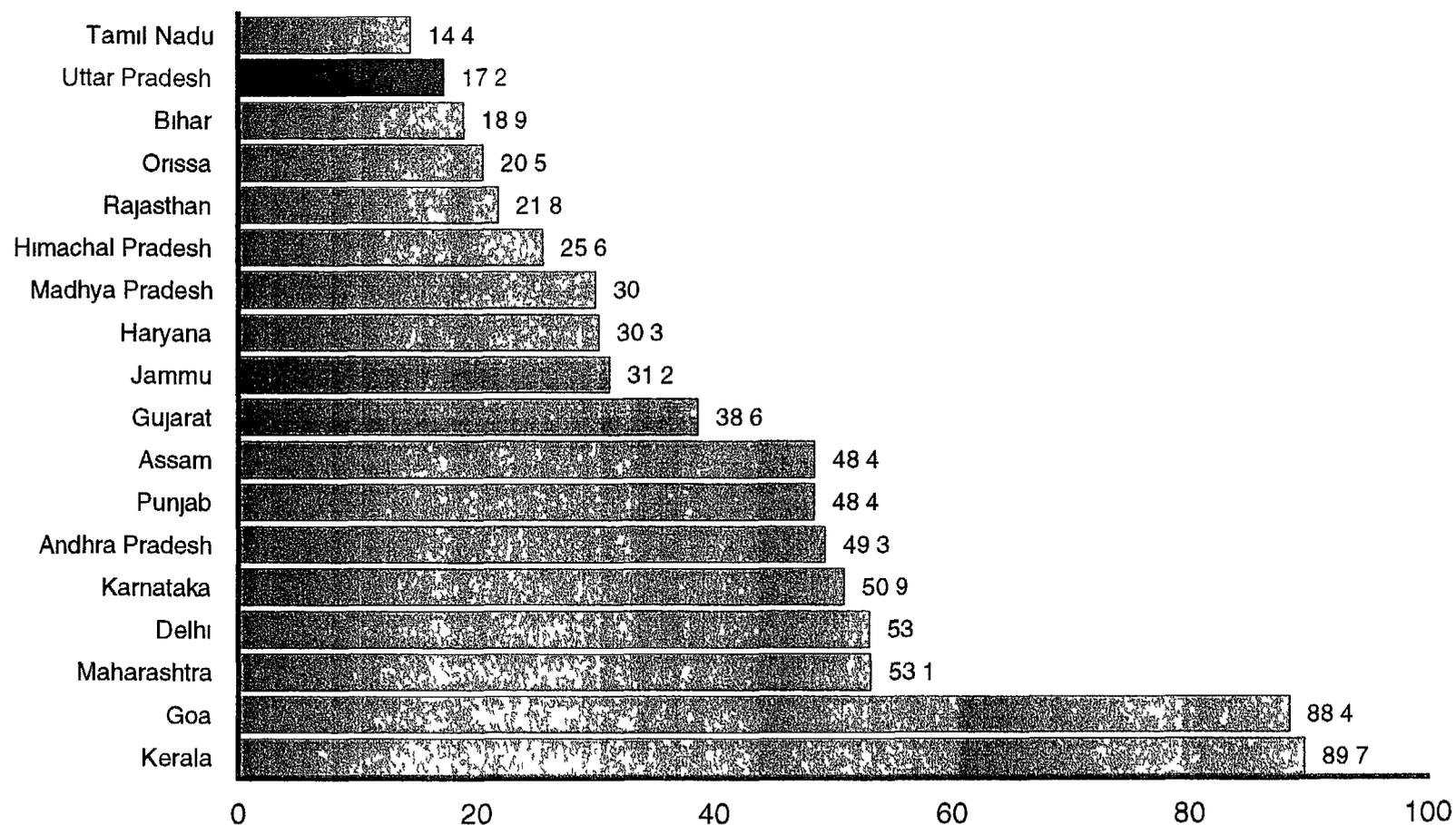


FIGURE 6

# Percent of Deliveries in Last Four Years Assisted by Doctor or Nurse/Midwife



# ANNEXES

DO NO L-17012/11/95-AP



सत्यमेव जयते

K S SUGATHAN

Joint Secretary

Tele / Fax 301 9066

भारत सरकार

स्वास्थ्य एवं परिवार कल्याण विभाग

विशेष भवन, ई. दिल्ली 110011

GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NEW DELHI 110011

June 23, 1997

Dear Mr Pogoch,

Please refer to our discussions today regarding the proposed Mid-term Assessment of the USAID Project in Uttar Pradesh. During the discussions, it was explained to USAID that the timing of the Mid-term review is not suitable because of the following reasons -

- (a) The implementation of the project effectively began only in 1994. Therefore, it is too early to make an assessment of the experience/process of implementation/impact.
- (b) The officials at the Government of India as well as at SIFPSA, Government of Uttar Pradesh will be pre-occupied with Parliament Session/Legislative work.
- (c) Since the project has currently taken off and is going through an active implementation stage, the Mid-term assessment at this stage will adversely affect the pace of implementation.

It was, therefore, suggested to USAID that a more appropriate timing for Mid-term Review would be in the months of May/June, 1998.

2. The USAID representative on their part explained that it was critical for them to go through the Mid-term assessment of the Project as proposed for the continued funding support. The outcome of such Mid-term assessment would also be useful for developing new strategies to achieve the project objectives.

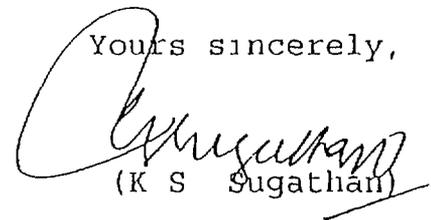
3. After detailed discussions it was agreed that despite the inconvenience of the timing to both Government of India and SIFPSA, Uttar Pradesh, we would go through the Mid-term assessment as proposed by USAID. It was also agreed that during the

-2-

Mid-term assessment, the on-going activities would not be affected and the development of new Performance Benchmarks would also be taken up. It is important to develop new Benchmarks because the Benchmarks which are already developed and agreed upon have an outlay of only US \$ 42.2 Million out of the outlay of US \$ 155 Million subject to PBD. The revised scope of work was also discussed and modifications in that which were agreed upon would be finalised and communicated to you shortly.

With best wishes,

Yours sincerely,



(K S Sugathan)

Mr John Rogosch  
Director,  
Population, Health & Nutrition,  
USAID,  
B-28, Qutab Institutional Area,  
New Mehrauli Road,  
NEW DELHI - 110016

Fax 91-11-6868594

ANNEX 1

राज्य परिवार नियोजन सेवा अभिनवीकरण परियोजना एजेंसी  
State Innovations in Family Planning Services Project Agency

No 02/FPS/SIFPSA/DGM/  
June 25, 1997



Aradhana Johri

Executive Director  
IFPS Project

Dear Sir,

Please refer to discussion held on 23rd June, 1997 regarding timing of the Comprehensive Assessment of the IFPS Project and the draft Scope of Work for the same.

Based on aforementioned discussion necessary changes have been incorporated in the document which is enclosed

With Best wishes

Yours sincerely,  
A Johri  
( ARADHANA JOHRI )

Encl As above

Mr K S Sugathan,  
Joint Secretary (P),  
Ministry of Health & Family Welfare,  
Government of India,  
Nirman Bhavan,  
NEW DELHI

✓ Mr. John Rogosch,  
Director,  
Office of Population, Health & Nutrition,  
USAID,  
B-28, Institutional Area,  
Qutab Hotel Road,  
NFW DELHI

S489  
6/25/97  
ACTION  
PHN-2  
INFO  
D/DD  
(PHN/FPS)  
PHN/PRE  
PDS  
CHRON  
RF

SIFPSADraft Scope of Work for Comprehensive Assessment of IIPS Project

- 1 Is the original design required to be partially amended in the light of the prevailing environment?

IIPS project has been designed to reduce fertility in UP. It is passing through the pilot phase. After adoption of the design, external changes have occurred. The policy of the GOI has changed leading to the adoption of the target-free approach.

- ◆ *Should any change be made in the IIPS Project in view of the target-free approach and other donor funding of family planning sector in UP?*

- 2 Is there a need to create specific infrastructure, systems etc. in the public and private sectors to ensure that the project achieves the envisaged goals?

- ◆ In the pilot phase, capacity building was crucial. Therefore, greater emphasis was placed on funding institutional strengthening. How can more integrated activities be promoted in the public sector?
- ◆ What more can be done to ensure a reliable supply of basic contraceptives for NGO projects and at Government facilities?
- ◆ How can quality and effectiveness of NGO projects be improved?

ANNEX 1

3. Is there a need to further strengthen SIFPSA's management structure to make it appropriate to face the challenge of scaling-up of activities in the replication phase?
  - ◆ Is the current implementing mechanism viable in the light of future implementation expectations?
  - ◆ Can operations be decentralised?
  - ◆ Would it be advantageous to have regional, district or divisional management offices?
  - ◆ *What are the additional institutional and human resources required in SIFPSA to greatly expand the project to cover the whole state?*
  - ◆ *How can the financial management system of SIFPSA be modernised and streamlined to increase the speed and effectiveness of financial transactions?*
  
4. Is there a need to amend or fine-tune the PBD system to make it a more effective and timely system for financial management?
  - ◆ Is there a more appropriate, efficient financial management system that could be adopted in place of PBD?
  
5. How best can we have activities all over the state given the fact that the goals are set for the entire state? What strategy can be adopted to go state-wide immediately?
  - ◆ Is the project ready to rapidly expand access, quality and promotion interventions on a *district-wise* basis to cover the *whole state* over the next three years?

## ANNEX 1

6 Is there a need to identify specific areas of funding and strategy which need greater emphasis so that the project achieves its goals?

- ◆ Many activities have been found to be successful on pilot scale. Can these activities be expanded rapidly over the entire state?
- ◆ What are the feasible alternatives for implementation of the key component for provision of contraceptive supplies to consumers and NGOs?
- ◆ How best can the activity of contraceptive supply be coordinated with other SIFPSA supported activities?
- ◆ What strategy can be adopted to quickly upgrade the vast public sector infrastructure to provide high quality services?
- ◆ Is there now a need to earmark broad values for funding different types of projects in the private sector based on rapid assessments and evaluation of impact already conducted?

7 Are the large number of SIFPSA sub-projects effective? Which ones can be scaled up on a large scale basis?

- ◆ How can the activities be designed so that SIFPSA with its managerial, financial and technical capacity may provide appropriate supervision for these activities?
- ◆ What is to be incorporated in the existing monitoring and evaluation mechanism to assess the effectiveness of sub-grants?

- 8 Are the GOI/GOUP/USAID co-operation and project policy and program decision making bodies working effectively? How have GOI/GOUP/USAID/SIIPSA co-operation / interaction worked out?
- ◆ Is it possible to prepare a fixed calendar for meetings to avoid attending a meeting at short notice?
  - ◆ Are the various decision and advisory committees functional and effective?
- 9 How can the inputs from CAs be made more effective and efficient? Is there a need to change the present system of selecting CAs and assigning work to them?
- ◆ Is the technical assistance being provided by the CAs appropriate as per requirements and effective?
  - ◆ What controls are required to ensure that CAs work to support project goals?
  - ◆ What improvement is required in the co ordination between CAs and SIIPSA and how can that be achieved?
  - ◆ At the present rate of expenditure of US \$ 100 million component, will the money last over the project life?
- 10 What is the future of the CSM component?

## ANNEX 1

- 1 How to initiate utilisation of US \$ 42 million component without further delay?
  - 2 How to ensure that the element of subsidy involved and the dependence on GOI supplies does not hamper CSM activities once they are initiated?
  - 3 Need for identifying segments of clients for which free, CSM, commercial supplies have to be made available and making provision for these supplies
- 11 Is there a need to include a broader range of more descriptive and quantitative reporting on results, given the size of the programme?  
Is there a need for additional progress indicators for the project?
- ◆ What could be the annual measures of the following?
    - (1) Access and/or use of services
    - (2) Quality of services
    - (3) Increased consumer knowledge on family planning services and other reproductive health areas
- 12 With greater focus on other reproductive health elements such as safe deliveries, what additional annual indicators need to be identified for use of project planners, implementors and for monitoring progress?



## Senior Technical and Policy Experts Review for IFPS Comprehensive Assessment

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### Purpose.

Provide independent senior level participation and feedback on IFPS Comprehensive Assessment to strengthen the content and broaden the perspective of the Report findings. In addition to any other reactions to the draft Assessment Report, the senior expert group is asked to comment on and put in writing responses to the following questions

- 1 Can the IFPS project achieve its planned impact? Is that impact clearly defined? Is the volume of resources to be devoted to the effort commensurate to the projected impact? How does the effort to date and project impact compare to experiences elsewhere in the world?
- 2 Are the proposed plans for substantiating the impact (i.e., reductions in fertility and increase in contraceptive use) and/or progress towards that impact (i.e., intermediate indicators, i.e., measures of access, quality, and knowledge) reasonable?
- 3 Does IFPS strategy and its program approaches support the development of a public-private system which, over time, will be increasingly sustained by resources other than USAID's?
- 4 Is the performance based disbursement financing system functioning as intended given Government of India and USAID policies and regulations? Is this a manageable system? Is it an effective way to administer resources for the IFPS project? Is there a better alternative?

