



# DISTRICT ACTION PLANS: Implementing Decentralized Health Planning

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# **Report on District Action Plans: Implementing Decentralized Health Planning**

**NOVEMBER 2006**

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FROM THE AMERICAN PEOPLE

## FOREWORD

India recognized early on the importance of population growth to the country's health and development, launching the world's first national family planning program more than 50 years ago. Since that time, India has made great strides in increasing awareness of family planning issues and in reducing total fertility. Yet, significant differences persist across the country, with the northern states generally experiencing higher fertility rates and poorer reproductive health indicators. Moreover, differences are evident from the state down to the district level, highlighting the need to tailor programs to local conditions.

In 1992, the United States Agency for International Development (USAID), in cooperation with the Government of India, embarked on an initiative to identify new models for family planning and reproductive health interventions, mobilize public and private sector resources to expand programs, and develop approaches to ensure sustainability. The Innovations in Family Planning Services (IFPS) Project tested a range of interventions designed to increase access to high quality family planning services in priority districts across Uttar Pradesh, home to one-sixth of India's population. Initially, however, lack of local ownership of programs hindered the achievement of project goals and, thus, IFPS devised a new strategy based on decentralized district action planning.

The district action plan process is perhaps the most important innovation of the IFPS Project because it underpins every other activity carried out by the project. For the first time ever in India's history, district stakeholders were actively involved in setting goals and devising locally feasible solutions to the family planning and reproductive health issues facing the district. The introduction of district societies and project management units ensured effective decentralization of program planning and implementation. This approach also made the family welfare program more accountable and responsive to local community needs. Areas with district action plans have regularly witnessed greater progress in terms of increasing contraceptive use and improving other reproductive health indicators, such as tetanus toxoid immunization and provision of iron and folic acid supplements for pregnant women.

As evidence of the significance of this decentralized approach, the Government of India has adopted district action planning as a key feature of the new National Rural Health Mission (2005–2012). Much like the district societies established under IFPS, district health missions will be charged with devising plans and strategies to address local health issues—not limited to family planning—but also including sanitation, nutrition, safe drinking water, and other issues.

The USAID-funded POLICY Project, which provided technical assistance to the IFPS district action plans, has produced a guide on district action planning to advise other states embarking on this process. It is hoped that the experiences from district action planning in Uttar Pradesh—as outlined here and in the guide—will provide valuable lessons as India strives to further decentralize health planning and programming across the country.

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# PREFACE

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The Health and Family Welfare programme in Uttar Pradesh, by and large, followed a centralized planning and management approach. Given the large population size, cultural diversity and considerable differences in development indicators between districts, centralized planning and management have yielded results that are not commensurate with resources spent and efforts made. Realizing this, and in order to address the local reproductive health and family planning needs of people, and provide quality services in an acceptable manner, SIFPSA, in collaboration with the POLICY Project funded by USAID, has deliberated on the issues, and reached the conclusion that decentralized programme planning and implementation are the keys to achieving specific objectives in a stipulated time period.

SIFPSA developed a set of elaborate processes to prepare decentralized district action plans for reproductive health, with particular emphasis on family planning. The preliminary steps involved collection of primary data with the help of population based surveys, focus group discussions, in-depth interviews and analysis of available secondary data. Following this, several consultative meetings were held with stakeholders drawn from the private sector, non-government organizations, elected representatives, and development departments, particularly those of women and child development, education and rural development. All this information was then shared in a workshop chaired by the District Magistrates of the respective districts. These workshops helped to identify intervention strategies, to prepare action plans and to evolve budget estimates for the district action plans.

To begin with, the district action plans were prepared for only a few districts. Thereafter, the experiences gained were rapidly transferred to the remaining districts where the IFPS project is in operation. Recognizing SIFPSA's strength in this area, Gol has funded a project to prepare district action plans covering five districts not within the purview of the IFPS Project area. In the country SIFPSA is, perhaps, a pioneer in undertaking the decentralized planning approach in the health sector, and has considerable experience not only in preparing plans but also in implementing them. SIFPSA has also helped the Health Systems Development Project in the preparation of block level plans in four districts.

I would like to take this opportunity to thank the staff in SIFPSA and Constella Futures who have painstakingly collected all the information, analyzed the strengths and challenges and documented all relevant experiences. This volume, I am sure, will be of immense help to those interested in decentralized approaches to social development.

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# ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CA	Cooperating Agency
CBD	Community-Based Distribution
CBFPT	Clinic-Based Family Planning Training
CHC	Community Health Centre
CMO	Chief Medical Officer
COPE	Client Oriented and Provider Efficient
CPR	Contraceptive Prevalence Rate
CSM	Contraceptive Social Marketing
CTU	Contraceptive Technology Update
DAP	District Action Plan
DHM	District Health Mission
DIFPSA	District Innovations in Family Planning Services Project Agency
DM	District Magistrate
EAG	Empowered Action Group
ED	Executive Director
FP	Family Planning
GoI	Government of India
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IFPS	Innovations in Family Planning Services
IIHMR	Indian Institute of Health Management Research
IPC	Interpersonal Communication
ISMP	Indigenous Systems of Medicine Practitioner
IUCD	Intra-Uterine Contraceptive Device

LHV	Lady Health Visitor
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Ratio
MO	Medical Officer
MoU	Memorandum of Understanding
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
NSV	No-Scalpel Vasectomy
PBDS	Performance-Based Disbursement System
PERFORM	Project Evaluation Review for Organizational Resource Management
PHC	Primary Health Centre
PIP	Project Implementation Plan
PM	Project Manager
PMU	Project Management Unit
QI	Quality Improvement
RCH	Reproductive and Child Health
RFWTC	Regional Family Welfare Training Centre
RH	Reproductive Health
RHIS	Reproductive Health Indicator Survey
RTI	Reproductive Tract Infection
SCOVA	Standing Committee of Voluntary Agencies
SIFPSA	State Innovations in Family Planning Services Project Agency
SIRD	State Institute for Rural Development
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
ToT	Training of Trainers
TT	Tetanus Toxoid
UP	Uttar Pradesh
USAID	United States Agency for International Development



# STUDY RATIONALE AND METHODOLOGY

The Futures Group/POLICY Project has reported numerous outcomes and results from the Innovations in Family Planning Services (IFPS) Project, conducted from 1994 to 2004 in Uttar Pradesh State. District action plans (DAPs) are considered to be one of the most critical and successful interventions of the project. As the second phase of the POLICY Project comes to an end, project managers sought to document the creation and implementation process of DAPs in order to record best practices and achievements in reproductive health in India. With the nationalization of DAPs under the Government of India's National Rural Health Mission, states in India can benefit from understanding the constraints and key success factors of these plans. Moreover, this study can provide insights to those around the world exploring decentralized health policy plans.

The POLICY Project India country office carried out this documentation with support from USAID. The following methodology was used to complete the study:

- Interviews with POLICY Project Staff: At the onset of

the study, in-depth discussions were held with senior staff of the POLICY Project, who were involved in the initial creation, design and implementation of district action plans.

These people include Dr. Gadde Narayana, Dr. K.M. Sathyanarayana and Mr. Ashok Singh, who were key players involved with DAPs since their inception and provided technical assistance to SIFPSA and USAID over the course of the project.

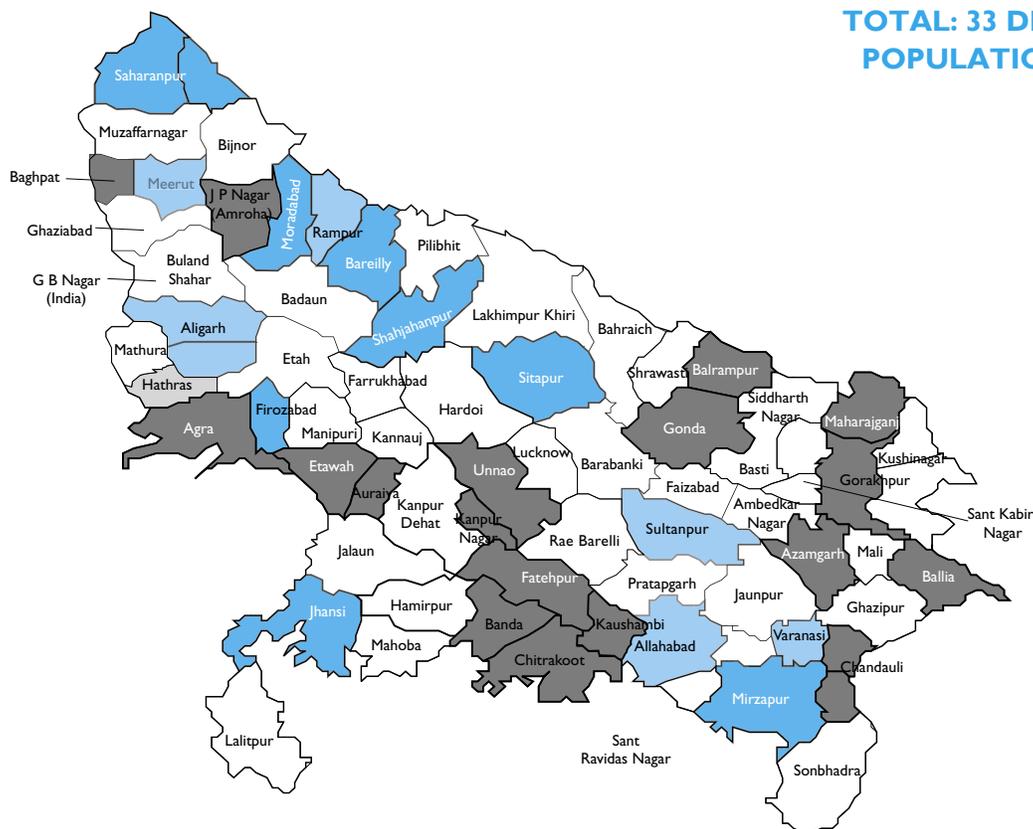
- Interviews with SIFPSA Headquarters Staff: Detailed interviews and discussions were conducted with senior staff of SIFPSA. Meetings were held with the managers and staff from the DAP Division, Private Sector, Public Sector, Training Cell and IEC Cell. SIFPSA research and data were shared with the POLICY Project to contribute to the report.
- Secondary Research Review: Data and research were collected from SIFPSA, POLICY Project, USAID and Project Management Units.

Various project documents, proposals, assessment studies, and performance reports were evaluated. Furthermore, Government of India documents and various internet resources were employed.

- Visits to Selected DAP Districts: A variety of DAP districts based on performance were selected for review. The districts visited include Varanasi (high-performing), Saharanpur (average-performing) and Fatehpur (low-performing). Meetings were held with the Project Management Unit and key stakeholders such as the District Magistrate, Chief Medical Officer (CMO), Deputy CMO, and NGO representatives. Furthermore, health facilities such as CHCs, PHCs and district hospitals were visited to analyze the impact of institutional strengthening and talk with medical superintendents and officers about the impact of DAPs.

**FIGURE I : MAP OF DISTRICTS WITH ACTION PLANS**

**TOTAL: 33 DISTRICTS  
POPULATION: 63.5M**



	<b>DISTRICT NAME</b>	<b>TOTAL POPULATION</b>	<b>VILLAGE SIZE</b>	<b>NO. OF VILLAGES</b>
1	Agra	2,052,727	2,273	903
2	Aligarh	2,127,592	1,803	1,180
3	Allahabad	3,729,320	1,331	2,802
4	Auraiya	1,011,026	1,303	776
5	Azamgarh	3,638,034	961	3,784
6	Baghpat	934,559	3,223	290
7	Ballia	2,491,676	1,362	1,830
8	Balrampur	1,546,770	1,548	999
9	Banda	1,293,316	1,896	682
10	Bareilly	2,427,139	1,301	1,865
11	Chandauli	1,469,693	1,036	1,419
12	Chitrakoot	689,665	1,265	545
13	Etawah	1,030,789	1,503	686
14	Fatehpur	2,070,634	1,530	1,353
15	Firozabad	1,430,405	1,799	795
16	Gonda	2,571,267	1,417	1,815
17	Gorakhpur	3,030,865	1,037	2,924
18	Hathras	1,071,551	1,633	656
19	Jhansi	1,033,171	1,352	764
20	Jyotiba Phule Nagar	1,130,881	1,203	940
21	Kanpur Nagar	1,370,488	1,508	909
22	Kaushambi	1,201,369	1,619	742
23	Maharajganj	2,063,278	1,715	1,203
24	Meerut	1,545,378	2,485	622
25	Mirzapur	1,829,536	1,035	1,767
26	Moradabad	2,647,292	1,698	1,559
27	Rampur	1,443,286	1,322	1,092
28	Saharanpur	2,149,291	1,700	1,264
29	Shahjahanpur	2,022,329	938	2,157
30	Sitapur	3,186,973	1,373	2,321
31	Sultanpur	3,062,574	1,226	2,499
32	Unnao	2,288,781	1,355	1,689
33	Varanasi	1,878,100	1,457	1,289
	<b>TOTAL</b>	<b>63,469,755</b>		<b>46,121</b>

Source: 2001 Census of Uttar Pradesh

# INTRODUCTION: CHALLENGES FACING UTTAR PRADESH AND THE IFPS PROJECT

## UP'S POPULATION AND RCH STATUS

Home to one-sixth of the country's people, Uttar Pradesh is India's most populous state with about 170 million residents. Only five countries in the world (including India) have larger populations than UP. About 80 percent of the state's population live in rural areas.

Each year UP adds approximately 3.8 million people to its population. By the year 2051, UP's population could reach 400 million (SIFPSA UP CD 2004). From 1981 to 1991, the state's population grew by 25 percent to 139 million, primarily due to high fertility.

UP is one of the poorest states in India. About 40 percent of its population live below the poverty line and the average annual per capita income is approximately Rs. 9,765 (US\$ 222) (Indian Business, 2002).

Reproductive and child health (RCH) indicators for UP are among the least favorable in India, characterized by high fertility, low contraceptive use, relatively few births delivered in a health facility or by a trained professional, and low immunization rates for children. Maternal and infant

death rates in UP are among the country's highest.

Prior to the inception of the IFPS project, the National Family Health Survey (NFHS-1) conducted in 1992/93 found that Uttar Pradesh had a total fertility rate (TFR) of 4.82—the highest in India—and 30 percent of married women wanted to delay future births by at least two years or have no more children, indicating a high unmet need for family planning (International Institute for Population Sciences, 1995).

Gender disparities are evident in the state. In 2001, the sex ratio for Uttar Pradesh was 898 females per 1,000 males, compared with a sex ratio of 933 for India as a whole. The female literacy rate in 2001 was 43 percent, yet for males the literacy rate was 70 percent (United Nations Development Programme). These challenges confront any program seeking to reach underserved populations, including women and rural populations, with improved RCH information and services.

In order to meet the need for RCH services and stabilize population growth, the Government of UP adopted a population policy with the objective of reaching replacement

level fertility of 2.1 births per woman by 2016 (Government of UP 2000). The policy implies an increase in modern contraceptive prevalence from 22 percent in 1998-1999 to 52 percent in 2016. Other policy objectives are: raising the average age at marriage, reducing the maternal and child mortality rates and developing region-specific strategies and service delivery systems.

