

WORKING DRAFT (2nd Version)

**Performance Monitoring Plan
Strategic Objectives 2:
Reduced Fertility and Improved Reproductive Health in India**

**Office of Population, Health and Nutrition
USAID/NEW DELHI**

*It is not important to measure everything, and,
all important things are not measurable.
Albert Einstein*

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1.0 Introduction

The increased reliance on performance data, for decision making within the USAID to better manage resources, demands a continuous improvement and refinement of performance monitoring methods. The Performance Monitoring Plan (PMP) presented in this document is used by the Mission for managing Strategic Objective 2 (SO2) activities, monitoring its performance, and to communicate its accomplishments and failures to stakeholders.

2.0 SO2 Background

With more than a billion people, India accounts for around 17% of the world's population, and adds a further 18 million people every year. The annual rate of population growth of India during 1991-2001 was 1.9 percent, around 36% more than the rate at which the world population grew (1.4 percent) during 1990-2000. India accounts for around one fifth of global population growth. In absolute terms, India has added about 181 million people between 1991-2000, more than the population of Brazil, the fifth most populous country in the world. At this pace of growth, India is estimated to overtake China by 2050.

The story of population growth in India is fairly in tune with the classical theory of demographic transition. During most of the nineteenth century and early twentieth century, up to 1921, India witnessed a more or less stagnating population growth. Thereafter, India's population started growing steadily and it recorded an average annual growth rate of 1.96 percent between 1951-61, 2.20 percent between 1961-71, and 2.22 percent between 1971-81. During the past two decades, India's population has shown definite signs of slowing down. The annual average growth rate in 1981-91 and 1991-2001 were 2.14 and 1.93 percent, respectively. The Census of India, 2001 report points out that these results are indicative of the fact that India has entered the fertility decline phase of demographic transition theory. Now, at what size India's population is going to stabilize will depend on how long this phase continues and when India achieves the replacement level fertility of around two children per couple.

The National Population Policy (NPP), 2000 of Government of India (GOI) endeavors to attain the replacement level fertility by 2010 so that the population stabilization can be achieved by 2045. There are significant regional variations in the population growth rate. The annual growth rates of the north Indian states are significantly higher than India's average growth rate of 1.93 percent and more than 40 percent of India's population reside in these states. In fact, these states are at a level where southern states of Tamil Nadu and Kerala were forty years ago. Therefore, at what size India's population is going to stabilize will depend largely on the north Indian states. Keeping this in view, USAID continues to concentrate its reproductive and child health, and population stabilizing efforts (i.e., SO2 activities) in north India. Within north India, USAID effort is concentrated in Uttar Pradesh (U.P.), the most populous state, accounting for about sixth of India's population.

3.0 Activities under SO2

3.1 The Innovations in Family Planning Services (IFPS) Project

The major activity under SO2 is a ten-year, \$325 million, Innovations in Family Planning Services (IFPS) project. A bilateral agreement to this effect was signed between USAID and Government of India (GOI) on September 30, 1992 to implement this project in Uttar Pradesh. The goal of this project is to assist the state of U.P. to significantly reduce the total fertility rate (TFR) and improve women's reproductive health through comprehensive improvement and expansion of family planning and other reproductive health services through public, private and marketing channels.

In order to implement the IFPS project, an autonomous society, the State Innovations in Family Planning Services (SIFPSA), was set up. SIFPSA, the implementing agency of the IFPS project, is responsible for planning, coordinating and funding activities consistent with IFPS project goals and objectives. SIFPSA also is responsible for monitoring and evaluation of these activities. Another important feature of IFPS project is that it is programmatically driven by a performance based disbursement (PBD) system wherein funds are disbursed against achievements of pre-negotiated benchmarks between SIFPSA and USAID. Though SIFPSA was registered in May 1993, its organizational structure was finalized in January 1994 and it received the first installment of funds in March 1994. After receiving the first installment, it took another 6-8 months for SIFPSA to be functional to initiate project activities. Thus, it took almost two years from the time of signing of the project agreement to initiation of project activities. Keeping this in view, the mid-term assessment report of 1997 recommended that the end-of-project goals should be defined for 2004, that is, 10 years from 1994 when active project implementation began. Subsequently, the IFPS project goals have been revised to 2004.

3.2 Program for the Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH)

Complementary to IFPS project is a seven-year, \$20 million, PACT/CRH project. It's a collaborative project with the ICICI Ltd, one of the largest financial institutions in India, designed to stimulate private sector participation and commercial partnerships for the development, promotion and availability of quality reproductive health and child survival technologies. Some of the important activities carried out under this project are transfer of technology to upgrade quality of condoms and IUDs, demand creation through communication campaigns to increase use of Oral Contraceptive pills and Oral Rehydration Salts, and, commercialization of rapid diagnostics kits for Malaria, Syphilis, HIV/AIDS and Hepatitis B. PACT/CRH contributes to SO2, SO3 and SO7, i.e, strategic objectives related to reproductive health, child survival and infectious diseases.

