innovations at work

reaching out with RCH services
Uttar Pradesh is the most populous state in India with an estimated population of 166.4 million in 1999. The state has one sixth of the total population and one tenth of the land area of the country. The total fertility rate in Uttar Pradesh in 1971 was 6.6 and declined to 4.8 in 1992-93. The infant mortality rate declined from 167 to 100 during the same period. Fertility and mortality rates in Uttar Pradesh are very high compared to other major states in India. In 1992-93 only 19 out of 100 currently married women in the reproductive ages of 15-49 were modern contraceptive method users. Of the total current users, only 29 percent were users of modern spacing methods and the remaining 71 percent were permanent method users. At the same time, the unmet need for family planning was 30 percent.

The slow pace of decline in the fertility rate is a cause for concern.

The expert group constituted by the Government of India to prepare state-wise population projections estimated that the population of Uttar Pradesh would reach 245 million in 2016, which is almost double its size in 1991.
Utilization of other reproductive health services is also very low in Uttar Pradesh. Less than half of the pregnant women received ante-natal care; slightly more than two thirds received two doses of TT injections; and 30 percent received iron and folic acid tablets. Only 11 percent of births occurred in health institutions.

Nearly 40 percent of the population was below the poverty line in Uttar Pradesh. In 1993, only 57 percent in the age of 5-14 were going to school in rural areas and 73 percent in urban areas. The female school drop out rate was very high. As per the 1991 census, male literacy was 56 percent; female literacy was 25 percent and total literacy was 42 percent. Uttar Pradesh ranks very low even in terms of basic household amenities. Only 20 percent of households in Uttar Pradesh have electricity connection, 15 percent have access to safe drinking water; 11 percent have toilet facility; and the public distribution system for food grains reaches only 5 percent of households.

Immediate attention is required to achieve population stabilization in Uttar Pradesh. It is a daunting task but achievable with inputs of additional resources and concerted efforts. If Uttar Pradesh does not achieve replacement level of fertility soon and population stabilization later, the meagre resources available will be under considerable strain and population size will be a major barrier in alleviating poverty and in achieving the desired levels of economic growth and prosperity.
The goal of the Innovations in Family Planning Services (IFPS) Project is to assist the State of Uttar Pradesh in reducing the rate of population growth to a level consistent with its social and economic objectives. In this long term goal, it is implied there is a need to lower the level of fertility significantly. Specifically, the IFPS project aims to reduce fertility from 4.8 in 1993 to 3.9 in 2004. To achieve this, the contraceptive prevalence rate is to be increased from 18.5 percent in 1993 to 25 percent in 1999 and to 35 percent in 2004. The other important objectives are to increase the percentage of pregnant women receiving ante-natal care from 30 to 40 percent and the percentage of deliveries assisted by trained providers is to be increased from 17 to 30 percent.

A baseline survey called PERFORM was conducted in 1995 in 28 districts of Uttar Pradesh to establish baseline values of key indicators. The project has followed a phased approach, beginning with 6 districts, later expanding to 15 districts and now certain interventions are being extended to all 28 PERFORM districts. The methodology has been to try out pilot projects, evaluate the outcomes, develop models, and replicate and upscale the successful elements.
The overall approach of the project is to increase demand, to improve quality and accessibility of services. The specific strategies of the IFPS Project are to:

- **Evolve partnerships with NGOs for community mobilization and with networks like cooperatives, ISM practitioners, government organizations, the private health sector and the organized sector so as to develop a synergistic relationship;**

- **Implement innovative integrated approaches, such as RCH camps and decentralized district action plans, and create conducive environment by involving religious leaders and elected representatives of Panchayats in programme implementation;**

- **Improve quality of services by improving skills and changing the attitudes and practices of government service providers by conducting a series of skill-development training programmes and by upgrading the facilities in public sector health institutions;**

- **Increase demand for, and facilitate access to contraceptives through a vigorous IEC campaign and social marketing programme;**

- **Provide wider access to family planning services, particularly to couples with unmet demand for family planning.**

**Expected Levels of Performance of IFPS Project**

![Graph showing expected levels of performance from 1993 to 2000](image)
The Innovations in Family Planning Services (IFPS) Project has certain innovative features which are the following:

- **Focus on outcomes and performance based disbursement of funds**
- **Involvement of the private sector in family planning in Uttar Pradesh for the first time and emphasis on a cafeteria approach including spacing services**
- **Creation of a registered society, SIFPSA, and direct fund flow to it in order to avoid delays and ensure flexibility**
- **Incremental system of funding wherein inputs are based on identified needs and local resources**
- **Technical support from a variety of specialist agencies called Cooperating Agencies**

A unique feature of the Project is the Performance Based Disbursement (PBD) system which is being tried out for the first time anywhere in the world. Here under, funds flow on achievement of certain predetermined, verifiable indicators of performance called Benchmarks as opposed to a traditionally funded project which relies on cost reimbursement. Thus, under the PBD
system there is a strong focus on outcomes.