## THE INNOVATIONS IN FAMILY PLANNING SERVICES (IFPS) PROJECT

Given the essential need for revitalizing and reorienting the family planning program in UP, the United States Agency for International Development (USAID) and the Government of India (GoI) agreed to sponsor a new bilateral project in 1992. The Innovations in Family Planning Services (IFPS) Project was a 12-year effort (1992–2004) initially focused on Uttar Pradesh but was extended to Uttaranchal and Jharkhand when these states were created in 2000. The primary goal of the project was to significantly reduce the total fertility rate and improve women's reproductive health in the state. The objectives of the project included:

- Improve quality of family planning and other reproductive

health services through a client-centered focus

- Increase access by strengthening public and private sector service delivery systems
- Increase demand through broadening support among leadership groups and increasing public knowledge of family planning.

The IFPS project was designed to be implemented and managed by a registered society with its headquarters in the state capital of Lucknow. Accordingly, the Government of Uttar Pradesh (GoUP) established the State Innovations in Family Planning Services Project Agency (SIFPSA) in 1993-1994. Assisted by a group of USAID-funded cooperating agencies (CAs), SIFPSA was to develop best practices and innovative models for improving the quality and availability of reproductive and child health services in UP. In implementing the IFPS Project, SIFPSA carried out innovative activities such as social marketing of contraceptives, establishing public-private partnerships, investing in capacity development and striving to improve the enabling environment for RCH. It is within this broad assistance framework that SIFPSA and USAID developed and tested the District Action Plan (DAP) methodology, and replicated it in 33 districts.

## **IFPS AND DISTRICT ACTION PLANS**

The IFPS Project start-up was lengthy. SIFPSA was not established

until 1993 and for the first several years, procedures and operational policies needed to be put in place, and staff recruited and trained before SIFPSA could receive, program, disburse and monitor funds. SIFPSA's initial activities were implemented by some of the established NGOs, government-supported networks such as cooperatives, and the government Department of Health. The result was that in the early years of the IFPS Project funds were programmed far and wide over the vast expanse of the state. Dispersing funds to individual programs without a focused, coordinated approach significantly reduced the chances that the objectives of the IFPS Project could be successfully achieved. Subprojects spread all over the state simply would not affect more than small groups of beneficiaries in handfuls of villages and towns. This approach would limit the potential for district-wide impacts – not to speak of state-wide impacts.

Recognizing that the IFPS project needed to focus its efforts and concentrate resources to achieve broad-based impacts, in 1995 USAID and SIFPSA designated 15 districts to be “focus districts.” These focus districts were to receive special attention and concentrated resources. In the next two years, SIFPSA and USAID emphasized these districts in programming activities and technical assistance. However, project design and coordination of activities were difficult. Because the activities

had been initiated with little if any consultation with district-level officials and NGOs, local commitment to implement the activities was weak. As a result, RCH performance barely improved.

At this time the Futures Group/ POLICY Project, a USAID-funded Cooperating Agency, was providing technical assistance to SIFPSA. The Country Director of POLICY Project began a dialogue with SIFPSA and USAID on the feasibility of designing and implementing District Action Plans (DAPs) as a means of enlisting the full commitment of district leaders in the RCH effort, mobilizing local resources in a coordinated manner and developing specific roles and timetables for the various partners including government health facilities, NGOs, religious groups, employers and cooperatives, private practitioners, as well as the district and village leadership. The DAP approach was piloted in 1997 and then extended to six districts in 1998. By the end of the IFPS project in 2004, the DAP approach had reached nearly 63.5 million people across the 33 IFPS funded districts of UP (see Figure 1). According to many stakeholders, the DAP methodology and its successful implementation were important for achieving the main objectives of the IFPS project.

# DECENTRALIZED PLANNING AND AN OVERVIEW OF DISTRICT ACTION PLANS

### WHY DECENTRALIZED PLANNING?

The Government of Uttar Pradesh has managed a highly centralized health and family welfare program for decades. Beginning in the 1970s, the Gol and GoUP started to expand the health infrastructure in terms of number of facilities and health personnel. Health programs became more complex and there was an attempt to emphasize quality and informed choice for patients. At the time, the state administration had 83 district units to oversee and was not able to effectively respond to the challenges imposed by expansion. Because of its large size and diversity, the state's local needs varied from region to region thus adding to the challenges of expanding the program. The Gol's family welfare program consisted of a uniform approach emphasizing sterilization and was not adapted to meet any particular state's family welfare needs—much less particular district needs. By the early 1990s, the family welfare program in Uttar Pradesh reached only a portion of the population, was poorly managed, and government and private services alike were fragmented and largely ineffective. The 1992/3 National Family Health

Survey found that Uttar Pradesh's modern contraceptive prevalence rate was one of the lowest in India at 19.8 percent of married women (IIPS, 1995).

In 1995, USAID commissioned the Project Evaluation Review for Organizational Resource Management (PERFORM) survey to measure performance indicators in the original 28 IFPS districts of Uttar Pradesh (which, due to bifurcation, now comprise 33 IFPS districts in Uttar Pradesh and six former IFPS districts in Uttaranchal). The main objectives of the PERFORM survey was to identify needs and measure improvements in access to, quality of, and demand for family planning/reproductive health (FP/RH) services. This survey allowed project managers at SIFPSA and USAID to better understand the differences across districts and to think about developing specialized approaches depending on local characteristics and needs. Further dialogue and planning exercises revealed that SIFPSA and its partners could improve project performance by focusing resources and programs at the district level.

At the same time, major changes in the district government created

a favorable environment for decentralization. In 1992, the 73rd Amendment to the Constitution of India mandated the election of panchayati raj institutions (village-level local bodies) and envisaged the role of the pradhan (elected village head) as promoting development activities, particularly public health and family welfare. Shortly thereafter, the GoUP shifted the authority for male health workers and frontline supervisors from the health department to the panchayati raj (it should be noted that this was recently reverted back). The state budget also sets aside approximately 4 percent of revenue to be devolved to panchayats. Decentralization was to be a priority for the implementation of all development programs.

Additional reasons for and benefits of decentralized health planning include:

- It can meet specific needs of local constituencies more effectively
- Flow of funds for implementing activities occurs faster
- Management capacity and efficient decision-making process are fostered at the local level
- Local resources are used more effectively through involvement

of local stakeholders

- It increases the accountability of the health program to the local community.

## FORMULATION OF DISTRICT ACTION PLANS

In 1997, the POLICY Project began discussing the creation of DAPs with USAID and SIFPSA. It was envisaged that the action plans would address community-specific FP/RH issues and concerns using locally feasible solutions. The plans would be created through a participatory approach evolved from the collective thinking of local medical officers, NGOs, employers, private practitioners, and government officials. Technical assistance would be provided by SIFPSA, USAID, and other cooperating agencies. The goals of DAPs included: (1) improving local ownership; (2) increasing accountability; (3) using resources efficiently; and (4) improving overall performance of the RCH program.

The IFPS partners agreed to carry out a pilot DAP in Rampur District in 1997. The result was a full-fledged District Action Plan that brought together all local providers of basic health, local NGOs, and other related government departments. The DAP was comprehensive and founded on a performance-based model for achieving the desired improvements in basic family welfare. The pilot was a success, and the DAP model was adopted by SIFPSA and USAID as a promising and feasible approach to maximizing the impact of the IFPS-funded activities in project areas.

In March 1998, SIFPSA decided to roll out the DAP model to five additional districts and to continue to support the implementation of the DAP in Rampur. The six initial districts, with a population of 15 million people, were Allahabad, Aligarh, Meerut, Rampur, Sultanpur, and Varanasi.

These DAPs were the first time in the history of the public healthcare system in India that a participatory approach involving all stakeholders was used for the planning and monitoring RCH programs at the district level. Within the initial six districts, the main focus and efforts of DAPs included:

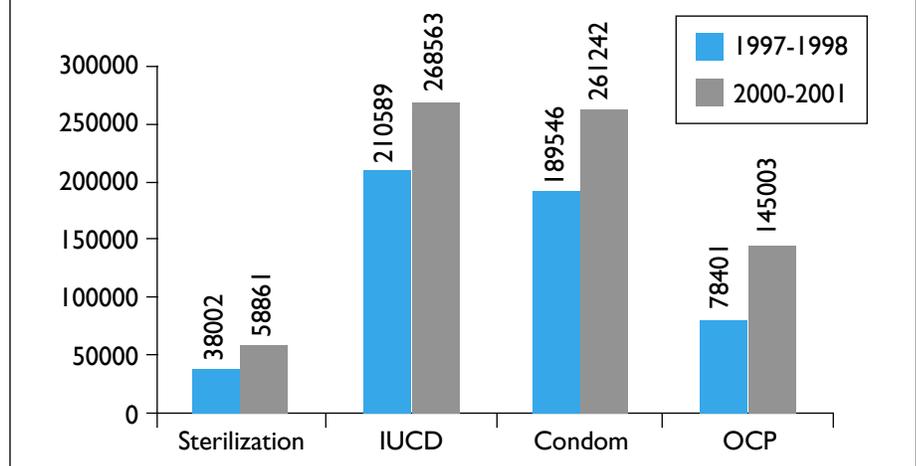
- Satisfying the unmet need for family planning and increasing the CPR
- Promoting of spacing methods
- Increasing coverage of tetanus toxoid (TT) immunization and iron and folic acid (IFA) supplements for pregnant women
- Improving the overall quality of RCH services.

At the completion of the first year of DAP implementation, the POLICY Project conducted an assessment of the effort. This assessment concluded that many new activities had been started and that, in most cases, outputs such as number of people trained and RCH camps held exceeded original expectations. In the six DAP districts, use of modern contraceptives—including condoms, oral pills, sterilization and intrauterine contraceptive devices (IUCDs)—increased (see Figure 2) (POLICY Project, 1999).

Building on this first phase of DAP implementation, SIFPSA launched DAPs in nine additional districts in 2001. In 2002, SIFPSA added the 18 remaining IFPS districts under the third phase of the program.

Expansion of DAPs to non-IFPS districts began in 2004. Based on the model developed under IFPS, DAPs were formulated in an additional seven districts under the Gol's Empowered Action

FIGURE 2: NUMBER OF CONTRACEPTIVE CLIENTS IN 1st PHASE OF DAPS



Source: Making Things Happen

Group scheme. These are known as the Decentralized Participatory Planning (DPP) districts. The planning activities in these districts were funded by the GoI and received technical assistance from

SIFPSA. Therefore, there are 40 districts with RCH-related action plans in Uttar Pradesh in total, of which 33 DAPs were funded through the IFPS project.

Throughout these phases, DAP programs have evolved and become a central strategy for achieving the objectives of the IFPS project.

## Section - 3

# DAP PLANNING PROCESS AND FORMULATION

### STEP 1 - BASELINE AND FACILITY SURVEY

The first step in the district action plan process (see Figure 3) was collecting reliable district-level data on current RCH behavior and resources. Such data provide essential information on where gaps lie and where solutions were needed. As a first step in the DAP timeline, baseline surveys were conducted in the district.

For the first 15 DAP districts, the POLICY Project subcontracted and trained local research groups to conduct baseline surveys. Prior to the survey, POLICY conducted a house-mapping and sampling exercise of districts towns and villages. Typically, the research groups used teams of 25 people to conduct the surveys: five teams comprised of four investigators and one supervisor. Approximately 20 households per village were visited, for a total of about 1,000 homes per district. On average, it took a minimum of 20 days to conduct training and 10 days to administer the baseline survey.

The health areas evaluated in baseline surveys include:

- Maternal health
- Childbirth deliveries
- Maternal mortality
- Breastfeeding
- Immunization of children
- Diarrhea
- Newborn healthcare
- Acute respiratory infections
- Fertility
- Awareness and use of family planning
- Abortions (medical termination of pregnancy)
- RTI/STI services.
- Streamlined logistics systems
- Review of facility budget allocations
- Role of NGOs in social mobilization and community involvement
- Private health infrastructure availability.

### STEP 2 - ANALYSIS OF SURVEY DATA AND DISTRICT INFORMATION

Using both the Integrated System for Survey Analysis (ISSA) and Statistical Package for Social Sciences (SPSS) software, the POLICY Project staff conducted statistical analysis of the household survey data. POLICY staff also analyzed the information collected by the district officials to provide a “situational analysis” of the local infrastructure and resources available. These two reports were presented in formats that were easily understandable to non-specialists and could be used by the participants in the subsequent workshops.

### STEP 3 - DAP WORKSHOP

After the data were collected and analyzed, POLICY Project staff created PowerPoint presentations summarizing the findings of the baseline and facility surveys and

In addition, the district Chief Medical Officer, panchayats, development officers and medical officers collected information and data on: numbers and locations of health facilities; numbers and location of medical and health personnel; condition of infrastructure, including availability of electricity, clean water, and medical equipment; numbers and types of private health providers; and all local NGOs that could contribute to the district RCH program. Specifically, DAP institutional and facility surveys evaluated the following areas:

- Geographic background of district
- Identification of gaps in human resources
- Government buildings that may need repair
- Equipment supply

the situational analysis. Next, a three-day DAP workshop was organized at district headquarters that was typically attended by 30 to 40 people, including the CMO, Chief Development Officer, District Magistrate, industry representatives, social workers, members of NGOs, auxiliary nurse midwives (ANMs), medical officers and private practitioners. Representatives of USAID-funded CAs that had programs in the district or were asked by SIFPSA to assist also participated in the DAP workshops.

During the workshops, staff from SIFPSA and the CMO delivered the presentations on the baseline surveys to inform local participants about the RCH status of the district. Next, the participants were divided into teams for group discussions. Each team discussed one topic, such as maternal health, child health, family planning and institutional strengthening. During these break-out sessions, the participants identified challenges, strategies and reasonable objectives for these health areas. On the last day of the workshop, the groups presented their suggested strategies and objectives to the rest of the participants. This process allowed the workshop participants to provide feedback and agree to goals and strategies for the interventions. The DAP document was then created based on the consensus of the workshops. Thus, the DAPs were framed in a participatory manner and were based on informed decision-making from key local players.

#### **STEP 4 - SELECTION OF OBJECTIVES AND STRATEGIES**

While the strategies were proposed, debated, and adopted during the DAP workshops, the POLICY Project staff used an analytic and simulation software package called SPECTRUM to create and confirm objectives to be agreed upon for the action plans. SPECTRUM allowed the users and participants to assess the feasibility of achieving specific RCH objectives and comprehend the magnitude of the task in terms of numbers of people to be reached by each intervention. The strategies in the action plan were then adjusted by the participants depending on the results of the feasibility analyses.

#### **STEP 5 - DAP DOCUMENT CREATED**

After the DAP workshop, advisors from the POLICY Project wrote a detailed report that contained the following information:

- Overview of baseline survey and situational analysis
- Demographic district profile
- Information on cultural or geographical considerations of the district
- Summary of consultative meetings and workshop proceedings
- Proposed strategies and suggestions on improving RCH in the district
- Specific objectives and strategies for maternal health, child health, fertility and family planning
- Resource, training, and facility renovation requirements.