3.3 Other Activities

In addition to IFPS and PACT/CRH, several activities related to policy and research are also supported under this SO. It includes National Family Health Survey (NFHS), review and development of state and national reproductive health policies, Indo-US

joint working group on contraceptive development and research, and technical assistance for strengthening census and civil registration systems of GOI.

4.0 Performance Monitoring Plan

The SO2 results-framework and performance indicators, that would be reported during the extension period, are depicted in diagram -1. Since the major activity under this SO is carried out through the IFPS project and PACT/CRH project complements the efforts of IFPS project, the strategic objectives (SO) level and intermediate results (IR) level indicators are guided by the goals and objectives of IFPS project.

SO 2 RESULTS FRAMEWORK

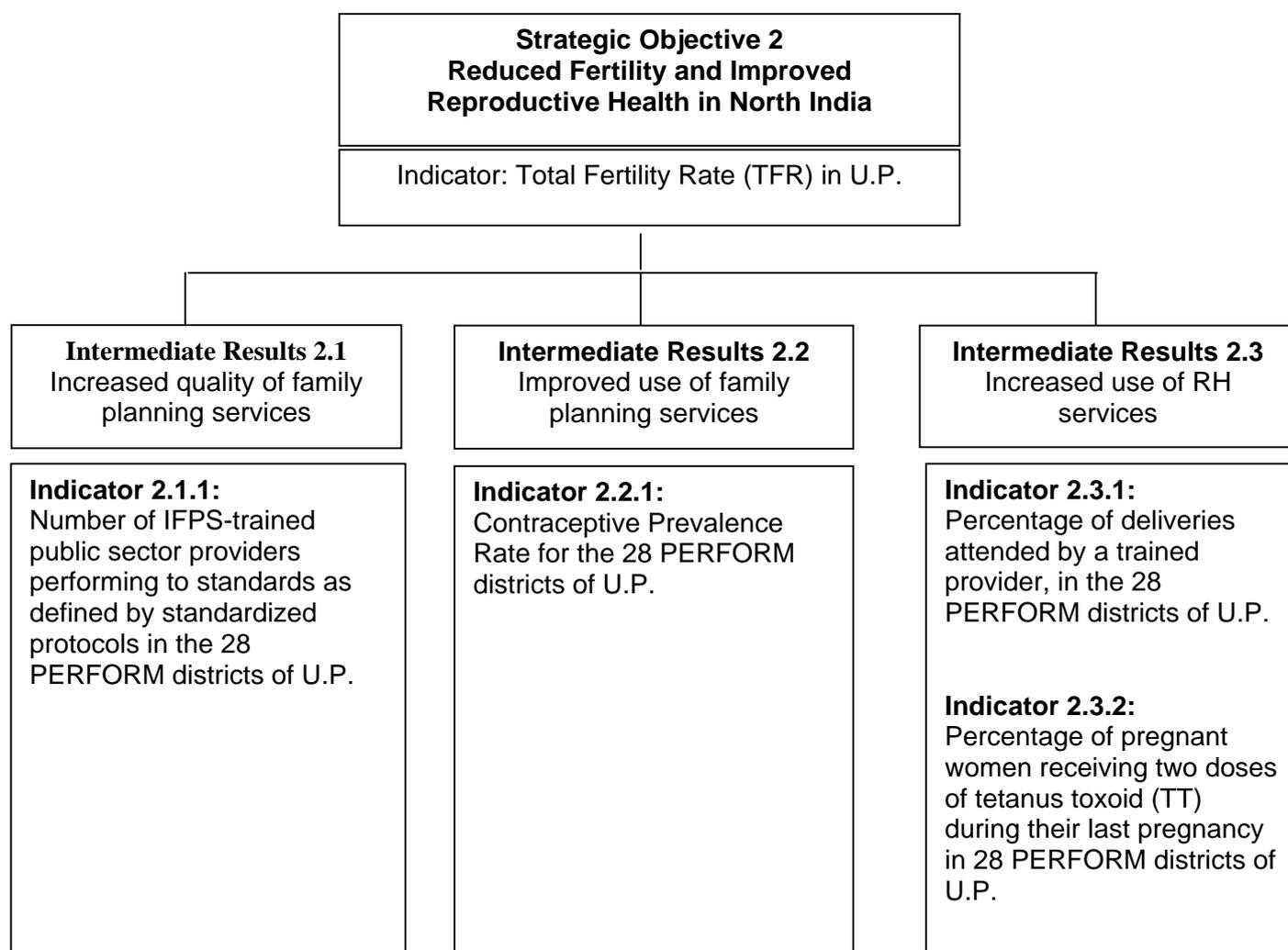


DIAGRAM 1

4.1 Update on SO Level Indicator: Total Fertility Rate (TFR) in U.P.

4.1.1 Universe for Measuring SO Level Indicator

The SO level indicator is expected to measure the TFR of U.P. At the time of the initiation of IFPS project, the population of U.P. was around 139 million. In November 2000, the hill regions of U.P. formed a new state, Uttaranchal. Per Census of India 2001, U.P. has a total population of 166 million distributed across 70 districts and Uttaranchal has a population of 8.5 million distributed across 13 districts. Thus, the universe for measuring this indicator is both U.P. and Uttaranchal that has a combined population of around 174.5 million distributed across 83 districts. The direct beneficiaries of this SO are approximately 27 million married women of childbearing age (15-49 years) in Uttar Pradesh (U.P.) and Uttaranchal.

4.1.2 Baseline and Planned Level of TFR Reduction

Reduction in TFR, through a comprehensive improvement and expansion of family planning and related reproductive health services, is the main objective of IFPS project. The IFPS project paper of 1992 envisaged reducing TFR in U.P. from 5.4 to 4.0 by 2002. While the project was being formulated, a wide range fertility estimates from different sources were available, the TFR estimate ranged from 4.5 to 6.0. However, a TFR estimate of 5.4 was considered to be most reasonable by considering other demographic parameters i.e., Contraceptive Prevalence Rate (CPR) and Crude Birth Rate (CBR).

In 1992-93, the National Family Health survey (NFHS) was carried out and the results of this survey became available in 1995. Per NFHS 1992-93, U.P. TFR was 4.8. In the light of this finding, in 1996 (ref: Program Performance Monitoring Plan, April 1996), the TFR goal was revised. The new goal was to reduce TFR from 4.8 in 1992 to 3.9 by 2001. The revision in TFR goal was also communicated to Washington through R4 of 1997.