Project performance is measured by a variety of methods such as physical verification, the management information system of SIFPSA, service statistics and independent surveys from time to time to evaluate the achievement of benchmarks.

A total of 65 benchmarks valued at US $ 43.9 million till 1998 have been created. All but six of these benchmarks have already been achieved. Rapid progress has been made in the last year by creating 112 additional benchmarks valued at US $ 45.6 million. Till date, 86 benchmarks valued at US $ 46.6 million have been achieved. Of the benchmarks that have been met so far, 67 percent have been achieved in the last 2 years. This clearly demonstrates the acceleration in the pace of the project and also charts out the course of the Project for the next three years.

Another significant aspect of the IFPS Project is technical assistance by the Cooperating Agencies (CAs) of USAID. CAs are technical organizations with recognized capacity to provide technical support to USAID projects worldwide. Critical aspects of the CA’s role include: to support SIFPSA and public and private sector partners to help develop strategies; to design and conduct training programs; to monitor project implementation; and to evaluate projects.

CEDPA, PRIME-INTRAH, JHU-PCS, The POLICY Project-The Futures Group International, CMS-DTT, and AVSC International, all US based agencies, are currently providing technical assistance to the IFPS project. In addition to CAs, SIFPSA also gets task-specific assistance from a variety of local institutions.

IFPS Project has several innovations, most important of which is PBD system which focuses on achievements and outcomes
almost two years to get the new society registered, to recruit personnel, to establish systems, and to chalk out procedures and processes for project funding. Although the State Innovations in Family Planning Services Project Agency (SIFPSA) was registered as a society on May 22, 1993, to implement the project, activities began only in the year 1994 and funding of public sector projects commenced only in April 1995.

The Project has been designed to facilitate flexibility in flow of funds and coordination and collaboration in decision making. All the partners, Government of India, USAID, Government of Uttar Pradesh and SIFPSA are represented on all the decision making bodies of SIFPSA.

SIFPSA’s organization arrangements include three main units: the Governing Body, the Executive Committee, and the Project Appraisal Committee. The Governing Body, with representatives from the Government of India and UP, USAID, and prominent persons from the private sector serves as a policy making 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 to review the project proposals and do their technical vetting. Together these three committees facilitate the project implementation processes.

Today SIFPSA has grown into a vibrant, flexible, professionally managed organization with the capacity to deliver. SIFPSA is headed by an Executive Director, a senior IAS officer on deputation from the Government of UP who has overall responsibility for project implementation. The Additional Executive Director of SIFPSA provides assistance to the Executive Director. To cater to all aspects of the Project, SIFPSA has 10 divisions covering public sector, training, social marketing, human resources, private sector, IEC, research and evaluation, family planning information system, finance and internal audit. Each division is manned by technically competent professionals and is headed by a general manager who receives support from the project coordinators and the assistant project coordinators or managers in the division. Inter-divisional collaboration is encouraged and professionals often work in teams. In addition, SIFPSA has field officers in 6 DAP districts. A total of about 45 professional staff at head quarters in Lucknow and 24 field personnel are constantly engaged in project development, project appraisal, monitoring and evaluation and development of new innovative strategies.

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<th>IFPS PROJECT MILESTONES</th>
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<td>Project Agreement Signed</td>
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<td>GOI Cabinet Approval</td>
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<tr>
<td>Registration of SIFPSA</td>
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<tr>
<td>Organization Structure of SIFPSA Finalized</td>
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<td>Funds (Advance) Received from GOI</td>
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<td>Financial Rules Approved and Powers Delegated to</td>
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<td>System of Funding Public Sector Finalized</td>
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<td>Baseline (PERFORM) Survey Conducted</td>
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<td>USAID Midterm Assessment Report</td>
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Private sector participation in family planning services was abysmally low in Uttar Pradesh before the launch of the IFPS project. There was considerable scepticism about the impact the NGOs could make on the programme. To begin with, SIFPSA, after collecting information from a variety of government and non-government organizations, prepared a list of NGOs working in the development field. These NGOs were then informed of the funding available for a limited period for innovative and sustainable family planning projects and were encouraged to submit project proposals. SIFPSA has also established a system to verify the credentials of NGOs seeking to work with it and also looks at their annual accounts and activities for the preceding three years. The programme officers of SIFPSA visit the NGO seeking funds to check the registration details of the organization, office infrastructure and type of activities carried out. Project proposals of only those NGOs fulfilling all the criteria are placed before the Project Appraisal Committee for technical vetting. SIFPSA has designed a computerized information system to monitor the performance of NGOs funded.
NGO projects generally select women volunteers for community based distribution (CBD) to promote family planning and maternal and child health services. Main emphasis of NGO projects is to increase the use of modern spacing methods among young, low parity couples. CBD volunteers visit all households in their villages at regular intervals and encourage couples to adopt the family planning method of their choice. At the end of the project period, NGO performance is evaluated by an external expert agency in light of the objectives given in the project agreement. Based on the evaluation findings, SIFSPA takes a decision to extend, expand or to discontinue a project. So far 49 NGO projects have been evaluated by external agencies.