Some reports also included adolescent health and innovative RCH strategies. The DAP report was shared with USAID, district officials and other CAs for additional feedback and suggestions.

#### **STEP 6 - APPROVAL BY SIFPSA PROJECT APPRAISAL COMMITTEE**

In the IFPS Project institutional arrangements, activities undertaken by SIFPSA were approved by a Project Appraisal Committee (PAC). DAP reports and budgets were reviewed and approved by the PAC. Members of the PAC, which typically meets once every three months, are the Chairman (Principal Secretary Family Welfare), Executive Director of SIFPSA, various general managers from SIFPSA, and representatives from USAID, POLICY Project, and Government of India.

#### **STEP 7 - CREATION OF DIFPSA AND PMU**

As a next step, SIFPSA and the district government created District Innovations in Family Planning Services Project Agencies (DIFPSAs). SIFPSA also established in each DAP district a Project Management Unit (PMU) that was charged with representing SIFPSA in providing technical and management assistance to the DIFPSA and the implementation of the DAP. Both these groups served as the local bodies that implemented and monitored the DAP. SIFPSA hired staff for the PMU from the open market on fixed-term contracts.

## STEP 8 - CREATION OF MONTHLY OPERATIONAL PLANS

In each district, operational plans were created with a set of activities to be completed in a specific timeframe. These formed the basis for monitoring and review both by DIFPSA and SIFPSA and provided a roadmap for achievement of objectives. Typically, the POLICY Project provided technical assistance for creating operational plans.

## STEP 9 - DAP LAUNCH

Once the DAP report was approved and staffing of the DIFPSA and PMU was underway, the district action plan was launched. There was typically a consultation meeting with district officers, USAID, POLICY Project, other CAs and SIFPSA in confirming and launching the action plan.

## STEP 10 - DAP IMPLEMENTATION BEGINS

Finally, district action plan implementation began. The DIFPSA and PMU began their work in implementing strategies. CAs such as CEDPA, EngenderHealth, Johns Hopkins University, and INTRAH/PRIME also provided technical assistance to the DAPs in clinical training, IEC and partnering with NGOs. On average, the DAP launch period took approximately three to four months.

## FUNDING FLOW MECHANISMS

**Logistical funding to DAP districts:** As soon as the DAP

is approved and the formal Memorandum of Understanding is signed between SIFPSA and the District Innovations in Family Planning Services Project Agency (DIFPSA), a two-year DAP budget is transferred to the respective DIFPSA account. This gives the DIFPSA full financial control in implementing the activities. The SIFPSA General Manager for DAPs estimates that the cost for one action plan across three years is 30 million Rupees (US\$681,818). All DAP budgets have a provision for “untied funds” to be utilized for local innovations. Also, additional funds can be requested from SIFPSA for special projects.

There are different levels of checks and balances created by SIFPSA to ensure there is no misuse of funds. For example, for state level RCH interventions that are centrally funded, the CMO gets money directly from SIFPSA and can use the money only as per guidelines issued for the account. There is a separate account strictly for state level interventions maintained by the CMO. For DIFPSA expenditures, there is a separate account that requires the following signatures:

- Checks below Rs. 10,000: CMO and Deputy CMO nodal officer SIFPSA sign jointly
- Checks below 1 lakh (less than Rs. 100,000): CMO and PM sign jointly
- Checks above 1 lakh (above Rs. 100,000): DM and PM sign jointly.

Furthermore, for a smooth functioning PMU at the district level, the project manager and the accounts manager maintain a separate account and sign jointly for all expenses incurred by the PMU.

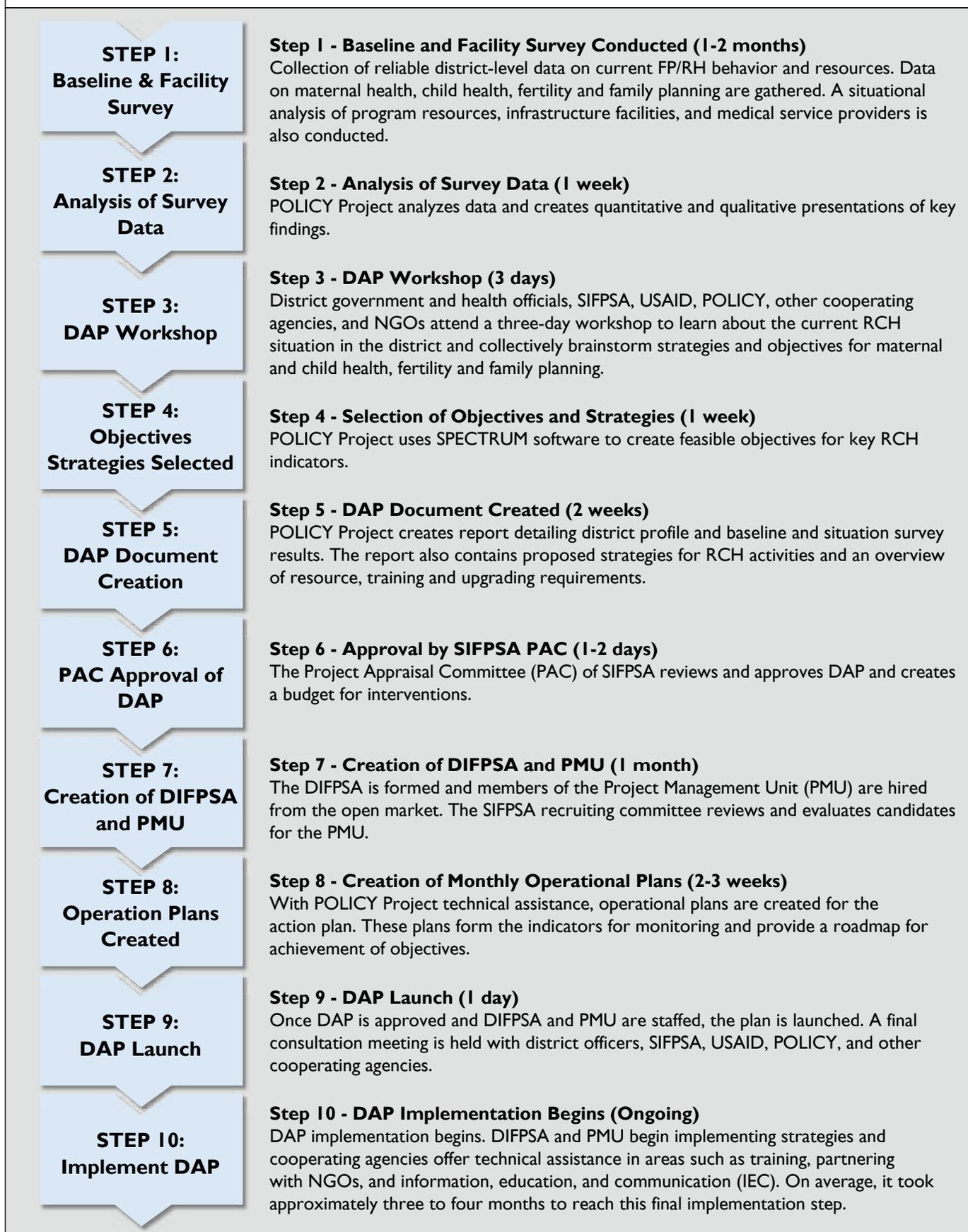
## DAP funding mechanism: Performance-based disbursement system.

The funding system for DAPs followed the performance-based disbursement system. This system is based on a set of benchmarks or indicators that are negotiated between USAID and SIFPSA. They also jointly decide the estimated financial resources required to achieve the performance indicators in each benchmark. Based on SIFPSA’s performance against the indicators, the payout amount is determined.

The disbursement of money from USAID first goes to the Gol and subsequently to SIFPSA. If the DAP districts achieve the expected level of performance, the stipulated funds are released; if they do not meet the benchmarks, the funds are not disbursed. For example, a district may have had a goal to increase CPR by 10 percent within five years. At the completion of the time period if the district had met or exceeded 10 percent, SIFPSA would receive the money. However, if the CPR increased by only 7.5 percent, SIFPSA would not receive any money from USAID.

The evaluation of achievement of benchmarks was done by external parties (not USAID or SIFPSA). Independent external research agencies measure and evaluate the performance of the districts. The POLICY Project, ORG Center for Social Research, the Indian Institute of Health Management Research, and Macro International have served as evaluators of benchmark performance.

**FIGURE 3: DAP PROCESS TIMELINE**



# DAP IMPLEMENTATION AND KEY PLAYERS

## DAP IMPLEMENTATION

The DAP system is based on two principles:

- **Decentralization:** to provide flexibility and allow decisions to be made based on local needs
- **Integration:** to identify and use all resources available in the district through public and private partnerships.

To achieve the main objectives of DAPs, five key strategies are used:

1. **Create a conducive environment** by garnering the support of religious leaders and village heads through meetings and training programs
2. **Improve quality of services** through training for all types of healthcare providers and upgrade service delivery facilities
3. **Generate demand through information, education, and communication** (IEC) campaigns, including interpersonal counseling and folk media
4. **Improve access to integrated services** through RCH camps that provide an array of services
5. **Involve the non-governmental sector** to assist in project implementation.

## IMPLEMENTING PARTNERS

### DIFPSA—Leadership at the Local Level

District Innovations in Family Planning Project Agencies (DIFPSAs) are district organizations that were set up to manage health and family planning programs at the district level. They consist of local stakeholders who are responsible for implementing DAPs. The DIFPSA has full authority to:

- Implement and examine IFPS-funded activities
- Monitor partial funding and implementation of the DAP activities as per local needs
- Make decisions related to DAP project implementation
- Review activities and make mid-course corrections.

Throughout the DAP process, the DIFPSA provides leadership and guidance to address problems that may arise. In monitoring the progress of the DAP, there is frequent dialogue between the DIFPSA, PMU and CMO.

### Project Management Unit

Because the DIFPSA has no staff to implement the DAP, the Project Management Unit (PMU) was created as the implementing agency. Described as ‘the hub of

all activities’ (POLICY Project, 1999, p. 13), PMUs serve as catalysts in implementing DAP interventions, mobilizing NGOs and pushing agendas forward. Their responsibilities include:

### Coordination and Liaison

- Provide monitoring and technical support to DIFPSA
- Serve as a critical link between SIFPSA and DIFPSA
- Serve as liaison between the District Magistrate and chief medical officer (CMO)
- Forge public-private partnerships.

### Problem-solving

- Solve local issues with tailored solutions
- Bring management capacity to the local level
- Address systemic problems.

### DIFPSA Secretariat

- Ensure smooth flow of funds to implementing partners
- Maintain DAP accounts based on SIFPSA requirements.

### Monitoring and Supervision

- Play a vital role in training programs of medical officers, pradhans, religious leaders and folk performers
- Monitor RCH camps
- Submit monthly and quarterly reports on progress of DAP.

### Technical Assistance

- Conduct daily interaction with local NGOs and private sector implementing agencies
- Ensure logistical management at district and block levels (SIFPSA, 2002).

The broad scope of responsibilities given to the PMU along with the easy flow of funds through the system gives the PMU great flexibility and the ability to implement decisions quickly.

During the IFPS project, the annual cost of operating PMUs was about Rs.10 lakh (US\$225,000); these funds supported staff salaries (see Figure 4), office expenses and program activities. Many stakeholders interviewed in this study stressed that the PMUs represent the most effective aspect of DAPs and thus are a sound investment. Looking to the future, a senior SIFPSA manager recommended that PMU staff receive more management and capacity building training in order to help them become more comfortable and independent in making decisions at the local level. The general orientation for PMU staff at SIFPSA headquarters should be supplemented by more training on problem-solving, interpersonal communication, working with government officials, leadership, and teamwork. A district-level manager stated that PMU staff could benefit from training on monitoring and evaluation, MIS reporting software and counseling.

PMU staff are recruited from the open market and, thus, bring private sector experience to

the role. Project managers are well-qualified, and many possess Master of Business Administration degrees. The staffing structure is performance-based and poor performing staff members can be removed quickly.

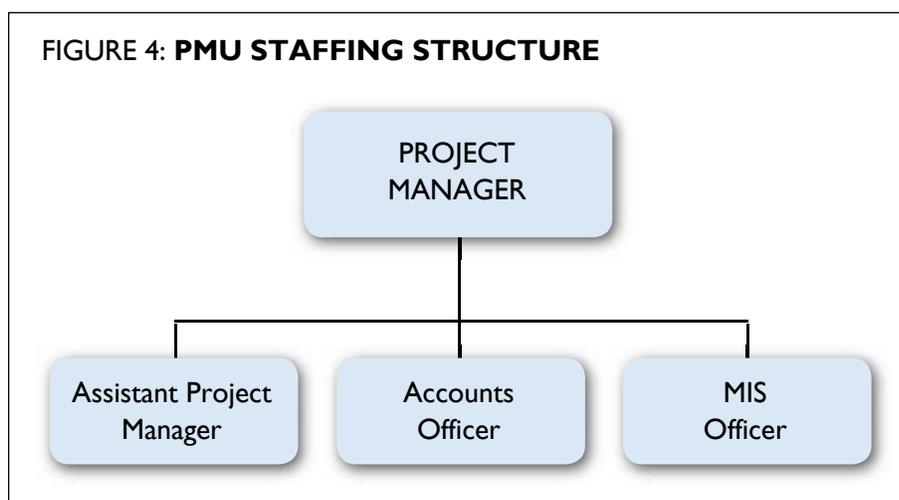
### THE POLICY PROJECT

The POLICY Project provided technical assistance to the DAPs to:

- Conduct baseline surveys and compile data
- Help organize and facilitate DAP formulation workshops
- Develop the DAP proposal document based on recommended strategies
- Develop operational plans for individual DAP interventions
- Help organize DAP launch workshops in the districts
- Participate in recruitment selection committee for PMUs
- Provide ongoing consultation for challenges, bottlenecks, and other issues
- Train SIFPSA staff on DAP creation process and transfer any required technical skills.

For the first 15 districts, POLICY Project staff provided significant technical assistance in the DAP conceptualization, design and implementation programs. POLICY staff also helped districts and SIFPSA manage the baseline surveys, analyze the data, carry out the DAP workshops, and write up the plans and implementation programs. By the third phase of DAP rollout, POLICY staff began to shift the responsibility of plan development to SIFPSA. To manage the DAPs from its headquarters in Lucknow, SIFPSA created a DAP management unit that supported the existing DAPs and oversaw the creation of new DAPs. By 2004, SIFPSA was adept at managing the entire DAP process and operated with minimal assistance. This transfer of capacity to develop and manage DAPs from POLICY staff to SIFPSA staff is one of the notable successes of the IFPS Project.

FIGURE 4: PMU STAFFING STRUCTURE



## Section - 5

# PUBLIC SECTOR INTERVENTIONS: INSTITUTIONAL AND MANPOWER STRENGTHENING

The ideas behind many interventions under the IFPS Project originated at the state level, drawn from previous program experiences in Uttar Pradesh and other states or from innovative strategic planning among the various IFPS partners, including SIFPSA, USAID and the cooperating agencies. These interventions were implemented throughout all IFPS districts. In districts with DAPs, the PMU and other local implementing agencies played a major role in strengthening these centrally-driven interventions and adapting them to local conditions. DAP leaders and stakeholders made a special effort to ensure that the necessary supporting elements were in place to keep interventions on track. Thus, the presence of PMUs in each district facilitated the implementation, monitoring, and evaluation of the centrally-driven interventions.

