



**ASSESSMENT
OF THE
INNOVATIONS IN FAMILY PLANNING SERVICES PROJECT
SUMMARY REPORT**

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ACRONYMS AND ABBREVIATIONS

BUCEN	U.S. Census Bureau
CA	Cooperating agency
CBD	Community-based distribution
CEDPA	Centre for Development and Population Activities
CMS	Commercial Market Strategies
CONRAD	Contraceptive Research and Development Program
DIFPSA	District Innovations in Family Planning Services Agency
FP	Family planning
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IEC	Information, education and communication
IFPS	Innovations in Family Planning Services
IMA	Indian Medical Association
ISMP	Indigenous system of medicine practitioners
IUCD	Intrauterine contraceptive device
JHU/PCS	Johns Hopkins University/Population Communication Services
LAM	Lactational amenorrhea method
MCH	Maternal and child health
MIS	Management information system
MMCP	Modern method contraceptive prevalence
MOHFW	Ministry of Health and Family Welfare
NFHS	National Family Health Survey (India)
NGO	Nongovernmental organization
NSV	No-scalpel vasectomy
PACT–CRH	Program for Advancement of Commercial Technology–Child and Reproductive Health
POPTECH	Population Technical Assistance Project
PSI	Population Services International
RH	Reproductive health
RTI	Reproductive tract infection
SIFPSA	State Innovations in Family Planning Services Project Agency
STD	Sexually transmitted disease
TBA	Traditional birth attendant
TFR	Total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization

CONTENTS

	Page
Executive Summary	i
Introduction.....	1
IFPS Accomplishments at the End of a Decade	5
Project Impact on Fertility and Use of Modern Methods of Contraception	9
Project Impact on Contraceptive Prevalence	11
The Performance-Based Disbursement System.....	20
Future Financial Resources.....	21
Recommendations.....	22

TABLES

1. Modern Method Contraceptive Prevalence in 28 IFPS Districts, All Other Districts in Uttar Pradesh, and for the Entire State of Uttar Pradesh 10
2. Total and Method-Specific Modern Method Contraceptive Prevalence Among Currently Married Women of Reproductive Age in All 28 IFPS Districts 10

EXECUTIVE SUMMARY

Late in 2002, a six-member consultant team from the Population Technical Assistance Project conducted an assessment of the Innovations in Family Planning Services (IFPS) project in the state of Uttar Pradesh, India. Only five countries in the world (including India itself) have more people than Uttar Pradesh (166 million). The government of Uttar Pradesh is committed to the ambitious goal of lowering the state's fertility rate to replacement level by 2016.

In 1992, the United States Agency for International Development (USAID) authorized the \$325 million, 10-year IFPS project to achieve significant reductions in the total fertility rate of Uttar Pradesh through comprehensive improvements in and expansion of family planning services. The project's aim was to double the use of modern methods of contraception, and its success was to be measured by monitoring modern method contraceptive prevalence in the state as a whole and particularly in the districts with earliest involvement in the project. The project was recently extended to 2004.

ACCOMPLISHMENTS

The IFPS project has been responsible for a wide range of important accomplishments, particularly in infrastructure and training. Some accomplishments may constitute the necessary preconditions for future, greater impacts on family planning.

Population Policy, Leadership, and Advocacy: With technical assistance from the IFPS project, the government of Uttar Pradesh adopted a comprehensive population policy, and the State Innovations in Family Planning Services Project Agency (SIFPSA) has extended its physical presence into each IFPS district.

Increasing Access to High Quality Sterilization Services in the Public Sector: Almost 700 public sector physicians have been trained in tubal ligation methods and 61 physicians have been trained in the no-scalpel vasectomy technique.

Improving the Family Planning Performance of Auxiliary Nurse-Midwives: Almost 9,000 auxiliary nurse-midwives who work in public sector health care facilities in Uttar Pradesh have completed a 6-day participatory, performance-based course covering a broad range of reproductive health care services. The performance of each auxiliary nurse-midwife has been tracked; 80 percent are performing according to standard. Physicians have reported that they believe there has been a significant reduction in intrauterine infections as a result of the training program.

Integrating Family Planning with Other Maternal and Child Health/Reproductive Health Services and Improving Those Services: More than 80 percent of all community health centers, postpartum centers, and block primary health centers have been upgraded. Sterilization is being provided in the context of antenatal services and childhood immunizations in reproductive/child health camps; sterilization and other methods of family planning are being discussed during childhood immunization.

Contraceptive Social Marketing: The proportion of rural villages with at least one commercial outlet selling condoms and one outlet selling oral contraceptives increased from 19 percent in 2000 to 43 percent in 2002. Condom sales in retail outlets increased by 93 percent from 2000 to 2002 in rural Uttar Pradesh.

Increasing Private Sector Involvement in Family Planning: IFPS has successfully positioned the nongovernmental organization (NGO) sector as an effective partner to the public sector. Contraceptive prevalence increased 2–5 times faster in areas where IFPS–supported NGO outreach services have been provided for at least three years compared with the increase in the entire project area.

Information, Education, and Communication (IEC): The “Aao Batién Karien” or “Come Let’s Talk” logo and message were produced as the unifying theme for selected family planning/reproductive health (FP/RH) IEC activities and materials.

Contraceptive Prevalence: During the six years between 1992–93 and 1998–99 (dates of the two most recent statewide contraceptive surveys), modern method contraceptive prevalence for the entire state has increased by 3 percentage points, from 17.8 to 20.8 percent, a gain of 0.5 percentage points per year. The increase as a percentage of the 1992–93 modern method contraceptive prevalence in the IFPS districts was approximately twice the increase in the non–IFPS districts.

Total Fertility Rate (TFR): The TFR for Uttar Pradesh fell from 5.2 in 1992–93 to 4.6 in 1998–99. Since TFR is affected by other proximate determinates in addition to contraceptive prevalence, it is not possible to attribute the observed decline in TFR to IFPS activities.

GENERAL RECOMMENDATIONS

Numerous recommendations are presented in the assessment summary report. The following have been identified as 10 of the most significant, general recommendations.

- 1. Consider reorienting the focus of SIFPSA’s project activities to innovation, and transferring successful innovations to others.**
- 2. Make available senior specialists with a clear mandate for collaborative policy discussions with government and nongovernment stakeholders.**
- 3. Project and SIFPSA management need to consider carefully future resource requirements in relation to currently planned activities.**
- 4. IFPS project designers should reconsider performance-based disbursement as the funding mechanism for the project.** At a minimum, project designers should consider performance-based disbursement funding according to the percentage of an activity implemented instead of the current approach.
- 5. Develop and implement an integrated communications plan to support project initiatives in the public, commercial, and private (including NGO) sectors.** Such a program should inform people of all effective methods of contraception that are

available to them, and where and how they can access those methods. This plan should provide for consistent messages and symbols of quality. Project messages embedded in IEC materials and other behavior change materials should be targeted to specific segments within the FP/RH market, for example, young girls who have not yet initiated sexual activity, young married couples who want to delay first pregnancy and birth, mothers who want to delay the next pregnancy and birth, and women who have completed their desired child bearing.

6. **Focus activities in the time remaining on a limited number of districts to achieve a sustainable number of FP/RH acceptors.** Introduction of the district action plan process/system in additional districts (eventually to the entire state) and continuing USAID support for a portion of that expansion has these significant caveats:
 - The district action plan process needs to involve authentic district-level planning based on a local strategy.
 - Funding for district action plan activities needs to come from a source other than USAID.
 - SIFPSA should launch an effort to build chief medical officer/project management unit FP technical and management capacity as well as a team culture that promotes the adoption of proven interventions and innovations in district action plan districts.
 - The private sector needs to be more broadly included than it is at present in the district action plan process.

It may also be cost-effective to expand the social marketing program to all of Uttar Pradesh, providing that a communications program with a solid strategy can be fully and effectively implemented in support of contraceptive social marketing efforts.

7. **The IFPS project should develop a client-centered strategy to replace its current provider-centered strategy as the basis for all future programmatic interventions.** SIFPSA needs to undertake new research and analyze existing data to identify the segments within the overall unmet need market and other potential FP/RH acceptors.
8. **Develop a strategy for the provision of USAID-funded technical assistance that will improve the relationship between SIFPSA and technical assistance contractors.**
9. **Expand the range of contraceptive methods available through project interventions to include injectable contraceptives, emergency contraception, and lactational amenorrhea method (LAM).** The interface between breastfeeding, LAM, the postpartum woman's need to start another contraceptive method, and the infant's need for immunizations should be much more fully exploited. Auxiliary nurse-midwives should be trained and supported to provide a broader range of effective temporary methods of contraception. Depo-Provera should be available

through both public and private sector service delivery outlets and providers. The contraceptive social marketing intervention should expand the points of sale of additional temporary contraceptive methods, such as intrauterine contraceptive devices and injectable contraceptives. (If funds and efforts should be expended to improve access to vasectomy, delivery services need to be combined with significant IEC efforts to be successful. Given limited project resources, such investments should probably not be made at this time.)

10. **The project must resolve the problems of the public sector management information system.** In addition to assuring an acceptable level of validity and reliability of the data generated by the system, there needs to be a way to measure contraceptive continuation.

TECHNICAL RECOMMENDATIONS

1. IFPS project management needs to consider the amount of project energy and resources that should be directed towards the objective of increasing auxiliary nurse-midwives' performance in the delivery of intrauterine contraceptive device services versus their wider role in FP, maternal and child health, and RH.
2. **Problems with the role of the subcenter auxiliary nurse-midwife should be investigated and addressed. If the government of Uttar Pradesh is planning to focus on this issue, SIFPSA and the cooperating agency that has been most involved with the training and support of auxiliary nurse-midwives should participate, provide information and insight based on their experience, contribute to bringing the necessary kinds and levels of people together to examine the auxiliary nurse-midwives' role from many perspectives, and test innovative approaches to improving auxiliary nurse-midwife job performance.** Innovative approaches include expecting auxiliary nurse-midwives to be onsite at the subcenter for a third day every week, with the additional day focused on family planning, and dropping the expectation of routine home visits but training and expecting them to partner with community-based workers (traditional birth attendants, community-based distribution workers, anganwadi workers, village volunteers) who make home visits to achieve the same results. There is also a need for better information on how auxiliary nurse-midwives are performing now, effects of the IFPS training, and barriers to more effective auxiliary nurse-midwife family planning performance. There should be serious discussion of the potential benefits and risks of changing the expectations (job description, training, and supervision) for subcenter auxiliary nurse-midwives. Can the auxiliary nurse-midwife role be restructured to enhance motivation, satisfaction, and success? Project management should consider conducting a service provision assessment of subcenter auxiliary nurse-midwives.
3. **USAID, SIFPSA, and the government of Uttar Pradesh need to decide whether efforts to expand access to sterilization** are going to be limited to reproductive/child health camps, district hospitals, and postpartum centers or whether there should be a concerted effort to also develop the ability to provide sterilization at most or all community health centers and block primary health centers on a daily basis. **Lady medical officers who are posted to primary health centers and community health**

centers should be trained to perform minilaparotomy sterilization procedures and to deal with obstetrical emergencies. A concerted effort is needed to find, recruit, hire, and train lady medical officers for these purposes. They should also be trained and given responsibility for management of the reproductive health of women in the catchment area served by their facilities, including supervision of the lady health visitors (and thus the auxiliary nurse-midwives). Such a service delivery/supervisory system would support both expanded access to sterilization and reduced maternal mortality in the districts served by this project.