Being an economic platform, having almost a million members with a good understanding of rural marketing and excellent logistics, milk cooperatives at the village level offer an opportunity to involve large networks of volunteers in promotion of family planning. Projects funded through Federation of Milk Cooperatives, use village level cooperatives which select a woman family welfare promoter from the community. Members of the milk cooperatives help the volunteers in provision of family planning services.

SIFPSA has funded the Prerena Population Resource Centre, Lucknow to train project managers, supervisors and volunteers working with NGO projects while the Centre for Development Studies, UP Academy of Administration, Nainital trains personnel of cooperative sector projects. In addition, SIFPSA draws on the expertise of Indian Institute of Health Management Research, Jaipur and State Institute of Health and Family Welfare, Lucknow for evaluation of projects. Services of the Indian Institute of Management, Lucknow have been used for design of management information system for NGO projects.
SIFPSA also works with organized industry in extending reproductive and child health services to their workers and their families and the community around them. Partnerships have been forged with apex chambers like FICCI and PHD Chambers of Commerce as also with individual units like Indo Gulf Fertilizers and Chemicals.

To make projects sustainable after the project period, SIFPSA has provided a revolving fund to NGOs and cooperative sector projects. Managers of these projects are encouraged to introduce subsidized commercial condoms and oral pills into their programmes using the revolving fund. Several NGOs and cooperatives have already successfully implemented this scheme.

SIFSPA has so far funded 114 NGO and cooperative sector projects and built their capacity for implementing family planning projects. 9,765 women volunteers have been recruited and trained to promote family planning particularly use of spacing methods. As of September 15, 1999 all the projects put together have 629,246 current users of spacing methods. Of these, 332,844 are using condoms; 258,628 oral pills; and 37,774 IUCD. In addition, 222,630 pregnant women have been given ante-natal care services.
Scaling New Heights

An evaluation study of NGO projects in 15 districts was conducted by an external agency in January 1999 to assess the extent of increase in number of spacing method users as a result of SIFPSA funded NGO projects. As part of this survey, 1,300 married women in the age group of 13–49 were interviewed. The survey findings showed that 7.2 percent were using any one of the spacing methods. This is almost double the prevalence rate of 3.7 percent for these methods which was found in June 1995. This means that the number of spacing method users in these districts increased from 238,000 to 463,000 in the last three and half years. Of the total 225,000 new users in these districts in the last three and half years, as many as 170,000 have done so since January 1998. Thus activities have really started picking up.

The evaluation report concluded by saying, “this shows that family planning services have grown rapidly and SIFPSA funded projects are contributing significantly to family planning use in Uttar Pradesh.”
launched two projects on a pilot basis in Sitapur and Jhansi districts to train ISM practitioners. A training needs assessment was done and training curricula and material were developed and tested.

An evaluation of the training programmes was conducted by an external agency in 1997. The evaluation findings revealed that the general client load of ISM practitioners had increased after training. There was also substantial increase in the proportion of ISM practitioners providing family planning services to clients after training. Encouraged by the results, SIFSPA scaled up the activities in the last two years to cover 10 more districts. So far, 6,821 ISM practitioners have been trained in these districts. The training projects not only provide basic training of 4 days duration to ISM practitioners but also re-orientation training after a period of 6 months. In addition, project staff visits trained ISM practitioners regularly to observe the counselling sessions identify needs for retraining and to solve problems related to contraceptive supplies.

