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

DECEMBER 2006
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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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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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FOREWORD

Healthy people are vital to a country’s economic and social development, and high fertility is an important factor that affects health. Large populations can strain already limited resources, from the household to the national levels. India’s voluntary family planning program has achieved significant results over the last 30 years. Nationally, contraceptive use by women of reproductive age reached 48 percent in 1998/99, and the average number of children per family dropped by over 40 percent from 1972 to 1998/99 (from 5.2 to 2.9).

Yet, while India has made significant progress in improving the health of its population, statistics on fertility rates and other reproductive and child health (RCH) indicators highlight the need for further attention. India’s population crossed the one billion mark on May 11, 2000. One out of every 75 women of reproductive age in India dies from childbirth-related causes and only 15 percent of mothers receive complete antenatal care. Moreover, only 34 percent of deliveries take place in facilities and 42 percent are assisted by a health professional. While some southern states have almost stabilized their population growth, the northern states experience higher population growth rates. Unmet need for family planning is high in the north with about 25 percent unmet need in Uttar Pradesh alone. Other reproductive health indicators are generally worse in the northern states than the national averages.

It was against this backdrop that the United States Agency for International Development (USAID) and the Government of India launched a 12-year initiative to improve reproductive health and reduce fertility in northern India, with a focus on Uttar Pradesh—home to one-sixth of India’s population. Carried out from 1992-2004, the Innovations in Family Planning Services (IFPS) Project sought to design, test, and expand innovative approaches for improving quality of and access to family planning and RCH services, particularly for women, rural populations, and other underserved groups.

Lessons learned from the IFPS Project, as reviewed in this document, have been instrumental in planning for USAID’s follow-up IFPS-II Project (currently implemented in Uttar Pradesh, Uttarakhand, and Jharkhand) and the central government’s RCH-II Program of the National Rural Health Mission (NRHM). Several of the key innovations first developed under IFPS in Uttar Pradesh—such as the establishment of district-level societies to guide health programs—are now integral components of the RCH-II Program and the NRHM.

It is hoped that this volume will provide further insights to policymakers and program planners, not only in Uttar Pradesh but across India and in other countries, as they seek to improve the reproductive and child health of their citizens.

Robert Clay
Director
Population, Health and Nutrition
USAID/India
The State Innovations in Family Planning Services Project Agency (SIFPSA) was constituted in 1992 to improve the demand for, the reach and the quality of reproductive health services, with particular reference to family planning in Uttar Pradesh. Over a period of 12 years, SIFPSA implemented a large number of innovative interventions in the state and achieved significant results. Major interventions included: decentralized district action plans, population policy development, integrated reproductive and child health camps, multimedia communication campaigns, community-based distribution projects in collaboration with nongovernmental organizations, cooperatives and the organized sector, up-gradation of physical facilities and skill levels, quality improvement initiatives, social marketing of contraceptives and public private partnership mechanisms. Some of these interventions were implemented in the entire state and others in 33 districts covering nearly half of the population of Uttar Pradesh.

This volume contains a detailed description of the interventions implemented, experiences gained, challenges and issues faced and lessons learnt. Covering, as it does, the wide range of interventions all directed towards improving the performance of the reproductive and child health programme in Uttar Pradesh, this volume can serve as a valuable guide for those responsible for implementing similar programmes.

I would like to take this opportunity to thank all those who have put in a dedicated effort to collate this vast amount of information, analyse it and prepare the document. My special thanks are due to the United States Agency for International Development and the staff of SIFPSA and Constella Futures for their valuable contributions at various stages of this documentation.

Shailesh Krishna
Executive Director
SIFPSA, Lucknow
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<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADC</td>
<td>Additional District Coordinator</td>
</tr>
<tr>
<td>ADO</td>
<td>Additional Development Officer</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
</tr>
<tr>
<td>AT</td>
<td>Abdominal Tubectomy</td>
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<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
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<td>Block Development Officer</td>
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<td>C&amp;FA</td>
<td>Carrying and Forwarding Agent</td>
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<td>Cooperating Agency</td>
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<td>CBD</td>
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<td>Clinic Based Family Planning Training</td>
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<td>CDO</td>
<td>Chief Development Officer</td>
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<td>CDPO</td>
<td>Child Development Program Officer</td>
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<tr>
<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
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<td>CFDRT</td>
<td>Center for Development Research and Training</td>
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<td>CHAMP</td>
<td>Community Health Action through Motivation Program</td>
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<td>Community Health Center</td>
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<td>Community Health Visitor</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>CMS</td>
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<td>Community Midwife</td>
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<td>COPE</td>
<td>Client Oriented and Provider Efficient</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>CSM</td>
<td>Contraceptive Social Marketing</td>
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<td>CTU</td>
<td>Contraceptive Technology Update</td>
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<td>DAP</td>
<td>District Action Plan</td>
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<tr>
<td>DCS</td>
<td>Dairy Cooperative Society</td>
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<tr>
<td>DDK</td>
<td>Disposable Delivery Kit</td>
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<tr>
<td>DHFW</td>
<td>Department of Health and Family Welfare</td>
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<td>DHM</td>
<td>District Health Mission</td>
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<tr>
<td>DIFPSA</td>
<td>District Innovations in Family Planning Services Project Agency</td>
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<tr>
<td>DLP</td>
<td>Distance Learning Program</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Strategy</td>
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<td>DPP</td>
<td>Decentralized Participatory Planning</td>
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<td>DUDA</td>
<td>District Urban Development Authority</td>
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<td>DUSS</td>
<td>Dugdh Utpadak Sahkari Sangh</td>
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<td>EAG</td>
<td>Empowered Action Group</td>
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<tr>
<td>ED</td>
<td>Executive Director</td>
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<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<tr>
<td>FICCI</td>
<td>Federation of Indian Chambers of Commerce and Industry</td>
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<tr>
<td>FLE</td>
<td>Family Life Education</td>
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<td>FMCG</td>
<td>Fast Moving Consumer Goods</td>
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<td>Family Planning</td>
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<td>Family Planning Association of India</td>
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<td>GoI</td>
<td>Government of India</td>
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<tr>
<td>GoUP</td>
<td>Government of Uttar Pradesh</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HLFPPT</td>
<td>Hindustan Latex Family Planning Promotion Trust</td>
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<tr>
<td>HLL</td>
<td>Hindustan Latex Limited</td>
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<td>IAS</td>
<td>Indian Administrative Service</td>
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<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<td>ICICI</td>
<td>Industrial Credit and Investment Corporation of India</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
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<td>IFA</td>
<td>Iron and Folic Acid</td>
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<td>IFFCO</td>
<td>Indian Farmers Fertilizer Cooperative</td>
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<td>Innovations in Family Planning Services</td>
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<td>IIHMR</td>
<td>Indian Institute of Health Management Research</td>
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<td>IIPS</td>
<td>International Institute for Population Sciences</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IMS</td>
<td>Institute of Medical Sciences</td>
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<tr>
<td>IP</td>
<td>Infection Prevention</td>
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<tr>
<td>IPC</td>
<td>Interpersonal Communication</td>
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<tr>
<td>IRMA</td>
<td>Indian Rural Medical Association</td>
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<tr>
<td>ISMP</td>
<td>Indigenous Systems of Medicine Practitioner</td>
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<td>ISP</td>
<td>Immunization Strengthening Project</td>
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<td>ISSA</td>
<td>Integrated System for Survey Analysis</td>
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<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
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<td>JHU/CCP</td>
<td>Johns Hopkins University/Center for Communication Programs</td>
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<td>JHU/PCS</td>
<td>Johns Hopkins University/Population Communication Services</td>
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<td>KGMU</td>
<td>King George’s Medical University, Lucknow</td>
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<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
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<td>LMO</td>
<td>Lady Medical Officer</td>
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<td>MARE</td>
<td>Male Roving Educators</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MFA</td>
<td>Mobile Field Agent</td>
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<td>MIS</td>
<td>Management Information System</td>
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<td>ML/LA</td>
<td>Minilaparotomy Under Local Anesthesia</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MOIC</td>
<td>Medical Officer In-Charge</td>
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<td>MoU</td>
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<td>MPW</td>
<td>Multi-purpose Worker</td>
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<td>MWRA</td>
<td>Married Women of Reproductive Age</td>
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<td>NC</td>
<td>Natal Care</td>
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<td>NCAER</td>
<td>National Council for Applied Economic Research</td>
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<td>NFE</td>
<td>Non-Formal Education</td>
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<td>NFHS</td>
<td>National Family Health Survey</td>
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<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NIRPHAD</td>
<td>Naujih Integrated Rural Project for Health and Development</td>
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<tr>
<td>NP</td>
<td>Non-project</td>
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<td>NPTS</td>
<td>Not Performing to Standard</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>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>OC</td>
<td>Oral Contraceptive</td>
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<tr>
<td>OCP</td>
<td>Oral Contraceptive Pill</td>
</tr>
<tr>
<td>OP</td>
<td>Oral Pill</td>
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<tr>
<td>ORS</td>
<td>Oral Rehydration Solution (or salt)</td>
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<td>OTC</td>
<td>Over-the-Counter</td>
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<td>PAC</td>
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<td>PCDF</td>
<td>Pradeshik Co-operative Dairy Federation Limited</td>
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<td>PDS</td>
<td>Public Distribution System</td>
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<td>PERFORM</td>
<td>Project Evaluation Review for Organizational Resource Management</td>
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<td>PHC</td>
<td>Primary Health Center</td>
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<td>PHN</td>
<td>Public Health Nurse</td>
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<td>PIP</td>
<td>Program Implementation Plan</td>
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<td>Project Management Unit</td>
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<td>PNC</td>
<td>Postnatal Care</td>
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<td>POPTECH</td>
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<td>PPRC</td>
<td>Prerana Population Resource Center</td>
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<td>PPS</td>
<td>Probability Proportionate to Size</td>
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<td>Population Services International</td>
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<td>PTS</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>Reproductive and Child Health</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RHFWTC</td>
<td>Regional Health and Family Welfare Training Center</td>
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<td>RHIS</td>
<td>Reproductive Health Indicator Survey</td>
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<td>Rs</td>
<td>Rupees</td>
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<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<tr>
<td>SC</td>
<td>Subcenter</td>
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<td>SEC</td>
<td>Socioeconomic Class</td>
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<td>SIFPSA</td>
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<td>SIHFV</td>
<td>State Institute of Health and Family Welfare</td>
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<td>SIRD</td>
<td>State Institute for Rural Development</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>SO</td>
<td>Strategic Objective</td>
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<td>Sahbhagi Shikshan Kendra</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>Technical Advisory Group</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>Total Fertility Rate</td>
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<td>Training Needs Assessment</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>TT</td>
<td>Tetanus Toxoid</td>
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<td>UIP</td>
<td>Universal Immunization Program</td>
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<td>Uttar Pradesh Academy of Administration, Nainital</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USD</td>
<td>U.S. Dollar</td>
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<td>USP</td>
<td>Unique Selling Proposition</td>
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<td>Village Health Committee</td>
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<td>VHV</td>
<td>Village Health Volunteer</td>
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INTRODUCTION: The Innovations In Family Planning Services Project

This monograph summarizes the goals and achievements of the first phase of the Innovations in Family Planning Services (IFPS) Project, an ambitious 12-year initiative to expand and improve family planning and reproductive health services in Uttar Pradesh, India's most populous state (see Box 1). Funded by the United States Agency for International Development (USAID), the IFPS Project was designed to revitalize the existing family planning program by testing new approaches and replicating effective strategies quickly.

Consistent with the project's broad scope, USAID authorized a budget of USD 325 million over 10 years (1992–2002), with matching funds provided by the Government of India. The project was subsequently extended for two more years (2002–2004). 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, Uttaranchal, and Jharkhand and at the national level.

IFPS OBJECTIVES
The IFPS Project was designed first and foremost as a family planning intervention. The main goals at inception in 1992 were to reduce Uttar Pradesh’s total fertility rate (TFR) from 5.4 children per woman to 4.0 and increase the contraceptive prevalence rate (CPR) from 35 percent of married reproductive-age women to 50 percent (USAID/India, 1992). These goals were later revised to reach a TFR of 4.0 and a CPR of 32 percent in the IFPS Project areas by 2004 (USAID/India, 2002).

The project’s original objectives were to:

- “Increase access to family planning services by strengthening service delivery in the public sector and developing or expanding the capacity for service delivery in the

BOX 1

Uttar Pradesh: A Country within a Country

With a population of about 170 million, only five countries in the world (including India) are larger than the state of Uttar Pradesh. The state has 70 districts comprising more than 97,000 villages and 630 cities. About 80 percent of the state’s population lives in rural areas and nearly one-third (31%) lives below the poverty line.

Gender disparities are evident in the state. In 2001, the sex ratio for Uttar Pradesh was 898 females per 1,000 males, compared to 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.

Source: United Nations Development Program (n.d.)
Access will also be expanded through hospitals, clinics, household and community-based distribution, and contraceptive social marketing (CSM) so that services will be available to a large proportion of clients living in the harder-to-reach rural, poor urban and peri-urban areas.

- Improve the quality of family planning services by expanding the choice of contraceptive methods, improving the technical competence of personnel, ensuring informed choice through effective counseling, and improving management and follow-up of client services, and improving contraceptive logistics.

- Promote family planning by broadening support among leadership groups, increasing the public’s understanding of the health and welfare benefits of family planning, creating a better image of the program, and providing information (or advertising in the case of the social marketing program) on the availability of services and methods. The project will also increase the participation of women in the implementation of the project at all levels” (USAID/India, 1992).

In 1998, project activities were expanded beyond family planning to include other reproductive health services, including attention to antenatal care and delivery by trained providers, tetanus toxoid immunizations for pregnant women, and distribution of iron and folic acid (IFA) tablets. The additional goals were: 36 percent of all deliveries to be attended by trained providers, 70 percent of pregnant women receiving two doses of tetanus toxoid, and 40 percent of pregnant women receiving a sufficient quantity of IFA tablets. In 2001, the project’s mandate was broadened to include HIV prevention and control.

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 distribution system; and (3) an emphasis on capacity building through technical assistance by USAID-funded cooperating agencies.

**SIFPSA’S MANDATE AND STRUCTURE**

The management agency, which became the State Innovations in Family Planning Services Project Agency (SIFPSA), was established in 1993 with the following mission statement:

“SIFPSA seeks to facilitate—through innovative means and partnerships with government and other agencies—the goal of ‘Health for All’ in Uttar Pradesh, by improving the quality, demand, access, and delivery of family planning and maternal and child health services and also improving other related quality-of-life parameters, including the status of women” (Oot et al., 1996).

SIFPSA was structured to circumvent the delays associated with working with the government sector and yet it was highly dependent on the state’s public health system to provide reproductive health services. Accordingly, SIFPSA adopted various strategies to increase the availability of public reproductive health services, especially voluntary sterilization and intrauterine contraceptive devices (IUCDs), to
improve the quality of public health services, and to engage private-sector entities to extend family planning and reproductive health information and services to rural villages and urban slums.

The IFPS Project was envisioned as having three primary phases: Phase I in Years 1–5; Phase II in Years 6–8; and Phase III in Years 9–10. The key activities were to:

- Expand access to reproductive health services by upgrading medical centers, train auxiliary nurse midwives (ANMs), expand family planning services through private practitioners and NGO networks, and pilot urban and rural community-based distribution programs and outreach from primary health centers and subcenters;
- Improve the quality of reproductive healthcare by improving program management, quality of care, logistics systems, sterilization services, and management information systems; and
- Increase demand for reproductive health services through policy support and public education and promotion.

These activities were translated into sub-objectives and benchmarks that could be used to gauge progress toward achieving project goals.

Within the family planning and reproductive health sector, the IFPS Project was charged with countering the heavy reliance on sterilization by expanding use of temporary contraceptive methods, especially among young low-parity couples. Studies had identified a high unmet need for spacing methods among young couples. Thus, the IFPS Project sought to make spacing methods more widely available through private-sector community-based distribution programs and social marketing programs in rural areas and urban slums.

SIFPSA was created as a registered society to give it more flexibility and reduce the bureaucratic delays endemic to government structures. The top two posts—the Executive Director and the Additional Executive Director—are delegated from the Indian Administrative Service. The remaining staff are recruited from the open market or seconded from different departments of the state government. Some SIFPSA Executive Directors have had relatively long tenures, but in recent years frequent transfers have proven challenging.

SIFPSA’s Governing Body—which included representatives from the Governments of India and Uttar Pradesh, USAID, and prominent private-sector experts—serves as SIFPSA’s policymaking body and approves annual plans and budgets. The Executive Committee takes administrative decisions relating to personnel and procurement of commodities and services. The Project Appraisal Committee is an advisory body that provides technical review and approval of project proposals.

Under the Executive Director and the Additional Executive Director, SIFPSA has 11 General Managers
Ideas, Insights, and Innovations

who oversee the following departments: Public Sector; Private Sector; Contraceptive Social Marketing; Training; Information, Education, and Communication (IEC); District Action Plans; Research and Evaluation; Family Planning Information System; Finance; Internal Audit; and Human Resources, Administration, and Procurement. Staff recruited for positions at SIFPSA were required to have training and work experience appropriate to each position and, thus, SIFPSA formed a strong technical team. As of 2005, SIFPSA had 87 staff at its Lucknow headquarters and roughly 65 district staff.

In addition to its headquarters staff, IFPS has established district-level offices, known as District Innovations in Family Planning Services Project Agencies (DIFPSAs) to oversee implementation of district action plans (DAPs). Each DIFPSA is chaired by the District Magistrate and has a governing board consisting of representatives from the major public and private sector agencies concerned with RCH work. The Project Management Unit (PMU) houses the staff responsible for implementing the DAP. The DIFPSAs are fully staffed and operational in 33 districts of Uttar Pradesh.

PERFORMANCE-BASED DISBURSEMENT

A unique feature of the IFPS Project was that USAID funds were channeled through a performance-based disbursement framework rather than paying project implementation costs directly. USAID and SIFPSA set mutually agreed project outcomes, known as benchmarks, linked to a specific payment amount. When SIFPSA reached the entire benchmark, USAID released the funds. This system did shift the focus from project outputs to project results, but it also created challenges because achievement of many benchmarks was tied to service provision in the public sector and other factors outside of the project’s control.

TECHNICAL ASSISTANCE FROM SPECIALIZED U.S. AGENCIES

As part of the planning for the IFPS Project, USAID identified specific U.S.-based cooperating agencies to provide technical assistance and set aside funds for this purpose. Cooperating agencies—nonprofit organizations, contractors, and universities with existing contractual mechanisms with USAID/Washington—were selected based on their expertise in specific facets of reproductive health program management. The agencies and their roles under IFPS are listed below:

- **Centre for Development and Population Activities (CEDPA)**—Project management, private-sector and community-based distribution programs, mobilization of pradhans, and adolescent health and family life education initiatives;
- **EngenderHealth**—Assessment of clinical sites, training public- and private-sector providers in family planning clinical skills and counseling, and improvement of quality of care in public-sector facilities;
Introduction

Futures Group/POLICY Project—Development of DAPs, facilitation of Uttar Pradesh’s state population policy, tracking IFPS Project performance, and conducting benchmark indicator surveys;

Futures Group/Commercial Marketing Strategies—Social marketing of contraceptives and other health products;

JHPIEGO—Training of medical providers in contraceptive technology updates;

IntraHealth International, University of North Carolina—Training of primary healthcare providers, including auxiliary nurse midwives, traditional birth attendants, indigenous systems of medicine practitioners, and other community-level healthcare workers;

Johns Hopkins University/Population Communication Services—Development of behavior change communication (BCC) strategies; campaign design and implementation; selection of production, research, and advertising agencies; and training and technical assistance in BCC;

John Snow Inc./DELIVER Project—Strengthening of the logistics management system through staff recruitment and training, software applications, and manuals on supply procedure and logistics training;

ORC Macro—Completion of benchmark surveys in Uttar Pradesh and technical assistance for the National Family Health Survey (NFHS) in 1992/93 and 1998/99; and

Population Council—Operations research.

The cooperating agencies have made important technical inputs in many aspects of the IFPS Project, especially in setting up training systems and monitoring mechanisms, strengthening clinical care and logistics systems, guiding policy formulation, and collecting data on project results. USAID allocated USD100 million for technical assistance support over the life of the IFPS 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

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 Uttaranchal. When this happened, IFPS activities ceased in Uttaranchal and continued to focus on the 24 IFPS 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 Uttaranchal became six districts. Overall, then, IFPS activities have been conducted, to some extent, in 39 districts throughout the two north Indian states.

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 toxoid 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 districts in Uttar Pradesh, 21 have been designated as “priority” districts. A list of the 33 districts and their population sizes is provided in Table 1.

### FUNDING ALLOCATIONS

As of February 2003, the IFPS Project had allocated about 40 percent of its budget to supporting public-sector RCH services, 26 percent each to private-sector initiatives and DAPs, and 8 percent to communication/IEC and social marketing (see Figure 2).

From 1993/94 to 2002/03, IFPS funded a total of 548 projects, of which 245 (45%) were in the public sector and 242 (44%)...
were in the private sector. The remaining projects supported IEC, social marketing, and research and program evaluation.

**MAJOR INTERVENTIONS AND ACCOMPLISHMENTS**

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 (see Section 1);
- Engaging nongovernmental/private-sector entities to make RCH information and services more widely available in rural areas and urban slums (see Section 2);
- Broadening access to contraceptive commodities and RCH information through social marketing and BCC (see Section 3); and
- Improving the policy foundation, encouraging leadership support for RCH services, and strengthening monitoring and evaluation (see Section 4).

These strategies, specific program interventions, and lessons learned are discussed in the chapters that follow.

Box 2 presents a summary of the IFPS Project’s major accomplishments. Data on project outputs and results are available from four main sources: (1) SIFPSA’s management information system; (2) external evaluations of IFPS-funded interventions; (3) external assessments by USAID-supported teams (a project management review in November–December 1995; a mid-term assessment in July–August 1997, and an assessment in November–December 2002); and (4) a series
Summary of Major IFPS Project Accomplishments

Improving Access to and Quality of RCH Services
- Upgraded more than 600 public-sector community health centers, postpartum centers, and primary health centers 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 districts have at least one provider trained to perform female and male sterilization procedures.
- Supported more than 50,000 integrated 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 checkups 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.

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 indigenous systems of medicine practitioners to provide family planning counseling and access to commodities in rural areas.

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 family planning and reproductive health issues and services among their communities.

Note: The exchange rate used throughout this monograph is 44 Indian rupees = 1 USD.
of USAID-funded impact surveys in project areas. These surveys are: the 1995 PERFORM survey, annual follow-up surveys from 1998–2002, and the Reproductive Health Indicator Survey (RHIS) in 2003.

Other USAID-funded surveys—such as the National Family Health Survey in 1992/93 (NFHS-1) and 1998/99 (NFHS-2)—also provided data on project impact.

REFERENCES


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Working with the government organizations, especially the public health service delivery system, was an integral part of the IFPS Project. Key IFPS objectives were to:

- Provide wider access to family planning and reproductive and child health (RCH) services through public-private partnerships and integrated services such as RCH camps; and
- Improve the quality of government RCH services by strengthening the skills and changing the attitudes and practices of government healthcare providers as well as upgrading public health facilities.

Public-sector leaders and healthcare providers were integrally involved in the IFPS Project at the state, district, and local levels.

**BUDGET**

The largest part of the IFPS Project budget—40 percent—was allocated to public-sector programs. The rest of the project budget consisted of 26 percent allocated to district action plans (which partly involved the public sector), another 26 percent to private-sector initiatives, and 8 percent to information, education, and communication (IEC) and social marketing.

Of the project funds allocated to public-sector programs, 28 percent went to infrastructure improvements, another 28 percent to equipment and maintenance, 23 percent to training, 15 percent to RCH camps, and 6 percent to other activities (see Figure 1).

**STRENGTHENING THE PUBLIC SECTOR**

From 1993/94 to 2002/03, SIFPSA supported 245 public-sector projects. This section reviews the IFPS Project’s major public-sector initiatives, which are described in the chapters that follow.
Upgrading clinical facilities. To improve public-sector capacity to provide RCH 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 insertion/removal of intrauterine contraceptive devices (IUCDs) and family planning counseling; and family planning and RCH-related equipment and supplies. In addition, the project funded strengthening of about 9,000 subcenters, which are staffed by auxiliary nurse midwives (ANMs). (See Chapter 2.)

Training healthcare providers. 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 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 family planning 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, the IFPS Project 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 a quality certificate and a Quality Gold Star Logo to display outside the facility. The top five scoring sites were granted 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 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 camp 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.)

REFERENCES


CHAPTER 2

FACILITIES UPGRADING:
Strengthening the Family Planning-related Public Health System Infrastructure

By Ruchira Gujral

RATIONALE AND OBJECTIVES

A key objective of the IFPS Project was to ensure greater access to public family planning and reproductive and child health (RCH) services in the project districts and to improve the quality of these services. To achieve this objective, the project embarked on a major initiative to improve the physical infrastructure of public health facilities where family planning services are provided while simultaneously providing training and support systems to strengthen the capacity of the service delivery staff.

In 1994, JHPIEGO, a USAID-funded cooperating agency, conducted a training needs assessment to determine the status of client-oriented family planning services in Uttar Pradesh. Based on the findings, the IFPS Project implemented a multifaceted clinic-based technical training system for public healthcare providers (see Chapter 3).

Program planners recognized, however, that training the staff alone was insufficient if they continued to work in substandard facilities that lacked basic amenities, such as running water and electricity, and medical equipment and supplies. Accordingly, the IFPS Project sought to provide an enabling working environment, with all the essential components and equipment present. In 1997, the project embarked on an initiative to strengthen and upgrade the public healthcare facilities for provision of family planning services. This initiative focused on strengthening four aspects of the government healthcare facilities: (1) civil works (buildings); (2) electricity connection and supply; (3) water supply; and (4) equipment and consumable supplies.

Four levels of the public healthcare delivery system were upgraded and strengthened under this intervention:

- District women’s hospitals/postpartum centers (PPCs);
- Community health centers (CHCs);
- Block primary health centers (PHCs); and
- Subcenters and health posts.

INTERVENTION COMPONENTS

The facilities improvement interventions were implemented from 1997–2005 in two phases:

1. Improvement of PPCs, CHCs
and PHCs; and (2) improvement of subcenters and health posts.

The facilities improvement projects followed the same approval process as other IFPS interventions. All projects under Rs. 5,000,000 (~USD 113,636) were reviewed by the SIFPSA Project Appraisal Committee (PAC). All projects over that amount were to be presented to the Chairman of the IFPS Governing Body for approval.

**Upgrading of Facilities**

Besides SIFPSA, EngenderHealth, a USAID-funded cooperating agency, was also involved in the facilities improvement program. The various steps in the process of upgrading and strengthening the PPCs, CHCs, and PHCs are detailed below.

**Step 1. Needs Assessment and Survey**

A team visited all PPCs, CHCs, and PHCs in each district to conduct an in-depth assessment of each site using set criteria. SIFPSA identified these assessment criteria and communicated them by letter to the Chief Medical Officer (CMO) of each district. The goal of the assessment was to ensure identification of critical needs, avoid duplication of funding, and help make accurate budget estimates. The assessment covered four areas: (1) civil work and condition of building; (2) electricity connection and provision; (3) availability of water; and (4) availability of essential equipment and supplies. The four-person team consisted of a Deputy CMO and the Junior Engineer of the district as well as representatives from SIFPSA and EngenderHealth.

**Step 2. Preparation of Estimates and Approval Process**

Based on the assessment findings, the Junior Engineer prepared an estimate of the cost to upgrade each site. The district CMO then forwarded this estimate to SIFPSA. SIFPSA officials then did a cross-verification of the proposed upgrading activities and cost estimates for each site based on their records from the joint assessment and standard costs for each line item. If SIFPSA found the estimate to be in compliance and within the approved budget for each item, it issued a letter of approval to the district CMO with details of the site, the approved cost estimate, detailed list of equipment to be purchased, and the procedures to be followed. If SIFPSA staff had queries about the estimate submitted, they sent the proposed plan back to the CMO for clarification.

The CMO was also instructed to obtain a “Technical Sanction” from the Directorate of Medical and Health Services, validating the work required at each site and the cost. After the technical sanction was submitted to SIFPSA, the project was officially considered approved and work could begin on the site. SIFPSA then released 85 percent of the total sanctioned budget for the site to the district CMO so that work could commence. The Junior Engineer managed all the construction-related work, and the CMO’s office purchased the necessary equipment.

**Step 3. Monitoring of Progress**

Monthly monitoring visits were made by SIFPSA officials to all the sites being upgraded. When the
project started, the district action plans (DAPs) had not yet been formulated and, therefore, no district-level Project Management Units (PMUs) were present to assist the process. However, from the second facilities upgrading phase onwards, DAPs had been initiated and the facilities upgrading activities were incorporated into the action plans. Subsequent monitoring of the upgrading and strengthening process was done by the PMUs, which forwarded their reports to SIFPSA.

**Step 4. Completion and Evaluation**
Once all the work on the facility was finished, the site was inspected. The CMO then issued a site readiness certificate and sent it to SIFPSA. After SIFPSA received the site readiness certificate and made a physical inspection of the upgraded facility, it released the remaining 15 percent of the budgeted amount to the CMO. Since each site had site-specific needs in terms of repair, renovation, water, electricity, and equipment, a standardized checklist was not used for evaluating the sites.

**Step 5. Documentation**
SIFPSA prepared a detailed documentation of the entire process for every district and kept these records for future reference and use.

**Strengthening of Subcenters**
Concurrently, training of lady health visitors (LHVs) and auxiliary nurse midwives (ANMs) on Clinic Based Family Planning Training (CBFPT) was underway (see Chapter 4). To expand the coverage to rural areas and improve the quality of RCH services, the strengthening of ANM subcenters, where the ANMs work and reside, was part of the facilities upgrading intervention (see Figure 1).

The primary objective of the strengthening of subcenters was to ensure that the trained LHVs and ANMs had the necessary infrastructure to provide quality family planning services and meet client needs. The indicator for this activity required 85 percent of all subcenters in a district to have the necessary equipment for intrauterine contraceptive device (IUCD) insertion. Of these subcenters, 33 percent had to meet the quality standards identified in order for the improvements to be considered successful.

**Step 1. Assessment Process**
To assess the condition of the subcenters, SIFPSA and another USAID-funded cooperating agency, Intrah/PRIME, conducted a survey of all the subcenters in the project areas. SIFPSA and Intrah/PRIME representatives visited each subcenter to collect information

![FIGURE 1. INITIATIVE TO STRENGTHEN ANM SUBCENTERS](image-url)
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<tr>
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<td>3. Adequate light source</td>
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<tr>
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</tr>
<tr>
<td>Place/Furniture</td>
<td>5. 1 Table</td>
</tr>
<tr>
<td></td>
<td>6. Water for washing</td>
</tr>
<tr>
<td></td>
<td>7. Stainless steel tray (12&quot;x8&quot;x2&quot;)</td>
</tr>
<tr>
<td></td>
<td>8. Tray cover (12&quot;x8&quot;x2&quot;)</td>
</tr>
<tr>
<td></td>
<td>9. Small bowl for antiseptic solution</td>
</tr>
<tr>
<td>Instruments (at least one set)</td>
<td>10. Kidney basin 10&quot;</td>
</tr>
<tr>
<td></td>
<td>11. Vaginal speculum cusco - Large</td>
</tr>
<tr>
<td></td>
<td>12. Sponge holding forceps 10&quot;</td>
</tr>
<tr>
<td></td>
<td>13. Volsellum forceps curved 10&quot;</td>
</tr>
<tr>
<td></td>
<td>14. Uterine sound</td>
</tr>
<tr>
<td></td>
<td>15. Mayo scissors curved 10&quot;</td>
</tr>
<tr>
<td></td>
<td>16. Bozeman forceps curved 10 1/2&quot;</td>
</tr>
<tr>
<td></td>
<td>17. Chettless forceps - 11 1/2&quot;</td>
</tr>
<tr>
<td></td>
<td>18. Gloves - 10 pairs - reusable</td>
</tr>
<tr>
<td></td>
<td>19. Cotton</td>
</tr>
<tr>
<td></td>
<td>20. Gloves (same as in 18)</td>
</tr>
<tr>
<td></td>
<td>21. IUCD</td>
</tr>
<tr>
<td>Consumable supplies</td>
<td>22. Oral pills</td>
</tr>
<tr>
<td></td>
<td>23. Nirodh (condoms)</td>
</tr>
<tr>
<td></td>
<td>24. Antiseptic solution</td>
</tr>
<tr>
<td></td>
<td>25. Client card</td>
</tr>
<tr>
<td></td>
<td>26. Kerosene</td>
</tr>
<tr>
<td></td>
<td>27. Soap</td>
</tr>
<tr>
<td></td>
<td>28. Bleaching powder</td>
</tr>
<tr>
<td></td>
<td>29. Mortuary utility gloves</td>
</tr>
<tr>
<td></td>
<td>30. Covered container for disposable</td>
</tr>
<tr>
<td></td>
<td>31. Bucket with lid and tap (10 liters)</td>
</tr>
<tr>
<td>I.P. Instruments</td>
<td>32. Plain plastic bucket (10 liters)</td>
</tr>
<tr>
<td></td>
<td>33. Tub-12&quot; at base for 0.5% chlorine</td>
</tr>
<tr>
<td></td>
<td>34. Autoclave / boiler</td>
</tr>
<tr>
<td></td>
<td>35. Stove in working condition</td>
</tr>
</tbody>
</table>

Score obtained for critical items
Meeting critical items - 100% Yes
on the availability of basic clinical equipment and supplies related to IUCD services, location and ownership of the subcenter building, and availability of amenities such as water and electricity. During these visits, they scored each subcenter based on a checklist of 35 critical items (see Figure 2). To meet the desired standard, each subcenter had to have at least 32 of the 35 critical items.

SIFPSA and Intrah/PRIME also asked the ANMs and LHVs to complete detailed forms pertaining to the inventory and condition of each subcenter. The forms were distributed to the ANMs and LHVs during their monthly meeting with the district CMO and were collected at the next meeting and forwarded to Intrah/PRIME for data analysis.

Based on the findings from the site visits and the reports from ANMs and LHVs, SIFPSA and Intrah/PRIME selected blocks and/or subcenters for phase-wise ANM training. Those subcenters that had equipment and supplies available and a private space for counseling of the clients were given priority for training.

**Step 2. Subcenter Improvement Plans**
As indicated by the assessment, the subcenter budget had two main components: improving the physical infrastructure and procurement of necessary equipment and instruments. About one-third of the subcenters were located in government-owned premises, and the remaining two-thirds were housed in a rented accommodation, often with insufficient area in an inappropriate location. For the subcenters that were not housed in a government building and needed extra space, SIFPSA provided Rs. 350 (~ USD 7.95) per subcenter to rent a larger and more suitable space. It must be noted, however, that no construction activity was undertaken while strengthening the subcenters, unlike the upgradation program for PPCs, CHCs, and PHCs.

The district CMO had the ultimate responsibility for ensuring that equipment and instruments were procured and made available at the subcenters. Once the DAPs were launched, the PMUs handled the procurement and distribution of equipment. In addition, IFPS provided the ANMs or LHVs a stipend of Rs. 50 (~ USD 1.14) per month for purchasing consumables such as infection prevention materials, kerosene, and flashlight batteries. During the CBFPT workshops, each ANM received an IUCD kit.

On completion of subcenter improvement and equipment purchases, the district issued a certificate of completion and submitted it to SIFPSA.

**Step 3. Monitoring**
Six months after the completion of the strengthening process, SIFPSA officials and district PMU representatives visited the strengthened subcenters to monitor the progress of the unit.

**RESULTS**

**Upgrading of Facilities**
During the facilities upgradation work from 1997–2005, 613 PPCs, CHCs, and PHCs in 53 districts of
### TABLE 1. UPGRADING OF FACILITIES BY DISTRICT AND BY YEAR

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>No. of Sites</th>
<th>Funds for Renovation and Repair (Rs.)</th>
<th>Funds for Essential Equipment (Rs.)</th>
<th>Funds for Maintenance of Equipment (Rs.)</th>
<th>Funds for Consumables (Rs.)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Gorakhpur</td>
<td>14</td>
<td>6751000</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>2.</td>
<td>Jhansi</td>
<td>10</td>
<td>2449000</td>
<td>700000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>3.</td>
<td>Kanpur Nagar</td>
<td>6</td>
<td>1804388</td>
<td>600000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>4.</td>
<td>Rampur</td>
<td>9</td>
<td>6891585</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>5.</td>
<td>Shahjanapur</td>
<td>14</td>
<td>5800000</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>6.</td>
<td>Unnao</td>
<td>16</td>
<td>4305411</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>7.</td>
<td>Sitapur</td>
<td>19</td>
<td>1871360</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1997</td>
</tr>
<tr>
<td>8.</td>
<td>Etawah +</td>
<td>14</td>
<td>3879203</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1998</td>
</tr>
<tr>
<td>9.</td>
<td>Auraiya</td>
<td>10</td>
<td>8334733</td>
<td>1000000</td>
<td>0</td>
<td>0</td>
<td>1998</td>
</tr>
<tr>
<td>10.</td>
<td>Moradabad +</td>
<td>19</td>
<td>5100000</td>
<td>2040000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>11.</td>
<td>Jyoti Phule Nagar</td>
<td>12</td>
<td>3044299</td>
<td>2040000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>12.</td>
<td>Agra</td>
<td>16</td>
<td>4353492</td>
<td>2040000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>13.</td>
<td>Banda +</td>
<td>15</td>
<td>7660371</td>
<td>2040000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>14.</td>
<td>Bareilly</td>
<td>17</td>
<td>3887243</td>
<td>2040000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>15.</td>
<td>Fatehpur</td>
<td>15</td>
<td>3740000</td>
<td>1402500</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>16.</td>
<td>Firozabad</td>
<td>11</td>
<td>5100000</td>
<td>1912500</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>17.</td>
<td>Saharanpur</td>
<td>14</td>
<td>4250246</td>
<td>2125000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>18.</td>
<td>Azamgarh</td>
<td>20</td>
<td>5370281</td>
<td>1785000</td>
<td>0</td>
<td>0</td>
<td>1999</td>
</tr>
<tr>
<td>19.</td>
<td>Ballia</td>
<td>20</td>
<td>3336760</td>
<td>1105000</td>
<td>0</td>
<td>0</td>
<td>2000</td>
</tr>
<tr>
<td>20.</td>
<td>Chitrakoot</td>
<td>17</td>
<td>4218090</td>
<td>9000000</td>
<td>0</td>
<td>0</td>
<td>2000</td>
</tr>
<tr>
<td>21.</td>
<td>Gonda +</td>
<td>19</td>
<td>3271613</td>
<td>1650000</td>
<td>0</td>
<td>0</td>
<td>2000</td>
</tr>
<tr>
<td>22.</td>
<td>Balrampore</td>
<td>11</td>
<td>2716957</td>
<td>6000000</td>
<td>0</td>
<td>0</td>
<td>2000</td>
</tr>
<tr>
<td>23.</td>
<td>Maharajganj</td>
<td>12</td>
<td>3044299</td>
<td>9000000</td>
<td>0</td>
<td>0</td>
<td>2000</td>
</tr>
<tr>
<td>24.</td>
<td>Mirzapur</td>
<td>17</td>
<td>3740000</td>
<td>1402500</td>
<td>0</td>
<td>0</td>
<td>2001</td>
</tr>
<tr>
<td>25.</td>
<td>Chandauli</td>
<td>11</td>
<td>3740000</td>
<td>1402500</td>
<td>0</td>
<td>0</td>
<td>2003</td>
</tr>
<tr>
<td>26.</td>
<td>Ghaziabad</td>
<td>11</td>
<td>3427280</td>
<td>1650000</td>
<td>0</td>
<td>0</td>
<td>2003</td>
</tr>
<tr>
<td>27.</td>
<td>Kanpur Dehat</td>
<td>11</td>
<td>3533848</td>
<td>1650000</td>
<td>0</td>
<td>0</td>
<td>2003</td>
</tr>
<tr>
<td>28.</td>
<td>Rai Bareilly</td>
<td>3</td>
<td>3400000</td>
<td>1650000</td>
<td>0</td>
<td>0</td>
<td>2003</td>
</tr>
<tr>
<td>29.</td>
<td>Mathura</td>
<td>10</td>
<td>4189017</td>
<td>1500000</td>
<td>0</td>
<td>0</td>
<td>2003</td>
</tr>
<tr>
<td>30.</td>
<td>Lalitpur</td>
<td>6</td>
<td>1627616</td>
<td>1500000</td>
<td>0</td>
<td>0</td>
<td>2003</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>613</td>
</tr>
</tbody>
</table>

**DPP: Decentralized Participatory Planning**

**Source:** SIFPSA

---

1 DPP districts are funded by the Government of India.
### TABLE 2. UPGRADE OF FACILITIES IN SIX INITIAL DAP DISTRICTS

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>No. of Sites Covered</th>
<th>Funds for Renovation, Repair, and Equipment (Rs.)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.</td>
<td>Allahabad</td>
<td>20</td>
<td>10300000</td>
<td>1998 and 2003</td>
</tr>
<tr>
<td>35.</td>
<td>Aligarh</td>
<td>11</td>
<td>5405000</td>
<td>1998 and 2003</td>
</tr>
<tr>
<td>37.</td>
<td>Rampur</td>
<td>8</td>
<td>840000</td>
<td>2003 only</td>
</tr>
<tr>
<td>38.</td>
<td>Sultanpur</td>
<td>22</td>
<td>10710000</td>
<td>1998 and 2003</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>81</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SIFPSA

### TABLE 3. UPGRADE OF FACILITIES UNDER QUALITY CIRCLE IMPROVEMENT INTERVENTION

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Units Covered</th>
<th>Funds for Renovation and Repair (Rs.)</th>
<th>Funds for Equipment (Rs.)</th>
<th>Funds for Maintenance/ Equipment/ Consumables (Rs.)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.</td>
<td>Allahabad</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Aligarh</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Meerut</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Rampur</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Sultanpur</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>Varanasi</td>
<td>8</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Total</td>
<td></td>
<td>81</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Source: SIFPSA

### TABLE 4. UPGRADE OF FACILITIES IN DECENTRALIZED PARTICIPATORY PLANNING (DPP) DISTRICTS

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Units Covered</th>
<th>Renovation and Repair (Rs.)</th>
<th>Funds for Equipment (Rs.)</th>
<th>Funds for Maintenance/ Equipment/ Consumables (Rs.)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.</td>
<td>Lakhimpur</td>
<td>13</td>
<td>3498351</td>
<td>1300000</td>
<td>390000</td>
<td>2004</td>
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<tr>
<td>41.</td>
<td>Bulandshahar</td>
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<td>3206635</td>
<td>1200000</td>
<td>360000</td>
<td>2005</td>
</tr>
<tr>
<td>42.</td>
<td>Bahraich</td>
<td>12</td>
<td>2041722</td>
<td>1200000</td>
<td>360000</td>
<td>2004</td>
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<tr>
<td>43.</td>
<td>Pilibhit</td>
<td>7</td>
<td>1041008</td>
<td>700000</td>
<td>210000</td>
<td>2005</td>
</tr>
<tr>
<td>44.</td>
<td>Lucknow</td>
<td>8</td>
<td>1645109</td>
<td>800000</td>
<td>240000</td>
<td>2004</td>
</tr>
<tr>
<td>45.</td>
<td>Bijnor</td>
<td>11</td>
<td>3290421</td>
<td>1100000</td>
<td>330000</td>
<td>2004</td>
</tr>
<tr>
<td>46.</td>
<td>Muzaffar</td>
<td>10</td>
<td>1809270</td>
<td>1000000</td>
<td>300000</td>
<td>2004</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>73</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Source: SIFPSA

Note: DPP districts are included under the Empowered Action Group Scheme of the Government of India.

### TABLE 5. UPGRADE OF FACILITIES OF FORMER IFPS DISTRICTS NOW IN UTTARANCHAL

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Units Covered</th>
<th>Renovation and Repair (Rs.)</th>
<th>Funds for Equipment (Rs.)</th>
<th>Maintenance/ Equipment/ Consumables (Rs.)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>47.</td>
<td>Almora</td>
<td>11</td>
<td>4400000</td>
<td>1650000</td>
<td>55000</td>
<td>1999</td>
</tr>
<tr>
<td>48.</td>
<td>Nainital</td>
<td>8</td>
<td>3200000</td>
<td>1200000</td>
<td>40000</td>
<td>1999</td>
</tr>
<tr>
<td>49.</td>
<td>Dehradun</td>
<td>8</td>
<td>4849060</td>
<td>1000000</td>
<td>40000</td>
<td>1998</td>
</tr>
<tr>
<td>50.</td>
<td>Tehri Garhwal</td>
<td>10</td>
<td>4000000</td>
<td>1500000</td>
<td>50000</td>
<td>1998</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SIFPSA
TABLE 6. UPGRAADING OF DISTRICT POSTPARTUM CENTERS

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Units Covered</th>
<th>Funds (Rs.)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.</td>
<td>Ghazipur</td>
<td>1</td>
<td>350000</td>
<td>1997</td>
</tr>
<tr>
<td>52.</td>
<td>Bara Banki</td>
<td>1</td>
<td>350000</td>
<td>1997</td>
</tr>
<tr>
<td>53.</td>
<td>Basti</td>
<td>1</td>
<td>350000</td>
<td>1997</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SIFPSA

Uttar Pradesh and Uttaranchal were upgraded (see Box 1). Detailed figures and costs are presented in Tables 1 through 6.

Upgrading of these 613 sites led to improved access to quality family planning services by the local communities. A minimum quality of standards was now observed in these facilities and an enabling environment was created for the service providers. It led to an enhanced capacity of the public healthcare system and contributed to a reported increase in sterilization rates. While the capacity building of service providers was a key accomplishment of the IFPS Project, the impact on service utilization would not have been as pronounced without the accompanying strengthening and upgradation of the PPCs, CHCs, and PHCs.

**Strengthening of Subcenters**

Strengthening of subcenters was carried out in 35 districts of Uttar Pradesh. In all, 8,934 subcenters were strengthened, of which about one-third were housed in government infrastructure and about two-thirds were operating out of rented premises. Equipment was provided to 8,067 subcenters, and additional provision of rent was made to 5,668 facilities.

**LESSONS LEARNED**

- One of the key lessons learned from this intervention was that provision for maintenance should be kept in the budget to ensure long-term maintenance of the improved standard of the facility. The Quality Improvement pilot initiative, discussed in Chapter 5, sought to provide for continuing monitoring and maintenance of facilities.

- Conducting the site assessment was one of the most challenging parts of the intervention. The skills of the assessment team in reorganizing the clinic layout for optimal utilization of space and other resources were very critical to the final output being useful and user friendly. On average, each site took between six to eight months from beginning to end to be completely upgraded. The time taken also depended upon the Junior Engineer’s timely submission of estimates and the technical sanction being obtained in time.
The three-pronged approach—training of ANMs and LHV, facilities upgradation, and provision of funds for consumables to ANMs and LHV—was helpful in increasing the quality standards as well as output of the strengthened subcenters. The improved subcenters helped achieve the larger goal of enhancing the quality of and access to family planning services under the IFPS Project.

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.
TECHNICAL TRAINING:
Improving Clinical Skills of Healthcare Providers

By Seema Talwar

RATIONALE
One of the main goals of the IFPS Project was to increase access to and availability of high-quality family planning services in public-sector health centers in 33 project districts in Uttar Pradesh. A key part of this strategy was to strengthen training for medical providers at these centers. Accordingly, in 1994, JHPIEGO, a USAID-funded cooperating agency, conducted a training needs assessment on client-oriented family planning. The major findings of the assessment were:

- The staffing patterns at existing training institutions were not effectively organized to meet current training needs;
- Training centers lacked self-contained clinical teaching facilities or access to a clinical site that could be maintained as a clinical training site;
- Existing training programs did not address some of the participants’ major needs, especially in the area of practical clinical training;
- There was a lack of training materials and educational equipment for master trainers;
- Family planning providers were following outdated clinical guidelines that were not consistent with internationally-accepted clinical service guidelines;
- Some providers were not following the Government of India (GoI) guidelines on surgical sterilization procedures;
- Concepts of infection prevention and protective measures among medical staff to prevent HIV and infectious diseases required greater attention; and
- There was a need to strengthen service delivery at health centers to ensure that adequate resources and supplies existed to implement the training interventions.

The needs assessment brought to light the pressing need for technical training and clinical skills development for rural medical providers. To address this need, SIFPSA created a Technical Advisory Group (TAG) that was led by the Director General Family Welfare–GoI and was composed of members from the Government of Uttar Pradesh (GoUP), SIFPSA, USAID, and cooperating agencies. The TAG was responsible for creating standardized guidelines for sterilization procedures and
designing the technical training materials.

OBJECTIVES
The training interventions introduced through IFPS focused on improving providers’ skills and knowledge in male and female sterilization methods, infection prevention, contraceptive technology, family planning counseling, emergency obstetric and newborn care, and management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs).

EngenderHealth (2005a) designed and conducted training with the aim of achieving three objectives:
1) Increase the pool of skilled providers through “induction training”;  
2) Create district resources in the form of district trainers who would mentor and provide support to the new trainees; and  
3) Improve service delivery quality by updating the knowledge and skills of practicing service providers through refresher training.

When the training interventions began in 1995, there was no set number of providers to be trained per district. The main goal was to expand technical training and ensure there was a surgeon and lady medical officers in each district who could perform sterilization procedures. Once district action plans (DAPs) were introduced in 1998, technical training interventions were a common component of DAPs.

INTERVENTION COMPONENTS
During the initial years of designing the technical training, JHPIEGO was the lead cooperating agency partnering with SIFPSA. In 1995, the first training module, the contraceptive technology update (CTU), was developed and introduced. It was initially implemented in Lucknow and Meerut medical colleges and then extended to other colleges. In 1996, EngenderHealth (formerly AVSC International) became the lead cooperating agency for this intervention and continued in this role until 2004, when SIFPSA took over this responsibility.

Training Design
The training strategy was based on a competency-based approach, including the creation of a regular follow-up system for assessing provider performance and facilitating the continuation of the learned skills. EngenderHealth (2005a, pp. 6–7) describes the process as follows:

- **Standardization Workshops.**
  The first step in the training intervention was a series of workshops to standardize procedures that providers would be trained to perform. Participants included professionals from medical colleges, SIFPSA, EngenderHealth, and JHPIEGO, as well as officials from the GoUP Department of Health and Family Welfare. In the workshops, experts reviewed and analyzed each procedure for which training would be offered. The discrete steps necessary for each clinical procedure were first identified and then analyzed to determine the most efficient and safe way to teach and learn them. Moreover, national and international guidelines were reviewed and
referred to throughout the process. These workshops resulted in standardization guidelines, competency-based learning guides, and checklists for the following procedures: laparoscopic tubal ligation, minilaparotomy, abdominal tubectomy (AT), and intrauterine contraceptive device (IUCD) insertion and removal.

- **Learning Guides.** Training manuals were created covering all the steps in the particular clinical procedure. This includes the initial counseling of the client, providing method choice, client assessment, and details of pre-operative, procedural, and post-operative steps. The learning guides provide a comprehensive list of all components and steps required to perform the procedure as per quality guidelines.

- **Training Location.** All trainings in sterilization procedures were provided at medical colleges and district hospitals where equipment, supplies, and support were available, and also where the caseload was sufficient to provide trainees with adequate opportunities to observe and practice on patients. Infection prevention training used the Whole-Site Training approach, which requires the participation of the staff at all levels, from sweepers to medical officers.

- **Training Follow-up Assessment.** Based on the learning guides that were developed during the training design phase, a follow-up checklist was created for each of the clinical procedures. The checklists were used to assess the provider’s competence in performing the clinical procedure.

### Key Training Components

The three main components of the technical training interventions were:

- **Comprehensive Training Approach.** IFPS technical training included a variety of learning tools including audio-visual, hands-on practice, group discussion, role play, the use of anatomic models of reproductive systems, samples of contraceptives, and class lecture. Furthermore, in addition to training, IFPS interventions included service delivery and resource requirement strengthening to help ensure that healthcare providers had the supplies to implement the newly learned techniques.

- **Institutional Collaboration.** SIFPSA collaborated with a number of medical colleges throughout Uttar Pradesh and developed strong relationships with these institutions. SIFPSA was responsible for maintaining contact with these institutions and providing the necessary upgrades and resources for the college to become a training center. This collaboration has resulted in strong ties between SIFPSA and medical colleges to embark on more training programs together and share clinical and management best practices (see Box 1).

- **Capacity Building for Sustainability.** Beginning in 1998–99, EngenderHealth worked closely with the GoUP to establish training centers in order to ensure
Ideas, Insights, and Innovations

the continuation of training activities post-IFPS. In total, 14 training centers were established in Uttar Pradesh and the districts incorporated into the new state of Uttaranchal.

To promote sustainability, training-of-trainer (TOT) courses were conducted for infection prevention, AT induction, laparoscopy induction, no-scalpel vasectomy (NSV), minilaparotomy, counseling, and RTIs/STIs. As of December 2005, 866 trainers were trained. TOT courses were open to all medical officers who qualified for the initial training and who wished to become trainers. All district trainers shared records of their training activities with EngenderHealth for review and feedback (EngenderHealth, 2005a).

OVERVIEW OF TECHNICAL TRAINING PROGRAMS
Seven technical training programs were implemented under the IFPS project. Training in all methods included standardized techniques, client assessment, infection prevention, counseling, post-operative care, and client follow-up (for a summary of training programs, see Table 1). Two levels of training were provided: a longer “induction” course for providers without experience, and a shorter “refresher” course for providers already practicing the method to standardize service delivery skills. (Details on the NSV training are located in Chapter 7 of this monograph.)

Laparoscopy
Laparoscopy is the predominant method of tubectomy in many areas of Uttar Pradesh, reflecting provider preferences as well as clients’ perceptions based on word of mouth. However, laparoscopy requires sophisticated equipment and skilled surgeons, thus limiting access in many areas. For practicing laparoscopists there was a two-day refresher training package given at the district level. Induction training began in 2002; the 12-day training program covers surgical procedure, anesthesia, management of complications, and post-operative recovery.

Minilap Under Local Anesthesia
Minilaparotomy, or “minilap,” under local anesthesia is a method of tubectomy that is popular in certain regions of Uttar Pradesh, based on previous patterns of provider availability. It is particularly suitable for places where support staff, equipment, and supplies are limited, and it can be conducted in the postpartum period or any time.

BOX 1
Benefits of Institutional Collaboration For Medical Colleges

The Head of the Obstetrics and Gynecology Department at Queen Mary’s Hospital in Lucknow indicates that there are several benefits for the medical college in partnering with IFPS to become a training center. These include:

- The teachers and trainers receive best practices to teach and learn from;
- The IFPS training shows the college what key features are missing from its own curricula;
- The experience provides better understanding of rural medical care and what challenges rural providers face;
- The college receives free (if required) renovation of its operating theater and the teaching facility’s supply of required medical resources;
- There is provision of teaching aids (e.g., TV, VCR, monitors, and projectors); and
- Funding is provided to cover the administrative costs for a part-time coordinator, accountant, and sweeper for training activities.
when a woman is not pregnant. The training is a six-day interactive program aimed at community health center (CHC) and primary health center (PHC) medical officers. This training provides skills on conducting the minilap procedure, post-operative care, management of pain and complications, follow-up, infection prevention, and quality assurance.

**Abdominal Tubectomy**
AT training involved a modified version of the conventional abdominal tubectomy procedure, yet used 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. It can be done in the postpartum period. AT induction training was introduced in 2002. It is a 12-day program for practicing sterilization providers covering surgical procedure, post-operative recovery, anesthesia, and management of complications. Refresher training for experienced sterilization providers is three days long.

**Contraceptive Technology Update and IUCDs**
All medical officers in IFPS districts participated in a three-day CTU at one of the seven selected medical colleges. The training discussed the latest features of contraception and the basics of counseling and informed choice in family planning. Lady medical officers were exposed to a further two-day module on issues related to IUCD insertion and removal. During this session, they get an opportunity to practice on pelvic models and to hone their IUCD skills.

**RTIs/STIs**
Prevention and management of RTIs/STIs is an essential component of the GoI Reproductive and Child Health (RCH) Program. In 2000, the IFPS Project introduced an RTI/STI training module. It is a six-day training that employs a combination of the “syndromic” approach (diagnosis based on symptoms) and simple laboratory diagnosis.

Three members from each district form the master training team. The team comprises a lady medical officer (preferably a gynecologist), a pathologist, and a skin/venereal disease specialist. The first three days of training focus on clinical training, while the last three focus on skill development. Furthermore, a one-day training for laboratory technicians was also organized in IFPS districts to discuss laboratory diagnosis of RTIs/STIs.

**Infection Prevention**
Reducing the risk of infectious diseases is an important component of high-quality reproductive health services. Infection prevention training teaches how to protect service providers, staff, and the community from infectious diseases that could originate in healthcare facilities. The training is a two-day, on-site program for all staff members working at the facility. It emphasizes hands-on learning and includes sessions on hand washing, glove use, surgical attire, antiseptics and disinfectants, decontamination, and processing, cleaning, and sterilization of

“We have learned about all these procedures and practices during our college days, but slowly and gradually forgot to use them. It was highly satisfying that these programs reminded us of the dangers involved in not following infection prevention practices. If you had visited the clinics before and after training, you would have noticed the change.”

—A medical officer

Trained providers were observed interacting with clients to ensure they met standards for quality of care.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Participants</th>
<th>Objectives</th>
<th>Duration</th>
<th>Site</th>
</tr>
</thead>
</table>
| **Abdominal Tubectomy (AT) Refresher** | Surgeons, medical officers | • Provide competency-based refresher training on standardized AT techniques  
• Impart knowledge and skills about counseling in AT, infection prevention (IP) practices, and client selection and management | 3 days | District Hospital |
| **AT Induction Training** | Medical officers | • Provide competency-based induction training on standardized AT techniques  
• Impart knowledge and skills about counseling in AT, IP, and client selection and management | 12 days | District Women’s Hospital at Agra, Jhansi, and Haldwani |
| **Minilaparotomy under Local Anesthesia (ML/ LA)** | Medical officers working in family planning | • Impart knowledge and skills about ML/LA  
• Impart knowledge and skills about counseling for ML/LA, IP, client selection, management of complications, and post-operative care and follow-up | 6 days | District Hospital |
| **Laparoscopy Refresher** | Certified laparoscopists and nurse assistants | • Provide competency-based refresher training on the standardized technique of laparoscopic sterilization  
• Impart knowledge and skills about counseling for laparoscopy, IP, client selection, management of complications, and post-operative care and follow-up | 2 days | District Hospital |
| **Laparoscopy Induction Training** | MS/MD/DGO in OB/GYN or surgeon | • Provide competency-based induction training on the standardized technique of laparoscopic sterilization  
• Impart knowledge and skills about counseling for laparoscopy, IP, client selection, management of complications, and post-operative care and follow-up | 12 days | Meerut and Lucknow Medical Colleges |
| **Contraceptive Technology (CTU) Intrauterine Contraceptive Device (IUCD)** | Medical officers, paramedical providers | • CTU: Provide contraceptive technology update  
• IUCD: Train providers in no-touch withdrawal technique of IUCD insertion | CTU=3 days  
IUCD=2 days | Medical colleges in Uttar Pradesh |
| **RTIs/STIs** | Medical officers and laboratory technicians | • Impart knowledge and skills regarding RTI/STI management  
• Enhance skills to counsel clients on treatment regimens, unsafe sexual behaviors, and managing RTIs/STIs | 3 days for doctors and 1 day refresher for lab technicians | On-site |
| **Infection Prevention (IP)** | All categories of staff | • Enable all categories of staff to understand the significance of IP and use recommended practices  
• Impart IP training at the work site through didactic and practical demonstrations | 2 days | On-site |
| **Emergency Obstetric and Newborn Care** | Medical officers and paramedical staff | • Increase access to quality emergency obstetric and newborn care at PHCs and CHCs  
• Improve referrals for complicated obstetric cases | 21 days | On-site and off-site |

Source: EngenderHealth, 2005a, pp. 8-9
instruments. Other topics include high-level disinfections, aseptic techniques, use and disposal of sharp instruments and multi-dose vials, and disposal of infected hospital waste. Trainees practice preparing 0.5 percent chlorine solution, cleaning instruments, autoclaving, and packaging linen, gloves, and instruments.

**Emergency Obstetric and Newborn Care**

Recognizing the high maternal mortality rate in Uttar Pradesh and the frequency of obstetric complications during pregnancy, in 2003, the IFPS Project conducted a pilot project on emergency obstetric and newborn care at four sites in Meerut District. Two training centers have been established in Meerut. Training was also conducted at eight sites in Uttaranchal. The 21-day training focuses on identifying and responding to an abnormal delivery and reducing delay in receiving care after arriving at the first referral-level facility. The training course for medical officers and paramedical staff required providers to practice in actual labor and emergency rooms to learn hands-on techniques.

**ROLES OF IMPLEMENTING PARTNERS**

In the implementation of technical trainings, there were three major implementing partners: GoUP, SIFPSA, and EngenderHealth. The TAG was a comprehensive group of experts from the GoUP Department of Family Welfare, SIFPSA, USAID, and EngenderHealth who worked together to design the modules and provide inputs to the intervention design. Box 2 presents the roles and responsibilities of the primary implementing partners.

**PROJECT MANAGEMENT AND COSTS**

**Project Management**

Technical training programs were generally implemented in seven steps:

- **Step 1: Selection of sites that need training.** EngenderHealth assessed health facilities throughout Uttar Pradesh and identified which type of training the sites required based on data detailing sterilization procedures, client load, and demand.
- **Step 2: Chief Medical Officers informed of upcoming training.**

---

**BOX 2**

**Partner Roles and Responsibilities**

<table>
<thead>
<tr>
<th>Government of Uttar Pradesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Director General Family Welfare provided key political support for implementation;</td>
</tr>
<tr>
<td>- Chief Medical Officers of IFPS districts selected trainees; and</td>
</tr>
<tr>
<td>- Trainees were GoUP medical officers, nurses, and health providers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIFPSA</th>
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</thead>
<tbody>
<tr>
<td>- Provided critical technical assistance in management and administration of the entire training program;</td>
</tr>
<tr>
<td>- Developed training modules and field tested them in partnership with EngenderHealth; and</td>
</tr>
<tr>
<td>- Maintained the monitoring and information systems for tracking training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Engender Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Developed training materials in partnership with SIFPSA;</td>
</tr>
<tr>
<td>- Took a leading role in creating standards for sterilization procedures;</td>
</tr>
<tr>
<td>- Established training centers throughout the state;</td>
</tr>
<tr>
<td>- Built the capacity of master and district-level trainers;</td>
</tr>
<tr>
<td>- Conducted monitoring and evaluation of providers to determine the extent to which they met performance standards for each procedure; and</td>
</tr>
<tr>
<td>- Provided on-the-job coaching during the monitoring and evaluation.</td>
</tr>
</tbody>
</table>
SIFPSA and the training centers both sent letters of request to each IFPS district informing the Chief Medical Officer (CMO) of the upcoming training program and the need to identify suitable trainees for the program.

- **Step 3: Selection of district trainers.** The district CMO and Chief Medical Superintendent (CMS), with the help of SIFPSA and EngenderHealth, identified the medical officers—including lady medical officers—that had the qualifications, experience, and interest in becoming a master trainer. Typically, there were one district trainer for every six to eight trainees to ensure that proper attention and hands-on experience were given to each trainee.

- **Step 4: Selection of trainees.** The CMO and CMS identified the medical officers and healthcare providers to attend the training sessions.

- **Step 5: District hospital or training center prepares for training.** The training center arranged for accommodations and meals for all trainees and arranged for all required training materials.

- **Step 6: Implementation of training program.** The training program was conducted at the given location. Modules varied in length, from one day to three weeks. Medical officers typically attended longer modules than nurses or lab technicians.

- **Step 7: Monitoring and evaluation.** EngenderHealth conducted a follow-up of trainees within one to three months of the training to evaluate whether individuals are performing to standard (PTS). If a provider was not performing to standard (NTPS), he/she received on-the-job counseling and the opportunity for further training.

**Training Costs**

While the costs associated with creating the training manuals and conducting the initial training needs assessment were not available, SIFPSA was able to provide details on honoraria provided to trainers and trainees and average total costs per participant for some training programs. For example, across all technical training interventions, daily honoraria were provided to trainers and trainees as follows: district trainers received Rs. 500 (~ USD 11.36); medical officers received Rs. 200 (~ USD 4.55); and nurses received Rs. 150 (~ USD 3.41).

Table 2 presents the per trainee expenditure on staff nurses and doctors for laparoscopic induction training at Meerut Medical College.

In addition, SIFPSA data indicate that the average cost per trainee for AT was Rs. 12,043 (~ USD 274) and for minilaparotomy Rs. 11,768 (~ USD 267).

