IDEAS, INSIGHTS, AND INNOVATIONS:
Achievements and Lessons Learned from the Innovations in Family Planning Services (IFPS) Project, 1992–2004

A SUMMARY

DECEMBER 2006
This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by Constella Futures.
Front Cover Photo: A group of women trained as community-based distribution workers meets in western Uttar Pradesh. These workers played an integral role in distributing family planning commodities and information in rural areas under IFPS-funded NGO projects. Photo by Anita Bhuyan.

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ISBN#: 1-59560-009-4

The POLICY Project is funded by the United States Agency for International Development (USAID) under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. It is implemented by Constella Futures in collaboration with the Centre for Development and Population Activities (CEDPA) and Research Triangle Institute.

The IFPS-II Technical Assistance Project (ITAP) is a three-year project funded by USAID under Contract No. GPO-1-01-04-00015-00 beginning April 1, 2005. The project is implemented by Constella Futures in partnership with Bearing Point, Sibley International, Johns Hopkins University, QED, Urban Institute, and the Association of Reproductive Health Professionals.

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The authors’ views presented in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
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Achieving worldwide reproductive health goals depends largely upon achieving progress in India as it accounts for one-sixth of the world’s population. Within India, there are important differences between northern and southern states. The northern states, with more than 40 percent of India’s population, are growing at a higher rate and have poorer reproductive health conditions than the rest of the country. Therefore, improvement in the reproductive health status of the northern states is crucial in helping to meet India’s reproductive and child health (RCH) goals.

Toward this aim, in 1992, the United States Agency for International Development (USAID) and the Government of India, in cooperation with the Government of Uttar Pradesh, initiated the Innovations in Family Planning Services (IFPS) Project. The project sought to directly address reproductive health and fertility in Uttar Pradesh—a state that is home to over 170 million people and that would be the sixth largest country in the world were it an independent nation.

An autonomous, registered society—the State Innovations in Family Planning Services Project Agency or SIFPSA—was established to manage the project with the aim of testing innovative approaches and integrating resources from both the public and private sectors. Under IFPS, SIFPSA and district-level partners implemented various interventions to improve access to and quality of family planning and RCH services in priority districts in Uttar Pradesh. Additional strategies were also carried out statewide. Factors that led to the success of IFPS interventions included decentralization, participation of local government officials and groups, public-private partnerships, and an emphasis on accountability and performing to standard.

Lessons learned from these efforts have been vital not only in the creation of the USAID-funded IFPS-II Project (2004–2008)—which works in Uttar Pradesh, Uttarakhand, and Jharkhand—but also in planning for the RCH-II Program of the Government of India’s National Rural Health Mission. The central government followed a highly consultative process to develop the five-year, $8.7 billion RCH-II program (2004–2008) and several interventions first applied in Uttar Pradesh by the IFPS Project are to be rolled out nationwide under the new initiative.

Building on the successes of the IFPS Project and with continuing national-level support to the RCH-II Program, regional assistance through the IFPS-II Project, and state-level assistance in the development of Uttar Pradesh’s Program Implementation Plan for RCH-II, USAID has remained a strong and committed partner as India strives to improve reproductive and child health across the country.

Robert Clay  
Director  
Population, Health and Nutrition  
USAID/India
The State Innovations in Family Planning Services Project Agency (SIFPSA) was constituted on May 22, 1993, to implement a ten year USAID funded project with the aim of reducing fertility and improving maternal health in Uttar Pradesh. The IFPS Project followed the unique approach of a performance based disbursement system that focused on results rather than on inputs. Over a period of ten years, SIFPSA implemented a variety of innovative projects with technical assistance from several USAID funded cooperating agencies.

Key interventions included: strengthening public-private sector reproductive and child health services; engaging private, cooperative, organized and NGO entities for implementing family planning and reproductive health interventions; and implementing behaviour change communication and social marketing strategies. Decentralized district action plans and population policy development are other milestones achieved. While some of these interventions were implemented throughout the state, others were implemented in 33 of the districts covering half of the population of Uttar Pradesh. The efforts made were unprecedented in the history of reproductive health and family planning programmes in Uttar Pradesh. The IFPS Project benefited several million people in the state.

This volume is a summary of the history of the project, major innovative interventions and lessons learned. We are thankful to the staff of Constella Futures for their efforts in collecting all the information and for preparing this report. The experiences documented in this volume will be of immense help to all those who are working in the health sector, and to those who are looking for innovative ways of approaching problems and implementing interventions.