The senior experts group will accomplish their task by

- 1 Reading and reviewing relevant background documents (July 1-27)

## ANNEX 2

- 2 By working as a group in India (July 28 - August 2)
- a) reviewing and commenting on the draft assessment report, especially findings and recommendations for future design,
  - b) Visit a sample of IFPS assisted project activities in Uttar Pradesh,
  - c) Participate in group discussions on the IFPS draft assessment with SIFPSA, Government of India, Government of Uttar Pradesh and USAID staff,
  - d) Provide in writing, comments on the Report and answers to the questions proposed in above Scope of Work to the IFPS assessment team

The detailed day-by-day team schedule is attached

### Team Members

- 1 Dr Nils Daulaire, Deputy Assistant Administrator and Senior Policy Advisor, Bureau for Policy and Program Coordination, USAID/Washington  
**Team Leader**
- 2 Mr Sidney Chernenkoff, Director, Office of East and South Asian Affairs, Bureau for Asia and the Near East, USAID/Washington
- 3 Dr Indra Pathmanathan, Public Health Specialist (RCH/India), World Bank, Washington, D C



# AGENCY FOR INTERNATIONAL DEVELOPMENT

## INNOVATIONS IN FAMILY PLANNING SERVICES (IFPS) PROJECT (386-0527)

July 21, 1997

### IFPS PROJECT MID-TERM ASSESSMENT July 7, 1997 - August 8, 1997

CORE TEAM MEMBERS			Dates
*	Jinny Sewell	Chief - Family Planning Services, USAID/India (Core Team Leader)	July 7 - Aug 8
*	Sigrid Anderson	Chief - Family Planning Services, Global Bureau Office of Population, USAID/Washington	July 20 - Aug 8
*	Keys MacManus	Senior Technical Advisor - Global Bureau Office of Field Support, USAID/Washington	Jun 30 - Aug 1
*	Harry Cross	Director, POLICY project - The Futures Group	July 14 - Aug 2
SENIOR TECHNICAL AND POLICY EXPERTS			
*	Nils Daulaire	Deputy Assistant Administrator and Senior Policy Advisor, Bureau for Policy and Program Coordination, USAID/Washington (Team Leader)	July 26 - Aug 2
*	Sidney Chernenkoff	Director, Office of East and South Asian Affairs, Bureau for Asia and the Near East, USAID/Washington	July 26 - Aug 2
*	Indra Pathmanathan	Public Health Specialist (RCH/India) World Bank, Washington	July 21 - Aug 2
TECHNICAL RESOURCE EXPERTS			
*	Alan Bornbusch	Advisor Office of Population Global Bureau USAID/Washington	July 7 - Aug 2
*	Amy Tsui	Project Director, EVALUATION project	July 25 - Aug 1
*	John Stover	Vice President, The Futures Group	July 21 - 30
*	N N Wahi	Deputy Controller, USAID/India	July 7 - Aug 1

**A. PREPARATORY MEETINGS****Monday, July 7, 1997**

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- 0900 - 1000 Meeting with John Rogosch, Director, Office of Population, Health and Nutrition  
(overview of the PHN program)  
Team Participants Jinny, Keys, Alan  
*John Rogosch's office*
- 1000 - 1200 Meeting with IFPS Staff (Develop Agenda)  
Team Participants Jinny, Keys, Alan  
*Director's conference room*
- LUNCH
- 1330 - 1430 Meeting with Saroj Pachauri, Senior Representative for South and East Asia, The  
Population Council  
Team Participants Jinny, Keys, Alan  
*India Habitat Center, Lodhi Road*
- 1500 - 1600 Meeting with Linda Morse, Mission Director  
Team Participants Jinny, Keys, Alan  
*Director's office*
- 1600 - 1700 Meeting with Tom Totino, Controller, Mr N N Wahi, Deputy Controller  
and Mr N Ramesh, Project Development and Support Office to discuss PBD  
Team Participants Jinny, Keys, Alan  
*Totino's office*

**Tuesday, July 8, 1997**

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- 0900 - 1100 Meeting with CAs  
Team Participants Jinny, Keys, Alan  
*4/2 Shanti Niketan*
- 1100 - 1200 IEC Coordination Group meeting  
Team Participants Keys, Alan  
*4/2 Shanti Niketan*
- 1200 - 1300 LUNCH with CAs  
*4/2 Shanti Niketan*
- 1400 - 1500 Meeting with Christina Bearing, UNFPA  
Team Participants Keys, Jinny  
*UNFPA, 55 Lodhi Estate*

## ANNEX 3

- 1400 - 1500 Meeting with P N Sushama, Policy, Research and Eval Division on indicators  
Team Participant Alan  
*P N Sushama's office*
- 1500 - 1600 Meeting with WB  
Team Participants Keys, Jinny  
*World Bank, 55 Lodhi Estate*
- 1630 - 1730 Meeting with Srinivasan  
Team Participant Alan  
*PFI, B-28 Institutional Area, Tara Crescent*

### **Wednesday, July 9, 1997 to Friday, July 11, 1997**

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FIELD VISITS (See attached itinerary -1)  
Team Participants Jinny, Keys, Alan

### **Sat /Sun July 12-13, 1997**

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WEEK END

## **B IFPS ASSESSMENT BEGINS**

### **Monday, July 14, 1997**

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- 0900 - 1000 Team Meeting  
Team Participants Jinny, Keys, Alan  
*Director's Conference Room*
- 1000 - 1100 Meeting with IFPS staff (Develop Agenda)  
Team Participants Jinny, Keys, Alan  
*Director's Conference Room*
- 1130 - 1230 Meeting with ODA  
Team Participants Keys, Jinny  
*ODA Health & Population Office, 50-M, Neeti Marg, Chanakyapuri*
- LUNCH
- 1500 - 1600 Meeting with Mr Chaturvedi, Secretary Family Welfare, MOHFW  
Team Participants Jinny, Keys, Alan  
*MOHFW*
- Harry Cross arrives

**Tuesday, July 15, 1997**

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0600	IC 435 flight to Lucknow Team Participants Jinny, Keys, Alan, Harry	
0900-1730	RAPID Assessment Seminar Team Participants Open to all CAs, partners and team	Taj Lucknow
1800-1900	Meeting with Dr Narayana Team Participants Alan	
1930-2300	SIFPSA to host reception for participants <b>(SIFPSA to take lead)</b>	Taj Lucknow

**Wednesday, July 16, 1997**

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0900-1730	RAPID Assessment Seminar Team Participants Open to all CAs, partners and team	Taj Lucknow
1600-1700	Meeting with Aradhana Johri, Executive Director, SIFPSA Team Participants Jinny, Keys, Alan, Harry	SIFPSA
1730-1800	Courtesy call on the U P Chief Secretary Team Participants Jinny, Keys, Alan, Harry	GOUP
1800-1830	Meeting with the Principal Secretary, Health (with SIFPSA) Team Participants Jinny, Keys, Alan, Harry	GOUP

**Thursday, July 17, 1997**

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0900 - 1000	Meeting with Ms Aradhana Johri, SIFPSA Executive Director Team Participants Jinny, Keys, Alan, Harry	
1000 - 1200	Meeting with SIFPSA staff Team Participants Jinny, Keys, Alan	SIFPSA
	LUNCH	
	Meeting with Secretary of Family Welfare with SIFPSA <b>(SIFPSA to take lead)</b> Team Participants Jinny, Keys, Alan, Harry	GOUP

## ANNEX 3

SIFPSA hosts team dinner (SIFPSA to take lead)  
Team Participants Jinny, Keys, Alan, Harry

Venue TBD

### Friday, July 18, 1997

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Morning flight back to Delhi  
Team Participants Jinny, Keys, Harry, Alan

### Saturday/Sunday, July 19/20, 1997

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WEEKEND  
Draft report  
Team Participants Jinny, Keys, Alan, Harry

Hyatt Hotel

John Stover arrives

### Monday, July 21, 1997

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0900 - 1000 Meeting between Indra Pathmanathan - John Rogosch

John's Office

0900 - 1000 Team meeting with John Stover  
Team Participants Jinny, Keys, Alan, Harry

Director's Conference Room

1000 - 1100 IFPS Staff meet with John Stover

Director's Conference Room

1100 - 1200 Meeting with PRE on IFPS project impact and indicators  
Team Participants John Stover

Bill's office

LUNCH

PM Draft report writing  
Team Participants Jinny, Keys, Alan, Harry, John S

PHN office

Sigr d arrives

### Tuesday, July 22, 1997

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0900 - 1000 Joint CAs meeting - Sigr d, Jinny and Indra

4/2 Shanti Niketan

147

## ANNEX 3

- 1000 - 1200 Individual CA meetings - Sigrid and Jinny  
4/2 Shanti Niketan
- 0900 - 1700 Draft report writing  
Team Participants Jinny, Keys, Alan, Harry, Sigrid, John S  
PHN Office

### **Wednesday, July 23, 1997**

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- 0900 - 1700 Draft report writing  
Team Participants Jinny, Keys, Alan, Harry, Sigrid, John S  
PHN Office
- 1100 - 1200 Meeting on PBD and IFPS pipeline between Wahı and Sigrid  
Wahı's office

### **Thursday, July 24, 1997**

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- 0900 - 1700 Draft report writing  
Team Participants Jinny, Keys, Alan, Harry, Sigrid, John S  
PHN Office

### **Friday, July 25, 1997**

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Amy joins team (arrives from Lucknow after completing EASYVAL training)

- 0900 - 1000 Team meeting to de-brief Amy  
Director's Conference Room
- 1000-1200 Debrief Mission Director and USAID staff  
Team Participants Jinny, Keys, Alan, Harry, Sigrid, Amy, John S  
(invitees Tom, Wahı, Ramesh, Peter, Ashı, Rekha, IFPS Team)  
Director's Conference Room
- 1400 - 1600 Meeting with SIFPSA  
Team Participants Jinny, Keys, Alan, Harry, Sigrid, Amy, John S  
Director's Conference Room
- 1630 - 1730 Meeting with Linda Morse on indicators  
Team Participants Jinny, Sigrid, John S, Amy, Sushama, Vathani, Samaresh, Sheena  
Director's Conference Room

### **Sat /Sun July 26-27, 1997**

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WEEKEND  
Revise Report

## ANNEX 3

Team Participants Jinny, Keys, Alan, Harry, Sigrid, John S, Amy

*Hyatt Hotel*

Senior technical/policy experts arrive

### **Monday, July 28, 1997**

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- 0900 - 1000 Meeting with IFPS staff, chaired by John Rogosch  
Team Participants Nils, Sid, Indra  
*Director's Conference Room*
- 1000 - 1100 Senior Experts Team Planning Meeting  
Team Participants Nils, Sid, Indra  
*Director's Conference Room*
- 1100 -1200 Meeting with Linda Morse, Mission Director  
Team Participants Nils, Sid, Indra accompanied by Jinny and John Rogosch  
*Director's office*
- 1200 - 1300 LUNCH
- 1300 - 1600 Review draft report and recommendations with team  
Team Participants Nils, Sid, Indra, Jinny, Keys, Alan, Harry, Sigrid, Amy, John S  
*Director's Conference Room*
- 1600 - 1700 Senior Experts Team Planning Meeting  
Participants Nils, Sid, Indra  
*Director's Conference Room*
- 18 00 Linda to host reception  
*Director's residence*

### **Tuesday, July 29, 1997**

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- 0600 IC 435 flight to Lucknow  
Team Participants Nils, Sid, Indra  
Accompanied by John Rogosch
- 0800 - 1800 FIELD VISIT (see attached itinerary -2)  
Participants Nils, Sid, Indra & John R
- 2000 Team to host dinner with SIFPSA's Executive Director  
Participants Nils, Sid, Indra & John R

**Wednesday, July 30, 1997**

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## FIELD VISIT

Participants Nils, Sid, Indra &amp; John R

Core team to work on the draft report

Team participant Jinny, Keys, Alan, Harry, Amy, Sigrid

John Stover leaves country

**Thursday, July 31, 1997**

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0600 IC 435 flight to Lucknow  
Team Participants Jinny, Keys, Alan, Harry, Amy, Sigrid

0900 - 1300 Senior Experts Team to provide comments & technical input on draft report  
Team Participants Nils, Sid, Indra, Jinny,  
Keys, Alan, Harry, Sigrid, Amy

*Taj Lucknow*

1500 - 1800 Debrief meeting with GOI, GOUP, SIFPSA and USAID  
Team Participants Nils, Sid, Indra, Jinny, Keys, Alan, Harry, Sigrid, Amy

*SIFPSA***Friday, August 1, 1997**

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0725 IC 436 flight to Delhi

0820 Arrival in Delhi

1100 - 1700 Senior experts to provide final comments on draft report  
Core team revises draft report

*USAID/Hyatt*

1500-1600 Meeting with Mr Y N Chaturvedi, Secretary, Family Welfare  
Team Participants John, Jinny, Keys, Sid

*MOHFW***Sunday, Aug 3, 1997**

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Senior, technical and core team members - Sid, Harry, Keys, Alan and Amy - depart country

**Monday, Aug 4, 1997**

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Revise report  
Team Participants Jinny, Sigrid

*PHN Office*

**Tuesday, Aug 5, 1997**

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0900 - 1000 Briefing for CAs Jinny, Sigrid

*4/2, Shanti Niketan*

1100 - 1300 Revise report Jinny, Sigrid

*PHN Office*

1400 - 1600 Review report with PHN

**Wednesday, Aug 6, 1997**

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Draft MOU (if time permits)  
Team Participants Jinny, Sigrid

*PHN Office*

Nils departs country

**Thursday, Aug 7, 1997**

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1000-1200 Debrief PHN (if necessary)

*Director's Conference Room*

1400 - 1600 Present final report and draft MOU to Mission  
Team Participants Jinny, Sigrid

*Director's Conference Room*

**Friday, Aug 8, 1997**

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1400 - 1600 Final wrap-up with IFPS staff  
Team Participants Jinny, Sigrid

*Director's Conference Room*

Sigrid leaves for the USA


**AGENCY FOR INTERNATIONAL DEVELOPMENT**

**INNOVATIONS IN FAMILY PLANNING  
SERVICES (IFPS) PROJECT (386-0527)**


July 7, 1997

**TRAVEL ITINERARY - 1  
FOR TECHNICAL RESOURCE EXPERTS  
July 9-11, 1997**

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**TEAM MEMBERS**

			Dates
*	Jinny Sewell	Chief - Family Planning Services, USAID/India (team leader)	July 9-11
*	Keys MacManus	Senior Technical Advisor - Office of Field Support, Global Bureau, USAID/Washington	July 9-11
*	Alan Bornbosch	Advisor, Office of Population, Global Bureau, USAID/Washington	July 9-11
*	Samaresh Sengupta	Project Management Specialist - Family Planning Services, USAID/India	July 9-11
*	P N Sushama	Project Management Specialist - Policy Research and Evaluation, USAID/India	July 9-11

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**Wednesday, July 9, 1997**

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- 0620 Leave Delhi by Shatabdi Exp Train for Agra
- 0800 Reach Agra Check in at Hotel Taj View
- 0900 - 1100 Visit Medical Collge to observe/discuss PPC, CTU/IUCD Training NSV activity  
(Drs I C Tiwari and Alok Banerjee will meet the team)
- 1130 - 1300 Visit to OR Project area of Population Council (M E Khan of Pop Council to join them)
- 1400 - 1500 Lunch at Hotel Taj View
- 1630 - 1800 Visit to Taj Mahal
- 1900 Night halt at Hotel Taj View

**Thursday, July 10, 1997**

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- 0815 Leave Agra for Jhansi by Shatabdi Express Train
- 1045 Arrive Jhansi
- 1115-1300 Meet CMO, Jhansi and Visit District PPC for public sector strengthening activity  
(Dr Alok Banerjee to join the team)
- 1330 - 1430 Lunch at Hotel Sita
- 1500 - 1600 Meet trained ISMPs/IRMA staff at Jhansi (Intrah representative will join)
- 1600 Leave Jhansi by car for Kanpur
- 2000 Arrive Kanpur Night halt at Kanpur in Hotel Landmark

**Friday, July 11, 1997**

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- 0900 - 1130 Visit Shramik Bharti (IEC & Service Delivery in Urban Slum of Kanpur Nagar) (Lily Kak of CEDPA will accompany)
- 1200 - 1430 Visit to Amin Welfare Trust & FICCI Project under organized sector activity (Rajbir Singh and Dr D Gupta of Profit will join)
- 1500 - 1600 Lunch
- 1700 Leave for Delhi by Shatabdi Express
- 2230 Reach Delhi