4. **SIFPSA should conduct research and test options for improving the cost-effectiveness and sustainability of using NGO CBD workers to educate and counsel rural women about family planning and to provide direct access to oral contraceptives and condoms and refer women for sterilization services.** Options could include
 - measuring the costs and impacts of CBD workers' current household activities on adoption, continuation, and discontinuation of temporary contraceptive methods by specific segments of women; and
 - pilot testing use of village (compared with household) advocacy and empowerment interventions and comparing the costs to the project, impacts on behavior, and sustainability of behavioral change achieved through village-based interventions versus household-based CBD outreach.
5. **SIFPSA should begin to develop, test, and provide CBD workers and other private sector providers with more targeted messages, materials, and strategies for dealing with specific segments of the FP/RH market.** A symptom recognition/recommended treatment strategy for teaching CBDs and others how best to inform, motivate, and serve various market segments (especially resistant clients) should be considered. **SIFPSA should use operations research to evaluate the effectiveness of and impact on the contraceptive behavior change of these IEC/communications interventions.**
6. **Develop and implement a strategy for forming effective partnerships between CBD workers and auxiliary nurse-midwives and/or other village providers.**
7. **Private sector activities should be intensified within a limited number of districts rather than spread out over a broad geographic area** to facilitate creation of the concentrated number of acceptors necessary to demonstrate the long-term sustainability of private sector services delivery. The concepts of institutional/technical and promotional sustainability as well as financial sustainability should be included. Sustainability (and its feasibility) as it relates to various points within the FP program continuum (i.e., from a low prevalence environment to a state of growing prevalence to sufficient prevalence to high prevalence) should be defined. The strategy document should also identify program components, if any, that may never be financially sustainable within the private sector (e.g., elements of demand generation).

8. **The government should become an active partner with the private sector to ensure the accessibility and safety of commercial sector FP/RH services through appropriate licensing and regulation, provision of population-based information, dissemination of information to consumers, and strategic planning.** Innovative methods to link public and private providers for more effective private sector service delivery and to enhance the credibility of private sector providers should be developed and tested.

INTRODUCTION

The population of the Indian State of Uttar Pradesh is 166 million. Only five countries in the world (including India itself) have more people than the state. If population growth were to continue at current rates, the population of Uttar Pradesh would reach 215 million by 2010, 325 million by 2030, and 440 million by 2050. Although this scenario is unlikely, high fertility magnifies almost every other problem in Uttar Pradesh and undermines the state's progress toward fuller social and economic development. The government of Uttar Pradesh is committed to lowering the state's fertility rate to replacement level by 2016. This is an extremely ambitious target.

The IFPS Project

In 1992, the United States Agency for International Development (USAID) authorized a \$325 million, 10-year project intended to achieve significant reductions in the total fertility rate of Uttar Pradesh through comprehensive improvements in and expansion of family planning services—the Innovations in Family Planning Services (IFPS) project. The project was to double the use of modern methods of contraception by

- increasing access to family planning services,
- improving the quality of family planning services, and
- promoting family planning.

The success of the project was to be measured by monitoring modern method contraceptive prevalence (MMCP) in the state as a whole and particularly in the districts with earliest involvement in the project.

Two particular focuses of project intent were to expand access to family planning beyond private and public sector service delivery outlets and to make temporary modern methods of contraception widely available and more broadly accepted to complement the longstanding Indian dependence on female sterilization.

Before 1992, there had been no tradition of birth spacing in Uttar Pradesh and little acceptance of family planning beyond limited use of government-promoted sterilization. Although sterilization is a powerful tool for reducing fertility, temporary methods of contraception are also needed to realize other values associated with family planning (e.g., for empowerment of women and families to control when and how many children they will have and for contributions to the health of both mothers and babies). Men were not overlooked in the project design. The IFPS Project Paper included a statement of the importance of addressing the needs of men more directly in family planning services and of identifying and utilizing communication channels targeted especially to men.

The title of the project, Innovations in Family Planning Services, and inclusion of research as an important component of project activities were intended to be significant. The project was expected to develop and test innovative approaches to expanding and improving family planning services and to replicate only those interventions that had been found to be successful. The project was to be carried out in three phases:

- The first five years would involve starting, testing, and evaluating innovative activities.
- The next three years would be used for replication of successful activities. It was expected that access to services would increase during this time and thus lead to increased use of services.
- During the last two years, the project was expected to yield measurable results, including an increase in contraceptive prevalence (from 20 percent of all married women in 1992 to 50 percent in 2002), an increase in the use of modern temporary (birth-spacing) methods of contraception by women under age 30, and an increase in the continuous use of contraception.

The project was designed to be implemented by an autonomous organization, which would allow the project to circumvent the delays inherent in working through a large government system and to overcome barriers to working with and dispersing funds to entities within the private sector. Nevertheless, the project was also designed to operate in conjunction with the Ministry of Health and Family Welfare's (MOHFW) public sector family planning program, staff, and facilities operating under the government of Uttar Pradesh.

A particularly innovative element of project design was a plan to fund most project activities through a performance-based disbursement system by which USAID would make periodic payments based on verifiable achievement of mutually agreed upon outcomes or benchmarks. Payments were to be deferred until a benchmark had been completely achieved.

The 1997 midterm evaluation recommended that the State Innovations in Family Planning Services Project Agency (SIFPSA) make expanding networks of service delivery in the private sector a priority.

The project was recently extended to 2004.

The IFPS Project Environment

The Challenge of Improving Family Planning in Uttar Pradesh

Nearly 40 percent of the population of Uttar Pradesh lives in poverty. The state ranks (with Bihar) lowest in India on the United Nation's Human Development Index, largely because of the high levels of poverty, widespread illiteracy, devastating health indicators, and growing population. One hundred children die before the age of 5 for every 1,000 born in Uttar Pradesh, 700 women die for every 100,000 live births, and almost 60 percent of couples do not use contraception.

Poverty and population growth are the state's most compelling challenges. Poverty reduction cannot be accomplished without improving the delivery of education, health, and family planning services. At the same time, implementation of development projects (especially family planning) has been historically poor in Uttar Pradesh because it has

been very hard to induce change—whether in personal behaviors, civil service performance, or political commitment.

Sterilization versus Spacing and Public Sector versus Private Sector

Family planning was introduced in India in the 1950s, and both female and male sterilization were introduced by 1966. National policy pressure to reduce the rapid rate of population growth led to a coercive sterilization program in the mid-1970s. This resulted in a political emergency, after which the further provision of sterilization services declined to almost nothing. The provision of sterilization services resumed cautiously after that, although the number of sterilization procedures performed per year declined again when the targeted approach was withdrawn by the government of India in April 1996. Although female sterilization is the most commonly used method of contraception in Uttar Pradesh, sterilizations have never returned to the level at which they were being performed before the withdrawal of the targeted approach.

Knowledge of sterilization is nearly universal among married women of reproductive age in Uttar Pradesh. Overall, sterilization accounts for more than 80 percent of total contraceptive use, and almost 70 percent of use of modern methods. Less than 20 percent of sterilized couples have ever used any method other than sterilization. Nevertheless, knowledge of other methods of contraception is also relatively high.

Given the near-exclusive emphasis on sterilization, women tend to adopt family planning only after they have achieved their desired family size. As a result, contraceptive use rises steadily with age and with the number of living children. Son preference has a strong effect on contraceptive use, especially regarding sterilization. Among women with two or more living children, only about one fourth of women with only daughters have been sterilized compared with almost half of women with at least one son.

Many women have all the children they want (or more, even considering gender preferences) at a relatively young age. Sterilization is very effective and long lasting and an excellent method for women who are sure that they never want to have another child. As of 1998–99, nearly 17 percent of currently married women of reproductive age had been sterilized, and 0.7 percent were married to men who had been sterilized. Less than 7 percent, however, were using any modern method of temporary contraception. Use of oral contraceptives, intrauterine contraceptive devices (IUCDs), and condoms is very low (National Family Health Survey [NFHS] India, 1998–99, Uttar Pradesh). Nevertheless, the proportion of women who wanted no more children but who were not practicing contraception was larger than the proportion who wanted to delay becoming pregnant but were not practicing contraception (i.e., the unmet potential need for sterilization was larger than the unmet need for temporary methods—13.4 percent unmet need for limiting versus 11.8 percent unmet need for spacing). Although unmet need as defined in this way does not automatically convert into the desire to have a sterilization procedure, 35 percent of rural women who were not using any method of contraception wanted to have a tubal ligation at some time in the future.

Total unmet need for family planning among married women in Uttar Pradesh is estimated at almost 30 percent. Unmet need is highest for women below the age of 20, who are particularly interested in spacing their births. Such facts underscore the need for

family planning service delivery strategies that provide spacing (temporary methods) as well as sterilization in order to meet the changing needs of women over their life cycle.

Women are more likely to use private than public services for therapeutic medical care. In fact, there is a strong trend for both men and women in Uttar Pradesh to use private sector providers to meet their health needs other than family planning. As of 1998–99, persons in 88 percent of the households in Uttar Pradesh used the private sector when sick; 71 percent of rural households used private doctors. The public sector, however, is by far the major source of family planning services in Uttar Pradesh. Nevertheless, the role of the private sector is increasing. The public sector was the source for almost 94 percent of sterilized women included in the 1998–99 NFHS, but for only 89 percent of sterilized women in 28 SIFPSA districts surveyed in January 2002.

Knowledge of HIV/AIDS

Perhaps as many as 70 percent of women in Uttar Pradesh have not heard of AIDS. Among women who have heard of AIDS, one third do not know of any way to avoid infection. Awareness of AIDS is particularly low among women not regularly exposed to the media, scheduled tribe women, illiterate women, women living in households with a low standard of living, and rural women. Among women who have heard of AIDS, almost 80 percent learned about the disease from television and 40 percent from radio, suggesting that the government's efforts to promote AIDS awareness through the electronic mass media have achieved some success.

