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## Priorities and Actions for IFPS 2.2: September 2008-September 2012/15

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## LIST OF ACRONYMS

ASHA	-	Accredited Social Health Activist
BCC	-	Behavior change communication
BPL	-	Below Poverty Line
CBD	-	Community based distribution
CHACS	-	Comprehensive Health and Counseling Sessions
CPR	-	Contraceptive prevalence rate
DAP	-	District action plans
DMPA	-	Depo-medroxy-progesterone-acetate
EAG	-	Empowered Action Group
FP	-	Family Planning
GOI	-	Government of India
IEC	-	Information, education and communication
IFPS	-	Innovations in Family Planning Services
ITAP	-	IFPS Technical Assistance Project
IUD	-	Intra-uterine device
JH	-	Jharkhand
JHS	-	Jharkhand Health Society
LAM	-	Lactational Amenorrhea Method
LOE	-	Level of Effort
MCPR	-	Modern Contraceptive Prevalence Rate
MDG	-	Millennium Development Goals
MoHFW	-	Ministry of Health and Family Welfare
NFHS	-	National Family Health Survey
NGO	-	Non-governmental organization
NHSRC	-	National Health Systems Resource Center
NRHM	-	National Rural Health Mission
PBD	-	Performance-Based Disbursement
PIP	-	Program Implementation Plan
PMU	-	Program Management Unit
PPP	-	Public-Private Partnership
PSO	-	Program Support Office
PSI	-	Population Services International
RCH	-	Reproductive Child Health
RCO	-	Regional Contracting Office
RFMO	-	Regional Financial Management Office
RH	-	Reproductive Health
SDM	-	Standard Days Method
SHSRC	-	State Health Systems Resource Center
SIFPSA	-	State Innovations in Family Planning Services Project Agency
SPMU	-	State Program Management Unit
TA	-	Technical assistance
UA	-	Uttarakhand
UAHFWS	-	Uttarakhand Health and Family Welfare Society
UP	-	Uttar Pradesh

## EXECUTIVE SUMMARY

USAID/India has supported family planning programs through the Innovations in Family Planning Services (IFPS) Project in Uttar Pradesh (UP) since 1992, and a broader set of maternal and child health activities since 2002 in UP, Uttarakhand (UA) and Jharkhand (JH). The IFPS II project began in September 2004 and is currently scheduled to end on September 30, 2008. In August-September 2007, an evaluation of IFPS II was conducted to assess progress and propose changes in the current project and provide suggestions for future programming in reproductive health and family planning. In late September 2007, a three-person team worked with USAID/India PHN staff to identify directions for the future through a visioning process; this process included site visits, key informant interviews, document review, analysis of recently released data from the National Family Health Survey 3, and culminated in an all-day meeting of the SO 14 team.

The visioning team concluded that overall IFPS II was on the right track with its strong emphasis on testing and scale up of public-private partnerships (PPPs). Rather than significantly change the IFPS II directions, the team proposed extending the project from 2008 to 2012/15, divided between two shorter time periods, with some important shifts in emphasis. During this extension period, IFPS is referred to as IFPS 2.2.

**Geographic Focus.** IFPS 2.2 will continue **national level** policy and programming support that has helped accelerate implementation of the National Rural Health Mission. At the state level, **Uttar Pradesh will remain the primary focus for IFPS 2.2** and will receive the majority of the funding. USAID will continue support for **Jharkhand's** state level implementing institutions and assess how best to expand family planning services in the state with a possible focus on non-tribal districts and delivery through PPPs that have been tested under IFPS II and adapted for Jharkhand. Because of its high unmet need, USAID will also assess prospects for working in **Bihar** possibly in a limited number of districts and in concert with other donors. Because of its high contraceptive use, **Uttarakhand** will receive reduced support, with emphasis on completing the testing and scale up of the public-private partnership (PPP) models already underway.

**Time periods.** IFPS 2.2 will have a Short-Term time frame from 2008-2010 that coincides with the time period for RCH 2 implementation; and a Medium-Term time frame from 2010 to 2012/15 that coincides with the NRHM/MDG time frame. The Short-Term period is important for completing the testing of the present public-private partnership models (PPPs), many of which are just getting started in Uttar Pradesh and Uttarakhand. It is also a critical period for technical assistance to the national and state level structuring of the National Rural Health Mission, which is setting the policy and public sector operational environment for funding and providing oversight to these PPPs.

The focus in the Medium-Term time frame must be on scale up of the PPPs in the target states and others, reinforcing the systems for monitoring the quality and scale up processes, and capacity-building of the partner institutions, including Indian institutions that will provide technical assistance to the public and private sectors in the long term.

**Major Thrusts.** All activities under the IFPS 2.2 must be undertaken in ways that emphasize and strengthen these critical thrusts of the project.

- **Focus on family planning** within the context of the NRHM. The IFPS 2.2 is USAID/India's primary vehicle for supporting information, access, and quality of family planning services. Given the high unmet need in the target states, increasing access is critical to meeting Indian government goals. Also USAID should strongly encourage, through its staff policy dialogue and the IFPS 2.2 program, the expansion of the method mix available to prospective users.
- **Use targeted flexible funding** to leverage the funding available for expansion of successful pilots and implementation at scale, even beyond the target states.
- **Use all opportunities to build institutional capacity** so that the need for USAID external technical support declines during this period. USAID must balance the need for quick turn-around and results with the need for strengthening capacity of local counterpart institutions, which often requires more time to produce results.

**Core Elements.** IFPS 2.2 should continue with and further emphasize and reinforce the work already started under IFPS II.

- **Public-Private Partnerships (PPPs).** The models that are now undergoing testing need to be implemented for at least a 2-3 year period to adequately assess their cost-effectiveness and impact on meeting unmet need for family planning and reaching BPL clients. Other models may also be identified and will need to be tested. The IFPS 2.2 models should be assessed along with other models being tested by USAID/India and Washington-funded activities, e.g., the Shakti model.

In some geographic areas, the different models being tested are interacting. For example, some clients of the voucher scheme are coming to CHACS sites implemented by the NGOs. Some of the providers in the voucher scheme are also private providers in the DMPA clinics. It will be important to assess the interrelationships and their outcomes as well.

IFPS 2.2 will also identify and test models for addressing the FP/RH needs of adolescents, a population group with high unmet need for FP/RH care, most likely by working with the private sector (NGO and commercial) partners and adapting PPP models already being tested for other groups.

In addition to the testing, assessment, and then documentation of the models, IFPS 2.2 needs to develop a strategy for scale up of these models with two major components: an advocacy component and an operational component that provides the tools needed to implement the models.

- **National and state public sector policy and program environment.** During IFPS 2.2, the USAID/India Mission needs to remain fully engaged in policy dialogue with national and target state policy makers to ensure that the policy and program environment remains conducive to partnering with and more effective utilization and relationships with the private sector. The policy discussions should include

encouragement of different roles for the public sector, shifting from primary service provider to one of strategic direction, accreditation and quality assurance, and contractor and financier. These are significant changes for government ministries, especially the Ministry of Health and Family Welfare.

- **Development and strengthening of key systems.** Both the public and private sectors have needs for important management systems.

**Behavior Change Communication (BCC).** To be more effective, the IEC/BCC activities need to be implemented as integral parts of an overall strategy with clear behavioral outcome objectives and integrated, reinforcing messages/components. IEC/BCC materials with the appropriate messages need to be available to all health service providers and promoters (public and private sector) at all levels.

**Training and Human Resources for Health Management.** Lack of adequately trained, skilled providers remains a problem in both the public and private sectors. Given these problems and USAID's experience in addressing them, IFPS 2.2 needs to provide support to strengthening training and training institutions, as well as other HRH management issues such as supervision, retention, and deployment.

**Quality Assurance (QA).** Through the establishment of accreditation systems and training to meet the accreditation standards, the PPPs are setting the groundwork for improving quality in the private sector. These systems need to be transferred eventually to the public sector along with stronger quality assurance approaches and systems that are needed and appropriate for the public sector.

**Monitoring and Evaluation (M&E).** On-going monitoring and adjusting the implementation of the PPPs and other interventions are critical for their effectiveness. As the PPPs continue and scale up is started, these systems are especially important to ensure effective implementation and high quality services.

**Decentralization processes.** The NRHM has adopted the District Action Planning process first initiated under IFPS I as the standard approach for decentralized planning and management for the country. The intent is to further decentralize these processes to the block level and below. USAID has a role to play, especially in its target states, to support this process, reinforce quality in preparing the plans and support effective implementation.

**Key Issues.** The Visioning team identified some important implementation issues that need to be addressed for IFPS 2.2 to have the desired impact.

- **The State Innovations in Family Planning Services Agency (SIFPSA)** is a society that USAID helped establish in 1992/3 to facilitate innovation and effective delivery of family planning services in UP. SIFPSA is acknowledged as a leader in family planning, district-level action planning, BCC, and training and management; however, challenges of internal leadership, staffing, governance and relations with the Directorate of Health and Family Welfare in the UP Government have affected

its operations. These challenges and its role in the state-level implementation of the NRHM need to be addressed as an urgent matter by all concerned parties.

- **IFPS Technical Assistance Project (ITAP)** is the primary provider of technical assistance to IFPS II. The visioning team agreed that ITAP should continue, but USAID should work with ITAP to strengthen its capacities and mobilize its resources to address priority areas: strategy development for scale up of the PPPs, BCC, and institution building of local TA partners and strengthening its own skills in organizational development, priority health areas, and market research.
- **Performance-Based Disbursement**, the financing mechanism for key activities in both IFPS I and II, is effective but time-consuming. A final decision on whether to retain this approach requires more analysis and discussion; in the interim, USAID/India should implement steps to streamline the process.
- **Coordination of PHN and Other USAID-funded Activities with IFPS 2.2.** The visioning team agreed that the important linkages and collaboration between IFPS 2.2 and other PHN and USAID-funded activities need strengthening to better support NRHM objectives; possible mechanisms include joint work planning and joint funding of key activities in selected geographic areas.

**Short-term Objectives for IFPS 2.2.** The objectives for the Short-Term period under IFPS 2.2 from 2008-2010 are:

- Proven cost-effective public-private partnerships that have increased family planning access and use by BPL and other underserved groups in the pilot districts and areas are documented and scale up started in selected districts.
- Continued positive policy environment at the national and state level for PPPs; mechanisms established that will allow use of NRHM funds for taking implementation to scale.
- Systems designed and tested to support PPP implementation, including training, QA, M&E, and BCC.
- Scale up strategy for the PPPs reviewed, approved, and launched.
- SIFPSA serving as the UP SHSRC and other functions significant for the NRHM.
- Indian partner institutions identified and a strategy for their future use as TA providers to NRHM developed and the assumption of TA responsibilities under IFPS 2.2 started.

## SECTION I. Introduction

In September 2007, USAID/India requested the assistance of a three-person team to follow up on the results of a recently completed evaluation of the Innovations in Family Planning Services (IFPS) II Project with the intent of identifying directions for the future for the Mission's family planning and reproductive health assistance to India. The team used a range of methods to collect and synthesize key problems and issues and led the USAID/India's SO 14 team in a daylong meeting that developed consensus on future directions. The visioning process was completed during a two-week period, from September 24-October 5, 2007.

## SECTION 2: Background on IFPS I and II

The IFPS project was originally designed in 1992 to assist the Government of India (GOI) in revitalizing family planning services using the state of Uttar Pradesh (UP) as the primary site and testing ground for program innovations. An independent society, the State Innovations in Family Planning Services Project Agency (SIFPSA), was created to oversee the implementation of activities in UP. While the numeric goals for the project were not fully met, the project demonstrated a number of successful implementation systems and innovations, which made substantial contributions to advancing family planning in the large geographic areas in which it worked.