In 1998-99, the second round of NFHS was carried out that indicated a TFR level of 4.0 in U.P. This level was significantly less than the TFR estimate of 4.6 for 1998, provided by the Sample Registration System (SRS), Office of Registrar General, GOI. To arrive at a more reliable TFR estimate for U.P., a comprehensive secondary analysis was conducted and a meeting of renowned demographers was held at MOHFW, GOI. The analysis indicates that both NFHSs have underestimated TFR. It was also noted that all large-scale population surveys in this part of the world underestimate TFR, which happens largely because of inaccurate reporting of age of women and children. Several indirect estimates were discussed and it was observed that SRS would be the best source to track changes in TFR estimate. Keeping this in view, the Mission decided to track TFR reduction based on the data provided by SRS and this decision was communicated to Washington through R4 2000. Because of the change in data source, the baseline and target values of this indicator were also changed. Using NFHS 1992-93 data, the fertility was estimated to decline by 0.9 child per woman, from 4.8 in 1993 to 3.9 in 2004. Per SRS, the TFR in 1993 was 5.2 and thus the corresponding value for 2004 is 4.3, 0.9 child less than the 1993 level. Thus, the net level of expected decline in U.P. under this SO because of the source change has remained unchanged (ref: reference sheet #1).

4.2 Update on IR Level Indicators

4.2.1 Universe for Measuring IR Level Indicators

The IFPS project has been implemented in a phased manner. In the initial years of implementation, six focus districts of U.P. received special emphasis. Thereafter, the project was expanded to 22 districts, 9 more priority districts and 14 other districts. Recently, one more district has been added. Thus, most program interventions of IFPS project are focussed in 29 (6 focus + 9 priority + 14 other + 1 recently added) selected districts of U.P. In 1995, a baseline survey, PERFORM, was carried in 28 IFPS districts to establish baseline values for most of the intermediate (IR) level indicators. Thus, the baseline estimates for IR level indicators are available for 28 of the 29 IFPS districts and to maintain consistency and comparability of data over time, 28 districts are being used for performance monitoring and reporting of IR level indicators.

Per the Census of India 1991, around half of the population of U.P, 67.5 million were in these 28 IFPS districts. The surveyed districts were split and as mentioned in section 3.1, a new state, Uttaranchal, was formed out of U.P. in 2000. Per Census of India 2001, the area covered by 28 IFPS districts corresponds to 33 districts of U.P. and 6 districts of Uttaranchal, however, to maintain consistency, these are still referred to as 28 districts. Thus, the universe for measuring IR level indicators is 28 PERFORM districts as per the 1991 classification of the state and districts. Per 2001 census, this corresponds to 39 IFPS districts, 33 districts of U.P., and 6 districts of Uttaranchal, which has combined population of 85.6 million.