Traditional birth attendants (TBAs) or dais in rural areas have always assisted and continue to provide assistance at the time of delivery especially in rural areas. A third of all

Uttar Pradesh has nearly 40,000 registered indigenous system of medicine (ISM), that is, unani, ayurvedic, and homeopathic medical practitioners, and, probably, an equal number of non-registered medical practitioners. A large proportion of rural population seeks health services from ISM practitioners because of their accessibility and low cost. Recognizing the potential of ISM practitioners to improve counseling and access to family planning services, SIFPSA

indigenous system of medicine practitioners and traditional birth attendants
deliveries taking place in Uttar Pradesh are conducted by these TBAs. A large proportion of dais have never been trained. The practices followed by untrained dais at the time of delivery have significantly contributed to neo-natal infant deaths. Recognizing the close relationship between infant mortality and family planning method use, SIFPSA has initiated training programmes for untrained dais. Pilot projects have been implemented in Rampur, Sitapur and Agra districts. The objective of these training programmes is to encourage dais to conduct deliveries in aseptic conditions, to identify and refer high-risk pregnant women to hospitals and to promote family planning. A complete census was done of dais in all villages of these three districts. The master and lead trainers were trained and, in turn, imparted training to 2,091 dais. Each dai has been given an identity card and also a dai delivery kit. Encouraged by the impressive findings of the evaluation study, SIFPSA has begun to scale up dai training to 12 more districts in a phased manner.

Rural networks of ISMPs and TBAs are bringing about an increase in family planning outreach and improvement in delivery services

An evaluation of SIFPSA supported dai training activity conducted by an external agency in 1999 found that after training:

- 98 percent dais were providing family planning services to clients
- 53 percent dais were able to identify high risk pregnancy conditions
- 28 percent dais were able to answer questions on pill use correctly
- Deliveries assisted by trained dais increased to 9 percent from 3 percent before training
SIFPSA has developed a package which introduces them to the latest features of contraception and the basics of counseling and informed choice. Women medical officers are exposed to a further 2 day module on issues related to IUCD insertion. During this session they also get an opportunity to practice on pelvic models and to thus sharpen their IUCD insertion skills.

Minilaparotomy under local anesthesia is a method of voluntary female sterilization which is popular in many parts of U.P. It is particularly suitable for places where support staff, equipment and supplies are limited. SIFPSA has designed a six day interactive programme for medical officers. In addition to providing skills of conducting the minilap procedure, the training also provides training related to post-operative care, management of pain and complications, follow-up and infection prevention. Minilap training is being provided at training centres set up at Varanasi and Gorakhpur.

Laparoscopy is the most preferred method of tubectomy in U.P. However, it requires sophisticated equipment, skilled surgeons and only women medical officers are accepted as providers in rural areas. SIFPSA has developed a two day refresher training...
package for laparoscopy under local anaesthesia. The curriculum covers surgical procedure, post operative recovery, anaesthesia, and management of complications. Participants who are trained laparoscopists are given demonstration of laparoscopic ligation on clients and practice on ZOE models to refine their skills. Laparoscopy refresher are being provided at district PPCs in 15 districts.

Acceptance of male sterilization method, vasectomy, is insignificant in Uttar Pradesh being less than half a percent. Therefore, No-Scalpel Vasectomy (NSV) is being promoted in order to popularize male voluntary sterilization. SIFPSA has set up 4 training and 34 service delivery centres for NSV which promote NSV to attract clients. Trainers use this client load to train NSV service providers. This training imparts skills to conduct vasectomy and also covers related issues like counseling, infection prevention and management of complications. The service providers are then followed up and on meeting standards, certified as trainers.

SIFPSA training programmes have been very successful, primarily because they are clinic-based, conducted in a participatory manner and address felt needs. 5,172 medical officers have undergone CTUs and 988 lady medical officers have been given IUCD insertion training. 96 medical officers have been trained in minilap with about 50 percent performing to standard while laparoscopy refresher have been given to 294 medical officers out of which 200 are performing to standard. Uttar Pradesh today has 16 certified NSV service providers, which number is expected to go up to 40 in the next 3 months.
LHVs (lady health visitors) and ANMs (auxiliary nurse midwives) are the female family welfare workers in rural areas. Studies conducted on practices followed by female health workers have shown that their IUCD insertion skills were poor, resulting in frequent infection and high expulsion rates. They were not able to screen or counsel IUCD clients.

To remedy this situation SIFPSA developed the Clinic Based Family Planning Training (CBFPT) package. Health facilities which had adequate IUCD case load were selected as training sites. A team of one woman medical officer and a public health nurse were chosen as trainers and given a two week TOT on clinical practices and training skills. Each team trains four ANMs in a week-long programme, which includes IUCD insertion practice on ZOE pelvic model and then on at least two clients. The trained ANMs are given IUCD kits and other supplies and followed up by trained Regional Family Welfare Training Centre (RFWTC) staff to verify whether they were performing to standard with respect to IUCD handling, insertion and counseling.

Counseling training is given to all female workers who have undergone CBFPT. A four day counseling training through a quality improvement in public sector: female workers and supervisors training.
participative, user-friendly package developed by SIFPSA is provided to further improve their client screening and counseling skills. This training has been very useful in changing attitudes of workers, inculcating in them the ability to discuss clients' needs and offer services according to the client's choice and preference.