### I. IFPS I Achievements

In Uttar Pradesh SIFPSA is now an organization with over 56 headquarters staff who have overseen more than 400 discrete projects and activities. It has focused its work in 38 of the state's 70 districts. Through efforts in IFPS I, CPR increased nearly twice as fast since 1998/99 in those districts where SIFPSA was working than it had in the remaining districts in the state. CPR rates achieved were 27.3% and 21.3% respectively.<sup>1</sup>

Much of this gain has been credited to SIFPSA's support for formulating and implementing district action plans (DAPs) by local institutions. In addition, where SIFPSA supported community-based distribution (CBD) of family planning information and services by local NGOs and cooperatives, statewide social marketing efforts have contributed to a doubling of condom sales in rural areas throughout the state, to more than 100 million units sold each year. Importantly, some of these interventions and the management systems through which they were delivered have served as models for broader use across India.

### 2. IFPS II Strategy and Accomplishments

The objectives of IFPS II remained the same as IFPS I, but the strategies for addressing them evolved in light of experience. The following were key changes:

- **Increasing public-private partnerships.** The major area for IFPS II is developing, demonstrating, documenting and leveraging expansion of working models of public-private partnerships, which deliver integrated reproductive and child health services in UP, Uttarakhand and Jharkhand.

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<sup>1</sup> Perform 1995 and RH Indicator Surveys 1998, 1999, 2000, 2001, 2002 & 2003

- **Catalytic role for technical assistance.** In the past USAID-financed technical assistance had supported direct implementation on a large scale. Under IFPS II such technical assistance was to be used catalytically to develop, demonstrate, document and leverage expansion of public-private partnerships.
- **Integrated client-centered services.** Services were to be integrated to the extent feasible to include family planning, reproductive health, maternal health and child survival concerns. Where epidemiologically appropriate, specific interventions addressing HIV/AIDS would be considered. Family planning, including child spacing and the expansion of the choice of contraceptive methods, including injectables, has been a major emphasis area of IFPS II.
- **Sustainability.** While USAID would use its resources to concentrate on innovation, the state governments would be responsible for financing interventions on a large scale. This includes both IFPS I interventions (e.g., DAPs, RCH (Reproductive and Child Health) camps, CBD programs) and the replication of new public-private partnership (PPP) models tested by IFPS II.

### 3. Selected Key Achievements of the IFPS II Project

1. Public private partnerships initiated in UP and Uttarakhand. Examples include:
  - Social franchising to be implemented statewide, in order to establish 70 fully franchised clinics offering comprehensive RCH services, 700 fractional franchisees and 10,500 referral networks by the end of project year three.
  - Social marketing of pills and condoms to be implemented statewide in UP.
  - Voucher schemes implemented in three districts of UP and UA.
  - NGO projects providing clinical FP services and mobilizing use of FP services in 11 districts of UP.
2. Alternative to the GOI ASHA (Accredited Social Health Activist) scheme tested in 6 blocks in UA to evaluate alternatives for ASHA recruitment, training and payment.
3. District Action Plans developed for all districts in UP (70) and UA (13), with district plans then reflected in state Program Implementation Plans (PIP) (under NRHM) for submission to GOI.
4. Comprehensive BCC campaigns launched at national level and in UP, UA and JH, including mass media, TV and radio spots, print media and interpersonal communication. Leveraged GOI funds to broadcast television spots nationwide.
5. Establishment of the NHSRC (National Health Systems Resource Center) through recruitment of 23 technical staff and logistical support for office infrastructure.

### 4. IFPS II Evaluation

An evaluation of IFPS II was completed in August-September 2007 that analyzed accomplishments of the project and the effectiveness of strategies to achieve them, identified barriers to achieving anticipated outcomes, and the project's success at impacting FP/RH status in the three focus states covered under the project. The evaluation assessed programmatic approaches, strategies, and the effectiveness of project systems and processes, documented lessons learned, and made recommendations for future directions. The evaluation team also suggested recommendations for mid-course corrections to be made before the end of the project in September 2008.

The key findings of the IFPS II Evaluation were to:

- Refocus on FP, including broadening the contraceptive method mix
- Continue PPP testing and scale-up
- Continue TA for National and target State level implementation of DAPs and PIPs, and
- Emphasize TA for systems strengthening (QA, M&E, BCC, strategic planning and coordination).

### **SECTION 3: Visioning Team Objectives and Methodology**

The purpose of the visioning team and its work was to integrate findings and information from a number of sources, including the IFPS II evaluation, an Adolescent Health Assessment and a Capacity Building Assessment which were carried out concurrently with the IFPS II evaluation, key informant interviews with state and central government officials, donors and implementing partners, and interviews with USAID Mission staff to arrive at a consensus on how the Mission's family planning and reproductive health priorities will be implemented following September 2008.

The evaluation and design process began with the IFPS evaluation in August 2007 and is anticipated to continue throughout the 2008 fiscal year through a process of consensus building and full participation with all key stakeholders. Key stakeholders in this process include USAID/India, USAID/Washington, GOI, NHSRC, the state governments of UP, UA and JH, other donors, technical assistance and other implementing partners.

The specific objectives of the visioning and consensus building exercise were to:

- Review IFPS II and key IFPS I lessons, including program strategies and technical approaches;
- Assist in developing a vision and consensus regarding future directions for the IFPS II program and USAID/India's program in FP/RH;
- Make recommendations for future directions and investment in FP/RH in India; and
- Produce drafts for follow-on design document(s), as appropriate.

Consistent with these objectives, the visioning team used the following methodologies:

- Review of the results of IFPS II Evaluation and discussions with the team members on their findings and recommendations;
- Consultation of documents on IFPS I and IFPS II (see Annex 1 for a list of documents consulted);
- Site visits and observation, particularly the public-private partnership models being tested in UP, including NGO CHACS, the voucher scheme, and social franchising (see Annex 3 for the itinerary for the site visits in Agra);
- Key informant interviews with over 60 individuals, including government, partner organizations, other donors and USAID staff (see Annex 2 for the list of people consulted during the two weeks);
- Review of NFHS 3 data recently made available;

- Review of documents on National Policies (see Annex 1 for the list of Indian government policy documents consulted); and,
- Visioning meeting with SO14 Mission team (see Annex 4 for the Agenda for this meeting). Visioning team members led the USAID/India SO 14 team in a review of the key findings, including identification of major problems and issues, and brainstorming and consensus building discussions about how Mission RH activities in India should be prioritized over the next four to five years, until 2012/15. The results were decisions about the future of IFPS as IFPS 2.2 as described in detail in Sections 5 and 6.

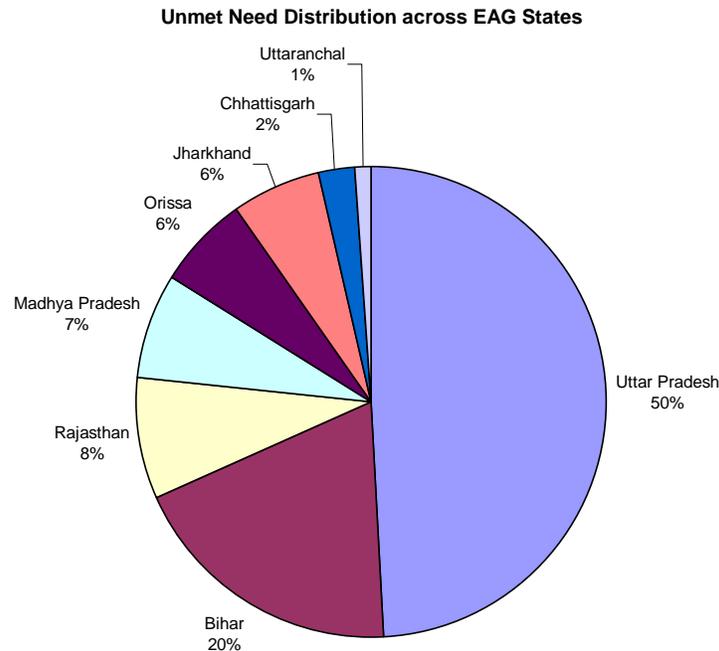
## **SECTION 4. Analysis: Key Problems and Issues**

The visioning team used information from analyses of the NFHS 3 data, key documents, findings and recommendations from the IFPS II evaluation, key informant interviews, site visits, and discussion with PHN staff in the visioning meeting, to synthesize a set of key problems and issues that the next phase of IFPS will need to address.

### **I. Analysis of NFHS 3 Data: Family Planning Needs in India**

Progress has been made in recent years in increasing access to and use of family planning in the high-need, Empowered Action Group (EAG) states of India, including the three focus states of the IFPS project. In Uttar Pradesh, modern contraception prevalence increased from 21 to 29 percent over the period 1999-2006. Over the same period, modern use increased from 40 to 56 percent in Uttarakhand and from 25 to 31 percent in Jharkhand. Despite this progress, tremendous need still exists. The bar chart below depicts family planning need in three segments: need met by modern contraceptive methods, need met by traditional methods, and unmet need, defined as women who want no more children or want to delay their next birth by two or more years and are not using a method of family planning. The 8 EAG states are shown on the left, with the other states of India shown on the right. Within each grouping, states are arrayed from low to high modern method prevalence.





One-half of all unmet need among these states is found in Uttar Pradesh. UP is followed by Bihar, with 20 percent and then by Rajasthan, Madhya Pradesh, Orissa, and Jharkhand, each ranging between 6 and 8 percent. When considered as a percent of all unmet need in India, UP and Bihar together account for about 42 percent. These two states also have the highest levels of fertility among all Indian states with TFRs of 3.8 and 4.0 children per woman, respectively, as shown in the table below.

The three states of UP, Jharkhand, and Bihar cluster together on many indicators. When comparing the actual TFR with Wanted Fertility Rate, there is a difference of more than one child for each of these states – that is to say that if women had the number of births they wanted, the TFR would be more than one child lower than actual – and each would be at or close to replacement fertility of 2.1 children per woman. Modern method use is about 30 percent in each of these states and slightly lower in rural areas. Sterilization as a percent of use is high in each state, although notably lower in UP and UA, likely attributable to the IFPS focus on improving access to a broader method mix. Unmet need ranges between 22 and 24 percent in these states, higher still if traditional method use is included as need that is not being met (or not adequately met). Under the expanded definition, unmet need rises to 34 and 36 percent in Bihar and Jharkhand and higher still in UP to 44 percent –owing to the heavy reliance on traditional methods in this state. Unmet need is about evenly split between need for limiting and spacing births, although there is a slightly higher need for limiting in UP, perhaps again due to programs that better meet the needs of women who want to space births, which has been an IFPS focus.

Early age at marriage is pronounced in these three states, especially in Bihar and Jharkhand, where about 60 percent of girls are married by age 18 – UP is lower at 53 percent. Early childbearing follows this pattern with 25-28 percent of girls in the 15-19 years age group

having already begun childbearing in Bihar and Jharkhand – with UP lower at 14 percent. While not shown in this table, birth spacing is also poorer in these states. Taken together, the higher fertility and lack of healthy timing and spacing of births are contributors to poor maternal and child health indicators. Both maternal mortality and infant mortality rates are high Bihar and UP (these are drawn from GOI statistics and were measured before Jharkhand and Uttarakhand became independent states), though notably higher in UP. Percent of all deliveries assisted by a skilled attendant are low for all three states, ranging from 29 to 31 percent. Percent of 2 year-old children who are fully immunized is also low, though notably lower in UP at 23 percent versus 33 to 35 percent for Bihar and Jharkhand.

In contrast, Uttarakhand has advanced levels of performance on reproductive and child health indicators that are either on a par with or exceed the average for India.