DAPs also generated innovative activities that were created as a result of brainstorming and partnerships with local stakeholders. These activities were typically limited to specific districts, although many of them were replicated in other districts after initial testing.

The following sections highlight the added value of DAPs, both

in strengthening centrally-driven interventions and in developing new approaches.

### SUPPORT TO PUBLIC SECTOR RCH SERVICES

The IFPS Project made a concerted effort to strengthen public sector RCH services in the 38 IFPS-cum-government funded project districts. These activities and the contributions of DIFPSAs and PMUs to their outcomes are summarized in this section.

#### Upgrading of Clinical Facilities

Throughout its duration, the IFPS Project upgraded hundreds of public health facilities in IFPS and non-IFPS districts. This process began in 1994 prior to initiation of the first DAP in 1997. Nevertheless, DAPs played an important role in the upgrading process. Every DAP contains interventions to upgrade public health facilities, including renovation of buildings, installation of electricity and clean water supply, and provision of new equipment and supplies. The facilities that consistently need the most maintenance are district postpartum centers (PPCs), community health centers (CHCs), and block primary health centers (PHCs).

From 1997 to 2005, the IFPS project assessed and strengthened 613 district postpartum centers, community health centers and primary health centers in 50 districts of UP. In addition, 9,302 subcenters in 35 districts of UP were strengthened.

The teamwork entailed in the upgrading process is exemplified in the following steps:

1. **Assessment:** A cooperating agency conducts assessments of each health facility to determine specific needs of the site.
2. **SIFPSA Standards:** SIFPSA provides standards and guidelines for assessments and estimates.
3. **Cost Assessment:** Civil engineers of the Department of Health and Family Welfare visit facilities to prepare cost estimates.
4. **Technical Sanction:** SIFPSA requests technical sanction from the Director General of Health Services.
5. **DIFPSA Implementation:** Once the plan and budget are approved, SIFPSA gives authority to the DIFPSA to begin facilities upgrading work (see Figure 5).

The DIFPSA follows GoI standards for selecting contractors for the

upgrading work, and CMOs follow GoUP guidelines to procure equipment and other supplies. The District Magistrate, CMO and PMU all work closely together to monitor the maintenance work. In addition, medical officers at the health facilities are heavily involved. Given the high level of teamwork and transparency, the work is of high quality and completed within a reasonable amount of time.

The IFPS project also supported an institutional strengthening initiative to provide basic facilities and equipment to village health subcenters, which are the most basic health facility available to the community. Typically, auxiliary nurse midwives (ANMs) work out of village subcenters. Roughly 70 percent of subcenters consist of

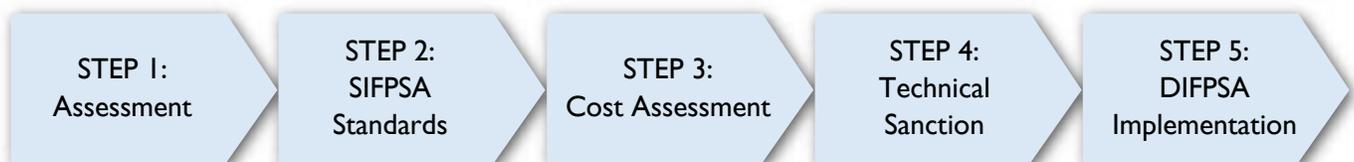
one or two rooms lacking basic amenities. About one-third of the subcenters are in government facilities, while two-thirds are in rented premises. To improve conditions, the IFPS project raised the allowance for facilities rental from Rs. 50 per month to Rs. 350 (US\$8) to ensure that the minimum specifications of the room are being met. The IFPS project also provided a stipend of Rs. 600 (US\$14) per year to ANMs to ensure all infection prevention supplies were available such as bleaching powder, soap, detergent, kerosene, batteries, and gloves.

### Capacity Building and Manpower Strengthening

One of the greatest challenges in providing RH services to rural areas is the lack of medical officers.

For example, the CHC in Bindaki, Fatehpur has openings for seven medical officers, but there are currently only three medical officers on the staff. Many doctors choose to enter into private practice because it is more lucrative and they can operate from cities. Doctors employed by the government do not want to reside in rural villages of UP because they lack good living facilities and good educational facilities for their children. Accordingly, the medical officers in rural areas typically do not live in the villages where the PHCs or CHCs are located, but rather in the larger towns of the state, often forcing them to commute considerable distances to their jobs. Another challenge is the frequent transfer of medical officers, which contributes to vacant posts. Transfers also hinder

FIGURE 5: FACILITIES RENOVATION PROCESS UNDER DAPS



### CASE STUDY: CHIRAIGAON PHC

Staff at the Chiraigaon primary health center in Varanasi report major improvements in resources and infrastructure as a result of IFPS upgrading, which included:

- Repairs and provision of new equipment to create a fully functional operating room
- Purchase of a water tank and generator
- Creation of a labor/delivery room
- Installation of electrical wiring and lighting in all rooms
- Painting and washing of all walls
- Steady medicine supply from SIFPSA
- Hiring of a lady medical officer

Approximately 250,000 people live in the area served by the PHC. The PHC staff report that the daily patient load has grown; they attribute this increased demand to the infrastructure improvements.

efforts to improve the quality of services because medical officers are not necessarily moved to new positions where they can use the technical skills imparted during specialized training.

The IFPS project sought to address the shortage of medical officers through several initiatives: (1) providing technical training to medical providers; (2) hiring private sector doctors; and (3) organizing medical teams to offer RCH services at camps (held at a designated facility on a specific day). These initiatives were implemented at the district level and thus relied heavily on the support of district workers, especially the Chief Medical Officers (CMOs) and DIFPSA and PMU staff. DIFPSAs disseminated information about training opportunities, and PMUs worked closely with CMOs and other officials to identify candidates for training, issue reminders regarding the timing and location of training sessions, and facilitate provision of travel funding. PMUs also provided feedback on training needs relevant to local conditions. PMUs identified the need to train auxiliary nurse midwives (ANMs) in IUCD counseling and insertion and worked with SIFPSA and the training agencies to implement the training sessions and follow-up assessment visits.

### **Improving the Clinical and Counseling Skills of Health Service Providers**

A key intervention across district action plans has been to enhance the technical competency of health service providers. Medical doctors, traditional birth attendants (TBAs), and indigenous systems of medicine

practitioners (ISMPs) all play pivotal roles in providing health care in UP. SIFPSA staff developed an extensive program to conduct up-to-date training and refresher courses for health providers covering safe sterilization procedures, management of complications and FP counseling skills. SIFPSA also created an infection prevention training program for all staff members at CHCs, PHCs and district hospitals. The two-day on-site training is hands-on and teaches infection prevention practices and how to prevent faulty procedures.

### **Technical Training for Medical Officers**

The training medical officers receive through DAP interventions mostly covers various sterilization procedures and the management of post-operative complications. EngenderHealth was the CA leading the design, management, and implementation of the technical training. Below is a summary of these training activities:

- **Laparoscopy:** Laparoscopy is the predominant method of tubectomy in many areas of UP, reflecting provider preferences as well as clients' perceptions based on word of mouth. SIFPSA created a two day refresher course for practicing laparoscopists and a 12-day course for new surgeons. Both courses covered surgical procedure, post operative recovery, anesthesia, and management of complications.
- **Minilap under local anesthesia:** Minilaparotomy is popular in some regions of UP, based on previous patterns of provider availability. This procedure is ideal for rural UP

because it can be conducted nearly anytime when a woman is not pregnant and requires minimal equipment. SIFPSA provided a six day course that covered skills on conducting the mini-lap procedure, post-operative care, management of pain and complications, follow-up, infection prevention and quality assurance.

- **Abdominal tubectomy:** Abdominal tubectomy is a modified version of conventional tubectomy with a smaller incision, same-day discharge of client, and improved local anesthesia infiltration technique. It is a simple technique well suited to low-resource settings, does not require costly instruments, and can be easily learned by providers with minimal surgical training. SIFPSA provided three-day courses for practicing laparoscopists and 12-day courses for induction training. The courses covered surgical skills, post operative recovery and management of complications.
- **No-scalpel vasectomy:** Because male sterilization is a simpler and safer procedure than female sterilization, the IFPS project sought to make no-scalpel vasectomy (NSV) more widely available in UP. The IFPS project trained at least one medical officer in each IFPS district in NSV. The three-day training program for service providers covered NSV techniques, counseling, infection prevention, and management of complications.
- **RTIs/STIs:** In 2000 SIFPSA introduced a six-day training

course for medical officers on the prevention and management of reproductive tract and sexually transmitted infections. The training teams consist of a lady medical officer, a pathologist and a skin specialist. The first three days of training focus on clinical training while the last three focus on skill development. SIFPSA also provided a one-day course for laboratory technicians on laboratory diagnosis of RTIs/STIs.

- **Contraceptive Technology Update (CTU) and IUCD:** SIFPSA provided a three-day course for medical officers to update their technical knowledge and contraceptive service provision practices, with a focus on counseling and providing patients with informed choices about family planning and RH. Female medical officers received an additional two days of training for IUCD insertion.

### **Management Development Program for Medical Officers**

In addition to clinical skills training, the IFPS project trained medical officers in the management of health services. As a part of DAP interventions, SIFPSA created a three-day management development program with the Indian Institute of Health Management Research (IIHMR) in Jaipur. IIHMR conducted an assessment of training needs and identified that medical officers needed help with managerial leadership and management of PHC/CHC/district hospital and RCH services, human resources and support systems.

The training had two objectives:

1. To improve the capacity and skills of medical officers for planning and management of health care systems and for the delivery of national and state-sponsored health programs
2. To develop a mechanism for problem identification and implementing solutions.

The training, which was held at district headquarters, focused on health and RCH services. Other topics covered in the training include managerial styles, team building, motivating for action, building partnerships and interpersonal communication. The interactive format included lectures, group exercises and individual and group presentations. During the IFPS project, a total of 1,185 medical officers in 13 DAP districts received management development training.

### **ANMs and Clinic-Based Family Planning Training**

Recognizing that auxiliary nurse midwives are typically the first-level of female health care in rural areas, there is a need to ensure they have proper training, especially in IUCD insertion due to high rates of infection and expulsion. SIFPSA and EngenderHealth created Clinic-Based Family Planning Training (CBFPT), a six-day training program, which covered the following components:

- Understanding temporary and permanent contraception
- Managing and referral for RTIs/STIs
- Developing counseling and clinical skills
- Changing providers' attitudes toward their clients.

Master trainers for the program were typically a female medical officer and a public health nurse in each district. ANMs were trained in small, interactive groups of four. The program had hands-on training in IUCD insertion, using the ZOE® pelvic model for demonstration and practice; trainees were also required to successfully perform the procedure on two clients. At the completion of training, the ANMs received IUCD kits and other supplies.

Under the CBFPT program, 10,854 auxiliary nurse midwives and lady health visitors were trained in clinical skills. Staff from the Regional Family Welfare Training Centre (RFWTC) visited the ANMs to determine whether they were performing to quality standards. Of the 9,550 trainees assessed one month after training, 88 percent were performing to standards. This proportion rose to 92 percent at the follow-up assessment six months after training.

In addition, 6,401 ANMs received a four-day counseling training course to improve their client screening and discussion skills. Many ANMs reported this training has helped to change their attitude towards patients because they better understand the client's needs and which services to offer to accord with the client's choice and preference.

### **Hiring Private Sector Medical Doctors**

SIFPSA hired private sector medical officers to fill vacancies in medical officer posts or to make a fixed number of visits to primary and

community health centers. For example, in some districts private lady doctors were hired to provide consultation and services at block PHCs and CHCs once or twice a week. In several districts SIFPSA carried out assessments of the number of medical officers needed to provide quality RCH services. Based on the gaps identified, doctors were hired on contract for a fixed number of visits per month to PHCs and CHCs. PMUs coordinated these placements with CMOs and other local officials and assisted the private sector medical officers when necessary.

### Coordinating and Staffing RCH Camps

#### RCH Camps—A One-Stop Shop for RCH Services

Pariwar Swasthya Sewa Diwas (Family Health Service Days), more commonly referred to as 'RCH Camps,' were one of SIFPSA's most effective and widespread vehicles for implementing DAP interventions. Because rural areas suffer from a shortage of doctors and villagers have limited access to public health facilities, RCH camps offer people a good option for obtaining free services. RCH camps were publicized and organized by the block-level primary or community health center with predetermined dates and locations at which the public can receive an array of RCH services, including:

- Sterilization
- IUCD insertion
- Family planning counseling
- ANC check-ups, including tetanus toxoid immunization and iron folic acid tablets
- Immunization for children
- RTI/STI check-ups.

Figure 6 shows the various RCH services obtained from RCH camp clients during 2003.

The advantage of RCH camps is that clients can be sure of receiving a broad array of clinical services on the designated date. At other times, medical staff may be absent or the necessary supplies may not be available. Another benefit of the camps is that they allow for follow-up of cases because they are arranged periodically (one or two per month per block) so patients can return for follow-up visits.

CMOs were responsible for creating RCH teams that included a surgeon, gynecologist, pediatrician, and anesthesiologist. It is mandatory that a lady doctor be present. CMOs had an additional budget for the transportation of doctors and sterilization of patients who are transported home after the procedures. The service sites were equipped with laparoscopes, autoclaves and other essential equipment. Holding an RCH camp costs approximately Rs. 4,000

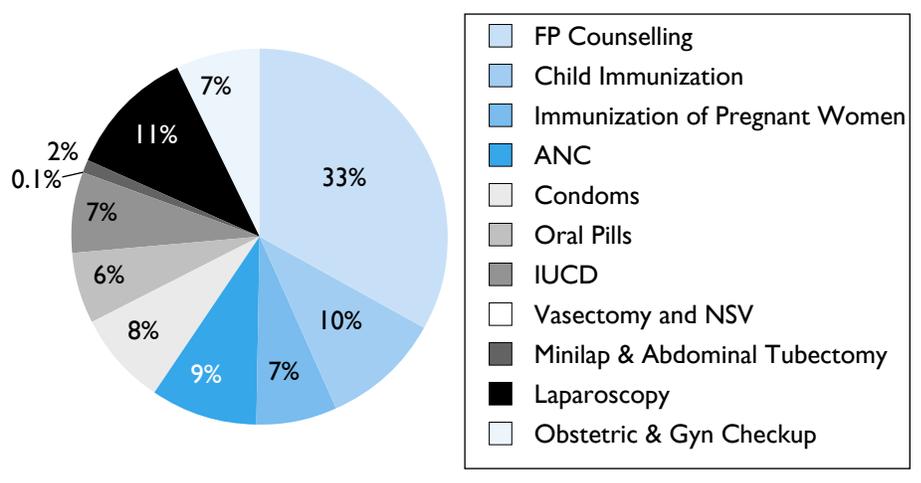
(US\$91), which includes expenses such as publicity, food, medical supplies, transport and tents.