**USAID****AGENCY FOR INTERNATIONAL DEVELOPMENT**

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

July 22, 1997

**TRAVEL ITINERARY - 2**  
**FOR SENIOR TECHNICAL AND POLICY EXPERTS**  
**July 29-August 1, 1997**

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**TEAM MEMBERS**

		Dates
*	John Rogosch Director - Office of Population, Health & Nutrition, USAID/India	July 29-Aug 1
*	Nils Daulaire Deputy Assistant Administrator and Senior Policy Advisor, Bureau for Policy and Program Coordination, USAID/Washington ( <b>Team Leader</b> )	July 26-Aug 2
*	Sidney Chernenkoff Director, Office of East and South Asian Affairs, Bureau for Asia and the Near East, USAID/Washington	July 26-Aug 2
*	Indra Pathmanathan Public Health Specialist, (RCH/India) World Bank, Washington	July 21-Aug 2
*	Samaresh Sengupta Project Management Specialist - Family Planning Services, USAID/India	July 29-Aug 1

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### Tuesday, July 29, 1997

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- 0600 Leave Delhi for Lucknow by CD 435
- 0655 Reach Lucknow
- 0745 Check in at Hotel Taj
- 0830 Leave Hotel Taj for St Mary's Polyclinic field site at Dewa Block, Barabanki District  
Accompanied by Dr Brigeetha of St Mary's
- 0930 - 1200 Visit Dewa and see St Mary's field activity in 2 villages
- 1300 - 1400 Lunch
- 1430 - 1600 Visit Prerana (Mr Abrar to brief about the activities)
- 1630 - 1800 Meet SIFPSA Management and other senior staff
- 2000 Dinner hosted for Ms Aradhna Johri at Hotel Taj by the team

### Wednesday, July 30, 1997

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- 0600 Leave Lucknow for Sitapur by road
- 0730 - 0900 Visit Dairy cooperative activity (at Milak Village, Khairabad block)  
(CMO, Sitapur will join the team)
- 1000 - 1100 Visit Parivar Seva Sanstha's *Urban outreach through static clinic project* in Sitapur
- 1130 - 1300 Visit Sitapur ANM training center to observe counselling skills workshop  
(Dr John Pile to meet the team at PP Centre)
- 1315 - 1415 Lunch at Hotel Mayur
- 1500 - 1700 Visit OR projects at CHC/PHC at Sidhauri and meeting with ISMPs in Sidhauri enroute  
to Lucknow
- 1715 Leave Sitapur for Lucknow by road
- 1800 Reach Lucknow Night halt at Hotel Taj

ANNEX 3

**Thursday, July 31, 1997**

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0900 - 1300 Senior Experts Team to provide comments & technical input on draft report  
Team Participants Nils, Sid, Indra, Jinny, Keys, Alan, Harry, Sigrid, Amy  
*Taj Lucknow*

1500 - 1800 Debrief meeting with GOI, GOUP, SIFPSA and USAID  
Team Participants Nils, Sid, Indra, Jinny, Keys, Alan, Harry, Sigrid, Amy  
*SIFPSA*

**Friday, August 1, 1997**

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0725 IC 436 flight to Delhi

0820 Arrival in Delhi

**LIST OF KEY CONTACTS**

**USAID/India**

Ms Linda Morse, Mission Director  
Mr Thomas A Totino, Controller  
Mr N N Wahi, Deputy Controller  
Mr N Ramesh, Program Management Specialist  
Mr John Rogosch, Director, Office of Population, Health & Nutrition  
Mr William R Goldman, Chief, Policy, Research & Evaluation Division  
Mr Samaresh Sengupta, Project Management Specialist  
Ms Sheena Chhabra, Project Management Specialist  
Dr P N Sushama, Project Management Specialist  
Ms Vathani Amirthanayagam, Population Development Officer

**Ministry of Health & Family Welfare, Government of India, New Delhi**

Mr Y N Chaturvedi, Secretary, Family Welfare  
Mr K S Sugathan, Joint Secretary  
Mr Inderjit Pal, Director (Policy)

**Government of U P**

Mr Brijendra Sahay, Chief Secretary  
Mr A P Varma, Principal Secretary, Medical, Health and Family Welfare  
Mr Lov Verma, Secretary, Family Welfare  
Dr A G Rizvi, Director General, Family Welfare

**SIFPSA**

Ms Aradhana Johri, Executive Director  
Mr Arun Sinha, Additional Executive Director  
Mr P K Sinha, General Manager (Finance)  
Mr K K Singh, General Manager (REMI)  
Mr R K Pal, General Manager (Training)  
Mr Mathur, General Manager (Public Sector)

## ANNEX 4

### Cooperating Agencies

AVSC	Dr John Pile Dr Alok Banerjee Ms Nirmala Selvam Ms Jyoti Bajpayee
CARE	Dr Y P Gupta Dr Vasanti Krishnan
CEDPA	Ms Lily Kak
CSF	Mr Kris Oswalt
INTRAH/PRIME	Ms Wilda Campbell Dr Rashmi Asif Mr Meenakshi Gautam Mr Ashok Shreshtha
JHPIEGO	Dr I C Tiwari
JHU/PCS	Mr V S Chandrasekhar Ms Sharmila Mukharji
POLICY	Dr Satyanarayana Mr Darshana Vyas Dr G Narayana Mr J S Deepak
Population Council	Dr Saroj Pachauri Dr M E Khan Mr Jayanti Tuladhar Ms Bela Patel Ms Liela Caleb Dr R B Gupta
PROFIT	Mr Rajbir Singh Dr Dhananjoy Gupta
SOMARC	Mr S S Modkar

**Donor Agencies**

Ms Christina Bierring, UNFPA  
Mr Anthony Measham, World Bank  
Dr Tom Alcedo, CARE/India  
Dr Robert Gross, ODA

**Population Foundation of India**

Dr K Srinivasan, Director

**AT THE FIELD**

**AGRA**

Dr Mrs Veena Mathur, Head, Ob & Gyn , Agra Medical College  
Dr A K Saxena, Chief Medical Officer, Agra  
Dr A K Bhardwaj, Deputy CMO, Agra  
Dr Dhir, Principal Agra Medical College

**JHANSI**

Dr L V Prasad, Chief Medical Officer, Jhansi  
Dr Bal Kishan, Deputy Chief Medical Officer, Jhansi, in charge of SIFPSA activities  
Dr Ms Savitry Aggarwal, Incharge PPC, Jhansi District Hospital  
Mr A K Sur, Indian Rural Medical Association

**KANPUR**

Dr R K Tandon, Chief Medical Officer, Kanpur  
Deputy Chief Medical Officer, Kanpur, in charge of SIFPSA activities  
Mr Ganesh Pande, Shramik Bharti  
Ms Usha Varkey, Secretary, Shramik Bharti  
Dr Rita Bose, Shramik Bharti  
Mr Iqbal Ahsan, Amin Welfare Trust  
Mr & Mrs Bhargava, Tracparts India  
Ms Sanjana Bhardwaj, FICCI, New Delhi

**LUCKNOW**

Dr V V Brigeetha, St Mary's Polyclinic  
Mr Abrar Khan, Director, PPRC  
Mrs Manju Shukla, Faculty, PPRC  
Ms Geetha Verma, Chairperson, PPRC  
Dr Ravi Anand, PPRC  
Consultant CEDPA, PPRC

**SITAPUR**

Dr O P Rai, CMO, Sitapur  
Dr Gupta, Dy CMO  
Dr Partho Roychaudhary, Consultant, CEDPA  
Mr Sharma, Coordinator, PCDF  
Dr Sudha Tiwari, Director, Parivar Sewa Sanstha  
Ms Rita Banerjee, Consultant, Parivar Sewa Sanstha  
Ms Kamala Chaturvedi, Trainer, Parivar Sewa Sanstha  
Superintendent, CHC, Sidhauri  
Ms Meena Kumari, ANM Main center, Sidhauri  
Ms Mayawati, ANM, Subcenter, Kamlapur  
Mrs Mishra, In charge, ANM Training Center, Sitapur

## RAPID ASSESSMENTS

The IFPS goal of reduction in fertility in Uttar Pradesh is to be achieved through strengthening and improving the quality of public sector services and large scale expansion of non-government projects. The plan is to test innovative projects on a small scale basis and identify and expand those projects that have greatest impact on the programme. Keeping in line with this, ten rapid assessments of innovative pilot projects have been conducted to identify successful elements of effective project implementation. The initial focus was on those that have at least two years of implementation experience. These included private sector projects such as Dairy Cooperatives, Indian Systems of Medical Practitioners, and PVO projects based on community based service delivery systems. Public sector projects assessed were the Contraceptive Technology Update Training and the implementation of the Short Term Strategy for Strengthening Public Sector Activities to provide quality sterilization services.

### Methodology

Qualitative and quantitative methodological tools have been used to collect data from different sources. The focus of data analysis has been not only to measure the extent of achievement of project objectives, but also to identify various issues related to project implementation, and scaling up of project activities. Rapid Assessments sampled the following

Eligible Women	3,344
Adolescents	309
In depth interviews	160
Interviews with government functionaries	<u>97</u>
Interviews with service providers	1,052

This apart, the assessment teams also observed on-going activities during data collection. The following table summarizes the projects covered, number and type of persons interviewed.

## ANNEX 5

### Summary of the Interviews

Sl No	Name of the Project	Type of Project	Beneficiaries Interviewed	In-depth Interviews with beneficiaries	Interviews with Government Functionaries	Interviews with Service providers
1	Safe Delivery and FW Services at Door Step in Shahjahanpur District (VSA)	CBD Project	-583 eligible women -104 adolescent girls	-30 eligible women -16 users of confinement center -23 village opinion leaders	-14 government functionaries that included CMO MOs LHV's and ANMs	-1 Project Director -8 Supervisory Staff -20 CBDs -20 Dais
2	Women s Welfare Project in Barabanki District (St Mary's)	-----do-----	-555 eligible women -105 adolescent girls	-5 users of VDC s	-15 government functionaries that included PHC medical and para medical staff	-1 Project Director -8 Supervisory Staff -37 CBDs that included 32 FGD's -15 Dais
3	Family Welfare Project in Kanpur Nagar Slums (Shramik Bharati)	-----do-----	-372 eligible women	-1 educationist	7 government functionaries representing the UFWC MCH District and Anganwadi workers	-1 Project Director 4 Supervisory Staff -8 CBDs
4	Integrated FW and Literacy Project in Lucknow District (DLC)	-----do-----	-552 eligible women - Around 100 adolescents	-16 eligible women -14 Opinion leaders	-15 functionaries that included the PHC district and 8 Anganwadi workers	-1 Project Manager -3 Supervisors -6 Literacy teachers -1 ANM of DLC
5	Rural FW Project of PCDF in Meerut and Sitapur Districts	-----do-----	-1237 eligible women	Focus group discussions with 28 couples 20 opinion leaders -3 trainers from Prerana	20 functionaries at subcenter, CHC/PHC and district	-30 staff members of PCDF that included managerial and supervisory staff, and VHV's -12 members of the DCS

162

## ANNEX 5

SI No	Name of the Project	Type of Project	Beneficiaries Interviewed	In-depth Interviews with beneficiaries	Interviews with Government Functionaries	Interviews with Service providers
6	Training of ISMP's in Sitapur and Jhansi Districts	Training for increasing access and quality of fp services	-40 fp clients	-2 Project Managers	-4 functionaries at the district level	240 ISMP s
7	CTU Workshops for Medical Officers of Public Sector	Training for updating contraceptive knowledge of MO's in public sector	Not applicable	-6 faculty members including the project coordinators	-8 in Lucknow and 14 in Meerut	296 MOs 317 ANMs LHV's and MOs who had not attended the workshop
8	The IMA FP Counsellors Training Project	Training for updating contraceptive knowledge of MO s in private sector	Synthesis of studies conducted by IMA CORT and SRI	1 person in-charge of IMA	Not applicable	1297 doctors trained by IMA before March 1995 -1562 doctors trained in the SIFPSA project
9	Short term strategy for strengthening government health services	Strengthening public sector service delivery	60 women	Not applicable	55 government functionaries includes CMOs, MOs LHV's ANMs	Not applicable
10	Short term strategy for strengthening government health services (follow up survey for benchmark validation)	Strengthening public sector service delivery	Not applicable	Not applicable	Data from 101 CHCs/PHCs were collected	Not applicable

## PVO Projects

## Key Findings

**Table 1 Awareness and Interactions Between the CBD workers and the Eligible Women**

Awareness and Interactions with CBDs	Shramik Bharati	PCDF	Vinoba Seva Ashram	St Mary's	DLC
Heard of CBD worker	74.0	36.0	61.0	94.4	24.0
Ever met with CBD	60.0	27.0	36.0	66.8	57.2
Frequency of Interaction - at least once a month	70.0	56.2	54.9	88.4	56.0

Majority of respondents interviewed informed that they had heard and met with the CBD workers

More than half of the respondents who were aware of CBD workers reported that they met with the CBD workers at least once a month

**Table 2 Method-wise Break Up of Current Users of Family Planning**

Methods/Agencies	Shramik Bharati		PCDF		Vinoba Seva Ashram		St Mary's		DLC	
	RA	BL	RA	BL	RA	BL	RA	BL	RA	BL
Sterilization	18.5	10.1	20.9	13.9	5.0	NA	6.1	NA	15.9	NA
IUCD	3.2	1.3	1.8	2.1	1.0	NA	6.5	NA	2.0	NA
Oral Pills	3.0	2.4	2.5	2.7	3.1	NA	7.4	NA	2.0	NA
Condoms	11.3	3.0	6.0	2.8	3.9	NA	16.0	NA	7.1	NA
Total	36.0	16.8	31.2	21.5	13.0	NA	36.0	NA	27.0	NA

RA Rapid Assessment BL Base line

A comparison between the estimates from baseline and rapid assessment, for projects with baseline data, indicates an increase in the contraceptive prevalence rate

Method wise analysis reveals that sterilization is still the prominent method. However, the percentage increase for spacing methods has been significant.

ANNEX 5

Table 3 Contraceptive Method Mix

Agency/Method Mix	Sterilization		IUCD		Condom		Oral Pill		Total	
	>2yrs	<2yrs	>2yrs	<2yrs	>2yrs	<2yrs	>2yrs	<2yrs	>2yrs	<2yrs
Shramik Bharati	60.1	51.4	7.7	8.9	17.9	31.4	14.3	8.3	100.0	100.0
PCDF	82.5	41.1	2.1	11.6	10.8	33.6	4.6	13.7	100.0	100.0
Vinoba Seva Ashram	66.6	11.6	0.0	16.3	16.7	48.8	16.7	23.3	100.0	100.0
St Mary's	65.8	5.6	2.6	21.6	23.7	49.4	7.9	23.4	100.0	100.0
DLC	NA	58.9	NA	7.4	NA	26.3	NA	7.4	NA	100.0

NA NOT AVAILABLE

Analysis by duration of use indicates an increase in the acceptance of spacing methods across the agencies. The percentage of users accepting condoms and oral pills have gone up in the past two years.