The End-of-Project Assessment

A six-member team was hired by the Population Technical Assistance Project (POPTECH) to conduct an assessment of the IFPS project. Areas of team expertise included management and finance, private sector service delivery, contraceptive social marketing, communications, and public sector service delivery/epidemiology.

The assessment team was asked to analyze, document, and assess the project's progress, challenges, opportunities, and current needs; provide recommendations for short and long-term project direction to meet identified needs; and consider the possible design and scope of any follow-on project.

After an initial 2-day meeting in Washington, D.C., for development of the team approach and work agenda and for briefings from relevant USAID and other donor staff, the assessment team spent 5 weeks (November 3 to December 5, 2002) in India gathering information and preparing its report.

The methodology used to conduct the assessment included a thorough review of relevant project documents, demographic and other research reports, project strategies, and subcontracts. Team members met in groups and individually with staff of USAID in Washington, D.C., and New Delhi; with staff of SIFPSA, the cooperating agencies (CAs) and other technical partners; and with representatives of other international funding and implementation agencies. The team visited national, state, district, and community-level offices and project activity sites and spoke with staff, service providers, and clients at public and private health facilities. Team members reviewed information, education and

communication (IEC) materials and observed community-level IEC activities, training sessions, and counseling and clinical procedures.

IFPS ACCOMPLISHMENTS AT THE END OF A DECADE

The IFPS project has been responsible for a wide range of important accomplishments. Some of these accomplishments may constitute the necessary preconditions for future, greater impacts on family planning.

Population Policy, Leadership, and Advocacy

- With technical assistance from the IFPS project, the government of Uttar Pradesh adopted a comprehensive population policy, which provides a referent for state family planning initiatives. In addition to fertility and contraceptive prevalence goals, the policy addresses relevant issues, such as the need to limit marriages to women 18 years or older.
- Through the impetus of the IFPS project, SIFPSA has been created to serve as a champion of family planning/reproductive health (FP/RH) issues in Uttar Pradesh.
- SIFPSA has extended its physical presence into each of the IFPS districts through the district action plan process. Fully staffed and operational District Innovations in Family Planning Services Agencies (DIFPSAs) act as a catalyst for family planning activities in each of the project districts. This fully operational system extends family planning policy, strategy, and service delivery planning processes down to the district level and thus broadens ownership of the overall FP/RH agenda. A district action plan and budget are developed to support implementation of each district's agenda. The result is a clearly defined plan of activities with accountability. A group of local representatives serves as a board of directors for the family planning agenda of the district. This group has complete program and budgetary authority for the FP/RH activities funded by SIFPSA and USAID. Thirty-three of Uttar Pradesh's 70 districts are now implementing district action plans. This may represent the first time that responsibility for family planning has been centered at the district level.
- The IFPS project contributed to the NFHS. The NFHS report is a fundamentally important document for demographic analysis, population and family planning assessment, and planning, and is critical in enabling population advocacy and policy in India.
- Advocating for and obtaining government approval for an IUCD with long-term effectiveness is a notable accomplishment of the IFPS project. The newly approved IUCD is effective for about 10 years. Availability of a longer acting IUCD should make this method more attractive as an alternative to sterilization for women who want no more children but feel insecure about permanently terminating their fertility at a relatively young age.

- The government of India has recently encouraged USAID (using unilateral funds) to implement a pilot project promoting and distributing Depo-Provera through its contraceptive social marketing activity.
- The IFPS project has initiated FP/RH advocacy in Uttar Pradesh through population policy development, press coverage, and networking with opinion leaders and decision-makers. While limited in scope, this advocacy for FP/RH issues is significant, especially in a political environment as sensitive to family planning as is India's.

Increasing Access to High Quality Sterilization Services in the Public Sector

- To assure the quality of the sterilization services provided, almost 700 public sector physicians have been trained in tubal ligation methods (laparoscopy, minilaparoscopy, or abdominal tubal ligation), and 61 physicians have been trained in the no-scalpel vasectomy (NSV) technique.
- Reproductive/child health camps were developed as a means to increase access to sterilization services and to perform sterilizations in the context of other maternal and child health (MCH)/RH services. Almost 26,000 reproductive/child health camps were held at block public health centers between May 1998 and March 2002.
- A variety of community-based workers has been trained to provide family planning information, counseling, and referrals to the auxiliary nurse-midwife at the local subcenter for women who want tubal ligation.
- The capacity to provide high-quality, performance-based training in female sterilization methods has been established in three medical colleges.

Improving the Family Planning Performance of Auxiliary Nurse-Midwives

- About half of the rural subcenters out of which auxiliary nurse-midwives function have been assessed and upgraded, which includes improvements to the physical facilities, equipment, and locations.
- The IFPS project successfully led to the use of World Bank funds to fill 1,825 auxiliary nurse-midwife positions.
- Almost 9,000 auxiliary nurse-midwives who work in public sector health care facilities in Uttar Pradesh have completed a 6-day participatory, performance-based course covering IUCD insertion and follow up, infection prevention, identification of sexually transmitted diseases/reproductive tract infections (STDs/RTIs), postabortion care, general and method-specific family planning counseling, and management of oral contraceptive and IUCD complications. In addition to training relevant to family planning, the course has focused on training in support of increasing tetanus toxoid immunization and distributing iron and folic acid to pregnant women. The performance of each trained auxiliary nurse-midwife is tracked; 80 percent met the standards. Physicians

reported that they believe that there has been a significant reduction in intrauterine infections as a result of the current training program.

- A multidisciplinary team of trainers from each of the 13 regional health and family welfare training centers in Uttar Pradesh is now experienced in the use of the auxiliary nurse-midwife training curriculum.
- IFPS was instrumental in converting the previously closed schools for auxiliary nurse-midwife preservice training and their tutors into active centers for on-the-job training in special vertical MCH/RH programs.

Integrating Family Planning With Other MCH/RH Services and Improving Those Services

- The IFPS project has improved the infrastructure of the public health system. More than 80 percent of all community health centers, postpartum centers, and block primary health centers have been upgraded to improve their capacity to provide safe and effective clinical MCH/RH procedures and care.
- Sterilization is being provided in the context of antenatal services and childhood immunizations in reproductive/child health camps; sterilization and other methods of family planning are being discussed during childhood immunization sessions run by auxiliary nurse-midwives. These are very important changes in India, where family planning once meant sterilization, which was provided in camps that had no interface with maternal and child health.
- Almost 12,000 traditional birth attendants (TBAs) have received 6 days of training in clean delivery practices, antenatal and postpartum healthy behavior messages, and postpartum family planning. An external assessment found evidence of increased use of tetanus toxoid and increased use of postpartum family planning among clients of trained TBAs.
- In IFPS project areas, the proportion of women who receive iron and folic acid supplements during pregnancy has increased. Packaging has been improved to encourage pregnant women to take the pills as directed. The proportion of women who receive at least one dose of tetanus toxoid immunization during pregnancy has also been significantly increased, from 44 percent of pregnant women in 1992–93 to 65 percent in 2001.
- Virtually all medical officers occupying posts in all public sector facilities in Uttar Pradesh in 2001 received training to update their knowledge of modern contraceptive technology. Virtually all medical officers occupying public sector posts in the IFPS districts also received training in diagnosis and treatment of STDs and RTIs.

Contraceptive Social Marketing

- The availability in rural and periurban areas of temporary modern methods of contraception (oral contraceptives and condoms) was significantly increased through the IFPS contraceptive social marketing activity. The proportion of rural villages with at least one commercial outlet selling condoms and one outlet selling oral contraceptives increased from 19 percent in 2000 to 43 percent in 2002.
- Condom sales in retail outlets increased by 93 percent from 2000 to 2002 in rural Uttar Pradesh. No other North Indian state had an increase in condom sales of this magnitude in rural areas. Sales of oral contraceptives also increased in the rural areas of Uttar Pradesh. This effective implementation of a social marketing activity is a model for the introduction, promotion, and distribution of other contraceptive methods and healthy lifestyle products.

Increasing Private Sector Involvement in Family Planning

- Project interventions in the private sector have led to significantly increased recognition of the private sector as a legitimate partner for the public sector in the provision of FP/RH services.
- IFPS has successfully and importantly positioned the nongovernmental organization (NGO) sector as an effective partner to the public sector in the provision of FP/RH services to eligible couples in rural and periurban areas. The interpersonal communications of community-based distribution (CBD) workers and their household distribution of spacing methods have been important in changing the RH behaviors of potential rural users where there is no tradition of birth spacing and little acceptance of family planning beyond limited use of government-promoted sterilization. Contraceptive prevalence increased 2–5 times faster in areas where IFPS-supported NGO outreach services have been provided for at least three years, compared with the increase in the entire project area.
- FP/RH has been successfully incorporated into the outreach services of a variety of NGOs and cooperatives and into services provided by businesses to their employees.
- IFPS initiated the incorporation of additional types of service providers into the FP/RH service delivery system (e.g., indigenous system of medicine practitioners and TBAs). While the overall impact of these interventions has been mixed, there have been reports of isolated successes of increases in the use of FP services.
- Selected private practice physicians have been trained in family planning counseling and updated in contraceptive technologies.

Information, Education and Communication (IEC)

- IFPS developed a *Communication Strategy for Health and Family Planning in Uttar Pradesh*, which was released by SIFPSA in 1995.
- As part of this overall strategy, the “Aao Batien Karien” or “Come Let’s Talk” logo and message were developed and produced. “Aao Batien Karien” serves as the unifying theme for selected FP/RH IEC activities and materials. It was prominently featured in a multimedia campaign promoting discussion of spacing methods among and between family members and providers and is widely used by NGO outreach workers in their home visits. In addition, 18,500 NGO workers and auxiliary nurse-midwives in 33 districts have been trained in the use of these IEC materials.
- Since the “Aao Batien Karien” campaign, several other statewide multimedia campaigns have been conducted or are underway through private sector advertising and media production agencies on priority FP/reproductive/child health themes. Statewide IEC has also been produced for the promotion of reproductive/child health camps, NSV, safe motherhood, and the launch of the Population Policy for Uttar Pradesh.
- IFPS provides IEC support to the districts for purposes such as measles vaccination and promotion of IUCD use. FP/RH messages have been placed on the panels of 300 state buses and on the walls of village subcenters in 15 districts. In smaller villages in 24 districts, 6,800 folk performances have been given to carry reproductive/child health messages to rural audiences in an entertaining way. “Grameeno Ke Beech” mobile fairs or melas have been used to promote awareness and immunization services in villages in 18 districts, with an average of 2,013 immunizations per district during the melas.
- Numerous staff members from SIFPSA and other Indian organizations have received training in communication planning and IEC at international workshop venues.

