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20 Years of the Innovations in Family Planning Services Project in Uttar Pradesh, India

The Power of Innovations and Partnership

Experiences, Lessons Learned and Achievements

APRIL 2012

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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FOREWORD

A country's overall progress and development depends on the health of its people. Although India has made significant progress in improving the health of its population, the health indicators of one of its most populous states, Uttar Pradesh (UP), command the need for further attention. In 1992, UP was home to one-sixth of India's population and the total fertility rate for the state was 5.2, the highest compared to any other state in India. The contraceptive prevalence rate in 1995 was one of the lowest in the country, at 21 percent.

It was in this scenario that the United States Agency for International Development (USAID), in collaboration with the Government of India, designed the bilateral Innovations in Family Planning Services (IFPS) Project to revitalize the family planning program in UP, by introducing innovative approaches and mainstreaming successful interventions. The IFPS Project was implemented in three phases and the interventions have spanned over two decades in UP (1992-2012). In the first phase (1992-2004), the IFPS Project sought to increase access to family planning services, promote family planning method use, and improve the quality of family planning services in the state, primarily focusing on 33 districts. To enable responsiveness and strengthen capacities of the state structure for implementation of such a large project, USAID supported creation of a state government-led autonomous society, the State Innovations in Family Planning Services Agency. In its second phase (2004-2009), IFPS expanded its scope and focused on development, design, and demonstration of public-private partnership (PPP) models to improve delivery of integrated reproductive and child health services. During the third phase of the IFPS Project (2009-2012), the main emphasis was on documentation and dissemination of PPP models introduced in the second phase and preparation of scale up strategies for successful models.

The IFPS Project efforts have contributed to the overall improvement marked in the family planning and reproductive health indicators for UP. The contraceptive prevalence rate for all modern methods has seen a significant increase, from 21 percent in 1995 to 31.6 percent in 2010. Significant improvements have also been seen in the maternal health indicators. The proportion of women receiving any antenatal care services increased, from 50 percent in 1995 to 91 percent in 2010.

Statistics on institutional deliveries substantially improved, from 13 percent of all births in the state in 1995 to 48 percent in 2010. Overall, the IFPS Project has been able to contribute to an increase in modern spacing method use, maternal health services and private sector participation in the delivery of both family planning and maternal health services in UP.

This documentation reviews the experiences, program successes, and lessons learned from two decades of IFPS Project implementation in UP. It is hoped that it will provide further insights for policy makers across India and other countries on implementing programs with innovative approaches to improve family planning and reproductive health of their populations.

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ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Mid-wife
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
BPL	Below Poverty Line
CBD	Community Based Distribution
CBFPT	Clinic Based Family Planning Training
CHACS	Comprehensive Health and Counseling Services
CHS	Community Health Supervisor
CHC	Community Health Center
CHN	Community Health Nurse
CMO	Chief Medical Officer
COE	Center of Excellence
COPE	Client Oriented Provider Efficient
CPR	Contraceptive Prevalence Rate
CTU	Contraceptive Technology Update
DAP	District Action Plan
DCS	Dairy Cooperative Society
DCTC	Divisional Clinical Training Center
DIFPSA	District Innovations in Family Planning Services Agency
EAG	Empowered Action Group
FICCI	Federation of Indian Chambers of Commerce and Industry
FLE	Family Life Education
FP	Family Planning
FRU	First Referral Units
FWC	Family Welfare Counselor
GoI	Government of India
GoUP	Government of Uttar Pradesh
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IFPS	Innovations in Family Planning Services
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
ISMP	Indian Systems Medical Practitioners
ITAP	IFPS Technical Assistance Project
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
JSY	Janani SurakshaYojana
L1	Level 1
L2	Level 2
L3	Level 3

LHV	Lady Health Visitor
MCH	Maternal and Child Health
MGHN	Merrygold Health Network
MMR	Maternal Mortality Ratio
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MO I/C	Medical Officer In-charge
NABH	National Accreditation Board of Hospitals
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
NSV	No-scalpel Vasectomy
OPD	Out-patient Department
ORS	Oral Rehydration Salts
PAC	Project Advisory Committee
PBD	Performance Based Disbursement
PCDF	Pradeshik Co-operative Dairy Federation Limited
PHC	Primary Health Center
PMU	Project Management Unit
PNC	Postnatal Care
PPC	Postpartum Center
PPFP	Postpartum Family Planning
PPP	Public-Private Partnerships
PPIUCD	Postpartum Intrauterine Contraceptive Device
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RH	Reproductive Health
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Reproductive Tract Infection
SO	Strategic Objective
SHG	Self-Help Group
SIHFW	State Institute of Health and Family Welfare
SIFPSA	State Innovations in Family Planning Services Agency
SRS	Sample Registration System
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TFR	Total Fertility Rate
ToT	Training of Trainers
TT	Tetanus Toxoid
UP	Uttar Pradesh
USAID	United States Agency for International Development
USD	United States Dollar
VHP	Village Health Plan
VHV	Village Health Volunteer
VHSC	Village Health and Sanitation Committee
VMU	Voucher Management Unit

Section I

A Summary of Interventions in Uttar Pradesh (1992-2012)

Chapter 1

ABOUT THE INNOVATIONS IN FAMILY PLANNING SERVICES PROJECT

Uttar Pradesh (UP) is the most populous state in India with a population of 199,581,477. Rural population constitutes 77 percent of the total population while urban population is 22 percent (Census of India, 2011). The state is administratively divided into 75 districts and 18 divisions.

In 1992, the total fertility rate (TFR) in UP was 5.2, the highest compared to any other state in India (Sample Registration System (SRS), 1992). In 1992, the contraceptive prevalence rate (CPR) for UP was one of the lowest in India at 19.8 percent (National Family Health Survey (NFHS)–1, 1992-93). A vast majority of modern contraceptive method users were using limiting methods such as female sterilization.

Funded by the United States Agency for International Development (USAID), the Innovations in Family Planning Services (IFPS) Project was designed to revitalize the family planning (FP) program by introducing innovative approaches and mainstreaming successful interventions. The IFPS Project was implemented in three phases. During the first phase (1992-2004), the project's main objectives were to increase access to FP services, to promote FP method use, and to improve quality of FP services in the state. In 1998, the project objectives were further expanded to include antenatal care (ANC), tetanus toxoid (TT) injections, and iron and folic acid (IFA) tablets to pregnant women and institutional deliveries by trained providers. In the second phase (2004-2009), the focus was on development, design, and demonstration of public-private partnership (PPP) models to improve delivery of reproductive and child health (RCH) services and to address equity issues. During the third phase (2009-2012), the main emphasis was on documentation and dissemination of the PPP models introduced in the second phase and to prepare scale-up strategies for successful models. During the first phase, the IFPS Project was primarily implemented in 33 districts of UP where a baseline survey was conducted in 1995. During the second phase, the districts were selected based on the proposed PPP models.

In 1993, the IFPS Project created an autonomous agency called the State Innovations in Family Planning Services Agency (SIFPSA) to provide flexibility and avoid bureaucratic delays endemic to government systems. SIFPSA's Governing Body that provides policy guidance, has representatives from the Governments of India (GoI) and UP (GoUP), USAID and prominent private sector experts. The Executive Committee takes decisions on procurement of personnel, products and services. The Project Appraisal Committee provides technical review and approval of project proposals. The Executive Director heads the agency, structured to function through 11 departments with 11 General Managers in place. In addition to its headquarter staff in Lucknow, SIFPSA has established District Innovations in Family Planning Services Agencies (DIFPSAs) to help implementation of project activities in all 33 districts.

A unique feature of the IFPS Project was that USAID funds were channeled through a performance based disbursement (PBD) system. The emphasis of the PBD system was on provision of funds based on outputs than inputs. USAID and SIFPSA set mutually agreed project outcomes known as benchmarks, identified measurable indicators that were to be achieved within a time-frame and assigned financial value to each benchmark. After documentation of the benchmark

achievement, the funds were disbursed as per the predetermined amount.

As part of the IFPS Project, USAID identified specific US based cooperating agencies to provide technical assistance. During the first phase of project, Center for Development and Population Activities, Engender Health, Futures Group, JHPIEGO, IntraHealth International, Johns Hopkins University, John Snow, ORC Macro and Population Council provided technical assistance. During the second and third phases, Futures Group, Johns Hopkins University – Centre for Communication Programs, and JHPIEGO were the main agencies that extended technical help to the IFPS Project.

1.1 PURPOSE AND ORGANIZATION OF THE REPORT

This report has been prepared to review the experiences, program successes, and lessons learned from the two decades of the IFPS Project implementation in UP. The report is mainly divided into two sections. Section one summarizes the programs and interventions implemented as part of the IFPS Project from 1992-2012 and section two provides an analysis of the project performance from 1992-2012. It is hoped that the experiences and successes will inform policy makers across India to design and implement programs with innovative approaches to improve FP and reproductive health (RH) indicators.

Chapter 2

UP-GRADATION OF FACILITIES

In 1997, the IFPS Project embarked on an initiative to strengthen and upgrade public healthcare facilities for provision of quality FP services. This initiative focused on strengthening four aspects of the government healthcare facilities: (1) civil works; (2) electricity connection and supply; (3) water supply; and (4) equipment and consumable supplies. District hospitals and post-partum centers (PPCs), community health centers (CHCs), block primary health centers (PHCs) and sub-centers, and urban health posts were selected for up-gradation.

SIFPSA prepared standard guidelines for assessment of each category of facilities and communicated them to the chief medical officer (CMO) of each district. A team consisting of representatives from the CMO office, junior engineer of the district and SIPFSA representatives visited and assessed each facility. The objective of the assessment was to identify critical needs, to avoid duplication of efforts and to prepare accurate budget estimates. The CMO sent the assessment report and the budget estimate to the Directorate for technical sanction. After getting technical approvals and financial sanction, the junior engineer ensured completion of all civil works and electricity and water connections. The CMO procured all medical equipment. After completing all up-gradation work, the CMO sent the site-readiness certificate to SIFPSA. Representatives of SIFPSA visited the site and verified all the up-gradation work.

During 1997-2005, 613 PPCs, CHCs and block PHCs in 53 districts of UP were upgraded. Specific activities to strengthen the sub-centers were carried out in 35 districts. In all, 8,934 sub-centers were strengthened, equipment was provided to 8,067 sub-centers and additional provision of rent (for those sub-centers established in rented buildings) was made available to 5,668 sub-centers. Up-gradation of the facilities led to improved access to quality FP services and an enabling environment was created for the service providers.

Recognizing that maternal and infant mortality can be positively influenced by ensuring availability of a package of obstetric services to communities, the GoI introduced the concept of first referral units (FRUs) and 24 hour functional units for providing round the clock delivery services and newborn care under the RCH II program. Guidelines were developed for operationalizing these units. States included the assistance required by them for up-gradation of identified facilities in their annual program implementation plans (PIPs) for the National Rural Health Mission [(NRHM), a GoI program launched in 2005. Despite the guidelines, the interpretation of functionality of these units varied for different states. It was decided that a rapid assessment be conducted to assess the functionality of FRUs and 24 hour functional units based on the list of functional units reported by the states. This assessment was carried out in UP and results were presented to the state, districts, and facilities. The total number of FRUs and 24 hour functional units assessed by early 2008 were 223 and 134 respectively. The assessment also identified gaps in operationalization, which provided information for strengthening facilities to measure up to the standards defined in the guidelines. From 2009-10 onwards, the component of strengthening facilities was included in the state PIP in phases. The state now has 141 and 841 functional FRUs and 24 hour functional units respectively.

Chapter 3

POPULATION POLICY OF UTTAR PRADESH

India's FP program followed the process of setting national objectives to achieve the replacement level of fertility and population stabilization, and converted these into specific quantitative targets in terms of new acceptors of FP to be achieved by each state. The state level targets were then distributed to districts, blocks and individual workers. This resulted in heavy reliance on sterilization and limited method choice, and an emphasis on quantity rather than quality. In response to these shortcomings, in 1995 the GoI pilot tested a target-free approach in Tamil Nadu and Kerala. The targets were replaced by expected levels of achievement that were to be set by the village level health workers based on community needs. In UP, the state government selected Sitapur and Agra districts to implement the target-free approach. In April 1996, the GoI rolled out the target-free approach in all states without taking into consideration the experiences of pilot states. In September 1997, the GoI renamed the target-free approach as the Community Needs Assessment approach. States with weak monitoring systems such as UP witnessed stagnation and/or decline in FP performance. In this context, the GoUP decided to provide direction to the program and strengthen its various components by formulating a comprehensive population policy. The IFPS Project provided technical assistance for policy development including drafting of the policy document.

Before formulating the policy, a thorough review of the existing issues was done by commissioning 28 papers on various components of the program. Based on the background papers, the Department of Health and Family Welfare convened a three-day policy issues identification workshop. More than 100 participants including demographers, social scientists, government officials, media, donors, nongovernment organization (NGO) representatives and private sector medical professionals attended the workshop. In addition to this, a series of consultation meetings were held with women, adolescents, NGOs and other stakeholders. The GoUP then appointed a drafting committee to write the initial draft of the policy based on the issues identified during the workshop and consultation meetings. Once the initial draft was completed, public officials, experts in the field, and representatives from 30 civil society and private sector groups reviewed the draft and provided comments.

These comments were incorporated in the final draft and the Cabinet approved the policy on July 9, 2000.

The Uttar Pradesh Population Policy recognizes the importance of addressing population issues in a holistic, open and transparent manner, and states that population stabilization and improvement of the health status of people, particularly women and children, are prerequisites for sustainable development. The document had three major sections: policy objectives, strategies to improve RCH services and policy implementation mechanisms. Policy objectives covered: age at marriage, fertility, maternal mortality, infant and under-5 mortality, reproductive tract infections (RTIs) and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). To achieve the objectives, a series of strategic interventions such as community involvement, collaboration with the private sector, access to and quality of RCH services, and improvement of service delivery systems were suggested. To facilitate implementation, the State Population and Development Mission, RCH Mission and societies at the district level under the chairmanship of the District Magistrate were suggested.

The adoption of Uttar Pradesh Population Policy created a state specific plan to track progress on FP and RH indicators, demonstrated the state's political commitment, established a multi-sectoral process of program implementation and stimulated decentralized planning.

Chapter 4

DISTRICT ACTION PLANS

The GoUP had managed a centralized health and family welfare program for decades. With the introduction of the multi-purpose program in 1970s, the number of health units expanded rapidly and the programs became more complex. The state administration had 83 districts to supervise and was not in a position to respond to the challenges faced by the healthcare personnel in the peripheries. The state's local needs varied from region to region because of its large size and diversity. By early 1990s, only one-fifth of the eligible couples in reproductive age were using modern contraceptive methods. Recognizing this, the IFPS Project decided to concentrate on decentralized planning at district level to identify and address local needs, to provide flexibility in the use of financial resources, to build local capacities to plan and execute programs, to encourage innovative activities taking local resources into consideration, and to involve other partners from private, NGO and cooperative sectors in program implementation. It was envisaged that the plans would be prepared through a participatory approach based on collective thinking of government health staff, NGOs, private practitioners and the organized sector.

The IFPS Project started decentralized planning as a pilot in Rampur district in 1997. The Rampur district action plan (DAP) was quite comprehensive and was funded through the PBD model/mechanism. Based on the experiences from the first DAP and recognizing the potential of DAPs to maximize the performance, the IFPS Project expanded the DAP model to six more districts in March 1998. For the first time in the history of the public healthcare system in India, a participatory approach involving all stakeholders was used for planning and monitoring RCH programs at the district level. An assessment of the DAP implementation after one year, showed significant improvement in maternal health and FP indicators. Building on this first phase of DAP implementation; the IFPS Project launched DAPs in nine additional districts in 2001. In 2002, the project added the remaining 18 districts. Based on the model developed under the IFPS Project, DAPs were formulated in seven more districts with funds drawn from GoI's Empowered Action Group (EAG) Scheme. At the end of the first phase of the IFPS Project, there were a total of 40 districts with DAPs.

The district program managers get together to prepare the district action plans

To achieve the main objectives of DAPs, five key strategies were used. These included: (1) create conducive environment by garnering the support of religious leaders and communities, particularly *panchayats*; (2) improve quality of services by training all service providers and up-gradation of healthcare facilities; (3) generate demand through behavior change communication (BCC); (4) improve access to integrated services through RCH camps; and (5) involve non-government sector in project implementation.

DAPs have had a significant impact on modern CPR and maternal health indicators. The use of modern contraceptive methods was six percentage points higher in DAP districts compared to non-DAP districts. While the state average annual increase in provision of sufficient IFA tablets was 2.5 percentage points, the increase in DAP districts was higher ranging from 2.9 to 8.9 percentage points (Constella Futures, 2006). Deliveries conducted by trained providers was significantly higher in the DAP districts compared to non-DAP districts. DAPs in general strengthened the local capacities to plan programs, taking local needs into consideration and to efficiently manage programs with emphasis on results.

In March 2005, the GoI launched the NRHM program. The concept of DAPs and decentralized health management was a critical component of NRHM. The Mission mandated all states to implement district health action plans and flexible funds were provided to implement these. The IFPS Project developed a DAP manual that had detailed guidelines for preparation of decentralized plans using participatory approaches.

During the second phase of the IFPS Project, the project provided assistance to the NRHM program management units at state and district level for preparation of DAPs covering all health programs in UP from 2009-2011. The project built capacities of the program managers in developing DAPs, and budget estimates using standardized formats. One day orientation workshops for program managers to inform development of efficient plans were conducted. During these workshops the managers were guided through the process of doing a situation analysis, assisted to set objectives, identify program strategies and innovative approaches to achieve results, and mechanisms to regularly monitor performance and incorporate all these components into the DAPs. The project also extended support for district planning meetings, which are supported by the Divisional Program Management Units (PMUs), based on which block and district level plans are finalized.

Decentralized planning is now an institutionalized process. Action plans at district as well as divisional levels inform the development of the State-level PIP.

Chapter 5

INVOLVEMENT OF PANCHAYATI RAJ INSTITUTIONS

Panchayati Raj Institutions (PRIs), local self-governments at village level, were given constitutional status in 1993. With this, *panchayats* became responsible for the provision of primary healthcare, maternal health, and family welfare services in India. In the mid-1990s, the GoUP devolved financial powers of 12 departments including Family Welfare to PRIs. The GoUP declared the year 2000 as decentralization year. Given this background, the IFPS Project considered PRIs ideally suited for implementation of the RCH program and integration of services at village level. The *gram pradhan*, head of the village *panchayat*, was recognized as the most influential person and one third of the *gram pradhan* positions in UP were reserved for women, providing an opportunity for greater involvement of women in program implementation.

Many of the elected representatives did not have a clear understanding of their roles and responsibilities furthermore, their knowledge of health programs and functions of health units within their area was very limited. SIFSPA considered it important to organize training programs for *pradhans* to encourage their participation in program implementation. The main objectives of the training programs were to make the *pradhans* aware of various health programs, particularly RH and FP; to strengthen the role of elected representatives as supervisors of health programs; to encourage *pradhans* to promote healthcare-seeking behavior among villagers; and to elicit their cooperation and involvement in implementation of health activities in villages.