4.2.2 Baseline and Planned Level of IR estimates

NFHS 1992-93 provided state level estimates on contraceptive prevalence rate (CPR), deliveries attended by trained providers and pregnant women receiving two doses of tetanus toxoid. The U.P state level estimates of these indicators were considered to be the baseline for IR 28 IFPS districts. This assumption was considered to be valid as the 28 IFPS districts had been selected randomly and in 1992-93 both IFPS and non-IFPS districts were receiving similar kinds of inputs from GOI and government of U.P. However, the PERFORM survey of 1995 provided valid and reliable estimates for IR 2.2.1 and IR 2.3.1 for 28 IFPS district. Subsequently, the baseline for IR 2.2.1 and IR 2.3.2 were taken from PERFORM (ref: reference sheet # 3 and 5) and the planned level of achievements for IR 2.3.1: Percentage of deliveries attended by trained providers was revised during 1999 R4 reporting (ref: reference sheet # 4).

The IR indicator 2.1.1 that pertains to training of providers and trained providers performing standard did not require any baseline, the base line was zero, and planned level were worked out on the basis of eligible providers who are providing family planning and reproductive health services in 28 IFPS districts, and the training strategy developed by SIFPSA and USAID.

5.0 Indicator Reference Sheets

The reference sheets for SO and IR level indicators are provided in this section.

Performance Indicator Reference Sheet # 1

Strategic Objective (SO2): Reduced fertility and improved reproductive health in North India

Intermediate Result: N/A

Indicator (SO level) : Total Fertility Rate (TFR) in U.P.

DESCRIPTION

Precise Definition(s): Average number of children that a women would bear in U.P. during her reproductive years, 15- 49 years, if she were to experience the current fertility schedule or the age specific fertility rates of that year. In 2000, a new state, Uttaranchal, was created out of U.P. Baseline data, actual performance and planned level of achievements for this indicator are available for the state of undivided U.P. Thus, the universe for this indicator pertains to the undivided state of U.P including Uttaranchal, as defined during Census of India 1991.

Unit of Measure: Number

Disaggregated by: N/A

Justification/Management Utility: The total fertility rate (TFR) sums up, in a single number, the fertility of all women at a given point of time. TFR provides the best picture of how many children women are currently having. Therefore, TFR is considered to be an appropriate indicator to gauge the achievement of SO level objective of reducing fertility. Further, the Sample Registration System (SRS), the Registrar General of India (RGI), Government of India (GOI) has been generating reliable and comparable TFR estimates for U.P. and other states of India since 1971.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: SRS selects a representative sample of villages and towns, and follows a dual-reporting method to generate information on fertility and mortality at the national and state level. Under dual-reporting method, investigators are selected from within the sampled units who record births and deaths on a regular basis. In addition to this, to check the accuracy of recorded information a census, 100% enumeration, of the selected sampled units are carried out by supervisors on a half yearly basis. The information generated by the investigators, through regular recording, and by the supervisors, through 100% enumeration, are matched to generate estimates of births and deaths.

Method of Acquisition by USAID: SRS report of RGI, GOI

Data Source(s): Office of Registrar General of India (RGI), GOI

Frequency/Timing of Data Acquisition: Every 2-4 years

Estimated Cost of Data Acquisition: Nil (GOI's official statistics provided free of cost)

Responsible Individual(s) at USAID: Research and monitoring activity manager, PREM and Service delivery team leaders and PHN Director **(To be decided by Vic.)**

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: The office of RGI has been generating comparable estimates on key fertility and mortality indicators through SRS since 1971. SRS follows standard scientific procedures (i.e., selects a representative sample, and collects information through a dual-reporting method) to collect, compile, analyze and generate annual estimates on fertility and mortality. SRS validates their estimates with the Census of India results.

Known Data Limitations and Significance (if any): There is usually a two-year time lag in reporting of SRS estimates. The 1998 estimates were released in February 2001. The 2002 and 2004 estimates are likely to be available in early 2005 and 2007, respectively.

Actions Taken or Planned to Address Data Limitations: The 2002 and 2004 estimates will be reported in FY 2004 and 2006 R4 reports, respectively. Mission will continue to undertake NFHS at interval of about five years.

Date of Future Data Quality Assessments: The Census of India 2001 preliminary results have been released very recently and the office of the RGI has already initiated the process of assessing the quality of SRS data in the light of the census findings.