PROJECT IMPACT ON FERTILITY AND USE OF MODERN METHODS OF CONTRACEPTION

The accomplishments linked to improvements in infrastructure and process are significant and important because they contribute to or facilitate the accomplishment of the project’s primary stated goals: an increase in use of modern contraceptives and a decrease in fertility.

The IFPS Project Paper called for a doubling in MMCP in Uttar Pradesh over the 10-year project. IFPS has not been able to meet this goal. During the six years between 1992–93 and 1998–99 (dates of the two most recent statewide contraceptive surveys), the MMCP for the entire state increased by 3 percent, from 17.8 percent in 1992–93 to 20.8 percent in 1998–99, a gain of 0.5 percent per year (see table 1, following page). The increase as a percentage of the 1992–93 MMCP in the IFPS districts was approximately twice the increase in the non-IFPS districts.

IFPS is directly involved in about half of the districts in Uttar Pradesh. Although annual surveys have been conducted in the IFPS project districts since 1999, no surveys have been conducted in the other nonproject districts since the 1998–99 NFHS. The MMCP in the IFPS project districts increased from 24.9 percent in late 1999 to 26.7 percent in late 2001. The absolute increase in the MMCP was 0.9 percent per year during the interval between these surveys, as shown in table 2 below.

Table 1
Modern Method Contraceptive Prevalence in 28 IFPS Districts, All Other Districts in Uttar Pradesh, and for the Entire State of Uttar Pradesh
 (Based on the NFHS, 1992–93 and 1998–99)

Districts	MMCP in 1992–93	MMCP in 1998–99	Increase in MMCP Between the 1992–93 and 1998–99 Surveys		
			Absolute Increase in MMCP	As a Percent of MMCP in 1992–93	Percent Increase in MMCP per Year, 1992–93 to 1998–99
28 IFPS Districts	18.4	22.4	4.0	21.7	0.67
All other Districts	17.2	19.0	1.8	10.5	0.3
All of Uttar Pradesh	17.8	20.8	3.0	16.9	0.5

Table 2
Total and Method-Specific Modern Method Contraceptive Prevalence Among Currently Married Women of Reproductive Age in All 28 IFPS Districts
 (Measured by the 1999, 2000, and 2001 SO 2 surveys)

Contraceptive Method	1999 SO 2 Survey	2000 SO 2 Survey	2001 SO 2 Survey	Increase Between 1999 and 2001 Surveys		
				Absolute Increase in Rate	As Percent of 1999 Rate	Percent Increase in Rate per Year
Sterilization	17.2	17.6	18.3	1.1	6.4	3.2
IUCDs	1.3	1.4	1.4	0.1	7.7	3.9
Oral Contraceptives	2.1	2.4	2.5	0.4	19.0	9.5
Condoms	4.3	4.4	4.5	0.2	4.7	2.3
All Temporary Methods	7.7	8.2	8.4	0.7	9.1	4.6
All MMCP	24.9	25.8	26.7	1.8	7.2	3.6

Method-specific contraceptive prevalence changes over time in the six districts in which the IFPS project began work earliest were closely examined by the assessment team. Two districts, Meerut and Varanasi, had significant changes. The total MMCP for Meerut was almost 45 percent in 2001, with an IUCD-specific contraceptive prevalence of 3.1. The total MMCP for Varanasi was 37.6, with an IUCD-specific contraceptive

prevalence of 2.6. These findings suggest that IFPS project inputs can have a significant impact where they are implemented strongly in a supportive environment. Although the expanded use of MMCP has been less than projected, most of the project's accomplishments are likely to constitute the necessary preconditions for future, greater impacts on contraceptive prevalence.

The total fertility rate (TFR) for Uttar Pradesh fell from 5.2 in 1993 to 4.6 in 1998. This reduction is well in line to achieve the project goal of 4.3 by 2004.

PROJECT IMPACT ON CONTRACEPTIVE PREVALENCE

Policy, Leadership, and Advocacy

To achieve change in Uttar Pradesh, a cohesive program for family planning and reproductive health is needed, with IFPS and SIFPSA working together to achieve this goal.

The new Population Policy (2000) for India reflects a shift from earlier, demographically driven, target-oriented policies to one that addresses the special concerns of reproductive health and asserts the centrality of human development, gender equity and equality, and adolescent reproductive health and rights, among other issues, in stabilizing India's population growth. It is not clear whether a document or reporting system that addresses or builds on these new policy directions has been developed.

There is now a National Commission on Population under the chairmanship of the prime minister to monitor the implementation of the new Population Policy, an empowered action group focused on the Hindi Belt states under the chairmanship of the Minister of Health and Family Welfare, and a National Population Stabilization Fund, which is intended to energize the new Population Policy.

The natural partnerships potentially available to the project through the international family planning movement and national-level leadership in family planning and population have not yet been realized.

Limitations Arising from General Project Implementation and Management Practices

During the IFPS project design and approval phase, there was advocacy and interagency relationship building at the highest levels. However, it did not facilitate the timely launch of the project, which caused program delays. Consequently, many interventions are in the beginning stages. Activity has lagged particularly in the areas of communications/IEC, contraceptive social marketing, development of reliable data, and research.

Lines of accountability and responsibility for overall project performance are not clear. The lack of a designated manager within USAID, coupled with less than full collaboration between geographic and programmatic centers of authority, has caused problems in communicating the project's purpose and direction to project staff. Moreover, responsibility for ensuring timely implementation of project activities seems

to be assigned to both SIFPSA and cooperating agency (CA) staffs; however, CA staff needs SIFPSA approvals to proceed.

Because of the increasing political and management pressure to cover more geographic territory with project activities than to cover a limited project territory more fully, measurable impact of project activities on contraceptive prevalence within the areas covered has been constrained.

Another limiting factor has been the lack of in-house senior leadership with deep experience and authoritative technical and programmatic expertise in family planning in both USAID and SIFPSA.

Because of the project's need for expertise in a large range of fields of competence, USAID engaged a group of CAs from the United States to provide technical support to project management and staff. These CAs include or have included the Centre for Development and Population Activities (CEDPA), the University of North Carolina (INTRAH/PRIME), EngenderHealth, The Futures Group (POLICY Project and Commercial Market Strategies [CMS]), Johns Hopkins University/Population Communication Services (JHU/PCS), John Snow, Inc., Macro International, the U.S. Census Bureau (BUCEN), Contraceptive Research and Development (CONRAD), and the Population Council. Each of the CAs has made important professional and technical contributions to the project. However, the staffs of the CAs are confined to New Delhi, nearly an hour away from Lucknow by air; lines of authority and responsibility are unclear; and the technical support services available are underutilized. SIFPSA apparently has little input in the selection of CAs and has appeared disinclined in the past to use the technical and professional capacities of the CAs to best effect.

The word “innovations” in the IFPS project title was important and had significance to project designers. Through an arrangement with the Population Council (no longer a part of the IFPS project), the project was supposed to have access to technical assistance for identifying and/or clarifying problems and developing and testing innovative solutions. Solutions would be implemented on a large scale after they were found to be effective. However, testing of the impact of strategies through operations research appears limited. There does not appear to have been a systematic collection of evidence on effective solutions.

Activity performance data were not necessarily used to implement correction of or to stop implementation of activities shown to have limited impact on project goals (e.g., training the indigenous system of medicine providers did not lead to increased service delivery). Interim monitoring/evaluative data were not always used for the implementation of midcourse corrections necessary to increase the impact of project activities on contraceptive prevalence.

Although the project was supposed to result in an improved family planning management information system (MIS), district family planning service statistics are not consistently reliable. This is the case for service data generated through public sector family planning service delivery sites and for data on NGO acceptor rates and NGO product sales and distribution. There does not appear to be a project focus on or an ability to measure contraceptive continuation—a critically important element in sustained growth in

contraceptive prevalence. Lack of reliable MIS data compromises the ability of the project to evaluate its own progress and to use data as a sound basis for decision-making. Much more data appear to be collected than effectively used.

The project has been involved in the promotion and provision of a limited array of temporary methods of contraception. Depo-Provera and emergency contraception have not been provided, and the importance of the lactational amenorrhea method (LAM) for postpartum women has not been emphasized. Research has demonstrated that increasing contraceptive method choice results in overall increases in contraceptive prevalence.

Problems Embedded in the Government Civil Service

SIFPSA was created to allow the IFPS project to proceed free of the bureaucratic barriers and burdens inherent in trying to implement a large family planning project through the government. However, SIFPSA is staffed predominantly by senior government employees, some of whom appear to be imbued with the culture of the government bureaucracy. As a result, although SIFPSA's position outside of government has provided some benefits, the organization retains some of the minuses of a government agency (e.g., it has been slow to invest in the private sector).

In some instances, SIFPSA's position in relation to governmental agencies has been a disadvantage. When the IFPS project and SIFPSA staffs have confronted issues that are based in government rules and practices (e.g., rules that limit the types of physicians that can be trained to perform laparoscopy, problems related to the role of the auxiliary nurse-midwife), they have tended to avoid the problem rather than try to resolve it. In the long term, however, many of these issues need to be faced (e.g., the numbers of some of the most important public sector outputs, such as physicians trained in sterilization methods, were lower than expected). Some differences between planned and actual inputs reflect good management responses to changing circumstances or recognition of problems that needed to be addressed, but some represent a failure to overcome conditions in order to meet the original project objectives.

Some programmatically relevant issues are embedded in the government civil service and seem to be beyond IFPSA's capacity to alter. For example, there is a functional shortage of auxiliary nurse-midwives for subcenter posts and of physicians to perform female sterilization operations. There is an absolute shortage of auxiliary nurse-midwives, and many are unwilling to accept and remain in posts with poor facilities. Some of the physicians who have received sterilization training are not posted to positions in which they can use that training. Other physicians do not show up for scheduled clinics or arrive late and leave early.

Performance-Based Disbursement

The performance-based disbursement system has worked against the original concept of the IFPS project as a tester of innovations because innovation inherently includes the possibility of failure. All innovations are not effective and/or efficient. The performance-based disbursement system, as currently implemented in the IFPS project, penalizes SIFPSA with nonpayment for any activity not carried to full implementation as described in preset benchmarks. The performance-based disbursement system has also

worked to focus SIFPSA management attention on initiating and completing activities rather than on the ongoing monitoring necessary to recognize the need for and make midcourse corrections in service delivery strategies.

Communications and IEC

The original plan for the IFPS project to use JHU/PCS to help formulate and execute an integrated communications program was not successful for a variety of reasons. SIFPSA has not yet succeeded in establishing an integrated communications strategy in-house.