An Infection Prevention Training package was also designed and implemented by SIFPSA. Its objective was to protect providers, clinic staff and the community from infectious diseases that originate in health care facilities. A two day on-site programme is conducted for all staff members working at health care facilities. A five day TOT has produced training teams comprising medical officers and staff nurses who conduct on site training. This training emphasizes hands-on learning to enhance knowledge and practice of disinfection, decontamination and sterilization of instruments and surfaces and involves all categories of service providers and support staff at CHCs and PHCs.

2,854 ANMs have been trained by SIFPSA in 12 districts. Further, infection prevention training has been conducted at 187 clinical sites in 17 districts.

**Upgrading skills of rural female health workers has improved the quality of services**

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**Steps Involved in Clinic Based Family Planning Training of LHVs and ANMs**

- Assessment of training needs
- Development of curriculum
- Selection of master trainers
- Selection and upgradation of training sites
- Selection of lead trainers
- Training of lead trainers
- Training of ANMs/LHVs at upgraded clinic sites
- Practice on pelvic models
- Actual IUCD insertion to clients under observation
- Distribution of IUCD insertion kits and gloves
- Follow up in the field by RFWTC staff
- Reorientation training during follow up
- Certification of ANMs/LHVs as performing to standards
Upgrading facilities is one of the approaches used to improve the quality of services in rural health centres. The specific needs for upgrading have been identified in District Women Hospital Post-Partum Centres (PPCs), all Community Health Centres (CHCs) and Block Primary Health Centres (PHCs) in 21 districts and this activity is ongoing in another 8 districts. This need assessment includes repair and renovation of buildings, water supply, electricity (including generator set), operation theatre, counseling rooms, equipment and supplies and is done by a team visiting each facility. This ensures identifying critical needs, avoids duplication of funding and helps make accurate budget estimates. Detailed guidelines have been drawn up for preparing estimates for each item in consultation with UP State Director General, Health Services; estimates have been prepared on site and Chief Medical Officers have contracted out the upgrading activities. Work is complete at 150 sites and in progress at another 147. With these clinical facilities appropriately equipped and trained medical officers and paramedics posted there, the quality and width of services provided by them has also increased.

One of the constraints in providing good quality reproductive health services in remote rural areas is the shortage of women medical
officers with the Health & Family Welfare department. As a consequence, a large number of vacancies exist in CHCs. There is also no sanctioned position of women medical officers at the block PHCs.

SIFPSA has initiated an innovative scheme for hiring women medical officers to serve at block PHCs and at CHCs where the position of woman medical officer is vacant. CMOs can contract practicing medical graduates who are paid on a visit basis. Postgraduate women doctors get a higher stipend. Where no allopathic doctor is available even women practitioners of the indigenous system of medicine can be hired.

The women medical officers provide services from 8 a.m. to 2 p.m. SIFPSA funds up to two visits a week at CHCs and one at the block PHCs in 15 districts. 156 women medical officers have been contracted under this scheme throughout UP and 35 are working at present. More than 14,000 visits have been made by women medical officers who have counseled 400,000 clients. This innovative scheme of SIFPSA which is an example of a unique public private sector partnership, has won wide acclaim and is being adopted by other donor funded RCH projects as well.
The organization of camps involves detailed planning relating to publicity, manpower deployment, camp arrangements, post-camp services including transportation, availability of consumables and medical equipment. Each camp is scheduled in advance and publicized through advertisements in local newspapers. Specially designed banners and hand bills promote them as Parivar Swasthya Seva Divas - family health day. In rural areas, word is spread by playing attractive jingles on audio cassettes carried around in hired rickshaws or vehicles. Since most of these camps are in remote rural areas, the availability of a team of surgeons, anaesthetist and female gynaecologist has to be ensured from the district level. Enhanced budget for maintenance and POL for vehicles is provided so that an adequate number of vehicles can be deployed to transport doctors to RCH camp sites and sterilization clients to their homes. SIFPSA has also provided funds for purchase of bleach, antiseptics, gloves, medicines and laparoscopes for use in these camps. Deputy CMOs monitor these camps as per a standard proforma.
This integrated approach of providing maternal, child health and family planning services is found to be more cost effective and also convenient for clients. SIFPSA has funded 13,000 of these camps over a 2 year period from May 1998 and 7,000 have been organized up to September 1999. On an average, 50 clients attend each camp and more than half of these access integrated MCH services. In many districts, more than 33 percent of sterilization procedures have been performed in such camps which indicates their success and popularity. Assured availability of services at these camps along with orientation of Pradhans to these services is also helping raise community awareness about reproductive health and mobilizing institutional support for them.