### Key Fertility & Health Indicators for India and Selected EAG States

	UP	Jhark	Bihar	UA	India
<b>TFR</b>	3.8	3.3	<b>4.0</b>	2.6	2.7
<b>Wanted Fertility Rate</b>	2.3	2.1	<b>2.4</b>	1.8	1.9
<b>MCPR</b>	<b>29</b>	31	<b>29</b>	56	49
<b>% Sterilization</b>	60%	77%	<b>85%</b>	61%	79%
<b>Rural MCPR</b>	<b>25</b>	<b>25</b>	27	54	45
<b>Unmet Need</b>	22	<b>24</b>	23	11	13
<b>Spacing Demand</b>	9	<b>12</b>	11	5	6
<b>Limiting Demand</b>	<b>13</b>	12	12	7	7
<b>% 15-19 Begun Childbearing</b>	14%	<b>28%</b>	25%	6%	16%
<b>% Married by Age 18</b>	53%	<b>61%</b>	60%	23%	45%
<b>MMR</b>	<b>517</b>	--	371	--	301
<b>% Assisted Delivery</b>	<b>29%</b>	<b>29%</b>	31%	42%	41%
<b>IMR</b>	<b>73</b>	50	61	42	58
<b>% Fully Immunized</b>	<b>23%</b>	35%	33%	60%	44%

These data indicate that greater attention needs to be given to the three EAG states of UP, Jharkhand, and Bihar. The relatively high levels of health status in Uttarakhand, on the other hand, argue for a lower level of attention for assistance. The USAID mission should consider carefully its geographic focus. There are strong arguments for remaining in UP where there has been substantial investment and impact, notable especially given the challenging environment and the sheer scale needed to achieve impact. A strong case can be made for remaining in Jharkhand based on level and numbers with unmet need. It may be too soon to assess the success of the IFPS interventions since it is a newly-added state. Future work in Jharkhand should be considered in the context of how readily structures can be put in place to address needs and the potential to adapt models to engage the private sector in family planning service delivery, which could vary by district. If another state can be added to USAID's geographic focus under IFPS, Bihar should be considered. This expansion would need to be considered relative to the overall capacity of the project, given demands in UP alone. Given social, economic, and environmental similarities between UP and Bihar, FP service delivery models including PPPs might be readily adapted and scaled up in Bihar. IFPS could potentially provide technical assistance in this arena. Any work in

Bihar would need to be coordinated with the work of other donors, notably the Packard Foundation, UNICEF, and potentially DFID and the World Bank.

## 2. Health Systems Context

A key change in the recent health context of India that affects the IFPS focus states and activities is the establishment of the National Rural Health Mission (NRHM). This mechanism provides GOI funding totaling \$8.6 billion over 5 years (2005-2010) to high-need states for a set of health interventions that encompasses maternal, reproductive and child health. These funds are intended for decentralized programming, driven down to the district, block, and community level. The funds are also intended for integrated programs. The availability of these funds changes fundamentally the role of USAID's assistance in health. With GOI funds available to support RCH service delivery, USAID's role shifts to a leveraging role that assures that the GOI funds are used most cost-effectively. Programs like IFPS can focus on testing and evaluating innovative service delivery models and providing technical assistance to build systems and strengthen local institutions in key areas, such as behavior change communication, quality assurance, training and human resource deployment, supervision, monitoring and evaluation, and planning at the national, state, and district levels.

Within this evolving context, the following are a synthesis of the key problems and issues to be addressed by IFPS 2.2:

**Underserved groups.** While high need exists across all age groups, modern contraceptive use is lowest and unmet need is highest among the youngest population segments, particularly ages 15-24. The same can be said for the poorest segments of the population and rural populations, although the urban poor are also a group that needs heightened attention. These groups often have very limited access to services and information. Creative approaches to reaching these underserved groups need to be developed and tested.

**Low-performing districts.** Within UP and other focus states, attention should be given to low-performing districts that often hold more promise for impact. In some cases, however, low-performing districts may not be the most promising, for example, districts that are home to tribal groups and minority ethnic groups that may be sensitive about family planning programming promoted by government.

**Imbalance of method mix.** In India, 79 percent of women use sterilization as their method of family planning. This reflects the traditional focus of family planning programs and has led to the common practice for women to begin childbearing early and with closely spaced births before adopting sterilization. By making temporary methods more widely available, women have the option of switching from less effective, traditional methods and achieving healthier timing and spacing of births with substantial improvements in maternal and infant mortality. IFPS has been successful to date in effecting a broader method mix. In UP, for example, sterilization is used by just 60 percent of women users, with higher use of temporary methods.

**Private sector health services issues.** In India, 80 percent of health care is provided through the private sector. In UP, this share is even higher, estimated at 96 percent. This encompasses both the formal and informal private sector – and services are of very uneven quality. Given this, there is tremendous potential for engaging the private sector to provide better quality services with greater accessibility to poor and other underserved segments of the population, including adolescents, and the rural and urban poor.

**Public sector health services issues.** Public sector health services are beset with many human resource issues, including poor skills, deployment, retention, and supervision. Efforts have been made to strengthen community-level cadres, most recently through ASHAs (Accredited Social Health Activists). While these community-level approaches hold promise, they have in many cases been established without strong systems of training and supervision. While attention needs to be focused on strengthening public sector institutions, it is important to recognize ways in which the public sector can be reoriented to support the private sector and unleash its potential to provide high quality and affordable services.

**Nascent NRHM structures.** The success of the National Rural Health Mission will hinge on the strengthening of the nascent institutions and procedures for managing GOI resources. These critical institutions at the state level include the SPMUs (State Program Management Units) and the SHSRCs (State Health System Resources Centers). In the focus states, IFPS 2.2 can play an essential role in strengthening these institutions to enable these resources to be deployed in cost-effective ways. Support is also needed for national level institutions, including the National Health System Resources Center and various divisions of the Ministry of Health and Family Welfare.

## **SECTION 5. Innovations in Family Planning Services (IFPS) Project 2.2: Major Design Elements**

### **I. Introduction/Summary**

Although the Evaluation of the IFPS II Project made many recommendations, and the visioning process revealed some significant issues, the visioning team concluded that overall IFPS II was on the right track with its strong emphasis on testing and scale up of public-private partnerships. Rather than significantly change the IFPS II directions, the team proposed extending the project from 2008 to 2012/15, divided between two shorter periods, with some important shifts in emphasis as described briefly in the “Overview” below, and in the more detailed sections that follow.

### **2. Overview of IFPS 2.2**

IFPS 2.2 is divided into two time periods, Short-Term and Medium-Term, to be implemented in up to four states and at the national level, with three Core Elements, and three Major Thrusts that underpin implementation. The scale of implementation will vary in each state.

**A. Time Periods.** IFPS 2.2 will have a Short-Term time frame from 2008-2010 that coincides with RCH 2, and a Medium-Term time frame from 2010 to 2012/15 that coincides

with the NRHM/MDGs. The Short-Term period is important for completing the testing of the present public-private partnership models (PPPs), many of which are just getting started in Uttar Pradesh and Uttarakhand. It is also a critical period for technical assistance to the national and state level structuring of the National Rural Health Mission, which is setting the policy and public sector operational environment for funding and providing oversight to these PPPs.

The focus in the Medium-term time frame must be on scale up of the PPPs in the target states and others, reinforcing the systems for monitoring the quality and scale up processes, and capacity-building of the partner institutions, including those Indian institutions that will provide technical assistance to the public and private sectors in the long term.

**B. Major Thrusts.** All activities under the IFPS 2.2 must be undertaken in ways that emphasize and strengthen these critical thrusts of the project.

- **Focus on family planning** within the context of the NRHM. The IFPS 2.2 is the USAID/India's primary vehicle for supporting information on, access to, and quality of family planning services. Given the high unmet need in the target states, increasing access is critical to meeting Indian government goals. USAID should also strongly encourage, through its staff policy dialogue and the IFPS 2.2 program, the expansion of the method mix available to prospective users. India relies heavily on sterilization, and families who want to space their children have few options. Emphasis needs to be given to expansion of access to the IUD, to injectables, (when the timing is right), as well as modern natural methods, including Lactational Amenorrhea Method (LAM) and the Standard Days Method (SDM).
- **Use targeted flexible funding** to leverage the funding available for expansion of successful pilots and implementation at scale, even beyond the target states. Technical assistance may be needed to help target and other states access the funds available, but the funding for NRHM services is more than adequate.
- **Use all opportunities to build institutional capacity** so that the need for USAID external technical support declines during this period. USAID must balance the need for quick turn-around and results with the need for strengthening capacity of local counterpart institutions, which often requires more time to produce results.

**C. Core Elements.** IFPS 2.2 should continue with and further emphasize and reinforce the work already started under IFPS II.

- 1) **Public-Private Partnerships (PPPs).** The models that are now undergoing testing need to be implemented for at least a 2-3 year period to adequately assess their cost-effectiveness, in particular in relation to addressing unmet need for family planning and reaching BPL clients. The marketing and promotion components of the present models, in particular, may need further assessment and fine-tuning. Over the next several years, other models may also be identified and will need to be tested. The IFPS 2.2 models should be assessed along with models being tested with USAID/India and Washington funding, such as the Shakti model.

In some geographic areas, the different models being tested are already interacting. For example, some clients of the voucher scheme are coming to CHACS sites implemented by the NGOs; some providers in the voucher scheme are also private providers of DMPA; other voucher clients may choose to attend a social franchising clinic accredited both for social franchising and for voucher programs. It will be important to assess the interrelationships and their outcomes.

IFPS 2.2 will also identify and test models for addressing the FP/RH needs of adolescents, a population group with high unmet need for FP/RH care, most likely by working with the private sector (NGO and commercial) partners and adapting PPP models already being tested for other groups.

In addition to the testing, assessment, and then documentation of the models, and their interrelationships, as appropriate, IFPS 2.2 needs to develop a strategy for scale up of these models. The strategy will need two major components:

--an **advocacy** component that draws on the evidence of how well they work in meeting the goals for the provision of services for BPL and other underserved populations, the range of services and impact of those services, and their cost-effectiveness; and,

--an **operational** component that provides the tools (manuals, guides, checklists, etc.) as well as targeted technical assistance to help the states and districts that adopt these models to adapt them as appropriate and effectively implement them at scale.

- 2) **National and state public sector policy and program environment.** During IFPS 2.2, the USAID/India Mission needs to remain fully engaged in policy dialogue with national and target state policy makers to ensure that the policy and program environment remains conducive to partnering with and more effective utilization and relationships with the private sector. In recent years and under NRHM, the public sector approach to the private sector has become much more favorable, opening the door to the testing of the models now underway. These doors need to remain open and welcoming not only to permit the testing to be completed, but, given the predominance of the private sector in the provision of health services in India and the target states, public sector engagement of the private sector is essential for improved health outcomes in India.

The policy discussions should also include encouragement of different roles for the public sector, shifting from primary service provider to one of strategic direction, accreditation and quality assurance, and contractor and financier. These are significant changes for government ministries, especially the Ministry of Health and Family Welfare.

- 3) **Development and strengthening of key systems.** Both the public and private sectors have needs for important management systems. Without such systems, the private sector will also not be able to provide adequate services, and will then fail to meet key health needs and change health outcomes.

**Behavior Change Communication (BCC).** Although there is significant unmet need for family planning and other services, information about contraceptives, services available, and other health information are often scarce. Access to mass media is spotty, especially in rural, remote areas, and the popular media may not provide accurate information. Given its experience in India and elsewhere, USAID is well regarded for its BCC activities. To be more effective, IEC/BCC activities need to be implemented as integral parts of an overall strategy with clear behavioral outcome objectives and integrated, reinforcing messages/components. IEC/BCC materials with the appropriate messages need to be available to all health service providers and promoters (public and private sector) at all levels.