Shailesh Krishna
Executive Director
SIFPSA, Lucknow
This document summarizes the highlights of a detailed monograph on the IFPS Project prepared by a team of writers, including Anita Bhuyan, Cynthia Green, Ruchira Gujral, Nancy McGirr, Sudhir Mehra, Gadde Narayana, Ajay Pandey, Sona Sharma, Shuvi Sharma, and Seema Talwar. The authors would like to acknowledge the many individuals from SIFPSA and its district counterparts, the USAID-funded cooperating agencies, the Lucknow-based staff of ITAP, and local implementing partners of the IFPS Project who contributed their time and insights during the development of this document. Finally, the authors would also like to acknowledge the technical oversight and review provided by USAID/India, in particular Randy Kolstad, Sheena Chhabra, Loveleen Johri, and Jyoti Shankar Tewari.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>CBD</td>
<td>Community-based Distribution</td>
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<tr>
<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>DAP</td>
<td>District Action Plan</td>
</tr>
<tr>
<td>DIFPSA</td>
<td>District Innovations in Family Planning Services Project Agency</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IFA</td>
<td>Iron and Folic Acid</td>
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<tr>
<td>IFPS</td>
<td>Innovations in Family Planning Services</td>
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<td>IIPS</td>
<td>International Institute for Population Sciences</td>
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<td>ISMP</td>
<td>Indigenous Systems of Medicine Practitioner</td>
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<td>ITAP</td>
<td>IFPS-II Technical Assistance Project</td>
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<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<td>NFHS</td>
<td>National Family Health Survey</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<td>NSV</td>
<td>No-scalpel Vasectomy</td>
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<td>PERFORM</td>
<td>Project Evaluation Review for Organizational Resource Management</td>
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<tr>
<td>PHC</td>
<td>Primary Health Center</td>
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<td>PMU</td>
<td>Project Management Unit</td>
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<td>PRI</td>
<td>Panchayati Raj Institution</td>
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<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RHIS</td>
<td>Reproductive Health Indicator Survey</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>SIFPSA</td>
<td>State Innovations in Family Planning Services Project Agency</td>
</tr>
<tr>
<td>SO</td>
<td>Strategic Objective</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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Given its demographic size, poor reproductive health indicators, and influence on national socioeconomic development, improving health conditions in Uttar Pradesh has been a leading component of the technical and financial assistance efforts of the United States Agency for International Development (USAID) in India. Home to one-sixth of the nation as a whole (see Box 1), improvements in the health and social conditions in Uttar Pradesh can have a significant impact on the country’s population, any improvements in the health and fertility. According to the 1992/93 National Family Health Survey (NFHS-1), Uttar Pradesh had a total fertility rate (TFR) of 4.82—the highest in India—and an unmet need for family planning of 30 percent among currently married women of reproductive age. From 1981 to 1991, the state’s population grew by 25 percent to 139 million, primarily due to high fertility. From 1981 to 1991, the state’s population grew by 25 percent to 139 million, primarily due to high fertility. According to the 1992/93 National Family Health Survey (NFHS-1), Uttar Pradesh had a total fertility rate (TFR) of 4.82—the highest in India—and an unmet need for family planning of 30 percent among currently married women of reproductive age. In response, USAID/India initiated efforts to address fertility and reproductive health needs in northern India, as part of the Mission strategy under Strategic Objective (SO) 2, which focused attention on Uttar Pradesh. Launched in 1992, the Innovations in Family Planning Services (IFPS) Project was an ambitious 12-year initiative to expand and improve reproductive health (RH) services in priority districts across the state. Conducted from 1992 to 2004, IFPS was designed to revitalize the existing family planning program by testing new approaches and replicating effective strategies quickly. USAID contributed USD 325 million to the project, with additional support provided by the Government of India. The second phase of the IFPS Project (2004-2008) continues to develop innovative strategies for improving reproductive and child health (RCH) services in Uttar Pradesh.

**Background**

With a population of 1.77 million, only five countries in the world (including India) have larger than the state of Uttar Pradesh. About 80 percent of the state’s population lives in rural areas and about one-third (31%) lives below the poverty line. Gender disparities are evident in the state. In 2001, the sex ratio for Uttar Pradesh was 988 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. These challenges confront any program seeking to reach underserved populations, including women and rural populations, with improved RCH information and services.

**Box 1: Uttar Pradesh: A Country within a Country**

Source: United Nations Development Program (n.d.)
Pradesh, Uttarakhand, and Jharkhand and at the national level.

This document presents highlights from a detailed monograph on the various aspects of the first phase of the IFPS Project. For more information and lessons learned from specific interventions, please see *Ideas, Insights, and Innovations: Achievements and Lessons Learned from the Innovations in Family Planning Services (IFPS) Project, 1992–2004* (Constella Futures, 2006).
OBJECTIVES

Based on the principles for effective family planning programs that came to the forefront in the mid-1990s, the IFPS Project sought to reduce fertility rates in Uttar Pradesh by expanding contraceptive choices, improving family planning service quality, and reaching out to underserved areas and groups. In 1998, USAID added reproductive health components to the project—including antenatal care, delivery by trained providers, and tetanus toxoid (TT) immunization and iron and folic acid (IFA) tablets for pregnant women. In that year, the project began placing even greater emphasis on quality of care. (See Box 2.) The project’s reproductive health mandate was also broadened to include HIV prevention and control. IFPS focused on 33 districts in Uttar Pradesh—but some interventions were carried out in selected districts, others reached out to non-IFPS districts, and still others were conducted statewide.

PROJECT MANAGEMENT AND APPROACH

The IFPS Project design had three special features: (1) the creation of an autonomous agency to guide all project activities; (2) a focus on results and accountability through a performance-based disbursement system; and (3) an emphasis on capacity building through technical assistance by USAID-funded cooperating agencies.

The State Innovations in Family Planning Services Project Agency

The desire to bring together the best elements of both the

IFPS Goals and Objectives

- Increase access to family planning services by strengthening the public sector, building capacity of the nongovernmental sector, and promoting social marketing
- Improve quality of services through an expanded range of contraceptive options, enhanced technical competence of healthcare providers, and strengthened management and logistics systems
- Broaden support for family planning efforts among leadership groups and the general public, including increased participation of women in implementation of the project at all levels
- Reduce TFR from 5.4 to 4.0 in project areas by 2004
- Increase the contraceptive prevalence rate in project areas to 32 percent by 2004
- Reach at least 70 percent of pregnant women in project areas with two doses of TT vaccination and 40 percent of pregnant women in project areas with IFA supplements
- Have 36 percent of deliveries in project areas attended by trained providers

Sources: USAID/India, 1992; USAID/India 2002.
public and private sectors was a driving factor in the establishment of the management structures that governed IFPS planning and implementation. It was decided that an intermediary agency should be responsible for project implementation and, on May 22, 1993, SIFPSA—the State Innovations for Family Planning Services Project Agency—was registered as an autonomous society. A senior Indian Administrative Service officer on deputation from the Government of Uttar Pradesh serves as executive director of SIFPSA. There is also a Governing Body, Executive Committee, Project Appraisal Committee, and Technical Advisory Group. It was envisioned that an autonomous society could avoid the delays inherent in working within a governmental, bureaucratic system and minimize difficulties in disbursing funds to private-sector implementing partners. Additionally, SIFPSA had the flexibility to recruit experts from the nongovernmental sector as well as government officers on deputation.