The PMU was responsible for monitoring the camps and ensuring the medical team's presence, publicizing the camp, and arranging for transportation of sterilization clients. At the completion of the camp, the PMU sent a detailed report for monitoring purposes to SIFPSA with the following information:

- Availability of resources
- Timeliness of event
- Safety and infection-free standards followed
- Number of pregnancy tests administered
- Number of male and female sterilization clients
- Number of sterilization clients rejected.

Approximately 100 clients attended each RCH camp, and 50 percent of the clients obtained integrated RCH services. In 2003, 30 percent of all sterilizations in IFPS districts occurred at these camps

FIGURE 6: MIX OF SERVICES PROVIDED AT RCH CAMPS

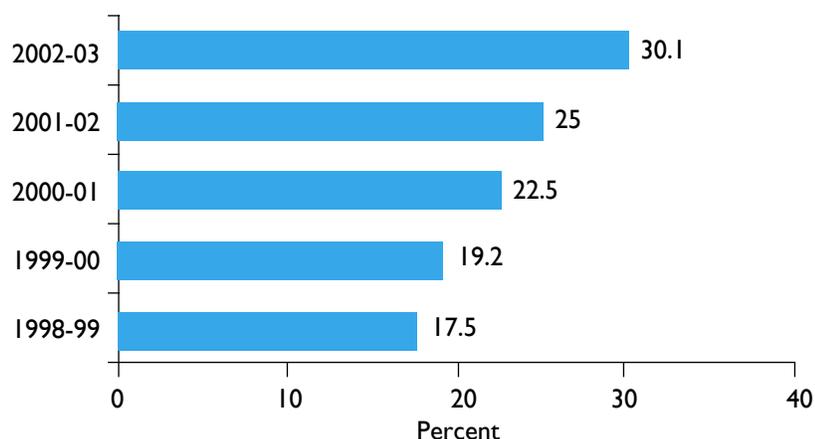


Source: SIFPSA MIS

## RCH CAMP PLANNING CHECKLIST

- Manpower: Surgeons, gynecologist, lady doctor, anesthesiologist, nurses
- Publicity: Newspaper ads, banners, audio cassettes, posters, public address systems, melas, pamphlets
- Camp arrangements: Layout of services, waiting areas, tents, chairs, refreshments, mattresses, pillows, generators, blankets, etc.
- Transportation and post-camp provisions: Vehicles for doctors, district officers and sterilization acceptors who need transport home, follow-up medicines, follow-up cards, communication materials
- Medical equipment: A variety of items are required, but not limited to: bleach, gloves, antiseptics, suture material, medicines for sterilizations, IFA and iron tablets, anemia medicine, laparoscopes (two per team), laparoscopic support instruments

**FIGURE 7: PERCENT OF STERILIZATIONS OCCURRING AT RCH CAMPUS IN IFPS DISTRICTS**

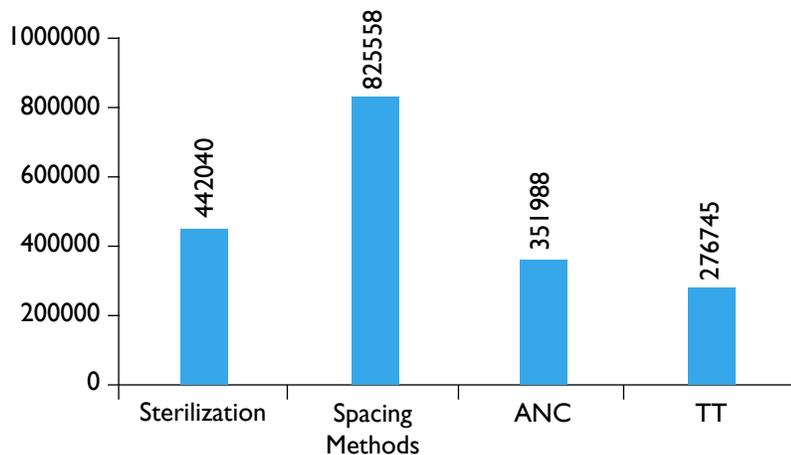


Source: SIFPSA MIS

(see Figure 7). Observers credit the publicity efforts of pradhans, NGOs, and ANMs with contributing to the growing attendance at the camps.

From 1998 to 2005, the IFPS project supported 53,427 RCH camps in all 33 IFPS funded districts. These camps provided family planning counseling to more than 1.7 million clients, birth spacing methods to more than 1.1 million clients, 770,000 female and male sterilization procedures, about 475,000 antenatal care checkups, and immunizations to more than 500,000 children. In 2003, more than 800,000 clients obtained spacing methods and more than 400,000 clients obtained sterilization procedures (see Figure 8).

**FIGURE 8: FP AND RCH SERVICES DELIVERED AT RCH CAMPS (2003)**



Source: SIFPSA MIS

Twelve DAP districts have created dedicated surgical teams to provide services at RCH camps. The CMO identifies the surgeons, gynecologists, and nurses to be part of the team and creates three mobile teams to provide services exclusively at camps. The team members rotate once a month in order to avoid major disruption to their normal duties. Medical officers receive a daily honorarium of Rs.200 (US\$4.55) and nurses and LHVs

receive Rs. 100 (US\$2.27). In order to receive the full honorarium, the medical officer-in-charge must certify that the doctor or nurse was punctual and present for the entire time.

### **Supporting No-Scalpel Vasectomy Services**

Many PMUs were instrumental in making no-scalpel vasectomy (NSV) services more widely available and spreading information about NSV. PMU staff helped to identify medical doctors for training, ensured that NSV was included in educational workshops with opinion leaders and other groups, helped with the logistical arrangements for special NSV camps and arranged for satisfied NSV clients to speak in group meetings about their experience.

### **Promoting Quality of Care in Public Facilities**

The family welfare program in UP has often been criticized as being too focused on quantity rather than quality, focusing more on increasing RCH client numbers rather than ensuring that clients receive high-quality services. In June 2002 SIFPSA and the Government of Uttar Pradesh, with technical assistance from Engender Health, launched the Quality Improvement (QI) Circle project to improve service quality standards in public health facilities. The project was piloted in 18 sites in Sitapur and Saharanpur districts.

The goal of the QI Circle activity was to raise the standards of care in community health centers. Major objectives were to:

- Enhance staff commitment, problem solving skills,

motivation, and ownership of delivering quality RH services

- Foster supervision, mentoring, and monitoring
- Improve client satisfaction, especially with regard to waiting time, staff courtesy and accurate family planning information
- Increase utilization of services, including temporary and permanent contraceptive adoption, as well as demand for other RH services.

The focus was on improving four areas of service delivery:

- Client service management: Ensuring that trained providers are present and that client rights and needs are met
- Site management: Ensuring the availability of equipment and supplies and appropriate infrastructure
- Information, education, and communication (IEC): Providing accurate information about services
- Management information systems (MIS): Registering clients and maintaining service records.

SIFPSA and EngenderHealth developed a Service Quality Standards Checklist with 100 indicators. Selected sites underwent an initial baseline assessment using this checklist; infrastructure gaps were identified and immediately addressed. District and site supervisors were trained in Client Oriented and Provider Efficient (COPE) techniques and facilitative supervision skills. COPE techniques include problem identification and action plan results orientation. In addition, the 'Whole-Site Training' approach was employed, meaning

that the learning needs of the entire staff are addressed through building a team-based approach to problem resolution. Other operational inputs were provided such as repair and maintenance of equipment, basic medical supplies, drinking water fountains and hospital cleaning staff.

Each participating site formed a QI team of seven volunteers recruited from the existing staff members. The teams met monthly to review and update action plans. The teams employed COPE techniques throughout the pilot. PMU staff were actively involved in overseeing activities, making monitoring and supervisory visits and participating in quarterly scoring of each site. Their participation was helpful in sustaining motivation and ensuring continued efforts.

To assess progress in improving quality of care, the district team conducted quarterly assessments of each site using the 100 indicator checklist. At the end of the pilot study, Engender Health conducted an assessment of all 18 sites to determine how the QI intervention had affected the quality and utilization of RH services. The team interviewed clients, providers, members of the QI team, and supervisors. Sites that scored 90 and above, on all four consecutive assessments, were certified as quality sites. Certification included a publicly awarded quality logo on the site and a flexible grant reward of Rs. 200,000 (US\$4,545).

Of the 18 pilot sites, nine were certified as quality sites and received the quality logo to display publicly.

The QI strategy resulted in overall improvement in functioning and service provision in both pilot districts across all sites. Service statistics show an overall increase in utilization of RH services, especially female sterilization and IUCDs (see Table I).

Clients interviewed expressed increased satisfaction with the quality of services following the intervention. Two in three (69%) of clients interviewed were aware of and utilized various RCH services, and 97 percent these clients were satisfied with the services they received. Service providers interviewed reported having better coordination among the staff, more accountability for their work, and increased teamwork and problem solving. Supervisors also noted a change in staff attitudes towards greater work motivation and

**TABLE I: REPRODUCTIVE HEALTH SERVICE UTILIZATION AT QI SITES**

Service	April 2002- March 2003	April 2003- March 2004	Percent Increase
Female sterilization	11,098	12,181	9.8%
IUCDs	45,092	45,567	14.3%
RTI/STI	4,481	4,890	9.1%
Deliveries	75,885	79,911	5.3%

capacity for solving site-specific problems.

Given the success of the pilot project, the QI Circle activity has

been introduced in five additional districts in UP including Jhansi, Etawah, Lucknow, Shahjahanpur, and Varanasi.

### **AN OBSERVABLE DIFFERENCE IN QUALITY**

In 2004, the Sarsawa Primary Health Center in Saharanpur District received a 2 lakh (Rs. 200,000) award for receiving a 90 percent grade or higher across all four quarterly evaluations. Dr. Sathya Prakash, the Medical Officer-in-Charge, stated that the QI award has greatly increased the reputation of the hospital and that the daily number of patients has increased tremendously. Moreover, his staff feel proud of their work and are even more committed to it.

## Section - 6

# PRIVATE SECTOR DAP PARTNERSHIPS AND INNOVATIONS

**B**ecause the public health system in India is often overburdened and lacks facilities and manpower, the private sector can play a crucial role in serving the family planning and reproductive health needs of the community. The private sector includes:

- **Non-governmental organizations** (NGOs) and nonprofit entities
- **Commercial, for-profit businesses** such as pharmaceutical manufacturers local/national/multinational corporations, and dairy cooperatives
- **Private providers** such as doctors, midwives and pharmacists.

SIFPSA has actively involved a range of NGOs, dairy cooperatives, and corporate sector companies to provide family planning counseling and services in the DAP districts. The chief aim of the Private Sector Cell of SIFPSA is to strengthen, expand and develop the private sector so that all couples have access to high quality reproductive health care.

Private sector agencies, including NGOs, dairy cooperatives, and employers/workers, were included in the planning meetings leading to the creation of DAPs and have been

closely involved in overseeing plan implementation. DIFPSAs and PMUs have been instrumental in identifying local private sector agencies to implement RCH programs. Of special note, PMUs have developed projects with their local District Urban Development Authorities, autonomous bodies under the state government, to provide RCH services in urban slums. Under the IFPS Project, most private sector interventions were incorporated into and budgeted under DAPs. PMUs also helped to identify key individuals such as private medical providers and traditional health practitioners for orientation and training on family planning and other RCH topics.

PMUs have been instrumental in monitoring private sector projects. PMU staff review quarterly performance and expenditure reports, accompany SIFPSA staff on monthly visits, and assist in verifying client records. PMUs conduct monthly meetings for all private sector project coordinators to share information and solve problems. The CMO or Deputy CMO attends these monthly meetings to ensure coordination with public facilities, especially in the planning of RCH camps. To ensure regular distribution of contraceptives and other supplies, PMUs also manage supply distribution

and provide monthly supplies to private sector projects.

### NON-GOVERNMENTAL ORGANIZATIONS AND COMMUNITY-BASED DISTRIBUTION

SIFPSA has engaged in partnerships with more than 150 NGOs throughout DAP districts. The ability to mobilize and involve communities in development programs is a key strength of non-governmental organizations “NGOs mobilize and know the pulse of the community,” states SIFPSA’s General Manager Private Sector. Also, NGOs are familiar with the challenges, infrastructure, and people of the community and thus are able to address local issues effectively.

Under the IFPS project, the main function of NGOs in DAP interventions was administering community-based distribution (CBD) projects. The CBD approach involves having local women volunteers make door-to-door visits in their community to deliver contraceptives, provide RCH counseling and make referrals to government facilities for clinical services.

CBD projects address an important gap in public healthcare services.

While ANMs play a critical role in delivering RCH services to villages, one ANM typically has a population of about 10,000 people to serve, leaving her extremely overburdened and overworked. Furthermore, an ANM rarely lives in the area where she works because the villages are often remote; this leaves the community without a permanent RCH provider. Accordingly, each CBD worker serves as a local health volunteer to cover approximately 2,500 people in 2-3 villages. The typical CBD worker is a female resident of the village, preferably married and between 25-45 years old, and educated up to at least middle school (eighth standard). CBD workers should be in favor of family planning and exhibit good interpersonal and counseling skills.

PRERANA Population Resource Center provides CBD workers with 10 days of induction training at its Apex Training Center in Lucknow. The first five days cover basic information on RCH and impart skills needed to collect baseline information in the worker's assigned area. After 30-45 days on the job, CBD workers receive another

five days of training that covers counseling skills, family planning, recording, and reporting. At the completion of training, the women receive a CBD kit, contraceptives to distribute, and a flipbook to use during discussions with village women on family planning and reproductive health.

A CBD worker is expected to visit 10 households per day. Her main job responsibilities are to:

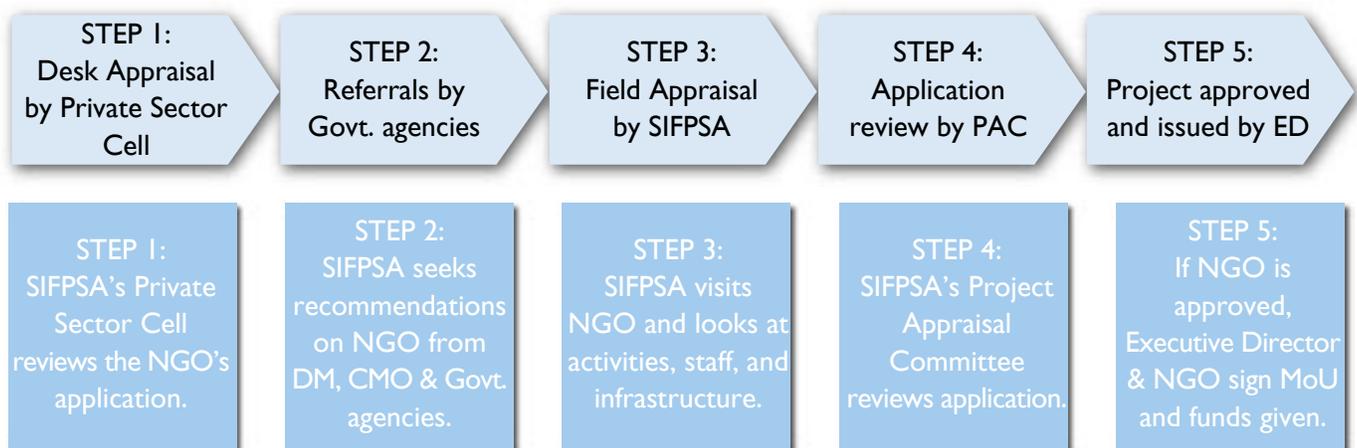
- Enumerate and survey all eligible couples
- Counsel on family planning
- Provide door-to-door supplies of condoms, oral pills and other health products
- Promote contraceptive social marketing brands
- Register pregnant women
- Refer clients requiring clinical RH services
- Coordinate with ANMs for child immunization.