The PRI training programs were conducted in four phases in 35 districts during 1998 to 2004. To begin with, a three day training of trainers (ToT) program was conducted at the district level. The participants included three prospective trainers from each block representing block level government officers such as the medical officer (MO) of the PHC, additional development officers of *panchayats* and Integrated Child Development Program officers. The ToT programs were conducted by the State Institute of Rural Development—a government organization and Shahbagi Sikshan Kendra—an NGO from Lucknow. Topics covered in the ToT programs included introduction to SIFPSA, the 73rd Constitutional Amendment and the role of *panchayats* in RCH, use of training material, the adult learning processes and 12 golden rules for trainers, mock training sessions, as well as a note on logistic requirements to conduct village *pradhan* trainings.

Block health quarters in each district were selected as the training venues. To ensure participation of village *pradhans, up-pradhans* and block *pramukhs* were also invited; an invitation letter signed by the district magistrate was sent well in advance. Husbands of female *pradhans* were also invited to encourage participation of female *pradhans*. Duration of each program was one day and three to four programs were conducted in each block to cover all selected PRI representatives. Each *pradhan* was given an information booklet to use and share with other members of the *panchayat*. The booklet contained information on synopsis of population policy, role of PRIs, gender equality and the role PRIs can play to promote it, RCH program, antenatal care (ANC) and nutrition, identification and referral of pregnant women, postnatal care (PNC) and immunization, RTIs, FP and services provided at RCH camps. A total of 4,119 *pradhans* were trained in the first phase in six districts. In the second phase, 11,757 *pradhans* from 15 districts attended the training programs. In the third phase,

10,237 *pradhans* from 10 districts benefited from the programs. The last phase covered four districts and trained 2,481 *pradhans*. A total of 28,594 *pradhans, up-pradhans* and block *pramukhs* were trained in all four phases.

In addition to the PRI training programs, SIFPSA developed eight pictorial comic books covering different RCH topics and distributed them to 30,000 village health committee members in three districts. Annual *panchayat melas* (fairs) were organized in each block once a year where BCC material was exhibited, quizzes conducted, competitions held and folk performances organized to educate people on health issues. To recognize the efforts of the *pradhans* who were doing a commendable job of improving RCH services in their villages, *pradhan* forums were organized for 15-20 village *pradhans* each, chaired by the district magistrate.

In the meantime, the NRHM was launched in 2005 and a key component of the mission was the development of a village health plan (VHP), prepared by a local team headed by the village *panchayat* representative. These teams are called Village Health and Sanitation Committees (VHSCs) and there was a need to augment and operationalize them according to the revised framework of the NRHM. Each VHSC is composed of selected *panchayat* members, retired government functionaries, and co-opted members such as accredited social health activist (ASHA), auxiliary nurse mid-wife (ANM), anganwadi worker (AWW), members of self-help groups (SHGs), or teachers, amongst others, who would be nominated based upon the consent of the p*anchayat*. The roles of VHSCs include: ensuring community participation in government health programs; ensuring maximum possible utilization of government health facilities; contributing to preparation of area-specific VHPs and ensuring their effective implementation.

Based on previous experience, SIFPSA formulated a project on capacity building of VHSCs in order to strengthen them to develop and implement VHPs. Accordingly, during 2005 and 2006, SIFPSA designed and implemented a project for training of VHSC members in one block each of six districts of UP through funds from GoI's EAG scheme. In 2007, the VHSC training was scaled up for implementation at district level in Shahjahanpur and Kanpur Nagar districts through IFPS Project funds.

The key features of the project included designing a training module through participatory processes, developing guidelines for preparation of VHPs, conducting sensitization workshops on the roles and functions of VHSCs, and implementing the three day training for VHSCs to strengthen and build their capacities within a timeframe of six months. The module for training was quite comprehensive and included sections on the PRI structure, VHSC roles and functions, RCH issues, PRA exercise, VHP development, and gender, amongst others. SIFPSA was the lead organization initiating these processes with support from DIFPSAs and PMUs at the district level.

The main strategy adopted was to establish partnership mechanisms with the development, panchayati raj and health departments for implementing the training workshops and conducting sensitization workshops at district, block and village level. The master trainers were identified from within these departments and were trained by lead trainers at the state level, during which they were familiarized with the training module and its content. Another strategy was to partner with a local NGO whose main role would be to facilitate the establishment of the VHSC and create a suitable training environment in the district, and further to motivate the VHSC members to participate with full interest and then work in the village to achieve the VHP objectives.

The state level master trainings were followed by a one-day district level and one-day block level awareness training. The lead trainers conducted the one-day *gram panchayat* level awareness and three days village-level VHSC members' training program. Twenty percent of these trainings were observed by the health, PRI, and development departments and NGO officials.

More than 17,000 members (out of 22,000 members) in 1,397 VHSCs were trained in 25 blocks of Shahjahanpur and Kanpur Nagar districts. This engagement with the VHSCs was instrumental in developing realistic health planning. The training and orientation led to greater interest and involvement of *pradhans* in RCH services. PRI interventions helped to build supportive environment for RCH activities.

Chapter 6

CAPACITY BUILDING

One of the core strategies of the IFPS Project was to equip human resources in the health sector in UP, engaged in implementation of program interventions at different levels with requisite knowledge and skills, and to create an enabling environment to practice these skills leading to an improved program performance. The first task was to create an institution that could initiate and coordinate these efforts. To meet these objectives SIFPSA was registered as an autonomous body, the organization structure was designed, technical and administrative staff from public and private sectors was recruited, financial manual was prepared and administrative systems were established to encourage open and objective processes at levels of decision making. The IFPS Project in collaboration with SIFPSA implemented several interventions that helped to strengthen the capacities of institutions and individuals. These interventions concentrated on enhancement of skills to develop training and workshop aids, to design and conduct research and evaluation studies, to launch systematic BCC campaigns based on client segmentation, to develop policies, strategies and plans to improve program efficiency and effectiveness, and to foster PPPs in the health sector. In addition, the IFPS Project improved the skills of SIFPSA staff in project management, particularly in preparation of request for proposals with clearly defined scope of work, selection of partners to implement interventions and monitoring of performance in the field.

The IFPS Project conducted a series of technical and interpersonal communication (IPC) skills training programs and workshops. The development of training material involved several systematic steps such as selection of institutions and individuals as partners within UP, review of existing material on a particular topic within and outside the country, revising the material to reflect best practices and standards, pretesting and finalizing the materials, effective utilization of materials during training programs, conducting pre-and post-training tests on trainees to measure effectiveness of training, planning for and execution of training programs as per plans, and hand-holding of trainees after the training. Individuals and institutions worked as teams, deliberated on issues and agreed on shared responsibilities. Select medical colleges were up-graded to provide technical training on sterilization methods, the Regional Health and Family Welfare Centers in the state played a crucial role in skill development for intrauterine contraceptive device (IUCD) insertion procedure using the latest techniques, and several NGOs were involved as master trainers to impart IPC skills. In all these capacity building efforts, knowledge and skills were first transferred to the institutions either from private or public sector, which in turn enhanced the skills of service providers from district level hospitals to community based workers.

All interventions funded under the IFPS Project have a built-in component of research, in addition to performance monitoring based on field visits and service statistics. The baseline and endline surveys informed program managers about achievements of each intervention in a particular geographical area. The design of research studies involved defining objectives of the study, methodology, selection of sample, analysis of data, report writing and interpretation of information for decision making. The IFPS Project conducted more than 100 surveys and studies during the three phases of the project and involved several agencies, and developed their skills to conduct systematic studies. In

addition to this, several qualitative and formative research studies were conducted for in-depth analysis of issues.

The IFPS Project, for the first time in the state, introduced systematic efforts to develop and launch BCC campaigns. A BCC strategy was developed in consultation with stakeholders, formative research was conducted to understand prevailing behavior and barriers, messages were developed and pretested, media plan prepared and campaigns conducted at defined intervals, taking into consideration the cultural zones in the state. These campaigns used mass media, mid-media and IPC channels. Advertising agencies of repute were involved in developing these campaigns. As discussed in the previous section on BCC, the large scale FP campaign called *Aao Batein Kare* was based on these systematic efforts, informed all program managers, and improved their knowledge on how to conduct a systematic BCC campaign to change behaviors.

The GoUP prepared the State Population Policy with support from the IFPS Project. Deviating from normal practice of confidentiality that governments follow during the policy making process, the population policy development encouraged stakeholder participation, conducted several workshops and shared draft document for comments, before it was finally approved by the Cabinet. The transparency followed during the process enhanced the ownership of the policy. All district program management staff was trained on how to prepare annual district health action plans. The workshops conducted at district level to enhance their skills in plan development involved collection of district specific data on all relevant indicators, analysis of data, setting annual objectives for the program components, identification of interventions to achieve set objectives, development of the monitoring and evaluation plan, and estimation of the required financial resources. Three to four staff members were involved in the entire process till the preparation of the final plan. Now all districts in UP have teams to prepare realistic and evidence-based decentralized district health action plans. The IFPS Project also enhanced the skills of the State NRHM program management unit (SPMU) staff to prepare State PIPs.

An IPC skills training underway in rural Uttar Pradesh

The RCH II strategy emphasized upon PPPs in the health sector to optimize resources, and to improve access to services. As discussed in the earlier sections of the report, the IFPS Project conducted a series of consultation meetings with the public and private sector partners to share the potential benefits of different PPP models and helped the state government to select models to be implemented in UP. Concept notes were developed for models such as voucher scheme, social marketing, social franchising and clinic based NGO projects. Project designs to test these models on pilot basis were prepared, and the models were pilot tested in a limited geographical area. To facilitate decisions on scale up strategies, all the processes followed for the pilot including baseline surveys, accreditation of facilities, client satisfaction surveys, training programs, audit of services for quality assurance and management systems were documented. The pilots conducted in UP helped both the public and private sectors to understand their respective roles and built trust among partners. The IFPS Project also helped GoUP in clearly defining pathways to take up PPPs in the health sector on a large scale.

Chapter 7

INDIAN SYSTEMS MEDICAL PRACTITIONERS

The training of Indian systems medical practitioners (ISMPs) in non-clinical FP counseling and services was one of the strategies adopted by the IFPS Project to address the high unmet need for FP, particularly modern spacing methods in UP. A typical ISMP in UP practices a combination of Ayurveda and Allopathic systems of medicine. Most often they treat minor illnesses and infectious diseases, and for serious illnesses, they refer patients to private or government hospitals. UP has nearly 43,000 registered ISMPs practicing Unani, Ayurvedic and Homeopathic systems of medicine. Nearly 37 percent of villages populated with 500 to 2000 people have ISMPs, whereas only about four percent of such villages have sub-centers.

In 1993, a study conducted by the Social Research Institute and the OPTIONS Project found that 43 percent of ISMPs were providing some FP services and the remaining were interested in provision of such services. None of them had received any formal training on FP methods. In 1995, SIFPSA initiated two pilot projects in Sitapur and Jhansi districts, targeting 600 ISMPs in each district. Before launching the training programs, a training needs assessment was conducted to understand the knowledge, attitudes and skills of ISMPs. Assessment findings were taken into consideration before finalizing the curriculum.

The ISMP training programs emphasized upon building strong counseling skills among practitioners to assure informed choices by clients. Gender sensitive counseling and awareness of the negative consequences of high fertility on the health of mothers and children, formed an integral part. The specific contents of the ISMP training included impact of population growth, FP methods particularly condoms and oral pills, management of side effects, counseling techniques, and issues related to RTIs. Classroom lectures, discussions, demonstrations, presentations, charts and role plays were used as pedagogic tools. After completion of the ISMPs training in two pilot districts, SIFPSA rapidly expanded training activities to 15 more districts by inviting proposals from local NGOs to conduct training. ToT programs were conducted for the staff of the selected NGOs. The duration of each training program was four days and each batch covered 20 to 25 ISMPs. To gauge the increase in the knowledge levels of the ISMPs, pre-and post-training tests were conducted on the first and the last day of the training programs. The successful trainees were given certificates, name plates, referral slips, registers, handouts and self-addressed post cards. After completion of the ToT programs, NGO representatives mapped ISMPs in their geographical areas. During the expansion phase, social marketing of contraceptives was added as an additional activity.

From 1996 to 2001, a total of 12,769 registered ISMPs were trained in 17 districts. A survey of the trained ISMPs showed that about 81 percent were performing well, up to the standards. Those ISMPs who sold social marketing products gained more clients as compared to those who entirely depended on distribution of free contraceptives. However, making socially marketed products available to all ISMPs remained a major challenge. The strategy of involving ISMPs, who were already an inherent part of the health service delivery systems in UP, was an innovative intervention to improve access to FP information and services.

Chapter 8

INVOLVEMENT OF TRADITIONAL BIRTH ATTENDANTS

The maternal mortality ratio (MMR) for UP was quite high at 707 per 1000 live births in 1998, almost 57 percent higher than the national average MMR of 407. The NFHS in 1998-99 estimated that 84 percent of the deliveries took place at home and nearly 52 percent of the total deliveries were assisted by traditional birth attendants (*dais*). Many maternal deaths and disabilities could be prevented by improving access to emergency obstetric services and FP. Policy makers and program planners faced the challenge of improving the quality of care at the time of delivery at home, in rural areas. Training traditional birth attendants was considered as one of the interventions to reduce maternal mortality and morbidity.

The primary objective of training *dais* was to equip them to conduct deliveries under hygienic conditions using the five cleans principle; to identify danger signs early and refer high-risk pregnant women to ANMs; to counsel women on the importance of seeking ANC and PNC; and promote birth spacing. The selection criteria used for identification of eligible *dais* for training were carefully worked out. *Dais* would have to be experienced, willing to assist in all phases including delivery, birth and cord cutting, and would have to be generally accepted by the community. Block mapping exercises were conducted to identify potential trainees; meetings were held with village *pradhans*, female members of *panchayat*, and other village level committee members to elicit their opinions on *dais* in their villages. The aim was to train at least one *dai* per village in the project area.

The PPP approach was used to train *dais*. In the first stage, the nodal training agency (Prerana Population Resource Center) trained master trainers selected from NGOs and public sector health staff. During the second stage, the master trainers trained select ANMs as lead trainers. The ANMs, in turn, imparted training to *dais*. The duration of the training was six days and the topics covered included identification of pregnant women, conducting safe deliveries, implementing five cleans, knowing when to refer high risk pregnancies to hospital, collaborating with ANM to provide antenatal and postnatal services, promoting FP, and keeping records of deliveries conducted in the supplied pictorial book. After completing the training, the *dai* received an identity card with her picture on it and signed by the CMO, a nameplate to display outside her house, 10 subsidized disposable delivery kits, and a record keeping book. These measures helped villagers to distinguish between trained and untrained dais in the village and improved the image and acceptance of trained *dais*.

A total of 22,064 *dais* were trained in 17 districts of UP during 1998-99 and 2003-04. The *dai* training project involved assessments and checklists for evaluating the performance of each aspect of the training program, from the nodal agency to the *dai* training at the field level. Knowledge and skills of the *dais* were assessed following the training and these results were shared with the MO at the PHC, CMO, DIFPSA and SIFPSA. At a three month follow-up, the ANM administered a nine- point check-list that covered knowledge of high risk factors and signs of complications, ANC and FP. A *dai* was considered to be performing upto standards if she scored eight out of nine points. The evaluation showed that the proportion of *dais* providing FP services and correct technical advice on method use increased from 4.2 percent before training to 27.9 percent after training. The proportion of trained *dais* who could identify high risk pregnancies increased from 10.7 percent to 52.6

percent. Comparative analysis of the PERFORM survey conducted in 1995 and Strategic Objective 2 (SO2) Indicator Survey in 2003 showed that the proportion of deliveries conducted by trained dais increased from nine to 17 percent, with a commensurate decline in deliveries conducted by untrained dais, relatives and friends.

Given the unpredictable nature of pregnancy related complications, even a trained *dai* is not a substitute for having access to high quality emergency obstetric care by skilled health professionals. Most *dais* were illiterate, making it difficult to upgrade their skills. USAID discontinued funding for *dai* training in 2003, informed by the World Health Organization studies that suggested that training *dais* did not significantly reduce maternal mortality.

Chapter 9

ENHANCING TECHNICAL SKILLS FOR IUCD INSERTION

9.1 BUILDING CAPACITIES OF ANMs AND LHVs

In UP, about one percent of the currently married women in reproductive age use IUCD and this has remained constant for the past several years. A study commissioned by the IFPS Project in 1994 found that IUCD insertion skills among providers were deficient, resulting in frequent complaints of infection and high discontinuation rates. The study also revealed gaps in FP knowledge and counseling skills among lady health visitors (LHVs) and ANMs. To address these issues, the IFPS Project rolled out the Clinic Based Family Planning Training (CBFPT) program to help ANMs and LHVs become more skilled in IUCD insertion, FP counseling and infection prevention practices. The purpose of the CBFPT program was to provide performance based training to ANMs and LHVs working at district postpartum centers, urban family welfare centers, urban health posts, CHCs, PHCs and sub-centers.

The CBFPT program had a three-tier training structure: First, six master trainers from medical colleges and district womens' hospitals attended a 12-day ToT program; second, the master trainers in-turn conducted a series of 12-day programs for district level trainers, comprising a lady medical officer and a public health nurse tutor drawn from each district; third, the district trainers provided a six-day training to ANMs and LHVs. Four health facilities in each district—district women's hospital, district post-partum center and two rural sites with high demand for IUCD services—were selected as venues for training. The sub-centers were assessed prior to the training and were strengthened to ensure that they had all the facilities and equipment essential for delivery of quality IUCD services.

The training materials were prepared, field tested and finalized. ZOE® (pelvic) model for IUCD insertion practice was supplied to all training venues. The training duration was six days and covered screening of clients, IUCD insertion skills, preparation of the instrument tray and chlorine solution, and sterilization of instruments and non-surgical items. To begin with, the trainees practiced IUCD insertion on the ZOE® model under the supervision of the lady medical officer using standard IUCD insertion and removal checklist. Trainees then attended outpatient department with the lady medical officer trainer and learned about counseling and history taking.

On the last day of training, a special session was held to hand over IUCD insertion kits and certificates. At one month and six months after training, a team of ANM training center tutors and the doctors and nurses of the Regional Health and Family Welfare Training Centers made follow-up visits to each ANM worksite to assess her IUCD insertion skills and to determine whether the ANM was performing upto standards or not. Refresher training programs were conducted for ANMs not performing upto the required standards.

The CBFPT programs were first pilot tested in Sitapur and Jhansi from February 1997 through January 1998. The CBFPT programs were then scaled up in a phased manner. By 2004, the program covered 33 districts of UP. A total of 10,854 ANMs and LHVs were trained in IUCD insertion skills. At baseline only 30 percent of the ANMs and LHVs had adequate scores in FP counseling and IUCD insertion. After training, about 85 percent of the ANMs and LHVs had adequate scores.