**Training and Human Resources for Health Management.** There are serious gaps in skilled health providers in the public sector; training institutions produce too few and the public sector system does not retain these providers, particularly in the more remote areas. A recent assessment indicates that salary is less of a factor for retention than such factors as service delivery environment (e.g., availability of supplies and equipment) and encouragement (non-salary reinforcement). Nonetheless, lack of adequately trained, skilled providers remains a problem in both the public and private sectors. Given these problems and USAID's experience in addressing them, IFPS 2.2 needs to provide support to strengthening training and training institutions, as well as other HRH management issues such as supervision, retention, and deployment.

**Quality Assurance (QA).** Even when accessible, important health services, both in the public and the private sectors, are often of low quality. Through the establishment of accreditation systems and training to meet the standards required for accreditation, the PPPs are setting the groundwork for improving quality in the private sector. These systems need to be understood and eventually transferred to the public sector, as well as systems for monitoring private sector quality over time. In addition, stronger quality assurance approaches and systems need to be established and maintained for the public sector. Many approaches have been tried out, and some have been promulgated under NRHM. These need to be effectively adopted, fine tuned, and scaled up.

**Monitoring and Evaluation (M&E).** On-going monitoring and adjustments of the PPPs and other interventions are critical to effective implementation. Monitoring requires data collection on relevant activities, beneficiaries and results as well as analysis, identification of actions to improve performance, and then follow up to ensure that revisions and improvements are implemented. As the PPPs continue and scale up is started, these systems are especially important to ensure effective implementation and quality.

**Decentralization processes.** The NRHM has adopted the District Action Planning process first initiated under IFPS I as the standard approach for decentralized planning and management for the country. The intent is to further decentralize these processes to the block level and below. USAID has a role to play, especially in its target states, to support this process, reinforce quality in preparing the plans and support effective implementation.

### 3. Short-term Objectives for IFPS 2.2

The objectives for the short-term period under IFPS 2.2 from 2008-2010 are:

- Proven cost-effective public-private partnerships that have increased family planning access and use by BPL and other underserved groups in the pilot districts and areas are documented and scale up started in selected districts.
- Continued positive policy environment at the national and state level for PPPs; mechanisms established that will allow use of NRHM funds for implementation at scale.
- Systems designed and tested to support PPP implementation, including training, QA, M&E, and BCC (private and public sector as appropriate).
- Scale up strategy for the PPPs reviewed, approved, and launched.
- SIFPSA serving as the UP SHSRC and other functions significant for the NRHM.
- Indian partner institutions identified and strategy regarding their future use in providing TA to NRHM developed and the assumption of TA responsibilities under IFPS 2.2 started.

### 4. National and State-by-State Activities in Geographic Focus Areas

IFPS 2.2 will work in the following geographic areas as summarized in the chart below and described more fully in the section after.

<b>Key activities outlined for IFPS 2.2</b>		
<b><i>India/States</i></b>	<b>Short term</b>	<b>Medium term</b>
<b><i>National level</i></b>	Technical support to National Health Systems Resource Center	All short-term support would continue in the medium term.
	National coordination with MoHFW and donors	Continue from short-term.
	Technical support to various divisions of MoHFW such as FP Division, MCH Division, Statistics Division, Social Marketing Division, and IEC Division.	Continue from short-term.
<b><i>Uttar Pradesh</i></b>	State wide activities in policy and management	Technical Assistance for systems, scale-up, institution-building, quality assurance, monitoring and evaluation, BCC and
	PPP testing and scale-up + other innovations (youth)	

	Systems designed/tested for quality assurance/monitoring and evaluation	training
	BCC, training	
	Health human resources and capacity building in FP/RH	
	Focus on low performing districts	
<b><i>Jharkhand</i></b>	Situation analysis	Institution building
	Support establishment of systems statewide	Monitoring systems
	PPP testing	PPP scale up
	Focus Family Planning in districts/blocks as indicated by situation analysis.	Support and provide Technical Assistance
<b><i>Bihar</i></b>	Situation analysis	Institution building
	Setting groundwork	PPP adaptation and scale up in select districts
	Review of options	Monitoring systems (Quality Assurance, Monitoring & Evaluation, training)
<b><i>Uttarakhand</i></b>	PPP testing and scale up in appropriate districts	Technical Assistance for PPP scale up

**National Level.** IFPS 2.2 will continue to provide technical support in particular to the National policy and program management level to help guide the effective implementation of the NRHM and assure a positive policy climate, structures and procedures, and mechanisms for public sector support for private sector participation in health programming and service delivery. More specifically, USAID and its technical assistance partners will:

- In the short term, continue to support positions to staff up the newly established National Health Systems Resource Center (NHSRC), and in the short- and medium-term provide technical support to the NHSRC.
- USAID staff will actively participate in key national health system coordination entities along with other development partners, so as to be fully informed of issues and directions in the national program and provide technical input as appropriate and as needed.
- Provide targeted technical assistance to specific divisions within the Ministry of Health and Family Welfare (MoHFW). Among those that are likely to be recipients

are the Family Planning Division, the IEC Division, the Social Marketing Division, the MCH Division and the Statistics Division.

**Uttar Pradesh.** UP will remain the state that is the primary focus for IFPS 2.2.

During the short-term phase, USAID will give priority to the following key activities:

- **State-wide activities in policy and management**, assisting the state in its establishment of the state-level State Program Management Unit (SPMU) and the state-level State Health Systems Resource Center (SHSRC), the development and implementation of Program Implementation Plans (PIPs), supporting districts in the development of district action plans (DAPs) and their implementation, and other initiatives and assistance that helps with effective decentralization of service delivery funding, authorities, and accountability.
- **Testing and scale up strategy for the newly initiated public-private partnerships**, including tracking progress in their implementation, fine tuning where needed, and assessing progress towards meeting objectives in family planning service delivery for BPL and other underserved groups. It is anticipated that these models will need to be tested and maintained over a 2-3 year period. In addition, USAID will support the documentation of the models, lessons learned, their impact, and their cost-effectiveness, so as to feed into the advocacy and scale up strategy that will be developed during this time period as well.
- **Support new models of public-private partnership if identified**, following the same approaches as used under IFPS II for gaining approval and working out implementation details with all concerned stakeholders. New models started in the later part of this Short-Term phase may need to run into the Medium-Term time period so as to have enough time to assess cost-effectiveness and impact.
- **Identify and test models for addressing the FP/RH needs of adolescents**, most likely by working with private sector (NGO and commercial) partners. As the delivery of information and services to adolescents remains controversial in the state, and most people look to the private sector for services, NGO and other commercial sector partners appear to be important resources for providing information and services to young people. IFPS 2.2 will help to develop and test models, perhaps building on on-going PPPs, and/or the youth-friendly pharmacy initiative being supported by USAID central resources.
- **Strengthening of systems** for quality assurance, training, BCC, and M&E will be emphasized as will assistance in looking at broader issues of human resources for health issues, such as deployment, retention and management, as well as training. These systems need to be supported as part of an overall strategy for scale up of the PPPs, as the PPPs will rely on them to assure quality, promote the services to prospective clients, and other service delivery support. In building the capacity of the institutions that will implement and maintain these systems, IFPS 2.2 needs to carefully select local partners and to develop clear strategies for their eventual utilization by the government with government financing.
- **Special attention and support to low-performing districts** will be needed so as to address demand and access issues for FP services in this very diverse state. This will require adapting the innovations of both IFPS I and II to these districts, and close

monitoring and follow-up. Some of the PPP models may be adapted to and tested in these particular settings.

During the Medium-Term phase, support will shift from the funding and implementation of models for PPPs, except for those that have started late, to targeted TA in areas such as scaling up of the models, systems strengthening, with emphasis on QA, M&E, training, and BCC, and institution building.

**Jharkhand.** USAID will continue to support the development of the state-wide institutions needed for management of effective service delivery under the NRHM, but will place greater focus on ways to assure access and demand for family planning services. During the Short-Term, USAID will support:

- **Continued technical and other support for the state-wide health services management institutions.**
- **Conduct a short situation analysis** to identify perspectives on and opportunities for expanding access to and information about family planning services. The results of this analysis will help define the extent of USAID assistance to Jharkhand under IFPS 2.2 and where and how this assistance will be provided in the state.
- **Test public-private partnerships** that are adapted from the experiences in UA and UP to the Jharkhand environment that will assure access to family planning information, products, and services.
- **Focus family planning access on districts/blocks as indicated in the situation analysis.** In discussions during this visioning process, areas identified where family planning may have a better chance of being accepted and expanded were the non-tribal districts and blocks as tribal and other minority ethnic groups may be sensitive to family planning programming promoted by the government. Whether this is the case will be assessed during the situation analysis mentioned above.

During the Medium-Term period, USAID support to Jharkhand will be contingent on the results of the activities in the short-term phase. If access to family planning information, products and services can be effectively expanded, particularly through PPPs, then these would be scaled up, and technical assistance provided for monitoring and other systems, institution-building, and to meet other specific, appropriate needs.

**Bihar.** Although Bihar is a state with very high unmet need and large demand and access problems for services, it is recognized as very challenging. The visioning team also recognized that USAID has relatively limited resources available and that other donors are interested in trying to help Bihar. Therefore, the team agreed that some initial, exploratory steps should be taken to assess the potential for some targeted, limited assistance that would take advantage of USAID's comparative advantage in working with the private sector. The following activities will be undertaken during the short-term period:

- **On-the-ground assessment of possibilities and prospects.** This would include an analysis of public sector structures, programming, and capacity; the capacity of the private sector and willingness to partner with USAID and the public sector in NRHM service delivery; geographic analysis of the state to determine whether

certain districts might warrant USAID attention; and an initial set of recommendations on how USAID should proceed.

- **Setting groundwork.** If the situation analysis above looks somewhat promising, then USAID would support more discussions in Bihar to identify possible partners and approaches that might work for assisting in the expansion of family planning information, products and services and to identify districts in which to focus. This process would be accompanied by on-going dialog with other development partners considering assistance to Bihar so as to identify ways USAID would work in concert with them.
- **Review of options.** By the end of the short-term period, USAID would review its experience to date in Bihar, the options for partnering with institutions there, both in the private and public sectors, the plans of other development partners, and make a decision as to whether to proceed with any activities in Bihar during the Medium-Term phase. Expansion into Bihar, depending on the size and potential scope of the activities, may also be contingent on additional funds in the USAID/India health budget.

As noted above, activities in the Medium-Term phase will rely on the outcomes of the Short-Term phase. If USAID does support activities in Bihar, they are likely to include: adaptation of selected PPP models and scale up in selected districts; development of key systems, such as QA, M&E, training, and BCC; and building of key institutions.

**Uttarakhand.** Of the states in which USAID is working, Uttarakhand is an outlier with high modern contraceptive prevalence and relatively low TFR. Nonetheless, interesting PPPs are being tested that may have applicability beyond its borders. Therefore, targeted TA will be provided as follows:

- **In the short term, to complete PPP testing and scale up,** for models appropriate for hilly districts, and for those appropriate for plains areas in the plains districts.
- **In the medium term, provide targeted TA to support scale up of PPPs.**

## 5. Key Issues

The Visioning team identified some important implementation issues that need to be addressed for IFPS 2.2 to have the desired impact. These include: the effectiveness of SIFPSA; the IFPS II Technical Assistance Project (ITAP), under contract through a Task Order under the project Private Sector Partnerships (managed by USAID Washington); Performance Based Disbursement (PBD); and, coordination within the PHN Office among the relevant projects. These are discussed in greater detail below.