Communications support for service delivery initiatives and behavior change has been the weakest IFPS project activity. When campaigns were developed and implemented (such as for the contraceptive social marketing effort and for auxiliary nurse-midwife insertion of IUCDs), they were initiated relatively late in the project. Frequently, communications campaigns were not developed and implemented in support of project service delivery activities (such as for a trained indigenous system of medicine practitioners), and the impact on contraceptive prevalence of project investments in these activities was greatly constrained.

SIFPSA has never implemented a promotional campaign for oral contraceptives.

Although established in Rajasthan and other states, there is no state-level IEC bureau in Uttar Pradesh. Currently, there are no communications and IEC professionals at the highest levels within the government of Uttar Pradesh MOHFW.

In the past, communications and IEC materials and activities have been initiated through the government of Uttar Pradesh system in an ad hoc manner, determined usually by the numerous health campaigns undertaken throughout the year. In Uttar Pradesh, as in many other states in India, less than one fourth of district and block-level health promotion posts are filled at any one time, creating little infrastructure for strategically planned and implemented communications and IEC campaigns

Efforts To Increase Use of IUCDs by Improving Services Provided by Auxiliary Nurse-Midwives

Increasing the use of IUCDs has been slow. Although a long acting and very effective temporary method of contraception, IUCDs are new to most women in Uttar Pradesh and require a well-trained service provider; a private, clean room and sterile equipment for insertion; and a functioning consultation and referral system for managing complications. The auxiliary nurse-midwife in the public sector health care system already has many demands on her services.

The auxiliary nurse-midwife position at a subcenter outlet is based on the assumption that one auxiliary nurse-midwife will serve as the primary source of preventive MCH/RH services for a population of approximately 5,000. However, the populations served by each subcenter have increased, with some now expected to serve as many as 10,000 to 12,000 people from three to six separate villages.

Training of auxiliary nurse-midwives was discontinued in Uttar Pradesh in 1989. Fifteen to 30 percent of auxiliary nurse-midwife subcenter posts are vacant, and some posts have been vacant for more than a year. In addition, the current cadre of auxiliary nurse-midwives is aging.

Three fourths of lady health visitor posts are unfilled.

The process of upgrading subcenters where auxiliary nurse-midwives provide services is incomplete and compromised by conditions in some rural villages of Uttar Pradesh. In addition, repair of subcenter facilities did not begin until 2001 in 8 of 33 SIFPSA districts, has not yet been completed in 15 districts, was not included in the plans for one district, and was planned for only one fourth of the subcenters in 5 districts. As of November 2002, less than half of the subcenters in the IFPS project area had been strengthened. While some subcenters were upgraded or a different building was leased when the existing one was uninhabitable or very poorly located, no new structures were built. In many villages, it has not been possible to find already existing, intact buildings with enough space for living quarters and a two-room clinic (for client privacy) in a secure, central location.

A substantial, sustained, well-designed, and well-developed effort to inform women in rural Uttar Pradesh about IUCDs has not yet begun. Moreover, a new IUCD IEC/promotional effort was initiated too late (summer of 2002) for any impact to be reflected in IFPS efforts on contraceptive prevalence in the project districts.

Efforts To Increase Use of Female Sterilization

To reduce fertility to replacement levels by 2016 with the current method mix, Uttar Pradesh would need 5,000 trained surgeons, each performing an average of 250 tubal ligations annually. Only 2,600 physicians posted to government positions in Uttar Pradesh have ever been trained in a method of sterilization.

The number of physicians trained in sterilization methods under the aegis of the IFPS project was much less than that anticipated in the IFPS Project Paper. So far, IFPS has increased the original pool of tubal ligation providers by less than 8 percent. Two thirds of sterilization method training given to physicians in Uttar Pradesh during the project was refresher training to upgrade the skills of physicians who had previously been trained in either laparoscopy or abdominal tubal ligation. Only 188 physicians were added to the pool of Uttar Pradesh physicians ever trained in a method of tubal ligation, and none of the training of new tubal ligation providers was started before 2002. Government policy prevents any physicians except obstetricians/gynecologists and other qualified surgeons from being trained in and using the laparoscopic technique for female sterilization. As a result, female general practitioners who fill positions in block primary health centers and community health centers have not been trained to perform sterilization procedures.

The decision to send a physician for project training in tubal ligation comes through the DIFPSA in each of the IFPS districts. Although 60 percent of IFPS districts had begun to send physicians for training in tubal ligation by at least 1999, three districts have not yet sent any physicians, and one district did not send anyone until August 2002.

It is government of Uttar Pradesh policy to provide all major MCH/RH services through static facilities that are open continuously or on a regular basis. Although sterilization is available on a regular basis at district hospitals and postpartum centers, the government remains unable to provide reliable access to sterilization services at most of its community health centers and block primary health centers. A physician trained in tubal ligation has been assigned to only about 30 percent of all community health centers and block primary health centers in the IFPS districts, and many of those physicians are not actually available to provide sterilization services on a regular basis. Public sector inability to provide consistent MCH/RH services, especially adequate access to sterilization, at static, full-service facilities has led to the IFPS project strategy of providing most of these services at reproductive/child health camps.

Efforts To Increase Use of Male Sterilization

All of the NSV training provided by IFPS was conducted in Uttaranchal. NSV is the fastest, safest, and least expensive method of sterilization, but there has been no effort to create demand for vasectomy in Uttar Pradesh. The project has been unable to find any substantial interest in this method in Uttar Pradesh as it is now configured.

NGO/CBD Projects

Only about one fourth of the population of the IFPS districts is covered by a CBD program. This is not sufficient to have a measurable impact on contraceptive prevalence for the entire area covered by the project. However, it must be recognized that one quarter of the project area represents more than 20 million inhabitants. The challenges and accomplishments of implementing CBD programs on such a large scale are not insignificant.

The relatively high dropout rate (about 50 percent) of NGO partners after three years has caused the proportion of the IFPS project population served by CBD projects to plateau over the past five years, rather than increase for greater impact. While SIFPSA has made 232 grants to NGOs, cooperatives, and employers since 1995, the number of active CBD projects per year has remained relatively steady since 1997. There does not appear to be any increase in the overall coverage of the population by CBD workers. Additionally, it is not clear to what extent dropout NGOs continue to offer FP/RH services to their constituents once the NGO's active participation in the IFPS project has ended.

SIFPSA's burden in time spent and number of staff required to manage directly every NGO partner grant is significant.

The project has not developed a system of messages specifically targeted to particular points in a woman's reproductive life cycle. The "Aao Batién Karién" ("Come Let's Talk") flip chart provides only general information and messages. It does not offer the CBD worker a specific message that may be particularly appropriate or effective for a newly married woman, a nursing mother with an infant, a young woman with two young children, or a woman with four children.

The cost per acceptor in a CBD service delivery network is higher than the cost per acceptor found in most public sector and other private sector channels. The cost

efficiency of CBD service delivery through large cooperative structures compared with smaller NGOs (as both are currently implemented by SIFPSA) has not been analyzed. The feasibility, cost-effectiveness, and impact of other channels for community-based interpersonal communications for FP/RH (such as community group meetings, the addition of FP/RH communication tasks to existing anganwadi workers, use of the CARE model in community mobilization) have not yet been tested and evaluated.

There is a debate in Uttar Pradesh (and in family planning circles around the world) regarding the wisdom and sustainability of an outreach/personal communications model based on such high costs. In response, in 2001 SIFPSA initiated a policy to encourage/enforce financial self-sustainability among its NGO grant recipients. Instead of supporting sustainability, SIFPSA's policy led to reductions in the number of CBD workers in some NGOs at an early point in the FP/RH acceptance continuum. The policy did not stress the importance of maintaining continued contraceptive use among early acceptors and probably slowed momentum in the increase in contraceptive prevalence in project areas.

Noncontraceptive products related to other aspects of reproductive health, such as iron folic acid tablets, are not currently distributed by CBD workers. While increasing the use of iron and folic acid tablets among pregnant women is a CBD grant objective, CBD workers must refer their clients to the local auxiliary nurse-midwife for product distribution. Noncontraceptive products are of particular importance because they may offer increased opportunity for profit through sales and therefore for increased financial sustainability of the NGO/CBD outreach intervention.

Contraceptive Social Marketing

Thirteen percent of the original IFPS project budget was allotted to social marketing (\$42 million); only \$7 million has been obligated for social marketing to date.

The original Project Paper did not envision SIFPSA as the conduit for bidding and awarding contraceptive social marketing contracts. However, because USAID was not permitted to award such contracts to the commercial sector, it was agreed that SIFPSA would function as the contracting entity in social marketing. SIFPSA launched the first contraceptive social marketing pilot project (with HLL, a parastatal distributor and manufacturer) in 1997.

In the interim, USAID's global support mechanism funded modest social marketing projects in Western Uttar Pradesh from 1994 to 1998. Although these projects expanded access to condoms and oral contraceptives, their performance and size were not adequate to have an impact on overall contraceptive prevalence.

To date, the contraceptive social marketing activity has resulted in good increases in the availability of oral contraceptives and condoms but has demonstrated unremarkable results in generating increased consumer demand for these products. Social marketing needs the creation of sufficient demand to make the commercial supply profitable.

The generation of demand for contraceptive social marketing products is largely dependent on the effective use of mass media and other advertising that regularly reaches

targeted consumers. It was originally planned that SIFPSA would use the technical resources of JHU/PCS to help formulate and execute an integrated communications program supporting the contraceptive social marketing effort. Ultimately, SIFPSA did not request that JHU provide communications support to the contraceptive social marketing project because it intended to develop the project communications strategy and campaigns and to outsource its own IEC contracts. However, SIFPSA has not been able to mount a successful integrated communications strategy in-house. Additionally, there has not been enough marketing research undertaken to support the launch of a successful promotional campaign.

Although condoms and oral contraceptives are now available in almost half the rural villages in Uttar Pradesh, not enough demand has been created to make it profitable for the contracted distribution companies to supply these rural areas without SIFPSA funding support.

Lack of an effective logistics system in the public sector may also have reduced the effectiveness of the private sector contraceptive social marketing program. A large supply of the leading contraceptive social marketing brand of oral contraceptives was diverted to the public sector when public sector supply of oral contraceptives was extinguished in April and May 2001. Consequently, contraceptive social marketing sales were forced to compete with the free distribution of its own branded product.

Continuation of oral contraceptive use by contraceptive social marketing consumers is very important to the impact of the contraceptive social marketing activity on contraceptive prevalence. Continuation of oral contraceptive use may be negatively affected by some women's perception that there is no one in the commercial sector to whom they can turn for advice or support in the event of side effects.

Other Efforts To Involve the Private Sector

Early project management distrust of the for-profit private sector limited collaborative and synergistic public-private partnerships in FP/RH service delivery as well as necessary project support for private sector providers' full participation in project service delivery activities.