Procedures for Future Data Quality Assessments: SRS works out population growth rates of last decade for different states and union territories on the basis of their annual birth and death rates. These rates, generated through the SRS, are then compared with the decadal growth rates recorded by the Census of India.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: The data will be analyzed to assess the actual performance against planned targets and also to gauge the contribution of USAID's activities to the achievements of results. PREM, service delivery and SO2 teams in consultation with CAs and implementing partner will carry out this exercise within two months of the release of data/TFR estimate.

Presentation of Data: Narratives with tables and graphs, power point slides and summary report

Review of Data: The data and the analysis would be reviewed first within the SO and then will be reviewed with all stakeholders.

Reporting of Data: Data will be reported in MRR (Mission Review Report) and MPP (Mission Performance Plan) and R4-2004.

OTHER NOTES

Notes on Baselines/Targets: The baseline was set from the NFHS 1992-93 and the planned levels of achievements have been arrived by analyzing the past trend.

Baseline, Planned/Target and Actual Values

Year	Planned	Actual
1993	Baseline value	5.2
1998	4.7	4.6
2002	4.5	
2004	4.3	

Location of Data Storage: PREM division of PHN office

Other Notes:

THIS SHEET LAST UPDATED ON: 06/03/02

Performance Indicator Reference Sheet # 2
<p>Strategic Objective 2: Reduced fertility and improved reproductive health in North India</p> <p>Intermediate Result 2.1: Increased quality of family planning services</p> <p>Indicator 2.1.1: Number of IFPS-trained public sector providers performing to standards as defined by standardized protocols in the 28 PERFORM districts of U.P.</p>
DESCRIPTION
<p>Precise Definition(s): Number of providers trained in providing sterilization and those trained in providing Intra Uterine Devices (IUD) services, performing to standards as per the standardized clinical protocols in the 28 PERFORM districts of U.P. and Uttaranchal. In 2000, a new state, Uttaranchal, was created out of U.P. The universe for this indicator pertains to the 28 districts of undivided U.P, as defined in Census of India 1991. Per the 2001 census, this corresponds to 33 districts of U.P. and 6 districts of Uttaranchal.</p> <p>Unit of Measure: Number</p> <p>Disaggregated by: N/A</p> <p>Justification/Management Utility: Number of providers trained in providing sterilization and Intra Uterine Devices (IUD) services, performing to standards as per the standardized clinical protocols is a valid, reliable and direct measure to gauge increase in the quality of family planning services. This indicator can be validated in a timely manner.</p>
PLAN FOR DATA ACQUISITION BY USAID
<p>Data Collection Method: USAID CAs (i.e., PRIME/INTRAH and Engenderhealth) provide information on number of providers trained and performing to standard.</p> <p>Method of Acquisition by USAID: Training Reports from USAID CAs</p> <p>Data Source(s): USAID's CAs (i.e., PRIME/INTRAH and Engenderhealth)</p> <p>Frequency/Timing of Data Acquisition: Every year, in October, the number of providers trained and performing to standards are compiled.</p> <p>Estimated Cost of Data Acquisition:</p> <p>Responsible Individual(s) at USAID: Research and monitoring activity manager, PREM and Service delivery team leaders and PHN Director (To be decided by Vic)</p>
DATA QUALITY ISSUES
<p>Date of Initial Data Quality Assessment: Every year, the completeness of SIFPSA's training MIS report is verified by comparing it with MIS reports of CAs. Further, a survey, to validate the accuracy of these reports, is done by randomly selecting a subset of providers from those providers who are recorded as performing to standard in MIS reports.</p> <p>Known Data Limitations and Significance (if any):</p> <p>Actions Taken or Planned to Address Data Limitations:</p> <p>Date of Future Data Quality Assessments: October – December 2001</p> <p>Procedures for Future Data Quality Assessments: A survey of a subset of providers from those providers who are recorded as performing to standard.</p>
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
<p>Data Analysis: The data will be analyzed to assess the actual performance against planned targets. PREM, service delivery and SO2 team in consultation with CAs and implementing partners will carry out this exercise within a month of the validation exercise.</p> <p>Presentation of Data: Narratives with tables and graphs, power point slides and summary report</p> <p>Review of Data: The data and the analysis would be reviewed first within the SO and then will be presented and reviewed with all stakeholders. It will also be reviewed at MRR (Mission Review Report).</p> <p>Reporting of Data: This indicator will be reported in MRR (Mission Review Report), MPP (Mission Performance Plan) and R4.</p>

OTHER NOTES

Notes on Baselines/Targets: The training of providers under the IFPS activities started in 1997. The planned levels of achievements have been arrived by keeping in view the objectives of IFPS project, the capacity of SIFPSA to implement various training modules and technical estimate of proportion of trainees that would actually perform to standard.