To further decentralize planning and implementation, District Innovations in Family Planning Services Project Agencies (DIFPSAs) and Project Management Units (PMUs) were established in 33 project districts. The District Magistrate serves as the chairperson of the DIFPSA. Other DIFPSA members include the Chief Medical Officer (CMO) and Deputy CMOs, NGO and business representatives, and other prominent citizens. DIFPSAs met monthly to review progress and propose solutions for any challenges that arise during project implementation. The PMU functioned as a problem solving group and was charged with promoting an integrated approach, which means identifying and making use of all resources available in the public and private sectors.

A Results Orientation

The IFPS Project not only tested new technical approaches to FP/RH issues, its design afforded the opportunity to explore mechanisms to roll out new concepts in managing development assistance programs. From the beginning, IFPS was designed with an orientation toward achieving results and accountability. A unique feature of the project was that USAID funds were disbursed according to a performance-based disbursement framework. USAID and SIFPSA outlined mutually agreed upon project results, known as benchmarks, linked to specific payment amounts. Rather than paying for all implementation costs upfront, USAID released funds to the Government of India, which then passed the funds to SIFPSA, only when the entire benchmark was achieved and verified. This
shift helped ensure that program implementers focused not only on the inputs (e.g., how many trainings were held), but also on the impact (e.g., how many trained providers perform to standard).

**Capacity Building through Technical Assistance**
To provide technical assistance for the IFPS Project, USAID funded nine U.S.-based cooperating agencies. These agencies—nonprofit organizations, contractors, and universities—and their roles under IFPS are listed in Table 1. The cooperating agencies made important technical inputs in many aspects of the project, especially in setting up training systems and monitoring mechanisms, strengthening clinical care and logistics systems, guiding policy formulation, and building capacity of local implementing partners. USAID allocated USD100 million for technical assistance over the life of the project. This investment supported cooperating agency efforts in India carried out primarily by Indian nationals—which took advantage of existing local knowledge and expertise and further built in-country capacity as a result of the technical assistance provided.

**COVERAGE AREAS**
Initially, IFPS was implemented in 28 districts of Uttar Pradesh. In 1995, a survey called the Project Evaluation Review for Organizational Resource Management (PERFORM) was conducted in these districts to provide baseline data for evaluating project performance. The project began work in six of the PERFORM districts, then expanded to 15 focus districts, and finally covered all 28 PERFORM districts. In 2000, northern districts of Uttar Pradesh, including four IFPS districts, were partitioned off and became the state of Uttarakhand. When this happened, IFPS activities ceased in Uttarakhand and continued to focus on the 24 districts remaining in Uttar Pradesh.

Over time, the state governments have bifurcated districts so that the 24 IFPS districts in Uttar Pradesh became 33 districts—though the population covered remained the same—and the four former IFPS districts in Uttarakhand became six districts. Overall, then, IFPS activities have been conducted, to some extent, in 39 districts.

*TABLE 1. USAID-FUNDED COOPERATING AGENCIES*

<table>
<thead>
<tr>
<th>Agency</th>
<th>Role in the IFPS Project</th>
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<tbody>
<tr>
<td>Centre for Development and Population Activities (CEDPA)</td>
<td>Project management, private-sector programs, and adolescent and family life education initiatives</td>
</tr>
<tr>
<td>EngenderHealth</td>
<td>Assessment of clinical sites, training of health providers in family planning clinical skills and counseling, and quality improvement in public-sector facilities</td>
</tr>
<tr>
<td>Futures Group</td>
<td>Development of district actions plans, facilitation of the Uttar Pradesh state population policy, tracking IFPS performance including benchmark indicator surveys, and social and commercial marketing of contraceptives</td>
</tr>
<tr>
<td>IntraHealth International, University of North Carolina</td>
<td>Training programs for providers, including auxiliary nurse midwives, traditional birth attendants, and indigenous systems of medicine practitioners</td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>Training of healthcare providers in contraceptive technology updates</td>
</tr>
<tr>
<td>Johns Hopkins University/Population Communications Services</td>
<td>Strategic planning, training and technical assistance in behavior change communication, and campaign design and implementation</td>
</tr>
<tr>
<td>John Snow Inc./DELIVER Project</td>
<td>Strengthening of logistics management system</td>
</tr>
<tr>
<td>ORC Macro</td>
<td>Completion of benchmark surveys and technical assistance for the NFHS</td>
</tr>
<tr>
<td>Population Council</td>
<td>Operations research</td>
</tr>
</tbody>
</table>
Since 2000, the focus of program efforts centered on the now 33 districts in Uttar Pradesh and, in general, this is the coverage area referred to when discussing IFPS project areas or districts (see Figure 1). The 33 IFPS districts in Uttar Pradesh have about 95 percent of the population of the original 28 target districts. Nearly 64 million people live in the areas in which IFPS has district-level activities in Uttar Pradesh. Interventions, such as the tetanus immunization campaign, have covered all of the state’s population of 170 million people, while still other interventions have covered both IFPS and selected non-IFPS districts in Uttar Pradesh.

Of the 33 IFPS Project districts in Uttar Pradesh, 21 have been designated as “priority” districts. A list of the 33 priority districts and their population sizes is provided in Appendix A.
The major strategies implemented during the IFPS Project included:

- Strengthening public-sector RCH services through upgrading of facilities (e.g., operation theaters, generators, water supply), training of healthcare providers, and support for integrated RCH camps at public-sector facilities;
- Engaging nongovernmental/private-sector entities to make RCH information and services more widely available in rural areas and urban slums;
- Broadening access to contraceptive commodities and RCH information through social marketing and behavior change communication campaigns; and
- Improving the policy foundation and encouraging leadership support for RCH services.

These strategies and related program interventions are discussed below. The corresponding chapter for each intervention found in the complete IFPS monograph (Constella Futures, 2006) is noted in parentheses.