**MONITORING AND EVALUATION**

Follow-up visits were conducted to assess the clinical competence of trainees against set standards and to determine if the providers were performing to standard, designated as PTS. It should be noted that observation of providers on-the-job was only conducted with their consent and with the consent of clients affected. The evaluation included the following steps:

- **Step 1:** The first follow-up visit...
### TABLE 2. AVERAGE COST FOR LAPAROSCOPIC INDUCTION TRAINING, MEERUT MEDICAL COLLEGE

<table>
<thead>
<tr>
<th>Cost Item for Laparoscopy Induction Training</th>
<th>Doctor (Amount in Rs.)</th>
<th>Doctor (Amount in USD)</th>
<th>Nurse (Amount in Rs.)</th>
<th>Nurse (Amount in USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel Allowance</td>
<td>1,720</td>
<td>39</td>
<td>1,720</td>
<td>39</td>
</tr>
<tr>
<td>Daily Allowance</td>
<td>1,796</td>
<td>41</td>
<td>700</td>
<td>16</td>
</tr>
<tr>
<td>Accommodation</td>
<td>3,850</td>
<td>88</td>
<td>1,298</td>
<td>30</td>
</tr>
<tr>
<td>Meals</td>
<td>3,024</td>
<td>69</td>
<td>1,512</td>
<td>34</td>
</tr>
<tr>
<td>Contingency</td>
<td>631</td>
<td>14</td>
<td>316</td>
<td>7</td>
</tr>
<tr>
<td>Trainer's Expenses</td>
<td>3,000</td>
<td>68</td>
<td>1,500</td>
<td>34</td>
</tr>
<tr>
<td>Mobility</td>
<td>2,295</td>
<td>52</td>
<td>765</td>
<td>17</td>
</tr>
<tr>
<td>Training Material</td>
<td>378</td>
<td>9</td>
<td>189</td>
<td>4</td>
</tr>
<tr>
<td>Stationery</td>
<td>36</td>
<td>1</td>
<td>36</td>
<td>1</td>
</tr>
<tr>
<td>Institutional Support</td>
<td>4,038</td>
<td>92</td>
<td>4,038</td>
<td>92</td>
</tr>
<tr>
<td>Administrative Cost</td>
<td>510</td>
<td>12</td>
<td>510</td>
<td>12</td>
</tr>
<tr>
<td>Total Cost Per Trainee</td>
<td>21,278</td>
<td>485</td>
<td>12,584</td>
<td>286.00</td>
</tr>
</tbody>
</table>

Source: SIFPSA public-sector management information system

...was conducted within three months following the training. The time period between the end of the training and the follow-up was specifically designed to provide the trainee with adequate opportunity to practice the learned skill(s). An assessment checklist for each procedure was used to assess provider performance during the follow-up visit. Each checklist included all the steps identified as critical or non-critical. Steps that are directly correlated with the providers’ competence and skill are identified as critical and the remaining steps are denoted as non-critical. The critical steps observed during this assessment determine whether the provider was PTS or not performing to standard, designated as NPTS. Providers must perform all critical steps correctly to be declared PTS.

In addition to evaluating the trainee, the follow-up visit allowed for on-the-job feedback and reinforcement, determining existing gaps in performance, and planning assistance or additional mentoring to identify individual trainee strengths and weaknesses and support service gaps.

- **Step 2**: If the provider was declared PTS in first evaluation he/she received a certificate formally indicating that he/she is an approved provider of the given procedure. If the trainee was assessed as NPTS, then the evaluator provided the trainee with feedback and on-the-job coaching, and a second follow-up was scheduled. Furthermore, the CMO, CMS, and SIFPSA were kept informed of and tracked which providers were NPTS and, therefore, should not be allowed to provide the service and required further training.
A provider declared NPTS twice was either re-trained or not assessed anymore and concerned managerial staff at the site were notified.

- **Step 3:** Results from follow-up visits and PTS declarations were incorporated into future training design and program design.

EngenderHealth managed the monitoring and evaluation of trainings until 2003–2004 and then SIFPSA took over this responsibility.

**RESULTS**

**Trained Providers**

From 1995 through December 2005, a total of 27,371 healthcare workers in the IFPS districts were trained in at least one of the following topics: sterilization techniques, RTI/STI management, infection prevention, CTU, and counseling skills (EngenderHealth, 2005a).

A total of 2,199 providers and trainers were trained in at least one of the following procedures: laparoscopic tubal ligation, AT, minilap, NSV, and IUCD insertion and removal. EngenderHealth followed up with 1,532 (70 percent) of those providers and found 87 percent (N=1,329) of them were PTS.

The number of providers NPTS after two follow-up visits was 8 percent (n=121) of the total number followed up. Of those trained and posted in IFPS districts, 5 percent (n=81) could not be assessed. A major challenge for conducting follow-up is that medical officers are transferred often and locating them for assessment was difficult. Table 3 shows the number of providers trained and the corresponding PTS levels.

A key accomplishment of the technical training is that, in all 33 IFPS districts, there is at least one provider trained in one or more methods of female sterilization. In addition, as of December 2005, 1,003 providers were trained in RTIs/STIs, 10,989 in infection prevention, and 5,599 in CTU.

**TABLE 3. PROVIDER PERFORMANCE FOR STERILIZATION AND IUCD TECHNIQUES, JULY 2005**

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Total No. Trained</th>
<th>Assessed as of July 2005</th>
<th>PTS</th>
<th></th>
<th></th>
<th>NPTS</th>
<th>Could not be Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>AT Refresher</td>
<td>220</td>
<td>218</td>
<td>197</td>
<td>90%</td>
<td>9</td>
<td>4.1%</td>
<td>12</td>
</tr>
<tr>
<td>AT Induction</td>
<td>165</td>
<td>41</td>
<td>37</td>
<td>90%</td>
<td>2</td>
<td>4.9%</td>
<td>2</td>
</tr>
<tr>
<td>Minilaparotomy</td>
<td>150</td>
<td>148</td>
<td>114</td>
<td>77%</td>
<td>25</td>
<td>17%</td>
<td>9</td>
</tr>
<tr>
<td>NSV</td>
<td>137</td>
<td>117</td>
<td>106</td>
<td>91%</td>
<td>10</td>
<td>9%</td>
<td>1</td>
</tr>
<tr>
<td>Lap Induction</td>
<td>222</td>
<td>152</td>
<td>145</td>
<td>95%</td>
<td>5</td>
<td>3%</td>
<td>1</td>
</tr>
<tr>
<td>Lap Refresher</td>
<td>359</td>
<td>359</td>
<td>309</td>
<td>86%</td>
<td>18</td>
<td>5%</td>
<td>32</td>
</tr>
<tr>
<td>IUCD</td>
<td>946</td>
<td>497</td>
<td>421</td>
<td>85%</td>
<td>52</td>
<td>10%</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,199</strong></td>
<td><strong>1,532</strong></td>
<td><strong>1,329</strong></td>
<td><strong>87%</strong></td>
<td><strong>121</strong></td>
<td><strong>8%</strong></td>
<td><strong>81</strong></td>
</tr>
</tbody>
</table>

Source: EngenderHealth, 2005a, p. 16
Training-of-trainers
As of December 2005, there were 866 trainers across the IFPS districts. The presence of trainers in nearly all districts ensures that there are doctors in each district who can train others and ensure sustainability of quality service delivery. Table 4 below provides a breakdown of trainers by procedure.

Training Centers
The IFPS technical training intervention established 14 training centers at medical colleges and district women’s hospitals in Uttar Pradesh and former IFPS districts now in Uttaranchal (see Table 5). The establishment of these centers helped institutionalize training interventions. The training centers had strong infrastructure, equipment, supplies, experienced trainers, and adequate client load.

Sustainability of the training centers is an issue, however. A 2006 review found that only two of the 14 training centers are currently functioning. Training centers at Lucknow and Meerut medical colleges are the only ones providing ongoing technical training with support from IFPS. Some of the training centers are now located in the newly created state of Uttaranchal, and other centers are no longer providing technical training due to lack of funding. Given the continuing demand for skilled medical providers and the need for high-quality services, health officials need to find ways of supporting these training centers or making their operations more financially sustainable.

Additional Outcomes of the Training
Other impacts of the technical training include:
- Promotion of quality service. The technical training interventions highlighted the need for

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**TABLE 4. NUMBER OF TRAINERS BY PROCEDURE, DECEMBER 2005**

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Total No. of Trainers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention</td>
<td>222</td>
</tr>
<tr>
<td>Counseling Skills</td>
<td>261</td>
</tr>
<tr>
<td>RTI/STI</td>
<td>109</td>
</tr>
<tr>
<td>AT Refresher</td>
<td>48</td>
</tr>
<tr>
<td>AT Induction</td>
<td>46</td>
</tr>
<tr>
<td>Laparoscopy Refresher</td>
<td>5</td>
</tr>
<tr>
<td>Laparoscopy Induction</td>
<td>109</td>
</tr>
<tr>
<td>NSV</td>
<td>15</td>
</tr>
<tr>
<td>Minilap</td>
<td>7</td>
</tr>
<tr>
<td>Emergency Obstetric and Newborn Care</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>866</strong></td>
</tr>
</tbody>
</table>

Source: EngenderHealth, 2005a, p. 17

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**TABLE 5. TRAINING CENTERS ESTABLISHED UNDER THE IFPS PROJECT**

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Number</th>
<th>Location</th>
<th>Year Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laparoscopy induction</td>
<td>2</td>
<td>Lucknow and Meerut</td>
<td>2001 and 2002</td>
</tr>
<tr>
<td>AT refresher</td>
<td>2</td>
<td>Jhansi and Haldwani</td>
<td>2000–2001</td>
</tr>
<tr>
<td>AT induction</td>
<td>2</td>
<td>Jhansi and Agra</td>
<td>2002</td>
</tr>
<tr>
<td>NSV</td>
<td>4</td>
<td>Jhansi, Almora, Dehradun, and Nainital</td>
<td>1999</td>
</tr>
<tr>
<td>Minilap</td>
<td>2</td>
<td>Varanasi and Gorakhpur</td>
<td>1997</td>
</tr>
<tr>
<td>Emergency obstetric and newborn care</td>
<td>2</td>
<td>Meerut and Dehradun</td>
<td>2003</td>
</tr>
</tbody>
</table>

Source: EngenderHealth, 2005a, p. 17
“Both the refresher and new provider training has led to a change in the mindset of providers. Providers are more willing and feel accountable for providing quality services at their sites. The follow-ups especially have resulted in improved infection prevention practices.”

—Supervisor

Source: EngenderHealth, 2005b, p. 4.

providers to deliver high-quality service and be up-to-date on standards and critical steps in family planning procedures. Approximately 87 percent of providers trained in sterilization and IUCD techniques performed to quality standards.

• **Closer access to services.** The availability of trained providers in every district helps ensure that clients have service providers closer to their homes and that they are receiving counseling and information regarding their options in family planning.

• **Availability of strong clinical training modules.** The in-depth training modules and audio-visual materials developed for the training programs can now be shared across India as best practice training information.

• **Providing sufficient resources to support the ability to perform to standards.** Medical officers face practical challenges in implementing training and PTS because they do not have the required supplies and materials in their clinics to follow all guidelines. For example, if medical officers do not have a clean, well-maintained laparoscope, they cannot follow certain infection prevention guidelines.

• **Expanding the availability of various sterilization methods.** Laparoscopy is the method of sterilization preferred by providers and clients in most parts of Uttar Pradesh. However, minilap procedures are popular in some areas. These local preferences for a specific method appear to result from providers’ reliance on the procedure that they have been trained in or have practiced the most. Over time, the procedure

LESSONS LEARNED

Some of the challenges and lessons learned while implementing the technical training involve:

• **Sensitizing government officials and medical officers about the need for training.** Advocating for the need to standardize training in clinical procedures and helping government officials understand how to adapt training materials and methods in a low-resource setting was often a difficult process. Ensuring the presence and participation of medical officers was also a challenge because many have their own private practices outside of their government medical duties and do not want to leave their practices or families. Some medical officers felt burdened because there are many other training programs they are asked to attend and they are often informed about the training programs with minimal advance notice. To increase their support and interest in technical training, implementing partner representatives suggest that CMOs should participate in a technical training orientation to get an overview of the benefits and topics covered in the programs. In addition, greater recognition of providers who successfully completed training programs and are declared PTS could help increase interest and participation.
most commonly practiced has become the method of choice and preference for clients in that area because they learn about sterilization from previous clients and want the procedure they have heard about. To give clients more options, a provider should be trained and practiced in a variety of sterilization techniques or local health authorities should ensure that several providers specializing in different methods are available in the district.

Increasing the number of master trainers can also help facilitate more trainings and help ensure that trainings do not become burdensome. Given that master trainers often have other responsibilities—such as their own patients and students to manage—capacitating more master trainers would reduce their workload and allow them to be more focused and available to trainees.

- Improving monitoring and evaluation. Conducting training and follow-up assessments was hampered by the frequent transfers of trained providers. In addition, aside from re-training providers, little could be done if a provider was found to be NPTS twice or could not be assessed at all. To ensure that all trained providers are meeting performance standards, more concerted efforts are needed to find and assess providers who have moved. Implementing partners suggest that a management information system for tracking trained medical officers and their locations could be developed and shared between GoUP and SIFPSA.

“Even though many women in my community had undergone the same procedure, I had fears about getting sterilization done, but after I met the doctor . . . I decided to get abdominal tubectomy done. The procedure took a few minutes and left a small stitch. After a few hours of recovery time, I returned home in time to join my family for dinner.”

—Client


REFERENCES

TRAINING OF AUXILIARY NURSE MIDWIVES: Enhancing Family Planning Clinical Skills

By Ajay Pandey

RATIONALE

For quality improvement in public health service delivery, changing the attitudes of service providers and enhancing their skills to meet standards of practice are essential. To meet this goal, public-sector health personnel need training in clinical skills and counseling. Key service providers at the community level are auxiliary nurse midwives (ANMs), who are female health workers primarily based at subcenters in rural areas, and lady health visitors (LHVs), who supervise ANMs and are based at block primary health centers (PHCs) or community health centers (CHCs).

A 1994 training needs assessment conducted by JHPIEGO (a USAID-funded cooperating agency), SIFPSA, and USAID found that intrauterine contraceptive device (IUCD) insertion skills among some providers were deficient, resulting in frequent infection and high IUCD expulsion rates among clients (JHPIEGO, 1994). The assessment also revealed gaps in family planning knowledge and counseling skills and a need for greater supportive supervision from LHVs to ANMs in regard to related techniques.

In response, the IFPS Project created a clinical skills training program for ANMs and LHVs to improve the quality of family planning services and expand coverage. With technical assistance from Intrah/PRIME (also a USAID-funded cooperating agency), the IFPS Project rolled out the Clinic Based Family Planning Training (CBFPT) program to help ANMs and LHVs become more skilled in IUCD insertion, family planning counseling, and infection prevention practices.

OBJECTIVES

The purpose of the CBFPT program was to provide performance-based training for ANMs and LHVs working at various levels of the government health delivery system, such as district postpartum centers, urban family welfare centers, urban health posts, community and primary health centers, and subcenters. The six-day training course for ANMs and LHVs was designed to improve the quality standards for IUCD insertion procedures and upgrade the skills of ANMs and LHVs in family planning service delivery and counseling. The training aimed to improve knowledge of family planning methods, strengthen
The key objectives of the training program were to:

1. Strengthen and institutionalize the capacity of public-sector institutions at state, regional, and district levels in performance-based training of ANMs and LHVs in family planning and other aspects of reproductive and child health (RCH);

2. Use the standardized CBFPT package for training LHVs and ANMs to ensure that the trainees acquire knowledge and become competent in clinical skills through practice on ZOE® gynecologic simulator models and through supervised hands-on experience with clients;

3. Develop a group of district-level qualified trainers who can provide CBFPT to ANMs and LHVs;

4. Build capacity of principals of Regional Health and Family Welfare Training Centers (RHFWTCs), medical doctors, and public health nurse instructors to observe and evaluate training as well as conduct follow-up assessments of trained ANMs/LHVs and subcenters to determine if they are meeting quality standards; and

5. Provide holistic training.

**IMPLEMENTING PARTNERS**

The key implementing partners in this training intervention included SIFPSA, Intrah/PRIME, the Government of Uttar Pradesh (GoUP) Department of Health and Family Welfare, and JHPIEGO, as detailed below.

**SIFPSA**

SIFPSA’s roles and responsibilities included:

- Assessing subcenters;
- Assessing and developing training sites and projects for districts;
- Facilitating and implementing training;
- Maintaining linkages with the GoUP, Department of Health and Family Welfare, Chief Medical Officers (CMOs), and RHFWTCs;
- Developing the training database at RHFWTCs;
- Designing and establishing the training management information system;
- Facilitating follow-up evaluations every year to assess trained ANMs (randomly selected) for performing IUCD services to standards, LHVs for supervision, and sites for meeting quality standards;
- Building capacity of trainers and observers;
- Supporting special contraceptive technology update and IUCD training at the medical college and training-of-trainers (TOT) at district women’s hospitals in Lucknow, Kanpur, and Varanasi;
- Documenting results; and
- Devising advance training and follow-up activity calendar and circulating it to CMOs.

**Intrah/PRIME**

- Developing and field testing the training curriculum and materials;
- Planning the training schedule;
- Building the capacity of state-level master trainers;
- Providing ongoing mentoring support to master trainers at the medical colleges;
- Training district-level lead trainers and ANMs/LHVs at the district/subdistrict level;
- Designing supportive supervision tools and capacity building of RHFWTC personnel and ANM Training Center tutors for providing effective supportive supervision and ongoing mentoring;
- Designing and maintaining master database for the project;
- Setting up and evaluating pilot projects in two districts; and
- Scaling up the project across IFPS districts.

**Department of Health and Family Welfare**

The GoUP Department Health and Family Welfare provided managerial support for ANM/LHV training and for training and involvement of CMOs. In each district, the CMO coordinated with SIFPSA to implement the training calendar, issue letters to trainees, coordinate with RHFWTC for follow-up activities, ensure procurement and supplies of IUCD kits to trainees, and ensure provision of equipment and supplies to subcenters.

Under the health department, RHFWTCs in 11 of Uttar Pradesh’s 15 revenue divisions were involved in the ANM/LHV training. The regional training center staff were responsible for maintaining the quality of the training by observing training methodology, mentoring the district trainers, observing CBFPT at all the sites in a district, and ensuring that each site had the necessary supplies, including training cards. They played an important role in conducting follow-up of trained ANMs/LHVs. At one and six months after the training, RHFWTC staff made follow-up visits to determine whether the ANMs/LHVs were performing to standards and whether their workplace subcenter was meeting quality standards.

The RHFWTCs were established under the Government of India’s Family Planning and Maternal and Child Health program to organize and provide training for government doctors and paramedical staff. They conduct short-term training courses as well as pre-service training of male basic health workers. The RHFWTCs are headed by a principal and have a staff consisting of a medical officer–epidemiology, medical officer–communicable diseases, public health nurse instructors, social science instructors, and data operators. Each center has an administrative block, office rooms, lecture rooms, laboratories, and hostel block to accommodate 60 candidates at a time. Due to funding cuts, many centers have reduced their activities.

**JHPIEGO**

JHPIEGO conducted the initial training needs assessment that identified the need to train ANMs in family planning clinical skills and counseling. JHPIEGO also trained the master trainers under the CBFPT program.

**INTERVENTION DESIGN AND STRATEGY**

From 1997–2004, the CBFPT program was conducted in the
Ideas, Insights, and Innovations

The CBFPT program had a three-tier structure: (1) six master trainers from medical colleges and district women’s hospitals attended a 12-day TOT course; (2) the master trainers, in turn, conducted a series of 12-day courses for district trainers—a lady medical officer and a public health nurse tutor; and (3) the district trainers provided six-day training courses for ANMs and LHVs. Four health facilities—the district women’s hospital, district postpartum center, and two rural sites having an adequate number of IUCD cases—were selected as training sites for ANMs and LHVs.

The ANM/LHV training covered clinical skills, client counseling, and supervisory skills. Trainees practiced IUCD insertion on ZOE® gynecologic models and then provided IUCDs to two to five clients under the supervision of a lady medical officer. Trainees received IUCD kits and a calendar indicating the timing of follow-up visits.

Training Program Sequence

1. A training needs assessment was conducted by USAID and JHPIEGO for government service providers of all categories, including ANMs/LHVs. The CMO and Deputy CMOs of the health facilities were also assessed and were included in the training needs assessment exercise.

2. Based on the needs assessment findings, an action plan for training of ANMs and LHVs (frontline workers) was developed and submitted to the Technical Advisory Group (TAG) for approval of piloting and implementation.

3. The TAG consisted of various stakeholders such as professors and heads of various medical colleges, principals of RHFWTCs, senior gynecologists/lady medical officers of district women’s hospitals, GoUP officials, Directorate General–Family Welfare/GoUP, ANM tutors/public health nurses, a few ANMs and LHVs, and staff from SIFPSA, USAID, UNICEF, and Intrah/PRIME. The TAG met several times to discuss and develop training materials for trainers as well as trainees. The training curriculum and materials thus developed formed an integrated training package with a contraceptive technology update and enhancement of reproductive health skills, including IUCD insertion and removal, counseling on contraceptive methods, infection prevention, postabortion care, follow-up of clients, management of side effects, management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), and HIV-related services.

4. The training materials were field tested and changes were incorporated into the final version as needed. These materials were used in the CBFPT Pilot Phase districts of Sitapur and Jhansi, conducted from February 1997 through January 1998. Intrah/PRIME evaluated the pilot phase during
visits conducted one month after the CBFPT program. The visits also included an assessment of the worksites (e.g., subcenters) of trained ANMs. In Jhansi District, 27 of the 29 ANMs trained were located in follow-up visits. Ten of these 27 ANMs were observed doing an IUCD insertion; 8 of these ANMs were rated as performing to standards. In Sitapur District, all 33 ANMs trained were located, and 28 of the 31 ANMs observed doing an IUCD insertion were rated as performing to standards.

A comparison of pre-test and post-test scores before and after the training sessions shows that the trainees did gain considerable knowledge. The knowledge level scores for 129 ANMs and LHVs trained at eight training centers in Jhansi and Sitapur districts increased from 51 percent to 85 percent. Average scores on counseling skills increased from 49 percent to 86 percent, while scores on IUCD insertion skills increased from 37 percent to 85 percent (Intrah/PRIME, 1998).

Implementation Strategy
A three-tier training strategy was adopted, as described in the following sections.

First Tier: Training of Master Trainers
The cadre of six master trainers was selected from professors and associate professors at three medical colleges and senior gynecologists from district women’s hospitals located near the medical colleges. The three medical colleges were: (1) King George’s Medical University (KGMU) in Lucknow; (2) the Institute of Medical Sciences (IMS), Banaras Hindu University, in Varanasi; and (3) Ganesh Shankar Vidyarthi Medical College, in Kanpur Nagar.

Training sessions for the master trainers lasted 12 days, with six days at a medical college covering contraceptive technology update plus six days at the district women’s hospital at a TOT course in IUCD insertion and removal skills. JHPIEGO conducted the courses for the master trainers in Lucknow at KGMU and Daffrin Women’s...
Ideas, Insights, and Innovations

Hospital. Some of the master trainers also attended the 10-day contraceptive technology update and IUCD insertion and removal skills training at Chulalongkorn University in Bangkok, Thailand, with funding from USAID and training support by JHPIEGO.

Intrah/PRIME subsequently trained three additional master trainers to maintain the full complement of six master trainers in the event of staff transfers or other absences.

**Second Tier: Training of District Trainers**
The six master trainers conducted a series of 12-day residential training courses for district trainers, known as “lead trainers,” since they were the main trainers of ANMs and LHVs. Six days consisted of a contraceptive technology update held at the medical college, and six days of training on IUCD insertion and removal skills were held at the district women’s hospital.

Courses for district trainers typically included 24 participants from two districts. The 12 district trainer candidates came from the four clinical sites selected from each district; the selected sites all had a lady medical officer posted to them. Each clinical site had two lead trainers—one lady medical officer to provide clinical inputs and one public health nurse tutor from the ANM Training Center in the district to provide non-clinical training and practice on the ZOE® gynecologic model.

Five district trainers from the RHFWTC—three doctors and two public health nurses—also attended the training course as observers in order to prepare for their role in post-training assessment. Principals, medical officers, and public health nurse instructors from the RHFWTCs were involved in mentoring the district trainers and making follow-up visits to trained ANMs at their workplace at one- and six-months post-training.

To upgrade the quality of care, the IFPS Project also supported the strengthening of infrastructure and personnel of key medical colleges and women’s hospitals at the district level. These facilities served as master training institutions and role models of quality services. RHFWTCs, ANM Training Centers, and clinical training units at the state, district, and block levels were developed and strengthened by improving their capability to provide performance-based training in reproductive health. Districts that had been strengthened by the IFPS Project were given priority to implement the CBFPT program.

**Third Tier: Training of Auxiliary Nurse Midwives/Lady Health Visitors**
The district trainers—a lady medical officer and a public health nurse tutor from the ANM Training Center—conducted six-day non-residential training courses for ANMs/LHVs at four training sites in each district. With a ratio of one trainer for every two trainees, the courses provided a high level of individual attention. The sites were chosen so that the ANMs and LHVs did not have to commute a long distance and could return home every day after the training.
The training courses were highly participatory and used hands-on practice to ensure that every trainee had mastered the necessary skills. One of the key innovations in the training strategy was use of the Team Training Approach in which the ANMs and their LHV supervisors were trained together. The ANMs and LHVs were trained on both technical and supervisory skills. The IUCD training covered screening clients for IUCD insertion, Copper-T insertion skills, preparation of the instrument tray and chlorine solution, and sterilization of instruments and non-surgical items. Trainees practiced Copper-T insertion on the ZOE® gynecologic model under the supervision of the lady medical officer trainer using the standard IUCD insertion and removal checklist. Trainees then attended the outpatient department with the lady medical officer trainer and assisted her in client counseling and history taking. The training in counseling skills used a module developed by SIFPSA and EngenderHealth, a USAID-funded cooperating agency.

On the fourth day of the training, a special session was held to distribute travel allowances, IUCD kits, and certificates to the trainees. The Deputy CMO responsible for ANM training in the district attended this session. In addition to IUCD kits (see Box 1), all trainees received a quarterly training calendar. ANMs were informed of the timing for one- and six-month follow-up visits.

Follow-up Assessments
The ANM Training Center tutors were mainly responsible for follow-up and on-the-job training of all the trainees at their work sites. At one month and six months after the ANM/LHV training, a team consisting of the ANM Training Center tutors, the doctors and public health nurses of the RHFWTCs who had observed the ANM training, and the LHV supervisor made follow-up visits to each ANM’s worksite to assess her IUCD insertion and counseling skills and to check the status of subcenter facilities. The observers used a standard checklist to determine whether the ANM was performing to standard and the subcenter was meeting quality standards. During these visits ANMs were expected to have a client for IUCD insertion in order for their clinical skills to be assessed. The observers

**“Earlier, I didn’t know what to do if the IUCD was being rejected by a woman... Now I know to check for infection first, how to cure it, then to insert the IUCD.”** —Deepa, ANM (Deepak et al., 2003, p. 14)

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**Box 1**

IUCD Kit Given to ANMs and LHVs

- Stainless steel tray 12” x 8” x 2”
- Stainless steel traycover 12” x 8” x 2”
- Stainless steel small bowl for antiseptic solution (3” in diameter)
- Stainless steel kidney tray 8”
- Cuscov vaginal speculum, bivalve (3), small, medium, and large size
- Forceps sponge holding (ring) straight 10”
- Uterine forceps valvellum curved 10”
- Uterine sound (Simpson, calibrated in centimeters 12-1/2”)
- Uterine scissors (Mayo’s) curved 8”
- Forceps uterine packing (Bozeman) curved 10-1/2”
- Forceps utility, sterilizing, cheattle 11-1/2”
- 10 pairs of surgical rubber gloves
- Betadine solution
- Plastic container with lid, 10 liter capacity—for dustbin
- Plastic container for preparing 5% chlorine solution, preferably a tube with 12” base
- Plastic bucket (one), 15 liter capacity with tap
- Plastic container, 10 liter capacity—for receiving waste water
- Flashlight with batteries

Total Cost Rs. 1,750 (~ USD 39.77) per kit
also checked to ensure that the necessary supplies, such as the complete IUCD insertion kit, were available and that standard infection prevention practices were being followed. The observers rated each ANM on whether she was performing to standards or not performing to standards. If the necessary equipment and supplies were not available or no IUCD clients were present, the observers were unable to assess the ANM’s skills and rated her as not performing to standards.

Training for Newly Hired ANMs
In September 2001, SIFPSA developed a project for Clinic-based Family Planning and Counseling Skills Training for ANMs newly appointed to regular positions and ANMs hired on a contractual basis. The newly hired ANMs had received basic ANM training for 18 months a decade ago but had not worked as ANMs due to unavailability of a government job. Accordingly, they needed updated knowledge in family planning and reproductive health services and practice of clinical skills. Of the proposed 2,706 newly recruited or contracted ANMs, 425 were trained.

Refresher Training for ANMs Not Performing to Standards
In 2002, at the request of Director General–Family Welfare/GoUP, SIFPSA developed a project to provide refresher training in IUCD insertion skills to ANMs who had been previously trained but were not performing to standards. Because these ANMs required more hands-on experience with clients, the refresher training was provided at the district women’s hospital and postpartum center in participating districts. Although 792 ANMs from 18 districts rated as not performing to standards were proposed for training, the training was not provided because the IFPS-I Project ended in 2004.

Monitoring and Evaluation
Intrah/PRIME provided technical assistance to the training institutions in monitoring the quality of training. To support assessments of service quality, Intrah/PRIME introduced the Systematic Performance Evaluation for Quality system. Program officers from Intrah/PRIME assessed skill retention by drawing a random sample of the ANMs who had been rated as performing to standards and revisiting them to assess their skills.

The training institutions were responsible for on-site assessment, monitoring and evaluation, and evaluation of service quality.

All assessments of ANM skills were based on the standard validation/checklist. The same checklist was used before and after training and at follow-up visits.

RESULTS
ANMs Trained
Under the CBFPT program, 10,854 ANMs and LHV were trained in clinic-based family planning services in Uttar Pradesh and Uttarakhand. The training emphasized IUCD insertion and removal, identification of RTIs, method-specific family planning counseling, HIV prevention counseling, and infection prevention. At baseline, only 30 percent of the 7,009 trainees observed had adequate scores in family planning counseling and IUCD insertion.
After training, 85 percent of the 5,632 trainees assessed had adequate scores (PRIME II, 2006).

Of the 9,550 trainees assessed at one month after training, 88 percent were performing to standards. This proportion rose to 92 percent at the follow-up six months after training (n=6,728). The relatively close proportion of trainees performing to standards at one and six months follow-up indicates that the ANMs were practicing clinical skills throughout these months and not just at the time of the follow-up (PRIME II, 2006).

Cost
IFPS funds for the CBFPT program were allocated to CMOs of the districts directly. SIFPSA used standardized budget items for costs such as travel allowances, food, and honoraria for trainers so that all CBFPT projects had uniform budgets. According to SIFPSA data, the total cost of the CBFPT program was about Rs. 1,070.72 lakh or about USD 2.4 million. Funding allocations averaged Rs. 30.62 lakhs (~ USD 69,591) per district, ranging from a low of Rs. 14.25 lakhs (~ USD 32,386) to a high of Rs. 56.7 lakhs (~ USD 128,864). Funding was also provided for special components, such as strengthening training centers and training of newly hired ANMs (see Table 1).

These costs average out to Rs. 9,865 per ANM/LHV trained, or USD 224. This calculation does not take into account the fact that training costs included many capital investments such as subcenter strengthening, development of training centers, training of master trainers, clinic equipment and supplies, and materials development. If this training system and materials were replicated over larger numbers of ANMs and other providers, the costs per person trained would be markedly reduced.

LESSONS LEARNED
The CBFPT program has been very useful in changing the attitudes of workers, instilling in them the ability to discuss client needs and offer services according to the client’s choice and preferences. The major strengths of the program were: provision of decentralized quality clinical services at the grassroots level; hands-on training using ZOE® gynecologic models and IUCD clients; individual attention, with one trainer for every two trainees; supportive supervision; continuous follow-up and evaluation at one- and six-month intervals; and institutional

<table>
<thead>
<tr>
<th>TABLE 1. SIFPSA GRANTS FOR ANM TRAINING</th>
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<tbody>
<tr>
<td>Project Implementer</td>
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<tr>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Strengthening of KGMC, Lucknow</td>
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<tr>
<td>Director General, Family Welfare, UP</td>
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<tr>
<td>CMOs of 29 Districts for training of newly recruited ANMs, ANMs on Contract, and ANMs in four newly created districts of Hathras, Kaushambi, Baghpat, and Chandauli</td>
</tr>
<tr>
<td>Total Cost</td>
</tr>
</tbody>
</table>
strengthening of subcenters. Using trainers from the health system and having a well-designed training module contributed to long-term sustainability and ensured quality training courses.

Some of the program elements that worked well were:

- **Team training approach.** By training ANMs and their LHV supervisors together on both technical and supervisory skills, the trainees benefited from understanding the broader context of their jobs. The LHVs gained improved clinical skills, while the ANMs benefited from improved IUCD and midwifery skills.
- **Supportive supervision.** Supportive supervision, or guided learning following training, gave the trainee an opportunity to use the skills and knowledge acquired during the training under the guidance and supervision of a senior colleague and the trainers. This mentoring and coaching approach had not been previously applied to ANMs and LHVs. For supportive supervision to be effective, the supervisors had to be competent in performing the task of those whom they supervise. Thus, the LHV was trained in the same curriculum as the ANM. Follow-up visits helped the LHV to develop her skills in supportive supervision. Effective supervision helps improve motivation and performance with a problem-solving approach.
- **Close monitoring.** The CBFPT program incorporated rigorous monitoring and regular follow-up that kept pressure on CMOs to ensure that standards were met. Based on feedback from observations at training sessions, SIFPSA suggested improvements in training content and techniques.
- **Set budgets.** Since the training program was a centrally-funded activity, the itemized budget was given well in advance to each participating CMO and could not be amended.
- **Advance training calendar.** CMOs in each participating district received an advance training calendar for a three-month period, including the time slot for one- and six-month follow-up visits. This advance planning helped to ensure that logistics and other required materials were made available.
- **Database at RHFWTCs.** The centers kept computerized lists of trainees, which were useful in tracking trainees by district and determining training needs and supporting supply distribution at the district level.

One of the major challenges in implementing the CBFPT program was that state-level government institutions did not take strong ownership of the training program. Once IFPS funding stopped, state agencies did not allocate funds to continue the training program. Among other challenges cited:

- Greater attention is needed for ANMs who were not performing to standard.
- Incentives for ANMs and LHVs for improved job performance are limited. The possibility of career advancement, better working conditions, or higher
pay could motivate ANMs to make an extra effort in their jobs and persevere despite difficult working conditions.

- Data were collected on the number of ANMs/LHVs trained, but not on the impact of the training on service delivery and method choice. Despite the CBFPT program’s emphasis on expanding access to IUCD services in the public sector and improving the quality of these services, IUCD use remains low in Uttar Pradesh. Moreover, roughly half of IUCD users obtain their method from the private sector, which was not covered by the training.
- In many settings, ensuring a sufficient number of clients for IUCD insertion was difficult. Greater efforts to raise awareness about the IUCD as a birth spacing method and generate demand for it would have helped.
- Frequent transfers of public health staff hampered the training program, since many master and lead trainers were transferred to new posts that did not utilize them as trainers.

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Intrah/PRIME. 1998. “Assessment Report of Indicator Achievement for Performance Based Training of LHVs and ANMs in Family Planning and Other Reproductive and Child Health Services for Sitapur and Jhansi Districts of Uttar Pradesh.” New Delhi, India: Intrah/PRIME.


THE QUALITY CIRCLE: Ensuring Sustained Quality RCH Service Provision

By Sudhir Mehra

RATIONALE

Although quality is an important aspect of any health service delivery system, health and family welfare programs in India have concentrated much more on the quantity of services provided rather than on their quality. However, in recent times, there has been a shift towards quality improvement, with particular emphasis being placed on client satisfaction. It is now increasingly recognized that improvement of quality has to be a continuous process and that efforts to improve quality must address systemic issues as well as form an integral part of healthcare management.

In Uttar Pradesh, during the course of implementation of the IFPS Project, a number of problems and issues were observed at block-level health facilities that affected their quality of services. Many of these problems are also experienced in other parts of India. Among the specific problems identified were:

- Staff vacancies, particularly a lack of specialist doctors posted at community health centers (CHCs);
- Inadequate staff skills or training for handling various clinical procedures;
- Infrastructure deficiencies, including no system for periodic maintenance and renovation of infrastructure;
- Poor logistics and supply support (e.g., no established system of timely and regular supplies of consumables and shortage of essential equipment, instruments, and funds for their maintenance);
- Lack of facilities, reagents, and medicines for various services;
- Delays in receiving funds for program activities;
- Limited facilitative supervision, inadequate supervision by district-level supervisors, and no institutionalized reward system; and
- Inadequate client orientation.

It was with the aim of establishing approaches to address these issues that a Quality Improvement (QI) pilot project was launched in June 2002 under the IFPS Project. The intervention, developed with technical assistance from EngenderHealth, was piloted mainly in block-level sites in two districts, Sitapur and Saharanpur. The 18 sites included in the pilot represented different categories of hospitals, including one district women’s hospital, seven CHCs,
The QI Circle program is a comprehensive and holistic approach to quality services that gives priority to quality of care at both the provider and client level. Staff are empowered to identify and address site-specific service delivery problems, and respond to client needs with improved sensitivity. Managers learn to take a mentoring, rather than a fault-finding, approach to staff supervision. The QI Circle program is based on the principle that well-managed, quality reproductive health (RH) service delivery will improve access to RH care and result in increased utilization of health facility services and improved RH outcomes.” (EngenderHealth, 2005b.)

OBJECTIVES
The QI Circle program has the following objectives:
- Shift attitudes of site managers and staff toward clients’ rights and provider needs;
- Strengthen commitment, problem-solving skills, and motivation for implementing high-quality reproductive health (RH) services;
- Enhance supervision, mentoring, and monitoring;
- Increase client satisfaction, particularly in terms of wait time, staff courtesy, and family planning (FP) information provided; and
- Increase use of and demand for FP/RH services.

INTERVENTION COMPONENTS
The QI pilot project was launched in June 2002 and ended in December 2005. Sitapur and Saharanpur were the districts selected for the QI pilot project. These districts reflected diverse characteristics: Saharanpur and Sitapur are in Western and Central Uttar Pradesh, respectively; the former was well performing in the health sector while the latter was comparatively poor performing. Other criteria applied for selection were that the district administrative and health authorities be interested in having a pilot QI project and that there should be sufficient staff at the sites. The 18 sites included in the pilot represented various categories of facilities. Eleven sites were selected in Saharanpur (eight block PHCs and three CHCs). Seven sites were selected in Sitapur (two block PHCs, four CHCs, and the district women’s hospital). The preparatory phase lasted for almost one year and the operation phase commenced in June 2003 in Saharanpur and July 2003 in Sitapur. The first quarterly scoring was completed in August 2003 for Saharanpur and September 2003 for Sitapur.

Table 1 highlights the major components of the QI process. Each step is described in more detail in the text that follows.

Quality Standards Checklist
Among the initial, most crucial steps was to define and delineate the concept of quality in practical and operational terms. Toward this end, EngenderHealth and SIFPSA designed a draft Quality Standards Checklist based on prior experience. The Checklist covers 100 items, each assigned a score of one point. The points were categorized under four components: client service management, site management, IEC component, and MIS component. The main quality parameters and total point scores for each component are summarized in Table 2.

District - and Site-level Workshops
Two-day district-level orientation workshops were organized for all stakeholders. Participants included key staff from the district level and the selected sites. The checklist-based scoring system was shared during these workshops and participants’ feedback was incorporated for finalizing the checklist.

Next, one-day workshops were conducted at each site to orient
<table>
<thead>
<tr>
<th>Steps in the Process</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Quality Standards Checklist developed</strong></td>
<td>Developed by SIFPSA and EngenderHealth, the Checklist defined “quality” in practical terms. The Checklist has 100 indicators covering client service management; site management; information, education, and communication (IEC); and the management information system (MIS).</td>
</tr>
<tr>
<td><strong>District-level workshops for orientation on QI and finalization of Checklist</strong></td>
<td>Participants included Chief Medical Officers (CMOs), chief medical superintendents, medical officers in-charge of CHCs and PHCs, health education officers, pharmacists, statistical assistants, and computers.</td>
</tr>
<tr>
<td><strong>Workshop at each site</strong></td>
<td>District and site supervisors trained in Client Oriented and Provider Efficient (COPE) techniques and facilitative supervision skills. COPE techniques include problem identification and action plan, and results orientation. “Whole-Site Training” approach employed: Learning needs of the entire staff are addressed through building a team-based approach to problem resolution.</td>
</tr>
</tbody>
</table>
### TABLE 2. QUALITY STANDARDS CHECKLIST CATEGORIES

| **Client Service Management** (31 points) | - Functional generator for facility  
- Functional inverter and air conditioner for operation theater and labor room  
- Vehicle/ambulance in running condition  
- Availability of running water at service points  
- All essential reproductive and child health (RCH) services available  
- Availability of trained provider for essential RCH services  
- Client satisfaction levels  
- Behavior of hospital staff  
- Water cooler for patients  
- Benches and fans in patient waiting area  
- Clean and functional toilets |
| **Site Management** (55 points) | - Earmarked space for counseling, labor room, intrauterine contraceptive device (IUCD) insertion, sterilization, scrub area, and change room  
- Essential operation theater and labor room requirements met  
- Essential equipments / instruments available in IUCD room  
- Functional equipment and adequate lab reagents for routine investigations  
- Essential infection prevention practices followed  
- Essential emergency drugs and services available  
- Availability of contraceptives and medicines for reproductive tract infections (RTIs)/sexually transmitted infections (STIs)  
- Client suggestions and feedback addressed |
| **IEC Component** (7 points) | - Essential local IEC material available  
- Client charter, service timings, directional arrows, and signage |
| **MIS Component** (7 points) | - All service delivery related and other requisite records maintained |

Note: The Quality Standards Checklist has been recently revised—mainly by way of re-allocation of scores—based on experience and stakeholder feedback.

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all staff to the QI concept. In these workshops, district and site supervisors were trained in Client Oriented and Provider Efficient (COPE) techniques and facilitative supervision skills. Site staff learned problem identification skills using the COPE approach; thereafter, an action plan was developed that outlined problems, action items, timelines, and roles and responsibilities. Facilitative supervision is an approach to supervision that emphasizes mentoring and joint problem solving, and represents a shift away from inspection and fault finding. The aim is to empower and enable staff to take action at various levels when appropriate.

COPE problem-solving tools were introduced using the Whole-Site Training approach, which is designed to meet the learning needs of the entire staff and build a team approach to problem solving. The Whole-Site Training model is based on the principle that most learning needs for QI can be met at the site, and thereby obviates reliance on centralized training courses conducted far away from the health facility where only a few service providers may participate because of the cost involved. (For more
information on COPE, facilitative supervision, and the Whole-Site Training approach, please see http://www.engenderhealth.org/ia/sfq/index.html).

**Formation of Quality Circles**

Quality Circles were formed at each site with the medical officer in-charge serving as chairperson. Members of Quality Circles represented all categories in the staff hierarchy. Each team member was assigned oversight responsibility for key aspects of quality (e.g., MIS, water supply, electricity, maintenance, infection prevention practices, IEC, logistics, and cleanliness). The Quality Circle team met every month to discuss issues and problems related to quality and possible solutions. The minutes of each meeting were noted down and solutions for identified problems were tracked.

**Gap Assessment and Provision of Inputs**

Using the Quality Checklist, each site was assessed for gaps in terms of water supply, infrastructure, equipment, and consumables. Furthermore, feedback from staff members was used to determine areas where, because of inadequate or irregular government funding, there is a chronic shortage of funds for maintaining even a minimum level of services and, therefore, quality is compromised.

**Site improvements.** The total outlay per site was Rs. 500,000 (~USD 11,363) for the three-year project. Table 3 presents the item-wise funding breakdown per site in terms of renovation, repair, and maintenance; medical and other equipment; and various recurring costs for which there was often a shortage in the facility’s budget. On an average, the recurring cost per site is around Rs. 4,200 (~USD 95) per month, which comes to about Rs. 50,000 (~USD 1,136) per site per year.

The funds provided for renovation and repair were flexible, meaning that the site staff had the power to decide how the funds would be spent. In general, the site budget had some measure of flexibility so that sites could request and avail sanctions to utilize unspent funds for other necessary purposes. Under the QI project, funds were released in advance and it was ensured that fund releases were timely.

The allocations for renovation and repair and for equipment procurement should be seen in the context that these were over and above inputs already made to upgrade and renovate health facilities. Prior to the QI intervention, under IFPS-supported upgrading, each facility received Rs. 400,000 (~USD 9,091) for renovation and Rs. 100,000–150,000 (~USD 2,273–3,409) for purchase of equipment and instruments. In addition, clinical skills training was provided for certain procedures, including non-scalpel vasectomy and abdominal tubectomoy.

**Availability of service providers.** Proper staffing was another important element of improved quality. At many of the sites, providers were already in position for most of the services that were

A quality-certified site in Saharanpur District.
<table>
<thead>
<tr>
<th>Item</th>
<th>Sites in Saharanpur (Rs.)</th>
<th>Sites in Sitapur (Rs.)</th>
<th>Sites in Saharanpur (USD)</th>
<th>Sites in Sitapur (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renovation and repair (Year I) and maintenance (Years II and III)</td>
<td>200,000</td>
<td>230,000</td>
<td>4,545</td>
<td>5,227</td>
</tr>
<tr>
<td>Purchase of medical equipment (as per Checklist)</td>
<td>30,000</td>
<td>30,000</td>
<td>682</td>
<td>682</td>
</tr>
<tr>
<td>Maintenance of equipment (including generator)</td>
<td>15,000</td>
<td>15,000</td>
<td>341</td>
<td>341</td>
</tr>
<tr>
<td>Petrol, oil, and lubricant for genset</td>
<td>36,000</td>
<td>36,000</td>
<td>818</td>
<td>818</td>
</tr>
<tr>
<td>Air conditioner for operation theater</td>
<td>30,000</td>
<td>30,000</td>
<td>682</td>
<td>682</td>
</tr>
<tr>
<td>Inverter for operation theater and labor room</td>
<td>15,000</td>
<td>15,000</td>
<td>341</td>
<td>341</td>
</tr>
<tr>
<td>Water cooler for patients</td>
<td>20,000</td>
<td>20,000</td>
<td>454</td>
<td>454</td>
</tr>
<tr>
<td>Payment of electricity bills</td>
<td>36,000</td>
<td>36,000</td>
<td>818</td>
<td>818</td>
</tr>
<tr>
<td>Washerman charges for clothing</td>
<td>18,000</td>
<td>18,000</td>
<td>409</td>
<td>409</td>
</tr>
<tr>
<td>Maintenance of water supply and electricity (e.g., all water and electrical points functional)</td>
<td>15,000</td>
<td>15,000</td>
<td>341</td>
<td>341</td>
</tr>
<tr>
<td>Printing of outpatient slips, bedhead tickets, and referral slips</td>
<td>3,000</td>
<td>3,000</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Painting of client charter at CHC/PHC (250 sq. ft.)</td>
<td>1,000</td>
<td>1,000</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Consumables (e.g., beta dine, surgical and utility gloves, syringes and needles, reagents for lab, cotton bandage, bleaching powder, shoes, slippers, broom, mop, wiper, soap, detergent)</td>
<td>28,800</td>
<td>28,800</td>
<td>655</td>
<td>655</td>
</tr>
<tr>
<td>Linens for operation theater (e.g., masks, cap, cut sheets, draw sheets)</td>
<td>3,000</td>
<td>3,000</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>15,000</td>
<td>15,000</td>
<td>341</td>
<td>341</td>
</tr>
<tr>
<td>Sub-total</td>
<td>465,800</td>
<td>495,800</td>
<td>10,586</td>
<td>11,268</td>
</tr>
<tr>
<td>Balance for contingency</td>
<td>34,200</td>
<td>4,200</td>
<td>777</td>
<td>95</td>
</tr>
<tr>
<td>Total Funds</td>
<td>500,000</td>
<td>500,000</td>
<td>11,363</td>
<td>11,363</td>
</tr>
</tbody>
</table>
The Quality Circle was supposed to be offered at the facility. However, a few of the sites did not have doctors trained in conducting sterilizations. The problem was resolved by arranging for trained providers from district headquarters or another nearby facility to be available at the site on the integrated RCH camp days.

**Monthly Meetings of Quality Circle**
The Quality Circle teams at each site were encouraged, through regular follow-up, to hold monthly meetings to review and update action plans. The teams employed COPE techniques throughout the pilot project.

**Monitoring, Quarterly Scoring, and Quality Certification**
Periodic monitoring and supervisory visits are made to the QI sites by the project manager of the Project Management Unit (PMU) and Deputy CMO. These officers make informal assessments and share these with the medical officer in-charge of the facility visited, and also point out the items where there are gaps based on the Quality Standards Checklist. The visits are meant to help the sites improve performance and prepare for the quarterly scoring.

Quarterly scoring of each site using the 100-point checklist was carried out by a team comprising a SIFPSA officer, PMU project manager, CMO or Deputy CMO, and a nominee of the District Magistrate. Sites that scored 90 points and above on all four quarterly assessments were given quality certificates. Quality-certified sites were given the Quality Gold Star Logo to be displayed on the hospital building. Furthermore, the five top scoring sites in the two districts were rewarded with flexible funds of Rs. 200,000 (~ USD 4,545) each.

**IMPLEMENTING PARTNERS**
The QI pilot project was implemented by SIFPSA and the Government of Uttar Pradesh (GoUP) with EngenderHealth technical assistance:

- The GoUP made its health facilities available for the pilot project, and its district program managers and site staff were actively involved in implementing the QI initiatives. District program managers were also involved in the monitoring, supervision, and quarterly scoring processes.
- EngenderHealth has, over the years, developed various QI approaches including facilitative supervision and Whole-Site Training. Among the tools the organization has developed to help implement these approaches is the COPE process. For the QI pilot project, EngenderHealth provided orientations on using these approaches and tools, as well as support for overall project design and training.
- SIFPSA was responsible for working out the detailed project design; budgeting and funding; conducting training and workshops; and the monitoring, supervision, and quarterly scoring processes.

**RESULTS**
At the end of the pilot test, EngenderHealth (2005a) conducted an assessment of the intervention.
The assessment covered all 18 pilot sites and broadly determined the extent to which the QI interventions improved the quality and utilization of family planning and reproductive health services. The assessment involved: comparison of data from the baseline and quarterly assessments; analysis of site records to determine changes in service utilization levels; and interviews with clients, site staff, and supervisors. Subsequently, the POLICY Project also conducted a study of the intervention that involved review of available documents, interviews with QI project planners, and field visits to selected sites where staff and clients were interviewed. The main findings and salient observations from these two studies are given in this chapter.

**Improvements in Service Quality Standards**

EngenderHealth (2005a) noted a marked improvement in service quality standards between baseline and the first quarterly assessment in both pilot districts, in both quality-certified and non-certified sites. Progress was found to be less dramatic in subsequent quarters, but the initial improvements were sustained throughout the project period. Of the 18 pilot sites, nine were certified as quality sites and received the Gold Star Logo.

**Problems Solved**

A review of the COPE-based action plans showed that approximately 30 percent of the problems identified by staff were effectively solved within days and an additional 40 percent in subsequent months (EngenderHealth, 2005a). In other words, 7 out of 10 problems had been effectively solved within months.

The monthly meetings seem to function as forums for generation of innovative ideas and creative solutions to problems. For example:

- At the Sidhauli CHC in Sitapur District, when it was observed that the pharmacists were unable to adequately manage stocks of contraceptives because of heavy workload and lack of familiarity with needs under the family planning program, this responsibility was shifted to the comptor (who does the report compilation and statistical work) under supervision of the health supervisor. Under QI, these two staff members were jointly responsible for records and reports. This led to considerable improvement in both record keeping and issuing of contraceptives from the CHC. Additionally, the comptor was in a better position to reconcile family planning performance data with contraceptives consumption data received from the PHCs. At the same CHC, assignment of oversight responsibility for IEC to specific Quality Circle members led to the discovery that posters and banners received that were meant for onward distribution were in fact lying unused at the CHC without being distributed.

- At the Rampur CHC in Saharanpur District there was a time when, because of certain anomalies in the layout design, there was no check on the movement of stray dogs, who used to move around freely, sometimes even intruding into

—Ophthalmic assistant at Machhreta block PHC, Sitapur District
the wards and offices. The Quality Circle then organized remedial measures, including the installation of wire mesh barriers.

- Also at the Rampur CHC, the metal spring beds in the wards were repaired; these had been broken and in disrepair for years. In fact, the broken springs had even been damaging the mattresses. This site has also considerably improved its indoor setup. For instance, the number of fans in the wards, which was inadequate earlier, has been augmented.

- At the Sidhauli CHC, there was once a complete breakdown in the power supply in the locality, and it was discovered that it could take up to a week for the supply to be restored. As a result, the CHC’s functioning virtually came to a halt. The CHC’s Quality Circle then held an emergency meeting and decided, as a short-term solution, to use the operation theater generator to supply electricity to the entire building. The CHC then obtained sanction from the District Innovations in Family Planning Services Project Agency (DIFPSA) to use part of the QI generator fuel budget for this purpose, and thereby managed to sustain services for a full five days, until the power supply was restored.

**Clients’ Experience of Services at QI Circle Sites**

Client exit interviews revealed a general satisfaction with the quality of services following the QI project (EngenderHealth, 2005a). Most clients (69%) were aware of and utilized various FP/RH services. Nearly all clients (97%) were satisfied that they had received the services they had sought. Sixty percent experienced positive staff behavior. Thirty percent reported cleanliness and privacy.

During the POLICY study team’s field visit, the Investigator-cum-Computer at Nanauta block PHC in Saharanpur District—who had been serving at the facility for about 20 years and hence was well-known to local villagers—summarized patients’ collective experiences:

> “Since the QI project-led changes, patients have reported experiencing reduced waiting time, better staff behavior, better follow-up, and fewer stockouts of medicines and supplies. In fact, patients have started coming to the QI site from neighboring PHC areas; some of these PHCs are in fact in the adjoining Muzaffarnagar District. These patients say they get better attention and services at this site.”

**Providers’ Experience**

**Teamwork and interaction.** It was observed that provider experience in site management and service provision showed a marked improvement at all of the QI sites (EngenderHealth, 2005a). Providers reported better coordination among site staff, improved supervision, and greater accountability. Further, joint problem solving and teamwork led to improved staff interaction. Staff reported treating clients with more respect, and giving due regard to informed choice and confidentiality.

**Changes in the sites.** Staff also pointed to important changes in the sites. These include: designated areas for registration, waiting, and

> “There is a lot of cooperation from the supervisor. We discuss things often and openly. This has made problem solving an easy task.”

—Provider
counseling; availability of electricity generators; and running water in the operation theater and processing rooms.

Funds made available under the project have been put to a variety of uses. While equipment and other supply inputs were provided as per a standard list of requirements, renovation and repair funds were used to solve site-specific problems. The impact and benefits of all these inputs have been far-reaching; they have made a tremendous difference in working conditions.

- **Uses of renovation and repair funds.** At the Sidhauli CHC, the maternal and child health center was renovated, a registration room was built, a defunct water supply was restored, and a separate room for doing dressings was created. Furthermore, seeing that road accident cases were often brought to the CHC owing to its location near the main road, an emergency room was established for in-patients.

- **What the equipment and other inputs have meant to the staff and patients.** Staff at the Rampur CHC reported that having an air conditioner in the operation theater has made a huge difference. Earlier, when they had only fans, both operation theater staff and patients sometimes had to suffer considerable discomfort. Additionally, having an inverter for the operation theater ensures that surgery can continue uninterrupted when the power fails. Previously, work had to be interrupted while the generator was being started.

The Sweeper at the Sidhauli CHC informed that with bleaching powder and phenyl now being regularly available—unlike in the past—he is able to maintain a higher level of cleanliness in the operation theater.

- **Utilization of reward money.** The Rampur CHC used part of the Rs. 200,000 (~ USD 4,545) award to repair the jet pump (used for groundwater extraction) and install a hand pump. Sidhauli CHC, which also received an award, used half to improve amenities in the facility and the other half for repair and renovation of the staff quarters.

**Supervisors’ Responses**

According to district-level supervisors, the intervention led to greater work motivation and capacity for solving site-specific problems. Further, periodic review of problem identification and solutions has ensured the maintenance of improved quality at most sites.

**Quantitative Findings**

Increases in service utilization were registered across almost all services, but there was considerable variation in the extent of increases. Relative to the baseline, the increase in the number of outpatients was 99 percent, and in the number of in-patients, 6 percent. Most significantly, there was an overall increase in utilization of FP/RH services. After one year, the number of female sterilizations increased by 10 percent over the baseline, RTI/STI consultations by 9 percent, and deliveries 5 percent. Table 4 shows the number of clients served during

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“The most impressive thing I liked about the facility was the availability of water. Two years back, when I was getting my [pelvic examination] done, I had to wait for an hour because there was no water in the facility. Now water is there all the time.”

—Client
the pilot study, which began in June 2002.

Experts interviewed during the study felt that QI interventions cannot be expected to result in significant improvements in service utilization in the short term. Furthermore, increases in service utilization are generally a result of many factors, of which QI is just one. Other factors include local presence of private service providers, health-seeking behaviors among the community, presence of larger government hospitals near the QI intervention site, and the amount of publicity given to QI initiatives, among others.

**LESSONS LEARNED**

A major outcome of the QI pilot has been the preparation of a larger scale project by SIFPSA. In view of the successful implementation of the pilot, SIFPSA and the GoUP plan to institutionalize the QI concept in the public health system. As a first step, they have decided to roll out the QI intervention to 12 additional districts. Accordingly, a proposal for an expanded QI project was prepared in early 2005 and was approved by the Project Appraisal Committee of the IFPS Project in July 2005. The districts to be covered under the three-year project are Allahabad, Agra, Ballia, Bulandshahar, Firozabad, Ghaziabad, Jhansi, Lucknow, Maharaiganj, Mathura, Rae Bareilly, and Shahjahanpur. Five block-level sites will be covered in each district, thus a total of 60 sites will be covered.

Specific lessons learned from the QI pilot project conducted under the first phase of the IFPS Project are discussed in below.

At the facility level, the quality of leadership seems to be the single most important determinant of success in implementing the QI intervention. Informants at district and state levels emphasized that effective leadership at the site is a necessary condition for successful implementation of the QI intervention. This is because the QI intervention requires several inputs and processes—involving all site staff—to be implemented over a long period in a coordinated and sustained manner. Naturally, such an effort calls for a dynamic and motivated leader at the facility. To the extent that the quality of leadership is inadequate, the intervention will be compromised, even if the rest of the staff are dedicated.

*Staff transfers from ongoing QI sites could compromise the process.*

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**TABLE 4. FP/RH SERVICE UTILIZATION AT QI SITES**

<table>
<thead>
<tr>
<th>Service</th>
<th>April 2002–March 2003</th>
<th>April 2003–March 2004</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sterilization</td>
<td>11,098</td>
<td>12,181</td>
<td>9.8%</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>14</td>
<td>16</td>
<td>14.3%</td>
</tr>
<tr>
<td>IUCDs</td>
<td>45,092</td>
<td>45,567</td>
<td>1.1%</td>
</tr>
<tr>
<td>RTI/STI</td>
<td>4,481</td>
<td>4,890</td>
<td>9.1%</td>
</tr>
<tr>
<td>Number of deliveries</td>
<td>75,885</td>
<td>79,911</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

Source: EngenderHealth, 2005a

*“Due to the availability of electricity, delivery services can also be provided during nighttime.”*

—Provider
Premature or untimely staff transfers, particularly transfers of managers, can hinder ongoing QI processes. Adverse effects are more likely if the changes take place soon after the project is initiated. However, if the QI process is reasonably well established by the time such transfers take place, the prognosis need not be negative.

It was observed that a variety of responses were employed when staff from other facilities were posted to QI sites. In one case, the incoming medical officer in-charge was inducted into the QI process by the PMU Project Manager and the concerned Deputy CMO. In another instance, the outgoing medical officer in-charge “handed over” the QI processes to the incoming officer. Incoming staff other than the medical officer in-charge are usually oriented on QI by the members of the Quality Circle.

The issue of untimely staff transfers should be addressed through appropriate changes in human resources planning to ensure a fixed tenure for program managers. Pending implementation of such measures, within the context of ongoing QI interventions, it then becomes crucial that the medical officer in-charge receive support from district- and state-level managers. For this, it is necessary that adequate feedback and supervision mechanisms are put in place. Furthermore, in the interim, to the extent feasible, transfers could be made among QI sites only. Eventually, once quality assurance systems are introduced in the large majority of facilities, this issue would perhaps cease to be a major concern.

Provision of “flexible” (discretionary) funds to health facilities is critical to success of QI interventions. Generally speaking, almost all funding for government health facilities is tied to specific budget line items, leaving the facility manager no room for discretion over how the funds might be spent. Also, fund releases are often not timely. This is a systemic issue that affects implementation of program activities and would also adversely affect QI efforts. Under the QI project, however, the funds provided were flexible, timely, and given in advance. This approach has empowered site managers and staff and has given them the sense that many local problems are surmountable.

Ownership by and support of district- and state-level program managers are crucial. No facility can initiate or sustain QI initiatives in isolation. While many of the problems faced by health facilities can be solved locally, there will be some issues that would need intervention from higher levels. Such problems could include manpower issues, supply logistics issues, and so on. Often, the requisite decisionmaking powers for remedial action can only be exercised at district or state levels. Moreover, since sustained QI measures are by and large unprecedented in the health system, facility staff need motivation and encouragement in the initial stages. For these reasons, ownership by and support from senior program management are extremely important.

It was observed that the periodic supervisory visits by the PMU project manager and Deputy CMO seem...
to be useful in sustaining motivation and keeping the focus on improving quality. These officers make informal assessments and share their findings with the medical officer in-charge, and also point out the items on the Quality Standards Checklist where there are gaps. In addition, many stakeholders feel that demonstration visits to exemplary sites would have a motivating effect and promote a positive competitive spirit.

As a result of the QI intervention, staff seem to develop a better understanding of their facility as an “organic” entity. The team approach is also good because it allows team members to provide back-up for each other. The existence of the Quality Circles, the sharing of responsibility for various aspects of the health center’s functioning, and regular team meetings all seem to inculcate in the staff a better understanding of their facility as an organic entity, rather than a mere “sum of the parts.” These factors, together with the availability of discretionary funds and facilitative supervision, create a conducive environment for problem identification and solving. They also help to highlight issues that would otherwise be missed or fall through the “cracks” between individual jurisdictions. These processes could presage a shift towards autonomous functioning, rather than being driven by directives and instructions alone.

Adequate funding is essential for maintaining quality healthcare. While some problems regarding quality relate to issues of work organization and staff behavior, several problems relate to resource constraints. Analysis of the QI pilot project experience shows that the funding to fill in gaps was a crucial ingredient for success. Adequate and consistent funding is, therefore, essential for maintaining quality healthcare. The source of funding could be user charges, public funding, community funding, or other sources.

Recognition is important to encourage staff and sustain the initiative. It has been observed that if people receive recognition, then they will take ownership of a project. That is why the Gold Star Logo is conferred on quality-certified sites—to serve as a symbol of accomplishment.

The nature and quality of the client-provider interaction is a very important ingredient of improved quality. In some cases, doctors are good at the science of medicine, but not the art of medicine. Training for better counseling and communication skills requires greater attention.

REFERENCES

RATIONAL

It was against the backdrop of dramatic changes in India’s approach to population and fertility stabilization that the IFPS Project devised a public-sector strategy in Uttar Pradesh based on Parivar Swasthya Sewa Divas (“Family Health Days”) or—as they are commonly known—integrated reproductive and child health (RCH) camps.

India’s family planning program had relied on method-specific targets for encouraging healthcare provider performance, and these targets often emphasized female sterilization over non-permanent spacing methods, such as oral pills or intrauterine contraceptive devices (IUCDs). Throughout the 1990s, India shifted its approach to family planning and reproductive health. In 1992, the country’s Eighth Five Year Plan identified factors that contributed to the inability to meet family welfare goals. Some factors included centralized planning, target-setting, and limited monitoring and evaluation that led to inflexibility in terms of developing innovative solutions to address community needs (Visaria et al., 1999). The plan articulated “human development” as its main focus and legislation adopted that same year decentralized family welfare programs to the panchayati raj institutions. In the lead-up to the 1994 International Conference on Population and Development (ICPD), state-level meetings were convened in India with various stakeholders that shed light on other shortcomings of the family planning program’s implementation. The ICPD itself highlighted the need to pursue population stabilization goals within the broader context of increasing access to comprehensive reproductive healthcare. In April 1996, India announced a target-free approach to family planning and, in October 1997, launched the Reproductive and Child Health (RCH-I) Program, which emphasized district-level planning and monitoring. In 1998, based on a mid-term assessment, USAID/India reoriented the mandate of the IFPS Project in Uttar Pradesh to incorporate a greater focus on reproductive health (not simply reduced fertility) and added new interventions to improve women’s and child health (USAID/India, 2005).

Taken together, these developments set the stage for new thinking regarding how best to meet comprehensive reproductive health needs from the perspective of clients, both in terms of services...
Ideas, Insights, and Innovations

offered and in management and implementation structures. The RCH camp approach under the IFPS Project was designed to increase quality of and access to integrated RCH services, particularly for rural women and other underserved groups (see Box 1).

OBJECTIVES
In Uttar Pradesh, the need for RCH camps emanated from the inability of the public sector to provide comprehensive reproductive health services on a regular basis beyond the district-level hospitals. As the IFPS Project placed a priority on reaching rural and underserved populations, it sought to devise interventions to meet the needs of those for whom accessing district-level or private facilities and services was not a viable option. SIFPSA convened a workshop in 1997 with international groups and state policymakers that worked out the RCH camp strategy. While sterilization camps were common under the centralized family planning program, the RCH camps provided for an integrated family health day. The IFPS-supported RCH camps differ from sterilization camps in that the objectives are to:

- Provide assured services as per a pre-determined calendar;
- Combine the benefits of rural outreach and high-quality services; and
- Offer an array of maternal and child health and family planning services (not simply sterilization) under one roof.

The camps seek to address the reproductive health needs of women and men, improve child immunization, and sensitize the broader community to RCH issues. While the institutionalization of offering comprehensive RCH services on a daily basis at community and primary health centers remains a long-term goal, the camp approach has served in the interim to increase access to services in rural areas and support institutional strengthening and provider training within the public health system.

INTERVENTION COMPONENTS
The RCH camp approach was included in the district action plans (DAPs) and, therefore, DAP planners had to consider several questions, for example: What services should be provided? Who should provide them? What logistics are needed? How will camps be publicized? How often should they be held? Who will monitor quality? What are the budgetary requirements? Accordingly, camp needs were classified into five major categories: manpower, publicity, camp arrangements, transport and post-camp provisions, and medical equipment (see Box 2).