**A. The State Innovations in Family Planning Services Agency (SIFPSA)** is a society that USAID helped establish in the state of Uttar Pradesh in 1992/3 to facilitate innovation and effective delivery of family planning services in UP. It has now a staff of about 56 who are actively engaged in the design and implementation of the private-public partnerships being tested in UP, along with supporting public sector programs in selected technical areas. While SIFPSA is acknowledged as a leader in family planning, district-level action planning,

BCC, training and management, its relationships with some departments of the UP government have at times been strained.

Under the NRHM mandate, SIFPSA has been proposed as the state's State Program Management Unit (SPMU); however, that proposal has met with political roadblocks and the team understood in its interviews that this option is probably not feasible. A more likely scenario is for SIFPSA to be designated as the UP State Health System Resource Center (SHSRC). Whatever SIFPSA's role is in the future, it will have to change its way of working considerably to ensure that it can interact effectively in the new State environment and effectively partner with a variety of organizations. Key issues that have affected SIFPSA's operations within the last few years in particular are:

- **Lack of consistent, committed leadership.** The Executive Director of SIFPSA has been a GOI IAS Officer. While advantageous for helping accelerate actions with government, it has meant that its leadership has changed frequently, especially within the last 3 years, while its staffing and programs have declined. Moreover, an IAS Assistant Executive Director position has mostly remained vacant, and a private sector Assistant Executive Director position has remained vacant most of the time. Therefore, in the absence of an ED, there is no leadership at the top of the organization and very limited decision-making authority for those in the layers below.
- **Staffing/Organizational Structure.** With a change in its mandate and programs, the organizational structure of SIFPSA needs significant overhaul. A reorganization study was undertaken by the technical assistance agency under IFPS II, the IFPS Technical Assistance Project (ITAP); it was subcontracted to KPMG and the study recommended a number of restructuring processes in order to enhance the profile and efficiency of SIFPSA. Whether these recommendations are still appropriate, given more recent discussions on SIFPSA's future role(s), needs to be reassessed.

Certainly to take on its new roles and functions under NRHM and more broadly to respond to technical assistance requests from within UP, SIFPSA will need to develop new skills and operational capacity, including, for example:

- mechanisms and skills to identify and contract for its own technical assistance;
- public health skills to respond to the full range of NRHM health programming; and,
- new supervisory arrangements and structures among the staff.

- **Governance.** Project approvals and other decisions regarding SIFPSA's programs and activities require many levels of approval outside the organization in the UP government. This can result in long delays in implementation. In addition, the organization has little scope to set its future directions and programming and hire personnel and make other decisions on its own.

- **Relations with the Directorate of Health and Family Welfare, Government of UP.** Even before, but also more recently with the uncertainty of SIFPSA's future, SIFPSA's relationships with key officials within the UP government have been strained. While relationships with district level staff have been recognized as strong, state-level collaboration needs to be substantially strengthened.
- **Use of Savings as an Endowment Corpus.** Through the IFPS I performance-based disbursement mechanism, SIFPSA received USAID funds provided through the GOI as it achieved benchmarks. Approximately \$30 million from these funds have not been spent, and represent a form of "savings" for SIFPSA. SIFPSA needs to develop a strategy for utilizing these funds to help sustain the organization, undertake activities that will yield results to achieve its mission, and provide flexibility in how it partners with other organizations.

After some lengthy discussion regarding SIFPSA's strengths and weaknesses, the visioning team agreed that there was merit to investing further in SIFPSA so that it could continue to play some important roles in UP. More specifically, SIFPSA is an important on-the-ground partner in the piloting and testing of the PPPs in UP; it has strong district connections and infrastructure that would have to be recreated if SIFPSA could not make this contribution; and, it retains important skills in training, BCC, and family planning.

Nonetheless, SIFPSA needs some urgent, immediate assistance and USAID must provide this help. More specifically:

- Resolution of leadership (an ED needs to be designated at the earliest possible date) and other key staffing vacancies, including administrative support.
- Provision of Organizational Development assistance by a competent Indian OD organization to help SIFPSA develop and clarify its Vision and Mission as an organization, restructure itself to more effectively play its roles, whichever roles are decided, address and resolve staffing needs; plan the implementation of the restructuring and realigning of staff to fill the roles in that structure; address the governance issues; and, galvanize SIFPSA to action. (See draft Scope of Work for this OD assistance in Annex 6.)
- Resolution of SIFPSA's role(s) under NRHM in UP.

**B. IFPS Technical Assistance Project (ITAP)** is the primary provider of technical assistance to IFPS. As noted by the IFPS II Evaluation Team, ITAP has been responsive to a wide range of technical assistance needs, and has accomplished a lot in its short life span (2+ years). It has a main office in Delhi, and smaller TA teams in UP, Uttarakhand and Jharkhand. Under its Task Order, ITAP is expected to support the PPPs and help develop a cadre of local Indian institutions competent to provide technical assistance when ITAP ends. This component of its mandate has not yet been fully implemented.

After discussing the strengths and some issues with ITAP, the visioning team agreed that ITAP should continue. However, USAID should work with ITAP to strengthen its capacities and mobilize its resources to address some priority areas. These areas could be the focus of a more strategic and systematic work plan development and approval process

and/or through systematic, periodic consultations and instructions provided to the ITAP team. The key actions include:

- Continue ITAP, by exercising the two one-year options sequentially, contingent on continued high quality performance. These extensions will take the TA team till March 2010.
- Through close consultation on the work planning process and follow up of implementation, ensure that ITAP takes on these priority areas:
  - development of strategies/strategic approaches for a) scale up of the PPPs; b) BCC at the project level that relates promotion of the PPPs, mass media and IPC messages and materials for all levels of service providers, etc.; and c) institution building, with an approach to selecting local partner institutions and preparing them for stronger roles in the provision of TA for partnering and contracting with the government.
  - strengthening its own skills in Organizational Development, as an important part of its support to the structuring, operations, and building of the NRHM institutions.
  - strengthening its skills in selected, priority health areas, including, for example, family planning, emergency obstetric care (EmOC).
  - expanding its own staff and competencies in market research and marketing.

**C. Performance-Based Disbursement** has been the financing mechanism for the implementation of key activities under both IFPS I and II. USAID funds are obligated under its bilateral agreement to the GOI, which transfers the funds to UP. When SIFPSA (and now similar state societies in Uttarakhand and Jharkhand) meet certain benchmarks, an agreed amount of those funds is transferred to SIFPSA and the other societies. If the benchmarks are not met in a timely manner, USAID/India can develop a large pipeline, a situation that plagued the IFPS I project in the 1990s and beyond. As a result of lessons learned from that experience as well as recommendations from an audit report, the benchmarks under IFPS II have been more tied to immediate activities and results.

From its long experience with the benchmarks approach to planning and results achievement, SIFPSA finds the setting and meeting of benchmarks useful and motivating. Nonetheless, the process of creating appropriate benchmarks, getting evidence that the benchmarks have been met, and verifying the evidence, and then processing the paperwork required is management intensive for USAID and its partners.

Whether to retain the benchmarking approach was discussed at length during the visioning meeting. One key conclusion was that more analysis and discussion are needed before making a final determination on the future of PBD under IFPS 2.2. In the interim, the following was proposed:

- **Simplify and streamline** to the extent possible both the benchmarks that are required and the processes for collecting information and achieving consensus on whether they have been met.

- **Consider using the work plans** as one approach for streamlining the benchmarks system. One benchmark may be the production of an annual work plan that meets certain criteria; then the following, perhaps quarterly, benchmarks may be the completion of components of the work plan.
- **Shift ratio of funding of financial resources** (over the period of IFPS 2.2) by funding implementation now done through PBD to TA (funded by non-PBD).
- **At the same time, examine other funding options** including their advantages and disadvantages, potential management burden for USAID PHN and support staff, and possible complications for funding of local NGOs and other partners.

**D. Coordination of Projects and Activities within PHN and with other USAID-funded Sectors** has been strong in some respects, but all agreed that more needed to be done so that the IFPS 2.2 would take the lead in family planning and link closely with MCH and Health Systems activities where projects are working in similar geographic areas. IFPS 2.2 is, in effect, the “flagship” USID/India family planning project, and must, given its funding from primarily USAID-tagged family planning funds, focus on family planning. Yet, the NRHM mandates integrated programming for primary health and other health services for the rural poor. USAID/India must then ensure that the appropriate linkages and joint funding of key activities needed to support NRHM are developed and implemented. All agreed that this is an opportune time to apply stronger coordination mechanisms because several new activities/projects have just been awarded or are planned for this coming year.

The most important linkages of IFPS 2.2 are with the following projects/activities:  
Under MCH: Vistaar, the MCH Flagship; the Urban Health Resource Center; and, the newly awarded MCH Star.

Under the Health Systems Division: several Mission and Centrally funded private sector activities being implemented by the PSP-One project, including the fractional franchising of DMPA in the clinics of private physicians and the Shakti model of community entrepreneurs for a range of products from Hindustan Lever to include pills and condoms. The Health Systems Division is also planning a new procurement to replace its former private sector-oriented project, PACT CRH. Given the focus on forms of PPPs, this future project and the other activities in the Health Systems portfolio are particularly relevant to IFPS 2.2.

Several steps were agreed on to improve this cross-PHN collaboration:

- Formal sharing and discussion of annual work plans among the PHN staff and partners;
- Quarterly meetings of PHN staff and partners to update on progress, changes and issues; and,
- Joint funding of activities, where appropriate, in particular for those activities that support NRHM implementation and integrated service delivery and should be funded by the range of health funding available.

## SECTION 6: Major Implementation Steps (Short-term)

In concluding the visioning process, the USAID/India PHN team committed to:

- Extend IFPS to 2012/15 through an Amendment that modifies the Revised Amplified Project Description (See Annex 5).  
*Timeline: March '08 Mission review*  
*April '08 White Board*  
*May-June '08 Government consultations*  
*August '08 Final sign-off*
- Exercise options (year by year) to extend ITAP to March 2010. Through work plan preparation, approval and monitoring processes, guide ITAP to strengthen/emphasize:
  - Strategies (for BCC, institution-building, PPP scale up)
  - Monitoring implementation of pilots to ensure quality and readiness for scale up
  - Marketing
  - Family Planning and other technical areas*Timeline: October '07 through March '08*
- Develop (to be led by ITAP) scale up strategy for PPP's including intermeshing of PPP's, etc.  
*Timeline: October '07 through March '08*
- Continue but modify PBD to streamline and reduce management burden; at the same time, examine other, alternative funding mechanisms.  
*Timeline: October '07 through March '08*
- Assure decisions on SIFPSA and initiate OD support for transition of SIFPSA.
  - Advocate with government for appropriate role in NRHM for SIFPSA, staffing, organizational status and structure*Timeline: October '07 through December '07*
- Assess Jharkhand FP potential and opportunities.  
*Timeline: October '07 through March '08*
- Assess and decide on options for Bihar.  
*Timeline: Groundwork: October '07 through December '08 Go/No Go Decision: January '09*
- Develop and implement PHN coordination plan.  
*Timeline: October '07 through December '07*
- Conduct Mid-term Assessment.  
*Timeline: December '08 through January '09*

**DOCUMENTS CONSULTED**Document(s) Specific to Assignment

Scope of Work: IFPS II Vision Beyond September 2008: Innovations in Family Planning Services Project II (IFPS II), Draft: September 13.