Table 4 Sources of Supply of Condoms and Oral Pills at the time of First Use and Current Use

Source Mix\Agency	Shramik Bharati		PCDF		Vinoba Seva Ashram		St Mary's		DLC	
	Current source	Previous source	Current source	Previous source	Current source	Previous source	Current source	Previous source	Current source	Previous source
Public Health Institution	9.6	14.3	12.0	14.6	15.4	19.2	7.9	10.1	12.0	10.0
CBD Worker	61.9	45.2	42.7	37.3	42.3	38.5	67.4	53.9	17.0	20.0
Shops	16.7	28.6	22.7	24.0	7.7	15.4	11.2	28.1	40.0	37.0
Husband/Friends/Others	11.8	11.9	22.6	24.1	34.6	26.9	13.5	7.9	31.0	33.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source Mix/Agency	Shramik Bharati		PCDF		Vinoba Seva Ashram		St Mary's		DLC	
	Current source	Previous source	Current source	Previous source	Current source	Previous source	Current source	Previous source	Current source	Previous source
Public Health Institution	9.1	9.1	25.8	29.1	20.0	13.3	9.8	9.8	10.0	30.0
CBD Worker	63.6	36.4	58.1	51.6	26.7	20.0	85.4	78.0	10.0	10.0
Shops	18.2	45.4	12.9	12.9	20.0	26.7	2.4	9.8	30.0	30.0
Husband/Friends/Others	18.2	9.1	3.2	6.4	33.3	40.0	2.4	2.4	50.0	30.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

CBD workers emerged as major source of supply for condoms and oral pills.

Comparison of previous and current sources of contraceptive use indicates a clear shift from other sources to the CBD. This shift is mainly due to CBD approach which improved access to contraceptive supplies.

15

**Table 5. Sources of Information Before Eligible Couples Began Using the Contraceptive Methods**

Sources of information for Oral Pills	Shramik Bharati	PCDF	Vinoba Seva Ashram	St Mary's	DLC
Public Health Institution	18 2	19 3	6 7	4 9	20 0
CBD Worker	45 4	58 1	46 7	82 9	20 0
Pvt Practitioners/ISMPs	9 1	3 2	- -	---	-
Husband/Friends/Others	27 3	19 4	13 3	12 2	60 0
Total	100 0	100 0	100 0	100 0	100 0

Sources of information for Condoms	Shramik Bharati	PCDF	Vinoba Seva Ashram	St Mary's	DLC
Public Health Institution	19 1	10 0	19 2	14 5	9 8
CBD Worker	47 6	37 0	30 8	73 0	4 7
Pvt Practitioners/ISMPs	---	---	---	- -	31 8
Husband/Friends/Others	33 3	53 0	50 0	12 5	53 7
Total	100 0	100 0	100 0	100 0	100 0

Sources of information for IUCDs	Shramik Bharati	PCDF	Vinoba Seva Ashram	St Mary's	DLC
Public Health Institution	16 7	50 0	71 4	14 5	20 0
CBD Worker	33 3	9 0	--	73 0	10 0
Pvt Practitioners/ISMPs	25 0	4 5	---	--	---
Husband/Friends/Others	25 0	36 5	28 6	12 5	70 0
Total	100 0	100 0	100 0	100 0	100 0

Sources of information for Sterilization	Shramik Bharati	PCDF	Vinoba Seva Ashram	St Mary's	DLC
Public Health Institution	17 3	69 0	68 0	8 8	85 0
CBD Worker	2 9	---	- -	---	5 0
Pvt Practitioners/ISMPs	10 3	29 0	- -	---	-
Husband/Friends/Others	69 5	2 0	32 0	91 2	10 0
Total	100 0	100 0	100 0	100 0	100 0

Main sources of information for condoms and oral pills have been the CBD workers followed by husband/friends/others

In case of clinical methods, and particularly sterilization the major sources of information were the public health institutions and husband/friend/others

**Recommendations**

Select NGO's who have prior experience with community based projects

Local structural constraints such as caste system and location and size of villages should be taken into consideration while recruiting CBD workers

CBD workers should be selected in collaboration with the community

CBD approach should have both male and female CBD workers

Need based capacity building to strengthen NGO's is required

NGO MIS has to be streamlined

Use client centered approach to meet unmet need

Establish linkages between public and private sector units for referrals

Ensure constant supply of contraceptives

**Issues for Scaling Up**

CBD approach has potential in increasing access to services and meeting the unmet demand

Activities to be scaled up in a phased manner so that lessons learnt are incorporated to refine on-going projects and develop future projects

Advance planning early on in the project is necessary to ensure public and private linkages and contraceptive supplies

Coordinated efforts among and within agencies working in the district are essential

21

## ISM Practitioners

## Key Findings

A total of 51 training programmes were conducted in the last 18 months

940 ISM practitioners were trained during this period (545 in Sitapur and 395 in Jhansi) of which 40 were female practitioners

**Table 1 Percentage of ISMP's Reporting Their Client Load After The Training**

Client Load	Jhansi	Sitapur
Increased	47 0	57 0
Remained Same	51 0	42 0
Declined/DK	2 0	1 0
Total	100 0	100 0

Overall, the general client load of the ISMPs increased after the training

About half of the respondents in Jhansi reported that the client load remained the same while their counterparts in Sitapur felt that the client load had increased after the training

**Table 2 Percentage of ISMP's Providing FP Services**

	Jhansi		Sitapur	
	Condoms	Oral Pills	Condoms	Oral Pills
Three months before training	43 0	30 0	34 0	31 0
Three months after training	69 0	62 0	59 0	58 0

Percentage of ISMPs providing family planning services during the reference period increased in both the districts

The number of oral pill clients in Sitapur has gone up from 738 to 2213 and in Jhansi it has increased from 119 to 490

Number of condom clients in Sitapur increased from 556 to 1608 while an increase from 510 to 1090 clients was observed in Jhansi

Of those practitioners providing family planning services, 51% were depending on

public sector for contraceptive supplies, 29% were buying from the commercial outlets and the remaining 20% procured their supplies from social marketing agencies

### **Recommendations**

Train all practitioners who are registered with a recognized body

Conduct census of all practitioners before conducting training

Capacity building of a local based professional training institution

Flexibility in training duration and timing to meet the needs of ISMP's

Modify training curriculum to suit the needs of ISMP's

The qualifications of ISMP trainers has to be redefined and their salary levels need to be revised to ensure quality and retention of faculty

Utilize existing training infrastructure and involve public sector medical officers in ISMP's training

Monitoring Information System has to be streamlined

Strengthen network between public and private sector units for supplies and referrals

Ensure constant supply of contraceptives

### **Issues for Scaling Up**

The ISMP training has potential in increasing access and demand for family planning services

Identify and develop a local professional training institution for training of trainers

Identify alternate approaches to cover more number of ISM practitioners in a shorter period without effecting the quality of training

Advance planning early on in the project is necessary to ensure coordination between ISMP's and public sector for better contraceptive supplies and referrals

**Contraceptive Technology Update Workshops-  
Training of Public Sector Medical Officers**

**Key Findings**

A total of 71 workshops have been held by all the six medical colleges in UP till March, 97

Till date, over 1500 doctors have been trained

Contraceptive updates have increased the knowledge of medical officers

Retention of knowledge was found to be high in the districts covered by the two medical colleges

Retention of knowledge of female MOs was higher than that of the male MOs. High level of involvement of the female MOs in family planning service delivery is the main reason for higher retention levels of knowledge

Above two-thirds of the MOs interviewed had introduced changes in Infection Prevention Practices and Counseling

Significant changes were reported in regard to advise on use of oral pills. However, only half of the MOs mentioned about pelvic examination before prescribing oral pills or advising minilap operations

A high percentage of MOs have shared the contraceptive knowledge to other MOs and para medical staff

The topics discussed and skills transferred by MOs in Meerut were limited to Infection Prevention and Counseling, whereas in Lucknow, MOs had uniformly discussed all the topics of the CTU

In Lucknow, none of the trainers considered CTU training as an additional burden but 30 percent of trainers from Meerut felt otherwise

Trainers from Lucknow rated all components of training as excellent or good while in Meerut the trainers felt that case teaching and use of transparencies was poor

Late arrival of participants affected the training

Reference materials were being rarely used by the MOs

A third of MOs interviewed suggested that the books should be translated in Hindi

There was no standard criteria of nominating MOs to the workshop

### **Recommendations**

There is a need to standardize the selection criteria as retention of knowledge is closely linked to the extent MOs were able to practice at their workplace

Reference material should be made available in English and Hindi

MOs should be trained on how to share information with colleagues

Relationship between skills imparted in training should be linked to availability of resources

Inter-institutional variations in commitment levels should be considered before preparing training strategies

### **Scaling Up**

Nomination procedure and selection criteria should be standardized

Institutionalization of training in terms of identifying training institutions and have trained trainers Periodic review of their institution is needed

A core group of trainers have to be developed in the State

Periodic review of training package has to be carried out

Advance planning early on in the project is necessary to ensure better coordination between training institution and the public sector

Linkages between non-clinical and clinical training need to be ensured

The CTU training should be incorporated as part of the medical curriculum

### **Indian Medical Association FP Counselor's Training Project**

#### **Key Findings**

IMA Provided 18 hour training to its members in three sessions

Trained 1562 doctors with the help of its 71 branch offices by September 1995

Training modules and participatory training methods were found to be effective

Increase in knowledge levels of trainees is found significant

There is a positive and sustained attitude change to FP counseling

There is an increase in proportion doctors providing FP services

Frequent changes of office bearers, lack of detailed data base on IMA members, inadequate IEC support, lack of comprehensive CSM on a visible scale and need for continuing support to trained members had adverse impact on the project

IMA has limited institutional resources to support administration of projects

#### **Recommendations**

Review of data, provider and client targeted IEC and CSM needs to be introduced,

IMA institution capacity development to encourage decentralization, networking and prioritized ownership transfer for sustainability should be integral in the project design

#### **Scaling -up Issues**

Limited institutional, capacity to sustain the program, difficulty in attracting key specialists through their network to participate in the training, and inadequate follow-up for IEC/promotional support, supply linkages and continuing education , limits the scope of this project to scale-up

**Rapid Assessment of Short-Term Strategy to  
Strengthen Public Sector Delivery System**

**Key Findings**

Supply of generator sets were not according to specifications in-terms of Indian Standards Institution (ISI) marks, capacity and direct supply to CHCs/PHCs. In some districts, gensets were supplied but not installed. In some districts improper installation was observed. Monitoring of installation of gensets was not done by the Directorate.

All divisions have not received all items under equipments and instruments. There is a considerable gap in distribution of items from divisions to CHCs/PHCs. Many CHCs/PHCs have the same instruments supplied under CSSM or IPP projects. Many CHCs/PHCs considered the equipment and instruments supplied not useful.

Out of 15 CHCs/PHCs visited only 7 were supplied with medicine boxes and only 3 CHCs/PHCs distributed medicine boxes so far.

Distribution of boxes depended on number of sterilizations performed.

Most CMOs asked MOs to spend money for fuel first and submit receipts for reimbursement.

Samples of wall paintings were sent to all districts by SIFPSA. Many wall paintings were done without specifications.

Of the 66 blocks which were to be benefitted with water supply, 21 blocks completed work, 12 blocks work is in progress and work to start in 33 blocks. Money allocated to improve water supply in PHCs/CHCs was less for some blocks and more for some blocks.

Private Lady medical officers weekly visit to PHCs is working well as client load to seek various reproductive health services has increased. However there are problems to find Private Lady Doctors.

Half of the districts were supplied with follow-up cards and stickers. However, none of the districts in the sample have received them.

## **Recommendations**

Allocation of resources should be specific to the needs of the health institutions  
Duplication of resources and effort could be avoided if a need based approach is followed

Involvement of lady medical officers is a useful intervention and be sustained and expanded

## **Scaling-up Issues**

Annual maintenance contract to continue proper functioning of the gensets is needed

Cost of fuel to run the gensets is essential

Plans should be made to increase the mobility of the lady doctors and ANMs to provide reproductive and family planning services

## **Evaluation of Achievement of Benchmark 26 of IFPS Project Short-Term Strategy to Strengthen Public Sector Delivery System**

### **Key Findings**

83 percent of total CHCs and PHCs have generator sets and in one third of these CHCs and PHCs, two or more generator sets are available

78 percent of CHCs and PHCs have gensets in working condition and 77 percent of CHCs and PHCs have gensets connected to regular electric supply system indicating their use in case of need

More than 76 percent of CHCs and PHCs have all items of basic equipment supplied to health institutions under different schemes

All CHCs and PHCs have been supplied with medicine kits for sterilization acceptors and they have been distributed to 69 percent of total sterilization acceptors. Stock of medicine kits is also comfortable in almost all PHCs and CHCs

Para-medical workers have visited 85 percent of sterilization acceptors for follow up

services. One of the reasons for this high level of follow up is a small number of sterilization acceptors.

The above findings confirm that the Directorate of Family welfare, the implementing agency of the Short term Strategy has achieved all required levels of performance given in benchmark 26.

### **Recommendations**

A need assessment of facility should be undertaken before planning a state wide supply of equipments, instruments and any other basic facilities required to provide family planning services.

### **Scaling -up issues**

Maintenance of the gensets for proper functioning and fuel to run the genset should be undertaken.