The very low coverage of pregnant women with tetanus toxoid immunization is one of the main causes of high infant mortality in Uttar Pradesh. Through advocacy SIFPSA motivated the UP Health and Family Welfare Department to organize the first-ever TT campaign in 2 phases in May and June 1999 covering all pregnant women throughout the state. It also provided technical assistance in the design and planning of the campaign which also made IFA tablets and ORS packets available to women visiting immunization points in villages. Survey formats to identify the target group, guidelines and instruments for functionaries at all levels were prepared by SIFPSA. Messages for the “tetanus hatao” (eliminate tetanus) campaign were developed and art work prepared for banners, leaflets, newspaper insertions, radio jingles and audio messages. SIFPSA also funded any gaps in budget availability related to IEC activities.

A quantitative evaluation was also conducted by an external agency, PRC Lucknow, which showed encouraging results. Pregnant women who had a single TT shot increased from 30.5 percent to 59.3 percent as a result of the campaign while those who had received two doses increased more than two and half times from 12.9 to 33 percent.
The planning process for reproductive and child health programme has remained highly centralized. But, effective and efficient implementation of programmes aimed at behavioural change require decentralized plans that take into consideration local resources available and client needs. SIFPSA recognizing the need for decentralizing RCH activity to the district level, facilitated the formulation of district action plans (DAPs) in 6 districts. This pioneering effort was the first of its kind in Uttar Pradesh and perhaps in all of India. Baseline surveys were conducted, information on key indicators was disseminated to all stakeholders in both public and private sectors, workshops were conducted to identify district specific issues and a census of facilities was done to identify gaps. Districts set their own objectives and evolved strategies through a decentralized management system to achieve the objectives. The Governing Body of SIFSPA approved the district action plans in March 1998.

In each district, the local District Innovations in Family Planning Services Project Agency (DIFPSA) was registered as a Society with representatives from private and public sectors. SIFPSA established Project Management Units at the district level to
solve problems at the time of implementation, to disseminate information, and to act as a link between public and private sectors. The district action plans include five clearly identified strategies: creating a conducive environment; generating demand through IEC; improving access to integrated services; improving quality of services; and involving the non-governmental sector. The planning teams identified specific activities for each strategy and prepared a time frame for implementation of each activity.

In 6 DAP districts, nearly 800 religious leaders attended the meetings on family planning; 4,500 pradhans attended training programmes; all workers in private and public sector were imparted interpersonal counseling skill training; 792 female health workers received IUCD insertion training; 1,128 integrated RCH camps were conducted and 28 innovative NGO and organized sector projects and 3 milk cooperative projects covering a population of 17.9 million were implemented.

At the end of one year implementation of district action plans, performance of all methods of family planning in both the private and public sectors improved considerably. The sterilization performance increased from 38,002 to 46,445; IUCDs from 210,589 to 217,488; oral pills from 78,401 to 86,346; and condoms from 189,546 to 215,654. Providing integrated services, improving the quality of those services, and increasing access to services have all contributed to the gains in performance in the DAP districts. This model has been found suitable for replication and SIFSPA encouraged by the results has taken a decision to extend the decentralized district action plan approach to 6 more districts.

Decentralized district action plans lead to better programme ownership and performance through a participatory approach
There is a large unmet need for spacing contraceptives in Uttar Pradesh. Also at the time of the baseline (PERFORM) survey in 1995, out of the 697,000 commercial outlets in Uttar Pradesh only 110,000 stocked condoms and oral pills. USAID over the past 10 years has funded several contraceptive social marketing projects in Uttar Pradesh. These projects have contributed to increased availability of condoms and oral pills.

Recognizing the need to further promote spacing method use in the state and the potential of contraceptive marketing in achieving this objective, SIFPSA entered into an agreement with Hindustan Latex Limited (HLL) in March 1997 to undertake a rural marketing project. The three year project covered 15 districts in the first phase and 28 districts in the second phase. Distribution strategy adopted by HLL included creation of distribution points in feeder towns and tehsils, direct van sales promotion, sales through CBD workers of PVO projects, sales through dairy cooperatives. HLL has appointed 97 stocklists to cover all 28 districts. Linkages have been established with 58 NGOs and milk cooperatives in 10 districts. SIFPSA has established an independent audit system to verify sales performance reported by HLL. Against the
sales target of 20 million pieces of condoms in the first two years of the project, 24.5 million condom pieces have actually been sold. Similarly the sales target for oral pills was 200,000 cycles and the actual sales have exceeded 320,000 cycles.