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Innovations in Family Planning Services (IFPS) Project Documents

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New Activity Document: IFPS II—The Second Phase of the Innovations in Family Planning Services Project, October 1, 2004 to September 30, 2008

Attachment A: Revised Amplified Project Description for the Second Phase of the Innovations in Family Planning Services Project, October 1, 2004 to September 30, 2008

IFPS II Evaluation Report (draft) (including Annexes)

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**SITE VISIT ITINERARY: AGRA**

Outreach Camp: CHACS counseling center and clinic, met with RNM and ASHAs

Ram Raghu Hospital, accredited for voucher referral, met with private doctor and ASHAs

Merry Gold L0 Social Franchising hospital staff

DMPA clinics, visited two sites and met with two private OB/GYNs

**Agenda  
Visioning Meeting  
October 1, 2007/New Delhi**

9:00–9:10 am	Opening/introductions Objectives Agenda Logistics
9:10–9:30 am	Results of NFHS 3: Focus on UP, Jharkhand and Uttarakhand
9.30–10:30 am	Key problems and issues: Recommendations from IFPS II Evaluation What team learned from site visits and key informant interviews USAID’s comparative advantage Suggestions for USAID regarding future areas/key themes
10.30–10:45 am	BREAK
10:45-12:00 noon	Parameters for follow-on What are the key areas and themes? What are the geographic areas?
12:00-12:30 pm	Vision, if successful By 2012/13
12:30-2:30 pm	LUNCH
2:30-2:45 pm	Review results of discussion
2:45-3:30 pm	Whither SIFPSA?
3:30-4:00 pm	Technical Assistance Mechanisms and Institution Building
4:00-5:00 pm	Other issues: Beyond core geographic areas Performance-Based Disbursement Fit within PHN Funding levels/mix Transition relating to IFPS II and ITAP
5:00-5:30 pm	Key conclusions/wrap-up

## IFPS 2.2: Modified, Amplified Project Description

### I. Summary

This modified project description describes the extension of the Innovations in Family Planning Services (IFPS) project for the four-year period from October 1, 2008, until September 30, 2012. During the extension period, project activities will maintain the fundamental orientation laid out in the “Revised and Amplified Project Description” to support development, demonstration, documentation and leveraged expansion of working models of public-private partnerships (PPPs) which improve the delivery of integrated reproductive and child health services in Uttar Pradesh, Jharkhand, and Uttarakhand. With the advent of the National Rural Health Mission and allocation of substantial GOI resources to support decentralized and integrated maternal, reproductive and child health services, there is a heightened need for IFPS to focus on key inputs to assure that these funds are used in cost-effective ways, including a focus on institution-building and system strengthening. This Modified Project Description also envisions the completion of ongoing PPP work in and then a phase-down of activities in Uttarakhand, where needs for family planning are largely being met. It also provides for an assessment of the potential for limited and targeted support to adapt and scale-up of proven innovations in Bihar, where substantial unmet need for family planning exists. Should the assessment conclude that such support would have substantial impact, this limited support would be undertaken. IFPS will continue to focus its assistance on Uttar Pradesh, where tremendous need still exists and where the program has had marked success. To differentiate the extension phase from the original project and the initial extension, it will be referred to as IFPS 2.2.

### II. Background

The IFPS project was originally designed in 1992 to assist the Government of India (GOI) in revitalizing family planning services using the state of Uttar Pradesh (UP) as the primary site and testing ground for program innovations. An independent society, the State Innovations in Family Planning Services Project Agency (SIFPSA), was created to oversee the implementation of activities in UP.

The original goal of the IFPS project was to assist UP in reducing its rate of population growth to a level consistent with its social and economic objectives. Specific numeric goals were attached to those objectives in terms of the total fertility rate and contraceptive prevalence rate (CPR). The most recent data from the 2005-2006 NFHS-3 survey, show that contraceptive prevalence in UP has increased from 21 to 29 percent over an eight-year period. This is in line with what a successful program can expect to achieve, i.e., a one point increase in modern contraceptive prevalence per year. Geographically, the IFPS-II formally extended its focus to encompass the neighboring new states of Uttaranchal (UA) and Jharkhand (JH), to support development of high quality health services delivery systems in those states. UA was originally part of UP and has shown even greater success, reflected in improving indicators. Modern contraceptive use in UA has increased from 40 to 56 percent over an eight-year period – an increase of 2 percentage points per year. In JH, where IFPS

activities have only recently begun, modern contraceptive use increased from 25 to 31 over the same time period – just short of one percentage point per year.

Originally, IFPS focused solely on family planning. Subsequently, the project was broadened to include maternal health, child survival and HIV/AIDS. The major focus for IFPS has remained on family planning. The IFPS project has been funded by a performance based disbursement (PBD) mechanism which links disbursements to achievement of specific performance objectives. In this system, the focus is on achieving results instead of tracking inputs.

#### **A. Current status**

In Uttar Pradesh, SIFPSA is now an organization with 56 staff members at the central level who have overseen more than 400 discrete projects and activities. It has focused its work in 38 of the state's 70 districts which are home to 94 million of its 170 million people. Much of the success in increasing contraceptive use in UP can be credited to SIFPSA's support for formulating and implementing district action plans (DAPs) by local institutions, support for community-based distribution, as well as support to service delivery through local NGOs and cooperatives. Importantly, some of these interventions and the management systems through which they are delivered serve as models for broader use across India. PPP models that tap the private sectors potential to provide quality health services

For the UP portion of IFPS, a total of 509 benchmarks have been established and \$120 million has been dispersed for achieving benchmarks. For UA, 18 benchmarks have been established and \$2.3 million has been dispersed for achieving benchmarks. For JH, 12 benchmarks have been established and \$285 thousand has been dispersed for achieving benchmarks.

### **III. Key Elements of IFPS 2.2**

IFPS II will build on the lessons learned and experiences of the 12-year IFPS project to continue improving reproductive and child health outcomes in the project areas.

#### **A. IFPS 2.2 Objectives**

The original objectives of the IFPS project were to increase access to and the quality of family planning services while promoting family planning more generally. Over time the project was revised to include reproductive health, child survival and HIV/AIDS concerns and to expand its reach beyond UP to include Uttaranchal and Jharkhand. The objectives of IFPS 2.2 remain the same, but the tactics for addressing them have evolved in light of experience. The following interests will be highlighted:

- **Engage the private sector:** In India, 80 percent of health care is provided through the private sector. In UP, this share is even higher, estimated at 96 percent. This encompasses both the formal and informal private sector – and services are of very uneven quality. Given this, there is tremendous potential for engaging the private

sector to provide better quality services with greater accessibility to poor and other underserved segments of the population, including adolescents rural, and urban poor.

- **Focus on underserved groups:** While high need exists across all age groups, modern contraceptive use is highest and unmet need is lowest among the youngest population segments, particularly ages 15-24. The same can be said for the poorest segments of the population and rural populations, although the urban poor are also a group that needs heightened attention. These groups often have more limited access to services and information. Creative approaches to reaching these underserved groups need to be developed and tested.
- **Focus on low-performing districts:** Within UP and other focus states, attention should be given to low-performing districts that often hold more promise for impact. In some cases, however, low-performing districts might not be the most promising, for example districts that are home to tribal groups where receptivity to family planning may be limited.
- **Balancing the method mix:** In India, 79 percent of women use sterilization as their method of family planning. This reflects the traditional focus of family planning programs and has led to the common practice for women to begin childbearing early and with closely spaced births before adopting sterilization. By making temporary methods more widely available, healthier timing and spacing of births can be achieved with substantial improvements in maternal and infant mortality. IFPS has been successful to date in affecting a broader method mix. In UP, for example, sterilization is used by just 60 percent of women, with higher use of temporary methods.
- **Strengthen the public sector:** The public sector health delivery system is beset by many human resource issues, including skills, deployment, retention, and supervision. Efforts have been made to strengthen community-level cadres, most recently through ASHAs, Accredited Social Health Activists. While these community-level approaches hold promise, they have in many cases been established without strong systems of training and supervision. Attention needs to be focused on strengthening public sector institutions, it is important to recognize ways in which the public sector can be reoriented to support the private sector and unleashing its potential to provide quality control and affordable services.
- **Support NRHM structures:** The success of the National Rural Health Mission will hinge on the strengthening of institutions and procedures for managing GOI resources. This will depend critically on the SPMUs (State Program Management Units) and SHRCs (State Health Resources Centers). IFPS can play an essential role in strengthening these institutions to enable these resources to be deployed in cost-effective ways. Support is also needed at the national level, including the National Health Resources Center and to various divisions of the Ministry of Health and Family Welfare.

In view of these interests, the revised performance targets for IFPS 2.2 are as follows.

1. Increase demand for reproductive and child health (RCH) services through behavior change communication and marketing.
2. Increase delivery of integrated RCH services through public-private partnerships.
3. Strengthen capacity of the public sector to manage the provision of public and private RCH services through appropriate policies, monitoring and evaluation, quality assurance, and the like.
4. Strengthen the capacity of SIFPSA so it may more effectively promote collaborative partnerships with Indian and US institutions to support the delivery of integrated RCH services.
5. Utilize the resources of other development partners and the government to scale up and sustain innovations.

### **B. Technical collaboration mechanism**

Experience in IFPS demonstrated the need for significant investments in flexible technical assistance and collaboration (TA). IFPS 2.2 continues the successful TA modality established under IFPS II, which provides technical assistance to develop and document high quality working models of public-private partnerships throughout the focus states.

The majority of TA for the three states will be provided through Indian partner institutions linked through formal sub-contracts and/or grants to an overall technical collaboration contract awarded and managed by USAID/India. An international-level resident advisor will be located in Lucknow as part of the state-level portion of the contract. Additional project staff will be located in Uttaranchal and Jharkhand.

In addition to TA at the state level, the technical collaboration contract will support establishment and operation of a cell within the GOI's Department of Health and Family Welfare that will focus on the needs of the Empowered Action Group (EAG) states.

To maintain links to international best practices, specifically targeted short term international-level assistance will be provided for all components of the technical collaboration contract.

### **C. Key activities**

The key activities outlined for IFPS 2.2 are as follows:

<b>IFPS 2.2: Key Activities</b>		
<i>India/States</i>	<b>Short term</b>	<b>Medium term</b>
<i>National level</i>	Technical support to National Health Systems Resource Center.	

	National coordination with MoHFW and donors.	
	Technical support to various divisions of MoHFW such as FP Division, MCH Division, Statistics Division, and Communications Division.	
<b><i>Uttar Pradesh</i></b>	State wide activities in policy and management.	Technical Assistance for systems, scale-up, institution-building, Quality Assurance, Monitoring and Evaluation, BCC and training.
	PPP testing and scale-up+other innovations (youth).	
	Quality assurance/Monitoring and Evaluation.	
	BCC, training.	
	Health human resources and capacity building.	
	Focus on low performing districts.	
<b><i>Jharkhand</i></b>	Situation analysis.	Institution building.
	Support establishment of systems statewide.	Monitoring systems.
	PPP testing .	PPP scale up.
	Focus Family Planning in non-tribal districts/blocks.	Support and provide Technical Assistance.
<b><i>Bihar</i></b>	Situation analysis.	Institution building.
	Setting groundwork.	PPP adaptation and scale up in select districts.
	Review of options.	Monitoring systems (Quality Assurance, Monitoring & Evaluation, training).
<b><i>Uttarakhand</i></b>	PPP testing and scale up in appropriate districts.	Technical Assistance for PPP scale up.

In keeping with the catalytic strategy of IFPS 2.2, some activities funded under IFPS will not be carried forward into the extension phase. Specifically, in Uttar Pradesh DAP activities, RCH Camps and CBD programs will not be funded through IFPS 2.2. Continuing funding for these activities is to be made available through UP's NRHM program and/or the GOI NGO program. The major activities are discussed in greater detail below.

## 1. Activities Financed Through Performance Based Disbursements

**Operations research.** Operations research will play a significant role in the development and demonstration of successful PPP models. Technical assistance will be used to develop the capacity of the partner organizations in each state to conceptualize, oversee and contract for appropriate operations research activities. Bilateral assistance for operations research

involving aspects of the RCH II program will be available to assist that program in the three states.