**LIST OF TRAINING MATERIALS****TRAINING MANUALS**

- 1 Reproductive Health Manual for Trainers of Community Health Workers (English and Hindi)
- 2 Community Mobilization and Service Delivery Manual for Trainers for Community Health Workers (English and Hindi)
- 3 Handbook for Community Health Workers (English and Hindi)
- 4 Management Training Manual for Managers (English)
- 5 Supervision Training Manual for Managers (English)
- 6 "Choose a Future " Training Manual for Adolescent Girls (Original in English Hindi adaptation being finalized)
- 7 "Your Future is Yours " Training Manual for Adolescent Boys (Hindi, under preparation)
- 8 Guidelines for Proposal Development
- 9 Critical Skills Checklist for assessing reproductive health quality of care
- 10 MIS system for NGOs record-keeping forms, family cards, monthly summary forms, quarterly report forms (Hindi)
- 11 Standardized Minilaparotomy under local anesthesia Training Package for Uttar Pradesh - jointly produced with JHPEIGO Corporation
  - I) Reference Manual
  - ii) Course Notebook for Trainers
  - iii) Course Handbook - Guide for Participants
  - iv) Minilaparotomy Photo Video
- 12 Laparoscopy under local anesthesia Training Package for Uttar Pradesh - jointly produced with JHPIEGO Corporation

## ANNEX 6

- I) Reference Manual
  - ii) Course Notebook for Trainers
  - iii) Course Handbook - Guide for Participants
  - iv) Laparoscopy Photo Video
- 
- 13 No-Scalpel Vasectomy - An Illustrated Guide for Surgeons
  - 14 No-Scalpel Vasectomy Training Curriculum - Draft
  - 15 FP Counseling Skill Workshop Trainers Guide
  - 16 Counseling Skill Reference materials (participants hand out)
  - 17 Target Free Approach Orientation for District level personnel - A Facilitators' Guide
  - 18 Target Free Approach Orientation for Block level personnel - A Facilitators Guide
  - 19 Prevention of Infection - Asepsis and Antisepsis Issues
  - 20 Infection Prevention Practices - Desk Reference
  - 21 IUCD Manual for UP
  - 22 MINILAPAROTOMY Manual for UP
  - 23 Resource Manual for ANM Training
  - 24 English and Hindi translation of 'Innovations in Family Planning Services (IFPS) Project, U P Volume I Training Manual' for Indigenous Systems of Medicine and Homeopathy Practitioners' Training project in Non-Clinical Methods of Family Planning
  - 25 IEC Training Manual - 1995

**OTHER TRAINING MATERIALS**

- 1 Trainer's Notebook for CTU workshops
- 2 Presentation Graphics for Trainers for CTU workshops
- 3 Trainer's Notebook for IUCD
- 4 Training Photo video for IUCD Refresher Workshops
- 5 Standardization of Minilaparotomy Training
- 6 Trainer's Notebook for Minilaparotomy
- 7 Participant's Handbook for Minilaparotomy
- 8 Minilaparotomy training Photo video
- 9 Laparoscopy Manual for U P
- 10 Trainer's Notebook for Laparoscopy
- 11 Participant's Handbook for Laparoscopy
- 12 Laparoscopy Training Photo video
- 13 Trainer's Notebook for ANM Training
- 14 Clinic-based training approach to standardize IUCD skills of ANM

**RESEARCH PAPERS**

- 1 Concept Paper on Reproductive and Child Health
- 2 Paper on Policy Framework
- 3 Paper on Monitoring and Evaluation Plan for SIFPSA

## ANNEX 6

- 4 Paper on Sex and Family Violence in Uttar Pradesh
- 5 Potential for Social Marketing in Uttar Pradesh
- 6 Major Survey Effort Provides Data for Family Welfare Programme Planning and Policy (1995)
- 7 A Situation Analysis of Public and Private Health Care Services Uttar Pradesh (1996)

### **RAPID ASSESSMENT REPORTS**

- 1 Safe Delivery and Family Welfare Services At Door Step in Shahjahanpur District
- 2 Women's Welfare Campaign in Barabanki District
- 3 Family Welfare Project in Kanpur Nagar Slums
- 4 Integrated Family Welfare Project and Literacy Project in Lucknow District
- 5 Rural Family Welfare Project of PCDF in Meerut and Sitapur Districts
- 6 Training of Registered Ayurvedic, Unani and Homeopathic Practitioners in Jhansi and Sitapur Districts
- 7 Contraceptive Technology Update Workshops for Medical Officers of Public Sector
- 8 The IMA Family Planning Counselors Training Project
- 9 Short Term Strategy Intervention in the Public Sector
- 10 Benchmark 26
- 11 Parivar Seva Sanstha in Sitapur

- 12 Scaling Up and Sustainability Strategies of Innovative Family Welfare Projects in Uttar Pradesh

#### **DISTRICT ACTION PLANS**

- 1 Rampur
- 2 Tehri Garhwal
- 3 Shahjahanpur

#### **STRATEGY PAPERS/DOCUMENTS**

- 1 Family Planning Service Delivery in the Public Sectors in Uttar Pradesh - Feb 1995
- 2 Infection prevention Workplan for IFPS Project activities - January 1996
- 3 AVSC's Strategy for addressing the Benchmark E, Sub-Objective 1 - March 1996
- 4 Action Plan for Public Sector Services during Phase I - June 1996
- 5 Strategy for Strengthening and Clinical Training in District Post Partum Centers - June 1996
- 6 Strategy for Strengthening Rural PPCs, CHCs and PHCs in UP - August 1996
- 7 Strategy for Strengthening Counseling Skills for service providers in CHCs and PHCs - December 1996
- 8 Operations Research Strategy India (September 1995)
- 9 Plan for Operations Research programme with the Ministry of Health and Family Welfare in Sitapur and Agra districts, Uttar Pradesh (October 1995)

## ANNEX 6

- 10 Initiating policy dialogue with policy makers and managers of India's family welfare programme A Plan of Action, 1997
- 11 Dissemination Strategy ANE OR/TA (1995) Sanjeev Kumar & Sahar Hegazi

### PUBLICATIONS/REPORTS

- 1 *Innovations* - SIFPSA Newsletter
- 2 "Friends of the Community Integrating Health and Community Development in the Urban Slums of Kanpur" (draft case study of Shramik Bharti project, pending SIFPSA approval for publication)
- 3 "Beautiful Lucknow Literate Lucknow, Literate Family Planned Family" (draft case study of District Literacy Committee, pending SIFPSA approval for publication)
- 4 Strategy for Involvement of Potential Voluntary Organizations in FW Program
- 5 An Inventory of Hindi Belt Women's Organizations with Potential to Implement FP Programs

EVALUATION OF ACHIEVEMENT OF BENCHMARK 26 OF IFPS PROJECT  
IN  
UTTAR PRADESH

March 12, 1997

The POLICY Project, The Futures Group International, New Delhi

and

AIMS Research, New Delhi

18/11/97

## EVALUATION OF ACHIEVEMENT OF BENCHMARK 26 OF IFPS PROJECT IN UTTAR PRADESH

SIFPSA based on the situation analysis of the public sector health service delivery system and after a series of meetings with the officers of the Directorate of Family Welfare evolved a short term strategy to strengthen the service facilities in the public health institutions. The main objectives of the short term strategy are to (1) convert the camp based sterilization programme to one providing continuous availability of services and care (2) fulfill the large unmet demand for sterilization (3) provide essential health and family welfare services specially reproductive health services and (4) to promote spacing services in one block of each district of the state.

To enable achievement of these programme objectives inputs of generators, surgical packages and medicines were provided to select CHCs and PHCs throughout the state on as needed basis to fill up gaps and complement existing equipment/supplies already in place. These supplementary inputs funded by SIFPSA would then equip all PHCs and CHCs to carry out the programme to provide continuous quality sterilization services and follow up to clients.

The Innovations in Family Planning Services Project in Uttar Pradesh follows performance based disbursement system which largely governs the financial transactions between the USAID, the GOI and the SIFPSA. For the short term strategy project the benchmark is

*Implemented state-wide program for strengthening government health infrastructure for voluntary sterilizations, spacing methods and reproductive health according to Action Plan*

Fulfillment of this benchmark depends on three indicators and these are

*(1) 75 percent of PHCs and CHCs in the State with available electrical power through operational generators*

*(2) 75 percent of PHCs and CHCs equipped with basic surgical package and drugs, and*

*(3) 50 percent of sterilization cases followed up with drug packet, visit and referral if necessary*

The broadly termed indicators require operational definitions to measure achievement.

### OPERATIONAL DEFINITIONS

The following operational definitions have been used for each of the terms in the list of indicators for benchmark 26.

**1. Generator Sets** - 75 percent of PHCs/CHCs have generator sets irrespective of source connected to the electrical wiring and are in working condition at a given time.

**2. Surgical Package** - Surgical equipment supplied under short term strategy includes

1. Automatic electrical
2. Stainless steel sterilizer
3. Dressing drum brass  
225 mm x 225 mm

- 4 Dressing drum brass  
275 mm x 240 mm
- 5 Stove four burner
- 6 Stove two burner
- 7 IV stand
- 8 Petromix
- 9 Forceps automatic straight Kelly
- 10 Forceps sponge holding straight
- 11 Forceps tissue spring type (1x2 teeth)
- 12 Forceps tissue spring type (1x5 teeth)
- 13 Forceps uterine vulselum straight
- 14 Forceps vaginal Sims medium blade
- 15 Curette uterine blunt Thomas
- 16 Dilator uterine

75 percent of PHCs and CHCs should have all major surgical instruments and equipment at the time of site visit. For the purposes of doing this, stove with two burners and stove with four burners are considered as one item. Similarly, forceps automatic straight Kelly and forceps automatic holding straight are considered as same and forceps tissue spring type (1 x 2 teeth) and forceps tissue spring type (1 x 5 teeth) are treated as one category. It is necessary to do this because CHCs/PHCs covered by other projects have supplied only one set of these items and therefore, categorisation gives a clearer picture of availability of all basic items of equipment. Data collection was done in all PHCs and CHCs whether provided assistance by IFPS or not.

**3 Supply of Medicines** Medicines were supplied to at least 75 percent of CHCs and PHCs in the past one year under short term strategy project.

#### 4 Sterilization Acceptors

**4.1 Medicine boxes** Verification for this will be based on number of sterilization operations done in a given period (excluding those acceptors who are from PHC area but operated outside the area) and proportion given medicine boxes.

**4.2 Follow Up of Acceptors** Verification for this will be based on records and/or reports of ANMs maintained at subcentre level or submitted to PHC with information on number of sterilization acceptors motivated and number given follow up services in a stipulated time period.

#### SAMPLE DESIGN

Uttar Pradesh has five distinctly identified regions. From each of Western, Central and Eastern regions given their size, two districts were selected randomly. From Hill and Bundelkhand regions one district each was selected. A total of 8 districts in the state were randomly selected for evaluation of achievement of benchmark indicators. From each selected district all CHCs/PHCs were covered.

**Table 1 Number of CHCs and PHCs in each selected district and number of CHCs and PHCs covered for data collection**

	Name of the district	Total number of CHCs and PHCs in the district			Number of CHCs and PHCs covered for data collection		
		PHCs	CHCs	Total	PHCs	CHCs	Total
01	Bareilly	11	02	13	11	02	13
02	Firoz abad	08	01	09	08	01	09
03	Gorakhpur	15	05	20	15	02	17
04	Jhansi	05	03	08	05	03	08
05	Lucknow	06	02	08	06	02	08
06	Meerut	16	02	18	16	02	18
07	Nainital	11	02	13	10	02	12
08	Varanasi	13	04	17	13	03	16
	Total	85	21	106	84	17	101

The table 1 gives the details of total number of CHCs and PHCs in each district and the number of PHCs and CHCs covered. Details of the names of CHCs and PHCs in each district, the names of medical officers or other personnel interviewed and the date of interview are given in appendix 1. Names of all CHCs and PHCs in the district have been collected from the district head quarters. Investigators visited all CHCs and PHCs and collected information from the concerned medical officers and store keepers. examined the records and physically verified the items.

Out of total 85 PHCs in all 8 districts information was collected from 84 PHCs (99 percent). Of the total 21 CHCs in these districts information was collected from 17 CHCs. A total of 4 CHCs and one PHC could not be covered mainly due to non availability medical officers at the time of data collection. They were either on leave or were attending the training programmes. The coverage rate is above 95 percent and is very high.

The schedule designed by POLICY in consultation with USAID is based on the operational definitions given to the terms in the list of benchmark indicators. The interview schedule consisted of four sections dealing with identification details of CHCs and PHCs selected, generators sets, equipment, medicine kits and follow up services to sterilization acceptors.

#### GENERATOR SETS

Information from all selected CHCs/PHCs has been collected to know whether CHCs/PHCs have any generators sets given to them under any scheme. If CHCs and PHCs have generator sets, the number of sets they have at the time of interview was recorded.

Different agencies supplied these generators at different points of time. Some of the recent projects that have supplied generator sets are Child Survival and Safe Motherhood, Innovations in Family Planning Services Project, Social Safety Net, and India Population Project VI. In addition to these projects funded by external agencies, regular planning of district health and family welfare has a component of generator sets. Information has been collected from CHCs and PHCs on sources of supply of generator sets.

Crucial aspect of generator sets is the working condition of generator sets supplied to CHCs and PHCs. Information has been collected to know the proportion of CHCs and PHCs having gensets.

ANNEX 7

in working condition and their connection to regular electric supply system indicating their utilization in case of need Table 2 on Availability, Sources of Supply and Working Condition of Generator Sets in 8 Districts provides complete information related to gensets

Of the total 101 CHCs and PHCs covered for data collection, 84 CHCs and PHCs (83.2 percent) have generator sets. All CHCs and PHCs in Jhansi, Lucknow, Meerut and Varanasi districts have generator sets. Almost all CHCs and PHCs in Bareilly (92.3 percent) and Nainital (91.7 percent) districts also have generator sets. In Gorakhpur district only 11 CHCs and PHCs (65 percent) out of total 17 CHCs and PHCs have generator sets. In Firozabad district, none of the CHCs and

Table 2 Availability, Sources of Supply, and Working Condition of Generator Sets in 8 Districts of UP

		Total	Bareilly	Firozabad	Gorakhpur	Jhansi	Lucknow	Meerut	Nainital	Varanasi
01	CHCs/PHCs covered	101	13	9	17	8	8	18	12	16
02	CHCs/PHCs having gensets	84	12	0	11	8	8	18	11	16
03	PC of CHCs/PHCs having gensets	83.2	92.3	0.0	64.7	100.0	100.0	100.0	91.7	100.0
04	Total gensets	124	16	0	11	15	12	21	14	35
05 Percentage of CHCs and PHCs having one or more gensets										
	One	52.0	61.5	0.0	64.7	25.0	50.0	83.3	83.4	12.5
	Two	25.0	30.8	0.0	0.0	62.5	50.0	16.7	0.0	56.3
	Three +	7.0	-	0.0	0.0	12.5	0.0	0.0	8.3	31.3
	None	17.0	7.7	0.0	26.3	0.0	0.0	0.0	8.3	0.0
06 Percentage of CHCs and PHCs having gensets from different sources										
	IFPS	41.1	25.0	0.0	72.7	66.7	50.0	19.0	35.7	40.0
	CSSM	0.8	0.0	0.0	9.1	0.0	0.0	0.0	0.0	0.0
	SSN	17.7	6.3	0.0	0.0	0.0	0.0	33.3	7.1	37.1
	IPP VI	8.1	6.3	0.0	0.0	6.7	8.3	23.8	14.3	0.0
	Department/Others	32.3	62.5	0.0	18.2	26.6	41.7	23.8	42.9	22.9
07 Percentage of gensets in working condition										
	Percentage of gensets in working condition to total gensets	83.0	68.8	0.0	81.2	93.4	66.7	100.0	92.8	77.1
	Percentage of CHCs/PHCs having gensets in working condition	78.2	76.9	0.0	70.6	100.0	62.5	100.0	91.7	93.8
08 Percentage of CHCs/PHCs having gensets connected to the electric supply system										
	Connected	77.0	84.6	0.0	82.4	87.5	75.0	83.3	86.7	87.5
	Not connected	33.0	15.4	0.0	17.6	12.5	25.0	16.7	13.3	12.5

PHCs have generator sets. Under IFPS short term strategy project, 8 generator sets were supplied to Firozabad and all of them are in the warehouse in Usayeni PHC. They have not yet been distributed to CHCs and PHCs in the district. Firozabad is a newly carved district and many of the CHCs and PHCs in the district do not have enough space to spare a separate room to prepare platform and mount 10 KVA generator sets. Theoretically all CHCs and PHCs have gensets, for the purpose of calculation these gensets in Firozabad have not been taken into consideration.

Some of the CHCs and PHCs have more than one generator set supplied under different schemes or projects by the department. A total of 124 gensets are available in 84 CHCs and PHCs. While 52 percent of total CHCs and PHCs have gensets, 25 percent have two gensets and 7 percent have 3 or more gensets. At the same time 17 percent of CHCs and PHCs do not have even a single genset. IFPS project is the main source for 41 percent of CHCs and PHCs, other projects covered 26.6 percent of gensets and 32.3 percent of CHCs and PHCs got gensets from department resources.