Location and Schedule of RCH Camps
Planners determined that the

<table>
<thead>
<tr>
<th>Rationale for the Integrated RCH Camp Approach in Uttar Pradesh</th>
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<tbody>
<tr>
<td>- High unmet need for sterilization and spacing</td>
</tr>
<tr>
<td>- 80 percent of the population is in rural areas, poor access to RCH services</td>
</tr>
<tr>
<td>- Camps had previously been provider-driven with little focus on clients’ needs</td>
</tr>
<tr>
<td>- Shortage of doctors in rural areas</td>
</tr>
<tr>
<td>- Inadequate public health system infrastructure and monitoring</td>
</tr>
</tbody>
</table>
The RCH Camp Approach

RCH Camps would be held at block-level community health centers (CHCs) and primary health centers (PHCs). These fixed sites would organize and host one camp per month from April to September and two camps per month from October to March, resulting in 18 camps per fiscal year per facility. This schedule was decided upon due to “seasonality” issues in rural areas—clients are less likely to have elective surgery, such as sterilization, during harvest months and there is a perception that post-operative infections are more likely during the warmer months.

Services Offered
The integrated RCH camps provide antenatal check-ups, gynecological exams, family planning counseling and services, tetanus toxoid (TT) immunizations for pregnant women, iron and folic acid (IFA) supplement distribution, sterilizations, pregnancy tests for female sterilization clients, and treatment for reproductive tract infections (RTIs)/sexually transmitted infections (STIs) (though this does not include testing for HIV). Some RCH services (such as antenatal care) are provided at the facilities on non-camp days, but the camp days offer additional services (such as sterilization and RTI/STI treatment) as well as the assurance that the medical staff will be present, making the RCH camps more convenient and cost-effective for clients.

Another important service offered on camp days is the provision of transportation home for sterilization clients. Transportation is also arranged for the medical team. Since many camps are in remote rural areas and the CHCs and PHCs do not have all the required staff posted there each day, the team of surgeons, anesthetist, and lady medical officers must be secured from the district level or, in some cases, from the private sector.

Budget
The total cost per camp is Rs. 4,240 (~ USD 96) (see Box 3). Resources are provided to the

<table>
<thead>
<tr>
<th>BOX 2</th>
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<tbody>
<tr>
<td>RCH Camp Planning List</td>
</tr>
<tr>
<td>- Manpower: Surgeons, gynecologist, lady medical officer, anesthetist, nurses</td>
</tr>
<tr>
<td>- Publicity: Newspaper announcements, banners, audio cassettes, public address systems, pamphlets, posters</td>
</tr>
<tr>
<td>- Camp Arrangements: Layout of services, waiting areas, tents, chairs, food/refreshments, linens and mattresses, pillows, generators</td>
</tr>
<tr>
<td>- Transport and Post-camp Provision: Transportation of doctors, district officers, and sterilization clients (vehicle maintenance); follow-up medicines, follow-up cards; counseling and information, education, and communication (IEC) materials</td>
</tr>
<tr>
<td>- Medical Equipment: Bleach, utility and surgical gloves, lab reagents, suture material, antiseptics, dressing materials, medicines for sterilization, anemia medicine, laparoscopes (two per team), laparoscopic support instruments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BOX 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RCH Camps: A Cost-effective Intervention</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At the CMO level</th>
<th>Rs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTI/STI medicines</td>
<td>600</td>
</tr>
<tr>
<td>Other medicines</td>
<td>850</td>
</tr>
<tr>
<td>Consumables including lab reagents</td>
<td>500</td>
</tr>
<tr>
<td>Surgical team transport</td>
<td>200</td>
</tr>
<tr>
<td>Pregnancy kits</td>
<td>240</td>
</tr>
<tr>
<td>Contingent support</td>
<td>250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At the CHC/PHC level</th>
<th>Rs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publicity, camp arrangements, refreshments</td>
<td>600</td>
</tr>
<tr>
<td>Sterilization client transport</td>
<td>750</td>
</tr>
<tr>
<td>Contingent support</td>
<td>250</td>
</tr>
</tbody>
</table>

Total (per camp) Rs. 4,240
office of the Chief Medical Officer (CMO) and CHC/PHC level to fund medicines, transportation, publicity, consumables, and other camp arrangements.

IMPLEMENTING PARTNERS AND LINKAGES

Roles and Responsibilities
SIFPSA conducted orientations on the RCH camp approach for public health officials and the Project Management Unit (PMU) of each district. During these orientation meetings, SIFPSA and district teams outlined schedules, publicity requirements, and other support services needed, as well as designed the monitoring and evaluation form. The district team, including the PMU and the district public health officials, was then responsible for coordination, implementation, and monitoring of the camps. An evaluation report was submitted after each camp.

In terms of roles and responsibilities, the CMO’s office identifies the medical teams (e.g., surgeon, gynecologist, pediatrician, and anesthetist) and makes a roster for deploying them to the camps. Where doctors are not available, particularly in the case of lady medical officers, they are provided by the district level or through arrangements with the private health sector. The Deputy CMOs are responsible for ensuring quality of the services provided and, therefore, have the primary task of setting up a system for supportive supervision and monitoring. A standardized checklist has been developed to facilitate monitoring and evaluation. A pre-determined calendar is established to allow for the Deputy CMOs to attend each camp, as well as enable the CHC/PHC to publicize the camps. Supplies, extra equipment, and transportation for the medical team are dispatched by the CMO’s office. The local medical team associated with the particular CHC or PHC is responsible for setting up the camps, arranging transportation for sterilization clients, and for follow-up with patients when necessary.

Linkages to Other IFPS Interventions
The RCH camp intervention is described by one SIFPSA official as the “one intervention in which all other IFPS activities must converge.” RCH camps have driven improvements in service access and quality; at the same time, the success of the camps depends, fundamentally, on linkages and coordination with other IFPS initiatives. Some of these linkages include:

- Facility readiness and quality. RCH camps were born from the fact that public health facilities did not have the equipment, supplies, or staffing to offer comprehensive RCH services on a regular basis. Before being able to roll out the camps on a wide scale, there was a need to upgrade and ensure facility readiness. Efforts to upgrade facilities began with a needs assessment of the CHCs and PHCs with a goal of determining needs in terms of repair and renovation, water supply, electricity/generators, operation theaters, counseling rooms, and equipment and...
supplies. In some cases, IFPS also supported the repair or purchase of vehicles for transporting sterilization clients. Lady medical officers at an RCH camp in Kanpur Nagar reported that the IFPS-supported generators have been essential in allowing them to perform procedures during the frequent power outages and that the provision of transportation for sterilization clients is one of the reasons for the convenience of the camps for clients. The IFPS Project has assessed and strengthened over 600 facilities in the project areas (see Chapter 2).

- **Human capacity development.**
  As a means for improving quality and access, the IFPS Project supported training of a range of medical personnel in various techniques and aspects of providing reproductive healthcare, including sterilization procedures, infection prevention, and diagnosis and treatment of RTIs/STIs (see Chapter 3). Providers would then practice their new skills at RCH camps. Follow-up assessments were conducted at one month and at three months to assess the extent to which providers were performing to standard. The training, therefore, helped to expand the availability of services and options (e.g., laparoscopy, minilaparotomy, IUCD insertion, no-scalpel vasectomy [NSV]) at the RCH camps, while the camps enabled providers to practice and strengthen the skills they had learned. In addition to training, the IFPS Project has tried to address medical personnel shortages, particularly with regard to lady medical officers. By 1999, 156 lady medical officers had been contracted by SIFPSA.

- **Promotion of awareness and client demand.** Various IFPS-supported activities helped to create client demand, leading to greater attendance at RCH camps. The “Come Let’s Talk” campaign raised awareness of family planning issues, while statewide campaigns highlighted the importance of TT immunization (see Chapters 14 and 15, respectively). At the block level, banners, handbills, and audio cassettes played on rickshaws or other vehicles were used to publicize RCH camp days. Orientations with village pradhans helped to mobilize local support and awareness, while community-based distribution (CBD) workers, auxiliary nurse midwives (ANMs), and trained traditional birth attendants also spread the word about the RCH camps and, in some cases, accompanied clients to the camps.

**RESULTS**

Integrated RCH camps began in May 1998 and were carried out in all 33 IFPS districts. The RCH camps constitute the largest public-sector service delivery intervention undertaken by the IFPS Project. Camps were essential to meeting several project goals, including those related to sterilization, spacing, TT immunization and IFA tablets for pregnant women, and access to antenatal care.
Attendance at the RCH camps has grown over time. When the camp approach initially got under way (May 1998 to September 1999), each camp served about 50 clients on an average. In many IFPS districts, more than one third of the sterilizations were performed at integrated RCH camps (SIFPSA, 1999). By 2003, each RCH camp served 100 clients on average and more than half (53%) of all sterilizations in IFPS districts were performed at RCH camps (SIFPSA, 2003). Throughout this period, about half of the clients at each camp accessed integrated RCH services—reflecting the popularity and convenience of offering a range of assured services under one roof.

Table 1 presents a year-wise breakdown of services provided. Through March 2005, SIFPSA had supported 53,427 RCH camps—providing about 475,000 antenatal care (ANC) check-ups, sterilization to about 770,000 women and men, family planning counseling to over 1.7 million clients, spacing methods to 1.1 million clients, and immunizations to nearly 525,000 children.

As discussed briefly above, the quality of service provision through different IFPS-supported activities was assessed in a variety of ways, including assessments of facilities and providers that were performing to standard. For the monitoring of the camps themselves, Deputy CMOs had the primary responsibility for attending camps, ensuring quality, and submitting a Quality Assessment Report to the PMU and the CMO. Data from 2004/2005 show that Deputy CMOs attended 6,575 out of 6,690 camps held (98%).

Other sources of assessment data include each district camp schedule, routine reports of contraceptive prevalence, and spot checks of quality of services. The DIFPSA in each district also holds monthly meetings in which achievements, progress, and challenges are discussed.

### Table 1. Total Performance of RCH Camps in IFPS Districts (May 1998 to March 2005)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of RCH Camps</th>
<th>Total Sterilization Clients</th>
<th>Total Spacing Methods Clients</th>
<th>Total ANC Check-ups</th>
<th>Total TT Immun.</th>
<th>Total Child Immun.</th>
<th>Total FP Counseling Clients</th>
<th>Total Number of IFA Tablet Cycles Given</th>
<th>Total Number of RTI/STI Cases Treated</th>
<th>Total Number of Pregnancy Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998–99</td>
<td>6,342</td>
<td>60,651</td>
<td>149,426</td>
<td>57,424</td>
<td>45,994</td>
<td>71,788</td>
<td>214,445</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999–00</td>
<td>6,782</td>
<td>74,538</td>
<td>124,640</td>
<td>51,519</td>
<td>37,425</td>
<td>65,146</td>
<td>209,565</td>
<td></td>
<td></td>
<td>24,902</td>
</tr>
<tr>
<td>2000–01</td>
<td>6,484</td>
<td>86,709</td>
<td>149,240</td>
<td>70,766</td>
<td>58,449</td>
<td>68,310</td>
<td>192,139</td>
<td>56,675</td>
<td>9,898</td>
<td></td>
</tr>
<tr>
<td>2001–02</td>
<td>6,580</td>
<td>107,942</td>
<td>144,297</td>
<td>57,592</td>
<td>46,659</td>
<td>68,430</td>
<td>208,357</td>
<td>46,465</td>
<td>21,846</td>
<td></td>
</tr>
<tr>
<td>2002–03</td>
<td>8,669</td>
<td>145,784</td>
<td>176,542</td>
<td>77,221</td>
<td>59,502</td>
<td>79,907</td>
<td>298,362</td>
<td>76,942</td>
<td>34,322</td>
<td>117,877</td>
</tr>
<tr>
<td>2003–04</td>
<td>9,771</td>
<td>145,970</td>
<td>184,993</td>
<td>80,815</td>
<td>61,792</td>
<td>84,251</td>
<td>307,851</td>
<td>104,237</td>
<td>34,802</td>
<td>132,464</td>
</tr>
<tr>
<td>2004–05</td>
<td>8,799</td>
<td>148,873</td>
<td>190,835</td>
<td>80,719</td>
<td>62,540</td>
<td>86,154</td>
<td>276,159</td>
<td>76,927</td>
<td>28,581</td>
<td>145,710</td>
</tr>
<tr>
<td>Total</td>
<td>53,427</td>
<td>770,467</td>
<td>1,119,973</td>
<td>476,056</td>
<td>372,361</td>
<td>523,986</td>
<td>1,706,878</td>
<td>386,148</td>
<td>129,449</td>
<td>396,051</td>
</tr>
</tbody>
</table>

Source: SIFPSA management information system
**RCH Camps Attract Clients: The Experience in Kanpur Nagar**

“SIFPSA has given us so much—generators and back up power, transportation, equipment, medicines, training of staff, and IEC support,” says a medical officer in-charge of a PHC in Kanpur Nagar. The facility is among the six block-level PHCs and four CHCs that organize RCH camps in the district. Kanpur Nagar is primarily urban (63%), is one of the most populous districts in Uttar Pradesh, and is considered the commercial center of the state.

At this PHC, two integrated RCH camps are held each month; they are fixed on Mondays and are open from 10:00am to 4:00pm, though staff will stay later when necessary to make sure all clients are attended to. A typical RCH camp will include a registration area, waiting area with refreshments, and different tables or stations to avail various services. A registration log is used to keep track of all services provided. The PHC has four beds for inpatient services. The facility provides routine immunizations, deliveries, antenatal care, TT and IFA, family planning, IUCD insertion, and other outpatient services on a regular basis.

On RCH camp days, there are also sterilizations, pregnancy tests for sterilization clients, RTI/STI diagnosis and treatment, and special counters devoted to immunization and spacing counseling. According to the medical officer in-charge, RCH camp days will generally serve about 150 patients while the PHC serves only about 30–35 patients on non-camp days. During camp days there are two additional medical officers on-site plus the surgical team.

District officials from the Kanpur Nagar CMO’s office and PMU report that IFPS support for RCH camps contributed to the improvement of quality of services. The integrated RCH camp approach, according to district officials, has led to an “increase in the number of clients for all types of services,” and while “previously there was not adequate staff, on camp days availability of staffing is compulsory.” IFPS trained healthcare providers, including the lady medical officers who come from the district health facilities to work at the camps. The IFPS Project also emphasized evaluation and meeting client needs. According to one Deputy CMO, aspects such as cleanliness and availability of medicines are assessed and care is taken to ensure that “patients do not wait long because if they are not attended to, they are not likely to return.”

Facility upgrading is another important component. Specific contributions noted by lady medical officers at the RCH camp include back-up generators that enable uninterrupted procedures, improved operation theaters, increases in equipment, and a decline in infection rates. Furthermore, the DIFPSA meets monthly to identify gaps and challenges and take corrective action. As one lady medical officer from Kanpur Nagar notes, “If there are any problems, SIFPSA is willing to resolve it immediately.”

While there have been substantial improvements in quality and access, implementing camps is not without its challenges. One of the challenges, the lady medical officers noted, is that they cannot always practice the skills that they have learned. For example, with a line of 14 patients waiting and only one set of equipment, it is difficult to implement 100 percent of the infection prevention control procedures, such as boiling each instrument for 20 minutes between procedures. According to the medical officer in-charge, another challenge is the pressure to achieve an “expected level of achievement.” He notes that, while there is a target-free approach, they feel pressure “from the District Magistrate on down” to carry out a certain number of procedures each month. The expected level is sometimes set at a number that is not possible to achieve given the number of hours the camps are open and the time it takes for each procedure.

Other challenges have included logistics issues, such as stockouts of tranquilizers and malfunctioning laparoscopes. IFPS support for integrated RCH camps ceased in March 2005; however, support for camps will continue under the new Government of India RCH-II Program. Despite this, in the interim, the district has managed to conduct 90 integrated RCH camps. Recognizing the value of sustaining the camps even without external support, district health officials have relied on relationships with NGOs, commercial market vendors (e.g., when there are shortages of essential medicines), and local repair shops (e.g., when equipment malfunctions)—but also have incurred debt. District officials feel that the “crisis in funding” will be relieved when RCH-II funds are allocated, but for now components such as transportation for clients, monitoring and evaluation reports, and publicity for the camps have suffered. In the meantime, organizers have worked with NGOs to help facilitate transportation and have re-doubled efforts to publicize camps by word-of-mouth, so the turnout at the camps has not diminished.
LESSONS LEARNED

The RCH camp approach began as a response to recognized limitations in the public health system. There is unmet need for family planning and RCH services and the goal is to set up static services that are available on a daily basis. The future vision is that the PHCs and CHCs will be fully staffed and have the equipment and commodities to provide a range of integrated RCH services every day. This will take time so, in the interim, “camps” or family health days have become a mechanism for increasing access to services, particularly in rural and underserved areas. The integrated RCH camp approach has proven to be cost-effective and convenient for clients. It has also served as a means for beginning to upgrade facilities and reinforce provider training. Furthermore, the concerted efforts of the IFPS Project to improve the quality of service delivery (as opposed to quantity) must continue. These efforts include training providers in sterilization techniques and IUCD insertion, upgrading facilities, and ensuring staff are performing to standard and are updated in contraceptive technology. The focus should continue to be directed at making services available and of a high quality, not toward meeting specific targets.

Critical Factors for Success

Some of the factors that led to the success of the RCH camps include:

- Assured availability of the medical team;
- Pre-determined schedules that are well-publicized;
- Provision of a range of RCH services in one location;

- Provision of transportation home for sterilization clients;
- Advance planning to address logistics issues (e.g., ensure doctors are available, that transportation is provided for the medical team, that funds are available in advance, that equipment is in proper working order, that medicines are re-stocked before they run out, and so on);
- Linkages with other IFPS activities (e.g., orientations with village pradhans, promotion of camps by traditional birth attendants, CBD workers, and ANMs);
- Proper training of medical staff and upgrading of facilities to improve quality and range of service options provided; and
- Monitoring and evaluation by district health officials.

Challenges

As the integrated RCH camps move forward under the RCH-II Program, planners and program implementers must also develop strategies to overcome a number of challenges that were identified during the IFPS Project:

- Healthcare providers and master trainers from NGOs report that infection prevention control is the first casualty when there are too many patients, not enough staff, and not enough equipment. In some cases, there has not been a sufficient client load to practice the new procedures for which providers have been trained (e.g., NSV). In other cases, provider habits may be slow to change, even with training and opportunities to practice. There is a

“Yes, challenges are everywhere, but the camps are very beneficial. If there are no camps, then IEC regarding reproductive and child health would stop, resource mobilization would stop, monitoring of the quality of services would stop. The camps have been a driving force for improving access to services.”

—Deputy Chief Medical Officer, Kanpur Nagar
provider bias, for example, for laparoscopy, which is the least cost-effective method and requires use of the laparoscope (which may be in limited supply and is costly to repair).

- Despite a target-free approach, district officials, including the District Magistrate, may tend to judge success in terms of the number of sterilizations performed. Instead, district health officials should encourage provision of a range of high-quality RCH services and family planning methods.

- Shortages in staffing persist, especially with regard to lady medical officers, who are needed at the camps for performing certain services, such as conducting pelvic exams.

- Problems with provider attendance, performance, and provider-client interaction have been noted. For example, providers assigned to a camp may arrive late or leave early. In some cases, this may be for legitimate reasons, such as lack of transportation or emergencies that arise at the district hospital where the provider is regularly posted. In other cases, private doctors may not want to lose out on their regular (paying) clients and, therefore, spend less time at the camps. In the worst cases, to avoid having to perform more procedures or stay late at a camp, providers may devise excuses as to why a patient is not eligible for surgery on that day and then send the patient for additional, unnecessary tests.

- Transportation, for both the medical team and sterilization clients, remains an issue. While funding to repair, purchase, or hire vehicles was provided under IFPS, district- and block-level health officials report that the costs for transportation often exceeded the allotted budget.

- Issues such as “seasonality,” method mix, and misconceptions regarding one method vs. another must be addressed (POLICY, 2001). Trends in the number of sterilizations per month reflect seasonality, which tends to pick up in November, peak in February, and then decline during the spring and summer months. At the same time, preference for sterilization may have limited impact on overall fertility in Uttar Pradesh. For example, women may wait until they reach a higher parity to accept sterilization; in this case, the sterilization has little effect on the population growth rate because women may have already exceeded their desired family size. However, promotion of spacing and non-permanent methods earlier in a woman’s childbearing life cycle can extend the intervals between births and help women avoid unplanned pregnancies. Block-level health personnel also suggest that more should be done to encourage demand for NSV and perhaps better integrate this service into the RCH camps.
REFERENCES


RATIONAL
Sterilization is an important method of family planning in India as well as in Uttar Pradesh, especially among women. Prior to 1978, male sterilization, or vasectomy, was more prevalent than female sterilization, but since “the Emergency,” acceptance of vasectomy has declined dramatically. In addition to longstanding mistrust of government involvement in implementing sterilization procedures, there are many misconceptions about the procedure, including that it can cause impotence and weakness among men. In an environment where couple’s communication about family planning is very limited, male involvement in family planning is minimal. Accordingly, the IFPS Project recognized the importance of addressing the needs of men in the provision of family planning services and identifying and using communication channels targeted to them.

Vasectomy offers considerable potential as part of overall efforts to promote increased male involvement in family planning efforts. About half the population is male; there is an abundance of male doctors so the procedure is not limited by the need for lady medical officers; and vasectomy is far simpler, quicker, and safer than female sterilization.

No-scalpel vasectomy (NSV) is a relatively new procedure; training for the procedure has been provided in India only since 1991. In Uttar Pradesh, the IFPS Project sought to reposition NSV as a simple, safe, and cost-effective method that is less risky than female sterilization. NSV does not require a high degree of medical training, and the procedure itself requires only 5–6 minutes. Since there is no incision, the procedure effectively removes the fear of incision and has fewer complications than regular vasectomy. Clients can leave the clinic soon after the procedure, and experience little or no discomfort. They can resume activities almost immediately. In the largely rural areas of Uttar Pradesh, where high-tech operating theaters are not commonly available, NSV offers great promise.

OBJECTIVES
The IFPS Project’s objectives in promoting NSV were to:
- Promote NSV and male participation in family planning;
- Create mass awareness of NSV as a simple technique through information, education, and
Strategies for involving men in family planning:
- Training more providers in NSV
- Making male sterilization services available in all community health centers and block primary health centers in a phased manner
- Launching information, education, and communication campaigns to educate men about responsible parenthood and encourage them to use family planning
- Modifying training curricula of healthcare workers, supervisors, and medical officers to include material on male involvement

INTERVENTION COMPONENTS
The implementation strategy for this intervention was to establish a trained network of providers; supply service delivery centers with necessary equipment and facility upgrades to perform the procedure; promote NSV and register prospective clients through local communication efforts; hold camps and issue certification cards to clients; and conduct follow-up to ensure success of the operation.

Training
In 1995, IFPS began promoting NSV with the training of public-sector doctors in Lucknow. EngenderHealth, a USAID-funded cooperating agency, provided technical assistance for training communication (IEC) activities;
- Increase the network of NSV service providers in the districts; and
- Improve reproductive health knowledge and practices in men through exposure to NSV and other reproductive health services through the camp approach (SIFPSA, 2005b).

EngenderHealth also created an assessment tool to evaluate the effectiveness of the training. Follow-up visits 4–8 weeks after training provided a means of verifying the competence of the trainees to determine whether they were performing to standard. These visits also provided a means for giving feedback to trainees, identifying gaps in knowledge and practice, and putting in place plans for remedying performance gaps if needed.

To ensure the sustainability of the approach and continuation of training after the project’s end, EngenderHealth and SIFPSA used a training-of-trainers approach to build a cadre of master trainers.
and institutionalized a training center in Jhansi for NSV. In 2002, mobile trainers were trained and then traveled to districts to provide training in local facilities, rather than relying on training centers. All 10 trainers work in mobile units, bringing training to districts with sufficient demand and client loads. Master trainers also trained district trainers. The newly trained providers work under supervision of the district trainers until performing to standard.

As of January 2004, all 33 IFPS districts had at least one trained NSV provider (EngenderHealth, 2004), although physicians trained in any type of sterilization procedures were still a scarce commodity. According to an IFPS Project impact analysis (POLICY, 2001), about 70 percent of the community health centers (CHCs) and block primary health centers (PHCs) in IFPS districts did not have any medical providers trained in any type of sterilization procedures. Thus, when special sterilization or NSV camps were planned, SIFPSA (or Chief Medical Officers) needed to bring in additional surgeons from neighboring districts (or even states) to satisfy the demand for services.

Information, Education, and Communication Efforts
On their own, providing training and increasing the availability of service delivery centers are insufficient for increasing male sterilization. A mechanism to make potential clients aware of the availability of services is also needed. As early as 1995, IFPS began promoting use of NSV through printing and distribution of handbills and brochures, publishing advertisements in local newspapers to inform clients of camp dates, and setting up billboards in prominent places to promote services at the health center.

In 2003, IFPS began active promotion of NSV in advance of NSV camps in local areas through IEC efforts and films for communities and healthcare providers, stressing correct information, dispelling misconceptions, and providing information on trained providers.

BOX 2
District Magistrates as Champions for NSV

Building on the successful approach of involving District Collectors to promote NSV in Karim Nagar in Andhra Pradesh, SIFPSA decided to elicit the support of District Magistrates to promote NSV in selected IFPS districts. In Amod Kumar, former Additional Executive Director of SIFPSA and current District Magistrate in Sitapur, SIFPSA found the ideal champion for this approach.

Mobilized by the District Magistrate, field workers from all sectors implemented a rigorous campaign to promote NSV, identify eligible couples, inform them of the advantages and benefits of NSV, and register prospective clients to participate in an upcoming NSV camp. In addition to marshaling the district’s resources to conduct the awareness and motivation activities, the District Magistrate pledged to undergo NSV himself, thereby serving as a role model and demonstrating the safety and merits of the procedure. Since this was an experimental approach, it was unclear how many of the men registered would show up for the camp. As it turned out, the scheduled NSV camp ultimately performed about 1,700 NSV procedures in four sites over a three-day period.

According to the District Magistrate, “When the whole machinery works in one direction, you can produce the results you want.”

He is quick to add that it was the strategy of active and widespread promotion that led to the large turnout, not solely his involvement and leadership. While the importance of good role models cannot be overlooked, providing correct information about the procedure, counseling clients both before and after the procedure, and offering convenient and good-quality services by highly skilled physicians are equally important.

\[1\] There is another government-supported training center for NSV in Lucknow.
Ideas, Insights, and Innovations

2). Some district action plans placed considerable emphasis on the IEC component of NSV, as evidenced by the proposed strategies in Moradabad District’s IEC plan, shown in Box 3.

Service Delivery

Based on the anticipated caseload and success of the promotion efforts, the procedure is typically scheduled to coincide with a regularly scheduled RCH camp or may be carried out in NSV training camps and in what have been called “mega-NSV camps.” SIFPSA also approved 23 service delivery centers for NSV in 16 districts (data as of July 2003). These centers were provided with necessary equipment and facility upgrades as needed.

Mega-NSV camps were periodically promoted in a few districts. Following extensive and widespread outreach efforts, Chief Medical Officers and other frontline workers registered prospective clients who wanted NSV and the procedures were performed in special NSV mega-camps. SIFPSA brought in trained physicians from other districts to satisfy the expected client load. District officials promoted the time and location of such camps well in advance and provided clients with transportation to and from the camps. In a mega-camp in Sitapur District, 1,700 men received NSVs over a three-day period in four locations throughout the district. Clients were provided with a certification card and follow-up instructions to come in for a check-up three months later. NSV camps were successful in providing a high volume of cases and generated lessons learned for extending NSV in other areas (see Box 4).

BOX 3

Moradabad District’s IEC Plan

Moradabad’s IEC strategy for promoting NSV has eight components:

- Project launch including opinion leaders, doctors, district information officers, press, and panchayat leaders, with a press release on the event;
- Handbills containing information on the method and where it can be obtained;
- Sensitization workshops where opinion leaders (e.g., presidents of cooperatives, leaders of youth organizations, members of industrial and trade unions, doctors [public and private], indigenous systems of medicine practitioners, government officials, religious leaders, voluntary organizations, social workers, and the press) can meet satisfied NSV clients and become effective advocates for NSV;
- Place a register in the counseling room to record remarks of NSV acceptors (positive remarks can be used to generate publicity and negative remarks can be used to improve performance);
- Billboards in hospital premises and in prominent places highlighting the method and center;
- Folk performances on NSV themes (two per month);
- Press publicity on special NSV camps, particularly in advance to generate interest; and
- Interpersonal communication through field staff.

Source: SIFPSA, No date (b)

BOX 4

Lessons Learned From Mega-NSV Camps

- Preplanned activities with extensive IEC can result in significant community awareness and mobilization.
- Involving all government departments under the leadership of the District Magistrate for coordination and the Chief Medical Officer for implementation contributes to the success of mega-camps.
- Involving frontline workers in different departments for interpersonal communication is a key to success.
- Subsequent follow-up of registered clients should be part of the mobilization strategy as only 20-25 percent of those registered typically show-up on camp days.
- Camps should not be held in more than four sites simultaneously given the need to ensure better coordination and management of the activities.

Source: SIFPSA, 2005b
IMPLEMENTING PARTNERS
NSV activities are managed through SIFPSA’s Public Sector Directorate/Division. From 1996–2004, EngenderHealth provided training for physicians in NSV (EngenderHealth, 2005). There is now a cadre of master trainers available to carry on this training without external technical assistance. SIFPSA provided the majority of promotional materials to districts through its IEC unit. Since most NSV procedures were carried out in special NSV camps and in RCH camps when the anticipated caseload warranted, there was close coordination with Chief Medical Officers in relevant districts.

RESULTS
Performance for NSV interventions is measured in terms of number of trained physicians, number of physicians performing to standard, number of procedures implemented, and number of satisfied users. Available data are summarized below.

Training Data
Between mid-2003 and 2005, the IFPS Project trained 175 service providers in 41 districts of Uttar Pradesh in addition to 12 master trainers, according to SIFPSA data. Of the 83 physicians who were assessed, 76 physicians (92%) were assessed as performing to standards and seven (8%) were not performing to standard. Many physicians who received training in 2005, however, had not yet been assessed. Moreover, at least 20 of these trained physicians had already been transferred to other posts.

For 2004–2005, 55 NSV training camps were organized in 19 districts, resulting in 8,036 NSV procedures performed, according to SIFPSA data (2005a). Many training camps did not have a sufficient number of NSV clients to adequately train the attending physicians; thus some doctors were recorded as needing retraining.

NSV Statistics
Data on NSV are collected via service statistics from NSV and other RCH camps and from public-sector service delivery sites. Performance of NSV has increased gradually over time, as a result of the increase in trained providers and the IEC campaigns carried out by the IFPS Project and Government of Uttar Pradesh (GoUP) officials in districts. However, acceptance of NSV is still low despite the availability of trained providers. Statewide, only 1–2 percent of total sterilizations performed are vasectomies (Director General for Family Welfare data).

EngenderHealth reported there were 1,046 NSV procedures performed in IFPS districts in 2002–2003 stemming from training programs, which increased fourfold to close to 5,000 in 2003–2004 (EngenderHealth, 2004). While earlier reports seemed to indicate that 95 percent of NSV performance occurred in IFPS districts (SIFPSA, 2003b), more recent data suggest NSV procedures are increasingly occurring in non-IFPS districts. For example, for the period 2004–2005, Hardoi, a non-IFPS district, contributed 1,681 of the 10,000 NSVs recorded statewide.

The GoUP Department of Health and Family Welfare reported 10,000
Ideas, Insights, and Innovations coming out smiling after the operation. I decided to have an NSV. It’s been two years since I had the operation and I am leading a happy married life.” (Quoted in EngenderHealth, 2004.)

LESSONS LEARNED
Promotion efforts are critical for increasing use of NSV. It is not enough to train providers and equip service delivery sites. An effective communication strategy is essential. NSV could become a more popular method if accurate information were widely available and misconceptions dispelled. Promotion, interpersonal communication, and involvement of district leaders and others are important to generate potential clients.

A multi-pronged IEC effort is needed, as a critical mass of NSV acceptors has not been reached to generate sufficient interest without active promotion. Doctors do not necessarily have time for promotion and IEC activities; this needs to be done by different officials and counselors who are skilled in communication. Promotion of NSV by a few District Magistrates has been successful, but a systematic approach building on this principle has yet to emerge. District Magistrate involvement has been important because he/she can mobilize and coordinate the efforts of all departments to raise awareness of the procedure and work in conjunction with the Chief Medical Officers to ensure that high-quality services are provided.

While considerable progress has been made in increasing the number of service centers and trained providers, more could be done.

**Profile of Satisfied NSV User**

A 32-year-old man with two male children from Jetahar village, Sitapur District, heard about NSV from his wife, an anganwadi worker. After getting more information, he obtained the procedure a few weeks later in the local CHC. The procedure took about 15 minutes from registration to completion. He has spoken to others in his village about the procedure; many of whom are waiting for the right day to schedule. Village women also contact him to talk to their husbands about NSV.

User Feedback

Some districts interviewed satisfied users and published these reports in newsletters disseminated to local audiences. An EngenderHealth (2004) study of 30 satisfied clients found that 80 percent had subsequently referred friends and relatives to adopt NSV and 90 percent said they had experienced no complications and were happy with the procedure and follow-up. As one NSV client explained:

“Although I wanted to limit my family, I had never thought of vasectomy, until one day when I visited the CHC during an NSV camp and I saw the men...”

male sterilizations during April 2004–March 2005. SIFPSA data for this same period indicate that RCH camps carried out 1,174 male sterilization procedures and 8,036 NSV procedures were performed in NSV training camps. Thus, SIFPSA reported a total of 9,210 male sterilizations—close to the 10,000 figure from the Department of Health and Family Welfare. If these data are correct and do not omit private-sector providers and the RCH camps, few male sterilizations (including NSV) are taking place outside of these organized special events.

Source: SIFPSA, 2005b
Not all CHCs have a medical officer trained in sterilization procedures. Indigenous system of medicine practitioners (ISMPs) could be trained for referring clients to trained providers. Doctors lose skills if not provided with opportunities to put those skills into practice. In many training camps, the number of clients was insufficient to ensure adequate mastery of NSV procedures. Thus, some doctors were not certified and listed as needing retraining. A few poorly performed NSVs and lack of proper follow-up could quickly undo many years of promotion for the procedure.

Efforts to expand sterilization services and promote their availability are hampered by the lack of consistent and complete data on doctors trained, training outcomes (e.g., trainees performing to standard or needing retraining), and sterilization service data. Data from each district need to be disaggregated by public vs. private sector and by NSV vs. other vasectomy procedures.

Despite some success in training physicians and carrying out a few mega-NSV camps, a systematic approach for NSV across all project districts did not emerge during the first phase of the IFPS Project. Toward the end of the project, and as a result of efforts in a few districts starting at the end of 2003 and in 2004, efforts began to pick up steam. In 2005, SIFPSA (2005b) prepared a new strategy building on earlier efforts. The strategy focuses on training additional physicians in all IFPS districts, providing funds for extensive outreach and promotion through District Magistrates and Chief Medical Officers, and conducting camps. The new strategy is expected to produce 338 trained physicians and close to 80,000 NSVs over a three-year period.

There are still many social and cultural factors to overcome, however, including fears and misconceptions about the procedure that are shared by men and women alike. While most women know about female sterilization, few are aware of NSV. Furthermore, there appears to be little published research on male sterilization in Uttar Pradesh. What is the profile of acceptors, their perceived needs for services, and their attitudes toward fertility? What is the best way to reach men to gain their support? What factors inhibit their participation in family planning decisions and use of services? Collecting this information could help guide future promotion and IEC activities.

There seems to be huge untapped potential for improving promotion of NSV. Beyond involvement of some District Magistrates, efforts to sensitize and involve village pradhans, local government officials, NGOs, religious leaders, and urban elites in promoting NSV could help generate more potential clients.

Another area with untapped potential would be to work more closely with the private sector to promote and provide NSV. IFPS could increase private-sector involvement through use of private medical facilities in urban areas, use of contracted private physicians in rural areas for RCH camps, or linking with clinical facilities of the
organized sector. More lower-level physicians, such as those with MBBS degrees, could be trained since surgeons are not needed for NSV. Community-based distribution workers are not generally aware of NSV; it could be incorporated as part of their training. ISMPs could also provide counseling and referrals to trained NSV providers.

Future efforts should give more systematic attention to finding workable models for generating demand and reaching a threshold of service delivery to help promote use of this simple, safe, and cost-effective procedure for fertility stabilization. However, promoting male sterilization and increasing uptake of NSV services should be only one component of a broader approach of helping men understand and appreciate their shared responsibilities as husbands and fathers in ensuring the health of their families.

**REFERENCES**


### THE PRIVATE SECTOR

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The IFPS Project involved the private sector for the first time in family planning service delivery in Uttar Pradesh. The private sector includes nongovernmental, non-profit, and for-profit entities. The IFPS approach to private-sector activities included work with NGOs, milk cooperatives, corporate entities, traditional practitioners, and groups of organized workers. The objective of IFPS-funded private-sector activities was to forge partnerships with the private sector to expand service delivery options and mechanisms for extending reproductive and child health (RCH) services to rural areas as well as reach special populations, such as organized sector workers, their families, and the surrounding community. IFPS also supported training for traditional birth attendants (dais) and indigenous systems of medicine practitioners (ISMPs) in order to expand access to RCH information at the community level and create a broader referral network to public and private clinical services.

A main focus of the IFPS-funded private-sector projects was to increase use of contraceptive spacing methods. Many of the private-sector projects were designed to support community-based distribution (CBD) workers, who distributed oral pills and condoms during home visits and referred clients to clinical sites for intrauterine contraceptive devices (IUCDs) as well as sterilization services. Prior to IFPS, use of spacing methods was relatively low due to clients’ lack of knowledge, fear of side effects, and misconceptions as well as poor availability of contraceptive supplies in underserved rural areas and urban slums.

IFPS-funded private-sector projects are credited with increasing use of oral pills and condoms as well as 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.

**BUDGET**

Of the total IFPS budget, 26 percent was allocated to private-sector programs. These funds were allocated as follows: 39 percent to NGO projects; 29 percent to dairy cooperatives; 13 percent to social marketing; 9 percent to information, education, and communication (IEC); 4 percent to training centers; 4 percent to ISMP training; and 2 percent to employer/organized sector projects (see Figure 1).
BUILDING PARTNERSHIPS WITH THE PRIVATE SECTOR

The major private-sector initiatives under the IFPS Project covered in this section are summarized below.

Community-based Distribution
IFPS supported 256 private-sector CBD projects implemented by NGOs, cooperatives, and organized-sector agencies. About 75 percent of these projects were with NGOs. Of the 24 million people covered by IFPS-funded private-sector projects, half were served by dairy cooperative projects, 36 percent by NGO projects, 9 percent by District Urban Development Authority branches in urban slums, and 5 percent by the employer/organized sector (see Figure 2).

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 provided counseling, contraceptive supplies, and referrals to 1.6 million family planning clients and 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.)

**Building Capacity of Traditional Providers**

**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, refer high-risk pregnancies, and promote 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. 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.** 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 covered 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.)

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COMMUNITY-BASED DISTRIBUTION THROUGH NGO:
Reaching Out to Communities, Empowering Local Women

By Cynthia P. Green

RATIONALE

The IFPS Project was designed to provide a broad array of sources for family planning/reproductive health (FP/RH) information and services. One of the major strategies was to engage community-level NGOs in reaching underserved populations with family planning information and services. Four in five Uttar Pradesh residents live in rural areas, and about 5 percent live in urban slums. Many of these people lack easy access to government health services and do not have even basic information on reproductive health. Rural villagers are especially cut off from external information sources: about three in five villages in Uttar Pradesh are not reached by radio or television. Illiteracy among women is high—according to the 1998/99 National Family Health Survey (NFHS-2) only 43 percent of women in Uttar Pradesh are literate (International Institute for Population Sciences [IIPS] and ORC Macro, 2000).

The IFPS Project identified NGOs as an important vehicle for reaching underserved populations because many NGOs already work with rural communities on social development programs, including health, sanitation, income generation, and education.

Because of their long association and positive contributions, NGOs are respected and trusted by villagers. Frequently they can mobilize resources for project support, including volunteer assistance and community in-kind contributions such as meeting venues.

NGOs not only provide access to information and services, but also promote an enabling environment, creating broad social support for family planning and changing social norms about contraceptive use, birth spacing and limiting, and husband-wife communication.

OBJECTIVES

Consistent with the IFPS Project’s overall goal of expanding access to family planning and other reproductive and child health (RCH) services, NGO activities were expected to reach broad coverage in project areas. An increase in the contraceptive prevalence rate (CPR) for modern methods was one of the primary indicators. NGO initiatives using community-based distribution (CBD) workers were expected to achieve an increase of 5 percentage points in modern method CPR per year. Some NGO projects, notably those in urban areas, met this target, while others found it too demanding.
within a two-year project time frame. In contrast, non-IFPS areas of Uttar Pradesh generally achieved an annual increase in CPR on the order of 0.7 or 0.8 percentage points.

Other RCH indicators included: (1) the number of women receiving antenatal visits, iron and folic acid (IFA) supplements, and tetanus toxoid (TT) vaccinations; (2) the number of deliveries by trained personnel; and (3) the number of children immunized.

**INTERVENTION COMPONENTS**

In most IFPS-funded NGO projects, the emphasis was on outreach to remote rural areas; recent activities have also covered urban slums. Each NGO typically worked in one or two blocks of a district. At SIFPSA’s request, some NGOs shifted project activities to new areas after 2–3 years.

NGO projects centered on the mobilization and training of CBD workers—women residing in the villages or slum areas who receive a small monthly stipend as well as fees from sale of contraceptives and other health supplies. Typically, the CBD worker provides oral contraceptives and condoms to village women and refers them to government workers and facilities for clinical methods such as intrauterine contraceptive devices (IUCDs) and sterilization. CBD workers provide both the free contraceptives supplied by the government as well as products sold under the contraceptive social marketing (CSM) system.

The CBD worker’s responsibilities are to: educate and counsel clients on family planning; distribute contraceptives; enroll pregnant women for antenatal care and children for immunization; refer clients for IUCD and sterilization services in coordination with the auxiliary nurse midwife (ANM); organize communication activities, especially group meetings; and encourage support from local opinion leaders. CBD workers are expected to provide supplies to current contraceptive users as well as recruit new acceptors.

Some NGOs have their own clinic facilities and are able to refer clients there. They may also hold special clinic sessions or take medical teams out to villages to provide clinical methods. Many of these activities involve NGO-paid healthcare workers as well as government workers such as ANMs and physicians assigned for a specific activity. Some NGOs have introduced a new category of worker, known as the Community Health Visitor (CHV), who is an ANM hired privately to work in areas where the ANM post is vacant or the ANM is absent. The CHVs provide antenatal and postnatal care, IUCD insertion/removal, immunizations, and family planning follow-up services. They also travel to village sites to provide outreach services.

**IMPLEMENTING PARTNERS**

SIFPSA worked with more than 150 NGOs, beginning with one NGO in 1994. Most of these NGOs were based in villages; a few worked in urban slum communities and in hill areas. Many of the NGOs had not previously done reproductive health work, although they had worked
in related areas such as community development, education, health, nutrition, sanitation, and income generation.

Following are some examples of the NGO partners:

- Shramik Bharti—an NGO founded in 1989 that has worked in education, primary healthcare, water and sanitation, and self-help groups—has provided RCH services in the urban slums of Kanpur City and villages in Kalyanpur Block of Kanpur Nagar District, covering a population of 303,000.

- SABLA, an all-women organization that seeks to promote self-reliance and empowerment of women, conducted an IFPS-funded project in Sultanpur District that included CBD, dai training, and youth mobilization.

- Naujhil Integrated Rural Project for Health and Development (NIRPHAD) conducted CBD programs in two blocks of Mathura District and organized fortnightly outreach RCH camps at two health centers.

- Dr. Shambu Nath Singh Research Foundation, which originated as a small theater group promoting youth involvement and community development, implemented a CBD project in 118 villages in Varanasi District.

- The District Urban Development Authorities (DUDAs)—autonomous bodies under the state government that implement women’s leadership and employment generation programs for the urban poor—implemented CBD activities in urban slums in 16 districts, reaching 2.2 million people.

NGO partners affiliated with medical facilities include St. Mary’s Polyclinic in Barabanki District, St. Catherine Hospital in Unnao District, Allahabad Agriculture Institute Hayes Memorial Mission Hospital, and Kamala Nehru Memorial Hospital in Allahabad District. NGOs working in agriculture and forestry include the Center for Agrarian Research Training and Education in Ghaziabad District, Society for Agro Industrial Education in India in Moradabad District, and the Indian Farm Forestry Development Cooperative Ltd. in Sultanpur District.

NGOs coordinate with local government health authorities by holding outreach RCH camps in their facilities using government health teams and referring clients to government clinics. NGOs work especially closely with the local Chief Medical Officer (CMO), who identifies health providers to participate in outreach RCH camps in private clinics and villages and maintains the schedule of physicians and ANMs.

NGOs also coordinate their activities with the existing village institutions, including the pradhan (elected village leader), panchayat leaders, and village health committee. NGO project coordinators and supervisors attend the monthly meetings of the ANMs at the primary health center. These meetings enable them to coordinate with the ANM’s scheduled visits to the project area and to provide the names of clients referred for various
RCH services. Supervisors regularly attend the meetings of the panchayat and village health committees. They also hold a meeting with male community members and remain in contact with the husbands of CBD workers, thus ensuring male participation in the project.

**PROJECT MANAGEMENT**

**SIFPSA Project Oversight Systems**

SIFPSA developed a comprehensive handbook (SIFPSA, 2003b) describing its procedures for managing NGO projects. Following are some of the highlights:

**NGO selection.** NGOs eligible for IFPS funding should have been legally registered for at least three years, have received funding and managed at least 1 lakh rupees (100,000 rupees or USD 2,273), have implemented social development programs covering a minimum of 25–30 villages in a block for at least two years in the area for which it is seeking funding, and should have adequate human and physical resources. After completing a desk appraisal of the documents submitted by the NGO and conducting a field appraisal, SIFPSA requires approval from the District Magistrate, Chief Development Officer of the district, and the CMO. If the desk and field appraisals are positive and local officials give their approval, the NGO is recommended for project proposal development.

**Proposal development.** NGOs are expected to develop the overall project concept, and SIFPSA staff ensure that all proposal elements are consistent with SIFPSA’s mandate and standards.

**Proposal guidelines.** SIFPSA provides NGOs with a detailed proposal format that includes a project summary, demographic profile of the district, situation analysis, profile of the NGO, project goal and objectives, target indicators, project strategy, project personnel, training, baseline survey, service delivery and promotion, linkages with village institutions, sustainability measures built into the project, systems and procedures, work plan, and project budget. The guidelines assume that 40 percent of spacing clients will purchase CSM products. Products to be promoted are: oral contraceptives, condoms, IFA tablets, oral rehydration solution (ORS), disposable delivery kits, sanitary napkins, and pregnancy test kits. Projects should plan for a ratio of one CBD worker per 1,500 to 2,000 rural inhabitants and 2,000 to 2,500 low-income people in urban areas. SIFPSA also provides a detailed listing of recommended amounts for budget items, including staff salaries, transportation, program expenses, training, and equipment.

**Project result indicators.** SIFPSA established a list of project indicators that guides project design. For example, the project is expected to increase CPR by 5 percentage points per year, to educate clients on spacing methods to promote a more diverse contraceptive mix with about 50 percent of new clients selecting spacing methods, and to ensure that at least 40 percent of spacing clients use CSM brands. Other indicators for RCH services...
include: antenatal check-ups to 60 percent of pregnant women; 80 percent of all pregnant women receiving two TT immunizations and 100 IFA tablets; and 85 percent of infants being immunized.

Proposal review. Proposals are reviewed by SIFPSA's Project Appraisal Committee, which includes senior staff from the state Department of Health and Family Welfare, SIFPSA, the Government of India, and USAID.

Project start-up. If the project proposal is approved, SIFPSA develops a legal agreement with standard terms and conditions that is signed by SIFPSA and the NGO. Then SIFPSA releases the first installment of funds. Most NGO projects are funded for an initial two to three years. If the project's performance is deemed satisfactory, SIFPSA may grant an extension.

Project management cycle. SIFPSA specifies the processes that the NGO should follow in implementing a project, including recruitment of project staff, developing an annual work plan, training project staff and CBD workers, conducting a baseline survey in project areas, initiating service delivery, record keeping, and reporting. The major elements of service delivery are: (1) counseling clients; (2) holding group meetings; (3) door-to-door distribution of both free (government-supplied) and CSM brand contraceptives and other supplies; (4) referrals to both government and private health facilities; (5) organization of pregnant women and children to receive immunizations from the ANM; (6) distribution of ORS packets and IFA tablets; and (7) follow-up for RCH clients. CBD workers also coordinate other awareness-raising activities, such as folk media performances, audio-visual shows, and wall writings.

Project extensions. Near the end of the NGO project's two-year term, SIFPSA hires an external agency to conduct an endline survey. Based on progress made since the baseline and other information, SIFPSA will rate each project's overall performance. Those projects with satisfactory performance may be given an extension to continue their work for 1–3 years. About 50–60 percent of NGO projects were extended.

A complete set of master forms and detailed explanations are included in the SIFPSA NGO Manual (2003b).

NGO Project Management

Project staff. The staffing pattern for NGO projects is largely dictated by SIFPSA. Table 1 lists the categories of workers, their main function, and the training provided by the IFPS Project through subcontractors.

Some NGO projects also employ a physician and/or an ANM (also called a Community Health Visitor) to provide clinical services and roving male educators to discuss family planning with men.

Recruitment of CBD workers is done in the village by the supervisors. The supervisors meet with women in the village and identify possible candidates for further discussion. The main criteria for CBD selection are that the women must be a resident of the village, acceptable to the community,
<table>
<thead>
<tr>
<th>Job Title</th>
<th>Responsibilities</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Director (unpaid)</td>
<td>Serves as chief executive officer; makes strategic and policy decisions; provides sustained direction; and monitors progress regularly.</td>
<td>Induction training at project start-up is usually for two days (previously six days).</td>
</tr>
<tr>
<td>Project Coordinator</td>
<td>Oversees project implementation; supervises entire project staff, including any medical staff hired; verifies 25 percent of client records in a quarter; and coordinates activities with other agencies.</td>
<td>The six-day (previously eight days) induction training covers RCH, CSM, logistics, management information system (MIS), communication, community participation and networking, gender sensitivity, male participation, micro planning, linkages with public-sector services, use of checklists, and sustainability. In the second project year, three-days of refresher training are provided.</td>
</tr>
<tr>
<td>Assistant Project Coordinator(s)</td>
<td>Reviews supervisors’ work plan and monthly reports, spending at least two days a month with each supervisor; verifies 50 percent of client records in a quarter; coordinates work with government health staff, especially the ANMs; oversees RCH camp referrals, outreach clinics, immunization camps, and field IEC activities; and organizes monthly meetings of field staff.</td>
<td>Receive the same training as the Project Coordinators.</td>
</tr>
<tr>
<td>Supervisor</td>
<td>Provides supportive supervision to 10–12 CBD workers, meeting with each one 2–3 times monthly; ensures adequate contraceptive supplies; compiles monthly reports; maintains regular contact with village leaders; organizes training courses for CBD workers; organizes IEC activities; oversees baseline survey; and verifies 100 percent of client records.</td>
<td>The six-day induction training covers the CBD approach, MIS, RCH, supervisors’ role and responsibility, communication, community participation, and linkages, CSM, work planning, and use of checklists. Training emphasizes practical skills and problem solving. Supervisors receive three days of refresher training after six months on the job.</td>
</tr>
<tr>
<td>Accounts in Charge and MIS</td>
<td>Maintains project financial records with vouchers; makes payments and monitors expenditures; maintains MIS; and records contraceptive stock levels and reports on consumption.</td>
<td>The two-day induction training and one-day refresher training cover accounting procedures, the SIFPSA MIS, record keeping, and reporting.</td>
</tr>
<tr>
<td>CBD Worker</td>
<td>Prepares and maintains records on eligible couples, new contraceptive acceptors, pregnant women, and children under 5; provides counseling and contraceptive supplies through door-to-door visits; refers clients for clinical services; provides follow-up of RCH clients; and conducts the baseline survey.</td>
<td>Induction training is for five days, with two days devoted to RCH and three days on conducting a baseline survey. After 30–45 days on the job, CBD workers receive another five days of training covering RCH services, community-based delivery, communication and counseling skills, MIS, gender, community participation, sustainability, micro planning, CSM, practical orientation on field issues, and linkages with the local community and public health systems. It emphasizes building skills in interpersonal communication and creating an enabling environment that supports behavior change and consistent use of RCH services. In the second project year, CBD workers receive four days of refresher training.</td>
</tr>
<tr>
<td>Office Attendant</td>
<td>Provides assistance to Project Coordinator.</td>
<td></td>
</tr>
</tbody>
</table>
CBD workers receive 600 rupees (USD 13.64) per month (an increase from 400 rupees [USD 9.09] previously paid) plus a travel allowance of 50 rupees (USD 1.14) to attend the monthly meeting at the project office. CBD workers visit 10–12 households in a day.

CBD supervisors oversee 12–16 CBD workers, meeting with every worker once every two weeks. They check the CBD workers' records, verify clients, and re-supply commodities. Most CBD supervisors are male, since travel by females is difficult. To enable supervisors to visit their project areas, the project provides them with motorcycles. Often male supervisors help with raising awareness among men as well as talking to in-laws and other family members. They also play an important role in securing the support of village leaders.

**Training.** Training of NGO project staff was done at several training centers, using experienced trainers and well-developed curricula. Training at some of these facilities has been discontinued. For example, the Regional Family Health Training Center was used to train CBD workers and staff of dairy cooperatives, but since it is now located in Uttarakhand (created in 2000), it is no longer used by Uttar Pradesh. By the end of the IFPS Project, NGO project administration staff were trained in Lucknow by the Prerana Population Resource Center (PPRC), while CBD workers and supervisors were trained by PPRC in the field. The training system and budget allow for staff turnover. Typically, 15–20 percent of NGO staff on a project change within two years’ time. The trainers fit new staff in with other training courses.

For each category of worker, SIFPSA and the PPRC developed a training manual and handbook. During training, NGO staff received a handbook that they can refer to when questions arise. Also the CBD workers’ daily diary book, which was used to report on every contact, included some reminder messages.

**Technical assistance.** Following training, PPRC staff visit CBD workers and their supervisors in the field to provide technical assistance as needed. They also provide support in administrative areas such as the management information system (MIS) and accounts.

Near the end of the first project year, SIFPSA arranges for technical assistance based on the project’s needs. Examples of such assistance are record keeping and reporting, MIS, referrals and networking, client counseling, and provision of quality family planning services. After 3–6 months, the PPRC trainers visit CBD workers (randomly selected) and observe them on the job.

**MONITORING AND EVALUATION**

SIFPSA has developed a sophisticated process for collecting and verifying project outputs and assessing impact. It provides the necessary MIS forms and trains NGO project staff in data...
collection. The key components are listed below.

**Baseline survey.** The CBD workers conduct a baseline survey of households in the project area. This survey provides data on each woman’s current reproductive health status (pregnant, breastfeeding, wanting another child, or using contraception) and helps introduce the CBD worker to the community. Newly appointed CBD workers receive training in survey procedures. As part of their initial training, CBD trainees go to local areas and practice conducting the baseline survey; one collects the data and the other one observes.

**Baseline data.** Data from the most recent Reproductive and Child Health Surveys are used to develop baseline indicators for contraceptive use and maternal and child health indicators. These data correspond to the entire district and may not necessarily be representative of the project area.

**Service delivery records.** The CBD workers fill out a daily diary listing each client they have visited and indicating which service(s) she has received. They also complete cards for each family indicating what immunizations and other RCH services each woman and child has received. Recordkeeping is covered in the initial 10-day training sessions as well as in refresher training. The CBD workers summarize information from the daily diary in a monthly report. The supervisors then consolidate the monthly reports from the CBD workers and submit them to the Assistant Program Coordinators.

The supervisors regularly visit the CBD workers to ensure that their records are being kept properly, that they have an adequate supply of contraceptives, and that they are providing accurate and complete information to clients. If the supervisor detects weak areas, he/she will help the CBD workers to improve their job performance. In their monthly meeting, supervisors and Assistant Project Coordinators review CBD records and fill in gaps.

**External monitoring.** The Program Management Unit (PMU) in the district-level counterpart to SIFPSA, known as the District Innovations in Family Planning Services Project Agency (DIFPSA), reviews each NGO project monthly, reports its findings to SIFPSA, and provides feedback to the NGO. PMU staff meet frequently with NGO project staff, especially in the early phase of the project.

**Endline evaluation.** To ensure objectivity, SIFPSA hires an external agency (usually a research firm or institute) to conduct an endline survey and to document the project’s achievements, weaknesses and difficulties. These findings are presented to the NGO. To determine whether the project has met its targets, the endline survey findings are compared with the baseline indicators and other available data.

SIFPSA has completed evaluation studies for all NGO projects. Most of these studies are available only in hard copy. Nevertheless, they represent a large body of program experience that can be used to inform future programs.
**RESULTS**

In the selected blocks of 28 districts in Uttar Pradesh in which NGOs operated, CBD workers provided counseling, contraceptive supplies, and referrals to 1.6 million family planning clients, out of a total population of 13 million. They have assisted 1.8 million pregnant women to obtain antenatal care and 3.1 million children and pregnant women to obtain immunizations.

An analysis of 43 IFPS-funded NGO projects in 18 districts found that 73 percent of the eligible women surveyed in the project areas (N=22,954) were aware of the project and 59 percent had met with project staff in the previous month. After three years of project implementation, the CPR in the study areas had increased from 23.3 percent to 36.4 percent. Use of spacing methods nearly doubled over the three-year period. Three in four clients received their oral contraceptive and condom supplies from CBD workers. One in five clients paid for their contraceptive supplies. The average cost per new acceptor was 720 rupees (USD16.36). Use of spacing methods was 17.4 percent in the NGO project areas, compared with 9 percent for IFPS districts as a whole. Three in four women surveyed had attended at least one antenatal care visit, 65 percent had had two TT injections, and 33 percent received IFA tablets (SIFPSA, no date).

Similarly, a 1999 study of NGO projects in 15 districts of Uttar Pradesh (N=1,300 married women aged 13–49), found that 7.2 percent of women in NGO districts were using spacing methods, nearly double the 3.7 percent prevalence rate found in the 1995 baseline survey. Thus, 225,000 new users of spacing methods were recruited during a three-and-a-half-year period (SIFPSA, 2003).

A comparison of data from the 2003 Reproductive Health Indicator Survey (N=9,474 currently married women) found that use of modern contraceptive methods was highest in NGO project areas with active CBD workers—30 percent, compared with 20 percent in non-NGO areas and 23 percent in rural Uttar Pradesh as a whole (see Table 2). Much of this difference in contraceptive prevalence is due to higher adoption of sterilization in the NGO areas, especially those with active CBD workers.

Many NGO projects did not reach the targets set by SIFPSA. Initially the targets called for an annual increase of 10 percentage points in the modern method CPR; this target was later reduced to a 5 percentage-point increase per year—still a challenge in areas where contraceptive prevalence was low at project outset. Since the average annual CPR increase in non-project areas is less than one percent, achieving five times this increment is difficult. Many NGOs were dependent on the public health system for clinical services such as sterilization, antenatal care, and immunization, and thus they were unable to meet their targets in these areas without the active cooperation and presence of local health providers.

SIFPSA’s CPR target was more easily met in urban slum areas than in rural villages. Between 1995 and...
SIFPSA supported 19 projects conducted by the DUDAs in urban slums of 16 districts covering a total population of 2.2 million people. Nearly all of the DUDA projects (13 out of 16 for which records exist) received a satisfactory rating by SIFPSA. Of the 13 DUDA projects for which endline survey data are available, the average increase in contraceptive prevalence was 14.6 percentage points over two years—an impressive accomplishment. DUDA projects in Fatehpur, Moradabad, and Sitapur Districts had a modern CPR increase of more than 20 percentage points over two years (SIFPSA, 2006). Factors that might have led to the rapid increase in CPR could be higher unmet need in urban areas, better access to health clinics, and greater efficiency in conducting CBD programs in densely populated areas. The DUDA project areas started with a higher initial CPR (11 of the 13 projects with endline data had baseline modern CPRs of 25 or higher), compared with rural areas. While this higher CPR would seem to indicate greater client interest in using family planning, programs in many areas of the world find it difficult to raise the CPR rate above the 30–40 percent plateau without major improvements in the health infrastructure.

It should be noted that CBD workers spend a lot of time educating clients about family planning and other RCH topics, counseling them on contraceptive use, and providing support and follow-up as needed. Thus, their value should not be seen solely in terms of the use of RCH services they generate. In many cases, they are the sole source of health information in their village. Women obtaining clinical services rely on them for transport and moral support, and they help clients cope with side effects and post-operative complications.

**LESSONS LEARNED**

SIFPSA’s approach to working with NGOs was eclectic: it wanted to reach as many areas as possible and involve as many NGOs as possible. Prior to the initiation of the IFPS Project, few NGOs were working in the reproductive health sector. SIFPSA showed that NGOs with no prior experience in reproductive health could develop into effective

### TABLE 2. PERCENTAGE OF WOMEN USING MODERN CONTRACEPTIVES IN RURAL AREAS OF UTTAR PRADESH, 2003

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>NGO Areas with Active CBDs (13 Million People)</th>
<th>NGO Areas without Active CBDs (8 Million People)</th>
<th>NGO Areas with Active and Inactive CBDs (21 Million People)</th>
<th>Non-NGO Areas (73 Million People)</th>
<th>Rural Uttar Pradesh (135 Million People)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td>22.8</td>
<td>16.2</td>
<td>19.8</td>
<td>14.8</td>
<td>17.1</td>
</tr>
<tr>
<td>IUCD</td>
<td>1.8</td>
<td>0.9</td>
<td>1.2</td>
<td>0.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td>1.6</td>
<td>1.4</td>
<td>1.6</td>
<td>1.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Condom</td>
<td>4.0</td>
<td>3.2</td>
<td>3.4</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Total CPR For All Modern Methods</td>
<td>30.2</td>
<td>21.7</td>
<td>26.0</td>
<td>20.2</td>
<td>22.8</td>
</tr>
</tbody>
</table>

Source: Tewari, 2004
partners with appropriate training and technical oversight. Some NGOs, including those new to reproductive health, did an excellent job. Other NGOs lacked the management infrastructure and zeal to implement IFPS-funded projects; they did not receive grant extensions.

By distributing NGO activities throughout the IFPS districts, the project diluted their effect. Had one district been saturated with NGO projects, their effect on contraceptive prevalence over a larger area could have been assessed. Similarly, forming a network of NGOs to share program experiences and advocate for improved public-sector health services would have created synergy among their disparate efforts and might have led to greater support for RCH services and more sustainable NGO RCH-related programs.

As previously stated, SIFPSA set high targets for NGO projects. NGOs were expected to achieve a 5 percent increase in contraceptive prevalence annually. Only about half of the NGOs were able to meet this target. In areas with low literacy, poor public health systems, and erratic provision of contraceptive supplies, generating such rapid increases in contraceptive use was unrealistic.

SIFPSA’s requirement that local officials approve each NGO’s selection insulated the process from political influence, but also led to delays in project start-up when officials hostile to NGOs withheld their approval or newly transferred officials had to be oriented to the IFPS Project. The approval process often took 4–6 months, thus slowing down program momentum.

SIFPSA’s well-developed system for planning and implementing NGO projects helped to expedite the process of engaging new NGO partners. The transparency and accountability that SIFPSA requires of its NGO grantees contributes to their performance and reinforces community respect. On the other hand, the rigidity of SIFPSA’s model for NGO projects did not allow NGOs to adapt programs to local conditions and socio-cultural norms. The program model inhibited the more experienced NGOs from introducing new program elements and expanding areas of coverage. For example, SIFPSA rejected a suggestion that husband-wife teams be deployed as CBD workers in order to relate to both men and women. Similarly, SIFPSA applied the same budget norms to all NGO projects, which did not consider adjusting budgets to suit local conditions or adapt to changes such as increased petrol costs.

In many areas, NGO programs did not have time to take hold. NGOs were funded for an initial two years, with the possibility of an extension for a third year. Successful NGOs were asked to end projects in their original sites and shift to new blocks within the same district. The concept of making projects sustainable by having CBD workers sell contraceptives and other products was introduced relatively late in the process with insufficient time for CBD workers to recruit a large group of regular contraceptive users willing to purchase social marketing brands. By project end, most CBD workers had insufficient income to replace their monthly stipend of 600 rupees.
Similarly, although NGOs were able to set aside some funds from CSM sales, the funds were insufficient to support project activities at the level funded by SIFPSA. Another issue affecting income generation was that clients receiving the free government-supplied contraceptives questioned why they should pay for the CSM-branded contraceptives. Some clients did purchase the CSM brands because they perceived them to be of superior quality.

The CBD workers were effective in reaching underserved areas and helping village women to understand the concept of pregnancy prevention and the use of specific contraceptive methods. This process was sometimes lengthy, requiring ten or more visits before women decided to use contraception.

For CBD workers, taking on the role of community educator represented a major change in their own self-image as well as the perceptions of their fellow villagers. The CBD workers gained self-confidence and flourished in their new role. CBD workers interviewed in Sultanpur and Mathura districts said that initially it was difficult for them to make door-to-door visits, but they gained confidence over time. At first their husbands were uneasy about their new position, but they became supportive when they saw the positive changes in their wives and welcomed the additional income they earned as CBD workers.

The IFPS Project supported the training of some 15,000 CBD workers. Even though most of them are no longer paid to educate their community on family planning and reproductive health issues, they form a large cadre of informal educators and agents for change. Many of them have been empowered to continue to address health and social issues in their communities. At least 12 CBD workers have been elected to panchayat posts in their villages (USAID/India, 2005). One of them, Shahjahan Begum, described her metamorphosis from CBD worker to gram pradhan (elected village leader) in her village: “Earlier I used to wear the black chuddar covering my forehead whenever I went out. . . . I was very shy. Now I can give a speech at any function. I make door-to-door visits and can talk to the men in the community without purdah” (Johri et al., 2002, p. 21).

Some of the lessons learned from the NGO projects are:

- The concept of income generation needs to be built into project design from inception, with an analysis of the cost of providing services and management support and the feasibility of project support from user fees. Private-sector programs directed at low-income groups need to work closely with government healthcare providers in order to offer quality but affordable services.

- Compensation for CBD workers is a sensitive issue. Shifting from a monthly stipend to payments related to outcomes—primarily product sales and clinic referrals—could create a hardship for CBD workers in areas where contraceptive use is low.