The CBFPT programs were useful in changing the attitudes of workers, instilling in them the ability to discuss client needs and offer services according to client's needs and

preferences. The major strengths of the programs were: hands on training using ZOE® model and IUCD clients; individual attention and supportive supervision provided to each trainee; continuous follow-up and evaluation each at one and six month intervals; and infrastructure strengthening of sub-centers. Using trainers from the health system and having well-designed training modules contributed to long-term sustainability.

9.2 BUILDING CAPACITIES OF MEDICAL OFFICERS AND PARA-MEDICAL STAFF

A three-day training program on contraceptive technology update (CTU) and IUCD was conducted for all MOs and para-medical staff in the IFPS Project districts. The three-day training was conducted at seven medical colleges across UP and the MOs were oriented on the latest features of contraception, the basics of counseling, and informed choice in FP. Two-day training on IUCD insertion and removal, including no-touch withdrawal technique was also conducted, specifically for lady medical officers. During this session, the MOs got an opportunity to practice on pelvic models and to improvise upon their IUCD skills. A total of 946 MOs were oriented on CTU and IUCD during these five days.

9.3 ALTERNATIVE TRAINING TECHNOLOGY FOR IUCD

During the third phase of the IFPS Project, the Ministry of Health and Family Welfare (MoHFW), GoI decided to revive and rejuvenate the IUCD program in the country, particularly in EAG States with low CPR. The effort was supported by the introduction of new IUCD technologies (380 A), which provided an opportunity to position and promote IUCD as both a limiting and spacing method. All these efforts required effective and quality oriented service delivery system, which would be ensured through quality training systems, and providers equipped with new skills and technology. The IFPS Project supported MoHFW to develop an IUD reference manual, trainer's notebook, and participants' handbook for the providers, and also drafted recommendations on rolling out IUD training using both classroom and online computer assisted learning approaches. Master trainers drawn from the National Institute of Health and Family Welfare (NIHFW) and state health departments were trained on alternative training methodology for IUCD services using ZOE® models. The no- touch technique of loading the CuT and the insertion techniques were new concepts introduced as part of the training curriculum.

These master trainers (NIHFW faculty, State Institute of Health and Family Welfare (SIHFW) faculty, state program managers and service providers) trained district level trainers for training the service providers (MOs, staff nurses, LHVs and ANMs of the identified pilot districts.

For UP as well, state trainers trained the service providers (doctors and staff nurses, LHVs, public health nurses) at 17 divisional headquarter districts as divisional master trainers. The training sites which were identified included one district women hospital and two FRUs in each district where a lady doctor is posted and a minimum of two CHCs with good client load. Post training of doctors and staff nurses, PHN tutors, LHVs, and public health nurses, ANMs were trained at FRUs and CHCs/PHCs. The trained ANMs were followed once within three months, to monitor their performance. They were provided certification only after observation of at least two IUCD insertion procedures conducted by a lady doctor.

Medical staff being trained on IUCD insertion

9.4 POSTPARTUM FAMILY PLANNING

A review in 2009 concluded that immediate postpartum insertion of IUCD was safe and effective (Kapp and Curtis, 2009). The results of this review influenced the GoI's decision to revitalize postpartum family planning (PPFP) and immediately expand postpartum IUCD (PPIUCD) services in a phased manner.

In line with the GoI approach, the IFPS Project designed and initiated a pilot PPFP intervention focusing on PPIUCD services.

The pilot was conducted at four sites in UP. The Queen Mary Hospital in Lucknow was developed as a training as well as service delivery site, and district women's hospitals in Jhansi, Allahabad and Lucknow were developed as service delivery sites. PPIUCD services were also introduced in the private sector by building capacities of the providers of the *Saathiya* network and Merrygold Health Network[1] to deliver these services in five cities in UP.

The IFPS Project developed the protocols and clinical guidelines for PPIUCD which were also adopted at the national level. A Competency-based Learning Resource Package for PPIUCD was also developed. This package was field tested, reviewed, finalized, and also endorsed by GoI. Specific anatomic models designed for teaching PPIUCD skills were also introduced.

Service providers were trained during a three day competency-based clinical training course. Sites were strengthened and provided with PPIUCD insertion forceps and anatomic models. Performance standards for PPIUCD services were also developed and introduced to assure the quality of the services. Post-training and on-site support was provided, which included development of PPIUCD BCC material for clients. As part of the BCC material, a short film/video on PPIUCD, that addresses myths and misconceptions about IUCD; posters for ANC, the postpartum ward and out-patient departments; leaflets; follow-up cards for clients; and a flipbook for counselors were developed.

Other support measures included, development of a computer-based PPIUCD training course, including an insertion video; a PPIUCD counselors' training curriculum in Hindi (two days duration); training on PPIUCD counseling and infection prevention at facilities where the services were offered; and two ZOE® models with postpartum uterus attachment and interval uterus attachment.

Forty eight doctors were trained for PPIUCD clinical services, and more than 3,000 PPIUCD insertions have since been performed. The pilot and its success have encouraged the GoUP to scale up the initiative. Currently, SIFPSA is in the process of introducing PPIUCD services in 13 new sites, including five medical colleges and eight district women's hospitals in UP , taking it to a total of 17 service sites.

[1] Merrygold Hospitals: For further information refer Chapter 23 of the report

Chapter 10

CLINICAL TRAINING TO HEALTHCARE PROVIDERS

One of the main objectives of the IFPS Project was to improve the quality of FP services. A study was conducted to identify clinical training needs of health staff in UP. The main findings of the study suggested that: training centers lacked self-contained facilities; existing training programs did not address the needs of practical clinical training; there were no training materials or equipment available with trainers; FP providers were following outdated clinical guidelines; and less attention was given to infection prevention practices. To realize its objectives, the IFPS Project felt the need for a comprehensive and systematic clinical training program that would address the shortage of trained providers and upgrade the skills of existing service providers.

A series of workshops with participants from the medical college faculty and medical professionals of the health department, were conducted to standardize the procedures that providers would follow. Based on discussions in these workshops and review of national and international guidelines, standard guidelines for laparoscopic tubal ligation, minilaparotomy, abdominal tubectomy and infection prevention were prepared. Training materials were prepared covering all the procedures for each clinical procedure. All trainings in clinical procedures were conducted at medical college hospitals and district hospitals where equipment, supplies and case load were available. A total of 14 training sites were established in the state. Infection prevention training followed whole site approach where staff at all levels of the health unit participated.

Laparoscopy is a preferred method by clients in many areas of UP. Laparoscopy requires sophisticated equipment and skilled and experienced surgeons. For practicing laparoscopists, a two-day refresher training program was conducted and 359 surgeons were trained.
A 12-day induction training program was conducted covering surgical procedure, anesthesia, management of complications and post-operative recovery. A total of 222 eligible MOs were covered in the induction training. Mini-laparotomy or mini-lap under local anesthesia is particularly suitable with minimum support staff, equipment and other resources.
A total of 150 MOs drawn mainly from PHCs and CHCs were trained. A modified version of abdominal tubectomy uses a smaller insertion, local anesthesia infiltration technique and clients are discharged on the same day. Abdominal tubectomy refresher training was also organized for three days and covered 220 doctors.
This was supplemented by a 12-day induction training which covered 165 doctors.

Infection prevention training imparts knowledge on the important practices to protect service providers, staff and clients from infectious diseases that could originate in healthcare facilities. The training was a two-day on-site program for all staff members working at the health facility. Its contents dealt with hand washing, glove use, surgical attire, antiseptics and disinfectants, decontamination, processing, cleaning and sterilization of instruments. Other topics included aseptic techniques, disposal of sharp instruments and hospital waste. A total of 10,989 health staff members were covered during on-site infection prevention training programs.

A key achievement of the technical training was that, in all 33 IFPS Project districts, there is at least one service provider trained in one or more methods of female sterilization thus improving the access to female

sterilization services. Infection prevention techniques improved the quality of services provided at health facilities.

In the second and third phase of the IFPS Project, clinical training for health staff continued and expanded to cover more facilities in other districts of the state. The platform created during the course of implementation of the first phase of the project, including standardization of procedures and guidelines, training modules, institutional collaboration and capacity building for sustainability were used to expand the training programs. The clinical systems developed during the IFPS Project were integrated with health systems under NRHM in the state. Since 2008, SIFPSA has been declared the nodal agency for clinical training for the state.

To strengthen the training infrastructure in a decentralized manner, divisional clinical training centers (DCTCs) were created at 10 divisional level district women hospitals. This approach reduced the work load of the medical colleges on one hand and facilitated increased participation of staff as trainers as well as trainees by reducing their travel time addressed the issue of continued absence from their duty stations. Laparoscopic Tubal ligation training was further initiated at seven DCTCs. Master trainers were trained at three medical colleges - Lucknow, Meerut and Kanpur. For abdominal tubectomy at DCTCs, the training was initiated at three divisional level women hospitals/PPC. Master trainers were trained at Agra Medical College and further provided induction and refresher training to MOs and paramedical staff. District monitors (doctors from districts) were trained for follow up of trainees in their respective districts. The state trainers trained doctors and staff nurses, LHVs, public health nurses on IUCD at 17 divisional headquarter districts as divisional master trainers. The training sites which were identified included one district womens' hospital/PPC, two FRUs in each district where a female doctor was posted, and a minimum of two CHCs with good client load and availability of a lady doctor.

Paramedics were trained on Infection Prevention, including proper disposal of hospital waste

There have been concerted efforts to strengthen clinical skills for FP services in the state through the IFPS Project. The readily available training guidelines, master trainers, and trained providers can be leveraged by the state in the future for further enhancing quality of FP services and increasing uptake.

Chapter 11

QUALITY ASSURANCE

The health service delivery system at both CHC and PHC levels in UP faced several problems. These included: staff vacancies, inadequate staff skills, infrastructure deficiencies, poor logistics support, limited facilitative supervision and inadequate client orientation. With an aim of establishing systems to address these issues on a regular basis, a quality improvement pilot project was launched in Sitapur and Saharanpur districts of UP in June 2002. A total of 18 sites from these two districts covering one district women's hospital, seven CHCs, and 10 PHCs were selected. The main objectives were to make the health staff understand client rights, to strengthen problem solving skills of staff and to encourage supportive supervision.

Among the initial most critical steps, one was to define and delineate the concept of quality in operational terms. A quality standards checklist was prepared covering 100 items with each item being assigned a score of one point each. These items covered client service management (31 points), site management (55 points), information, education and communication (IEC) (7 points) and MIS (7 points). At the district level, a two-day workshop was held for district MOs who supervise all health facilities in the district. Following this, one-day workshops were held at each of the selected sites in two districts. During these workshops, the participants were trained on Client Oriented and Provider Efficient (COPE) techniques and facilitative supervision skills. Site staff learned problem identification skills using the COPE approach, prepared action plans and timelines to implement action plans, and identified the staff responsible for implementation. Facilitative supervision emphasized upon mentoring and problem solving rather than fault finding. These workshops followed the 'whole-site model' that involved all health staff at the facility.

Quality circles were formed at each site with the MO I-C serving as the chairperson. Members of quality circles represented all categories of staff. Each member was assigned oversight responsibility for key aspects of quality such as water supply, electricity, logistics, MIS, maintenance, infection prevention, etc. The quality circle team met every month to discuss problems related to quality and possible solutions. The minutes of each meeting were recorded and solutions for identified problems were tracked.

Considering the fact that the government funding was inadequate and irregular to improve and/or maintain quality of services, the IFPS Project provided a financial grant of Rs. 500,000 (USD 10,000) per site for a period of three years. Quality circles were given flexibility on how to utilize these funds. Periodic monitoring and supervisory visits were made by SIFSPA staff and the district health officers. Quarterly scoring of each site was done by a team representing SIFPSA, Chief Medical Officer's Office and the District Magistrate. Sites that scored more than 90 points were given quality certificates and a Gold Star Logo to be displayed on the hospital building. Furthermore, the five top scoring districts were rewarded with flexible funds of Rs 20,000 (USD 400) each.

An assessment of the sites showed that 30 percent of the problems identified by staff were effectively solved within a month and an additional 40 percent in subsequent months. Exit interviews with clients revealed that 97 percent of clients were satisfied with services they

received. Quality circles improved interactions between staff and that resulted in better coordination. Quality improvement efforts empowered staff to seek solutions to problems at site level.

Based on the quality improvement efforts at the state level, including development of quality assurance strategies and procedures, the GoI adapted and developed guidelines with technical support from cooperating agencies. These guidelines and protocols were scaled up across states in the country, to adequately assess and improve quality of service provision.

Chapter 12

INTEGRATED REPRODUCTIVE AND CHILD HEALTH APPROACH

The Eighth Five Year Plan (1992-1997) in 1992 identified the factors that contributed to the inability to meet family welfare objectives. These included centralized planning, target setting and limited monitoring and evaluation that led to inflexibility in terms of developing innovative solutions to address community needs. In April 1996, India announced a target free approach to FP and in 1997, launched the RCH Program which emphasized district level planning and monitoring. Altogether, these developments set the stage for new thinking regarding how best to meet comprehensive RH needs from the perspective of client needs.

In UP, the need for RCH camps emanated from the inability of the public sector to provide comprehensive RH services on a regular basis, particularly at the PHCs and CHCs. As the IFPS Project placed priority on reaching rural and underserved population, designing interventions that would provide access to RH services became a necessity. In 1997, a workshop was conducted with policy makers and program managers that worked out an integrated RCH camp strategy. RCH camps were designed to provide assured services as per a predetermined calendar, to combine the benefits of rural outreach and high quality services, and to offer an array of maternal and child health (MCH) and FP services under one roof. RCH camps were held at fixed sites—PHCs and CHCs—and these fixed sites organized one camp per month from April to September and two camps per month from October to March, resulting in 18 camps per fiscal year per facility.

The integrated RCH camps provided antenatal check-ups, gynecological examinations, FP counseling, sterilization and IUCD insertion services, tetanus toxoid (TT) injections to pregnant women, IFA tablets, pregnancy tests and treatment of RTI /or sexually transmitted diseases. Another important service provided on camp days was the provision of transportation for sterilization clients. Usually, a team of medical professionals consisting of surgeons, anesthetists, and lady medical officers from the district hospital attended these camps to provide services. Wide publicity to inform about camp dates in all villages covered by PHCs and CHCs was done. Camp arrangements included layout of services, waiting areas, tents, chairs, food/refreshments, linen, mattresses and generators. Camp managers also organized medical equipment such as bleach, utility and surgical gloves, lab reagents, suture material, antiseptics, medicines and laparoscopes (two per team).

Integrated RCH camps began in May 1998 and were carried out in all 33 IFPS districts. The RCH camps constitute the largest public health intervention undertaken by the IFPS Project. Attendance at the RCH camps grew over time. Initially, when the camp approach got under way, each camp served about 50 clients. By 2003, each camp on an average served 100 clients and more than half of the sterilization operations in the IFPS districts were performed at the RCH camps. Through March 2006, IFPS had supported 60,148 RCH camps, providing 525,000 antenatal check-ups, sterilization services to 810,000 men and women, FP counseling to above 1.8 million clients, modern spacing methods to 1.2 million clients and immunization to 575,000 children (SIFPSA Management Information System).

Subsequently, the intervention was successfully adopted and replicated at the state level through NRHM

funds. Twelve camps a year are held at fixed facilities including CHCs, PHCs and additional PHCs that have a functional operation theater. Separate funds were allocated to conduct IEC activities for each camp and ANMs as well as ASHAs mobilized clients for availing services. The services offered and the guidelines for these camps were similar to the earlier camps, including facility for transportation.

Doctors provide services at an RCH camp

To support the NRHM activities, SIFPSA was nominated for developing a mechanism for monitoring these camps to ensure availability and quality of services. A needs assessment was conducted based on a review of the reports from districts as well as field visits. The gaps identified through this assessment were shared with the district and state level officials who worked to strengthen facilities and upgrade them to the defined standards over three months. In the meantime, a 90 point Quality Assurance Checklist was developed that covered general camp arrangement, availability of IEC materials, power supply including generator, availability of funds in time for the camp, running water in operation theater and IUCD room, facilities available at operation theater, availability of equipment, medicines, vaccines and contraceptives, laboratory facilities, personnel, communication, record keeping, infection prevention practices, spot observation of procedures, client exit interviews and achievements of the camps. Camps were supervised by district level officials by administering checklists, and observations were shared with CMOs for their action. Additional visits by state officials were also conducted.

In the scenario where there is a shortage of human resources, the camp approach ensures availability of all RH and FP services. With the mainstreaming of this intervention, the number of clients availing services through these RCH camps has increased manifold.

Chapter 13

PROMOTION OF MALE STERILIZATION METHODS

Male involvement in FP is minimal and the proportion of male sterilization among limiting method users in UP is insignificant. The IFPS Project recognized the need for promoting male sterilization methods by repositioning no-scalpel vasectomy (NSV) as a simple, safe, and cost effective method that is less risky than female sterilization, and does not require a high degree of medical training. Since there is no incision involved in the procedure, clients can leave the clinic soon after the procedure and experience little or no discomfort. The IFPS Project's objectives in promoting NSV were to encourage male participation in FP, create mass awareness about NSV as a simple and safe method, and to expand the network of NSV service providers.

To begin with, a training center was institutionalized at Jhansi and in 2002, 10 master trainers were trained at the center. These trainers worked in mobile units, visited districts with enough client loads and trained MOs at district health centers, CHCs and PHCs. The three-day NSV training included standardized techniques, client assessment and counseling, infection prevention, post-operative care and client follow-up. An assessment tool to evaluate the effectiveness of the training was developed. Follow-up visits after eight weeks of training provided a means of verifying the competence of trainees to perform upto standards. As of January 2004, all 33 IFPS districts had at least one trained NSV provider. Between mid-2003 and 2005, 55 NSV training camps were organized in 19 districts and 175 doctors were trained.

Providing training and increasing number of service providers is not sufficient to improve acceptance of male sterilization. A mechanism to make potential clients aware of the availability of services is also required. In 2003, the IFPS Project began active promotion of NSV camps in local areas through IEC efforts. Films were screened in villages stressing upon the correct information, dispelling misconceptions and providing information on trained providers.

In order to institutionalize NSV training, a Center of Excellence (CoE) for NSV in the Urology Department of King George Medical College, Lucknow (now known as Chhatrapati ShahuJi Maharaj Medical University- CSMMU) was established in the year 2005. This CoE was involved in conducting NSV induction, refresher training and ToT, and other promotional activities. Based on the experience from the CoE for NSV at Lucknow, three satellite centers were established at the Department of Surgery at Allahabad, Kanpur and Meerut Medical Colleges in the year 2009-2010. All the three centers were strengthened and promotional activities for generation of client load were initiated. Induction and refresher training batches are being conducted at all the three satellite centers since inception.

There were 1,046 NSV acceptors in 2002-2003, close to 5,000 acceptors in 2003-2004, and this number had reached 10,000 in 2004-2005 (Constella Futures, 2006). Despite some success in training doctors and conducting NSV camps, there was no significant improvement in acceptors of male sterilization. Many social and cultural factors including fears and misconceptions still remained, required to be overcome among men and women alike. A huge potential for improving acceptance of NSV remains untapped.