Of the total 124 gensets in the 8 districts 83 percent are in working condition and out of total 101 CHCs and PHCs, 78.2 percent centres have gensets in working condition. More or less same proportion of CHCs and PHCs have gensets connected to the electrical system indicating the regular use of gensets. It is, however, found that connection to the electrical system is not a very good indicator of use. Most of the CHCs and PHCs have temporary connection between generator set and regular electrical system. Only when needed particularly at the time of camps, CHCs and PHCs use this connection and otherwise generator set is kept in the store room for reasons of safety and security. Therefore, generator set in working condition is a better indicator of its use.

## EQUIPMENT

As part of the short term strategy, to encourage high quality institution based sterilization operations, equipment and instruments necessary to do sterilization operations were provided to all CHCs and PHCs. A total of 16 items were distributed to CHCs and PHCs not covered by any other scheme or projects earlier. Information has been collected from all CHCs and PHCs about the availability of these items at the time of survey and the scheme under which these instruments have been given.

Basic list of equipment, supplied by different projects or department schemes, including IFPS Project consists of the following items:

- 1 Autoclave electrical
- 2 Stainless steel sterilizer
- 3 Dressing drum brass 225 mm x 225 mm or 275 mm x 240 mm or any other size
- 4 Stove four or two burner
- 5 IV stand
- 6 Petromax
- 7 Forceps automatic straight Kelly or forceps sponge holding straight
- 8 Forceps tissue type (1 x 2 teeth) or (4 x 5 teeth)
- 9 Forceps uterine vulselum straight or vaginal slims medium blade
- 10 Curette uterine blunt thomas
- 11 Dilator uterine

Not many medical officers are aware of the projects under which these equipment were purchased by the department. Even in the stock registers there is no provision to know about the source. Information on sources of supply, therefore could not be collected. Table 2 gives the details of

Table 3 Percentage of CHCs and PHCs with Basic Items of Equipment

	Equipment	Total	Bareilly	Firozabad	Gorakhpur	Jhansi	Lucknow	Meerut	Nainital	Varanasi
01	Autoclave	92.6	92.3	66.7	100.0	100.0	75.0	100.0	100.0	93.8
02	Stainless steel sterilizer	96.8	100.0	88.9	100.0	100.0	100.0	100.0	91.7	93.8
03	IV stand	89.5	100.0	77.8	100.0	100.0	100.0	77.8	75.0	93.8
04	Petromax	78.9	53.8	88.9	81.8	100.0	62.5	100.0	58.3	87.5
05	Dressing drums	95.8	100.0	88.9	100.0	100.0	100.0	94.4	100.0	87.5
06	Stove	76.8	76.9	88.9	54.5	100.0	87.5	66.7	66.7	87.5
07	Forceps straight kelly /holding Straight	92.6	100.0	77.8	100.0	100.0	100.0	88.9	100.0	81.3
08	Forceps tissue spring type	75.7	76.9	66.7	72.7	100.0	62.5	66.7	83.3	75.0
09	Forceps uterine vulselum	89.5	84.6	77.8	100.0	100.0	100.0	100.0	83.3	81.3
10	Curette uterine blunt thomas	73.5	76.9	44.4	81.8	87.5	50.0	94.4	83.3	75.0
11	Dialator uterine	92.6	76.9	77.8	100.0	87.5	87.5	83.3	75.0	75.0

percentage of CHCs and PHCs in each district having the basic items of equipment. In the appendix 2 details of availability, quantity and sources of supply of equipment is given in Table 3.

More than 75 percent of CHCs and PHCs have all items of equipment. Infact some of this equipment is in excess in some CHCs and PHCs. What is needed at CHC/PHC level is inventory of all equipment, condemnation of equipment that could not be repaired and re distribution of equipment in excess in a particular institution to other institutions in need. All these basic items of equipment are being used by CHCs and PHCs to conduct sterilization camps. In case of items of equipment not available, CHCs and PHCs borrow them from district hospitals on the days camps are conducted. IFPS inputs considerably helped CHCs and PHCs to have basic items of equipment to provide quality of sterilization services.

### MEDICINE KITS

To improve quality of services medicines kits were supplied all CHCs and PHCs in the state who are in turn expected to give these kits to sterilization acceptors. Each medicine kit contained tetracycline capsules, paracetamol tablets, bruffen tablets, and B-complex tablets. Directorate of Health and Family Welfare contracted this component to the UPDPL. First round of supply of medicines commenced on March 29 1996 and all districts in the state were supplied required quantity of medicine kits by August 1996. The distribution of medicine kits at CHC and PHC level to sterilization acceptors has begun in the month of September 1996. Information was collected from all CHCs and PHCs in each selected district on number of medicine kits supplied, number distributed to sterilization acceptors and number of kits in stock at the time of survey (Table 4).

**Table 4 Medicine Kits Supplied, Distributed and in Stock**

	Name of the district	Total medicine kits supplied	Total medicine kits distributed to sterilization acceptors	Total medicine kits available in stock	Total sterilization acceptors	Percentage of acceptors given medicine kits
01	Bareilly	1,400	245	1,155	709	34.6
02	Girozabad	4,694	1,250	3,444	1,650	75.8
03	Gorakhpur	1,600	631	969	756	83.5
04	Jhansi	3,305	2,440	865	2,779	87.8
05	Lucknow	510	100	410	1,238	0.8
06	Meerut	2,353	1,373	980	2,199	63.1
07	Nainital	1,347	855	499	1,642	52.1
08	Varanasi	5,050	3,765	1,285	4,338	86.8
	Total	20,259	10,659	9,600	15,311	69.6

All CHCs and PHCs in the selected districts have received medicine kits. Total number kits supplied however varied from minimum of 510 in Lucknow district to a maximum of 5,050 in Varanasi district. Percentage of medicine kits distributed to sterilization acceptors varied from 0.8 percent in Lucknow district to 88 percent in Jhansi district. Distribution of kits to a large extent depends on sterilization performance of the district. High performance districts such as Jhansi, Varanasi and Nainital distributed more kits than low performance districts such as Lucknow and Bareilly. Of the total 15,311 sterilization acceptors up to December 96 in these 8 districts, 10,659 acceptors (69.6 percent) were given medicine kits. The sterilization performance in almost all

districts, due to introduction of self determined target approach has declined considerably in 1996-97 compared to 1995-96. Medicine kits available in stock in some of the districts are sufficient to cover all sterilization acceptors in the next fiscal year as well.

#### FOLLOW UP SERVICES TO STERILIZATION ACCEPTORS

Supply of medicine kits and additional POI budget to facilitate use of vehicles are expected to result in better follow up services to sterilization acceptors. Information has been collected on number of sterilization operations done by each of the selected CHCs and PHCs within and outside PHC/CHC area from September to December 1996, number of camps conducted during this period and number of sterilization acceptors given follow up services. Details of the findings are given in table 5.

Table 5 Percent age of Sterilization Acceptors Given Follow Up Services

Name of the district	Number of CHCs and PHCs covered	Number of camps conducted	Number of sterilization acceptors from CHC/PHC area	Number of sterilization acceptors from outside CHC/PHC area	Total sterilization acceptors	Percentage of acceptors given follow up services
Bareilly	13	49	101	383	484	77.3
Firozabad	9	49	53	075	128	100.0
Gorakhpur	17	104	406	201	607	95.4
Jhansi	8	82	1245	55	1300	35.8
Lucknow	8	9	359	205	564	81.9
Meerut	18	59	401	647	1048	100.0
Namital	12	75	618	95	713	80.5
Varanasi	16	512	1775	444	2219	91.8
Total	101	939	4958	2105	7063	85.1

Most of the CHCs and PHCs have hardly conducted any sterilization camps. The number of camps conducted varied from 9 in Lucknow district to 512 in Varanasi district. Number sterilization acceptors who availed services at these camps also varied from 53 to 1,775. On an average each camp served about 5 sterilization acceptors. In some of the districts with low sterilization performance the number of sterilization acceptors who availed services outside CHC/PHC area has exceeded the total performance of all CHCs and PHCs in the district. In Bareilly district 383 availed services outside health institutions compared to only 101 from CHC/PHC facilities. Similar is the situation in Firozabad and Meerut districts. In districts where the number camps conducted is high the sterilization acceptors who availed services of CHCs and PHCs is higher than the sterilization acceptors who were operated outside CHC and PHC areas. In all most all districts except for Jhansi district the follow up services given to sterilization acceptors is above 75 percent. In all selected districts 85.1 percent of sterilization acceptors have been visited by para-medical workers to provide follow up services.

#### CONCLUSIONS

83 percent of total CHCs and PHCs have generator sets and in one third of these CHCs and PHCs, two or more generator sets are available.

78.2 percent of CHCs and PHCs have gensets in working condition and 77 percent of CHCs and PHCs have gensets connected to regular electric supply system indicating their use in case of need

More than 76 percent of CHCs and PHCs have all items of basic equipment supplied to health institutions under different schemes

All CHCs and PHCs have been supplied with medicine kits for sterilization acceptors and they have been distributed to 69.6 percent of total sterilization acceptors. Stock medicine kits is also comfortable in almost all PHCs and CHCs

( ) Para-medical workers have visited 85 percent of sterilization acceptors for follow up services. One of the reasons for this high level of follow up is a small number of sterilization acceptors

The above findings confirm that the Directorate of Family Welfare, the implementing agency of the Short Term Strategy, has achieved all required levels of performance given in the benchmark 26

## Names of CHCs and PHCs covered in each district, personnel interviewed and date of visit

District BAREILLY			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Nawab Ganj	Rajeesh Aggarwal	Feb 28 97
02	Baheri	Surendra Singh	Feb 28 97
03	Meer Ganj	Mahendra Kumar	Mar 1 97
04	Ram Nagar	-	Mar 1 97
05	Bhamora	S Chandra	Mar 1 97
06	Fatfeh Ganj	T P Singh	Mar 1 97
07	Mudia Nabi Baksh	Raj Kumar	Feb 28 97
08	Bhutia	Brij Pal Singh	Feb 28 97
09	Kyara	V S Sharma	Mar 1 97
10	Bithari Champuri		Feb 28 97
11	Sher Ghar	S P Mishra	Mar 1 97
12	Dalal Nagar	M R Nigam	Mar 1 97
13	Bhoji Puri	S S Saxena	Feb 28 97

District FIROZABAD			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Jasrana	O P Gupta	Feb 27 97
02	Khairgarh	DK Kulshreshta	Feb 26 97
03	Madanpur	Lal Singh	Feb 26 97
04	Tundla	R C Sharma	Feb 26 97
05	Araon	D K Kulshrashta	Feb 26 97
06	Kotla	B J L Dwivedi	Feb 27 97
07	Ekaa	B P Singh	Feb 27 97
08	Usayeni	M I Mishra	Feb 26 97
09	Dhanpura	R K Bhadauriya	Feb 26 and 28 97

District GORAKHIPUR			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Campiangan	D K Singh	Mar 3 97
02	Bansagaon	S P Singh	Mar 4 97
03	Piprauli	R M Sharma	Mar 4 97
04	Khorabar	Vijay Prasad	Mar 4 97
05	Bhathat	B P Singh	Mar 3 97
06	Khajani	D N Jha	Mar 3 97
07	Sahjanwa	Durgeshwar Lal	Mar 4 97
08	Derwa	Shamim Abidi	Mar 5 97
09	Sadar Nagar	K K Mishra	Mar 4 97
10	Jungle Kodia	V K Pandey	Mar 3 97
11	Pali Tharapur	A K Sharma	Mar 5 97
12	Chagavavan	A D Singh	Mar 4 97
13	Brahmpur	Ram Aasrey	Mar 4 97
14	Gagaha	Binay Ram gupta	Mar 4 97
15	Belghat	S K Singh	Mar 4 97
16	Kauri Ram	B P Gupta	Mar 4 97
17	Urwa Bazar	M P Singh	Mar 4 97

District JHANSI			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Mauranipur	R P Gupta	Feb 28 97
02	Babina	V N Saha	Feb 28 97
03	Moth	R C Mehta	Feb 28 97
04	Gursara	Kripa Ram Verma	Feb 28 97
05	Bamore	A K Tripathi	Feb 28 97
06	Chirgaon	K L Rajoria	Mar 1, 97
07	Bara Gaon	G S Awasthi	Mar 1 97
08	Bangra	P N Divedi	Feb 28 97
09	Dhamha	Mukesh Dubey	Mar 1 97
10	Rampura	P K Srivastava	Mar 1 97
11	Erach	Sitaram Verma	Feb 28 97
12	Garotha	Om Prakash Shukla	Mar 1 97
13	Samthar	R K Gupta	Feb 28 97
14	Barua Sagar	J P S Singh	Feb 28 97
15	Sakpar	R K Gupta	Feb 28 97
16	Todifatehpur	Madanlal	Mar 1 97

District LUCKNOW			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Mahilabad	Y C Sharma	Feb 27 97
02	Mohanlal Ganj	R P Mathur	Feb 27 97
03	Chinhat	A K Saxena	Feb 26 97
04	Kakori	Jay Singh	Feb 27 97
05	Sarojini Nagar	R K Singh	Feb 27 97
06	Mial	R C Chandra	Feb 27 97
07	Gosai Ganj	M G Deanne	Feb 27 97
08	Bakshika Falib	A K Mishra	Feb 26 97

District MEERUT			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Bagpat	Ram Gopal Vohra	Feb 28 97
02	Mawana	M D Vyas	Mar 3 97
03	Binoli	Daleep Singh	Feb 28 97
04	Daula	Anil Rao	Feb 27 97
05	Bhoor Baral	M K Gupta	Feb 27 97
06	Jaani	A K Goyal	Feb 27 97
07	Rohta	Suresh Chand	Feb 28 97
08	Parikshit Garh	S C Shrivastava	Feb 28 97
09	Hastinapur	S C Johri	Mar 3 97
10	Bhawan Pur	B S Bahyan	Mar 4 97
11	Kharkuda	R K Mishra	Mar 4 97
12	Machhra	Raj Kumar	Mar 4 97
13	Bijouli	R S Aggarwal	Mar 4 97
14	Sardhana	S K Tyagi	Mar 3 97
15	Flawda	Krishan Murari Diwedi	Mar 4 97
16	Khekra	R Chandra	Feb 27 97
17	Sordrupur Khurd	Rajendra Singh	Mar 5 97
18	Daurala	P R Singh	Mar 5 97

District NAINITAL			
S No	Name of the CHC/PHC covered	Name of the medical officer contacted	Date of interview
01	Nainital	Uma Singh	Mar 3 97
02	Ram Nagar	D C Dyans	Mar 3 97
03	Jas Pur	A N Yohra	Mar 3 97
04	Gadarpur	K D Pandey	Mar 3 97
05	Bhimtal	-	Mar 4 97
06	Ram Garh	-	Mar 4 97
07	Kota Bagh	P P Kuantwal	Mar 3 97
08	Pudanpuri Dhari	Manoj Srivastava	Mar 4 97
09	Okhal Khanda	S B Prasad	Mar 3 97
10	Motauldu	A K Prashna	Mar 4 97
11	Batal Ghuti	A K Bisht	Mar 5 97
12	Kichha	P L Shah	Mar 4 97

## DISTRICT PLANNING

### RATIONALE

The rationale for District Planning is to develop a critical mass of programme inputs in select districts through a district level planning exercise carried out to identify and prepare strategies for strengthening public and private sector participation. Data show that basic infrastructure like physical facilities, equipments, utilities etc are needed to improve the quality of care in the public sector. At the same time, addressing these needs alone will not result in improving programme performance. Simultaneous interventions like training, IEC and logistics improvement are equally important to achieve programme objectives. Often local reasons and strengths exist in the private sector which could be used to cater to specific needs. Thus in order to maximise the potential of programme impact it is desirable to finance inputs such as those described above only on the basis of comprehensive integrated and well designed plans based on local needs and programme gaps. Such plans should be focussed on results and have clearly settled objectives, intermediate outcome indicators and implementation schedule. The District Planning exercise using DIFPSAs has potential to create an operational link for planning and project implementation in the public and private sectors combining the mobilisation and community strength of NGOs with the wide reach of public sector infrastructure.