Baseline, Planned/Target and Actual Values

Year	Planned	Actual
1997	NA	69
1998	725	409
1999	2336	2346
2000	3933	4348
2001	4343	5367
2002	TBD	
2004	TBD	

Location of Data Storage: PREM division of PHN office

Other Notes:

THIS SHEET LAST UPDATED ON: 06/03/02

Performance Indicator Reference Sheet # 3

Strategic Objective 2: Reduced fertility and improved reproductive health in North India

Intermediate Result 2.2: Improved use of family planning services

Indicator 2.2.1: Contraceptive prevalence rate for the 28 PERFORM districts of U.P.

DESCRIPTION

Precise Definition(s): Number of currently married women of age 15-49 years who are using modern contraceptive methods (i.e., condoms, pills, IUDs, sterilization), at the time of data collection in the 28 PERFORM districts of U.P and Uttaranchal, per 100 currently married women of age 15-49 years. In 2000, a new state, Uttaranchal, was created out of U.P. The PERFORM survey that was conducted in 1995 covered 28 districts of undivided U.P. by following the Census of India 1991 district frame/classification. Baseline data, achievement levels and planned levels of achievement for this indicator are available for the 28 PERFORM districts. Thus, the universe for this indicator pertains to the 28 districts of undivided U.P, as defined in Census of India 1991, that were covered by PERFORM survey in 1995. Per the 2001 census, this corresponds to 33 districts of U.P. and 6 districts of Uttaranchal.

Unit of Measure: Percent

Disaggregated by: N/A

Justification/Management Utility: Contraceptive prevalence rate (CPR) is a valid, reliable and direct population-based measure to track improvement in the use of contraceptive methods. This indicator can be generated in a timely manner with a high degree of precision.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Representative population-based survey conducted in January each year (the annual SO2 survey)

Method of Acquisition by USAID: Survey report

Data Source(s): The Policy Project, Futures Group International

Frequency/Timing of Data Acquisition: Every year; Data for 1995 is available from PERFORM survey. The annual SO2 surveys are being done in the month of January since 1999.

Estimated Cost of Data Acquisition:

Responsible Individual(s) at USAID: Research and monitoring activity manager, PREM and Service delivery team leaders and PHN Director **(To be decided by Vic).**

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: The Evaluation Project, Carolina Population Center, University of North Carolina provided technical assistance to conduct the PERFORM surveys that were carried out by local/India research organizations. The Policy Project, Futures Group International conducts the annual SO2 survey with the help of local/Indian research organizations. The standard quality control procedures, developed by DHS (Demographic Health Survey), are being followed to collect, analyze and compile these survey data.

Known Data Limitations and Significance (if any): Like any other sample surveys PERFORM and SO2 surveys have also sampling errors associated with them. However, these surveys are designed and implemented in a way so that the magnitude of error of CPR estimates generated through these surveys are less than the expected annual change this indicator intends to measure.

Actions Taken or Planned to Address Data Limitations: The size of sampling error depend on the sample size. Utmost care is taken while conducting these surveys to minimize sampling error, to keep the errors less than the magnitude of change the indicator intends to measure. USAID, through its CAs also provides technical assistance to the local research organizations to improve data quality right from the design of the survey to data collection, analysis and reporting.

Date of Future Data Quality Assessments: January 2002

Procedures for Future Data Quality Assessments: The DHS quality control/assessment procedures, i.e., generation of field check control table, double data entry and computer-based consistency checks, will be employed.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: The data will be analyzed to assess the actual performance against planned targets and to gauge what contributed to achievements and failures. PREM, service delivery and SO2 teams in consultation with CAs and implementing partner will carry out this exercise within a month of the release of CPR estimate.

Presentation of Data: Narratives with tables and graphs, power point slides and summary report

Review of Data: The data and the analysis would be presented and reviewed with all stakeholders, will also be reviewed at MRR (Mission Review Report) to explore ways to improve performance.

Reporting of Data: Data will be reported and reviewed at MRR (Mission Review Report) and also reported in MPP (Mission Performance Plan) and R4.

OTHER NOTES

Notes on Baselines/Targets: The baseline was set from the PERFORM Survey 1995 and the planned levels of achievements have been arrived by the past trend and IFPS project objectives.