- The extensive recordkeeping done by CBD workers under
the IFPS Project, with oversight by field supervisors, may be difficult to maintain if project resources are reduced.

- Inactive CBD workers are an untapped resource for health programs. For example, some CBD workers expressed a desire to be trained to provide basic medicines so that they could increase their earnings.

- Clients and CBD workers need to be consulted regarding the CSM product range. For example, many CBD workers stated that smaller packets of better-quality sanitary napkins could increase sales.

- CBD workers and other NGO staff appreciate visiting other CBD sites. They learn from their peers and feel valued as community workers.

In March 2005, the Government of India launched the National Rural Health Mission (NRHM) program, which seeks to extend access to healthcare to rural populations, especially vulnerable groups such as women and children. Focusing on 18 states, including Uttar Pradesh, the NRHM will bring together all health programs. The CBD model developed by under IFPS is a key component of NRHM. The program will establish the post of Accredited Social Health Activist (ASHA) (asha means “hope” in Hindi). The plan is to have one ASHA per 1,000 population. ASHAs will be trained in RCH issues, tuberculosis, safe water, and nutrition. Each ASHA reports to the gram pradhan and will be assisted by the Village Health Committee.

CBD workers having a minimum of three years’ experience in community work could become ASHAs, if they are selected by the village leader. However, some observers believe that only a small proportion of the current CBD workers employed in IFPS-funded projects will be selected to become ASHAs due to the political nature of the appointment. On the other hand, SIFPSA and the Uttar Pradesh Department of Health and Family Welfare could weigh in on this process, ensuring that new initiatives take advantage of already trained, experienced community-based workers.
Ideas, Insights, and Innovations

BOX 1

CBD Workers Impart Confidence and New Information

Making a special visit to the maternal and child health center to meet some foreign visitors, some 25 CBD workers sit in rows and smile politely. With their saris glistening in the sunlight, they exude enthusiasm for their work. Less than two years ago, they were asked if they would take on the task of discussing family planning and other health topics with women in their villages. Even though they knew little about such matters, they agreed to undertake this task. Initially, it was difficult to make women understand how contraceptive methods work and to overcome their reticence to discuss family planning with their husbands. Women responded to suggestions regarding child health (such as immunizations and oral rehydration therapy), but some clients were suspicious of the CBD workers’ motives.

“Now women realize that family planning is good for their health,” one CBD worker reported. The CBD workers are pleased that they were able to learn new information and serve their community. Several CBD workers have had sterilizations, and others are using contraceptive spacing methods. Following their example, village women have begun to use family planning. According to the CBD workers, clients have more confidence in using medical services because the CBD worker is a continuing presence in the community. One CBD worker explains the client’s view that “She [the CBD worker] is with me [during the laparoscopy] so she will take me to the hospital [if complications arise].”

The CBD workers are employed as part of the IFPS-funded NIRPHAD project. In its first year of operation, the NIRPHAD project in Mathura District, an area with more than 205,000 inhabitants, has made progress. The 103 CBD workers recruited 441 oral contraceptive users, 560 condom users, and made referrals for 77 IUCD insertions, 645 female sterilizations, and 25 no-scalpel vasectomies. Nearly all of the oral contraceptive and condom users purchased their supplies. This willingness to pay gives hope that the project can generate income to support its activities.

CBD workers are the heart of NGO programs. As the NIRPHAD program manager remarked, “They [CBD workers] are our best people. Maybe I will be here for 10 years. But they will be here forever.”
REFERENCES


DAIRY COOPERATIVES: Providing RCH Services through Village-level Networks

By Cynthia P. Green

RATIONAL

Founded in the early 1900s, dairy cooperatives are well established throughout India. The idea for using dairy cooperatives for reproductive and child health (RCH) programs in Uttar Pradesh came from the Centre for Development and Population Activities’ (CEDPA) successful pilot project with dairy cooperatives in Bihar in 1988. Dairy cooperatives were selected as major partners in the IFPS Project because of their deep penetration into rural areas, their democratic structures, and their efficient management systems. The reach of dairy cooperatives is unsurpassed. They cover nearly all villages in a district, except the few without a dairy cooperative society (DCS). In contrast, nongovernmental organizations typically cover 60–70 out of 100 villages in their area (usually one or two blocks in a district).

Dairy cooperatives have links to millions of villagers with little or no access to health services. Because milk must be transported twice daily to cooling and processing facilities, contact with village DCS members is frequent and year-round (unlike crop producers’ unions, for example). The milk pick-up points in village DCSs are centrally located and can be used to provide contraceptive supplies and information and hold meetings. Membership in the village DCSs is open to anyone regardless of caste, creed, and sex. Since most milk pourers are women, dairy cooperatives are especially useful in expanding RCH services. Villagers trust and respect dairy cooperatives and, thus, are receptive to their various programs.

OBJECTIVES

Similar to IFPS-funded NGO projects, the dairy cooperative projects are designed to increase:

- Contraceptive prevalence;
• Immunization of newborn infants and pregnant women;
• Immunization of children under age 5; and
• Deliveries assisted by trained health personnel.

They are also intended to improve linkages with public-sector health services and increase private-sector involvement in RCH care.

Individual projects may have additional objectives specific to local conditions. For each project, SIFPSA sets performance targets such as the number of spacing clients, antenatal care (ANC) coverage, and infant and child immunization.

INTERVENTION COMPONENTS

SIFPSA began working with the Pradeshi Co-operative Dairy Federation Limited (PCDF) in 1994, initiating pilot projects in Sitapur and Meerut Districts. After 18 months, contraceptive prevalence increased by roughly 40 percent in the two project areas, thus justifying scale-up of the dairy cooperative model. During 1997–2000, SIFPSA funded dairy cooperative projects in six districts of Uttar Pradesh. Nine districts were added during 2002–2003, and two more districts were added in 2004, making a total of 18 districts. All but four of the 18 district-level projects closed during 2003–2005; these four projects will end by August 31, 2006.

Of the 18 district PCDF projects, six were funded for five years or longer, 11 for two years, and one for three years. The longest-running projects were in Agra, Aligarh, Banda (Karvi), Fatehpur, Firozabad, and Sultanpur Districts.

At its peak, the PCDF project covered 5,672 village DCSs and a population of 11.6 million people—roughly equivalent to 7 percent of the state’s population. The project trained 14,000 volunteers, including dairy cooperative members, some 5,000 village health volunteers (VHVs), and community-based distribution (CBD) workers from NGOs.

The main program components of dairy cooperative projects are:
• RCH counseling and services by trained VHVs;
• Maternal health services in coordination with government auxiliary nurse midwives (ANMs);
• Health camps with RCH services provided by a project female physician (known as a lady doctor); and
• Communication activities such as wall paintings, signs on milk vans, group meetings, health fairs, and folk performances.

These four components are well-coordinated and are designed to extend services to remote areas.

Village health volunteers. The foundation of the dairy cooperative program is the provision of family planning and reproductive health counseling and supplies by local women known as Village Health Volunteers or VHVs. These specially trained women are in contact with 75–95 percent of women in the village (see Box 1). They visit 10–12 households per day, providing family planning counseling, referrals for
VHVs are selected by the village committee that runs the DCS. They are mostly female village residents with a middle school, 7–8 standard education. Their initial training is for five days and focuses on their initial assignment, which is to conduct a baseline survey in the village to identify reproductive-age couples and determine family planning and reproductive health needs in the area. A second five-day training course covers RCH services, community work, and counseling skills. After one year of work, VHVs attend four days of refresher training.

VHVs receive a monthly stipend of 300–600 rupees (USD 6.82–13.64) plus a 50-rupee (USD 1.14) travel allowance to attend monthly meetings at the project office. Turnover is about 5–10 percent annually. The main reasons for VHVs leaving their post are marriage, migration, or poor performance.

More than 5,000 VHVs worked in the dairy cooperative projects, forming an important link between the village and health services. Putting village women in these positions also served to raise their status in the community and increase their self-confidence and sense of self-efficacy. Some VHVs have become community activists on a range of health, education, and development issues. Some have been hired as anganwadi (child nutrition) workers. A few have been elected as village pradhans, and one woman has been elected to the State Dairy Board.

VHVs provide free supplies of condoms, pills, and IFA from the government as well as socially marketed brands of condoms and pills. By selling condoms, pills and other health products, the project gains some income to defray expenses and promote sustainability. Also, clients believe that the socially marketed brands are of higher quality than the government stocks. By paying some money for the products, the clients indicate that they value them and intend to use them.

Some VHVs have generated extra income from selling contraceptives purchased from manufacturers, earning 40–80 rupees (USD 0.91–1.82) a month. Other VHVs report that clients resist paying for contraceptives, since the government provides them free of charge.

**Maternal health services.** Community health visitors (e.g., ANMs) employed under the IFPS-funded projects provide clinical services

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**BOX 1**

<table>
<thead>
<tr>
<th>Clients’ Views of Village Health Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “We love her services as she is one of us. She stays in the village and gives us service at our doorsteps.”</td>
</tr>
<tr>
<td>• “She is available all of the time. She is from our village. We go to her whenever we need to re-supply. We have confidentiality [and] do not have to leave our homes to get this. She is easily accessible.”</td>
</tr>
<tr>
<td>• “We keep her at home till she has satisfactorily answered all questions.”</td>
</tr>
</tbody>
</table>

— From focus group discussions conducted by CEDPA in 2002 (Levitt-Dayal, 2003)
such as prenatal and postnatal care in DCS facilities.

**Village health camps.** To provide RCH services in remote villages, district unions organized health camps with services provided by a physician and the project’s medical team. The health camps provide antenatal and postnatal care, intrauterine contraceptive device (IUCD) insertions, tetanus toxoid (TT) immunization, IFA tablet distribution, child immunization, and assistance in addressing contraceptive side effects. As shown in Table 1, 3,745 outreach RCH camps were held from 1994 to 2003, providing services to nearly 215,000 women and children.

**Information, education, and communication (IEC).** Dairy cooperative projects emphasized community mobilization through group meetings and discussions, involvement of village leaders, and provision of information on RCH. Health fairs (melas) were held quarterly, wall writings with geru were used to announce the place and date of service availability and schedules of maternal and child health services, and folk performances (organized by SIFPSA) drew large crowds. Milk vans were painted with RCH-related messages.

Data from Dugdh Utpadak Sahkari Sangh, Ltd. (DUSS), a milk producers union in Moradabad District, attest to the numerous IEC activities. During 2002–2004, the project held more than 584,000 group meetings and discussions, made more than 7,000 wall writings, and held 288 audio-visual shows plus 367 cultural programs. It also distributed flipcharts, banners, books, handbills, posters, leaflets, and video cassettes.

A survey of reproductive-age women in the project area found that 63 percent of the respondents had met the project staff; the majority had met with project staff at least every two months.

**IMPLEMENTING PARTNERS**

The primary implementing partner for dairy cooperative activities, PCDF, was organized in 1961 and

<table>
<thead>
<tr>
<th>Camps held</th>
<th>3,745</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cases treated</td>
<td>214,717</td>
</tr>
<tr>
<td>Copper-T IUCD insertions</td>
<td>11,401</td>
</tr>
<tr>
<td>Pill user check-ups</td>
<td>5,006</td>
</tr>
<tr>
<td>Antenatal care clients</td>
<td>20,565</td>
</tr>
<tr>
<td>Reproductive tract infections (RTIs) treated</td>
<td>30,895</td>
</tr>
<tr>
<td>Urinary tract infections treated</td>
<td>11,422</td>
</tr>
<tr>
<td>Child check-ups</td>
<td>41,131</td>
</tr>
<tr>
<td>Diarrhea cases treated</td>
<td>15,026</td>
</tr>
<tr>
<td>Pregnant women immunized for TT</td>
<td>11,276</td>
</tr>
<tr>
<td>Children under age 1 immunized</td>
<td>26,000</td>
</tr>
<tr>
<td>Children aged 1–5 immunized</td>
<td>4,045</td>
</tr>
</tbody>
</table>

**TABLE 1. OUTREACH RCH CAMPS HELD BY DAIRY COOPERATIVE SOCIETIES, 1994–2003**
has 31 district-level milk unions covering 11,650 village-level dairy cooperative societies.

The project staff work closely with the staff of the district health department and primary health centers (PHCs). Community health visitors work closely with the ANMs working in government facilities in their area and are also in contact with the local traditional birth attendants trained under the IFPS Project. VHVs refer clients to the PHCs for clinical family planning methods and to government clinics for prenatal and postnatal care and other RCH services. The project also collaborates in special campaigns such as Pulse Polio, outreach RCH camps, and child and TT immunization camps.

**PROJECT MANAGEMENT**

The state DCS oversees the work of the district-level unions. The SIFPSA Project Director, who is responsible for overall coordination of the SIFPSA-funded projects, is based at the state headquarters. A finance officer and management information system (MIS) officer round out the state project team.

At the district level, the union of cooperatives processes milk and manufactures and markets milk products. Each union is usually managed by a paid Chief Executive. The Board or managing committee of the district union is elected from among the chairpersons of the village societies. To support the IFPS-funded activities, each union has one accounts officer.

At the village level, members hold an annual general meeting to elect members of a managing committee, which oversees the daily operations of the society and is responsible for program planning. The society employs a local person (called a Secretary) to collect milk, test for fat and solids non-fat, sell cattle feed, and pay milk producers. Many village societies provide other services to their members, such as veterinary first aid for livestock.

**Project staff.** The staffing pattern for dairy cooperative projects is similar to that of NGO projects. Some of the differences are that the supervisors oversee a larger number of community-based workers and the project team includes an ANM known as a community health visitor. Another difference is that the VHVs are trained at PCDF facilities, with PCDF staff serving as master trainers. Project management staff are trained at the Prerana Population Resource Center, as are all levels of NGO staff in IFPS-funded projects.
<table>
<thead>
<tr>
<th>Job Title</th>
<th>Responsibilities</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Honorary Assistant Director</strong> (District General Manager)</td>
<td>Makes strategic and policy decisions, provides sustained direction to the project, reviews progress, coordinates donors, and plans future activities</td>
<td>Induction training at project start-up is usually for two days (previously six days)</td>
</tr>
<tr>
<td>District Coordinator and Additional District Coordinator (ADC)</td>
<td>Prepares work plans, oversees implementation, coordinates referrals and commodity supplies with district government health system, and prepares reports. ADCs cover half of the project area</td>
<td>The eight-day orientation training covers community participation, management, MIS, accounts, communication, materials development, RCH, government health facilities, contraceptive social marketing (CSM), quarterly progress and expenditure reporting, data analysis, and financial management</td>
</tr>
<tr>
<td>Assistant District Coordinator</td>
<td>Oversees project implementation in assigned project area; reports on progress; organizes field staff meetings, outreach RCH camps, and visits of lady doctors; and ensures contraceptive supplies</td>
<td>The six-day (previously eight days) induction training covers RCH, CSM, logistics, MIS, communication, community participation and networking, gender, male participation, and linkages with public-sector services. In the second project year, three days of refresher training are provided</td>
</tr>
<tr>
<td>Health Supervisors</td>
<td>Oversees the work of 20–30 VHVs through monthly visits, meets with village leaders, prepares monthly and quarterly reports, distributes commodities to VHVs, and coordinates RCH referrals and IEC activities</td>
<td>The three-day induction training covers the CBD approach, MIS, RCH, supervisors' role and responsibility, communication, community participation, CSM, work planning, and use of checklists. After six months on the job, three days of refresher training are given</td>
</tr>
<tr>
<td>Community Health Visitor</td>
<td>Provides family planning counseling, IUCD insertion, antenatal check-ups, TT, IFA, child health check-ups, and treatment for RTIs</td>
<td>Community health visitors receive six days of initial training to familiarize them with project objectives and their own responsibilities</td>
</tr>
<tr>
<td>Village Health Volunteer (VHV)</td>
<td>Provides counseling and contraceptive supplies door-to-door, organizes group meetings in the village, refers clients for clinical services, maintains client records, checks on RCH clients, and conducts the baseline survey</td>
<td>Induction training for VHVs is for five days—two days on RCH and three days on conducting a baseline survey. After 30–45 days on the job, VHVs receive another five days of training covering RCH services, CBD, communication and counseling skills, MIS, gender, CSM, community participation, field issues, and referral sites. In the second project year, VHVs receive four days of refresher training on RCH and other topics</td>
</tr>
<tr>
<td>Accountant/ Store Keeper</td>
<td>Maintains project financial records with vouchers, makes payments, monitors expenditures, records contraceptive stock levels, and reports on consumption</td>
<td>The two-day induction training and one-day refresher training cover accounting procedures, SIFPSA's MIS, record keeping, and reporting</td>
</tr>
<tr>
<td>MIS</td>
<td>Maintains MIS</td>
<td></td>
</tr>
<tr>
<td>MIS in charge</td>
<td>Maintains MIS for field office activities</td>
<td></td>
</tr>
</tbody>
</table>
Table 2 lists the categories of workers at the district and village levels as well as their main responsibilities and training provided by the project.

The village DCS Secretaries also assist in project activities, although they receive no additional pay for this work. They support the VHVs and serve as depot holder for family planning supplies. Since most of them are male, they often meet with men in the village to raise awareness of RCH issues.

**MONITORING AND EVALUATION**

One of the strengths of the IFPS Project design is that it incorporates close monitoring and supervision into regular project activities. The supervisors meet with the VHVs frequently and are responsible for identifying and correcting any shortcomings in the VHVs’ work. Project management staff and VHVs meet monthly as a group.

Project staff maintain standardized records of various project activities and outputs, as required by SIFPSA. These records include a daily diary listing each VHV’s visits, a register of eligible couples, stock register, and records of health status, immunization, and referrals. Each district dairy cooperative submits a Quarterly Progress Report to SIFPSA. After this report is reviewed, SIFPSA releases funds for the next stage of work.

VHVs conduct the baseline survey, which provides data on the number of reproductive-age women who are currently pregnant, nursing, using contraception, or wanting to become pregnant.

For the endline evaluations of dairy cooperative projects, SIFPSA hired an outside research company. The evaluation of the project implemented by the milk producers union in Moradabad District serves as an example of the evaluation process. The methodology consisted of: (1) discussions and in-depth interviews with SIFPSA staff, project staff, and community health workers; (2) analysis of project output data provided by project staff and SIFPSA; and (3) a survey of 1,000 married women aged 15–49 from a stratified random sample of households in the project area (DUSS, 2004). The survey covered awareness and use of family planning methods, immunization status of children under age 5, place of delivery and assistance at delivery, antenatal care, TT immunization, IFA tablet distribution, exposure to communication activities, interaction with project staff and satisfaction with services, and awareness of RTIs and sexually transmitted infections (STIs).

**RESULTS**

As shown in Table 3, between 1997 and 2005 the PCDF projects served nearly 887,000 family planning clients. Of these clients, more than half (57%) used condoms, 18 percent received referrals for female sterilization, 15 percent used oral contraceptives, and 10 percent received referrals for Copper-T IUCDs (see Figure 2). The dairy cooperative projects were successful in promoting use of contraception for birth spacing. Greater use of spacing methods is
Ideas, Insights, and Innovations

Socially marketed contraceptives constituted more than half of the non-clinical methods distributed (59% of condoms and 56% of oral contraceptives). The shift from free to paid products (albeit heavily subsidized) is important to ensuring that dairy cooperative family planning activities can continue.

A SIFPSA analysis of the dairy cooperative projects found that the contraceptive prevalence rate (CPR) had doubled in most of the projects, with an average yearly increase in CPR of 3.7 percentage points. The Impact BM Survey found that more than 65 percent of eligible couples had been contacted by VHV's (Singh, 2005).

Immunization rates were higher in the dairy cooperative project areas compared with the statewide average. The 2002 USAID-funded survey found that 67 percent of pregnant women in project areas had received two doses of TT immunization, compared with 61 percent statewide (Singh, 2005).

The districts with the longest-running projects have had impressive gains in contraceptive prevalence. In Sitapur District, the CPR increased from 18 percent in 1995 to 25 percent in 2000 and 31 percent in 2002. In Meerut District, the CPR rose from 27 percent in 1995 to 42 percent in 2000 and 45 percent in 2002. In Varanasi and Allahabad

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**TABLE 3. PCDF DAIRY COOPERATIVE PROJECTS, AUGUST 1997–AUGUST 2005**

<table>
<thead>
<tr>
<th>Number of districts</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population covered</td>
<td>11,553,963</td>
</tr>
<tr>
<td>Number of village Dairy Cooperative Societies covered</td>
<td>5,672</td>
</tr>
<tr>
<td>Number of active family planning clients</td>
<td>886,688</td>
</tr>
<tr>
<td>Number of family planning clients receiving government-supplied condoms</td>
<td>208,745</td>
</tr>
<tr>
<td>Number of family planning clients receiving government-supplied oral contraceptives</td>
<td>59,412</td>
</tr>
<tr>
<td>Number of family planning clients receiving social marketing condoms</td>
<td>319,344</td>
</tr>
<tr>
<td>Number of family planning clients receiving social marketing oral contraceptives</td>
<td>79,096</td>
</tr>
<tr>
<td>Number of clients referred for Copper-T IUCD insertion</td>
<td>86,639</td>
</tr>
<tr>
<td>Number of clients referred for female sterilization</td>
<td>160,604</td>
</tr>
<tr>
<td>Number of clients referred for male sterilization</td>
<td>2,151</td>
</tr>
</tbody>
</table>

---

**FIGURE 2. CONTRACEPTIVE MIX IN DAIRY COOPERATIVE PROJECTS**

- Condoms 57%
- Oral Contraceptives 15%
- Female sterilization referrals 18%
- Copper T referrals 10%

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essential for ensuring that young couples achieve their reproductive intentions and offering a wide array of contraceptive choices.
Districts, CPR doubled from 18 percent in 1997 to 36 percent in 2002 (Levitt-Dayal, 2003).

LESSONS LEARNED
Working through the dairy cooperatives was an effective way to extend RCH services to remote areas and achieve large coverage in project districts. The existing infrastructure reached thousands of villages. Even though the dairy cooperatives had no prior experience in health work, they were respected and trusted by villagers and thus were a good source of health information. The dairy cooperatives also had well-developed management systems that facilitated setting up project systems. Similarly, because the dairy cooperatives were already engaged in marketing, they readily adopted the concept of social marketing of contraceptives and other health products. Building the capacity of local women as VHVWs was also beneficial, since it created new service providers while empowering women (Singh, 2005).

The dairy cooperative model could be readily scaled up because it had been tested and its structure was well-defined. Chaudan and Kumar (2003, p. 11) list six factors that facilitated scaling up: “trusted relationship with rural communities; strong management systems/MIS; standardized, quality training; village-based supervision; direct linkages to social marketing agencies; and results-oriented implementation and monitoring.” The PCDF project built on the existing infrastructure effectively. The dairy cooperative system was flexible enough to incorporate RCH work into its regular activities. The only drawback in the system was that district coordinators were frequently transferred, thus slowing down project momentum as new staff became oriented.

While the PCDF appears to have a bright future, the business climate for dairy cooperatives is changing. Entrepreneurial companies are loaning funds for villagers to buy a cow and then purchasing the milk, thus siphoning off current and potential DCS members. Some DCSs have closed because many villagers have shifted to commercial milk buyers.
REFERENCES


Rationale

The rationale behind using the organized or industry-based sector in family planning/reproductive health (FP/RH) service provision is two-fold: employees benefit from better health and economic status; and employers benefit from increased productivity of workers, especially through reduced absenteeism, and lower costs for health benefits. Providing access to information and services at the workplace takes advantage of a delivery system where workers spend a good deal of time. Extending services to the areas surrounding the workplace promotes better health and well-being of the workers, families, and relatives and provides a service for the broader community.

Objectives

Specific objectives of the IFPS-funded activities with corporate entities and other groups of organized workers were to:

- Reach out to worker populations to encourage family planning and to identify those who could themselves promote family planning among their colleagues;
- Encourage industries with appropriate infrastructure to add family planning services or extend existing health facilities to surrounding rural areas; and
- Increase the contraceptive prevalence rate (CPR) and uptake of reproductive and child health (RCH) services in project areas.

Indicators to measure project results were similar to those of other private-sector projects: increased use of modern contraceptive methods, especially contraceptive social marketing (CSM) spacing methods; increased number of pregnant women who received antenatal care and complete tetanus toxoid immunization; and increased immunization of children under age 5.

Intervention Components

Under the IFPS Project, about one-fourth (26%) of the budget was allocated to private-sector activities; and within the private-sector portfolio, 2 percent of funds supported activities with employers. Activities in this area were intended as pilot projects designed to test various models of project implementation. Activities were generally small in scale, with the notion that successful projects could be scaled up at a later time.

“FP/RH has been successfully incorporated into the outreach services of a variety of NGOs and cooperatives and into services provided by businesses to their employees.”

SIFPSA awarded 21 projects in 15 districts in the employer sector over the life of the IFPS Project. Initially working in only a few districts with a few partners were identified and successful projects were renewed upon satisfactory completion of activities. Project extensions enabled the corporate entity to modify its approach based on lessons learned and to expand and broaden the scope of its activities to better meet the needs of the covered populations. For example, the Indo Gulf Jan Sewa Trust project started as factory-based service provision, oriented to workers in the areas immediately surrounding the plant. Indo Gulf extended the project to additional blocks and added community-based distribution (CBD) workers to raise awareness of RCH issues and supply villagers with spacing methods and iron and folic acid (IFA) supplements. The CBD workers also referred clients for clinical services to outreach clinics staffed by private healthcare workers hired by the project and to Indo Gulf’s corporate-run hospital for sterilization services and other medical procedures (see Case Study).

**TYPES OF SERVICE PROVISION MODELS IN THE ORGANIZED SECTOR**

Under the IFPS Project, four main types of activities were carried out with the organized sector:

1. Projects with organized industry to provide family planning and RCH services to factory workers, their families, and the surrounding community (using trained factory workers and CBD workers to provide information about family planning methods);

2. Partnerships formed with apex organizations, such as the Federation of Indian Chambers of Commerce and Industry (FICCI);

3. Partnerships formed with trusts of the corporate sector, such as Jan Sewa Trust of Indo Gulf Fertilizers and Chemicals (using the CBD model, combined with clinical provision of services through corporate-supported facilities and medical staff); and

4. Other promotion efforts initiated through district action plan implementation in selected districts (such as outreach work with postal workers and agricultural extension workers).

Project activities in the organized sector made use of both non-clinical and clinical strategies for service provision. Non-clinical projects focused on raising awareness, counseling, and promoting use of spacing methods and other RCH services. Trained factory workers and CBD workers raised awareness and provided contraceptives to

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**BOX 1**

**Strategies for Working with the Organized Sector Proposed in the Uttar Pradesh Population Policy**

- Work with large industrial units in public and private sectors, using their in-house hospital facilities to provide clinical services to the community.
- Harness networks of railways and postal offices with extensive rural outreach and strong hospital set-up to promote small family norm and disseminate information.
- Ask chambers of commerce and industry to manage and implement RCH projects for the unorganized sector workers and small-scale industry workers.

workers and village women. Later on, IFA tablets, oral rehydration salts, and sanitary supplies for women were included in the list of products that could be distributed. Community workers referred clients to clinic-based facilities for intrauterine contraceptive device (IUCD) insertion, sterilization, and immunizations. Clinical strategies in the organized sector often relied on public-sector medical staff and facilities and RCH camps or involved partnering with a corporate entity with its own hospital or clinical facility. Some project models used a combination of strategies.

The overall process for initiating RCH activities in the organized sector began with efforts to identify appropriate and interested corporate entities. Identifying such industries was not easy as Uttar Pradesh does not have a large organized sector. In some cases, SIFPSA would help the corporation set up a nonprofit trust before SIFPSA could enter into a contractual agreement with it. While IFPS funds covered most of the implementation costs, corporate entities were expected to contribute to project implementation costs by providing an honorary project director for overall supervision, office space and related furnishings, a part-time accountant, and money to cover some transportation costs. Corporate entities prepared a project design proposal for review and approval by the SIFPSA Project Appraisal Committee.

Once the project was approved, the project director would gather needed inputs (project office, commodities, facility upgrades, equipment, educational materials, etc.) and hire staff to initiate work. The Prerana Population Resource Center (PPRC), in its capacity as the IFPS Project’s apex training organization, trained the program managers, supervisors, other trainers, and CBD workers in all aspects of project implementation: proposal and project development, management, implementation and service delivery, gender sensitization, communication, supervision, and monitoring.

The next step was to initiate promotion efforts and the CBD component of the project. Trained factory workers would provide information and promote use of family planning and RCH services at prescribed times and in designated areas of the factory. In projects oriented to reaching the communities surrounding the factory and its immediate township, village-level CBD workers were selected and trained to provide family planning and RCH outreach. Each CBD worker prepared a baseline roster of all eligible women and children in her village area. Using this framework, she would provide counseling and family planning information as needed, distribute contraceptive supplies.
and other commodities, and make referrals for immunization and clinical family planning methods. Her daily records would be cumulated monthly and sent to the Project Management Unit (PMU) to measure progress. In addition, monthly meetings and supervisory visits allowed problems to be identified and resolved.

At the end of the project, SIFPSA would commission an independent evaluation of the project’s activities and accomplishments. Then SIFPSA would decide whether to extend the project based on the evaluation findings.

OTHER ACTIVITIES WITH THE ORGANIZED SECTOR
The IFPS Project experimented with several other innovative private-sector initiatives proposed in selected district action plans. These projects largely involved outreach activities using organized groups of workers, such as postal workers and agricultural cooperative workers, to provide information about family planning to their contacts or clients.

Difficulty in Getting Private-Sector Entities to Participate in Family Welfare Activities

Family planning and RCH are still sensitive issues among many in Uttar Pradesh. Private-sector entities must be willing to participate before projects can be designed and initiated. In the case of the Indian Farmers Fertilizer Cooperative in Allahabad and Bareilly Districts, support was difficult to generate. The General Manager sat in Delhi and it was necessary to get his commitment before the managers in Uttar Pradesh would take up the projects. In another instance, SIFPSA wrote and contacted a corporate manager seven times in an unsuccessful effort to get the company to participate in RCH activities. Corporate social responsibility is not a concept that has caught on in many areas of Uttar Pradesh.

These interventions, however, had limited success and ultimately were not implemented in more than one or two districts. For example, in Sitapur District, 534 postal workers were trained in RCH issues in 13 batches in March 2002. Additional promotional activities included 228 wall paintings on post offices, 741 letterbox paintings, and installation of 41 condom vending machines in sub post offices. In January 2004, SIFPSA closed the activity because the postal workers had little commitment to promote family planning and RCH and were ill-equipped to provide adequate counseling to potential clients. In addition, the condom vending machines were difficult to maintain, and there was no logistics system to keep them filled. Thus, machines were often broken down and empty.

Overall, the lessons learned from these activities suggest that more than a brief training session is needed to create a sufficient level of expertise and proficiency in content and that follow-up, support systems, and monitoring are integral to ensure success.

IMPLEMENTING PARTNERS AND LINKAGES
SIFPSA entered into project agreements with apex organizations, such as the PHD Family Welfare Foundation; the Rampur Chamber of Commerce; FICCI; Uttar Pradesh Industrial Estate Manufacturers Association; and the Employees State Insurance Scheme Directorate. Project partners also included private organizations, such as the Giant Group/Noida, and the trusts of private corporations. The prominent trusts included the Amin...
The IFPS Project’s support of the Jan Sewa Trust of Indo Gulf Fertilizers and Chemical Limited illustrates the full range of activities carried out in the organized sector. The intervention initially encompassed 25 villages of Jamo Block of Sultanpur District covering a population of 72,838 people. It involved identifying factory workers who could generate awareness about family planning and distribute contraceptives among their colleagues. They also organized audio-visual shows and discussions with other workers to raise awareness of family welfare concerns during lunch breaks. Indo Gulf used the cable network within the townships to display messages on family welfare. Contraceptive supplies were made available weekly outside the factory gates, which introduced workers to social marketing products. Indo Gulf workers could avail the corporate clinics and hospital facilities to obtain clinical RCH services.

To extend the reach of RCH services into communities, Indo Gulf established six maternal and child health clinics. Gradually, family planning services were added. CBD workers were selected and trained to raise awareness of RCH issues in the community and to work in conjunction with the ANMs and other medical staff in local facilities. They referred clients for clinical family planning methods and immunizations to project facilities and periodic RCH camps. Indo Gulf also began partnering with social marketing efforts to provide oral pills, condoms, IFA tablets, and other supplies that CBD workers could sell—thereby enabling the workers to earn a bit of additional money. Moreover, introduction of social marketing products enabled the project to deposit monies from sale of products into a corpus fund that was used to extend activities through CBD workers.

The final phases of the project are designed to increase access to clinical methods, respond to unmet demand for sterilization, use the available infrastructure to build a sustainable village-based family welfare program, and foster community ownership. Project staff include one lady medical officer and seven community health visitors, in addition to 190 CBD workers. The medical staff have been equipped with a range of supplies, instruments, and transportation needed to fulfill their responsibilities. Indo Gulf also provided access to its corporate hospital, which is fully staffed by the corporation with highly qualified doctors. It now provides 90 percent of its services to the surrounding community, with the remaining 10 percent devoted to the corporate employees. Because Indo Gulf has a vested interest in ensuring that its corporate name is not tarnished, services are of the highest quality and appropriate follow-up is provided for all family planning services.

While not without its share of difficulties associated with providing outreach and information to large, rural, and remote communities within a short period of time (two-year project cycle), the Indo Gulf project has been largely successful. The evaluation of the Phase II expansion project in Jamo Block showed achievement of the indicators as presented below.

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>TARGET</th>
<th>ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase CPR by 10 points from base of 12.3%</td>
<td>22.3%</td>
<td>22%</td>
</tr>
<tr>
<td>Sustain existing family planning users</td>
<td>--</td>
<td>55% sustained</td>
</tr>
<tr>
<td>Supply CSM brands to existing users</td>
<td>40%</td>
<td>30% (condoms); 50% (pills)</td>
</tr>
<tr>
<td>Provide antenatal care to women</td>
<td>80%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Ensure TT coverage (two doses) among pregnant women</td>
<td>80%</td>
<td>71.3%</td>
</tr>
<tr>
<td>Provide complete immunization of infants 0-1*</td>
<td>85%</td>
<td>54.0%</td>
</tr>
<tr>
<td>Provide complete immunization of children ages 1-5*</td>
<td>60%</td>
<td>57.0%</td>
</tr>
</tbody>
</table>

*Immunization efforts were hampered by lack of availability of vaccines.

Source: Indian Institute of Health Management Research, 2004a
Welfare Trust (Super Tanneries), Star Paper Mills Welfare Trust, Indo Gulf Fertilizer and Chemical Limited’s Jan Sewa Trust, and Indian Farmers Fertilizer Cooperative’s (IFFCO) Aonla Jan Kalyan Samiti.

Once the partnerships were formed with the corporate entities, project activities involved linkages with other aspects of the IFPS Project. First, private-sector interventions were typically identified as part of the district action planning process. Therefore, the PMU, through the District Innovations in Family Planning Services Project Agency (DIFPSA), played a critical role in monitoring activities and in providing a link with public-sector initiatives and service delivery options in the district. CBD workers also worked in close coordination with the public-sector auxiliary nurse midwives (ANMs) whenever possible so as to foster cooperation rather than competition in encouraging clients to use RCH services. In projects without a direct link to a corporation-owned hospital or clinic, cooperation with public-sector service provision in static facilities, including RCH camps, was essential for clinical service provision.

Project directors also had to coordinate with the social marketing component to ensure regular supplies of commodities for CBD workers and others to distribute as part of the doorstep delivery system. PPRC, the apex training organization, provided training and technical assistance for CBD workers, project coordinators and supervisors, and others involved with organized-sector interventions. Finally, some organized-sector projects also made use of IFPS-supported information, education, and communication (IEC) efforts, including folk performances and leafleting in selected project areas.

SIFPSA prepared a detailed NGO Manual that describes systems, policies, procedures, and norms for private-sector projects (SIFPSA, 2003b). The manual documents the process of NGO selection, steps in developing project proposals, programmatic and budgetary norms, the project management cycle, monitoring and evaluation at various levels, audits, and financial accounting requirements. The manual includes annexes containing sample forms, sample proposal formats, guidelines and checklists, and policies. The NGO Manual is an invaluable resource and model for any future work involving nongovernmental partners.

**MONITORING AND EVALUATION**

Private-sector projects had specific indicators for achievement, a designated monetary value, and limited timeframe; therefore, monitoring was integral to successful completion of individual projects. Monitoring and evaluation occurred at several levels:

- Each project was monitored by the project director, project coordinators and their assistants, and supervisors, with position-specific guidelines prepared for their overall responsibilities, including monitoring of progress. PPRC submitted a monitoring report on the training it conducted as
CBD workers conducted a baseline survey of eligible couples in their respective areas and recorded service statistics as clients were visited. Data were collated monthly and sent to the PMU. The PMU monitored project implementation through monthly meetings to review progress and identify and remedy problems. The PMU collected project MIS data and forwarded them to SIFPSA.

SIFPSA monitored project implementation through periodic field visits and use of checklists at different stages of implementation. SIFPSA also measured progress toward program objectives through analysis of data collected on indicators of interest, such as number of clients of various family planning methods.

Upon completion of each project period, each project prepared a final report. Additionally, an external agency carried out an independent evaluation to measure the project’s progress against program objectives. Projects rated satisfactory could be extended.

**RESULTS**

Overall, organized-sector interventions funded by IFPS covered about 1.2 million people, or about 5 percent of the people covered by all private-sector projects (SIFPSA, 2003a). Disaggregated impact data for the organized-sector projects are not available. However, data for all private-sector projects indicate that the CPR was higher in project areas covered by CBD workers than in project areas without CBD workers. RCH indicators were likewise higher.

Performance of the organized sector as a separate entity can only be assessed on a case-by-case basis. Of the 21 organized-sector projects funded by IFPS, 15 showed satisfactory achievement of project objectives, as measured through indicators specified in terms of increases in CPR, number of acceptors, and uptake of other RCH services. Reasons for lack of success with some projects in the organized sector stemmed from the short timeframe to demonstrate impact; lack of sustained interest on the part of corporate partners, especially as they learned some of the difficulties associated with implementation of RCH activities; problems associated with generating demand for services that could not be fulfilled in inadequately staffed and equipped public-sector facilities; staff turnover; and difficulties in accessing areas because of the difficulty of the terrain.

However, when SIFPSA teamed with the “right” corporate entities, overall results and individual project models clearly demonstrated that well-run and resourced projects could be successfully implemented and have an impact on improving RCH indicators in the project areas.

**LESSONS LEARNED**

As increased industrialization occurs in Uttar Pradesh and corporate social responsibility begins to gain a foothold, there is potential for creating increased opportunities for
public-private partnerships in the delivery of RCH services. The IFPS Project now has several successful models to its credit to help induce other corporations to become more involved in family welfare activities. IFPS-II will now place increased emphasis on building public-private partnerships to foster improved RCH service provision.

Many of the lessons learned associated with use of CBD workers are discussed earlier (see Chapter 8). Project activities with the organized sector suggest the following additional lessons:

- Selecting partners that are interested in and committed to family welfare issues is necessary to ensure that they devote appropriate management and resources to project activities. Managing and supporting RCH project activities requires a lot of dedication and support, in terms of both human and financial resources. Without project funds, many corporate entities would be unable to continue their program support as the costs are too great for a single company to undertake. Lack of qualified and committed corporate-sector partners was a major constraint to further program expansion in this area under IFPS. One of SIFPSA’s greatest difficulties was in finding appropriate partners to implement the program. There are a limited number of partners with corporate commitment to promoting RCH, and the few that exist and are participating cover only limited geographic areas. SIFPSA is now making a concerted effort with DIFPSAs and District Magistrates to compile a comprehensive list of prospective private-sector and factory- and industry-based partners.

- Even with strong private-sector projects in selected districts, the private sector cannot work in the absence of a strong public-sector health infrastructure. Gaps in public-sector service provision—in terms of staff availability, quality of facilities, and supply of vaccines and commodities—can hinder successful referrals by CBD workers or trained factory workers. For example, when women referred by CBD workers are unable to obtain the desired service because the doctor or ANM is absent that day or because the site is out of supplies (e.g., measles vaccine), they may be less likely to make a second trip.

- Some of the more successful project models with the organized sector occurred when clients were able to partake of services in clinics and other facilities managed by the corporate entity itself, or in facilities staffed by private medical staff, such as lady medical officers funded by the project to provide services in outreach clinics. The clinical service delivery model—pairing with a privately owned and operated hospital and/or providing services through outreach clinics with project-supported staff—seemed to provide best coverage and uptake of services. In such cases, the corporate entity has an incentive to provide high-quality services as the corporation’s reputation is at stake.
REFERENCES


DAI TRAINING: Improving Delivery Assistance in Rural Areas

By Anita Bhuyan

RATIONALE

When the IFPS Project began efforts to train traditional birth attendants (TBAs) or dais in 1997/98, Uttar Pradesh had the highest maternal mortality ratio (MMR) in India; the vast majority of deliveries were at home; and women lacked access to antenatal care. Uttar Pradesh’s MMR of 707 in 1998 was far above the national average for India, which stood at 407 maternal deaths per 100,000 live births (Office of the Registrar General, 1999). Moreover, for each woman who dies of pregnancy-related complications, another 20–30 will suffer short- and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease.

The 1998/99 National Family Health Survey (NFHS-2) found that 84 percent of deliveries were at home and that more than one-third of births (34.6%) were assisted by TBAs, while only about 14 percent were assisted by doctors and about 8 percent by auxiliary nurse midwives (ANMs), nurses, midwives, or lady health visitors (International Institute for Population Sciences [IIPS] and ORC Macro, 2000). Access to antenatal check-ups in Uttar Pradesh was limited, with nearly two-thirds (64%) of women who had given birth in the three years preceding the NFHS-2 reporting that they had no antenatal check-ups during pregnancy.

Many maternal deaths and disabilities can be prevented by improving access to emergency obstetric services and family planning (which reduces the number of unplanned pregnancies). Given the unpredictable and sudden nature of some pregnancy-related complications, increasing the number of institutional births assisted by trained health personnel is essential for significantly reducing maternal mortality across India. Increasing institutional births can also help reduce neonatal mortality. Uttar Pradesh’s estimated infant mortality rate in 2003 stood at 76, above India’s infant mortality rate of 60 (Office of the Registrar General, 2005).

However, for both cultural reasons and limitations within the health system, there is a preference for having deliveries at home. According to the 2003 Reproductive Health Indicator Survey (RHIS), four out of five deliveries (79.4%) still took place at home, with the rest of the deliveries taking place at a public health facility (7.4%) or private health facility (13.2%) (see Box 1). Only one-quarter of pregnant
women reported receiving no antenatal check-up (25.8%) in 2003, a significant improvement. At the same time, TBAs remained the major source of assistance at the time of delivery, with more than half of deliveries being attended by trained (14.1%) or untrained (38.6%) TBAs across Uttar Pradesh.

While institutional births must be encouraged, policymakers and program planners faced the challenge of improving the quality of care pregnant women receive at home and at the time of delivery, particularly in rural areas. It was believed, during the early phases of the IFPS Project, that training dais could help reduce maternal mortality. USAID discontinued funding for dai training in 2003/04 as studies by the World Health Organization showed that such training did not significantly reduce maternal mortality.

**OBJECTIVES**
Recognizing the need to take immediate steps to help improve maternal and child health in the interim, and given the reality that the majority of births continue to be delivered in the home, the IFPS Project designed a program to train dais. The primary objectives of the training were to equip dais to:

- Conduct deliveries under hygienic conditions using the “five cleans” principle (e.g., clean surface, clean hands, clean blade, clean cord tie, and clean clothes);
- Identify danger signs early and refer high-risk pregnant women to ANMs;
- Promote birth spacing and family planning;
- Counsel on the importance of seeking antenatal care and postnatal care; and
- Encourage institutional births.

**INTERVENTION COMPONENTS**

**A Three-tiered Training Approach**
One aspect that marked a difference between the IFPS approach and previous training efforts targeting TBAs is that it utilized collaboration between the public sector and NGOs (SIFPSA, 2003). The training approach operated on three tiers and involved both the public health system and NGOs. The process was as follows: 1) a nodal training center trained NGO and public health sector master trainers; 2) master trainers trained the public

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**BOX 1**

<table>
<thead>
<tr>
<th>2003 Reproductive Health Indicator Survey: Uttar Pradesh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Source of Antenatal Check-ups During Pregnancy:</strong></td>
</tr>
<tr>
<td>No antenatal check-up</td>
</tr>
<tr>
<td>Doctor</td>
</tr>
<tr>
<td>ANM, nurse, or lady health visitor</td>
</tr>
<tr>
<td>Indigenous systems of medicine practitioners (ISMPs)</td>
</tr>
<tr>
<td>Dai / traditional birth attendant</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td><strong>Place of delivery:</strong></td>
</tr>
<tr>
<td>Home</td>
</tr>
<tr>
<td>Public health facility</td>
</tr>
<tr>
<td>Private health facility</td>
</tr>
<tr>
<td><strong>Assistance during delivery:</strong></td>
</tr>
<tr>
<td>Any health professional</td>
</tr>
<tr>
<td>Trained dai</td>
</tr>
<tr>
<td>Untrained dai</td>
</tr>
<tr>
<td>Relatives/friends/others</td>
</tr>
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<td>None</td>
</tr>
</tbody>
</table>
health sector ANMs as lead trainers and other ANMs in the area; and 3) the ANM lead trainers conducted the dai training and the other ANMs in the area provided supervision and follow-up of the dais. The curriculum for training of the dais was covered in six days; for the ANM lead trainers in five days; and for the ANMs who follow-up with the dais in four days.

The dai training encompassed topics such as identifying pregnant women, conducting safe deliveries, implementing the five cleans, knowing when to refer high-risk pregnancies to the ANM or hospital, encouraging antenatal and postnatal care along with ANMs, promoting family planning, and keeping records of deliveries and services provided in a pictorial book. Dais are generally low caste, married women over the age of 25. Because the dai is typically an illiterate village woman, efforts were made to keep record-keeping to a minimum and were completed in pictorial form. By utilizing the ANMs as trainers of the dais a conscious effort was made to use the training process to begin strengthening the ANM-dai relationship, because it is this link that was critical for ensuring greater access to reproductive and child health (RCH) services.

After completing the training, the dai received an identity card with her picture on it signed by the district’s Chief Medical Officer (CMO), a nameplate to display outside her home, 10 subsidized disposable delivery kits, and a record-keeping book. This recognition was provided to help raise the status and acceptability of the trained dai in the community.

**Selection Criteria and Process**

Another aspect that was unique to the IFPS approach was the selection criteria and process for determining which dais to train. The selection criteria were that the women should be experienced, practicing dais (e.g., assisted five deliveries in the past year); they are willing to assist in all phases, including both delivery and cord cutting; and they are generally accepted by the community.

Block mapping exercises were conducted to identify potential trainees; meetings were also held at the community level with village pradhans and female members of panchayats or other village committees to gather their feedback. An attempt was made to select and train one dai per village in the project area, with the ultimate goal of having one trained dai per 1,000 population. Where there was no other availability, newer dais were selected from the village or an additional dai may be trained from a neighboring village.

**Coverage and Scope of the Training**

Following the IFPS Project’s general approach of designing and testing a model before wider scale up, a pilot project on performance-based TBA training was undertaken in 1997–1998 in Rampur District and selected blocks in Agra and Sitapur Districts. Based on an external evaluation (Macro International and ACNielsen, 1999), the dai training was found to have exceeded its

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1 Dai training was supported only in revenue villages.
project performance indicators and was extended to other districts. Recommendations were also incorporated from the “End Term Review Report of PRIME’s Technical Assistance on Performance-based TBA Training Project” (Ganguly Thukral et al., 1999). This review identified areas for improvement regarding the training curriculum, the selection of trainers, the articulation of roles and responsibilities, and the need for greater emphasis on pre-training preparation and post-training follow-up.

Table 1 presents the year-wise and district-wise number of dais trained under the IFPS Project from 1998/99 to 2003/04. USAID discontinued funding for dai training in 2003/04. Overall, 17 districts conducted dai training during this period, resulting in 22,064 dais being trained. This means that nearly half of the villages in IFPS districts had one dai trained under the IFPS Project.

### IMPLEMENTING PARTNERS

#### Roles

As mentioned above, the dai training involved a partnership between NGOs and the public health sector. SIFPSA approached Intrah/PRIME, an international technical assistance agency, to develop a model for a performance-based TBA training program. SIFPSA and Intrah/PRIME selected Prerana Population Resource Center (PPRC) as the nodal training agency, which was strengthened to enable it to serve as the implementing agency for the overall training project. Particular areas of strengthening included curriculum development, adult learning techniques, pre- and post-

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**TABLE 1. DISTRICT-WISE TRAINING OF TBAs, 1998/99–2003/04**

<table>
<thead>
<tr>
<th></th>
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<td>3,318</td>
<td>6,407</td>
<td>7,432</td>
<td>22,064</td>
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</table>

Source: SIFPSA Public Sector Data
test evaluations, and documentation and management information systems. A consultative process led by PPRC and Intrah/PRIME resulted in the curricula and training package, which included the master and lead trainer training manual, the dai training manual, and training and job aides, including flash cards. Assessment tools and checklists were also developed for each tier. It was the role of PPRC to train the master trainers, usually six individuals from the district-level NGO and two individuals from the public health system (e.g., a lady health visitor, a medical officer in-charge) selected by the CMO. These master trainers trained the ANM lead trainers and other ANMs in the area, drawn from the public health sector and selected by the CMO or Deputy CMO.

PPRC, NGOs, and staff from the CMO’s office and the District Innovations in Family Planning Services Project Agency (DIFPSA) worked together to implement the program at the district level. PPRC conducted an orientation with all key stakeholders in the district. NGOs, along with ANMs and other district health staff, carried out the block mapping exercise to identify dais for training. They also met with community leaders to gain their support and solicit feedback on the dais to be trained. The public health system generally provided the training venue, such as a primary health center, so that the dais could see institutional deliveries take place and become more comfortable referring cases to the center. The CMO’s office ensured the supply of training materials. The CMO’s office also provided for the subsidized disposable delivery kits and social marketing commodities that dais receive through the ANMs. At the district level, an NGO was selected as the implementing agency responsible for training the ANMs and supporting the dai training.

**Linkages to Other IFPS Interventions**

Dais provide a link between the public health system and clients at the village level. The dais can serve as a resource for the clients, ANMs, and community-based distribution (CBD) workers. They are trained to identify pregnant women early on (as dais were often called just at the time of delivery) and register them with the ANM, who calls the woman to the subcenter for tetanus toxoid (TT) immunization and provision of iron and folic acid (IFA) supplements. As one ANM is generally responsible for serving a surrounding population of about 5,000–7,500, it is helpful for her to have a presence in each village through the dais. The dais have also been trained in family planning and help distribute commodities—after the clients have registered with the ANM and received their initial supply. An assessment of the IFPS Project noted that an “external review found evidence of increased tetanus toxoid [immunization] and increased use of postpartum family planning among clients of trained TBAs” (LTG Associates, Inc. and TvT Global Health and Development Strategies, 2003, p. 7). Dais have also been found to generate clients for the IFPS-supported RCH camps by referring clients for sterilizations and other services and even accompanying them to the camps.
Dai Training in Two Districts: Kanpur Dehat and Kanpur Nagar

Kanpur Dehat is known as the only “100% rural” district in India, while Kanpur Nagar is Uttar Pradesh’s second most populous district with more than 4 million inhabitants in 2001. The Association for the Prevention of Blindness was responsible for the dai training in both districts.

Kanpur Dehat is composed of 10 blocks and has a population of about 1.58 million. In each block, master trainers from the Association trained six ANM lead trainers and 28 ANMs in the area who provided supervision and follow-up of the dais. There is agreement among the trainers, ANMs, and dais that the skills and role of the dais have increased due to the training, though all note that refresher training is needed. An ANM who has been working with dais for 10 years reported that the skills of the dais have improved in every way, including timely referrals, identifying the five cleans, and supporting family planning and newborn care. A trained dai said that she registers the pregnant women with the ANM and then visits the women each week. After the first birth, she counsels for spacing and after the third birth she provides information on sterilization. Another thing she has learned is not to clean the delivery room with cow dung as she used to do. She is proud to show her identity card that proves she has been trained.

In neighboring Kanpur Nagar, a group of dais who had accompanied their clients to an RCH camp said that the training, completed in 2002–2003, helped them perform various tasks. They can now recognize the warning signals of complications and refer cases. If complications arise, relatives arrange for transportation and the dai accompanies the woman to the district hospital or private nursing home. Each dai covers up to a 5 km radius and travels either on foot or by the client’s vehicle. The dais are not paid by the government or by NGOs and do not charge for their services—they rely on the clients to give what they can, which may be monetary or in the form of food, such as wheat or rice. The dais said that they would like a regular salary as well as additional training, for example, on giving immunization injections. Some younger dais said they would also like literacy training.

NGO and DIFPSA staff reported that the skills of trained dais have improved and have helped to increase the number of referrals of complicated cases, mother and child immunizations, referrals to RCH camps, and use of family planning. They believe that dais must continue to have a role by serving as a link between clients and the public health system. Two areas of improvement were identified: 1) the need for refresher courses, particularly to reinforce knowledge among the illiterate dais; and 2) the need to improve the relationship between dais and ANMs, since some ANMs may not be using the dais to the fullest potential and may not be providing enough supervision.

Dais and ANMs attend an RCH camp with their clients in Kanpur Nagar
RESULTS
IFPS supported training of about 22,000 dais—which means that approximately half of the villages in the project districts had at least one dai trained under IFPS. Survey data for the IFPS districts indicate 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 (see Chapter 20). 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. Therefore, reducing maternal mortality requires comprehensive programs to increase access to emergency obstetric care in rural areas.

The dai training project involved assessments and checklists for evaluating the performance of each aspect of the training initiative, from the nodal training center to the trainers to the dais themselves. Knowledge and skills of the dais were assessed following training and these results were shared with the CMO, medical officer in-charge, DIFPSA, and SIFPSA. At a three-month follow-up, the ANM administered a nine-point checklist that covers knowledge of high-risk factors and signs of complications, antenatal care, and where clients should go to obtain family planning methods. A dai is considered to be performing to standard if she received at least eight out of nine marks.

Available quantitative data from external evaluations of the dai training are summarized below.

- Before expanding the dai training, USAID and SIFPSA commissioned an evaluation of the pilot training program. Macro International and ACNielsen (1999) conducted a survey of a sample of 300 trained dais in Agra and Sitapur Districts to assess the proportion who were providing family planning methods and had correct knowledge of all five items relating to method use. The assessment also measured the proportion who responded correctly to all six items relating to identifying high-risk pregnancies. Baseline data on the dais’ knowledge level comes from a pre-training skills assessment of 1,202 dais who participated in the training course. The trainings occurred in the last half of 1998 and the assessment was conducted during May–June 1999. In total, 262 dais completed the surveys.

The evaluation found that the training far exceeded the expected project performance indicators. The proportion of dais providing family planning and correct technical advice on method use increased from 4.2 percent before training to 27.9 percent after training. The proportion of dais who could correctly identify high-risk pregnancies increased from 10.7 percent to 52.6 percent. These results show great progress. However, they also reveal the limits of a one-time training—for
example, the proportion of dais who could identify high-risk pregnancies had increased by five times, yet still half of the dais going through the training could not correctly identify all of the signs of high-risk pregnancies.

- An assessment of the dais’ taking part in the pilot training was also included as part of Intrah/PRIME’s end-term review (Ganguly Thukral et al., 1999). The findings presented in Table 2 highlight one of the inherent challenges of training dais, particularly if the approach is to train one dai per village. Responsibilities during childbirth, especially in Hindu communities in Northern India, are based on caste divisions. Most dais are low caste women, yet the responsibility of cutting the cord—viewed as the most polluting part of the process—is done by the lowest caste dais. Higher caste dais and Muslim dais typically do not want to cut the cord, while the lowest caste dais are not generally allowed by the family to be involved in other aspects of the delivery. In such a context, it is a challenge to select a dai that is willing to do each aspect; and, even if she is willing, the dai may not be allowed by the family to practice or use all of the skills and services for which she has been trained. While dais interviewed during field visits reported that caste was not a barrier that limited their work, this perception did not match with the reports of NGO workers and the external evaluation. As shown in the summary below, about 70 percent of dais took part in both the delivery and cord cutting.

- Results of an assessment of trained dais as of May 2001 were presented in an external evaluation of IFPS by the POLICY Project (2001). The assessment provides information on the number of dais trained and receiving a satisfactory result in the seven districts that had initiated dai training by that time (see Table 3). In this case, a dai received a satisfactory result if she received 100 percent in each of the three post-tests administered to her (covering knowledge, hand washing, and cord cutting). According to this assessment, 97.5 percent

| TABLE 2. SUMMARY OF DAIS TAKING PART IN THE PILOT TRAINING IN AGRA, RAMPUR, AND SITAPUR DISTRICTS, 1999 |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| District        | No. of Trained Dais | Literacy | Used Disposable Delivery Kits | Type of Delivery Conducted | Meet During Antenatal Period |
|                 |                  | Literate | Illiterate | Yes | No | Delivery Only | Cord Cut Only | Both | Yes | No |
| Agra            | 600              | 56      | 544        | 94  | 506 | 123           | 199           | 278  | 270 | 330 |
| Rampur          | 891              | 65      | 826        | 165 | 726 | 30            | 30            | 831  | 593 | 298 |
| Sitapur         | 600              | 48      | 552        | 168 | 432 | 120           | 78            | 402  | 380 | 220 |
| Total           | 2,091            | 169     | 1,922      | 427 | 1,664 | 273          | 307          | 1,511 | 1,243 | 848 |

Source: Ganguly Thukral et al., 1999.
With the end of technical assistance support for the project, gathering current systematic data and monitoring the performance of the trained dais on a wide scale has been a challenge, according to NGO and DIFPSA staff. The primary responsibility for supervising the dais rests with the ANMs, who are responsible for a range of services, not simply those related to dais or even to RCH services in general. In this context, the amount of time and the frequency with which an ANM meets with the dais she supervises ranges from block-to-block and district-to-district. Refresher courses for dais have not been developed or supported under the IFPS Project so any responsibility for correcting the dais’ knowledge if deficiencies are found would rest primarily with the individual ANMs.

**LESSONS LEARNED**

Questions have been raised about the value and effectiveness of training TBAs given the perceived failure of such training to affect maternal mortality ratios. While the immediate goals of the IFPS-supported dai training were to promote hygienic conditions at the time of delivery, improve identification of complications, increase referrals of high-risk cases earlier in the pregnancy, and promote family planning, a long-term objective would be to reduce maternal mortality. At the district level in Uttar Pradesh, trainers, program implementers, and dais themselves reported that the IFPS-supported training of TBAs has made a difference in terms of the quality of care provided to pregnant women. Dais are better able to refer complicated cases, promote family planning, and follow hygienic guidelines. With the majority of deliveries taking place in the home and some women lacking access to antenatal check-ups, dais often remain the pregnant woman’s only link to the public health system.

However, particularly given the unpredictable and sudden nature of pregnancy-related complications, even a trained TBA is not a substitute for having access to high-quality emergency obstetric care and skilled health professionals. Furthermore, that most dais are illiterate makes upgrading and maintaining their skills a labor-intensive endeavor. NGOs report that while training in itself has succeeded in improving dais’ knowledge and skills, it is not possible for dai training to have a greater impact on reducing maternal mortality without a more comprehensive approach for mentoring dais and ensuring community access to emergency obstetric care.

“In every aspect, there has been a great change in the dais’ performance. They can refer cases in a timely manner, identify the five cleans, provide breastfeeding counseling, and support newborn care.”

—ANM, Kanpur Dehat

<table>
<thead>
<tr>
<th>District</th>
<th>No. of Dais Assessed</th>
<th>No. of Dais with a Satisfactory Result</th>
<th>Percent with a Satisfactory Result</th>
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</tr>
<tr>
<td>Meerut</td>
<td>559</td>
<td>542</td>
<td>96.9</td>
</tr>
<tr>
<td>Moradabad</td>
<td>30</td>
<td>30</td>
<td>100.0</td>
</tr>
<tr>
<td>Rampur</td>
<td>891</td>
<td>890</td>
<td>99.8</td>
</tr>
<tr>
<td>Shahjahanpur</td>
<td>735</td>
<td>735</td>
<td>100.0</td>
</tr>
<tr>
<td>Sitapur</td>
<td>1,083</td>
<td>991</td>
<td>91.5</td>
</tr>
<tr>
<td>Sultanpur</td>
<td>177</td>
<td>177</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>4,635</td>
<td>4,519</td>
<td>97.5</td>
</tr>
</tbody>
</table>

Source: POLICY, 2001
The IFPS Project’s dai training intervention faced many of the challenges and limitations that confront any project working with the public health system of a developing country—for example, a lack of consistent, steady supplies of delivery kits; a limited number of ANMs to cover the population size; and weak primary health facilities. Several specific challenges and recommendations, based on the pilot test, are contained in the Intrah/PRIME end-term review (Ganguly Thukral et al., 1999) and are not recounted here. Three key challenges, as evidenced by the field visits, interviews, and the document review, are discussed below.

**Linking Knowledge and Skills with Motivation and Support**

Assessments and checklists have been put in place to evaluate whether dais are performing to standard. Available data, both quantitative and qualitative, suggest that the training has improved the dais’ knowledge and skills. In terms of qualitative feedback, ANMs and NGO and DIFPSA staff agree that the skills, role, and status of dais have improved. Dais themselves report being able to perform their tasks better and having a higher status and greater acceptance within the community.

However, the implementing organizations at the district level found that there was little motivation and support provided after the training component ended. Dais are a link to the public health system, but they are not an integrated part of the system. They do not receive a salary, so they are essentially volunteers except for what is given by clients. The supervision and mentoring of dais are the responsibility of ANMs, who themselves are generally overworked, limited in number given the population size, and may lack the proper skills or motivation to provide proper supervision. Even though dais report that they would like additional training, no refresher training was offered by the project.

**Changing Community Practices**

Intrah/PRIME’s review of the pilot program reports that “the performance of the TBAs is governed not just by her skills, but also by the tasks she is allowed to perform in the community and how much weight her opinion carries” (Ganguly Thukral et al., 1999, p. 33). The review identified caste divisions as an issue both in terms of selecting the dais to be trained and also affecting the extent to which the trained dai can then use her skills. Other community beliefs will also be slow to change, such as when to cut the umbilical cord, when to remove the vernix from the newborn, and how best to support the nutrition of the mother.

Sufficient preparatory work is needed within the community to gain support for the program and for any new techniques that the dai may suggest. This involves the need to work at a variety of levels to increase knowledge and support not only of families, but also of key opinion leaders. Given this need, SIFPSA sought NGO partners who were knowledgeable of and respected in the project area communities. However, certain societal obstacles, such as significantly challenging caste...
divisions of labor, remain out of the scope of the NGOs' work. It was incumbent on the NGOs, in these cases, to work with community leadership structures to select dais that would be most accepted.

Integrating Dai Training within a Broader Safe Motherhood Program
The dais operate in a context that hinders their ability to refer complicated cases—which is essential for reducing maternal mortality. In some cases, a dai may refer a case to the district hospital, but the patient is not accepted because the doctors do not want to take responsibility for complicated cases—in such cases it is easier to have the blame for the woman’s death fall to the dai. In other cases, a dai may recognize warning signs of complications yet no transportation is available in the village or the nearest district hospital may be a two-hour drive away. Efforts must focus on strengthened, accessible health facilities and increased access to emergency obstetric care. Primary health centers and district hospitals must accept the referrals from dais and should have the staff, training, and logistical support needed to respond to complicated cases. As frontline health workers, ANMs must also be trained and be legally allowed to do procedures that can assist in managing complicated cases.

Despite the limitations noted above, the consensus among state- and district-level staff interviewed as part of this documentation project is that dai training must be supported given the reality that most births in Uttar Pradesh will continue to be delivered in the home. They also suggest that this training should not be isolated or confined to a one-time activity; the training must be integrated within a broader initiative to improve safe motherhood and access to emergency obstetric care. Communities should mobilize in support of safe deliveries by developing “birth preparedness” plans. Several considerations must be taken into account to ensure that complications that arise during a home delivery are addressed effectively. Some key questions, for example, relate to how to transport the woman to the health facility: Is a vehicle available? Who will drive the vehicle? Is money on hand to hire a driver if needed? To address these and other issues, NGOs suggest, a birth preparedness plan is needed in advance that draws on resources and mobilizes the community to help dais and families anticipate and prepare for any complications that may arise.

BOX 2

Comprehensive Approach to Traditional Birth Attendant Training

“A recent meta-analysis of 60 studies showed that training traditional birth attendants was associated with significant improvements in performance and mortality [Sibley and Sipe, 2004]. Concerns about the cost effectiveness of training traditional birth attendants are legitimate where their coverage or workload is low. Nevertheless, they are often key providers of support and opinion in their communities. We believe that in countries where maternal mortality is high and use of traditional birth attendants is common, programmes should collaborate with them to promote reproductive health and hygiene, avoid delays in seeking care for complications, and perhaps to help with vital surveillance.”

Source: Costello et al., 2004, p. 1,168.
REFERENCES


CHAPTER 12

ISMP TRAINING:
Promoting Family Planning through Indigenous Systems of Medicine Practitioners

By Ruchira Gujral

RATIONALE

The training of indigenous systems of medicine practitioners (ISMPs) in non-clinical family planning counseling and services was one of the strategies adopted by the IFPS Project to satisfy unmet need for family planning. The ISMP training project was aimed at increasing the number of non-clinical service access points and, thereby, the volume of people accepting these services in Uttar Pradesh.

Uttar Pradesh has nearly 43,000 registered ISMPs comprising Unani, Ayurvedic, and Homeopathic medical practitioners. These practitioners are concentrated in villages, since most rural people seek health services from private ISMPs and allopathic (western medical) doctors (NCAER, 1992). Thus, ISMPs have a tremendous reach in the rural areas, and they are the main providers of outpatient health services for the rural populations.

The ISMPs are mostly men. Very few women are found among this group. These practitioners tend to serve villages that have between 500–2,000 inhabitants. More than one-third (37%) of the villages of this size have ISMPs (Levine et al., 1993), whereas only about 4 percent of such villages have government health subcenters.