**STRENGTHENING THE PUBLIC SECTOR**

**Upgrading Public Health Facilities**

To improve public-sector capacity to provide family planning services, the IFPS Project assessed postpartum centers, block primary health centers (PHCs), community health centers (CHCs), and subcenters. Based on assessment findings, IFPS provided the necessary funds to upgrade sites. In all, 613 postpartum centers, PHCs, and CHCs were upgraded in both IFPS and non-IFPS districts in Uttar Pradesh and Uttarakhand. These funds covered building repair and renovation; water and electricity supply (including generator set); an operation theater; rooms for family planning counseling and insertion/removal of intrauterine contraceptive devices (IUCDs); and FP/RH-related equipment and supplies. In addition, about 9,000 subcenters were strengthened. (See Chapter 2.)

**Training Medical Officers**

The IFPS Project made a concerted effort to ensure that public-sector providers have adequate clinical and counseling skills to provide family planning and RCH services. In 2001, the project provided contraceptive technology update training to virtually all public-sector medical officers throughout Uttar Pradesh. In the IFPS districts, more than 27,000 healthcare workers were trained during 1995–2005 in at least one of the following topics: contraceptive technology....
update, counseling skills, sterilization and IUCD techniques, infection prevention, and management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs). Of the 2,199 providers trained in clinical techniques, 51 percent were trained in female sterilization procedures (abdominal tubectomy, laparoscopy, and minilaparotomy), 43 percent in IUCD insertion and removal, and 6 percent in no-scalpel vasectomy (NSV) (EngenderHealth, 2005). A unique aspect of IFPS training is that trained medical officers are assessed on the job to determine if they are performing procedures to medical standards. Those who were performing to standard were certified to perform the procedure, whereas those not performing to standard were re-trained and assessed at an additional follow-up. As of July 2005, 87 percent of the 1,532 providers trained in clinical techniques that were assessed were found to be performing to standard. As a result of the training, every IFPS district has at least one provider trained in female sterilization and NSV. (See Chapter 3.)

Building Capacity of Auxiliary Nurse Midwives
Public-sector auxiliary nurse midwives (ANMs) are the main source of clinical care for many villagers in India. IFPS supported training of nearly all ANMs as well as their supervisors (known as lady health visitors) in project districts. A total of 10,854 ANMs and their supervisors received training in IUCD insertion and other clinical and counseling skills related to FP/RH services. Additionally, across project districts, IFPS upgraded 8,934 ANM subcenters, which is where the ANMs work and reside. Upgrading involved providing equipment and supplies, as well as funding for renting extra space when required. A team of medical specialists made follow-up visits at one- and six-month intervals after training to assess the ANMs’ clinical and counseling skills and check the status of the subcenter. According to a follow-up assessment of 6,728 trained ANMs, 92 percent were performing to standard six months after their training (PRIME II, 2006). (See Chapters 2 and 4.)

Improving Quality of Public Health Facilities
In 2002, IFPS initiated a pilot Quality Improvement Circle initiative in selected district women’s hospitals, CHCs, and PHCs in two districts. The approach involved development of a standardized 100-point quality checklist; formation of “Quality Circle” teams at each site; flexible funds for renovation, repair, and equipment; and quarterly assessments of facilities. The Quality Circle teams included representative staff from all levels, from the medical officer in-charge to the sweepers, and gave them responsibility for various aspects of quality. The teams met monthly to discuss issues and devise site-specific solutions, which helped encourage teamwork and supportive supervision. Sites that received a score of 90 or above on all four quarterly assessments were given quality certificates and a Quality Gold Star Logo to display outside the facility. The top five scoring sites received additional funds for site improvements. Half of the 18 pilot sites were certified as meeting the quality standards.
though improvements were noted in both certified and non-certified sites. SIFPSA has plans to extend this quality improvement approach to 12 additional districts in Uttar Pradesh. (See Chapter 5.)

Ensuring Access to Integrated RCH Services at the Community Level
Due to staff shortages and lack of supplies, it has been difficult for the public sector to provide comprehensive RCH services on a regular basis beyond the district-level hospitals. To bring these services to rural communities, the IFPS Project organized “family health days”—or, as they are commonly known, “RCH camps”—in all project districts. RCH camps are conducted in fixed sites, such as the PHCs and CHCs, and differ from other camps in that an integrated set of RCH services—including sterilization, spacing methods, antenatal care, and RTI/STI treatment—is offered. If necessary, a medical team is mobilized from other facilities to ensure all staff are on-hand to provide the range of services. Camps attract large numbers of clients because they are guaranteed a range of clinical services under one roof on these days. IFPS supported more than 50,000 RCH camps from May 1998–March 2005, providing family planning counseling to more than 1.7 million clients, spacing contraceptive methods (oral pills and condoms) to more than 1.1 million clients, sterilization services to about 770,000 clients, immunizations to nearly 525,000 children, and about 475,000 antenatal check-ups. (See Chapter 6.)

Promoting Male Involvement and Expanding Family Planning Options
Permanent family planning methods in Uttar Pradesh have focused heavily on female sterilization. NSV—no-scalpel vasectomy—does not require a high degree of medical training, can be completed in 5–6 minutes, does not involve an incision, and requires minimal recovery time. Given this, the IFPS Project sought to reposition NSV as a simple, safe, and cost-effective family planning method that is less risky than female sterilization. The project trained 175 service providers as well as a group of 12 master trainers in NSV procedures and client follow-up. Providers had the opportunity to practice the procedure during RCH camps and specially organized mega-NSV camps. As of 2005, of the 83 trained providers who had been assessed, 92 percent (n=76) were found to be performing to standard, while 8 percent (n=7) were not performing to standard. In terms of raising awareness of the procedure, in some cases, District Magistrates and satisfied NSV clients served as opinion leaders who spoke out on the benefits of NSV. While the procedure remains underutilized, greater communication efforts to raise awareness of and dispel misconceptions about NSV could lead to increased uptake of the procedure. (See Chapter 7.)