To give a further boost to marketing programme efforts, SIFPSA prepared a detailed marketing plan based on a series of studies conducted covering market movement, market segmentation and marketing strategies of fast moving consumer goods companies. These studies identified a huge potential that existed to market condoms in rural areas and oral pills in both rural areas and urban areas. PERFORM 1995 survey data shows that Uttar Pradesh had 354,000 intending users of condoms, 75 percent of which were in rural areas. Nearly 1.7 million were intending to use oral pills while only 400,000 were currently using. Reaching the intending users in remote rural areas is a challenging task. A large proportion of intending users prefer to buy either subsidized or fully priced products from the private sector. The potential private sector market for oral pills is 13 million cycles and for condoms, 13.6 million pieces.

To harness this vast potential, SIFPSA has invited competitive bids from commercial firms with marketing strengths to promote oral pill and condom sales in rural areas of UP. A technical advisory group has been set up to review these bids and SIFPSA will soon enter into agreements with successful bidders.
To generate demand for reproductive health services, SIFPSA has launched a major multimedia IEC campaign in UP. The campaign titled, “Aao, Batein Karein” (Come, Let’s talk), is illustrated by the Tota and Mynah birds derived from folklore, which are recognized in UP as secular symbols associated with story telling. The campaign is intended to stimulate a dialogue on family planning between young couples, between providers and clients, and is being used to raise awareness and knowledge of family planning methods and allay myths and misconceptions. The campaign theme and the logo have been chosen based on research findings that lack of discussion about family planning is the main reason for fears and myths associated with various methods of contraception.

The campaign has a comprehensive interpersonal counseling (IPC) package targeted at 15 selected districts of UP in which SIFPSA works presently. Over 9,000 grassroots level workers, public sector ANMs, and community based workers of NGOs and dairy cooperatives, have been oriented to the campaign theme and trained in the use of a variety of campaign IPC material. The training was conducted in 252 workshops using lectures, exercises and a 25 minute training video film specially developed for

SIFPSA has been undertaking a variety of IEC activities to provide support to NGOs, and to promote providers and services like RCH camps and the TT campaign. It has also funded setting up of a Media & Material Resource Centre (MMRC) as part of the IEC Bureau in Lucknow to develop, procure, produce and act as a clearing house for video, audio and print material related to reproductive health. The centre gets material from various sources and distributes it to SIFPSA partners.
this purpose. In addition, an entertaining and interactive mela (local fair) approach was used in blocks with more than 100 workers.

At the end of the training workshop or mela, participants received IPC materials which include a flip book, poster, sticker, badge, a bag with the campaign logo (for field workers); a mailer-cum-wall chart and desk calendar displaying methods of family planning (for ISM Practitioners); and attractive take-away calendars for distribution to clients. This training has improved the counseling skills of service providers in both public and private sectors and IPC materials have facilitated interaction with community members and clients.

Folk performances are a popular form of entertainment in rural areas. UP has a rich tradition of Nautanki (folk theater), Qawali (devotional songs in Urdu), Allah-Birah (traditional ballad singers) and puppetry. 35 professional folk troupes of these 4 forms have been trained to incorporate a family planning message into their performances. More than 600 performances have been conducted in 12 districts and the response of the community has been overwhelming. 2,000 more are planned in as many villages in 1999-2000. These performances are also being used to promote the local community health worker and the services being offered by her.

Mass media is an efficient way to reach young couples in the age group of 17-25 years which SIFPSA is targeting. Radio and TV have a large reach in both rural areas and urban slums. The multimedia campaign, which will be on from the second half of 1999-2000, will cover the whole state of UP and have the following components:

- Radio spots on campaign theme and family planning method specific on UP channel and 8 primary channels of All India Radio
- TV spots on the campaign theme and also method specific over Lucknow and Delhi Doordarshan
- Press advertisements in both Hindi and English newspapers, primarily for advocacy

Bill-boards, wall paintings and bus posters would be used to serve as a reminder medium.

Folk performances have effectively carried family planning and RCH messages to rural population
IFPS Project has well defined pathways to achieve the strategic objective of reduced fertility and improved reproductive health. Intermediate results, required on annual basis to achieve the strategic objective, have been worked out in December 1997. The first household survey was conducted in January 1999 to measure the project performance on key reproductive and child health indicators. The survey covered 5,000 households and 6,326 currently married women in reproductive age 15-49 and the results were compared with the baseline survey conducted in 1995. It was found by a survey that in 15 districts where SIFPSA had maximum interventions, the modern spacing method use had almost doubled. This clearly brought out that the project impact had begun to accelerate.