The majority of ISMPs have had some kind of formal training in indigenous systems of medicine; only a few have had allopathic training. The remaining ISMPs learned their profession through passing down of family knowledge or by working in a related area such as a chemist’s shop.

The ISMPs generally practice a mixed system of medicine using techniques from indigenous and “western” systems. The typical ISMP in Uttar Pradesh practices a combination of ayurveda and allopathy. Most often they treat minor illnesses, infectious diseases, and some communicable diseases and handle basic healthcare, including maternal and child health (MCH) services. For serious illnesses and problems requiring treatment at secondary and tertiary facilities, ISMPs often refer patients to government institutions (Levine et al., 1993).

In 1993, a study conducted by the Social Research Institute and the OPTIONS Project found that 43 percent of practicing ISMPs were already providing some family planning services and that virtually all the rest were interested in providing such services (Levine et al., 1993). A great interest was also perceived among the ISMPs for receiving more training in family planning, since many
of them had never received any formal training. Even though family planning services are not a major source of income for the ISMPs, any additional training would raise their image in the community and consequently improve their practice.

Added to this was the easy accessibility of the practitioners due to their rural location; cultural familiarity and their knowledge of local customs; sensitivity to the non-medical demands and expectations of the patients; familiarity with the local language; and their willingness to provide services on credit when the patient urgently needs care but cannot afford to pay immediately.

OBJECTIVES
Realizing that these providers are a large and latent resource having the potential to improve access to family planning services, particularly condoms and oral pills, USAID and SIFPSA initiated a project on training ISMPs as family planning counselors and suppliers of non-clinical family planning methods.

The main objective of training ISMPs was to equip them with the correct knowledge of various family planning methods along with information about their appropriateness and suitability for various clients. This was to help them become the first point of contact in the community for provision of family planning information and services. The goal of the training was to enhance the knowledge and skills of the ISMPs in provision of quality family planning services, including counseling, particularly for condoms and oral contraceptives (see Box 1). Because spacing methods are non-surgical, it was also considered safe for ISMPs to counsel people on them. By enhancing ISMPs’ skills and making timely and ample supplies available through the ISMPs, it was felt that contraceptive use would increase.

INTERVENTION COMPONENTS
To support the technical aspects of the project, USAID and SIFPSA requested the PRIME project of Intrah, a USAID cooperating agency, to assist in a pilot effort and later in the expansion of this program. A detailed curriculum and training approach was developed through Intrah’s close collaboration with USAID, SIFPSA, and the two pilot implementing agencies. The program emphasized building strong counseling skills among these practitioners to assure informed choice by clients through an open and honest client-provider relationship. Gender-sensitive counseling and awareness of the negative consequences of high fertility on the health and well-being of mothers, children, and families formed an integral component of the training curriculum (Luoma et al., 2003). Box 2 presents the

### BOX 1

**Role of ISMPs Under the IFPS Project**

1. **Create awareness among individuals/couples about:**
   - a. Consequences of uncontrolled fertility on health and survival of mothers and children and quality of life
   - b. Fertility control measures
   - c. Prevention of sexually transmitted infections (STIs) including HIV
2. **Counsel individuals/couples about various family planning measures**
3. **Provide individuals/couples:**
   - a. Quality services for condoms and oral contraceptive pills
   - b. Referral services for intrauterine contraceptive devices (IUCDs), vasectomy and tubectomy, and for management of side effects/complications of condoms and oral contraceptive pills.
various steps and strategies adopted for the ISMP trainings.

The Phased Approach
In 1995, SIFPSA initiated two pilot projects in Sitapur and Jhansi districts in partnership with the Center for Development, Research, and Training (CFDRT) and the Indian Rural Medical Association (IRMA). Both two-year projects aimed at targeting 600 ISMPs each in the two districts. To properly plan for the trainings, training needs assessment surveys were conducted in these districts based on the tasks to be performed by the trainees and the knowledge, attitudes, and skills required to carry out the tasks efficiently and effectively. Assessment findings fed into the curriculum preparation for the training sessions prepared by PRIME/Intrah.

On successful completion of these two projects, the strategy was refined and scaled up. In 1996, SIFPSA awarded a new project to the Family Planning Association of India (FPAI) in Gorakhpur District. In 1997, SIFPSA initiated seven new projects with NGOs in the districts of Allahabad, Banda, Rampur, Shahjahanpur, Sultanpur, Tehri Garhwal (Uttaranchal), and Unnao. In 1998, SIFPSA initiated three projects in Aligarh, Moradabad, and Varanasi districts plus a second project in Rampur with a different implementing agency.

Based on the experiences from previous projects, the new projects had revised strategies and modifications in implementation. For example, the topic of family planning commodity marketing and sales was introduced into the ISMP training and follow-up support. It was hypothesized that if the ISMPs could sell condoms and oral contraceptive pills in the same way as their other medicines, the resulting monetary gains would serve as a self-sustaining mechanism.

A rapid assessment conducted in 1998 concluded that while the quality of family planning counseling was good when it occurred, the percentage of eligible clients being counseled was low. A performance needs assessment conducted in 1999 revealed that in addition to good training, ISMPs required additional encouragement to provide counseling, better access to family planning supplies, and better linkages to referral sites. These improvements formed a new strategy for training and supporting ISMPs (Luoma et al., 2003).

During 1999 and 2000, four more projects were initiated; only one of these was in a new district, Meerut. By the end of the year 2000, approximately 7,000 ISMPs had been trained under in 14 districts. Nine new projects were approved in 2001, and two new districts—Kanpur Nagar and Etawah—were added to the list. In 2002, two

### BOX 2

**ISMP Training Steps and Strategies**

- Preparation of training material and design of curriculum and management information system (MIS) by Intrah
- Identification of partner NGO in each district
- Appointment and training of project staff
- Baseline survey to identify ISMPs
- Training of identified practitioners by the project staff
- Regular follow-up for monitoring
- Refresher training program for trained ISMPs
projects were given extensions; these were the last projects to be granted. The last ISMP training project ended in January 2003 (see Table 1).

Training Components
A training curriculum development workshop was held at the Institute of Management Development, Lucknow, from July 24 to August

TABLE 1. ISMP TRAINING PROJECTS BY DISTRICT

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Agency</th>
<th>Start Date</th>
<th>End Date</th>
<th>Project Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Aligarh</td>
<td>Tibbiya College (Follow-up and Training)</td>
<td>March 2001</td>
<td>November 2002</td>
<td>18 Months</td>
</tr>
<tr>
<td>5.</td>
<td>Gorakhpur</td>
<td>FPAI (Training)</td>
<td>April 1996</td>
<td>May 1999</td>
<td>36 Months</td>
</tr>
<tr>
<td>6.</td>
<td>Gorakhpur</td>
<td>FPAI (Follow-up)</td>
<td>August 1999</td>
<td>August 2000</td>
<td>12 Months</td>
</tr>
<tr>
<td>11.</td>
<td>Meerut</td>
<td>Subharti Sewa Sansthan (Follow up)</td>
<td>March 2001</td>
<td>March 2002</td>
<td>12 Months</td>
</tr>
<tr>
<td>16.</td>
<td>Rampur</td>
<td>FPAI (Follow-up)</td>
<td>March 2001</td>
<td>March 2002</td>
<td>12 Months</td>
</tr>
<tr>
<td>17.</td>
<td>Rampur</td>
<td>IRMA (Training Project)</td>
<td>December 1997</td>
<td>December 2000</td>
<td>36 months</td>
</tr>
<tr>
<td>20.</td>
<td>Allahabad</td>
<td>Allahabad Agriculture Institute</td>
<td>March 1997</td>
<td>March 2000</td>
<td>36 months</td>
</tr>
<tr>
<td>21.</td>
<td>Sitapur</td>
<td>CFDRT</td>
<td>April 1995</td>
<td>February 1997</td>
<td>22 months</td>
</tr>
<tr>
<td>22.</td>
<td>Sitapur</td>
<td>SSESS (Follow-up)</td>
<td>August 1999</td>
<td>February 2000</td>
<td>6 Months</td>
</tr>
<tr>
<td>23.</td>
<td>Sitapur</td>
<td>SSESS (Follow-up)</td>
<td>March 2001</td>
<td>September 2001</td>
<td>6 Months</td>
</tr>
<tr>
<td>24.</td>
<td>Sitapur</td>
<td>SSESS (Follow-up)</td>
<td>January 2002</td>
<td>July 2002</td>
<td>6 Months</td>
</tr>
<tr>
<td>28.</td>
<td>Tehri Garwal</td>
<td>GCDWS (Follow-up)</td>
<td>November 1999</td>
<td>November 2000</td>
<td>12 Months</td>
</tr>
<tr>
<td>29.</td>
<td>Unnao</td>
<td>St. Catherine’s Hospital (Training)</td>
<td>February 1997</td>
<td>June 1999</td>
<td>27 months</td>
</tr>
<tr>
<td>31.</td>
<td>Varanasi</td>
<td>Department of Prasuti Tantra (Follow-up)</td>
<td>March 2001</td>
<td>September 2002</td>
<td>18 Months</td>
</tr>
</tbody>
</table>
1, 1995. The course outline, curriculum, mode of training, duration of training, time schedule, pedagogic tools, reference materials, evaluation system for the trainees, and recertification workshops for trainees were discussed and finalized. In addition, formats for certificates and their distribution, monitoring and follow-up of trainees, referral slips to maintain linkages with other agencies, type of faculty to be recruited, and the dates for conducting the training-of-trainers (TOT) workshop were decided.

A call for proposals was made for most districts and each of the proposals was submitted to the SIFPSA Project Appraisal Committee, which made the final decision regarding the projects to be allotted. Before the project activities were rolled out in any district, the entire project staff was trained. The project was based on the TOT approach. Intrah organized a six-day training session for the master trainers of the implementing NGOs before any training project began. Representatives from SIFPSA also participated in the trainings to monitor and observe the activity.

The contents covered during the training included topics such as fertility in Uttar Pradesh, impact of population growth, family planning methods with a focus on condoms and oral pills, side effects of family planning methods, counseling techniques, and issues related to HIV, STIs, and reproductive tract infections (RTIs). The various methods adopted for the training of these master trainers included classroom lectures, group discussions, demonstrations, presentations, charts, and role plays.

After the completion of the TOT, each NGO conducted a baseline survey in the project area to map out the registered ISMPs in all the blocks of the district. Through site visits, information regarding their address, timings, status of training, and areas of specialization was collected in the format prescribed by Intrah. Once the baseline survey was completed for a block, the training of the identified trainees started immediately. Therefore, in a district, while one block was already having the training sessions, another was still undergoing the mapping exercise, making it a simultaneous process (ORG Center for Social Research, 2003).

A series of four-day training sessions using Intrah’s training module were held for the ISMPs in batches of 20–25 each. All training sessions were held at the block level and enough sessions were organized in each of the blocks to ensure participation of all the interested ISMPs of the block.

To gauge the increase in the knowledge levels of the ISMPs, pre- and post-tests were administered on the first and the last day of the training, respectively. The successful trainees received certificates, name boards, a conference bag, referral slips, record sheets, handouts, self-addressed post cards, a supply of condoms and oral pills, and information, education, and communication (IEC) materials. In cases where ISMPs did not score a passing 65 percent on the post-test, they were requested to attend specific sessions of a subsequent
training to complete the process. An honorarium was paid to the practitioners to compensate for the loss of income in the four days of the training.

A refresher course was conducted for all the trained ISMPs six months after completion of their initial training. In the meanwhile, the NGO staff and the SIFPSA representatives made regular visits to their clinics to provide help and support.

IMPLEMENTING PARTNERS
Three organizations were responsible for various aspects of the management of the ISMP training project.

Intrah was responsible for preparing the resource materials, designing reporting formats, and conducting training sessions for master trainers of the NGOs. Additionally, a representative from Intrah was always present for any ISMP training being conducted in the various project districts.

SIFPSA’s role was pivotal right from the conceptualization of the project. All the processes related to the call for proposals, short-listing of prospective NGO partners, checking references, and then finally sanctioning the projects were handled by the SIFPSA secretariat. At every step of the way, SIFPSA was involved in all the activities as a monitor and facilitator. All matters pertaining to finance, monitoring and evaluation, administration, and impact assessment were SIFPSA’s responsibility. SIFPSA also played the important role of acting as a link between the private and public sectors. All interactions with Chief Medical Officers (CMOs), including obtaining clearances, were done by SIFPSA.

NGO partners’ project staff consisted of a project director, project coordinator, trainers, program assistants, accountant-cum-typist, and office attendant. While the project director was a senior NGO representative, a selection committee was formed to recruit the other staff. Activities carried out by this core team included planning, implementation, administration, consultation, follow-up and monitoring of trained ISMPs, and establishing linkages between trained ISMPs and government health functionaries at district/block/village levels.

Initial supplies of oral pills and condoms were provided to all the trained ISMPs immediately after the training programs. Thereafter, the supplies were provided during the monitoring visits and quarterly follow-up visits. Some NGOs purchased contraceptives such as condoms and oral pills from Hindustan Latex Limited, under the social marketing scheme. Information regarding the referral cases was collected during the monitoring visits as well.

MONITORING AND EVALUATION
During the course of the trainings, representatives of SIFPSA and Intrah were present to ensure the quality of the training. Pre- and post-tests were conducted on the first and last day of each training session to assess the level of increase in knowledge of the ISMPs. The trained ISMPs were also asked

“Even though I have done my diploma in Unani medicine, family planning as a component was never dealt with in much detail. But during our training, we not only got to know more about the subject, but also had some of our myths and misconceptions clarified.

My practice has not exactly boomed, but I have the satisfaction that I am providing the correct guidance to the people of my community. It would have been an additional help had we been personally introduced to the government health services, making our referral process smoother.”

—Trained ISMP, Rampur District
to fill out a feedback form about the entire process to ensure that the level of interest of the ISMPs was high during the trainings.

While SIFPSA played a key role in facilitating and supporting the implementation, ensuring that the trainings translated into increased contraceptive use was a major responsibility. Therefore, while ensuring the quality of training was important, ensuring that the trained ISMPs also use this skill and perform was the major challenge.

Follow-up Visits
The follow-up of trained ISMPs was carried out by the project coordinators and the trainers. These visits started between one to three months after the completion of training. Follow-up visits included job assessment in counseling skills and technical assistance for any queries or doubts. The trained ISMPs were encouraged to keep records of clients counseled and family planning services given. During these visits, the project staff observed counseling skills of trained ISMPs and also the information being provided by them to oral pills and condom users. (See Box 3.)

To cross-check the total number of patients as quoted by the ISMPs, visits were also made to their patients’ homes and they were asked about their level of satisfaction with the services received. While the NGO carries out these activities as part of their project management obligations, SIFPSA also undertook all these tasks independently to assess the level of impact of the trainings in the given block and the district.

Management Information System
To ensure uniformity and detail of reporting, Intrah prepared formats for the reporting system. For the NGOs, formats for submitting the quarterly reports were provided, which they needed to fill out and send to SIFPSA. All the pre- and post-test questionnaires, along with the feedback forms, were prepared and also provided in the training manuals. On completion of training, referral slips (see Figure 1) and recordkeeping sheets were given to the trained ISMPs for use once they began counseling clients. The NGOs also had a format for reporting the progress of each training session.

RESULTS
From 1995 to 2001, the IFPS Project supported training for 12,769 registered ISMPs based in 17 districts of Uttar Pradesh (see Table 2). Of the 12,162 trained ISMPs assessed post-training, 81 percent were performing to standard when assessed in general family planning counseling and method-specific counseling for oral contraceptive pills and condoms (PRIME II, 2006).

“In Gorakhpur, the community-based distribution project was already in progress, therefore locating and mapping the ISMPs was not a big problem. Six master trainers had been trained from our side and each training session was attended by representatives from SIFPSA, Intrah, and other representatives from FPAI.”

—Manager, FPAI, Lucknow

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### BOX 3

#### Checklist for Monitoring ISMPs

- The IEC material provided (e.g., name board and certificates have been displayed)
- Number of clients should average about 10 per month
- At least 10 cycles of oral contraceptive pills and 50 condoms are available at all times with the ISMP
- Number of referrals (IUFD/sterilization) done by referral cards signed/honored available at the primary health center (PHC)/community health center (CHC) and at the ISMP’s clinic
- Record maintenance by ISMPs

Source: SIFPSA
In 2003, the PRIME II project conducted a study on “ISMP Contraceptive Sales Motivation in India” to determine the impact of selling family planning commodities on the ISMPs' interest and willingness to provide family planning services. The results indicated that those ISMPs who sold socially marketed family planning commodities gained more clients than those who gave away free government supplies. The study concluded that the involvement of implementing agencies is important to enable the ISMPs to be successful in selling contraceptives (Luoma et al., 2003).

The ISMP training initiative was successful in tapping this latent resource and ensuring that any advice that ISMPs gave to their clients on family planning was correct and appropriate. ISMPs helped in correcting the myths and misconceptions about various methods of contraception and their correct usage. The training of ISMPs helped address fears, rumors, misconceptions, and concerns relating to methods, source of service, and quality of service, which often deter those who intend to use contraceptives from actually using them.

**LESSONS LEARNED**
The strategy of using the ISMPs—who are already an inherent part of the health service delivery systems of the rural and urban poor in Uttar Pradesh—was an innovative strategy of involving the private sector with the aim of increasing access to family planning. The project saw its share of successes and setbacks, and each experience

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TABLE 2. ISMPs Trained by District (Through 2001)

<table>
<thead>
<tr>
<th>No.</th>
<th>District</th>
<th>Total Trained Through May 2001</th>
</tr>
</thead>
<tbody>
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<td>Varanasi</td>
<td>1,800</td>
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<tr>
<td>2.</td>
<td>Unnao</td>
<td>534</td>
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<td>3.</td>
<td>Moradabad</td>
<td>900</td>
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<tr>
<td>4.</td>
<td>Gorakhpur</td>
<td>2,027</td>
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<tr>
<td>5.</td>
<td>Tehri Garhwal</td>
<td>210</td>
</tr>
<tr>
<td>6.</td>
<td>Allahabad</td>
<td>665</td>
</tr>
<tr>
<td>7.</td>
<td>Kausambi</td>
<td>124</td>
</tr>
<tr>
<td>8.</td>
<td>Aligarh</td>
<td>1,000</td>
</tr>
<tr>
<td>9.</td>
<td>Jhansi</td>
<td>600</td>
</tr>
<tr>
<td>10.</td>
<td>Rampur</td>
<td>615</td>
</tr>
<tr>
<td>11.</td>
<td>Banda</td>
<td>153</td>
</tr>
<tr>
<td>12.</td>
<td>Shahjahanpur</td>
<td>482</td>
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<tr>
<td>13.</td>
<td>Sitapur</td>
<td>545</td>
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<tr>
<td>14.</td>
<td>Meerut</td>
<td>1,500</td>
</tr>
<tr>
<td>15.</td>
<td>Sultanpur</td>
<td>750</td>
</tr>
<tr>
<td>16.</td>
<td>Etawah/Auraiya</td>
<td>564</td>
</tr>
<tr>
<td>17.</td>
<td>Kanpur Nagar</td>
<td>300</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>12,769</td>
</tr>
</tbody>
</table>

Source: ISMPs' Training Manual, Vol. 1, Intrah
was fed back into the system and contributed to making the future trainings more effective.

Success Factors
- The clear line of control and the limited size of the project staff resulted in a sense of ownership and a team spirit among Intrah, SIFPSA, and the implementing NGO partners.
- Baseline surveys carried out district-wise helped ensure that all registered ISMPs were approached at least once. It also helped map the client load of each of the ISMPs and, therefore, shed light on the health service utilization pattern of the block as well as the district.
- The pre- and post-tests were extremely useful in identifying the ISMPs who needed further training and, therefore, ensured that no sub-standard ISMP was certified.
- The certificate and name board given to ISMPs at the end of the training acted as additional credentials for them and had a positive impact on the number of clients accessing their services specifically for family planning counseling.
- The refresher training helped in addressing the knowledge gaps in the ISMPs and also helped answer their queries based on real-life experiences of dealing with clients.
- The training helped replace incorrect knowledge about family planning with correct information and ensured that ISMPs, who would anyway have continued practicing, do not misguide the people.

Challenges
- In some cases, the cooperation from the CHC/PHC staff was lukewarm and the services provided to referred patients and the access to free supplies of contraceptives were based purely on the personal relationship between the ISMPs or the NGOs and the CHC/PHC staff. Orientation workshops for local CHCs/PHCs with participation from the NGOs and the trained ISMPs of a district could help create and strengthen the linkages between them, making the referral process smooth and effective.
- The involvement of the community leaders and panchayat was limited, which could have contributed to the sustainability of the project (Jayakrishnan et al., 2000).
- Making the distinction between a good-quality and a poor-quality ISMP was very difficult. Even among the registered ISMPs, some were degree holders while others were diploma holders, and they had all been trained by various institutes. The ISMP strategy did not have the scope or tools for differentiating them based on their competencies.
- Follow-up and tracking mechanisms, though detailed, were not comprehensive enough to monitor all the trained ISMPs on the quantitative and qualitative indicators. Also the nomadic nature of ISMPs made long-term follow-up with them very challenging.
- Convincing the ISMPs to leave their practice for four days and ensuring that they attend the
entire training program proved to be an uphill task for many NGOs. The honorarium given to ISMPs was not equivalent to their earnings from a day’s practice.

- Inclusion of other services, such as routine immunization, to the family planning services would make the services of the ISMPs financially more sustainable. The ISMPs felt that the sale of contraceptives and condoms did not generate enough profits to sometimes even cover the cost of travel to procure them.

**REFERENCES**


## SOCIAL MARKETING AND COMMUNICATION CAMPAIGNS

Social Marketing: Expanding Access to Spacing Methods  
*Shuvi Sharma*

Behavior Change Communication: Reaching Diverse Audiences  
*Sona Sharma*

Tetanus Toxoid Campaigns: Reducing Neonatal and Maternal Mortality  
*Seema Talwar*
A major challenge for the IFPS Project was to reach out to millions of Uttar Pradesh residents who knew little about family planning/reproductive health (FP/RH), maternal healthcare, or child health services. Misinformation and rumors about contraceptives were common, and cultural norms—such as early marriage—contributed to elevated health risks for women and children. Accordingly, one of the objectives of the IFPS Project was to increase demand for and facilitate access to contraceptives through a vigorous information, education, and communication (IEC) campaign and social marketing program.

**BUDGET**
About 8 percent of the IFPS Project’s budget was allocated to IEC and social marketing projects. In addition, other programs had communication components. For example, training for public healthcare providers and community-based healthcare workers included interpersonal communication, counseling, and use of visual aids. Folk theater and music, exhibits at fairs, wall writing, video vans, and other communication channels were used to promote reproductive and child health (RCH) camps and local public and private health clinics. District action plans included public education activities, promotion of RCH services, and orientation of local self-government and religious leaders.

**COVERAGE**
IFPS initiatives in social marketing and communication were designed to reach the entire state. The social marketing component greatly expanded the number of sales outlets for condoms and oral contraceptive pills, especially in small towns and villages. The various communication activities reached large numbers of people, but data on overall coverage is limited. Surveys indicate a high recall of family planning messages in media channels, but media exposure is low in rural areas of Uttar Pradesh. Other communication channels such as video vans, traditional theater and songs, panels on buses, wall writing, and mobile fairs attracted large audiences.

**BROADENING ACCESS TO FP/RH INFORMATION AND SERVICES**
*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. 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, indigenous systems of medicine practitioners, 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 over a short two-year period.

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.)

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, 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 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 districts. Additionally, an estimated 18,000 community-based distribution (CBD) workers and ANMs were trained in interpersonal communication and use of the campaign’s IEC 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 at 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. Additionally, a rapid appraisal of the age at marriage campaign, which had made extensive use of wall paintings to reach the target audiences, found a high level of message recall. (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.)

REFERENCES


CHAPTER 13

SOCIAL MARKETING:
Expanding Access to Spacing Methods

By Shuvi Sharma

RATIONALE

In 1992, when the IFPS Project was signed by the Government of India (GoI) and USAID, USD 42 million was allocated for the social marketing program. With technical assistance from the POLICY Project, USAID funded a series of market studies, including a market segmentation analysis (Berg, 2000). These studies fed into a marketing action plan that proposed to channel the majority of funding through SIFPSA. SIFPSA, in collaboration with USAID, would design and manage specific social marketing programs.

At the start of IFPS, the contraceptive prevalence rate (CPR) in Uttar Pradesh was low. The 1992/93 National Family Health Survey (NFHS-1) found that though the knowledge of family planning methods was very high, use of any method of contraception was only 19.8 percent, while use of a modern contraceptive method was 18.5 percent (International Institute for Population Sciences [IIPS], 1995). Sterilization had the largest proportion of users (13.1%), followed by condoms (3.2%) and oral contraceptive pills (1%). The evidence clearly showed that family planning method use in the state was skewed in favor of terminal methods.

According to the 1995 Project Evaluation Review for Organizational Resource Management (PERFORM), nearly one-third of the women not using contraceptives wanted to use a family planning method in the future, indicating a high unmet need. Forty-one percent of urban women and 34 percent of the rural women said that they intended to use some form of contraception in the next two years. Despite this high unmet need, availability of contraceptives in the state was quite poor. Statewide estimates from the PERFORM survey revealed that fewer than one in six (110,000 out of 697,000) retail outlets in Uttar Pradesh stocked contraceptives (SIFPSA, USAID, and the EVALUATION Project, 1996).

Need for Social Marketing to Expand the Condom Market

When the IFPS Project initiated social marketing activities in 1997, the condom market in Uttar Pradesh was crowded with different brands. There were 15 subsidized brands and 125 commercial brands. All these brands competed with each other in the market; as a result, much energy was directed at achieving market share rather than increasing the overall market for condoms. Despite all these players, the overall condom market was showing a sharp decline, because the commercial
players—such as Hindustan Lever Limited, ITC, and Brooke Bond—had withdrawn their support to the public-sector subsidized marketing effort. In addition, there were procurement and supply issues with the market leader, Deluxe Nirodh, along with limited efforts in promoting condom use.

The urban market analysis indicated that the market did not provide much opportunity for growth because nearly 10 percent of the total eligible couples in urban areas were using condoms and the number of intending users was low. Though urban clients were using subsidized brands, they shifted to commercial brands in the case of a stock-out. The rural market, however, offered a high potential for growth because the number of intending users was high. Stock-outs affected usage patterns in rural areas because, unlike their urban counterparts, rural users did not have access to multiple supply points or to commercial products.

Moreover, condom use had a negative image and stigma attached to it, leading to embarrassment for potential users in buying condoms and reluctance among retailers in displaying them. These factors indicated a need to increase access and promotion at the point of sales in the urban areas. In the rural areas, there was a need to expand to non-traditional outlets to increase access.

Need for Social Marketing to Expand the Oral Contraceptive Pill Market
In 1996/97, Mala-D, a principal subsidized brand for oral contraceptive pills (OCPs), was the undisputed market leader. In the urban areas of Uttar Pradesh, commercial brands of OCPs had a market share of about 24 percent in 1996/97, with Mala-D making up the balance of 76 percent. However, in rural areas, Mala-D was the only available brand of contraceptive pills.

The market for OCPs in Uttar Pradesh had both demand and supply issues. It had not been supported with adequate demand generation activities and, therefore, there were misconceptions about the pill, especially among women. On the supply side, rural areas had not been adequately reached and there were often stock-outs. Both the commercial and subsidized sectors depended on chemists for the distribution of pills. Few non-chemists stocked oral pills. The distribution of pills through non-chemist outlets was an unexplored idea for expanding the market for OCPs.

The differences between users in urban and rural areas were minimal. There was, thus, a potential market for oral pills in the rural as well as urban market. However, a substantial effort was required to convert the intending users alongside the effort to improve access to products in rural areas. All efforts needed to be supplemented with advertising and counseling to encourage women to continue the use of the pills.

The Social Marketing Challenge in Uttar Pradesh
This situation represented a marketer’s paradise, with a high market potential indicated by a high unmet need. However, the bulk of the potential market resided
in rural areas, bringing in the challenge of making the products accessible, affordable, and available for the rural population of Uttar Pradesh. The challenge also lay in reaching out to the rural population through commercial marketing with promotion of specific brands along with creating a distribution network in the villages and small towns.

Recognizing these factors, IFPS intervention partners developed a marketing plan in which the first three years would focus on developing an infrastructure to expand the markets for pills and condoms, followed by a second phase in which new products would be introduced. The first phase would focus on involving the commercial sector and conducting operations research and pilot projects.

OBJECTIVES
Recognizing the need for social marketing, the activity under IFPS was initiated with the objectives to:

- Increase the penetration of condoms and oral contraceptives in rural Uttar Pradesh.
- Expand the sales of Deluxe Nirodh and other subsidized and commercial brands of condoms in the rural areas; and
- Expand the sale of OCPs, both subsidized and non-subsidized, in rural areas.

INTERVENTION PARTNERS
Various partners have been associated with the social marketing component of the IFPS Project. A Technical Advisory Group was constituted with representatives from SIFPSA, USAID, GoI, the Government of Uttar Pradesh, SOMARC, Commercial Market Strategies, and the POLICY Project.

The main implementing partner for the state-level social marketing component was Hindustan Latex Ltd. (HLL), a public-sector company founded in 1966 under the GoI’s Ministry of Health and Family Welfare. From 1997–2002, HLL implemented the Chhota Sansar Pariyojana (translated as “Small World Project”). In 2000, the statewide project was expanded and renamed as Sukhi Sansar Pariyojana (translated as “Happy World Project”). HLL was awarded this new project, and the project was extended to 2003–2006.

In 2002, Population Services International (PSI), an international nonprofit organization, began operating a social marketing project in Moradabad Division. In 2003, two sub-state projects began: (1) a project in the central and Bundelkhand region managed by DKT India, an international nonprofit organization; and (2) a project in the western region managed by Hindustan Latex Family Planning Promotion Trust (HLFPPT), a nonprofit trust affiliated with HLL and founded in 1992.

INTERVENTION COMPONENTS

Phase I: Launching the Brands
With the marketing action plan in place and SIFPSA as the coordinating body, HLL, a GoI-supported company that distributes and manufactures contraceptives, was awarded a three-year (1997–2000) contract for a statewide social marketing program. Its project, Chhota Sansar Pariyojana, was the first social marketing
project initiated in 28 districts of Uttar Pradesh (now 33 districts due to bifurcation). Consistent with the marketing strategy, the project’s broad objectives were to expand the sales and ensure the availability of the social marketing brands of condoms and OCPs through appropriate communication and distribution strategies. The project was designed to cover the major towns and blocks with populations of less than 20,000 through conventional channels. In this start-up phase, the whole distribution network was created for providing social marketing brands of contraceptives in project areas. The products included were condoms (Deluxe Nirodh, Ustad, and Rakshak), OCPs (Mala-D and Arpan), and intrauterine contraceptive devices (IUCDs). The project launched a new brand of low-priced non-subsidized condoms called Rakshak (meaning “Protector”). Using the platform of protection, the brand was promoted with the unique selling proposition (benefit statement) of “Pyar banata hai har purush ko Rakshak!” (“Love makes every man a Protector”).

Phase II: Extending Distribution Networks
The second phase of implementation began in 2000. A competitive bidding process was followed, and a performance-based contract was signed with HLL for the years 2000–2003. During this phase, called Sukhi Sansar Pariyojana-I, coverage was increased with a focus on C and D category villages to widen and consolidate the distribution network of rural Uttar Pradesh. Contraceptive products were distributed through non-conventional outlets. After the launch of the brands in the first phase, this phase consolidated on all the brands with emphasis moving from “Rakshak only” to “Rakshak also.” Deluxe Nirodh was promoted as “Jeevan ke rang Deluxe Nirodh ke sang” (“Colors of life with Deluxe Nirodh”). Mala-D was promoted extensively on the platform of total safety and contraception: “Mala-D de nischit suraksha; garbnirodhan ka wada pakka” (“Mala-D gives complete protection with a promise of contraception”).

During this phase, SIFPSA launched its mass media campaign, known as Aao Batein Karein (“Come Let’s Talk”) to encourage discussion about contraceptive methods (see Chapter 14). Follow-up campaigns on specific contraceptive methods were not implemented, although print materials on family planning

Packshots for Rakshak and Ustad condoms and Arpan and Mala-D brands of oral contraceptive pills.

1 During the project, villages were classified as A, B, C, and D on the basis of population. Category A for >10,000 population, Category B for 5,000–9,999, Category C for 2,000–4,999 population, and Category D for 1,000–1,999 population.
were widely distributed and auxiliary nurse midwives and community-based distribution (CBD) workers were trained in interpersonal communication.

**Rural Salesmen and Intermediate Distributors.** In 2002, SIFPSA funded the Venture Rural Project, an integrated rural marketing project in Moradabad Division. Designed to pilot the concept of the rural salesmen offering a basket of products, this project was implemented by PSI. The basket of products included reproductive and child health (RCH) products such as condoms (*Masti* and *KamaSutra*), OCPS (Pearl), dispensable delivery kits (New Born), oral rehydration salts (Neotral and Neotral Orange), iron and folic acid (IFA) tablets (Vitalet-IFA and Vitalet-Preg), and safe drinking water kits. The project also had an objective of reaching villages with populations between 1,000 to 5,000 people (C and D categories of villages).

One of the innovations of the project was to introduce mobile field agents who traveled from village to village and provided products as well information on their usage. Another innovation was to add super stockists and large rural retailers to the distribution chain. These stockists and retailers bought stocks from the Moradabad office, stored them in adequate quantities for their regions, and then sold the products directly to the mobile field agents. This facilitated effective allocation of time (of project employees) and resources (by the mobile field agents), and increased the overall efficiency of the project.

The intervention also involved the private sector on a cost-sharing basis. The original plan was to seek contributions from private companies to cover distribution costs but the project shifted to charging a flat fee, which was more acceptable to commercial partners. Product margins (profits) were also used to defray distribution costs in order to make the distribution system more cost-effective. The project found that it was difficult to partner with national-level commercial partners as the project was based in Moradabad Division only. Eventually, the Venture Rural Project tied up with local commercial entities such as JK Ansell Pvt. Ltd., Metha Pharmaceuticals, Metha Surgicare Pvt., Bombay Marketing Company, Kopran Pharma, and Gufic Pharma for marketing brands including *KamaSutra* (condoms), *Methas Satpudina* (digestive tablets), Radiplast (medicated strips), *Ajanta* (toothbrushes), Smyle (vapor rub and toothpaste), and Shapers (sanitary pads). All the products were distributed through the Saadhan Network, which consisted of retail outlets, village-based workers, field agents, and other members who were promoting the health products under the project.

One of the Venture Rural Project’s successful innovations was product bundling, which encouraged retailers to stock condoms, contraceptive pills, and oral rehydration salts together. These products were made available to retailers in a small jar at a cost of Rs. 25. Another innovation included sales of products during interpersonal communication meetings. For this, a small seed...
amount was made available to the community educators, who could then sell the products to women during meetings. The distribution network established in Moradabad continued operating until March 2005.

Phase III: Expansion
Beginning in 2003, IFPS supported implementation of both state and regional social marketing programs under multiple contracts. This approach was designed to have statewide impact on contraceptive sales while addressing barriers to OCP and condoms use, especially in rural areas. To increase the cost-effectiveness of marketing contraceptive products, other health products, including oral rehydration salts, IFA tablets or syrups, and disposable delivery kits, were added to the basket of socially marketed products. SIFPSA also suggested that agencies add other products, at their own expense, to improve the efficiencies of the distribution channel, increase competition, and make the efforts more sustainable.

As discussed below, the statewide contract and contracts for all regions except for the eastern region of Uttar Pradesh were awarded. No projects were awarded in the eastern region as the financial proposals of the short-listed agencies were not cost-effective even after negotiations.

Statewide Project. After competitive bidding, HLL was awarded the extension of the statewide social marketing project called Sukhi Sansar Pariyojana-II for 2003–2006. Like the previous statewide initiative, this project involved coverage of A and B villages (with more than 5,000 people) plus a special focus on the C and D category villages (with 1,000–5,000 inhabitants) for increased penetration. The project withdrew support for the condom brand Rakshak; only the category leaders Deluxe Nirodh and Mala-D were promoted through the network. The platform used for promoting Deluxe Nirodh was protection: “Santushti aur Suraksha Dono Mein Khara” (“Passes both the tests for satisfaction and safety”). The unique selling proposition for Mala-D used during this phase was: “Bacchon mein antar har haal; Ma swastha ghar khushhal” (“[There should be] spacing between children under any circumstances [for a] healthy mother and a happy family”). It was during this phase that there was an effort to convert conventional and non-conventional outlets as program stakeholders.

Central and Bundelkhand Region Project. DKT India was awarded the project for intensive rural marketing efforts in Uttar Pradesh’s central and Bundelkhand region from 2003–2006. The project, called Project Pahal, based its community education activities around “Market Town Haats,” weekly markets or haats where people from nearby villages sell their produce and purchase their necessities. During
these haats, the project arranged for a nautanki (the traditional traveling theater) to perform and for leaflets and brochures about RCH to be distributed. The project also established personal contacts with stakeholders and peer leaders in the villages and held group meetings with men and women to provide RCH information. The project promoted a basket of products, such as Zaroor condoms, Choice contraceptive pills, Neotral oral rehydration salts, Vitalet-Preg IFA tablets, and New Born disposable delivery kits. The emphasis of the distribution activities was to stock contraceptives in non-traditional outlets. The project extended the distribution of the basket of products out to villages with populations less than 2,000 in 14 districts (DKT India, 2003).

Western Region Project. HLFPT was awarded the Western regional project (excluding Moradabad Division) for 2003–2006. For this project, known as Project Khushhali, the basket of products included condoms (commercial and subsidized brands other than Deluxe Nirodh), OCPs (Arpan), oral rehydration salts (Jal Jeevan), IFA tablets (Ferro Plus), disposable delivery kits (Shishu Raksha), sanitary napkins (Sakhi), and medicated plaster (Plastaid). The project was envisaged as penetrating rural markets in all A and B villages and reaching 20 percent of C and D category villages of western Uttar Pradesh by the end of the project through conventional and non-conventional distribution channels. The distribution network was to be strengthened through a network of village-based vendors (called Village Network Builders) along with building their capacities at the community level.

Project Cutbacks. Soon after the regional projects were awarded, SIFPSA requested the implementing agencies to stop all promotional activities and curtail project expenditures. At this time, SIFPSA was facing funding constraints and uncertainty regarding future funding. In April 2005, SIFPSA cancelled the regional projects, even though the contracts were scheduled for completion in March/April 2006. The statewide project, however, continued for the contract period.

Evolution of the Marketing Strategy

Products
The initial contraceptive marketing plan listed OCPs and condoms as the products to be included in the first phase. Other RCH products—such as oral rehydration salts, IFA tablets, disposable delivery kits, sanitary napkins, and other products that the social marketing organizations wanted to distribute—were added to the basket of products. Table 1 presents a list
of the social marketing products distributed under the IFPS Project.

As the project evolved, the platform (benefit statement) for condoms moved from meeting only family planning needs to providing dual protection (e.g., contraception and protection from sexually transmitted infections). Initially, the statewide project focused on promoting *Rakshak* as a condom brand. The idea for introduction of *Rakshak* was to promote a non-subsidized low-price brand so as to reduce dependence on the subsidized brands of condoms. Later, however, *Rakshak* was withdrawn and *Deluxe Nirodh* was promoted as the condom brand in the statewide project.

In the other product categories, social marketing organizations promoted their brands in their areas of operation. This increased

<table>
<thead>
<tr>
<th>TABLE 1. SOCIAL MARKETING PRODUCTS DISTRIBUTED DURING THE IFPS PROJECT</th>
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<tbody>
<tr>
<td><strong>Phase</strong></td>
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<td>-----------</td>
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<tr>
<td>Phase I</td>
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<tr>
<td>Phase II</td>
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<tr>
<td>Phase III</td>
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<tr>
<td>(2003–2006)</td>
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<td>HLFPPT</td>
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the choice available to the consumers.

Pricing

A key goal of the IFPS Project was to make contraceptive products more affordable. The project sought to make priced products available in both urban and rural areas, with an effort to induce behavior change through effective communication “to pay for and use” contraceptive products. Accordingly, all the products were priced so as to be affordable to middle- and low-income groups (classes B, C, and D).

The products that were marketed through the course of the project were either low-price commercial brands or subsidized social marketing brands of condoms and pills. In addition, the social marketing organizations offered discounts to consumers to encourage trial (e.g., for OCPs, price discounts were offered to consumers on the purchase of three packs at the same time).

### TABLE 2. PRICING STRUCTURE OF PRODUCTS

<table>
<thead>
<tr>
<th>S.No</th>
<th>Category</th>
<th>Brand Name</th>
<th>Pack Size</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Condoms</td>
<td>Rakshak</td>
<td>3 condoms per wallet</td>
<td>Rs. 5/- per wallet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deluxe Nirodh</td>
<td>5 condoms per wallet</td>
<td>Rs. 2/- per wallet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ustad</td>
<td>5 condoms per wallet</td>
<td>Rs. 5/- per wallet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moods</td>
<td>3 and 10 condoms per wallet</td>
<td>Rs. 12/- per wallet and Rs. 25/- per wallet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Masti</td>
<td>4 and 10 condoms per wallet</td>
<td>Rs. 5/- and Rs. 10/- respectively</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Zaroor</td>
<td>3 and 10 condoms per wallet</td>
<td>Rs. 4/- and Rs. 10/- respectively</td>
</tr>
<tr>
<td></td>
<td></td>
<td>KamaSutra Plain</td>
<td>3 condoms per wallet</td>
<td>Rs. 10/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>KamaSutra Dotted</td>
<td>3 condoms per wallet</td>
<td>Rs. 14/-</td>
</tr>
<tr>
<td>2</td>
<td>Oral contraceptive pills</td>
<td>Mala-D</td>
<td>1 cycle of 28 pills</td>
<td>Rs. 2/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arpan</td>
<td>1 cycle of 28 pills</td>
<td>Rs. 5/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Choice</td>
<td>1 cycle of 28 pills</td>
<td>Rs. 7/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pearl</td>
<td>1 cycle of 28 pills Pack of 3 cycles</td>
<td>Rs. 5/- and Rs. 10/- respectively</td>
</tr>
<tr>
<td>3</td>
<td>Oral rehydration salts</td>
<td>Jal Jeevan</td>
<td>28.5 grams sachet</td>
<td>Rs. 10/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neotral</td>
<td>28.5 grams sachet</td>
<td>Rs. 4.80 + local tax</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neotral Orange</td>
<td>28.5 grams sachet</td>
<td>Rs. 7.50 + local tax</td>
</tr>
<tr>
<td>4</td>
<td>IFA tablets</td>
<td>Ferro-Plus</td>
<td>3 strips of 10 tablets each</td>
<td>Rs. 12/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vitalet-IFA</td>
<td>1 strip of 10 tablets</td>
<td>Rs. 9/- + local tax</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vitalet-Preg</td>
<td>1 strip of 30 tablets</td>
<td>Rs. 15/-</td>
</tr>
<tr>
<td>5</td>
<td>Disposable delivery kits</td>
<td>Shishu Raksha</td>
<td>1 pack containing sheet, string, half blade, gauze swabs, and soap</td>
<td>Rs. 14.50 per pack</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New Born</td>
<td></td>
<td>Rs. 15.00 per pack</td>
</tr>
<tr>
<td>6</td>
<td>Sanitary napkins</td>
<td>Sakhi</td>
<td>8 napkins per pack</td>
<td>Rs. 20/- per pack</td>
</tr>
<tr>
<td>7</td>
<td>Iodized salt</td>
<td>Purak</td>
<td>1 kg</td>
<td>Rs. 3/-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Purak Gold</td>
<td>1 kg</td>
<td>Rs. 6/-</td>
</tr>
<tr>
<td>8</td>
<td>Medicated plaster</td>
<td>Plastaid</td>
<td>15 pieces per wallet- Washproof</td>
<td>Rs. 30/- per wallet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Per piece- Cotton</td>
<td>Rs. 1.75 per piece</td>
</tr>
</tbody>
</table>
Placement
One of the main objectives of the IFPS Project was to increase access to family planning products in rural areas. The project used both conventional as well as the non-conventional sales outlets for making products available to consumers. Commercial brands were supplied through the social marketing organization’s regular channel to the Carrying and Forwarding Agent or the distributor in the state. However, for social marketing brands, the stocks were first issued from the Government Medical Stores Depot to the social marketing organization and then distributed through the regular channels. This system sometimes led to stock-outs of social marketing brands, despite the capacity of the social marketing organizations to maintain inventories for up to six months.

Use of multi-tiered distribution systems enabled the social marketing organizations to penetrate hard-to-reach rural areas. Use of conventional distribution channels was supplemented by innovative efforts to increase the availability of contraceptives and other health products in rural areas. These included:

- **Van distribution.** Vans were used during the project for retailing and merchandising contraceptive and health products. The vans operated in villages that could not be reached by conventional marketing channels and did not have any redistribution stockists. There was an effort to link the Permanent Journey Cycles of these vans to the *haat* or *mela* activities.
- **Linkages with other institutions.** Social marketing activities were initiated through existing networks of IFPS-funded NGOs and dairy cooperatives (see Chapters 8 and 9). These projects established CBD networks in their area of operation through a CBD worker based at the village level who directly sold contraceptives to the consumer. The margins earned from the sale of products were shared between the CBD worker and the NGO/cooperative. This was a very innovative and sustainable initiative for increasing access to contraceptives and RCH products. Another interesting linkage that was developed towards the end of the project was with the Public Distribution System for sale of iodized salt. The response was very encouraging, and system managers expressed interest in stocking and distributing contraceptives and other health products through their systems.
- **Establishment of health networks.** The social marketing organizations established branded networks of existing service providers, including retail outlets, mobile promotion units, field agents, and NGO workers. This linking of the members of the network will be very useful in sustaining the penetration of the products. Also, these networks could be

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2 Socio-economic class classification is based on occupation and education and divided into eight categories: A1, A2, B1, B2, C, D, E1, and E2. A1 indicates the highest education and employment options and E2 indicates skilled/unskilled workers with little or no formal education.
leveraged as sales networks in rural areas for making other fast-moving consumer goods (health-related products) available. This association with a “quality” brand has been a motivational factor for the network members. PSI had its Saadhan Health Family Network, and HLFPPT developed the Tarang Network.

- Increasing penetration with intensified efforts. Traveling rural salesmen, rural-based distributors, rural sales representatives, and village-based volunteers were identified and included in the distribution network of the social marketing organizations. Of these, the rural sales representatives were the paid employees. The other distributors earned money from the margins (profits) on the contraceptive and health products that they sold.

- Expanding to non-chemist outlets. From the very beginning of the social marketing effort, there was a need to make contraceptive products available in non-chemist outlets in the rural areas. These non-chemist outlets included pan and beedi shops, grocery stores, barber shops, bangle shops, beauty parlors, bars, and liquor shops. Distribution through these outlets had to be supplemented with capacity building efforts to increase the knowledge and counseling skills of the sales personnel. The prospect of increased margins along with contribution to a cause has influenced these outlets to continue stocking all the products.

As can be seen from the above initiatives, distribution was a major focus area for the social marketing initiatives in the project.

**Promotion**

The project has been using various “above the line” and “below the line” promotion activities. Culturally-sensitive, innovative media have been used as a part of this project to promote contraceptives. Besides the promotion of brands, generic communication campaigns have been undertaken to facilitate behavior change for adoption of contraception and other health products. Various media and activities undertaken during the projects are discussed below:

- **Consumer schemes.** To enhance shelf movement of brands in a particular market, freebies have been offered to the consumers on purchase of the product. For example, in the rural market, HLL initiated the “Maha Suraksha Offer” in which two Topaz blades (a popular brand in the rural market) were given free on the purchase of one wallet of Rakshak condoms. Other consumer schemes and contests have been used effectively to increase sales of products. In rural areas, a scheme for Mala-D contraceptive pills called “Sona hi Sona” was offered as a scratch card scheme to consumers and registered medical practitioners. This scheme was further linked to other series of promotions for retailers.

- **Trade schemes.** To increase the trade channel uptake of contraceptives and to motivate the members, timely,
innovative motivational schemes were implemented during the project. Some of these schemes included frequent buyer schemes, window displays, retailer contests, trade schemes, and gift schemes. The window display contests led to elaborate merchandising by retailers, thus creating an enabling environment for trial of contraceptive products.

- **Point-of-purchase materials.** Posters, shelf stickers, product dispensers, inflatables, information leaflets, and other point-of-purchase materials have been designed so as to increase the visibility of the social marketing brands in the traditional and non-traditional outlets.

- **Mass media.** Television, radio, and press were used during the course of the project. In the initial phase, generic advertising promoting contraceptive products was undertaken using TV and radio. The branded communication during this phase took place mainly through radio. There was increased emphasis on press from 2003 to 2004. However, because of a preference for wall paintings, folk troupes, hoardings, and other interpersonal communication initiatives, spends on media were withdrawn.

- **Video vans.** As a part of the promotion exercise, video vans would reach rural villages as per a pre-determined journey cycle. Vans were fitted with audio and video equipment to make public announcements as well as for pre-program publicity during the day. In the evening, a cultural performance such as a video show, puppet show, or a *nautanki*, would be performed for the crowd gathered from nearby villages. The content of the video vans gradually evolved from being pure song and dance entertainment shows interspersed with brand jingles to an “info-tainment” program, for example, with puppet show storylines around health. The vans also traveled to market towns/haats to reach a larger audience. These vans now serve as counseling and health vans for couples wanting to adopt any of the advertised contraceptive or health products.

- **Wall paintings and hoardings.** Wall paintings and hoardings were used to remind consumers of the brands. Wall paintings have proven to be especially successful in the rural areas, where media penetration is low. However, monitoring the standardization of display and ensuring that the wall paintings have been done are challenges.

- **Folk troupes.** Troupes that performed traditional theater and singing, such as *birha*, *nautanki*, *qawali*, and *alah*, were trained to incorporate specific messages around family planning to reach rural audiences.

- **Special events.** Other special events, such as healthy baby contests, *mehndi* (henna application) contests, and healthy family contests, were used in the village to create a setting for bringing the target audience together. Along with the contests, messages on family planning and reproductive
health were discussed with the gathered audience, thus creating an enabling environment for uptake of products and services.

All the media mentioned above have been used for the generic campaigns, such as the Aao Batein Karein campaign, as well as for specific brand promotions by the social marketing organizations. However, when SIFPSA awarded the project grants, the media and advertising budgets of the organizations were reduced with the assurance that generic advertising would be undertaken by SIFPSA. However, the generic advertising allocations were not commensurate with the needs of the market. Accordingly, promotion efforts for contraceptives and health products in Uttar Pradesh remain limited.

**MANAGEMENT**

A Technical Advisory Group (TAG), a Project Appraisal Committee (PAC), and the Social Marketing Division of SIFPSA constituted the management structure for the social marketing component of the IFPS Project.

*Technical Advisory Group.* The TAG was chaired by the Executive Director of SIFPSA and included members from Ministry of Health and Family Welfare, Government of Uttar Pradesh (Secretary–FW and Director General–FW), SIFPSA, USAID, and technical assistance agencies namely Futures Group and Deloitte Touche Tohmatsu (through their SOMARC/Commercial Marketing Strategies Project and POLICY Project). The chairperson could also call on experts as required by the subject matter of the meeting. The TAG had the responsibility for reviewing marketing plans, reviewing requests for proposals, reviewing the proposals that have been received, forwarding the proposals to the PAC with recommendations for selection, and monitoring technical progress.

*Project Appraisal Committee.* The PAC is the body through which the TAG recommends the proposals to the Executive Director or the Governing Body for their approvals, depending on the amount of funds required for project implementation. Since most of the social marketing proposals had large budgets, the projects were referred to the Governing Body for approval.

*Social Marketing Division.* The Social Marketing Division of SIFPSA managed the social marketing components on a day-

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**FIGURE I. MANAGEMENT STRUCTURE OF THE SIFPSA SOCIAL MARKETING DIVISION**

- Executive Director
- Additional Executive Director
- General Manager – Marketing
- Deputy General Manager – Sales
- Deputy General Manager – Promotion
- Project Coordinator – Sales (2)
- Project Coordinator – Promotion (2)
to-day basis with the assistance of local organizations and USAID cooperating agencies. The division was led by the General Manager–Marketing with a support structure as shown in Figure 1.

However, at no point in time since the Marketing Division was established have all seven positions in the above structure been fully functional. At its maximum strength, the division had a staff of four: a General Manager, two Deputy General Managers, and one Project Coordinator.

**MONITORING AND EVALUATION**

The 1995 PERFORM Survey formed the baseline for the project. The broad scale evaluation was carried out for the project through the 2003 Reproductive Health Indicator Survey (RHIS) (Futures Group/POLICY Project, 2004), which measured the contraceptive prevalence for condoms and pills, expansion in the numbers and types of outlets stocking contraceptives, and changes in consumer attitudes and understanding about spacing contraceptives.

Monitoring focused on the progress of the work. After the initial award of a project, the performance of the social marketing agencies was measured on the basis of actual sales. For the statewide project, the market research agency ORGMARG was contracted to conduct the sales audits in the state. These data were used to measure the performance of the agencies. For the regional projects, sales were tracked through the secondary sales figures, whereas the village penetration was measured through customized surveys commissioned by SIFPSA.

**RESULTS**

Following are some of the key results of the social marketing program:

- **Contraceptive prevalence rate.** There has been an increase in the adoption of modern contraceptive methods in urban as well as rural areas of Uttar Pradesh. The contraceptive prevalence rate increased for OCPs and condoms as well as for sterilization. OCPs and condoms account for 21 percent of modern method use in rural areas, although sterilization remains the dominant method in rural areas, accounting for 75 percent of modern method use. Generic advertising (like Goli ke Hamjoli) along with specific

**BOX 1**

**Challenges in Monitoring Sales Efforts**

Results of the ORG Retail Audit showed a decline from 3.4 million OCP cycles in 1999 to 2.8 million cycles in 2002. The decline was attributed largely to the fall in sales of Mala-D, the single largest brand of OCPs in rural areas. SIFPSA commissioned a detailed study to understand the reasons behind the decline in sales.

During the study, it was observed that while the ORG Retail Audit figures showed a decline in sales, the ground realities suggested a steady sales growth, if not a steep hike in sales. HLL’s secondary sales figures put the OCP sales at 5.8 million cycles in 2002 against the 2.8 million cycles reported by the ORG Retail Audit. This gap of 3.0 million cycles was attributed to the market phenomena of undercutting of stock by the market players, expired stock of HLL, and the sales in class IV towns (below 20,000 population). The study revealed that the stock was circulating more in the class IV towns and not percolating into the interiors of C and D villages (with 1,000 to 5,000 people), indicating stocks were being pulled into the urban markets (SRI-IMRB, 2003).

The study highlights the challenges in tracking the sales and penetration of products especially in the rural areas.
marketing efforts have led to an increase in OCP use in urban areas.

- **Unmet need for family planning methods.** The unmet need for spacing methods remains high. In fact, the unmet need for limiting methods has increased since the IFPS Project began. This increase has been observed in urban as well as rural areas, highlighting the need to increase access to services for limiting methods. The reason that unmet need continues to be high despite increased use of contraception is that many couples are deciding to have fewer children and, thus, express an interest in spacing or limiting births.

- **Increased rural penetration.** The marketing plan at the beginning of the project identified rural areas as areas of emphasis for family planning initiatives. Accordingly, the IFPS social marketing projects were designed to reach out to rural areas extensively. The proportion of Uttar Pradesh villages with between 1,000 and 5,000 people that have sales outlets for OCPs and condoms has more than doubled in just two years, rising from 19 percent of these villages in 2000 to 43 percent in 2002 (see Figure 2).

- **Sales of condoms.** Condom sales have nearly tripled during the years with social marketing projects, rising from 89 million pieces in 1997 to 241 million pieces in 2004 (see Figure 3). The average annual growth of 39 percent during this seven-year period is remarkable for any product category. Sales of
Ideas, Insights, and Innovations

decline in sales in the last year of the social marketing projects. This could have been due to a reduction in the communication activities and other field activities of the projects.

- **Networking.** The project collaborated with more than 6,000 dairy cooperatives as well as NGOs and private-sector groups to promote condoms and pills (see Figures 5 and 6). The prominent groups with whom linkages were established include Pradeshik Co-operative Dairy Federation (PCDF-Operation Flood III), the Federation of Indian Chambers of Commerce and Industry in Bareilley and Moradabad, the Family Planning Association of India in Agra, District Urban Development Authorities, Shramik Bharti in Kanpur, Vinoba Sewa Ashram in Shajahanpur, and the Himalayan Institute of Health and Technology in Dehradun (now in Uttaranchal). Sales of both condoms and oral pills grew dramatically from 1998/99 to 2002/03.

Deluxe Nirodh have doubled, from 65 million pieces in 1995/96 to 130 million pieces in 2004. The increase in sales is seen in urban as well as rural areas.

- **Sales of pills.** Sales of OCPs have nearly doubled, from 4.27 million cycles in 1997 to 8.04 million cycles by 2004 (see Figure 4). However, the pill market has been stagnant since 2002 and, in fact, has shown a decline in sales in the last year of the social marketing projects. This could have been due to a reduction in the communication activities and other field activities of the projects.

Clearly, the NGOs and other community-based organizations have played a significant role in increasing access to condoms and pills, especially Deluxe Nirodh and Mala-D, in the rural areas of Uttar Pradesh. As a result of such integrated and concerted efforts, the sale of Deluxe Nirodh doubled in the state and the penetration of condoms and OCPs has also increased.

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The methodology adopted for conducting the ORG Retail Audit was changed in the year 2002 and, therefore, the trend in sales is shown from 2002 onwards.
LESSONS LEARNED AND CHALLENGES
The IFPS Project made spacing methods and information about their use more widely available, and demonstrated that it is possible to increase rural access to contraceptive methods even in a state as diverse as Uttar Pradesh. Innovative social marketing efforts dramatically increased the proportion of villages with access to condoms and oral pills.

Challenges
While the above sections detail the evolution and the achievements of the social marketing projects, there were many challenges that should be taken into consideration in the future design of projects. These include:

- *Delays in project approval and payment.* The approval process for award of social marketing projects was very lengthy, especially since projects with large budgets must be approved by the SIFPSA Governing Body, which meets once a year. In addition, all the implementing agencies faced delays in receiving payments from SIFPSA. There are many reasons for these delays, including commissioning surveys for performance appraisals for which the process is very long.

- *Coordination of communication and social marketing efforts.* Social marketing and communication efforts should complement each other in the field. This coordination was limited in the IFPS-I Project, where social marketing and communication were viewed as discrete activities. There is a need to synergize the activities of the two divisions through an inclusive planning process.

- *Monitoring project performance.* The rural sample adopted for the ORG Retail Audit was based on a limited number of outlets. Since the retail audit affects the payments to the social marketing agencies, other mechanisms for validating the sales figures should also be evaluated. Auditing the secondary sales figures of the social marketing organizations for disbursement of funds could also be considered, though there are limitations in this as well. Furthermore, the ORG Retail Audit does not adequately capture the sales made through innovative channels such as NGOs and cooperatives. A standard percentage (10%) of the total sales was estimated as the sales component through NGOs. However, there have been times when the NGO sales have exceeded 10 percent and these variations affect the performance appraisal and, thus, the payment to the social marketing organizations. This issue of documenting the NGO sales component has not been resolved.

- *Logistics management.* Since the social marketing organizations have to wait for supply from the GoI for the social marketing brands, there are times when there are stock-outs of condoms and pills in the market, leading to a reduction in the sales performance of the social marketing organization. Moreover, the occurrence of undercutting and sale of nearly
expired stock of contraceptive products at lower rates distorts the market equilibrium in the state. Proper logistics management and ensuring fresh stock from the beginning of the project could help address these two issues.

**Lessons Learned**

- *Encouraging demand for services.* The emphasis of the social marketing efforts has been on supply and distribution. Although condoms and oral contraceptives are now available in nearly half of rural Uttar Pradesh, there is a need to generate adequate demand for the products also. Only then would the social marketing efforts be sustainable.

- *Increasing the contraceptive pill market.* Though the contraceptive pill market has grown over the years, this growth is not commensurate with the market potential that exists, especially in the rural areas. Generic advertising with brand-specific promotion should be considered for increasing the pill market while taking into consideration issues of project management.

- *Facilitating coordination.* Because there were so many players in the same project, it would have been useful to have developed an overall strategy for the product categories to ensure consistent brand promotion by the social marketing organizations.

- *Building capacity in non-traditional outlets.* Greater coverage of non-traditional outlets has led to increased trial of the products. However, there is a need to build the capacities of the sales personnel at these outlets so that they can address consumers’ queries and anxieties.

- *Enhancing access and sustainability.* Expanded product baskets increased the cost efficiency of the system. With more and more products being included, the profits to the CBD workers as well as to the members of the distribution network grow, thereby increasing the sustainability of the channel. Moreover, using existing networks—such as NGOs, dairy cooperatives, and the Public Distribution System—to increase the availability of health products in the rural areas is an example of a public-private partnership that could be carried forward in the years to come.

- *Improving understanding of potential and existing contraceptive users.* Studies to understand the motivators and barriers to adoption of the health practices, including other knowledge-attitude-behavior-practice indicators, need to be undertaken. This would also help to assess the product strategies that have been developed for the project. Performance monitoring indicators should also include behavior change indicators along with sales and penetration indicators.
REFERENCES


BEHAVIOR CHANGE COMMUNICATION: Reaching Diverse Audiences

By Sona Sharma

RATIONALE

In the planning stage of the IFPS Project, it was clear that behavior change communication (BCC) would be an important component. Survey data indicated that a large unmet need for family planning existed. According to the 1992/93 National Family Health Survey (NFHS-1), an estimated 4.1 million women in Uttar Pradesh wanted to space births and an additional 3.3 million women wanted to limit births, but these women were not using contraception. If this unmet need could be fulfilled, the contraceptive prevalence rate (CPR) would be more than double the existing level. Various studies have attributed non-use of contraception in India to myriad factors, including dislike of existing methods, fear of side effects, misconceptions about contraception, and lack of access to contraceptive services.

Furthermore, the NFHS-1 found that awareness of family planning was high: nearly all (96%) currently married women knew of at least one contraceptive method and nearly four in five of these women (77%) knew where to obtain a method. However, only 29 percent of women living in urban areas of Uttar Pradesh were using any contraceptive method, and this proportion was only 15 percent in rural areas of Uttar Pradesh.

IFPS planners recognized that a robust communication component was required to inform potential users about family planning and to support a change in contraceptive use. Available data also indicated a need to improve the quality of family planning services. Studies identified inadequate technical competence of healthcare providers, misconceptions among family planning workers, and a dearth of client education materials as key factors affecting the quality of services. The 1994 baseline survey for Uttar Pradesh found that the amount of information provided to clients about contraceptive methods varied greatly across districts. Accordingly, the IFPS Project planners realized that BCC initiatives would have to address both reproductive-age consumers as well as healthcare providers in many parts of Uttar Pradesh.

OBJECTIVES

Within the overall project goal of reducing the total fertility rate by increasing the CPR, the IFPS communication objectives were to:

- Promote the concepts of birth spacing, legal minimum age of marriage, optimum childbearing age, and gender equality and
status of women through imaginative communication;
- Ensure appropriate communication, especially between spouses, to empower young couples to make family planning decisions on the basis of informed choice;
- Increase demand for and facilitate access to contraceptives, including a vigorous social marketing program; and
- Facilitate appropriate behaviors so that the program is sustainable.

**INTERVENTION COMPONENTS**

**Communication Strategy, 1995—the Base**

NFHS-1, the IFPS baseline survey, and literature reviews formed the basis for developing the project communication strategy. Johns Hopkins University/Population Communication Services (JHU/PCS), a USAID-funded cooperating agency, provided technical assistance on communication programs to SIFPSA. The process of communication strategy development began in October 1994 with a strategy development workshop attended by about 30 eminent communication experts from both the private and public sectors. Workshop attendees formed a Communications Advisory Group, including external communication experts, representatives of the Government of India (GoI), Government of Uttar Pradesh (GoUP), JHU/PCS, and SIFPSA. This group conducted a detailed program analysis, literature review, and an analysis of lessons learned from communication programs implemented by group members. In April 1995, SIFPSA’s Governing Body approved the communication strategy for the IFPS Project developed as an output of the workshop.

The communication strategy document contains: a review of the current status of family planning in Uttar Pradesh; identification of potential communication approaches and selection of the most appropriate approach; the primary audience segments; possible relevant media; and an introduction of steps to move from strategy to action that would guide BCC and information, education, and communication (IEC) interventions. The strategy recommended repositioning family planning in a health framework, i.e. stating that small families benefit from better health. This approach was selected after reviewing the pros and cons of several alternative approaches within the Uttar Pradesh context, including economic, sociological, developmental, and global approaches.

The primary audience identified for communication interventions included young adults aged 17–25 years who have an unmet need for spacing births. The basis for this selection was NFHS-1 data indicating that contraceptive use among young adults aged 15–19 years and 20–24 years was only 6 percent and 14 percent, respectively. Furthermore, the survey found that more than half (51%) of births in Uttar Pradesh in the previous three years were to mothers under age 25; three in four (76%) births were to mothers under age 30. The Communications
Advisory Group concluded that to have any impact on the population growth rate it was necessary to reach young people in their prime childbearing years before they have exceeded their desired family size.

In addition to the primary audience of young adults who are potential and current contraceptive users, three secondary audiences were identified: influential community members, policymakers, and health service providers.

The IFPS Project communication strategy called for use of multiple interpersonal and media channels. Mass media exposure is relatively low in Uttar Pradesh. The NFHS-I found that 33 percent of households owned a radio receiver and 17 percent had a television set. Use of print materials was also limited, since only 42 percent of residents over age 7 were literate, and only one in four females were literate. Accordingly, the strategy recommended that the appropriate mix of communication channels be determined by the particular audience segment to be reached. Communication interventions were to use various combinations of mass media, folk performances, and listener groups linked to interpersonal communication and client education by healthcare providers.

It was emphasized that research would play a key role throughout the life of the project. The main research components were: formative research to support message design and materials development, pre-testing of messages/materials, monitoring of BCC activities to identify mid-course corrections, and impact evaluation.