Baseline, Planned/Target and Actual Values

Year	Planned	Actual
1995	Baseline value	20.9
1998	23	24.5
1999	25	24.9
2000	27	25.8
2001	29	26.7
2002	31	
2003	33	
2004	35	

Location of Data Storage: PREM division of PHN office

Other Notes:

THIS SHEET LAST UPDATED ON: 06/03/02

Performance Indicator Reference Sheet # 4

Strategic Objective 2: Reduced fertility and improved reproductive health in North India

Intermediate Result 2.3: Improved use of RH services

Indicator 2.3.1: Percentage of deliveries attended by a trained provider, in 28 PERFORM districts of U.P.

DESCRIPTION

Precise Definition(s): Percentage of deliveries in past 12 months, by currently married women of age 15-49 years, which were attended by trained providers (i.e., public and private physicians, nurse – midwives and traditional birth attendants) in the 28 PERFORM districts. In 2000, a new state, Uttaranchal, was created out of U.P. The PERFORM survey that was conducted in 1995 covered 28 districts of undivided U.P. by following the Census of India 1991 district frame/classification. Planned levels of achievement for this indicator are available for the 28 PERFORM districts. Thus, the universe for this indicator pertains to the 28 districts of undivided U.P, as defined in Census of India 1991, that were covered by PERFORM survey in 1995. Per the 2001 census, this corresponds to 33 districts of U.P. and 6 districts of Uttaranchal.

Unit of Measure: Percent

Disaggregated by: N/A

Justification/Management Utility: Percentage of deliveries attended by a trained provider is a valid, reliable and direct measure to gauge increase in the use of delivery services. Clean and safe deliveries are a priority from the standpoint of child survival and health of mother. This indicator can be generated in a timely manner.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Representative population-based survey conducted in January each year that captures deliveries occurred between January to December of previous year (Annual SO2 Survey)

Method of Acquisition by USAID: Survey report

Data Source(s): The Policy Project, Futures Group International / a USAID CA

Frequency/Timing of Data Acquisition: Every year; Data for 1993 and 1995 are available from National Family Health survey (NFHS) 1992-93 and PERFORM survey respectively. The annual SO2 surveys have been conducted every year in the month of January since 1999.

Estimated Cost of Data Acquisition:

Responsible Individual(s) at USAID: Research and monitoring activity manager, PREM and Service delivery team leaders and PHN Director **(To be decided by Vic).**

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: Macro International provided technical assistance to conduct the National Family Health survey (NFHS) and the Evaluation Project, Carolina Population Center, University of North Carolina provided technical assistance to conduct the PERFORM survey. The standard DHS (Demographic Health Survey) quality control procedures were followed to collect, analyze and compile the data for both these surveys that were conducted by local/Indian research organizations. The Policy Project, Futures Group International conducts the annual SO2 survey with the help of local/Indian research organizations.

Known Data Limitations and Significance (if any): Like any other sample surveys NFHS, PERFORM and SO2 surveys also have sampling errors associated with them. The magnitude of error of this indicator, generated through SO2 surveys, is slightly greater than the planned annual change this indicator intends to measure. However, the magnitude of planned change for two years is less than magnitude of sampling error associated with this indicator. Thus, this indicator provides reliable data to measure performance against plan on a two-yearly basis and it's indicative of direction of change on an annual basis.

Actions Taken or Planned to Address Data Limitations: USAID, through its CAs provides technical assistance to the local research organizations to improve data quality right from the design of the survey to data collection, analysis and reporting. Utmost care is taken while conducting SO2 surveys to minimize sampling and non-sampling errors.

Date of Future Data Quality Assessments: January 2002

Procedures for Future Data Quality Assessments: The DHS quality control/assessment procedures, i.e., generation of field check control table, double data entry and computer-based consistency checks, will be employed.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: The data will be analyzed to assess the actual performance against planned targets, to gauge the direction of change. PREM, service delivery and SO2 teams in consultation with CAs and implementing partners will carry out this exercise within a month of the release of data/survey estimate.

Presentation of Data: Narratives with tables and graphs, power point slides and summary report

Review of Data: The data and the analysis would be reviewed first within the SO and then will be presented and reviewed with all stakeholders. It will also be reviewed at MRR (Mission Review Report).

Reporting of Data: This indicator will be reported in MRR (Mission Review Report), MPP (Mission Performance Plan) and R4.

OTHER NOTES

Notes on Baselines/Targets: The baseline was set from the NFHS 1992-93. The baseline value captured deliveries conducted by trained health providers excluding the trained traditional birth attendants (TBAs). Thus, the PERFORM Survey 1995 estimate, that includes trained providers as well as trained TBAs, is considered to be a more appropriate baseline for assessing progress than NFHS 1992-93 estimate. This aspect was acknowledged in the FY 2003 R4 report. The planned levels of achievements have been arrived by analyzing the past trend and IFPS mid-term assessment recommendation.