BUILDING PARTNERSHIPS WITH THE PRIVATE SECTOR
A cornerstone of the IFPS Project’s technical approach was to involve private-sector partners—often an untapped resource—in the provision
of FP/RH services, commodities, and information. In this case, the “private sector” includes nongovernmental, nonprofit, and/or for-profit organizations as well as traditional practitioners.

**Expanding Access to FP/RH Services through Community-based Distribution and Private Facilities**

The 256 private-sector activities supported by IFPS covered a population of 24 million people in project districts. These interventions established an extensive network of community-based distribution (CBD) workers who traveled door-to-door to provide family planning counseling, contraceptive supplies, and referrals for clinical services. Project staff also organized community education programs and collaborated with public-sector healthcare providers to hold outreach camps offering clinical services at the community level.

- **NGOs.** The IFPS Project worked with more than 150 NGOs working at the community level in civic affairs, health, education, income generation, nutrition, and sanitation, and assisted them in implementing RCH projects. NGOs have provided counseling, contraceptive supplies, and referrals to 1.6 million family planning clients and have assisted 1.8 million women to obtain antenatal care and 3.1 million children and pregnant women to obtain immunizations. (See Chapter 8.)

- **Dairy Cooperatives.** Dairy cooperatives, with their network of 5,672 village-level societies in project districts, brought RCH information and services to remote rural areas. Under IFPS-funded interventions, these cooperatives served nearly 887,000 family planning clients and provided nearly 250,000 referrals for clinical family planning methods between 1997 and 2005. (See Chapter 9.)

- **Organized Sector.** The IFPS Project collaborated with industry-based organizations on various activities, including provision of RCH services to factory workers and their families, partnerships with large employers and chambers of commerce, strengthening of RCH services provided by corporate trusts (employee welfare programs), and public education by organized workers such as postal workers. (See Chapter 10.)

IFS-funded private-sector projects are credited with increasing use of oral pills and condoms as well as increasing overall use of modern contraceptive methods. For example, modern contraceptive prevalence was 30.2 percent among married women in areas where NGOs had active CBD workers, compared with 20.2 percent in areas where no NGOs were operating (Reproductive Health Indicator Survey [RHIS], 2003).

**Building Capacity of Traditional Practitioners**

- **Traditional Birth Attendants.** Recognizing that most deliveries still take place at home, IFPS supported training of about 22,000 traditional birth attendants (also known as dais)—which means that approximately half of the villages...
in the project districts had at least one dai trained under IFPS. The training was designed to help dais prevent infection, recognize danger signs early and refer high-risk pregnancies to ANMs, and promote the need for antenatal and postnatal care along with ANMs. An assessment of 4,635 dais trained as of May 2001 found that 97.5 percent performed to standard based on three categories (knowledge, hand washing, and clean cord cutting) (POLICY, 2001). Survey data for the IFPS districts indicated that the proportion of births assisted by trained dais nearly doubled—from 9 percent in 1995 to 17 percent in 2003—with a commensurate decline in deliveries assisted by untrained dais, relatives, and friends. While this is a step in the right direction and dais report benefits of having been trained, even trained dais are not a substitute for the skilled healthcare providers and facilities needed to respond to complications that can arise during delivery, often with little warning. ¹ Therefore, reducing maternal mortality requires comprehensive programs to increase access to emergency obstetric care in rural areas. (See Chapter 11.)

- **Indigenous Systems of Medicine Practitioners (ISMPs).** Uttar Pradesh has more than 40,000 registered ISMPs (including unani, ayurvedic, and homeopathic practitioners). Many rural people seek their services because ISMPs are nearby, trusted by the local community, and less expensive than other providers. To broaden the sources of family planning information and methods, IFPS supported training of 12,769 ISMPs as family planning counselors and depot holders, which covers nearly one-third (32%) of the registered ISMPs in Uttar Pradesh. The training sessions were conducted from 1995 to 2001 in selected project districts. Of 12,162 ISMPs assessed post-training, 81 percent (n=9,851) were performing to standard when assessed in general family planning counseling and method-specific counseling for oral contraceptive pills and condoms (PRIME II, 2006). A 2003 study found that those ISMPs who sold socially marketed family planning commodities gained more clients than those who gave away free government supplies (Luoma et al., 2003). (See Chapter 12.)

**SOCIAL MARKETING AND COMMUNICATION CAMPAIGNS**

*Expanding Access to Spacing Methods through Social Marketing*

When the IFPS Project began, fewer than one in six retail outlets in Uttar Pradesh stocked contraceptives. Yet

¹ USAID discontinued funding for dai training in 2003/2004 as scientific studies by the World Health Organization emerged that showed training of traditional birth attendants did not significantly reduce maternal mortality.
there was unfulfilled demand for contraceptives: one in three women who were not using contraception said that they intended to use a contraceptive method in the next two years. To supplement the existing system of subsidized contraceptives available in pharmacies in larger towns, IFPS supported an initiative to place subsidized contraceptive products in non-conventional outlets, such as grocers in villages, and to link these outlets with NGOs, ISMPs, and dairy cooperatives. By 2002, 43 percent of rural villages in Uttar Pradesh had at least one retail outlet selling oral contraceptives and condoms, compared with 19 percent in 2000—more than doubling rural access to contraceptives.

The IFPS Project also sought to expand the choice of non-permanent contraceptive methods. Many couples did not use any contraception to space births and opted for sterilization when their family was complete. Thus, they were not able to plan or space births reliably. IFPS made spacing methods and information about their use more widely available. Consequently, condom sales in Uttar Pradesh have nearly tripled, increasing from 89 million pieces in 1997 to 241 million pieces in 2004, and oral contraceptive sales have nearly doubled, growing from 4.27 million cycles in 1997 to 8.04 million cycles in 2004. These increases have occurred in both urban and rural areas. (See Chapter 13.)