The strategy called for development of an action plan as an immediate next step. One of the early initiatives was to select advertising agencies to work with SIFPSA on specific campaign themes, messages, and selection of media channels to reach priority audiences.

**Aao batein karein—the First Multimedia Campaign**

Thompson Social, a well recognized advertising agency with experience in the social sector, was entrusted with the task of designing and implementing the first campaign to promote spacing methods of contraception. The primary audience for the campaign was young couples aged 17–25 years with an unmet need for spacing births. The first phase of the campaign was to be implemented in six focus districts and then extended to other districts after a mid-term evaluation.

The campaign theme was developed by Thompson Social in consultation with the Communications Advisory Group, SIFPSA, JHU/PCS, and other external experts and after extensive concept testing amongst identified audiences. The campaign theme was intended to provide a unifying effect, linking all pieces of communication together, and to highlight one clear action point.

The campaign theme, *Aao Batein Karein* (“Come, Let’s Talk”), evolved from an analysis that a key barrier to adoption of a spacing method was the lack of dialogue—between spouses, between the service provider and the couple.
predisposed to using contraception, and between the policymakers and program implementers. The theme aimed to trigger discussions within and between these groups so that: spouses would discuss contraceptives together, predisposed couples would actively seek information, service providers would discuss contraception with potential users, and policymakers and program implementers would discuss strategies to respond to the demand for services and ensure availability of contraceptive supplies. Campaign planners identified service providers as the most effective catalyst for change and interpersonal communication as the most effective tool. Hence, the campaign focus was aimed at bringing the potential user and the service provider together. The campaign also included an advocacy component directed at policymakers to foster a supportive environment for family planning.

Creative execution of the theme featured the Tota (parrot) and Maina (mynah). The Tota-Maina cycle of stories-with-a-meaning have existed throughout northern India for more than 1,000 years and were still popular and easily recognized as talking birds. They also represented the “male” and “female” in legends and folklore. The theme was visually represented by the two birds sitting on the mythical Kalpavriksh—a tree of plenty that gives you all that you want. The tree was later simplified to a branch of an apple tree to reduce visual clutter. The visual together with the tag line of Aao Batein Karein formed the campaign logo. Visuals of the birds and the tree were used in all media/materials produced under the campaign, with some adaptations depending on the purpose of the specific media/materials.

Campaign components included a mix of mass media, community-level media, and interpersonal communication. Radio and TV spots, press advertisements, hoardings (billboards), paintings on bus panels, and folk performances were used. Educational materials were developed for use by frontline healthcare service providers. Thompson Social was responsible for the design and production of all print and audio-visual materials and initial release through mass media. Training for interpersonal communication and folk performances was contracted out to agencies with proficiency for the task and bus panels were implemented with a direct contract with the Uttar Pradesh State Road Transport Corporation. All materials were developed after pre-testing by external research agencies.

A major effort focused on training frontline healthcare providers in interpersonal communication. SIFPSA and JHU/PCS conducted training-of-trainers workshops for a large team of trainers from external agencies contracted to implement the training program. Altogether, more than 18,000 auxiliary nurse midwives (ANMs) and community-based distribution (CBD) workers from both the private and public sectors in 33 districts were trained. ANMs and CBD workers received orientation on the campaign theme and effective use of the campaign materials through a series of one-day workshops at the block level. Training and materials provided to ANMs and CBD workers
increased their confidence and morale. Additionally, conducting the interpersonal communication training jointly for healthcare workers from the public and private sectors helped foster a team approach.

From 1998 to 2002, the IFPS Project implemented the Aao Batein Karein campaign in six-month phases, beginning with training of providers and distribution of interpersonal communication materials to them, followed by mass media dissemination designed to generate demand for family planning services. The campaign was initiated in six focus districts—Aligarh, Gorakhpur, Jhansi, Rampur, Sitapur, and Tehri Garhwal (then in Uttar Pradesh). The interpersonal communication and local media components were later rolled out to 15 districts and then extended to 33 districts of Uttar Pradesh. The cost of the five-year campaign was approximately Rs. 100 million (~ USD 2.3 million).

**Age at Marriage Campaign**

IFPS designed and implemented a multimedia campaign to increase awareness of the legal age of marriage. Early marriage is a serious problem in Uttar Pradesh, where about 64 percent of girls marry before reaching the legal age of marriage. Early marriage not only contributes to the high fertility rate, but also leads to early childbearing, which has greater health risks for both the mother and child.

Increasing public awareness of the legal age of marriage for girls and boys was a key strategy identified in the GoUP’s Population Policy. Specific objectives stated in the policy are to:

- Increase the median age at marriage for women from 16.4 years to 19.5 years by 2016;
- Increase awareness about the legal age of marriage for males from 18 percent to 80 percent by 2011; and
- Increase awareness about the legal age of marriage for females from 27 percent to 80 percent by 2011.

The IFPS campaign on legal age of marriage was designed to aid the government in achieving these objectives.

M/s Percept Advertising was contracted for the design and implementation of this campaign. The campaign developed was a straightforward reminder of the legal age of marriage. Creative execution of the campaign highlighted the legal, education, and health implications of early marriage. Campaign messages were hard-hitting, stressing the dire legal consequences, the feeling of humiliation of a girl remaining uneducated due to early marriage, and the outcome of poor health due to early marriage.

The campaign was implemented in all 70 districts of Uttar Pradesh over a five-month period during 2002–03. Campaign components included radio and television spots, press advertisements, and local and outdoor media. Total cost of the campaign was approximately Rs. 33 million (~ USD 750,000).

**Family Life Education**

IFPS Project planners recognized that bringing about behavior change and creating demand for family planning services called for
addressing diverse audiences. Youth, especially adolescents and young married couples, were identified as a key audience. To educate the youth of today before they become the parents of tomorrow, IFPS initiated a family life education (FLE) program in 1995–96. Three priority groups were identified: secondary school students, college/university students, and youth outside the conventional education system. Students within the university system were perceived as important for behavior change with respect to population planning, and perhaps the most perceptive and the least controversial due to their age, exposure, and maturity. The first phase of FLE activity hence concentrated on this group; the program was later extended to rural, out-of-school youth.

The FLE program was piloted in Lucknow through a series of workshops at four degree colleges for girls and for male students at Lucknow University. The workshop curriculum was designed around the two focus themes of “responsible” and “healthy” living in the context of entering adulthood. A component of career counseling was also included. Based on the feedback from these pilot workshops, SIFPSA drafted an FLE policy that laid out the basic approach and themes of the FLE program.

Two large, three-year projects developed in line with the FLE policy were implemented through NGOs in colleges affiliated with Gorakhpur University and Kanpur University. JHU/PCS trained a team of master trainers from each district. The trainers included both teachers and students from the colleges.

CEDPA developed the FLE curriculum for rural youth and pre-tested it in three districts. Nehru Yuvak Kendra, an association of non-student rural youth, implemented a project for out-of-school youth in rural areas of Uttar Pradesh.

Despite general recognition of the importance of family life education, the FLE program was not scaled up during IFPS-I. The intensity of program activities varied across program sites. The FLE program continues in limited districts in IFPS-II.

Other Communication Efforts
In addition to integrated multi-media campaigns, communication activities under the IFPS Project were implemented in support of various service delivery projects. Following are some such communication initiatives.

**Tetanus Toxoid (TT) Campaign.** From 1999–2002, IFPS and the state Department of Health and Family Welfare organized five statewide campaigns to provide TT immunization services to pregnant women. This was a perfect example of a well-coordinated effort between the public and private sectors. While ANMs enumerated, listed, and provided immunization shots to pregnant women from village to village, the NGO CBD workers made home visits and organized group meetings to spread awareness about the importance of TT immunization and publicize campaign dates and venues. Handbills and posters with key messages were provided to the frontline health workers. The initiative was also supported by hailer messages, TV and radio spots, and
press advertisements released prior to the immunization drives. (See Chapter 15.)

Reproductive and Child Health (RCH) Camps. Integrated camps providing an array of maternal and child health and family planning services under one roof at block-level health centers were implemented through the public health system. IFPS introduced the concept of a “family health day” to improve access to quality services. These camps were organized on a specific day of the week based on a pre-planned calendar. Communication support was designed to draw in people to the camps and inform potential clients about the range of quality services available, venues, and dates. Press advertisements, banners displayed at strategic locations, handbills, and announcements through public address systems were used to publicize the RCH camps. (See Chapter 6.)

Private-sector Projects. Activities carried out by NGOs, dairy cooperatives, and the corporate sector constituted local level implementation of centrally planned and executed multimedia campaigns (*Aao Batein Karein*, Age at Marriage, and TT campaigns). These projects also included a small, yet significant communication component planned and implemented locally. NGO workers undertook writing of slogans on walls within the villages, holding regular group meetings, and composing and singing songs propagating messages on immunization and family planning. Some projects included organizing local health fairs and video shows; others developed community-specific posters. NGOs also developed indigenous materials such as *phads* (scroll paintings on cloth) locally. The dairy cooperative projects had RCH messages painted on all the milk vans plying the village routes to collect milk and on milk packets. A project with the postal department in Sitapur District involved development of messages for painting on post boxes and printing on postcards and postal envelopes. (See Chapters 8–10.)

Training Projects. Training projects in both the public and private sectors had communication inputs. To recruit volunteer clients for no-scalpel vasectomy trainings, advertisements were printed in local newspapers. Leaflets and other print materials were developed as reference materials for distribution to trained healthcare providers. Wall paintings on the five “cleans” for safe delivery were done in villages where dais (traditional birth attendants) were trained. Trained dais received pictorial flash cards for client education and a pictorial record-keeping book. Trained indigenous systems of medicine practitioners (ISMPs) received leaflets on spacing and limiting contraceptive methods and a name-board announcing their skilled status. (See Chapters 7, 11, and 12.)

Capacity Building and Advocacy Training workshops were organized for various levels within the government health system to build capacity for efficient management of the communication component within the reproductive health program. While advocacy was an important part in all campaigns,
these workshops were also a means of advocating for the importance of communication in all health programs.

As part of its technical assistance for the IFPS Project, JHU/PCS hosted several health communication workshops and study tours for NGO representatives, government managers and officials, and university specialists from Uttar Pradesh. These workshops were intended to help them to design, implement, and evaluate health communication interventions. They also included orientation in skills for advocacy, program analysis, media planning, community mobilization and management of communication programs. Selected participants from the government and NGOs were also sent every year to the Johns Hopkins University, in the United States, to attend additional training on health communication.

**Media Mix**

Women in Uttar Pradesh have limited exposure to mass media and, therefore, a multi-channel approach was needed. The 1992/93 NFHS-1 study found that about a third of the households in Uttar Pradesh owned a radio receiver and 17 percent had a TV set, predominantly in urban areas. Among ever-married women having access to mass media, 19 percent said they watched TV at least once a week, 28 percent listened to radio at least once a week, and 4 percent visited a cinema theater at least once a month. Media exposure in urban areas was much greater than in rural areas.

In the six years between the two NFHS surveys, media exposure among women in Uttar Pradesh did not change much, except that more urban and rural women were watching television in 1998/99 compared with 1992/93 (see Table 1). During this period, the proportion of women who were not exposed to any media declined from 65 percent to 55 percent. In 1998/99, three in five rural women still had no access to mass media. Roughly 30 percent of the women surveyed in 1998/99 were exposed to television and radio. Exposure to newspapers/magazines and cinema/theater was relatively low.

### Table 1. Reported Mass Media Exposure Among Ever-Married Women Aged 15–49 in Uttar Pradesh

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not regularly exposed to any media</td>
<td>64.5% (31.4%, 72.8%)</td>
<td>54.7% (20.2%, 63.4%)</td>
</tr>
<tr>
<td>Reads a magazine or newspaper at least once a week</td>
<td>--</td>
<td>12.6% (33.9%, 7.3%)</td>
</tr>
<tr>
<td>Watches television at least once a week</td>
<td>19% (58.5%, 9.1%)</td>
<td>32.1% (74.7%, 21.4%)</td>
</tr>
<tr>
<td>Listens to the radio at least once a week</td>
<td>29.7% (50.6%, 24.5%)</td>
<td>29.5% (43.8%, 25.9%)</td>
</tr>
<tr>
<td>Visits the cinema/theater at least once a month</td>
<td>4.1% (16.3%, 1.6%)</td>
<td>3.5% (11.7%, 1.5%)</td>
</tr>
</tbody>
</table>

Sources: NFHS-1 (International Institute for Population Sciences, 1995) and NFHS-2 (IIPS and ORC Macro, 2000).

**Television.** Despite low TV exposure in rural areas, some studies in rural areas of Bihar, Madhya Pradesh, and Uttar Pradesh found that TV viewers had very high gains in health knowledge, particularly due to TV spots. Based on these findings, TV spots were an integral part of all multimedia campaigns, including the *Aao Batein Karein*, Age at Marriage, and TT campaigns.

The *Aao Batein Karein* campaign had 30- and 60-second spots on four...
Behavior Change Communication

topics: an overarching theme spot and one each on the three spacing methods—condoms, oral pills, and intrauterine contraceptive devices (IUCDs). Mr. Ketan Mehta, an internationally renowned filmmaker from M/s Maya Entertainment Ltd., directed the production of these spots.

Three types of spots based on the legal, educational, and health aspects of early marriage were produced for the Age at Marriage campaign. For the TT campaign, an existing spot developed by the GoI was modified and used.

The TV spots were broadcast over both national and local programs. National programs had a much wider penetration in rural areas, but they were expensive and some of the coverage overlapped with local programs. While local programs reached fewer people in Uttar Pradesh, they were inexpensive and, therefore, could be broadcast more frequently. Hence, the media plan called for an optimal mix of national and local programs.

Radio. To aid easy recall, audio versions of TV spots were developed for broadcast on radio within the same campaign themes. The spots were broadcast during popular film music programs and the regional news in all primary channels of Uttar Pradesh All India Radio for statewide coverage.

Nine types of radio spots were developed for the Aao Batein Karein campaign. One spot each was developed on: (1) the campaign theme; (2) the ideal service provider; and (3) advocacy with pradhans and opinion leaders in the villages. Six spots covered spacing methods and addressed common fears, myths, and misconceptions relating to the three spacing methods.

Three types of radio spots were developed for the Age at Marriage campaign and two types for the TT campaign. Spots for the TT campaign included announcements of the campaign dates.

Press advertisements. Given the limited press readership in rural areas due to low literacy levels, press advertisements were mainly aimed at advocacy for the program and garnering the support of key decisionmakers at various levels.

For the Aao Batein Karein campaign, five press advertisements in Hindi and English were developed. One introduced the campaign theme and four others targeted doctors, pradhans, service providers, and journalists. The unusual inverted T layout of the advertisements attracted special attention.

The three types of press advertisements developed for the Age at Marriage campaign were consistent with the themes used in TV and radio spots. For wider reach, these advertisements were developed in Hindi, Urdu, and English.

Press ads for the TT campaign mainly highlighted the importance of TT immunization and announced the campaign dates.

Interpersonal communication materials. Materials on campaign themes were produced to assist the frontline
Ideas, Insights, and Innovations

health workers in their contacts with clients.

Materials for the Aao Batein Karein campaign included: a flipbook describing spacing methods and their correct usage and tackling myths and misconceptions; a poster displaying the campaign logo listing the range of contraceptive choices available; stickers as a reminder for the campaign theme; calendars for distribution to clients, prospective clients, and opinion leaders; and an identity badge and bag for the frontline health workers. Other materials were wall charts and desk calendars for the trained ISMPs and method-specific leaflets for spacing and limiting methods. All materials were easily recognizable as part of the campaign theme with a green foliage border, common colors, and the use of Tota-Maina and the campaign logo.

Outdoor media. Hoardings (billboards), wall paintings, and bus panels were outdoor media used in the Age at Marriage campaign to serve as a reminder of the campaign themes. The Aao Batein Karein campaign employed only wall paintings and bus panels. Simple designs with prominent, focused messages were developed for wall paintings, hoardings, and bus panels.

Folk media. The use of folk media by SIFPSA to disseminate messages commenced as part of the Aao Batein Karein campaign promoting greater discussion of spacing methods. Recognizing the limitations of print and electronic media owing to low literacy levels and ownership of TV and radio, it was deemed necessary to reach out to these ‘media-dark’ areas through a medium that would have a lasting impact even with a single exposure in a village. Folk performances, with their high entertainment appeal and acceptability, were hence the obvious choice.

Implementation of folk performances followed a rigorous three-stage process: (1) identification of region-specific folk forms and selection of troupes in these folk forms; (2) script writing by experts in selected folk forms and training of troupes on performing the standardized scripts; and (3) route-planning, performances, and monitoring of both the quality and quantity of performances.

Six popular folk forms—puppetry, qawwali, nautanki, birha, alha, and magic—were chosen for carrying messages initially under the Aao Batein Karein theme. They were later extended to include messages on the legal age at marriage, TT immunization, and RCH camps. Puppetry and qawwali, essentially a religious form of singing of Sufi origin, are popular throughout Uttar Pradesh. Nautanki, a musical folk drama, has universal appeal across regions and across all age groups. Birha is a folk singing style of the eastern part of Uttar Pradesh, and alha traditional folksongs are popular in the Bundelkhand region for their war themes, tunes, and singing style. Magic shows are especially popular among young men and women throughout the state.

Troupes specializing in these folk forms and registered with the state Information Department and the
Song and Drama Division were auditioned by experts and selected for training. Brij Lok Madhuri, an agency with professional expertise in script writing, production, and training, was selected for identification of troupes, script writing, and training of troupes. JHU/PCS assisted in drawing up the training module. Since 1999, IFPS has trained more than 100 troupes in the selected folk forms in four workshops. Scripts written by experts featured stories that were rich in entertainment value and contained standardized, technically accurate messages on reproductive health.

NGO workers were involved in the venue selection, management of the performances, and advance publicity for the performances. From 1999–2003, about 10,000 performances were held in villages. These performances were closely monitored, with feedback mechanisms in place.

The IFPS Project spent a total of Rs. 26 million (USD 551,000) on folk media campaigns through seven phases.

Fairs (melas). To leverage opportunities for greater audience outreach, IFPS participated in prominent traditional fairs and exhibitions such as Kumbh Melas at Allahabad and Haridwar and Nauchandi Mela at Meerut. Campaign communication vehicles were woven into exclusive health melas organized by the GoI. Stalls in these fairs were designed around the spacing campaign theme of Aao Batein Karein using the Tota-Maina mnemonics. Based on the popularity of melas, especially in rural areas, IFPS participated in syndicated mobile fairs held in villages to increase rural markets for commercial products. These fairs attracted large numbers of people across various socioeconomic, gender, and age groups. IFPS partner agencies organized an information booth and provided selected RCH services on-site plus referrals for other services. The IFPS stall had illustrated panels with reproductive health messages, which formed the backdrop for counseling and on-site immunization. Many local health service providers participated in the melas. Counseling and audience interaction were supported with activities combining entertainment and education, such as embroidery and quiz competitions based on identified topics and message strategies. Other activities such as magic shows and film showings were designed to attract large audiences. A feature film screened in the evening had video spots with campaign messages interspersed to reinforce messages.

During the IFPS Project, a total of 450 fairs were held, covering 1,350 villages in 18 districts. This initial success was followed by a series of mobile health fairs in villages and haats (local weekly markets).

**Revised Communication Strategy, 2003**

In late 2002 a six-member consultant team from the Population Technical Assistance Project (POPTECH) conducted an assessment of the IFPS Project. The team made three specific recommendations for communication work, which are quoted below:
• Develop and implement an integrated communications plan to support project initiatives in the public, commercial and private (including NGO) sectors. Such a program should inform people of all effective methods of contraception that are available to them and where and how they can access those methods. This plan should provide for consistent messages and symbols of quality. The required tasks for project management and staff are to emphasize communications, address the issues and test SIFPSA’s ability to move aggressively and to engage competent outside technical support as necessary.

• Project messages embedded in IEC materials and other behavior change materials should be targeted to specific segments within the FP/RH market, for example, young girls who have not yet initiated sexual activity, young married couples who want to delay the next pregnancy and birth, and women who have completed their desired childbearing.

• Over time, SIFPSA should build behavioral science into program design, increase the use of entertainment-education through the mass media, stimulate discussion and debate, design communication strategies broad enough to accommodate a range of reproductive health concerns and yet specific enough to deliver clear and simple messages that will lead to family planning outcomes, and introduce new communication technologies. (LTG Associates and TvT Global Health and Development Strategies, 2003, p. 27)

Based on the external assessment and an IFPS stocktaking exercise facilitated by USAID, a revised communication strategy was developed by SIFPSA with technical assistance from JHU/PCS in early 2003. While the overall communication approach remained the same, the earlier strategy was revisited in light of the changed scenario as presented by the 1998/99 NFHS-2, 2001 Census, and other studies (e.g. Sample Registration Survey and Reproductive and Child Health Survey). The revised project objectives that now included reproductive health indicators were also taken into consideration as were the lessons learned in managing past communication programs.

The revised strategy identified key topics that needed to be addressed through communication to help achieve program goals. These topics included the five family planning methods (condoms, oral contraceptive pills, IUCDs, female sterilization, and male sterilization); selected maternal and child health issues (safe delivery, breastfeeding, and immunization); promotion of trained providers and upgraded clinics; and building capacity to manage communication programs. The strategy also identified primary and secondary audiences for future communication activities.

The strategy recommended the use of mass media for an “enter-educate” approach through a drama series, extensive use of community media (video vans, folk media, and
special health events), interpersonal communication, and multimedia campaigns for specific topics. Capacity building needs, research needs, and the need for synergy with social marketing campaigns were also discussed.

To ensure smooth and timely implementation of communication interventions, the strategy suggested that the Technical Advisory Group be re-activated. This group would meet periodically to make major recommendations regarding program management. The execution of campaign components would be managed by the SIFPSA IEC Division, with the Division-in-Charge as the approving authority. The strategy recommended that the design and development of campaigns should either be done by a single, large advertising agency or a consortium of agencies led by one, to ensure synergy among all communication efforts.

**Planned BCC Campaigns and Radio Series**

Post revision of the strategy, three BCC campaigns and two radio series were designed (see Table 2). However, these initiatives were carried over to the second phase of the IFPS Project, for implementation. The voluntary female sterilization campaign was launched in mid-2006, the two radio series have been produced and are ready for launch, and the IUCD campaign launch is scheduled for late 2006.

**PROJECT MANAGEMENT**

Every campaign and major activity was developed as a project by either a Project Coordinator or an

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**TABLE 2. COMMUNICATION INITIATIVES PLANNED DURING THE IFPS-I PROJECT**

<table>
<thead>
<tr>
<th>Campaign</th>
<th>Objective</th>
<th>Media Channels</th>
<th>Target Audience</th>
<th>Creative Designer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sterilization</td>
<td>Inform potential clients and families about method’s use, availability, and benefits</td>
<td>Television, radio, print, outdoor signage</td>
<td>Couples wishing to limit childbearing</td>
<td>LOWE (Lintas)</td>
</tr>
<tr>
<td>IUCD</td>
<td>Inform potential clients about the Copper T380A</td>
<td>Television, radio, print, package design for IUCD and leaflet for clients</td>
<td>Women needing a long-term spacing method, their husbands, and mothers-in-law; service providers</td>
<td>O&amp;M</td>
</tr>
<tr>
<td>Emergency obstetric care and newborn care</td>
<td>Help families prepare for obstetric emergencies</td>
<td>Posters, flipcharts, hoardings (billboards)</td>
<td>Pregnant women, their husbands, and families; service providers</td>
<td>O&amp;M</td>
</tr>
<tr>
<td>Distance learning for healthcare providers</td>
<td>Provide information on various family planning and RCH issues to providers</td>
<td>26 radio programs</td>
<td>Healthcare providers, especially ANMs and community health workers</td>
<td>Production – New Media (Harish Bhimani); script writer – independent consultant</td>
</tr>
<tr>
<td>Radio drama series</td>
<td>Provide enter-educate material on family planning and RCH issues</td>
<td>Drama series on radio</td>
<td>General audience, couples, and their families</td>
<td>Production – New Media (Harish Bhimani); script writer – independent consultant</td>
</tr>
</tbody>
</table>

Sources: Adapted from Piet-Pelon, 2005, p. 12.
Assistant Project Coordinator of the IEC Division of SIFPSA, which followed an approval process similar to projects from other divisions. The approval process for BCC projects tended to take longer because projects with large budgets had to be approved by SIFPSA’s Governing Board, which met once every year.

Once approved, the project was then managed by the concerned Project Coordinator/Assistant Project Coordinator in collaboration with the implementing agency. However, even when a BCC project had been given overall approval, every activity within campaigns had to be approved by the Executive Director through appropriate channels. This process often took considerable time and led to delays in implementation.

**Staffing**

The staffing for the IEC Division of SIFPSA has evolved over the years. Initial approved positions included a General Manager, two Project Coordinators, and one Assistant Project Coordinator. This four-person staff was later expanded to seven positions, including a Deputy General Manager and an additional Project Coordinator and Assistant Project Coordinator. However, many positions in the IEC Division have been vacant during the IFPS Project, limiting the division’s productivity. The top leadership posts—the General Manager and Deputy General Manager—were often vacant, thus undermining the IEC Division’s ability to advocate for communication interventions as a priority.

**Collaboration**

The IEC Bureau of the state Health and Family Welfare Directorate, based in Lucknow, has the mandate to lead reproductive health communication efforts in Uttar Pradesh. With technical support from JHU/PCS, the IFPS Project provided audio-visual equipment to establish a resource center at the IEC Bureau. However, by late 2005, this resource center was no longer functional (Piet-Pelon, 2005) owing to frequent changes in the management within the IEC Bureau. SIFPSA’s expertise in planning and managing communication interventions could be positively used to strengthen the government efforts. However, this is an area that needs to be explored further.

**MONITORING AND EVALUATION**

Research was recognized as an important part of campaign planning, monitoring, and evaluation of communication interventions. Campaigns were designed on the basis of existing research data and extensively pre-tested through external agencies. Campaigns such as the Aao Batein Karein campaign underwent three rounds of pre-testing—starting with pre-testing of different concepts, followed by that of the visual depiction of the finalized concept, and lastly by pre-testing of all materials developed within the campaign.

Every component of campaigns was intensively monitored by NGO staff, SIFPSA officers, and the district Project Management Unit (PMU) officers. To illustrate the rigorous monitoring, folk performances were
monitored at four levels on specified formats:

- Daily monitoring done by the supervisors of IFPS NGO partners;
- Detailed periodic monitoring by senior functionaries of NGO partners;
- Periodic monitoring and trouble-shooting by SIFPSA and PMU officers (more than a third of the total performances were monitored); and
- Monitoring of quality of performances by experts.

The monitoring covered aspects of pre-publicity efforts undertaken, involvement of village influentials, venue suitability, stage, lights and sitting arrangements, quality of sound systems, costumes and musical instruments used by troupes, overall quality of performance, audience size, composition and reaction of audience, and capacity of the troupe to hold audience attention.

Independent research agencies conducted evaluations for the TT campaign and the pilot project on mobile health fairs. However, the two major campaigns—**Aao Batein Karein** and Age at Marriage—did not have campaign-specific evaluations.

The **Aao Batein Karein** campaign had a robust research plan, which included a baseline study, mid-term evaluation for mid-course corrections, and an endline evaluation. SIFPSA selected an external research agency and commissioned it to conduct the entire study. However, the baseline study report ran into several problems. The entire dataset had to be re-entered as the soft copy of data entered earlier was lost.

The final baseline report was made available long after the end of the campaign implementation; by then it was considered too late to do an endline survey. Hence, there is no campaign-specific evaluation available as planned. However, surveys were conducted immediately after the campaign in five districts (see Results section below).

**RESULTS**

From the beginning of the project, benchmark indicators were formulated to assess the impact of communication interventions in the 15 project districts. Baseline values for the indicators came from the 1995 PERFORM survey conducted in 28 districts. The benchmark indicators were extrapolated from the proportion of PERFORM survey respondents who had specific characteristics such as knowledge of family planning. (Men were not surveyed in 1995 but were assumed to have the same characteristics as women.) After completion of three phases of the **Aao Batein Karein** campaign, ORC Macro and the ORG Center for Social Research (2000a) conducted the evaluation of the Benchmark in March 2000. The evaluation was based on multi-cluster random samples of currently married women aged 13–49 and their husbands. The survey was done in five districts, with the results extrapolated to the 15 project districts. ORC Macro and the ORG Center for Social Research (2000b) conducted a second survey in October 2000 using a stratified random sample in five districts. Key findings from the two surveys were:

- Knowledge of family planning health benefits. The number of women who reported 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 Center 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 Center 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.

The Aao Batein Karein and the Age at Marriage campaigns were also considered in a Rapid Communication Appraisal Study conducted by the Center For Advocacy and Research (CFAR) and commissioned by the Hindustan Latex Family Planning Promotion Trust in March 2003. This study included an organizational review as well as a field-based appraisal through focus group discussions in
villages in three districts of Uttar Pradesh. The report states:

“More recently, all three districts witnessed very high profile campaigns related to pulse polio and the legal age at marriage for girls. Since these campaigns took on many forms and in the case of the latter used wall paintings to impress upon the target audience the gravity of the message, the recall was almost instantaneous.”

“They not only recognized the Aao Batein Karein as a SIFPSA campaign, but also explained to us that folk drama conducted by them had educated them about the health needs of adolescent girls and had impressed upon them the need to have a gap of three years between two children. (CFAR, 2003, p. 34).”

The recall of the Aao Batein Karein campaign is especially significant, since the CFAR study was conducted nearly a year after the campaign had ended.

Analysis of monitoring and feedback formats from 2,100 folk performances (Deepak and Seema, 2004) provided useful insights about the impact of folk media. The key findings were:

- Attendance at most performances was good, with about 27 percent of them drawing an audience of more than 1,000 people. Only about 9 percent of the performances attracted crowds of fewer than 300 people. Opinion leaders attended 96 percent of the performances.
- Ninety-eight percent of the troupes could create a rapport with the audience—an important feature for effectiveness of the performances.
- The audiences correctly comprehended that the messages through the performances were on health and family planning: 43 percent said that the messages were on temporary methods of family planning and 16 percent mentioned health messages.

Evaluation of a pilot project on mobile fairs in two districts, Shahjahanpur and Gonda, was done by the ORG Center for Social Research (2003). The study used a mix of quantitative and qualitative techniques with an overall sample of 840 respondents in two districts. The evaluation revealed that:

- Four in five (80%) of the respondents had heard the pre-publicity announcements of the fair and were aware of it in advance.
- The key motivating factors to attend the melā were availing immunization services (44% in Shahjahanpur and 53% in Gonda), followed by acquiring health and family planning information (46%) and curiosity/inquisitiveness (45%).
- Among the male respondents in Gonda district, awareness about various activities was quite high (up to 98 percent for Male Camp and Magic Show). When asked about the visit, 97 percent of respondents confirmed visiting the Male Camp followed by the Magic Show (90%) and Lucky Draw (78%).
- Awareness among females was quite high for the Mahila Mandal, Immunization Camp,
and Pregnant Women Camp (about 94–98%). Participation in the movie show was found to be low: among male respondents 62 percent in Gonda and 22 percent in Shahjahanpur had watched, while females seldom watched the movie show.

- Seventy-nine percent and 64 percent of the visitors to the Pregnant Women Camps in Gonda and Shahjahanpur, respectively, received a TT injection at the camp.
- Among men, about 86 percent of respondents in Gonda and about 93 percent in Shahjahanpur were able to recall the information provided in the camp on spacing methods of contraception. Information on gender issues (80%), family planning counseling (79%), and AIDS (74%) were other high recall responses.
- Among women, 86 percent of respondents in Gonda and 84 percent in Shahjahanpur were able to recall the information provided on the legal age at marriage. In Gonda, immunization information (89%) and advice on antenatal care services (75%) were other top recalls. In Shahjahanpur, family planning counseling (89%) and advice on antenatal care services (60%) were recalled by most of the respondents.

LESSONS LEARNED
The communication component was an important element of the IFPS Project. Although the initial communication strategy was carefully planned, with technical inputs from JHU/PCS and experts in the field, the strategy was not fully executed. Some of the factors impeding timely implementation of communication programs were SIFPSA’s internal processes that led to delays in approval and implementation, lack of a long-term strategic action plan, and inadequate staffing in SIFPSA’s IEC Division. Other factors—such as penetrating rural areas that had limited media reach, compensating for a weak health infrastructure, and overcoming cultural barriers—were beyond the IFPS Project’s control.

The main outcome of centralized communication initiatives was the Aao Batein Karein campaign, which supported efforts to educate couples about birth spacing methods. The TT campaign clearly increased awareness of and use of TT immunization among pregnant women. The communication components of the IFPS Project that supported RCH camps, private-sector projects, and training of health providers were generally acknowledged to be effective. Due to the lack of evaluation research, there was little opportunity for learning or for creating new messages building on past ones.

The major lessons learned in execution of the communication component are drawn from SIFPSA documents, reports by the USAID-funded POPTECH evaluation team (LTG Associates and Tvt Global Health and Development Strategies, 2003) and Nancy Piet Pelon (2005), interviews with SIFPSA staff, and external sources. Following are the key points.
Critical Factors for Success

Strengthening interpersonal communication. One of the impressive outputs of the IFPS Project was the training of 18,000 frontline health workers during a three-month period. This initiative demonstrated that these workers could be trained in specific RCH topics and interpersonal communication and that training workers from the public and private sectors together was feasible. One lesson for the future was that the trainings relied mainly on the skill of the facilitators and hence varied in quality. In the future, training agencies need to develop a training methodology that does not rely so much on the facilitators’ skills.

Unifying theme. The use of a unifying theme with a single focused action point such as Aao Batein Karein was very effective in binding campaign elements together and aided instant recall as evidenced through monitoring visits and mentioned in the CFAR report.

Local involvement in folk performances. Folk theater and singing were very popular with rural audiences. However, their overall effectiveness in changing attitudes and behavior was not measured, so there is no information on which to base future program decisions. Nevertheless, several important lessons were learned during implementation of folk performances, which were incorporated mid-course as well:

- Regional preferences for folk styles were an important consideration in planning performances. For instance, birha is not liked by audiences in western Uttar Pradesh, whereas alha is preferred and understood only in the Bundelkhand region.
- Involvement of district officials and NGOs in logistics planning and scheduling is effective and necessary.
- Adequate pre-publicity of the performance a day in advance is imperative for crowd mobilization. The crowds were larger in places where NGO workers had done the pre-publicity, compared with the areas where the pradhan was expected to assist in pre-publicity but had not shown adequate interest in doing so.
- Calling the local NGO worker, dai, or ANM to the stage and introducing him/her to the audience helped to increase the self-esteem of these providers.

Challenges

Sequential implementation. Development of the communication strategy was to be followed by a detailed action plan that would specify all areas that required communication support and action. Instead, a step-by-step approach of designing one campaign, implementing it, and then designing another was followed. The efforts, therefore, did not seem coordinated and comprehensive. Clear next steps and a detailed, comprehensive action plan are essential components in implementation of any communication strategy.

The Aao Batein Karein campaign was designed as a multimedia campaign to be launched simultaneously in different media to reach a wider audience and maximize the impact of different media. However, the process of materials development
and, hence, the launch for interpersonal communication and mass media were staggered initially, thereby diluting impact. However, they were later re-launched simultaneously and positive results were achieved.

**Procedural delays.** The IFPS Project communication strategy had assumed a series of multimedia campaigns. However, only three campaigns (*Aao Batein Karein*, Age at Marriage and TT) were implemented between 1995 and 2003. Three campaigns and two radio series were developed towards the end of the IFPS-I Project in 2004, but they were not implemented until 2006 under IFPS-II. The approval process in the IEC Division is centralized and time-consuming, resulting in campaigns taking a year or more to produce (Piet-Pelon, 2005). Piet-Pelon recommends that internal procedures be simplified and decentralized to ensure timely implementation of campaigns.

**Need for advocacy.** The best of communication plans often do not get implemented if the key decisionmakers are not convinced about their effectiveness and need. Advocacy to persuade decisionmakers to give priority to communication interventions is critical to ensure timely implementation of plans.

**Research underutilized.** While the importance of research was undisputed, it remained underutilized for campaign evaluation and further planning. It was hence not possible to statistically validate the positive impact of various campaigns that was reported in informal feedback from monitoring visits and field workers. An important lesson learned is that well-planned and implemented research studies are essential to communication programs.
REFERENCES


State Innovations in Family Planning Services Project Agency (SIFPSA), United States Agency for International Development (USAID), and the EVALUATION Project. 1996. “Performance Indicators for the Innovations in Family Planning Services Project.” Lucknow, Uttar Pradesh, India: EVALUATION Project.

TETANUS TOXOID CAMPAIGN: Reducing Neonatal and Maternal Mortality

By Seema Talwar

RATIONALE

In India, a leading cause of death in infancy is neonatal tetanus, which is caused by newborn infants becoming infected by tetanus organisms, usually at the umbilical stump. Neonatal tetanus typically occurs when babies are delivered in unhygienic environments, non-sterilized instruments are used to cut the umbilical cord, or animal dung is applied to the umbilical stump. Furthermore, tetanus can infect mothers during delivery due to the same causes, leading to maternal tetanus. Neonatal tetanus typically develops during the first or second week of life and is fatal in about 70 percent of cases (National Family Health Survey [NFHS] 2, 1998/99). If neonatal tetanus infection occurs where expert medical help is not available, as is common in many rural areas in India, death is almost certain. According to a 2002 survey, 28 percent of neonatal deaths in Uttar Pradesh were caused by tetanus (ORG Center for Social Research, 2003).

Neonatal tetanus is a preventable disease. Two doses of tetanus toxoid (TT) vaccine given to the mother one month apart during early pregnancy are nearly 100 percent effective in preventing tetanus among newborn infants and their mothers. Immunity against tetanus is transferred to the fetus through the placenta when the mother is vaccinated. The TT vaccine is stable and can withstand exposure to room temperature for months and up to 37 degrees Celsius for a few weeks without a significant loss of potency (World Health Organization, 2006).

National Tetanus Toxoid Immunization Program

Recognizing the need to safeguard pregnant women and newborns against tetanus, the TT immunization program for expecting mothers was initiated in India in 1975–76 and was integrated with the multi-vaccine Expanded Program on Immunization (EPI) in 1978. To step up the pace of the immunization program, the Government of India (GoI) initiated the Universal Immunization Program (UIP) in 1985–86. An important objective of the UIP was to achieve 100 percent coverage of TT vaccination among pregnant women by 1990. In 1992/93, the government integrated the UIP into the Child Survival and Safe Motherhood Program, which in turn was subsequently integrated into the Reproductive and Child Health (RCH) Program (NFHS-2).
An Immunization Strengthening Project (ISP) conducted from 2000 to 2003 had three main components: polio eradication, strengthening routine immunization, and strategic framework development. According to the GoI’s RCH II plan document, the objectives of the three-year ISP plan are being worked toward and improved upon. The impact of the UIP is measured in terms of vaccine preventable diseases burden. However, while objectives were being worked upon, the stated ISP goals were not fully achieved, which highlighted the urgent need to address the deficiencies in immunization systems and emphasized the need for strengthening the system and vigilant monitoring and surveillance (GoI, 2005). Increased emphasis was given to improving immunization coverage rates, including those for TT vaccination.

According to the Indian National Immunization Schedule, a pregnant woman should receive two doses of TT vaccine, the first when she is 16 weeks pregnant and the second when she is 20 weeks pregnant. Reinoculation is recommended every three years with a booster dose. If two doses were received less than three years earlier, a single booster injection is recommended (NFHS-2).

**Uttar Pradesh’s Low Reproductive and Child Health Indicators**

Uttar Pradesh’s TT campaign approach was initiated in 1999 following an evaluation of key reproductive and child health (RCH) indicators for the state. The 1998/99 NFHS-2 revealed that Uttar Pradesh’s maternal mortality ratio was the highest among all states in India, access to antenatal care services was low, and trained personnel provided assistance to less than one-quarter of the total deliveries in the state (see Table 1). Also, nearly one-third of currently married women aged 15–44 years had symptoms of reproductive tract infections (RTIs).

Analysis of NFHS-1 and NFHS-2 data revealed that one of the leading causes for high maternal and infant mortality rates in Uttar Pradesh was tetanus contracted during delivery. Moreover, the state lagged far behind the national coverage level of 66.8 percent of pregnant women receiving two doses of TT vaccine. After an analysis of strategic options, SIFPSA concluded that, in the context of Uttar Pradesh, a campaign approach would be the best mechanism to improve coverage levels of TT vaccination in rural areas.

**Advocacy with the State Government in Support of the Campaign Approach**

In 1998, SIFPSA suggested a campaign approach for TT vaccination to the

<table>
<thead>
<tr>
<th>TABLE 1: MATERNAL AND CHILD HEALTH INDICATORS, 1998/99</th>
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<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>Maternal Mortality Ratio</td>
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<tr>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>Pregnant women receiving two or more TT injections</td>
</tr>
<tr>
<td>Pregnant women receiving iron and folic acid (IFA) tablets or syrup</td>
</tr>
<tr>
<td>Pregnant women receiving antenatal check-ups from health professionals</td>
</tr>
</tbody>
</table>

Source: NFHS-2 (International Institute for Population Sciences [IIPS] and ORC Macro, 2000)
Tetanus Toxoid Campaign

Director General Family Welfare of Uttar Pradesh. Lobbying and advocacy was needed to convince the Department of Health and Family Welfare of the need for the TT campaign because the department had several competing priorities, such as polio eradication and RCH camps. Because these latter activities are typically conducted during the months December to March, SIFPSA suggested May and June as the “lean” months to conduct the proposed TT campaign to ensure that it would not clash with other activities. During these months government health workers and auxiliary nurse midwives (ANMs) were more available to implement the campaign. Also, because the TT vaccine is fairly heat stable even at room temperatures, campaigns can easily be conducted during hot summer months.

In 1999, the Department of Health and Family Welfare, in partnership with IFPS, launched a special TT vaccination campaign to immunize pregnant women in the state (this included all 70 districts of Uttar Pradesh and 13 districts of present-day Uttaranchal). The goal of the intervention was to achieve a near zero incidence of tetanus among women and newborns and thereby contribute to reduction in maternal and neonatal mortality. An accelerated campaign approach was therefore introduced in order to increase coverage of pregnant women with two doses of TT, with special focus on remote villages. From 1999 to 2002, five TT campaigns were conducted:

- Campaign I: May – June 1999
- Campaign II: April – May 2000
- Campaign III: May – June 2001
- Campaign IV: November – December 2001
- Campaign V: May – June 2002

Campaign IV was introduced during the winter months to further improve coverage and because project goals for TT had increased.

Initial Campaign Design Workshop

To get inputs for designing the first TT campaign, a workshop was organized by SIFPSA on February 5, 1999, in which program managers representing district, division, and state levels participated. The meeting was chaired by the Principal Secretary Health and Family Welfare. Meeting participants included the Special Secretary Family Welfare; Secretary Health; Secretary Family Welfare; Director General National Programs and Evaluation; Joint Director (EPI); Additional Director (UIP); SIFPSA Executive Director; SIFPSA Consultant; Additional Executive Director of SIFPSA; CMOs of the 15 SIFPSA priority districts; and 10 Additional Directors of concerned divisions.

Workshop participants identified logistical and systemic issues and discussed possible solutions. The meeting also identified the medical materials readily available and the additional resources required at service delivery points. The Director General National Programs and Evaluation and state immunization officials assured participants that adequate quantities of vaccines, needles, and syringes would be available (SIFPSA, 1999).

After the initial TT workshop, special meetings were conducted by District Magistrates to elicit
cooperation and support from other relevant government departments, specifically the urban development and child welfare departments as well as elected village heads, known as pradhans (SIFPSA, 2003).

**INTERVENTION COMPONENTS**

**Key Features of Campaigns**

Some key features of the campaigns included:

- The campaign was for the entire state (70 districts of Uttar Pradesh and 13 districts of present-day Uttaranchal).
- National immunization program schedules did not overlap with TT campaign schedules.
- Fixed timings and a schedule for TT immunization were set.
- Iron and folic acid (IFA) supplements and antenatal care counseling were also provided at the time of vaccination.
- TT vaccination was promoted through the mass media.
- A TT awareness week was held prior to vaccination in IFPS project districts.
- NGOs in IFPS districts were involved in community mobilization.
- The campaign was monitored by state-level observers.
- The post-campaign evaluation was conducted by an independent agency.

It should be noted that the word “campaign” may be misleading, since it generally connotes a large-scale and resource-intensive activity. During the two months of the TT campaign, only two extra vaccination days were added to the existing schedule.

**Building on the Current Routine Immunization Infrastructure**

Key informants involved with the TT campaigns emphasized that because the campaigns were designed to use the existing routine immunization infrastructure, implementation was very effective and efficient. Before the campaign, TT immunization in Uttar Pradesh was carried out according to the routine immunization schedule that occurred twice a week on Wednesdays and Saturdays. On these set days, ANMs would provide standard immunizations such as polio drops, hepatitis B shots, and TT vaccinations.

The campaign approach used the current routine immunization structure and simply added one extra day of immunization during the campaign week. During the week of a campaign, ANMs provided TT vaccines for three days rather than two. The introduction of this third day to visit the villages helped cover missed candidates and ensured a wider coverage of eligible women.

Each TT campaign had two rounds: the first round was conducted for three consecutive days (e.g., April 24–26). Exactly one month later, a second three-day round was conducted (e.g., May 24–26). The first two days of the campaign were the state government’s routine immunization days.

The TT Awareness Week was introduced by IFPS in Campaign II to generate awareness and publicity about the campaign. Awareness generation activities were conducted in the week prior to the vaccination days and included group meetings.
led by ANMs, enumeration of pregnant women in villages, and the distribution of various information, education, and communication (IEC) materials on the importance of immunization. TT Awareness Weeks were conducted only in IFPS Project districts, not throughout the state. Following below is the number of districts covered in each campaign:

- Campaign II: 14 districts
- Campaign III: 19 districts
- Campaign IV: 19 districts
- Campaign V: 23 districts

In addition to the ANM home visits, over 27,000 fixed immunization centers (over 20,000 in rural areas alone) were utilized during the TT campaigns for vaccine delivery (ORG Center for Social Research, 2004). To cover remote areas of the state, special groups of ANMs were employed; these groups were assisted by male workers who carried out supportive activities.

**Information, Education, and Communication Interventions**

IEC interventions were a critical component of the TT campaigns. SIFPSA was responsible for the design, funding, and distribution of IEC materials. A varied media mix including home visits, print materials, village meetings, and mass media was employed. The IEC materials were used to indicate vaccination days and venues and to teach the importance of the TT vaccination. The various IEC mechanisms included handbills, posters, banners, pre-recorded cassettes, wall writings, TV, radio, newspapers, panel discussions with experts, and radio talk shows (ORG Center for Social Research, 2004).

Primary health centers (PHCs), community health centers (CHCs), NGOs, and dairy cooperatives distributed IEC materials. All IFPS-funded NGOs and dairy cooperatives were utilized for extensive coverage of the campaign. Home visits provided direct, face-to-face, contact to distribute messages, answer questions, give details about specific dates, and convey locations of immunization sites.

Handbills and banners were common IEC media because ANMs could easily distribute handbills to pregnant women and arrange for banners in prominent places. Press insertions were also made intermittently in leading Hindi, English, and Urdu newspapers as well as in district-level local newspapers.

Prior to the first campaign, former Uttar Pradesh Chief Minister Kalyan Singh appeared in a live TV telecast where he discussed the importance of TT immunization and held discussions with health experts. He also sent a message to all elected officials, including Members of the Legislative Assembly and State Ministers, in which he stressed the importance of TT immunization and asked these political leaders to give their support to the campaign. This well-publicized political support from the head of the state government was instrumental in galvanizing the campaign.

**Monitoring and Evaluation**

An elaborate performance monitoring system was in place during the preparatory and implementation phases of each campaign. Independent observers, including the General Manager and
Deputy General Manager from SIFPSA and personnel from the Department of Health and Family Welfare, were responsible for visiting the districts to observe activities and give direct feedback to the Secretary of Health. The Department of Health and Family Welfare observers visited two to three districts each before and during the campaigns, and officers from SIFPSA’s Monitoring and Evaluation Division visited project districts. Feedback for course correction was given to districts by the Director General Family Welfare based on the observers’ reports.

In addition to the monitoring by independent observers, after each campaign every PHC had to complete a report on TT coverage achieved during the campaign to the block Medical Officers In-Charge who, in turn, submitted a report on campaign performance to the Chief Medical Officer (CMO). The CMO was responsible for collating performance reports from all the blocks in the district and submitting these to the Department of Health and Family Welfare.

Another key component of monitoring and evaluation was the post-campaign survey conducted by an independent agency to evaluate overall impact. After the first campaign in 1999, the Population Research Center of the Department of Economics at the University of Lucknow conducted the evaluation survey. ORG Center for Social Research, a division of ORG-MARG Research Pvt. Limited, was responsible for conducting evaluations for Campaigns II through V. The objectives of the evaluation surveys included understanding overall impact on TT awareness, determining TT coverage during the campaign, and estimating the neonatal mortality rate. In the ORG surveys, the performance in both project and non-project districts was evaluated. In each study, eight to ten districts were evaluated based on interviews with approximately 1,600–2,000 women. These evaluation studies are the main source of performance data on the TT campaigns.

IMPLEMENTING PARTNERS

Role of SIFPSA

While the Department of Health and Family Welfare was responsible for procurement and distribution of the TT vaccine and implementation of the campaigns, SIFPSA played a crucial role by providing technical assistance for the design and planning of the campaigns, including:

- Advocacy, lobbying, and planning with the government for the campaigns;
- Design of detailed timelines and plan processes involving manpower and resource requirements;
- Development of tools for identification of pregnant women and data collection formats;
- Guidelines and instructions for ANMs, community-based distribution (CBD) workers, and supervisory staff;
- Design and funding of IEC materials;
- Awareness and mobilization activities through CBD workers of IFPS-funded NGOs;
- Training NGO coordinators in TT mobilization techniques; coordinators in turn train CBD workers; and
- Development of a standardized monitoring, reporting, and post-campaign evaluation system.

Role of the Department of Health and Family Welfare
While SIFPSA played an integral role in the design and planning of the TT campaign, actual implementation of the intervention was conducted by the Department of Health and Family Welfare (DHFW). Figure 1 details the responsibilities at different levels of the state government for TT campaign implementation.

During interviews, experts involved in campaign implementation emphasized that the success of the campaigns was due to detailed planning of organizational arrangements and implementation processes. Timelines detailing responsibilities for public-sector stakeholders were implemented beginning one month prior to the campaign vaccination days. Below is a sample timeline of TT campaign implementation activities conducted by CMOs throughout the state.

Also below is a sample timeline of TT campaign-related activities conducted by Medical Officers In-Charge at the block-level for the same campaign.

Role of ANMs
ANMs played a major role in the TT campaign implementation. Across all five campaigns, ANMs served as the primary provider of TT vaccine to pregnant women. They also

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**FIGURE 1. STATE GOVERNMENT ORGANIZATION AND RESPONSIBILITIES FOR TT CAMPAIGN IMPLEMENTATION**

<table>
<thead>
<tr>
<th>Specific responsibilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Procure TT vaccine and supplies</td>
</tr>
<tr>
<td>- Distribute vaccine</td>
</tr>
<tr>
<td>- Supervise and organize health personnel</td>
</tr>
<tr>
<td>- Compile final reports and feedback of field staff</td>
</tr>
</tbody>
</table>

**State**
Director General Family Welfare
(Oversees entire TT campaign implementation process)

**District**
Chief Medical Officer
(Oversees TT campaign implementation process in district)

**Block**
Block Medical Officer In-Charge
(Oversees TT campaign implementation process in block)

**Specific responsibilities:**
- Create district action plan for campaign
- Manage cold chain
- Distribute IEC materials
- Monitor implementation
- Monitor supply and availability of vaccine and resources

**Specific responsibilities:**
- Develop action plan for PHC
- Educate ANMs about campaign
- Compile block-level reports
- Work with NGOs/CBD workers
- Monitor implementation
- Ensure ANMs have resources and IEC materials

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provided IFA tablets and antenatal care. The percentage of pregnant women receiving the vaccine from ANMs ranged from 95.9 in Campaign I to 79.7 in Campaign V. Other providers of the TT vaccine included government doctors and private doctors.

**IFPS NGOs and CBD Network**

After the first campaign, the IFPS Project wanted to further promote demand for TT vaccination. Consequently, IFPS mobilized its NGO network of more than 8,000 CBD workers to increase awareness of the TT campaigns through group meetings and direct contact with households (SIFPSA, 2003). Because the network of NGOs had been established only in IFPS Project areas, the other districts did not use NGOs as awareness-raising mechanisms.

CBD workers are trained community-based workers who cover a population of approximately

<table>
<thead>
<tr>
<th>Key Activities for CMOs</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meeting at district with Medical Officer In-Charge for dissemination of information (with special emphasis on IFA and counseling for consumption)</td>
<td>April 9</td>
</tr>
<tr>
<td>2. Monitor availability of vaccine</td>
<td>April 9</td>
</tr>
<tr>
<td>3. Monitor availability of IFA</td>
<td>April 9</td>
</tr>
<tr>
<td>4. Allocate block areas among Deputy CMOs for supervision</td>
<td>April 9</td>
</tr>
<tr>
<td>5. Allocate urban localities among Deputy CMOs for supervision</td>
<td>April 9</td>
</tr>
<tr>
<td>6. Estimate TT vaccine requirement and inform Director General Health</td>
<td>April 10</td>
</tr>
<tr>
<td>7. Estimate IFA requirement for campaign</td>
<td>April 10</td>
</tr>
<tr>
<td>8. Inter-departmental coordination meeting under chairmanship of District Magistrate</td>
<td>April 12</td>
</tr>
<tr>
<td>9. IEC materials ready in the district</td>
<td>April 15</td>
</tr>
<tr>
<td>10. Action plan prepared</td>
<td>April 17</td>
</tr>
<tr>
<td>11. Supply of TT vaccine to CHCs/PHCs</td>
<td>April 18</td>
</tr>
<tr>
<td>12. Supply of IFA to CHCs/PHCs</td>
<td>April 18</td>
</tr>
<tr>
<td>13. IEC materials distributed to PHCs/CHCs</td>
<td>April 20</td>
</tr>
<tr>
<td>14. District action plan sent to state</td>
<td>April 22</td>
</tr>
<tr>
<td>15. Ice packs for cold chain to be prepared</td>
<td>April 23</td>
</tr>
<tr>
<td>16. TT campaign days for first round</td>
<td>April 24, 25, &amp; 26</td>
</tr>
<tr>
<td>17. Compile first round report to State</td>
<td>May 10</td>
</tr>
<tr>
<td>18. TT campaign days for second round</td>
<td>May 24, 25, &amp; 26</td>
</tr>
<tr>
<td>19. Compile second round report to State</td>
<td>June 10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Activities for Medical Officers In-Charge</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meeting with ANMs and staff at PHC/CHC to introduce campaign with emphasis on IFA consumption counseling</td>
<td>April 11</td>
</tr>
<tr>
<td>2. Develop action plan for PHC</td>
<td>April 11</td>
</tr>
<tr>
<td>3. Action plan delivered to district headquarters</td>
<td>April 15</td>
</tr>
<tr>
<td>4. Receive vaccine from district headquarters</td>
<td>April 16</td>
</tr>
<tr>
<td>5. Doctors and ANMs attend NGO meeting at PHC</td>
<td>April 17-19</td>
</tr>
<tr>
<td>6. Ensure availability of vaccine carrier, immunization cards, and receipt of IFA at PHC</td>
<td>April 20</td>
</tr>
<tr>
<td>7. Distribution of IEC materials and IFA tablets to ANMs</td>
<td>April 20-22</td>
</tr>
<tr>
<td>8. Prepare ice packs for campaign</td>
<td>April 23</td>
</tr>
<tr>
<td>9. Ensure vaccine supply for immunization days to ANM</td>
<td>I day prior to immunization day or same day as per location of subcenter</td>
</tr>
<tr>
<td>10. TT Campaign Days for first round</td>
<td>April 24, 25, &amp; 26</td>
</tr>
<tr>
<td>11. Report on first round of campaign to district headquarters</td>
<td>May 5</td>
</tr>
<tr>
<td>12. TT campaign days for second round</td>
<td>May 24, 25, &amp; 26</td>
</tr>
<tr>
<td>13. Report on second round of campaign to district headquarters</td>
<td>June 6</td>
</tr>
</tbody>
</table>
2,500 (about two to three villages) and help address gaps in ANM services. A CBD worker is typically a married female resident of the village aged 25–46 years old who provides family planning counseling and commodities and referrals for additional services.

Figure 2 shows the activities carried out by CBD workers during TT Awareness Weeks and during both rounds of the campaign.

**CAMPAIGN COSTS**

As discussed earlier, the existing government health infrastructure and supply system for RCH services were utilized for the TT campaigns, hence the incremental costs incurred on the campaigns were limited. According to SIFPSA’s analysis, during the TT campaigns the total incremental cost of protecting one woman and her Suneeta is an ANM who has been working in the village of Sidhauli in Sitapur District since 1987. Her main job responsibilities are to provide antenatal care counseling and TT vaccination and distribute IFA tablets. She visits approximately 25 to 30 houses per day.

When reflecting on the TT campaign, she states that the use of disposable needles during the campaign helped her tremendously. Prior to the TT campaign, ANMs did not have disposable needles and would have to reuse needles and sterilize them in a pressure cooker. Suneeta would have to carry the heavy cooker from village to village. Now the use of disposable needles has made her job more manageable. One of her chief complaints regarding the campaign is that May and June are very hot months and conducting the campaign during this time is very exhausting.

Suneeta notes that the TT campaign had a significant impact on awareness about the need for the vaccine. She says that even though the formal TT campaigns have ended, the demand for TT has increased and more women come on their own asking her for the vaccination. The ANMs sometimes conduct informal TT camps at a central location to administer TT vaccines.

**BOX 1**

**Suneeta—An ANM’s Perspective**

Suneeta is an ANM who has been working in the village of Sidhauli in Sitapur District since 1987. Her main job responsibilities are to provide antenatal care counseling and TT vaccination and distribute IFA tablets. She visits approximately 25 to 30 houses per day.

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**FIGURE 2. ROLE OF CBD WORKER DURING TT AWARENESS WEEK AND CAMPAIGN**

<table>
<thead>
<tr>
<th>Step 1: Coordinate with local area ANM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Get information on ANM’s village visit schedule for vaccination.</td>
</tr>
<tr>
<td>• Select venue for vaccination booth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Carry out door-to-door publicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Talk to women about TT vaccine and provide information on campaign</td>
</tr>
<tr>
<td>• Discuss IFA and give ANC counseling</td>
</tr>
<tr>
<td>• Distribute IEC materials</td>
</tr>
<tr>
<td>• Enumerate pregnant women in area</td>
</tr>
<tr>
<td>• Invite women for group TT meeting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: Manage village meeting on TT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attendees include local village women, ANM, female pradhan, anganwadi worker, and local female teacher</td>
</tr>
<tr>
<td>• Program includes discussions on TT, IFA, and vaccination dates</td>
</tr>
<tr>
<td>• Motivate women to obtain TT vaccine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4: Role in 1st Round of Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arrange wall painting showing vaccination dates</td>
</tr>
<tr>
<td>• Attend vaccination booth and give support to ANM</td>
</tr>
<tr>
<td>• Answer questions and concerns of patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 5: Role in 2nd Round of Campaign</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Make door-to-door visits and re-motivate women who received TT-1</td>
</tr>
<tr>
<td>• Inform women of Round 2 dates</td>
</tr>
<tr>
<td>• Promote IFA compliance</td>
</tr>
<tr>
<td>• Encourage women who did not receive TT-1 to attend Round 2</td>
</tr>
</tbody>
</table>
unborn child from tetanus with two doses of TT vaccine came to approximately Rs. 10 (~ USD 0.23) (SIFPSA, 2003). The incremental costs of the TT campaign were IEC costs covering mass media and local promotion activities, fielding state-level observers, and honoraria for field-level health workers.

The data available from SIFPSA indicate that local promotional activity costs remained fairly constant during all campaigns at approximately Rs. 35,000,000 (~ USD 795,455). However, mass media costs greatly increased from Rs. 1,880,217 (~ USD 42,732) in the second campaign to Rs. 6,741,456 (~ USD 153,215) in the fifth campaign, reflecting the greater emphasis placed on TV, radio, and newspapers for publicity.

During the preparatory and implementation phases of Campaigns IV and V, state-level observers made monitoring visits to the districts. Also, during these two campaigns, ANMs and health supervisors were paid honoraria for their special efforts made during the campaigns. The total cost of these inputs during Campaign IV was Rs. 2,489,000 (~ USD 56,568) and during Campaign V was Rs. 3,087,000 (~ USD 70,159).

Under the RCH program, supplies of IFA are funded and procured by GoI and delivered to the states. However, it should be noted that at the time of the fourth campaign there was a breakdown in GoI supplies of IFA and SIFPSA had to procure the supplies using its own funds. This was a one-time measure undertaken to ensure that the campaign did not fail in providing IFA to pregnant women.

The TT campaign was a low-cost intervention, with the incremental costs related to IEC and some adjustments in the immunization program. Because the costs of the vaccine and manpower costs associated with ANMs and medical officers were already being paid for out of the regular budget from the Department of Health and Family Welfare, minimal additional expense was incurred, thus making the effort cost-effective. A detailed overview of IFPS expenditures across the five campaigns can be found in Table 2.

### TABLE 2. EXPENDITURES BY CAMPAIGN

<table>
<thead>
<tr>
<th>Campaign</th>
<th>Year</th>
<th>Activity</th>
<th>Cost (Rs.)</th>
<th>Approximate Cost (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1999</td>
<td>Total IEC</td>
<td>3,043,157</td>
<td>69,163</td>
</tr>
<tr>
<td>II</td>
<td>2000</td>
<td>Mass Media Creatives</td>
<td>1,880,217</td>
<td>42,732</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local Promotion Activity</td>
<td>3,588,651</td>
<td>81,560</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total:</td>
<td>5,468,868</td>
<td>124,292</td>
</tr>
<tr>
<td>III</td>
<td>2001</td>
<td>Mass Media Creatives</td>
<td>1,591,592</td>
<td>36,173</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local Promotion Activity</td>
<td>3,299,740</td>
<td>74,994</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total:</td>
<td>1,591,592</td>
<td>36,173</td>
</tr>
<tr>
<td>IV</td>
<td>2001</td>
<td>Mass Media Creatives</td>
<td>3,949,776</td>
<td>89,768</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local Promotion Activity</td>
<td>3,498,910</td>
<td>79,521</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. IFA Procurement*</td>
<td>10,000,000</td>
<td>227,273</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. State Observer</td>
<td>289,000</td>
<td>6,568</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. ANM/LHV</td>
<td>2,200,000</td>
<td>50,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total:</td>
<td>19,937,686</td>
<td>453,129</td>
</tr>
<tr>
<td>V</td>
<td>2002</td>
<td>Mass Media Creatives</td>
<td>6,741,456</td>
<td>153,215</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local Promotion Activity</td>
<td>3,538,360</td>
<td>80,417</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others (State Observers &amp; ANM)</td>
<td>3,087,600</td>
<td>70,173</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total:</td>
<td>13,367,416</td>
<td>303,805</td>
</tr>
</tbody>
</table>

* IFA Procurement was a one-time activity that had to be undertaken because of a breakdown in GoI supplies. Source: SIFPSA
RESULTS

TT coverage Performance

TT Coverage for Entire State. Across all interviews conducted, experts emphasized that the TT campaign was one of the chief documented successes of the IFPS Project. More than one million pregnant women were protected in each of the campaigns and six million pregnant women received at least two doses of TT as a result of all five campaigns (SIFPSA, 2003). According to the evaluations conducted after each campaign, TT coverage increased from 33 percent in Campaign I to 68 percent in Campaign V, representing an increase of 35 percentage points over four years—more than doubling the proportion of pregnant women with TT coverage (see Figure 3).

Key informants involved in the campaigns said that once the TT indicators reached around 60 percent in the third and fourth campaigns, the performance levels had hit a peak. Given external factors—such as shortage of ANMs, difficulty in reaching all remote areas, and inefficiencies in the existing health system—experts suggested that raising coverage levels beyond 70 percent would be difficult.

TT Coverage in Project and Non-Project Districts. According to data collected from the annual ORG surveys for Campaigns II through V, TT coverage was higher in IFPS Project districts compared with non-project districts (see Figure 4).

USAID Survey Results. The original objective was to increase the TT coverage in the IFPS districts from the 1993 level of 37.4 percent to 47 percent by 2001. A survey in project districts found TT coverage to be 62 percent in 2001—15 percentage points more than what was expected (according to the 2001 SO2 Indicator Survey). Keeping this in view, the target of 70 percent was set for the year 2002. After the campaign, however, TT coverage in project areas remained at 63 percent in 2003 (according to the 2003 Reproductive Health Indicator Survey [RHIS]).
Current Status of TT Coverage

In the year following the last campaign, TT coverage declined. However, two years later coverage increased slightly (see Figure 5). As a result of Campaign V, statewide TT coverage was 68 percent, as detailed in the Coverage Evaluation Survey conducted by ORG Center for Social Research. However, in 2003 when there was no campaign, the RHIS revealed that coverage decreased to 61 percent. The most recent TT coverage figures from 2005 reveal 64 percent coverage. This represents a decline of only 4 percentage points from the Campaign V peak of 68 percent, despite three years without a campaign. These results suggest that the five campaigns have had some degree of sustainable impact on TT vaccination-seeking behavior, thus preventing a downward slide and a relapse to pre-campaign coverage levels.

Exposure to TT Campaign Materials

During the TT Awareness Week and the time leading up to the campaigns, CBD workers and NGO staff were responsible for distributing and displaying various IEC materials. Findings from post-campaign surveys conducted by ORG, however, show that the majority of women had not seen or received any IEC materials prior to the campaign. This is a disappointing finding because much of the funding and management effort in the TT campaigns were allocated to publicity and awareness interventions. The explanation is that CBD workers cover typically only two blocks in each district, and thus IEC reach was limited. While the proportion of women reporting having received some material increased through successive campaigns, by the fifth campaign more than half of the women interviewed said they had not seen or received any IEC materials (see Table 3).