In addition the District Planning strategy enables focussing on

- a) Implementing activities which have been tried out on pilot scale elsewhere and found successful on evaluation
- b) New strategies which address weaknesses identified through different studies and assessments
- c) Devolution of financial and administrative authority to the district level
- d) Ensuring adequate links between public and private sectors so that there is an integration of services in the most optimum manner to create synergy

### FUNDS FLOW

SIFPSA will release funds directly to DIFPSAs for all activities. DIFPSAs in turn will fund the implementing agencies for private sector activities and the CMOs / CMSs for

## ANNEX 8

public sector activities. However, the project cost for private sector activities and the budget for public sector activities along with the amounts of quarterly instalments would be decided by SIFPSA and would be mentioned in the agreement to be signed with private sector partners soon after project sanction.

### **MANAGEMENT OF DISTRICT PLANS BY SIFPSA**

The District Plans will be implemented by DIFPSA which is a registered society. The DIFPSA will work through a Project Management Unit (PMU) headed by a full time Project Manager and core staff for maintenance of accounts and MIS etc. The Project Manager will facilitate the implementation of public sector initiatives and will also be responsible for providing support to it. For private sector activities he will liaise directly with the implementing agencies. Local level problem solving, supportive supervision and monitoring will be the responsibility of PMU which will also act as a bridge between SIFPSA and DIFPSA. The Project Manager will function like the Chief Executive of DIFPSA but will be under the administrative control of SIFPSA. SIFPSA will identify technical assistance required and provide it to the CMO for public sector initiatives and directly to implementing agencies for private sector sub-projects. The concerned Cooperating Agency will be involved for this purpose. For instance INTRAH will provide technical assistance for ISMP and TBA training projects and will be involved in the implementation in the same way as in similar project in other districts. AVSC which has assessed the gaps in public sector infrastructure will continue to play its role in upgradation of district PPC, CHCs and PHCs.

### **MONITORING OF DISTRICT PLANS BY SIFPSA**

While district planning attempts to empower DIFPSAs to fund, facilitate and monitor activities, it is necessary to ensure that resources allocated for this purpose are utilised optimally and prudently. This will require that all activities are monitored closely by SIFPSA and funds are released to DIFPSA on a periodic basis after receiving reports on the financial and physical progress. The first six months of implementation of district plan would require specially close monitoring and regular monitoring thereafter. The monitoring system will have the following components -

- 1) Monitoring format will be designed to record the progress of implementation of each or a set of identified activities. This will be a monthly report submitted to SIFPSA by DIFPSA. Progress of implementation will be measured against the time frame agreed upon for the commencement and completion of activities in the

activity plan

- 2) The Project Manager and the CMO / Dy CMO will review the activities weekly Exceptions will be identified and local level problems identified and sorted out
- 3) SIFPSA will nominate a nodal officer for this project Monthly meetings will be held between SIFPSA nodal officer and district staff to review the progress to identify bottlenecks if any and chalk out future course of action After first six months these meetings could be held quarterly
- 4) Rapid assessment of the implementation of district action plan and results achieved till the end of each year of the project will be reviewed and time frame for activities to be implemented next year will be prepared
- 5) A high level group at SIFPSA consisting of Executive Director / AED, Director (FW) and other officers will review the progress quarterly This group will also have representation from USAID and GOUP Cooperating Agencies and other experts may be co-opted when required

SIFPSA will, for this purpose require very little additional resources A Programme Officer at SIFPSA would have to be earmarked as a nodal officer for each district plan In times to come, on an average, a nodal officer could support district planning in 4 to 5 districts

#### **MANAGEMENT & MONITORING BY DIFPSA**

DIFPSA is chaired by the District Magistrate who is also the Chairperson of District Rural Development Agency (DRDA) and is responsible for implementation of various developmental activities like the District Plan, Anti Poverty Programmes and social programmes like the Total Literacy Campaign, Blindness Eradication and Leprosy Eradication Programme He is also Chairperson of the Red Cross Society The Total Literacy Campaign and other social programmes are managed by societies which are similar to DIFPSA The Project Manager will function as a Chief Executive Officer of DIFPSA and he along with the core staff for accounts and MIS would provide assistance to DIFPSA Rules for spending money and other financial systems like competitive bidding for procurement etc will be as laid down by SIFPSA

The DIFPSA, which will also contain representatives of private sector organisations

## ANNEX 8

implementing projects in the district, would meet once a quarter atleast, to review the progress and monitor programme activities and release funds for them DIFPSA would thus fulfil the role of an umbrella organisation or mother NGO These meetings would also be attended by the SIFPSA nodal officer and CA representatives The Chairman DIFPSA would be authorised to take decisions up to a certain financial level in between meetings of DIFPSA but these will have to be ratified by the DIFPSA at its next meeting

The staff requirement for each DIFPSA would be a PMU consisting of a Project Manager along with Assistant Project Coordinator, Accounts Officer and a MIS Officer, who would function from a rented office in the district head quarters

### **ROLL OUT**

It is proposed that District Action Plans should be formulated and implemented for the six focus districts in the financial year 1997-98 After rapid assessment of the functioning of the process as well as performance in October 1998, if the exercise is found suitable, it can be extended to a further nine PERFORM districts in 1998-99

### **SELECTION OF DISTRICTS**

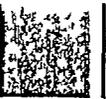
The initial selection of districts should be in representative geographical areas Thus the six focus districts would be the first to have district level planning This will also help building on strengths as the IFPS Project has better presence in these districts and comparatively more NGOs are established here in the field of family planning Another criteria would be to work in those districts first which are less difficult ( more urban, easily assessable and with substantial private sector presence ) for making a quick demonstrable impact

### **MECHANISM TO ENSURE PRIVATE AND PUBLIC SECTOR INPUTS SIMULTANEOUSLY**

The very basis of district planning exercise is to ensure simultaneous availability of services in the public and private sector so that each can support the other This would be ensured through detailed activity plans for each strategy Identification of activities, persons responsible for the activity and time lines would be decided and would be closely monitored both by DIFPSA and at SIFPSA

RAMPUR DISTRICT ACTION PLAN  
1997-2000

11



JUNE 1997  
DIFPSA, RAMPUR  
AND  
SIFPSA, LUCKNOW

200

## RAMPUR DISTRICT ACTION PLAN

## INTRODUCTION

Rampur district has a total population of 1 502 141 in 1991. The decennial growth rate of the district has reached peak level of 30.78 in 1971-81 and declined to 27.12 in the last decade. This decline could be either due to fertility transition in the district or due to a large number of out migrants. Of the total population 808 419 are males and 693 722 are females with a sex ratio of 858 females per 1 000 males which is much below the state average of 879. The total literacy rate in the district is one of the lowest in the state. While the total literacy rate in the state in 1991 is 41 percent Rampur district has a literacy rate of 25 percent. Literacy rate differentials are very sharp between urban and rural areas and between male and female population. Urban literacy 42 percent as compared to rural literacy of 19 percent. Female literacy is only 15 percent compared to that of males which is 34 percent. Proportion of urban population to total district population is 26 percent.

Of the total workers Rampur has 73 percent in primary sector mainly agriculture, 10 percent in secondary sector and 16 percent in tertiary sector. The district economy has not undergone major changes in the last decade. The proportion of workers in primary, secondary and tertiary sectors remained more or less same from 1981 to 1991. Rampur has a few industrial units and many of them except one are small. Only 9 015 persons work in the organized sector.

Low literacy levels particularly among females, predominantly agrarian economy and unchanging economic scenario impose serious constraints on acceptance of family planning methods. About 40 percent of Rampur population belong to minority community. Muslims form majority in urban areas of Rampur district. Religious influence on use of family planning methods in Rampur district is not confined to one religion but looks like an integral part of competing religions. Given this setting family planning is a relatively more sensitive issue in Rampur compared to other districts in Uttar Pradesh.

Rampur is a small district with a total area of 2 367 SKMs and with a population density of 635 per SKM. Compared to average density of population 200 more persons live in a SKM area in Rampur district which imposes serious constraint on district resources. Further growth in population at current level is going to escalate the problems.

Administratively Rampur district has been divided into 6 blocks, 75 Nyaya Panchayats and 742 gram sabhas. Rampur district has a total of 1 092 villages. Of these 455 villages are very small with less than 500 population, 576 villages have above 500 but below 2 000 population and the remaining 61 villages have more than 2 000 population. Urban population of Rampur lives in 8 towns. Of these only Rampur town has more than 100 000 population and the other 7 towns are very small with less than 50,000 population.

The PERFORM Survey in Rampur district was conducted from May to August 1995. A total of 55 villages and 26 urban census enumeration blocks were selected using PPS method. From a total of 1500 households selected from rural and urban primary sampling units, 1747 currently married women in 13-49 age group were interviewed. In addition to this, 73 fixed service delivery points both from private and public sectors, 149 staff persons and 883 individual agents were covered. Moradabad division results were presented to health and family welfare officials, NGO and private industry representatives in Moradabad in January 1996. Audio visual prepared by The POLICY Project specifically focusing on Moradabad division PERFORM survey results was shown to the participants. Based on discussions, the main issues related to access, demand and quality of reproductive health and family planning services were identified. Audio-visual was shown to and the issues were further discussed with workers, supervisors and medical officers of all PHCs with particular attention to alternate solutions to improve performance. Based on these discussions, on new strategies to improve performance in a two day workshop organized by SIFPSA for district and block level officers of Rampur district in Rampur on January 29-30, 1996. The district action plan given here is based on these suggestions from different sources and levels and information collected on various aspects from the district with the help of health and family welfare department.

#### ACTION PLAN OBJECTIVES

The action plan prepared is for a period of three years. The specific objectives have been worked out keeping in view the demographic profile of the district, present levels of performance and additional resources that will be made available by SIFPSA. First, the objectives are set in terms of lowering the total fertility rate in Rampur district. The current fertility rate in Rampur district is 5.3 and age specific fertility rate peaks for women of 20-29 age group. The currently married women in this age group and their spouses are the main target group for the action plan. If Rampur district has to achieve a reduction in total fertility rate from present 5.3 to 4.8 in the next three years, the required increase in contraceptive prevalence rate has been calculated. Contraceptive prevalence rate at the end of three year district action plan period should increase from the current level of 19 percent users of all modern methods to 30 percent.

The table given below describes the expected output and outcome achievement levels in Rampur district. Since the envisaged new inputs as part of action plan are not going to be in place till the end of the first year, the rate of increase in contraceptive prevalence rate has been kept low for the first year and was gradually moved upwards for the second and the third years of district action plan. Method mix has been worked out keeping in view the method preference given by the future intending users. Nearly half of the currently married women not using any contraceptive method at present would prefer to use one or the other modern method in future. Nearly one third of total women would like to use one or the other methods within next one year but 6 percent of total women did not have definite method choice. So the real demand for contraceptive services works out to 27 percent. There is always a gap between demand for services and actual utilisation of services due to complex set of factors that influence decisions on use. This will be reduced considerably.

### Expected Decline in Total Fertility Rate and Increase in Contraceptive Prevalence Rate in Rampur District

	TFR	CPR
1997	5.27	20.6
1998	5.12	21.9
1999	5.02	26.4
2000	4.77	30.3

Based on this method mix and estimated level of achievement in terms of contraceptive prevalence rate the total number of new acceptors required for each of the methods in actual numbers have been calculated and these numbers are adjusted to annual performance objective in terms of contraceptive prevalence rate in Rampur district. These quantitative estimates will not be considered as targets to be distributed to units below district level but to be used to provide direction and pathway to the levels to be reached. Given below are the estimated number of current users for various methods.

	1998		1999		2000	
	Total Users	New Acceptors	Total Users	New Acceptors	Total Users	New Acceptors
Condoms	17 858	1 194	22 280	4 422	26 462	4 182
Oral Pills	9 162	903	11 818	2 656	14 497	2 679
IUCD	11 181	1 107	14 143	2 962	17 028	2 885
Sterilization	31 055	4 500	37 199	6 144	43 951	6 752

Rampur district has conducted less than 3 000 sterilization operations in 1996-97. The total new acceptors of sterilization has to be 4 500 in 1997-98, 6 144 acceptors in 1999 and 6 752 acceptors in 2000. New IUD acceptors should go up by 1 107 in 1998, 2 962 in 1999 and 2 885 in 2000. Oral pill acceptors should increase by 903 in 1998, 2,656 in 1999, and 2 679 in 2000. Condom acceptors should increase by 1 194 in 1998, 4,422 in 1999 and 3 182 in 2000.

### EXISTING SIFPSA INTERVENTIONS IN RAMPUR

SIFPSA has initiated several activities which are being implemented in Rampur. All these interventions have been taken into consideration while preparing this district action plan. The list of existing SIFPSA interventions and amount sanctioned for each intervention is given in the table below.

Intervention	Amount Sanctioned (In rupees)
Private lady doctors on hire for service at CHC/PHC	1 24 800
Imprest money for consumables at CHC/PHC/Subcentres	4 55 000
Operation theatre equipment and money (thru directorate)	30 800
Medicine packets for sterilization clients (thru directorate)	
POL for mobility	84 000
POL for generator sets	42 000
Intensive IEC campaign in block	42 800
Water supply at one PHC	40 000
Wall paintings at block PHCs and CHCs	3 500
Generator sets (2) for CHC/Block PHC	80 000
Strengthening district PPC	4 23 000
New laparoscope (1) and CTU and IUCD training	322 000
Orientation training camp on TFA	131 490
AMC for Laparoscope (thru directorate)	-- -
	768794

The Indian Institute of Development (IID) is an NGO implementing the ICDS based health project in one block of Rampur district. They will also be implementing TBA training given in the district action plan. PIID Chamber of Commerce will be implementing the family welfare project for the organized sector in Rampur town while RMA will be involved in training ISM practitioners.