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Raising Awareness of FP/RH Issues and Promoting Dialogue

Communication interventions included multimedia campaigns, folk performances and mobile fairs in villages, messages on state buses, wall writing in village subcenters, creation of job aids, and training of providers in interpersonal communication. These interventions supported behavior change communication campaigns as well as promoted other IFPS activities, such as RCH camps, the TT campaigns, and training efforts.

Two major multi-media communication efforts were:

- **“Come, Let’s Talk”**: From 1998–2002, IFPS conducted the Aao Batein Karein (“Come, Let’s Talk”) multimedia campaign to promote greater discussion of spacing methods between couples and with their healthcare providers. The campaign, using a mix of mass and traditional media, covered all IFPS project districts. Additionally, an estimated 18,000 ANMs and CBD workers were trained in interpersonal communication and use of the campaign’s information, education, and communication materials.

- **Age at Marriage**: During 2002–2003, the IFPS Project supported a multimedia campaign highlighting the legal, education, and health implications of early marriage—an important issue in Uttar Pradesh, where six in 10 girls marry before the legal age of marriage. The five-month statewide campaign featured TV and radio spots, press advertisements, billboards, wall paintings, and folk media, including theater and songs.
While evaluation data for the communication campaigns are limited, results from an early evaluation estimate that exposure to FP/RH messages more than doubled in the initial 15 IFPS project districts, increasing from 0.9 million women in 1995 to 2.0 million in 2000 (ORC Macro and ORG Center for Social Research, 2000). The number of men and women who reported hearing or seeing a FP/RH message in the previous month increased from 5.6 million in 1995 to 8.5 million in 2000. During this period, the number of women in the focus districts who knew that family planning has health benefits increased from 4.6 million to 5.7 million women, an increase of 24 percent. A rapid appraisal of the age at marriage campaign, which made extensive use of wall paintings to reach target audiences, found a high level of message recall (Center for Advocacy and Research, 2003). (See Chapter 14.)

Using a Campaign Approach to Promote Maternal and Child Health
Tetanus is a major cause of death in newborns, especially those delivered in non-hygienic conditions. Mothers can also be affected during delivery. These deaths are easily prevented by giving pregnant women two doses of tetanus toxoid (TT) vaccine. Accordingly, IFPS supported five statewide campaigns from 1999 to 2002 to promote TT immunization involving both mass media and interpersonal communication approaches. Other antenatal care services, including provision of IFA tablets, were also provided.

As a result of the campaigns, 6 million pregnant women were fully immunized against tetanus. Immunization coverage increased from 33 percent of pregnant women in 1999 to 68 percent in 2002—more than doubling in four years. Since then, TT coverage declined to 64 percent in 2005, three years after the special campaigns ended. Even so, this level indicates that the concept of TT immunization has taken hold and that it is becoming part of routine antenatal care.

Interpersonal communication was an important factor in raising awareness of the need for TT immunization. According to a survey conducted after the fifth campaign in 2002, in IFPS Project areas, CBD workers were the primary source of TT awareness, cited by 83 percent of the pregnant women surveyed. In non-project areas, ANMs (38%) and anganwadi workers (27%) played a major role. (See Chapter 15.)

STRENGTHENING THE POLICY ENVIRONMENT, LEADERSHIP, AND MONITORING

Fostering an Enabling Policy Environment
In 2000, the Government of Uttar Pradesh adopted a comprehensive state population policy. The policy development process used a participatory, consultative approach that allowed for the viewpoints of different sectors to come to the forefront. Representatives from various groups, including about 30 civil society and private-sector organizations, reviewed and commented on the draft policy. The IFPS Project also played a significant role in the policy development process.
role in the policy’s formulation. Three out of five members of the policy drafting committee were directly involved in SIFPSA or in providing technical assistance to the IFPS Project. Additionally, many of the IFPS-supported interventions served as models for strategies adopted by the policy. The final policy provides a state-specific plan for improving FP/RH; established a participatory, multisectoral process of policy development and implementation that has been adapted to other policy areas; and fosters a long-term framework to guide the family health and welfare program even in the midst of changes in the state’s political or bureaucratic environment. (See Chapter 16.)

Decentralizing Planning Efforts
Using a participatory approach, the IFPS Project engaged local government officials and other stakeholders in the process of designing District Action Plans (DAPs). These plans specify strategies and activities for improving RCH programs at the district level and present a workplan and budget for implementation. District-level organizations assume oversight of the plans’ implementation and budgets. The DAPs helped to decentralize program planning, respond to local needs, and foster local ownership of RCH programs. Nearly half (33 out of 70) of Uttar Pradesh’s districts are currently implementing IFPS-supported DAPs for RCH activities. (See Chapter 17.)

Based on the model developed under IFPS, DAPs were formulated in an additional seven districts under the Empowered Action Group scheme of the Government of India. These are known as the Decentralized Participatory Planning or DPP districts. Therefore, there are 40 districts with RCH action plans in Uttar Pradesh in total, of which, 33 DAPs were created through the IFPS Project.

Promoting Public-Private Partnerships
Prior to the IFPS Project, public and private entities in Uttar Pradesh seldom worked together in the health sector. IFPS introduced various mechanisms for collaboration and brought new partners, including NGOs, corporations, and cooperatives, into the RCH field. Some of the partnership models that are now being replicated in Uttar Pradesh and other states include contracting private practitioners to work in government health centers, contracting with private entities to provide services for low-income residents, and adding FP/RH services to health facilities operated by an NGO-operated health facility.
Summary of Major IFPS Project Accomplishments

**Improving Access to and Quality of RCH Services**
- Upgraded more than 600 public-sector CHCs, postpartum centers, and PHCs for improved family planning service provision.
- Trained more than 27,000 public-sector providers in family planning clinical and counseling skills, plus more than 10,000 ANMs in IUCD insertion and family planning counseling.
- Ensured that all IFPS project districts have at least one provider trained to perform female and male sterilization procedures.
- Supported more than 50,000 RCH camps that provided family planning counseling to more than 1.7 million clients, spacing methods to 1.1 million clients, sterilization to about 770,000 clients, immunizations to nearly 525,000 children, and about 475,000 antenatal check-ups over a seven-year period.
- More than doubled the proportion of rural villages in Uttar Pradesh that had at least one retail outlet or shop selling oral contraceptives and condoms.