Chapter 14

BEHAVIOR CHANGE COMMUNICATION

According to the NFHS in 1992-93, an estimated 4.1 million women in UP wanted to space births and another 3.3 million wanted to limit births, but these women were not using contraceptive methods. The IFPS Project realized that these couples with unmet need should be reached through appropriate communication strategies to increase the CPR. The process of development of a communication strategy began in 1994 with a workshop attended by about 30 eminent communication experts from both the private and public sectors. After the workshop, a communication advisory group was formed to conduct a detailed program performance analysis, literature review and an analysis of lessons learned from earlier BCC efforts. In April 1995, after a series of consultation meetings, the communication strategy was finalized for the IFPS Project. The communication strategy document contained a review of the current status of FP in UP, identification of potential communication approaches, primary and secondary audience segments, relevant media and steps required to move from strategy to action. The primary audience identified for communication interventions were young married men and women aged 17-25, who had unmet need for modern spacing methods. The secondary audience identified for the interventions included influential community members and health service providers. Formative research to support message design and materials development, pretest of materials, and monitoring of BCC activities to carry out the required mid-course corrections were central to all BCC interventions.

The campaign theme, developed by a leading advertising agency, was intended to provide a unifying effect, linking all pieces of communication and highlighting one action point. The campaign theme, *Aao Batein Karien* (come, let us talk) evolved from an analysis that a key barrier to adoption of spacing methods was the lack of dialogue between spouses, between the service provider and the young couples. Creative execution of the theme featured *Tota* (parrot) and *Maina* (mynah)—two birds, male and female, taken from the folklore. From 1998-2002, the IFPS Project implemented the *Aao Batein Karein* campaign in six-month phases beginning with training of service providers followed by mass media dissemination to create demand for FP services. More than 18,000 ANMs and community based distribution (CBD) workers from both the public and private sector were trained in IPC skills and counseling. Materials such as flip books, posters, stickers and calendars to be used while interacting with the couples were developed and distributed to all workers.

The *Aao Batein Karein* campaign had 30 and 60 second television spots on four topics—an overarching theme spot and one each on the three spacing methods (condoms, oral pills and IUCD). The television spots were broadcast over national and regional channels. To aid easy recall, audio versions of the television spots were developed and broadcast during the popular film music programs on all radio stations in UP. In addition, nine radio spots and five press advertisements were developed to advocate FP among opinion leaders and to dispel fears, myths and misconceptions. To reach media dark areas, folk performances were selected. Six popular folk forms such as puppetry, *qawwali, nautanki, birha, alha*, and magic were selected. Nearly 100 folk troupes and more than 10,000 folk performances were held in villages. To leverage opportunities for greater audience outreach, the IFPS Project organized exhibitions at *Kumbh Melas* (Big fairs) at Allahabad

IPC Flipbook designed for the 'Aao Baatein Karein' Campaign

and Haridwar, and *Nauchandi Mela* (Fair) at Meerut. Information booths were organized at nearly 450 fairs.

The IFPS Project designed and implemented a multimedia campaign to increase awareness of the legal age of marriage. Early marriage has been a serious issue in UP with a majority of girls marrying before reaching the legal age at marriage. Early marriage leads to early child bearing which has greater health risks for both the mother and child. The campaign was implemented in 70 districts of UP over a five-month period during 2002-2003. The campaign components included radio and television spots, press advertisements, and local and outdoor media.

After the introduction of NRHM, during the second phase of the IFPS Project, the project management felt the need for revisiting and revising the BCC strategy for UP. A comprehensive situation analysis was conducted and a series of consultation meetings at different levels were held, involving program managers and civil society members to share the findings of the situation analysis and to identify BCC strategies relevant for the state. BCC interventions addressing priority behaviors across 14 health programs were identified and a strategy document was prepared. Following this, a guide was developed and distributed to all district and block level BCC managers to help them implement activities as outlined in the BCC strategy.

Under NRHM, nearly 130,000 ASHAs were selected in villages. Capacity building for ASHAs was seen as a continuous process going beyond initial induction training. This could be done by regular and continuous sharing of up-to-date healthcare information and by providing solutions to challenges faced by the ASHAs. A quarterly 12-page newsletter, called *Ashayein*, was developed from September 2008 onwards and distributed to all ASHAs in the state. To improve IPC skills of ASHAs and to enable ASHAs to provide accurate information to clients, a flip book covering topics such as health and sanitation, MCH, HIV/AIDS, FP, adolescent health and disease prevention was developed and distributed to 129,450 ASHAs in 71 districts. To motivate and empower frontline health workers by instilling in them a sense of pride and self-esteem, a 26 episode radio educational program was developed and broadcast. Family welfare counselors were recruited under NRHM and positioned in major hospitals. BCC material on IPC skills and training modules were developed and used by the SIHFW to train the family welfare counselors in the state. A comprehensive poster providing information on FP methods and services, and MCH services was designed, printed and distributed to 162,767 health facilities covering sub-centers, PHCs, CHCs and district hospitals in all 70 districts of UP.

To improve sterilization performance in UP, a multi-media campaign was developed and initiated in two phases: from May to August 2006 and June to September 2007, targeting couples aged 25 and above having unmet need for limiting methods. Two television spots of 60 and 30 seconds duration, five radio spots, posters, wall paintings and hoardings were used as part of the campaign. Newly introduced CuT 380A was launched with the brand name *Suvidha* (convenience) and to encourage its use multimedia campaign material was developed.

Chapter 15

TETANUS TOXOID CAMPAIGN

Neonatal tetanus is a preventable disease. Two doses of the TT vaccine administered to the pregnant woman one month apart, are nearly 100 percent effective in preventing tetanus among mothers and new born. UP's TT campaign approach was initiated in 1999 following an evaluation of key RCH indicators. The NFHS conducted in 1998-99 showed that the MMR in UP was the highest compared to any other state and indicators for provision of ANC services to the pregnant women were one of the lowest in the country. The IFPS Project concluded that, in the context of UP, a campaign approach would be the next mechanism to improve coverage levels of TT vaccine in rural areas.

To get inputs for designing the first TT campaign, a workshop was organized by SFIPSA on February 5, 1999 in which program managers representing state, division and district levels participated. Workshop participants identified logistical and systemic issues, and discussed possible solutions. An analysis of the BCC material readily available and the additional resources required in terms of vaccines, needles, and syringes, was done during the workshop. The months of May and June were considered suitable for the campaign to ensure that the TT campaign would not clash with other program activities and/or campaigns such as the pulse polio campaign. After the initial TT workshop, special meetings were organized by the District Magistrate to elicit cooperation from staff of all departments. In 1999, the Department of Health and Family Welfare launched a special TT vaccination campaign covering all districts. The main objective of the intervention was to achieve zero incidence of tetanus among women and newborn, and thereby contribute to reduction in maternal and neonatal mortality.

Before the campaign, TT immunization was carried out according to the routine immunization schedule that occurred twice a week on Wednesday and Saturday. The campaign approach used the current routine immunization structure and added one extra day of immunization during the campaign week. The introduction of this third day helped cover missed clients and ensured wider coverage of women. Prior to the first campaign, the then Chief Minister appeared in a live telecast on television and appealed to the people to make the TT campaign a success. He also sent letters to the Members of Legislative Assembly requesting them to extend support to the campaign. In the second year of the TT campaign, the TT Awareness Week was introduced to generate awareness. The Awareness Week activities included enumeration of pregnant women, group meetings conducted by ANMs and distribution of IEC material. The various IEC materials distributed and used during the Awareness Week included handbills, posters, banners, pre-recorded cassettes, wall paintings and TV, radio and newspaper advertisements. Five TT campaigns were conducted between 1999 and 2002.

TT campaigns covered more than one million pregnant women in each campaign and six million women received two doses of TT injections as a result of the five campaigns. The survey results showed that the TT coverage increased from 33 percent before the TT campaign to 68 percent at the end of fifth campaign, representing an increase of 35 percentage points over four years (Constella Futures, 2006). Three years after the campaigns concluded, TT coverage declined by four percentage points to 64 percent in 2005. These results suggest that TT campaigns have had sustainable impact on TT vaccination seeking behavior, thus preventing a significant downward slide in coverage.

Chapter 16

ADOLESCENT HEALTH

The IFPS Project recognized that adolescents have a fundamental right to quality healthcare and services. However, they face unique barriers in accessing such services. In 1995-96, during its first phase, the IFPS Project launched a family life education (FLE) program. Three priority groups were identified: secondary school students, college/ university students and youth outside the conventional education system. The FLE program was piloted in Lucknow through a series of workshops at four degree colleges for female and male students at Lucknow University. The curriculum was designed around the concept of responsible and healthy living in the context of entering adulthood. After the pilot phase, the FLE projects were sanctioned to cover Gorakhpur and Kanpur Universities. The FLE curriculum was modified to cover rural youth in the rural areas of three districts under this initiative.

As part of the program, a Saloni diary was presented to each student

Prevalence of anemia among adolescents in UP was 49 percent in 2005-06 (NFHS III). Forty two percent of young women had a below average body mass index. With this scenario, the GoUP in 2008 launched an initiative called *Saloni Swasth Kishori Yojana* to test the effects of a nutrition and RH behaviors' intervention on young adolescents (11 to 14 years). The program sought to improve adolescents' knowledge related to health issues, as well as their self-efficacy, intergenerational communication with their parents and other actions that have been proven to affect health behaviors.

At the request of NRHM in UP, the IFPS Project designed a pilot intervention in Hardoi district during 2009-2011. The randomized trial was conducted in 15 schools in three blocks for the intervention and another 15 schools in three blocks were treated as comparison group. A baseline survey was conducted with the objective of understanding the nutritional status, anemia status and hygiene behavior among adolescent girls in schools. The girls in intervention schools were exposed to 10 monthly sessions that covered topics such as nutrition, hygiene, age at marriage and age at first conception. A *Saloni* diary was presented to each student. The two other components such as IFA tablets to be consumed weekly using Direct Observation Treatment method and biannual de-worming, were applied to students in both intervention and comparison schools. In October 2011, an endline research was conducted to measure the results and impact of the *Saloni* pilot project.

The endline data indicated that the intervention had an impact in all three behavioral domains: reproductive health, nutrition and hygiene. More than 73 percent of girls in the intervention group indicated that they had maintained weekly consumption of IFA tablets compared to 21 percent in the comparison group. Similarly, 65 percent of the girls in the intervention schools reported having received a health check-up at school compared to only 10 percent in comparison group.

Eighty one percent in intervention schools received a de-worming dose compared to 15 percent in comparison group. The proportion of girls washing their hands once a day increased from 15 to 47 percent in intervention schools compared to insignificant increase in comparison schools (ITAP, 2012).

The *Saloni Swasth Kishori Yojana* intervention faced several challenges. The primary challenge was to get the same girls to attend the *Saloni* sessions due to high level of absenteeism in schools. The intervention originally planned to take Hemoglobin test for anemia in schools, but due to the invasive process of taking the blood samples, the state government decided not to go ahead with the plan. The *Saloni* pilot illustrates how a successful partnership with district authorities and the education department can enable effective implementation of adolescent initiatives within the government school system.

Chapter 17

COMMUNITY BASED DISTRIBUTION OF CONTRACEPTIVES

The IFPS Project identified community level NGOs in urban and rural areas as an important vehicle for reaching the underserved population. At the time of initiation of the project, unmet need for modern spacing methods was very high and many intending to use contraceptives did not have access to information and services. NGOs work in a small geographical area and due to their long association and intensive efforts, they are in a position to mobilize and educate communities, and use local resources. The IFPS Project prepared a comprehensive handbook that facilitated the open and systematic processes and procedures for selection of NGOs.

NGOs eligible for IFPS funding should have been registered for at least three years, should have received funding and managed projects worth at least Rs.1 lakh (USD 2000), and should have implemented social development programs covering a minimum of at least 25 villages for two years. NGOs should have also had adequate human and physical resources. SIFPSA conducted field appraisals of eligible NGOs and obtained approvals from the District Magistrate, the chief development officer of the district and the CMO. For selected NGOs, SIFPSA established a list of project indicators that included CPR, percent pregnant women receiving antenatal check-ups, two doses of TT injections and sufficient quantity of IFA tablets.

The staffing of NGO projects normally included the project director (honorary), project coordinator, assistant project coordinator, supervisor, accountant and CBD workers. A week's induction training was given to all staff to make them understand their roles and responsibilities. The major elements of service delivery included client counseling, holding group meetings, door to door distribution of free or socially marketed products, referrals to government facilities for clinical methods, coordination with auxiliary nurse mid-wives (ANMs), organization of children and pregnant women for immunization, distribution of oral rehydration solution (ORS) and IFA tablets, and follow-up for clients. NGO projects also coordinated other awareness raising activities such as folk media performances, audio-visual shows and wall paintings. CBD workers, women selected from the same community, visited 8-10 households per day to distribute products or to share FP information.

During the first phase of the IFPS Project, SIFPSA funded 150 NGO projects covering 33 districts. After three years of project implementation, a survey of 28 randomly selected NGO projects in 18 districts showed that 73 percent of eligible women were aware of project activities and 58 percent met with a CBD worker in the previous month. The CPR in NGO project areas had increased from 23.3 percent to 36.4 percent. Use of modern spacing methods nearly doubled. Three in four women surveyed had at least one antenatal check-up, 65 percent had two doses of TT injections and 33 percent received sufficient quantity of IFA tablets (Constella Futures, 2006).

In the next phase of the IFPS Project, the project design evolved to cover a wide range of services and innovative local specific approaches with no restrictions on the population size to be covered. The emphasis of the project design at this stage was on the following aspects: innovative local specific approaches and interventions; gender considerations; promotion of informed choice; increasing the choice of FP methods available; mobilization of community support; creation of demand for RH/ FP services; provision of quality FP services including terminal and modern spacing methods; provision of quality maternal health services including essential obstetric

care, institutional deliveries, emergency obstetric care and post-partum care; partnership with private clinics and/ or hospitals to provide clinic based services; and sustainability including cost recovery measures. Based on discussions during the project advisory committee (PAC) meetings of SIFPSA, the initial project design was modified to mainstream these NGO projects with other NRHM interventions. The NGO projects now included ASHAs as the community workers, coverage of maximum of two blocks by any NGO, and withdrawal of financial support to private hospitals for clinic based services. Performance based remuneration to ASHAs was introduced in this phase which was in line with the NRHM framework.

SIFPSA selected and funded 21 NGO projects covering 40 rural blocks in 10 districts. Services were provided from October 2006 to September 2007, and the projects worked towards increasing contraceptive use, institutional delivery, complete antenatal check-ups, and complete immunization. The NGOs had the objective of increasing CPR by five percentage points in areas that were covered in earlier CBD projects and seven percent for new areas. A key feature of the project was the introduction of Comprehensive Health and Counseling Services (CHACS). The concept of CHACS was introduced to make FP and RH services, especially counseling easily accessible to the community. CHACS clusters were formed, each covering about 20,000 people with a community health supervisor (CHS) at the helm. An appropriate location in terms of access and convenience for the community was identified for organizing CHACS on a regular basis. A consultant lady doctor and a community health nurse (CHN)/ ANM were engaged for the CHACS events along with assistance from the supervisor and ASHAs. About 15-20 CHACS camps at different pre-decided locations were organized by NGOs every month. The CHACS events also included fixed days of immunization sessions and sub-center visits. All the CHSs did advance publicity in their areas to mobilize women and children for attending the CHACS events with support from ASHAs. NGOs procured government supplies of contraceptives, IFA, TT, and vaccines for child immunization from the primary health center (PHC) or CMO office, and procured contraceptives from social marketing organizations on a regular basis for utilization at the CHACS events. A registration fee of Rs. 2.00 (USD 0.04) for the services provided at the CHACS was charged from the clients. The income received from the CHACS contributed to the corpus fund.

The clinic based NGO projects reached out to a population of approximately 73 lakhs by involving 21 NGOs in 40 blocks in 10 districts of UP. Some of the innovative strategies for successful implementation of the program include, involvement of CHSs, use of participatory rural appraisals by NGOs for social mapping, involvement of SHGs for motivation to adopt FP methods, linkages with adolescent groups, social marketing through ASHAs and involvement of ASHAs' husbands as role models for promotion of NSV. Further, the program helped to strengthen the capacities of ASHAs to conduct monthly meetings, door to door visits and support IUCD and sterilization cases. Besides, it helped the ASHAs in building a good rapport with the NGOs and working closely with the medical officer in-charge (MO I-C) of PHCs. Results from the endline survey (SIFPSA, 2009) conducted for 13 of these clinic based NGO projects showed that 12 had achieved their objective with more than five percentage points increase in CPR from respective baseline levels. The highest increase was in Meerut where the CPR increased from 32.9 percent to 44 percent. This increase was attributed to an increase in the use of spacing methods where spacing method use increased from 7.7 percent to 17.2 percent.

Chapter 18

DAIRY COOPERATIVES

Dairy cooperatives cover millions of villagers and almost all villages in UP have dairy cooperative societies (DCSs). Membership in the village DCS is open to all. Members of a DCS gather at milk collection points every day and sometimes even twice a day, offering an opportunity to hold community meetings and to provide FP services and information.

SIFPSA began working with the Pradeshik Co-operative Dairy Federation Limited (PCDF) in 1994, initiating pilot projects in Sitapur and Meerut districts. These pilots were given project funds for 18 months. Survey results conducted at the beginning and end of the pilot projects showed an increase of 40 percent in CPR (Constella Futures, 2006). Encouraged by the results, SIFPSA scaled–up the dairy cooperative projects to six more districts during 1997-2000. Eight more districts were added during 2002-03 and two more districts in 2004, with the projects being implemented in a total of 18 districts. The main objectives of these projects were to increase CPR, improve immunization coverage of infants, pregnant women and children below five years and, promote deliveries by trained providers.

The management structure for each project district included an Assistant Director (honorary), Additional District Coordinator, health supervisors, community health visitor,village health volunteers (VHVs), accountant and MIS in-charge. PCDF projects in 18 districts covered 5,672 village level dairy cooperative societies and a population of 11.6 million, roughly equivalent to seven percent of the UP population. The projects trained 14,000 volunteers including dairy cooperative members. About 5,000 VHVs, women selected by the village DCS committee were imparted training in two stages. During the first stage of training, the VHVs were imparted skills on how to conduct a baseline survey and identify the FP and RH needs of pregnant women. During the second stage of training, they were imparted interpersonal communication (IPC) and counseling skills. VHVs received a monthly average stipend of Rs. 500 (USD 10) and also earned a small additional amount by selling socially marketed products.

District unions of dairy cooperatives organized health camps in remote villages with the services being provided by a physician and para-medical workers. A total of 3,745 camps were held during 1994-2003 and services were provided to nearly 215,000 women and children (Constella Futures, 2006). During this period, PCDF projects served nearly 887,000 FP clients. Of these clients, 57 percent used condoms and 15 percent used oral pills, while 18 percent received referrals for sterilization and 10 percent received referrals for IUCD. Socially marketed products constituted more than half of the condoms and oral pills distributed. The districts with the longest running PCDF projects witnessed substantial increases in the CPR. In Sitapur district, the CPR increased from 18 percent in 1995 to 31 percent in 2002. Similarly, the CPR in Meerut district increased from 27 percent in 1995 to 45 percent in 2002.