Baseline, Planned/Target and Actual Values

Year	Planned	Actual
1993	Baseline value	17
1998	18	33
1999	34	29.9
2000	35	36.3
2001	36	41.3
2002	37	
2004	TBD	

Location of Data Storage: PREM division of PHN office

Other Notes:

THIS SHEET LAST UPDATED ON: 06/03/02

Performance Indicator Reference Sheet # 5

Strategic Objective 2: Reduced fertility and improved reproductive health in North India

Intermediate Result 2.3: Improved use of RH services

Indicator 2.3.2: Percentage of pregnant women receiving two doses of Tetanus Toxoid (TT) during their last pregnancy in 28 PERFORM districts of U.P.

DESCRIPTION

Precise Definition(s): Percentage of women who gave birth during last year for which the mother received two doses of Tetanus Toxoid (TT), during their pregnancy, in the 28 PERFORM districts. In 2000, a new state, Uttaranchal, was created out of U.P. The PERFORM survey, conducted in 1995, covered 28 districts of undivided U.P. by following the Census of India 1991 district frame/classification. Planned levels of achievement for this indicator are available for the 28 PERFORM districts. Thus, the universe for this indicator pertains to the 28 districts of undivided U.P., as defined in Census of India 1991, that were covered by PERFORM survey in 1995. Per the 2001 census, this corresponds to 33 districts of U.P. and 6 districts of Uttaranchal.

Unit of Measure: Percent

Disaggregated by: N/A

Justification/Management Utility: Percentage of pregnant women receiving two doses of Tetanus Toxoid (TT) during their last pregnancy is a valid, reliable and direct measure to gauge increase in the use of antenatal care services, a very important component of RH services. This indicator can be generated in a timely manner.

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Representative population-based survey conducted in January each year that captures births to women who received two doses of TT between January to December of previous year (Annual SO2 Survey)

Method of Acquisition by USAID: Survey report

Data Source(s): The Policy Project, Futures Group International / a USAID CA

Frequency/Timing of Data Acquisition: Every year; Data for 1995 are available from PERFORM survey. The annual SO2 surveys have been conducted every year in the month of January since 1999.

Estimated Cost of Data Acquisition:

Responsible Individual(s) at USAID: Research and monitoring activity manager, PREM and Service delivery team leaders and PHN Director

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: The Evaluation Project, Carolina Population Center, University of North Carolina provided technical assistance to conduct the PERFORM survey. The standard DHS (Demographic Health Survey) quality control procedures were followed to collect, analyze and compile the data for both these surveys that were conducted by Indian research organizations. The Policy Project, Futures Group International conducts the annual SO2 survey with the help of local/Indian research organizations.

Known Data Limitations and Significance (if any): Like any other sample surveys PERFORM and SO2 surveys also have sampling errors associated with them. The magnitude of error of this indicator, generated through SO2 surveys, is slightly greater than the planned annual change this indicator intends to measure. However, the magnitude of planned change for two years is less than magnitude of sampling error associated with this indicator. Thus, this indicator provides reliable data to measure performance against plan on a two-yearly basis and it's indicative of direction of change on an annual basis.

Actions Taken or Planned to Address Data Limitations: USAID, through its CAs provides technical assistance to the local research organizations to improve data quality right from the design stage of the survey to data collection, analysis and reporting stage. Utmost care is taken while conducting SO2 surveys to minimize sampling and non-sampling errors.

Date of Future Data Quality Assessments: January 2002

Procedures for Future Data Quality Assessments: The DHS quality control/assessment procedures, i.e., generation of field check control table, double data entry and computer-based consistency checks, will be employed.

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: The data will be analyzed to assess the actual performance against planned targets, to gauge the direction of change. PREM, service delivery and SO2 teams in consultation with CAs and implementing partners will carry out this exercise within a month of the release of data/survey estimate.

Presentation of Data: Narratives with tables and graphs, power point slides and summary report

Review of Data: The data and the analysis would be reviewed first within the SO and then will be presented and reviewed with all stakeholders. It will also be reviewed at MRR (Mission Review Report).

Reporting of Data: This indicator will be reported in MRR (Mission Review Report), MPP (Mission Performance Plan) and R4.

OTHER NOTES

Notes on Baselines/Targets: The planned levels of achievements have been arrived by analyzing the past trend.

Baseline, Planned/Target and Actual Values

Year	Planned	Actual
1995	Baseline value	43
1998	44	40.5
1999	45	59
2000	46	62.8
2001	66	61.8
2002	70	
2004	TBD	

Location of Data Storage: PREM division of PHN office

Other Notes:

THIS SHEET LAST UPDATED ON: 06/01/01