**Social franchising.** Actually a subset of the working models of public-private partnerships, social franchising refers to the use of franchising methods to achieve social rather than financial goals. There are several different models of social franchising, including stand alone networks and fractional franchises. Each franchising activity has three basic programmatic goals: assuring the availability of services, the quality of services, and increased awareness and use of services. As part of this activity in the three states, national and international experience will be drawn upon to develop, demonstrate and document a number of models appropriate for these goals.

Key themes of the franchising models in all geographic areas will be concerted efforts to expand the basket of contraceptive choice to include methods such as the standard days method, emergency contraception, and injectables. Additionally, substantial efforts will be made to establish suitable systems for quality assurance and monitoring and evaluation, to incorporate gender and equity considerations, address HIV/AIDS where epidemiologically appropriate, and to develop working models that can be scaled up without substantial modification.

**Increasing public-private partnerships.** Developing, demonstrating, documenting, and leveraging expansion of appropriate working PPP models for increasing provision of integrated RCH services is the fundamental tenet of the IFPS 2.2 project. A number of examples of such partnerships exist within India and throughout the world. Incorporating international best practices, appropriate examples of these models will be developed for the project area.

The range of possibilities for such models is very large. Initially, the primary focus of IFPS 2.2 will be on developing models of social franchising for increasing availability of high quality integrated reproductive and child health services, including appropriate HIV/AIDS services. It is anticipated that social franchising models will be developed initially in urban areas. Subsequently, efforts will be made to expand to serve rural populations as the models evolve and prove themselves.

## 2. Technical assistance and collaboration (non-PBD) activities

**Assistance for Empowered Action Group Cell within MHFW.** The primary focus of the EAG cell within the MHFW will be to provide support to the EAG states in areas such as health planning and policy and guideline development. IFPS 2.2 technical assistance could potentially support central government efforts to liaise with EAG state RCH II implementers and synthesize state-level experience into more broadly applicable guidelines.

**Social marketing.** IFPS has proven that social marketing efforts increase sales and use of specific methods of modern contraception. Technical assistance funded by IFPS 2.2 will continue to be made available to assist in designing and evaluating social marketing efforts. However, funding for implementation is anticipated to come from the GOI's RCH II program. It is anticipated that funds for social marketing will flow from the RCH II

program at some point in the future. Until that time, USAID will support social marketing implementation activities that have begun under IFPS.

**Behavior change communication.** Experience in IPFS has shown that merely increasing service provision does not ensure that service utilization will follow. Therefore, IFPS 2.2 will provide significant technical assistance to design and evaluate behavior change communication efforts that are implemented using national RCH II program resources. Similar to the case for social marketing, it is anticipated that funds will begin to flow from the RCH II program in April 2005. Until that time, USAID will support implementation of behavior change communication activities that have begun under IFPS. After that time, RCH II is expected to fund implementation of these behavior change communication interventions.

**Support for technical cells in Uttarakhand.** In Uttarakhand, a Health Directorate has been established. To build the capacity of the Directorate to implement, coordinate and monitor health programs, the management and technical capacities of the Directorate will be augmented and specialized technical cells will be established. These specialized cells would look after training, immunization, public-private partnerships, monitoring and evaluation, logistics, civil registration, and information, education and communication (IEC) activities. IFPS 2.2 will support two to three key positions in each cell. Once the capabilities of the cells and staff are established, the positions will be shifted to the Government of Uttaranchal in a phased manner. Technical assistance will be provided to operationalize these cells.

**Public sector training in Uttarakhand and Jharkhand.** A major thrust of IFPS in UP was to enhance skills of public sector providers and improve the condition of health facilities to meet established quality standards. During IFPS 2.2, Uttaranchal and Jharkhand will benefit from the best practices established for training various providers in family planning counseling skills, clinical skills related to various sterilization procedures and IUDs, and skills related to infection prevention and the upgrading of clinical sites. The emphasis will be on transferring knowledge, building capacity and establishing standards, rather than on full-scale implementation of various training programs. It is envisaged that the trainings themselves (apart from training-of-trainers) will be done with RCH II funds.

#### **D. Relationships between IFPS 2.2 and the NRHM program**

As seen above, IFPS 2.2 will explicitly operate within the overall NRHM program framework. In UP, the extent to which RCH II will be implemented through SIFPSA has yet to be finalized. However, regardless of the final decision regarding RCH II implementation in UP, IFPS 2.2 will work within its overall programmatic framework, addressing innovative aspects of public-private partnership development and demonstration. In Uttarakhand and Jharkhand, IFPS 2.2 support will support the organization that will implement RCH II activities. In all three states, local activities and technical assistance funded under IFPS 2.2 will complement and inform appropriate aspects of RCH II implementation through model development and operations research activities.

The outcomes expected by the end of IFPS 2.2 are presented below:

<b>Expected End of Project Outcomes</b>			
<b>Results</b>	<b>UP</b>	<b>UA</b>	<b>JH</b>
1. Modern CPR rate increased by one percentage point per year.	X		
2. Over 420 million condoms sold in rural areas.	X		
3. Over 14 million cycles of oral pills sold in rural areas	X		
4. State proposals for RCH II developed & funded with local resources.	X	X	X
5. Over \$240 million leveraged from GOI resources.	X	X	X
6. At least one PPP model funded by other agencies for wider implementation	X	X	X
7. State systems in place and utilized for procuring technical assistance.	X	X	X
8. State Implementation Plan completed without external assistance.	X	X	X

#### **IV. Management Plan for IFPS 2.2**

The implementation structures and arrangements that have been established for implementation of IFPS and IFPS II will be continued during IFPS 2.2.

The national level Steering Committee will continue to provide overall policy, financial and management oversight of the project. The Steering Committee will function as a mechanism for open and continuous dialogue among the GOI, GOUP, GOU, GOJ, USAID and implementing entities.

Each state will have a separate Governing Body, operating under the broad policy directives of the Steering Committee under already-established guidelines. The Governing Bodies will review and approve annual implementation plans and budgets for the entities in their states. The Governing Bodies will be composed as per the agreements laid out in previous project agreements.

##### **A. Assessment**

An extensive assessment will be undertaken late 2008/early 2009. The assessment will consider the specific technical assistance requirements for a follow-on mechanism to the current ITAP. It will also consider the appropriateness of continued assistance to UA, a state with advanced and the potential for future limited, targeted assistance to Bihar, which has substantial levels of unmet need for family planning. It will identify and assess problem areas or constraints which may limit progress and recommend options to overcome such problems or constraints. The assessment will also consider the appropriateness of extending project activities beyond September 30, 2012 to September 30, 2015 which would align with a new five-year technical assistance contract, as well as the end-point of the Millennium Development Goals.

## V. Project Funding

**Project budget.** The IFPS project agreement has included a performance based disbursement component to finance all local costs except for those related to research and evaluation. These two activities were financed under a non-performance based disbursement component. In addition, a supplementary unilateral investment by USAID financed IFPS's technical assistance activities.

In contrast, IFPS II and 2.2 will use the PBD mechanism to fund local cost activities in all three states, and it will initiate the use of the non-PBD component to fund the USAID-managed technical assistance contract.

As illustrated in the attached budget table, the total amount obligated to finance IFPS's combined PBD and non-PBD components through September 2007 is \$140 million. The estimated total cost of IFPS 2.2 over the four-year period from October 1, 2008 through September 30, 2012 is an additional \$60 million. Therefore, the combined total of \$200 million falls within the \$225 million initially authorized for this activity by USAID.

With this amendatory agreement, new budget line items are established for IFPS II. Line items for IFPS are closed and no more obligations are planned against them. (Please see attached budget table).

**Annual obligations.** USAID funds will be obligated annually subject to the availability of funds.

**Funds from non-USAID sources.** Each state organization receiving support from IFPS 2.2 may receive funds from other development partners or the GOI, provided that a separate account is maintained by the organization for USAID funds and that USAID funds are utilized subject to the already existing conditions outlined in previous amendments to the original IFPS Project. In the case of SIFPSA, such an arrangement has been established so that the organization can receive funds from other agencies.

**Host country contribution.** The IFPS project, as amended, required a \$407 million contribution by the Government of India. By March 31, 2000, \$550.2 million had been contributed. Recently, the GOI has established the National Rural Health Mission which makes resources available for decentralized and integrated RCH services to high-need states in India, including the focus states for IFPS 2.2. The resources total \$8.6 million over a five-year period. USAID expects that the GOI will continue financing the field implementation and upscaling of IFPS 2.2 interventions. However, annual contribution reporting will not be required.

**SCOPE OF WORK**  
**ASSISTANCE IN ORGANIZATIONAL DEVELOPMENT FOR**  
**THE STATE INNOVATIONS IN FAMILY PLANNING SERVICES AGENCY**  
**(SIFPSA)**

**I. Background.**

The **Innovations in Family Planning Services (IFPS I) Project** was originally designed as a ten-year (then extended to 12), 325 million dollar project focused on family planning services, with the aim of increasing contraceptive prevalence and reducing fertility (TFR) in the state of Uttar Pradesh (UP). In 1992/1993, in UP as a whole, modern method contraceptive prevalence was 17.8 and in 1998/9 it was 20.8 as measured by the National Family Health Survey II. The project focused on increasing access to, improving quality of and expanding demand for FP/RH in a significant portion of the state of UP. The strategy was to develop innovative approaches to the improvement of family planning services in the public and the private sectors and then to support the broad scale implementation of those approaches in approximately half of the districts of the state.

**SIFPSA.** To support implementation of the IFPS I Project, USAID helped to establish the State Innovations in Family Planning Services Agency (SIFPSA), a quasi-governmental society that can act both with and independently of UP state authorities. Although it took some time for SIFPSA to be fully established and functional, it has now been in existence for almost 15 years and is an organization with over 56 headquarter staff who have overseen more than 400 discrete projects and activities. It has focused its work in 38 of the state's 70 districts which are home to 94 million of its 170 million people. As a result of SIFPSA efforts in IFPS I, CPR increased nearly twice as fast since 1998/99 in those districts where SIFPSA was working than it had in the remaining districts in the state. CPR rates achieved were 27.3% and 21.3% respectively.

Much of this gain has been credited to SIFPSA's support for formulating and implementing district action plans (DAPs) by local institutions. In addition, where SIFPSA supported community based distribution (CBD) of family planning information and services by local NGOs and cooperatives, CPR increased by an average of two to three percentage points each year. Statewide social marketing efforts have contributed to a doubling of condom sales in rural areas throughout the state, to more than 100 million units sold each year. Importantly, some of these interventions and the management systems through which they were delivered have served as models for broader use across India. As a result, SIFPSA is a recognized resource in the state for family planning and program implementation.

**IFPS II.** Following the evaluation of IFPS I, there was a major shift in the approach, strategy, and breadth of issues addressed by IFPS II (2004 – 2008) (see NAD, IFPS II, 2004). The executive summary of that document states that “during the extension period (04-08), project activities will be reoriented toward development, demonstration, documentation, and leveraging expansion of working models of public-private partnerships, for provision of integrated reproductive and child health services in UP, Uttarakhand, and

Jharkhand.” Major differences with IFPS I include the shift from development of new approaches and direct implementation, to development of innovations and promotion and technical assistance for scaling up, a shift from an exclusive family planning focus to a broad RCH approach, a much shorter timeframe and smaller budget, as well as a broader geographic focus to two states beyond UP. This refocused approach applied to both the SIFPSA component as well as a new consolidated TA component of the project. For SIFPSA this shift in approach represented a major challenge to the role and operations of the organization.