Working with the dairy cooperatives is an effective way to extend reproductive and child health (RCH) services to villages and achieve coverage of inaccessible and remote areas. The existing infrastructure and management systems of PCDF are conducive to dissemination of FP information and supply of condoms and oral pills.

Chapter 19

CORPORATE SOCIAL RESPONSIBILITY

The rationale behind using the organized sector in provision of RH services is to benefit employees from better health status and employers from increased productivity of workers. Provision of access to information and services at work place, and extension of services to the areas surrounding the workplace, promotes better health and well-being of workers, families and relatives. Specific objectives of the IFPS Project funded activities with respect to the organized sector were to: (1) reach out to worker populations to encourage FP and to identify those who could promote FP among their colleagues; (2) encourage industries with appropriate health infrastructure to add FP services or extend existing health services to surrounding rural areas; and (3) ultimately, increase CPR and uptake of RH services in project areas.

The overall process for initiating projects in the organized sector began with efforts to identify appropriate and interested corporate entities. Identifying such industries was not easy as UP did not have many big industries. In some cases, SIFPSA helped the corporation set up a non-profit trust before entering into contractual agreement with the newly created trust. While the IFPS funds covered most of the implementation costs, the organized sector contributed to project implementation costs by providing staff, office space, transportation and other infrastructure.

SIFPSA awarded 21 projects in 18 districts to the organized sector, over the life of the first phase of the IFPS Project. Initially working only with a few organized sector entities, employer-sector activities expanded gradually as new partners were identified and successful projects were renewed upon satisfactory completion of activities. Some of the organized sector projects were, to begin with, confined to work place interventions but gradually expanded to cover villages or urban slums surrounding the factories. For instance, Indo-Gulf Fertilizers started with work place intervention and expanded the project activities to cover rural communities surrounding the factory with the help of CBD workers. Later, hospital facilities in the factory were made available to villagers for clinic based FP services.

SIFPSA entered into project agreements with apex organizations such as the PHD Family Welfare Foundation; the Rampur Chamber of Commerce; Federation of Indian Chambers of Commerce and Industry (FICCI); Uttar Pradesh Industrial Estate Manufacturers Association; and the Employee State Insurance Scheme. Project partners also included individual companies or trusts promoted by companies such as the Giant Group/ Noida; Amin Welfare Trust; Star Paper Mills Welfare Trust; Indo Gulf Fertilizers and Chemicals Limited Jan Sewa Trust; and Indian Farmers Fertilizer Cooperative's Jan Kalyan Samiti.

Overall, the organized sector interventions, funded by the IFPS Project, covered about 1.2 million people. There are no survey results available for organized sector projects. Based on service statistics, SIFPSA had determined that 15 out of 21 projects achieved the objectives, such as increase in CPR and uptake of RH services. As increased industrialization occurred in UP and corporate social responsibility began to gain a foothold, there was a potential for creating increased opportunities for public-private partnerships (PPPs) in the delivery of RCH services.

Chapter 20

SAMBHAV VOUCHER SCHEME

Design of effective, pro-poor policy and finance strategies must be based on clear understanding of the nature and level of inequalities, barriers to service access and use, different finance and service delivery options, and the best approaches for addressing inequalities and facilitating access to services. A survey of households and currently married women in the reproductive age was carried out in six blocks of Agra-a district selected for piloting voucher scheme in UP. The results showed that the CPR among the lowest quintile women (poor) was only 22 percent compared to 42 percent among the highest quintile women (rich). Only two percent of the poor women received full antenatal services compared to 22 percent among the rich. Among the poor, 19 percent of the total deliveries among the poor were institutional deliveries compared to 69 percent among the rich. Key barriers included traditional beliefs and practices, low levels of literacy, limited awareness of availability of services and high monetary costs. The IFPS Project also reviewed the voucher schemes implemented in other states in India and in other countries.

To reduce the inequities among the rural population, the IFPS Project introduced a voucher scheme, called *Sambhav* (possible), in six blocks of Agra district. A voucher is given as a token that can be used in exchange for a restricted range of goods and/or services. Vouchers provided for free ensure cashless transactions. The voucher scheme targeted resources to those most in need. Proof of eligibility to participate in the voucher program was the below poverty line (BPL) card. For those not having a BPL card, eligibility was based on certification by the village *pradhan*. The Voucher Management Unit (VMU) established at the CMO's office managed the scheme and reported to the CMO. The responsibilities of the VMU included distribution of vouchers, implementation of BCC activities, coordination with providers, reimbursement to providers and collection and analysis of data. The IFPS Project, with the help of Agra Medical College, prepared accreditation guidelines, assessed private facilities willing to participate in the voucher scheme and accorded accreditation to private hospitals if they received a score of 75 out of 100.

A community health volunteer hands a voucher to a BPL client

The package of services included three ANC checkups, two TT injections, IFA tablets, nutritional advice, ultrasound, deliveries (normal, complicated and cesarean), two PNC checkups, counseling on breast feeding, pills, condoms and sterilization, sexually transmitted infection (STI)/RTI checkups, treatment and partner counseling, pregnancy test, hemoglobin test, blood group with Rh factor, blood sugar, urine examination and WR VDRL test. Cost of each of these services was negotiated and made uniform across nursing homes.

The VMU distributed vouchers to NGO representatives who in turn provided vouchers to ASHAs. All ASHAs were trained by NGOs on how to distribute vouchers and eligibility for voucher benefits. The IFPS Project designed the vouchers in different colors such that the color of the voucher indicated the type of service. Each voucher had three parts: one retained by the ASHA, the second retained by the nursing home and the third submitted to the VMU for reimbursement. All vouchers were printed with holographic stickers to prevent misuse and carried eight digit numbers indicating the block and village to track the clients. The addresses along with telephone numbers of nursing homes were printed at the back of the voucher to facilitate client's choice. An information system was designed and implemented to monitor the performance. Medical audits to ensure quality standards were conducted at periodic intervals. Client satisfaction surveys were conducted once a year to identify issues from clients' perspective. At the conclusion of the pilot program in Agra, an endline survey was conducted.

Women from BPL families who received all three ANC checkups increased from 17.5 percent to 34.3 percent; institutional deliveries increased from 22 percent to 30 percent. Any PNC checkup increased from nine percent to 72 percent; and modern FP method use increased from 27 percent to 31 percent (ITAP, 2012). With the introduction of Janani SurakshaYojana as part of NRHM, GoUP decided to discontinue the *Sambhav* voucher scheme in rural areas to avoid duplication in efforts. Recognizing the usefulness of the voucher scheme in providing services to the poor, the state government decided to launch the scheme in slum areas of urban cities. Kanpur City was selected for the launch of voucher scheme in the first phase. After one year, the scheme was extended to slum areas of four more cities—Agra, Lucknow, Varanasi and Allahabad. The voucher scheme improved access to quality RH services and considerably reduced inequities between the rich and poor.

Chapter 21

PUBLIC-PRIVATE PARTNERSHIP INITIATIVES

After completion of the RCH I program in March 2005, the MoHFW, GoI decided to revamp the program. A series of consultation meetings with stakeholders led to identification PPPs in the health sector, as one of the areas required to be emphasized upon for effective implementation of the RCH program. The IFPS Project assisted the government in drafting a PPP strategy that was included as one of the sections in the overall RCH strategy. The PPP strategy defined PPPs, identified benefits of partnerships for the RCH program, listed different PPP models and services that could be brought under the program, and provided guidelines for capacity building to manage PPPs.

During the second phase of the IFPS Project, a series of consultancy meetings were held with senior administrators of the health department in UP to implement PPPs in the health sector. Two workshops were conducted in Agra and Kanpur Nagar involving public and private health representatives. The main objectives of these workshops were to share different models of PPPs suitable for the health sector and also to identify models that could be piloted specifically in UP. These workshops were jointly organized by the Department of Health and Family Welfare and the IFPS Project. Based on deliberations in these workshops, voucher scheme, social franchising, social marketing, and clinic based NGO projects were identified as potential models for pilot testing. The IFPS Project developed concept notes, designed the pilot programs and implemented all the four identified models.

During the third phase of the IFPS Project, the GoUP took a decision to introduce PPPs on a large scale, covering primary, secondary and tertiary sectors in rural and urban areas of UP. The proposed PPP initiatives included management of mobile health units, management of ambulance services, management of urban health centers, CHCs and district hospitals, management of diagnostic services at the regional

Social Franchising was identified as one of the models for pilot testing

level, and management of referral transport services. Since these initiatives were to be undertaken on a large scale, it was considered necessary to have transaction managers who would assist in chalking out the most effective arrangements to involve the private sector, and in selection of a specific agency for each PPP initiative through open bidding process. The IFPS Project assisted the government in preparation and finalization of the request for proposals. These proposals were sent to qualified agencies, and agencies to act as transaction managers were selected for each PPP initiative. The GoUP is still working out details to carry this forward.

Chapter 22

SOCIAL MARKETING

The IFPS Project emphasized on increasing the use of contraceptive methods to space pregnancies. At the time of inception, the project allocated USD 42 million for an unspecified social marketing program. Market segmentation analysis based on NFHS I (1992-93) and the PERFORM Survey identified the need for free or subsidized oral contraceptive pills and condoms, especially in rural UP. The market segmentation analysis provided inputs for developing the marketing plan, as per which the first three years would focus on developing an infrastructure to expand the markets for pills and condoms, followed by introduction of new products over subsequent years. This plan once approved by GoI and USAID, laid the foundation for the first major contraceptive social marketing effort in UP. A competitive bidding process was initiated and a social marketing agency was selected.

The emphasis of the social marketing effort was to expand the sale of branded condoms and oral pills, both subsidized and commercial, and increase their penetration in rural markets.

In the beginning, the IFPS Project awarded a three-year (1997-2000) contract for a state-wide social marketing program. The project was designed to cover the major towns with less than 20,000 people through conventional channels. In addition to existing brands, the project launched a new brand of low-priced non-subsidized condoms called *Rakshak*.

This was followed by a competitive bidding process in 2000, wherein a performance based contract was signed with a social marketing agency from 2000-2003. In this phase, the project reach was increased to smaller villages (with population between 1000 and 5000) throughout the state. Contraceptive products were made available through non-conventional outlets. The GoI social marketing brands, namely Deluxe Nirodh for condoms and Mala-D for oral contraceptives, were promoted along with other social marketing and commercial brands.

In 2002, SIFPSA funded the Venture Rural Project to pilot the concept of the rural salesman offering a basket of products in Moradabad Division. The basket of products that the rural salesmen carried were RCH products such as condoms, contraceptive pills, disposable delivery kits, ORS, IFA tablets, and safe drinking water kits.

Beginning in 2003, in addition to the state-wide project, regional projects implemented by other social marketing agencies were also initiated. This approach was designed to have a state-wide impact on contraceptive sales while addressing barriers to contraceptive pills and condoms use, especially in rural areas. The state-wide project was implemented from 2003 to 2006, and covered a larger number of villages with a population between 1,000 and 5,000 people, for increased penetration. Only GoI brands were promoted through this project. The emphasis of the state level project, however, was on communication and demand generation. For the central and Bundelkhand region Project *Pahal* was initiated, extending the distribution of the basket of products to villages with less than 2000 population, in 14 districts. The western region project, called Project *Khushhali*, was envisaged to reach all villages with a population of more than 5000 people, and 20 percent of villages with population between 1000 and 5000 people. No project was awarded for the eastern region as the financial proposal of the short-listed agencies was not cost-effective. The emphasis of the regional projects was to stock contraceptives in non-traditional outlets. Implemented from 2003-05, the regional projects strengthened the distribution network through village-based vendors, and non-conventional outlets or other community level members.

Promotion was an integral part of all the social marketing projects. Culturally-sensitive, innovative media were used. Besides the promotion of brands, generic communication campaigns were undertaken to facilitate behavior change, adoption of contraception and other health products. These included mass media, video vans, point-of-purchase materials, wall paintings, folk troupes and special events.

Linkages with other institutions, such as NGOs, dairy cooperatives and public distribution system, had an encouraging response.

In the first phase of the IFPS Project, the social marketing projects collaborated with more than 6,000 dairy cooperatives as well as NGOs, and private sector groups to promote condoms and pills. The proportion of villages between 1000 and 5,000 people that had sales outlets for contraceptive pills and condoms, more than doubled in two years, increasing from 19 percent of these villages in 2000 to 43 percent in 2002. Condom sales in UP nearly tripled during the years of implementation of social marketing projects, rising from 89 million pieces in 1997 to 241 million pieces in 2004. Rural UP contributed to 47 percent of these sales with a total of 112.96 million pieces. The sales of contraceptive pills also nearly doubled in UP from 4.27 million cycles in 1997 to 8.04 million cycles in 2004 with 36 percent contribution from rural UP (2.87 million cycles). However, sales for pills were stagnant since 2002 and started to decline in 2004, due to reduction in communication activities (Constella Futures, 2006).

In the second phase of the IFPS Project, in continuation to the earlier social marketing efforts, USAID funded a state wide social marketing project. Based on a competitive selection process, a social marketing agency was selected to implement the project in 2007. The emphasis of this phase was to have atleast one retail outlet stocking both condoms and oral contraceptives in villages with population between 1,000 and 5,000 people. At the same time, efforts were made to expand the overall condom and oral contraceptive market in rural UP. The project limited its emphasis to condoms and oral contraceptive pills. GoI brands, in addition to the social marketing agency's own brands were promoted and distributed to ensure that products were available at a range of price points.

In order to generate demand for contraceptives, a mix of IPC, mid-media campaigns and mass media advertising were used to reach out to the target audience with relevant messaging. These included community meetings, counseling sessions, market town activities, health baby and mother events, van activities, and *gram panchayat* meetings. Television and radio spots were also aired for reaching larger populations.

A team of 140 staff, 70 sales representatives and 70 outreach workers, supported stockists in making products available at outlets in the smaller villages. In addition, retailer meetings and AWW meetings were also conducted.

During the second phase of implementation, the IFPS Project reached out to an estimated 1.5 million men and 700,000 women, over 20,000 AWWs, 30,000 retailers, and 6,000 *gram panchayat* members through various activities. The overall condom market in UP more than doubled from 213 million pieces in 2005 to 439 million pieces in 2011. A similar trend was seen in rural

A retail outlet stocking condoms and oral contraceptives in a village

UP with condom sales increasing from 124.84 million pieces in 2005 to 257.51 million pieces by the end of 2011. Contribution of the rural market to total sales increased to 64 percent. The overall oral contraceptives market in UP increased from 8.49 million cycles in 2005 to 12.54 million cycles in 2011. In rural UP, sales for oral contraceptives increased from 3.99 million cycles in 2005 to 6.89 million cycles in 2011 (Nielsen, 2011). Penetration, implying availability of both condoms and oral contraceptive pills at least one outlet in the small villages (with population between 1,000 and 5,000 people), increased from 41 percent in 2006 to 70 percent in 2011 (CREATE, 2011).

By increasing penetration to smaller villages and total rural market sales, efforts have been made to expand the overall market and reach out to remote village communities. Social marketing is an effective strategy to increase availability, accessibility and affordability of contraceptive products.

Chapter 23

SOCIAL FRANCHISING

In UP, the uptake of modern FP methods and use of institutional facilities for deliveries is low, especially among the poorest. Out-of-pocket expenditure on RCH services in both government and private facilities is high, with the healthcare systems imposing an enormous burden on poor. The private sector, though available, is highly unregulated. In this context, PPPs have emerged as an important strategy for tapping the private sector while providing affordable quality services to vulnerable populations. Taking cognizance of the health requirements in the state and stakeholder consultations on possible models, social franchising emerged as an innovative PPP mechanism that would tap the private sector to meet the health needs of the people of UP.

The objective of social franchising was to increase access to equitable, affordable and quality healthcare services for low income groups, by engaging the private sector through sustainable partnerships and developing a network of franchised hospitals. Salient features of this model were: low cost, high volume to achieve financial viability, pricing of services at 30 to 40 percent lower than the prevailing market rate to drive volumes, comprehensive basket of services to cross subsidize preventive and promotive care, and revenue generation so as to be sustainable in the long term.

The social franchising network, branded as the Merrygold Health Network (MGHN), had a three-tiered 'hub and spoke' model. The first tier (Level1 (L1), branded as Merrygold, consisted of fully franchised health facilities. The second tier (Level 2 (L2), called Merrysilver, consisted of fractionally franchised facilities and the third tier (Level 3 (L3) named Merrytarang was a referral network consisting of members at the community level. For each L1 it was envisaged that there will be 10 L2s and each L2 would have 15 L3s. Initially, there was no referral fee between the different tiers.

The MGHN expanded in phases and covered 35 districts of UP, with an objective of including 70 L1s, 350 L2s and 10,500 L3s into the network over a period of three years.

Branding for the network was developed after audience segmentation and analysis, and the platform chosen was 'quality health services at an honest price'. The brand imagery, consisting of a marigold flower, leveraged on its auspicious and positive symbolism. A multi-pronged communication strategy was deployed with television spots, radio spots, newspaper advertisements, communication collaterals, and internal and external branding of facilities, using the same branding for consistent experience for the consumer. Extensive branding and marketing of the network was a primary reason for private providers to join as franchisees.

Services at each level included:

- L1 Full Franchisees: Basic obstetrics care and C-section deliveries; normal delivery cases; FP counseling; ANC; counseling on contraceptive methods and distribution of contraceptives and related products including wellness products/ over the counter medicines; and other additional services related to obstetrics/gynecology and pediatric care.
- L2 Fractional Franchisees: Basic obstetrics care; counseling on contraception methods counseling; IUD insertions and distribution of contraceptives and related products.

The L1 facilities also have facilities for ambulatory care, tie-ups with diagnostics facilities, and pharmacy.

To meet the sustainability objective of MGHN, L1 facilities would pay Rs. 300,000 (about USD 6,000) as an initial franchise fee and three percent of revenues. L2 facilities would pay a

Patients wait at a Merrygold health facility

one-time franchise fee of Rs. 1,000 (about USD 20).

Quality standards have been established through protocols and guidelines. Meticulously planned trainings for L1 as well as L2 franchisees were conducted on the standard protocols for the Network (430 doctors, 2000 paramedics and 475 non-clinical staff trained). Periodic medical audits determine whether franchisers are following the standards and protocols established. In addition,these were supplemented with management development programs, workshops in collaboration with National Accreditation Board for Hospitals (NABH) on accreditation standards, newborn care, and trainings for L3 members. Recently, an e-learning program has been planned and is in its initial stages of implementation.

Partnerships for pharmaceutical products, information systems, health insurance, diagnostics, and financial institutions for loans were established. These partnerships were important for cost efficiencies for franchisees and for a one stop RH facility for consumers. The MGHN health facilities were also linked with other existing schemes such as voucher system, FP sterilization scheme, Rashtriya Swasthya BimaYojana (RSBY) and Soubhagyavati Yojana.

For health information management, a computerized model was developed. A log-frame with indicators for increased demand for services, quality and range of products and services provided by franchisees, and enhanced capacity of franchisees to sustain a profitable practice were defined for better monitoring.