SIFPSA's process of selecting NGOs to administer CBD projects is rigorous and comprehensive. In order to find strong and effective NGOs, SIFPSA advertises possible grants to NGOs to the public through local newspapers, although

most NGOs learn about the funding possibility through word-of-mouth. SIFPSA selects organizations with a strong local presence and a proven track record of performance to administer CBD projects. According to the General Manager Private Sector of SIFPSA, the chief criteria for selecting a NGO is "strong community organizational capacity." The NGO must have implemented action programs in the field of social development with a minimum coverage of 25 to 30 villages for at least two years and should have experience in handling funds of exceeding Rs. 100,000 (US\$2,273) per year. NGOs applying for project funds must submit their annual report of activities for the last three years, audited financial statement, bylaws, and registration certificate. SIFPSA's process for reviewing NGO grant applications is shown in Figure 9. All IFPS-funded NGO projects must be approved by the District Magistrate.

NGO projects collected detailed information on key outputs such as number of users of childspacing methods, pregnant women receiving ANC and children immunized.

**FIGURE 9: SIFPSA'S REVIEW AND APPROVAL PROCESS FOR NGO GRANTS**



Reports from CBD workers were reviewed and verified by their supervisors. The NGO project team compiled output data into quarterly progress reports for SIFPSA. External agencies such as research companies conducted an endline evaluation for each NGO project based on the objectives set in the project agreement.

NGO projects have been credited with raising awareness of family planning, increasing use of spacing methods, making RH services more accessible to rural communities and raising women's status. An analysis of 2003 survey data found that the contraceptive prevalence rate was higher in areas that had active CBD workers.

## **PARTNERING WITH DAIRY COOPERATIVES**

Uttar Pradesh has approximately 50 dairy cooperatives with nearly one million members. Dairy cooperatives account for the major share of processed milk sold in India. The cooperatives collect milk at numerous rural sites and bring it to processing centers. Because of their regular contact with villagers, understanding of rural marketing, and logistical strength as well as strong relationships and networks with the community, IFPS managers enlisted them as a partner agency.

From 1994 to 2005, SIFPSA supported dairy cooperative projects in 18 districts of UP covering more than 5,000 villages with a population of 11.6 million people. These projects focused on community-based distribution of family planning services in which a female village

health worker selected by the village cooperative conducted home visits during which she provided non-medical contraceptives, FP counseling and referrals.

## **CORPORATE-SECTOR PARTNERSHIPS**

The IFPS project collaborated with the industry-based organized sector in conducting four types of activities:

- Projects with organized industry to provide RCH services to factory workers, their families and the surrounding community;
- Partnerships with apex organizations such as the Federation of Indian Chamber of Commerce and Industry;
- Partnerships with corporate trusts to provide RCH services in corporate clinics and community outreach
- Other promotion efforts initiated through district action plans implemented in selected districts.

One example of such partnerships is SIFPSA's collaboration with the Indo-Gulf Sewa Trust, which is affiliated with Indo-Gulf Fertilizers Limited, one of the largest fertilizer companies in India. From 1998 to 2005, the Trust partnered with SIFPSA to provide RCH services under the Sultanpur DAP. The project covered more than 75,000 people in the larger community, including factory workers across 58 units. Major components of the project were: contraceptive distribution, audiovisual shows and group discussions among factory workers; contraceptive sales in villages; provision of RCH care in six project clinics; and health camps. A 2003 evaluation found that

awareness of RCH, immunization coverage and use of antenatal care services increased in communities served by the project.

## **DAI (TRADITIONAL BIRTH ATTENDANT) TRAINING**

UP's maternal mortality ratio (MMR) is very high at 707 deaths per 100,000 live births compared with the national average of 407. One factor contributing to high maternal mortality is the high proportion of women who give birth without assistance from trained medical professionals. Approximately 70 percent of deliveries in UP occur in the home with the assistance of dais (traditional birth attendants) and family members. Dais are typically illiterate married women over age 25 who live in the local village.

Recognizing that dais can play a major role in reducing neonatal and maternal deaths, SIFPSA created a training program for dais as part of district action plans. With technical assistance from INTRAH-PRIME, SIFPSA developed a three-tier training system in collaboration with local NGOs and the public health system. The system consisted of: (1) a nodal training center that trained master trainers from NGOs and the public health sector; (2) training of ANMs as lead trainers for other ANMs in their block; and (3) training of dais and follow-up and supervision of dais by ANMs. In each district an NGO is selected to facilitate the project and the CMO ensures timely supply of training materials. In order to select dais for training, a complete census of dais in all villages of the district is done using a block mapping

## CASE STUDY: SUSTAINING INTEREST IN REPRODUCTIVE HEALTH

Founded in 1989, the Dr. Shambhunath Singh Research Foundation focuses on women's empowerment, protection of children's rights and empowerment of laborers. It works in 52 villages throughout Varanasi District in UP.

From 1997–2003, the Foundation implemented the IFPS-funded Community Health Action through Motivation Program (CHAMP). The project staff consisted of 48 CBD workers, six supervisors, one project coordinator, one assistant project coordinator and one monitoring and reporting specialist. Initially the Foundation had difficulty finding appropriate workers. Most of the women in the villages had minimal education and were not accustomed to working at a job. It took time to find women who were educated enough to serve as CBDs and to train them.

Nevertheless, once the project took hold, it was well-received. Community members now refer to the CBD workers as the "CHAMP-walla bhenji" (The Champ Sister). Contraceptive use has increased from 53 percent of married women in 1997-98 to 68 percent in 2003—a 28 percent increase over four years. Other indicators of change are that more Muslims are requesting contraceptive methods and sterilization and parents' preference for male children is decreasing.

The Foundation's President notes that client demand for contraceptives and FP counseling remains high even though the project ended in 2003. The CBD workers remain active, with nearly all of them (90%) still serving as women health educators under other government programs. The Foundation President comments, "CBDs don't want to leave their jobs, they want to stay as local health development activists and contribute to the community."

The CBD project also had an effect on women's empowerment. First of all, it greatly increased the status of the CBD workers. CBD worker Prem Sheila stated that her job has changed her life in many ways: "This job has given me so many options. I can travel around the district freely. This has been more than a job; it has been a life change. I am distinguished in the community and I am proud to not be a housewife that just stays at home in the village." Another effect was that the CBD workers educated many women about reproductive health during their fortnightly visits to schools. The workers created suggestion/question boxes where girls could submit questions about puberty, life changes, and other topics; these questions were then discussed with all the girls.

process. One TBA per village is selected; only those actively conducting deliveries are chosen.

The ANMs trained dais in groups of ten in order to create an effective linkage between the ANMs and the trained TBAs. The training was hands-on and intensive, with one trainer for every two trainees. The courses for dais covered the following topics:

- Knowledge of the '5 cleans' to conduct a safe delivery (clean delivery surface, hands, cord tie, blade, and cord stump)
- How to identify and refer high-risk pregnancy cases
- Screening and counseling for spacing methods.

From 1998–2005, a total of 33,189 dais in 29 districts received training.

Evaluation studies have confirmed that the dais had learned useful skills and were applying them in their communities. Macro International and ACNielsen (1999) conducted a study of trained dais in two districts and estimated that the number of births attended by trained dais rose from 6,448 births in 1997 to 36,327 births in 1999—more than a five-fold increase. Also, the proportion of dais who provided family planning supplies and information increased from 4 percent before training to 28 percent after training. Similarly, the proportion of dais who could recognize high-risk pregnancies rose

from 11 percent before training to 53 percent after training. A POLICY Project 2001 assessment of dais in seven districts found that 97.5 percent of the trained dais received a satisfactory score in tests covering knowledge, handwashing and cord cutting (POLICY Project, 2001). Observers have reported that the training raised the status of dais in their community, leading to an increased demand for their services.

The annual USAID-funded surveys to measure the impact of the IFPS project found that the proportion of deliveries assisted by trained dais rose from 9 percent in 1995 to 17 percent in 2003 (Narayana 2006). To put these numbers in context,

over the course of the IFPS project, the proportion of deliveries in health institutions increased, although 76 percent of births in 2003 still took place at home. Having trained dais available to attend these home births represents progress in making deliveries safer, although the long-term goal is to have most births attended by health professionals such as medical doctors, nurses and ANMs.

## TRAINING FOR INDIGENOUS SYSTEMS OF MEDICINE PRACTITIONERS

UP has nearly 43,000 registered Indigenous Systems of Medicine Practitioners (ISMPs) comprised of Unani, Ayurvedic and Homeopathic medical practitioners, and probably an equal number of non-registered practitioners. ISMPs are often the first and main point of contact for health care in rural areas of UP because many people do not have access to government facilities and cannot afford to visit a private physician.

Recognizing that ISMPs can play a major role improving access to

RCH services provided by the DAP interventions, the IFPS project initiated a training program to educate ISMPs to be family planning counselors and providers of non-clinical contraceptives (condoms and oral pills).

With technical assistance from INTRAH-PRIME, SIFPSA developed a training curriculum and introduced pilot projects in two districts in 1995. From 1996 to 2003, SIFPSA supported training projects in 31 districts of UP. More than 12,000 ISMPs were trained from 1995 to 2001.

SIFPSA selected local NGOs to manage the ISMP training program in each district and provide master trainers for step-down training. Each NGO completed a baseline survey to identify the registered and unregistered ISMPs. All interested ISMPs were invited to training sessions, which were held at the block level. The ISMP training curriculum covered the following topics:

- Facts and figures about population growth
- Effects of high fertility and advantages of FP

- Interpersonal communication
- FP counseling and various spacing methods
- Overview of STDs and HIV/AIDS.

Six months after completion of the initial training course, a refresher course was held for all of the trained ISMPs.

Observers report that the trained ISMPs did provide more FP counseling and supplies than they had previously done and that the ISMPs helped to address fears, rumors and misconceptions related to contraceptive methods. However, the idea of involving ISMPs in contraceptive social marketing programs did not prove feasible because it was difficult to maintain contact with them. Staff implementing the ISMP training program had difficulty reaching many ISMPs via phone or mail. A directory of ISMPs in UP does not exist, and many of them move frequently. Therefore, ISMPs would not be suitable for a role that requires ongoing contact with program staff.

## Section - 7

# COMMUNICATION INITIATIVES

### THE AAO BATEIN KAREIN CAMPAIGN—“COME, LET’S TALK”

To generate demand for reproductive health services, SIFPSA launched a major information, education and communication (IEC) campaign called Aao Batein Karein (Come Let’s Talk on family planning). The campaign was illustrated by the folkloric Tota and Mynah birds (a male parrot and its partner, the female mynah), which are recognized in UP as secular symbols associated with storytelling. The goal of the campaign was to raise awareness, increase knowledge and promote discussion of family planning methods and allay myths and misconceptions about family planning practices.

The campaign was designed by SIFPSA with technical assistance from the Johns Hopkins University/ Population Communication Services project. Research studies indicated that a major factor inhibiting adoption of spacing methods is the lack of dialogue between husband and wife, between service providers and clients, and between policy makers and program implementers. Accordingly, the campaign was designed to foster communication

between couples aged 17–25 years old and between clients and health service providers. Most importantly, the dialogue and communication were presented in a non-threatening, invitational manner that was respectful of cultural and religious norms.

To support the multimedia Aao Batein Karein campaign, SIFPSA trained more than 18,000 auxiliary nurse midwives and CBD workers in 33 districts in order to orient them to the campaign theme, impart client counseling skills, and familiarize them with the campaign materials. The one-day interpersonal communication workshops used lectures, games, exercises, and a 25-minute training video. The training was conducted in the format of melas (village fairs) which about 100 workers at a time attended. Workshop participants received a bag of IEC materials such as a flip book, posters, stickers, wallcharts, a calendar displaying family planning methods and a badge. The badge gave them a source of identity in the villages and the bag of materials helped them to facilitate meetings in the villages. The PMUs in each district monitored the training.

From 1998 to 2002 the Aao Batein Karein Campaign was

implemented in six-month phases in six focus districts. Some campaign components were extended to all IFPS districts. The campaign used diverse communication channels. TV and radio programs were used to convey FP messages in a fun and entertaining manner. The programs were aired on popular channels, regional television networks and All India Radio to reach intended audiences. Print media included advertisements on FP in Hindi and English daily newspapers. Other innovative approaches used in the campaign were:

- **Wall painting:** Research reveals that wall paintings and hoardings were the most popular marketing strategy used in DAPs, as 25 percent of women in urban areas and 12 percent in rural areas report having seen a wall painting or hoarding with an FP message. At the district level, the CMO and PMU determined the sites for the wall paintings and contacted an agency to do the painting according to SIFPSA specifications. Typically, each village had at least one painting and other hoardings were posted at district hospitals, CHCs and PHCs.
- **Video vans:** Video vans visited villages with more than 2,000

residents throughout the IFPS project districts. The vans typically held an afternoon and an evening show featuring short movies on family planning, spacing methods, age at marriage, and other RCH issues. The vans typically held two shows, one in the afternoon and one in the evening. The local ANM was on hand to answer questions from the audience and distribute relevant information materials. District PMUs and local NGOs were responsible for planning the shows. Video vans were one of the most successful audiovisual media to reach rural audiences, according to the SIFPSA Project Manager of Fatehpur district. In this district more than 500 video-van performances were held, and the Project Manager reports that the shows were well-received and enjoyed by the villagers.

- **Folk media:** Given UP's regional variations in dialects and religion, traditional folk media is an effective communication tool because it is localized, region-specific, and need-based. Folk media is popular in UP because it is entertaining. Given the low literacy level in UP, folk media has proven to be an excellent medium for health communication. Folk media used in the Aao Batein Karein campaign contained puppetry, magic shows, Nautanki (folk theater), Qawali (singers of devotional songs), Allah/Birha (traditional ballad singers), and singing and dance performances. From 1999 to 2004 more than 8,500 performances were conducted throughout IFPS districts.