**Promoting Maternal and Child Health**
- Contributed to major increases in antenatal check-ups, delivery by trained providers, and access to IFA supplements in IFPS project areas.
- Organized five statewide campaigns that led to 6 million pregnant women being fully immunized against tetanus and raised overall TT immunization rates throughout Uttar Pradesh.
- Trained approximately 22,000 dais, nearly doubling the proportion of births attended by trained dais in project areas—increasing from 9 percent in 1995 to 17 percent in 2003.

**Strengthening Local Participation and Ownership**
- Decentralized RCH program planning by engaging local government leaders and other stakeholders to develop and implement DAPs in 33 districts—nearly half of Uttar Pradesh’s 70 districts.
- Trained more than 28,000 Gram Pradhans and other local leaders to build their capacity to raise awareness about FP/RH issues and services among their communities.

Fostering New Partnerships
- Broadened private-sector participation in RCH services through projects with more than 150 NGOs, more than 5,000 village-level dairy cooperatives, urban development agencies, and employer groups. These community-based projects covered some 24 million people.

- Trained nearly 13,000 ISMPs to provide family planning counseling and access to commodities in rural areas.

 corporate entities that provide clinical services to their employees and the broader community. (See Chapter 18.)

**Strengthening Local Leadership Commitment for FP/RH**

Panchayati raj institutions (PRIs) are village-level self-governing bodies. In 1993, the 73rd Constitutional Amendment granted constitutional status to the PRIs and decentralized authority for certain functions, including primary healthcare and family welfare, to the local level. In addition, one-third of panchayat positions are reserved for women. Accordingly, the IFPS Project organized training programs on FP/RH for Gram Pradhans, who are the locally elected heads of the panchayats. The primary aim of the training was to build capacity of pradhans to create awareness about RCH services among the local population, monitor healthcare workers’ performance, mobilize additional resources if required, and
promote the use of health services in general. From 1998–2004, IFPS trained 28,594 Gram Pradhans and other local government leaders, representing about 60 percent of pradhans in the districts where the trainings occurred. (See Chapter 19.)

**Improving Monitoring and Evaluation**

The IFPS Project supported a series of surveys in Uttar Pradesh that helped track progress toward reaching target indicators as well as identified areas needing more attention. These surveys were the PERFORM baseline study in 1995; five Strategic Objective 2 (SO2) Indicator Surveys conducted annually from 1998 to 2002; and the Reproductive Health Indicator Survey (RHIS) conducted in 2003. USAID also funded the NFHS surveys throughout India, including Uttar Pradesh. Findings from these surveys and numerous other assessments, as well as project output data, were indispensable to both project managers and external agencies. Specific findings from the surveys are summarized in the Results Section. (See Chapter 20.)
The IFPS Project made substantial progress in increasing use of RCH services and changing attitudes about family planning and maternal and child healthcare among consumers and public officials (see Box 4). The summary of results below, based on the 1995 PERFORM survey and the 2003 RHIS, provides performance trends for selected indicators of FP/RH in the 33 IFPS districts in Uttar Pradesh.

**CONTRACEPTIVE PREVALENCE**
- More women are using modern methods of contraception. Use of modern contraceptives among married women of reproductive age (15–49) in IFPS districts rose from 20.9 percent in 1995 to 27.3 percent in 2003, which is an increase of about 31 percent in eight years. This increase averages to 0.8 percentage points per year and represents about 250,000 additional couples availing modern methods each year.
- Use of spacing methods accounts for nearly half of the growth in contraceptive use. Nearly half (47%) of the increase in the modern contraceptive prevalence rate came from spacing methods. Prior to the IFPS Project, many couples did not use any contraceptive method until they had reached (or exceeded) their desired family size, when they opted for female sterilization. In terms of method mix, reliance on sterilization among users of modern contraception declined from 72 percent in 1995 to 67 percent in 2003. Condoms were used by nearly one in five (19%) users of modern contraception in 2003, up from about one in seven (15%) users in 1995. The proportion of users of oral contraceptive pills and IUCDs remained unchanged, with 8 and 6 percent of users choosing these methods, respectively, in 1995 and 2003.

### BOX 4

**Key IFPS Results**
- A 31 percent increase in contraceptive prevalence over eight years;
- A 51 percent increase in use of condoms and oral contraceptives;
- Improved health among pregnant women through greater TT immunization, provision of IFA supplements, and access to antenatal check-ups; and
- Shifts toward deliveries attended by trained providers—both health professionals and trained traditional birth attendants.
• *Contraceptives are increasingly becoming available through the private sector.* In IFPS districts, contraceptive users have increasingly shifted to private-sector services and products. In 2003, nearly one-third (32%) of modern contraceptive users obtained their method from the private sector. This proportion represents a major increase from 1995, when only about one-fourth (24%) of contraceptive users obtained their method from the private sector.

While the public sector still accounts for the vast majority of sterilizations—86 percent in 2003—clients are starting to turn to the private sector for sterilization services despite the fact that they must pay for private-sector services whereas public-sector services are provided free of charge.

The private sector's share of the condom and oral contraceptives market further increased under the IFPS Project. In 2003, about four in five condom (81%) and oral contraceptive (83%) users purchased their supplies from the private sector, rather than obtaining free supplies from public-sector sources—up from 72 percent and 60 percent, respectively, in 1995. One factor that may have contributed to this shift to the private sector is that contraceptive products are increasingly available in retail outlets in villages and small towns. IUCD users also shifted to the private sector, which accounted for nearly half (48%) of IUCD users in 2003, compared with about one-third (36%) in 1995.