The MGHN is now operational in 36 districts across UP. It has been successful in bringing together more than 430 (67 L1s and 367 L2s) hitherto disaggregated private health service providers and nearly 10,000 community level workers into the folds of the network, making it one of the largest networks in India

From October 2007 till February 2012, the network has provided 756,100 antenatal checkups, 133,900 deliveries, 10,600 sterilizations and 38,200 IUCD insertions. Family planning services provided including distribution of condoms and oral pills, the network has generated more than one million couple years of protection (MGHN MIS, Feb 2012). Client satisfaction with the network was high. Thirty eight percent of the women rated that they were 'very satisfied' and 53 percent as 'satisfied' (n= 66) with services they received at the network. Of all the women who knew about MGHN, 65 percent (n=474) reported they would visit the facilities again (presumably for a future birth) and 90 percent would recommend the network to a friend.

Medical audits conducted from September 2009 to August 2011 indicate that facilities have improved their quality of services with health facilities meeting more than 80 percent of the criteria.

Over the implementation period, the MGHN has proved that social franchising as a model, was capable of harnessing substantial private sector resources for health and could be rolled out and expanded very quickly.

Section 2

IFPS Project Performance

1992-2012

Chapter 24

PROJECT PERFORMANCE

The major objective of the IFPS Project in UP was to reduce the TFR by increasing the use of modern contraceptive methods, particularly modern spacing methods. To begin with, USAID decided to measure the project performance on key FP indicators such as total CPR, CPR by limiting methods and CPR by modern spacing methods. As the implementation of the project progressed, it was considered important to add new performance indicators to capture all project interventions in UP. Expanded list of indicators, in addition to FP indicators, included antenatal check-ups of pregnant women, two doses of TT injections, sufficient quantity of IFA tablets and in-facility deliveries.

24.1 SURVEYS TO CAPTURE PROJECT PERFORMANCE

A baseline survey called the PERFORM Survey was conducted in 1995 covering 14 administrative divisions and 28 districts (later bifurcated to 33 districts). Since the district is the focal point for introducing innovative approaches, the sample design for the PERFORM Survey was directed towards providing estimates at the district level. The sample design was a systematic multi-stage cluster sample of households. At the time of survey design, UP had 14 administrative divisions and two districts were selected from each division using the probability proportional to size (PPS) methodology. The total sample of households per district was set at 1500 to allow sufficiently precise estimates for each district. The total sample size for the state was 42,006 households and 48,002 currently married women in reproductive age with an overall response rate of 96 percent (Table 1).

In 1998, USAID took a decision to conduct annual surveys to capture the project performance on select indictors. The IFPS Project was funded under USAID/India's Strategic Objective (SO) 2, i.e. to reduce fertility and improved RH in North India. Accordingly, the annual surveys were named as SO2 Indicator Surveys. A total of five SO2 Indicator Surveys were conducted from 1998 to 2002. A three-stage sample design was adopted in all the SO2 Indicator Surveys. In the first stage, districts were selected followed by selection of villages in rural areas and wards in urban areas. The third stage included selection of households. Both in the first and the second stages, selection of districts and villages/wards was done using the PPS methodology. However, in the third stage, household selection was done using systematic circular sampling with a random start. The targeted numbers were 30 households from each selected village and 20 households

TABLE 1: SAMPLE SIZE AND RESPONSE RATE OF SURVEYS

Surveys	PERFORM	S02 INDICATOR SURVEYS					RHIS		
Years	1995	1998	1999	2000	2001	2002	2003	2005	2010
Sample size									
Number of households	42,006	4,951	9,558	9,368	9,460	9,332	9,256	4,759	5,000
Number of eligible women	48,022	5,965	10,206	10,144	9,692	9,285	9,474	4,420	4,777
Response Rate									
Household	96.7	99.5	99.5	97.0	95.9	95.3	96.4	95.2	95.5
Eligible women	94.3	94.4	97.2	95.6	95.1	93.2	93.3	91.1	90.4
Overall	95.6	93.9	96.7	92.7	91.2	88.8	89.9	86.7	86.3

Source: Compiled from different Survey Reports

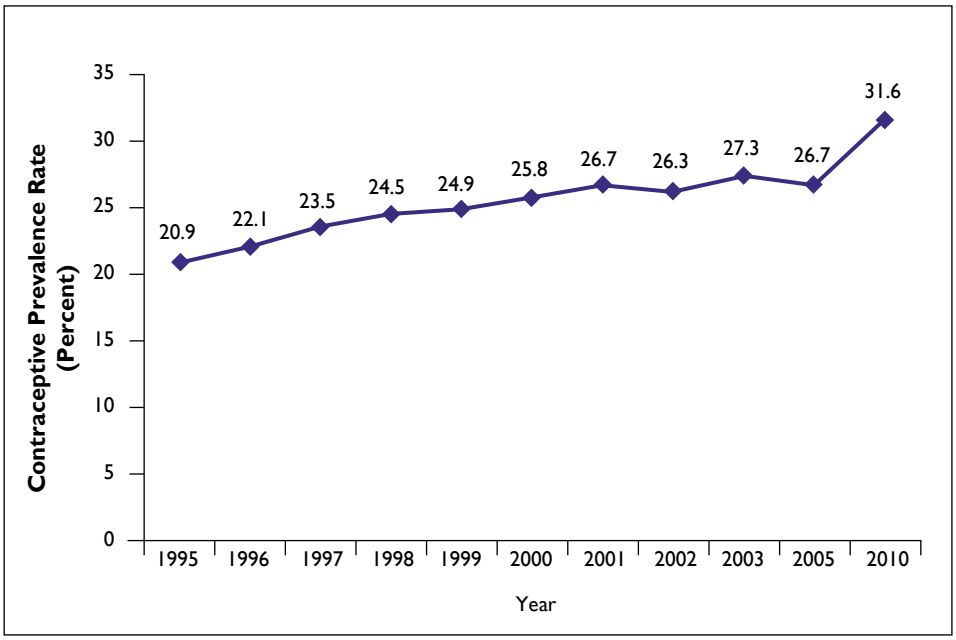
from each urban ward. The sample size of the first SO2 Indicator Survey was 5,000 households and the size was increased to 10,000 households from the second survey onwards. For all five SO2 Indicator Surveys, the response rate was above 90 percent for both households and currently married women in reproductive age.

In the year 2003, when USAID decided to continue with the IFPS Project in UP, more detailed Reproductive Health Indicator Surveys (RHIS) were commissioned to capture performance during the extended phase. The first RHIS was conducted in 2003 followed by two more surveys in 2005 and 2010. For the RHIS, a two stage sample design was adopted. The first stage included selection of villages and urban wards and the second stage covered selection of households using the same methodology as used in SO2 Indicator Surveys. While the sample size for the first RHIS was 10,000 households, the second and the third RHIS' had a sample size of 5,000 households.

24.2 STUDY INSTRUMENTS, DATA COLLECTION AND FIELD MONITORING

The Futures Group, a USAID funded cooperating agency, conducted all nine surveys with assistance from local survey research agencies. Futures Group prepared the study instruments such as mapping and household listing forms, household interview schedules, women's interview schedules, and instruction manuals for field investigators. The data collection process was carried out with the help of local survey research agencies. Mappers, listers, and investigators were trained on mapping, listing and data collection. Female investigators collected the data in all surveys. Spot checks and back checks were done in all surveys systematically to ensure quality of data.

FIGURE 1: TRENDS IN CONTRACEPTIVE PREVALENCE RATES FOR MODERN METHODS IN UTTAR PRADESH (PERCENT)



24.3 DATA ENTRY, ANALYSES AND REPORT WRITING

For all surveys, the data entry software was developed using the Integrated System for Survey Analysis (ISSA) software, and the data analysis was done using Statistical Package for the Social Sciences (SPSS) software. The Futures Group developed the data entry package, analyzed the data and prepared the reports.

The following section presents the performance of various indicators by calculating z-scores (refer Appendix A for calculation details):

24.4 FAMILY PLANNING

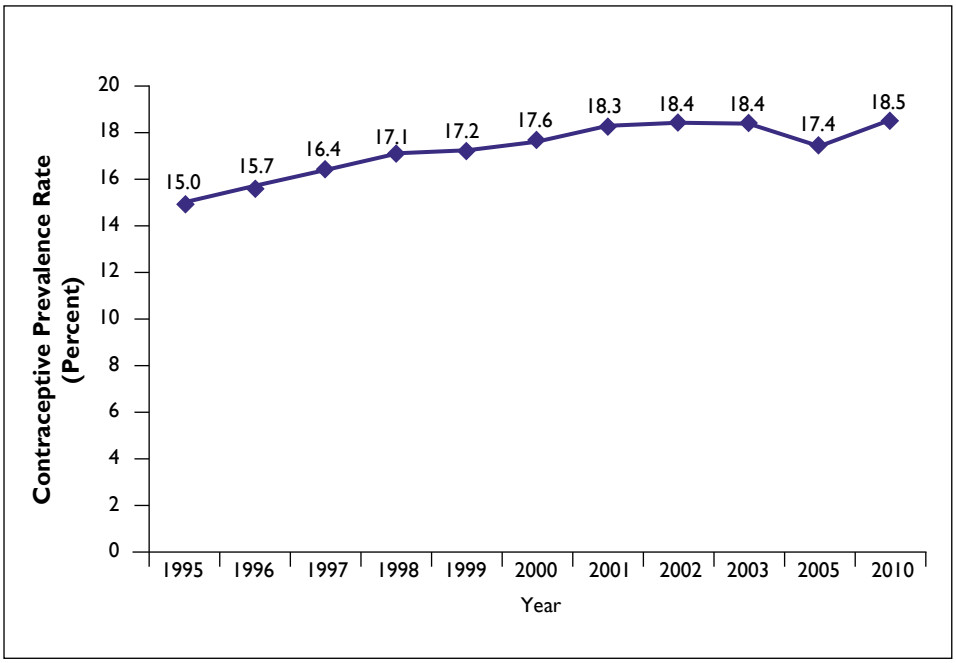
Contraceptive Prevalence Rates in Uttar Pradesh

The CPR for all modern methods in UP saw an increase from 20.9 percent in 1995 to 31.6 percent in 2010 - an increase of 10.7 percentage points over a period of 15 years (Figure 1), which is significant ($p < 0.01$). This works out to an average annual increase of 0.7 percentage points. During the first five years of the IFPS Project, the CPR had increased from 20.9 percent to 24.9 percent, with an annual average increase of 0.8 percentage points (significant, $p < 0.01$). During the next five years up to 2005, the annual average increase of CPR was only 0.3 percentage points, which is statistically not significant at any level. The CPR increased significantly ($p < 0.01$) from 26.7 percent in 2005 to 31.6 percent in 2010, an annual average increase of one percentage point and the fastest pace of increase in CPR during the past 15 years.

Contraceptive Prevalence Rates for Limiting Methods

The CPR for limiting methods (sterilization) increased from 15 percent in 1995 to 18.5 percent in 2010-an increase of 3.5 percentage points in 15 years (significant,

FIGURE 2: TRENDS IN CONTRACEPTIVE PREVALENCE RATES FOR LIMITING METHODS IN UTTAR PRADESH (PERCENT)

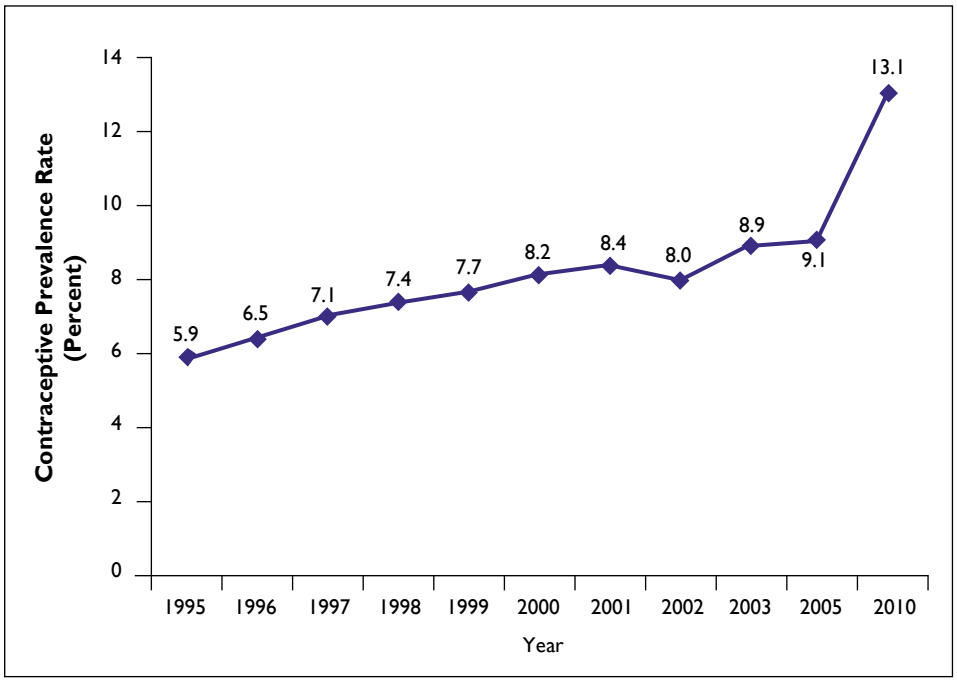


$p < 0.01$). However, this is one of the lowest increases in limiting method use compared to any other state in India, during this period. Inspite of the 10 percent unmet need for limiting methods, an annual average increase of 0.23 percentage points indicates considerable short comings in service delivery systems. One acute problem that the state faces has been the non-availability of trained providers and fully functional health institutions, particularly the CHCs, to meet the unmet need for limiting methods. Use of limiting methods had increased from 15 percent in 1995 to 18.4 percent in 2003 (significant, $p < 0.01$). During the years 2001 and 2003, the use rate had remained almost stagnant. UP limiting method use rate saw a decline from 18.4 percent in 2003 to 17.4 percent in 2005. During the years, 2005 and 2010, the increase in limiting method CPR was only one percentage point for the five year period, which is statistically not significant at any level.

Contraceptive Prevalence Rates for Modern Spacing Methods

Use of modern spacing methods (condoms, oral pills, IUCD), that received considerable emphasis during IFPS Project implementation, improved significantly compared to limiting method use. The CPR for modern spacing methods increased from 5.9 percent in 1995 to 13.1 percent in 2010—an annual average increase of 0.48 percentage points (significant, $p < 0.01$). This was almost double of the average annual increase of limiting methods. Annual average increase for the first 10 years was only 0.32 percentage points. During the years 2005 and 2010, the annual average increase was 0.8 percentage points (significant, $p < 0.01$). The increase could be entirely attributed to an increase in the number of condom users. One of the reasons for this could be the implementation of the social marketing program as part of the project in rural UP. As a result of this intervention the access to condoms and condom sales improved considerably in rural areas, particularly in small population size villages. IUCD and oral pill use almost stagnated without any appreciable increase in users.

FIGURE 3: TRENDS IN CONTRACEPTIVE PREVALENCE RATES FOR MODERN SPACING METHODS IN UTTAR PRADESH (PERCENT)



Sources of Modern Contraceptive Methods

At the beginning of IFPS Project, three in four users of modern contraceptive methods depended on the public sector for services and products. In 2003, dependence on public sector for products and services had declined to 68 percent. During the year 2010, the dependence on private sector for services and products increased to 42 percent. Consequently, dependance on public sector saw a decline to 58 percent. The public sector in UP is no longer a dominant source for contraceptive services. However, there could be method specific variations in sources of supplies. This has been examined in the following section.

FIGURE 4: TRENDS IN SOURCE OF MODERN CONTRACEPTIVE METHODS IN UTTAR PRADESH (PERCENT)

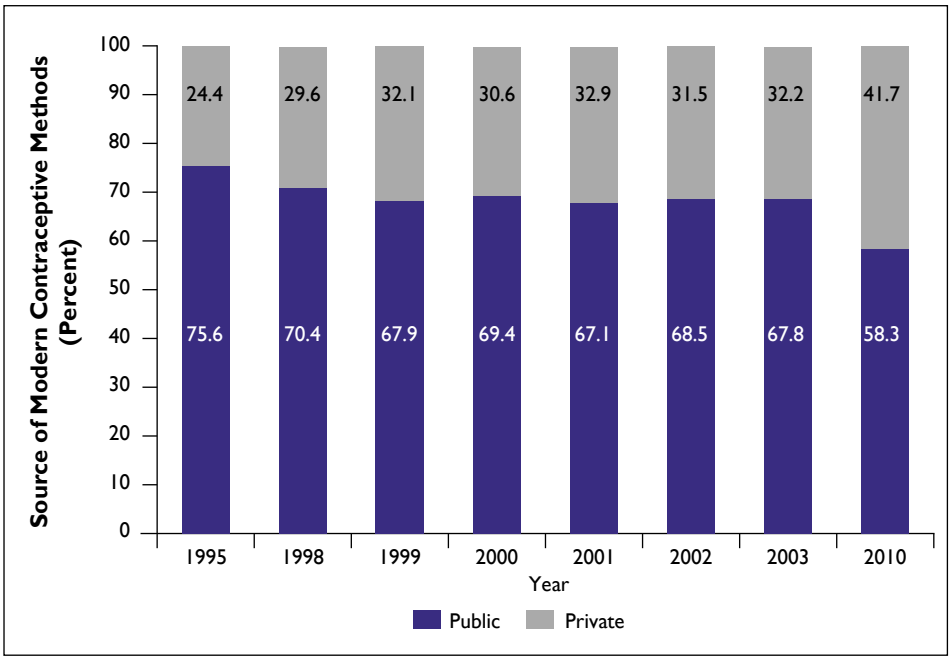
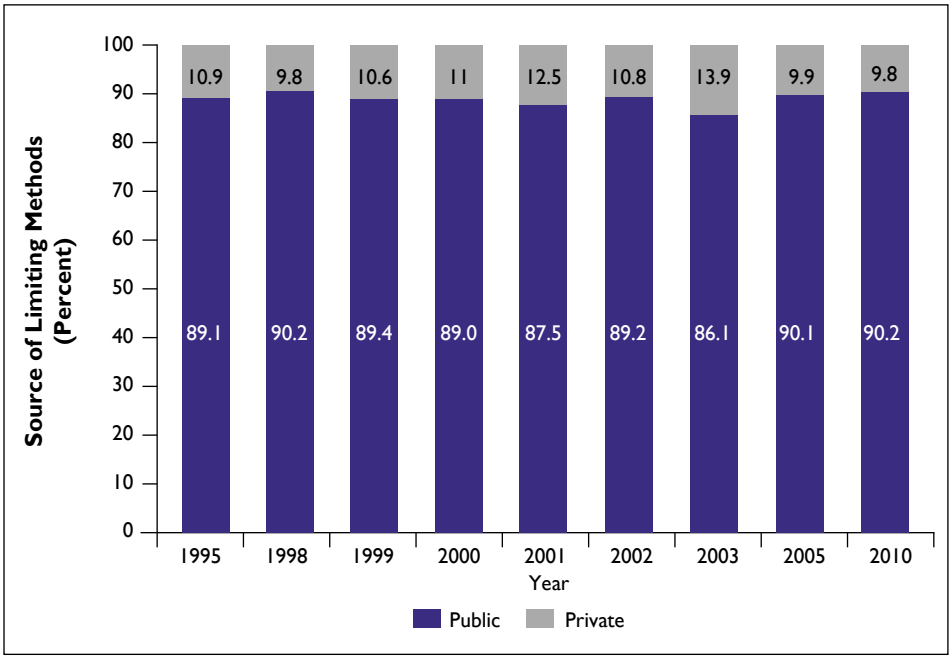


FIGURE 5: TRENDS IN SOURCE OF LIMITING METHODS IN UTTAR PRADESH (PERCENT)



Sources of Limiting Methods

Public sector has been the predominant source for sterilization services. In 1995, nine out of 10 users of limiting methods were dependent on the pubilc sector for services. However, there was a slow and gradual shift from the public to private sector sources over time. Of the total limiting method users in 2003, 86 percent availed services from the public sector and the remaining 14 percent from the private sector. During the year 2010, this trend was reversed. Of the total limiting method users, 90 percent depended on public sector and only 10 percent on private sector. The government provides free service and financial compensation to acceptors of limiting methods if they avail services from public sector. In contrast, the private sector charges a fee for services that have to be borne by individuals availing services. Increasing cost of sterilization services in private sector is also a deterrant for many. These two factors make public sector a more preferred option for limiting method services.