Although more than 12,000 indigenous systems of medicine practitioners (ISMPs) from rural and periurban areas have received SIFPSA-funded initial and refresher training, the ISMPs were not promoted as outlets for quality family planning information and spacing methods. Although the ISMPs demonstrated considerable improvement in family planning counseling skills following this training, a formal assessment found that the training had not led to increased use of FP services. Based on the assessment findings, a revised strategy for encouraging ISMP provision of FP/RH services was developed with CA assistance. Trained ISMPs were to be linked to the contraceptive social marketing distribution chain so that they could provide oral contraceptives and condoms to their clients for a price that allowed some level of profit to the ISMP. While the revised ISMP strategy was approved by SIFPSA, it has not yet been implemented.

In 1995, SIFPSA contracted with the Indian Medical Association (IMA) to train private practice physicians in FP counseling and contraceptive methods; 1,562 physicians had

been trained by September 1996. Perhaps because of the problems that occurred, there has been no further effort to train private practice physicians or to use the physicians already trained for further private sector service delivery interventions.

Private sector health care providers are not willing to spend time learning new service delivery techniques if the training is not valuable to their practices/businesses. SIFPSA, however, has appeared reluctant in the past to support project activities that will increase income for practitioners, even if those activities will generate increased access to FP/RH services for targeted consumers.

In general, IFPS project experience with private sector interventions has shown that improvement in the quality of services delivered does not necessarily lead to increased use of those services.

SIFPSA does not appear to have a compelling strategy for recruiting commercial partners into project ventures and has not conducted a comprehensive assessment of the potential for employment-based delivery of FP/RH services, other than through CBD outreach, to reach unserved or underserved segments of the FP/RH market in Uttar Pradesh.

Logistics

Some efforts have been undertaken under the aegis of the IFPS project to improve the logistics of contraceptive commodity supply within the government system. Occasional stockouts have occurred.

Cost-Effectiveness and Sustainability

IFPS has not emphasized the need to institutionalize successful interventions and to build in long-term sustainability of successful interventions. The absence of either financial or operational sustainability in project activities appears to be due primarily to a lack of strategic plans for sustainability; structural and funding regulations that inhibit the establishment of sustainable programs (e.g., finite NGO contracts, finite project management unit contracts); insufficient numbers and/or timeframe to support sustainability; and an MIS that does not provide reliable information for monitoring either the effectiveness or the efficiency of specific project interventions.

The cost-effectiveness of innovative interventions has not been assessed, although projects and demonstrations are often not replicable because they are not financially sustainable in the long term. Basic financial data (e.g., unit cost information to ascertain the most financially efficient approach to obtain specific outputs) do not exist.

Another programmatic illustration of the impact on cost and sustainability of service provision modalities can be seen in how sterilization services are provided in the IFPS project. Laparoscopy equipment is expensive, including the costs for maintenance, repair, and parts replacement. Of nearly 323,000 tubal ligations performed at SIFPSA-funded reproductive/child health camps between May 1998 and March 2002, 88 percent were laparoscopic procedures.

Validity of the Original Project Model

The expectations for impact expressed in the IFPS project design were predicated on the expected synergy among the project's strategic elements (access, quality, promotion, and research) and assumed that the impact from the whole created by effective interaction of the strategic elements would be greater than the sum of the elements themselves. Since there is no IFPS district where all the strategic elements have been implemented, assessment and validation of the project design is not possible. In fact, some interventions are at the beginning stages of implementation, and it is too early to draw conclusions about their effectiveness. Additionally, there is no regular system within the project to review performance indicators for specific elements or activities.

If all the components of the original project design had been put in place—most notably an integrated communications program—project results (i.e., the impact of project interventions on contraceptive prevalence) would probably have been substantially better than they were.

THE PERFORMANCE-BASED DISBURSEMENT SYSTEM

An important innovation in the IFPS project is its method of funding—performance-based disbursement—that is triggered by the implementation and completion of preset activity benchmarks. This funding mechanism was chosen not only to establish clearly defined activities but also to ensure accountability and to create an incentive system for carrying out project activities. Benchmarks have each been assigned a dollar value. Once the benchmark is completed, SIFPSA submits documentation to USAID. Upon USAID's concurrence that the benchmark has been met, funds are released to the government of India. The Indian government treats the funds as reimbursement for the upfront costs associated with the SIFPSA activities that achieved the benchmark.

The performance-based disbursement system has had considerable success in motivating and maintaining considerable momentum within the project. At the same time, performance-based disbursement is cumbersome since it requires multiple agencies and stages to complete the payment process. Currently, there are 344 benchmarks, and each must be monitored and evaluated before reimbursement. The identification, negotiation, monitoring, and evaluation of each of these benchmarks is a daunting task for a project as large as IFPS.

Although SIFPSA management and staff articulate a preference for performance-based disbursement as the development instrument most likely to induce change in Uttar Pradesh, there are many problems. Disbursements are tied to an all-or-nothing formula:

- payment cannot be made for benchmarks until they are completed in entirety;
- benchmarks are too numerous, too detailed, and too intrusive;
- benchmarking has resulted in corrosive effects on learning and transparency;
- negotiation and verification of benchmarks confuse evaluative, fiduciary, policing, and partnership roles of various stakeholders; and

- tying payments to completion of a prespecified quantity of a particular activity makes it hard to make midcourse corrections based on experience.

This last-noted outcome of the performance-based disbursement process appears to have had a particularly negative effect on the innovative process within the IFPS project and on ensuring maximum positive impact of project activities on contraceptive prevalence. Some innovative interventions will fail to produce the desired results and should be discontinued or modified before completion of the initial design/benchmark. Under current performance-based disbursement guidelines, discontinuation or modification of an approved activity before completion results in loss of funding.

The performance-based disbursement funds process is not able to adequately track expenditures through the use of generally accepted accounting principles. The complexity of the process mitigates the positive impact of the incentive and accountability benefits of the system because payments are not disbursed as the benchmarks are accomplished but are instead lumped into one disbursement from the government of India each year. Passing funds through so many channels also makes it more difficult to track the money from an accounting standpoint.

While the USAID Mission's intent to improve the effectiveness of foreign assistance is noteworthy, a much more careful assessment of the performance-based disbursement system and process is warranted. The performance-based disbursement system inadvertently discourages innovation, trial and error, and midcourse correction and thus is out of step with an important intended characteristic of the IFPS project. Where performance-based disbursement may help push an implementation-focused project forward, it is not attuned to the nuances of a more deliberate, risk-taking innovation strategy that might better be tied to indicators than benchmarks. The performance-based formula is probably better suited to program and budget-support modalities than to project, indicator-driven modalities.

FUTURE FINANCIAL RESOURCES

The performance-based disbursement system will create a cash flow crisis for SIFPSA operations by midyear 2003 because benchmark commitments are outpacing performance-based disbursements. Now that the programmatic operations of SIFPSA have geared up as originally planned, disbursement under current policies and regulations will not be able to keep up with the current SIFPSA operating requirements.

The amount of funds obligated by USAID to IFPS is considerably less than the projected budget for planned activities for fiscal years 2003 and 2004. This shortfall is estimated at \$22–30 million less than currently projected expenditures. A reduction in operations will probably be forthcoming. To alleviate this problem, it will be necessary to develop strategic work plans for SIFPSA, the CAs, and USAID to determine the budgetary requirements for the next two years.

RECOMMENDATIONS

Focus of the Project and Roles of SIFPSA and USAID

1. ***Consider reorienting the focus of SIFPSA's project activities to innovation and transferring replication of successful innovations to others.***

Innovation—identifying, developing, and testing solutions within the local context—provides an effective vision for the future and an appropriate response to the growing disconnection among project strategies, state mandates, and available resources. The innovative models already introduced in the IFPS project need to be refined (e.g., district action plan activity criteria and selectivity, coordination and cooperation between the chief medical officer and project management unit, auxiliary nurse-midwife/CBD collaboration).

Focusing on innovation as its primary role would require that SIFPSA increase its strategic selectivity and strengthen its quality assurance and results orientation. Replication is necessarily the responsibility of main service providers—the directorates of health and family welfare within the government of Uttar Pradesh, as well as communities, NGOs, and private sector providers. Those institutions have the institutional wherewithal (assuming that the public sector follows through on recommendations for system reform) and financial resources (assuming that the government of Uttar Pradesh continues to receive budget support from major donors like the World Bank) to expand the implementation of successful, innovative interventions.

Mainstreaming activities (i.e., moving them from an innovative pilot to replication throughout the health care system) will require that SIFPSA and USAID develop a closer collaborative relationship with the directorates of health and family welfare, with the reform efforts of the European Commission, and with the programs and financial resources of the World Bank. SIFPSA and USAID will also need to become more entrepreneurial in order to market innovation and system change to the stakeholders that have the resources for replication. Successful marketing of innovative service delivery activities will require that SIFPSA demonstrate technical efficacy, improved outcomes, cost-effectiveness, and institutional feasibility of the innovations it wants other stakeholders to implement.

2. ***Consider reorienting USAID's current project focus to include engagement with a set of larger issues relevant to family planning in Uttar Pradesh and India.*** USAID should use its worldwide technical leadership and well-established convening role in India to create appropriate forums at a variety of levels for policy discussion and the building of intellectual consensus and broadbased coalitions necessary for strengthening the enabling environment for family planning and reproductive health in India and Uttar Pradesh.

USAID has had an important global leadership role for more than a generation in areas of family planning/population policy development, research and data collection, advocacy, and training. It furthers intellectual advances on determinants of health that lie outside the medical care system, including behavioral change and cross-sectoral interventions. USAID in New Delhi also has an opportunity to link its work

in the areas of economic growth and fiscal reform at the state level with issues of sustainability related to family planning services delivery and population growth.

3. ***Make available senior specialists with a clear mandate for collaborative policy discussions with government and nongovernment stakeholders.*** USAID's Office of Population and Reproductive Health should base (or make available on a more regular basis) in the Mission senior FP/RH specialists with a clear mandate for collaborative policy discussions with stakeholders at the highest levels both inside and outside of government and for ensuring that centrally funded resources are directed to key targets of opportunity in the enabling environment.
4. ***USAID should make a concerted effort to strengthen work with family planning partners (such as WHO, UNFPA, UNICEF, the World Bank, the European Commission, and other bilateral donors).***

Goals of the Project

5. ***Decline in the TFR should be dropped as an explicit goal of the project.*** Contraceptive prevalence is only one of the four proximate determinants of fertility. The others are marriage (age at marriage and proportion of women married), abortion (proportion of pregnancies that are terminated), and infecundity (including lactational amenorrhea and infertility secondary to sexually transmitted diseases). Education and health status, child survival, economic conditions, urbanization, status of women, religion, socioeconomic organization, and the diffusion of ideas also influence decisions regarding family planning and childbearing. The IFPS project cannot affect significantly many of the factors influencing fertility and therefore should not be held directly accountable for changes in the TFR.

