



Community workers in Uttar Pradesh learn about the benefits of HTSP and MNCH during a training session.

The Extending Service Delivery (ESD) Project, funded by USAID's Bureau for Global Health, is designed to address an unmet need for family planning (FP) and to increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, to improve health and socioeconomic development. To accomplish its mission, ESD has strengthened global learning and application of best practices; increased access to community-level RH/FP services; and improved capacity for supporting and sustaining RH/FP services. ESD has worked closely with USAID missions to devise tailored strategies that meet the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

Increasing Health Service Visits and Family Planning Use Among Young Women in Rural India

Scaling-Up Best Practices in India

This paper shows how the Extending Service Delivery (ESD) Project used a best practices approach to increase health service visits among pregnant women in India and enhanced community awareness of family planning methods through public and private partnerships.

PROBLEM ADDRESSED

In rural India, antenatal checkups (ANC), postpartum visits, and contraceptive use remain among the least utilized family planning services. The World Health Organization (WHO) recommends at least four ANC visits per pregnancy, but fewer than 23 percent of Indian women reported having three visits before their last delivery.^{1,2} In remote regions of India, where health services are more difficult to access, only 29 percent of women receive any postpartum checkups within two days of giving birth. This problem is especially severe in Uttar Pradesh, the most populous state in India with 166 million residents³, where only 13 percent of women receive postpartum checkups.⁴

The low rate of contraceptive use in Uttar Pradesh – IUD use is 0.8 percent, pill use is 1.3 percent, condom use is 6.2 percent – exacerbates these existing health issues by leading to closely spaced pregnancies, which is associated with higher maternal morbidity and child mor-



tality.⁵ Knowledge of child spacing remains low in India; technical experts to WHO recommend an interpregnancy interval of at least twenty-four months⁶ between a live birth and the next pregnancy (the equivalent of approximately a three year birth-to-birth interval) to reduce the risk of adverse maternal, perinatal, and infant outcomes, but 30 percent of births in Uttar

¹ World Health Organization. (n.d.). Health Services Coverage Statistics: Antenatal care coverage (percentage). Retrieved January 12, 2011 from <http://www.who.int/healthinfo/statistics/indantenatal/en/index.html>.
² International Institute for Population Sciences (IIPS) and Macro International. (2008). National Family Health Survey (NFHS-3), India, 2005-06:Uttar Pradesh.
³ Census of India. (2001). Retrieved January 12, 2011, from http://www.censusindia.gov.in/Census_Data_2001/India_at_Glance/popu1.aspx
⁴ IIPS and Macro International. (2008).
⁵ DaVanzo, Julie and Mizanur Rahman. *Reproductive Patterns and their Association with Maternal, Newborn, and Child Health in Matlab, Bangladesh: New Findings from a Recent ESD Project*, Presentation at Healthy Timing and Spacing of Pregnancy Community of Practice Meeting, USAID, Washington, DC, May 3, 2011.
⁶ World Health Organization Department of Reproductive Health and Research and Department of Making Pregnancy Safer. (2007). Report of a WHO technical consultation on birth spacing: Geneva, Switzerland 13-15 June 2005. Geneva: World Health Organization.

Pradesh take place inside that timeframe.⁷

BEST PRACTICES TO IMPROVE CARE

Under a grant from the Extending Service Delivery (ESD) Project, the Population Council implemented an intervention in conjunction with public and private partners from the Department of Health & Family Welfare, Government of Uttar Pradesh; the Integrated Child Development Scheme (ICDS) program, Department of Women & Child Development, Government of Uttar Pradesh; and Lala Lajpat Rai Memorial Medical College, Meerut. The program revolved around expansion of quality antenatal and postpartum care, including introduction of messages related to healthy timing and spacing of pregnancy (HTSP), while building on a successful experience of implementing postpartum family planning services. Approaches included:

- Incorporation of family planning counseling into ANC and postpartum checkups
- Expansion of family planning/maternal, newborn, child health (MNCH) education beyond pregnant women to include husbands, mothers-in-law, and community leaders
- Coordination between two key government entities to ensure future institutionalization
- Promoting public (community workers) and private (academic institutions) partnerships to improve coverage along the continuum of care
- Creation of a community worker supervision structure to improve service delivery quality

STARTING THE SCALE-UP

ESD's collaboration with the Population Council began with a 2007 USAID-funded knowledge exchange meeting in Bangkok, Thailand, where the Council representatives, along with government officials and other stakeholders from India, learned best practices in reproductive health and created country action plans. In June 2009, ESD awarded the Population Council a small grant to implement an intervention in Uttar Pradesh, India.

This intervention was based on experiences gained from the USAID-funded FRONTIERS project, which had

focused on HTSP by promoting LAM and postpartum contraception (see sidebar for more information on ESD's work in HTSP). The FRONTIERS project developed a set of culturally acceptable strategies to promote behavior change and significantly increased the odds of contraceptive use postpartum. At nine months postpartum, 63 percent from the experimental group used contraceptives, compared to 32 percent from the control group.⁸ It also increased the range of family planning methods women were comfortable using. However, a follow-up survey indicated no significant differences between the experimental and control groups in key ANC indicators, including the number of ANC visits and whether counseling was provided during those visits. The Population Council decided to strengthen these ANC program weaknesses during its ESD-funded intervention.