Sources of IUCD Services

At the beginning of the IFPS Project, two out of three IUCD users in UP availed services from the public sector. Over a period of time, dependance on the public sector gradually declined and that of the

private sector significantly increased (significant, $p < 0.01$). During the year 2001, only half of the IUCD users were dependent on the public sector and the other half on the private sector for services. During the years 1995 to 2010, there was a complete reversal of sources of IUCD services. Nearly two thirds, in 2010, depended on the private sector and the remaining one third on the public sector for IUCD services. The declining share of the public sector, given the huge advantages it has over the private sector, in terms of number of service providers, free services and service delivery points, is a cause for concern. Gradual erosion in credibility of the public sector as provider of quality IUCD services could be one of the reasons for decline. Since the public sector is not playing a major role in providing IUCD services, the number of IUCD users in the state have remained stagnant over a period of time. The recent efforts of the GoI to revive and rejuvenate the IUCD program have not yielded any positive results as yet.

FIGURE 6: TRENDS IN SOURCE OF IUCD SERVICES IN UTTAR PRADESH (PERCENT)

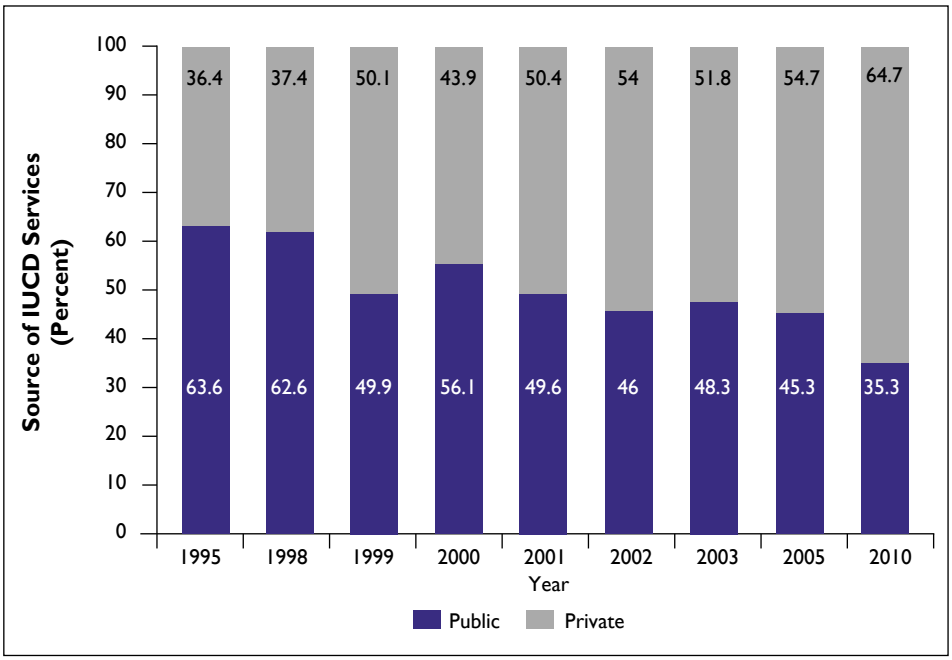
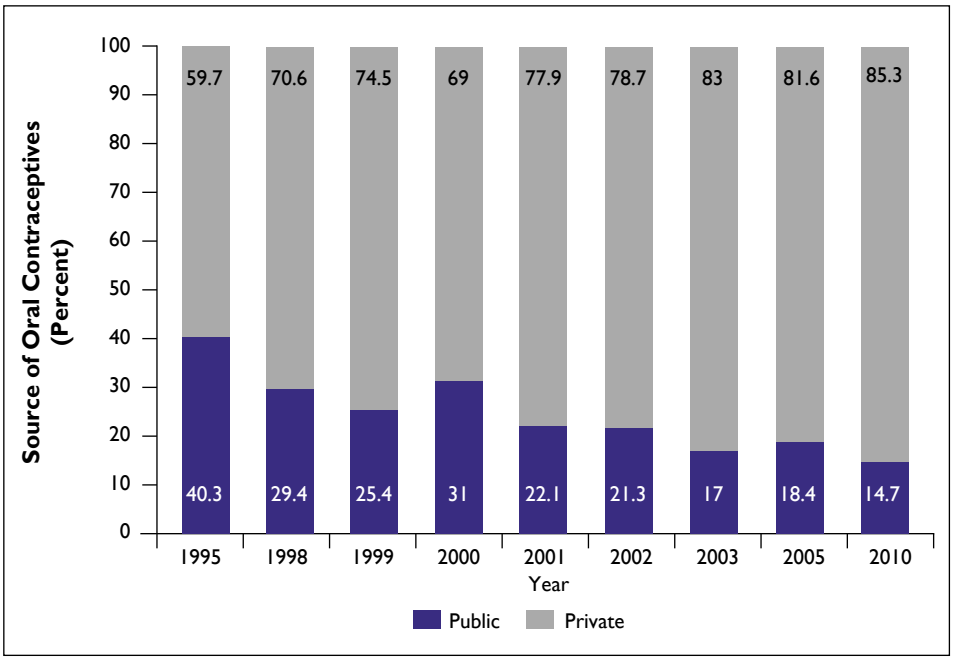


FIGURE 7: TRENDS IN SOURCE OF ORAL CONTRACEPTIVES IN UTTAR PRADESH (PERCENT)



Sources of Oral Contraceptives

In the year 1995, three in five oral contraceptive users purchased oral contraceptives from the private sector, while two in five depended on the public sector for free supplies. The proportion depending on the private sector for supplies increased to 75 percent in 1999, 83 percent in 2003, and 85 percent in 2010. Nearly nine out of 10 oral contraceptive users in 2010 were dependent on the private sector for supplies. Increasing dependance on the private sector for supplies could be due to the social marketing efforts as part of the IFPS Project, that helped marketing agencies to create demand and to penetrate into villages and small towns.

Sources of Condom Supplies

Dependence on the private sector for condom supplies was always high among the condom users in UP. Of the total condom users in 1995, 72 percent depended on the private sector and 28 percent on the public sector sources. During the year 2001, dependence on the private sector for condom supplies increased to

FIGURE 8: TRENDS IN SOURCE OF CONDOM SUPPLIES IN UTTAR PRADESH (PERCENT)

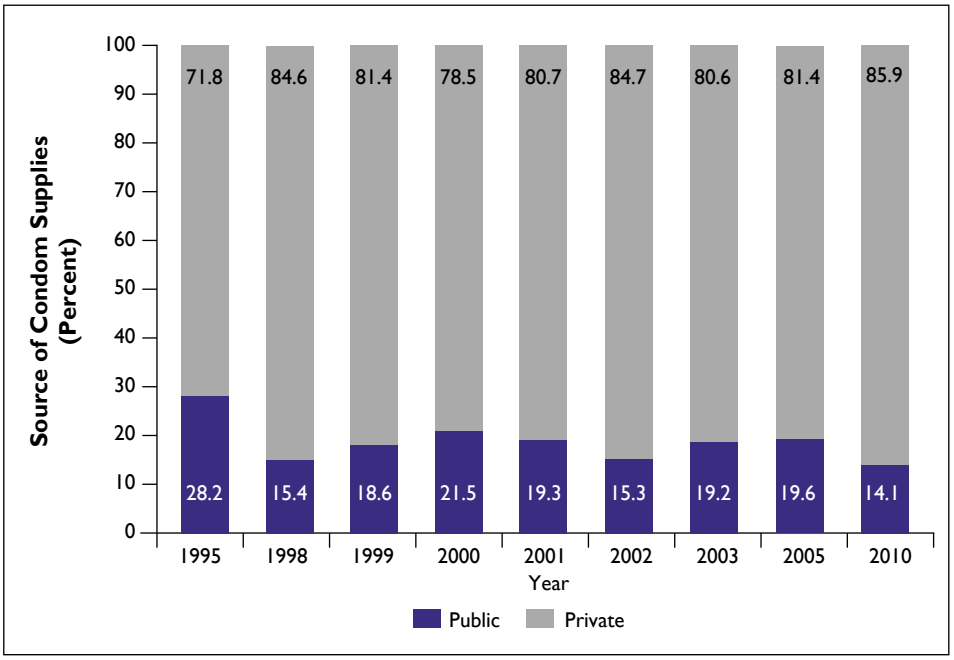


FIGURE 9: FAMILY PLANNING METHOD MIX IN UTTAR PRADESH IN 1995

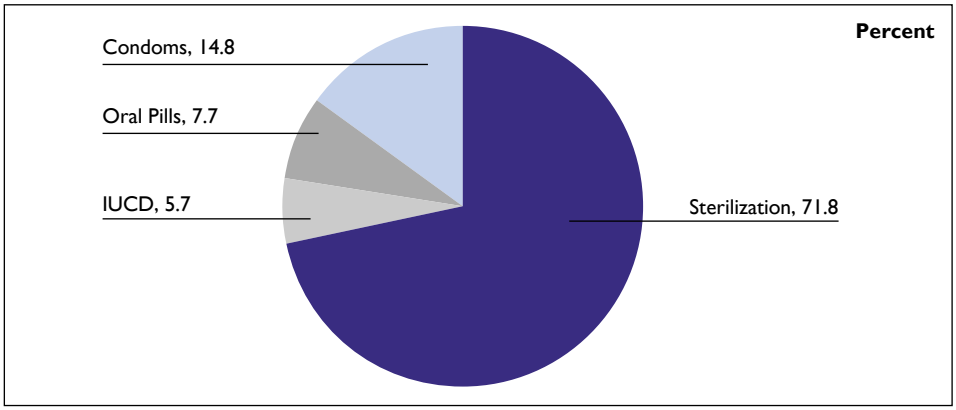
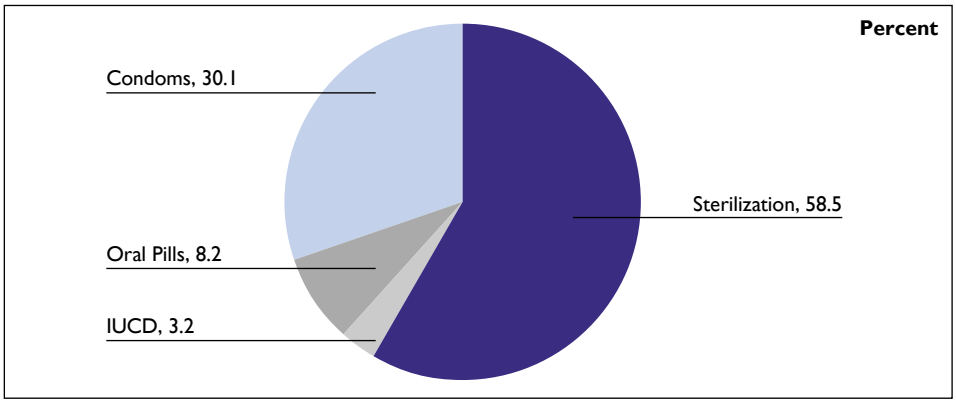


FIGURE 10: FAMILY PLANNING METHOD MIX IN UTTAR PRADESH IN 2010



81 percent and the public sector free supplies as a source declined to 19 percent. In 2010, only 14 percent depended on the public sector for condom supplies while the remaining 86 percent purchased condoms from the private sector, mainly products promoted by the social marketing agencies.

Method Mix

The contraceptive method mix in 1995 was skewed in favor of sterilization. Of the total modern method users, 72 percent were limiting method users and the remaining 28 percent, spacing method users. Most of the spacing method users (15 percent) were condom users followed by eight percent oral contraceptive users and six percent IUCD users. Over time, the proportion of sterilization users to total users declined from 72 percent to 67 percent in 2003, with a corresponding increase in modern spacing method users (33 percent). During the year 2010, the proportion of limiting method users to total users further declined from 67 percent to 59 percent. Within modern spacing method users, the proportion of oral pill users remained more or less the same while that of IUCD declined from 5.7 percent in 1995 to 3.2 percent in 2010. During this period, the proportion of condom users doubled from 15 percent in 1995 to 30 percent in 2010.

Unmet Need for Family Planning

Unmet need for FP as an indicator was introduced as part the RHIS. The SO2 Indicator Surveys did not collect information on unmet need. Currently married women who are not using any method of FP but who do not want any more children or

want to wait two or more years before having another child are considered having an unmet need for FP.

Total unmet need for FP in 2003 was 29 percent, almost equally divided between liming (15 percent) and spacing (14 percent). Unmet need for FP was higher in rural areas (31 percent) compared to urban areas (24 percent). In 2005, unmet need for FP declined to 24 percent (significant, $p < 0.01$) with equal proportion distributed across limiting and spacing. Unmet need for FP in rural areas was higher (25 percent) compared to urban areas (22 percent). While in 2010, total unmet need for FP increased to 31 percent (significant, $p < 0.01$) with 16 and 15 percent distributed across limiting and spacing methods respectively. Unmet need in rural areas was higher (32 percent) compared to urban areas (27 percent). Unmet need for spacing and limiting was equal (16 percent) in rural areas. In urban areas, unmet demand for limiting was slightly higher (16 percent) compared to spacing (11 percent). FP program strategies have to address the unmet need issues and create enabling environment for couples to choose methods of their choice.

24.5 MATERNAL HEALTH

Antental Care Services

Only half of the pregnant women during the PERFORM Survey in 1995 received any ANC services. This proportion substantially increased over a period of time. In 2001, three fourths of women received any ANC services. During the years 2001 and 2005, the proportion receiving any ANC services, more or less stagnated. However, in the year 2010, the proportion of pregnant women who received any ANC services reached its peak level with more than nine out of 10 obtaining any ANC services.

FIGURE 11: TRENDS IN UNMET NEED FOR FAMILY PLANNING IN UTTAR PRADESH (PERCENT)

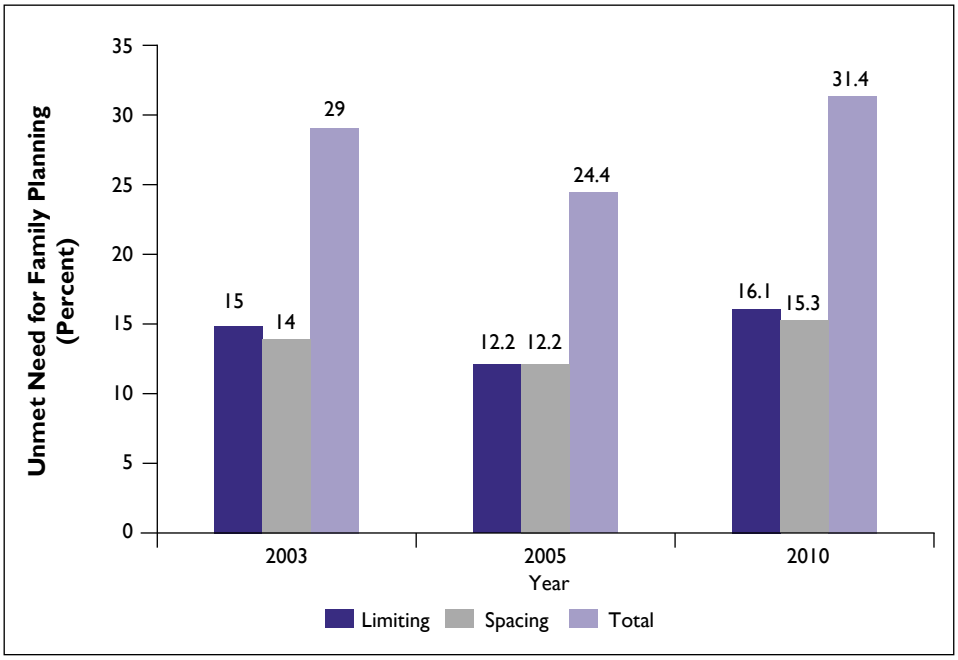


FIGURE 12: TRENDS IN PREGNANT WOMEN WHO RECEIVED ANY ANTENATAL CARE SERVICES IN UTTAR PRADESH (PERCENT)

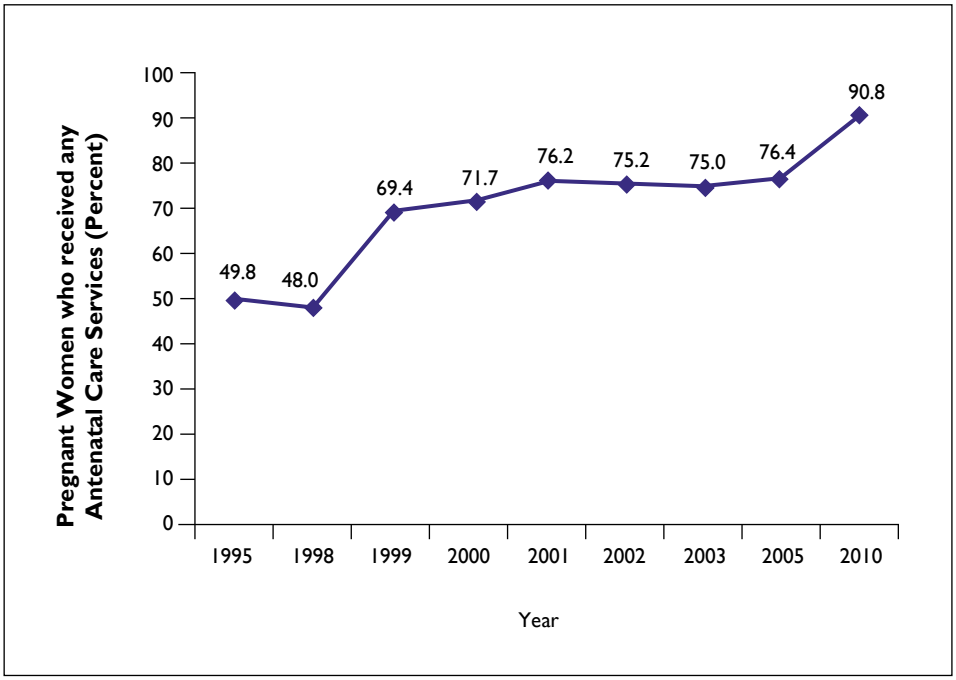


FIGURE 13: TRENDS IN PREGNANT WOMEN WHO RECEIVED ANY IFA TABLETS/LIQUID IN UTTAR PRADESH (PERCENT)