Source of TT IEC Messages

Among the women who were exposed to TT messages, the majority report that interpersonal contact was their primary source of information on the TT campaign. When reviewing ORG post-campaign survey data, it is apparent that IEC media varied in their primacy between project and non-project districts. For example, in the project districts the primary source of information cited by respondents was interpersonal contact, reflecting the crucial role that ANMs and CBD workers played in conducting home visits to educate women. Handbills played a significant role in project districts because ANMs and CBD workers distributed them in their communities.

In non-project districts, media varied in their primacy across
campaigns, with interpersonal contact as the leading source for information in some campaigns and mass media in other campaigns. Generally, interpersonal contact had a lower reach in non-project districts as compared to project districts. This reflects the fact that CBD worker home visits were not employed in non-project districts. Interestingly, although mass media including radio, TV, and newspaper were used throughout the state, relatively more respondents in non-project districts cite mass media as information sources. This is probably because interpersonal contact was less extensive in the non-project districts and mass media rose to prominence in respondents’ top-of-mind awareness and recall. Table 4 details the most common forms of IEC used during the campaigns and the corresponding receipt of messages through these sources.

### Impact on TT Awareness

A key impact of the TT campaigns in Uttar Pradesh is that overall awareness about tetanus and the need for the vaccination among pregnant women increased over the course of the interventions. During Campaign I, 88 percent of pregnant women were aware of the

| TABLE 3. PERCENT OF PREGNANT WOMEN WHO RECEIVED IEC MATERIALS ON TT CAMPAIGN (PROJECT DISTRICTS) |
|---|---|---|---|---|
| **Campaign** | **II** (April-May 2000) | **III** (May-June 2001) | **IV** (Nov-Dec 2001) | **V** (May-June 2002) |
| Received Only | 6.9 | 14.2 | 25.0 | 37.3 |
| Seen Only | 4.9 | 4.4 | 9.6 | 2.5 |
| Both Received and Seen | 11.3 | 3.9 | 10.0 | 5.6 |
| Not received / seen | 76.9 | 77.5 | 55.4 | 54.6 |

| TABLE 4. PERCENT OF WOMEN RECALLING VARIOUS MEDIA AS INFORMATION SOURCES DURING THE TT CAMPAIGNS |
|---|---|---|---|---|
| **Source** | **II** (April-May 2000) | **III** (May-June 2001) | **IV** (Nov-Dec 2001) | **V** (May-June 2002) |
| | **Project** | **NP** | **Project** | **NP** | **Project** | **NP** | **Project** | **NP** |
| Interpersonal Contact | 70.2 | 77.8 | 88.8 | 11.8 | 85.4 | 44.7 | 96.6 | 59.6 |
| Group Meetings | 9.2 | 2.1 | 3.6 | 0 | 1.7 | 0 | 9.3 | 0 |
| Handbills | 28.2 | 10.5 | 11.5 | 20.6 | 29.6 | 2.6 | 13 | 1 |
| Posters/Pamphlets | 10.3 | 1.0 | 21.1 | 8.8 | 4.7 | 2.6 | 21.7 | 1.0 |
| Radio/TV | 6.6 | 11.5 | 0.6 | 5.9 | 7.3 | 47.4 | 2.5 | 8.1 |
| Newspaper | N/A | N/A | 9.1 | 29.4 | 0.9 | 5.3 | 0.3 | 35.4 |

*NP = Non-Project
Source: ORG Center for Social Research Coverage Surveys
Ideas, Insights, and Innovations

need for TT vaccine. This proportion increased to 96–97 percent in the four subsequent campaigns (see Figure 6).

At the onset of the campaign there were many misunderstandings regarding the number of doses of TT required and the prescribed interval between two doses. For example, through all the campaigns there were at least 15–20 percent of women who thought that three doses of TT are required. Figure 7 shows that over the course of the five campaigns, the awareness of the need for two doses increased by nearly 14 percentage points, from 66.4 to 80.1 percent. It should also be noted that project and non-project districts demonstrated similar results in both these categories, demonstrating the overall impact on the state as a whole.

Impact of NGOs and CBD Network
In 2002, 51 NGOs were employed across IFPS Project districts to generate awareness and publicity for the campaign. The NGOs and CBD workers helped to increase overall awareness levels regarding the need for TT vaccination for pregnant women, the requirement for two doses of the vaccine, and basic knowledge about causes of tetanus. Survey data from Campaign V show that in the project districts where the project funded NGOs, CBD workers were overwhelmingly the primary source for TT awareness (84 percent). However, in the non-project districts where CBD workers were not used, the primary sources for TT information included ANMs (38 percent) and anganwadi workers (27 percent). Mass media,
including TV and radio, played more of a role in non-project districts, but were less significant in project districts. Figure 8 details the relative contributions of the various sources for TT information during Campaign V. (It should be noted that the findings for the previous campaigns were similar.)

Another interesting finding is that overall awareness of the TT campaign was higher in project districts than non-project districts. Table 5 shows that across the second to fifth campaigns, significantly more pregnant women in project districts were aware of the campaign, reflecting the wide reach that CBD workers had in educating women about the intervention. However, even in project districts, fewer than half of the pregnant women were even aware of the campaigns. This highlights the difficulty in reaching women in remote areas.

**Venue of TT Vaccination**

One of the goals of the TT campaigns was to increase TT delivery to rural and remote locations. Therefore, home visits by ANMs and CBD workers served as the primary venue for vaccination throughout the five campaigns. In non-project districts where CBD workers were not employed, locations such as PHCs, CHCs, and district hospitals served as leading locations for TT vaccination, since women needed to travel to get the vaccine because there were fewer home visits by ANMs. The subcenters played a major role for TT delivery in both project and non-project districts because they are primary locations for health service delivery in rural areas (see Table 6).

**Reasons for Not Receiving TT Vaccine**

In evaluating the impact of the TT campaigns, it is important to identify the reasons why women did not receive the vaccinations. This analysis helps program planners assess whether the reasons could be addressed through education and awareness. In the evaluations conducted by ORG, women who

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**TABLE 5. OVERALL AWARENESS OF TT CAMPAIGNS AMONG PREGNANT WOMEN**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project districts</td>
<td>47.0%</td>
<td>43.7%</td>
<td>28.4%</td>
<td>38.6%</td>
</tr>
<tr>
<td>Non-project districts</td>
<td>11.0%</td>
<td>10.5%</td>
<td>5.5%</td>
<td>23.8%</td>
</tr>
</tbody>
</table>

Source: ORG Center for Social Research
receiving IFA tablets or syrup in Uttar Pradesh was only 32.4 in 1998/99, compared to the national figure of 57.6 percent. Furthermore, in Uttar Pradesh, out of those women who received IFA, 73.3 percent consumed the entire supply whereas the corresponding national figure was 80.5 percent.

Given the history of low IFA distribution in Uttar Pradesh, SIFPSA introduced the delivery of IFA tablets along with TT injections during the second TT campaign in May and June 2000. One of the biggest challenges associated with IFA consumption is compliance. While distributing the tablets or syrup does not present significant challenges, ensuring that women are consuming their daily supply of this supplement is very difficult. Experts suggest that it is easier to deliver two shots of TT injections than to ensure compliance with IFA consumption because the tablets have to be taken daily for 100 days throughout pregnancy, which requires more diligent compliance by pregnant women.

Interviewed individuals suggest that women in Uttar Pradesh prefer the

<table>
<thead>
<tr>
<th>Location</th>
<th>II (April-May 2000)</th>
<th>Project</th>
<th>NP*</th>
<th>Project</th>
<th>NP</th>
<th>Project</th>
<th>NP</th>
<th>Project</th>
<th>NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC/CHC/District hospital</td>
<td>18.1</td>
<td>30.4</td>
<td>16.8</td>
<td>34.1</td>
<td>9.8</td>
<td>28</td>
<td>14</td>
<td>24.9</td>
<td></td>
</tr>
<tr>
<td>Subcenter</td>
<td>21.7</td>
<td>24.7</td>
<td>17.2</td>
<td>9.2</td>
<td>17.8</td>
<td>17.2</td>
<td>24.7</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>Village booth</td>
<td>11.8</td>
<td>6.9</td>
<td>9.1</td>
<td>8.4</td>
<td>12.9</td>
<td>6.5</td>
<td>6.8</td>
<td>8.1</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>29.8</td>
<td>26.5</td>
<td>33.2</td>
<td>27</td>
<td>33.8</td>
<td>30.8</td>
<td>32.8</td>
<td>26.0</td>
<td></td>
</tr>
<tr>
<td>Private nursing home</td>
<td>14</td>
<td>9.7</td>
<td>14.3</td>
<td>15.8</td>
<td>16.9</td>
<td>14.8</td>
<td>10.6</td>
<td>17.7</td>
<td></td>
</tr>
<tr>
<td>Camp</td>
<td>1.6</td>
<td>0</td>
<td>3.1</td>
<td>4.8</td>
<td>1.7</td>
<td>0.6</td>
<td>3.9</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>3.1</td>
<td>1.9</td>
<td>6.4</td>
<td>0.7</td>
<td>7.1</td>
<td>2.2</td>
<td>7.3</td>
<td>1.7</td>
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</tr>
</tbody>
</table>

*NP = Non-Project
Source: ORG Center for Social Research

had not received any dose of TT during the campaigns were asked their reasons for not getting the vaccination. The primary reasons included:

- ANM did not visit village
- Felt current stage of pregnancy was too early for vaccination
- Felt no need
- Fear of vaccination
- Did not get time

In the first campaign, 27 percent of the women who did not receive the vaccine reported that the reason was because an ANM did not visit their village. By Campaign V, only 12 percent gave this reason, reflecting increased ANM home visits. However, the proportion of women stating they did not get the vaccination because they “felt no need” increased from 6 percent to 32 percent over the course of the five campaigns (see Table 7). In this category, there appears to be little difference between project and non-project districts.

**Provision of Additional Antenatal Services**

According to NFHS-2 data, the percentage of pregnant women receiving IFA tablets or syrup in Uttar Pradesh was only 32.4 in 1998/99, compared to the national figure of 57.6 percent. Furthermore, in Uttar Pradesh, out of those women who received IFA, 73.3 percent consumed the entire supply whereas the corresponding national figure was 80.5 percent.

Given the history of low IFA distribution in Uttar Pradesh, SIFPSA introduced the delivery of IFA tablets along with TT injections during the second TT campaign in May and June 2000. One of the biggest challenges associated with IFA consumption is compliance. While distributing the tablets or syrup does not present significant challenges, ensuring that women are consuming their daily supply of this supplement is very difficult. Experts suggest that it is easier to deliver two shots of TT injections than to ensure compliance with IFA consumption because the tablets have to be taken daily for 100 days throughout pregnancy, which requires more diligent compliance by pregnant women.

Interviewed individuals suggest that women in Uttar Pradesh prefer the
Tetanus Toxoid Campaign

The liquid form of IFA because the pills come in a dark color and there is a fear among many rural women that the pills will result in children with darker skin. However, the government supply of IFA is typically in tablet form only. Moreover, the GoI supply of IFA is very sporadic and sometimes unreliable. For example, during the fourth campaign there was a breakdown in GoI supply of IFA so SIFPSA had to purchase IFA supplements for that campaign.

Beginning in the second campaign, ANMs and CBD workers began distributing IFA tablets to pregnant women. A supply of the full requirement of 100 tablets was given to pregnant women and counseling on compliance was provided. In addition, oral rehydration solution (ORS) packets were distributed for children suffering from diarrhea. Sometimes ANMs would also conduct general antenatal check-ups during TT vaccination delivery. Experts suggest that the convergence of IFA and TT was very successful because these two antenatal care services go “hand in hand” for helping secure a safer and healthier delivery.

The proportion of women receiving additional antenatal services during the TT campaigns increased from 33.9 percent in Campaign I to 67 percent by Campaign V, touching a high of 82.5 percent in Campaign IV. Of the women who reported receiving additional antenatal care services during the TT campaign, nearly all received IFA tablets as shown in Table 8 (ORG Center for Social Research Coverage Surveys). It is very likely that the peak of 82.5 percent for other antenatal services in Campaign IV was largely because of better distribution of IFA due to its procurement by SIFPSA. This only serves to underscore the crucial importance of effective supply systems for antenatal care services.

Impact on Neonatal and Maternal Mortality

Since one of the primary objectives of the TT campaign was to reduce maternal and neonatal mortality in Uttar Pradesh, it is important to review these indicators over the course of the campaigns. NFHS-2 data from 1998/99 show that at the inception of the campaigns, the Uttar Pradesh maternal mortality ratio was 707 maternal deaths out of every 100,000 live births. Unfortunately, no data have been collected since then that can be used to determine whether

# Table 7. Leading Reasons for Pregnant Women Not Receiving TT Vaccination (Entire State) (Percent)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>ANM did not visit village</td>
<td>27.1</td>
<td>20.1</td>
<td>21</td>
<td>15.8</td>
<td>11.6</td>
</tr>
<tr>
<td>Early stage in pregnancy</td>
<td>20.3</td>
<td>3.9</td>
<td>18.9</td>
<td>7.1</td>
<td>3.7</td>
</tr>
<tr>
<td>Felt no need</td>
<td>6</td>
<td>19.1</td>
<td>12.4</td>
<td>20.2</td>
<td>32.2</td>
</tr>
<tr>
<td>Fear of vaccination</td>
<td>16.6</td>
<td>10.5</td>
<td>6.5</td>
<td>12.8</td>
<td>13.9</td>
</tr>
<tr>
<td>Did not get time</td>
<td>4.3</td>
<td>13.4</td>
<td>12.4</td>
<td>16.1</td>
<td>11.1</td>
</tr>
</tbody>
</table>

Source: ORG Center for Social Research
Ideas, Insights, and Innovations

the maternal mortality ratio has improved or not.

Fortunately, there are data that track neonatal mortality. According to the Sample Registration Survey of the Registrar General of India, in 1998, the neonatal mortality rate in Uttar Pradesh was 52 per 1,000 live births. By 2002, when the last campaign was conducted, the neonatal mortality rate had decreased to 47 per 1,000 live births. While many factors can help reduce the incidence of neonatal tetanus, it is likely that the TT campaigns also contributed to a reduction in neonatal deaths.

Qualitative Impact

Interviewed individuals commented that there were substantial undocumented successes related to the intervention. These impacts are not easily quantifiable because they represent changes in behaviors, relationships, and the ways that different groups work together. Some qualitative achievements of the TT campaigns were:

- Increased antenatal care awareness: The TT campaigns drew much needed attention to the importance of comprehensive antenatal care. The campaign’s IEC activities educated women, mother-in-laws, husbands, and grassroots workers about antenatal care and provided actual service delivery.

- “Ice-breaking” between client and health system: The TT campaigns encouraged direct interpersonal contact and broke the barriers between clients and health service personnel. The campaigns emphasized open communication, group meetings, and forging of relationships between clients and the government health providers.

- Strengthening of NGO and government-sector relationship: IFPS project NGOs worked closely with the Department of Health and Family Welfare in the implementation of the campaigns. CBD workers and ANMs established mutually supportive relationships and NGOs worked closely with CMOs, district magistrates, and health officers. This led to enhanced appreciation and understanding of NGOs’ work.

LESSONS LEARNED

Critical Success Factors

The GoI’s RCH-II Program Implementation Plan (2005) draws specific attention to the IFPS TT campaign as a behavior change

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<tbody>
<tr>
<td>Yes</td>
<td>33.9</td>
<td>34.4</td>
<td>82.5</td>
<td>67.1</td>
</tr>
<tr>
<td>If yes, what type of service did you receive?</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IFA Tablets</td>
<td>98.3</td>
<td>98.5</td>
<td>99.5</td>
<td>99.8</td>
</tr>
<tr>
<td>ORS Packets</td>
<td>6.2</td>
<td>5.6</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>Check-up</td>
<td>14.1</td>
<td>19.9</td>
<td>12.7</td>
<td>10.7</td>
</tr>
</tbody>
</table>
communication success story for increasing the percentage of women receiving two doses of TT. The Plan states:

“SIFPSA’s tetanus toxoid campaign in Uttar Pradesh demonstrates how results can be achieved on a substantial scale even under circumstances that are not conducive to behavioral change … A combination of mass media, local media and home visits covered 100,000 villages and 700 urban centers. In two years, the proportion of pregnant women receiving two doses of TT increased from 33% to 68%. An important factor in this success was the role played by NGOs.”

Critical success factors that led to the high performance of the TT campaigns can be categorized into five key themes:

- **Organization and management structure:** The use of detailed timelines, efficient management structures, clear reporting relationships, and specific delineation of responsibilities between the Department of Health and Family Welfare and SIFPSA led to effective implementation.

- **Government commitment:** The active participation and support from the former Chief Minister Kalyan Singh, the Principal Secretary Health, state development officers, District Magistrates, and village pradhans ensured that all critical government stakeholders at each level of government were involved in the campaigns and helped ensure effective execution of activities.

- **Need for technical support agency:** Several experts emphasized that SIFPSA played a critical role in the success of the TT campaigns through its advocacy and technical assistance in campaign design, awareness raising, and monitoring and evaluation. Experts recommend using a technical support agency such as SIFPSA to support the Department of Health and Family Welfare in TT campaign delivery.

- **NGOs and CBD workers:** The proportion of pregnant women receiving two doses of TT was higher in areas where NGO CBD workers were employed. This demonstrates that community mobilization and interpersonal communication through NGOs can contribute to greater coverage. Since these grassroots workers generally have the support of the community, they can be effective as behavior change agents.

- **Information, education, and communication:** While research data indicate that the receipt and exposure to IEC materials was lower than desirable, media such as handbills, TV, radio, and newspapers were useful in educating women about the importance of the vaccine.

- **Use of existing health infrastructure:** The campaigns optimally utilized existing structures and personnel for implementation. The campaigns introduced only two additional vaccine days a month (only during the campaign months). Furthermore, the only significant additional costs incurred were for IEC. This enabled the
campaigns to be a cost-effective, replicable, and sustainable activity.

- **Immunization vans:** Mobile clinics are a useful means for service delivery in remote areas where home visits and interpersonal communication are difficult to manage on a regular basis. For areas that are difficult to cover even through large-scale campaigns, SIFPSA has suggested the use of mobile vans for carrying out essential immunization.

### Challenges

In assessing the challenges faced during the planning and implementation of the TT campaigns, most interviewed individuals report that the intervention faced few difficulties. Observers mentioned three key problems associated with the intervention:

- **Logistical issues:** TT promotions faced occasional logistical challenges relating to the procurement and delivery of supplies and ensuring that program implementers were on target with timelines. While no major gaps occurred, ensuring the timely and efficient implementation of TT campaigns required significant management work.

- **Need for extensive lobbying:** To encourage the state government to launch the TT campaigns, significant lobbying and advocacy by SIFPSA was required. Furthermore, lobbying had to be repeated before every campaign because there were competing priorities, such as polio and RCH camps. Since several donor agencies work in the state, SIFPSA’s efforts to promote TT campaigns had to compete with programs and priorities of other donor agencies.

- **Choice of season:** May and June are very hot summer months to implement any field-level campaign and, by this period of the year, healthcare workers are often exhausted after the pulse polio campaigns and the RCH camps. The choice of season proved to be challenging on these counts.

- **A campaign vs. routine approach:** Given the busy schedule of health personnel working on other campaigns such as polio and family planning, the TT campaign was felt to be an additional burden and led to increasing resentment among healthcare workers who felt burned out. It is important to note that between 1996 and 2004, the frequency of polio campaigns increased dramatically. Initially in 1996, there were two campaigns per year, which then increased to three, then six, and finally eight per year by 2004. In 1999, when TT campaigns began, the pulse polio program was not so burdensome; but by 2002 it had become a more exhausting activity. This progressively affected motivation to implement TT campaigns. However, others believed that a campaign approach was best for Uttar Pradesh because its maternal and infant mortality indicators were very high and a campaign approach was needed to accelerate coverage and to generate enough demand to improve the situation. Some
experts argue that while the ultimate objective is to strengthen the service delivery infrastructure to deliver routine immunization, the campaign approach is a more effective method for reaching out to remote areas.

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*Seema Talwar*

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*Anita Bhuyan*

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*Ruchira Gujral*

Survey Research: Measuring Performance of the IFPS Project in Uttar Pradesh  
*Gadde Narayana*
P

olicy formulation, district-level planning and implementation, training of local self-government leaders, and program evaluation studies were integral parts of the IFPS Project. All of the five IFPS objectives had components related to policy and evaluation:

- Evolve partnerships with NGOs for community mobilization and networks such as cooperatives, indigenous systems of medicine practitioners, government organizations, the private health sector, and the organized sector so as to develop a synergistic relationship;
- Implement innovative integrated approaches, such as reproductive and child health (RCH) camps and decentralized district action plans, and create a conducive environment by involving religious leaders and elected representatives of panchayats in program implementation;
- Improve the quality of government RCH services by strengthening the skills and changing the attitudes and practices of government health providers and upgrading public health facilities;
- Increase demand for and facilitate access to contraceptives through a vigorous information, education, and communication (IEC) campaign and social marketing program; and
- Provide wider access to family planning services, particularly to couples with unmet need for family planning.

Decentralized planning through district action plans (DAPs) helped to integrate the various components into coordinated district and local programs and became the organizing principle for IFPS-funded programs.

BUDGET

More than one-fourth (26%) of the IFPS Project budget was allocated to the development and implementation of DAPs. Of the IFPS funds allocated to DAPs, 39 percent went to public-sector initiatives, 28 percent to private-sector initiatives, 10 percent to training, 8 percent to management, 3 percent to IEC, and 12 percent to other categories (see Figure 1).

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 played a significant 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 RCH; 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 DAPs or district action plans. These plans specify strategies and activities for improving RCH programs at the district level and present a work plan 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 formulated and implemented IFPS-supported DAPs for RCH activities. (See Chapter 17.)

Based on the model developed under IFPS, SIFPSA provided assistance in the formulation of DAPs in an additional seven districts under the Empowered Action Group scheme of the Government of India (GoI). 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.
Decentralized district action planning, covering an array of health issues, will also be rolled out across states as part of the GoI’s National Rural Health Mission.

Promoting public-private partnerships. Prior to the IFPS Project, public and private entities in Uttar Pradesh seldom worked together in the health sector. The project 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 family planning/reproductive health (FP/RH) services to health facilities operated by corporate entities that provide clinical services to their employees and the broader community. (See Chapter 18.)

Strengthening local leadership commitment for FP/RH issues. 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 Project Evaluation Review for Organizational Resource Management (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 National Family Health 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. (See Chapter 20.)
REFERENCES


BACKGROUND

Various conditions and developments in India throughout the 1990s highlighted the need to design population policies in Uttar Pradesh and other states. The same factors also posed challenges for the development of such policies (for more details, see Goliber and Cross, 2006). By 2000, India’s population had reached one billion and the country was on-track to surpass China as the world’s most populous nation. Health indicators, such as life expectancy at birth and infant mortality, had improved dramatically. However, fertility rates remained high and contraceptive use was low, particularly in the northern and central states. At that time, Uttar Pradesh—which alone accounts for one-sixth of India’s total population—had a modern contraceptive prevalence rate of 22 percent and an unmet need for family planning of 25 percent (see Box 1).

International thinking as to how to best address these issues also experienced a paradigm shift in the 1990s. The “Program of Action” emerging from the International Conference on Population and Development in 1994 emphasized the need to promote reduced fertility within the context of meeting broader reproductive health needs and linking these efforts to development activities, including poverty reduction, improved education and literacy, and empowerment of women and girls. In 1996, the Government of India (GoI) adopted a “target-

**BOX 1**

Demographic Factors Underlying Formulation of the Uttar Pradesh Population Policy, 1998–1999

<table>
<thead>
<tr>
<th></th>
<th>Uttar Pradesh</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age at marriage among women age 20–49</td>
<td>15.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Total fertility rate (for the past 3 years)</td>
<td>3.99</td>
<td>2.85</td>
</tr>
<tr>
<td>Current contraceptive prevalence—use of any modern method (among currently married women age 15–49)</td>
<td>22.0</td>
<td>42.8</td>
</tr>
<tr>
<td>Percent with unmet need for family planning (among currently married women age 15–49)</td>
<td>25.1</td>
<td>15.8</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>86.7</td>
<td>67.6</td>
</tr>
<tr>
<td>Percent of births whose mothers received an antenatal check-up from a health professional</td>
<td>34.3</td>
<td>65.1</td>
</tr>
<tr>
<td>Percent of births whose mothers received two or more tetanus toxoid injections</td>
<td>51.4</td>
<td>66.8</td>
</tr>
<tr>
<td>Percent of births whose mothers were assisted at delivery by a doctor</td>
<td>14.2</td>
<td>30.3</td>
</tr>
</tbody>
</table>

free approach” for meeting population-related goals and subsequently sought to base program performance objectives and monitoring on a “community needs assessment” as opposed to centrally-determined targets. The policy change was met with mixed results. The change was communicated in a confusing manner with little guidance on implementation and use of modern family planning methods declined in most states, but particularly in Uttar Pradesh and Bihar (Narayana and Sangwan, 2000).

Other changes in the national policy and political landscape further strengthened momentum for the development of state population policies. While India had instituted a family planning program in 1951, efforts to adopt a national population policy did not gain traction until the 1990s. As a result of backlash against coercive methods used to increase sterilizations during the Emergency period (1975–1977), fertility reduction and population stabilization remained sensitive issues. However, recognizing the inherent link between population and the ability to achieve the country’s socio-economic development goals, the GoI went through a lengthy process to formulate a new more comprehensive national strategy which lasted some eight years. It was not until the year 2000 that the GoI issued the National Population Policy calling for replacement-level fertility by 2010 and population stabilization by 2045. Additional changes in the political landscape included the creation of new states in 2000,1 decentralization of key functions from the central government to the states, and strengthening of the role of local government institutions (e.g., panchayati raj),2 as well as further economic liberalization.

Together, these factors converged to set the stage for the drafting and adoption of state-level population policies in six states across northern and central India. Uttar Pradesh formally adopted its policy in July 2000 when the Cabinet approved it after six months of development and debate. This comprehensive policy sets forth the objectives, strategies, and implementation mechanisms for the state family planning and reproductive health program.

This chapter first explores the policy and program implications of the national government’s shift to an approach based on the assessment of community needs.

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1 In 2000, the GoI established three new states: Uttarakanchal from Uttar Pradesh; Jharkhand from Bihar; and Chhattisgarh from Madhya Pradesh.
2 For example, the 73rd and 74th Constitutional Amendments Act, 1992, made health, family welfare, and education a responsibility of village panchayats.
In developing Uttar Pradesh's state policy, the formulators sought to devise strategies that could best meet client needs while motivating the health system apparatus to improve the quality and coverage of service delivery in the absence of method-specific targets. The chapter then reviews the policymaking process in Uttar Pradesh, highlights the importance of the IFPS Project in shaping the population policy, describes the policy's significant features, and discusses lessons learned for future policy development and implementation.

A PARADIGM SHIFT: IMPLICATIONS OF THE COMMUNITY NEEDS ASSESSMENT APPROACH

Understanding the national government's shift to the community needs assessment approach is critical for understanding the challenges that states, including Uttar Pradesh, faced in designing their own population policies at the end of the 1990s. From the 1960s to mid-1990s, India's family planning program was highly centralized. The program was intended to achieve certain fertility levels and, to do so, the central government determined contraceptive method-specific targets for each state on an annual basis. These targets were then disseminated and used to set specific targets at the state, district, block, and facility levels. The overall results—aside from failing to achieve the desired total fertility rate—were a heavy reliance on sterilization (and thus an almost total focus on women), an emphasis on quantity rather than quality when providing services, and limited family planning options for clients (Narayana and Sangwan, 2000).

In response to these shortcomings, the Indian government pilot-tested a “target-free” approach beginning in September 1995. The entire states of Tamil Nadu and Kerala as well as 1–2 districts in all other states were exempted from the target-based approach. The targets were to be replaced by “expected levels of achievement” that were to be set by grassroots workers, such as auxiliary nurse midwives, in response to community needs. The target-free approach was intended to be client-driven as opposed to provider-driven; it was to be based on community needs as opposed to centrally-determined targets; and the goals were improved reproductive health and quality of care as opposed to demographic impact. The approach also called for decentralizing program planning and management to the districts and building partnerships with the community.

In Uttar Pradesh, at that time, the IFPS Project was already in the process of testing innovative ways to improve family planning and reproductive health. The state government selected Agra (high-performing) and Sitapur (low-performing) Districts for the pilot test of the target-free approach and contacted SIFPSA to help introduce the approach (Deepak, 2000). With assistance of the Population Council, SIFPSA also conducted operations research to aid in identifying lessons learned. While family planning declined in both districts, a slight improvement was observed with regard to maternal and child health services (Population Council, 1999).
In April 1996, the central government rolled out the target-free approach to all states and districts, with little consideration of the results and experiences of the pilot tests in the different states. Lack of proper implementation guidance (including a manual produced in English only), overly complex formats for estimating community needs, and inadequate training further hindered scale-up of the new approach. The resulting confusion gave some state governments and local authorities the impression that no targets meant that no work was required (Narayana and Sangwan, 2000). In September 1997, the GoI Ministry of Health renamed the approach the Community Needs Assessment (CNA) approach to highlight the fact that the family planning program still sought to achieve defined goals, but that these goals were to be based on an identification of community needs. In Uttar Pradesh, the Department of Health and Family Welfare contacted SIFPSA in late 1997 to assist in training all workers on the new CNA approach. However, the new national manual for how to implement the CNA approach did not arrive in Uttar Pradesh until March 1998, and by that time the state government had decided not to re-train all workers using this manual (Deepak, 2000).

In analyzing implementation of the CNA approach, Narayana and Sangwan (2000) found that after the elimination of method-specific targets, states with weak monitoring systems, such as Uttar Pradesh, “could not avert significant declines in performance” (p. 14). While Uttar Pradesh experienced difficulties in adapting to the new approach—particularly in terms of uniform training of workers and improved monitoring and supervision—the state nevertheless made efforts to implement the new approach, including reintroducing annual household surveys to help identify unmet need for family planning and reproductive health services. Most significantly, the state also sought to address broader policy gaps, the potential conflicting strategies of the old and new national guidelines, and problems with program implementation by deciding to prepare and adopt a state population policy specifically tailored to Uttar Pradesh’s needs and circumstances.

**ROLES OF DIFFERENT STAKEHOLDERS IN THE STATE POLICYMAKING PROCESS**

The decision to develop a state-level population policy came from the Government of Uttar Pradesh (GoUP) at a time when India and other individual states were also engaged in policy formulation. The GoUP sought technical assistance from the USAID-funded POLICY Project which, from 1997–2004, also supported population and health policy development in Andhra Pradesh, Jharkhand, Madhya Pradesh, Rajasthan, and Uttaranchal (Goliber and Cross, 2006). A wide range of groups—including women’s groups, NGOs, and the private sector—participated in the consultative policymaking process in Uttar Pradesh. The roles of some of the major players are as follows:

- **Government of Uttar Pradesh.** The government lent political support for development of the policy; convened an
issues identification workshop; assembled an expert group to draft the population policy; consulted with various stakeholders in the writing of the policy; adopted and disseminated the policy; and set up implementation structures at state and district levels. Senior administrators from various government departments reviewed the draft policy before final approval.

- **USAID.** Uttar Pradesh began receiving USAID population assistance in early 1993 as part of the Mission’s strategic objective to help the GoI meet couples’ family planning needs in northern India by improving the quality and coverage of services. The significant element of this assistance to the policy development process was USAID’s support of the IFPS Project, which was already in the process of pilot-testing several interventions that were incorporated into the state policy. USAID also financed the National Family Health Surveys (NFHS)—which provided the Indian government and states with critical data to guide the decisionmaking process and helped serve as an impetus for policy change (Malkin, 2005). USAID technical staff also participated in many of the technical planning and dialogue sessions (see below).

- **POLICY Project.** The USAID-funded POLICY Project provided technical assistance to the GoUP in development of the population policy—helping in the collection and analysis of data, improving understanding of key issues, and coordinating participation of various stakeholders. The project provided SIFPSA technical assistance in conducting reproductive health indicator surveys that provided data to help identify client needs, which are essential for a community needs assessment approach. POLICY commissioned background papers on key family planning and reproductive health issues, helped the GoUP organize the issues identification workshop, and served on the policy drafting committee. At the same time, POLICY was providing technical assistance to SIFPSA in the formulation of district action plans, which served as a model for how to involve diverse partners as well as devise practical decentralization and implementation strategies and mechanisms. Years later, POLICY also provided assistance in the development of health and population policies in the newly-created states of Uttaranchal and Jharkhand (see Box 2).

- **SIFPSA and IFPS Partners.** As a key stakeholder in family planning and reproductive health issues and programs in Uttar Pradesh, SIFPSA was an active participant in the state’s population policy development process. The agency supported early efforts to introduce and train workers in the target-free approach. SIFPSA staff and IFPS-supported partners were involved in the state policy issues identification workshop as both presenters and participants. Several IFPS
activities served as models for the activities outlined in the policy’s strategy section and, thus, play a significant role in working to achieve the policy’s goals. Through the IFPS Project, SIFPSA staff also lent assistance to the formulation of policies in Uttaranchal and Jharkhand (see Box 2).

In both Uttaranchal and Jharkhand, two issues identification workshops were held, one each for population and health issues. At the direction of the Chief Minister, Uttaranchal opted for an integrated *Health and Population Policy* that highlights the impact of population and reproductive health on overall health status. The policy was adopted in 2002. In Jharkhand, two policies were adopted in 2004: the *Jharkhand State Health Policy* and the *Population and Reproductive & Child Health Policy of Jharkhand*.

For more on health and population policies in Uttaranchal and Jharkhand, see Goliber and Cross (2006).

### THE POLICY DEVELOPMENT PROCESS
The policy development process in Uttar Pradesh involved the following steps (Goliber and Cross, 2006):

- **Background papers.** POLICY commissioned 28 papers on population-related topics, including contraceptive use and behavior; reproductive and child health (RCH) services; management of the health and family welfare program; decentralization of program implementation; linkages with other departments; advocacy and the media; the role of NGOs; and gender and informed choice. Information and insights from the background papers helped to identify key issues and provide data for policy development.

- **Issues identification workshop.** Based on the background papers, POLICY and the Department of Health and Family Welfare convened an issues identification workshop in March 2000. More than 100 participants attended the three-day workshop, including population experts, social scientists, government officials, program managers, donors, NGO representatives, and others. The inclusion of civil society and private-sector groups helped to highlight key issues (such as gender equity) and helped bring a holistic perspective to the policy process.

Among the featured speakers were the Chief Minister, Chief Secretary, and Minister for Family Health and Women and Child Welfare of GoUP; the Joint Secretary for the Ministry of Health and Family Welfare of GoI; and the Executive Director of SIFPSA. Several SIFPSA and IFPS partners also participated as discussants and attendees. The involvement of high-level central and state government officials demonstrated political

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**BOX 2**

**Fostering an Enabling Policy Environment for Reproductive Health in Northern India: Policy Development in Uttaranchal and Jharkhand**

As newly-formed states in 2000, Uttaranchal (constituted of the hill districts of Uttar Pradesh) and Jharkhand (carved out of southern Bihar) had both the need and the opportunity to establish a clear vision, objectives, and strategies to guide development of the health sector. The IFPS Project had fostering an enabling policy environment for achieving population-related goals in northern India as one of its primary objectives. Thus, the project served as a natural conduit for USAID, POLICY, and SIFPSA to extend technical assistance to the new states in formulating their health and population policies.

In both Uttaranchal and Jharkhand, two issues identification workshops were held, one each for population and health issues. At the direction of the Chief Minister, Uttaranchal opted for an integrated *Health and Population Policy* that highlights the impact of population and reproductive health on overall health status. The policy was adopted in 2002. In Jharkhand, two policies were adopted in 2004: the *Jharkhand State Health Policy* and the *Population and Reproductive & Child Health Policy of Jharkhand*.

For more on health and population policies in Uttaranchal and Jharkhand, see Goliber and Cross (2006).
commitment for improving family planning and reproductive health, while the consultative nature of the workshop allowed for participation of various groups in the process.

- **Drafting and review of the policy.** In addition to the issues identification workshop, policymakers conducted “consultations with a wide range of stakeholders, including women, adolescent, and non-government organizations and the private sector” as well as “discussions within the department of health and family welfare and with other development departments” (Narayana and Sathyarayana, 2001, p. 1). The GoUP then appointed a drafting committee to write the initial draft of the policy based on the issues and strategies identified during the workshop and consultations. Three of the five members on the drafting committee were directly involved with SIFPSA or in providing technical assistance to the IFPS Project.

During the drafting process, key details had to be worked out. A significant issue, for example, was what date should be set for the achievement of replacement-level fertility: “Should the target be as ambitious as possible? Or should it be realistically descriptive of what is most likely to happen in the state over time?” (Goliber and Cross, 2000, p. 11). It was ultimately decided to set 2016 as the goal. Once the initial draft was completed, public officials, experts in the field, and representatives from about 30 civil society and private-sector groups reviewed and provided comments on the draft, which were incorporated into the final document.

- **Approval and dissemination.** In a relatively short time period, a revised draft was produced and submitted for final approval, which came from the Cabinet on July 9, 2000. Dissemination included press briefings and printing and distribution of the policy to all districts. Sessions on key elements of the policy were incorporated into all related training programs and workshops conducted by SIFPSA and others as well.

### UTTAR PRADESH POPULATION POLICY HIGHLIGHTS

The Uttar Pradesh Population Policy (Department of Health and Family Welfare, 2000) recognizes the importance of addressing population issues in a “holistic, open and transparent manner” and states that population stabilization and improvement of the health status of people, particularly women and children, are prerequisites for sustainable development. The document is divided into three sections: policy objectives, strategies to improve RCH services, and policy implementation.

#### Objectives

Policy objectives are divided into six major categories, each with specific sub-objectives. The major categories relate to age at marriage; fertility; maternal mortality; infant and under-5 mortality; reproductive tract infections (RTIs)/sexually transmitted infections (STIs); and family planning and reproductive health.
The major goals of the policy are to achieve replacement-level fertility by 2016; help families meet desired family size; reduce infant and maternal mortality; streamline RCH services; and other associated goals (see Box 3).

Throughout the document, year-wise and region-wise tables of RCH indicators are presented to help chart the progress needed to achieve the policy’s overall goals by 2016. Importantly, the policy notes that achievement of family planning objectives is to be encouraged by focusing on factors such as quality and access to services, satisfying unmet family planning need, and promoting demand for services.

**Strategies**

To guide implementation, the policy outlines several strategies that relate to community involvement, collaboration with the private sector, access to and quality of RCH services, and service delivery systems. The impact of the IFPS Project—which had developed innovative approaches and pilot-tested a range of interventions in these various categories—is evident throughout the strategies adopted and recommended in the state policy. Some examples of IFPS-supported interventions integrated into the policy include:

- A media campaign to disseminate information on the legal age at marriage and adverse consequences of early marriage for adolescent girls;
- Sensitization of pradhans and panchayat members to foster demand for family planning and RCH services and to promote the small family norm;
- Partnerships with NGOs, dairy cooperatives, and the organized sector in clinical service delivery and community-based distribution of contraceptives;
- Training of indigenous systems of medicine practitioners and traditional birth attendants;
- Social marketing of contraceptives and other commodities, such as disposable delivery kits and oral rehydration salts/solution;
- Special campaigns to increase uptake of tetanus toxoid vaccination and iron and folic acid tablets by pregnant women;
- Integrated RCH camps, including contracting of private lady medical officers and the creation of a pool of surgeons to provide services to rural areas through camps;
- Upgrading of community and primary health centers;

### BOX 3

<table>
<thead>
<tr>
<th>State Population Policy Main Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce total fertility rate from 4.3 in 1997 to 2.6 in 2011 and further to replacement-level fertility of 2.1 by 2016</td>
</tr>
<tr>
<td>• Increase median age at marriage for women from 16.4 years to 19.5 years by 2016</td>
</tr>
<tr>
<td>• Reduce the maternal mortality ratio from 707 in 1997 to 394 in 2010 and further to 250 in 2016</td>
</tr>
<tr>
<td>• Reduce the infant mortality rate from 85 in 1997 to 73 in 2006, to 67 in 2011 and to 61 in 2016</td>
</tr>
<tr>
<td>• Reduce under-5 mortality from 125 in 1997 to 105 in 2006, to 94 in 2011 and to below 84 in 2016</td>
</tr>
<tr>
<td>• Reduce RTI and STI prevalence and incidence substantially and to improve awareness of HIV/AIDS among men and women</td>
</tr>
<tr>
<td>• Develop region-specific strategies and service delivery systems for each of the five regions in Uttar Pradesh (Bundelkhand, Central, Eastern, Hill, and Western regions)</td>
</tr>
</tbody>
</table>

infections (STIs) and HIV/AIDS; and regional-level objectives. The major goals of the policy are to achieve replacement-level fertility by 2016; help families meet desired family size; reduce infant and maternal mortality; streamline RCH services; and other associated goals (see Box 3).
Implementation Mechanisms

To facilitate implementation of the policy’s strategies, the following committees and mechanisms were envisaged:

- **State Population and Development Commission.** The State Population and Development Commission is the apex body responsible for guiding and reviewing policy implementation, including providing policy directives and coordinating multisectoral engagement. The commission was constituted with the Chief Minister as chairperson.

- **Reproductive and Child Health Mission.** To help devise region-specific strategies, a three-member technical advisory group—called the Reproductive and Child Health Mission—would be established to advise the Department of Health and Family Welfare. This strategy was subsumed in several national initiatives and is currently being implemented in Uttar Pradesh under the National Rural Health Mission and the RCH-II Program.

- **District-level Societies.** Much like the DIFPSAs of the IFPS Project, the state policy recommended establishment of autonomous societies to be headed by the District Magistrate and supported by a project management unit. The societies include both government and nongovernmental partners who meet monthly to plan, implement, and monitor program activities. SIFPSA and the GoUP worked to expand these local societies, which have now been established in all 70 districts.

In these ways, the IFPS Project provided diverse models for program planning and implementation in both the public and private sectors that were institutionalized in the statewide population policy.
Monitoring. The policy called for monthly monitoring, by the Chief Secretary, of indicators relating to family planning, child immunization, and antenatal care. The policy also stated that the performance of districts will be evaluated biannually using a survey. These monitoring systems have been established.

RESULTS

Only five years after official adoption of Uttar Pradesh’s state population policy, it is difficult to assess the long-term impact of the policy. Having a policy in place is no guarantee that the policy will be implemented and institutionalized throughout the state. And, indeed, achievement of the policy’s objectives—whether it is lowering the total fertility rate or raising the average age at marriage—is dependent on several factors, many of which may be beyond the policy’s control. However, quantitative data and qualitative assessments can give an indication of the effect of the policy and associated efforts.

In terms of quantitative data, a comparison of the policy’s 2005 objectives and the 2005 Reproductive Health Indicator Survey (RHIS) shows that Uttar Pradesh has met or exceeded its goals to date in some cases (e.g., current contraceptive use for any modern spacing methods and any antenatal coverage). Other indicators, such as the percent of deliveries taking place in institutions, are lagging behind the policy objective set for 2005 (see Table 1). Additionally—given the increases in contraceptive prevalence rates, contraceptives sales, number of trained providers, proportion of pregnant women receiving two doses of tetanus toxoid vaccine, and use of integrated RCH services in IFPS districts—it can be inferred that, with proper support, further improvements in health indicators will be evidenced statewide as interventions are scaled up to other districts.

On a more qualitative side, the adoption of the Uttar Pradesh Population Policy has created a state-specific plan for improving family planning and reproductive health; demonstrated the state’s political commitment; established a participatory, multisectoral process of policy development and implementation that has been adapted to other policy areas; and stimulated decentralized planning efforts (Goliber and Cross, 2006). The policy continues to guide activities within the state and facilitate implementation of related national initiatives. Several innovations under the IFPS Project are to be scaled up to other districts under the state population policy and have been incorporated into the GoI’s National Rural Health Mission and RCH-II Program. The state policy also served as the

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2005 Goals</th>
<th>2005 RHIS</th>
</tr>
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<tbody>
<tr>
<td>Contraceptive prevalence use – any modern methods</td>
<td>31.2</td>
<td>26.7</td>
</tr>
<tr>
<td>Current contraceptive use – modern limiting methods</td>
<td>22.0</td>
<td>17.4</td>
</tr>
<tr>
<td>Current contraceptive use – any modern spacing methods</td>
<td>9.2</td>
<td>9.3</td>
</tr>
<tr>
<td>Any antenatal care coverage</td>
<td>64.5</td>
<td>76.4</td>
</tr>
<tr>
<td>Percent of institutional deliveries</td>
<td>33.0</td>
<td>18.9</td>
</tr>
</tbody>
</table>
underpinning framework for Uttar Pradesh’s “Program Implementation Plan” for RCH-II. The policy has provided for consistency and established 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.

LESSONS LEARNED
Some of the policy development and implementation challenges and lessons learned from Uttar Pradesh include:

- **Encouraging provider performance.** In terms of policy content, a significant challenge for policymakers in India has been to determine how best to encourage improved performance in the public health sector in the absence of method-specific targets. While new policies at the national and state levels call for a “target-free” approach, in practice, targets still exist—yet they are to be determined on the basis of community needs. In drafting Uttar Pradesh’s state policy, some government officials felt that disincentives should be included to ensure that objectives were met (Goliber and Cross, 2006). Disincentives were not included in the final policy, but general incentives are mentioned in the policy.3

- **Using a participatory approach.** The GoUP adopted a participatory policymaking process involving a range of stakeholders. While this approach may be more cumbersome, difficult, and time-consuming—given the need to satisfy various groups to achieve consensus—experience has shown that “policies formulated without openness and broad consensus failed at implementation stages” (Narayana and Sathyanarayana, 2001, p. 1). Widespread inclusion and participation in family planning and reproductive health policymaking educates the various stakeholders of the viewpoints, needs, and assets of other groups; encourages consensus on priority issues and approaches; strengthens ownership and buy-in across sectors, enhancing implementation; empowers those who take part in the process; promotes open dialogue on sensitive community issues (e.g., delaying age at marriage); and bestows greater legitimacy on the policy approaches adopted, thereby increasing likelihood of effective implementation.

- **Linking policy to implementation structures.** As noted above, efforts are needed to ensure that adopted policies are put into practice. In October 2000, the Uttar Pradesh Cabinet approved a state population policy implementation plan designed by an expert committee in consultation with various departments. The implementation plan has two components: a plan for activities for each strategy listed in the policy document.

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3 Some examples include “NGOs that have successfully implemented innovative projects will be recognized and rewarded” (Section 3.2.1) and “Districts and officers showing good performance will be recognized” (Section 4.6).
and a monthly activity plan to facilitate program monitoring. For each strategy, the plan seeks to identify: What is the activity to be implemented?; Who should implement the activity?; What is the time frame for implementation?; and Who should monitor the implementation? (Narayana and Sathyanarayana, 2001).

- **Improving monitoring and evaluation.** One of the factors that impeded Uttar Pradesh’s transition to the target-free and subsequent community needs assessment approach in 1996/1997 was a weak program monitoring system. The state population policy adopted in 2000 called for establishing an expert committee that would meet every three months and would be responsible for monitoring program performance. However, the committee was never created and, according to key informants, monitoring of implementation has been weak following adoption of the policy (Goliber and Cross, 2006).

- **Ensuring sustainability.** Several factors contribute to the sustainability of policy directives and corresponding program implementation efforts. Paramount among these factors in Uttar Pradesh are political commitment and resource mobilization. One benefit of a policy is that it can provide stability and guidance even in the context of political or leadership changes. In Uttar Pradesh, for example, from 1996 to 2005, 13 different Indian Administrative Service officers have filled the post of Secretary for Family Welfare. However, while a policy can support consistency during times of change, new governments may not share the same commitment to a particular policy as the one that originally adopted the policy (Goliber and Cross, 2006).

The ultimate success of the policy and organizational changes that have occurred in India and various states with regard to family planning and reproductive health depends on proper planning, implementation, and stabilization (Narayana and Sangwan, 2000). The USAID-funded IFPS Project played a critical role in the population policymaking process in Uttar Pradesh, particularly in aiding planning and implementation of the state’s family welfare program. In doing so, the project was a catalyst for state policy change and helped to guide the policy development and implementation process by providing field-based models for operationalizing strategies to meet the policy’s goals. In moving forward, the state must now focus on issues of scale-up, sustainability, and stabilization—which will require strong political commitment and multisectoral coordination, mobilization of internal and external resources, and effective monitoring and evaluation systems. As Uttar Pradesh endeavors to improve the quality and coverage of its RCH program over the coming decades, the state population policy will have played an important role in setting the stage and direction for meeting the needs of its population.
REFERENCES


DISTRICT ACTION PLANS:
Supporting Decentralized Health Planning

By Seema Talwar

RATIONALE
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 (now 21 due to bifurcation of districts) as “focus districts.” Over the next two years, SIFPSA and USAID emphasized these districts in programming activities and technical assistance. However, because activities had been initiated with limited consultation with district-level officials and NGOs, local commitment to implementing activities was weak. As a result, reproductive and child health (RCH) performance did not improve as much as anticipated.

At this time the USAID-funded POLICY Project was providing technical assistance to IFPS. POLICY 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, and district and village leaders.

The DAP approach was piloted in 1997 and then extended to six districts in 1998. By 2004, the DAP approach had reached 63 million people across the 33 IFPS districts of Uttar Pradesh. According to many stakeholders, the DAP methodology and its successful implementation were essential for achieving the main objectives of the IFPS Project.

Why Decentralized Planning?
The Government of Uttar Pradesh (GoUP) has managed a centralized health and family welfare program for decades. Beginning in the 1970s, the Government of India (GoI) and GoUP started to expand the health infrastructure in terms of number of facilities and health personnel. Moreover, the programs became more complex and there was an attempt to increase emphasis on quality and informed choice for patients. At the time, the state administration had 83 district units to oversee and was not in a position 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 GoI’s family welfare program consisted of a uniform approach and was not adapted to meet any particular state’s family welfare needs—much less needs at the district level. 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. As a result, according to the 1992/93 National Family Health Survey (NFHS-1), Uttar Pradesh’s contraceptive prevalence rate (CPR) was one of the lowest in India at 19.8 percent of married women aged 13–49 (International Institute for Population Sciences [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 Uttarakhand). The main objectives of the PERFORM survey were 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 decisionmaking processes 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.

**INTERVENTION COMPONENTS**

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.

**A Phased Approach**

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 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, IFPS extended the DAP model to five additional districts and continued to support implementation of the Rampur action plan. 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; and
- 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 (POLICY Project, 1999).

Building on this first phase of DAP implementation, IFPS launched DAPs in nine additional districts in 2001. In 2002, IFPS added the 18 remaining project 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
Step 1 - Baseline and Facility Survey Conducted (1-2 months)
Collection of reliable district-level data on current FP/RH behavior and resources. Data on maternal health, child health, fertility, and family planning are gathered. A situational analysis of program resources, infrastructure facilities, and medical service providers is also conducted.

Step 2 - Analysis of Survey Data (1 week)
POLICY Project analyzes data and creates quantitative and qualitative presentations of key findings.

Step 3 - DAP Workshop (3 days)
District government and health officials, SIFPSA, USAID, POLICY, other cooperating agencies, and NGOs attend a three-day workshop to learn about the current RCH situation in the district and collectively brainstorm strategies and objectives for maternal and child health, fertility, and family planning.

Step 4 - Selection of Objectives and Strategies (1 week)
POLICY Project uses SPECTRUM software to create feasible objectives for key RCH indicators.

Step 5 - DAP Document Created (2 weeks)
POLICY Project creates a report detailing the district profile and baseline and situation survey results. The report also contains proposed strategies for RCH activities and an overview of resource, training, and upgrading requirements.

Step 6 - Approval by SIFPSA PAC (1-2 days)
The Project Appraisal Committee (PAC) of SIFPSA reviews and approves the DAP and creates a budget for interventions.

Step 7 - Creation of DIFPSA and PMU (1 month)
The DIFPSA is formed and members of the Project Management Unit (PMU) are hired from the open market. The SIFPSA recruiting committee reviews and evaluates candidates for the PMU.

Step 8 - Creation of Monthly Operational Plans (2-3 weeks)
With POLICY Project technical assistance, operational plans are created for the action plan. These plans form the indicators for monitoring and provide a roadmap for achievement of objectives.

Step 9 - DAP Launch (1 day)
Once the DAP is approved and DIFPSA and PMU are staffed, the plan is launched. A final consultation meeting is held with district officers, SIFPSA, USAID, POLICY, and other cooperating agencies.

Step 10 - DAP Implementation Begins (Ongoing)
DAP implementation begins. DIFPSA and PMU begin implementing strategies and cooperating agencies offer technical assistance in areas such as training, partnering with NGOs, and information, education, and communication (IEC) activities. On average, it took approximately three to four months to reach this final implementation step.
additional seven districts under the GoI’s Empowered Action Group scheme. These are known as the Decentralized Participatory Planning or DPP districts. The planning activities in these districts were funded by the GoI and received technical assistance from SIFPSA. Therefore, at the end of IFPS-I, there were 40 districts with RCH-related action plans in Uttar Pradesh in total, of which, 33 DAPs were funded through the IFPS Project.

The DAP Formulation Process
DAP programs have evolved and become a central strategy for achieving the objectives of the IFPS Project. Figure 1 provides an overview of the DAP formulation process and steps.

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 (USD 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.

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 GoI 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 did 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.

Key Principles and Strategies
The DAP system is based on two principles:
- Decentralization—to provide flexibility and allow decisions to
be made based on local needs; and
- 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; and
5) Involve the nongovernmental sector to assist in project implementation.

**IMPLEMENTING PARTNERS**

**DIFPSA—Leadership at the Local Level**

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; and
- Review activities and make mid-course corrections.

**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)

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:

- 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 committees for PMUs;
- Provide ongoing consultation for challenges, bottlenecks, and issues; and
- Train SIFPSA staff on DAP creation process and transfer 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.

DAP ENHANCEMENT OF IFPS INTERVENTIONS

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.

This section highlights the added value of DAPs, both in strengthening centrally-driven interventions and in developing new approaches.

**Support to Public-sector RCH Services**

As discussed in Chapters 2–7, the IFPS Project made a concerted effort to strengthen public-sector RCH services in the 33 project districts. These activities and the contributions of DIFPSAs and PMUs to their outcomes are summarized below.

**Upgrading of clinical facilities.** As discussed in Chapter 2, the IFPS Project upgraded more than 600 community health centers, postpartum centers, and primary health centers 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-sector health facilities, including renovation of buildings, installation of electricity and clean water supply, and provision of new equipment and supplies. The teamwork entailed in the upgrading process is exemplified in the following steps:

- A cooperating agency conducts assessments of each health facility to determine specific needs of the site.
- SIFPSA provides standards and guidelines for assessments and estimates.
- Civil engineers of the Department of Health and Family Welfare visit facilities to prepare cost estimates.
- SIFPSA requests technical sanction from the Director General of Health Services.
- Once approved, SIFPSA gives authority to the DIFPSA to begin facilities upgrading work.

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.

**Provision of clinical training.** IFPS supported technical training for medical providers throughout the project districts (see Chapters 3–4). At the local level, 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.

**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. DAPs coordinated these placements with CMOs and other local officials and assisted the private-sector medical officers when necessary.

**Coordinating RCH camps.** DAPs played a major role in supporting integrated RCH camps. Organized at a primary or community health center, the RCH camps required careful management to ensure that the necessary medical personnel, equipment, and supplies were on site on the appointed day (see Chapter 6). CMOs were responsible for creating RCH camp teams consisting of a surgeon, gynecologist, pediatrician, and anesthesiologist and including a lady medical doctor. CMOs also manage the budget for transportation of doctors and sterilization clients who are transported home after procedures. The PMU is responsible for monitoring the RCH camps and ensuring medical team presence, adequate camp publicity, and transportation of sterilization clients. Twelve DAP districts have created dedicated surgical teams to provide services at RCH camps. The DAP also helps to coordinate the publicity efforts of pradhans, NGOs, and ANMs. After the camp, the PMU prepares a detailed monitoring report for SIFPSA, including information on the availability of resources, timeliness of the event, assurance that safety and infection prevention practices were followed, and provision of services.

**Promoting quality of care in public facilities.** In the two districts implementing pilot projects under the Quality Improvement Circle program (see Chapter 5), 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.

**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 experiences (see Chapter 7).

**Private-sector DAP Partnerships and Innovations**

**Involving the nongovernmental sector.** Private-sector agencies, including NGOs, dairy cooperatives, and employers/workers, were included in the planning meetings leading to 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 (see Chapters 8–12).

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.

**Communication Initiatives**

**Support to multimedia campaigns.** DIFPSAs and PMUs actively supported SIFPSA’s larger multimedia campaigns as well as introduced local communication activities. For the 1998–2002 Aao Batein Karein (“Come Let’s Talk”) campaign, PMUs ensured that interpersonal communication and local media components were in place to support the campaign’s mass media elements (see Chapter 14). 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. Similar local initiatives supported the legal age at marriage (see Chapter 14) and TT campaigns (see Chapter 15).

**Workshop for mother- and daughter-in-law pairs.** An innovative DAP intervention designed by the PMU, DIFPSA, and health department in Banda District recognized the mother-in-law’s influence in important family decisions, especially related to family planning. 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; and a competition of singing folk songs advocating women’s empowerment. After the event, many daughter-in-laws decided to have a sterilization procedure. They also reported more open discussions with their mother-in-laws regarding family planning options (SIFPSA, 2005).

*Training barbers to promote male involvement.* Sitapur District conducted a DAP pilot intervention to involve barbers to promote male awareness of family planning, especially in the use of condoms and NSV. 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.

**Engaging Local Leaders**

*Engaging village leaders in RCH.* DIFPSAs and PMUs have been actively involved in training local political leaders in RCH issues. As authority for health services is increasingly devolved to local governing bodies, the role of pradhans becomes pivotal. IFPS has supported training on RCH issues and services for more than 28,000 pradhans and other local leaders (see Chapter 19). The training has helped pradhans understand the nature of DAPs and their role in promoting RCH services in the community. Following the training, many pradhans attended RCH camps, community meetings, and folk performances where they discussed health issues with community members.

*Working with religious leaders.* PMUs have developed contacts with religious leaders in their districts and have sought their support for RCH issues. Initially, the PMU meets with a small group of religious leaders and provides them with literature on family planning. Then the PMU holds informal meetings to discuss the material and obtain input on ways to conduct broader meetings on sensitive issues in a culturally appropriate manner. Finally, the PMU organizes 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 assist the PMU in encouraging key religious leaders to attend the meeting. During the IFPS Project, 2,735 religious leaders in 10 districts attended the orientation meetings. The meetings were helpful in initiating discussions about previously taboo topics and motivating religious leaders to express their support for family planning and RCH issues to community members.
RESULTS: IMPACT OF DAPs
When considering the macro- and micro-level impact that DAPs have had, it becomes clear that DAP districts perform better than non-DAP districts. Salient performance indicators highlighted in this section reaffirm the crucial role DAPs and their support structures have had. Moreover, there are significant qualitative indicators that reveal a long-lasting impact that DAPs have had on local stakeholders and citizens of participating districts.

DAP Impact on Family Planning and Maternal Health Indicators
DAPs have had a significant impact on modern CPR and maternal health indicators such as adequate supply of IFA tablets received, two or more TT injections, and the presence of trained personnel (e.g., health personnel or trained dai) at time of delivery. Figure 2 shows that, in 2003, the use of modern contraception among married women aged 15–49 was 6 percentage points higher for DAP districts than non-DAP districts. Moreover, Figure 3 demonstrates that maternal health indicators were better in DAP districts compared with non-DAP districts, particularly with regard to trained personnel (e.g., health professional or trained dai) at the time of delivery.

Furthermore, in reviewing the increase in contraceptive use across several years within DAP districts, a tremendous impact can be seen (see Figure 4). The 1995 PERFORM survey and 2003 Reproductive Health Indicator Survey (RHIS) both assessed contraceptive use in DAP districts.
Another way to assess the impact of DAPs 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. Furthermore, while the Uttar Pradesh average annual increase in family planning use is 0.5 percentage points, the average annual increase for DAP districts is nearly always higher than the state average. Additionally, while the Uttar Pradesh average annual increase in provision of sufficient IFA tablet supplies is 2.5 percent percentage points, the DAP districts increase is higher, ranging

**TABLE 1. INCREASE IN MODERN FAMILY PLANNING USE FOR DAP DISTRICTS**

<table>
<thead>
<tr>
<th>District</th>
<th>Baseline Modern FP Method</th>
<th>Base Year</th>
<th>Benchmark Evaluation Modern FP Method</th>
<th>Benchmark Year</th>
<th>Percentage Point Increase</th>
<th>DAP Avg Annual Percentage Point Increase</th>
<th>Uttar Pradesh Avg Annual Percentage Point Increase</th>
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</thead>
<tbody>
<tr>
<td>Sitapur</td>
<td>17.1</td>
<td>2000</td>
<td>22.2</td>
<td>2004</td>
<td>5.1</td>
<td>1.3</td>
<td>0.5</td>
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<tr>
<td>Jhansi</td>
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<td>2000</td>
<td>53.4</td>
<td></td>
<td>3</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Mirzapur</td>
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<td>2000</td>
<td>33.2</td>
<td></td>
<td>3.4</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
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<td>14.9</td>
<td>2000</td>
<td>16.5</td>
<td></td>
<td>1.6</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Moradabad</td>
<td>23.3</td>
<td>2000</td>
<td>26.6</td>
<td></td>
<td>3.3</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Agra</td>
<td>29.1</td>
<td>1999</td>
<td>33.3</td>
<td></td>
<td>4.2</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Firozabad</td>
<td>18.5</td>
<td>1999</td>
<td>22.8</td>
<td></td>
<td>4.3</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Unnao</td>
<td>16.6</td>
<td>2001</td>
<td>18.9</td>
<td></td>
<td>2.3</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Bareilly</td>
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<td>1999</td>
<td>30.0</td>
<td></td>
<td>3.9</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Saharanpur</td>
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<td>1999</td>
<td>34.2</td>
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</tr>
<tr>
<td>Bagpath</td>
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<td>2001</td>
<td>36.4</td>
<td></td>
<td>2.6</td>
<td>0.7</td>
<td></td>
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</tbody>
</table>

**TABLE 2. INCREASE IN PREGNANT WOMEN RECEIVING SUFFICIENT QUANTITY OF IFA TABLETS FOR DAP DISTRICTS**

<table>
<thead>
<tr>
<th>District</th>
<th>Baseline IFA</th>
<th>Base Year</th>
<th>Benchmark Evaluation IFA</th>
<th>Benchmark Year</th>
<th>Percentage Point Increase</th>
<th>DAP Avg Annual Percentage Point Increase</th>
<th>Uttar Pradesh Avg Annual Percentage Point Increase</th>
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<tr>
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<td>62.8</td>
<td></td>
<td>29.3</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Mirzapur</td>
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<td>2000</td>
<td>36.3</td>
<td></td>
<td>17.6</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Shahjahanpur</td>
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<td>38.9</td>
<td></td>
<td>35.6</td>
<td>8.9</td>
<td></td>
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<td>22.4</td>
<td>4.5</td>
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</tr>
<tr>
<td>Firozabad</td>
<td>9.9</td>
<td>1999</td>
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</tr>
<tr>
<td>Unnao</td>
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<tr>
<td>Bareilly</td>
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<td>34.1</td>
<td></td>
<td>23.1</td>
<td>5.8</td>
<td></td>
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</tbody>
</table>
from 2.9 to 8.9 percentage points. Tables 1 and 2 below confirm that DAP districts perform better than the state as a whole.

**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;
- 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; and
- Strengthened local capacity building due to decentralization.

When evaluating the performance of DAPs, it is also important to note that the GoI has expanded this intervention nationally through the National Rural Health Mission (NRHM). Furthermore, even before the NRHM, the GoI 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 GoI scheme and based on the IFPS DAP approach.

**LESSONS LEARNED**

**Challenges in DAP Implementation**

*Frequent transfers.* The GoUP system is hindered with 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 Magistrates and CMOs 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...
District Action Plans are near retirement age, they may not be as responsive to RCH issues. Ultimately, this slows 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 to urban locations to have a better standard of living and more resources for 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, and
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 contraceptives often come 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 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 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 recognition 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 family planning 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 GoI 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. The NRHM marks the GoI’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 the 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.” (GoI/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 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 and the CMO’s office and local NGOs.

When asked about the sustainability of DAPs, interviewees noted that

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**BOX 2**

**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.
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 the government has budgeted money towards DAPs and releases money for the plans in a timely manner.
- **Zila Parishads** (local district administrations) 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 entire system.

### CONCLUSIONS

In reviewing DAPs, it becomes clear that this intervention is based on four main doctrines:

- **Decentralization.** Operational functions are handled at the local district level, which provides flexibility and allows decisionmaking 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, technical 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 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 issues.
REFERENCES


PUBLIC-PRIVATE PARTNERSHIPS: Fostering Innovative Service Provision Models

By Anita Bhuyan

RATIONALE

From its inception, the IFPS Project sought to develop innovative ways to reduce fertility and, later, to improve reproductive healthcare quality and access in Uttar Pradesh. This philosophy applied both to the management of the project itself and to the specific interventions it supported. While the public health system had been the backbone of family planning and reproductive healthcare service provision in the state—particularly for those in rural areas and among poor populations who cannot afford private sector services—there was recognition that the public sector alone could not meet all reproductive health needs. For example, the public sector was the source for nearly 94 percent of sterilizations among women, according to the 1998/99 National Family Health Survey (NFHS-2). At the same time, there was high unmet need for family planning, the use of spacing methods was limited, and many women lacked access to maternal health care. In this context, the IFPS Project recognized the need to explore alternative service provision models, concurrently building capacity of the public sector and promoting involvement of the private sector.

With this in mind, public-private partnerships (PPPs) became a key model for many interventions implemented under the IFPS Project. A public-private partnership involves:

“collaborative efforts, between private and public sectors, with clearly identified partnership structures, shared objectives, and specified performance indicators for delivery of a set of health services in a stipulated time period” (Policy Division, Ministry of Health and Family Welfare, 2005, p. 4).