**REPRODUCTIVE AND CHILD HEALTH SERVICE USE**

• More women seek antenatal care. Project districts experienced a major shift in use of antenatal services, with three out of four (75%) pregnant women receiving at least one antenatal check-up in 2003, compared with half (50%) of the pregnant women in 1995.

• Campaigns led to significant increases in pregnant women immunized against tetanus. The proportion of pregnant women in IFPS project districts receiving at least two TT vaccinations rose from 41 percent in 1998 to 63 percent in 2003—an increase of more than 50 percent. Statewide, 6 million pregnant women received two doses of vaccination. TT coverage across the state increased from 33 percent in 1999 to 68 percent in 2002. Much of the increase can be attributed to the five statewide TT campaigns conducted between 1999 and 2002.

• Provision of IFA supplements increased, though more attention is needed. Access to IFA supplements has more than doubled in the project districts, from 26 percent of pregnant women in 1995 to 55 percent in 2003. However, only one in three (34%) of the women who received IFA supplements were given an adequate supply in 2003. Furthermore, only half of the women who received IFA supplements consumed the
entire quantity that was given to them.

- *Deliveries are increasingly attended by trained providers.* In 1995, nearly 71 percent of deliveries in project districts were attended by untrained dais, relatives, and friends. By 2003, half of all births were attended by trained persons (e.g., doctors, ANMs, and trained dais). Health professionals such as medical doctors, nurses, and ANMs accounted for two-thirds (66%) of births attended by trained persons, with the remaining one-third (34%) attended by trained dais.
LESSONS FOR PROGRAM MANAGEMENT

1. Establishing an autonomous agency (SIFPSA) to implement the IFPS Project was critical to the project’s success. IFPS involved multiple, complex components in both the public and private sectors. Activities touched on infrastructure, service delivery, training, quality, communication, policy and planning, monitoring, and social marketing, among others. The project also served diverse regions and districts across Uttar Pradesh. In response, SIFPSA was able to draw expertise from and work with both the public and private sectors, including NGOs with ties to local communities.

2. While setting up an autonomous society allowed for greater flexibility, testing of new approaches, and leveraging of resources from various sectors, program designers and implementers must work to ensure that such a society does not duplicate or run parallel to the government or fall prey to the same challenges that traditionally characterize the public sector (e.g., bureaucratic processes, frequent transfers of key personnel). Indeed, SIFPSA
was at its best during periods when it had consistent, stable, and committed leadership. To promote sustainability and government accountability, there is also a need for greater collaboration between the implementing agency and the public sector so that initiatives to be scaled up in that sector are eventually funded by and integrated into the state government (USAID/India, 2005).

3. The IFPS Project’s performance-based disbursement system, tied to the achievement of benchmarks, directed the implementation of activities toward results. This orientation was essential for ensuring that investments were used effectively and that programs achieved their desired impact on the communities they served.

4. At the same time, the performance-based disbursement system as it was designed created an all-or-nothing situation in which achieving 95 percent of a benchmark was not rewarded. In addition, while this system did shift the focus to project results, it created difficulties for SIFPSA because achievement of many benchmarks was tied to service provision in the public sector and other factors outside of the project’s control. Also, careful attention is needed to ensure that evaluation mechanisms consider important achievements that are not easily quantifiable and that “the quality of interventions” is not neglected (USAID/India, 2005).

5. The provision of technical assistance by cooperating agencies helped to build the capacity of the public sector (e.g., provider training, quality improvement and infection prevention practices, facility upgrades); SIFPSA and its district-level counterparts (e.g., planning, monitoring); and local implementing partners (e.g., training of trainers).

6. The IFPS Project sought to encourage interventions to meet district-specific needs, often as a result of the DAP process. Activities, therefore, varied across districts based on identified needs, targets of opportunity, and other factors. While it is worthwhile to tailor interventions to local conditions, the downside of the approach—from a program management and monitoring perspective—was that it was difficult to assess the impact of individual interventions as well as the total package of interventions. Activities were rolled out in selected districts and blocks, over diverse time frames, and in differing levels of intensity. Some activities were also introduced late in the project. Accordingly, there was no IFPS district in which the full slate of interventions was implemented as a coordinated whole for the entire duration of the project.

LESSONS FOR TECHNICAL APPROACHES

1. The IFPS Project demonstrated that rural areas can be reached with family planning and integrated RCH services and information, even in a state as diverse and expansive as Uttar Pradesh. IFPS implemented a
2. Interventions to improve the availability and quality of RCH services need to address limitations of public health systems. However, improved quality and training alone does not increase service uptake. Stepped up efforts are needed to raise awareness of upgraded facilities, quality improvements, and enhanced training; create client demand for services; and dispel any misconceptions potential clients may have about new methods or services.

3. Decentralizing program planning and management to the district level, by engaging local leaders and stakeholders in developing and implementing DAPs, helped to ensure effective programs and to foster local ownership. In addition, PMUs mobilized local stakeholders, provided continuity, and helped function as problem solving units that could address local issues, needs, and concerns in a timely manner.

4. The IFPS Project positioned private-sector groups as effective partners of the public sector in the provision of RCH programs. These partnerships bring additional expertise and resources and broaden the base of support for FP/RH activities.

5. Program approaches to meet FP/RH needs can have additional benefits. For example, women trained as CBD workers report increased status within their communities and at least 12 CBD workers have been elected as village pradhans (USAID/India, 2005).
REFERENCES


## APPENDIX A: IFPS DISTRICTS

<table>
<thead>
<tr>
<th>DISTRICT NAME</th>
<th>TOTAL POPULATION</th>
<th>VILLAGE SIZE</th>
<th>NO. OF VILLAGES</th>
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Source: 2001 Census of Uttar Pradesh
IDEAS, INSIGHTS, AND INNOVATIONS:
Achievements and Lessons Learned from the Innovations in Family Planning Services (IFPS) Project, 1992–2004

A SUMMARY

DECEMBER 2006
This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by Constella Futures.