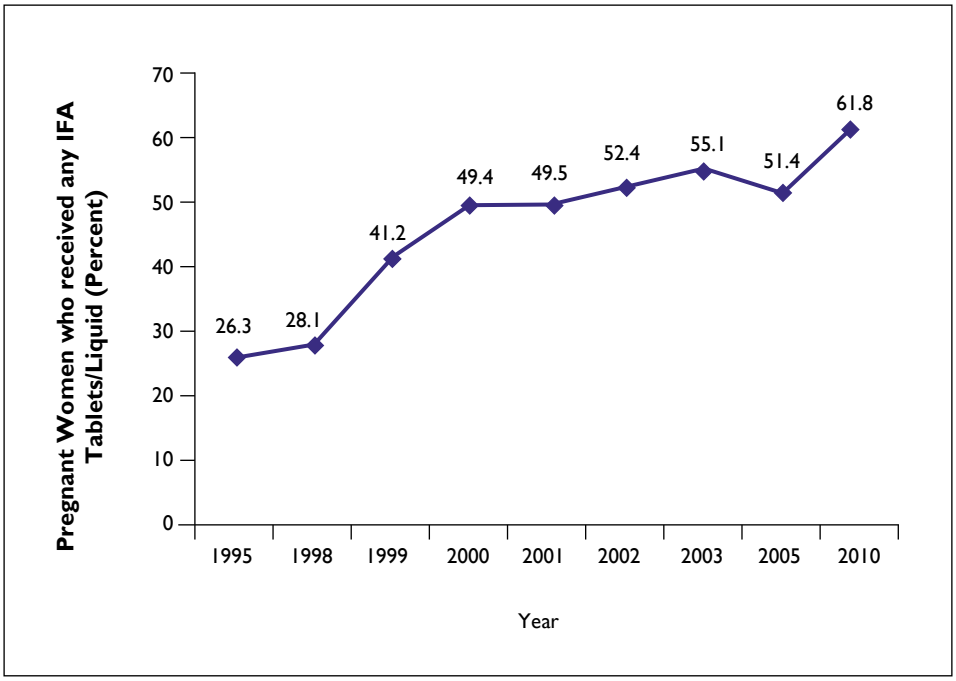
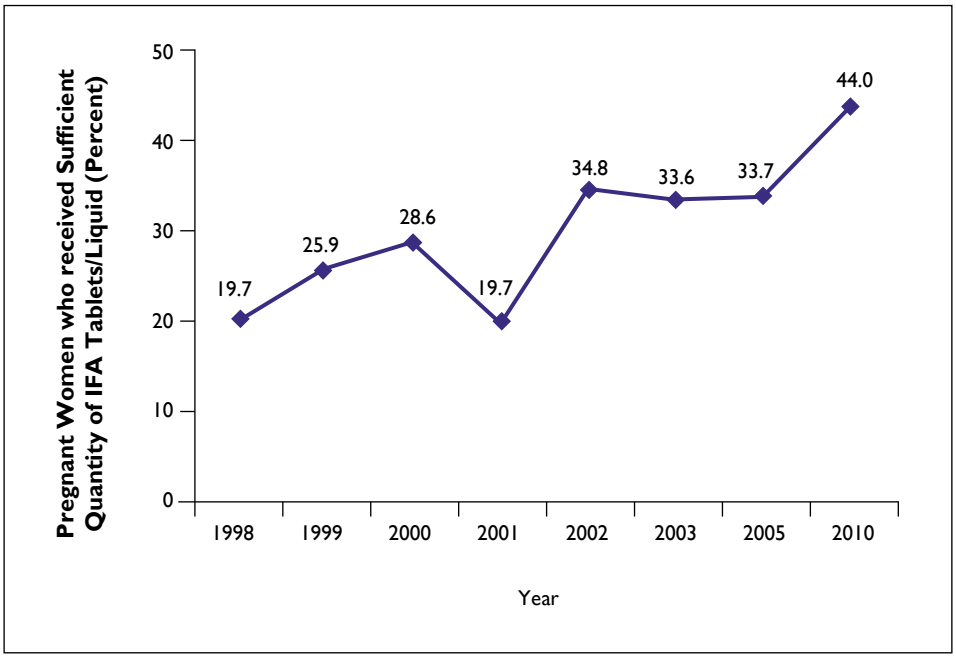


FIGURE 14: TRENDS IN PREGNANT WOMEN WHO RECEIVED SUFFICIENT QUANTITY OF IFA TABLETS/LIQUID IN UTTAR PRADESH (PERCENT)



Iron and Folic Acid Supplements

Slightly above one fourth of the pregnant women in UP received IFA supplements in 1995. This saw a substantial increase to 49 percent in the year 2000. Every year, after this, a gradual increase was seen in the proportion of pregnant women who received IFA supplements to reach 62 percent coverage in 2010. From the beginning of the project to 2010, the increase in proportion of pregnant women receiving the benefit was 36 percentage points—an average annual increase of two percentage points.

Adequacy of IFA Supplements

During the SO2 Indicator Surveys, pregnant women were asked whether they received sufficient quantity of IFA tablets (100 tablets) or liquid. Only one fifth of the pregnant women received sufficient quantity of IFA tablets/liquid in 1998. This proportion increased to 29 percent in 2000 but witnessed a sharp fall in 2001 (20 percent) due to supply problems. With improved supplies in the following year, the proportion increased to 34 percent. The proportion receiving sufficient quantity of IFA tablets/liquid reached 44 percent in 2010. Still there is a huge gap in the proportion of pregnant women receiving any IFA tablets/liquid and those receiving sufficient quantity. While out of the 62 percent of pregnant women who received any IFA tablets/liquid, only 44 percent were given sufficient quantity of IFA tablets/liquid. Public health sector service delivery points are predominant sources of supply of IFA tablets/liquid.

Women Receiving Two Doses of Tetanus Toxoid Injections

The proportion of pregnant women who received recommended two doses of TT injections was 40 percent in 1998. This proportion gradually increased to 63 percent in 2003. During the year 2010, nearly 80 percent pregnant women received two or more doses of TT injections. During the 15 year project period, the proportion of women receiving two or more doses of TT injections almost doubled from 40 percent in 1998 to 80 percent in 2010.

Place of Delivery

At the beginning of the IFPS Project in 1995, nearly seven out of eight deliveries (87 percent) were took place at home and only one in eight deliveries (13 percent) had taken place in public or private health institutions. There was slow and gradual increase in institutional deliveries from 13 percent in 1995 to 24 percent in 2003. The increase in institutional deliveries, during this period, was largely due to an increase in the use of private health facilities. The proportion of pregnant women delivering in private health institutions increased from 6.5 percent in 1995 to 17 percent in 2003—an average annual increase of 1.3 percentage points. During this period, the proportion of pregnant women delivering in public health facilities increased marginally from 6.5 percent in 1995 to 7.2 percent in 2003 — a total increase of 0.7 percentage points in an eight-year period. In 2010, the proportion of pregnant women delivering in institutions increased to 48 percent. Every alternate pregnant

FIGURE 15: TRENDS IN PREGNANT WOMEN WHO RECEIVED TWO OR MORE DOSES OF TT INJECTIONS IN UTTAR PRADESH (PERCENT)

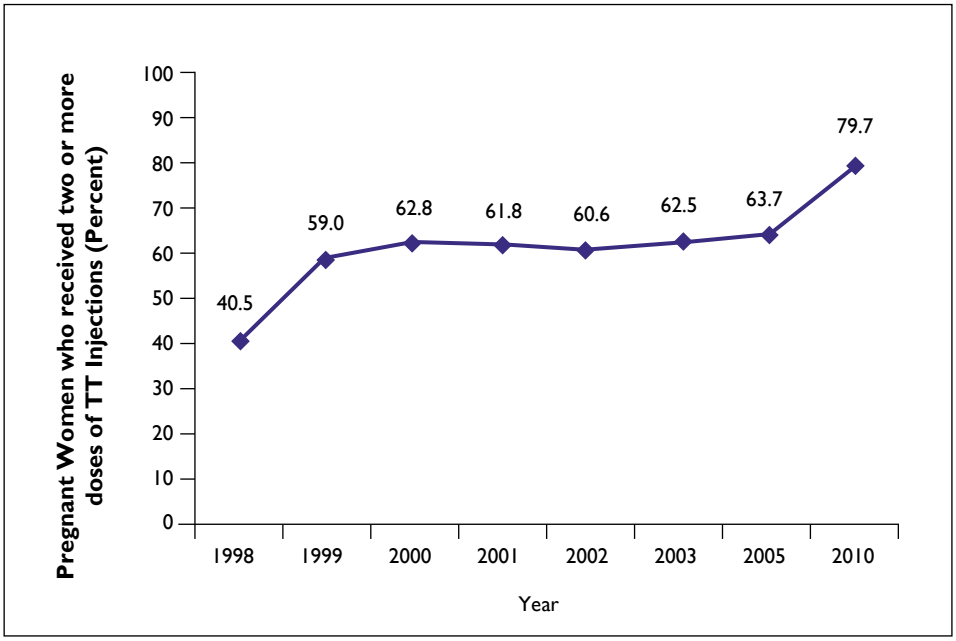
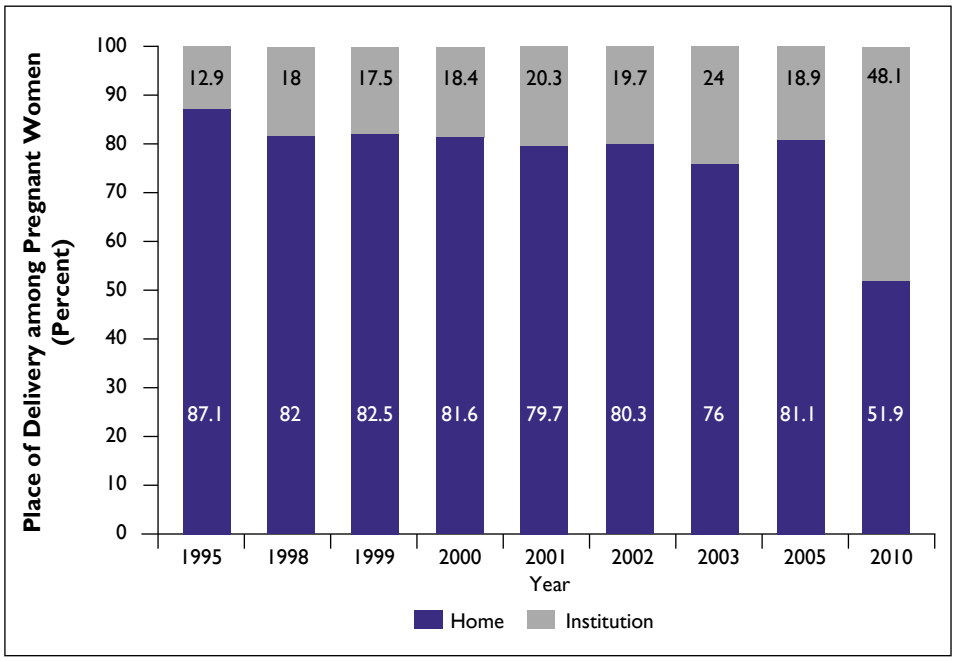


FIGURE 16: TRENDS IN PREGNANT WOMEN BY PLACE OF DELIVERY IN UTTAR PRADESH (PERCENT)

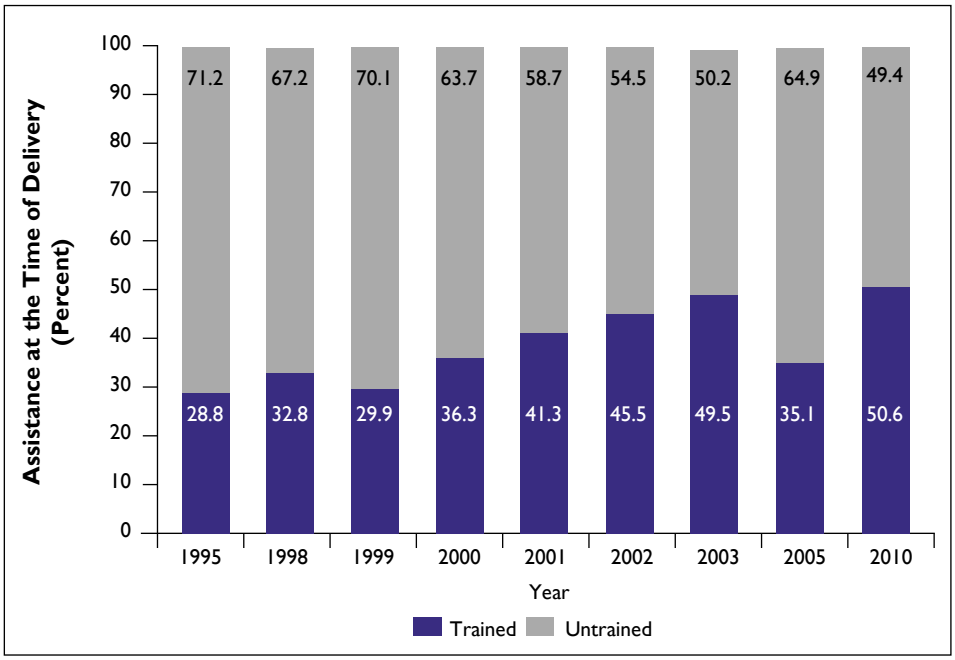


women opted for institutional delivery indicating a substantial increase. The cash transfer scheme introduced by NRHM for rural pregnant women opting to deliver in public health institutions coupled with the *Sambhav* voucher scheme introduced by USAID in select rural and urban areas to utilize private health facilities for deliveries, resulted in a huge spurt in institutional deliveries. The proportion of women using government health facilities for deliveries increased from seven percent in 2005 to 30 percent in 2010, while the proportion using private health facilities increased from 12 percent in 2005 to 19 percent in 2010.

Assistance during Child Birth

At the time of the first SO2 Indicator Survey in 1998, 71 percent of the women giving birth were assisted by untrained *dais*, relatives and friends, while 29 percent were assisted by trained *dais*, ANMs, nurses, and doctors. In 2010, the proportion of women assisted by trained personnel was 52 percent—an increase of over 23 percentage points in the 12-year period. This was largely due to an increase in the institutional deliveries during this period. The proportion of women assisted by trained providers, in 2010, was 63 percent in urban areas and 49 percent in rural areas. As per the standard of living index, the respondents were divided into five quintiles. The proportion of women in the lowest quintile receiving assistance from the trained providers was 39 percent and in the highest quintile it was at 69 percent. A substantial gap still remains among rich and poor in terms of assistance at the time of delivery and this needs to be bridged with rigorous implementation of schemes meant for the poor.

FIGURE 17: TRENDS IN WOMEN WHO RECEIVED ASSISTANCE AT THE TIME OF DELIVERY BY TRAINED AND UNTRAINED PERSONS IN UTTAR PRADESH (PERCENT)



24.6 CONCLUSION

From 1995 to 2010, the CPR by modern methods increased from 20.9 percent to 31.6 percent-an increase of 10.7 percentage points over a 15-year period. The annual average increase was only 0.7 percentage points. The CPR for limiting methods increased from 15 percent in 1995 to 18.5 percent in 2010-an annual average increase of 0.23 percentage points. In contrast, the CPR for modern spacing methods increased from 5.9 percent in 1995 to 13.1 percent in 2010 - an annual average increase of 0.48 percentage points, almost double that of the limiting methods.

In 1995, three fourths of the modern contraceptive users were dependent on the public sector for services and supplies. While in 2010, 58 percent of users depended on the public sector and 42 percent were dependent on the private sector. Even in 2010, the public sector was the predominant source (90 percent) for limiting methods. For modern spacing methods such as IUCD (65 percent), oral pills (85 percent) and condoms (86 percent), the private sector has emerged as the dominant supplier of services and products. This shift could be due to deterioration in the public sector services and could also be due to rigorous implementation of IFPS funded social marketing programs particularly in rural areas of the state.

During the IFPS Project period, there was substantial improvement in maternal health indicators. The proportion of women receiving any ANC services increased from 50 percent in 1995 to 91 percent in 2010-an annual average increase of 2.7 percentage points. Similarly,

pregnant women receiving any IFA tablets and liquid increased from 26 percent in 1995 to 62 percent in 2010 – an annual average increase of 2.4 percentage points. However, pregnant women who received sufficient quantity of IFA tablets/ liquid was low at 44 percent. During the project period, the proportion of pregnant women who received two or more doses of TT injections doubled from 40 percent in 1995 to 80 percent in 2010. Institutional deliveries substantially improved from 13 percent in 1995 to 48 percent in 2010. The IFPS Project has significantly contributed to an increase in modern spacing method use, maternal health services and private sector participation in the delivery of FP and maternal health services in UP.

Appendix A

DETAILS OF CALCULATION OF z-scores

z-scores are calculated to test the significance of differences between proportions at two different time periods. The formula to calculate z-score is presented below:

$$z = \frac{p1 - p2}{SE\,(p1 - p2)} : \textit{where p1 and p2 are taken in proportion}$$

$$SE\,(p1 - p2) = \sqrt{\frac{p1(1 - p1)}{n1} + \frac{p2(1 - p2)}{n2}}$$

Prediction interval (percent)	Standard Score (z)
50	0.67
68	1.00
90	1.64
95	1.96
99	2.58

TABLE 2: DETAILS ABOUT NUMERATORS AND DENOMINATORS FOR VARIOUS INDICATORS FROM SURVEYS USED FOR CALCULATION OF *Z*-SCORES, UTTAR PRADESH

			PERFORM 1995		RHIS 2005		RHIS 2010	
			Nume-rator	Denomi-nator	Nume-rator	Denomi-nator	Nume-rator	Denomi-nator
Users of contraceptive methods	All modern methods		10037	48022	1180	4420	1510	4777
	Limiting methods		7203	48022	769	4420	884	4777
	Modern spacing methods		2833	48022	402	4420	626	4777
ANC	Any ANC		22993	45262	965	1260	1051	1157
	IFA	Received adequate liquid/tablets			425	1260	508	1157
		Consumed adequate liquid/tablets			253	1260	387	1157
	TT	2 or more doses			723	1260	921	1157
		Adequate coverage			845	1260	979	1157
Delivery characteristics	Place of delivery	Institutional	4934	45262	238	1260	556	1157
		Public health facility			87	1260	342	1157
		Private health facility			151	1260	214	1157
	Assistance	Trained provider			442	1260	654	1157
		Untrained provider			818	1260	389	1157

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