Finance and Performance-Based Disbursement

6. ***Project and SIFPSA management need to consider carefully future resource requirements in relation to currently planned activities.*** Expenditures may increase while resources may become more constrained.
7. ***New project designers should reconsider performance-based disbursement as the funding mechanism for the IFPS project*** in light of the current performance-based disbursement system's lack of flexibility and burdensome management as well as its inability to support the innovation process. ***At a minimum, project designers should consider performance-based disbursement funding according to the percentage of an activity implemented instead of the current approach.***

Geographic Expansion and Significant Numbers: Impact on Contraceptive Prevalence and Sustainability

8. ***Focus activities in the time remaining on a limited number of districts to achieve a significant number of FP/RH acceptors.*** To be an effective innovator and to achieve a sufficient number of acceptors in districts in which the project is already engaged, SIFPSA should limit its implementation agenda to some or all of the existing project

districts—and, if moving out at all, moving out only to additional blocks within current IFPS districts rather than to more districts.

9. ***Introduction of the district action plan process/system in additional districts (eventually to the entire state) and continuing USAID support for a portion of that expansion has these significant caveats:***

- ***The district action plan process needs to involve authentic district-level planning based on a local strategy.*** Currently, activities emerging from the district action plan process appear to be arbitrarily selected from a list of activities that have been tried in other districts and are not based on a real local strategy.
- ***Funding for district action plan activities needs to come from a source other than USAID.*** The government of India, the directorates of health and family welfare, and the World Bank have all expressed interest in adding technical interventions and system innovations to their programs. If SIFPSA has an activity that works, it may find funding for it. USAID should fund the district action plan process itself and some scaled-back staffing of the DIFPSA project management unit but not activities emerging from that process.
- ***SIFPSA should launch an effort to build chief medical officer/project management unit family planning technical and management capacity as well as a team culture that promotes the adoption of proven interventions and innovations in DIFPSA districts.*** Neither the project management unit nor the district chief medical officer have had either technical or management training to prepare them for the kind of forward-looking strategic thinking required for the catalytic role of the project management unit. For the district action plan process to operate to its full potential requires consistent, coordinated, cooperative, and integrated action among the district magistrate, chief medical officer, and chief development officer.
- ***The private sector (including private sector practitioners, the pharmaceutical sector, and employers) needs to be more broadly included than at present in the district action plan process.***

It may also be cost-effective to expand the social marketing program to the whole of Uttar Pradesh, providing that a communications program with a solid strategy can be fully and effectively implemented in support of contraceptive social marketing efforts.

Focus on the Consumer

10. ***The IFPS project should develop a client-centered strategy to replace its current provider-centered strategy as the basis for all future programmatic interventions.***

The principles of marketing and behavior change should become the guiding principles of IFPS programmatic strategy and interventions. Behavior change, whether it is undertaken through the efforts of the public sector or those of the private sector, is, in essence, marketing. Focus on the client/consumer (not on the provider/seller) is the underlying principle of good marketing and behavior change process. Real focus on the consumer should lead to a broader range of method choices as well as more targeted messages, channels of communications, and service delivery interventions for better identified segments of the FP/RH market. Accurately and specifically targeted interventions directed to correctly identified segments of the market population are most likely to produce the desired healthy behavior results and have the greatest impact on contraceptive prevalence.

11. To support a focus on the consumer, ***SIFPSA needs to undertake new research and analyze existing data to identify the segments within the overall unmet need market and other potential FP/RH acceptors.*** Qualitative research must be implemented among the identified segments that will allow future strategic planning to be based on specific knowledge of the consumer, her/his needs and concerns, and preferences related to family planning and reproductive health.

Much additional research needs to be done to understand rural women's needs at various stages of their reproductive lives and their socioeconomic circumstances. More needs to be known about the types of family planning messages that will effectively reach and motivate these women and their husbands.

Technical Assistance

12. ***Consider reorienting technical support from contractual arrangements with U.S. organizations to locally based, market-oriented arrangements emphasizing the institutional and professional capacities of Indian organizations, the longer term potential of partnerships between Indian and U.S. institutions, the development benefits of moving from concepts of technical assistance to technical collaboration, and the potential for diversifying sources of financial support in collaboration with other donors and the private sector in India and the United States.***

One alternative is to reduce or eliminate the resident U.S. presence on the technical assistance teams (thereby reducing overall costs), construct a retainer arrangement to keep a core local staff engaged, allocate a budget to SIFPSA to buy into those services as appropriate (including expertise from the United States as required), and encourage the CAs to diversify their own business links in India by marketing services to state governments and international donors. This approach would put technical support services into the competitive marketplace.

A second alternative is to identify a few Indian institutions (e.g., education and research organizations, such as State Institutes of Health and Family Welfare, medical colleges, institutes of management) and develop institutional strengthening arrangements through partnership agreements with other Indian institutions (e.g., a collaboration between IIM Lucknow and the Operations Research Group in New Delhi) and/or U.S. institutions (e.g., a collaboration between one of the medical colleges in Uttar Pradesh and a medical or public health school in the United States).

These arrangements might include faculty/staff exchanges, technical reference arrangements, and/or joint degree or certificate programs. This proposal would move away from contractual agreements between USAID and U.S. institutions to direct cooperative agreements between Indian and U.S. institutions based on mutual advantage. In such a scenario, USAID might have a role similar to a foundation in some of these relationships (e.g., providing retainer support on both the Indian and U.S. side on behalf of SIFPSA) and could help in identifying private/philanthropic support for such arrangements. USAID's proposed partnership foundation might experiment with this idea as one of its initial activities.

Policy

13. *A policy executive committee should be convened per Policy Reform 2000 and should review the current FP/RH health policies established for Uttar Pradesh.* Some of the goals may need to be readjusted downwards to reflect the difficulty in achieving fertility reduction and contraceptive prevalence increases in Uttar Pradesh. Equally important, some of the goals incorporated in the recently developed policy plan for Jharkhand might also be considered for addition to the Uttar Pradesh policy. These would include the goals for human resource development as well as the drug and logistics policies. Other policies that should be considered include
- HIV/AIDS awareness and prevention,
 - availability of a wider array of temporary contraceptive methods,
 - allowing physicians who are not surgeons to be trained in tubal ligation, and
 - continued focus on policies that address gender issues.

Contraceptive Method Mix and the Interface Between Family Planning, Reproductive Health, and Child Health Interventions

14. *SIFPSA should work to expand the range of contraceptive methods—including injectable contraceptives, emergency contraception, and LAM—available through project interventions.*
15. *Efforts should be made to concentrate proven interventions in a few good opportunity districts to maximize contraceptive use by means of a method mix that meets needs for child spacing as well as termination of fertility.*
16. *The interface between breastfeeding, LAM, the postpartum woman's need to start another method of contraception, and the infant's need for immunizations should be much more fully exploited* for the benefit of both the mother and her child and the future of her family. Doing so would advance FP as well as other aspects of MCH/RH. A huge proportion of children in Uttar Pradesh are undernourished. Although traditional breastfeeding practices are flawed, they are amenable to improvement. Improved breastfeeding can save babies' lives and improve their health while increasing time between the mothers' pregnancies. Understanding and teaching LAM can help women and their care providers extend the contraceptive effect of breastfeeding and know better when the woman must adopt another method or risk another pregnancy.

17. ***Depo-Provera should be available through both public and private sector service delivery outlets and providers.*** The government of India has recently encouraged USAID (using unilateral funds) to implement a pilot project promoting and distributing Depo-Provera through its contraceptive social marketing intervention. USAID should take advantage of this opportunity by implementing a sound and well-researched strategy. Women must be well informed about the side effects of injectable contraceptives and should be followed up through appropriate research methodologies to monitor their satisfaction with the method.
18. ***The primary implementation partners in the IFPS project need to decide whether any additional project funds and level of effort should be expended to improve access to vasectomy.*** If so, to be successful, the delivery of vasectomy services needs to be implemented in conjunction with significant IEC efforts. Given limited project resources, such investments should probably not be made at this time.

Communications and IEC

19. ***Develop and implement an integrated communications plan to support project initiatives in the public, commercial, and private (including NGO) sectors.*** Such a program should inform people of all effective methods of contraception that are available to them and where and how they can access those methods. This plan should provide for consistent messages and symbols of quality. The required tasks for project management and staff are to emphasize communications, address the issues enumerated above, and test SIFPSA's ability to move aggressively and to engage competent outside technical support as necessary.
20. ***Project messages embedded in IEC materials and other behavior change materials should be targeted to specific segments within the FP/RH market,*** for example, young girls who have not yet initiated sexual activity, young married couples who want to delay the first pregnancy and birth, mothers who want to delay the next pregnancy and birth, and women who have completed their desired child bearing.
21. ***Over time, SIFPSA should build behavioral science into program design, increase the use of entertainment-education through the mass media, stimulate discussion and debate, design communication strategies broad enough to accommodate a range of reproductive health concerns and yet specific enough to deliver clear and simple messages that will lead to family planning outcomes, and introduce new communication technologies.***

Public Sector

22. ***The project needs to resolve the problems of the public sector MIS system and its contraceptive logistics.***
23. ***Auxiliary nurse-midwives should be trained and supported to provide a broader range of effective temporary methods of contraception.*** Auxiliary nurse-midwives may be particularly appropriate for the provision of Depo-Provera, emergency contraception, and LAM.