As per the intermediate results framework, the contraceptive prevalence rate expected for the year was 23 percent whereas the actual CPR achieved was 24.5 percent. Thus the project was found to be well on track and with the potential of achieving its ultimate objectives. Further, it was found that the method mix among family planning users had improved slightly in favour of oral pills and condoms.
On reproductive health indicators too, performance has been encouraging.

- Of the total pregnant women, the percentage availing ante-natal services increased from 45 percent to 48 percent.

- Number of women who availed ante-natal care from doctors and paramedical staff increased by 10 percentage points which is an indication of considerable improvement in quality of care.

- Institutional deliveries increased from 11 percent to 19 percent. Assistance at the time of delivery by health professionals and trained dais increased from 17 percent to 33 percent.

The survey results indicate that the IFPS project has achieved more than the expected outcomes in 1998 and the intervention strategies implemented in the past three years in both public and private sectors have begun to yield results.
The design of the IFPS Project envisages service delivery both through the public and private sectors. In addition, interventions are to be made for social marketing of contraceptives, IEC activities, as well as for research, evaluation, audit, capacity building and management activities.
SIFPSA has, therefore, worked through various partners in both the private and public sectors. Of the total expenditure incurred on funding projects, 52 percent has been spent on public sector, 32 percent on private sector, 12 percent on DAPs and 4 percent on IEC and contraceptive marketing.

**SIFPSA places equal emphasis on private and public sector activities**
• SIFPSA has, for the first time, actively involved the private sector - NGOs, milk cooperatives, employers and private practitioners - in family planning in UP. Models for providing family planning services through these networks have been developed, tested and replicated in a cost effective way. Today, SIFPSA supports about 160 private sector projects, which have about 10,000 community health workers providing reproductive health counseling and services at the door steps of homes in rural areas and urban slums in 15 districts of UP.

• Clients now have a choice of family planning services in the districts where SIFPSA works. Spacing methods have been brought on the agenda and their use has doubled in the last 4 years. SIFPSA supported NGOs have more than 600,000 continuing spacing clients.

• Incremental inputs have been provided to improve the quality of services provided by the public sector. Improving buildings, water supply and availability of electricity at district PPCs, CHCs, block PHCs and village
subcentres; provision of equipment and consumables; and training to upgrade skills of providers have made an impact.

- SIFPSA has kick-started the government sterilization programme after setbacks due to the introduction of the target-free approach and expanded services provided in camps by funding 13,000 integrated RCH camps in 29 districts of UP.

- Pioneered decentralization of RCH activities by delegating funding and management of the RCH programme to district societies in 6 districts covering a population of 17.8 million. Objectives and strategies have been decided by a participatory process and are being implemented locally, with technical support from SIFPSA.

- Involved Pradhans and religious leaders in community mobilization for RCH activities and, for the first time, established a link between them and the Health and Family Welfare Department.

- Promoted demand for family planning services by launching a state wide multimedia campaign involving improvement of counseling skills of 9,000 grassroots workers; funded 2,700 folk media performances in villages; radio and TV spots to allay fears and remove misconceptions about family planning methods.

- Built capacity for expanding activities to more districts by setting up apex training centres for training NGO volunteers, cooperative workers and Panchayat functionaries.

SIFPSA supports 160 private and 130 public sector projects in IFPS Project districts
Reaching replacement level fertility at the earliest, ultimately leading to population stabilization, is the foremost challenge before us in Uttar Pradesh today. To achieve this task, a multi-pronged approach has to be adopted and all possible resources need to be marshalled.

SIFPSA was registered in 1993 and though the IFPS project had a slow start, perhaps largely because of its complexity and the fact that it was trying to break new ground in many areas, the last few years have seen some substantial achievements. SIFPSA has now become one of the most important partners assisting the Government of Uttar Pradesh in achieving its health and demographic objectives. It is working towards this goal by developing innovative models for improving the quality and availability of reproductive and child health services.

From the very beginning we have stressed on the importance of forging partnerships. In the private sector we are working with private voluntary organizations, milk cooperatives, the employers sector besides tapping rural networks like Indigenous Systems of Medicine Practitioners and Traditional Birth Attendants. Rapid strides have also been made in partnership with the public sector wherein substantial quality improvements in services have been brought about by training public sector service providers as well as upgradation of infrastructure. In addition, a large programme for marketing commercial and subsidized brands of condoms and pills is on the anvil, and when implemented will fill an important gap in services. Our multi-media campaign on reproductive health is allaying misconceptions related to contraceptive methods.

Today, we have developed capacity and systems to fund and facilitate a variety of reproductive health interventions. During this period we have also won international acclaim, but a lot more needs to be done. We will continue to strive to scale new heights in the years to come.

I have great pleasure in sharing with you the objectives, activities and achievements of SIFPSA.

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