The private sector consists of both for-profit and non-profit groups. While PPPs in the health sector often focus on a point of service delivery—such as a clinic, nursing home, or hospital—they can also involve a cluster of networked “providers” such as community midwives, physicians, or kiosk owners. The private sector can include NGOs, companies, private health professionals, and others, including traditional birth attendants and indigenous systems of medicine practitioners (ISMPs). Some of the advantages of working with these groups are that they can cover different segments of the population than the public health sector; are dynamic and flexible in
through IFPS, partnerships between the public and private sector ranged from statewide immunization campaigns to reduce maternal and neonatal mortality, to contracting of lady medical officers to provide services to rural women, to community-based distribution of family planning commodities. The intention was that such partnerships could help improve service quality and access (on the supply side), promote services to various groups (on the demand side), and mobilize greater resources (both material and human).

**MANAGEMENT AND STRUCTURE OF THE IFPS PROJECT**

The desire to bring together the best elements of both the public and private sectors was a driving factor in the establishment of the management structures that govern 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. SIFPSA is headed by a senior Indian Administrative Service officer on deputation from the Government of Uttar Pradesh (GoUP) who serves as executive director. There is also a Governing Body, Executive Committee, and Project Appraisal Committee. The Governing Body itself includes representatives from the Government of India (GoI), GoUP, USAID, and prominent persons from the private sector who serve as a policymaking group and are responsible for approving annual plans and budgets (SIFPSA, 2003). By setting up SIFPSA as an autonomous society, it was believed that the project could “circumvent the delays inherent in working through a large government system and overcome barriers to working with and dispersing funds to entities within the private sector” (LTG Associates and TVT Global Health and Development Strategies, 2003, p. 2). Additionally, SIFPSA had the flexibility to recruit experts from the nongovernmental sector as well as government sector officers on deputation.

To decentralize planning and implementation, District Innovations in Family Planning Services Project Agencies (DIFPSAs) and Project Management Units (PMUs) were established in project areas “to provide operational linkages between SIFPSA, the districts, and the public and private sectors” (USAID/India, 2005, p. 4). 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 meet monthly to review progress and propose solutions for any challenges that may arise in project implementation. The PMU—which consists of a project manager, assistant project manager, accountant, management information system specialist, and support staff—provides for the extension of SIFPSA to the district level. PMU staff are recruited from the open market, thereby bringing private-sector
Public-private Partnerships

The unit is designed as a problem solving group and is charged with promoting an integrated approach, which means identifying and making use of all resources available in the public and private sectors as well as linking and sharing information between the two sectors.

Therefore, from the state-level implementing agency to the functionaries and support units in the districts, the IFPS Project structure was designed to take advantage of and nurture PPPs. The project’s legacy in establishing institutions that can manage such partnerships has been recognized. Mr. Prasanna Hota, Secretary of Health and Family Welfare, GoI, remarked:

“The most important outcome [of the IFPS Project] … has been in the area of institution building. SIFPSA has been created, established, and is in a position to manage a sophisticated reproductive and child health program which includes public-private partnership, communication, marketing, training, and service delivery.”

PUBLIC-PRIVATE PARTNERSHIPS UNDER THE IFPS PROJECT

Several IFPS interventions sought to involve private-sector partners in the delivery of family planning and reproductive health information, commodities, and services. Specific details on these interventions are available in the various chapters throughout this monograph. Rather than recounting each activity here, selected examples have been presented that highlight how collaboration between the public and private sectors contributed to the achievement of results that may not have been realized otherwise.

Contraceptive Social Marketing and Community Outreach

In Uttar Pradesh, there has been a strong preference for female sterilization as the primary method of family planning and there has been less attention given to promoting non-permanent spacing methods. To expand access to a variety of methods, including oral contraceptive pills and condoms, the IFPS Project supported contraceptive social marketing in collaboration with various partners. SIFPSA partnered with groups such as Hindustan Latex Ltd., the Hindustan Latex Family Planning Promotion Trust, DKT International, and Population Services International to provide socially-marketed brands of oral pills, condoms, and other products (e.g., disposable delivery kits, oral rehydration salts, and iron and folic acid tablets) (see Chapter 13). Products were made available through retail outlets, mobile promotion units, and field agents. Availability of socially-marketed products in rural villages more than doubled—the proportion of rural villages with at least one commercial outlet selling condoms and oral contraceptives increased from 19 percent in 2000 to 43 percent in 2002. Through social marketing with private sector partners, the needs of more family planning clients across a greater geographic area were met than could have been done by the public sector working alone.

1 Written communication to USAID/India Mission Director, June 10, 2004.
On the demand creation and distribution side, contraceptive social marketing was also aided by NGOs (see Chapter 8), dairy cooperatives (see Chapter 9), and the employer sector (see Chapter 10). Through NGO projects, community-based distribution (CBD) workers provided family planning counseling, contraceptive supplies, and referrals to 1.6 million clients. Clients may be referred to public sector facilities or, where available, a facility operated by the private-sector partner. The CBD workers, who earn a stipend as well as commission from supplies sold, distributed contraceptives to current users, but also sought to recruit new acceptors. Dairy cooperatives trained about 5,000 village health volunteers who provided family planning and reproductive health counseling and supplies. These volunteers would typically visit 10–12 households per day, offering both the free government-supplied contraceptives as well as socially-marketed brands, which were perceived as being of higher quality. Over an eight-year period, from 1997–2005, the dairy cooperative projects served nearly 887,000 family planning clients. CBD workers also became part of the approach supported through employer sector projects. Trained factory workers and CBD workers raised awareness about family planning methods and provided contraceptives to workers, their families, and the surrounding communities. Interpersonal communication—with the CBD workers and village health volunteers contacting clients multiple times—played an important role in helping to sustain contraceptive use and encourage adoption of spacing methods by new clients.

Reproductive Healthcare Service Delivery Quality and Expansion

Expanding access to both clinic-based and outreach services became an important strategy for achieving the goal of improved reproductive health under the IFPS Project. Two primary PPP approaches were used to expand access to services: 1) operation of facilities and outreach camps by private-sector partners, and 2) contracting of private-sector medical practitioners to provide services at public health facilities.

IFPS supported certain implementation and training costs to enable NGOs, dairy cooperatives, and employer sector partners to offer reproductive healthcare services through their own clinics and outreach camps. For example, the Indo Gulf Jan Sewa Trust project initially started as a factory-based intervention, whereby workers would be encouraged to avail of services at the corporate-supported hospital. Indo Gulf eventually established six maternal and child health clinics that offered free services, including family planning, to the wider community. As another example, the Pradeshik Cooperative Dairy Federation managed health facilities as well as organized outreach camps in rural areas.

To improve access to clinic-based services, another PPP approach involved hiring lady medical officers to provide services through public health facilities. One of the constraints in providing high-quality reproductive health services in rural
areas in Uttar Pradesh has been the shortage of lady medical officers within the Department of Health and Family Welfare. In response, the IFPS Project initiated a scheme for hiring private lady medical officers to serve at block primary health centers (PHCs) and community health centers (CHCs). CMOs contracted practicing medical professionals who are paid on a per visit basis.

The lady medical officers generally provide services from 8:00am to 2:00pm. IFPS funded up to two visits a week at CHCs and one at the block PHCs in 15 districts. In total, 156 lady medical officers were contracted under this scheme. More than 40,400 visits were made by the lady medical officers who have counseled nearly 630,000 clients. Where necessary, private doctors were also hired to staff the integrated reproductive and child health (RCH) camps held periodically at PHCs and CHCs.

**Training of Providers from Across Sectors**

The IFPS Project has supported training for both public sector healthcare providers (e.g., doctors, auxiliary nurse midwives [ANMs]) and providers from other sectors (e.g., private lady medical officers, ISMPs, and traditional birth attendants). In many cases, the training process adopted involved an international cooperating agency providing technical assistance to build the capacity of local nongovernmental groups who would then carry out the trainings. For example, across 17 districts, NGO master trainers conducted training workshops with ISMPs to build their capacity to provide family planning counseling (see Chapter 12). In the case of traditional birth attendants, more than 20 NGOs conducted training-of-trainer workshops for public-sector ANMs; the ANMs, in turn, trained village-based traditional birth attendants in hygienic delivery practices, family planning counseling, and recognition of high-risk pregnancies (see Chapter 11).

To increase the number of trained sterilization providers, update provider knowledge regarding the latest contraceptive technology, and promote infection prevention control, the IFPS Project worked with international cooperating agencies and medical colleges to train public-sector healthcare providers (see Chapter 3).

By implementing various models with a range of partners, the training components of the IFPS Project sought to draw on the best available skills from both the private and public sectors, with each group—when appropriate—contributing to curriculum development and serving as master trainers. Members of each sector were also the beneficiaries of the training component because their skills as trainers and implementers were strengthened (e.g., capacity development of local NGOs) or they were the direct recipients of technical training that helped them to better perform their jobs and offer high-quality services.

**Awareness Raising and Information, Education, and Communication Efforts**

Over the life of the project, IFPS worked with private advertising agencies to carry out large-scale communication campaigns on
TT vaccine, a third day was added to the routine schedule that already included two days. The third day enabled ANMs to visit villages and ensure wider coverage.

Beginning with the second campaign, SIFPSA organized TT Awareness Weeks to raise awareness of the need for pregnant women to receive two doses of TT vaccine. In project districts, all IFPS-funded NGOs and dairy cooperatives were utilized for distribution of relevant IEC materials. CBD workers also used direct, face-to-face, interpersonal contact during home visits to distribute messages, answer questions, and give details about specific dates and locations of campaign sites. In this way, private-sector groups enhanced the coverage and reach of a primarily public-sector immunization campaign.

Local Policy and Planning Initiatives

“Decentralization” and “integration” were two key principles that guided the IFPS Project’s approach to policy and planning initiatives. Through decentralized district action plans (see Chapter 17) and training of village pradhans and other local leaders (see Chapter 19), the project worked to address community needs, build local ownership, mobilize local resources, and improve coordination. Integration—meaning coordinating and making the best use of resources from both the public and private sectors—became critical for success in meeting local family planning and reproductive health needs.

The district action planning process used a participatory approach designed to bring
together the best thinking from various local stakeholders. The purpose was to identify specific community needs and propose locally-feasible solutions. The plans outlined roles and responsibilities for different groups, including government health personnel, NGOs and cooperatives, employers, private practitioners, and district and local leaders. As discussed above, DIFPSAs and PMUs supported planning and implementation at the district level. DIFPSAs involved a variety of stakeholders who met monthly to review progress and address any implementation challenges. The PMUs, which employed staff drawn from the private sector, were active in responding to any bottlenecks or shortages in the system (e.g., lack of commodities, lack of medical staff), thereby improving program efficiency. While many of the interventions outlined in the district action plans were originally devised at the state level, the local planning process—built on the strengths of public and private sector entities—improved implementation, adapted approaches to local needs, and led to the development of innovative ideas at the district level.

**LESSONS LEARNED**

Specific results from the individual PPP interventions are discussed in the various chapters. One of the overall contributions of the IFPS Project, however, has been its ability to involve private-sector entities in the delivery of family planning and reproductive healthcare services, while also building links and cooperative relationships between the public and private sectors.

**Facilitators of Successful PPPs**

Some of the factors that led to the IFPS Project’s ability to develop and take advantage of PPPs are as follows:

- From the start, SIFPSA was designed and established as an autonomous society to enable it to more effectively interact with the public sector and with diverse private-sector partners. SIFPSA worked hand-in-hand with state and district public health officials. At the same time, SIFPSA’s organizational structure allowed it to undertake competitive contracts with private-sector groups while avoiding some of the difficulties of government contracts.

- The project was also enhanced by authentic involvement and participation of various stakeholders at the district level—through district action planning, DIFPSAs and PMUs, and individual project activities.

- As this was the first time that private-sector groups had been involved in family planning and reproductive health in Uttar Pradesh, the IFPS Project needed to devise new management structures to guide the establishment and maintenance of partnerships. As such, SIFPSA established detailed criteria, training, and monitoring mechanisms for identifying appropriate project partners and evaluating performance.

**Benefits of Successful PPPs**

Each sector, public and private, brings certain assets to the partnership (see Table 1).
The public sector has a large infrastructure, has a presence in rural areas, and can take advantage of economies of scale. It also has extensive technical expertise with regard to health service provision and is oriented toward social responsibility. The private sector, including both for-profit and non-profit elements, has a presence at all levels of the community, may be more attuned to local needs and cultures, and has greater flexibility in responding to specific needs. This sector also has more of a business orientation that may be more efficient and directed towards satisfying client needs.

Positive outcomes of partnerships under the IFPS Project can be categorized in terms of improvements in coordination and efficiency, participation, and capacity development (see Table 2). Working together, the public and private sectors could reduce duplication of effort and wastage, better utilize the existing capacity within the system, and mobilize additional resources. Efforts such as social marketing (to clients who could afford to pay), community outreach, and extension of services in rural areas enabled the project to target resources to the poor and to underserved areas. The approach of establishing PMUs at the district level introduced a private-sector style of management that helped the project overcome obstacles and respond to challenges in a timely manner. Moreover, the project actively encouraged participation and capacity building. More stakeholders and a wider range of partners (e.g., NGOs, cooperatives, businesses, and local leaders) are now involved in addressing family planning and reproductive health issues in Uttar Pradesh.

**CHALLENGES IN IMPLEMENTING PPPs**

Implementing PPPs is not without its challenges. Some of the hurdles the IFPS Project had to overcome include:

- **Trust Issues.** The public and
private sectors (and particularly the for-profit sector) may have different approaches to service delivery, in terms of both their means and ends. The public sector, historically, is supposed to operate for the greater social good, while the private sector may have more of a business orientation. In the earlier stages of the IFPS Project, it was noted that “project management distrust of the for-profit private sector limited collaborative and synergistic public-private partnerships …” (LTG Associates and TvT Global Health and Development Strategies, 2003, p. 18).

Corporate social responsibility is still in its formative stages in Uttar Pradesh and SIFPSA often struggled to identify and nurture relationships with for-profit sector partners. At the same time, each partner should recognize and appreciate the assets that the other partner brings to the project. Employer-sector partners, for example, have a stake in ensuring healthy workers and communities and may be more efficient in meeting client needs than the public health sector. It is critical, therefore, to identify partnership opportunities in which the goals and capacities of each group are in line and complement each other.

- **Quality Assurance vs. Flexibility.** The project brought in new stakeholders; however, these partners may not have had experience in the family planning and reproductive health arena. Many of the rural development NGOs and dairy cooperatives, for example, had not designed and implemented reproductive health service delivery projects prior to their involvement with IFPS. To help ensure high-quality services, SIFPSA outlined specific criteria for identifying eligible partners as well as for planning and monitoring project activities. While this framework allowed SIFPSA to ensure quality projects, it also may have hindered the potential for flexibility and innovation that is historically an advantage of working with the private sector.

- **Referral Linkages.** While working to increase private-sector involvement, the project still had to rely on the public health system and PPPs can be negatively affected due to shortcomings in that system. For example, CBD workers would often refer clients to ANMs or public health facilities for additional services. If clients encounter difficulties in seeking services, they may be less inclined to try again in the future. At the same time, the public health system also had to rely on the private sector, for example, in the hiring of private healthcare providers to work at RCH camps. If the providers fail to show up at the designated time or leave the camps early, there is the potential that clients will become frustrated and not seek services. For a PPP to work, both partners must hold up their end of the bargain. However, significant issues, such as limitations within the public health infrastructure, are difficult for any one project to change on its own.
Contract Mechanisms. There is a need for involvement of implementing partners in devising contract mechanisms. For example, preparation of the PPP contracts did not solicit input from key stakeholders and often included extensive government conditions. In doing so, cost estimates were unrealistic in some cases and would be based on input estimates (e.g., the unit cost for a particular commodity) as opposed to a more holistic assessment of actual expenditures (e.g., the cost to increase family planning use). Moreover, despite setting up SIFPSA as an autonomous society in an effort to avoid delays, contracting and payment mechanisms involved lengthy verification procedures at multiple levels, which sometimes resulted in delays in payment to private-sector partners.

Ideally, the institutionalization of PPPs will encourage greater choice, better quality, and added resources for reproductive health programs. A key next step will be to develop mechanisms to ensure the long-term sustainability of private-sector projects and PPPs. Many of the lessons learned and models developed under the first phase of the IFPS Project will be continued not only in IFPS II, but also through the RCH-II Program of the National Rural Health Mission. Strategies to promote PPPs will be an important part of these new initiatives.

REFERENCES


CHAPTER 19

PANCHAYATI RAJ INSTITUTIONS:
Building the RCH-related Capacity of Local Governing Bodies

By Ruchira Gujral

RATIONALE

India is the largest democracy in the world, and panchayats (councils of elected leaders) are an age-old institution in India for governance at the village level. On April 24, 1993, the 73rd Constitutional Amendment Act of 1992 came into force to provide constitutional status to panchayati raj institutions (PRIs). In the Indian Constitution, panchayats are given powers and authority to function as institutions of self-government. In the panchayati raj system, the Gram Sabha, which is the general assembly of villagers, has a key role for effective functioning of panchayats (see Figure 1). In the Gram Sabha meetings, the rural poor, the women, and the marginalized people have an opportunity to voice their concerns, resolve local disputes, and participate in decisionmaking on matters affecting their lives. Active functioning of the Gram Sabha ensures a participatory democracy with transparency, accountability, and achievement. India has 231,815 Gram Panchayats (village councils) with a total of 2,186,452 elected representatives.

Panchayati Raj Institutions and Health and Family Welfare—A Brief History

By the enactment of the 73rd Constitutional Amendment, PRIs became responsible for the provision of primary healthcare, maternal health, and family welfare at the local level.

Several policy documents recognize the potential of PRIs to manage health programs. The 2000 National Population Policy includes decentralization and convergence of service delivery at the village level and recognizes the PRIs as the agencies responsible for...
ensuring this change. The Tenth Plan document (2002–2007) also states that it is essential to ensure that there is appropriate delegation of powers to PRIs so that there is local accountability for the public healthcare providers and problems relating to poor performance can be resolved locally.

In 2001, the Government of India’s Planning Commission set up a Task Force to review PRI involvement in various sectors and to make recommendations specific to each sector. Box 1 presents the Task Force’s recommendations for the reproductive and child health (RCH) sector.

In the mid-1990s, changes in the Government of Uttar Pradesh (GoUP) created a favorable environment for decentralization and this became a priority for the implementation of all development programs. As part of this process, the state government devolved financial powers of 12 departments, including family welfare, to PRIs. The GoUP declared the year 2000 as the time for decentralization and conferred on the Gram Pradhan (the head of the village panchayat) the authority for supervising certain village-level workers of the health department (SIFPSA, 2000).

**OBJECTIVES**

To achieve broad-based impact by concentrating resources and strategizing at the district level, the IFPS Project introduced the District Action Plan (DAP) approach in 1997. For the first time in India, the DAPs provided a participatory approach involving all stakeholders for planning and monitoring district-level RCH activities.

With their vast reach and influence, panchayats were found to be ideally suited for implementing the RCH program and integrating service delivery at the village level. The most influential member in the panchayati raj system is the village Gram Pradhan, whom most villagers have faith in as the community leader. Therefore, SIFPSA felt it was important to orient panchayat leaders to the roles they can play, not only as information disseminators, but also as opinion leaders and problem solvers (SIFPSA, 2000).

At this time, there was little demand for RCH services at the village level. Although many couples expressed

<table>
<thead>
<tr>
<th>SPECIFIC INTERVENTIONS</th>
<th>ROLE OF VARIOUS LEVELS OF PRIs</th>
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<tr>
<td>Identification of pregnant women and children 0-12 months</td>
<td>Gram Sabha will be involved in the identification of key target groups.</td>
</tr>
<tr>
<td>Ensuring antenatal and postnatal coverage of target group in the ANM allotted villages</td>
<td>Gram Panchayat will designate a fixed day for service provision to ensure regularity.</td>
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<tr>
<td>Arranging for immunization</td>
<td>Panchayats will ensure ANM visits through a roster and facilitate the visits by ensuring mobility.</td>
</tr>
<tr>
<td>Referral of cases to primary health centers (PHCs)/community health centers (CHCs)</td>
<td>Panchayats will facilitate referral of community members as required to the PHCs/CHCs.</td>
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<tr>
<td>Delivery of contraceptive services</td>
<td>Gram and Block Panchayats will undertake periodic reviews of program implementation.</td>
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<td></td>
<td>Block Panchayats will ensure attendance of doctors, and other staff and identify bottlenecks to services at PHCs/CHCs.</td>
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a desire to limit or space births, they did not seek family planning services and information. Both health providers and clients lacked adequate information about family planning. IFPS Project managers identified the Gram Pradhan as a key figure who could encourage couples to seek RCH services and mobilize healthcare providers. Also, that one-third of the seats in panchayat elections are reserved for women presented an opportunity for their greater involvement in village-level RCH programs.

However, many of the elected members of PRIs did not have a clear understanding of their roles and responsibilities, and their knowledge of health and family welfare programs was very limited. Accordingly, the IFPS Project organized training programs on RCH and family planning for Gram Pradhans. The primary aim of these training workshops was to build capacity of pradhans to create awareness about RCH services among the general population, monitor healthcare workers’ performance, mobilize additional resources if required, and promote the utilization of health services in general (see Box 2).

**INTERVENTION COMPONENTS**

The PRI training programs were conducted in four phases from 1998 to 2004 in 35 IFPS and additional districts. The process for approval of the intervention was the same as all other interventions. It was presented to the SIFPSA Project Appraisal Committee (PAC) as a stand-alone intervention as well as a part of the DAPs for most of the project districts.

### BOX 2

**PRI Training Objectives**

- To make the Gram Pradhans and indirectly all the elected members aware of the various components of the RCH program;
- To strengthen the role of elected members as supervisors of health program implementation at the grassroots level;
- To encourage the elected members to promote healthcare-seeking behavior among villagers;
- To expose the elected members to integrated services provided at RCH camps; and
- To orient the Gram Pradhans to the community-based distribution workers and their role and indirectly garner support and establish linkages.

**Intervention Strategy**

The training program of Gram Pradhans and Up Pradhans (deputy heads of panchayats) was conducted at the block level and involved a one-day training session. During the first phase, a one-day re-orientation was conducted six months after the initial training. This practice was discontinued after the first phase. The training sessions were conducted by trainers from the block level of district health and development departments.

**Training-of-trainers**

The three-day training-of-trainers (TOT) workshops were conducted at the district headquarters. The main objectives were to create a cadre of trainers and introduce the PRI training module to the trainers from the health and development departments to ensure that they were familiar with the training content and able to use it in PRI training. The participants included three prospective trainers from each block, selected from the Medical Officer In-Charge (MOIC), Additional Development Officers (ADOs) (panchayats), Block
Approximately 30 trainers attended each TOT workshop. In the first phase of the PRI training, the TOT was conducted by the State Institute for Rural Development (SIRD), a state-level apex NGO. For the other three phases, Sahbhagi Shikshan Kendra (SSK), a Lucknow-based NGO, conducted the TOT workshops.

The TOT workshops were conducted in a participatory manner, using techniques such as presentations, group discussions, role playing, and brainstorming. Using participatory approaches not only made the TOT workshop more interesting and interactive, it also helped demonstrate the correct use of these techniques for conducting the actual training session.

The training module for the TOT as well as the training for Gram Pradhans was prepared by SIFPSA, with inputs from the Centre for Development and Population Activities (CEDPA), a USAID-funded cooperating agency. Topics covered in the sessions included:

- Introduction to SIFPSA,
- The 73rd Constitutional Amendment and role of PRIs in RCH,
- Using the training manual,
- The adult learning process and 12 golden rules for trainers,
- Mock training sessions, and
- Logistic details of conducting PRI trainings.

Besides the subject content, the trainees were also trained to motivate the panchayat members and encourage them to take action. The Program Management Unit (PMU) staff of the District Innovations in Family Planning Services Project Agency (DIFPSA) also participated in the TOT workshops in order to involve them in the PRI trainings right from the beginning. At the end of the three-day training, two trainers of the three attending from each block were chosen to conduct the training sessions, based on their skills and responses during the TOT workshop. All participants attending the TOT workshops filled out evaluation forms after every session. The NGO conducting the workshop then prepared and submitted an overall report to SIFPSA.

**Pradhan Trainings**
The one-day workshops for Gram Pradhans were organized at the block level and conducted at the block headquarters. To cover all the Gram Pradhans of a block, three to four sessions were organized for each block. Attendees consisted of the Gram Pradhans, the Up Pradhans, and the Block Pramukhs (nominated heads of all the gram panchayats of one block) from each village. The sessions were conducted by the MOIC of the block and the other trainer who had been selected (either the ADO/BDO or the CDPO). The training module developed for the pradhans was used for the training. Later, for the second phase, the module was reviewed and a section on action points for the pradhans was added.

The ADO/Multi-purpose Worker informed all the participants about
the workshop and sent them an individually addressed letter, together with an invitation from the District Magistrate. The letter was delivered 7–15 days before the session. In some places, the auxiliary nurse midwives (ANMs), angandwadi workers, and NGOs also informed the Gram Pradhans and Up Pradhans about the workshops.

Ensuring the presence and attendance of all the Gram Pradhans was a challenge. Since NGOs such as SSK already had contacts and a rapport with most of the Gram Pradhans, the NGOs played a major role in mobilizing these Gram Pradhans and ensuring their attendance. To ensure the participation of women pradhans, their husbands were also invited to the training workshops. In general, separate training sessions were conducted for males and females, although this was not followed strictly and common sessions were also conducted in some places.

Each pradhan was given an information booklet to keep, use, and share with other panchayat members to orient them as well, along with a poster that they could display. The booklet contained information on:

- Synopsis of the population policy of Uttar Pradesh and role of PRIs
- Village committees
- Gender equality and the role that Gram Pradhans can play to promote it
- Reproductive and child health
- Antenatal care and nutrition
- Identification and referral of pregnant women in the village
- Postnatal care and immunization
- Reproductive tract infections, sexually transmitted infections, HIV, and AIDS
- Family planning
- Contraception and sterilization
- RCH camps and services provided by them
- SIFPSA and its role and activities
- Ways that the Gram Pradhans could turn these ideas into actions

Each section of the booklet included a text box describing the role of Gram Pradhans in supporting these issues to help them identify areas in which they could contribute and make a positive impact in their villages. By making the pradhans aware of the government schemes and services available, they were encouraged to spread this message to their communities so that the demand for health services and information could increase. They were also encouraged to form Village Health Committees (VHCs) to actively work towards improving the health status of their villages.

At the end of the workshop, a post-test was conducted to obtain feedback from the participants. During this post-test, participants often acknowledged their need for such trainings and expressed their appreciation for the effort made on their behalf. Based on the feedback, SSK prepared a report on the PRI training activities.

The workshop organizers did not give formal certificates to the pradhans. An important lesson learned was that some form of recognition would have helped in motivating more Gram Pradhans to attend the PRI trainings.
Distance Learning Program
The IFPS Project managers gave special attention to the VHCs, which were either not established or not functional in many places. The managers thought that helping VHC members to understand their roles and responsibilities might help them to become more active. To encourage greater community participation and reach out to the VHC members directly, the IFPS Project designed a Distance Learning Program.

The Distance Learning Program, which was included in the DAPs, centered around distribution of a series of eight pictorial comics in Hindi on various RCH topics (see Box 3). The comics were distributed only to the VHC members and not to the Gram Pradhans and Up Pradhans. In all, 30,000 copies of the comics were distributed in three districts—Firozabad, Rae Bareilly, and Unnao.

The comics were designed for low-literate audiences, consistent with the limited education of most VHC members. New Concept, a Delhi-based media agency, developed the comics with inputs from CEDPA. The comics were reviewed by various local organizations and revised in response to their comments.

Annual Panchayat Melas
Following the PRI trainings, the IFPS Project organized 120 panchayat melas (village fairs) in 25 districts. Held annually at the block level, the melas were designed to obtain feedback and create interest among community members in using RCH services. The melas were very popular, with as many as 20,000 persons attending, including PRI members. Exhibitions based on the life cycle approach, quizzes, competitions, and folk performances were organized. With the support of the district health and development departments, interactive sessions on health topics were conducted. The GoUP Department of Health and Family Welfare was also involved in organizing the melas. This strategy helped immensely in increasing the reach and acceptance of family planning services in the community.

Pradhan Forums
To recognize the pradhans who were doing a commendable job of improving RCH services in their villages and to encourage them to increase their activities, the IFPS Project organized pradhan forums in 29 districts. (The districts not covered were Agra, Rae Bareilly, Firozabad, Saharanpur, Bareilly and Kanpur Dehat.) The PMU staff selected 15–20 pradhans to attend the forums, based on their RCH promotion and monitoring efforts (see Box 4). The forums were designed to allow the pradhans to share their experiences and learn
from each other’s approaches. Conducted twice annually, the forums were presided over by the District Magistrate.

**The Phased Approach**

As mentioned earlier, the entire PRI training intervention was carried out in four phases, covering 35 IFPS Project and non-project districts in total.

**Phase I**

The first phase of PRI training was piloted in 1998/99 in six districts at the same time as the pilot rollout of the DAPs in these districts. The six pilot districts were:
- Allahabad
- Aligarh
- Meerut
- Rampur
- Sultanpur
- Varanasi

A total of 4,119 pradhans were trained in this first phase.

In the first phase, SIRD—the State Institute for Rural Development—conducted the TOT workshops to train the trainers for carrying out trainings at the block level. SIRD conducted a re-orientation for these trainers after six months. However, this two-stage training model proved to be unworkable, since often a new person who had not attended the initial training came to the re-orientation, thus limiting the prospects for reinforcing the previous training.

**Phase II**

The second phase of PRI training started in 2001 and covered 15 DAP districts. A new partner NGO, Sahbhagi Shikshan Kendra (SSK), was enlisted from this phase onwards to conduct the TOT workshops and help to encourage the pradhans to attend the sessions. From the second phase onwards, no further follow-up training was done with the trained pradhans after the one-day session.

The 15 districts were:
- Agra
- Auriya
- Baghpat
- Banda
- Bareilly
- Chitrakoot
- Fatehpur
- Firozabad
- Jhansi
- Mirzapur
- Moradabad
- Saharanpur
- Shahjahanpur
- Sitapur
- Unnao

The major challenge faced in the second phase was in persuading the Gram Pradhans to attend the training sessions. To address this issue, NGOs were asked to help mobilize the Gram Pradhans to ensure their acceptance of the

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**BOX 4**

**Criteria for Selection of Pradhans for Forums**

- Has referred or brought cases to the RCH camps or PHCs
- Arranges transport for obstetric emergency
- Provides support during information, education, and communication (IEC) activities
- Provides support during TT campaign
- Supervises services of trained dais
- Visits subcenters and/or PHC and meets with healthcare providers (MOIC, ANM) regularly
- Promotes legal age at marriage
- Creates awareness among people and encourages them to use family planning, antenatal care, and other RCH services

Nomination of a female pradhans is encouraged.
Ideas, Insights, and Innovations

idea as well as their attendance for the training. Additionally, the PMU program manager oriented Panchayat Development Officers (PDOs) on the PRI training and met with them to encourage them to contact the pradhans about the training sessions. Thus both the government and the NGOs mobilized local leaders. Of the 21,738 pradhans eligible and invited for trainings in these 15 districts, slightly more than half—11,757—were trained.

Phase III
The third phase of PRI trainings was conducted in 10 DAP districts during 2002/03:
- Azamgarh
- Ballia
- Balrampur
- Chandauli
- Etawah
- Gonda
- Gorakhpur
- Hathras
- Kaushambi
- Maharajganj

In the first two phases, the training strategy sometimes varied from district to district. However, a common strategy was developed in the third phase and was approved by SIFPSA’s Project Appraisal Committee. Under the new strategy, SIFPSA provided TOT training to the staff from the health, ICDS, and community development departments at the district level. Three trainers per block per district participated in the TOT workshop. They, in turn, provided a two-day orientation to Zila Parishad members via satellite programs or video cassettes. In earlier phases, the Block Pramukh was sometimes included in the training; in the third phase the Block Pramukh was always included.

The additional efforts started during Phase II to increase and ensure participation were continued, and their results were visible in this phase. Of the 16,029 panchayat leaders invited, 10,237 (64%) successfully completed the training.

Phase IV
Four districts were covered in the fourth and final stage of the PRI training during 2003/04:
- Mathura
- Ghaziabad
- Lalitpur
- Kanpur Dehat

Out of the 3,968 panchayat leaders invited, 2,481 attended the training sessions in Phase IV. On completion, SSK prepared a report of all training workshops conducted in the four districts.

A total of 28,594 Gram Pradhans, Up Pradhans, and Block Pramukhs were trained in all four phases combined. The participation of women pradhans was very low; only about 20–30 percent of the women pradhans attended the training sessions. It was interesting to note, however, that occasionally their husbands attended the training on their behalf.

Budgeted Items
When the PRI trainings started in 1998–99, the budget allocation per trainee for the TOT for the PRI training workshops was less than Rs. 100 (USD 2.27) per head, and the amount varied from district to district. In 2001, during the second phase of the trainings, the
## TABLE 1. SUMMARY OF PRI TRAINING WORKSHOPS BY DISTRICTS

<table>
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<tr>
<th>No.</th>
<th>District Name</th>
<th>No. of Blocks</th>
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<th>No. of Up Pradhans to be Trained</th>
<th>No. of Block Pramukhs to be Trained</th>
<th>Total to be Trained</th>
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*Data for bifurcated districts are not available.*
allocation for the PRI trainings was increased to a uniform Rs. 100 per trainee, part of which was used as an honorarium of Rs. 200 (USD 4.55) per day for each of the three trainers. For the TOT, the cost per trainee was increased to Rs. 750 (USD 17.05) per head for three days, and a per diem of Rs. 150 (USD 3.41) per day was paid to all the trainees. A travel allowance of Rs. 2,350 (USD 53.41) per person was paid to the state-level trainers. These budget allocations remained the same in all subsequent phases of the intervention.

The panchayat melas had a fixed one-time cost of Rs. 2,500 (USD 56.82) per mela and included expenditures on arrangements, sound system, photography, communication materials, snacks, and transportation.

IMPLEMENTING PARTNERS
SIFPSA. SIFPSA played a pivotal role in the entire intervention. SIFPSA took the lead at every stage, including conceptualization, development, facilitation, implementation, and monitoring. The DIFPSA PMUs were the local coordinating agencies for managing the PRI training activities at the district level.

Government of Uttar Pradesh. At the district level, the Chief Medical Officers (CMOs) of the districts also cooperated in the PRI training. They allowed the MOICs to attend the TOT workshops and subsequently conduct the orientation sessions for pradhans. The CMOs also facilitated data collection from block offices. At the block level, the BDOs, ADOs, and CDPOs all participated in the training, and those who were selected as trainers also conducted the pradhan training workshops.

NGOs. The selection of NGOs was based on their linkages and rapport with the panchayats and panchayat members. SIRD, a state institute working in villages and collaborating with PRI members, conducted the TOT workshops in Phase I. SSK, which conducted the workshops during Phases II through IV, had previous experience in training decisionmakers and working with other donors. With partners at the district level that could support them in the field, SSK had good reach into the community. SSK’s responsibility was to identify Gram Pradhans and mobilize them.

To aid their work, SSK also partnered with grassroots NGOs at the district level. The role of these NGOs was to:

- Coordinate invitation letters with PMUs;
- Contact the pradhans and deliver the invitations along with verbal briefings about the time, venue, and objectives;
- Ensure an attendance of 60–70 percent during the training workshops; and
- Be present during the training sessions to ensure smooth functioning.

Centre for Development and Population Activities. CEDPA was the USAID-funded cooperating agency responsible for overall management of the IFPS Project. CEDPA also provided technical support to SIFPSA in conducting the PRI training activities. It assisted in developing the strategy and
curriculum for pradhan trainings as well as guidelines for the formulation and operationalization of pradhan forums and TOT workshops.

**PROJECT MANAGEMENT**
The project had strong linkages with the other components of the IFPS Project. At the time that the PRI trainings were conceptualized, the other RCH and family planning components under the IFPS Project were not receiving full attention.

The entire project was developed, implemented, and monitored primarily by SIFPSA. Any change in strategy or deviation in budget allocation was presented to SIFPSA’s Project Appraisal Committee to seek their approval. To implement the programs and strategies at the district level as one of the components of DAPs, the PMUs managed the PRI training program at the district level. The responsibilities of the PMU included:

- **a. TOT Workshops**
  - Nomination of TOT participants through DIFPSA
  - Arrangement of training venue and ensuring the availability of information, education, and communication (IEC) materials
  - Logistics arrangements in coordination with the CMO
  - Presentation of district demographic data during TOT workshops

- **b. Pradhan Trainings**
  - Ensuring effective participation by working with the block-level officials to ensure the timely delivery of invitations
  - Ensuring placement of training schedule at a prominent place at the block office for wider circulation
  - Ensuring separate training arrangements for the female pradhans
  - Finalizing block-level training venues in consultation with the officers
  - Collecting training reports from trainers, preparing briefs, and forwarding to SIFPSA
  - Monitoring the sessions and reporting back to SIFPSA, based on the prescribed format
  - Handling the financial aspects of the intervention, including making the necessary payments
  - Coordinating and organizing pradhan forums

**MONITORING AND EVALUATION**

**Monitoring of Training Workshops**
Responsibility for monitoring the program was shared by SIFPSA, the PMUs, the NGO partners, CEDPA, and the Department of Health and Family Welfare. To monitor the TOT workshops, representatives from one or more of the stakeholders (e.g., SIFPSA, PMUs, CEDPA, and SIRD or SSK) were present at all TOT workshops. The training team prepared a report on each workshop and submitted it to the PMU, which then submitted it to SIFPSA. These reports basically consisted of numbers and details of participants, without much detail.
about the qualitative aspect of the training. SIFPSA officials prepared trip reports after every monitoring visit to a TOT workshop and the pradhan training program. These reports contained some qualitative information in the form of observations made by the SIFPSA staff during the trainings.

Because of the large number of pradhan training workshops, it was not possible for the PMU and SIFPSA staff to attend all sessions. Therefore, it was decided that SIFPSA staff would monitor 5 percent of pradhan trainings conducted at the block level, and the PMU staff would monitor an additional 20 percent. For the remaining 75 percent of pradhan training workshops, an NGO representative as well as block officials were always present to monitor these workshops.

**Evaluation of Progress**

Evaluation was built into the initial program design. SIFPSA staff designed feedback formats for both the TOT and the pradhan training workshops. After each training session, the participants were asked to complete evaluation sheets. SSK collected and analyzed the evaluation sheets from the TOT workshops and prepared a report for each workshop and a summary report for the entire district.

The evaluation sheets for the pradhan trainings were collected by the district and forwarded to the PMUs, which then forwarded them to SIFPSA. Although these evaluation sheets were collected for each district, no analysis by district was done. However, using the cumulative data from all districts covered in a particular phase, SSK prepared a comprehensive report for each phase. No separate evaluation was conducted for the entire intervention spanning four phases.

**RESULTS**

From 1998 to 2004, the IFPS Project trained 28,594 Gram Pradhans, Up Pradhans, and Block Pramukhs in 35 districts on RCH services, including family planning, for the first time in the history of Uttar Pradesh’s family welfare program. The PRI training workshops reached three out of five (59%) of the 48,392 targeted local officials in the participating districts.

The PRI training workshops led to greater interest and involvement of pradhans in RCH services and community education. The pradhans not only increased their knowledge of RCH issues but they also began to understand the role of community health workers such as ANMs and community-based distribution workers better. They also gained greater clarity on the services provided by primary health centers and the objectives and importance of RCH camps. Some female pradhans were especially appreciative of being involved in a program that directly addressed their concerns, and they became actively engaged in RCH activities (see Box 5).

The involvement of pradhans helped to build a supportive environment for RCH and made it easier for people to talk about family planning and use health services. After the orientation the Gram Pradhans began to become involved in service
delivery and began accompanying clients to RCH camps. They also played a more active role in providing information to the community on the various RCH and family planning programs. They took pride in attending the folk performances and helped mobilize other villagers to attend as well.

The training gave pradhans confidence that they could become involved in RCH issues and contributed toward improved maternal and child health in their communities. By offering concrete ideas about the pradhan’s leadership role in RCH, the workshops encouraged many of them to become more active in RCH activities. Their involvement was further strengthened by attending the pradhan forums organized in 29 districts. The sharing of experiences and information at these semiannual meetings, combined with the participation of the District Magistrate, gave recognition to their RCH work.

After orientation, the pradhans began to appreciate the importance of health and family planning and started demanding that the Department of Health and Family Welfare make these services more accessible. In the process of conducting the training sessions, the MOIC developed a rapport with the pradhans, leading to closer working relationships between the pradhans and the local health authorities. At the workshops they committed themselves to supporting each other.

The PRI training had broader implications for RCH programs as well. The direct involvement of stakeholders in program implementation was credited with better outcomes at the block and district levels. The PRI training program showed that it was possible to implement a bottom-up approach based on client needs rather than the traditional top-down approach. The IFPS Project demonstrated the feasibility and positive outcomes of training PRIs. This activity has become an active component of the Government of India’s National Rural Health Mission.

LESSONS LEARNED

Attendance. One challenge of the PRI training initiative was motivating the pradhans to attend the training sessions. Motivating the female pradhans to attend was especially challenging. The workshop organizers invited the female pradhan’s husband to attend the workshop along with her; however, in many cases only the husbands attended the workshop. One strategy adopted to convince more pradhans to attend the workshops was to involve grassroots NGOs. Since these NGOs already had a rapport with the pradhans, they were more successful in mobilizing them to attend the workshops.

District-level support. Convincing district authorities to conduct the PRI training workshops was also a challenge. While district officials were open to the idea of PRI training, they wanted to add more topics to the RCH components. Since the PRI training already covered numerous topics in a single day, this overload would have diluted the effect of the RCH training.
Training approach. Training the trainers to use the participatory approach and techniques also proved to be a demanding task, since most trainers were accustomed to traditional techniques of one-way communication.

Recognition of good performance. One lesson learned from the PRI trainings was the importance of recognition in any orientation program. The aim should be to provide a conducive and receptive environment for the participants to contribute enthusiastically. Likewise, proactive participation needs to be recognized and rewarded. Positive feedback goes a long way in maintaining high dedication levels of the Gram Pradhans and, consequently, the panchayats.

Some other important lessons that came out of the PRI trainings include:

- The one-day orientation served as an ice breaker and helped create a supportive environment, but it could have been further reinforced with more training time.
- Follow-up visits to the trained Gram Pradhans, helping them put some of the learnings into practice at their villages, could increase the impact.
- Involvement of the other panchayat members as well as a few nominated villagers would help the messages spread faster and have a broader reach.
- A stronger feedback mechanism is needed while conducting this type of training.
- More printed materials that could be used by the trained PRI members to sensitize the villagers need to be developed. These materials should contain graphics for all topics and avoid heavy text sections.
- Community participation is key to the success of any program. It is essential for making an impact at the local level and sustaining programs. More responsibility and authority could to be delegated to the PRIs, so that the onus of the overall development of their villages and the success of village-level interventions rests with them.

After attending a workshop for pradhans, Sitara Devi, a female pradhan from a village in Gauriganj block of Sultanpur District, began to advocate use of family planning. Soon she had assisted 23 women to obtain voluntary sterilization procedures. She provided transportation for them and sometimes accompanied them to the primary health center. She also provided food to their families for three days until the women were ready to resume their household chores (POLICY Project, 1999).

“The trainings were extremely helpful in helping us understand issues that we otherwise ignore or take for granted. However, it would have helped had the one-day training been followed up by more such sessions every six months. Though we retained the booklet and still have the poster pasted on our wall, more reading and communication material with lots of graphics would have helped us while discussing some of the issues with other panchayat members and villagers.”

—Ram Bahadur, former Gram Pradhan, Kundanpur Village, Unnao District
REFERENCES


CHAPTER 20

SURVEY RESEARCH:
Measuring Performance of the IFPS Project in Uttar Pradesh

By Gadde Narayana

INTRODUCTION

This chapter reports on the findings of seven USAID-funded surveys designed to measure the performance of the IFPS Project implemented in 33 districts of Uttar Pradesh. Conducted from 1995 to 2005, the seven surveys provide data on trends in key indicators of family planning and maternal health.

The major objective of the IFPS Project is to reduce the total fertility rate (TFR) by increasing the use of modern contraceptive methods in selected districts of Uttar Pradesh. A baseline survey for the project called The PERFORM Survey was conducted in 1995. The IFPS Project was funded under USAID/India’s Strategic Objective 2, reduced fertility and improved reproductive health in North India. Accordingly, the five surveys conducted annually during 1998–2002 are referred to as Strategic Objective 2 (SO2) Indicator Surveys. In addition, USAID funded two Reproductive Health Indicator Surveys (RHIS) conducted in 2003 and 2005.

The PERFORM Survey was conducted in 28 districts using separate household and women’s questionnaires to provide district and state level estimates on a series of indicators dealing with fertility and contraceptive behavior. All five SO2 Surveys used a uniform set of questionnaires and instruction manuals to gather information in order to allow comparison of performance over time. Two types of questionnaires—the household and women’s questionnaires—were used in all five SO2 Indicator Surveys. The RHIS retained the questions used in SO2 Indicator Surveys and widened their scope to include detailed information on reproductive health and quality of care parameters.

The seven surveys were conducted by the Futures Group, a USAID-funded cooperating agency, with the assistance of local survey research agencies.

Sample Size and Coverage

The PERFORM Survey provides estimates for the entire state. The SO2 Surveys provide estimates for the 33 IFPS Project districts. The RHIS provide estimates for the entire state as well as the project districts. The sample size of these surveys was determined based on the indicators selected for measurement. The actual number of households and eligible women (aged 15–49) covered is given in Table 1.
Survey Design
Since the district is the focal point for introducing innovative approaches, the sample design for PERFORM is directed toward providing estimates at the district level. The sample design is a systematic, multi-stage cluster sample of households. At the time of survey design, Uttar Pradesh had 14 administrative divisions and two districts were selected from each using probability proportional to size (PPS) procedures. The total sample of households per district was set at 1,500 to allow sufficiently precise estimates.

A three-stage sample design was adopted in all the SO2 Indicator Surveys. In the first stage, districts were selected, followed by selection of villages in rural areas and wards in urban areas. The third stage included selected households. Both in the first and second stages, selection of districts and villages/wards was done using the PPS methodology. However, in the third stage, household selection was done using systematic circular sampling with a random start. The targeted numbers were 30 households from each selected village and 20 households from an urban ward.

In the RHIS, however, a two-stage sample design was adopted. The first stage included selection of villages/wards, and the second stage covered selection of households using the same methodology as used in the SO2 Indicators Surveys. The targeted number of households was 25 and 20, respectively, for selected villages and urban wards.

Study Instruments, Data Collection, and Field Monitoring
The Futures Group prepared the following study instruments for the surveys:
1. Mapping and household listing forms
2. Household questionnaire
3. Women’s questionnaire
4. Instruction manual

The data collection process was carried out with the help of local survey research agencies. Listers, mappers, and investigators were trained on listing, mapping, and collection of data. Female investigators collected the information in all surveys. In all surveys spot checks and back checks of questionnaires were done to ensure quality of data.

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<tr>
<td>Overall</td>
</tr>
</tbody>
</table>
Data Entry, Analysis, and Report Writing
For all surveys, the data entry software was developed using the Integrated System for Survey Analysis (ISSA) software, and the data analysis was done using Statistical Package for the Social Sciences (SPSS) software. The Futures Group developed the data entry package, analyzed the data, and prepared the reports.

FAMILY PLANNING

Contraceptive Prevalence in IFPS Project Districts
The contraceptive prevalence rate for modern methods in IFPS Project districts of Uttar Pradesh has increased from 20.9 percent in 1995 to 27.3 percent in 2003—an increase of 6.4 percentage points over a period of eight years (see Figure 1). This works out to an average increase of 0.8 percentage points per year. During the period 1998 to 2003, for which annual data are available, the increase has ranged from 0.4 percentage points to 1 percentage point. At a 0.8 percentage point increase per annum, it represents about 250,000 additional couples using modern contraceptive methods each year.

Contraceptive Prevalence for Limiting Methods
The contraceptive prevalence rate through use of limiting methods (sterilization) has increased from 15 percent in 1995 to 18.4 percent in 2003—an increase of 3.4 percentage points over a period of eight years, and an annual average increase of 0.43 percentage points (see Figure 2). Given the attrition rate of limiting method users and the addition of new couples to the base, the annual sterilization performance in Uttar Pradesh project districts has been able to retain the contraceptive prevalence rate through limiting methods only at more or less the same level. The use rate has remained almost stagnant during the years 2001 to 2003. The annual average increase of limiting methods in the state is merely around half that of the annual average increase in the contraceptive prevalence rate for any modern method. Uttar Pradesh project districts have been able to retain the contraceptive prevalence rate through limiting methods only at more or less the same level. The use rate has remained almost stagnant during the years 2001 to 2003. The annual average increase of limiting methods in the state is merely around half that of the annual average increase in the contraceptive prevalence rate for any modern method.

Note: Surveys were not conducted in 1996 and 1997.
Pradesh does not have a sufficient number of surgeons to provide services for limiting methods, nor the necessary equipment. These factors and others are reflected in performance.

**Contraceptive Prevalence for Modern Spacing Methods**

Use of modern spacing methods (e.g., condoms, oral contraceptives, and intrauterine contraceptive devices [IUCDs]) has increased from 5.9 percent in 1995 to 8.9 percent in 2003—an increase of 3 percentage points during the period (see Figure 3). A slow and steady increase in performance since 1995 was interrupted by a minor dip in performance during 2002. An increasing trend was again apparent from 2003.

Condom use has consistently increased over time, from 3.1 percent in 1995 to 5.3 percent in 2003—the largest increase for any modern spacing method during this period. Oral pill use showed an upward trend from 1.6 percent in 1995 to 2.5 percent in 2001 and then declined in the following two years to remain at the 2.1 percent level. IUCD use has more or less remained stagnant at 1.2 percent with no significant variations over time.

**Sources of Modern Contraceptive Methods**

At the beginning of the IFPS Project, three in four users of modern contraceptive methods depended on the public sector for services and products. During the project period, the dependence on the private sector as a source of services and products has increased from 24 percent to 32 percent. Consequently, the public sector as a source of supply of services and products has declined from 76 percent in 1995 to 68 percent in 2003 (see Figure 4).

**Sources of Limiting Methods**

Limiting method users have depended predominantly on public-sector sources for services. In 1995, 89 percent of contraceptive users obtained limiting method services.
from public-sector health units, compared with only 11 percent from the private sector. However, there has been a slow and gradual shift from public to private sector sources over time. Of the total limiting method users in 2003, 86 percent availed of services from the public sector and the remaining 14 percent from the private sector, indicating the growing presence of the private sector (see Figure 5). Public-sector health units provide limiting method services free of cost and also, at times, free transport to acceptors. In contrast, the private sector charges a fee for services that has to be borne by individuals. Despite this, a significant proportion of users availed of services from the private sector, and this number is expected to grow.

**Sources of IUCD Services**

At the beginning of the IFPS Project, more than three in five (64%) users accessed the public sector for IUCD services. Since then, the private sector has significantly increased its presence from 36 percent of IUCD users in 1995 to 50 percent in 1999. From 1999 onwards, about half of IUCD users depended on the public sector and the other half on the private sector (see Figure 6). These changes have occurred without any major interventions to promote the private sector. The declining share of the public sector, given the huge advantages it had over the private sector in terms of number of service providers, free services, and the greater number of service delivery points, is a cause for concern. At the same time, note should be taken of the initiative and role of the private sector in promoting and providing quality services.

**Sources of Oral Contraceptives**

In 1995, three in five (60%) oral pill users depended on the private sector for supplies, while two in five (40%) obtained free supplies from public-sector sources. The proportion depending on private-sector sources increased considerably from 60 percent in 1995 to 75 percent in 1999, and this further increased to 83 percent in 2003 (see Figure 7). Eight out of every 10 oral contraceptive

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**FIGURE 5. SOURCES OF LIMITING METHODS IN IFPS DISTRICTS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public %</th>
<th>Private %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>89.1</td>
<td>10.9</td>
</tr>
<tr>
<td>1998</td>
<td>90.2</td>
<td>9.8</td>
</tr>
<tr>
<td>1999</td>
<td>89.4</td>
<td>10.6</td>
</tr>
<tr>
<td>2000</td>
<td>89.0</td>
<td>11.0</td>
</tr>
<tr>
<td>2001</td>
<td>87.5</td>
<td>12.5</td>
</tr>
<tr>
<td>2002</td>
<td>89.2</td>
<td>10.8</td>
</tr>
<tr>
<td>2003</td>
<td>86.1</td>
<td>13.9</td>
</tr>
</tbody>
</table>

Note: Surveys were not conducted in 1996 and 1997.

**FIGURE 6. SOURCES OF IUCD SERVICES IN IFPS DISTRICTS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public %</th>
<th>Private %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>63.6</td>
<td>36.4</td>
</tr>
<tr>
<td>1998</td>
<td>62.6</td>
<td>37.4</td>
</tr>
<tr>
<td>1999</td>
<td>49.9</td>
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<td>2000</td>
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<tr>
<td>2002</td>
<td>46.0</td>
<td>54.0</td>
</tr>
<tr>
<td>2003</td>
<td>51.8</td>
<td>48.2</td>
</tr>
</tbody>
</table>

Note: Surveys were not conducted in 1996 and 1997.
users in 2003 were dependent on the private sector for supplies and paid for the oral contraceptives. Increasing dependence on private-sector sources could be due to deeper penetration of marketing agencies to retail outlets located in villages and small towns.

Sources of Condom Supplies
Dependence on the private sector for condom supplies was always high among condom users. Of the total condom users in 1995, 72 percent were dependent on private sector sources and 28 percent on public-sector sources. The private sector, as a source of supplies, has increased substantially to reach a level of 81 percent in 2003, with only 19 percent of condom users opting for free products from the public sector (see Figure 8).

Method Mix
The method mix, for historical reasons, was skewed in favor in sterilization. In 1995, 72 percent of modern method users were sterilization users, followed by 15 percent condom users, 8 percent oral contraceptive users, and 6 percent IUCD users (see Figure 9). Over time the proportion of sterilization users among total users declined from 72 percent in 1995 to 67 percent in 2003. While the proportion of IUCD and oral contraceptive users during this period remained the same, condom users increased from 15 percent in 1995 to 19 percent in 2003. In total, the proportion of modern spacing methods users increased from 28 percent in 1995 to 33 percent in 2003, with a corresponding reduction in the proportion of sterilization users (see Figure 10).

Need for Family Planning
The SO2 Indicator Surveys did not collect information on unmet need (women’s desires to space or limit future births). Currently married women who are not using any method of family planning, but also do not want any more children or want to wait two or more years before having another child are considered as having unmet need for
family planning in the 2003 RHIS. The total unmet need for family planning in the state was 29 percent, almost equally divided between spacing (14 percent) and limiting (15 percent). Unmet need was higher in rural areas (31 percent) compared to urban areas (24 percent). Unmet need for both limiting and spacing was higher in rural compared to urban areas. The women in the low standard of living index category had higher unmet need (33 percent) compared to those who belonged to the high standard of living index category (22 percent). These findings indicate the need to evolve strategies to reach out to the people with a low standard of living in rural areas.

MATERNAL HEALTH

Antenatal Care Services
Only half of the pregnant women in IFPS Project districts in 1995 received any antenatal care (ANC) services and this proportion remained the same until 1998. During 1999, there was a significant increase in ANC services provided to pregnant women, with more than two-thirds receiving ANC services. This proportion further increased to 76 percent in 2001. Three out of four pregnant women in IFPS districts now receive some ANC services (see Figure 11).

Iron and Folic Acid Supplements
The proportion of pregnant women who received iron and folic acid (IFA) tablets/liquid more than doubled between 1995 and 2003. In 1995, one in four (26%) pregnant women in IFPS Project districts received IFA tablets/liquid from healthcare workers. This proportion increased to 55 percent in 2003—an increase of nearly 29 percentage points during the project period (see Figure 12).

Adequacy of IFA Supplements
In 1995, only 20 percent of pregnant women in IFPS districts received a sufficient quantity of IFA tablets/liquid. This proportion increased to
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26 percent in 1999 and 29 percent in 2000. There was a sharp decline in the percentage of those given a sufficient quantity in 2001 due to irregular and insufficient supplies. With improved supplies, the proportion covered increased to 34 percent in 2003 (see Figure 13). Half of the pregnant woman in IFPS Project districts received any IFA tablets/liquid and only one in three received a sufficient quantity of IFA tablets/liquids. Public-sector health units or providers are predominant sources of supply of IFA tablets/liquid. Four out of five pregnant women who received supplies depended on public health units in 2003. Only half of the women who were given IFA tablets/liquid consumed the entire quantity that was given to them.

**Women Receiving Recommended Tetanus Toxoid Injection Dosages**

Consistent with the recommended dose of two tetanus toxoid (TT) injections to provide protection, the proportion of pregnant women in IFPS districts who received two or more TT injections increased from 41 percent in 1998 to 63 percent in 2003 (see Figure 15). In addition, the proportion of pregnant women who received only one dose of TT increased from 5 percent in 1998 to 10 percent in 2003.

**Place of Delivery**

At the beginning of the IFPS Project, nearly seven in eight (87%) deliveries in IFPS districts in 1995 were at home, and only one in eight (13%) deliveries had taken place in either a public or private health institution. The proportion of home deliveries declined slowly to 76
percent in 2003 while the percent of institutional deliveries increased to 24 percent (see Figure 16).

The increase in institutional deliveries was largely due to an increase in the use of private health facilities rather than public health facilities. The proportion of pregnant women delivering in private health facilities increased from 6.5 percent in 1995 to 17 percent in 2003—an average increase of 1.3 percentage points annually over eight years. During this period, the proportion delivering in public health facilities remained at more or less the same level. Public health institutions provided services to 6.5 percent of pregnant women in 1995 and 7.2 percent in 2003—an increase of 0.7 percentage points over eight years. Non-availability of 24-hour delivery facilities in the majority of public health institutions, coupled with lack of equipment and vacant positions of lady medical officers, could be the main reasons for stagnation in performance.

Assistance During Childbirth
At the time of the first SO2 Indicator survey in 1998, seven in 10 (71%) women giving birth were assisted by untrained dais, relatives, and friends, while three in 10 (29%) were assisted by trained personnel (including doctors, auxiliary nurse midwives [ANMs], nurses, and trained dais). During the IFPS Project, the proportion of women assisted by trained personnel during delivery increased to 50 percent. Today, about half the women are assisted by a trained person during delivery (see Figure 17).

During the IFPS Project, assistance during delivery by health professionals, such as medical doctors, nurses, and ANMs increased from 20 percent in 1995 to 33 percent in 2003. The proportion of deliveries assisted by trained dais increased from 9 percent to 17 percent during the same period.

CONCLUSIONS
From 1995 to 2003, the contraceptive prevalence rate in IFPS districts in Uttar Pradesh has increased by an average of 0.8 percentage points per year. This
The proportion of pregnant women who received any IFA tablets/liquid nearly doubled during the project period. The proportion of pregnant women receiving at least two TT injections increased from 41 percent in 1998 to 63 percent in 2003. More women are giving birth in health institutions, with deliveries in public and private health institutions rising from 13 percent in 1995 to 24 percent in 2003. Nevertheless, more than three in four women still deliver at home. Increasingly, women are receiving assistance from trained personnel (health professionals and trained dais), with the proportion of deliveries attended by trained personnel increasing from 29 percent in 1995 to 50 percent in 2003.

FIGURE 17. ASSISTANCE AT THE TIME OF DELIVERY BY TRAINED AND UNTRAINED PERSONS IN IFPS DISTRICTS

Note: Surveys were not conducted in 1996 and 1997.
CONCLUSION: Major Results and Lessons Learned

The IFPS Project did indeed live up to its name, enlivening family planning and reproductive and child health (RCH) programs throughout Uttar Pradesh and Uttarakhand states. The overall strategy was one of seizing opportunities—identifying partner agencies that could extend reproductive health services and information to underserved areas. SIFPSA’s intent was to jump-start reproductive health activities in as many places as possible. The project districts were representative of the state as a whole, with a mixture of relatively high and low contraceptive prevalence rates. Accordingly, the IFPS Project showed what was possible in various areas of Uttar Pradesh and Uttarakhand.

RESULTS
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 1).

The summary of results below provides performance trends for selected indicators of family planning and RCH in the 33 IFPS districts in Uttar Pradesh.

BOX 1

### Key Results in IFPS Project Districts

- A 31 percent increase in contraceptive prevalence over eight years
- A 51 percent increase in use of condoms and oral contraceptives for birth spacing
- Improved health among pregnant women through greater TT immunization, provision of sufficient IFA supplements, and access to antenatal check-ups; and
- Shifts toward deliveries attended by trained providers—both health professionals and trained traditional birth attendants.

### Contraceptive Prevalence

- More women are using modern methods of contraception. Use of modern contraceptives among married women of reproductive age (15–49) in the project areas 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 of 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 intrauterine contraceptive devices (IUCDs) remained unchanged, with 8 and 6 percent of users choosing these methods, respectively, in 1995 and 2003.

- "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 pill (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 Healthcare 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 a significant increase in pregnant women immunized against tetanus." The proportion of pregnant women in IFPS 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 TT 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, auxiliary nurse midwives [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 LEARNED**

The IFPS Project has been a rich source of new knowledge and insights. The lessons learned pertain to management systems, program expansion, collaboration with public- and private-sector partners, service delivery systems, community education, program research, and financial sustainability. Following are the main points cited by USAID/India, external evaluators, and other knowledgeable sources:

- **Management.** Setting up an autonomous society (SIFPSA) to manage and provide technical support to the IFPS Project was a key factor in its 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. SIFPSA was designed to be flexible, make decisions quickly, and develop partnerships across sectors. At the same time, 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.

- **Decentralization.** By engaging local leaders and stakeholders in developing and implementing district action plans, SIFPSA strengthened local support for RCH programs. Local participation with oversight by SIFPSA’s district staff helped to ensure that the programs were well coordinated and implemented efficiently.
• **Replication and scale-up.** The IFPS Project showed that innovations can be tested and replicated on a large scale. For example, the DAP approach has been extended throughout Uttar Pradesh and nationwide.

• **Collaboration with the Government.** The IFPS Project’s work to upgrade clinical facilities and train public healthcare workers did make RCH services more widely available. Despite these massive undertakings, the project was hampered by the systemic difficulties inherent in the public health system, such as frequent staff transfers, staff absences, lack of motivation, and a cumbersome decisionmaking process.

• **Assessing impact of a comprehensive approach.** 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.

• **Public-private partnerships.** The IFPS Project made a concerted effort to involve government agencies, NGOs, businesses, and other groups in RCH programs. These partners brought expertise and resources to programs, thus promoting efficiency. They also raised the profile of family planning and led to more open discussions about it.

• **Demand creation.** The IFPS Project invested heavily in upgrading clinics and training service providers in clinical skills and counseling. Despite these efforts, use of reproductive health services did not rise as sharply as expected because demand creation activities were limited. More intensive communication activities are needed to address client needs and concerns and explain how they can benefit from reproductive health services. Specifically, campaigns to educate consumers on the IUCD and vasectomy could have helped broaden the contraceptive method mix.

• **Rural marketing.** SIFPSA designed a social marketing program that focused on making pills and condoms more widely available in mid-sized villages. This program demonstrated the feasibility of reaching large numbers of rural villagers within a relatively short time.

• **Community-based distribution.** NGO and dairy cooperative projects using community-based workers did increase
contraceptive prevalence and child immunization rates and use of maternal health services such as antenatal check-ups and TT immunization. Community workers were important sources of RCH information to women living in rural areas and urban slums. Many of the women trained as community workers became empowered as change agents in improving local living conditions.

- **Sustainability.** SIFPSA introduced income-generating measures such as commodity sales midway through the first phase of the IFPS Project. Often the time frame for generating profits was unrealistic, given the focus on low-income, hard-to-reach clients. For example, contraceptive social marketing initiatives were expected to reach a financial break-even point within three years. Similarly, community workers were expected to generate sufficient income from sales of contraceptives and other commodities to offset the monthly stipend provided from subproject funds. The lesson learned is that measures to promote financial sustainability need to be carefully planned, implemented, and monitored from the start of the project.

- **Performance-based distribution system.** The use of a performance-based disbursement system in which costs were linked with results rather than project activities was innovative. In this system, USAID and SIFPSA set mutually agreed and verifiable project outcomes, known as benchmarks, that were tied to a specific payment amount. 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. SIFPSA had to achieve the entire benchmark before funds were released. The focus on results was largely effective and did lead to greater accountability than systems that reimburse grantees for project expenditures. On the other hand, many factors—such as service provision in government facilities—were outside of SIFPSA’s control.

- **Technical assistance.** 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, facilities upgrades); SIFPSA and its district-level counterparts (e.g., planning and monitoring capacity); and local implementing partners (e.g., through training of master trainers).

**FUTURE DIRECTIONS**

To maintain the momentum of the IFPS Project, USAID initiated a follow-on project known as IFPS-II. The objective of the four-year IFPS II Project (2004–2008) is to meet the need for family planning and RCH services by expanding public-private partnerships in Jharkhand, Uttar Pradesh, and Uttarakhand states.

Many of the innovations from IFPS will be incorporated into the Government of India’s National Rural
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Health Mission (NRHM), which seeks to bring all health programs together. With an emphasis on maternal and child health, the NRHM incorporates reproductive health, nutrition, water, sanitation, and disease control programs. Planned for 2005–2012, the NRHM’s main objectives are to reduce the maternal mortality ratio to 100 deaths per 100,000 births and reduce the infant mortality rate to 30 deaths per 1,000 live births. It seeks to decentralize health programs to the district level and to revitalize local health traditions. The NRHM will focus on 18 states, including Uttar Pradesh, Uttarakhand, and Jharkhand.

A key component of NRHM is the Reproductive and Child Health (RCH) II Program—a five-year (2005–2010) national program to continue the work of RCH-I, with an emphasis on reducing maternal and infant mortality rates and increasing contraceptive use. With a budget of USD 8.7 billion, the RCH-II program is designed to support state-level strategies and program implementation plans (Government of India/Ministry of Health and Family Welfare, 2004).

In Uttar Pradesh, the RCH-II Program will build on the accomplishments of the IFPS Project and will extend decentralized planning activities to the non-IFPS districts. SIFPSA helped to develop the state’s Program Implementation Plan and will continue to provide technical support to the new program (USAID/India 2005).

REFERENCES


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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