**Changing Context: National Rural Health Mission.** In 2003, the Government of India initiated a transformation of the system for delivery of primary health services to the rural poor of India. It established the National Rural Health Mission (NRHM) with the intent to achieve:

- key fertility and health indicators as reflected in the Millenium Development Goals (MDGs) as well as India’s development plans
- decentralization of health service management and accountability from the central, to the states, districts, and ultimately to the blocks and community levels
- integration of formerly vertical primary health care programs, such as family planning, maternal health, child health, malaria, etc.
- restructuring of the management of the services covered by the NRHM into single units, to include Project Management Units (PMUs) that would oversee the disbursement and utilization of funds and Health Systems Resources Centers (HSRCs) to provide technical support for implementation, at the National, State, and District levels.

The Government of India and the donor partners have committed to investing significant resources, approximately \$8.6 billion, in operationalizing the NRHM mandate over the next xx years.

**NRHM In UP.** Although UP has shown positive trends in relevant indicators, UP still has some of the worst indicators in the country and has a long way to go to catch up with other States and achieve State goals under the NRHM program. UP, therefore, is a high priority for NRHM. Even so UP has lagged behind other States in responding to the demands and opportunities of the NRHM, and has delayed in the establishment of relevant structures in large part due to the complex political environment, state elections and frequent transfer of senior officials. Over the past year there has been more stable and strategic leadership from the Principal Secretary for the health sector in general, but key decisions regarding the SPMU and SHSRC have been delayed.

**SIFPSA’s Future Role(s).** Although relatively new, SIFPSA now represents a well-acknowledged and well-established resource for the National Rural Health Mission (NRHM) and for the UP state government. The strengths of SIFPSA as perceived by State officials include its strong management systems, good practices and interesting innovations undertaken, and flexibility compared to the government system. SIFPSA has shown that successful partnerships can be developed with the private sector, especially with NGOs, and their contribution to the development of IEC/BCC materials and campaigns, improved training methodologies, and district action plans is positively acknowledged. UP officials also

praised SIFPSA's expertise in family planning and in clinical training, both roles for which UP may contract with SIFPSA under NRHM.

The Principal Secretary has put forward a proposal to the UP Cabinet nominating SIFPSA as the State PMU and/or the State Health Systems Resource Center for the NRHM program. If it is not appointed as either body, then the future is less certain, but there may be a role as an additional technical assistance agency specializing in FP/RH. In either scenario, SIFPSA clearly still needs to become more proficient. The discussion on the future role of SIFPSA has been going on for a number of years and the decision pending for at least three (first mooted in 2003 for RCH-2); the uncertainty has resulted in departure of some of the most qualified experts and other negative impacts.

From discussions during the team visit (September 25-October 6, 2007) for visioning the future for IFPS 2.2, it was evident that the most likely and most desirable scenario would be that SIFPSA be designated as the State Health Systems Resource Center (SHSRC).

**Action Needed.** To ensure that this more favorable scenario for SIFPSA is realized, USAID/India will need to do the following:

- To the extent possible in collaboration with other donors, encourage an early decision regarding the designation of SIFPSA as the SHSRC as soon as possible;
- Use the project management mechanisms available with the Government of UP to propose the designation of SIFPSA as the SHSRC, preferably in October 2007
- Assist in any way needed to prepare the documentation and other paperwork required to make the designation official.

If SIFPSA is not designated the State Health Services Resource Center, then USAID should support SIFPSA in pursuing an independent role in supporting programs in UP.

**Key Issues: SIFPSA.** Whatever SIFPSA's role is in the future, it will have to change its way of working considerably to ensure that it can interact effectively in the new State environment and effectively partner with a variety of organizations. Key issues that have affected SIFPSA's operations within the last few years in particular are:

- **Lack of consistent, committed leadership.** The Executive Director of SIFPSA has been a GOI IAS Officer. While advantageous for helping accelerate actions with government, it has meant that its leadership has changed frequently, especially within the last 3 years while its staffing and programs have declined. Moreover, an IAS Deputy Executive Director position has never been filled, and a private sector Deputy Executive Director position has also never been filled. Therefore, in the absence of an ED, there is no leadership at the top of the organization and very limited decision-making authority for those in the layers below.
- **Staffing/Organizational Structure.** With a change in its mandate and programs, the organizational structure of SIFPSA needs significant overhaul.

A reorganization study was undertaken by the technical assistance agency under IFPS II, the IFPS Technical Assistance Project (ITAP); it was subcontracted to KPMG

and recommended a number of restructuring processes in order to enhance the profile and efficiency of SIFPSA. Whether these recommendations are still appropriate, given more recent discussions on SIFPSA's future role(s), needs to be reassessed.

Certainly to take on its new roles and functions under NRHM and more broadly to respond to technical assistance requests from within UP, SIFPSA will need to develop new skills and operational capacity, including, for example:

- mechanisms and skills to identify and contract for its own technical assistance
- public health skills to respond to the full range of NRHM health programming, and
- new supervisory arrangements and structures among the staff.

- **Governance.** Project approvals and other decisions regarding SIFPSA's programs and activities require many levels of approval outside the organization in the UP government. This can result in long delays in implementation. In addition, the organization has little scope to set its future directions and programming and hire personnel and make other decisions on its own.
- **Relations with UP Government, including NRHM and Directorate at State level.** Even before, but also more recently with the uncertainty of SIFPSA's future, SIFPSA's relationships with key officials within the UP government have been strained. While relationships with district level staff have been recognized as strong, State level collaboration needs to be substantially strengthened.
- **Use of Savings as an Endowment Corpus.** Through the IFPS I performance-based disbursement mechanism, SIFPSA has received USAID funds provided through the GOI as it has achieved benchmarks. Approximately \$30 million from these funds have not been spent, and represent a form of "savings" for SIFPSA. SIFPSA needs to develop a strategy for utilizing these funds to help sustain the organization, undertake activities that will yield results to achieve its mission, and provide flexibility in how it partners with other organizations.

## II. Scope of Work

### A. Purpose and Objectives

The purpose of this consultancy in organizational development is to assist SIFPSA to transform itself into an organization adept at identifying and availing opportunities to provide technical assistance and implementation support services for priority health programs in UP and fully capable of performing its new roles under the NRHM.

**Objectives.** To assist SIFPSA to:

- Develop a strategic vision and clear mission for itself as an organization consistent with its potential for achieving priority family planning and health objectives in UP.

- Describe the structure and functioning of the organization that is desired (i.e., defining point B), and develop overall plan for changing from what SIFPSA is now (point A) to point B.
- As part of overall plan:
  - review and revise, as appropriate, the organizational structure proposed by KPMG, and plan for its implementation (with key steps, timeline)
  - develop communication linkages and procedures within the organization to ensure information and experience sharing and facilitate team-building
  - develop mechanisms to strengthen relationships with UP government officials
  - review and propose revisions to governance structures and procedures so as to ensure close collaborative relations with UP government as well as independence of functioning for SIFPSA as appropriate
  - clarify roles and responsibilities of SIFPSA and ITAP.

## **B. Activities to be Undertaken**

The OD consultants will work with SIFPSA and its stakeholders over an extended period of time, most likely for the time period January 1, 2008-December 31, 2008, for approximately 125 days, to be scheduled in collaboration with SIFPSA and its stakeholders. Key activities will include the following:

- **Review of key background documents** relating to SIFPSA's activities under the IFPS I and II projects as well as proposed changes under IFPS 2.2, the NRHM, and related matters. (See attachment A for preliminary list.)
- **Interviews/meetings with key stakeholders.** These include: USAID officials and key staff (Mission Director, PHN, RH staff, contracts and program staff; government officials in UP; officials in counterpart/partner organizations, including NGOs, private, commercial sector partners; government officials at the district (SIFPSA and non-SIFPSA) level; donor partners, especially those working in UP (e.g., World Bank); service providers at the peripheral level who have participated in SIFPSA-related training and programs.
- **Liaise with other technical assistance resources.** The ITAP team supports the activities of SIFPSA with additional expertise when it is not available within the society. While ITAP has complemented the work of SIFPSA considerably, ITAP assistance is not acknowledged by SIFPSA and seems to be more reactive than a strategic role in influencing the quality of SIFPSA's work. ITAP is a resource for future on-going assistance to SIFPSA in various organizational matters, and they need to agree on their respective roles and work more effectively together.
- **Conduct Interviews/Meetings with SIFPSA staff.** Individual and small group meetings with SIFPSA staff to assess morale, key issues from their perspectives, understand their ideas for future directions and structuring, and proposed options for implementation of change.

- **Facilitate All Staff Meetings with SIFPSA staff (3-5 over 9 months).** Series of team-building and strategic planning meetings to discuss key issues and develop solutions; once process launched, then use all staff meetings to assess progress and identify possible corrective actions.
- **Document and Check on Progress within SIFPSA and with Key Stakeholders.** As plans and changes are developed and decisions made, they need to be documented and feedback and reactions solicited from SIFPSA staff as well as key stakeholders. Frequent checking in with those most concerned will ensure that all are kept apprised of the changes, and be able to provide guidance as appropriate. Given SIFPSA's likely role as the SHSRC, the UP NRHM staff, in particular, will be concerned that SIFPSA's structure and staffing is able to provide the needed support.
- **Facilitate implementation/transition to new organizational structure and staffing.** Once the new structure is agreed and the transition plan prepared, SIFPSA will need help in its implementation, and ensuring that the transition is as smooth as possible. As noted earlier, these roles and modes of operation represent significant changes for SIFPSA, and the leadership and staff will need help in their management.
- **Coach SIFPSA staff.** Organizational change is challenging and the staff and leadership of SIFPSA will need periodic help in solving a wide range of problems. In addition, it will be helpful for external, but concerned people to check in with those affected periodically and share their findings with SIFPSA's leadership.

### C. Reporting/Deliverables.

The OD consultant team will provide the following key deliverables and will report back to USAID on an agreed-on periodic timetable. The team will report to the Reproductive Health Division Chief.

**Work Plan.** No later than the end of Month 1. To include major activities per the above list and blocks of time; should show expected date to achieve key objectives and deliverables (see below), e.g., restructuring and staffing plan and implementation schedule.

**Draft of new structure.** No later than the end of Month 3. To include organizational structure, titles and numbers of staff, with explanation of why and how the structure will be effective.

**Final, new structure.** No later than end of Month 4. This structure should have all of the features mentioned above and be prepared for approval by all of the relevant stakeholders, including the Government of UP.

**Draft Transition Plan.** No later than the end of Month 5. The plan should reflect agreement with all key parties on how the new structure will be implemented over the following 3-6 months.

**Final Transition Plan.** No later than the end of Month 6. Approved by all key stakeholders including the leadership and key managers at SIFPSA.

**Bi-monthly meetings and reports.** At the end of each two month period, the OD team will report formally to USAID on progress, key issues, assistance required, and upcoming activities and schedule. The oral and written formats for this reporting will be agreed to by the parties at the beginning of the consultation.

#### **D. Logistics**

At the beginning of the consultation period, USAID, the consultant team, SIFPSA and ITAP will work out roles and responsibilities for the logistics required to support this effort. Most likely, the roles will be as follows:

- SIFPSA and ITAP will be responsible for logistical arrangements required for visits to field sites and visits to government officials in Uttar Pradesh
- SIFPSA will be responsible for arrangements for all staff meetings,--including, in consultation with the consultants, site selection, room arrangements, etc.
- Consultant team will be responsible for their transport and arrangements for meetings with officials in Delhi and travel to Lucknow and other sites from Delhi

#### **E. Qualifications of Team Members**

Two team members are proposed so that at least one will be available for coaching and other assistance. The two team members should have the following qualifications and experience:

- 5-7 years experience with organizational development work similar to that reflected in this scope of work
- Familiarity with the GOI health system and programming in rural areas of India, preferably in UP or similar northern state
- Demonstrated understanding of operations of quasi-governmental organizations or societies such as SIFPSA
- Experience in OD that demonstrates ability to solve organizational structure and operations problems so as to strengthen the organization and its functioning