### STRATEGIES

The district based strategy suggested in the Action Plan focuses on the following -

- 1 Implementing activities which have been tried out on a pilot case elsewhere and found successful on evaluation
- 2 New strategies which address weaknesses identified through different studies and assessments
- 3 Devolution of financial and administrative authority to the district level

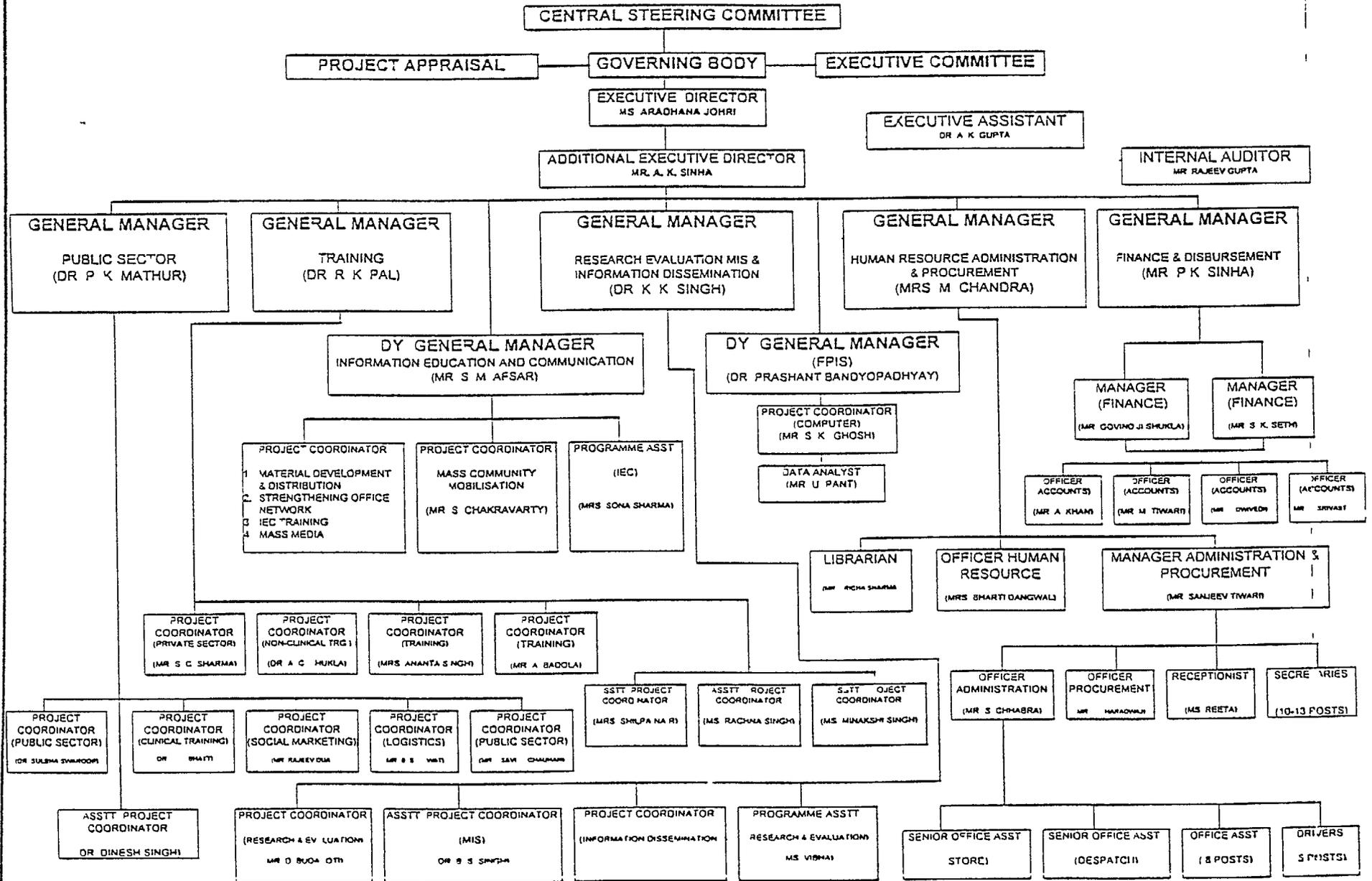
- 4 Ensuring adequate linkages between the public and private sectors so that there is an integration of services in the most optimum manner to create synergy Thus in many strategies like Mahila Swasthya Sangh, use of ISM Practitioners, training of various functionaries, mobilisation strength of the NGOs is sought to be combined with the wider reach of the public sector

Efforts have been made to detail strategies develop elaborate activity plans and budgets and suggest a monitoring system However, detailed plans will be drawn up for each strategy during the Management Development Programme for medical officers Process indicators for each of the sub-activities/projects would also be developed and tracked regularly Yearly evaluation of performance on these indicators would be used to take a decision on the need to fine-tune activities, make mid-course corrections, or even drop poorly performing interventions if the need arises Thus an element of flexibility has been introduced into the District Action Plan

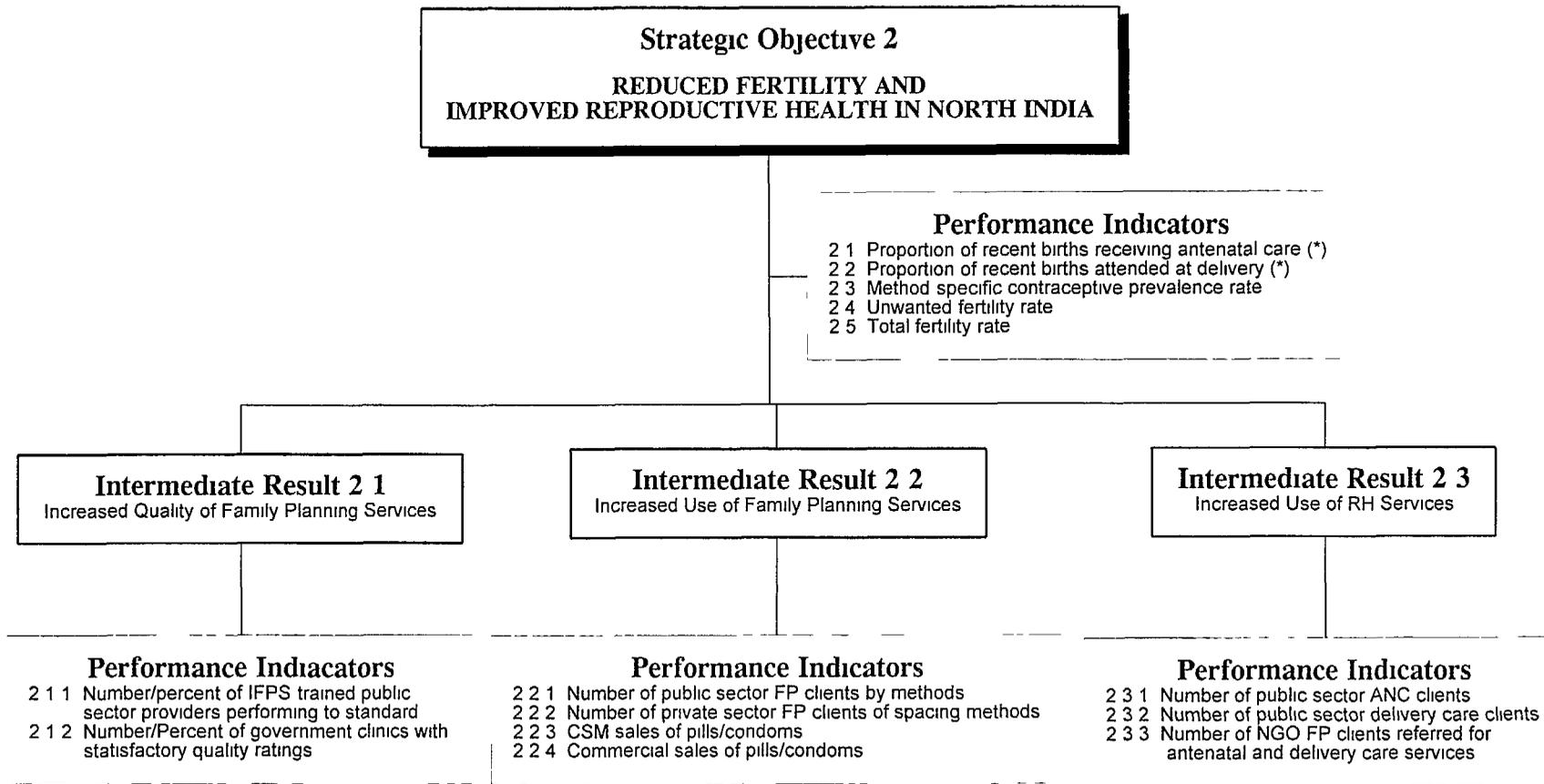
The nine key strategies to be implemented in Rampur include

- 1 Involvement of community members through Mahila Swasth Sangh women's groups designed to effectively impart information on key reproductive health interventions
- 2 Involvement of indigenous medical practitioners to extend the service reach into the community
- 3 Training of a variety of program and medical staff including management training for medical officers and health education officers, NSV training for medical officers, IUCD training for lady medical officers, female supervisors and female workers, training on spacing methods and interpersonal communication skills for ANMs, LHVs and anganwadi workers, and training for traditional birth attendants
- 4 Quality improvements in the public sector through ANM outreach, RCH camps, and sterilization camps
- 5 Improved contraceptive logistics supply system
- 6 Development and implementation of IEC strategies
- 7 Strategy to build a conducive and supportive environment through involvement of panchayat and other community leaders and linkages to other key programs such as the literacy campaign
- 8 Infrastructure and transport improvements
- 9 Innovative projects that can be incorporated as necessary to respond to any gaps

# SIFPSA ORGANISATION CHART



206



(\*) From/by a trained health provider

207

**SO 2 Reduced Fertility and Improved Reproductive Health in North India**

<u>Indicator</u>	<u>2.1</u>	<u>Proportion of recent births receiving antenatal care</u>
Unit of measure		Percentage
Source		NFHS, other surveys
Indicator description		Proportion of births in last 4 years receiving antenatal care from trained health provider To increase from 30% (1993) to 40% (2004)
Comments		Baseline survey was conducted in 1992-93 and will be conducted every 5 years
<u>Indicator</u>	<u>2.2</u>	<u>Proportion of recent births attended at delivery</u>
Unit of measure		Percentage
Source		NFHS, other surveys
Indicator description		Proportion of births in last 4 years attended at delivery by trained health provider To increase from 17% (1993) to 25% (2004)
Comments		Baseline survey was conducted in 1992-93 and will be conducted every 5 years
<u>Indicator</u>	<u>2.3</u>	<u>Method-specific contraceptive prevalence in U P</u>
Unit of measure		Percentage
Source		NFHS, other surveys
Indicator description		Proportion of married couples with wife aged 15-49 using modern contraception To increase from 18.5% (1993) to 35% (2004) Proportion of married couples with wife aged 15-49 using modern spacing methods To increase from 5.5% (1993) to 11% (2004)
Comments		Baseline survey was conducted in 1992-93 and will be conducted every 5 years
<u>Indicator</u>	<u>2.4</u>	<u>Unwanted fertility rate</u>
Unit of measure		Rate
Source		NFHS, other surveys
Indicator description		Number of unwanted births a woman would bear during her

reproductive years if she were to experience the current unwanted fertility schedule  
 To decrease from 1.0 (1992-93) to 0.5 (2004)  
 Comments The unwanted fertility rate should be compared against the total fertility rate to determine what percentage of the TFR is unwanted and what the TFR can be if all unwanted births are prevented. Baseline survey was conducted in 1992-93 and will be conducted every 5 years.

Indicator 2.5 Total fertility rate

Unit of measure Rate  
 Source NFHS, other surveys  
 Indicator description TFR is the number of children a woman would bear during her reproductive years if she were to experience the current fertility schedule  
 To decrease from 4.8 in 1992-93 to 3.9 in 2004  
 Comments Baseline survey was conducted in 1992-93 and will be conducted every 5 years.

IR 2.1 Increase Quality of Public Sector FP Services

Indicator 2.1.1 Number/percent of IFPS-trained public sector providers performing to standard

Unit of measure Number/percent  
 Source IFPS Project records/Special Provider Study  
 Indicator description Number and percent of public sector providers trained by the IFPS who meet quality standards in providing clinical FP services (IUD and sterilization)  
 Baseline and target to be determined after further review  
 Comments Annual data, quality standards as defined by the Johns Hopkins-produced Contraceptive Technology Handbook used in the training programs. Data to be collected through qualitative assessment visits to a sample of providers and clinics.

## ANNEX 11

Indicator 2 1 2 Number/percent of government clinics with satisfactory quality ratings

Unit of measure	Number/percent
Source	Special clinic study
Indicator description	Number/percent of government clinics in selected areas which have achieved satisfactory quality ratings
Comments	Baseline and target to be determined after further review Annual data, quality standards to be established by project technical experts Data to be collected through qualitative assessment visits to a sample of clinics

IR 2 2 Increased Use of Family Planning Services in U P

Indicator 2 2 1 Number of public sector FP clients by method

Unit of measure	Number
Source	GOUP Family Welfare service statistics
Indicator description	Number of clients provided FP services by method (sterilization, IUD, pill, condom) in IFPS districts
Comments	Baseline and target to be determined after further review Annual data

Indicator 2 2 2 Number of private sector FP clients of spacing methods

Unit of measure	Number
Source	SIFPSA NGO Management Information System
Indicator description	Number of clients provided FP services by method (IUD, pill condom)
Comments	Baseline and target to be determined after further review Annual data

Indicator 2 2 3 CSM sales of pills/condoms

Unit of measure	Condoms in millions, Oral pills in thousand cycles
Source	Government, CSM select companies, and IFPS Project reports
Indicator description	Number of condoms and oral pills sold through contraceptive social marketing programs

Comments Baseline and target to be determined after further review  
Annual data

Indicator    2 2 4 Commercial sales of pills/condoms

Unit of measure            Condoms in millions, Oral pills in thousand cycles  
Source                      Manufacturer reports (Wyeth, Hindustan Latex)  
Indicator description      Number of condoms and oral pills sold to commercial outlets  
Comments                  Baseline and target to be determined after further review  
Annual data

IR 2 3            Increased Use of RH Services

Indicator    2 3 1 Number of public sector ANC clients

Unit of measure            Number  
Source                      GOUP Family Welfare service statistics  
Indicator description      Number of pregnant women receiving ANC care at government service points  
Comments                  Baseline and target to be determined after further review  
Annual data, data to be compiled for IFPS districts

Indicator    2 3 2 Number of public sector delivery care clients

Unit of measure            Number  
Source                      GOUP Family Welfare service statistics  
Indicator description      Number of pregnant women receiving delivery care at government service points  
Comments                  Baseline and target to be determined after further review  
Annual data, data to be compiled for IFPS districts  
**Note    The number of pregnant women receiving iron folic acid tablets is an SO3 indicator and the number of pregnant women receiving maternal TT was considered to be a child survival indicator**

ANNEX 11

Indicator    2 3 3    Number of NGO FP clients referred for antenatal and delivery care services

Unit of measure	Number
Source	SIFPSA NGO Management Information System
Indicator description	Number of FP clients served by IFPS NGOs referred to antenatal and/or delivery care services at government service points
Comments	Baseline and target to be determined after further review Annual data, data to be compiled for IFPS districts