DIFPSAs and PMUs actively supported SIFPSA's larger multimedia campaigns as well as introduced local communication activities. For the Aao Batein Karein campaign, PMUs ensured that interpersonal communication and local media components were in place to support the campaign's mass media elements. For example, the CMO and PMU selected sites for wall paintings in villages and billboards at district hospitals, community health centers and primary health centers. PMUs monitored the training of healthcare workers in interpersonal communication and use of IEC materials. They also identified villages for folk music, theater performances, and video van screenings and prepared detailed route maps and schedules. PMU staff attended the folk performances and sent detailed feedback to SIFPSA. PMUs provided support to the mass media campaigns by monitoring local radio and television broadcasts and ensuring that print materials were distributed.

The impact of the Aao Batein Karein campaign was assessed through two surveys conducted in 2000. Key findings from these surveys were:

- **Knowledge of FP health benefits:** The number of women who report that family planning has health benefits increased from 66.5 percent in the 1995 baseline to 68.7 percent in the March 2000 survey. If these data from five districts are applied to the 15 project districts, an estimated 5.7 million women know that family planning has health benefits (ORC Macro and the ORG Centre for Social Research 2000a).

- **Women's recall of birth spacing information:** The proportion of women who recalled hearing or seeing information about birth spacing in the previous month increased by more than 50 percent from 1995 to March 2000. Thus an estimated 2 million women were exposed to a birth spacing message during the month before the survey (ORC Macro and the ORG Centre for Social Research 2000a).
- **Exposure to FP/RH messages:** Based on the March 2000 survey findings, nearly two-thirds (66.3%) of the men and women—67.5 percent of the men, 65.0 percent of the women—in the 15 project districts heard or saw FP/RH messages in the previous month. Based on these data, an estimated 8.5 million men and women heard or saw FP/RH messages in the previous month (ORC Macro and the ORG Centre for Social Research, 2000a).
- **Awareness of FP:** The October 2000 study found that 94.4 percent of women know that pregnancies can be controlled by the couple (ORC Macro and the ORG Centre for Social Research, 2000b).
- **Recall of media channels:** The 1995 baseline survey found that women recalled having seen or heard an average of 0.69 channels—e.g. radio, television, cinema, printed materials, hoardings, wall paintings, and group meetings—that contained an FP/RH message in the previous month. Men interviewed in the October 2000 survey recalled

seeing or hearing an average of 2.24 channels; women respondents reported an average of 2.1 channels. Accordingly, the average of 2.17 channels recalled by men and women represents a tripling of the channels cited at baseline (ORC Macro and the ORG Centre for Social Research, 2000b).

The two surveys indicate that the Aao Batein Karein campaign, combined with other communication activities, did reach large audiences through multiple media channels and that their messages were understood and recalled by their primary audience—men and women of reproductive age. In addition, qualitative field appraisals indicate that the discussion of family planning has become far more open and acceptable in the community. The embarrassment and awkwardness of discussing reproductive health issues (even admitted by the health workers themselves) has declined and is being replaced with discussion and dialogue.

## **SUPPORTING FAMILY DECISION-MAKING**

Within families in India, the mother-in-law often plays a crucial role in important family decisions, especially regarding family planning. The mother-in-law's powerful position in the household can lead to friction with her daughter-in-law, and thus there is a need to improve communication between them. Recognizing the influence of mothers-in-law, the PMU, DIFPSA, and the health department of the Banda district in UP designed an innovative DAP intervention. Called *Saas Bahu Sammelan* ("Mother-in-law and Daughter-in-law Get

Together"), the project consisted of a two-day workshop for mother- and daughter-in-law pairs to increase awareness of RCH issues, including age at marriage, contraceptive options and use, antenatal care, small family norms, infant feeding practices, and immunization. About 500 mother- and daughter-in-laws attended the event as well as the District Magistrate, CMO, and other health functionaries. The women participated in group discussions and debates; various games, including rangoli (floor painting) competitions, bridal dressing, and three-legged races, were held as well as a competition of singing folk songs advocating women's empowerment. The workshop was also a platform to recognize the good performance in RCH activities from the previous year: medical service providers were honored and sterilization acceptors received certificates. After the event, many daughters-in-law decided to have a sterilization procedure. They also reported more open discussions with their mothers-in-law regarding family planning options (SIFPSA, 2005).

## **USING BARBERS TO INCREASE MALE PARTICIPATION IN FAMILY PLANNING**

One of the greatest challenges for family planning in UP is getting men actively involved in RH. Many people believe that women should be responsible for FP, including sterilization. However, female sterilization is a more complicated procedure and entails higher health risks than male sterilization. Educating men on the range of contraceptive choices could lead

to better decision-making. Sitapur District embarked on an innovative DAP pilot intervention to involve barbers to promote male awareness of family planning, especially in the use of condoms and no-scalpel vasectomy (NSV). Since barbers interact with men in the community on a regular basis, they are a good medium to pass along important FP messages. In March 2002, district authorities held a one-day workshop for 129 barbers in the Kasmanda block of Sitapur. Barbers were selected by panchayat development officers. During the workshop the barbers were oriented on RCH issues with an emphasis on male involvement and were taught communication and counseling skills to discuss family planning with their male clients. They received a booklet on RCH issues, leaflets and posters on family planning methods, and a bag with a family planning message on it to serve as additional publicity when traveling to villages. In follow-up interviews, the barbers said that they were sharing family planning information with their clients and had made numerous referrals to the local primary health center for RCH services.

Another important goal of the barber training was to organize an NSV camp. However, it was realized that a few hours orientation was not enough training for the barbers to learn how to effectively convince and counsel NSV clients. A key lesson learned was that additional training would be required for barbers to create enough demand for a NSV camp. All in all, the barbers were a good grassroots medium to spread messages on the importance of RCH and FP to community males.

## Section - 8

# ENGAGING LOCAL LEADERS

### ENGAGING VILLAGE LEADERS IN RCH

The 73rd Amendment to the Constitution of India mandated the election of panchayati raj (village council) institutions and envisaged that the pradhan (village leader) would become involved in health and family welfare. The government has mandated that 33 percent of pradhans be women, thus bringing more women into local leadership positions. In decentralizing its health programs, the UP government shifted authority for female health workers and front-line supervisors from the state health department to the panchayati raj. However, since pradhans typically focus on activities with visible returns such as managing land, construction and water resources, their knowledge about health services is often minimal.

Recognizing the lack of RCH awareness of pradhans, who play a pivotal role in leading the community, SIFPSA organized an extensive pradhan training program in all DAP districts. SIFPSA partnered with the State Institute for Rural Development (SIRD), an apex institution at the state level, to train pradhans on RCH issues. The one-day training sessions are held once a year at the block level. The

main objectives of the training are to:

- Educate pradhans on RCH issues and services
- Help pradhans understand district action plans and their role in implementing plans
- Encourage pradhans to promote RCH services in the community
- Explain how the RCH services provided are of high quality.

Another innovative training medium that has been used with pradhans is a series of eight Hindi comic books discussing RCH issues. About 30,000 copies of the comic books have been distributed in the districts of Bareilly, Firozabad and Unnao. The pradhans remarked that the material provides useful knowledge and relevant information about RCH services and helps them to counsel villagers to avail of these services.

Under the IFPS project, 28,594 pradhans in 35 DAP and non-DAP districts have received training on RCH services. The participation rate is approximately 60 percent throughout the districts. Now pradhans often attend RCH camps and various folk performances where they discuss health issues with the community. Furthermore, under the leadership of the District Magistrate, a “Pradhan Forum” of

about 50 pradhans active on RCH issues has been created in four districts. These pradhans meet monthly to discuss ideas for RCH awareness generation. As an example of the way that pradhans serve as role models for their community, the pradhan from the village of Lakshit Khera in Fatehpur District underwent a vasectomy operation. Also, pradhans in this district were responsible for encouraging 400 couples to adopt a family planning method. The involvement of pradhans has ensured that local leaders reinforce the importance of family planning in the community and help facilitate required infrastructural needs for RCH activities.

### WORKING WITH RELIGIOUS LEADERS

Religious leaders are trusted, respected, and admired within the community and have great influence over the actions of local people. Accordingly, SIFPSA embarked on a sensitization training of religious leaders to apprise them of the consequences of rapid population growth and the benefits of FP. At the district level, PMU staff prepared a list of religious leaders belonging to the various religious communities. Initially, they invited a small group of leaders and provided

them with literature on family planning. Next, they held informal meetings to discuss the material and to gather input on ways to conduct broader meetings on sensitive issues in a culturally appropriate manner. Finally, the PMU organized a larger meeting of religious leaders in order to orient them to family planning and maternal and child health. The District Magistrate and chief development officer assisted the PMU in encouraging key religious leaders to attend the meeting.

PMU staff made a special effort to reach out to Muslim leaders, since studies show that many Muslims believe that family planning is

forbidden in Islam. NGOs operating in Muslim-dominated areas involved Imams (Muslim leaders) in the program to prevent any religious conflicts in the area. Some NGOs have been successful in encouraging Imams to make announcements about maternal and child health activities during namaz (prayers) at mosque every Friday to reassure people that the RCH program has the support of religious leaders.

During the IFPS Project, 2,735 religious leaders in 10 districts attended the orientation meetings. SIFPSA staff stated that this training has several benefits:

- Initiates debate among Hindus and Muslims on issues that are usually considered taboo
- Encourages religious and opinion leaders to express their support for family welfare
- Disseminates messages on maternal and child health and contraception to the Muslim community
- Gains wider support for the RCH program in the community.

In sum, gaining the support of this influential group was helpful in reaching communities with RCH information.

# PERFORMANCE AND IMPACT OF DAPS

When considering the macro- and micro-level impact that DAPs have had, it becomes clear that DAP districts performed better than non-DAP districts under the IFPS project. Salient performance indicators highlighted in this section reaffirm the crucial role that DAPs and their support structures have played. Moreover, qualitative reports suggest that DAPs have had a long-lasting impact on local stakeholders and residents of participating districts.

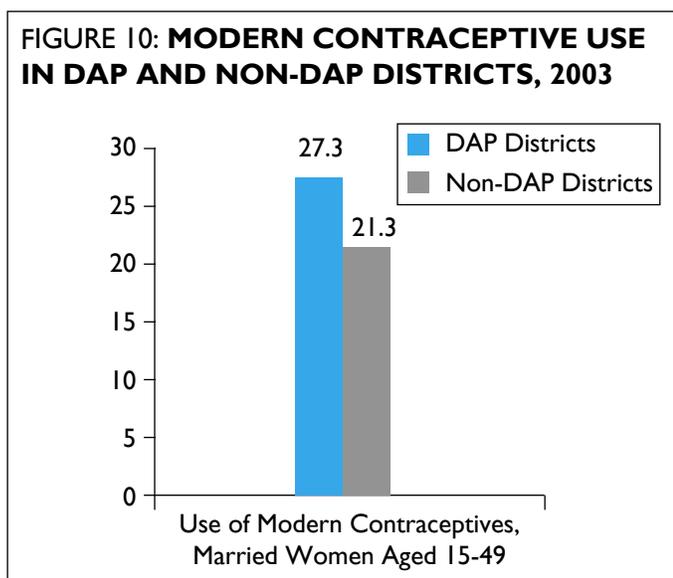
## DAP IMPACT ON FAMILY PLANNING AND MATERNAL HEALTH INDICATORS

Family planning and maternal health indicators were higher in

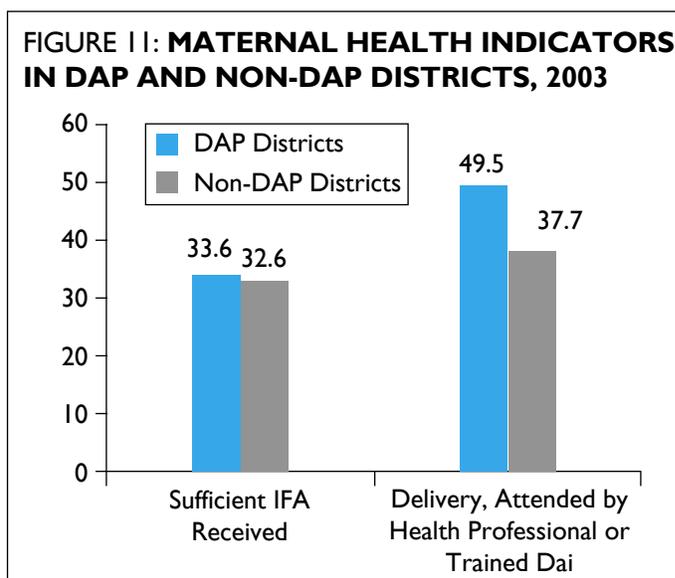
districts with DAPs, compared with other districts that were not focus districts of the IFPS project. The 2003 Reproductive Health Indicators Survey found that the use of modern contraception among married women was 6 percentage points higher in DAP districts than in non-DAP districts (see Figure 10). With regard to maternal health indicators, the proportion of pregnant women who received sufficient iron folic acid tablets was slightly higher in DAP districts, while the proportion of births assessed by a trained person (either a health professional or trained dai) was nearly 12 percentage points higher in DAP districts compared with non-DAP districts (see Figure 11).

The long-term effects of the DAP process are illustrated in Figure 12, which shows a significant increase in contraceptive use between 1995 and 2003. In DAP districts use of modern contraception rose from 21 percent of married women, as measured in the 1995 PERFORM survey, to 27 percent, based on the 2003 Reproductive Health Indicator Survey (RHIS).

Another way to assess the impact of district action plans is to compare the initial baseline survey data with the endline benchmark evaluation. When doing this, there is always a significant increase in the indicators, especially when compared with the state average. For example, while the Uttar Pradesh average annual



Source: RHIS Survey 2003



Source: RHIS Survey 2003

increase in FP use is 0.5 percentage points, the average annual increase for DAP districts is nearly always higher than the state average (see Table 2). Also, while the UP average annual increase of pregnant women receiving sufficient IFA tablets is 2.5 percentage points, the increase in DAP districts is higher, ranging from 2.9 to 8.9 percentage points.

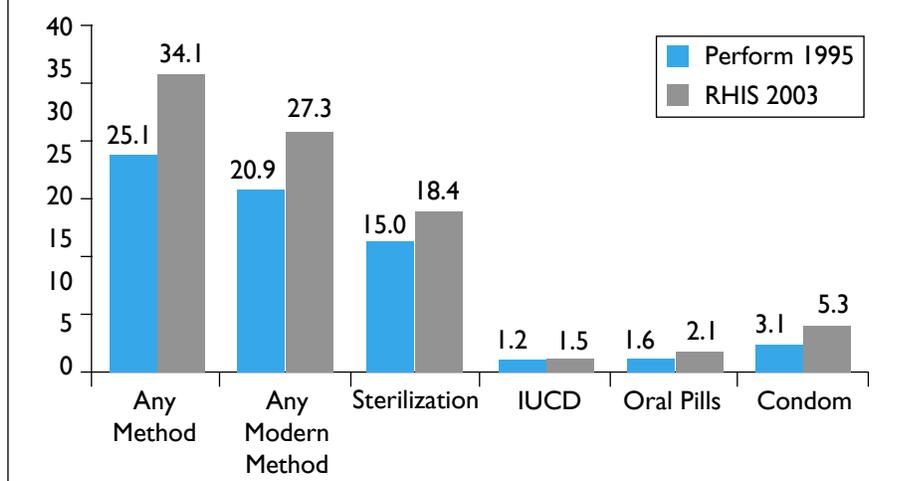
- Expanded public-private partnerships
- Increased role of NGOs in RCH programs
- Enhanced monitoring and reporting procedures
- Increased involvement of political figures, such as the District Magistrate, in RCH
- Enhanced skills of healthcare providers due to extensive training
- Integrated health services through RCH camps
- Increased male involvement in family planning and RCH
- Increased dialogue and openness regarding family planning

## LONG-TERM QUALITATIVE PERFORMANCE IMPACT

Many of the key results of the DAPs are not adequately measured by project output data or other quantitative indicators, but are readily noted by field observers and program implementers. These qualitative impacts are:

- Improved image of public sector health facilities
- Reduced bottlenecks and fewer delays in handling local health issues
- Introduction of private sector style of management through PMUs.