The Council began its intervention in 52 villages in the Meerut District of Uttar Pradesh. By training community workers in HTSP and MNCH education, the

Scaling Up Best Practices in the AME Region

An important mandate for the Extending Service Delivery (ESD) Project is to scale up family planning and Healthy Timing and Spacing of Pregnancy (HTSP) best practices in the Asia and Middle East region. ESD uses a multipronged approach consisting of knowledge exchange, small grants, and technical assistance. This approach involves introducing high-level country teams to state-of-the-art best practices, jointly developing action plans, and sharing tools and methodologies. (See *Scaling-Up Best Practices to Meet Millennium Development Goals 4 & 5: a Tailored Approach to Spreading Best Practices* for more information on the ESD approach.)

Population Council aimed to increase ANC, postpartum checkups, and contraceptive use to reduce maternal and infant mortality. As a long-term goal, it also hoped to institutionalize these processes in the project area.

⁷ IIPS and Macro International. (2008).

⁸ Khan, M.E., M.P. Sebastian, R. Idnani, and K. Kaushal. (2008). "Promoting Postpartum Contraception among Young Low Parity Women: Some Salient Findings." Research Update No. 14. New Delhi: Population Council/FRONTIERS.

FROM ACTION TO ACCELERATION

The main operational aspects of the intervention included training community health workers, training private practitioners, promoting an education campaign, and establishing a supervision system.

Training community health workers: Three sets of community workers were trained to launch an education campaign in the Meerut project area: Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activists (ASHAs) from the Ministry of Health & Family Welfare, and Anganwadi workers from the Integrated Child Development Services of the Department of Women & Child Development. Community workers were oriented in antenatal and postnatal care, LAM, and postpartum contraception, as well as counseling skills to manage the reproductive health needs of young couples. Job aids on HTSP, contraceptive methods and their efficacy, and checklists were provided to assist their counseling efforts. Supervisors held monthly meetings with community workers to refresh their knowledge and address any field issues.

Training of Private Practitioners: Lala Lajpat Rai Memorial Medical College trained qualified private doctors in the project area in DMPA provision, IUD insertion and removal, and other modern contraceptive methods. Community workers would often refer women to these doctors during their counseling sessions.

Advocacy and Education Campaign: Community workers used an education campaign to reach pregnant women as well as husbands, mothers-in-laws, and local opinion leaders. Previous approaches to family planning in India have often focused on sterilization, but this intervention emphasized family planning counseling with LAM and other modern methods. Community health workers visited women several times before birth. Early visits primarily emphasized the mother's and baby's health. During later antenatal visits, community workers discussed LAM, post-delivery contraceptive options, and birth spacing to ensure healthy outcomes for both mothers and children.

The three sets of community workers also collaborated to provide comprehensive education messages in the project area. In addition to conducting community meetings, they distributed leaflets, posters, wall paintings, and booklets covering topics such as HTSP, post-



In rural regions of India, health services are often difficult to access. Consequently women are less likely to visit providers for ANC and postpartum checkups.

partum contraception, LAM, emergency contraception, safe motherhood, and child care.

Supervision System: The Population Council and Meerut College established a system for supervisors to monitor and support community workers. A monitoring team drawn from the Department of Health & Family Welfare and Department of Women & Child Development followed up with mothers to verify the content of the community workers' home visits; in addition, they performed spot checks to ensure the quality of counseling. Monthly meetings between supervisors and community workers added another dimension to the supervision structure.

These core program elements were originally rolled out in four blocks in Meerut District, Uttar Pradesh in September 2009. An additional round of funding in the fall of 2010 allowed the intervention to expand to an eleven-block area. (Due to the project timeline, baseline/endline data was only collected from the four-block initial phase).

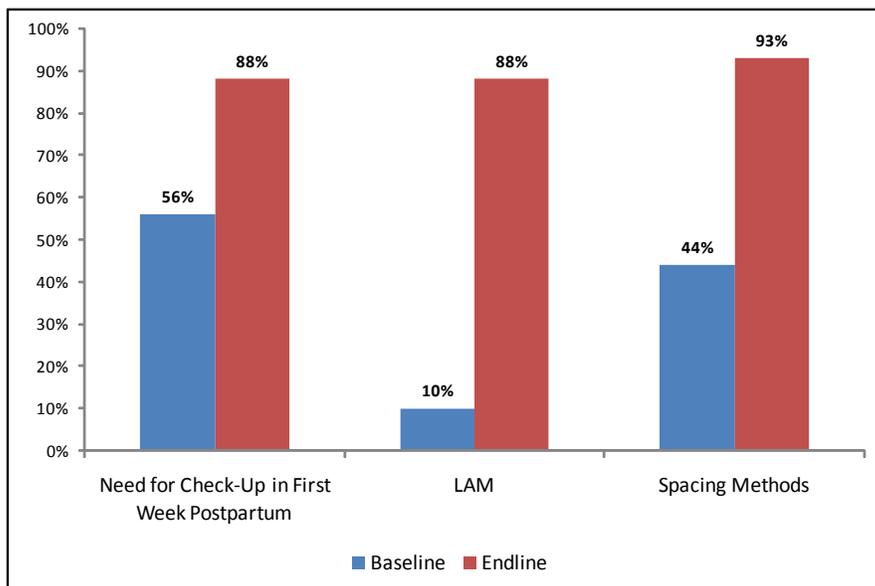
OUTCOME AND RESULTS

Since the start of the intervention, ESD has observed the following:

Successful training of community workers and private practitioners: The Population Council has trained 484 ASHAs, ANMs, and Anganwadi workers from the government ministries since the project's inception. Meerut College has educated 37 private practitioners on various family planning methods. Together, these public and private workers have advocated for improvements to family planning practices in Uttar Pradesh.

Widespread reach of the project: Community workers initially visited 52 rural villages in a four-block area in the Meerut District. With the expansion to an eleven-block area, community workers have reached 7,000-9,000 women in Uttar Pradesh with family planning, HTSP, and safe motherhood information.

Figure 1. Counseling topics covered by community workers, as reported by registered women.



Increase in family planning knowledge: Baseline (820 registered women) and endline (807 registered women) survey data indicated the community workers had successfully enhanced community awareness in several areas, particularly postpartum care, LAM, and contraceptives for birth spacing.

Awareness of the importance of postpartum visits increased by 32 percent during the course of the project, indicating the community workers' renewed emphasis on MNCH. While only 10 percent of community workers mentioned LAM prior to the intervention, nearly 90

percent discussed it with women by the project's end. Furthermore, communication of birth spacing methods more than doubled as a result of the intervention, increasing from 44 percent at baseline to 93 percent at endline.

Greater use of family planning methods: At baseline, only 2 percent of women could describe the three conditions of LAM. At endline, however, 78 percent of women interviewed could state all three LAM conditions. Nearly a third of women (29.5 percent) reported using LAM to prevent pregnancy at some point postpartum. At the time of the endline survey, 13 percent of women were still using LAM and 54 percent were using some form of modern contraception. Compared to the historically low use of contraceptives in Uttar Pradesh – only 42.4 percent use some form of modern contraception⁹ – these results highlight the intervention's positive effects in the area.

Surge in ANC visits: The community workers helped to significantly increase ANC during the project's timeframe. At baseline, 43 percent of pregnant women had three or more ANC visits. At endline, 85 percent of pregnant women had three or more ANC visits – double the baseline data and nearly four times India's national average.

CHALLENGES

The Population Council faced difficulties setting training dates for community workers, given their other responsibilities in polio and immunization campaigns. Fortunately, the master trainers and project staff were able to produce a schedule that allowed the necessary sessions to take place. A second challenge was reviewing and supporting the ASHAs' work due to a lack of monthly meetings. To remedy the situation, project-specific monthly sessions were added to the ASHAs work schedule.

Turnover of state officials also presented a challenge, as this led to several postponed meetings. The Population Council provided status updates and rescheduled meetings for new officials as needed.

A fourth challenge was identifying private doctors for the intervention. After the Population Council discovered several practitioners did not meet required

⁹ India Demographic and Health Survey 2006-7

standards, it had to verify all doctors associated with the project had adequate IUD and DMPA training; this process delayed the overall training of private providers.

A fifth challenge was the existing patriarchy in rural India, as the ultimate decision on contraceptive method use and choice still often remains with husbands. As one woman explained, “I was interested in adopting an IUD, but the doctor discussed the injection with my husband and he agreed. They did not ask me or discuss with me about my likes.” Such stories stress the need for private practitioners to discuss health care choices with women and allowing them to make informed decisions on contraceptive methods.

Lastly, project sustainability has been a challenge. Continued advocacy efforts and dissemination of results to key officials are needed to ensure the longevity of the project’s new activities.

LESSONS LEARNED

- Targeted interventions in family planning counseling can increase knowledge and postpartum contraception use to space births and improve maternal and infant health outcomes.
- Bolstering monitoring systems using checklists, spot checks, and monthly meetings can improve the consistency and quality of home counseling visits.
- Coordinating community workers from different ministries to achieve a shared objective is both feasible and effective. Partnering with government departments to develop, scale up, and sustain health interventions is critical for the success of the program.
- Using the academic private sector to train and supervise providers appears to improve quality of care.



ESD provides technical assistance and on-site workshop training to community workers at a local health clinic.



ESD IS MANAGED AND DIRECTED BY:



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PARTNERS INCLUDE:



This paper was written by:
Salwa Bitar
MNCH/RH Regional Advisor for Asia and the Middle East, ESD

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THE EXTENDING SERVICE DELIVERY PROJECT

1201 Connecticut Ave., N.W., Suite 700
Washington, DC 20036
Phone: 202-775-1977
Fax: 202-775-1988
www.esdproj.org

PATHFINDER INTERNATIONAL

(Contact for this project after September 2010)
9 Galen Street, Suite 217
Watertown, MA 02472, USA
Phone: 617-924-7200
www.pathfind.org

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