24. ***IFPS project management needs to consider the amount of project energy and resources that should be directed towards the objective of increasing auxiliary nurse-midwives' performance in the delivery of IUCD services versus their wider role in FP and MCH/RH.***
25. ***SIFPSA should implement a study in at least one district, probably Varanasi, in which the impact of providing full support for training auxiliary nurse-midwives in IUCD counseling and insertion can be monitored and evaluated.*** Robust, professionally developed and produced communications/IEC support for IUCDs (where, how, when, and from whom IUCDs can be obtained) needs to be an integral part of the study in the test district. Results from this study should form the basis for reconsideration of the current strategy of training auxiliary nurse-midwives for IUCD insertion.
26. ***Problems with the role of the subcenter auxiliary nurse-midwife should be investigated and addressed. If the government of Uttar Pradesh is planning to focus on this issue, SIFPSA and the CA that has been most involved with the training and support of auxiliary nurse-midwives should participate, provide information and insight based on their experience, contribute to bringing the necessary kinds and levels of people together to examine the auxiliary nurse-midwives' role from many perspectives, and test innovative approaches to improving auxiliary nurse-midwife job performance.*** Innovative approaches include expecting auxiliary nurse-midwives to be onsite at the subcenter for a third day every week, with the additional day focused on family planning, and dropping the expectation of routine home visits but training and expecting them to partner with community-based workers (TBAs, CBD workers, anganwadi workers, village volunteers) who make home visits to achieve the same results. There is also a need for better information on how auxiliary nurse-midwives are performing now, effects of the IFPS training, and barriers to more effective auxiliary nurse-midwife family planning performance. There should be serious discussion of the potential benefits and risks of changing the expectations (job description, training, and supervision) for subcenter auxiliary nurse-midwives. Can the auxiliary nurse-midwife role be restructured to enhance motivation, satisfaction, and success? Project management should consider conducting a service provision assessment of subcenter auxiliary nurse-midwives.
27. ***The curriculum developed by INTRAH/PRIME for the planned community midwife demonstration project should be considered for adaptation and use in a new auxiliary nurse-midwife training program.*** If, however, the curriculum and expectations are appropriate for a professional midwife, the product of the reopened schools should not be identified as an auxiliary nurse-midwife. If the auxiliary nurse-midwife schools are reopened for preservice training, the goal of a nurse-midwife should be in keeping with 21st century expectations for a professional rather than an auxiliary-level midwife.
28. ***Lady medical officers who are posted to primary health centers and community health centers should be trained to perform minilaparotomy sterilization procedures and to deal with obstetrical emergencies.*** A concerted effort is needed to find, recruit, hire, and train lady medical officers for these purposes. They should also be trained and given responsibility for management of the reproductive health of

women in the catchment area served by their facilities, including supervision of the lady health visitors (and thus the auxiliary nurse-midwives). Such a service delivery/supervisory system would support both expanded access to sterilization and reduced maternal mortality in the districts served by this project.

29. ***USAID, SIFPSA, and the government of Uttar Pradesh need to decide whether efforts to expand access to sterilization are going to be limited to reproductive/child health camps, district hospitals, and postpartum centers or whether there should be a concerted effort to also develop the ability to provide sterilization at most or all community health centers and block primary health centers on a daily basis.***
30. If NGOs are encouraged to develop full-coverage, high-energy projects in specified districts, ***an important part of the NGO effort should be directed towards building in reinforcement for referral for sterilization.*** The NGO/CBD should be given some kind of meaningful credit for referring women to local auxiliary nurse-midwives for referral for sterilization. Collaboration between auxiliary nurse-midwives and NGO project staff, both supervisors and CBD workers, should be a focus in the design of any relevant intervention. ***SIFPSA should evaluate the effect of changing the expectation of NGO/CBD grant performance from 80 percent temporary methods/20 percent sterilization to a 50/50 mix.***
31. ***Leading faculty from the three medical colleges that are now providing tubal ligation and other family planning training for physicians should develop plans with other medical education leaders for indepth family planning training in preservice medical education and for setting standards for the preservice training of obstetricians/ gynecologists.***

Contraceptive Social Marketing

32. ***An overall strategic communications/demand creation plan should be prepared before the project's response to the recently solicited regional and statewide requests for proposals for contraceptive social marketing product distribution and promotion.*** This plan should provide for consistent messages and symbols of quality to permeate statewide behavior change and promotional activities. The content of these messages should be consistent with the information communicated through the IFPS project's FP/RH IEC materials and other communications channels. The design of such a communications effort would need to be client based, with messages targeted to address the various reproductive life cycle needs of women and men in Uttar Pradesh. Such a targeted strategy will require consumer research in districts where the contraceptive social marketing activity is implemented. The best available communications/advertising professionals (whether from India or the United States) should be used to develop and produce the contraceptive social marketing communications/advertising campaign.
33. ***SIFPSA and USAID should study the success of the Program for Advancement of Commercial Technology–Child and Reproductive Health (PACT–CRH) that appears to be responsible for a substantial increase in oral contraceptive sales in urban areas of North India.*** Any new project design team should examine how such successful efforts and lessons learned might be integrated into the overall IFPS

contraceptive social marketing program or work cooperatively with existing IFPS contraceptive social marketing efforts.

34. ***The project should take advantage of economies of scale by expanding the social marketing program to all Uttar Pradesh***, if a well-strategized communications program can be fully and effectively implemented in support of contraceptive social marketing efforts.
35. ***The contraceptive social marketing intervention should expand the points of sale of additional temporary contraceptive methods, such as IUCDs and injectable contraceptives.***
36. ***SIFPSA should consider the design and implementation in one project district of a pilot reproductive health franchise system that could, if successful, be replicated in other IFPS project areas in Uttar Pradesh.*** The design should ensure that the franchise model will become self-sufficient (probably through selling subsidized products) within two years. The Green Star Project, the Andhra Pradesh Social Marketing Project, and the Janani project in Bihar all have elements that might be instructive in designing a franchise health network system. The Green Star model may be of particular interest to IFPS project designers since many of Pakistan's circumstances—including a high unmet demand for family planning and limited capacity of the public sector to meet fully its citizens' reproductive health needs—mirror those of Uttar Pradesh. It may also be useful for project designers to explore health care models that involve insurance plans, loans, credit schemes, and other instruments that might give rural and poorer communities better and/or more affordable access to health care providers, particularly to reproductive health care providers who can help clients make informed contraceptive choices. Above all, project design should take into consideration the key components of the social franchising formula: the business format, the brand, and quality assurance. A decision would also be required regarding which of the two principal types of social franchise should be used: stand-alone franchises or fractional franchises.

NGOs and CBD/Outreach

37. ***SIFPSA should conduct research and test options for improving the cost-effectiveness and sustainability of using NGO CBD workers to educate and counsel rural women about family planning and to provide direct access to oral contraceptives and condoms and refer women for sterilization services.*** Options could include
 - measuring the costs and impacts of CBD workers' current household activities on adoption, continuation, and discontinuation of temporary contraceptive methods by specific segments of women;
 - pilot testing use of village (compared with household) advocacy and empowerment interventions and comparing the costs to the project, impacts on behavior, and sustainability of behavioral change achieved through village-based interventions versus household-based CBD outreach; and

- studying the Sharmick Bharti social entrepreneurial experience to determine if it may offer lessons regarding the sustainability of NGO CBD activities.
38. ***Data currently collected through NGO/CBD projects should be analyzed to provide information useful for management decision-making, market segmentation, refinement/midcourse correction of NGO/CBD interventions, and impact analysis.*** Use of these potentially valuable data should not be limited to verification of NGO compliance with grant conditions.
 39. ***SIFPSA staff should intensify the search for economies of scale regarding NGO/CBD interventions through the involvement, if possible, of large cooperatives, autonomous public enterprises, and NGOs to enhance the ratio of personnel, management, and financial investment to results.***
 40. ***Analyze data currently being collected through NGO/CBD projects to provide information for midcourse corrections.*** Project managers should not wait until the grant term is completed to evaluate NGO performance and then eliminate an NGO for nonperformance. Research should be implemented to ascertain the reasons for past and current NGO turnover. ***On the basis of information learned from the research, SIFPSA staff should develop and implement a strategy for better, longer term NGO retention in project activities.***
 41. ***The feasibility/potential impact of involving the clinical facilities of participating NGOs/cooperatives/places of employment in increased provision of clinical FP services should be investigated by SIFPSA staff.*** Where feasible, a strategy for use of these private sector service clinical outlets for initiating, developing, and evaluating innovations in FP services delivery should be developed and implemented.
 42. ***SIFPSA management should reconsider the current criteria for NGO selection for project participation, at least under certain conditions.*** In order to expand CBD services into areas where less served segments of the population, such as Muslims and the scheduled classes, are living, it may be necessary to work with newer or less well-established NGOs.
 43. ***SIFPSA should begin to develop, test, and provide CBD workers and other private sector providers with more targeted messages, materials, and strategies for dealing with specific segments of the FP/RH market.*** A symptom recognition/recommended treatment strategy for teaching CBDs and others how best to inform, motivate, and serve various market segments (especially resistant clients) should be considered. ***SIFPSA should use operations research to evaluate the effectiveness and impact on contraceptive behavior change of these IEC/communications interventions.***
 44. ***Develop and implement a strategy for forming effective partnerships between CBD workers and auxiliary nurse-midwives and/or other village providers.***
 45. ***SIFPSA should strengthen project NGO/employment-based efforts to influence men to become family or village-level advocates for FP/RH services.*** Staff should

design an operations research activity that tests the ability of employment-based outreach workers to motivate male employees to become family level advocates/supporters of FP/RH behaviors within their families and communities and measure the impact of this effort. Interventions that test the effectiveness of cooperatives' infrastructures (e.g., agricultural extension workers, agents) in reaching men with messages and activities that increase their role as family level advocates/supporters of FP/RH behaviors within families and communities should also be developed and implemented.

Other Private Sector Service Delivery

46. ***Develop a strategy (annual or biennial) for enhanced provision of FP/RH services through the private sector in Uttar Pradesh.*** The strategy document should describe program and project objectives within a common context as well as targeted segments of the population, provide rationales for interventions selected to reach identified segments of the market, show how each intervention/element is to be linked with others to achieve maximum effectiveness and impact, demonstrate a time line according to which related activities need to occur, describe the plan for monitoring and evaluating each component of the strategy, and set out priorities for resource allocation.
47. ***SIFPSA should review and revise any existing project strategy for sustainability as it related to private sector involvement in FP/RH service delivery or develop a sustainability strategy if one does not currently exist. Private sector activities should be intensified within a limited number of districts rather than spread out over a broad geographic area*** to facilitate creation of the concentrated number of acceptors necessary to demonstrate the long-term sustainability of private sector services delivery. The concepts of institutional/technical and promotional sustainability as well as financial sustainability should be included. Sustainability (and its feasibility) as it relates to various points within the FP program continuum, that is, from a low prevalence environment to a state of growing prevalence to sufficient prevalence to high prevalence, should be defined. The strategy document should also identify program components, if any, that may never be financially sustainable within the private sector (e.g., elements of demand generation), but which should still be implemented. ***Operations research that can inform what may be critical elements in any follow-on project, such as assessment of the potential for financially sustainable FP/RH service delivery by ISMPs and medical doctors, should be designed and implemented.***
48. ***Government should become an active partner with the private sector to ensure the accessibility and safety of commercial sector FP/RH services through appropriate licensing and regulation, provision of population-based information, dissemination of information to consumers, and strategic planning.*** Innovative methods to link public and private providers for more effective private sector service delivery and to enhance the credibility of private sector providers should be developed and tested.
49. ***Innovative private sector channels for interpersonal communications and household/village-level distribution of contraceptives and related products should be identified, tested, and evaluated.***