FIGURE 12: CONTRACEPTIVE USE IN DAP DISTRICTS, 1995-2003



Source: RHIS 2003

TABLE 2: INCREASE IN MODERN FAMILY PLANNING USE IN DAP DISTRICTS

District	Baseline Modern FP Method	Base Year	Benchmark Evaluation Modern FP Method	Benchmark Year	Percentage Point Increase	DAP Avg Annual Percentage Point Increase	Uttar Pradesh Avg Annual Percentage Point Increase
Sitapur	17.1	2000	22.2	2004	5.1	1.3	0.5
Jhansi	50.4	2000	53.4		3	0.8	
Mirzapur	29.8	2000	33.2		3.4	0.9	
Shahjahanpur	14.9	2000	16.5		1.6	0.4	
Moradabad	23.3	2000	26.6		3.3	0.8	
Agra	29.1	1999	33.3		4.2	0.8	
Firozabad	18.5	1999	22.8		4.3	0.9	
Unnao	16.6	2001	18.9		2.3	0.6	
Bareilly	26.1	1999	30.0		3.9	0.8	
Saharanpur	30.6	1999	34.2		3.6	0.7	
Baghpat	33.8	2001	36.4		2.6	0.7	

**TABLE 3: INCREASE IN PREGNANT WOMEN IN DAP DISTRICTS RECEIVING SUFFICIENT QUANTITY OF IFA TABLETS**

District	Baseline IFA	Base Year	Benchmark Evaluation IFA	Benchmark Year	Percentage Point Increase	DAP Avg Annual Percentage Point Increase	Uttar Pradesh Avg Annual Percentage Point Increase
Sitapur	6.3	2000	40.9	2004	34.6	8.7	2.5
Jhansi	33.5	2000	62.8		29.3	7.3	
Mirzapur	18.7	2000	36.3		17.6	4.4	
Shahjahanpur	3.3	2000	38.9		35.6	8.9	
Moradabad	5.2	2000	30.7		25.4	6.4	
Agra	21	1999	43.4		22.4	4.5	
Firozabad	9.9	1999	35.8		25.9	5.2	
Unnao	19.3	2001	41.4		22.1	5.5	
Bareilly	6.3	1999	31.8		25.5	5.1	
Saharanpur	16.9	1999	31.6		14.7	2.9	
Baghpat	11.0	2001	34.1		23.1	5.8	

- Strengthened local capacity building due to decentralization.

When evaluating the performance of DAPs, it is also important to note that the Gol has expanded this intervention nationally through the National Rural Health Mission

(NRHM). Furthermore, even before the NRHM, the Gol wanted to expand the program and asked SIFPSA to expand its mandate of 33 IFPS districts for decentralized planning to an additional seven districts with low demographic indicators that are included in the

Empowered Action Group. As a result, there are seven districts—known as the Decentralized Participatory Planning or DPP districts—with local RCH action plans, funded by the Gol scheme and based on the IFPS DAP approach.

# DAPS: REFLECTION AND MOVING FORWARD

## CHALLENGES IN DAP IMPLEMENTATION

**Frequent transfers:** The GoUP system is hindered by frequent job transfers. Government civil servants' roles, titles, and job locations change frequently, leaving the system constantly filling positions and training new people. This results in a loss of time and productivity. This challenge trickles down to DAP implementation; the majority of positions in the DAP process face frequent job transfers as well. For example, the roles of the District Magistrate and CMO are essential in the DAP implementation process, yet there are very frequent job transfers at these levels. The PMU constantly has to re-educate new District Magistrate and CMO to obtain their support for RCH and family planning programs.

**Working with Chief Medical Officers:** Working with CMOs is often challenging because they have many competing priorities and family planning issues may not be viewed as pressing. Also, because many CMOs are near retirement age, they may not be as responsive to RCH issues. These factors slow down the DAP implementation process because CMO support is required for many interventions.

**Lack of medical officers:** Most rural health facilities lack adequate numbers of medical officers. Medical officers often seek transfers from the CMO position to urban locations in order to secure better living conditions and resources for themselves and their families.

**DAPs' scope too large:** Another critique of DAPs is that they tend to do everything and anything, and results can often get diluted. Thus there is a need to focus attention on a few tangible items. Some informants suggested that it is better for DAPs to focus on a few key activities with trusted local stakeholders than to implement numerous interventions with a variety of players because coordination is difficult. An average DAP has about 25 interventions, but concentrating on 10 essential strategies might have greater impact and also require less resources and management.

**Political support:** Political support and involvement in the DAP process is essential to the success of the project. Having the District Magistrate involved is crucial for motivating district officers, and pradhan support is essential in garnering village interest in family planning programs. Unfortunately, it may be difficult to encourage

political support because RCH issues have less tangible, fiscal results than other areas such as transportation or infrastructure development. Therefore, SIFPSA and PMUs have to invest significant time in securing political buy-in to DAP interventions.

**Tailoring solutions:** A critique of the DAP process is that many of the districts end up using the same strategies, which results in plans that are not truly unique and responsive to local needs. While it is true that some action plans look similar across districts because some "tried and tested" strategies are frequently used, district-specific interventions are used as well. For example, if there are 25 strategies employed in a district, 15 may be common with other districts; however, the remaining 10 are unique to the needs of that district. SIFPSA currently has 67 DAP interventions. Of those strategies, the most common are:

1. Strengthening health facility infrastructure
2. Training for health service providers
3. RCH camps
4. Folk media IEC campaigns
5. Pradhan training.

**Inconsistent supply of contraceptives:** A challenge many health providers report is the irregular and infrequent supply and delivery of contraceptives. Providers report that contraceptive delivery often comes in one large shipment and then months pass before a new shipment is received. Furthermore, the delivery is irregular, and many providers report receiving expired condoms. This situation is frustrating for service providers such as ANMs and community-based distribution (CBD) workers, who spend so much of their time encouraging new family planning users, and then find that there are no contraceptives to provide to them through the public system.

## CRITICAL FACTORS FOR SUCCESS

**Strong presence of NGOs:** The presence of NGOs that can implement DAP interventions is essential to the success of the action plan. For example, the Project Manager for Varanasi District, which is considered to be one of the most successful DAP districts, stated that the critical component of his district's success comes from the large number of NGO partners. In contrast, Fatehpur District, which has faced challenges in achieving stated goals, has few NGOs to work with in the community.

**Effective Project Management Unit:** Experts interviewed in this study consistently noted that the active involvement, leadership, and coordination of the PMU are critical to DAP implementation. Because the PMU staff operate with a private sector approach, the PMU is efficient

in responding quickly to issues. Also, ensuring that the Project Manager has a long tenure and that transfers are kept at a minimum helps ensure the continuity and flow of the project.

**Involvement of key stakeholders:** Engaging local stakeholders such as village pradhans, religious leaders, ANMs, NGOs, and private health providers is essential to the success of the DAP. Grassroots workers know the needs, concerns, and resources of the community and are able to develop feasible solutions. DAPs sensitize local players about effective practices, what resources are available, and how they can work together to achieve goals. Furthermore, grassroots workers are critical for garnering village support for the interventions.

**Active involvement of District Magistrate and CMO:** The senior public sector players in implementing the DAP are the District Magistrate and CMO. These two roles have significant influence at the district and village levels and have key responsibility in motivating the rest of the DAP team and disbursing DAP funds. Their active and dedicated involvement leads to strong results in DAP interventions.

**Effective monitoring and reporting:** A key success factor in implementing a DAP is having frequent and reliable monitoring and information systems. Regularly tracking key indicators such as RCH camp attendance, sterilization rates, and number of new family planning users is essential to document the success of the action plan. This requires detailed reporting by the PMU.

**Recognition of performance:** Embodied in most DAPs are interventions that recognize the performance of local stakeholders and health service providers. Rewarding high performance increases the effectiveness of the health system in providing quality service and increasing staff commitment. Rewarding performance also dispels the common belief that in the government system work performance makes no difference. Many action plans recognize the best performing ANM with a certificate of excellence by the District Magistrate. Similarly, medical officers, pradhans, dais, and NGOs receive awards based on performance. They are typically recognized in public functions and given certificates and gifts of a symbolic nature.

**High literacy and strong infrastructure:** Another critical success factor for DAPs is the average level of education of the community. For example, in Varanasi where the literacy rate is nearly 70 percent, the community is able to understand and respond more quickly to FP counseling and interventions. Furthermore, the more developed a district is in terms of infrastructure, roads, and transportation, the easier it is to distribute contraceptives, for ANMs to visit villages, and for people to travel to health facilities to seek care.

## THE NATIONALIZATION OF DAPS

In March 2005, the Gol launched the National Rural Health Mission (NRHM). The NRHM seeks to provide effective healthcare to rural

populations, especially disadvantaged groups such as women and children. The program aims to improve access, community ownership and demand for health services, while also strengthening the public health system through promotion of decentralization. It covers all of India, with a special focus on 18 states (Uttar Pradesh included) where public health systems are the weakest. NRHM marks the Gol's paradigm shift from a centralized to decentralized approach to implementing health programs.

The concept of DAPs and decentralized health management is a critical component of NRHM. The program mandates that all states implement district health plans that are "an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition." (Gol/Ministry of Health and Family Welfare, 2005, p. 5). Through the NRHM budget, every

state receives a flexible budget for the creation of DAPs. Every state is required to submit two sample DAPs with its State Project Implementation Plan to the Ministry of Health and Family Welfare. The POLICY Project created a DAPs manual to teach all the states how to create and conduct district action plans.

The NRHM and IFPS district-level action plans have many similarities. For example, the NRHM structure is modeled from the IFPS DAP, calling for the provision of project management units for all districts to manage the implementation of district health plans. Similar to IFPS DAPs, the involvement of the panchayati raj institutions and strengthening of health subcenters and community health centers are critical steps in the NRHM. Another key similarity between NRHM and IFPS DAPs is the promotion of public-private partnerships to achieve health goals.

The NRHM plan indicates that district-level action plans should be developed by the District Health Mission (DHM), which has a similar structure to the DIFPSA. The DHM is composed of the district health department, NGOs, private professionals and other relevant departments. States are expected to procure technical assistance for districts to support the development of DAPs. A unique difference is that IFPS DAPs solely focused on RCH issues, whereas NRHM plans also include other health issues, sanitation, nutrition and safe drinking water. Some districts in Uttar Pradesh and Uttaranchal will need to rework their DAPs for RCH to include the other components under NRHM.

## SUSTAINABILITY OF DAPS

Sustainability is an important goal of development programs. While initial efforts are often centered on providing resources, guidance, and support to people who require help, in time project planners hope to empower people to implement the project without outside assistance. Similarly, one of the ultimate goals of the POLICY Project is to develop the framework and infrastructure within DAP districts to enable districts to carry out the process on their own.

Initially, SIFPSA required significant technical assistance from the POLICY Project on collecting baseline survey data, conducting DAP workshops, drafting DAP documents, and determining key indicator goals. In 2002, the POLICY Project transferred many of these functions to SIFPSA and trained the team on analysis of survey data and

### SIFPSA ADVICE ON IMPLEMENTING NRHM DAPS

As the only state organization with experience in creating and implementing district-level health action plans, SIFPSA has a unique opportunity to share its best practices with other states embarking on NRHM DAPs. When asked to provide advice for states creating DAPs for the first time, SIFPSA managers provided seven suggestions:

- Clearly define the scope of work in each DAP intervention
- Respect local-level decisions and priorities
- Ensure there is a proper balance of centralized and localized management
- Implement DAPs using a business, corporate-sector mindset
- Involve and build trust of local stakeholders and private sector partners to ensure effective decentralization
- Ensure that the PMU has money, power, and resources to implement DAP activities
- Establish effective monitoring and evaluation of all activities

creation of benchmark goals and DAP documents. This contributed to further sustainability of DAPs, as SIFPSA is completely empowered to administer the entire process with minimal assistance from the POLICY Project.

The next question that arises regarding DAP sustainability is how empowered the districts themselves are to manage the process. In nearly all interviews conducted, respondents indicated that SIFPSA plays a crucial role in DAP management and that without its role and support, DAPs could not exist. They stated that there needs to be a government-linked society that oversees, manages, and monitors the DAP process to ensure success. Three factors that have been especially important in

promoting the sustainability of DAPs are: (1) increased capacity building of district- and sub-district-level government functionaries through exchange of information on best practices and specialized training; (2) a strengthened monitoring system, with reporting and monitoring systems, embedded into the project; and (3) closer relationships between the PMU, the CMO office and local NGOs.

When asked about the sustainability of DAPs, interviewees noted that districts continue to need a lot of support and coordination from SIFPSA. Long-term sustainability of DAPs is a possibility, but it requires a lot of support from a government society. According to the POLICY Project, the following actions will

help ensure DAP sustainability:

- **National and state government support of DAPs** is essential. It must be ensured that government has budgeted money towards DAPs and releases money for the plans in a timely manner.
- **Zila Parishads** (local district administration) should have DAP ownership.
- **Capacity building training** is required for district-level officials to empower them to implement DAPs.
- **Micro-level planning** at the block and village level needs to be encouraged so that decentralized planning is embodied throughout the entire system.

# CONCLUSIONS

The DAP intervention is based on four main doctrines:

- **Decentralization:** Operational functions are handled at the local district level, which provides flexibility and allows decision-making to respond to local needs and conditions. This is evidenced through the DAP formulation workshop, PMU, and DIFPSA.
- **Integration:** DAPs identify and use all resources available in the district in both public and private sectors to achieve plan objectives. CBD projects with local NGOs, training of pradhans and religious leaders, and partnerships with the corporate sector are examples of this integration.

- **Increased accessibility to quality services:** Strengthening service delivery points and improving the technical competency of health providers have been basic interventions for DAPs. Examples of these interventions are the RCH camps, medical skill training, and the Quality Improvement Circle intervention.
- **Sustainability:** Creating self-sufficient and long-lasting systems is one of the core objectives of the DAP intervention. By fostering capacity building of local government functionaries, sound reporting and monitoring systems, and strategic relationships with

local stakeholders, DAPs have promoted sustainability at the local level.

District action plans are an effective decentralized health planning intervention that has fundamentally altered the state and national governments' approaches to reproductive health planning. This intervention now serves as the skeleton for the current public health care planning system of India and can serve as a model for other countries seeking to revolutionize and empower local stakeholders to address reproductive and maternal health problems.

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